Taking a Closer Look at Physician-based Coding

by Karen M. Kostick, RHIT, CCS, CCS-P

Since 1997, AHIMA has offered a Certified Coding Specialist--Physician-based credential (CCS-P) for HIM professionals who are employed in the physician setting. In recent interviews, an office manager, coding manager, coding coordinator, and two physician-based consultants shared their coding practices in the physician setting with AHIMA.[1] This article will highlight some of the challenges and responsibilities of the physician-based coding setting.

Shared Responsibilities

Coding responsibilities in a physician-based setting offer their own unique challenges as opposed to those of hospital-based coding. For example, it is typical for physician office coders to code from outpatient superbills (patient encounter forms designed to make the billing process more efficient), inpatient physician charge forms, and operative notes instead of an entire medical record. When a complete record is used for coding, physician-based coders rely on copies of medical records to be shipped to their off-site office.

Most often, physicians and coders both assign ICD-9-CM and CPT codes for professional services, whereas in the hospital setting only coders are responsible for code assignments. You will most likely find physician-based coders working within the physician billing department.

Who Codes What?

The coders interviewed all said that their physicians are responsible for assigning ICD-9-CM diagnosis codes and CPT codes for their outpatient evaluation and management (E/M) services and minor office procedures (i.e., immunizations). The coder is responsible for ensuring the outpatient superbill is accurate and complete for billing. The coder verifies that the physician selected an ICD-9-CM diagnosis code, CPT E/M visit code, and attached modifiers to procedures or services when applicable. The coder also verifies that the physician applies regulatory agency guidelines to coding principles so that the claim is filed correctly with the insurance carrier (i.e., linking ICD-9-CM codes to proper CPT codes). If any elements are missing or incorrect, the coder updates and completes the superbill for the physician.

In one group practice, the coders do not have the outpatient pre-billing superbill preparation responsibility. Instead, coding service representatives perform this function. They work on site at the clinics, whereas the coding staff is located off site. Being a coding service representative requires a background in medical terminology and training in general ICD-9-CM and CPT coding guidelines in order to prepare outpatient superbills. When a question related to the superbill arises, the coding service representative is required to consult a coding staff member or physician. The coding service representative is not allowed to change or assign ICD-9-CM or CPT procedure codes without the consent of a coder or physician.

In the inpatient setting, it is common for physicians to complete individual inpatient charge forms, which includes checking off applicable inpatient CPT E/M visit codes and procedures. The physician also documents the patient's diagnoses on the inpatient charge form. Once the patient is discharged, the charge form is routed to the coding staff for processing. Similar to the outpatient clinic setting, the coder is responsible for verifying that all the required coding and billing elements are included on the inpatient charge form.

Coders will assign the ICD-9-CM codes to the diagnoses listed on the inpatient charge form. Without reviewing the inpatient medical record, the coder is unable to verify that the physician has captured all charges and selected the correct CPT E/M visits. One coding manager's facility receives copied dictated history and physicals, discharge summaries, and consultation reports. The coder uses the dictated reports to verify the physician's E/M code level assignment.

When it comes to coding diagnostic and therapeutic procedures, one multispeciality group practice leaves the ICD-9-CM diagnosis and CPT procedure coding to the coding professionals. Coders responsible for identifying these services obtain dictated procedure reports and code the services for the physicians. The coding manager assigns the procedures to her coders by physician specialty. Having the coders focus on certain specialties is beneficial because the coders begin to develop an ongoing relationship with the physicians.

Multiple Responsibilities

In addition to coding, other common responsibilities of physician office coders include following up with physicians when there is insufficient documentation, reviewing denials received from various insurance carriers, and educating physicians on correct coding guidelines and billing regulations. Other responsibilities that are unique to a specific physician practice include having coders generate and analyze monthly coding management reports and accounts receivable follow up on insurance claims.

In some physician practices, coders are responsible for ensuring that all physicians' charges are captured by closely monitoring daily emergency department admission reports, inpatient discharge reports, and operative room schedules. When missing patient coding information is identified, the coder is responsible for follow up with the physician or the responsible hospital department in order to request the missing coding information. All participating coding managers said that a data entry clerk usually performs data entry of physician charges. If the coder is employed in a small physician office, traditional HIM records management is a common responsibility.

Measuring Data Quality, Productivity

Common ground in the physician-based setting and the hospital-based setting is in the area of productivity and data quality measures. Everyone has found developing internal coding productivity and data quality measures to be challenging because in most cases the physician and the coder are assigning ICD-9-CM and CPT codes to the same superbill or inpatient charge form.

There are non-traditional ways to measure coder productivity and data quality in the physician-based setting. One method is to regularly evaluate the success of meeting the physician practice's turnaround time for claim processing. For example, one coding department has contracted with their physicians to submit bills to all insurance carriers no later than 10 days from the date of service.

Another coding department is responsible for submitting bills to all insurance carriers within 48 hours of the date of service. When these goals are not met, management begins to look at the coding/billing process, coders' individual performance, and the performance of the other physician billing staff. Late superbills, emergency department records, and operative notes, for example, are not held against the coders' performance.

Other group practices establish their claim processing turnaround time from the date the coding information becomes available in the coding department. The coding information is usually date stamped the day it is received and then the clock begins ticking for their claim processing turnaround time goal.

Another effective productivity measurement includes running weekly coding reports that identify how many patient claims were coded by each coder on a daily basis. One coding manager mentioned that she sees anywhere from 48 to 65 patient claims coded per day. The report monitors how many patient claims were coded, not how many services or procedures were coded per patient claim.

When it comes to data quality standards, the same challenges hold true. When physicians and coders both assign CPT codes together, it can be difficult to separate who coded what in order to measure the coder's performance. Coding management regularly reviews explanations of benefits (EOBs), which include insurance denials due to coding discrepancies. This is the most common data quality measurement for managers to evaluate the coding staff's quality performance. One consultant pointed out that reviewing denials is also important in order to adhere to the Office of Inspector General compliance programs when specifically dealing with small physician group practices.

Most of the coding managers interviewed stated that they outsource coding reviews at least annually to a consulting firm. The coding reviews focus on E/M code level assignments that either the physician assigned or the coder assigned for the physician.

Others perform internal E/M audits at the managerial level. An emergency department coordinator said that she performs E/M audits at least biannually, reviewing five to 10 records per physician.

Over the past few years, physicians have become much more aware of the unique and specialized skills found in the physician-based coding professional. One consultant mentioned she has noticed a real improvement in the physicians' relationship with coding and billing staff. For example, physicians are much more attentive to coders' requests for additional documentation so that a claim may be properly coded. Physicians also value and respect the coders' expertise in physician coding and billing education. As a career path for the coder, a physician-based setting is both a challenging and rewarding option.

Note

1. These professionals represented emergency department, primary care, and multi-specialty physician group practices, some of which are affiliated with one or more hospitals. The number of physicians in each group practice varied from 28 to 150. The number of full-time employees per group practice ranged from 2.5 to four. All the group practices employed RHIAs, RHITs, or CCS-Ps. The majority of the physician practices employed full-time employees while a few employed both full and part-time employees. All the coders worked on site with the exception of one part-time remote coder who worked from a home-based office.

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