How a Dedicated Coder Can Help Improve Your Bottom Line

by Cindy C. Parman, CPC, CPC-H, RCC

In an ideal world: sophisticated software allows staff to capture charges as they complete work. The charge capture system communicates with the billing system, and the codes are automatically transferred to the insurance claim. Technology provides a fool-proof system that eliminates the need for human intervention.

In the real world: CPT® coding guidelines, HCPCS Level II codes, payer policy, bundling issues, medical necessity, and constantly changing government regulations create a complex situation. As the level of complexity in medical coding increases, so does the risk of lost revenue and increased liability.

Whether oncology care is being provided in an office setting, at a freestanding cancer center, or at a hospital-based cancer program, adding a dedicated coder to your staff can benefit your program. Options include hiring an experienced coder or training an existing staff member; both will require a financial investment. Coders with nationally recognized coding certifications have generally completed a standard course of study, passed a nationally recognized coding examination (generally 150 questions or more), and are required to maintain CEUs on an annual basis. There are a number of 'certifications' available, but not all of them are nationally recognized. Nationally certified coders typically require a higher salary.

Here are 12 activities that a dedicated medical coder can complete:

1. Ensure the correct assignment of evaluation and management (E&M) codes, and provide immediate feedback on documentation issues. Approximately one third of the Medicare dollars spent annually reimburses patient visit services. As a result, E&M visits are an audit target and have been a focus of the Office of the Inspector General (OIG) Work Plan for several years. An average practice may lose $50,000 a year due to under-coding, often because staff or physicians are fearful that claims coded too high will be rejected, or trigger a payer audit.

2. Capture all services, detect potential for unbilled services, and track emerging reimbursement issues. Payer policy is dynamic. Oncology practices must stay up to date on covered services, new codes for emerging technologies, and changes in reimbursement allowances. Even small changes in procedural or diagnostic codes can result in increased payment. The use of current codes also results in the presentation of a more accurate provider profile to local payers.

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3. Maintain the accuracy of diagnosis codes. Correct diagnosis code assignment documents the medical necessity for complex services. In addition, oncologists frequently treat more than the malignancy, and diagnosis codes are necessary to report all patient conditions. For example, if an oncologist treats anemia, hair loss, skin erythema, nausea, pain, or other medical issues, these diagnosis codes would be reported in addition to the primary diagnosis representing the malignancy.

Diagnosis codes are added, deleted, and/or updated on Oct. 1 each year. With the elimination of the "grace period" to implement these changes, a dedicated medical coder can update diagnosis codes on charge tickets or in computer systems.

4. Ensure that correct procedure codes are submitted. CPT® and HCPCS Level II procedure codes are updated throughout the year, and a dedicated medical coder will remain current on these coding changes. The American Medical Association (AMA) updates Category III CPT procedure codes twice a year (during the annual update of the CPT Manual, and July 1). The Centers for Medicare & Medicaid Services (CMS) may perform quarterly updates of HCPCS Level II procedure codes that affect oncology practices.

5. Guarantee correct modifier application. Omission or incorrect use of procedure code modifiers can result in lost revenue. While modifier -59 requires close monitoring to ensure that it is not overused, other modifiers such as -76 (repeat service) and -58 (staged procedure) may require manual application in certain situations. A dedicated medical coder can ensure that claims requiring modifiers are submitted correctly the

first time, eliminating the need to re-file or appeal denials.

6. Ensure that charge tickets and dictation templates are updated and review all forms used for documentation. When superbills or charge capture documents are not updated annually (at a minimum), practices run the risk of assigning outdated or incomplete codes for diagnoses and procedures. Documentation of all services provided to an individual patient is crucial to reimbursement, and a dedicated coder can review any forms or templates for compliance with regulatory guidelines.

7. Decrease denials and ensure that timely filing deadlines are met. According to Medicare statistics for calendar year 2004, the specialty of radiation oncology experienced a denial rate of 7.2 percent of the services billed. It is possible that practices leave money on the table because billing staff do not have the time or the necessary resources to appeal denials, or maybe no single individual is responsible for following up on appeals.

8. Monitor managed care/contractual reimbursement. The medical coder can ensure that copayments, deductibles, and other patient responsibilities are communicated to front desk staff. To maintain an oncology practice's financial health, these repetitive, small dollar charges must not be neglected. In addition, a dedicated coder can track reimbursement by insurance payer and provide information that assists with future contract negotiations.

9. Monitor Medicare regulatory changes, such as quarterly changes to bundling guidelines, transferred patients from skilled nursing facilities, and medical necessity updates. In certain situations, procedures will not be covered by insurance and preauthorization may be required for complex treatment plans. For Medicare, an Advance Beneficiary Notice (ABN) is required to obtain payment from the patient for these non-covered services, and certain other insurers require a waiver of liability to be signed by the patient.

10. Remain current on non-physician practitioner, teaching physician, and locum tenens regulations.

11. Perform compliance monitoring (e.g., internal audits).

12. Provide physician and staff education.

Physicians and facilities are responsible for knowing the coding guidelines—or employing someone who does. In addition to staying current with coding changes, oncology practices and hospital-based programs need to establish processes to monitor compliance with payer guidelines. The good news is that through appropriate coding oncology practices and hospital-based programs may improve their bottom line.

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