Money Troubles: Changing Reimbursement Models Shake Up Physician and Outpatient Healthcare Industry

By Mary Butler

With all of the public and political debate over the last nine months about healthcare reform and its consequences for consumers, it's easy to forget that providers are grappling with a world of changes on their own. These changes are meant to improve patient care delivery, yet the biggest change patients might not see is that their clinician feels chained to their keyboard—and the procedures they need are being moved from hospitals to more focused ambulatory settings.

If patients start to pull back the curtain to peek into the back of a physician office, not only will they find doctors working on computers, but also billing and health information management (HIM) professionals familiarizing themselves with a host of new acronyms—and pleading with doctors to break some old, bad documentation habits.

Why? Because physician practices and outpatient care facilities are facing changes in their reimbursement models. These changes include moving to Medicare's Merit-based Incentive Payment System (MIPS), Alternative Payment Models, and Hierarchical Condition Category (HCC) Coding as part of the Medicare Access and CHIP Reauthorization Act (MACRA), or moving to accountable care organizations (ACOs) through the Affordable Care Act (ACA). Other alternatives to fee-for-service reimbursement gaining traction in the industry include episode-based and bundled payments, shared savings, and medical homes. Home health clinicians and coding professionals are also still getting used to new Medicare reimbursement models closely tied to the Outcome and Assessment Information Set (OASIS), a tool they've been using since 2000.

While the move to these systems is intended to get healthcare away from the overly expensive fee-for-service payment system and tie payments to the quality of care provided, these changes do come with risk if physicians/outpatient facilities can't meet the quality threshold goals used by programs, or just don't accurately adjust to new requirements. Often the individuals most impacted by these reimbursement changes are the coding professionals. This article discusses the various reimbursement system changes facing physicians and outpatient facilities in recent years, and how specifically physician and outpatient coding has been impacted.

Impact of HCCs on HIM Professionals

The ACA and MACRA are the driving forces behind the government's push to align reimbursement with quality care, moving reimbursement from the overly expensive fee-for-service system to payment based on outcomes. In order for Medicare to make proper payments based on how sick a patient is, it is increasingly relying on HCC coding, as well as other variables such as demographics, says Betty Stump, MHA, RHIA, CPC, CCS-P, CPMA, CDIP, a senior consultant for outpatient at Optum360. HCCs are diagnostic categories based on diagnosis codes on encounter claims and are primarily used in outpatient coding in physician practices.

HCCs were implemented in 2004 for Medicare Advantage reimbursement, but many coding professionals weren't exposed to them until the ACA and MACRA made them more important for assessing a patient's acuity and helping to predict expenditures on that patient for a coverage year. HCC codes are driven by diagnosis and are derived from conditions that are monitored, assessed, or treated during an encounter.

"Now that's a very different perspective than from a reimbursement perspective that says the first listed diagnosis should be the condition that prompted the patients to come in the door," Stump says.

She adds that technical issues, such as outdated practice management software that limits the number of codes that can be reported, or similar difficulties with claims clearinghouses, can complicate HCC reporting.

"You also have a very pervasive mindset out there in the smaller physician practices that still believe that Medicare still only looks at a single diagnosis code, and so there's really no value or point in reporting all those additional secondary conditions—because your claim is going to be processed and paid on one single diagnosis code," Stump says.

Before risk adjustment and quality reporting, only one code was expected on a claim, but now problem lists and HCC coding allows the addition of more codes to demonstrate severity of illness.

"And if you have a patient that has five or six stable underlying chronic problems, it's important that information gets captured and reported—not just when they have an acute exacerbation and end up in the hospital," Stump adds.

Anny Yuen, RHIA, CCS, CCDS, CDIP, vice president of revenue cycle at the consulting firm Intellis, says HIM professionals and clinical documentation improvement specialists are needed to ensure HCC coding is done right. Too often, physicians have been taught the importance of capturing HCCs but go about reporting them in problematic ways. For example, when documenting a diabetic patient, a physician might choose "diabetes HCC" from a drop-down menu in the problem list, and leave that as the only mention of diabetes in the chart, ignorant of the need for more specificity. From a compliance perspective, having a physician that does this is a headache, Yuen says.

"The diagnosis needs to be treated or monitored, needs to be evaluated and it needs to be assessed. So just documenting a diagnosis like diabetes with the HCC next to it in the problem list is not going to work… Most of the time it's an innocent mistake and due to a lack of training or knowledge. And there are times when providers are trained to take bits and pieces of education. So they attend a seminar and hear HCCs are a great thing and that's ingrained in their head that it's something they need to make sure they are capturing," Yuen says.

For HCC capture, chronic conditions need to be noted in the chart annually. This is important for conditions such as an amputation, which is a high-risk adjusted diagnosis. If the condition isn't assessed, monitored, or treated every year, Medicare doesn't validate the risk. And it's almost as if the limb grows back if it's not regularly documented on the chart, Yuen says.

Challenges in Physician Practices

Faith McNicholas, RHIT, CPC, CPCD, PCS, CDC, manager, coding and reimbursement, government affairs, at the American Academy of Dermatology, says the introduction of MACRA, MIPS, and APMs are presenting a huge challenge for anyone who works with physician documentation.

Despite the fact that evidence of medical necessity is more important than ever, McNicholas says physicians still too frequently rely on templates for documenting certain conditions and procedures, and also rely too heavily on copy-and-paste to meet the demand for more specific documentation. Because physician offices lack the resources hospitals have for clinical documentation improvement (CDI) initiatives, they rely on the help of specialty societies, such as the American Academy of Dermatology, for guidance on meeting new quality measures.

"What I have seen, when you look at the physician documentation, what we're asking for is 'Don't give me 20 pages of nothing just because your EMR [EHR] is capable of creating this template. I want specific information pertinent to the encounter and the patient,'" McNicholas says.

An example that McNicholas uses when she does CDI training for physicians is documenting the treatment for actinic keratosis (AK), precancerous skin lesions. The most common treatment is to apply liquid nitrogen (LN2), which freezes the lesions, followed by electrodessication and curettage (ED&C) which means cutting off the growth and using an electronic current to remove the remaining cancerous cells.

Before MACRA and other payment forms, the physician would just write: "Patient presents with AK. LN2. ED&C X 4."

"We've had so many audits where they've taken back tens of thousands of dollars because the documentation is not supporting the claim codes that were reported. And when I look at the documentation I say, 'Can you explain to me how this encounter transpired? From the patient walking into the office to yanking off this lesion, what happened in between here? I don't see it.' This has been a huge challenge," McNicholas says.

With some coaching McNicholas trains clinicians to write a note about a paragraph long. Medicare or an insurance company would want to know that a physical exam was completed, where on the patient's body the lesions were located, how long they had been there, if the lesions changed color or size, if the patient had a family history of skin cancer, whether the patient had lesions treated previously, and the treatment options the doctor presented the patient with as well as how they decided on the treatment they used.

Challenges for Behavioral and Rural Health Physician Practices

Carolyn Veith, RHIT, a patient account representative for Pullman Regional Hospital Clinic, in Pullman, WA, does billing and coding for behavioral, pediatric, and ENT practices, most of which will be participating in the Merit-based Incentive Payment System (MIPS) section of MACRA. The payment changes and the coding and documentation adjustments that come with them have presented a steep learning curve for coding professionals, especially for providers who, like Veith's organization, have applied and been designated with rural health clinic status. Pullman Regional serves rural communities in eastern Washington and part of Idaho.

Veith says that for the most part, the behavioral health providers have done a great job learning the nuances of documenting their encounters, but coding professionals really have to "X-ray" the documentation and re-train providers to stop using unspecified codes, according to Veith. One hiccup is that different commercial payers are willing to accept certain behavioral health codes from mid-level providers, such as advanced practice registered nurses, where others, such as Medicaid, will not.

"With behavioral health, unless the provider is documenting exactly as it is in the code book it's really difficult to make a lot of jumps. For example, providers like to document 'alcohol use disorder' and it's like, 'OK, is it mild, moderate, or is it abuse?' You really have to know your 'use' and 'dependence' rules. Or, one other example is with anxiety and depression. A lot of times a patient will have, as the provider will say, 'anxiety and depression' for which there are two separate codes. There's also a combination code for anxiety with depressive features. Unless they come out and document that, you can't use that combination code unless the provider specifically says," Veith explains.

Gaining the rural health designation also added another layer of difficulty for coding professionals, Veith says. For one thing, providers have to be very strict when filling out their Health Care Financing Administration form. The claim will get rejected if the service location isn't identified, and Medicare and Medicaid each prefer different coding structures, Veith says. She notes that in rural areas, there are a lot of children on Medicaid, and there's a lot that coding professionals and billers have to keep in mind when working with pediatric Medicaid claims. For example, Medicaid does not like the use of external cause codes and they are picky about evaluation and management (E&M) codes.

"For example, a kid will come in and the parent will ask about vaccines but the child doesn't need them done. How do I bill out the physician's time? Do I use an office visit E&M or preventive care code? If the patient has private insurance then yes I can bill out preventive codes," though that's not necessarily the case if the child is on Medicaid, Veith says.

Since Veith does coding and billing for so many different types of practices, in two states in rural settings, working through all the nuances is time consuming.

Home Health is a 'Moving Target' for Payment Changes

Home health coding and documentation have seen many changes over the years and can expect plenty more to come. The Centers for Medicare and Medicaid Services has been discussing the implementation of a new prospective payment system in 2018 called the Home Health Grouper Model, which would be an update to the current Home Health Prospective Payment System currently in effect.

Additionally, home health agencies are currently in the process of complying with the IMPACT Act, which created a standardized assessment tool for post-acute care facilities such as home health, inpatient rehabilitation facilities, and skilled nursing facilities. Additionally, auditors are taking a closer look at the patient assessment tool (OASIS), which home health clinicians have used to assess patients during home visits since 2000. It wasn't until 2008 that OASIS started to become tied to reimbursement.

All of these past and future changes make home health a "moving target" in the outpatient world, according to Sparkle Sparks, PT, MPT, COS-C, a senior associate consultant at OASIS Answers, Inc. Further, Sparks says not all home health agencies are reimbursed in the same way. Some agencies might be attached to an orthopedics practice, where patients are healthy enough to undergo major surgeries and need home health for follow-up. Other home health agencies serve a sicker population such as those affiliated with county hospitals. The most unique aspect of coding for home health is that coding is done on a prospective basis, at the beginning of an episode, which can last for 60 days or more.

"That brings other challenges because… not only are we having to make a decision to code what is directly impacting the plan of care, but what could potentially impact the plan of care. So that is definitely a challenge, because that language requires us to look at a crystal ball into the future," says Nick Dobrzelecki, BSN, RN, vice president of coding services at Corridor.

With all of this in flux, Sparks has straightforward advice for home health coding professionals. "All you need to do is code as accurately and consistently as possible. You need to tell the patient's story using diagnostic codes because we only use diagnostic codes in home health. Tell the patient's story as accurately as possible," Sparks says. "You've got to know your guidelines and conventions but stick to the truth and everything else will work out. As far as assigning codes, you don't need to know which can contribute to reimbursement and which ones won't or how they'll impact risk adjustment. Your job is to compliantly, accurately, consistently apply codes per the guidelines."

The current changes in home health coding reflect the larger move of patients from hospitals to outpatient settings. Dobrzelecki says that in 2011 hospitals started getting rid of their affiliated home health agencies due to lack of reimbursement. But with the overall move to accountable care organizations and bundled billing, hospitals started to realize that was a huge mistake. And as they started buying back home health agencies they started assigning inpatient coding professionals to tackle home health coding.

When this happened, Dobrzelecki worked on a study to evaluate how well inpatient coding professionals did working on home health claims when coding was still under ICD-9-CM. "Reimbursement was a lot less because they were using all the inpatient guidelines vs. home health guidelines. We haven't done that under ICD-10-CM yet, but we saw pretty significant changes then," Dobrzelecki says.

He adds that prior to 2008, coding professionals were primarily RNs, but with all the new changes and especially the conversion to ICD-10-CM, home health agencies are starting to look for certified coding professionals.

Outpatient Proves HIM Mettle

Whether it's helping home health agencies meet myriad payment, quality, and documentation changes or helping physician practices prepare for MACRA, HIM professionals' coding and documentation expertise makes them invaluable in the outpatient setting. Their CDI skills will also become more in demand.

"Outpatient CDI is like a Pandora's box," Yuen says. "There are many, many different opportunities, but there's no cookie cutter methodology. Every organization needs to know their data, needs to know where risk areas are, and where they have opportunities to improve."

Giving HIM professionals the chance to prove their mettle in these settings helps everyone in the industry.

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