Where We've Been, Where We're Going

by Rita A. Scichilone, MHSA, RHIA (formerly RRA), CCS, CCS-P

As conditions in the healthcare industry have become more challenging, many jobs have evolved. Not least among them in the HIM world is the role of the coder. In more ways than one, coding professionals are making their mark in the industry. And today, changes in coding requirements are part of a revolution in healthcare delivery systems and claims processing.

Forces inside and outside the profession have profoundly affected the role of the coding professional in the last few decades. This article will examine this evolution and discuss changing roles and opportunities from a coding professional's perspective.

In Search of the "Good Record"

"The only fee for which the doctor pays for the use of a thoroughly equipped and serviced workshop, the hospital, is the good medical record,"[1] author Betty Wood McNabb wrote in 1958. Coders have always had to contend with records that are not "good" for optimal data capture. Yet we strive to paint an accurate clinical picture for external agencies and internal use from what we have. We work with good records of bad patient care, bad records of good care, bad records of bad care, and often excellent records of excellent care.

Because the canvas is limited to a HCFA 1500 or a UB-92 form and so many rules govern code selection, creation of a reimbursement "masterpiece" is no easy task. Clinical coding continues to be a process of piecing together data elements to create a consistent and uniform data set that accurately represents what was done for the patient and why.

McNabb also warns prospective coders that the "...career you have chosen is a career; it is complex, responsible, and professional in caliber -- you are not a clerk. Decide to learn as much as you can about medical record science, and you will find every medical record librarian, everywhere, ready to help you."[2] Although our profession has changed, coders and HIM professionals are still distinguished by our dedication and willingness to help. As a group, we have developed unique skills due to the requirements of our jobs.

In the past, many coders were trained on the job. Formal education programs were scarce and expensive, and employers did not usually provide financial support. Average annual rates of growth in Medicare and private health insurance spending per enrollees between the years of 1970 and 1996 were between 10.8 and 11.3 percent.[3] In the workplace, this trend created a need for systems that would increase both the accountability of clinicians and facilities receiving payments from health insurance companies and the government.

Before 1983, when DRGs were introduced, insurance firms paid for care on a "usual and customary" fee basis or on a percentage of charges according to policy terms. Before reimbursement was affected by coding, a limited need for accurate coding existed, except in research-oriented institutions that depended on correct use of a classification system for data retrieval. Few hospitals invested significant resources in coding salaries, coding education, or any effort to enhance coding skills, because there was no financial return for good coding or punishment for inaccurate coding.

Boom Times for Coders

As the inpatient prospective payment system evolved in the second half of the 1980s and a requirement for CPT submission by hospitals was implemented, coding became a key element of HIM practice. Coding certification programs developed and flourished as employers demanded reliable coding skills. Because of its links to reimbursement and statistic gathering, coding also was the ticket to career advancement and promotion in a variety of non-hospital settings.

Moreover, our knowledge of disease processes and reimbursement principles and training in documentation requirements made HIM professionals the best candidates for data management and reimbursement coordinator roles. Our role changed from

literal translators of diagnostic statements into codes to advisors on correct code selection based on clinical evidence recorded in the chart. A critical shortage of qualified coders emerged as the demand exceeded the supply of professionals. This shortage still exists today.

As reimbursement and decision support became tied to code assignments, new organizations were created, such as AHIMA's Society for Clinical Coding and the American Academy of Professional Coders to support the needs of practicing coding professionals. Salaries increased to record levels in many organizations as hospitals competed for skilled professionals with each other and with other facilities. Certified coding professionals were able to make a good salary without college degrees if they were committed to lifelong learning.

Technology has changed coding practice significantly. Once, a few references kept us current with coding principles, but today we must use a variety of resources just to keep abreast of constant changes in reimbursement methods, advanced therapies, and new health conditions. We now use the Internet to review payer policies and CD-ROM-based references that put vast clinical references at our fingertips. It is predicted that the "next generation" of the Internet will operate at speeds up to a thousand times faster than today, making Internet/intranet communication a likely avenue for healthcare data management.

New Roles, New Opportunities

Analysis and use of coded data has revolutionized the industry by providing consistent and reliable clinical data that is accessible in electronic formats. Coding professionals have learned how to be real "detectives," finding data within health records that legitimately improve reimbursement by DRG, ASC, or RBRVS. We analyze abnormal findings, medications, and surgical therapies so that complications, comorbidities, or valid operating room procedures overlooked by a physician in a final diagnostic statement may be used to optimize hospital reimbursement. We also apply confusing HCFA/AMA guidelines to physician documentation for professional services so we can assign the appropriate level of service or validate levels assigned by physicians and keep our physicians from fear of audits and overpayment.

External forces continue to shape our jobs into what is projected to become the Vision 2006 role of the clinical data specialist. This role provides data management functions in a variety of application areas, including clinical coding, outcomes management, specialty registries, and research databases.[4] Projects such as HCFA's OASIS for home health continue to expand horizons for professionals with data management backgrounds.

Because of the use of computers to process claims and future electronic transactions, insurance carriers demand coded data fields instead of narrative descriptions of clinical services. Payment systems use these data fields to determine reimbursement amounts rather than allowing providers to bill for services without accountability.

Code numbers became the universal product code of the health service marketplace. Payers today have edits within claims management systems that determine if the diagnosis code selected is "payable" or not, so coders are expected to know and apply billing guidelines for medical necessity. The right code is like the PIN used on an ATM card. If it is valid and you are entitled to receive it, the money comes. When the code doesn't match up with payer guidelines, the money does not come as expected or desired, and everyone gets frustrated in the process, just as when you forget your PIN or your bank account has a negative balance.

What the Future Holds

Since technology has not yet evolved to the point where information may be captured at the point of service, coders will continue to be necessary intermediaries in the process. Today, in most facilities we are still required to read the text account of documentation of an encounter and assign the appropriate code for entry into the automated billing system. This is clearly an inefficient and ineffective way to accomplish data transfer, so we know this process will be eliminated as soon as technology allows point-of-service transactions.

Today's documentation methods are often delayed until well after the event, increasing the chances of memory loss and omission of important data by the clinician. After that, a subsequent person must re-analyze the information and apply appropriate guidelines, which may create an unintended yet erroneous view of events based on individual bias, lack of clinical knowledge, or gaps in recorded data.

The record of the future may be an audio or video image rather than text-based accounts of care, creating a dynamic medium of more useful health observations. The clinical data specialist will continue to be an essential member of the healthcare team, managing and displaying clinical data sets, evaluating clinical trends, and assuring data quality. The clinical skills that serve us today will continue to serve coding professionals in this new role, and our determination to "learn all that we can" will keep coding professionals gainfully employed.

The sheer complexity of the system will keep coders in demand, too. "Due to the complexities involving coding and reimbursement, physicians, allied health professionals, reimbursement specialists, and third-party payers become focused on that 'piece' of the health care environment in which they directly work,"[5] author Denise Stace-Naughton, RRA, CPC, writes. Coding professionals are holding the most important piece of all -- the clinical picture that provides a snapshot of healthcare services provided during a specific time period.

Notes

1. McNabb, Betty Wood. *Medical Record Procedures in Small Hospitals.* Chicago, IL: Physicians' Record Co., 1958, p. 8.

2. Ibid, p. 20.

3. HCFA/Office of the Actuary. As reported in *A Profile of Medicare Chart Book*. Department of Health and Human Services: Washington, DC, 1998, p. 33.

4. "Vision 2006." AHIMA Web site.

5. Stace-Naughton, Denise. *Coding and Reimbursement: The Complete Picture within Health Care.* Chicago, IL: AHA Press, 1999, p. xiii.

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Rita Scichilone *recently became a coding practice manager at AHIMA. She can be reached at RitaScic@ahima.org.*

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