A Reflection on Coding and Compliance Changes

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As an organization, Coker Group is honored to work with many outstanding physicians, health systems, and healthcare organizations throughout the country. Seismic shifts, however, are occurring in healthcare. The growth of hospital employed physician networks, single/multi-specialty mega-groups, clinically integrated networks, and the emphasis on the importance of quality-based metrics are just a few of the responses to the changing landscape of healthcare.

Last week, I attended the American Health Lawyers Association (AHLA) Fraud and Compliance Forum and was reminded how important proper coding/documentation is for both inpatient and ambulatory services, as well as Clinical Documentation Improvement (CDI). When a conference starts its program with Stark-related issues, Anti-Kickback, and False Claims, you've captured my attention.

Many healthcare organizations do not know their weaknesses and vulnerabilities in coding and documentation. And what you don't know about the compliance and financial matters of your healthcare organization can hurt you. When you know your exposures, you can take appropriate action. An effective coding audit can result from a well thought-out compliance plan, a customized approach, and investment in the time and energy to create a proactive atmosphere for education and support.

You must begin by asking whether or not there is a written compliance plan in place. If one exists, you must then locate it. A plan buried in files communicates a lack of attention to following the policies. Once located, you must ensure the approach to compliance aligns with the written policies.

After aligning the compliance approach with the plan, invest time to educate physicians on coding policies and ways to improve. Approach this education carefully and respectfully. Be prepared, learn the physician's current level of coding knowledge, prioritize the message, and seek solutions. Communicate that it is proactive education and not correctional education.

Thankfully, Coker's coding team includes clinicians (nurses and physicians), AHIMA and AAPC certified advisors, as well as AHIMA-approved ICD-10-CM/PCS trainers. Coding has long been one of our core services to our clients, and we provide coding professionals for guidance and expertise in establishing a coding compliance plan that addresses the numerous areas of concern that the federal agencies are reviewing.

October 1, 2016, signified the end of the ICD-10-CM/PCS freeze for coding updates, along with the leniency granted by CMS for denials related to code specificity; therefore, it is imperative to maintain proper documentation and revenue integrity.

The value-based payment system will be based on 2017 claims data. Coding accuracy, with the appropriate documentation to support it, becomes paramount to successful revenue cycle management. Hopefully, your organization used the year of ICD-10 flexibility to improve documentation to a level that supports a higher specificity of coding. Unspecified codes still exist, but code assignment of unspecified codes should be limited and occur only in instances when clinical documentation is unknown or unavailable. Complete and accurate documentation will ensure optimal revenue and data integrity while demonstrating the quality of care provided.

Frequent documentation and coding assessments along with consistent provider and coding education will ensure compliance with all regulatory guidelines.

To learn more about how Coker can assist you and your organization with coding and compliance, please contact Craig Hunter, Senior Vice President, at chunter@cokergroup.com or by calling 678-832-2021.