

Top 5 Documentation and Coding Challenges Confronting Hospital Specialty Service Lines

Written by Sean Benson, co-founder and vice president of consulting, ProVation Medical
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Perhaps no process has as great an impact on a hospital's revenue cycle as procedure documentation and coding. When done accurately and efficiently, it can accelerate the billing cycle, reduce rejected or returned claims and increase revenues.

The reverse is also true. Problems with clinical documentation at the front-end negatively impact the ability to code appropriately on the back-end. It can cause delays in the revenue cycle when gaps in documentation must be filled. If those gaps remain unfilled, it can also lead to lost revenues due to under-coding or paybacks.

Specialty service lines like cardiology and gastroenterology are particularly susceptible to problems because of the highly complex nature of their documentation and coding environment. Further exacerbating the situation is the reality that separate teams of coders are typically responsible for reviewing documentation and assigning the codes used to generate bills for professional and facility fees.

The first step in preventing the revenue-draining problems associated with the specialty service line documentation and coding environment is understanding what the top challenges are. Here are the five most common.

1. Human error. Procedure documentation and coding is primarily a manual, redundant, inefficient paper-based process that is fraught with potential for human error. For example, during a cardiac catheterization procedure, physiological monitoring systems gather an abundance of information like hemodynamic data, medications, supplies used and other specific measurements. This information is often compiled in a data worksheet that the physician or technologist reviews and dictates for inclusion in the procedure record. That dictation is typically done in a separate room days or even weeks later, often by physicians who are rushing to keep up with busy procedure schedules.

Dictation is then transcribed and sent for coding. Once there, a coder must work with the information provided in the transcribed clinical documentation. They may spot potential gaps in documentation and follow up to obtain the necessary information to code at the most appropriate levels, leading to delays in billing. Worse, when that information is not provided or when the gaps are not identified and filled, the most likely outcome will be under-coding that leads to lower revenues.

2. Complex documentation. As previously noted, the complex nature of documentation and coding for specialty procedures such as cardiology, gastroenterology, etc., is a significant challenge for hospitals. In fact, one facility conducted an internal audit and found error rates as high as 90 percent in their cardiac catheterization lab, while another found an average error rate of 70 percent in cardiology peripherals.

More often than not, these errors are caused by documentation gaps. For example, a cardiac catheterization can entail five or more individually codeable components, any one of which can easily be missed. Or a physician performing dual catheterizations may mistakenly omit one side from dictation, or perhaps fail to note left ventriculography or the indication for renal

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arteriography during left cardiac catheterization.

But omissions are not the only problem. In some cases, failure to properly note findings — such as a congenital finding — will result in lower reimbursement rates.

3. Mismatched fee/service invoices. Since the teams of coders responsible for generating codes for professional and facility fees rarely work together or perform any kind of internal reconciliation, it is easy for ambiguous or incomplete documentation to be interpreted and therefore coded differently. The result is inconsistency between the two bills, raising a red flag with payers and the OIG.

In fact, the OIG estimates that 23 percent of all claims do not match between the facility and the professional components. These mismatched bills are typically returned by the payor and require costly reprocessing before they can be resubmitted. That is the best-case scenario. Worst case is a permanent loss of revenue and even fines by the OIG, which is now checking for billing discrepancies and has already levied record-breaking fines for construed overbilling.

4. Denied/delayed claims. Failure to properly capture data at any point along the clinical documentation and coding continuum may result in rejected claims because the appropriate documentation does not exist to support them. This causes significant delays in the revenue cycle as research is conducted to respond to payors' requests for justification.

When that documentation does not exist, delayed revenues become lost revenues due to outright rejection of claims. In many cases, inaccurate or incomplete documentation, or a lack of confidence in documentation, leads to lost revenues because facilities err on the side of caution and under-code rather than risk having claims rejected.

5. Repayment. Without appropriate systems in place to fully and accurately capture the data necessary to support payment claims, the likelihood of receiving a demand for repayment is high. What's more, the likelihood of winning on appeal is extremely low. For hospitals already operating on razor-thin margins, even a relatively small repayment can be a devastating blow to the bottom line.

Overbilling, even when unintentional, can have a significant impact on a hospital's bottom line, and not just due to repayment demands from payers. In addition to becoming a target for the RAC program, which recouped nearly \$1 billion during its three-year demonstration project, hospitals now face possible repayment demands under the Medicaid Integrity Project. Though no hard figures are yet available, many expect that MIP could recoup significantly more than RAC.

Eliminating the challenges

The good news in all of this is that it is possible to eliminate the redundancies, inefficiencies and human errors that underlie the top documentation and coding challenges plaguing hospitals today.

One strategy that has shown promise is the deployment of concurrent coding programs, which

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one study found resulted in the ability to code an increased severity of illness by 16 percent and risk of mortality by 17 percent. Additional findings include the ability to increased severity of illness coding by one category in 27 percent of patients and the risk of mortality by one category in 23 percent of patients. These types of changes can significantly impact financial reimbursement.

Establishing quality improvement teams is another way in which hospitals can improve documentation and coding. These teams, which are responsible for reviewing the quality of documentation in their peers' records, identify the most common errors and alert clinicians to their mistake so they can avoid repeating them in the future. It is also an opportunity to reiterate the proper codes and documentation techniques that should be used.

Ensuring that clinician coding education emphasizes documentation of secondary diagnoses is also useful. Service-line specific training results in improved quality and completeness of physician documentation, which results in faster and more accurate coding and higher billings.

While these strategies can reduce the problems plaguing the current manual processes, only automation through deployment of a specialty-specific automated documentation and coding solutions can eliminate them.

Automation eliminates the vast majority of human errors that are the root cause of over-payments and under-coding. It also speeds the revenue cycle by eliminating the delays caused by missing or incomplete documentation.

By automating procedure documentation and coding with a physician- and coder-friendly solution, hospitals can streamline and accelerate the overall process and remove the weaknesses inherent in a manual system. This results in an immediate and tangible ROI, as well as the added bonus of increased compliance and greater clinician, coder and patient satisfaction.

Ultimately, each hospital must determine which solution is best for them, both financially and procedurally. What is most important is that they begin addressing the documentation and coding challenges that are slowing the revenue cycle and impacting the bottom line.

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