Bringing Physician Practice Coding Under the HIM Umbrella: Three Leaders Share their Experiences

By Marna Witmer, RHIA

Quality coding has always been a goal for health information management (HIM) departments. Traditionally, HIM focused on coding for acute care services while physician practice coding was accomplished by physician office staff—typically using super-bills with CPT lists and generic ICD-9-CM codes. In 2015, two new programs changed the landscape of physician coding: ICD-10-CM and the Medicare Access and CHIP Reauthorization Act (MACRA).

The passage of MACRA—specifically, the Quality Payment Program (QPP)—officially ended the Sustainable Growth Rate formula that had been used since 1997 to calculate payment for physicians. The QPP's focus is improving the quality of patient care and patient outcomes. Physician payment adjustments will now be based upon four connected pillars: quality, clinical practice improvement activities, meaningful use of certified electronic health record (EHR) technology, and resource use.[1]

With 72 percent of physicians now employed by hospitals[2] and one in four practices hospital-owned,[3] some healthcare organizations have decided to put physician practice coding under the auspices of their own HIM departments to ensure complete and accurate coding across all areas of the organization.

In July 2017 three HIM leaders with responsibility for physician practice coding came together for the following virtual roundtable, moderated by Marna Witmer, RHIA, director of HIM operations for himagine solutions, to discuss lessons learned and share advice for organizations considering a similar realignment:

- Cassi L. Birnbaum, MS, RHIA, CPHQ, FAHIMA, serves as the system-wide director of health information management and revenue integrity for UC San Diego Health (UCSD), based in San Diego, CA. UCSD is an academic teaching hospital with 1,150 beds and 1,475 clinics/physician practices that employs 65 coding professionals.
- Jaime James, MHA, RHIA, is the senior director of health information management services for Banner Health (Banner), based in Phoenix, AZ. Banner operates 28 hospitals in six states, including three academic medical centers, and employs more than 2,800 providers in health centers and clinics that includes Banner Medical Group (BMG) and Banner University Medical Group (BUMG). Banner employs approximately 250 full-time employees on their coding team.
- Lisa Hart, MPA, RHIA, is the former director of physician practice coding at the University of Arizona Health Network (UAHN) in Tucson, AZ prior to its merger with Banner in 2015. UAHN was an academic organization with 487 beds and 1,200 physician practices. They experienced over one million physician inpatient and outpatient visits annually and employed 70 coding professionals. Hart currently serves as director of HIM operations at himagine solutions.

Witmer: What was the impetus within your organization to move physician practice coding under HIM, and in what year did the alignment occur?

James: The BMG and BUMG-Phoenix coding services were aligned under HIM in 2012. The merger of the University of Arizona Health Network into Banner Health in 2015 resulted in the addition of BUMG-Tucson coding services. Our impetus was to align physician practice revenue cycle services, including front office and coding, to use and deploy Banner Health revenue cycle best practices.

Birnbaum: Both sides of the revenue cycle, and specifically coding, were struggling prior to my joining the organization in mid-September 2015. My role was redefined, scope was expanded, and alignment of both the faculty practice physician organization (now clinical practice organization (CPO)) and medical center was accomplished during the same year. We also

established a revenue integrity program for both the facility and professional fee sides of UCSD. This group is responsible for charge capture oversight and corrections, simple visit coding, all coding edits, coding denials, charge description master, fee schedule, and defense auditing.

Hart: When the University of Arizona Health Network decided to align the physician practice coders under one leadership structure, our EHR system build out had already taken place. Each practice department had built their charge capture process based on individual needs. As a result, the coding process was inconsistent among the 15 departments.

Unfortunately, this caused a great deal of confusion and it took almost two years to standardize the coding process across all departments. A consultant was brought in to review the current state and offer best practices for physician practice coding. Lack of standardization and inefficiencies in the coding process were the two key findings, which included:

- Each department had their own coding guidelines
- Coder pay was inconsistent
- Charge capture and coding was defined by each department
- Coders were the departmental compliance liaisons
- Education was sparse and inconsistent
- Monitoring of productivity or quality was non-existent
- Numerous backlogs existed that had not been disclosed

Witmer: Were the providers and practice managers involved in the alignment decisions? What is their current role with the coding process?

James: An executive steering team was formed that solicited input from regional teams and boards for the initial alignment decision. The teams included physicians and practice leadership. Coding alignment included creation of a new organizational structure and determining standardized workflows for coding. Roles and responsibilities for providers, coders, and practice staff were also defined.

In determining our best practice workflows and roles and responsibilities, a series of coding visioning sessions were held across the organization that included key stakeholders—clinical, practice leaders, finance, compliance, coding, and the C-suite.

Birnbaum: Yes, both providers and practice managers were involved in the decision. They were also included in the review of our coding metrics, charge capture policies, and RVU capture by procedure process.

Hart: There was a transition team that included three physicians, human resources, department administrators, the coding operations team, CFO, CEO, and COO of the physician practice plan.

Witmer: As you acquire additional practices or merge with new systems, do they automatically fall under your HIM umbrella? Or, are there different considerations that come into play?

James: All new practices we acquire fall under the centralized coding and HIM organizational structure. The few exceptions may be where we are not billing for those services through our central business office due to the status of the acquisition.

Any provider added to the Banner system also goes through an onboarding process by the HIM Physician Practice Coding Team. The Physician Practice Coding Education Director, as well as the Directors of Physician Practice Coding, meet with the new providers to educate them on documentation, HCCs, assigning their own E/M levels, as well as other operational issues.

Birnbaum: Yes, most automatically fall under the corporate HIM umbrella. Though there have been a few acquisitions in which the practice site already had a contract and had to go through a termination process first. Several sites that previously reported directly to the department (i.e., Anesthesia and the Oncology Infusion Centers) were brought under my division.

Hart: As new physicians joined UAHN, they were part of a specialty department that fell under the already established coding leadership process.

Witmer: What is the basic structure of your organization?

James: We are comprised of academic and community practices that include employed and non-employed physicians. The coding team supports the employed providers and some non-employed providers where we contract to do their coding and billing. The teams support a full spectrum of specialties in provider-based and free standing clinics in academic and non-academic centers.

Birnbaum: We are mostly academic (faculty practice); however, we have a clinically integrated network (CIN) which includes community practices and hospitals. The physicians we bill for are all employees of UCSD.

Hart: UAHN was an academic organization with no community physicians.

Witmer: What is your leadership structure for physician practice coding?

James: All coders report through HIM. There are two coding leadership teams, one for acute care coding and one for physician practice coding. Both coding teams, along with HIMS Operations (which conduct document imaging, release of information, transcription, EMPI, etc.), report up to the HIM senior director. The physician practice coding team consists of three directors: two directors for physician practice coding operations and one director for physician practice coding education.

Birnbaum: We have two separate coding leadership teams. They each have a coding manager and both report to the assistant director of system-wide coding.

Hart: At the time of the UAHN alignment, there was one director, two senior managers, and six supervisors. At that point HIM was a separate, but integral, partner in the coding process. When UAHN merged with Banner, it was integrated with the HIM leadership, which was a welcomed change.

Witmer: Please describe benefits gained from your physician practice coding alignment under HIM.

James: We have experienced many benefits, some of which include:

- Centralization and standardization of policies and procedures with consistent application of coding and regulatory guidelines
- Improved metrics
- Stronger relationship with practice administrators
- Team building among the managers, team leads, and coders
- Ability to react and make decisions quickly
- Opportunity to compare facility and professional procedure coding
- Identify areas to streamline processes and information based on service lines

Birnbaum: We doubled up our efforts to improve clinical documentation to support both sides of our business to provide and deliver a consistent approach and message. Also, we are integrating our charge capture and coding process to minimize any duplication of efforts. Clinical documentation management (CDM) leaders were also involved to improve professional fee schedule compliance.

With the implementation of our professional fee coding (health IT system), we will implement one path coding to further minimize duplication of effort and reduce multiple coder touches on the same account (i.e., facility, professional, and anesthesia coding).

Hart: At UAHN we saw the following results:

- Centralization and standardization of policies/procedures
- Collaboration among managers in setting quality and productivity expectations for their teams
- Ability to focus on academic coding as a team and ensure compliance across the coding department
- Enhanced relationship with practice administrators via standard meetings with them as a leadership team to strengthen the qualities of an aligned coding team
- Consistent communication from the coding quality and education department and operations to internal and external customers
- Availability to discuss ideas, solutions, and opportunities, resulting in the ability to quickly react and make decisions

Witmer: What metrics are you using to determine success?

James: We monitor our providers' E/M level distributions. This process has led to educational opportunities for both the coders and the providers.

In addition, we monitor:

- Lag days
- Hold accounts
- Coding operations cost as a percent of net revenue
- Standard metrics of coder productivity, coder quality, de- nial rates, staff turnover, and staff satisfaction

Birnbaum: For Professional Fee, we measure:

- Days in Pre-AR
- wRVU per account and specialty
- Denials related to coding
- Accuracy rate
- Productivity rate by work type

For Facility Coding, we measure:

- DNFB for coding
- Denials related to coding
- Productivity rate by work type
- MCC/CC capture rate—surgical versus medical
- APR-DRG metrics
- PSI/HACs/POA

Hart: We measure:

- Lag days
- Cases deferred due to physician documentation issues
- Claim edits
- Education provided to physicians
- Coder quality
- Quality of providers coding their own clinic visits

Witmer: What advice would you give to other HIM leaders considering physician practice coding alignment under HIM?

James: Develop coder and provider communication. Aligning a coder with a provider has been very successful. We accomplished this by scripting weekly e-mails from coder to provider, facilitating direct provider feedback on E/M and procedure coding. We also cross-trained the coding staff to code all types of cases (inpatient, outpatient, surgical).

Build collaborative partnerships with department administrators. We assigned coding team lead liaisons to hold monthly coding meetings with department administrators. We continually educate providers on E/M coding and have instituted a provider self-coding project.

Engage the coders and keep them connected. We accomplish this by holding monthly meetings with a standard agenda including recognition, employee of the month, education, and updates. We created an Employee Recognition Team (ERT) and hold daily huddles to celebrate successes.

E/M coding can be very subjective. The Banner team works collaboratively with key stakeholders to create guidelines to reduce E/M variability, which is no small task.

There are many detailed regulations that impact physician practice coding. Developing a plan to communicate updates and changes to these regulations with consistent revenue integrity monitoring is a key to success.

Birnbaum: Build relationships with physician leaders, administrative officers, and directors.

Identify and validate historical information and provide an accurate picture of the current state, including gaps and opportunities.

Address the inherent gaps in coding and reimbursement on the professional fee side as they relate to technology (i.e., immature, inadequate, lack integration with the EHR) and resources (i.e., require coders to act more like billers).

Invest in coder education and develop a career path to help coders achieve the ultimate level of specialty certification along with obtaining their CCS (presently the bottom two levels require a CPC only at my facility).

Don't underestimate the level of support and communication that providers need to assure them that you are capturing and coding everything necessary to meet their expectations. Our staff had to be increased to meet their analytic, communication, and auditing needs and requirements.

Hart: Set expectations and develop a standard set of metrics that all departments can agree on.

Develop a process where the coders can provide feedback to each physician who self-codes. Our coders send the physicians a message explaining the reason for the change in the code, then they wait three days. If the physician does not respond, the coder drops the account with the assumption the physician agreed. If the coder and physician do not agree, the case is sent to the coding quality coordinator, and if not resolved, to the compliance department for resolution.

Manage the change, monitor the change, and promote the benefits and outcomes of the change.

Prior to transition, the practice plan coding and billing department needs to be fully assessed. Develop an organized transition plan based on this assessment.

Fully align the coding staff; do not split by inpatient, outpatient, or surgical coders.

Notes

[1] Centers for Medicare and Medicaid Services. "Episode-Based Cost Measure Development for the Quality Payment Program." December 23, 2016.

[2] Peckham, Carol. "Physician Compensation Report 2016." MedScape. April 1, 2016.

[3] Physicians Advocacy Institute. "Physician Employment Trends." September 7, 2016.

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