



The 10-Year Coder Challenge: Growing Your Skills beyond CCs and MCCs

By Kristi Pollard, RHIT, CCS, CPC, CIRCC, AHIMA-Approved ICD-10-CM/PCS Trainer
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Today's coder must embrace APR-DRGs and HCCs in order to stay relevant.

At the beginning of the year, Facebook's "10-year challenge" hit the web, with users posting comparison profile pictures from 2009 alongside their 2019 selfies. I've since seen a recent resurgence of the challenge over the last week and will admit that even I took part by posting a drawn image of a 2009 stick figure alongside a plumper 2019 version holding tacos. That got me thinking about the coding industry, what's happened in the last 10 years, and where we're headed in the next decade.

In 2009, I launched my Coder Coach blog and started regularly presenting to coding and billing students at a local trade school, with the intent of giving them additional intel on what they won't learn in school. My blogs and presentations were filled with tidbits on what to expect as a coder, why it's so hard to get a coding job, and how you land that first position. They were also filled with (almost) timeless hits, such as "What the Heck is DRG?" and "Why Should I Care About Case Mix?" – a primer on MS-DRGs in "simple" terms.

Ten years later, and a lot has happened. We implemented ICD-10, and have seen the emergence of risk adjustment models in coding. We've seen clinical documentation improvement (CDI) programs explode for both the inpatient and outpatient settings, more electronic medical records (EMRs) and computer-assisted coding (CAC) programs executed, and what now seems to be mainstream acceptance of offshore coding.

The industry is changing, but the number one question from new coders continues to be, "how do I get coding experience when the requirement for every coding position is a baseline 2-3 years of experience?" While the question hasn't changed over the last decade, what has is the number of certified coders competing for a limited number of positions. Add to that the uncertainty of the future of coding for many professionals, and the question is now, "how do I set myself apart?"

As with others, my own career has evolved over the last almost 25 years. Conveying my own career path as an example of how to climb the coding career ladder is no

longer relevant. I've worked most of the last 10 years for one company, writing and presenting coding education programs and assisting in auditing, and here's my new secret for sustainability, as a career coder: you need to be more than a coder. The industry is changing, and you need to change with it. There was a time when knowing CCs and MCCs and the intricacies of MS-DRG modeling was enough, but with the increased focus on APR-DRGs and risk adjustment, a coder's staying power lies beyond MS-DRGs.

Here's a shortlist of the significant areas I think coders need to brush up on to ensure their staying power:

- The severity of illness (SOI) and risk of mortality (ROM) scores in the All-Patient Refined Diagnosis-Related Groups (APR-DRGs): If you haven't been exposed to APR-DRGs, or you have limited knowledge of them, now is the time to learn more. APR-DRGs are used by most state Medicaid plans for reimbursement, but many hospitals use them for statistical data. In short, this DRG model focuses on how sick the patient is (SOI) combined with the likelihood of death (ROM). I've seen them used extensively in pediatric hospitals, which is a specialty all its own. Working knowledge of APR-DRGs could give you a leg up when applying for a coding position at such an organization. There's a myth about APR-DRGs, that they can only be used for Medicaid. That's not true; any inpatient case can be grouped to an APR-DRG (which, again, can be useful for internal data mining). This type of data has a high value for organizational decision-makers.
- Risk adjustment models: Risk adjustment is the new buzz-term in coding. I first heard about them about 15 years ago, when a physician with a coding interest described them to me as DRGs for physicians. Like assessing risk before insuring a person's life or car, risk adjustment models individually assess the financial risk of providing medical care under certain payment plans. CMS-HCCs are used by Medicare Part C (Medicare Advantage), and HHS-HCCs are used under the Patient Protection and Affordable Care Act. While DRG systems focus on acute conditions, HCCs more often focus on chronic conditions, and many nonspecific codes are excluded from the models. If you are a hospital coder who thinks HCCs are all about physician office coding, these programs also use data from hospital inpatient and outpatient encounters. In my view, HCCs and risk adjustment models are the future of coding, and they will continue to evolve. As coding professionals, now is the time to learn about HCCs, and how they are impacted by documentation.
- CPT codes outside the surgical range: I think this concept is not as foreign as it was 15 years ago. I've done a lot of work with interventional radiology and cardiac catheterization lab coding in hospitals, and often the cases are hardcoded by the chargemaster. Since many of the codes assigned by

these departments are outside the traditional surgical range of CPT codes that are assigned by health information management (HIM) department coders, many coders have adopted an “it’s not my problem” attitude. But there is job security in knowing how to apply all codes that are reportable in a hospital setting. We’ve seen the emergence of skilled specialty coders who work with clinical departments, the chargemaster team, and billing to ensure clean claims.

- CAC review and optimization: This may come as a surprise. The number one issue my auditing coworkers find when auditing our clients is incorrect secondary diagnosis reporting. And many of our clients utilize CAC software. As we’ve dug into the issues, the over-capture of secondary diagnosis codes doesn’t appear to be a knowledge gap for coders, but rather a lack of “reading” the codes before completing the record to make sure it accurately and concisely tells the patient’s story (I refer you back to my July article about patient-focused coding).
- Artificial intelligence (AI): Full disclosure – this isn’t my area of expertise. As more coding functions are going the way of AI, such as CAC and the use of SNOMED-CT within EMRs, it’s becoming more critical for coders to understand how coding is being used and is impacted by AI. You can either be intimidated by this phenomenon (which the casual observer may think will replace coders someday), or you can become a master of it. If you have the opportunity to become a software superuser, take advantage of it!

Don’t Fall for the Red Herring

ICD-11 is coming. And while we’re seeing articles about this new coding system, which was recently released by the World Health Organization (WHO), it’s not an immediate need. I’m not saying those articles aren’t valuable and you shouldn’t read them, but the points I listed above are more important to actualize now. Don’t spend too much energy on the next coding system. Spend your time and energy becoming an expert not only on code assignment, but on the use of coding data. That is what will give you staying power as coding jobs are outsourced and more coding functions are relegated to the AI pile.

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Kristi Pollard, RHIT, CCS, CPC, CIRCC, AHIMA-Approved ICD-10-CM/PCS Trainer

Kristi Pollard is a senior coding consultant at Haugen Consulting Group. Kristi has more than 20 years of industry experience. She develops web-based and instructor-led training material and conducts training in ICD-10-CM/PCS. Kristi has an extensive background in coding education and consulting and is a national speaker on topics related to ICD-9, ICD-10, and CPT coding, as well as code-based reimbursement. Kristi is a member of the ICD10monitor editorial board and a popular guest on Talk Ten Tuesdays.

kpollard@thehaugengroup.com

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445 Minnesota Street | Suite 514 | St. Paul, MN | 55101 • TOLL FREE: 800.252.1578