Revenue Cycle and Coding:
Painting Your Unique Picture and Reducing Denials

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AGENDA

On Conclusion of this In-Service you should be able to successfully:

- Understand the “state” of Coding
- Identify Trends and Patterns of Coding Quality
- Unspecified Code use and It’s Impacts
- Identify Trends and Findings of Clinical Documentation Opportunities
- Develop and Identify Best Practices and Action Plans
State of Coding
Revenue Cycle and Coding: Painting Your Unique Picture and Reducing Denials

Timeline, going back in time...

- 1979 ICD-9-CM Implemented in United States
- 1999 ICD-10 implemented in US for Mortality reporting
- 2008 HHS notice of proposed rule for ICD-10 adoption by 10/1/2011
- 2009 HHS published the Final rule for ICD-10 adoption by 10/1/2013
- January 1, 2010 Payers and providers to start beginning internal testing of Version 5010 standards for electronic claims
- December 31, 2010 Internal testing of Version 5010 should be complete for Level 1 5010 compliance
- January 1, 2011 External testing of Version 5010 for Level II Compliance
- January 1, 2012 All electronic claims must use version 5010 Version 4010 are no longer accepted.
- 2012 ICD-10 implementation deadline delayed by HHS to 10/01/2014 October 1, 2013 Claims for services provided on or after this date must use ICD-10-CM/PCS codes
- October 1, 2015- ICD-10-CM/PCS Go Live
Understanding the volume of differences

<table>
<thead>
<tr>
<th>Code Sets</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10,000</td>
<td>14,025</td>
<td></td>
</tr>
<tr>
<td>10,000-20,000</td>
<td></td>
<td>69,823</td>
</tr>
<tr>
<td>20,000-30,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30,000-40,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40,000-50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50,000-60,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60,000-70,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70,000-80,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80,000+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Understanding the volume of differences
Where are the changes specifically?

![Greater Specificity Chart]

- Musculoskeletal: 34,250
- Fractures: 17,045
- Fracture Codes that Distinguish LT/RT: 10,582
- ICD-10-CM that distinguish LT/RT: 25,000
Benefits to ICD-10

- Better reflection of current medical terminology
- Expanded detail
- Enhanced system flexibility
- Improved collection and tracking of new diseases and technologies
- Space to accommodate future expansion
Anatomy of an Unspecified Code in ICD-10-CM
Anatomy of a Unspecified Code in ICD-10

- What is a Unspecified ICD-10-CM Diagnosis Code?

M79.606

Pain in leg, unspecified

Pain in lower limb NOS
There are more Unspecified Codes with ICD-10-CM, then there were with ICD-9-CM

Wait, what?!
Anatomy of a Unspecified Code in ICD-10

- What does use of a Unspecified code tells the payer
- Quantifying the Volumes
- Why is this a HOT Topic?
Anatomy of a Unspecified Code in ICD-10

Reasons for Unspecified Code Use

- Documentation is insufficient.
- Documentation isn’t accessible at the time of reporting.
- The billing sheet has an overabundance of unspecified codes.
- Coders have “frequent use codes” committed to memory.
ICD-10 and the Freeze Impacts on Unspecified Codes
ICD-10 and the Freeze Impacts on Unspecified Codes

- What was “The Freeze” defined by CMS?
- Purpose of the freeze
- Timeline of the freeze
- Who it impacted and what was the benefits
ICD-10 and the Freeze Impacts on Unspecified Codes

What were the unintended drawbacks

- Poor workflows are successful today
- Bad habits are reinforced
- Many lost focus on ICD-10
ICD-10 and the Freeze Impacts on Unspecified Codes

Risk of Unspecified Codes

- Denied claims
- Increasing AR
- Physician productivity loss
- Coding productivity loss

Long Term Risk

- Flat or declining revenue
- Value Based Reimbursement
CMS and Source Guidance
Regarding Unspecified Code Use
Source Guidance Regarding Unspecified Code Use: CMS

“...While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis....”

Source Guidance Regarding Unspecified Code Use: CMS continued.....

“.....When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code...”

Source Guidance Regarding Unspecified Code Use: Coding Guidelines

“Unspecified” codes: Codes titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the “other specified” code may represent both other and unspecified.

Coders Perspective of Unspecified Code Use
 Coders Perspective of Unspecified Code Use

- Inpatient Coders

- Considerations

- Unspecified codes as secondary or supplemental codes
Coders Perspective of Unspecified Code Use

- Outpatient Coders
- When to query and when not to
- Unspecified codes as secondary or supplemental codes
Payers Perspective of Unspecified Code Use

ICD-10-CM L89109 = ?
Payers Perspective of Unspecified Code Use: Georgia Medicaid

Question:
If a provider bills multiple procedures with both specified and unspecified diagnoses on the same line on a 1500 professional claim form, will the claim deny?

A: Yes, all professional claims submitted with ICD-10 unspecified diagnosis codes (as listed and posted on the GAMMIS web portal, which is updated periodically) will deny regardless of the diagnosis code position, Dx Rel 1, Dx Rel 2, Dx Rel 3, etc. When billing ICD-10 diagnosis codes, the code should support the level of specificity and laterality being billed based on the physician’s medical evaluation and treatment plan.
Payers Perspective
of Unspecified Code Use: *Georgia Medicaid continued*....

The physician is required to bill at the highest specificity or diagnosis code level by selecting the most appropriate specified code. The physician’s documentation must support and justify the level of ICD-10 diagnosis code being billed.

If the claim consists of multiple diagnosis codes on the first line (diagnosis pointers include all diagnoses) with the procedure code and one of the ICD-10 diagnosis codes is unspecified then *the entire professional claim will deny* in GAMMIS.

*Source: https://dch.georgia.gov/sites/dch.georgia.gov/files/ICD-10%20FAQ%20REVISED%20and%20FINAL%2020151109%20FOR%20POSTING.pdf*
Payers Perspective of Unspecified Code Use: Georgia Medicaid continued....

- **NOS versus NEC**
- **There is a no fly list!**

Source: https://dch.georgia.gov/sites/dch.georgia.gov/files/ICD-10%20FAQ%20REVISED%20and%20FINAL%2020151109%20FOR%20POSTING.pdf
Identifying Unspecified Code Usage Now:
Taking Action
Identifying Unspecified Code Usage Now: Taking Action

- This is what we know
- This is what impacts are starting to arise
- What we can expect
- Where we can expect it
Revenue Cycle and Coding: Painting Your Unique Picture and Reducing Denials

Step 1
Know your Unspecified Code Use Rate!
Identifying Unspecified Code Usage Now: Taking Action

<table>
<thead>
<tr>
<th>Rate of Unspecified Code Use</th>
<th>Potential Denials per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>?</td>
</tr>
<tr>
<td>10%</td>
<td>?</td>
</tr>
<tr>
<td>20%</td>
<td>?</td>
</tr>
<tr>
<td>30%</td>
<td>?</td>
</tr>
</tbody>
</table>
Step 2
Identify Gaps
Identifying Unspecified Code Usage Now: Taking Action

Are your tools and helping or hindering you?

- Benefits of EHR use and Templates
- Encounter forms
- If so, what next
Identifying Unspecified Code Usage Now: Taking Action

Educate your Providers

- Assess
- Educate
- Monitor
Identifying Unspecified Code Usage Now:

Taking Action

Coding Quality Gaps

- Rule out the obvious (Coder Error)
- Compliancy Coding Audits to validate code Selection (internal/external audits)
- Credentialed coders are necessary
- Out with the old habits
“Does the documentation and code selection reflect as accurately and precisely as possible the patient’s condition or the services performed?”
Step 3
Registration is the Gate Keeper
Identifying Unspecified Code Usage Now:

**Taking Action**

- Proactive on the front end (referring clinics)
- Involve coding if needed
- Look to MN tools
Step 4

Monitoring Denials
Identifying Unspecified Code Usage Now:

- **Tracking**
- **Compiling**
- **Sharing**
- **Monitoring for improvement as a KPI**

**Revenue Cycle and Coding: Painting Your Unique Picture and Reducing Denials**
Step 5

HIM and Coding Considerations
Query Policy and Procedures

- Do you have any Query P&P’s
- What do they currently state
- Are they specific to OP and IP processes
- Do they state when to query and when not to
- Do they drop the account at a certain time frame
- Considerations to include (payer guidance)
- Have the coders been educated to this, and do they have access to these policy and procedures
Breaking the Cycle of denials!

Revenue Cycle and Coding: Painting Your Unique Picture and Reducing Denials
Compliance Check List

- Internal Audits
- External Ongoing Compliance Audits
- Clinical Documentation Improvement
  - Focus on important areas
- Identify tools and Resources to improve coding
- Consider “Specializing” Coders IP vs. OP
- Monitor Query Rates
- Identify top Unspecified Code use Codes
Audits and Monitoring
Take the Test to determine your risk

- Do you have regular scheduled internal audits performed on your coders?
- Do you have regular scheduled external audits performed on your coders?
- Have you had ICD-10 Specific audits post Go Live to measure coder proficiencies?
- Does administration see these coder audit reports?
- Do you complete CAPS (Coding Action Plans as part of the corrective action)
Nationwide ICD-10 testing challenges
the “all is fine theory”

Coder Credentials

- Published results from Central Learning “contest”
- 550 coders tested
- 59% AHIMA Certified
- 28% AAPC Certified
- 13 % did not specify credentials
Nationwide ICD-10 testing challenges
the “all is fine theory”

*Experience Level of Participants*

- Inpatient Coders experience - 13 years
- Same Day Surgical Coders - 9 years
- Emergency Room Coders - 8 years
Nationwide ICD-10 testing challenges
the “all is fine theory”
Nationwide ICD-10 testing challenges
the “all is fine theory”

The results........

- Coders accuracy and proficiency in ICD-10 is much lower than thought
- Sub-par findings with DRG Accuracy, significantly impacting revenue
- Concerns with ED coders and External Code reporting
- Average inpatient coder accuracy: 55 percent
- Average ambulatory surgery coder accuracy: 46 percent
- Average emergency department coder accuracy: 33 percent
2017 New Data Shows.....

<table>
<thead>
<tr>
<th>Case Type</th>
<th>2016 Average Coding Accuracy</th>
<th>2017 Average Coding Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Inpatient</td>
<td>55 percent</td>
<td>61 percent</td>
</tr>
<tr>
<td>Inpatient (same five cases in 2016 and 2017)</td>
<td>60 percent</td>
<td>64 percent</td>
</tr>
<tr>
<td>Inpatient (five new cases in 2017)</td>
<td>NA</td>
<td>57 percent</td>
</tr>
<tr>
<td>Ambulatory Surgery</td>
<td>46 percent</td>
<td>45 percent</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>33 percent</td>
<td>36 percent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRG Accuracy 2016</th>
<th>DRG Accuracy 2017 (same 5 cases as 2016)</th>
<th>DRG Accuracy 2017 (5 new cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>72 percent</td>
<td>71 percent</td>
<td>73 percent</td>
</tr>
</tbody>
</table>

Audits should be front and center to identify risk

Internal audits
- Identify your own risk

External audits
- Understand and manage external audits
- Government and commercial rules
- How do your coders stack up?
Types of Audits

• Baseline Audits
• Ongoing Audits
• Internal Audits
• Benefits of External Audits
• Remedial Audits
Areas to Consider looking at

- DRG’s
- APR DRGs versus MS DRGs
- Diagnosis
- PCS Coding
- CPT Coding
- E/M Coding
- Modifier use
- E/M’s
Hot Topics: The Revolving door

Become Familiar with the “Hot Topics”

- Annual work plan for the Department of Health and Human Services (HHS)
- Office of Inspector General (OIG) work plan or focus areas
- Fiscal Intermediaries provider bulletins
- Targeted audits for risk assessment such as certain DRG’s
Taking a look at the data

- PEPPER Reports
- Monitor Denials
- Monitor Internal items such as Bell Curves
- Evaluate current performance, comparing to peers
Coding/Corrective Action Plans (CAP)

- What is a Coding Action Plan
- Items CAP typically covers
- Focus on Remediation
- Follow up is key
- Goals and Outcomes Measurement
Take the Test to determine your risk

- Do you offer mandatory education to your coders currently?
- Are your coders credentialed?
- Do you validate your coders recertification and mandated CEU’s?
- Do you have coders who code multiple specialties (i.e. inpatient/outpatient)?
- Do you have access to and review the most current education, such as Coding Clinics quarterly, CPT assistants?
Learning Outcomes

- Understand the “state” of Coding
- Identify Trends and Patterns of Coding Quality
- Unspecified Code use and It’s Impacts
- Identify Trends and Findings of Clinical Documentation Opportunities
- Develop and Identify Best Practices and Action Plans
References

• ICD-10-CM/PCS 2018

• CPT 2018, AMA 2018

• AHA Coding Clinics

• AMA CPT Assistants
THANK YOU FOR YOUR TIME

We welcome all questions
jcuster@hccscoding.com