Breaking the Code

How documentation can unlock the matrix to a health group practice, happy providers, and a productive relationship with your hospital partners.

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We live and work in a rapidly evolving healthcare environment. The Affordable Care Act and ACO's present a fundamental change in how patients interact with healthcare providers. Tighter government regulations, such as Value Based Purchasing, a newfound focus on Utilization Review, and at-risk Medicare dollars affect how providers deliver their care. On the state level, in Maryland in particular, the Global Budget Revenue system presents numerous challenges. Groups and hospital partners are continuously adapting to a reimbursement culture that includes increased denials and audits and decreasing reimbursements, coupled with an increase of medical malpractice and health care premiums. Need I mention a massive overhaul to ICD-10, rising employee deductibles, an increase in urgent care centers, and dropping ED volumes? [If none of these items affect you, feel free to change the channel]

I completely understand the angst and fear about the uncertain future of medicine. I am also proud and confident to say that here at EMA and ASE, we have the support, infrastructure, and vision to not only adapt to these changing times, but to become trailblazers into the new era.

Creating a chart involves equal parts of science and art. With some of the top recruits and providers in the Mid-Atlantic area, mastering the science of Emergency Medicine has always been our strength. Our infrastructure and focus on the art of documentation, however, is what really sets us apart from our competitors.

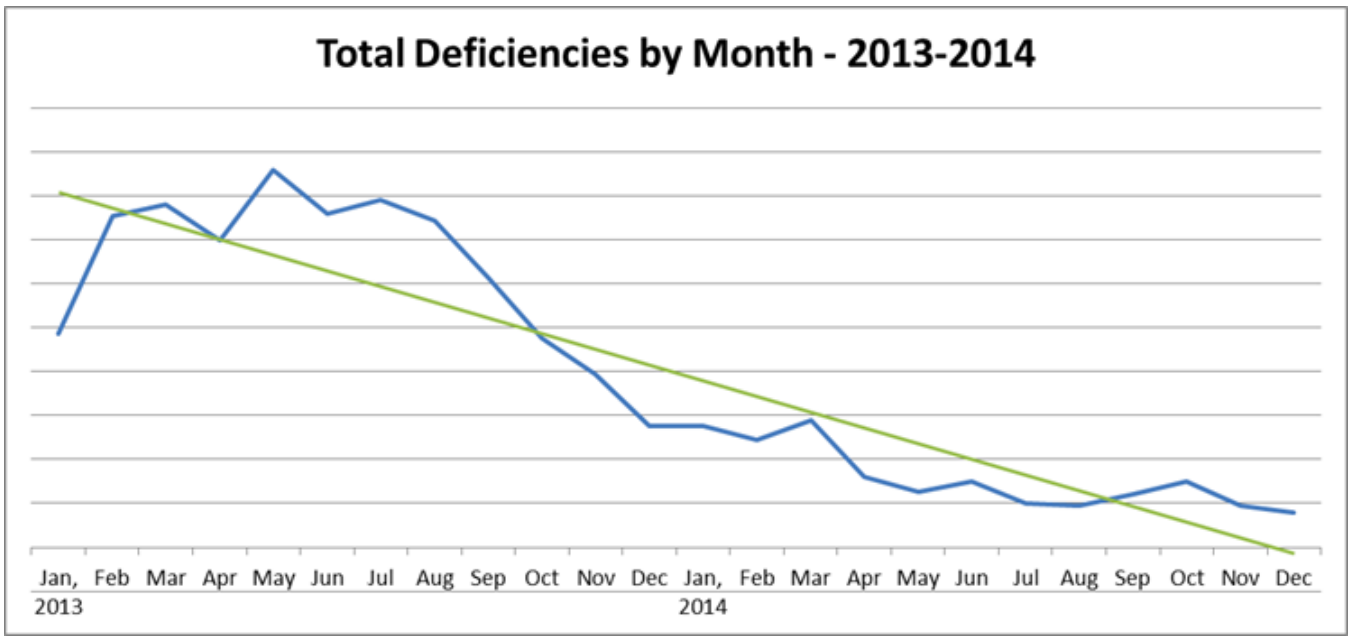
We are at work long before the chart is created Our providers get a comprehensive orientation and multi-faceted continuing education program focusing on increasing accuracy and optimizing documentation. The foundations of our program include understanding the Marshfield Coding Rules, the specifics of procedure documentation, critical care identification, and how all of these impact reimbursement and future compliance audits and reviews. We also discuss the pitfalls of the EMR, such as upcoding, cloning, and other compliance risks. Our comprehensive program focuses on educating providers on documentation optimization; improving accuracy, decreasing denials, and avoiding compliance or audit risks.

Introducing the Documentation Champion

With 15 clinical sites and hundreds of providers, our Coding, Billing and Reimbursement team is responsible for managing tens of thousands of charts monthly. Our in house team is complimented by the Documentation Champion; a site-specific provider who is familiar with the EMR, local culture, and enthusiasm for system improvement. Also a content expert in the subject of coding and documentation, the Documentation Champion is responsible for facilitating system-wide initiatives, including deficiency review, critical care initiatives, and EMR modifications. This program ensures that our site-specific documentation is congruent with up to date regulations, and aligned with our hospital partners and their case management team. They also represent real time resources to the providers on site.

Awareness Campaign

The Awareness Campaign is an initiative focused on chart accuracy. Every month, we review all the deficiencies system-wide, and in the spirit of transparency and improved quality, we



communicate our findings to our providers. Working with our Documentation Champions, we identify trends and create action plans for improvement. Since the development of this program, we have decreased our deficiencies by 85%.

Critical Care and Procedural Competency

Critical Care and procedures account for a significant element of any Emergency Medicine practice. The Practice continually monitors the accuracy of our documentation of both components. Specifically, our infrastructure allows us to start with macro data review on system-wide level, drilling all the way down to the individual provider performance trends. We compliment the services provided by our coding company, and internally audit/review our work to ensure a compliant, accurate, and quality product. This allows for targeted/focused educational efforts to directly address any areas for improvement. As such, we are proud of our ability to capture the clinical encounter to accurately reflect the services and intervention we provide, while being mindful of the nuances required to compliantly code the chart, satisfy Interqual criteria, and decrease denials for services provided.

MDM Matters!

Quality. Integrity. Completeness. Taking care of patients has always been at the root of medicine. With an increasing number of regulations and tighter oversight of healthcare dollars, the definition of a quality provider has broadened to include an explanation of how and why decisions are made. Enter the medical decision making note. A strong MDM:

- Unifies the chart to anyone reviewing it long after the patient has left the building.
- Allows the coder to accurately assign a level of service for a given encounter.
- Justifies medical necessity and assists our hospital partners in the correct bed assignment in the hospital, thus retrospectively decreasing denials based on medical need.
- Supports high quality care and justifies utilization review.
- Protects the provider in peer review while providing a more medico-legally robust record, therefore supporting any third party review,

including the private payer or government auditor, as well.

At the Practice, we take the time to coach our providers to include an accurate MDM in every patient chart. Quality care with quality documentation.

Limiting the Cognitive Mindshare

We at EMA feel it's our responsibility to put providers in a position to succeed. We fully recognize that providers are pulled in a myriad of directions during any given shift: managing a busy department, reassessments, ambulances, phone calls, consultants, etc. It's very easy to see how documentation can fall by the wayside. In addition to the initiatives already mentioned, we are constantly improving our systems to support our providers. Scribes play a significant role in that process, constantly being updated on our evolving programs. We have fostered great relationships with our hospitals' IT departments and have a dedicated staff focusing just on EMR related issues. By helping the EMR work for you, we tailored each system to what we do best, treat patients. With drop box items that provide a streamlined approach to capturing what we are doing, and scribes that are able to identify and document correctly, we are successfully limiting the documentation burden without sacrificing quality.