Accuracy and Productivity

AN ACCURATE HEALTHCARE CLAIM depends upon multiple components. To help ensure that medical claims are accurate coders stay up-to-date with annual coding changes, follow standard coding guidelines, and keep detailed patient records. Today, medical practices and facilities' financial success hinges upon their medical coders' ability to be accurate and productive.

Objective:

Summarize medical coder accuracy and productivity expectations and how they justify their code selections.

Key Terms:

accuracy
medical coding
modifier
overcoding
productivity
undercoding

Medical Coding Accuracy and Productivity Expectations

Medical coding is "the transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes." (Source: AAPC at https://www.aapc.com/medical-coding/medical-coding.aspx) It is a process that accurately assigns codes to the description of a patient's condition and communicates the correct information to insurance companies. Diagnosis codes are retrieved from medical records (e.g., physician's notes, lab and X-ray results, etc.).

Medical coding is an integral part of the healthcare system and requires the use of thousands of codes to ensure providers have the full picture of a patient diagnosis. It is a specialized occupation that requires the coder to be extremely accurate and detailed-oriented. Medical coding is crucial to ensure that health systems, hospitals, and physicians are properly reimbursed for the services they provide.

ACCURACY AND PRODUCTIVITY EXPECTATIONS

Accuracy

Accuracy is being true, correct, or exact. Medical coders seek an error-free identification of medical codes for an insurance claim. Coders play an important role in the healthcare system because they serve as the translator between service providers and insurance companies. They review patient records to assign the proper codes to the appropriate diagnoses, so the facilities and the providers can get paid. Coding claims correctly is essential and lets the insurance payer know the illness or injury of the patient and the method of treatment.

FIGURE 1. Medical coders must be adequately trained to maintain accuracy and productivity benchmarks. The current accuracy target for medical coders is 95%.

Correct reimbursement is dependent on coding accuracy. The current accuracy target for medical coders is 95% that was set when ICD-9 was in place. The 2016 introduction of ICD-10 codes saw accuracy levels decrease due to additional codes and changes requiring a higher level of specificity. As coders become more familiar with the new ICD-10 codes, 95% accuracy is again an expectation.

Maintaining the high standards for coding accuracy are essential for a facility's financial security and decreases the risk of audits and financial penalties. An error in the coding can result in the claim being denied. Incorrect diagnoses may not be covered by insurance plans, or it may only be partially covered, resulting in the underpayment to the provider for the services rendered, or a patient being unexpectedly responsible for paying for the services out of pocket.

ACCURACY FORMULA: Medical Coding Accuracy = Total Number of Records Reviewed – Total Number of Records With a Coding Error ÷ Total Number of Records Reviewed

FURTHER EXPLORATION...

ONLINE CONNECTION: Working From Home as a Medical Coder

The prospect of working from home is one of the most appealing aspects of the medical coding profession. At-home jobs offer coding professionals flexibility to balance their personal lives and careers. This type of flexibility is unusual for coders who work in offices or hospitals. Visit the "Medical Billing and Coding Online" website at https://www.medicalbillingandcodingonline.com/student-guide/working-from-home/ to learn more about the pros and cons of coding from home.

The Bureau of Labor Statistics estimates that 10 to 30 percent of medical billers and coders are stay-at-home contractors.

Productivity

Medical coder **productivity** is a measure of the number of patient charts completed within a certain amount of time. The average coder completes 15 to 18 patient records per day. Productivity standards allow an organization to measure employee performance and identify work processes that could be changed to improve productivity. For example:

- If 90 percent of the employees in a coding department can meet the standards, the remaining 10 percent might need more training or may have performance problems.
- If 50 percent of experienced coders can meet the productivity targets, workflow issues could be impeding (hindering) the coder's ability to do their work.

Overcoding and Undercoding

Overcoding is the reporting of a higher-level code than what accurately reflects the work performed by the physician. Overcoding often results in a higher payment being made by the insurance company. This can be considered fraud and can lead to prosecution, with legal and financial penalties.

Undercoding is failing to identify codes for all of the procedures performed or is coding procedures that are reimbursed at a lower rate. Undercoding results in lost revenue for the provider.

JUSTIFY CODE SELECTIONS

The medical billing process is facilitated by medical coding selections. Medical coding's recognizable codes bring uniformity to the billing process and are standard for all insurance companies. Specifically, medical coders conduct the following processes:

- Double-Checking: Reading every medical report at least twice, and never becoming "too familiar" with a particular code set or set of procedure codes help justify code selection. Many medical coding errors are avoided by double-checking the coding selection work.
- Justifying Code: When submitting claims for payment, the diagnosis codes reported with the service justify to the payer "why" a service was performed. The diagnosis reported helps support the medical necessity of the procedure. [NOTE: For a service to be considered medically necessary, it must be reasonable and necessary to diagnosis or treat a patient's medical condition.]
- Communicating with Providers: It is recommended that all coders, especially off-site coders, frequently talk with the providers. Medical coders work to develop relationships at each provider's office through regular communication with staff. Regular communication makes it easier for a medical coder to ask the provider for clarification on any particularly difficult medical reports.
- Documenting Physician Claims: The physicians' job is to document the medical record with accurate descriptions of all services, tests, and procedures exactly as performed and adequately detailing the patients' symptoms, complaints, conditions, illnesses, and injuries. Coders are only able to code what is documented. It is important that the codes recorded on the medical claim are consistent with the documentation within the medical record. While there are many different coding techniques, based on the medical practice specialty, there are some basic rules for coding that will always exist. Providers should ensure that their documentation accurately and meticulously reflects a full picture of the encounter. This maximizes reimbursement and revenue. Good documentation supports:
  - Accountability. Accessible records provide a system of checks and balances and allow for transparency in healthcare.
  - Communication. Precise and clear-cut documentation helps ensure proper communication and dissemination of information within the circle of care. Accurate information makes a big difference in a patient's condition coding.
  - Comorbid conditions. Detection of comorbid conditions, with proper documentation, increases the possibility of detecting conditions that may be responsive to treatment.
  - Validation. Good documentation allows coders to easily substantiate charges and treatment(s) provided. Good documentation helps validates care in situations when questions about billing or care occur.
  - Analytics. Healthcare analytics allow providers to run statistical analysis on their patient population and the services they render.

Additional Coding Justification Techniques

Staying Up-To-Date: Keeping coding skills sharp is imperative when justifying code selection. Medical coders must stay up-to-date about annual coding changes and follow updated coding guidelines. It's up to coders to learn any new or reorganized codes as they are introduced and to use those codes correctly. [NOTE: Part of the reason professional medical coding organizations, such as AAPC and AHIMA, require every member to complete a set amount of educational credits every two years.]

FIGURE 2. Many professional organizations, such as AAPC and AHIMA, require members to complete continuing educational hours to maintain their certification.

Modifiers: Selecting the appropriate modifiers is key to justifying code selections. A **modifier** is code that indicates a service or procedure has been performed and altered by some specific circumstance. Some codes require the use of modifiers.

Modifiers are described by using two-digit characters (e.g., numbers, two letters, or alphanumeric) and provide additional information about the service or procedure performed.

Modifiers are sometimes used to identify the area of the body where a procedure was performed, multiple procedures in the same session, or indicate a procedure was started but discontinued.

Online Research. Answering a medical coder's tough questions can be achieved through online research. Most medical coder professional organizations provide forums for difficult or puzzling encounters. These forums offer expert professionals from all facets of healthcare to answer tough questions.

Summary:

Accuracy is being true, correct, or exact. Medical coders seek an error-free identification of medical codes for an insurance claim. Coders play an important role in the healthcare system because they serve as the translator between service providers and insurance companies.

Coder productivity is measured in a variety of ways: commonly by number of charts reviewed, claims coded, claims submitted, and denials appealed. A medical coder averages 15 to 18 charts per day, but that number fluctuates depending on the specialty. Productivity averages are notably higher for coders who have certifications. Online coding sites are frequently used for difficult or puzzling encounters allowing coders to discuss coding conventions.

Checking Your Knowledge:

1. Describe the relationship between medical coders, healthcare facilities, and insurance companies.
2. What is the formula to calculate medical coder accuracy?
3. Differentiate between overcoding and undercoding.
4. What are three techniques to justify code selection?
5. What is the role of 'modifiers' in medical coding?

Expanding Your Knowledge:

Medical coding certifications are available for various professionals that work in medical records and health information. They are also offered by a number of different organizations. As you plan your career goals, do your research to get the basic facts about certification and opportunities for specialization.

The Medical Billing and Coding Online website serves as a comprehensive resource about medical billing and coding. The website provides reliable data to prospective billing and coding students, so you can make informed decisions about whether to pursue this career. The website is not affiliated with any schools or professional billing and coding associations and seeks only to provide an unbiased perspective for students. To learn more about 21 different specialty certifications visit the website at https://www.medicalbillingandcodingonline.com/certification/. The site emphasizes coding problems related to those fields, as well as professional requirements to work in each area.

Web Links:

Centers for Medicare & Medicaid Services: Coding and Billing Information

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html

A Student Guide to Medical Billing and Coding

https://www.medicalbillingandcodingonline.com/student-guide/

The Web's Free 2018 ICD-10-CM/PCS Medical Coding Reference

https://www.icd10data.com/