Decisions, decisions: Should you outsource coding to comply with ICD-10?

The primary function of an ambulatory surgery center (ASC) is simple and easily described: to perform surgery for which patients can be discharged within 24 hours, to do this efficiently, safely, and cost effectively, and to collect adequate, timely payment.

The path to achieving these results is not so simple.

To be paid for a procedure, an ASC must submit a claim to an insurer or to the Centers for Medicare & Medicaid Services (CMS) with very specific information about the procedure—not in words, but in codes of letters and numbers.

Some physicians have made the effort to learn how to code claim forms for their specialties and the various services they provide, but these physicians are the exception rather than the rule. Most ASC employees, like their hospital counterparts, have too many other responsibilities and interests to get involved in coding. Even many billing professionals, who work with the codes when submitting claims, often find the vast array of codes intimidatingly complex.

Later this year, the stakes will rise when the US healthcare system converts to the global code standard, International Classification of Diseases-10 (ICD-10), and related procedural codes. The new system will contain an estimated 155,000 codes, though “only” about 70,000 will apply to ASCs.

Many ASC managers are saying, “Perhaps it’s time to call in a specialist.”

More than a detail

“Not everyone is a coder,” explains Reacal Martin, herself a coder. She is 1 of 126,400 members of the American Academy of Professional Coders (AAPC) in Salt Lake City, which certifies medical coders, billers, auditors, and practice managers. Martin was part of an AAPC team that developed a test for the ASC coding credential. “The coding world is not as simple as the world believes,” she says.

Coding is a team effort, with each specialty making a contribution. Whenever a patient receives treatment, the provider must document the service. A coder’s job is to translate the information in the documentation into codes based on details of the specific procedure. The codes also incorporate laboratory tests, imaging, and information from the patient’s medical record. The codes appear on the claim or bill to back up the charges. “It always goes back to the documentation,” Martin notes. “A coder is only as good as the documentation.”

For that reason, she is gratified when physicians take an interest in coding. Martin works with The Coding Network, a company in Beverly Hills, California, that provides outsource coders to ASCs. Lately, she has been working with a group of neurosurgeons, 1 of whom is a very good coder. “I was excited to hear that 1 physician felt it was important enough to take a class directly after medical school,” she says.

As the AAPC website notes, a coder’s training starts with an understanding of anatomy and medical terminology. Then the coder must master the provisions in various insurance plans and regulations.

The codes themselves are developed and published by the American Medical As-
What codes mean

If an audit reveals repeated errors in coding of claim forms, an ambulatory surgery center (ASC) faces a couple of risks; either it is underreporting its services and thus losing money, or it is overreporting them and subjecting itself to liability for noncompliance, or even fraud.

As US healthcare providers begin the transition to ICD-10 during 2014, there will be more room than ever for error. To illustrate, an ASC audit by The Coding Network revealed these wrong codes for a hammertoe repair: use of an obsolete modifier, “SG”; 2 wrong codes; and a missing modifier for the second right toe, “T6.”

CPT codes for services that an ASC is likely to provide include the following:

- Evaluation and management: 99201–99499
- Anesthesia: 00100–01999; 99100–99150
- Surgery: 10021–69990
- Radiology: 70010–79999
- Pathology and laboratory: 80047–89398
- Medicine: 90281–99099; 99151–99199; 99500–99607

For specific transactions, the codes under ICD-9 have 3 to 5 digits, and they may be alpha or numeric. If the first digit is a letter, it may be only E or V. The first 3 digits indicate the procedural or diagnosis category; the final 2 indicate the anatomic site and severity.

Under ICD-10, codes will be up to 7 digits, with different alphanumeric combinations, and offer more detailed information about the case. The following example from the American Medical Association shows how the longer code for a treatment of a broken arm contains more specific detail:

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S52   Fracture of forearm
S52.5 Fracture of lower end of radius
S52.52 Torus fracture of lower end of radius
S52.521 Torus fracture of lower end of right radius
S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture
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The first 3 characters, S52, indicate the category. The fourth and fifth characters of 52 add clinical detail and anatomic site. The sixth character, 1, indicates laterality (right radius). The seventh character, A, is an extension that provides additional information, which means “initial encounter” in this example.

Budgets and revenues

There are many factors to consider when deciding whether to outsource, but the principal one is typically financial.

If payments are not processed quickly enough, or if claims are returned because of faulty codes, the ASC could lose money.

The goal, Martin says, is to maximize reimbursement through rapid, accurate submission of claims. “The reason outsourcing is a great option for surgery centers,” she says, “is that the turnaround time is wonderful. I have 24 hours from the procedure report to when the bill is transmitted.”

However, part of the debate over whether to outsource is that for some managers it may appear to be an added expense. Cross training the billing staff may seem more economical than paying others to do the coding.

The AAPC estimates the average monthly salary for a certified coder is $3,500, as does the job website Indeed.com. The Coding Network estimates that taxes and benefits bring the monthly average to more than $5,000. In contrast, The Coding Network charges a flat $17 per case up to 100 cases per month, and then fees decline with increasing volume.
Compliance concerns
Deciding whether to outsource coding is not only about money, however; it’s also about convenience. Contract coding providers offer vacation coverage, training, and auditing services.

More critically, they offer protection from legal liability that could arise from failure to comply with coding and billing regulations. In the past, healthcare providers have been charged with criminal offenses in cases of repeated coding errors. For example, choosing the wrong code could result in upcoding, or charging for a higher level service than was performed.

Any decision to bring in outside coders should begin with a thorough assessment of the present situation. AAPC and other professional associations, along with Internet research, can identify outside auditors specializing in ASC procedures.

Choosing an outsource coder
Regardless of their employment status, coders are subject to patient privacy laws. There is no substitute for independent research before selecting a coder. An organization with staff based outside the US may present a risk of violation of the Health Insurance Portability and Accountability Act (HIPAA), so it is important to ask about location.

Coders should be certified by AAPC or a similar organization to ensure that they have regular training and current knowledge. Expertise will be more critical than ever as the industry prepares to convert from the current ICD-9 codes to ICD-10 beginning October 1.

The new codes will be longer and more complex, covering more detailed diagnostic and procedural information to conform to World Health Organization standards. ASC staff will need to be trained and claim systems will need to be upgraded (as will those of insurers) to make the transition.

—Paula DeJohn

References
