Overcoding:

Putting a Strategic Stop to a Silent Revenue Killer

Overcoding is in the crosshairs as the Centers for Medicare and Medicaid Services (CMS) continues its quest to ferret out fraud and abuse and recoup improper reimbursements—a focus that returns $8 for every $1 spent on audits. There are no signs that they are letting up any time in the future, as the federal government has increased funding for audits and fraud investigations.

Overcoding—intentional or accidental—can bring significant fines in addition to repayment of the original claim. And the reputational damage of a fraud finding is hard to overcome. As such, provider organizations need to be vigilant with their compliance and education programs to avoid finding themselves on the losing end of a CMS or other third-party audit. Overpayments also have a negative impact on patient acquisition and experience, thereby deflating growth. The whole idea of declaring financial results to the public domain and restating the results repeatedly due to uncertain compliance risks is a nightmare for most of the financial leaders within health systems.

CMS Gets Serious

Together, CMS, the Department of Justice (DOJ), and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) are investing in predictive modeling and artificial intelligence tools to scrutinize claims more closely before adjudication to reduce improper payments without adding administrative burden. At the same time, retrospective audits can claw back revenue from current and past years, putting financial pressure on providers that have long used those funds for continuing operations.

According to the MDaudit Annual Benchmark Report, 82% of all claim denials are associated with Medicare, so providers must focus their efforts on this area—even as federal auditing efforts continue to proliferate. On the commercial side, Medicare Advantage and Medicaid managed care plans are under constant scrutiny as OIG and CMS have ongoing concerns about efforts to combat fraud, including a lack of fraud referrals.

The FY 2023 HHS budget provides $2.5 billion in mandatory and discretionary investments for the Healthcare Fraud and Abuse Control (HCFAC) and Medicaid Integrity Programs. The budgeted $899 million in discretionary HCFAC funding is more than $26 million above the FY 2022 enacted level.

According to a recent NPR article, 90 audits of Medicare Advantage (MA) plans from 2011-2013 found an average yearly overbill of more than $1,000 per patient. Extrapolated across populations, that represents $650 million in excess payments. Further, a New York Times analysis finds that eight of the largest MA insurers, representing more than two-thirds of the market, have submitted inflated bills to the government. Additionally, four of the five largest providers have been accused of fraudulent upcoding by the government.

If you don't think the federal government is serious about overcoding, think again.

Overcoding Problem Areas

Overcoding remains an issue across the healthcare landscape. At the office-visit level, compliance teams

should pay attention to Evaluation and Management (E/M) coding and justification of different levels to maximize reimbursement. In hospital billing, bundling is a major driver of compliance issues, followed by billing and coding errors. In 2022, overcoded charges reclaimed 21% of the revenue recovered from undercoded claims.

Compliance teams should be efficient in managing external payer requests to retain at-risk revenues, with close attention paid to the below areas for overcoding, medical necessity, clinical documentation, and bundling-related issues. Getting paid on time for these high-value services can significantly impact an organization's profitability and financial health. Pay particular attention to these focus areas:

Outpatient Billing:

- Surgeries that involve multiple services performed by the same surgeon must be billed together and cannot be separately billed by different physicians
- Surgeries: orthopedic, spine, neurosurgery
- Specialty drugs and clinical justification for units administered for treatment
- Hospital observation care services
- Implants/medical devices
- Laboratory: chemistry, general classification, hematology, immunology, bacterial

Inpatient Billing:

- Short stay inpatient
- Rehabilitation facilities
- DRGs that drive higher healthcare costs
- Sepsis
- Cardiology
- Digestive system
- Kidney

Compliance teams should have a consistent playbook for auditing these claims, appealing denials to payers, and educating providers on mistakes.

Better Coding Compliance

When it comes to a proactive strategy, as tempting as it may be, undercoding claims is not the answer to overcoding to avoid an audit or potential federal penalties. Indeed, undercoding simply makes the problem worse by depriving organizations of critical income at a time when expenses are rising faster than revenues. The key is to accurately capture all aspects of a patient visit, a test, or a procedure the first time.

Education is critical to any overcoding prevention strategy, as coding changes occur frequently. Assign someone to update internal coding manuals frequently, sending out specific updates and links when warranted. Reviewing updates can become a central facet of an ongoing educational program for coders. Finally, schedule coder audits more frequently to ensure compliance with coding procedures and policies while reducing errors that can delay revenue.

Innovative and robust auditing workflows are necessary to ensure claims are accurate and reflect the particulars of the patient encounter. While undercoding may mean missing out on vital revenue to which the provider or facility is entitled, overcoding is a more significant problem that puts organizations at risk for audits that can stretch back years and jeopardize significant revenue, not to mention reputational risk and patient loyalty.

Healthcare organizations can benefit on the compliance front from a single-platform approach to coding workflows that eliminate manual processes and streamline tasks such as auditing, rebuttal, follow-up audits, and reporting. Workflows should include risk-based and retrospective audits for professional, inpatient, and outpatient charges, as well as the ability to identify new coders who may need additional guidance. The platform should enable dialog between coders and auditors, while providing full visibility into coder workloads and auditing tasks. It should also enable full reporting of end-to-end activities and outcomes.

A Proactive Compliance Strategy

CMS has made it clear that eradicating fraud, waste, and abuse is a top priority. And historically, where CMS goes, so do commercial payers. With overcoding in the crosshairs, healthcare organizations should take immediate steps to implement a proactive, tech-enabled strategy to ensure coding compliance and reduce the risk of external audits.

The right strategy can also reduce delays, thereby accelerating the revenue cycle while ensuring providers are reimbursed at the highest appropriate level for services provided.

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