Revenue Cycle and Coding: Painting Your Unique Picture and Reducing Denials
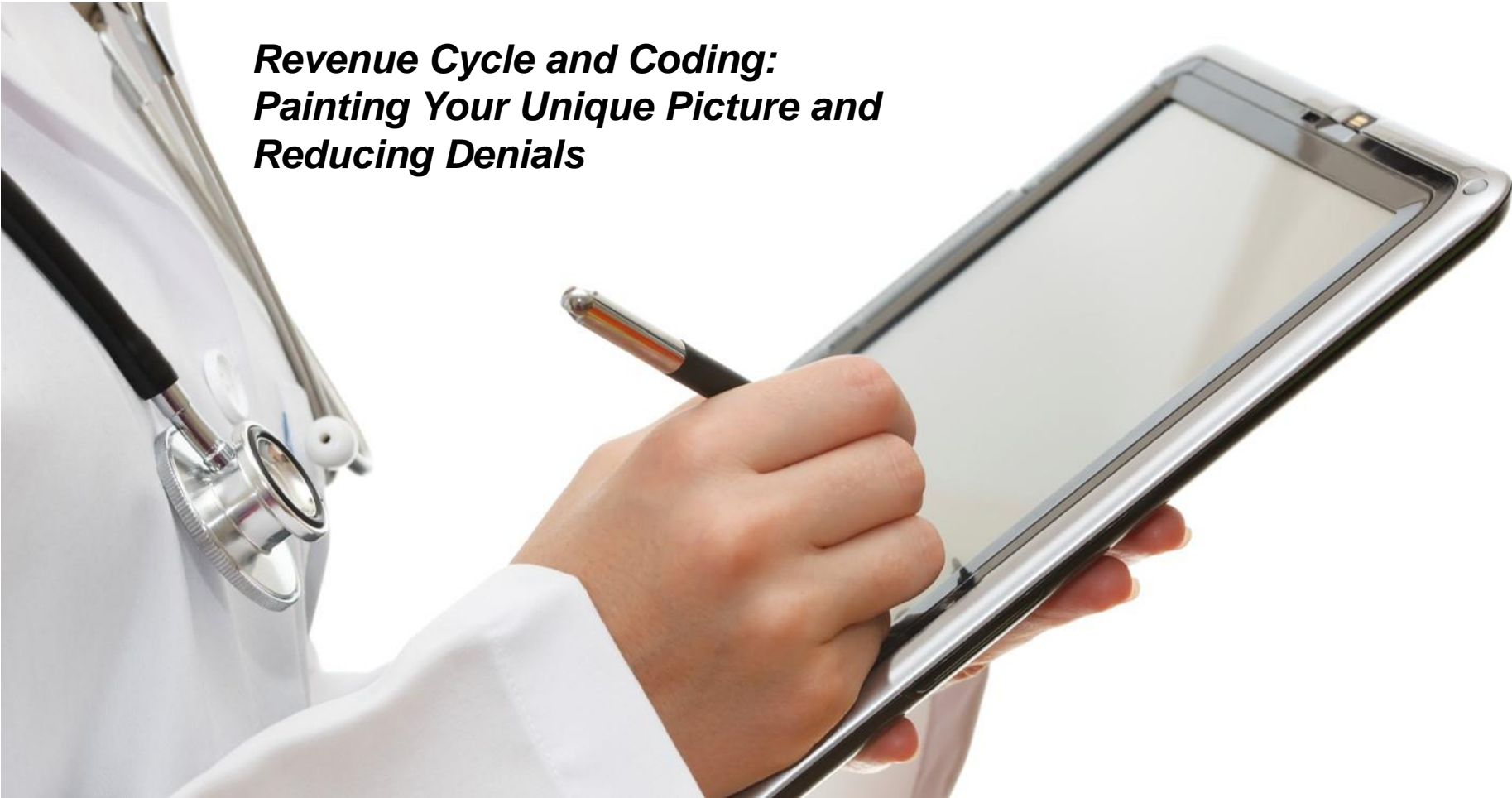
JENAN CUSTER RHIT, CCS, CPC, CDIP
AHIMA Approved ICD-10-CM/PCS Trainer
Director of Coding
Healthcare Coding and Consulting
Services (HCCS)

HCCS
HIM SERVICES

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
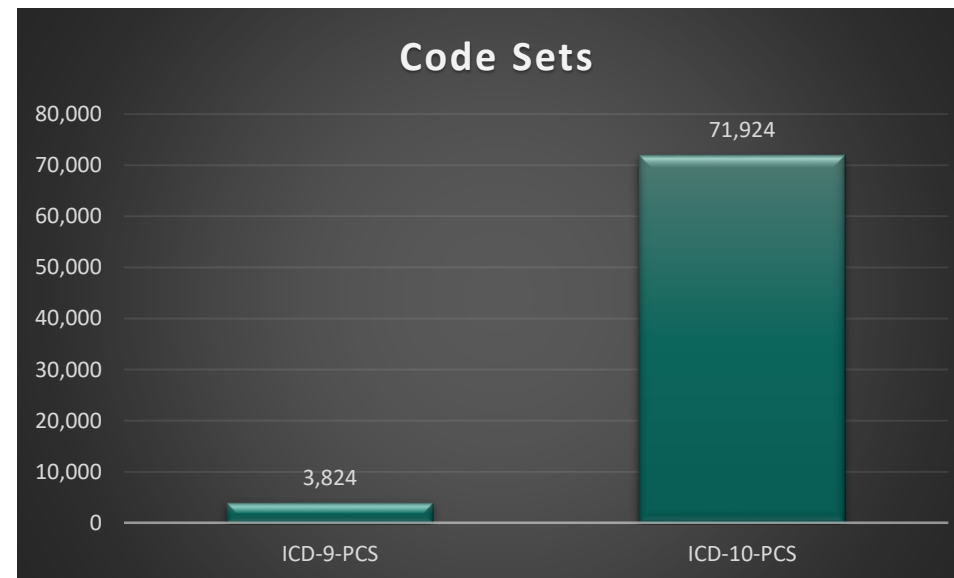
- October 1, 2015- ICD-10-CM/PCS Go Live
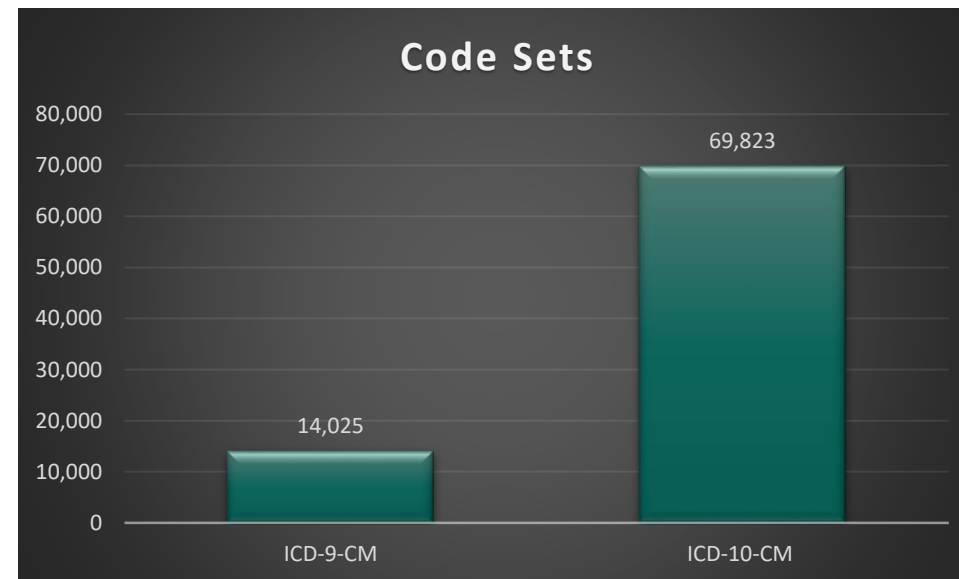
Understanding the volume of differences

Understanding the volume of differences

Code Sets

Code Set	Number of Codes
ICD-9-PCS	3,824
ICD-10-PCS	71,924

Where are the changes specifically?
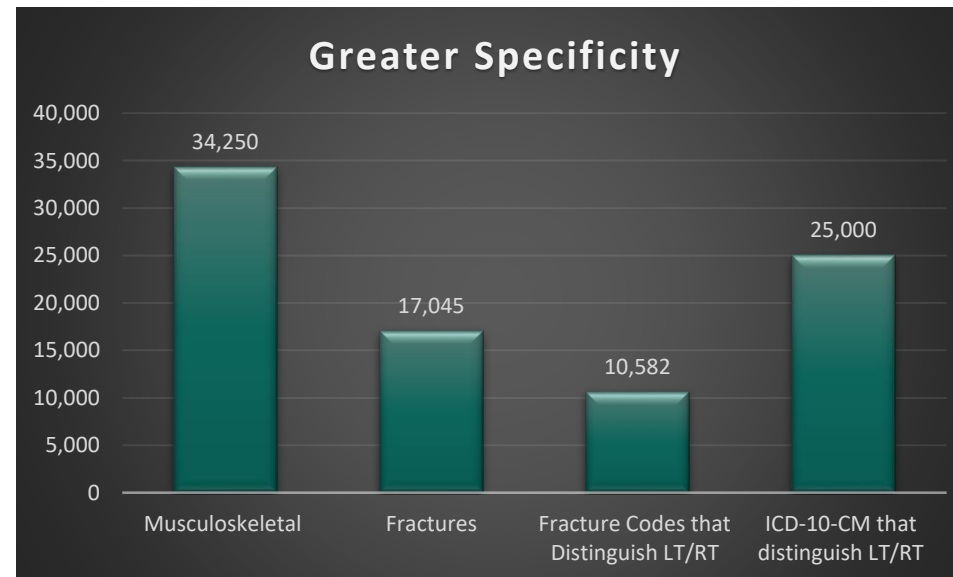
Greater Specificity

- 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

DID YOU KNOW?
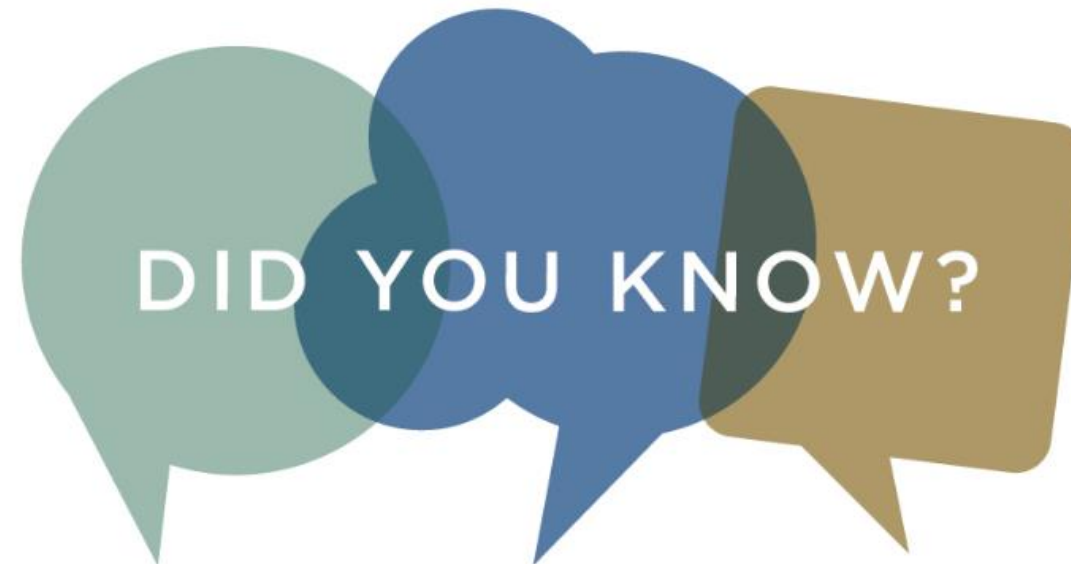
There are <u>more</u> Unspecified Codes with ICD-10-CM, then there were with ICD-9-CM

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: https://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10Overview.pdf

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: https://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10Overview.pdf

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.

Source: https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf

Coders Perspective of Unspecified Code Use

Coders Perspective
of Unspecified Code Use

- <u>Inpatient</u> Coders

- Considerations

- Unspecified codes as secondary or supplemental codes

Coders Perspective
of Unspecified Code Use

- <u>Outpatient</u> 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

= ?

25

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 is what impacts are starting to arise

- What we can expect

- Where we can expect it

Step 1
Know your
Unspecified Code
Use Rate!

Identifying Unspecified Code Usage Now:
Taking Action

Rate of Unspecified Code Use	Potential Denials per Day
5%	?
10%	?
20%	?
30%	?

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)

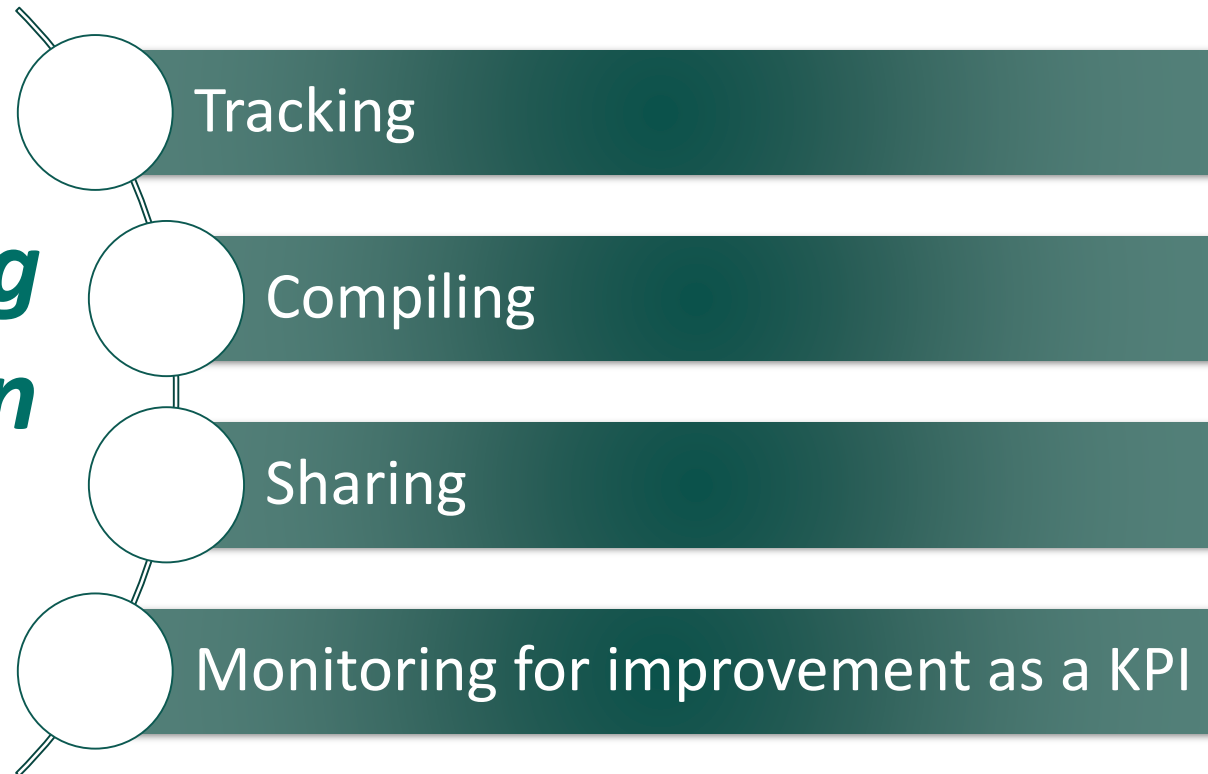✓ Involve coding if needed

✓ Look to MN tools
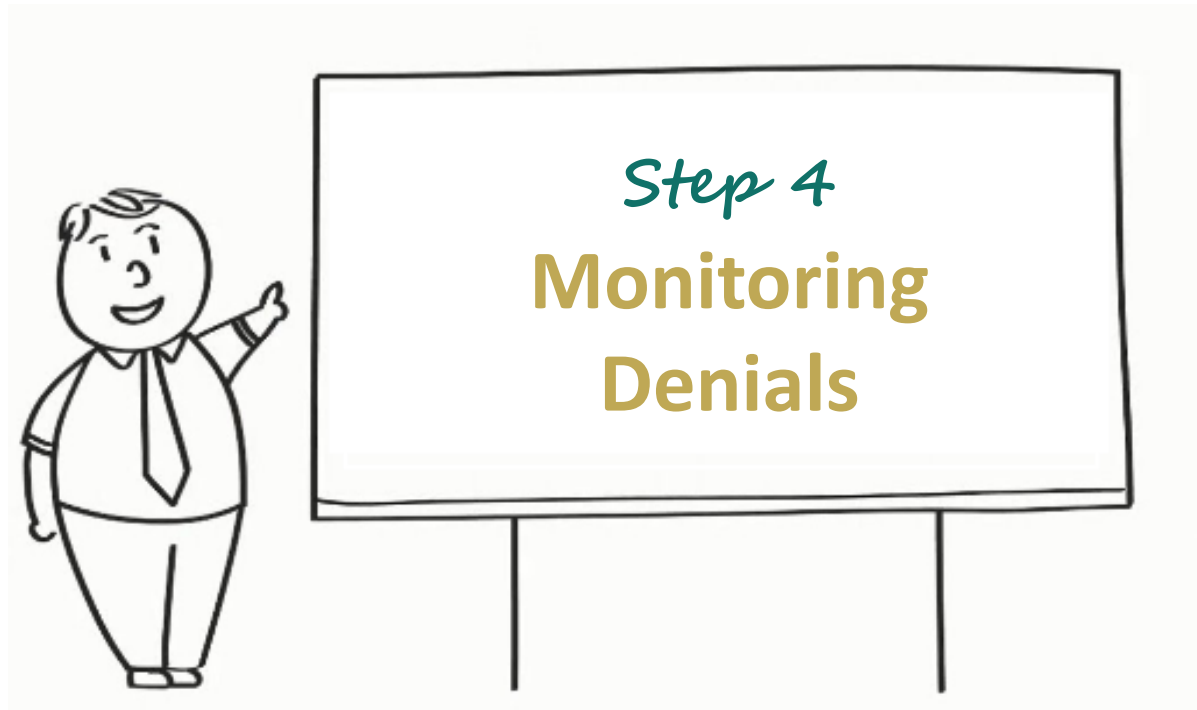
Step 4
Monitoring Denials

Identifying Unspecified Code Usage Now:

Taking Action

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

Step 5
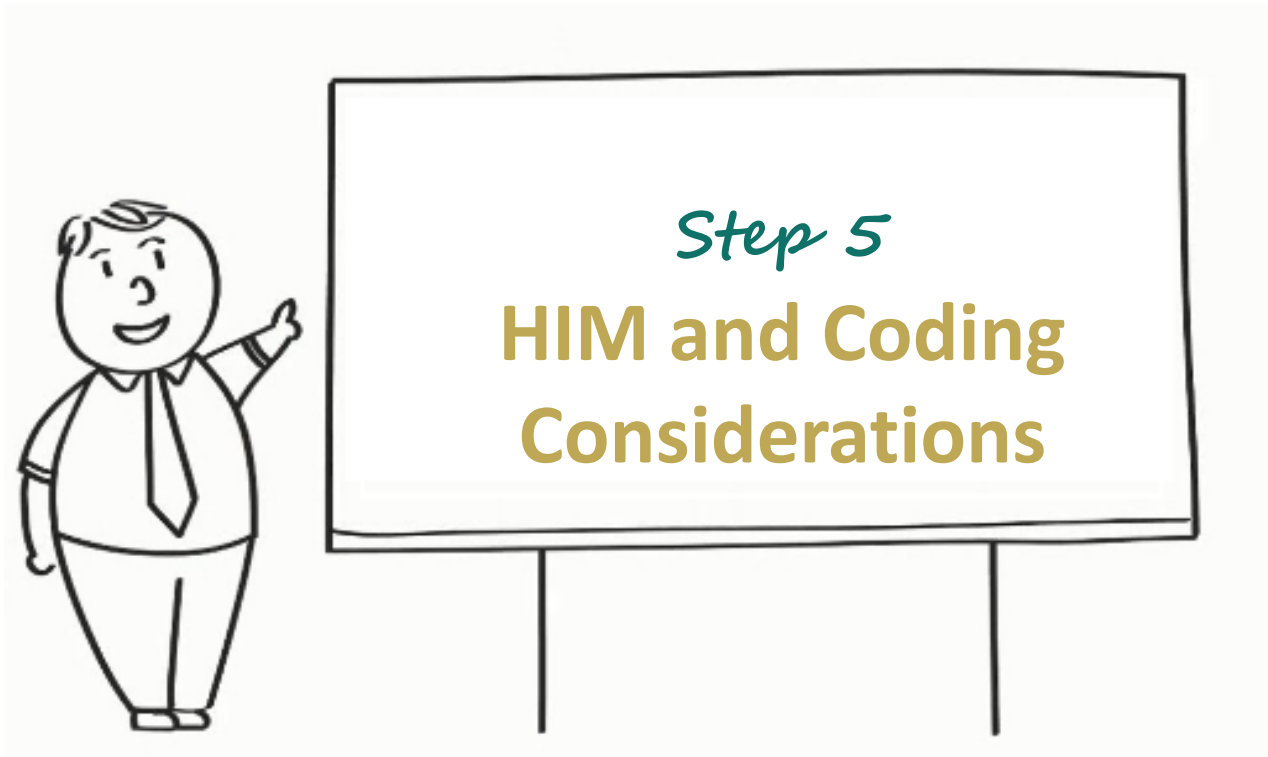
HIM and Coding Considerations

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

- Due 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!
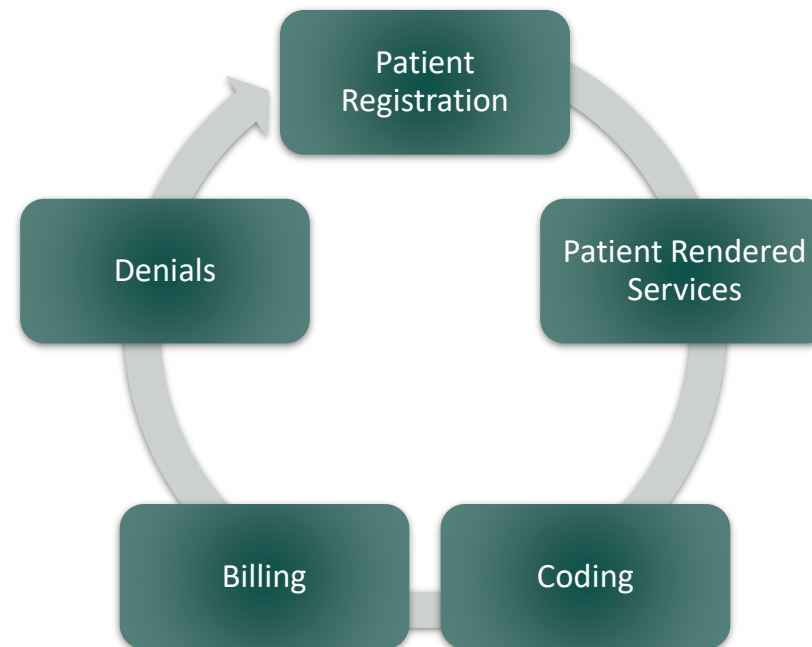
Compliance Check List

❑ 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

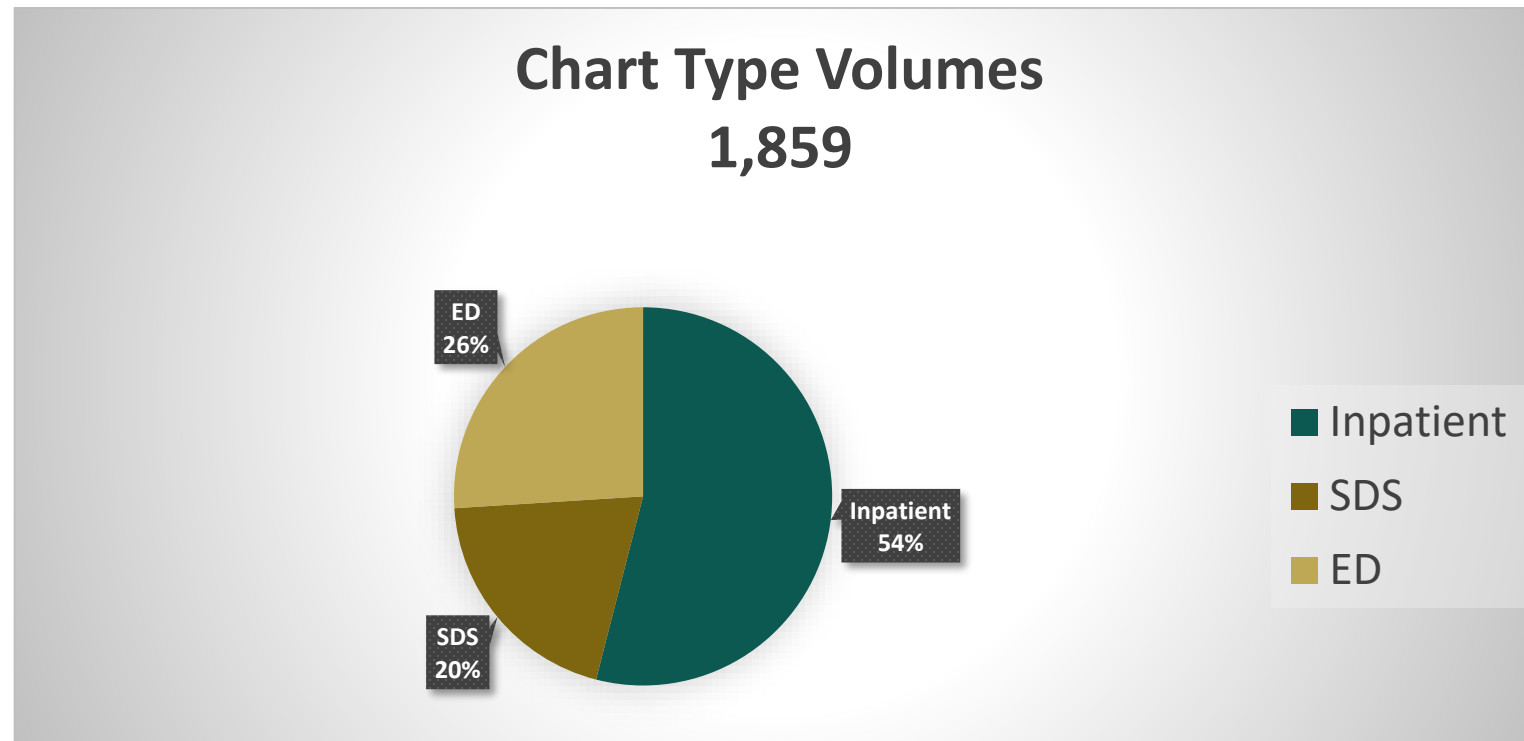**Nationwide ICD-10 testing challenges**

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"

Chart Type Volumes
1,859

Legend:
- Inpatient
- SDS
- ED

Pie chart labels:
- ED 26%
- Inpatient 54%
- SDS 20%

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.....

Case Type	2016 Average Coding Accuracy	2017 Average Coding Accuracy
Overall Inpatient	55 percent	61 percent
Inpatient (same five cases in 2016 and 2017)	60 percent	64 percent
Inpatient (five new cases in 2017)	NA	57 percent
Ambulatory Surgery	46 percent	45 percent
Emergency Department	33 percent	36 percent

DRG Accuracy 2016	DRG Accuracy 2017 (same 5 cases as 2016	DRG Accuracy 2017 (5 new cases)
72 percent	71 percent	73 percent

Source: http://journal.ahima.org/2017/10/06/2nd-annual-icd-10-coding-contest-results-sponsored/

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

Compliant Coding, Auditing and the Evolving Complexities

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

Value

Quality

THANK YOU
FOR YOUR TIME

We welcome all questions

jcuster@hccscoding.com