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THOUGHT LEADERSHIP

PROFESSIONAL SERVICES CODING — WHY IS IT IMPORTANT?

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INTRODUCTION

Paying adequate attention to and investing in a professional service coding program is crucial for employed network sustainability. An effective program directly supports patient care revenue generation and ensures corporate compliance. While technical services coding and billing are also important facets of the network revenue cycle – especially in provider-based billing scenarios, many networks experience greater inadequacies in the professional services elements as these differ significantly from other hospital billing practices.

PROFESSIONAL SERVICES CODING ELEMENTS

CPT E&M codes and CPT procedural coding (and HCPCS codes) usually receive the greatest attention – and rightfully so as these form the basis for revenue generation and productivity determinations. E&M codes are determined by patient interaction complexity – but the medical record documentation must match the complexity and effort reported. CPT procedural codes (and HCPCS codes) are generally more straight forward but also depend on the accuracy and completeness of the encounter documentation.

Both types of codes are further complicated by numerous modifiers that more specifically define the circumstances of the encounter and the provider's role in it. These modifiers are often poorly understood by providers and by inexperienced revenue cycle staff but have a profound effect on coding accuracy.

ICD codes define patient conditions pertinent to the encounter. The level of required specificity increased tremendously with ICD 10 system implementation and is even more crucial when establishing patient complexity – and, hence, hierarchical condition category (HCC) determinations. Using non-specific or unspecified condition codes can lead to woefully under-appreciated patient complexity.

PROFESSIONAL SERVICES CODING IMPORTANCE

1 Patient care revenue. Appropriately coding patient care encounters accurately captures direct patient care efforts and directly determines network revenues related to these efforts. Under coding leads to receiving less reimbursement than the provider or the organization is entitled to for the level of effort expended. In other words, under coding leaves money on the table.

Indirectly, the coding of patient encounters impacts the determination of HCC status; which, among other uses, factors into performance scoring for the MIPS path of the CMS Quality Payment Program and per member per month payments in capitated environments. Under coding under-reports patient complexity and adversely impacts the HCC.

Finally, coding accuracy can also impact health insurer driven, claim-based pay-for-performance programs.

2 Productivity measurement. Coding levels are directly linked to wRVU calculations, the foundation of many productivity models. Since coding generated wRVU credit is the cornerstone of common provider compensation models, coding accuracy directly impacts provider compensation – an issue for both network administrators and providers alike. In addition, individual wRVU levels and associated specialty-specific performance percentiles provide objective measures that drive capacity determinations for network performance improvement initiatives and recruitment prioritizations.

3 Corporate Compliance. Ensuring coding accuracy protects organizations from erroneous claims submissions and resulting reimbursements The greater risk in this area is over coding leading to over payment and recoupment/restitution scenarios. When discovered, dilemmas arise related to self-disclosure versus discovery (think whistleblower) and associated False Claims Act implications.

A second compliance risk is related to wRVU-based provider compensation. Providers are ultimately responsible for the code assigned to each patient encounter. When providers self-code patient encounters, they could hypothetically upcode to their own inurement. Since wRVU calculations are based on encounter coding and higher levels of E&M codes result in higher levels of wRVUs, provider upcoding or over coding can result in additional/excessive compensation for providers. Not that any provider would intentionally over code to his/her own benefit, but it is incumbent on organizations to ensure that checks and balances are in place to avoid any perceived or actual impropriety.

POTENTIAL PITFALLS

Accuracy

As alluded to above, coding accuracy is crucial for optimum revenue generation and minimum risk. However, physician and APP (Advance Practice Professional) training in professional services coding is minimal to non-existent in their education and training curricula. Although these programs are starting to include coding education, competing priorities in the training environment and lack of immediate applicability hinder the impact of these efforts. Many currently practicing providers admit that they have limited understanding of coding processes.

Capture

While many primary care and episodic care providers render patient care in a single location, many other specialties do not. The latter individuals may experience difficulties in fully capturing encounters from multiple sites of care – especially when documented in different EHR platforms. Thus, not all clinical activity may be accounted for and billed.

Timeliness

This primarily refers to completing and locking the encounter note so that claims can be legitimately created and submitted. Delays lead to accounts receivable issues and impaired revenue cycle function. Timeliness issues can also arise when an organization's Certified Professional Coders (CPCs) review provider coding and generate a coding discrepancy. Timely provider responses to coding queries are required to avoid inordinate delays in the billing process.

Aligned Incentives

Providers whose compensation is unrelated to professional services coding accuracy (such as a straight salary model – which includes many APPs) do not have any direct incentives to maximize coding. As an aggregate group, these individuals tend to under code as under coding entails less risk (and less critical thinking and less documentation effort). Attempts to overcome this situation is often met by a lack of provider urgency.

CONCLUSION

Coding accuracy and maximization have historically been undervalued and under-supported in many employed provider networks. The impact, both positive and negative, can no longer be ignored. This aspect of practice operations much be embraced as a critical sustainability issue and corresponding investments pursued to develop robust coding support programs that maximize the benefits of accurate coding and address the potential downside for the organization.

BUILDING A PROFESSIONAL SERVICE CODING PROGRAM

HSG can help build a program that supports patient care revenue generation and ensures corporate compliance. Contact Dr. Terry McWilliams to discuss your health system's current professional service coding program, or for assistance in building a new program.

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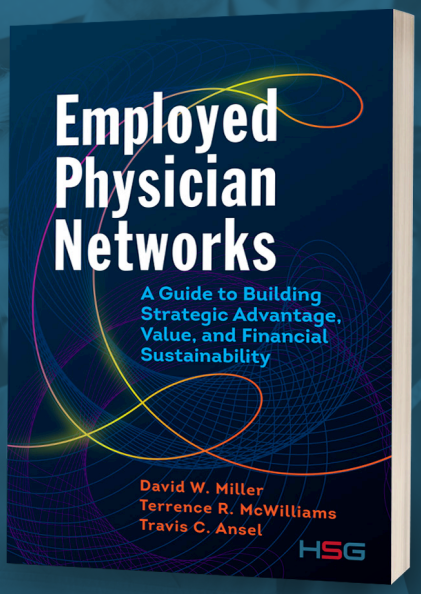

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