

# GETTING PAID FOR ALL YOU DO

## The Value of Coding Education

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*Site of care is evolving in the face of the Covid-19 pandemic. Whether through a traditional office visit or telehealth, it is critical to stay abreast of best practices for coding. If not, practices are doing a disservice to themselves and their patients.*

### The Need for Knowledge

In medical school, physicians typically received some training on the proper use of medical coding to bill payers. However, this education usually doesn't offer an in-depth understanding of how coding aligns with and impacts reimbursements. To complicate matters, the medical coding landscape can be a challenge to navigate as the codes can frequently change. There can be as many as 1,000 unique changes across all specialties within a single year alone.

Physician practices have more than enough to do. Keeping up with the latest coding changes can prove difficult as we've seen with the recent surge in activity for telehealth. Indeed, a lack of coding knowledge can have significant consequences on a physician practice's bottom line, in some cases even threatening the financial health of the practice itself.

### The Urgency is Clear

Now more than ever, it is critical for physicians to have the expertise to select codes to the highest level of specificity. To begin with, the evolution from fee-for-service (FFS) models to value-based care (VBC) has changed the way providers are reimbursed for care.

There are four main types of value-based payment models:

- Pay for Performance
- Shared Services
- Capitation
- Shared Risk

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#### WHAT IS HIGH SPECIFICITY CODING?

*Hierarchical condition category (HCC) coding is a risk-adjustment model originally designed to estimate future healthcare costs for patients. HCC relies on ICD-10 coding to assign risk scores to patients. Each HCC is mapped to an ICD-10 code. Along with demographic factors (such as age and gender), insurance companies use HCC coding to assign patients a risk adjustment factor (RAF) score. Using algorithms, insurances can use a patient's RAF score to predict costs.*



### 1. PAY FOR PERFORMANCE

Providers can qualify for performance-based incentive payments in accordance with their success in achieving quality patient outcomes for targeted populations. For example, if you have 65 patients out of 100 over a certain age, a goal could be to screen at least 55 of them for a colonoscopy. Conversely, providers may be penalized for poor performance.



### 2. CAPITATION

Providers take on full responsibility for their patients. If they have 100 patients, they are given a set amount of money to care for them all. Providers are penalized for allocating too much money for some patients and not enough for others (known as “overutilization”).



### 3. SHARED SAVINGS

Also called value-based contracts, payers use these programs to measure provider performance against care quality and expenditure targets. If a provider can meet those targets, they have the opportunity to share in any savings. If not, the payer does not penalize the provider.<sup>1</sup> Because there is no risk to the provider, these programs can help expand a patient’s access to new therapies, which improves patient outcomes and allows providers to better meet targets in the future.

Shared savings programs are different from gain sharing programs, where hospitals directly pay physicians based on their ability to reduce hospital costs and meet quality of care standards.<sup>2</sup> Shared savings, on the other hand, allow insurers to decrease spending by incentivizing physicians to use the lowest cost services to meet these standards.



### 4. SHARED RISK

Like a shared savings program, when physicians fall below the set target amount allotted for treating a patient, they are allowed to keep the difference. However, if physicians spend over that limit, they have to pay the difference.

According to proprietary research conducted by R1 RCM, at least 50% of practices don’t participate in any kind of value-based contract. As healthcare continues to focus on value-based care, practices still using fee-for-service models will find it difficult to secure a steady source of reimbursement without optimizing the benefits that come from coding to the highest level of specificity.

**The second major need for coding expertise comes from new technology.** As it continues to advance, technology changes standard processes and adds greater complexity to the coding landscape. For example, when the U.S. adopted the latest ICD-10-CM codes in 2015, many small practices estimated that the cost of the transition would fall anywhere between \$56,639 and \$226,105.<sup>3</sup> For practices that have trouble keeping up with new coding changes, their claims can be denied from using outdated codes. And with new codes needing implementation every few months, this constant state of transition requires significant resources that could otherwise be allocated to patient care.

**Finally, new legislation accelerates the need for coding expertise.** Centers for Medicare and Medicaid Services (CMS) is currently making significant changes to coding and documentation requirements, which are set to take effect in 2021. For example, CMS has finalized add-on codes to more fully capture the resource costs of serving patients who require complex care. Changes to support the recent upsurge in telehealth are occurring as well and are expected to continue.

In particular, CMS has introduced three new codes:

- 1. Primary Case Complexity Code:** for the additional resources that a practice expends when caring for a patient that requires complex care.
- 2. Non-Procedural Specialty Care Complexity Code:** for the use of additional specialties outside of procedural care that a complex patient requires
- 3. Extended Visit Code:** for the additional time that a practice spends on caring for a patient that requires complex care.<sup>4</sup>

Generally speaking, physicians believe they are properly coding to capture the full breadth of and maximum reimbursement for the services they provide. But in many cases, this may not be true. For example, one physician who performed a routine alcohol screening on the appropriate patients believed he was properly coding for and receiving the maximum reimbursement for services performed. A review of this physician's coding practices revealed that the practice was leaving \$10,000 on the table by not coding to the highest level of specificity.

## The Solution: Adopt Coding Best Practices

**In today's value-based world, it is essential to properly code chronic conditions and report on them annually to ensure both quality of care and maximum reimbursement.** This means always documenting to the highest level of specificity in every specialty and for every contact with every patient – especially chronically ill patients with co-morbidities.

When physicians see chronically ill patients annually and document care to the highest level of specificity, *the payer has the information required to allocate sufficient funds to care for that patient* and support quality outcomes. In contrast, a lack of complete documentation due to improper coding can lead to a negative balance in the funds required to care for the patient.

*In a sense, coding is communication. Data and analytics are the common language that providers and payers share to help improve outcomes and costs at the same time. If a physician doesn't fully communicate a patient's comprehensive care needs, how can the payer know how much money to allocate?*

The engine that drives this level of coding specificity is the *Hierarchical Condition Category (HCC)* coding payment model. By leveraging it, physicians can help ensure payers are allocating the maximum funding for patients – empowering providers to deliver excellent care while being appropriately compensated.

## How HCC Coding Works

HCC coding is a value-based rule that offers more funding for sicker patients by assigning an HCC score based on the number of symptoms they display. Each symptom is assigned a specific value. This means that higher specificity coding grants patients more points, qualifying their care for higher reimbursement rates. For example, if a physician codes a patient for pneumonia, the total HCC score will be 1.323, which will result in a \$12,152.14 reimbursement.

On the other hand, if the physician had been more specific and coded for “Aspiration Pneumonia, Sepsis, Mild Malnutrition, Personal History of Nicotine Dependence and Disease Interaction Sepsis/Aspiration Pneumonia,” the total HCC score would have been 2.876, which would have yielded \$26,416.89– more than double what would have been made if the physician had coded to low specificity.

**Failing to code to the highest specificity can lower a patient’s HCC score, reducing the risk adjustment factor (RAF) and preventing physicians from getting the funds they need for treatment.**

In addition, a physician can potentially create a conflict with another provider (with a different specialty, usually) who codes to a higher specificity. By essentially providing two different sets of data for the same patient, it can become difficult for payers to determine which of the two claims is the most accurate, resulting in both claims potentially being denied.

Low Specificity	
Pneumonia	J18.9
<b>Total HCC</b>	<b>1.323</b>
	<b>\$12,152.14</b>

High Specificity	
Aspiration Pneumonia	J69.0 .067
Sepsis	A41.9 .346
Mild Malnutrition	E44.1 :260
Personal history of Nicotine Dependence	Z89.891 :0
Disease Interaction Sepsis/Aspiration Pneumonia	.321
<b>Total HCC</b>	<b>2.876</b>
	<b>\$26,416.89</b>

*\* Calculations based on most recent scoring protocols.*

## Five Best Practices

**What can physicians do to help overcome the complexity of coding and maximize reimbursements?**

Follow these five best practices to increase or retain revenue:

- 1. ELIMINATE UNDER-CODING:** Use the HCC model to your advantage and document to the highest level of specificity. This is perhaps the most common area in which practices can improve.
- 2. ELIMINATE UNDER-REPORTING:** Many physicians take their skills for granted and fail to document a number of small procedures made when diagnosing a patient. While these procedures may be routine for you, it’s important to report that you did them, as this level of specificity can significantly increase your HCC score. The physician who performed routine alcohol screenings, for example, failed to report them and lost an additional \$10,000 as a result.
- 3. USE THE CORRECT CODES:** Make sure that the codes you’re using are up to date. Failing to cross-check your codes with the latest guidelines could result in reimbursement denials.
- 4. CONNECT PAST REPORTS TO CURRENT SYMPTOMS:** Use a patient’s medical history to support higher reimbursements both today and in the future. A thorough background check can ensure whether a past diagnosis has any impact on a patient’s current condition. Past conditions can count toward your HCC if you can find a connection, raising the patient’s RAF and granting you more funding.
- 5. PERFORM CENSUS AUDITS:** Defend your documentation practices so revenue already received isn’t recouped by the payer.

**Following these five best practices can increase practice revenue by as much as 20%.** For example, R1 reduced denied claims for one practice by just over 80% (from 229 to 44), which saved the practice \$549,000. In another instance, a provider was choosing incorrect codes and the staff was indicating the wrong place of service. By addressing these issues, R1 helped reverse \$2 million in denials.

## Identifying Next Steps

**First and foremost, code to the highest level of specificity.** This holds true for both a traditional office visit or telemedicine. Use your medical decision-making as an overall guide for code selection. It's not about how much time you spent or what tests you ran, it's about each and every decision you made – regardless of how quick, simple, or easy that decision was. Noting every decision is the easiest way to make codes more specific.

Then, it's important to stay abreast of constantly changing coding requirements. Timely awareness of coding changes can pay great dividends in terms of payments received – and how quickly you receive them. That said, your staff is naturally focused on patient care and may not have the time or resources to ensure you're following coding best practices. **Coding education is a focus at R1: we have the staff, training and commitment to help ensure you follow the best practices that can lead to healthier patients and maximum reimbursements.**

## Unmatched ROI Through Measurable Results

R1 customers typically realize high-impact results such as:

**5-10% INCREASE**  
in RVUs via More Compliant, Complete Coding\*

**20-30% REDUCTION**  
in Coding Costs\*

\*Averages from R1 previous client engagements.

### SOURCES:

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4. AAPC.com. "Changes Ahead for CMS E/M Requirements and Reimbursement."



### ABOUT R1 RCM

R1 RCM is a leading provider of technology-enabled RCM services which transform and solve revenue cycle performance challenges across hospitals, health systems and group physician practices. R1's proven and scalable operating models seamlessly complement a healthcare organization's infrastructure, quickly driving sustainable improvements to net patient revenue and cash flows while reducing operating costs and enhancing the patient experience.

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