THOUGHT LEADERSHIP

EMPLOYED PROVIDER NETWORKS

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Provider Productivity: Impactful Factors

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INTRODUCTION

Provider productivity has become a controversial topic related to employed provider networks and their sustainability. As healthcare economics continue to deteriorate, the topic garners increasing attention. Administrators in many networks feel that overall provider productivity is not optimal and could be improved to generate greater revenues and financial sustainability. Providers, on the other hand, state that the focus on increasing productivity is not realistic as they already have excessive workloads, insufficient time with patients, and high levels of burnout. They point to staffing shortages, high rates of staff turnover, and EMR inefficiencies as factors that further exacerbate productivity issues.

Understanding the factors that directly impact individual provider productivity may provide objective common ground that can cut through subjective impressions. Primary components directly impacting provider productivity include:

- Encounter coding and documentation
- Provider availability – as determined by:
  - Number of bookable hours
  - Appointment durations
  - Appointment types and mix

Let’s explore each of these areas, and their impact, in greater detail.

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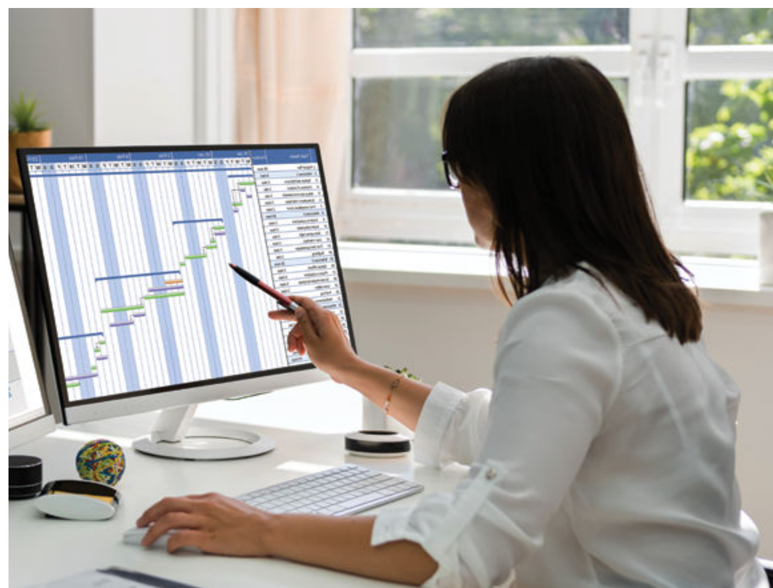
Encounter Coding and Documentation



Accurate encounter documentation and coding is critical for ensuring that full credit is captured and received for the clinical effort being expended – and revenues and workload (wRVU) credit are optimized. Most individuals and organizations focus on the coding aspect of this equation, but think less in terms of (and resources devoted to) the underlying documentation that determines the level of encounter code – and how that might be improved.

The entire framework for E/M encounter documentation and coding changed with the 2021 and 2023 Medicare Physician Fee Schedule (MPFS) Final Rules. The 2021 MPFS introduced medical decision-making (MDM or total time dedicated to the face-to-face encounter (Time) as the primary determinants for the coding level of office-based encounters (99202-99205 and 99211-99215) effective January 1, 2021. The 2023 MPFS extended these criteria to all other E/M encounters, including inpatient, emergency department, skilled nursing facility, home visits, and others, effective January 1, 2023. The MDM and Time determinants replaced the 1995 and 1997 criteria previously in place, which quite heavily weighed the number of systems reviewed and examined. Under the new criteria only a medically appropriate history and physical examination is required for the condition(s) being addressed.

The new MDM criteria require documentation of the problems evaluated during the encounter, the data considered during that evaluation, and the patient risks considered and/or addressed in the encounter or associated with the treatment plan. The focus shifts to documenting the thought processes involved in clinical decision-making, and the outcomes of that process. The extent of the history and physical examination is no longer a primary coding determinant, and the extensive checklists previously used to ensure that an adequate number of systems were reviewed and examined are no longer paramount. Unfortunately, they still linger as primary components of EMR documentation templates in many locations. Those same documentation templates tend to be woefully inadequate for capturing the critical thinking involved with creating and considering differential diagnoses and arriving at conclusions from which the plan of care is generated. These shortcomings present challenges with fulfilling the new coding criteria.

Learning the new MDM coding criteria and how they are applied are challenges in and of themselves. Many decision aids are available to help with that process – but they can also be time-consuming to use until they are learned well and internalized. Additionally, "pointers" have been published by various specialty and consulting groups to further streamline, and maximize, the provider documentation and coding process. Tips include "what" and "how" documentation qualifies as a required element. For instance, how should data reviewed be counted– both in number and during which encounter credit is achieved? Regarding number, a comprehensive metabolic panel consisting of 12 or 23 individual tests, only counts as one test reviewed for MDM purposes. A CBC and an SMA-7 reviewed together count as two.

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Regarding credit, the guidance indicates that credit is received when the test results are analyzed, which tends to be when they are reported. However, tests ordered during an encounter can be captured with that encounter (even though the results are not yet known) and when tests are ordered outside of an encounter, they are captured during the next encounter when the analysis is noted and converted into action.

Clear?

Thought so. Another tripping point is when conditions are improving, but not yet at goal. Just indicating that diabetes control is improving can lead to the impression that it is stable and doing well – even though the Hgb A1C is 8.2. The caveat of "still not at goal level of control" or something similar allows the condition to be considered "unstable" according to MDM criteria. A third tripping point involves prescription management. Comments must be made about consciously increasing, decreasing, or keeping medications and dosages at the current levels to indicate prescription management was undertaken – and receive MDM credit.

Using the Time criteria involves accounting for and documenting the total time the provider spent on the day of service preparing for the E/M encounter, conducting the encounter, documenting the encounter, talking with consultants, family members, or caregivers about the encounter, and similar activities. Providers have not historically thought of nor captured time in this manner. The transition can be quite a challenge. The documentation needs to report the actual minutes spent and ideally delineate exactly how much time the provider spent on which activities and that they all occurred on the day of service. Providing documentation support mechanisms and directly incorporating the information in the clinical documentation allow this approach to be very successful. Questions about whether to use MDM or Time to determine the coding level led to several studies examining this dilemma. The results indicate that Time might be most beneficial to use for longer encounters compared to shorter encounters.

Another factor to consider when utilizing the Time approach is that the time spent must also be considered medically reasonable. Spending an hour with an established patient discussing a single, stable medical

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condition with no changes in the plan of care and no testing would be difficult to justify as a level 5 encounter – unless specific reasons were justifiable and very well documented.

Regardless of how well-versed providers become with the new coding and documentation criteria, they are unlikely to acquire the level of expertise that certified coders possess. Implementing a coding documentation audit and education program promotes routine review, critique, and feedback about individual record coding level assignments compared to the documentation … and what could be improved to optimize effort capture. Reviewing the audit results directly with the provider while having the actual documentation in front of them tends to produce the best and longest-lasting results. Doing this well involves intentional investment in the personnel expertise and the time allocation to be effective. However, such a program can achieve beneficial outcomes for both the providers and the organization without requiring additional volumes of care.

Bookable Hours

Bookable hours refer to the number of hours per week that the provider is available to be scheduled and conduct direct patient care. The time designation includes office hours, operating/procedure room blocks, and inpatient time (if utilized on a regular basis). Bookable hours are benchmarkable by specialty and are key determinants for how productive a provider can be compared to benchmark expectations. As a rule, productivity varies directly with bookable hours – higher numbers of bookable hours tend to yield higher productivity. The relationship is tempered by how care is scheduled during those bookable hours (expounded upon in the next section). However, at face value, a primary care provider with 30 bookable hours per week will have difficulty meeting median benchmark productivity expectations that are based on a median of 37 bookable hours per week.

Setting an expectation for bookable hours is best accomplished during the recruitment process and codified in contractual language. Crucial conversations to address these issues with existing providers can be undertaken at any time, but are best initiated by formally designated provider leaders or addressed through provider leadership councils – perhaps sparked during the review of a formal network performance assessment reports or provider compensation model redesign projects. Achieving incremental increases in bookable hours per week that move providers toward benchmark levels should benefit the involved providers (increased wRVUs), the organization (increased revenues), and patients (increased access to care). Note that initiatives to increase bookable hours per week for providers are often complicated by needing increased staff or adjusted staffing schedules.

Template Management – Appointment Durations and Mix

Not only are the number of bookable hours per week an important individual provider productivity determinant, but so are the appointments scheduled during those hours. Both appointment durations and their mix in a provider's schedule impact productivity. As a rule, productivity against benchmarks varies inversely with appointment durations with longer appointment durations compared to benchmarks by appointment type yielding less productivity compared to benchmarks. Stated another way, providers with appointment durations that exceed benchmarks will see fewer patients per hour or day and have difficulty achieving benchmark productivity outcomes. For example, a primary care provider with 60-minute new patient appointments and 30-minute established patient appointments will not achieve median productivity expectations which are associated with a median of 30-minute new patient appointments and 15-minute established patient appointments. A similar relationship exists for appointment mix – though complexities associated with wRVU generations make the relationship less straightforward. Both appointment duration and appointment mix have external benchmarking available for many specialties. Sub specialties that do not have sufficient national survey respondents to define benchmarks can utilize the aligned general medical or surgical category as a proxy with good validity.

Template management can be a thorny topic as providers tend to resist efforts to "mess with" their schedules, which tend to be the last bastion of provider autonomy. As with bookable hours, appointment parameters are usually best addressed by formally designated provider leaders or through discussions and resolutions achieved through provider leadership councils. Similarly, achieving incremental progress toward benchmark values should be beneficial for the involved providers (increased wRVUs), the organization (increased revenues), and patients (increased access to care). Complicating these changes is the need for sufficient, effective staffing and efficient care delivery models that accommodate the higher patient volume.

Increasing individual provider productivity is possible but can require additional resources to do so effectively – and is not a matter of just requesting the providers "do better." **Tackling some of the underlying elements involved in provider productivity can lay the foundation for positive change in this important, mutually beneficial area.**

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