COSEHC Live CME Education Meeting and PTN Live Collaborative

March 13-15, 2019 at the Wild Dunes Hotel, Isle of Palms (Charleston), SC
Correct Coding to Enhance Reimbursement

• Dr. Nick Ulmer and
• Dr. Stephen Combs
Objectives

• Discuss reasons for having a compliant coding and documentation strategy

• Know that accurate and appropriate coding is vital, not only for payment purposes, but for documentation and compliance

• Show examples of failures opportunities to improve within a large employed medical group

• Share a possible way to avoid arrogance/ staunch independence / ignorance / controlling personalities / ineffective roll-outs of complex processes
Documentation...? Coding...?
Who needs coding and documentation education...?

- Use on EVERY patient encounter.
- Has tremendous economic implications if not done well
  - Studies in past have shown ~ 10-15% of a PCP salary is lost due to ignorance in this area
    - My personal experience shows it closer to 5-10% (EMR implementation and comfort of providers over time)
  - Has tremendous economic implications if done wrong
    - Accepting payment for work not completed (if not documented, then not done) is fraud (so you should pay it back) or non-billable to patients (unless an ABN), so you cannot bill the patient when denied payment
- Has tremendous PR/marketing implications if not done correctly
- Has tremendous compliance implications if not done correctly
- It changes every year and is “run by the government” and we are “told what to do” and liable if we don’t...
- Not taught in medical or NP or PA school except mostly as an afterthought.....
The Medical Group heard about TCM ...

- An initiative to be deployed centrally by the Regional HealthPlus CarePlus Care Transitions team
- They had read about it in throw-away journals and were aware of the economic value of these “hospital follow-up” patients
- RHP deployed a pilot....and the medical group practice became aware.....SO
- THEY launched their point of care TCM initiative (covertly)
- Dr. Ulmer was called about 2 months later with a random question from one of the office managers wanting me to explain a concept related to TCM (and he became intrigued)
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The Medical Group heard about TCM ...

- Compliance found out and did an audit
- Global failure → payback (charge correction) for claims not billed correctly
- Compliance asked me to look into it and I offered to help
- One meeting with a sparsely attended provider presence
- 3 months later, compliance looked again and found improvement
  - ONLY A 60% FAILURE RATE THIS TIME AROUND (charge corrections...!)
  - Compliance shut down TCM and the medical group was saddened 😞
When you start a new project...

• Determine the why?

• Outline a map for the how.

• Vet it with others, multidisciplinary team
  • Operational lead, Revenue Cycle, Coding/Documentation, Compliance,
    Admin staff at point, clinical staff at point, IT point person, Data Analytics
    point person

• Do a focused pilot, listen for bombs and watch for fallout. Get front
  line feedback.

• Regroup the team and re-deploy with tweaks

• Repeat as necessary
TCM take-aways

• Complex process, ignorance was great and an ultimate global deployment would be daunting

• Education broadly delivered simultaneously needed
  • On-line video with post test

• RHP CarePlus staff coordination to queue up patient was key to “checking the boxes at the right time”
  • Allowed the clinical staff to focus on clinical issues

• Even with a streamlined process, the end user will fall short
  • Not bill correctly, restrict access so not seeing pt within 2 wk timeline, not cover the basic documentation required, etc.

• Feedback to medical group leadership for accountability and for comparison to peers re: success
  • Work with outliers (re-educate), applaud success stories
Dr. Stephen Combs
Slides Follow

• Ballad Health Medical Group (formerly Wellmont Medical Associates)
Correct Coding to Enhance Reimbursement

1. Discuss how Ballad Health Medical Group (Legacy Wellmont Medical Associates) followed a yearly fiscal educational cycle to implement meaningful Physician and Provider coding education that appropriately captured the work that was being performed for our patients.

2. Discuss how this educational cycle was placed into annual measures of Physician and Provider “pay at risk / bonus”

3. Discuss how this educational cycle was annually revised around Physician and Medical group goals.
Rationale

1. All Providers need to stay Up-to-Date on Coding Changes
2. Accurate claims are dependent on several components:
   a. following standard coding guidelines
   b. keeping detailed patient records
3. Accurate claims coding delineates to insurers a patient’s:
   a. Symptoms
   b. Illness and/or injury
   c. Method of treatment performed by the Physician/Provider.
4. When the claim is submitted with the wrong diagnosis or procedure code, reimbursement to you and care for the patient can be denied
Identification and Plan

1. Coding opportunity identified based upon data from the Advisory Board’s Crimson Medical Group Advantage program.

2. Education is cornerstone of coding.

3. Focused Education:
   a. Adding additional work to Physician and Providers needs to be meaningful
   b. Engagement of Dr. Nick Ulmer for focused sessions
   c. Applied PTN resources available on-line, and
   d. Placed completion of coding education into Physician/Provider bonus structure

4. We tracked results over the next 11 months:
   a. $1 million improvement in charges for our group – more than enough to pay for the education
   b. improved Physician self-competence and satisfaction with the education
   c. currently continue to track
Coding Education and Reviews

Educational Workshops:

Coding Education included two opportunities annually 2015-2018.

• Speaker Format- In person workshops from national coding program speaker and nationally recognized Physician Coder.
• Web based workshops- provider access to on demand coding reviews of HCC, E&M coding and CCM coding.

Coder Reviews and Teaching:

WMA Quality Department Coders

• Provider coding audits performed- PCP and specialist.
• Personalized education on coding and correct documentation is performed after audits.
• Review of payer suspected HCC codes. Documentation available, code added, if not, provider tasked for next appointment.
• New urgent care provider coding reviews completed with education.
QUALITY METRICS - FISCAL YEAR
Three areas of concentration are used to represent metrics associated with the provider scorecards.

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<tr>
<th>All Specialties</th>
<th>Care Sustainability</th>
<th>Care Outcomes</th>
<th>Care Management</th>
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</thead>
<tbody>
<tr>
<td>2 main metrics worth 15% of the bonus</td>
<td>5 metrics worth 75% of bonus (15% each metric)</td>
<td>5 points worth 10% of bonus</td>
<td></td>
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# All Specialty - Common Metrics

## Care Sustainability (2 Common Metrics) - Worth 15% of the bonus

**Financial Performance Goals:**
- 100% of the potential bonus if clinic results better than budget;
- 75% if the clinic is within $5K per provider of budget;
- 50% if the clinic is within $10K per provider of budget;
- 25% if the clinic is within $15K per provider of budget.

**OR**
- 100% if the clinic overall results are break even or better;
- 75% if the clinic loss is $5K per provider or less;
- 50% if the clinic loss is $7,500 per provider or less;
- 25% if the clinic loss is $10K per provider or less.

Annual target.

**Achievement of Practice Growth:**
- Measured by achievement of one of the following options:
  - Growth in total wrv'u's as a practice compared to FY 16 of 7.5%; or
  - Individual provider growth in new patients seen of 7.5%; or
  - Individual provider wrvu productivity of 90%ile or greater using MGMA.

**OR**
- Management of a panel size measured as active patients in two years.
- The tiered goal is as follows:
  - 100% achievement with 2200 patients or more; or
  - 75% achievement with 1800 patients or more; or
  - 50% achievement with 1500 patients or more.

## Care Outcomes - 5 metrics worth 75% of bonus (15% each metric)

**Patient Experience Results:**
- 50% based on provider achievement of top box target of 80% ranking or greater for the provider related questions.
- 50% based on practice achievement of top box target of 80% ranking or greater for the practice overall satisfaction question.

Based on the patient’s ranking of a score of 9 or 10 out of 10.

## Care Management - Worth 10% of bonus

**Citizenship Requirements - 5 points**
- 1 WMA sponsored Coding Workshop (required) AND
- 4 Points from below - each represents 1 point:
  - WMA committee regular attendance (50%) meetings annually, including:
  - WMA sponsored committees, including:
  - WMA Board of Directors; WMA QVS Committee; WMA Finance Committee; WMA E-Strategies Committee; WMA Controlled Substances Advisory Committee; WMA Advanced Practitioner Committee; Wellmont Health System Medical Staff Meeting: regular attendance (50% or greater)
  - Wellmont Health System Hospital Committee: regular attendance (50% or greater)
  - Lead a WMA Innovation lab Project; Give a lecture for IPH Osteopathic Family Medicine Residency Program;
  - Quarterly Crimson Usage
  - Attend a WMA sponsored Quality Workshop
    - Give a lecture for Grand Rounds at a WHS facility
      - Participate at WHS Sports Physical Events
      - HPI committee meetings; regular attendance (50% or greater)
<table>
<thead>
<tr>
<th>Care Sustainability-worth 15% of the bonus</th>
<th>Care Outcomes-5 metrics worth 75% of bonus (15% each metric) MIPS metrics marked in yellow/orange.</th>
<th>Care Management-worth 10% of bonus</th>
</tr>
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<tbody>
<tr>
<td>Achieve Financial performance Goal</td>
<td>Breast Cancer Screening- Percentage of women 60-74 years of age who had a mammogram to screen for breast cancer in the prior 27 months-84% Compliance</td>
<td>Colorectal Cancer Screening-Age 50-75 had one of the following tests: FOBT in past year; FIT-DNA (Cologuard) in 3 years; CT Colonography in 5 years; Flex sig in 5 years; Colonoscopy in 5 years. 80% compliance</td>
</tr>
<tr>
<td>Achievement of Practice Growth in Population Covered</td>
<td>Patient Experience Results- 80% top box target</td>
<td>Citizenship Requirements</td>
</tr>
<tr>
<td>Patient Experience Results- 80% top box target</td>
<td>Controlled Substance Monitoring-90% compliance</td>
<td>COPA Metrics</td>
</tr>
<tr>
<td>Controlled Substance Monitoring-90% compliance</td>
<td>Together 2 Goal Diabetic Bundle 45% compliance</td>
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**COPA Metrics**

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<td>Depression Bundle: 1) Depression Screening (PHQ9), and 2) Depression Treatment Plan When Diagnosed.</td>
<td>BMI &gt; 29: Assessment &amp; Action Plan</td>
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Measure and not score New Opioid Prescriptions percent.
Cycle Results
1. 95% of Physician and Providers attending live sessions felt they both were more confident with their coding and would code encounters more appropriately (9 or 10 on scale of 1-10)

2. 90% of those watching on-line felt the same (9 or 10 on scale of 1-10)
Using CMGA Data to Track Improved Coding Trends

Wellmont Medical Associates • Kingsport, TN • 275 Providers

- Wellmont identified a need to improve E&M coding practices for new and established patient encounters
- Providers incorporated training into daily coding patterns, and CMGA began monitoring changes in coding trends
- CMGA identified significant increases in coding levels and net collections per E/M charge

$1,114,449
Additional Collections due to coding level Increase (Within 11 months)

February 2017
- Wellmont brought in a coding expert to meet with and train all providers on improved coding practices

April
- CMGA compared Wellmont coding data for 10 months pre- and post-training, normalized per encounter

May
- CMGA helped identify specific providers and service lines to prioritize for continued improvement efforts

March 2018

Source: Wellmont Hospital

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April

CMGA compared Wellmont coding data for 10 months pre- and post-training, normalized per encounter.

May

November 2018

CMGA helped identify specific providers and service lines to prioritize for continued improvement efforts.

$2,264,967

Additional Collections due to coding level Increase (After 19 months)

Source: Wellmont Hospital
Coding Improvement Over Time

Coding Level Distribution Changes

New Patients

- Distribution of Total Codes, May16-Mar17
- Distribution of Total Codes, May17-Mar18
- Distribution of Total Codes, Apr18-Nov18
Coding Improvement Over Time

Coding Level Distribution Changes
Established Patients

Distribution of Total Codes, May16-Mar17
Distribution of Total Codes, May17-Mar18
Distribution of Total Codes, Apr18-Nov18
1. Because of accurate coding focus:
   a. HCC scores over time increased from 1.116 to 1.151
   b. Important for our Medicare Advantage contracts and as we move towards ACO and risk
Thank You