Five Tenets for Success in Academic Medical Center Coding

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According to the Association of American Medical Colleges (AAMC), 44 states and the District of Columbia have accredited medical schools and teaching hospitals.[1] Numbering nearly 120, these academic medical centers provide critical services not available elsewhere, including comprehensive cancer centers, burn units, Level 1 trauma centers, and pediatric intensive care.

While academic medical centers account for a small percentage of the nation's hospitals, they are responsible for nearly 25 percent of clinical care based on total hospital revenue, according to the AAMC. Properly documenting and coding clinical care in academic medical centers is the foundation for correct payer reimbursement.

Ensuring coding accuracy in teaching facilities comes with unique challenges not found in community care. This article identifies five unique principles to follow for improving accuracy, productivity, and compliance in academic medical center coding.

1. Conquer Case Complexity

First and foremost, acknowledging the complex nature of cases is key for success with academic coding. The ability to attract and retain coders with academic or trauma experience is essential since these two types of settings usually go hand in hand. Academic coding positions are also difficult to fill when coders depart. This makes partnerships with several outsourced coding vendors, not just one, more valuable in the academic medical setting.

Factors increasing case complexity at academic medical centers include:

- Higher number of experimental procedures
- Prevalence of pioneering research
- Frequent organ transplants
- Different treatments and patient case management

Even when coders are assigned only to emergency medicine cases, prior experience with academic and trauma cases is critical. Emergency encounters are significantly more complex at academic medical centers than at critical access or community hospitals.

2. Manage the Reality of Residents

Residents are the norm in academic medical centers. Their annual influx requires additional resources and coder time to build relationships and establish progress note documentation rules with attending physicians.

Clear guidance on what can be coded based on which clinician's notes is a key element for coding accuracy and consistency. Coders should also understand how residents are involved in care. This is especially important for professional fee coding where there are specific modifiers for residents versus attendings.

3. Watch for Claim Edit Issues During EHR Change

Academic medical centers are frequently involved in mergers and acquisitions. Technology changes are an inevitable consequence. Electronic health record (EHR) upgrades, conversions, and entire system transitions notoriously cause spikes in claim rejections and payer denials as new systems' billing edits are implemented.

Some academic medical centers report thousands of cases stuck in edit queues post-EHR go-live. More time is needed to review these complex cases, identify the root cause of a failed edit, correct the case, and work with IT to correct system edits. This reality causes significant workflow disruption to medical record coding teams as coders are asked to:

- Correct failed coding and billing edits following EHR upgrades
- Set aside day-to-day production and clean up backlogged work queues
- Work with IT teams to correct faulty billing and coding edits in the new EHR

Matt Hoeger, director of revenue integrity at Penn State Health's Milton S. Hershey Medical Center, recalls his team's experience with the implementation of a new EHR in June 2018. "Our coders became half as efficient immediately following go-live as thousands of new edits appeared and cases couldn't be billed. All facets of our business were impacted, and new coding resources were required until we could get the new edits back under control."

One way to relieve the burden of edit spikes is to establish a specialized edit team. This team could include outside resources or designated internal specialists.

4. Designate a Specialized Edit Management Team

A specialized edit team is much more effective and efficient in remedying the post-EHR edit challenges mentioned above. Academic medical center coders remain focused on day-to-day production while editors review and clear up to 25 accounts per hour. Here are seven best practice guidelines to establish and manage a designated edit management team:

1. Ensure editors have the ability to code and that they possess some coding experience.
2. Work with coders to clearly understand coding workflows within the new EHR.
3. Train the team on EHR edit specifics and establish collaboration with IT experts to build out specialized queues.
4. Clear edits as quickly as possible, including medical necessity edits, correct connection between diagnosis and procedures, etc.
5. Educate editors on Medicare rules, broad coding guidelines, and local payer guidelines for the most common payers.
6. Specialize and subdivide the team down to specific edits and work queues. For example, queue #131 includes all medical necessity edits while queue #132 includes all patient demographic edits.
7. Compile a list of most common issues and learn from each case to establish proactive edit practices and mitigate unbilled risk.

5. Work Collaboratively with Coding Vendors

The final tenet for better outcomes in academic medical center coding is coding vendor management.

It is common for large academic medical centers to partner with several outsourced coding companies. Hoeger confirms the benefits of maintaining relationships with multiple resources. "There are too many contracting challenges and onboarding technology tasks to frequently switch coding vendors in the academic setting. I prefer to retain a core group of contracted partners to support our in-house team, understanding that outsourced coders may not be needed forever," Hoeger says.

Vendors should also be open to working directly with internal clinical documentation improvement (CDI) teams. CDI programs are typically larger and more specialized in academic settings, requiring closer collaboration with coding professionals on complex cases. Accommodations for frequent team calls, technology-supported communications, DRG mismatch procedures, and more should be included in academic medical centers' outsourced coding vendor agreements to achieve mutual goals:

- Ensure coding and CDI teams are in agreement before a complex case is submitted for billing
- Verify principal diagnosis across all stakeholders
- Agree on what exactly happened to the patient during the encounter including all therapies, surgeries, testing, etc.

For complex academic medical center cases, strong collaboration and clarification are essential to stand behind coding decisions and the coding team's overall performance.

Note

1. Association of American Medical Colleges. “America’s Medical Schools and Teaching Hospitals: Improving the Health of All.” May 2018. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/aa/41/aa41a4ce-26c3-4167-a54e-cc4cd0c5ec51/what_is_academic_medicine_infographic_-_20180516.pdf.

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