Practical Guide *to* Coding Management

Second Edition

Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, FAHIMA, CHPS

JustCoding

Practical Guide to Coding Management

Second Edition

Rose T. Dunn, MBA, RHIA, CPA, FACHE,

FHFMA, FAHIMA, CHPS

HCPro

a Simplify *Compliance* brand

Advice given is general. Readers should consult professional counsel for specific legal, ethical, or clinical questions.

Arrangements can be made for quantity discounts. For more information, contact:

Table of Contents

About the Author

Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, FAHIMA, CHPS

Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, FAHIMA, CHPS, is a past president of the American Health Information Management Association (AHIMA) and recipient of its 1997 Distinguished Member and 2008 Legacy awards. In 2011, she served as the interim CEO of AHIMA and received a Distinguished Service Award from its board of directors. Dunn is the chief operating officer of First Class Solutions, Inc., a health information management (HIM) consulting firm based in St. Louis.

Dunn began her career as director of medical records at Barnes Hospital, which at that time was a 1,200-bed teaching hospital in St. Louis; it is now the flagship hospital of the BJC HealthCare system. Early in her career at Barnes, she became vice president and was responsible for more than 1,600 employees and new business development. Dunn later joined Metropolitan Life Insurance Company, where she served as assistant vice president in MetLife's HMO subsidiary. She also served as chief financial officer of a dual hospital system in Illinois and was heavily involved in its successful bond application.

Her consulting firm, First Class Solutions, focuses on HIM-related services, including coding support, coding audits, regulatory compliance, and operations improvement in both the acute and post-acute care environment. Dunn assists clients with their operational, revenue cycle, compliance, and strategic planning needs. She and her team of HIM and coding professionals supports more than 125 hospitals, physician practices, and skilled nursing facilities with operational, coding, and compliance services. It is this broad experience base that allows Dunn to share everyday guidance in her book.

Acknowledgments

This book is dedicated to the talented coding professionals at First Class Solutions, Inc., with whom I have had the honor to work for more than 30 years. Thank you for your commitment to our clients you serve and your determination to ensure data integrity through compliant and high-quality coding.

No book is ever the product of one person's efforts. Many individuals contributed to its development, editing, formatting, and publication. I was fortunate to have some of the best working with me on this edition. Editor Sarah Gould thoroughly reviewed the manuscript and offered many valuable suggestions while keeping the production running smoothly. AnnMarie Lemoine, cover designer, designed the book's cover. To them and those other individuals working behind the scenes, thank you.

Finally, thank you to all those health information management and coding professionals who have read this or prior editions and have been able to apply some of my recommendations to their daily operations. I appreciate your reliance on my guidance and for the comments and feedback you have shared with me directly that I always consider when preparing the next edition.

Thank you.

Rose T. Dunn

Introduction to Coding and Management

Objectives

After reading this chapter, you will be able to:

- Define coding
- Discuss the purpose of each of the coding classifications used in the U.S.
- Recognize the challenges confronting a new manager
- Describe the five functions of management

What Is Coding?

Coding is the review of clinical documentation and assignment of a predefined alphanumeric code to a patient's health condition or medical or surgical procedure performed on a patient. With limited exceptions, each condition or procedure has its own code. Coding also is known as *nosology*. According to Webster's dictionary, nosology is a branch of medical science that deals with the classification of diseases (Merriam-Webster, n.d.).

The classification of diseases used in the U.S. and other industrialized countries is the International Classification of Diseases, Tenth Revision (ICD-10), which was developed by the World Health Organization (WHO) and its participating member countries. In the U.S., the classification is modified to meet the clinical assignment, research, and payment needs of the U.S. Here, the classification is called *ICD-10-CM*, or clinically modified.

Various certifications are available to coding professionals and are issued by several professional organizations. Some of these certifications appear below.

Figure 1.1: Coding certifications

Certification	Meaning	Issued by
CCA	Certified Coding Association	AHIMA
CCS	Certified Coding Specialist	AHIMA
CCS-P	Certified Coding Specialist—Physician-based	AHIMA
COC	Certified Outpatient Coder	AAPC
CPC	Certified Professional Coder	AAPC
CPC-H	Certified Professional Coder—Hospital	AAPC
CIC	Certified Inpatient Coder	AAPC
CRC	Certified Risk Adjustment Coder	AAPC
CPC-P	Certified Professional Coder—Payer	AAPC
CIRCC	Certified Interventional Radiology Cardiovascular Coder	AAPC

AAPC: American Academy of Professional Coders; AHIMA: American Health Information Management Association

Additionally, American Health Information Management Association–approved coding certificate programs and the health information management (HIM) degree program, leading to the credential of registered health information administrator, and the health information technology degree program, leading to the credential of registered health information technician, offer coursework that prepares individuals to launch a career in coding.

What Is Management?

Management is the process of getting things done through others. Management functions include:

- Deciding what needs to be done
- Planning how and when the work will be done
- Deciding how many individuals and what resources are necessary to do what needs to be done
- Deciding who will do what needs to be done
- Ensuring that staff members' assignments are completed as expected, within budgetary constraints and on schedule

Healthcare managers often are promoted from within. Coding specialists who are promoted should be proud to have been identified as professionals who can lead others. Likely, they were exceptional coding professionals—individuals with coding-specific education, certifications, and excellent work ethics. However, these individuals may lack any formal management education or experience. Transitioning

Additionally, if the team codes from incomplete records, the manager may wish to review the records in the sample to verify that there are no significant errors or omissions, because the records now may be complete or have additional documentation that was not present at the time of coding. The manager's organizing efforts should position appropriate staff and resources to perform the tasks within the time frame available to be prepared for the audit.

Selecting

Selecting the right staff is a challenge for inexperienced and experienced managers alike. Over time, managers develop skills that limit the selection of the wrong candidates, but still the best candidate may not be chosen. Even seasoned leaders select candidates that just don't work out as expected. The selection or staffing function includes:

- Developing a position description for human resources or your human assets management department
- Defining minimum skills and certifications or credentials
- Screening applicants
- Evaluating potential candidates
- Interviewing potential candidates
- Assessing the results of any screening tests completed by the candidates
- Conducting reference checks
- Selecting one or more candidates to offer employment
- Conducting background checks and health screenings
- Offering employment

Once the candidate is chosen and agrees to join the organization, there may be other steps in the process before the candidate becomes an official member of the team. However, after those steps occur, the manager will facilitate the new employee's transition into the team by ensuring the new employee is introduced to coworkers and properly oriented to the department, team rules, department and organization policies and procedures, use of technology, and access to required resources.

Motivating

While the orientation to the coding function can introduce an employee to expectations as well as benefits to working for the organization, it will not be sustained without the manager's continuous encouragement. Motivating is the process of inspiring employees to do what is expected of them within established time frames, enlisting their support, and eliciting their promise to accept the challenge and/ or assignments that have been given to them. A manager may have an abundance of staff members, but if those staff are unwilling to do what was asked of them, the manager will fail to achieve the goals

<p style="text-align:center">Chapter 2</p>

Effective Coding Work Environment

Objectives

After reading this chapter, you will be able to:

- List and describe the responsibilities of a coding manager
- Review the scheduling and resource requirements for on-site and remote workforces
- Describe considerations when employing remote workforces
- Discuss the features of an effective work environment

Organizing the Coding Function

Coding is a crucial component of the revenue cycle. The coding function drives reimbursement. Coders seek additional documentation from clinicians and charge-generating departments to support billed services and assist the organization in receiving the full reimbursement to which it is entitled.

In addition, coding specialists collect additional data elements that are used by other departments, such as performance improvement, and various registries in their population health surveillance activities. Coders also raise the flag for the risk management department by signaling unexpected patient care occurrences, such as a nicked organ during surgery, that may require intervention by the risk management department or the chief medical officer.

See Figure 2.1 for a commonly used occurrence reporting form used by coding professionals to report documented issues requiring risk management's attention.

Figure 2.1: Suspected occurrence report

Reported by: _____   Report date: _____

Account number: _____   Occurrence date: _____

Description:

____ Organ injury   ____ Transfusion reaction   ____ Unapproved abbreviation

____ Medication error   ____ Unexpected return to OR   ____ Left/right confusion

____ Psychological damage   ____ Other:

Description/additional information: _____

_____

_____

Source: Rose T. Dunn.

Finally, coding professionals collaborate with clinical documentation specialists and quality analysts to ensure the clinical indications support the codes submitted with billed claims and that submitted data accurately populates patient profiles used by the facility, providers, and payers.

With the advent of patient safety indicators (PSI) and their impact on reimbursement, coding professionals must collaborate with others in the organization to agree on the proper reporting of PSIs, while ensuring that official coding guidelines are followed. Patient safety initiatives and other healthcare quality measures have been developed and endorsed by several organizations, including the Department for Health and Human Services, Agency for Healthcare Research and Quality, and IMPAQ International, LLC, and federal programs such as Medicare Access and CHIP Reauthorization Act, the Long-Term Care Hospital Quality Reporting Program, Medicaid and CHIP, Hospital Inpatient Quality Reporting, and quality improvement organization. The prudent coding manager will become familiar with these quality and patient safety initiatives to ensure the coding team maintains rapport with other professionals who are immersed in demonstrating the organization or practice's compliance with the initiatives.

PSIs and quality measures support the patient safety goals that often are included in accreditation standards for ambulatory, specialty inpatient, long-term care, and acute care organizations. Some of the focus areas include:

- Death in low-mortality diagnosis-related groups
- Pressure ulcer

diverse tasks, the structure of this function must support its roles. However, coding roles are evolving along with how and where coding tasks are performed. Coding managers must forecast the effect of environmental, governmental, and organizational changes and adjust the structure of the coding function accordingly.

The manager must consider:

- **The daily workloads:** What is the average number of cases per day?

- **The composition of the daily workloads:** How many of the average daily cases are inpatient versus outpatient? Are there anomalies (e.g., does a spinal surgeon do all of his or her cases on a certain day of the week)?

- **The timing of claims processing:** Are claims processed and transferred to the clearinghouse throughout the day or only after batch processing at the end of the day?

- **The volume of edits:** Edits are built-in criteria that assess the content of the claim before the claim is released to the clearinghouse or payer. Edits may be part of the organization's billing system as well as incorporated into the clearinghouse's system. Are edits addressed by the coders or another member of the coding or patient financial services (PFS) team?

- **When cases are available:** Do all discharges appear in the coding queue the day after discharge, or is there a display delay associated with the suspense period? Or a delay associated with the clinician closing the case?

- **Organization expectations:** Is there a rule that all high-dollar cases will be coded first each day? Is there an expectation that all cases will be coded within five days of discharge?

- **Other duties:** Do the coders perform other duties that must be done at the same time or at other intervals or have additional expectations beyond those associated with coding?

- **Noncoding team members:** In some organizations, the clinical documentation improvement (CDI) team is in the coding or health information management (HIM) department. The work of the CDI staff is so closely aligned with the work of the coding team that it makes sense to consolidate the two teams. Referring below to the 2018 Coding Productivity Survey conducted by HCPro and published in *HIM Briefing*s, both CDI and coding make up 46% of the respondents. This is down slightly from the 2016 survey, and the 2018 survey included more than twice the number of respondents (n = 98) than in 2016.

- **External demands:** Is the coding function the go-to source for physician office codes? How many reports are prepared for others on a weekly or monthly basis? Are there external audits occurring at a faster/slower pace than usual? Are code changes occurring that impact the CDM? If so, how much time needs to be allocated to working with the respective departments in updating the CDM? Has the organization lost coders to another organization due to compensation competition?

Figure 2.5: Survey results

Are CDI and coding in the same department at your facility?	Response percent	Response count
Yes, both are under the HIM department	42.41%	95
Yes, both are under another department other than HIM	4.02%	9
No, coding is under HIM; CDI is under another department	22.77%	51
No, CDI is under HIM; coding is under another department	1.79%	4
No, coding and CDI are under different departments	8.04%	18
We do not have CDI at our facility	16.96%	38
We do not have coding at our facility	00.0%	0
We do not have coding and CDI at our facility	4.02%	9
TOTAL		224

Source: HCPro 2018 coding survey.

Staffing the coding function to accommodate these considerations may require space and equipment on-site at the organization as well as in the coders' homes. The manager must lay out the master schedule based on the workloads and timing of cases appearing in the coding and edit queue. The manager may need to establish work schedules that use part-time (PT) and full-time (FT) employees who are available to work different days of the week to handle the workload and achieve the expectations. For example, if the organization wishes to maximize the cashflow from the emergency department (ED), it may need to staff the ED coding seven days per week. Similarly, if inpatients are being discharged on Friday, the manager should consider Saturday coding coverage to reduce the discharged-not-final-coded. A sample staffing schedule for both scenarios appears below, where the inpatient coders are working four 10-hour shifts. In this situation, the two coders may alternate every other week or every other two weeks for the Wednesday–Saturday coverage. For the ED scenario, the manager may wish to hire a PT coder to work weekends and an FT coder to work Monday through Friday.

Figure 2.6: Sample staffing schedule

Sample Staffing Schedule							
Work type	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Inpatient		Coder 1	Coder 1	Coders 1 and 2	Coders 1 and 2	Coder 2	Coder 2
ED	PT Coder	FT Coder	FT Coder	FT Coder	FT Coder	FT Coder	PT Coder

Source: Rose T. Dunn.

- A high volume of outpatient tests and procedures before the year's end, because patients have met their insurance deductibles and wish to undergo any preventive or diagnostic testing performed before the new insurance year begins and the annual deductible is effective once again.

- The typically busy month of September for obstetrical deliveries.

- Higher volumes of inpatient discharges on Thursday through Saturday to expedite getting the patient home over the weekend.

- Higher volumes of outpatient visits and tests on Monday through Wednesday, following weekends when physician offices are typically closed.

- Clinician vacations and attendance at national clinical conferences create valleys in certain procedures.

- The decline in all types of encounters in southern climates after March (when snowbirds return to their northern climates).

- The increase in encounters in northern climates following snow and ice storms (namely from injuries resulting from recreational and nonrecreational activities).

Collaborating with the decision-support manager or the individual who captures statistics for the organization helps identify patient volume patterns. If such an individual is unavailable, managers may need to capture this information themselves. Develop a spreadsheet, similar to this one, that facilitates this task:

Figure 2.10: Discharges by day of week
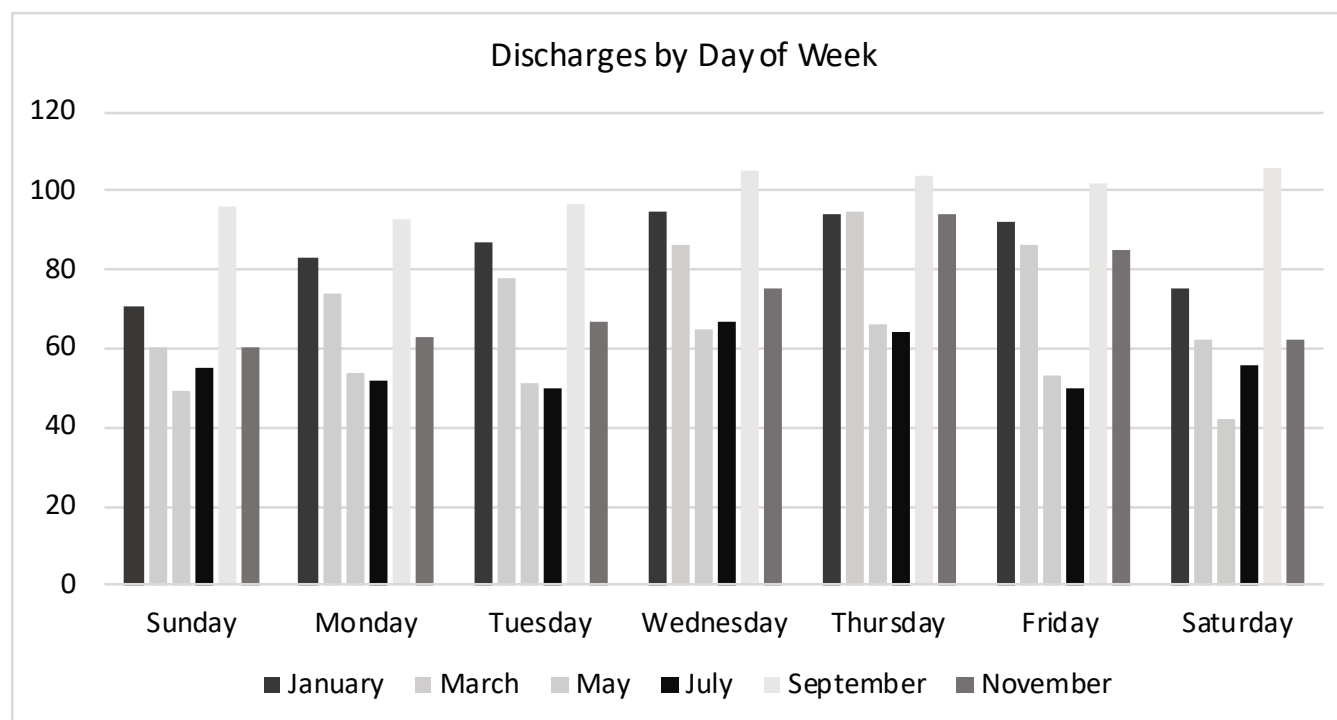
Source: Rose T. Dunn.

To determine the number of coders needed, begin with the assumption that the facility has a 40-hour work week. Therefore, the number of hours for a full-time employee is 40 hours per week multiplied by 52 weeks, or 2,080 hours. However, no full-time employee works 2,080 hours. Full-time employees attend education meetings, typically take two weeks of vacation, enjoy days off on certain holidays, and take two 15-minute breaks daily. So how many hours will an employee actually be working?

Simple arithmetic facilitates this calculation:

- 2,080 hours − 12 education hours − 80 vacation hours − 80 holiday hours = 1,908 hours
- 1,908 ÷ 8 hours per day = 238.5 days that an employee is at work
- 238.5 days × 0.5 hours per day = roughly 119 hours per year spent on breaks
- 1,908 hours − 119 hours = 1,789 hours annually

This calculation indicates that the average employee works approximately 1,789 hours annually. Further adjustment may be necessary, but the listed activities constitute common non-work but paid hours.

Determining the number of necessary full-time employees is the next step. This calculation provides the number of full-time equivalent (FTE) employees, who work 1,789 hours in this hypothetical situation. Suppose that two employees each work 894.5 hours; together they represent one FTE employee.

Projected annual volumes indicate a need for 19,128 coding hours. Dividing this number by 1,789 hours/FTE reveals that 10.7 FTE employees are necessary. The figure below illustrates the results of this calculation for each type of record. This calculation is necessary if the department will consist of specialized coders rather than coders who perform all types of coding.

Figure 3.5: Labor requirements based on volume projections

Patient Type	Volume 1st Year	Total Hours	FTEs
Inpatients	8,400	4,844.0	2.71
Outpatient Surgery	8,640	2,476.8	1.38
Outpatient Diagnostic Tests	28,800	3,456.0	1.93
Observations	2,920	929.5	0.52
Emergency Visits	36,500	7,421.7	4.15
Total Work Hours and FTEs Required:		19,128	10.69

Source: Rose T. Dunn. Reprinted with permission.

Coding Compliance and External Forces

Objectives

After reading this chapter, you will be able to:

- Discuss the standards of ethical coding
- Distinguish between ethics and integrity
- List the many regulations and external entities that are involved in monitoring coding

Compliance Environment

Up to now, we have been discussing the coding process. However, the application of codes to a claim ignites the compliance ember. Coding plays a major role in claims and, therefore, reimbursement compliance. While much of our discussion in this chapter will be about externally imposed compliance initiatives and coding's relationship to reimbursement, we will also touch upon those internal departmental and personal compliance initiatives that should be occurring on a daily basis.

Personal Compliance Initiatives

Each coding professional is expected to act ethically. According to Bob Czimbal and Michele Brooks (n.d.), motivational speakers who offer conference keynotes and staff trainings out of Portland, Oregon:

> *Ethics is an external system of rules and laws. Usually there are rewards when we follow the rules and punishments when we break them. A professional board or committee often monitors compliance.*

by identifying where it is an outlier for these risk areas. These data can help identify both potential overpayments as well as potential underpayments. The report provides comparative data to allow the organization to assess when it has trends that are inconsistent with comparable organizations and surface areas to conduct internal quality reviews.

- *Standards of Ethical Coding*, which can be viewed on AHIMA's website, are based on AHIMA's Code of Ethics. Both sets of principles reflect expectations of professional conduct for coding professionals involved in diagnostic and/or procedural coding or other health record data abstraction. *AHIMA's Standards of Ethical Coding* (updated 2016) appear below:

Figure 4.1: Interpreting the Standards of Ethical Coding

Standards and Guidelines

The following ethical principles are based on the core values of AHIMA in the Code of Ethics and apply to all coding professionals. Guidelines for each ethical standard are a noninclusive list of behaviors and situations that can help clarify the standard. They are not meant to be a comprehensive list of all situations that can occur.

1. Apply accurate, complete, and consistent coding practices that yield quality data.

   Coding professionals **shall**:
   1.1. Support selection of appropriate diagnostic, procedure, and other types of health service–related codes (e.g., present-on-admission [POA] indicator, discharge status).
   1.2. Develop and comply with comprehensive internal coding policies and procedures that are consistent with requirements.
      - Example: Developing internal policies and procedures for the coding function such as facility coding guidelines that do not conflict with the requirements and use as a framework for the work process; providing education and training on their use.
   1.3. Foster an environment that supports honest and ethical coding practices resulting in accurate and reliable data.
      - Example: Regularly discussing the standards of ethical coding at staff meetings.

   Coding professionals **shall not**:
   1.4. Distort or participate in improper preparation, alteration, or suppression of coded information.
      - Example: Assigning diagnosis and/or procedure codes based on clinical documentation not recognized in requirements (as defined above in the definitions).
   1.5. Misrepresent the patient's medical conditions and/or treatment provided that are not supported by the health record documentation.
      - Example: Permitting coding practices that misrepresent the provider documentation for a given date of service or encounter such as using codes from a previous encounter on the current encounter (except with bundled payment models or other methodologies).

(continued)

Chapter 5

Coding Compliance Policies and Plans

Objectives

After reading this chapter, you will be able to:

- Describe the elements of a coding compliance plan
- Create a coding compliance plan
- Identify coding-related topics to validate

In Chapter 4, we discussed coding integrity and the many watchdogs that monitor the quality of coding. To limit our exposure to claim denials and external reviews, the best safeguard is to have a robust, effective internal coding compliance policy, plan, and implemented program.

When developing a coding compliance program, begin by reviewing any existing coding policies and procedures to determine whether they are consistent with the organization's compliance plan as well as the latest *Official Guidelines for Coding and Reporting*. If your department lacks coding compliance policies and procedures, excellent guidelines are available at JustCoding.com, AHIMA.org, and various healthcare organization sites, such as HCA Healthcare's website (*https://hcahealthcare.com/ethics-compliance/policies/regs.dot*).

Studying publications from the various organizations in this chapter and other respected organizations can help managers anticipate what external auditors are observing and targeting. This includes auditors whose services were retained by the facility and auditors from federal agencies and third-party payers. Recognizing vulnerabilities helps identify areas that require evaluation and mitigation.

In this chapter, we will first describe some of the components of a coding policy and plan and then approaches to monitoring coding quality.

Coding Compliance Policy

All providers, including healthcare facilities, should have a coding compliance plan. Basic guidance is available from the Office of Inspector General (OIG); see Chapter 4. The policy should be brief but clearly state the reason for and extent (scope) of the plan, such as this one for a physician group:

Figure 5.1: Coding compliance plan

Policy: XYZ Physician Practice intends to abide by federal and payer coding rules. To do so, it will maintain a coding compliance program to periodically review the coding that is applied to claims and the documentation associated with the coding.

The compliance program shall be directed by the compliance officer and implemented by the office manager. External contracted coding consultants will be utilized by the office manager to assist in implementing this program.

Scope: The program will apply to all XYZ Physician Practice personnel responsible for performing clinical documentation and personnel billing, supervising, recommending, or assigning codes to claims that are submitted to a payer for reimbursement purposes.

Source: Rose T. Dunn.

Coding Compliance Plan

The coding compliance plan may be a subsection of the policy. If you format the compliance plan as a subsection, the document should be labeled "coding compliance policy and plan." The plan component should be much more detailed and include the specifics of what, when, and how often. Each organization should tailor its coding compliance plan to its organization.

When developing a new coding compliance plan, managers should begin by asking these questions:

- Why am I establishing a plan?
- What will I review?
- How will I select a sample?
- How will I assess accuracy?
- What action will I take when the results are known?
- How will I monitor progress?

The coding manager should collaborate with the compliance officer in developing the plan.

Rebill accounts found to have coding errors regardless of whether discovery of the error results in additional payment or a reduced payment. The refunding of overpayments should occur within 60 days of finding the error. See the February 11, 2016, Centers for Medicare & Medicaid Services (CMS) notice *Medicare Reporting and Returning of Self-Identified Overpayments, CMS 6037-F Final Rule* (*https://www. cms.gov/newsroom/fact-sheets/medicare-reporting-and-returning-self-identified-overpayments*).

Send a cover letter like the one in the following figure.

Figure 6.1: Sample cover letter

<div align="center">
Central Health Regional Center
123 North Street
Big City, IL 89898
</div>

XYZ Insurance Co.
567 Minnesota Street
Anytown, MO 32323

Re: Account 123456; Ins. No. 345678

Dear Sir/Madam:

Attached find a revised claim for patient _____. As part of our compliance plan, this encounter was randomly selected for review of code assignment accuracy. The reviewer determined that an incorrect code was previously submitted. The attached claim reflects the revised coding. Also attached is a copy of the patient's record should you wish to reconfirm our reviewer's findings.

We believe that we [are entitled to additional reimbursement based on this review/owe you a refund based on this review]. Please make the necessary adjustment on the next remittance.

Thank you.

Sincerely,

Coding Manager

Enclosures: Revised Claim for Account 123456

Copy of Record for Account 123456—Patient Name: _____

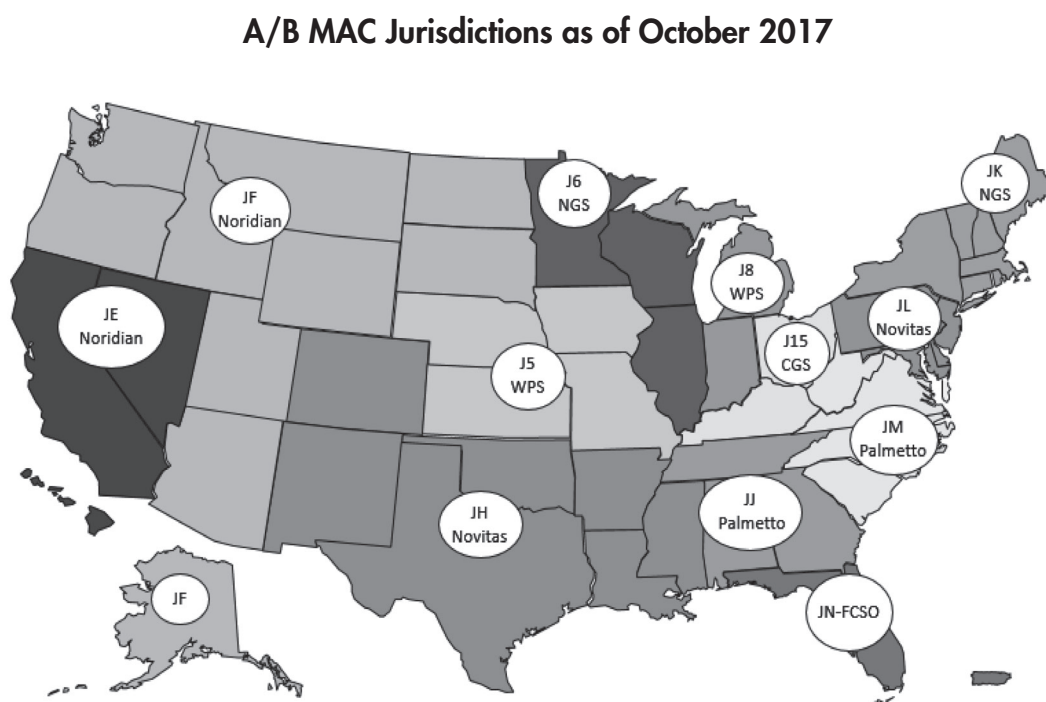*Source: Rose T. Dunn. Reprinted with permission.*

Let's consider how coding accuracy affects reimbursement for the emergency department (ED) encounters. Assume an organization bills 10,000 ED encounters annually. A coding quality audit reveals an APC accuracy rate of 94%. Based on the review, this accuracy rate translated to a loss of revenue averaging $150 per encounter for the 100 sample cases. Multiplying the total number of ED cases by the average loss (10,000 × $150) projects an annual loss of $1.5 million. Of course, if the findings reveal that overcoding resulted, the organization would need to refund the overpayment. Remember, quality reviews should not stop at codes assigned. For the ED, the manager may wish to assess the quality of the assigned ED levels or units of infusion.

Summary

Facilitating coding integrity is a responsibility of the coding manager. Developing a plan and implementing a program to improve the quality of coding will support the data needs of multiple departments within your organization. Quality reviews do not need to be limited to auditing codes alone. There are data integrity benefits to considering other coding-related activities.

To validate the coding, the manager must select an unbiased sample of an adequate size to accurately predict the coding quality. When the actual quality does not meet the manager's expectation, corrective actions need to be taken and should ideally start with remedial education. Providing appropriate resources, education, and feedback to the coding team will develop a workforce committed to the quality goal.

Figure 6.2: Jurisdiction map

A/B MAC Jurisdictions as of October 2017

Source: CMS. (2017). Retrieved from https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/AB-MAC-Jurisdiction-Map-Oct-2017.pdf

In the figure, we were able to establish stretch goals for several specialties. And for those coders who are exceeding the stretch goal, there would be no expectation that they drop their productivity to meet the goal. However, there are several individuals who are the only coder for the specialty. In these cases, the manager should reach out to colleagues for benchmarks.

For example, if the manager reaches out to a few colleagues and finds that their colorectal coders are coding an average of seven encounters per hour and these coders do no more or less than Karen, then she would be exempt from the stretch goal because she already exceeds it (Exceeds Stretch).

Just as hospital settings have nuances with duties assigned to coders, so do physician practices.

Some organizations count the break time in the productive time. When this is done, it raises the total productive minutes and therefore raises the average minutes per record. Either way is acceptable, but the manager may need to show how the average increases to the coders so that they do not think they are being penalized and expected to work through their break times. The average is actually being credited for the break time minutes. Plus, taking this approach with break time reduces the amount of times that need to be calculated by the manager.

Communicating the Expectation

Once the standards are established, communicate them verbally and in writing to the coding team. Couple productivity standards with accuracy standards, which vary by organization. In the December 2018 HCPro survey, quality expectations varied with a range of 90% to greater than 97%. Sixty-three percent of respondents expect a 95% accuracy level. See the following figure.

Figure 7.8: Coding accuracy expectations
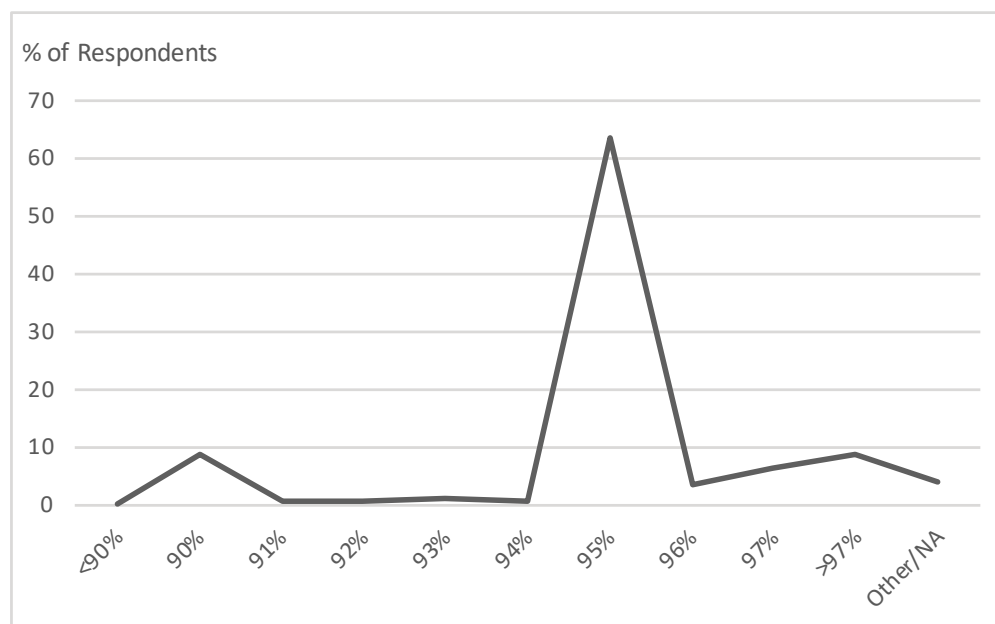
Source: HCPro 2018 coding survey.

The medical review specialists employed by the CERT contractor review each claim and determine whether the provider followed the proper coding and billing rules. Errors are classified into categories as shown below.

Figure 9.1: Improper payment error categories

Improper Payment Error Categories, Definitions, and Examples		
Insufficient Documentation	The documentation is insufficient to determine whether the claim was payable. This occurs when: • Medical documentation submitted is inadequate to support payment • It could not be concluded that the billed services were actually provided, were provided at the level billed, and/or were medically necessary • A specific documentation element, that is required as a condition of payment, is missing	A hospital billed for infusion of a medication provided in the outpatient department. The CERT program received a visit note to support the medical necessity of the medication. However, the order and the administration record for the infusion were missing.
Medical Necessity	Medical documentation supports: • Services billed were not medically necessary based upon Medicare coverage and payment policies	A provider billed for an inpatient rehabilitation facility (IRF) stay. There was not a reasonable expectation that the beneficiary was able to benefit from an intensive rehabilitation program because she was completely independent.
Incorrect Coding	Medical documentation supports: • A different code than what was billed • The service was performed by someone other than the billing provider • The billed service was unbundled • The beneficiary was discharged to a site other than the one coded on the claim	A provider billed for Healthcare Common Procedure Coding System (HCPCS) code 99214. The submitted documentation did not meet the requirements for 99214 but met the requirements for 99213.
No Documentation	The provider or supplier fails to respond to repeated requests for the medical records	A supplier billed for diabetic testing supplies. The provider did not submit any medical records to support the claim.
Other	An improper payment that does not fit into any of the other error categories	A DMEPOS supplier billed for an upper limb orthosis, which the CMS Pricing, Data Analysis and Coding (PDAC) contractor determined was classified as exercise equipment. Exercise equipment is not covered by Medicare. 11

Source: CMS. (2019). Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/IntroductiontoComprehensiveErrorRateTesting.pdf

Chapter 10

Coding's Role in the Revenue Cycle

Objectives

After reading this chapter, you will be able to:

- Define the revenue cycle
- List the common components of the revenue cycle
- Understand the meaning of key revenue cycle terms
- Discuss how coding and the coding manager can support the components of the revenue cycle

Health information management (HIM) occupies a pinnacle position in the revenue cycle, and coding is the component that revs the reimbursement engine. This chapter addresses the revenue cycle in general terms and highlights the effect of coding on its numerous spokes, illustrated in Figure 10.1, but let's first explore what the revenue cycle is.

Figure 10.1: HIM/coding spokes
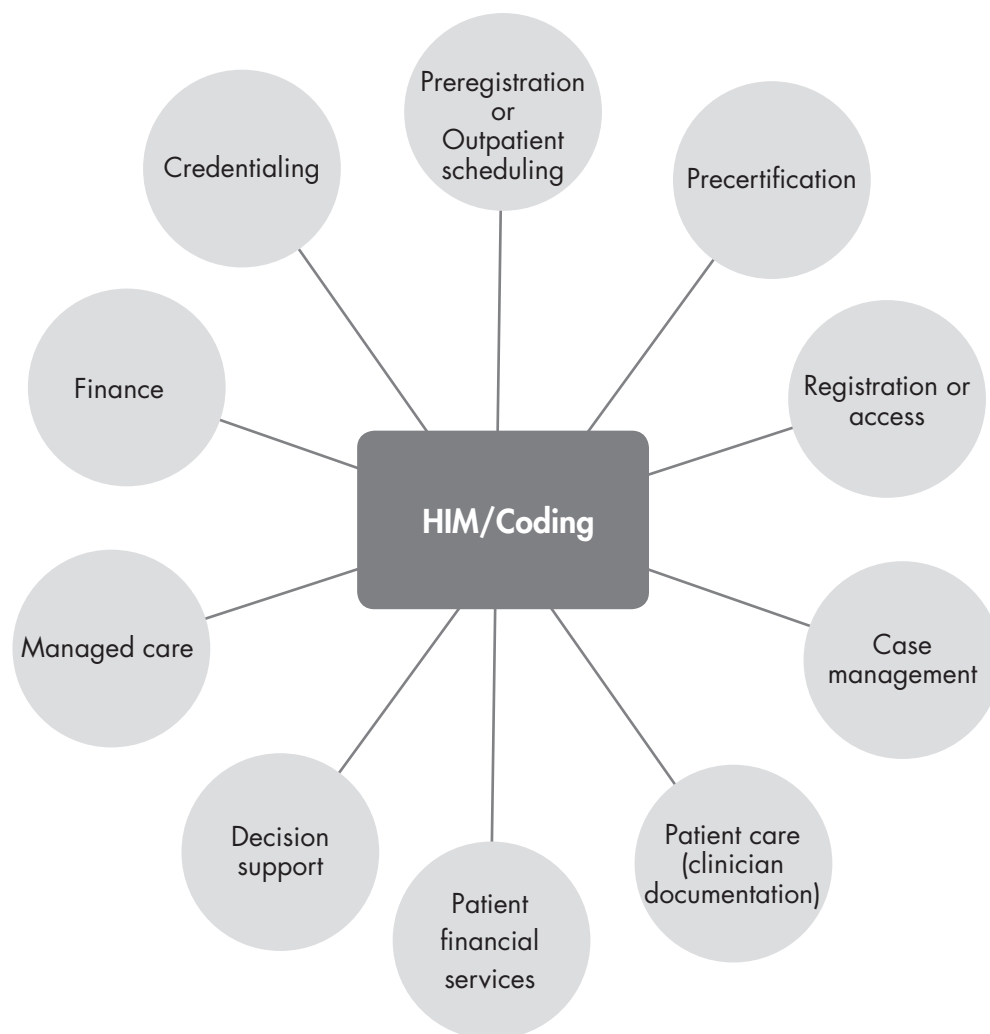
Source: Rose T. Dunn. Reprinted with permission.

Revenue Cycle—What Is It?

The revenue cycle is the function of an organization that captures, processes, supports, and collects charges for services rendered in an organization. Because coding applies the codes that support the charges rendered, it is one of several spokes of the cycle.

Other components include the intake and registration function, care management or utilization review, patient care charge capture (e.g., operating room, routine patient care, pharmaceutical, central supply), using the charge description master (CDM), coding, and patient billing (patient financial services).

During the intake, registration, or access function, the patient's insurance is verified to determine whether it will cover the services the patient will be receiving. If eligibility is confirmed, then the patient may be advised of the deductible or amount that he or she is responsible for paying.

Chapter 11

Summarizing Important Points

Objective

After reading this chapter, you will be able to:

- Discuss topics covered in this book

In Chapter 1, we explored the role of the coding manager and management in the process of getting things done through others.

Management functions include:

- Deciding what needs to be done
- Planning who will do the work and when it will be done
- Deciding how many individuals and what resources are necessary to do what needs to be done
- Ensuring that staff members' assignments are completed as expected, within budgetary constraints, and on schedule

Management entails the functions of planning, organizing, selecting, motivating, and monitoring resources. In doing these functions, managers control four Ms:

- Manpower—the coders
- Materials—supplies, such as coding reference books
- Machinery—furnishings, computer, dual monitors
- Money—the budget

Figure 11.3: Staff certification
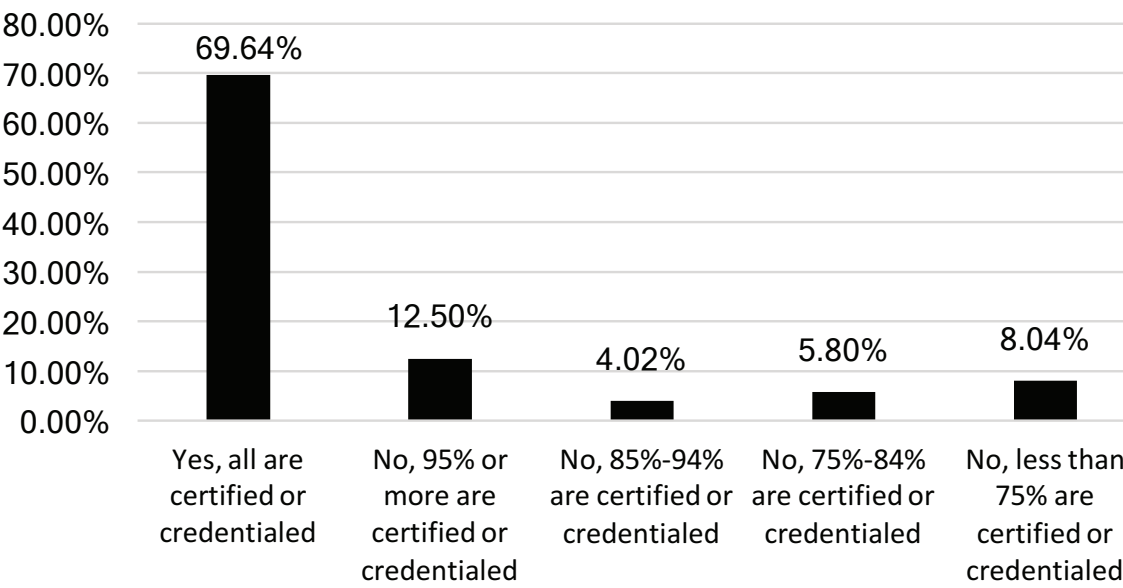
Source: Blackmer, D. (2018). Salary survey: Credentials serve our members well. AAPC. Retrieved from https://www.aapc.com/blog/45517-2018-salary-survey-credentials-serve-our-members-well/

The increase to 70% for all staff members puts a dent in the 95%–99% range from 2016's 21%. In 2018, this category fell to 12%. Finding certified or credentialed staff in some regions of the U.S. may be challenging if there are no accredited coding or health information management programs in the region. However, the growth of distance learning opportunities should not hold anyone back from achieving credentialed or certified status. Coding managers should guide their noncertified or credentialed staff to programs that may be compatible. Working with human resources to provide tuition reimbursement or a scholarship to attend the program will further incentivize individuals to attend.

Recruiting and retaining staff require more than compensation and "things." The working atmosphere can override lower pay if the place where one works is fun, respects the employees for their skills, involves staff in decisions and changes, and keeps the team fully informed. To learn more about how to care for your employees like they are your family, consider reading the book *Everyone Matters: The Extraordinary Power of Caring for Your People Like Family* by Bob Chapman and Raj Sisodia, published by Penguin Publishing Group in 2015. Your staff are valuable resources and costly to replace.

I hope this book provides you with many of the tools you will need in your role as a coding manager. I welcome your input and will keep it in mind for the next edition.

Thank you.
Rose T. Dunn, MBA, RHIA, CPA, CHPS, FACHE, FHFMA, FAHIMA, CHPS
Rose.Dunn@FirstClassSolutions.com

Appendixes

A

2018 Coding Productivity Survey: Remote Coders on the Rise, Productivity Holds Steady

In 2018, most organizations held the line on coder productivity, according to the results of a 2018 coding productivity survey conducted by HCPro's **HIM Briefings (HIMB)** newsletter. **HIMB** collected information on productivity benchmarks for facility and professional fee coding measured by number of records coded per hour or per day, as well as factors that have negatively or positively affected coder productivity, remote coders, and collaboration between coders and CDI specialists.

Demographics

Most survey respondents were coding directors/managers (33.9%), coders (29.8%), or HIM directors/managers (25.7%). That's similar to the mix of top titles reported in the 2017 coding productivity survey.

About half of respondents work in an acute care hospital (53.8%). Other respondents work in:

- Physician offices/physician-owned group practices or associations (8.8%)
- Critical access hospitals (8.2%)
- Home health agencies (6.4%)

- Hospital-owned physician offices/group practices or associations (6.4%)

Some respondents (8.2%) wrote in to describe additional facility and organization types, including contract coding firms and payer organizations.

Of those respondents who work in an acute care facility, most (26.1%) work at a facility with 500 or more beds while 22.8% work at a facility with 200–299 beds.

Figure 1: Which best describes the setting in which you work?

Answer Choices	Responses
Acute care hospital	53.80%
Critical access hospital	8.19%
Inpatient rehab hospital	0.00%
Long-term acute care hospital	0.58%
Psychiatric/behavioral health hospital	1.17%
Healthcare system corporate office	4.68%
Home health agency	6.43%
Skilled nursing facility	0.58%
Ambulatory surgery center	1.17%
Physician office/Physician-owned group practice or association	8.77%
Hospital-owned physician office/group practice or association	6.43%
Urgent care facility	0.00%
Other	8.19%

Source: HIM Briefings' 2018 coding productivity survey.

Productivity

In 2018, **HIMB** revised its productivity benchmarks to include options for facility and professional fee coding.

Half of all respondents (50.9%) indicated that they measure productivity by number of charts coded per hour. Other respondents said they measure productivity by:

- Number of charts coded per day (18.7%)
- Number of charts coded per hour or per week but weighted based on length of stay, DRG weight, or other factors (9.9%)
- Average number of charts coded per month (4.1%)
- Number of charts coded per week (3.5%)

JustCoding

Practical Guide *to* Coding Management Second Edition

It's 2019 and ICD-10 has been fully implemented for more than three years, fundamentally changing how coding managers assess the productivity of coders, the quality of their work, the number of coders available in the workforce, the need for coder education and training, and the need for auditing. Coding managers must continue to update their strategies to keep up with everchanging code and regulation updates.

JustCoding's Practical Guide to Coding Management, Second Edition, provides coding managers with benchmarks, standards, and tips to ensure they're running an effective department. It provides strategies to retain coders and best practices on how to balance internal and outsourced coders, as well as how to manage on-site and remote staff. This book provides much-needed information for managers on how to educate their teams on the role of coding within the revenue cycle as a whole.

About Simplify Compliance

Simplify Compliance, with its three pillars of thought leadership, expertise, and application, provides critical insight, analysis, tools, and training to healthcare organizations nationwide. It empowers healthcare professionals with solution-focused information and intelligence to help their facilities and systems achieve compliance, financial performance, leadership, and organizational excellence. In addition, Simplify Compliance nurtures and provides access to productive C-suite relationships and engaged professional networks, deploys subject matter expertise deep into key functional areas, and enhances the utility of proprietary decision-support knowledge.

800-650-6787

www.hcmarketplace.com