

Single path coding and the growing complexity of hospital reimbursement

Combining facility and professional coding can better equip you for the future



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Introduction

As reimbursement pressures mount, is your medical coding strategy built for long-term sustainability?

In today's reimbursement landscape, coding directly influences cash flow, payer audit exposure, risk adjustment, and performance reporting. As healthcare organizations adapt to value-based care payment models, the way coding teams operate can either strengthen financial stability or introduce avoidable risk.

This guide demonstrates how single path coding replaces fragmented coding processes and consolidates them into one streamlined workflow. Hospitals considering a transition to a single path approach can expect a more consistent, accurate, and efficient revenue cycle.

How traditional coding structures create financial risk

Hospitals face growing pressure to protect margins while managing increasing complexity in coding and reimbursement. Inefficient coding processes, rising payer scrutiny, and changing reimbursement models are creating unprecedented pressure on revenue cycle management teams. Every day, coders spend more time handling denials and appeals.

Despite years of investment in revenue cycle optimization, one inefficiency remains common — facility and professional coding, sometimes known as pro fee coding, still operate separately.

Hospitals historically focused on facility coding. The acquisition of physician practices and employment of more physicians and mid-level medical professionals required the addition of professional coders.

Today, this split system creates duplicate work, inconsistencies, and delays. It contributes to inefficiencies in the revenue cycle that are responsible for the loss of 15 cents of every healthcare dollar¹. As hospitals seek ways to reduce expenses and increase revenue, transitioning to single path coding is one approach that can positively impact the bottom line.

How fragmented coding workflows increase administrative costs

To understand single path coding, it helps to understand the traditional model. In traditional coding, separate teams assign codes for two different claim types:

- **Facility claims**, which capture resources used to deliver care, such as staff, equipment, and supplies.
- **Professional claims**, which reflect the clinician's work and clinical decision-making.

These parallel workflows create higher administrative costs due to redundant effort and slow productivity. Multiple coding routes also lead to unnecessary rework when claims are denied due to mismatched coding.

Denials push hospitals into costly cycles of correction, resubmission, and appeal.

15%

of hospital claims are rejected on first submission

\$57+

average cost to rework each denied claim

\$25B

lost across the industry due to denials and rework

What is single path coding and how does it work?

Single path coding is sometimes called dual coding. It involves performing both facility and pro fee coding for the same encounter by the same coder in the same workflow.

In practice, one coder reviews the complete patient record and assigns both facility and professional codes during the same session. Instead of separate processes and staggered claim submission timelines, claims move forward together. The coder can address any facility and pro fee coding requirements, reducing coding-related denials due to mismatched claims.

Having one coder manage both components of the encounter changes how work moves through the revenue cycle, resulting in:

One record review

The coder looks at the entire patient encounter once rather than splitting it between teams.

Facility and professional codes assigned together

The coder completes both components during the same workflow session.

Coordinated claim submission

The coder assigns facility and pro fee codes during the same process instead of through separate workflows.

Issues addressed before submission

The coder checks for services that should be billed together under one code and fixes those issues so the claim goes out cleanly.

Fewer internal handoffs

One coder maintains responsibility, reducing the need to have separate coding queues.

How fragmented coding disrupts congestive heart failure (CHF) coverage

One coder reviews the chart and selects an unspecified CHF code, I50.9. Another coder reviews the same encounter, diving deeper, and selects I50.32 for chronic diastolic CHF. The mismatch can affect reimbursement if a payer doesn't cover unspecified CHF. It can also trigger a denial when the coding on the claims doesn't align.

Coding is a representation of the patient experience for accurate reporting, risk adjustment, and reimbursement. A single path allows coders to describe the entire episode of care consistently and inclusively.

Amy Larsson, Vice President, TruBridge®

Single path vs. traditional coding workflows

Revenue cycle step	Single path coding	Traditional coding	Key advantages of single path coding
Clinical documentation	Medical practitioners document all billable services, procedures, supplies, and resources.		
Medical coding	One coder reviews the entire record and assigns the facility and professional codes in a single pass.	Facility and professional coders review the record separately and assign codes.	Improves efficiency and supports coding accuracy.
Coding review and edits	One coder addresses the facility-specific edits and the practitioner-specific edits.	Coders address edits independently without a mechanism to coordinate their efforts.	Increases alignment between facility and professional claims.
Clinician queries	One coder reaches out to the clinician for clarification regarding missing, incomplete, or unclear documentation.	Each coder may ask the clinician for clarification, resulting in duplicate queries for the clinician.	Reduces duplicate queries and supports process continuity.
Claim submission	Claims are more likely to be submitted at the same time.	Claims are often sent at different times.	Accelerates filing of claims.
Payer adjudication	Payer receives claims that comply with the applicable coding requirements, and processes them accordingly.	Payer may receive non-compliant claims, causing a denial.	Decreases rejections and denials.
Denial management and follow-up	One coder re-reviews the clinical documentation and coding.	Both coders may have to re-review the clinical documentation and coding.	Streamlines claims resolution process.

Benefits of single path coding for hospitals

How does combining facility and pro fee coding enhance efficiency at each step of the revenue cycle? Potential outcomes include:



Stronger financial performance

Better code alignment helps reduce errors and payer rejections. It supports more predictable reimbursement.



Improved cash flow

Having one coder handle both components shortens revenue cycle timelines and reduces payment delays.



Decreased administrative costs

Streamlined workflows decrease rework, appeals, and administrative overhead.



More complete revenue capture

Viewing both the technical and professional components of services rendered helps ensure that the practitioner's work relative value units (RVUs) are accurately captured.



Enhanced workforce flexibility

Cross-trained single path coders can support broader operational needs, strengthening staffing performance.

How single path coding supports value-based care reimbursement

As more reimbursement becomes tied to quality reporting and risk scoring, consistency across claim types becomes increasingly important.

The accuracy provided by single path coding also matters more as payer models evolve. Value-based and episode-based care programs rely on comprehensive and consistent data for benchmarking performance and quality.

If the same patient encounter is coded differently in facility and pro fee claims, value metrics could be underreported or invalidated. This misalignment can affect revenue and coding compliance. A single, standardized coding path supports a clear linkage between documentation, coding, risk adjustment, and reimbursement.



How single path coding benefits key stakeholders

Adopting single path coding can impact roles and workflows across the organization. Coders and managers benefit from streamlined operations. Clinicians spend less time on queries, while executives see improved financial integrity. Table 2 demonstrates how stakeholders benefit from single path coding and the metrics used to quantify the benefit.

Stakeholder benefits of single path coding and how to track them

Stakeholder	Benefit	Metrics
Coders	Enhanced accuracy and productivity	Coding accuracy rate Coding productivity
Managers	Smoother day-to-day operations	Clean claim rate Days in accounts receivable
Executives	Reduced denials and increased reimbursements	Claims denial rate Net collection rate
Clinicians	Fewer queries and more accurate capture of patient risk and services provided	Clinician query rate Work RVUs per encounter

What hospitals should consider before transitioning

Shifting to single path coding requires an evaluation of technological, operational, and organizational factors to avoid creating new challenges. To ensure success, consider the following:

- **Systems readiness**

Assess whether your EHR and coding software applications can support a single path from documentation to claim submission.

- **Workflow processes**

Develop a new single path coding workflow for encounters through the revenue cycle.

- **Staff training**

Since each component of coding has specific guidelines and reimbursement models, training is essential. Determine how you will cross-train coders on coding rules and the new single path process.

- **Outcomes measurements**

Identify metrics to track potential slowdowns during the transition and improvements once new procedures are in place.

- **Scalability**

Plan how the transition may affect you as your hospital service lines grow and payer requirements change.



Is your hospital ready for single path coding?

Coding complexity and reimbursement pressure are unlikely to ease, especially for community and mid-size hospitals.

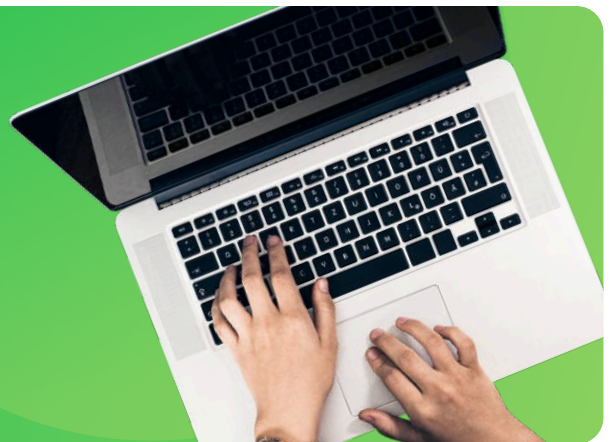
Single path coding offers a practical way to adapt without adding administrative burden. It's both an operational improvement and a financial strategy.

Implementing single path coding requires more than process change. It calls for careful evaluation, staff training, and ongoing performance monitoring. TruBridge partners with hospitals to navigate this transition, ensuring changes are operationally sound and financially sustainable.

If your organization is assessing whether single path coding is the right fit, our team is available to discuss your goals and next steps.

**Schedule a 30-minute demo
and receive our Single Path
Coding Upskilling Toolkit.**

[Schedule Demo](#)



“Learning a new coding approach takes time. Developing your own in-house training helps align your coding operations with your specific workflows, payer mix, and technology.”

Lolita Jones, RHIA, CCS, CPC, Product Owner for the Professional Coding Encoder at TruBridge®



About us

TruBridge proudly supports rural and community healthcare providers in their efforts to stay strong, independent, and deeply rooted in the communities they serve.

Backed by more than 45 years of healthcare experience and trusted by over 1,500 clients nationwide, TruBridge offers a mix of technology, services, and strategic expertise – including revenue cycle management (RCM), electronic health records (EHR) and analytics – all designed singularly for the realities of rural and community healthcare.

With a steadfast commitment to keeping care local, TruBridge helps hospitals flourish as the economic heart of their communities, delivering high-quality, deeply personal care close to home.

References

- 1 . Finn P, Pellathy T, Singhal S. US healthcare payments: Remedies for an ailing system. McKinsey on Payments. April 2009.
- 2 . Premier Inc. Claims adjudication costs providers \$25.7 billion - \$18 billion is potentially unnecessary expense. February 2025.