5 Coding Challenges That Can Make or Break a Practice's Financial Future

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In the world of healthcare revenue cycle management there are numerous scenarios that can put a stranglehold on your revenue if you're not prepared. With the COVID-19 pandemic causing varying degrees of change in patient volumes and visits, and telemedicine coming further into play, physicians and their practices are having to quickly navigate the nuances of their financial wellbeing. A practice may be buttoned up from the time the patient walks in the door, but what happens after the visit 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.

COVID-19 and telemedicine are frequently bringing on new codes and code sets, all with different variations and modifiers to make the matter even more complex. Medical coders spend a lot of time researching and learning new codes, but every year – and throughout the year – changes and updates are made. Payers don't only want to know the diagnosis and the treatment; they want to know the cause as well. The Coronavirus Aid, Relief, and Economic Security Act passed in March of 2020 allows for an additional payment from Medicare of 20 percent for claim billed for inpatient COVID-19 patients, however it was later indicated that a positive COVID-19 test must be stored in the patient's medical records in order to be eligible for this payment. Being able to stay on top of codes specific to the patient's diagnosis at treatment is more difficult than ever before.

Upcoding

While code specificity is important, so too is ensuring the claims do not contain codes for exaggerated procedures, or even procedures that were never performed, resulting in reimbursement for these false procedure. 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 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 or comprehension of the medical record, refraining from upcoding will help ensure a sturdy and compliant revenue stream.

Missing or Incorrect Information

There's a common theme to coding challenges, and that's having the sufficient information necessary. This information typically is pulled from a patient's chart or record of a visit, which is often completed by the attending physician. However, even when a claim is submitted, providing required information relative to the procedure to the payer is critical as well. 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.

Furthermore, information in a patient's electronic health record may also contain inaccurate information. Keystrokes and other human errors can cause these situations to flare up, and it takes a diligent, thoughtful coder to read between the lines and ensure claims have 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 sustain 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 120 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

However, finding experts well versed in coding claims quickly, accurately and in compliance with the False Claims act is not always an easy task. As you 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-CM coding can easily cause a bottleneck in the revenue cycle. Health executives expressed their struggles to find talent back in 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.

The time has come for practices to begin looking outside of their organization for coding support. How is your practice planning to tackle the coding conundrum? When choosing a partner for your medical coding needs, you need to pick an expert to help your practice stay on target. TriZetto Provider Solutions, a Cognizant Company, has available highly-trained, AAPC & AHIMA certified coders have the experience of getting the details right the first time and understand the importance of coding to the medical practice.

Email **RCMS@cognizant.com**, or dial **800-989-1526**, to learn how our Medical Coding services can help.

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