Developing a coding and compliance infrastructure that is both appropriately sized and equipped can be tricky for many independent and hospital-based physician groups. The tug-of-war that occurs when trying to maximize revenue without compromising compliance with professional fee billing can be daunting, especially when placing equal focus on productivity and performance.

In some cases, just bringing this topic to the forefront of discussions with clinical and management teams can be problematic, as coding and compliance specialists may be viewed as impediments to productivity. However, with the preponderance of recovery audit contractor (RAC) audits, complexity of ICD-10 coding, and changes in payer reimbursement policies, many organizations are now realizing the importance of enhancing their coding infrastructure to ensure success.

WHY IS CODING IMPORTANT?

The coding process is no easy task—there are more than 8,000 CPT codes and 69,000 ICD-10 diagnosis codes to choose from, as well as a litany of complex payer and regulatory guidelines to follow, in order to code accurately. Moreover, organizations utilize a wide array of resources and workflows to complete the coding process. Some require providers to select codes via an EHR or encounter form, while others utilize support staff to abstract directly from the medical record, and each approach has its own benefits and drawbacks.

The challenges associated with billing and collections are not new, as inadequate attention to coding has always had the potential for high-cost repercussions (e.g., increased billing lag, unnecessary denials, increased cost to collect). In addition, the Office of the Inspector General’s ongoing focus on RAC audits for evaluation and management (E/M) coding signals increasing scrutiny on physician billing in the ambulatory setting, adding high audit and recoupment costs (or worse) to the list of challenges. For an organization to successfully manage the tug-of-war between cost and benefit for its coding and compliance program, it must first recognize the importance of the functions provided by its revenue cycle teams.

WHAT DOES IT TAKE TO PERFORM WELL?

High-performing organizations maintain coding and compliance programs that appropriately balance revenue maximization, coding compliance, and costs to ensure each visit is coded for optimal reimbursement. All of the coding and compliance functions detailed in the tables below play an active role in fostering an organization’s overall success, and should be evaluated to see if there are opportunities for improvement within your own organization. Each activity is equally important builds upon the others to drive consistent professional fee coding.
The first set of activities to consider are pre-bill coding activities.

<table>
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<tr>
<th>Pre-bill coding</th>
<th>Functional Attribute</th>
<th>Key Considerations</th>
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|                 | Develop consistent coding policies and practices across the organization.            | » Coding and compliance policies should be established based on payer- and specialty-specific guidelines. For example, some payers will reimburse for certain coding events that Medicare will not. Organizations shouldn’t forfeit reimbursement opportunities by instituting an unnecessarily rigid compliance program.  
  » A communication plan should be developed to inform providers or abstracting coders of payer- and specialty-specific policies. The plan should document the source/rationale for each policy to facilitate buy-in and support. |
|                 | Identify true coding work, and determine which tasks can be automated and which should be completed by the provider. | » Organizations should review coding workflows to determine if low-risk encounters can utilize technology, such as code selection tools or custom edits, to improve the coding process and minimize manual interaction by providers or staff.  
  » Where possible, certified coders should be responsible for reviewing high-risk code selection and abstracting complex procedures to maximize reimbursement and reduce errors. |
|                 | Ensure staff are appropriately deployed to increase efficiency.                       | » Based on updated coding workflows, a review of historical, specialty-specific coding volume is necessary to understand how coding staff should be structured and deployed to meet the anticipated volume of coding abstraction, edit, and denial work.  
  » In certain instances, it may be beneficial to review the usage of third-party coding support for low-volume/high-complexity specialties. |

Next, organizations should review audit and compliance activities.

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<tr>
<th>Audits and compliance</th>
<th>Functional Attribute</th>
<th>Key Considerations</th>
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|                       | Design thorough provider and coder audit programs.                                   | » Annual audits should be completed, and results should be shared with each provider and abstracting coder.                                                                                                           
  » Certain specialties may require different degrees of E/M coding or procedure audits; however, in general, specialties should have a consistent quantity of encounters reviewed during each audit cycle.  
  » Audits should focus on compliance, not revenue maximization. |
|                       | Establish and enforce accuracy standards across the organization.                    | » Providers or coders who are performing below a predefined accuracy rate should be coached and re-audited within a probationary period.                                                                           
  » New providers or coders should be audited and coached more frequently until a predefined accuracy rate is attained.  
  » Policies should include a disciplinary action plan for providers or coders who fail to meet organizational standards. |
|                       | Periodically review coding policies and procedures to ensure compliance is maintained. | » Compliance staff should periodically review and update coding policies or procedures to ensure language is consistent with changing payor requirements.                                                                    
  » Policy updates should be communicated regularly and made easily accessible across the organization. |
Finally, coding education and feedback loops should be reviewed.

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<tr>
<th>Functional Attribute</th>
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| Develop an education program that is both proactive and reactive. | » A consistent feedback loop should be established between providers and coders, to include real-time feedback on error trends, tips, changes made to charges, etc.  
» Providers and coders should receive periodic and ongoing coding education to better understand compliance expectations and documentation improvement opportunities to allow for optimal reimbursement. |
| Review coding trends to identify risks or education opportunities. | » Organizations should consider establishing a coordinated education team that includes coding denial resources, as this will allow education to be tailored to denial trends across payers and/or specialties.  
» A periodic review of provider or abstracting coder E&M code selection can identify potential compliance risks and allow for targeted education and issue resolution. |
| Monitor the use of educational material throughout the organization. | » The development of a central education repository with user tracking can ensure material is consumed across an organization.  
» Continuing education requirements should be reviewed annually and standardized, particularly for staff who require ongoing education to meet accreditation needs. |

Please note, while education is listed last in this series of functions, it is by no means least important. Creating something of a “chicken-or-egg” scenario, provider education needs to be informed by policy and audit, but also influences the ability to effectively perform.

**HOW SHOULD PROGRAMS BE ORGANIZED?**

For most organizations it is infeasible to have certified coders abstract and/or review every professional encounter. To that end, the ideal operational structure is a function-based model, where coders are deployed to support critical activities based on their skill sets and expertise, while providers maintain a high degree of responsibility in the coding process for more routine encounters. In this model, illustrated below, the production team (responsible for abstraction, edits, and coding denials) and the audit team (responsible for compliance audits) provide trends feedback to the education team, which in turn acts as a resource for providers by communicating issues and opportunities for improvement.

**Figure 1: Sample Organization Structure**

<table>
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<tr>
<th>Sample Roles and Responsibilities</th>
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<tbody>
<tr>
<td>Role</td>
<td>Sample Responsibility</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>Document the coding process; assign CPT and ICD-10 coding for E&amp;M and standard/specialized procedures.</td>
</tr>
<tr>
<td><strong>Clerk/Charge Entry</strong></td>
<td>Validate standard charges; work with physicians and production coders to resolve front-end edits.</td>
</tr>
<tr>
<td><strong>Coding and Compliance</strong></td>
<td>Abstract complex procedures; validate complex or high-risk charges; resolve coding-related edits and denials.</td>
</tr>
<tr>
<td><strong>Education Team</strong></td>
<td>Provide proactive and reactive provider and/or coder education to ensure compliance and maximum reimbursement (e.g., documentation and coding).</td>
</tr>
<tr>
<td><strong>Audit Team</strong></td>
<td>Audit physicians and coders to ensure compliance, and provide feedback as needed.</td>
</tr>
</tbody>
</table>
Given that each team is responsible for defined tasks, the best practice model enables consistency and quality and allows management to easily measure/monitor results. Work standards and performance expectations should also be established to confirm adherence to policies and protocols and ensure proper management of work volumes and backlogs.

Additionally, it should be noted that the audit team reports to a separate authority from the production team. This reporting structure helps guarantee that chart reviews are focused solely on compliance and are not influenced by cash opportunity.

That said, despite the segregation of duties, it is important that all members of the infrastructure adhere to a common set of policies and that teams are led by qualified individuals with deep coding expertise. Finally, while the model above describes distinct teams, there may be instances where qualified coders would be responsible for multiple functions (e.g., audit and education)—functional duties should be driven by size/necessity of the coding or compliance work.

**HOW SHOULD PROGRAMS BE STAFFED?**

While system tools and automation should be used where possible, the final step in establishing a successful coding and compliance program is to review the staffing model to ensure:

1. The appropriate number of resources are working in unison to complete the coding and compliance activities required; and
2. The work is segmented and structured in a way that allows for a streamlined and consistent approach to the workday.

Figure 2 provides a summary of the process organizations should follow to estimate necessary staffing levels.

**Figure 2: Staffing Determination Process**

<table>
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<tr>
<th>Quantify the Work</th>
<th>Determine the Throughput</th>
<th>Calculate the Staffing Need</th>
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<tbody>
<tr>
<td>» Review historical coding and compliance activity volumes (e.g., charge review, edits, abstraction).</td>
<td>» Calculate throughput by task for the activities identified.</td>
<td>» Determine the time needed to accomplish each task to estimate FTE requirements.</td>
</tr>
<tr>
<td>» Determine future needs for new activities.</td>
<td>» If historical values or KPIs don’t exist, perform a time study.</td>
<td>» Incorporate continuing education and other value-add activities to staff as needed to determine the true FTE need.</td>
</tr>
<tr>
<td>» Estimate growth within the organization.</td>
<td>» Further segment tasks by complexity as needed.</td>
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</table>

In short, reviewing your organization’s coding and compliance infrastructure and implementing best practices can ultimately protect your organization from compliance-related risks and increase your organization’s reimbursement in a cost-effective manner. An examination of the activities highlighted above will ensure the charge submission process is efficient, claims are billed and adjudicated appropriately, and risk and subsequent expenses are mitigated.

**Practice spotlight**

With more than 1,600 providers across Utah and Idaho, Intermountain Healthcare is widely recognized as a leader in clinical quality improvement and efficient healthcare delivery.
Intermountain Health developed a model that prioritizes provider audit and education over coder abstraction. Generally speaking, under the model, providers are responsible for their own coding and charge entry; however, approximately 50 coding-certified consultants meet with the providers regularly to discuss areas of opportunity identified from audits and denials. It is important to note that given the complexity of select areas, coders are utilized to support procedural coding for orthopedics, cardiology, and neurosciences.

The rationale for Intermountain’s model is based upon the notion that educated providers need to clearly understand their role in the revenue cycle, as well as their exposure to risk. As Adam Freebairn, director of professional documentation and coding at Intermountain, put it, “when you disconnect doctors from billing, their documentation tends to suffer. They also tend to forget that they are ultimately accountable for the accuracy and compliance of their coding, regardless of whether a coder abstracted from the record.” In addition, the model is described as being a reaction to the expense and challenges associated with recruiting. According to Adam, “our research has found that coders are no more accurate than physicians that have received coding education and have the right tools in place. On top of that, it is hard to find great coders.”

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