The change to ICD-10 impacted more than just code selection. It affected coder productivity and accuracy, the number of available coders, the need for coder education and training, and the increased need for auditing—all core responsibilities and issues that coding managers now face in this post-ICD-10 world. The old rules and standards for running a department no longer apply, and coding managers must update their efforts just as the coders themselves did.

This book gives readers new 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.
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JustCoding’s Practical Guide to Coding Management | v
About the Author

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

Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, 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, Dunn served as the interim chief executive officer of AHIMA and received a Distinguished Service Award from the board of directors. Dunn is the chief operating officer of First Class Solutions, Inc., a health information management (HIM) consulting firm in St. Louis, Missouri.

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. She 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.

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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 25 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. Editors Steven Andrews and Amanda Tyler thoroughly reviewed the manuscript and offered many valuable suggestions while keeping the production running smoothly. Reggie Cunningham, cover designer, and Susan Robinson, graphic artist, designed the book’s cover and interior, respectively. Amanda Tyler served as editor and Amanda Donaldson as the proofreader. To them and those other individuals working behind the scenes, thank you.

Rose T. Dunn
Chapter 1

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 United States
• 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 classification of diseases (Merriam-Webster, n.d.).

The classification of diseases used in the United States, and many countries worldwide, is the International Classification of Diseases (ICD), 10th edition, or ICD-10, which was developed by the World Health Organization (WHO) and its participating member countries. In the United States, the classification is modified to meet the clinical assignment, research, and payment needs of the United States.
Here, the classification is called ICD-10-CM, or clinically modified. Many countries use a classification to capture health-related condition data for mortality and morbidity purposes. The United States collects procedure-related data as well. Therefore, there is a second classification system, known as ICD-10-PCS, or the procedure coding system, for inpatient procedure coding and CPT-4® or Current Procedural Terminology, 4th edition.

Finally, another coding system is DSM-5®. The DSM or Diagnostic and Statistical Manual of Mental Disorders is used in the behavioral health arena. It is modeled after ICD-10-CM but provides additional guidance to the behavioral health counselor or physician that guides them in the proper selection of the code based on clinical signs and symptoms.

When Did Coding Begin?

In 1860, during the International Statistical Congress held in London, Florence Nightingale made a proposal that resulted in the development of the first model of a systemic collection of hospital data. In 1893, a French physician, Jacques Bertillon, introduced the Bertillon Classification of Causes of Death at a congress of the International Statistical Institute in Chicago. A number of countries and cities adopted Bertillon’s system, which was based on the principle of distinguishing between general diseases and those localized to a particular organ or anatomical site, as used by the city of Paris for classifying deaths.

In 1898, the American Public Health Association (APHA) recommended that the registrars of Canada, Mexico, and the United States also adopt it. The APHA also recommended revising the system every 10 years to ensure it remained current with medical practice advances. As a result, the first international conference, which took place in 1900, revised the name from Bertillon to the International Classification of Causes of Death, with revisions to the classification occurring every 10 years thereafter.

Prior to the sixth revision, responsibility for ICD revisions fell to the Mixed Commission, a group composed of representatives from the International Statistical Institute and the Health Organization of the League of Nations. In 1948, the WHO assumed responsibility for preparing and publishing the revisions to the ICD every 10 years. It later became clear that the established 10-year interval between revisions was too short.

In addition, some countries—including Australia, Canada, and the United States—have developed their own adaptations of ICD, with condition and procedure codes for classification of conditions and operative or diagnostic procedures.

Beginning with deaths occurring in January 1999, the United States began using ICD-10 to classify causes of death reported on death certificates (Center, 2004). DSM-5 was launched in April 2015 for use in the United States, while PCS was introduced for routine use for healthcare provider and reimbursement purposes in the United States at the same time as ICD-10-CM: October 1, 2015.

CPT-4 is a classification that is maintained by the American Medical Association (AMA). It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS is divided into two principal subsystems, referred to as level I and level II.
Level I of the HCPCS is composed of CPT. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. These healthcare professionals use the CPT to identify services and procedures for which they bill public or private health insurance programs. The AMA makes decisions regarding the addition, deletion, or revision of CPT codes. The AMA updates the CPT codes annually. Level I of the HCPCS, the CPT codes, does not include codes separately needed to report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services, durable medical equipment, prosthetics, orthotics, and supplies, when used outside a physician’s office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items. The development and use of level II of the HCPCS began in the 1980s. Level II codes are also referred to as alphanumer-ic codes because they consist of a single alphabetical letter followed by four numeric digits, while CPT codes are identified using five numeric digits (CMS, n.d.).

Who Are Coders?

The job title of nosologist has not become popular in the United States. Instead, those in healthcare who have positions that assign codes and classify conditions and procedures are called coders, coding or data integrity specialists, or coding professionals. Regardless of the job title, these individuals have acquired specialized knowledge in medical terminology, anatomy, physiology, and pathophysiology. Many coding professionals have completed a formal coding educational program. However, other individuals with clinical education, such as nurses and physicians, may be coders as well.

A coding professional also has in-depth knowledge of rules governing coding. CMS and the National Center for Health Statistics, two departments within the U.S. Federal Government’s Department of Health and Human Services, publish the guidelines for coding and reporting using the ICD.

Coders work in a variety of healthcare settings, including, but not limited to, physician offices, hospitals, skilled nursing facilities, research environments, pharmaceutical firms, and ambulatory surgery settings.

Analyzing the level of expertise of the coding staff is an important management function. It serves to identify the work that can be assigned to each coder and what education opportunities are needed to bring all coders to the level of competency and proficiency of meeting both productivity and quality expectations. The level of certification of a coder may be one factor in determining coder expertise. Certification is defined as:

*A process by which a nongovernmental agency or association recognizes the competence of individuals who have met certain qualifications as determined by the agency or association* (Wilson & Dunn, 2009).
Various certifications are available to coding professionals and are issued by several professional organizations. Some of the certifications appear below.

**Figure 1.1 | Coding Certifications**

<table>
<thead>
<tr>
<th>Certification</th>
<th>Meaning</th>
<th>Issued by</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCA</td>
<td>Certified Coding Association</td>
<td>AHIMA</td>
</tr>
<tr>
<td>CCS</td>
<td>Certified Coding Specialist</td>
<td>AHIMA</td>
</tr>
<tr>
<td>CCS-P</td>
<td>Certified Coding Specialist - Physician-based</td>
<td>AHIMA</td>
</tr>
<tr>
<td>COC</td>
<td>Certified Outpatient Coder</td>
<td>AAPC</td>
</tr>
<tr>
<td>CPC</td>
<td>Certified Professional Coder</td>
<td>AAPC</td>
</tr>
<tr>
<td>CPC-H</td>
<td>Certified Professional Coder - Hospital</td>
<td>AAPC</td>
</tr>
<tr>
<td>CIC</td>
<td>Certified Inpatient Coder</td>
<td>AAPC</td>
</tr>
<tr>
<td>CRC</td>
<td>Certified Risk Adjustment Coder</td>
<td>AAPC</td>
</tr>
<tr>
<td>CPC-P</td>
<td>Certified Professional Coder - Payer</td>
<td>AAPC</td>
</tr>
<tr>
<td>CIRCC</td>
<td>Certified Interventional Radiology Cardiovascular Coder</td>
<td>AAPC</td>
</tr>
</tbody>
</table>

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

Additionally, American Health Information Management Association (AHIMA)–approved coding certificate programs and the health information management (HIM) degree program leading to the credential of RHIA, and health information technology degree program leading to the credential of RHIT 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 someone who can lead others. Likely, they were an exceptional coding professional—an individual with coding-specific education, certifications, and an excellent work ethic. However, these individuals may lack any formal management education or experience. Transitioning from a subordinate to a supervisory role can be anxiety inducing. This book is designed to provide guidance for the new coding manager or supervisor.
Individuals who ascend the ladder of leadership positions in coding may follow the traditional route of senior coder, coding coordinator, team leader or lead coder, coding supervisor, coding manager, and director of coding. Each of these titles infers that the individual has gained coding expertise in more than one coding classification and/or is respected for his or her knowledge of coding and coding rules. These leaders may supervise coding specialists who code the same type of records or different record types. As we discussed earlier, there are three common coding systems in the United States: ICD-10-CM, ICD-10-PCS, and CPT-4. Additionally, there are HCPCS and DSM-5, which are less widely used.

**New manager challenges**

New managers face a variety of challenges.

First, the new manager is no longer a peer of the individuals with whom they work. The new manager now assigns work and ensures that members of the team complete it accurately and on a timely basis. Additionally, the new manager may continue to be a doer while at the same time serving as a counselor, reviewer, and teacher to ensure that coders are functioning as a team and are up to date on current coding issues, coding rules and guidelines, and the latest clinical techniques.

Second, the manager probably has a larger workspace that affords greater privacy for conversations and meeting with others. However, this new space also separates the manager from former coworkers and puts him or her out of earshot of conversations in which the manager previously participated.

Third, the manager now has some new duties that include:

- Understanding the flow of coding data through the organization’s information systems
- Designing and running reports
- Answering questions from team members
- Addressing concerns surfaced by patient financial services, compliance, denial management, or physician offices
- Conducting reviews of coding performed

These new duties take the manager away from the work he or she formerly enjoyed—day-to-day coding. Instead, the new duties allow the manager to use his or her coding expertise while learning, developing, and honing management skills.

Fourth, the new manager will have exposure to others outside of the coding function. Often the coding manager will be asked to participate on various committees or task forces. In doing so, the manager learns new communication skills while collaborating with others who rely on the coding manager’s expertise and the coding team’s services.

Finally, the coding manager will be forming new friendships with colleagues who support coding and who are supported by coding. As a new manager, one must assess potential career aspirations, balance the time required to perform the new responsibilities with family and social obligations, and do what is necessary to meet the expectations of a new supervisor.
Any and all of this can occur during the first few days in the new position and can leave the new manager wondering whether the promotion was worth it. Reflecting on the first days of being a coder, where there were comparable challenges that were successfully knocked out, should reassure the new manager that these new challenges, too, can be overcome.

**What does a manager do?**

All managers perform essentially the same functions. A manager’s success depends on how well he or she performs each of those functions. Even without the “manager” title, individuals perform management functions in their daily activities. Management entails the functions of planning, organizing, selecting, motivating, and monitoring resources. The diagram below illustrates these management functions. Each day, regardless of whether one is a manager, individuals plan their day or for an upcoming event, organize their activities to achieve their plan, encourage others or oneself to do what is necessary to achieve their plan, and ensure they do not spend more time or resources than they anticipated to complete the daily plan or event.

**Figure 1.2 | The Five Functions of Management**

![Diagram of the Five Functions of Management]

_Source: Rose T. Dunn, reprinted with permission._

Now, the new manager must expand the scope of these functions to include staff members who report to them. The manager will have the authority to:

- Direct staff members (assign work and schedule team members)
- Order and use supplies (resources)
- Identify, select, and/or recommend equipment for purchase or lease
- Establish budgets to pay for these items
Essentially, the new manager will be controlling the integrated use of the four Ms:

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

**Figure 1.3 | The Four Ms**

![Image of the Four Ms diagram](source: Rose T. Dunn, reprinted with permission.)

**Planning**

Planning is the first managerial function. It is the process of establishing goals for the coding function and defining how to achieve those goals with the four Ms that have been allocated to the manager. If the coding function is a component of a larger department, such as HIM or revenue cycle, these goals must support the goals of the department, which in turn support the goals of the organization. We plan every day; the new role will expand the scope of this task to include the coding staff, the technology, and equipment the team will use, the materials that will be consumed, and the associated budgetary constraints.

The planning horizon will be relatively short—that is, likely not the next 5–10 years. Rather, the planning would take place in the next week or month, though the horizon for items such as technology or coding system changes, or when organization mergers are occurring, planning may take one to three years. Consider planning for ICD-11. Other countries will be launching ICD-11 in 2018, but the United States will probably not implement it until 5–10 years later. The manager will need to monitor the nation’s plans and start preparing the coding staff one to two years in advance.
In contrast, short-term planning includes considering how to fill the gap created when one of the coders is on maternity leave. Another example of a short-term plan might be preparing for an on-site audit by an external auditing entity. The plan for the external audit may include identifying the records that will be reviewed, determining how to queue them in the electronic health record (EHR) system for the auditors, securing limited access to the EHR from the reviewers, identifying a space that has computer access for the reviewers, and assigning an individual for the team to be the reviewers’ go-to person.

**Organizing**

After the necessary resources have been identified, the organizing function begins. Organizing means assembling resources (the 4 Ms) in a manner that ensures that the coding function’s goals are efficiently and effectively achieved. For example, in anticipation of the previously described on-site audit, the manager may:

- Use system analytics to select a random sample of cases for the audit
- Assign a clerk to populate the audit queue with the records selected for the audit
- Ask the office administrative assistant to gather the confidentiality and information systems access forms from the auditors, and then forward them to information systems to establish access for the auditors
- Contact the conference room coordinator to identify a room with computer access and of sufficient size to accommodate the auditors
- Assign a coder to review each record to ensure each of the items that may have been requested by the auditing firm (e.g., claims, coder summaries, physician queries) is present in the record or queue, and to serve as the go-to person

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, since 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. 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
• Offering employment

Once the candidate(s) are chosen and agree 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, 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 members are unwilling to do what was asked of them, the manager will fail to achieve the goals established for the coding function. Team members want to know what is expected of them, and they will accept the responsibilities or duties assigned to them if they consider the manager’s expectations:

• Realistic
• Appropriate
• Ethical
• Consistent with the mission of the department

Once accepted, however, the manager cannot walk away and assume that each of the team members will complete their assignments.

**Monitoring**

The manager is ultimately responsible for the work of the coding team, regardless of any assignments delegated to others. Consider the on-site audit. The manager will need to circle back around to the administrative assistant to ensure he or she has obtained all forms and secured access for the auditors in advance of the audit start date; similarly, the manager will need to check with the coder to see if all records have been rechecked and so forth.

The manager remains responsible for overseeing the team’s work product, ensuring that it is completed on time and in an appropriate and accurate manner. If the coder found some coding errors in the on-site
audit sample, the manager may need to develop a plan for addressing the errors, including having the accounts rebilled to the payers with the corrected information.

Monitoring is a control activity—it is continuous and triggered by variations.

Variations may include:

- Not completing all cases within a defined time frame (e.g., discharges must be coded within five days of discharge)
- Cases rejected by prebill edits for missing codes (e.g., operating room charges but no procedure code assigned by the coder)
- Cases not meeting medical necessity
- Excess dollars in unbilled (e.g., unbilled may not exceed five days’ worth of gross revenue)

The five managerial functions overlap, so one should not consider them separate activities. They complement each other and are applicable for anyone in a supervisory or managerial position. Subsequent chapters will amplify the managerial/supervisory role in managing the coding function. However, for a new manager, it may be beneficial to take a college course in management to gain a broader understanding of management’s many dimensions.

References

The change to ICD-10 impacted more than just code selection. It affected coder productivity and accuracy, the number of available coders, the need for coder education and training, and the increased need for auditing—all core responsibilities and issues that coding managers now face in this post-ICD-10 world. The old rules and standards for running a department no longer apply, and coding managers must update their efforts just as the coders themselves did.

This book gives readers new 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.