

Six Strategies to Build Outpatient Coding Accuracy and Quality

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As healthcare services migrate toward outpatient settings, hospitals and health systems are struggling to ensure coding accuracy and quality for owned practices and clinics. With the steady increase in outpatient services, revenue integrity challenges are more complex than ever. And the expansion of those services is further complicated by the rising volume of mergers and acquisitions.

Earlier this year, Definitive Healthcare released its 2019 Healthcare Trends Survey, which tracked 803 mergers and acquisitions as well as 858 affiliation and partnership announcements. The healthcare analytics firm predicted the consolidation trend would accelerate in 2019 and beyond. As mergers increase, health systems must integrate coding from physician practices, emergency departments, radiology, pathology, anesthesia, and more, meaning revenue integrity on the outpatient side is now susceptible to chargemaster errors, missing codes, and documentation gaps, which are increasingly difficult to identify, track, manage, and improve.

Today's Outpatient Revenue Integrity Challenges

- **Managing the claims editing process:** The claims editing process on the outpatient side has become a part of the coding process to address edits such as missing documentation, multiple codes, and charges on the account. To resolve issues, coders need access to the Centers for Medicare and Medicaid Services (CMS) website at <https://www.cms.gov>, where they'll find resources and tools—including claims-scrubbing software, analytics programs, and other applications—to help them pull together the necessary pieces of information to ensure that claims are properly submitted. The claims editing process has become increasingly difficult as organizations struggle to maintain skilled, knowledgeable staff at levels sufficient enough to complete the continuing increase of complex work.
- **Merging professional fee and hospital outpatient coding:** When physician practices are integrated with healthcare systems, professional fee services coding and billing must be merged with hospital-based outpatient coding and billing. Coders who have primarily performed professional coding now must collaborate with the hospital-based outpatient coders. Merging the two can be tricky because each group has had distinct training and has its own specialized knowledge. It is important to determine the hospital coders' level of expertise with professional fee coding.
- **Keeping up with coding changes:** Coding changes can occur on an annual basis and should be updated and reviewed routinely to ensure accuracy. Use of outdated codes is a root cause of inappropriate charges, increased denials, time-consuming appeals, and delayed reimbursement.
- **Meeting medical necessity:** The concept of medical necessity is a major factor on the outpatient side, more so for hospitals. Without an effective process for checking medical necessity on the front end and without proper documentation and coding to support a valid diagnosis, hospitals sometimes write off the low-dollar cost of outpatient diagnostic tests rather than attempt to fix the problem or resubmit claims. A recent [Advisory Board](#) update shows a surge in medical necessity denials, indicating the challenge many facilities face, particularly those without a clinical defense infrastructure.
- **Shifting to value-based care:** The shift from volume to value requires outpatient physician practices to prioritize wellness and preventive care, which means a shift in how information is captured. For example,

consider chronically ill patients who need greater attention to keep them well and out of the hospital. Documentation and coding must be completed properly to ensure chronic conditions and preventive treatments are captured according to value-based purchasing criteria. Some quality initiatives have specific requirements for certain treatments and conditions. Failure to check the right boxes and provide the right documentation can potentially reduce payments.

Six Strategies to Improve Outpatient Revenue Integrity

How can providers build quality to ensure optimal outpatient coding, documentation, and revenue integrity? Consider the following proven strategies:

1. **Build a multidisciplinary team:** Include members from health information management (HIM), coding, clinical documentation improvement (CDI), physician practices, managed care contracts, revenue cycle, legal, IT, financial, denial management, audits, and compliance. Meet on a regular basis to identify issues, develop strategies, and assess outcomes.
2. **Conduct chargemaster review and maintenance:** Routine chargemaster cleanup helps eliminate claims edits and denials by ensuring all codes, supplies, and revenue codes are current and accurate. The main focus of a chargemaster review is to confirm accuracy of CPT and HCPCS codes. Because these codes are hard coded in the chargemaster for most ancillary departments, an annual review for new, revised, and deleted codes is recommended to ensure accurate payment.
3. **Provide ongoing coder training and education:** Ongoing education for outpatient coders is critical to compliance with quality-based reimbursement initiatives, so be sure to assess the skills, knowledge, and experience of professional fee coders and hospital-based outpatient coders. Acknowledge differences and develop a training and education program that builds competencies and encourages collaboration.
4. **Consider a single-path coding model:** Some organizations have successfully transitioned to hospital and physician coding performed by one coder. With proper education and cohesive teamwork, single-path coding is an effective way to streamline workflow, reduce costs, and ensure greater integrity and consistency.
5. **Ensure medical necessity up front to avoid issues with claims edits and denials:** The clinical documentation must clearly state the reason for outpatient services, such as CT scans, MRIs, lab tests, or same-day surgery. Coding, CDI, and physicians should work together to ensure that complete and accurate clinical support is provided for reviewers to acknowledge medical necessity. Though medical necessity software built into the EHR can be useful, technology is not a standalone solution.
6. **Promote communication among all areas involved in the denial and appeal process.** Work collaboratively to create a denial management process from a root-cause perspective aimed at denial prevention to support timely, accurate reimbursement.

It's All About People, Process, and Technology

Addressing the complexities of outpatient services and the impact on revenue cycle outcomes requires strategies to assess risk, evaluate IT assets, streamline processes, manage human resources, and more. HIM professionals have an opportunity to lead efforts that ensure outpatient services are properly captured, billed, and reported. Their expertise is essential to achieving outpatient revenue integrity.

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