Coding Connections in Revenue Cycle Management

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Recently, there has been a significant amount of talk in the healthcare industry about revenue cycle improvement. So what is all of the excitement about? It is about the bottom line. Specifically, how we can improve our bottom line through more effective and efficient revenue cycle management. For hospitals to maintain financial viability under the pressures of the current healthcare environment, the revenue cycle must be a significant focal point, and HIM and coding professionals should play major roles in the process. This article will highlight many of the coding connections for the key revenue cycle processes within patient access, HIM, and patient financial services.

The Coding Connection in Patient Access Services

Critical revenue cycle processes that occur in the patient access department include initial data collection (e.g., name, date of birth, insurance information, reason for admission, patient type); medical record number (MRN) assignment; and medical necessity determination. Coding connects (or needs to connect) with patient access services in the following areas: **MRN, patient type, source documentation,** and **medical necessity.**

The MRN is vital in connecting the patient documentation to the services provided to the patient. If an inaccurate MRN is used, complete and historical clinical information may not be available, resulting in potentially incomplete or inaccurate code assignment. Regular communication and collaboration between HIM and patient access to maintain accurate MRN assignment is imperative.

The patient access department, in many facilities, is responsible for assigning the patient type (e.g., inpatient versus observation patient). It is very frustrating for the coding staff to have to alter a patient type post-service due to inappropriate assignment. This correction process slows down the revenue cycle. The coding staff should collaborate with patient access in identifying ways to resolve inaccurate patient type assignments.

During the scheduling and patient registration process, test order documentation, including reason for the test, should be presented. Source documentation is critical for the final code assignment. Coding professionals should be involved in educating front-line personnel (i.e., those registering patients) regarding appropriate test order requirements. The coding staff should also have access to the source documentation when coding to ensure complete, accurate, and consistent coding.

Hospitals and healthcare providers must determine if services will be covered based on the reason for the test *prior to services being rendered.* In most healthcare organizations, this is left to the front-line staff in patient access. Often, these individuals are in entry-level positions with little or no healthcare background. Connecting the patient access department with coding professionals is critical in complying with medical necessity requirements and reducing the risk of denials on the back end.

Although it is not always feasible to employ a coding professional in patient access, healthcare providers should consider creating a coding liaison position to assist patient access in determining medical necessity and following up with physicians on proper test orders. Coding orientation courses should be provided as a requisite for patient access staff as well. The revenue cycle can be dramatically affected by connecting coding to the patient access process.

Documentation, HIM, Coding, and Chargemaster Services

Key focal points in documentation, HIM, coding, and chargemaster services that affect revenue cycle performance include **who assigns the codes; source documentation; coding quality and productivity;** and **revenue integrity.**

Healthcare providers must determine where CPT and HCPCS codes will originate, or "who codes for what." Information system requirements should be considered when determining whether a code will be generated with a charge (i.e., hard-coded in the chargemaster) or whether the code will be assigned by coding staff based on source documentation.

Typically, routine diagnostic services such as lab and radiology are hard-coded in the chargemaster while surgical interventions are normally assigned by a coder. Lack of coordination between coding and chargemaster staff can cause conflicts, duplicative coding, and billing errors.

When determining whether a code belongs in the chargemaster or if it should be coded by a coder, ask yourself the following questions: "Is the code always the same for the procedure or service provided?" If yes, then the code likely belongs in the chargemaster. "Is coding assignment variable, contingent upon site, method, or complication?" If yes, then the code should be assigned by a coder. "Are there variables inherent in the documentation that would modify the code?" If yes, then the code should be assigned by a coder.

Equally important as who codes for what is the source documentation a coder uses to assign the appropriate ICD-9-CM and CPT or HCPCS code. As we all know, if it was not documented, it was not done. Whether the code is hard-coded in the chargemaster or is assigned by a coder, the source documentation must paint a clear picture of the clinical condition of the patient and the services provided. Often clinicians will witness services being provided; however, final dictation or documentation may omit specifics, which allow additional codes or charges to be added. Coding plays a critical role in validating source documentation for coding and billing purposes.

Concurrent clinical documentation management programs and query processes should be implemented to ensure physician documentation appropriately reflects the clinical picture of the patient and the services provided so that accurate and complete coding and billing can be accomplished.

HIM departments should establish coding quality and productivity standards. Ongoing internal and external quality audits are essential to ensure both compliance with coding rules and regulations, and appropriate payment for services. Coders need to keep current on coding and payment guidelines through continuing education and regulatory alerts and updates. To improve the efficiency of the revenue cycle (specifically, to reduce the discharged not final billed cases), coding productivity standards should be in place with a tool to effectively monitor daily progress.

Revenue integrity is the process of validating documentation, charges, and codes to ensure complete, compliant, and accurate billing and coding processes. A good revenue integrity team, which includes coding professionals, identifies lost charges and coding issues along with providing education and the development of processes to improve this component of the revenue cycle.

The Coding Connection and Patient Financial Services

Of the many activities that occur in patient financial services (PFS), two key revenue cycle components are billing and denial management. Data collected from patient access, information from the chargemaster, and HIM coding all come together in the form of a bill. Sophisticated bill edit systems have the ability to apply Medicare medical necessity, Outpatient Code Edits (OCE), and Correct Coding Initiative (CCI) edits to the claim prior to submission. Once these edits are applied, someone knowledgeable in coding and clinical protocols must resolve the edits to try to avoid claim delays and denials.

Coding connects (or needs to connect) with PFS in the following areas: **discharged not final billed (DNFB) monitoring; medical necessity; OCE and CCI edits;** and **payment verification.**

Every HIM department should have an effective DNFB reporting tool. HIM staff should be able to quickly identify high-dollar cases and the oldest cases. A process should be in place to quickly address the cases identified. Goals should also be set (e.g., one day over the bill hold days), and aggressive monitoring should be done on a daily basis. Significant communication and collaboration among the entire revenue cycle team is required to maintain the DNFB at industry best-practice standards.

Medical necessity does not take place only in the patient access area. Most billing systems allow providers to check for medical necessity one last time prior to claim submission. Connecting the billing process to coding is critical in reducing the number of medical necessity denials. Coding professionals are key players in querying the physician a final time for additional documentation to support services ordered and performed.

Coders are also critical in resolving OCE and CCI edits. Edit conflicts may be caused by a number of reasons, including lack of knowledge by the clinician entering charges and codes coming from both the chargemaster and the coding process. Coders should be involved in the daily bill edit process in order to avoid delays in final billing and claim rejections. Coders can resolve difficult edits by removing an inappropriate charge, recommending a chargemaster change, or evaluating source documentation to ensure complete and accurate coding. Some bill edit systems allow specific edits to be driven or assigned to certain individuals or departments. Edits such as comprehensive, component, and mutually exclusive should be assigned to a coder for resolution.

Finally, a verification process should be in place to ensure expected payments are received on both the outpatient (APC) and inpatient (DRG) assignment.

For healthcare providers to survive under the surmounting financial and operational pressures in an ever-changing environment, the coding process must be connected to the key services within the revenue cycle. Ongoing teamwork between coding and the areas of patient access, chargemaster maintenance, and PFS creates an exciting opportunity for HIM and coding professionals to spotlight their leadership skills. Make sure you are connected!

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