

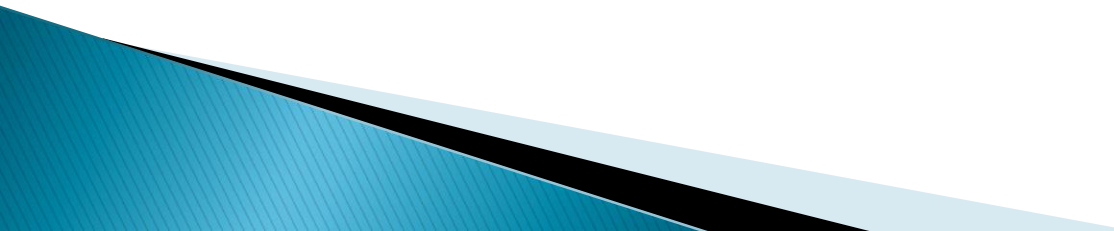


a california *health+* center

**Your Health. Our Mission.**

# Coding in FQHCs

# Agenda

- ▶ Background with a little data
  - ▶ How to build a coding department
  - ▶ Giving providers the choice to code or not
  - ▶ Why coding is even more important in 2017
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# Background

- ▶ In CY 2012, FHCN had over 435,000 medical encounters per the UDS report
- ▶ In 2016, FHCN did 532,000 medical encounters per the UDS report
  - 655,939 total visits
- ▶ FHCN already had a Certified Coding Coordinator– mostly a liaison with providers for training
  - Billing Manager was also certified coder

# How FHCCN arrived at this solution

- ▶ DHCS audits
  - Scrutiny on documentation was becoming a theme
- ▶ Moving to a new EHR (eClinical Works) was more conducive to tracking
- ▶ Physicians and mid-levels not trained to code in school, only how to document
  - As a result lots of questions and claims sent back to the provider to review or change
- ▶ Engaged a consultant who recommended against adding coders, but we ignored!

# Why have a coding department?

## ▶ What was the goal?

- 100% of medical visits reviewed by a coder
- Physicians and mid-levels operating at top of license
- Capture more \$ by showing acuity of patients; many programs already moving to quality over quantity

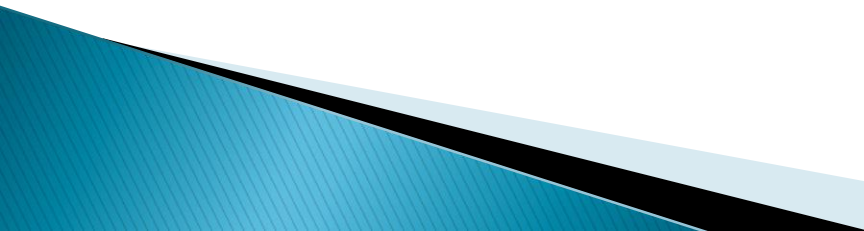
## ▶ What were the perceived benefits?

- Better demonstrations of clinical quality for programs like Medicare, FPACT, Managed Care contracts, Medical, etc
- Demonstration of robust compliance
- Provider retention from added flexibility

# The Quick Math

- ▶ **FHCN's productivity expectation is 24 per day**
  - On average if a provider spends 1–2 minutes looking for codes, that is 24+ minutes per day. That time can be spent seeing additional patients or providing even better care to the current visit load.
  - While not the only factor, for the rolling 12 months ended January 2017, 85% of medical providers were at 99% of budget or higher.
    - This represents an increase over when coders were not available to assist with claims.
    - Four years ago it was about 50%

# Building a coding department

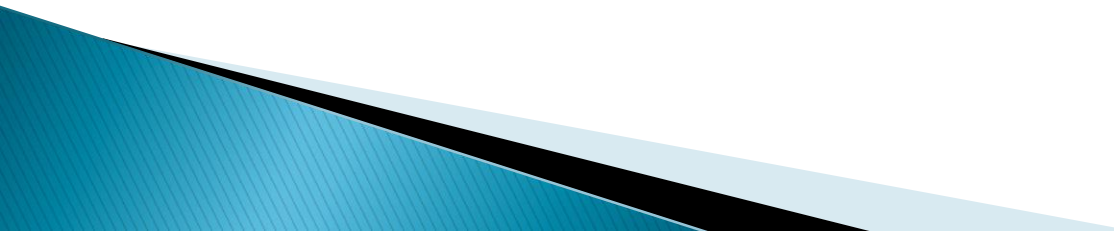
- ▶ The first step was determining how to create a coding function and split it out from billing
    - Guideline at the time (before ICD-10), was close to 50,000 claims per year
    - Thus our first job posting was for 6 coders
  - ▶ High potential billing clerks were offered books and exam costs to prepare to become certified coders adding a new career pathway in the organization
  - ▶ Workflows had to be adjusted as part of the process
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# Building a coding department

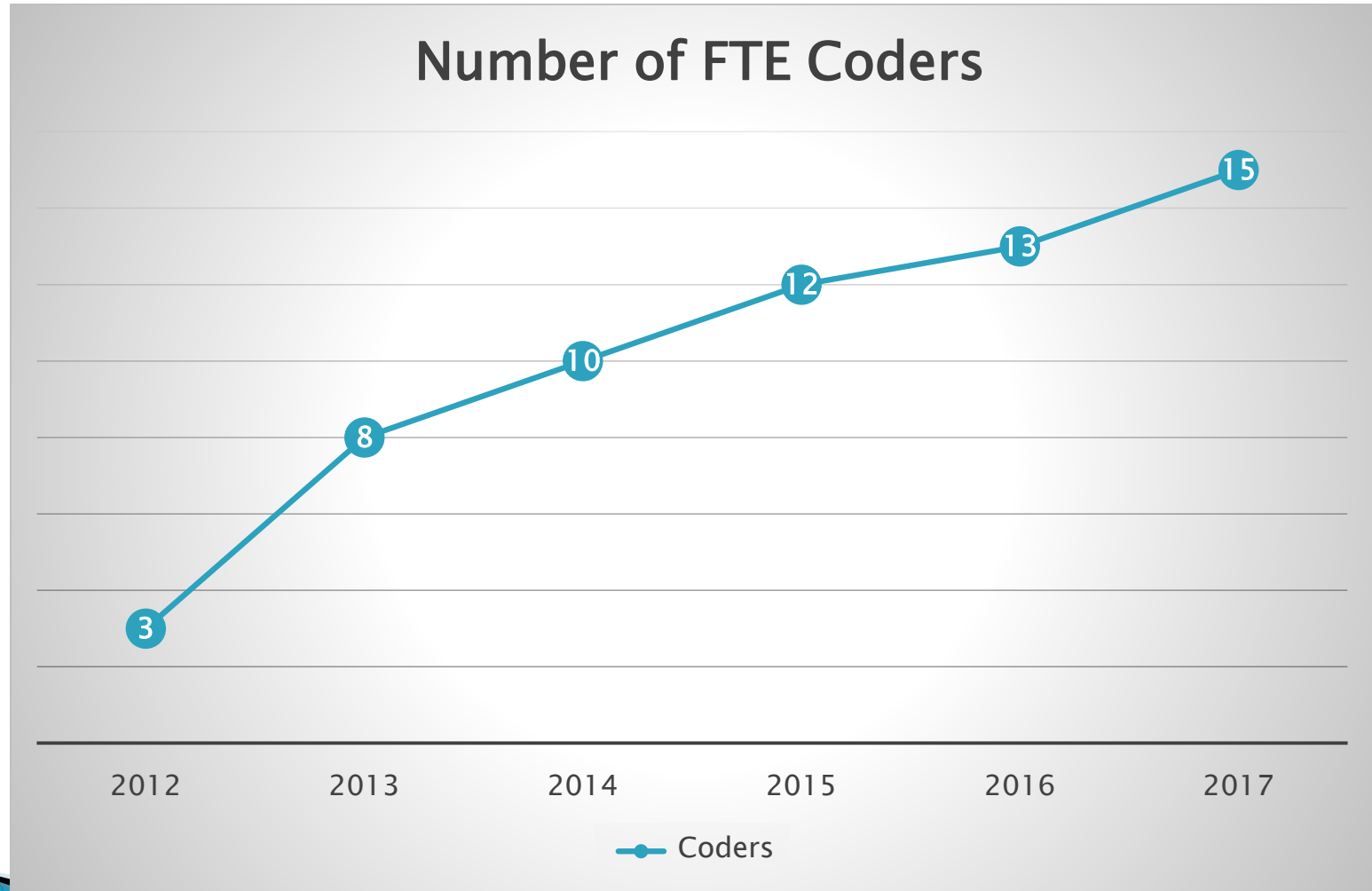
- ▶ Started with temp coders and built from there
  - Eventually added inpatient claims to coding process
- ▶ Initially coded by site to build relationships with providers, but eventually moved to by program due to complexities of FPACT, Medicare, etc.



# Documentation and Quality

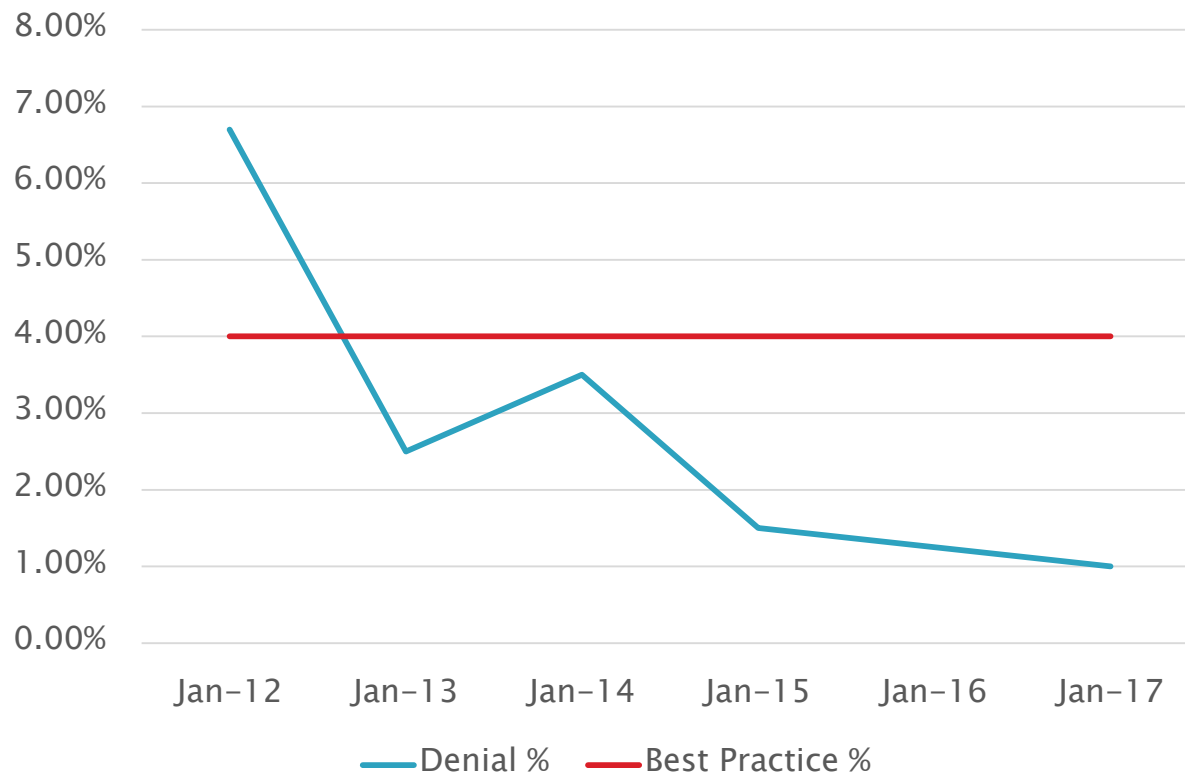
- ▶ FHCN was committed to improving clinical documentation to demonstrate our quality care.
  - ▶ This change allowed providers to quit looking up CPT codes and focus on documenting the care provided to patients
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# Staffing the coding department



# What were the results?

- ▶ Claims denials went from close to 7% in 2012 to less than 1.5% on average now



# Is this replicable?

- ▶ Absolutely, as long as you have some potential coder candidates in your organization
  - Don't necessarily have to be billers, but need to know your EHR and culture to get up and going quickly
  - Or need coders with the right skill set that can be a good fit with a community health center's unique payer structure