Billing: Coding Made Easier

July 15, 2007 | Coding [1]
By Pamela Moore, PhD [2]

It’s confusing, tedious, and time-consuming — and for most practices, it’s the only way to get paid for the work you do. Now the good news: There are tools available to make coding easier. Here’s our rundown.

With some 8,500 CPT codes, 16,000 or so diagnosis codes, untold numbers of supply codes, and endless rules about medical necessity and bundling, it’s no wonder practices find coding confusing.

“The complexity of coding has been steadily increasing,” explains Bill Dacey, a certified coder who makes a living auditing charts and training physicians on coding.

How tough has it become? When a group of highly trained coders was asked to code, then code again, the same set of notes four weeks apart, they agreed with their own CPT choices only 85 percent of the time, and with their own ICD-9 codes barely more than half the time, according to Perspectives in Health Information Management (Fall 2006).

And of course, payers make matters even worse, with each throwing in its own coding and billing regulations.

Clearly some help would be appreciated. That’s where computer-assisted coding applications come in. These tools aim to make coding more of a science than an art — and keep you in the money and out of hot water.

They come in several flavors. Some can be used together; some vendors offer several kinds. If you are ready to throw away your paper codebooks, it’ll be useful to understand the general categories of products out there and how they work. Here’s our guide.

Making research easy

The most basic coding software is the encoder. Encoders put your CPT, ICD-9, and HCPCS book — plus many other resources — in an electronic format so it’s easy to look up codes. You can type in the name for a procedure or problem — say, ankle fracture — and get a list of possible codes. Or if you get a denial, you can use an encoder to try and figure out why.

You could use paper instead, but why would you? “Once upon a time they trained me to get square roots without a calculator, too, but why would anyone do that now?” asks Dacey.

CodeCorrect is one example of an encoder. In addition to its database of codes, the online service gives easy access to relevant transmittals and bulletins from Medicare, advice from the AMA’s CPT Assistant, correct coding initiative (CCI) edits, and details from national coverage decisions (NCDs), all of them keyword-searchable.

“We have some people with very thick glasses, and they just peruse what’s going on with [Medicare] and what’s going on with various payers on a state-by-state basis, and [they] incorporate that into the site,” says Jim Keleher, vice president, partner solutions, of Accuro Healthcare Solutions, the company that creates CodeCorrect. “It’s meant to be the authoritative content. It’s not somebody’s opinion about coding. When I go into that knowledge base, I’m going to find articles that ... I could use to defend something.”

The product, like most encoders, focuses on Medicare and some rules generally used by other major payers, but users who have the time and knowledge (that may not include very many) can also add rules from local payers.

Ingenix, long a leader in printed coding reference materials, has a similar Web-based product called EncoderPro, which also includes a bevy of research tools. “It’s all the things a coder would have to reference,” explains Ralph Wankier, vice president of physician solutions for Ingenix. While Ingenix’s paper products still provide more revenue than its electronic products, the software is growing faster, says Wankier. “It’s growing very robustly. It’s double-digit growth.”

Want to check out other encoders? Try FlashCode or EncoderPro.

Coder beware
Encoder options abound. But keep in mind that these tools are only as good as the folks using them. Lehigh Valley Physician Group, a Pennsylvania multispecialty practice with more than 300 physicians, uses CodeCorrect, but Kathleen Sharp, the quality improvement adviser for the group, still relies heavily on people power. “We acknowledge it as a tool, but just like any tool, you want to make sure the person using the tool knows how to use it. A hammer is a wonderful thing, but you can do a lot of damage if you don’t know how to use it properly.”

Wendy Johnson, who also uses CodeCorrect as compliance manager for Sharp Healthcare in San Diego, agrees. “You really need some baseline knowledge. I prefer when some person can look at the codes and select the right one. You may see a lot of denials if you assume the computer is right, and then you are not sure where the problem is.”

As part of her shopping process, Sharp had her staff use various products and compared them head to head. The expert coders could use any of them with good accuracy, but the novices had trouble with some systems.

“When we had folks in our coding and compliance department test [the products], they could tell very quickly when the systems were getting them to the right code. When we rolled it out further, we found people typing in other terms that made it less useful or it took too many clicks and they weren’t likely to use it,” Sharp recalls.

Here is an example of why people matter despite the best technology: Say a physician documents that he had a nurse infuse a dehydrated patient with a bag of glucose solution. A beginner could type “glucose” into some search engines and find various glucose tests for diabetics but nothing for infused solutions. The coder would have to know that the solution used was actually probably dextrose and confirm that with the physician, or would need to know enough to try “dehydration” as a keyword instead.

Another software shopping tip: Look for hardware while you’re at it. “If staff or physicians have to travel across the office to a shared computer to use the software, you might as well have a book locked in a cabinet,” says Sharp. Her physicians all access their encoder Web site from pen-based tablets they carry with them. “Otherwise, in the flurry of the day, it just won’t happen.” Overall, though, Sharp is pleased with her encoder. “We do know that we are capturing services that we otherwise would have missed. People will put something in, and the system will tell them, ‘You really are looking at two codes, not just one.’ Also, the claims are cleaner, which means faster turnaround times.

“It has also helped us in the appeals process. For third-party payers that don’t publish their guidelines, we can easily pull up the Medicare guidelines and say [in an appeal], ‘This is how Medicare says to bill.’ They don’t always pay, but if they come back and say, ‘Our policy is different,’ they sometimes produce their unpublished guideline. We keep that policy in our records, and understand that payer better for future claims.”

Manage revenue

So encoders help physicians and staff pick the right code according to the CPT rules, but correct coding and good billing are not necessarily the same thing. That’s because of the varied demands of different payers and the relative complexity of filing thousands of claim forms accurately. That is where the second category of tools for coding help comes in: advanced claim scrubbers and revenue-cycle management products.

“Once you’ve selected a code, we can tell you if the codes you’ve used are appropriate for the payer you are billing,” says Jim Denny, president and CEO of Navicure, a revenue-cycle management company.

Here’s how it works. A practice sends claims through Navicure’s secure Web site. “The claims are edited in real time as they are received. We apply standard types of edits: CCI edits, NCDs, payer-specific data, too,” Denny explains. Such systems typically also scrub claims looking for blank fields, missing place-of-service codes, and confirm that the diagnosis and procedure codes link up. For their part, payers use similar products on their end to screen claims containing errors for quick denial.

In short, revenue-cycle management products get claims cleaned up before they ever reach a payer, reducing denials down the road, and educating staff about how to fix problems ahead of time. They are like really smart claim-processing centers merged with some elements of a practice management system.

If denials happen anyway, staff at revenue-cycle management companies study what caused them and try to put preventive measures into their databases. “When an LMRP, for example, gets kicked back, we not only say that it is denied and why, but provide a link to the policy. It’s two clicks away...
from the source,” says Denny. Most use an application service provider model, meaning clients use the products online instead of buying software that gets installed on a server in the physician office. The Web-based approach means the software stays up to date. Indeed, many vendors update their knowledge base of payer rules on a weekly or even daily basis, gathering data from tens of thousands of physician offices. Athenahealth, whose products include many aspects of revenue-cycle management, is an extreme example of the kind of research embedded in this type of software. “We are students of payers,” says Kim LaFontana, vice president of operations for the Massachusetts-based company. “We have about a dozen analytical people who study denials and bulletins and payment processes. We write about 100 new rules a week, and they go live immediately. ... In fact, we often know more about how a payer pays claims than the payers do.” Imagine your staff duplicating that by trying to memorize every flier that comes through the door — while still sending out claims and calling on late accounts. That’s unlikely to happen thoroughly in a manual system. There is simply too much to master, and it changes too fast.

Many revenue-cycle management tools also help practices understand where to focus staff and what needs to change through the coding and billing cycle to improve revenue. Navicure, for example, allows practices to generate reports pointing out where they are underperforming. The goals: Better productivity for your billing staff and fewer days in accounts receivable.

Donna Knapper, who runs DRK Billing Specialists, based in Phoenix, used AdvancedMD, another revenue-cycle management company, to fix billing problems for her client, Arizona Back Institute. When Knapper arrived, Medicare owed the practice more than $825,000. Using the revenue-cycle management program, she brought that number down to just $3,000 in 30 days with 100 percent allowable payment.

“The practice couldn’t get any claims for Medicare paid and couldn’t figure out why,” Knapper says. “I saw that claims were being resubmitted over and over. They were mostly being denied because they were missing a modifier, but when staff called Medicare, Medicare just said, ‘The claim is missing something,’ and staff didn’t know what. They don’t know where to find answers and fix the problem.”

The revenue-cycle management tool helped them identify the problem quickly. Knapper also likes knowing if a claim needs a correction when she submits it, rather than waiting 60 or 90 days to get a denial. She looks for alerts immediately. If a claim is just missing an ID number, she explains, you don’t want staff spinning their wheels trying to figure out what’s wrong with the coding.

Of course, even the best database can’t catch everything. Jayne Lavariere, chief coder for 25-provider, multispecialty Williamstown (Mass.) Medical Associates, likes her product from athenahealth, but found that her version didn’t alert staff when one common procedure — a breast biopsy followed by a mastectomy — needed a modifier. She’d have to run a report to find them. That’s better than getting denial after denial and not knowing why, and Lavariere says other versions of the product would have alerted her. Still, she says, it’s important to realize that rules can’t capture everything. “You are always more or less a detective trying to find out [whether] the patient [was] here, did they have the surgery, and was the claim filled out correctly? You still need someone to watch over things who has a vested interest in the group.”

**Doubling up**

Sharp uses a claims cleaning product along with her encoder for ideal results, a combination Navicure’s Denny recommends: “Something reference-based will help guide the biller to a code. We don’t do that. But I can’t imagine why someone wouldn’t benefit. Once you’ve determined what the code is, that is where we come into play. My recommendation would be to do both.”

“We use ClaimsManager [a scrubbing system from Ingenix] as a double-check,” Sharp says. “It’s a hard stop in the charge-entry process, alerting a person during charge-entry that they need a modifier and offering a list. Of course, the operator has to have some coding knowledge to pick the right one.”

For a more complete list of revenue-cycle management vendors, visit the [Physicians Practice Buyers Guide](http://www.physicianspractice.com/buyers-guide).

Don’t be scared off by the price tags. The higher your volume of claims, the more reasonable the pricing seems. And keep in mind the cost savings you might realize in reduced denials and faster revenue. Of course, if you already have few denials and low days in A/R, these might not be the systems for you.

As you shop, keep your users in mind. Knapper looked at some systems that she thought were too
sophisticated for some of the billing staff she works with. Several members “of my staff don’t have the computer skills they would have needed to get the information in correctly.”

Make sure, too, that the system will allow you to create unique codes or modifiers, such as those sometimes required by state Medicaid programs.

**Thinking solutions**

Most revenue-cycle management programs run by following consistent rules: *For Payer X always do Y.* Vendors in the third category of coding tools — natural language processing software, including CodeRyte, PlatoCode, LingoLogix, and A-Life, among others — offer software that seems to “think” about the appropriate code based on the documentation.

The basic premise of natural language processing is “to make human beings interact with computers without forcing human beings to write in coding language,” explains Andy Kapit, CodeRyte’s CEO.

Send the system any electronic document — Word, electronic medical records, you name it — via the Web and it gives back automatically assigned diagnoses and procedures codes, along with their definitions. Coders then confirm the code.

CodeRyte accomplishes this feat using statistics. The Web-based system identifies patterns of language that humans — actual coders — have decided are important in thousands of coded claims, and assigns a code based on the statistical consensus, Kapit says. “The engine doesn’t miss stuff so long as there is any indication in the notes; humans might not consider [certain language] important each time, but the engine would.”

If CodeRyte can’t identify a pattern, it alerts a human, which happens about 5 percent of the time, according to Kapit, who adds, “Usually if the engine couldn’t code it, a human can’t, either.” Typically, information is missing.

CodeRyte also uses a competency assessment model: If the computer can code it, it provides a statistical analysis of how many times a human at this practice location has ever changed the codes it offered for this sort of documentation. Then customers have the option of not even reviewing the codes, instead sending them straight to billing. Radiological Associates of Sacramento, Calif., a CodeRyte client, is now sending 20 percent of its notes directly to billing with no human intervention, according to Kapit.

Natural language processing seems to be the wave of the future. CodeRyte’s model isn’t the only one out there. For instance, instead of using statistics, PlatoCode’s software “reads” each word, sentence, and the document as a whole to formulate a response — a sort of artificial intelligence.

For now, though, the use of natural language software is somewhat limited, partly because it takes time to build knowledge of all the medical processes out there.

**Can EMRs solve it all?**

The fourth major type of product that can help your coding is the electronic medical record. Many EMRs include automated coding functions; they “read” your documentation and offer a coding suggestion. It’s particularly handy for those pesky E&M codes, and improved coding is one way practices get a return on investment from their EMR.

But coding and billing experts are a little wary about using an EMR exclusively. Sharp’s physicians were using an EMR with coding capabilities — but they ended up turning off that functionality. The dictionary their system ran was simply too static to be very useful. Suppose a physician was documenting a laceration. The practice’s EMR wouldn’t provide a code; it could only identify the term “wound,” the term prioritized in CPT.

“We had coding and compliance experts help clean up the dictionary, but even then there were character limitations” and other problems, Sharp reports. She encourages other groups to ask ahead of time if an EMR has a robust database for coding. CodeCorrect, for example, is partnering with some EMRs.

Coder Bill Dacey is less worried about the codes EMRs select than the way they subtly encourage physicians to overdocument to get a higher code than may be appropriate.

“I am frightened by EMRs’ tendency to lead the physician. … It makes it too easy to bump up that record. I see a tremendous potential to overdo it on the history and exam because the machine is doing it for you.”

“I have seen a trend toward higher levels of coding. There was a significant increase of 99214s from 2004 to 2005 for Medicare. It shows a pretty steady uptick. Some of that I agree with, because I think that physicians have been doing a significant amount of undercoding. But on the other hand, is it just machines turning level threes into fours?”

When he audits charts, he sees EMR-produced notes that may *technically* be a level four or five E&M but “in essence” are level threes.
“It’s a machine and machines like lists and data. If you let it bring you into data-land,” mistakes can happen, Dacey warns. For example, these days he sees a lot of notes documenting that the patient’s pupils are alert to light and accommodation. “How often are physicians actually testing for accommodation? How often do they do it for a kid with a bellyache? I see it ad nauseam. I’ve got 100 charts to do tonight. I’m going to know three charts in if the guy is doing it by machine or not.”

As with any software, EMRs can’t replace the need for human oversight and restraint. There is a whole new world of gadgetry for coders, billers, and physicians to explore. The keys to success are making sure the solution or combination of solutions you choose solve the coding problems specific to your practice.

Pamela L. Moore, PhD, is senior editor, practice management, for Physicians Practice. She can be reached at pmoore@physicianspractice.com.

This article originally appeared in the July/August 2007 issue of Physicians Practice.

Disclosures:

Source URL: http://www.physicianspractice.com/articles/billing-coding-made-easier

Links: