Physician Revenue Cycle: Optimizing Coding Operations and Encouraging Growth

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VP of Revenue Cycle, Coding & Health Information Services
Aurora Health Care

Adrianne Lovett
Director of Physician Coding
Aurora Health Care
Today’s Speakers

Cathy Ptak, MS, RHIA
Vice President of Revenue Cycle, Coding & Health Information Services

Cathy has more than 35 years of experience in health information management (HIM) leadership and consulting—including work with coding, transcription, privacy/release of information, clinical risk management, quality management, case management, documentation improvement, infection control, electronic health records, and other areas. She was also an integral piece of Aurora’s transition to the ICD-10 code set. She has a bachelor’s degree in health information administration and a master’s degree in management.

Adrianne Lovett, PhD, MBA, CCS-P
Director of Physician Coding

Among her other degrees and certifications, Adrianne has a doctorate degree in leadership and education and more than 20 years of combined experience in the healthcare industry. She is a content expert on medical coding operations, revenue cycle strategies, change management concepts, and other healthcare leadership hot topics.
Objectives

- Utilizing the strength in numbers to specialize and develop expertise for each professional coding responsibility, which includes both coder and physician education.

- Converting from “jack-of-all-trades” to focused expertise coders.

- Exploring strategies for encouraging coder development and career longevity—including outlining coding career ladders within each specialty and partnering with a local academic institution.

What We Will Cover:

- Introductions
- Aurora at a glance
- Aurora’s revenue cycle concept
- Partnering HIM and coding
- Aurora’s professional coding department and its production coding, department support, and provider support teams
- Coder quality
- Departmental successes
- Educational partnerships
- Moving forward
Aurora at a Glance

Wisconsin’s largest home care organization and private employer

- **15** Hospitals
- **150+** Clinics
- **70** Pharmacies

- **32,000** caregivers, including **1,600** employed physicians
- **$4.7B** in Annual Revenue

- **1.2 million** unique patients
- **8.8 million** patient visits last year

- **U.S. News & World Report**
  Aurora St. Luke’s ranked #1 hospital for 2015–2016

- **Milwaukee Journal Sentinel**
  Named a Top Work Place for 2016

- **Becker’s Hospital Review**
  Nick Turkal named among Top 100 Physician Leaders for 2015
Aurora at a Glance – Volume Statistics

70 Pharmacy Locations
- Prescriptions Filled
  - 2014: 1.82M
  - 2015: 1.83M

Home Care
- Home Visits
  - 2014: 206K
  - 2015: 223K

159 Clinics
- Visits
  - 2014: 3.48M
  - 2015: 3.57M

15 Hospitals
- Inpatient Days
  - 2014: 324K
  - 2015: 330K

Labs
- Tests Performed
  - 2014: 17.04M
  - 2015: 17.58M

Source: Aurora Health Care YTD September
Aurora’s Revenue Cycle Concept

Senior Vice President of Revenue Cycle

VP Revenue Cycle Patient Services *(Pre-Service)*

Vice President Revenue Cycle Coding/HIM *(Mid-Cycle)*

Director of HIM

Director of Hospital Coding

VP Revenue Cycle Business Operations *(Post-Service)*

Director of Physician Coding

Mid-cycle
Partnering HIM and Coding Operations

• It’s all about the documentation!
  – Clinical documentation improvement (CDI)
  – Integrating operations in integrated delivery
  – HIM
  – Hospital billing coding
  – Professional billing coding
Physician Coding Department Structure

Aurora Health Care
Revenue Cycle
Physician Coding
February 2017

Coding/Health Information Revenue Cycle VP

Executive Assist.

Admin. Assist. Sr.

Department Support Manager

Primary Care Production Manager

Specialty Production Manager

Provider Support Manager

Coding Appeals Supervisor
Quality & Educ. Supervisor
System Support
PC Prod. Brown Supervisor
PC Prod. Green Supervisor
PC Prod. Gold Supervisor
Spec Prod. Blue Supervisor
Spec Prod. White Supervisor
Spec. Prod. Silver Supervisor
Prov Doc Improv Supervisor
NE Liaison Supervisor
SW Liaison Supervisor
“Best in Class” Vision

Vision Statement
The Aurora Health Care Physician Coding Department provides expert, ethical, timely and accurate provider coding—as well as provider and coder feedback and education—all at a cost-effective price.

Expert

Ethical

Timely

Accurate
Designing a Physician Coding Model

• Aurora’s current physician coding model supports its transformation from three legacy medical groups into one unified group.

• “Mid-cycle” component of the revenue cycle includes HIM and coding, as HIM supports coding efficiency.

• Operations are split into four separate teams that collaborate and work toward the same goals:
What Was the Redesign Plan?

- Redesign structure of teams
- Planning short-term and long-term goals
- Provide continuing coding/organizational specific education
- Measurement/learning/improvement – creating key performance indicators for all areas
- Accountability and appreciation
- Engagement/communication
- Teamwork/respect/partners
- Flexibility for coding caregivers (remote coding option)
- Specialization to develop expertise
- One touch coding: quality and productivity improvement
- Elbow-to-elbow support for providers – “Who is my coder?”
Coding Production

- An Epic work queue redesign was implemented to streamline and create system efficiencies for the processing of all coding charges.

- Two production teams were created to allow for process and guideline development along with standardization of workflow based on specialty.

- Key performance indicators and reports were developed to measure improvements.
Fostering Coder Expertise

• Coders within Aurora’s primary care and specialty production teams are grouped by provider specialty.
  – Each team has Coder I (office visits), Coder II (non-office visits), and Coding Lead positions

• This structure allows coders to become experts in their chosen specialty, while also providing ongoing development opportunities.
  – For instance, coding leads each obtain an additional specialty-specific coding certification

• Each team is responsible to process entered charges from their specialty’s providers, as well as claim edits and insurance rejections.
  – Allows for ongoing learning and improved opportunities toward “one touch” coding
Key Performance Indicators

- **Charge Review**: Pre-A/R, charge sessions that need to be reviewed by a coder.
- **Claim Edit**: A/R, charge sessions that have hit an Epic “error/rule” that must be reviewed/corrected by a coder.
- **Follow-Up**: A/R, claims that have hit a claims scrubber error/edit or have been “first pass” rejected by the payer and need coder review.
- **Goal**: Maintain less than two A/R days in each set of work queues.

Performing well in 2016 except in follow-up work queues.
Lag Days (Average Days in Coding Work Queues)

- **Goal**: Five days or less on average for charge review
- Measured from the time charge enters the coding work queue until the time it is submitted to the claim
- Causes for longer lag days may include:
  - Insufficient documentation
  - Pending charge fee setup
  - Coder staffing
  - Incorrect provider setup
  - Waiting on query response from provider
Medical Group Standardization Challenges

- Example medical group standardization challenges that affect coding or coding processes include:
  
  - Obstetrics component charging
  - Resident/fellow versus supervising field usage
  - Using national correct coding initiative bundling rules for all
  - Office supply/durable medical equipment charging/pricing
  - Use of APPs – who bills and gets the relative value unit credit?
Coding Department Support

• The department support team focuses on coding quality, research, education, and system testing and optimization.

Team Roles
• Coding research
• Coding appeals
• Coding instructors
• Coding quality
• Systems support

Efforts
• Hosting an annual, onsite conference where coders earn continuing education units
• Having certified instructors teach classes onsite, as well as providing departmental education on coding trends/updates
• Compiling coding accuracy review data and trends, and evaluating coding denials for preventable causes
• Generating resources to help coders educate physicians
• Publishing internal website resources, regular newsletters, and more
• Testing automated coding resources to enhance quality and productivity
• Updating coding policies
The department recently hosted an annual, two-day educational conference for all of Aurora’s professional coders

<table>
<thead>
<tr>
<th>Speakers</th>
<th>Logistics</th>
<th>Achievements</th>
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<tbody>
<tr>
<td><strong>Keynote Speaker:</strong> CFO Gail Hanson shared information on the value of employed coders and the positive future ahead</td>
<td><strong>Day Two:</strong> Coding leadership and certified coding instructors provided education</td>
<td><strong>Attendance:</strong> 2017 included more than 275 coders</td>
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<td><strong>Additional Speakers:</strong> Physician coding department, HIM, physician compensation, compliance, clinical informatics, diversity and inclusion, and human resources leaders</td>
<td><strong>Engagement:</strong> Both days included raffles and trivia</td>
<td>Attendees earned the majority of their CEUs to maintain their certifications.</td>
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<td>The event itself also represents a chance for remote coders to connect and network with team members.</td>
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Annual Coding Conference (Cont.)

<table>
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<tr>
<th>Time</th>
<th>Topic and Speaker</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>7:00 am-8:00 am</td>
<td>Registration</td>
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</table>
| 8:00 am-9:00 am | Conference Welcome                                   | Adrienne Lovett, PhD, MBA, CCS-P  
                              |            | Director of Physician Coding  
| 9:00 am-10:00 am | VP Update                                            | Carty Pek, MS, RHIA  
                              |            | Vice President of Revenue Cycle, Coding and Health Information  
| 10:00 am-11:00 am | SVP Update                                           | Camie Dovis, MHA, CAMPE  
                              |            | Senior Vice President, Revenue Cycle Operations  
| 11:00 am-12:00 pm | Physician Compensation                              | Connie Rubis, MBA  
                              |            | Director of Physician Compensation  
| 12:00 pm-1:00 pm | Lunch                                                |            |

**Talent Wins Games ~ Teamwork Wins Championships**
Informal reviews include coding reviews of new coders on their assigned workflow and job expectation.
- These are usually conducted by the department’s supervisor or lead

Coders may also:

- Be assigned a peer mentor
- Receive coaching and daily support through a mentor, lead, or supervisor
- Participate in frequent touch-base meetings/team huddles
Coding Quality Program (Cont.)

- Formal processes measure the accuracy and effectiveness of the work performed by certified coders; both production and non-production coders are evaluated.

- The expected compliance rate is 95% or more.

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<tr>
<th>Quality Standard Percentages</th>
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<tr>
<td>98.5–100%</td>
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<tr>
<td>Superior strength</td>
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<tr>
<td>95–98.4%</td>
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<tr>
<td>Meets quality expectations</td>
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<tr>
<td>90–94.9%</td>
</tr>
<tr>
<td>Does NOT meet quality expectations</td>
</tr>
<tr>
<td>0–89.9%</td>
</tr>
<tr>
<td>Work improvement plan or corrective action plan may be initiated</td>
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Coding Quality Program (Cont.)

- Performed biannually
- Utilizes assessments specific to each caregiver’s duties
- Aggregate data tracked and monitored, and all issues addressed
- Follow up with leads, supervisors, and coding education team
- Results form part of the caregiver’s annual performance review

<table>
<thead>
<tr>
<th>Production Coder Requirements</th>
<th>Non-Production Coder Requirements</th>
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<tr>
<td><strong>Adherence to:</strong></td>
<td><strong>Knowledge of:</strong></td>
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<tr>
<td>• Code of ethics</td>
<td>• Code of ethics</td>
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<tr>
<td>• Official coding guidelines</td>
<td>• Official CPT, HCPCS, and ICD-10</td>
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<tr>
<td>- Aurora’s PB coding guidelines</td>
<td>guidelines</td>
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<tr>
<td>- Appropriate CPT, HCPCS, ICD-</td>
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<tr>
<td>10 code application, including</td>
<td>- Aurora coding and documentation</td>
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<tr>
<td>sequencing and modifiers</td>
<td>guidelines</td>
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<td></td>
<td>• Payer regulations</td>
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<td></td>
<td>• Communication with internal and</td>
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<td></td>
<td>external entities</td>
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Provider Support Team

• The provider support team focuses on physicians and is split into two branches:

  **Coding Liaison Team or the Face of Coding**
  ✓ Provides initial and recurrent coding and documentation education, answers physician’s coding questions
  ✓ Notifies providers of their performance and improvement opportunities
  ✓ May collaborate with Aurora’s quality and education team to create informational materials
  ✓ Elbow-to-elbow onsite coding support for providers

  **Documentation Improvement Team**
  ✓ Documentation improvement specialists review cases as part of new provider onboarding education, and those identified as outliers in a data analytics system
  ✓ Review findings (e.g., accuracy, opportunities to improve, compliance risks) are shared with physicians during virtual conversations
Deploying Successful Coding Liaisons

- **Top requirement for coding liaisons:**
  The ability to build positive relationships with both physicians and physician practice administrators

- Each liaison supports at least 50 providers, and is required to contact their assignees and provide performance reports at least once per month
  - Reports include:
    - Upcoming code changes and bundling rules
    - Other regulations affecting coding/billing practices
    - Successes of the individual provider
    - Outstanding issues to work on
    - And more

**May Coordinate With:**
- Medical group leadership
- Physician compensation
- Compliance
- Human resources
- Information technology
- Informatics (EHR technicians)
- Finance
- PB & J committee
Provider Review Objectives

- Data-driven samples/reviews focusing on documentation quality

- Total review includes:
  - ICD-10 diagnoses
  - CPT procedures
  - Level of service
  - Components for Medicare Wellness Visits, resident supervision, scribe statements, and hierarchical conditions

- Focus on improvement rather than “the stick”
Demonstrated Improvements

- Redesigned claim edit and follow-up work queues for greater efficiency
- Move toward “one touch” coding
- Standardization of legacy medical group charging/coding practices
  - CCI, OB charge entry, no charge services
- Preparation and coordination of impending anesthesia coding/billing from McKesson

- Decreased coder vacancy %
- Fully complied with action plan and internal audit deadlines
- Increased physician communication from 10K touch points per month in late 2015 to over 12K per month by end of 2016
- Processed nearly 5M new claims
  - First pass claims remained under the 5-day threshold
  - Follow-up was reduced from more than 6 days to less than 1 by the end of the year

- Documented all coding workflows, revenue risks, and mitigation strategies for internal controls
- Leadership development and outstanding caregiver engagement scores
- Revamp of coding career ladder and coder equity adjustments
- After successful implementation of physician coding quality program, approximately 100 coders were qualified to work from home
Developing Potential Coders

• In addition to these efforts, Aurora actively contributes to the education process of qualified coding students through partnerships.

• As part of a collaboration with Lakeshore Technical College, Aurora hosts approximately four students at a time to learn onsite as part of its medical coding practicum.
Developing Potential Coders (Cont.)

• The students then spend 18 hours over the course of three weeks at Aurora.

• This time breaks down to six hours spent in the coding, billing and registration, and follow-up/back-end denial departments.

• Observing the three areas gives students a more global view of the revenue cycle.
Coding Student Requirements

- In the follow-up and denial areas, the students are responsible for:
  - Reviewing five Medicare and five Medicaid denials
  - Pinpointing denial root causes
  - Observing the appeal and claim resubmission process
  - Summarizing the general denial process
Moving Aurora Forward

• Helping coders take control in, develop, and share their expertise

• Leads to greater effectiveness
  – Autonomy, competence, and relatedness (engagement)
  – Achieving high accuracy rates

• Individual achievements combined with collective team success
  – Reduces denial rates

• Team approach is key, as effective teams lead to outstanding outcomes
  – Best brand, best value, best people

• From individual wins to team championships
  – “Talent wins games … teamwork wins championships”

Themes

• Caregiver engagement
• Department collaboration
• Operationalizing new initiatives
• Creating process efficiencies
• Creating system efficiencies
• Planning
• People – Processes – Systems
Questions?

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