PREPARING NONCODERS FOR NEW 2020 CODES

By Maureen Kelly and Fred Wulf

In August, the Centers for Medicare & Medicaid Services (CMS) published the Final Rule for fiscal year 2020's inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) code set changes. IPPS updates take effect for discharges occurring from October 1, 2019, through September 30, 2020. OPPS updates go into effect January 1, 2020.

Naturally, medical coders are expected to become familiar with the changes and be prepared to assign appropriate codes on or before the effective date. However, the effects of new codes and coding rules reach far beyond an organization's coding team. HIM, clinical documentation integrity, patient financial services, clinicians, executives, and even the IT team play a role in ensuring successful implementation of updated codes and a healthy revenue cycle.

A good program involves revenue cycle awareness and education across the organization. This article spotlights health care personnel who should be on top of code changes and provides recommended steps for preparing staff in those roles.

CDI Specialists and Physician Advisors: Establish Awareness

Preparing for the implementation of new ICD-10 codes or coding rules begins with ensuring that coding and clinical documentation improvement (CDI) teams are fully informed of the changes. With this knowledge, they can assist in preparing the rest of the organization. When implementing an updated code set, coding managers, CDI nurses, and physician advisors should meet to develop a launch plan well ahead of the CMS implementation dates. The following tasks should be on the agenda:

- Determine which codes apply to a particular facility.
- Review the clinical details that support the use of updated codes.
- Determine which service lines, specific staff, and systems will be affected by the changes.

Another essential aspect of the planning phase includes developing a training program and an awareness campaign to ensure clinicians understand the following:

- the date of the code changes and how they will affect their service line(s);
- the reason the codes have changed; and
- the clinical documentation specificity required to support appropriate code assignment.

IT and Information Systems: Update and Test

When codes are changed or added, they must be loaded into the EHR and other information and financial systems. Encoders and other coding support technologies must also be updated to include the new code set and tested to confirm compliance. Taking a team approach that includes IT, HIM, utilization management, and the chargemaster will allow organizations to verify the system configuration and updates.

Scheduling time for these activities in an implementation plan helps ensure an organization's readiness.

When updating EHR systems with new codes, pay particular attention to the user interface, clinical thought processes, and user workflows. For example, clinical staff expect the most commonly used code options to appear at the top of the drop-down selection list. Adding a new, more obscure code to the first position in the list will either frustrate clinicians or cause them to choose an inappropriate code. When the IT team works with the physician advisor on the rollout of new codes, it can validate the proper list order and avoid these pitfalls.

Physicians: Connect Clinical Rationale to Code Assignment Terminology

Almost every health care organization wants to streamline the documentation process and create a comprehensive clinical picture of the patient encounter to support efficient, accurate billing. Achieving those goals requires a common understanding among clinicians: the reason why a code was established/changed and the clinical rationale for its use.

The ICD-10 Coordination and Maintenance Committee supports the needs of clinicians and other health care roles who must be aware of coding changes. The committee supplies meeting minutes, video recordings, and reference materials that describe the reason for code creation and changes and provides guidance and case studies on how to use them.

Coding managers can use these materials to provide physicians with code examples, definitions of related clinical symptoms, supporting treatment, and more.

A proactive approach to clinician training can stimulate documentation compliance from the start, helping to alleviate unnecessary queries for physicians and free more time for patient care.

CFOs and Chief Operating Officers: Analyze and Understand Financial Impact

Health care leadership may sometimes think of medical coding and CDI as simply a production activity designed to reach the ultimate end goal: a paid bill. Yet, changes to the code set can have a dramatic effect on more than just discharged-not-final-billed statistics and revenue cycle speed. For example, code updates may include changes to diagnosis-related groups (DRGs), which affect the amount payers reimburse both providers and facilities.

The proposed ICD-10 update originally included 294 code changes, 30 title changes, and nearly 1,500 changes to the complication or comorbidity (CC) and major complication or comorbidity (MCC) designations. Eighty-seven percent of the proposed severity changes were downgrades or loss of CC/MCC status in relation to the DRG.

While CMS ultimately postponed the proposed severity-level downgrades in the Final Rule, health care organizations should be on the lookout for similar downgrades in future CMS updates.

What would this mean for health care organizations? Glenn Krauss, CEO of Core CDI, says, "When severity levels are decreased, facilities and providers would receive significantly lower reimbursement amounts for associated diagnoses. It is estimated that the DRGs originally targeted to be downgraded from a CC to a non-CC in fiscal year 2020 could have resulted in an approximate 33% decrease in reimbursement for each case. Those codes reflect common diagnoses that clinicians see and treat regularly, which would naturally lead to serious financial ramifications. With any type of DRG severity decrease, CFOs should carefully analyze their patient financial mix to identify anticipated payment reduction and prepare for the loss of revenue that will result."

Coding is an integral and vital part of the revenue cycle process. When health care executives understand the realities of coding changes, such as CC/MCC severity reductions, they can plan the best strategic approach to address such occurrences. To mitigate financial impacts and make informed decisions, they must explore the updated code set and use that information to analyze their patient portfolio. Working with coding subject matter experts can help achieve this goal.

Patient Financial Services: Empower to Win Appeals

Patient financial services, or the "back office," doesn't control the data that factor into the final bill. However, CFOs often turn to this group first when attempting to decrease denial rates related to medical necessity, clinical validation, and DRG downgrade issues.

A dedicated team reviews and responds to denials from payers. Based on the denial reason code or remarks, they work with coding, CDI, case management, or the chargemaster to resolve the issue and perhaps submit an appeal.

Sometimes the root cause of a denial can be a payer problem. Payers do not always load new code sets into their systems in a timely fashion (it happens more often that one would expect). In this case, when a bill is submitted to a payer with a DRG/principal diagnosis along with a new code, it results in an "unprocessable" or "invalid" reason code and is automatically denied.

When adequately trained on new codes and coding changes, an empowered denials and appeals team can immediately respond to a denied claim with validated codes and the supporting information necessary to refute the findings or gain an overturn. Over time, demonstrating solid coding knowledge can help a health care organization win a large percentage of appeals and, ultimately, streamline the denials management process.

New Codes. New Day. Opportunity for a New Mindset.

Robust utilization, high observation rates, and a strong case mix index can indicate a healthy revenue cycle. Yet even when health care organizations meet those criteria, they can experience increasing denial rates and negative operating margins, which are signs of possible revenue leakage.

The annual ICD-10 code set update offers the coding and CDI teams opportunities to create a new mindset across the organization and take ownership of the revenue cycle. The beginning of Medicare's new fiscal year is a good time to introduce the executive team to new key performance indicators designed to help drive down denial rates.

Beyond commonly reported metrics such as case coverage, agreement rates, and query rates (or even case mix index), measuring the number of denials received due to clinical validation and medical necessity can bring valuable awareness to cross-functional teams affected by the annual code update.

Organizationwide knowledge of nonpayment issues enables teams to explore the root cause of denials. From there, they can work together to drive improvements in areas such as training, information systems, documentation quality and specificity, and coder and CDI knowledge.

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