# EXECUTIVE OVERVIEW

In September 2016, a national coding contest was conducted to measure real world ICD-10-CM and ICD-10-PCS coding accuracy and productivity. To date, the contest reflects the most extensive quantitative assessment of coding quality in ICD-10.

Despite many healthcare executives' belief that all is well with ICD-10 coding, the published results painted a much different picture. Coding accuracy was well below the 95 percent industry benchmark for all record types: inpatient, ambulatory and emergency department coding.

This finding raises important red flags for healthcare revenue cycle and health information management (HIM) executives. It reminds us that accuracy cannot be compromised for higher coder productivity, and that serious concerns with ICD-10 coding quality remain. The pursuit of lower discharged-not-final-coded (DNFC) days should never outweigh the importance of coding accuracy or completeness. In fact, the contest revealed a converse relationship between coding productivity and accuracy.

**"Focusing primarily on coding productivity is counter productive. If healthcare organizations expect to thrive in today's environment, they must first concentrate on coding quality."**

~ Julie Boomershine, RHIA, CCS, CTR, AHIMA-Approved ICD-10 Trainer, HRS Manager of Coding Operations

Coders with high productivity levels scored much lower in ICD-10 coding precision, resulting in diminished DRG accuracy rates, higher potential for payer audits and significant risk of revenue loss for inpatient cases. These findings highlight our premise as stated by Julie Boomershine, RHIA, CCS, CTR, AHIMA-Approved ICD-10 Trainer, Manager of Coding Operations, HRS, "Focusing primarily on coding productivity is counterproductive. If healthcare organizations expect to thrive in today's environment, they must first concentrate on coding quality."

This white paper explores the key components of establishing a solid quality coding program to improve reimbursement and reduce operational costs for healthcare provider organizations.

# 4 Attributes of a Quality Coder

Quality coding goes beyond assigning a code to a chart. It involves multiple coding skills that are often overlooked by executives who are focused solely on coding productivity. The following four components are essential for building an exceptional coding team.

## 01 PROFICIENCY WITH CODING WORKFLOW

High-quality coders understand the facility-specific nuances of their organization, including technology, workflows and guidelines. These coders master the use of electronic health record systems, know how coding queues are designed and prioritized, and grasp the importance of following specific processes for completion of daily coding responsibilities. As a result, they can quickly assimilate the organization's coding and reimbursement guidelines without having to verify and validate details throughout the day.

## 02 ABILITY TO INITIATE APPROPRIATE PHYSICIAN DOCUMENTATION QUERIES

Exceptional coders know when physician documentation is sufficient to assign a precise code versus when a physician query is necessary to ascertain diagnosis, procedure or present on admission information. Coders should be well versed in the organization's physician documentation query procedure, including ensuring that queries are not leading and contain sufficient information to obtain the required documentation. Additionally, coders must be cognizant of the time typically required to submit and process a query. As coders learn physician-specific documentation patterns, fewer queries will need to be initiated, but it's important to remember that documentation improvement is a continuous process.

## 03 EXPERTISE WITH CODING AND PAYER GUIDELINES

Professional coders maintain a strong working knowledge of coding guidelines while remaining abreast of new coding changes. This encompasses familiarity with payer denial specifics for the organization and facility—as these vary by region, geography and payer mix. Having an understanding of these distinctions during the coding process saves time later in avoiding reimbursement delays and denials.

## 04 VERSATILITY IN COMPETENCIES

Quality coding requires knowledge and skills across various service lines along with ability to adapt to changing priorities. For example, an outpatient coder assigned to cover multiple modalities such as MRI, nuclear medicine and CT, should be able to shift seamlessly from one specialty to another throughout the day to support specific organizational needs.

Knowledge beyond coding is important since coders are often asked to perform multiple tasks. For example, strong organizational skills support the ability to coordinate and prioritize work required to achieve daily goals. Finally, effective communication is paramount as coders must convey succinct and timely information regarding status of coding and any challenges or obstacles impacting coding.

Many hospitals are experiencing an increase in coding denials with financial impact estimates for an average-size hospital of $1 to $3 million annually. With denials on the rise, quality coding plays an even more important role in protecting revenue and reducing operational costs.

## Set Quality Coding Expectations

Building a quality coding team takes time. Even seasoned coders need sufficient time to master an organization's coding nuances. As a general rule, minimum time requirements fall into three categories:

- Professional fee coders— two to three months depending on type of specialty and prior coding experience.
- Experienced inpatient coders—one to three months, potentially longer for complicated case mix cases
- Contract/outsourced coding partner—one to three months, potentially longer for complicated case mix cases

All coders will need time to master multiple components—workflow, facility-specific guidelines, computer systems and more. Furthermore, timelines shift when onboarding a newly trained or newly certified coder. A recent graduate may need up to one year to adapt to various aspects of an organization's coding process before hitting their stride in both productivity and accuracy.

# Mitigate Coding Denials Through Quality Processes:

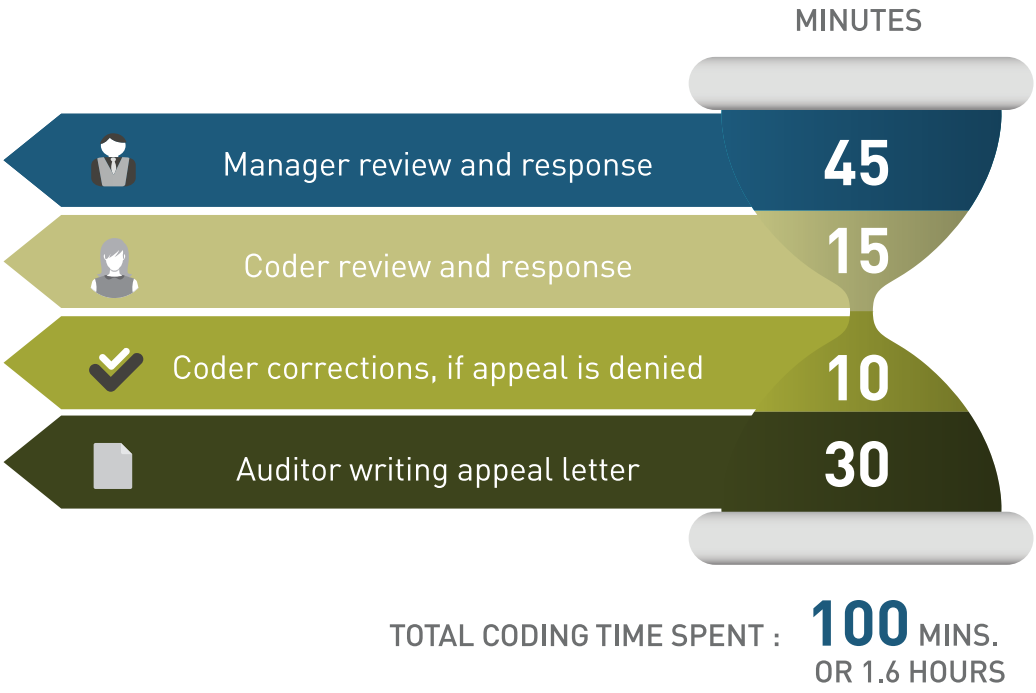
## Consistency, Collaboration and Education

A major goal of a successful quality coding program is to minimize denials and recoupments. Every denial attributed to incorrect coding expends a significant amount of staff time to research and defend or rectify. As a result, reimbursement is delayed and operational costs climb.

In our experience, a single inpatient DRG denial review requires an average of 1.6 hours to research and resubmit to patient accounts or the payer. More complex cases may require even longer to investigate and provide the necessary feedback.

**Average Coding Time to Research and Defend or Rectify a Denial—Single Inpatient Case**

DRG DENIAL REVIEW PROCESS




TOTAL CODING TIME SPENT : **100** MINS. OR 1.6 HOURS

These estimates are in addition to the initial thirty (30) minutes average time spent by the coder to code the case. Finally, patient accounting time to resubmit corrections or continue working the case if the appeal is denied may increase the time spent, ranging from additional minutes to hours.

## Denial Analysis Reveals Post-Op Revenue Opportunity

One facility observed repeated coding denials for patients with post-operative acute respiratory failure. Upon closer scrutiny, the coding and denials team determined patients were not actually experiencing a post-operative complication. Instead, it was a normal, expected outcome for patients with underlying COPD who needed to remain on the ventilator for an extended period of time post-surgery.

Documentation training for physicians and coding education for the coders was conducted. Ongoing denials for this patient type were successfully eliminated using this process.

**"Where a solid coder training process exists, compliance and audit anxiety are greatly diminished. Remain loyal to your quality program even during times of backlogs and delayed DNFC."**

~ Marilyn Holley, RHIT, CPC, CPC-I, HRS Supervisor of Pro-Fee Coding

## Mitigate Coding Denials Through Quality Processes (continued):

Three core strategies to reduce coding denials in ICD-10 have emerged:


### 1 Consistency Builds Quality Coding Practices and Procedures

Whether onboarding new coders or consolidating coding departments across an organization, consistent coding policies, procedures and practices form the foundation for coding quality. Consistent coding guidelines must be established, followed and communicated to all staff. This includes compliance with published correct coding guidelines and knowledge of facility-specific practices.

**Common facility-specific coding decisions to confirm during onboarding include:**

1. Will coders apply a limited or maximum number of diagnoses codes to each account?
2. Are coders required to apply all external cause codes or can they forego using these codes?
3. Will coders apply procedure codes for non-surgical procedures such as hemodialysis, chemotherapy, radiation, and insertion of Foley catheters? Or are these codes built into the organization's charge description master?

## Mitigate Coding Denials Through Quality Processes (continued):

### 2 Collaboration Supports Effective Denial Management and Prevention

Engage denial management teams to review all denials due to miscoded records. At a minimum, include representatives from revenue cycle, coding, Recovery Audit Contractor, case management, utilization management and clinical documentation improvement (CDI). The team should create a consistent process to research and monitor every coding denial.

**Here are five important steps to take:**

1. Review and research the original coding on the case. Revisit the case to see if coding was incorrect or if there is another applicable issue such as medical necessity. The case can be reviewed by an auditor, a manager and/or another coder.
2. Conduct a team brainstorming session to determine if the organization can still be reimbursed for the condition or procedure with support from the clinical documentation.
3. Communicate with payers regarding the denial. If you believe the case was coded correctly, write an appeal letter.
4. Manage the appeal process and communicate with the payer throughout the next level of review. If timelines are in jeopardy, reach out to the payer to request an extension.
5. Track time spent on addressing coding denials to calculate the estimated organizational cost of addressing each case. Share results with executive leadership.

Finally, preventing denials up-front is always more cost effective than researching and responding to them retrospectively.

**Here are seven tactics to proactively mitigate coding denials:**

1. Review reports to identify past denial patterns
2. Track denials by payer and cross-reference by denial type
3. Document specific coding denial trends
4. Make recommendations for corrective action on how to mitigate coding issues
5. Analyze data following corrective action to identify any recurring patterns
6. Communicate results back to coders to keep them apprised of coding issues.
7. Build or maintain payer specific edits within claim scrubbing software to alert coders to possible payment issues early in the coding process.

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# Achieving a Strong Bottom Line: Healthcare Leaders Need to Put Coding Quality First

CODING ELEVATED

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## Mitigate Coding Denials Through Quality Processes (continued):

### 3 Coder Education Improves Overall Quality

An effective training process begins by thoroughly explaining the onboarding process to each coder in detail. Coders should know what to expect and understand that asking questions during the onboarding process will not be viewed negatively by the trainer or manager.

A consistent coding quality program with adequate time allotted for coders to fully integrate and practice applying knowledge gained in training modules is essential. Ask questions to identify knowledge gaps among coders and create education that addresses appropriate topics, service line issues and specific modality nuances.

**A high-quality coder training program includes the following topics:**

- Coding workflow within the organization and department
- Facility-specific guidelines and procedures
- EHRs and other computer systems the coders will access
- Physician documentation habits and patterns
- Physician queries—process to request additional information needed to code a chart
- CDI specialist workflow and the process coders should follow in coordination with CDI

Set expectations with the coding team. Explain that coding audits will be conducted throughout the training program and educate coders to view coding audits as valuable opportunities for greater understanding and validation of the important work they perform. Best practice is to audit coded records prior to billing and maintain coders in training until their coding quality reaches 95 percent or higher. Also, share the overall coding quality plan with coders to ensure understanding of the importance of coding accuracy.

**"Organizations need to motivate coders as they progress through training with assurance that when the focus is on quality, productivity will soon follow."**

~ Jessica Coleman, CCS, HRS Manager of Training Operations

Jessica Coleman, CCS, Manager, Training Operations, HRS, suggests that "Organizations need to motivate coders as they progress through training with assurance that when the focus is on quality, productivity will soon follow"

Maintain close contact with the individual being onboarded, trained or retrained. Assign a mentor to help guide new coders through the process, and give them time to gain confidence in their skills. Keep an open forum for coders to ask questions without fear of recrimination.

During times of staff turnover, it may be tempting to forego the established quality process, but it's important to avoid falling prey to that shortcut. While dropping bills quickly is important, managing an increase in denials on the back end is burdensome and costly.

# CONCLUSION

The implementation of ICD-10 on October 1, 2015 ushered in a new chapter in the creation and tracking of data for healthcare organizations. The blessing, and curse, of ICD-10 is the specificity and granularity of its codes.

Accuracy and quality can't be achieved when coders are pushed to meet unrealistic productivity goals. Coding productivity is important, but not at the expense of quality. When productivity is the sole concern of revenue cycle executives, denials, additional costs and payer takebacks are the result—creating a negative impact on cash flow.

Progressive organizations are investing in coding quality programs focused on consistency, denial prevention and training to ensure their coding teams achieve high accuracy rates. The long-term outcome is better reimbursement, lower costs and stronger bottom lines.

HRS has been providing expert coding, auditing and documentation services to the healthcare industry since 1979.

Learn more about how HRS can work for you.

**800.329.0365** | **info@hrscoding.com**
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