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THOUGHT LEADERSHIP

DEVELOPING AN EMPLOYED PHYSICIAN NETWORK PROFESSIONAL SERVICES CODING PROGRAM

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INTRODUCTION

Paying adequate attention to and investing in a professional service coding program is crucial for employed network sustainability. An effective program directly supports patient care revenue generation, provider productivity determinations, and corporate compliance assurance. While technical services coding and billing are also important facets of the network revenue cycle – especially in provider-based billing scenarios, many networks experience greater inadequacies in the professional services elements as these differ significantly from other hospital billing practices.

PROFESSIONAL SERVICES CODING PROGRAM ELEMENTS

Programs that offer one-time or episodic general provider education tend to be relatively ineffective as the information often does not "stick" with the providers – especially if the session(s) are perceived to lack direct applicability to an individual provider's circumstances. It is also difficult to provide a "one size fits all" educational session – even by specialty – as circumstances vary so significantly within and across specialties.

Effective programs tend to combine regularly performed audits with timely individual educational feedback about each audited patient encounter – while reviewing the encounter documentation and providing direct insight. This approach tends to make the interaction more "real" and to produce more enduring results. For newly hired providers, this audit process should ideally start within the first 30 days after arrival and continue indefinitely.

Provider audits should sample all visit types (new, acute, chronic, preventive) – including procedures. Specialists who practice in both the inpatient and outpatient environments should have sampling of encounters in each area. Other potential targets for audits include encounters typically associated with modifiers (such as surgical assisting) or bundling (such as global surgical or obstetrical reimbursement packages).

The frequency of provider audits can be guided by performance over time. As a general rule of thumb, providers that do not consistently achieve at least an 80% concurrence rate should be audited more frequently. Customization should occur over time with concentration on encounter types with which the individual provider tends to have greater difficulty.

Providers that consistently achieve near perfect performance could be audited less frequently. However, considering the benefit of regular feedback and the variety of encounter types that can and should be reviewed, ongoing feedback and support can foster greater confidence and better professional relationships.

Some organizations only perform compliance audits once a year on a small sample of encounters. While this level of review might satisfy corporate compliance requirements, it is woefully inadequate to truly impact coding proficiency. A more robust program fulfills both goals – coding improvement and corporate compliance.

Another aspect of a robust coding program that is often overlooked is the direct linkage of the assigned encounter codes with the documentation contained in the medical record. Clinical Documentation Integrity (Improvement) efforts target information capture in encounter documentation that fully supports maximum E&M, CPT (and HCPCS) procedural, and ICD codes reflecting the true essence of both the encounter and the effort expended.

EHR IMPACT

EHRs can assist with both documentation efforts and the resulting coding assignment for patient encounters. Templated electronic documentation can assist with encounter documentation – particularly for common presenting conditions – and with encounter element capture as data that can be directly translated into coding and HCC determinations.

EHRs also have "coding assistant" capabilities to assist providers with the E&M coding process. These "assistants" utilize documentation "data" to generate a suggested E&M code for the patient encounter. These "coding assistants" have historically experienced limited provider utilization for a variety of reasons. One reason is that providers feel too busy to check one more thing during encounter execution and documentation. Most of the "assistants" require providers to actively access the "assistant" as opposed to having options appear once a provider enters an encounter code. Additional clicks create barriers that are often not overcome. A second reason is that the "assistant" requires specific encounter documentation to be created in a data entry fashion (clicking boxes) as it cannot usually interpret free text entries. Documentation templates can help with this process but they are often underdeveloped (and underutilized) and not available for all interactions. Thirdly, the "coding assistant" requires that all documentation for the encounter is complete in order to suggest an accurate code. Many providers will assign the visit code long before completing the encounter documentation. This non-sequential work flow renders the "assistant" immaterial. One final note about "coding assistants." The capability should not be relied upon as a sole source of truth – regular coding audits and provider feedback should still be conducted to assist with both the documentation and subsequent coding functions.

CONCLUSION

Coding accuracy and maximization have historically been undervalued and under-supported in many employed provider networks. The impact – both positive and negative – can no longer be ignored. This aspect of practice operations much be embraced as a critical sustainability issue and corresponding investments pursued.

BUILDING A PROFESSIONAL SERVICE CODING PROGRAM

HSG can help build a program that supports patient care revenue generation and ensures corporate compliance. Contact Dr. Terry McWilliams to discuss your health system's current professional service coding program, or for assistance in building a new program.

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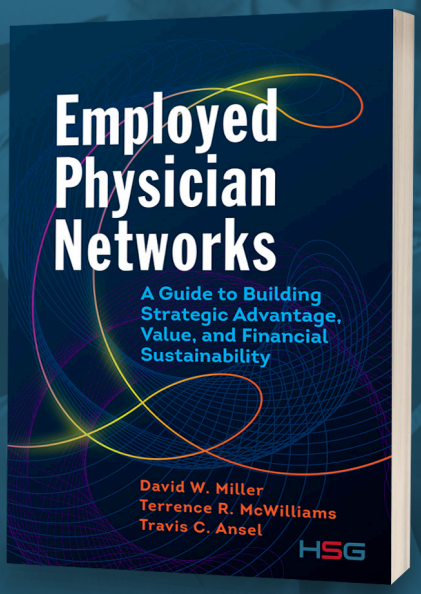

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