The #1 Reason You Are Losing Hundreds of Thousands of Dollars Each Year (and 10 strategies to fix it)

Back when ICD-10-CM was implemented, I sat in a room full of industry leaders, from associations to health plans. Under discussion was how to lessen the impact to providers. It was suggested to just tell providers they could just use unspecified codes.

I spoke up back then because I knew that advice would be a disservice to providers. I had worked with healthplans on their mappings, and I understood what their long-term intentions were going to be.

I am coming to you now because it is coming full circle. Providers are losing hundreds of thousands of dollars a year and are not even realizing this due to their use of unspecified codes. In my consulting business I have had so many providers come to me with the complaint that they just don't seem to get paid as much anymore. Here's what they don't understand.

Payers have implemented edits to downcode both level 4 and 5 codes based solely on diagnosis codes. They tell you they are doing it via their coding edits (if you are actually reading those), but what they fail to tell you is what codes they are applying to the edit. For example, one payer says:

"We evaluate the appropriateness of levels 4 and 5 E&M codes to determine the level of service billed correlates to the intensity of the service and severity of the illness. We review level 4 and 5 New and Established patients E&M codes for Office, Outpatient, Consultation and Ophthalmological services in context of these guidelines."

The E/M policy of course refers you to the AMA/CMS rules but nowhere spells out or tells you exactly what the edits are. "Intensity of the service" – "Severity of the Illness". Payers can't review all of your documentation, but they are banking on you doing it incorrectly. So, they enact edits to try to catch it based on diagnosis coding.

A review of one practice showed the potential of losing over $260,000 based off the use of unspecified codes.

The only way for you to truly catch this downcoding is to put all of your fee schedules into your PM system so that your payment posters can catch this, otherwise, the audit process after the fact is even more time consuming.

Even if it is caught, the amount of money you will lose to appeals is significant. Practice data for the above referenced practice showed about 600 instances in one month. It costs about $30 to appeal a claim. Meaning not only are they losing $260,000 on downcoding, they are losing another $180,000 on appeals. That totals $440,000. Staggering.

Here are some strategies to protect your practice.

1. Run a practice management report on frequency of your diagnosis codes. Start reviewing for unspecified codes, and work on education to stop using those codes.
2. Work with your EHR vendor to remove the unspecified codes from your system. If your EHR system has a quick pick feature on the diagnosis coding be sure to not default to older unspecified conditions.
3. Add your fee schedules to your PM system. Yes, this is extremely burdensome to start with but then only requires yearly updates. If your PM system doesn't allow for the addition of the fee schedules work with an outside vendor to reverse adjudicate the claim for you. I am a huge fan of Experian's Contract Manager.
4. Audit your billers. Make sure they are not just clicking through the warnings when payment posting so that you are actually capturing the lost revenue and appealing.
5. Pay to have someone audit this. The math above shows you must have someone working those appeals.
6. Stop putting routine health codes on E/M visits. Save it for the preventive. If you are treating medical, then leave it at that, period. Using it as secondary or lesser diagnosis codes does not reduce your risk of downcoding.
7. Don't just start billing level 3's to keep yourself off the radar. This is financial suicide.
8. Don't accept the lesser payments when your documentation clearly supports the level billed. Fight.
9. When you notice unfair edits and downcodes and you cannot influence change alone, involve your specialty societies and state medical societies.
10. Educate, educate, educate. Include the impact on your audits and educate on the better diagnosis codes that could have been used.

The best defense is a good offense. You lose 100% of the appeals you don't try for. Most appeals can be won with good documentation. But the best way to not have to try to appeal is by submitting the best diagnosis code in the first place.

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Rhonda has authored numerous articles for healthcare publications and has spoken at numerous national conferences for AAPC, AMA, HIMSS, MGMA, AAO-HNS, AGA and ASOA. She is a past co-chair for the WEDI ICD-10 Implementation Workgroup, Advanced Payment Models Workgroup and has provided testimony for ICD-10 and standardization of data for NCVHS and is on the National Advisory Board for AAPC. Rhonda is a John Maxwell Team Executive Director where she fulfills her life's purpose by adding value to other people.