Legislative Fiscal Bureau

One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

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May 23, 2013 Joint Committee on Finance Paper #337

Certified Medical Coder Position (DHS -- Medical Assistance and FoodShare -- Administration)

[LFB 2013-15 Budget Summary: Page 244, #7]

CURRENT LAW

There are several diagnostic and procedure codes that are commonly used by health care providers to submit claims for reimbursement for the medical services they provide, including the international statistical classification of health diseases and related health problems (ICD), diagnostic related groups (DRGs) used by hospitals, health care procedure coding system (HCPCS) and the current procedural terminology (CPT) codes use by physicians and other medical professionals. These codes serve as the basis for reimbursement under the state's medical assistance (MA) program and other payers of health care services.

Professional medical coders have expertise in translating diagnosis and treatments into medical codes. Two associations currently certify individuals who have completed their training requirements -- the American Association of Professional Coders and the American Health Information Management Association.

The Department of Health Services (DHS) currently employs 2.0 positions who have become certified as medical coders. One is a program and policy analyst position in the Division of Health Care Access and Accountability, but the position's primary responsibilities are not related to coding. The second position is a nurse consultant for mental health and substance abuse services in the Office of the Inspector General. While the position uses her coding expertise as it relates to mental health and substance abuse services, she does not work with all provider types and specialties.

GOVERNOR

Reduce funding by $1,179,100 (-$476,800 GPR and -$702,300 FED) in 2013-14 and by $2,412,400 (-$980,700 GPR and -$1,431,700 FED) in 2014-15 to reflect the estimated net savings that would result by authorizing 1.0 additional position (0.5 GPR position and 0.5 FED position), beginning in 2013-14, to review DHS reimbursement policies and to ensure accuracy in the medical procedure codes DHS uses as the basis for reimbursing health care providers under the state's MA program. This item includes: (a) funding to support a certified medical coder ($35,500 GPR and $35,500 FED in 2013-14 and $43,800 GPR and $43,800 FED in 2014-15); and (b) a reduction in MA benefits funding to reflect the administration's estimates of savings that could be realized by improving payment accuracy (-$512,300 GPR and -$737,800 FED in 2013-14, and -$1,024,500 GPR and -$1,475,500 FED in 2014-15).

DISCUSSION POINTS

1. Under provisions enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Secretary of the U.S. Department of Health and Human Services (DHHS) is responsible for developing and adopting standards and requirements to facilitate the electronic transmission of certain health care information. In January, 2009, DHHS promulgated rules that modify the standard medical data code sets used for coding diagnosis and inpatient hospital procedures by adopting: (a) the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding; and (b) the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. These new codes replace the previous versions (ICD-9-CM and ICD-9-PCS).

2. The ICD-9-CM, which has been used by health care providers and payers in the United States since 1979, is currently used to calculate provider payments, compile statistics, and assess health care quality. Primarily due to changes in medical procedures and technologies over the past 30 years, the current ICD-9-CM cannot incorporate emerging diagnoses and procedures, and cannot identify diagnoses and procedures precisely. The ICD-10-CM will incorporate greater specificity and clinical information, which DHHS expects will result in improved ability to measure health care services, increased sensitivity in determining conditions for provider reimbursement purposes, improvements to conducting public health surveillance, and decreased need for providers to include supporting documentation with the claims they submit. The ICD-10-PCS provides improved detail on procedure, can be easily modified to incorporate new technology and devices, and has a more logical structure, than the ICD-9-PCS.

3. By federal rule, every health plan covered by HIPAA, including all state MA agencies, must conduct health care transactions using the ICD-10 codes by October 1, 2014. Claims for all services and hospital inpatient procedures performed on or after that date must use the ICD-10 codes. Claims that do not use ICD-10 codes cannot be processed. However, claims for services and inpatient procedures provided before that date may use the ICD-9 codes.

4. Health plans and providers are expected to incur significant costs in converting to

the new system. In narrative that accompanied the final DHHS rule, promulgated in January, 2009, DHHS estimated that state MA agencies would incur information technology systems change costs totaling between $200 million and $400 million. These costs are funded 90% with federal funds and 10% with state funds. Under a separate item, Assembly Bill 40 would provide DHS an additional $9,900,000 ($990,000 GPR and $8,910,000 FED) in the 2013-15 biennium to fund contracted services provided by the state's fiscal agent to implement changes to the Department's claim processing system to accommodate the new codes. DHS indicates that the medical coder position would be expected to devote a significant amount of time reviewing the new codes for accuracy as the transition occurs and will be critical to a successful conversion to the new codes.

5. In addition to the work DHS will incur to implement the ICD-10-CM codes, DHS makes several arguments for the additional position, including:

a. It is standard practice for private insurance companies to employ certified coders to ensure claims they receive are properly coded.

b. DHS currently has insufficient expertise with respect to these codes, with the result that the MA program may be paying currently for services for which it should not be paying, or at higher rates than it should pay, based on the services MA recipients are receiving.

c. Certified medical coders can better respond to claims-related questions from health care providers.

6. Although DHS has cited examples of how DHS could have benefitted from the expertise of an experienced, certified medical coder, it is difficult to estimate the potential cost savings to the MA program that might result from authorizing this position. The administration's annualized saving estimate of $2.5 million (all funds) is based on DHS estimates of average savings that are realized with each DHS auditor. However, while auditors generally review claims payments after they have been made, the medical coder would assist DHS in ensuring that MA payment is accurate before the provider receives it.

7. Based on work relating to the transition to the new ICD-CM codes and the potential to reduce MA benefits costs, it is likely that DHS would benefit from employing an individual with this specialized expertise and whose responsibilities include serving as a resource to other analysts as MA claims policies are developed and modified, and to review MA claims policies for coding errors. For these reasons, the Committee could adopt the Governor's recommendations (Alternative 1).

8. However, if the Committee wishes to ensure that DHS has a staff person with this expertise, but does not wish to increase state positions, it could delete the additional position that would be provided in the bill for this purpose and instead direct DHS, by January 1, 2014, to allocate 1.0 position in the Division of Health Care Access and Accountability who has been certified as a medical coder to work exclusively on improving payment accuracy for all MA services. (The funding in the bill that would be provided to support this position reflects an estimated January 1, 2014, start date.).

Under this option, DHS would be required to reprioritize workload within the Division to meet this need, which may reduce the Department's ability to complete other high priority work. The Division is currently authorized approximately 648 positions (304 GPR positions and 344 FED positions) to administer the MA and FoodShare programs. This number includes 357 (all funds) positions that provide income maintenance services in Milwaukee County. Consequently, there are considerably fewer base positions in the DHS Madison office (291) that would be available to carry out this function if DHS were required to reallocate a position for this purpose.

9. Finally, if the Committee did not wish to authorize and fund an additional position to DHS, as recommended by the Governor, but did not want to direct DHS to perform a function without providing additional resources, it could delete this item from the bill. Under this option, DHS could decide whether or not to allocate a current position for this purpose.

ALTERNATIVES

1. Adopt the Governor's recommendation.

2. Modify the Governor's recommendation by deleting 1.0 position (-0.50 GPR position and -0.50 FED position), beginning in 2013-14, and reducing funding by $71,000 (-$35,500 GPR and -$35,500 FED) in 2013-14 and by $87,600 (-$43,800 GPR and -$43,800 FED) in 2014-15. Further, modify Chapter 49 provisions relating to the administration of the MA program to require DHS to maintain at least 1.0 certified medical coder position to improve payment accuracy for all services the MA program covers, beginning January 1, 2014.

ALT 2	**Change to Bill**	
	Funding	Positions
GPR	- $79,300	- 0.50
FED	- 79,300	- 0.50
Total	- $158,600	- 1.00

3. Delete provision.

ALT 3	**Change to Bill**	
	Funding	Positions
GPR	$1,457,500	- 0.50
FED	2,134,000	- 0.50
Total	$3,591,500	- 1.00

Prepared by: Charles Morgan