Minnesota American Association of Healthcare Administrative Management

Revenue Cycle Improvement
Hospital and Clinic Professional Billing

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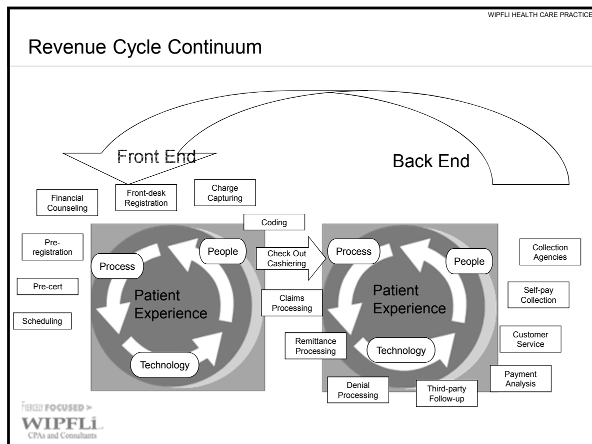
Agenda for Discussion

- Revenue Cycle Continuum
- Revenue Cycle Opportunities
  - Front End
  - Back End
- Understanding Data Elements Included on Medical Claim Forms Specific to:
  - Emergency Department
  - Anesthesia Services
- Medicare Revalidation

Revenue Cycle Continuum



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Revenue Cycle Opportunities

Paradigm Shift

Front End

Back End

1. Moving back office functions to the front office
2. Shrink work in the back office
3. Capability to discuss “price” with patients

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Revenue Cycle Opportunities

Front End

Back End

Revenue Cycle Opportunities

Scheduling

The revenue cycle begins with patient scheduling. Not only is there revenue opportunity if the daily schedules are not filled, but also if the providers have schedules that are so full that patients cannot be seen within a reasonable amount of time.

- Implement standard scheduling guidelines
- Eliminate scheduling restrictions

Benchmark Opportunities:

- Measure open access
- Monitor RHC productivity standards

Revenue Cycle Opportunities

Registration

Better performing practices focus more of their scarce resources on collecting accurate and timely registration information than in managing the business office operations (specifically, the collections aspect of the revenue cycle).

Benchmark Opportunities:

- Percentage of registrations complete (and accurate)
- Demographic data completed
- Insurance benefits verified
- Financial counselor alerted as defined (defined criteria of self-pay and high coinsurance deductible plan patients)
- Precertification process completed

Revenue Cycle Opportunities

Insurance Verification

The insurance verification process is often the first opportunity to identify an at-risk patient:

- Insurance eligibility verified
- Coverage determined for service
- Deductible/co-pays *collected*

Revenue Cycle Opportunities

Insurance Verification (continued)

Benchmark Opportunities:

- Technical denials rate:
  - Number (or percentage) of claims denied due to incorrect insurance or demographic information
- Clinical denials rate:
  - Number (or percentage) of claims denied due to lack of prior authorization

Revenue Cycle Opportunities

Financial Counseling

Patient-focused financial counseling includes early identification of at-risk cases for collection. Patients have a right to understand their financial obligation *before* the service is rendered.

Maxim: No surprises…

Revenue Cycle Opportunities

Financial Counseling (continued)

Best Practices:

- Patient-focused financial counseling ("patient advocate") is an integral part of patient access. Staff should be well trained to refer potential patients to financial counselors during the registration process (preferably the pre-registration process).
- Credit card arrangements, electronic funds transfer, and other financial payment options should be creatively deployed (such as longer payment periods with or without interest).
- Patients qualifying for Medicaid and charity care should be identified in the patient access portion of the revenue cycle.

Revenue Cycle Opportunities

Financial Counseling (continued)

Benchmark Opportunities:

- Days revenue in accounts receivable (self-pay portion)
- Bad debt write-offs as a percentage of self-pay revenue
- Percentage of bad debts that could have been classified as charity care

Revenue Cycle Opportunities

Charge Capture

Numerous components of the revenue cycle pertain to charge capture, coding, and documentation. Each serves an important aspect of the revenue cycle.

Charge capture is often identified as an area of significant shortcoming in medical practices.

Revenue Cycle Opportunities

Charge Capture (continued)

- Charging tools (e.g., charge tickets, EMR) should be simple and include prompts to providers along with an option to request special c☑ing review (“ CR”) as needed.
- EMRs offer several advantages. Provider education and ongoing training is critical to successful use.
- EMRs that calculate the level of service should have a built-in mechanism to require the provider or coder to confirm the selected level of service.
- Avoid using EMR functions that offer “exploding elements” that don’t require the provider to verify and click on each element to ensure data specific to that patient.

Revenue Cycle Opportunities

Charge Capture (continued)

Benchmarking Opportunities:

- Coding compared to benchmarks (CMS, internal)
- Documentation reviews that show consistent improvement
- Missing charge (entire visit) analysis

Revenue Cycle Opportunities

Coding

Overlooked Opportunities:

- Capture of new patient visits
- Capture of hospital visits, including code 99239 (30+ min discharge)
- Coding based on time
- Status of three chronic or inactive conditions (1997 E/M Guidelines)
- Preventive medicine and “sick” visits

Revenue Cycle Opportunities

Coding (continued)

- Compare physician E/M utilization to:
  - Self (changes/improvements over time)
  - Same-specialty peers
    - Within the practice
    - Outside the practice

CMS E/M Utilization Data, by specialty:

http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/04_MedicareUtilizationforPartB.asp#TopOfPage

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Revenue Cycle Opportunities

Front End

Back End

Revenue Cycle Opportunities

Back End – Billing

The business office represents the last opportunity for charges to be modified/corrected. While this remains an important task at every practice, revenue cycle management must recognize the importance of obtaining correct information as early as possible in the revenue cycle.

Revenue Cycle Opportunities

Back End – Billing (continued)

Best Practice:

- Issues with the business office often highlight the importance of improvement efforts on the front-end aspects of the revenue cycle.

We suggest an integrated, cross-functional Revenue Cycle Team with significant business office representation to help design the standard work and processes for patient access-related activities.

Revenue Cycle Opportunities

Back Office – Billing (continued)

Benchmark Opportunities:

- There should be meaningful metrics established for the revenue cycle for process improvement monitoring purposes:
  - A/R days
  - Total cash collections
  - Denial rate
  - Bad debt rate
  - Charity care rate
  - Payment verification

Revenue Cycle Opportunities

Back Office – Collections & Denials Management

The collections function goal is to secure the greatest amount of reimbursement possible. Typically, this is only accomplished through persistence and proper alignment of goals.

Revenue Cycle Opportunities

Back Office – Collections & Denials Management (continued)

- Denials management is a key element of the revenue cycle.
- A recent study identified 77% of the errors leading to denials were associated with front-end deficiencies.
  - Eligibility accounted for 25% of denials
  - Demographic information accounted for 33% of denials
  - Authorizations accounted for 19% of denials in the survey

Revenue Cycle Opportunities

Back End – Collections & Denials Management (continued)

Best Practices:

- Tracking denials to identify sources (root cause analysis) and acting upon the trends
- Employing Revenue Cycle Team to develop sustainable solutions
- Tracking of all bad debt for all payers, since bad debt for co-pays and deductible is a reimbursable expense for RHCs

Revenue Cycle Opportunities

Denial Tracking

Service Date	Denial Date	Staff Member	Payer	Pt Acct #	Denial Reason	Appealed (Y/N)	Denied Amount	Appealed Amount	Payment Received

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Revenue Cycle Opportunities

Back End – Collections & Denials Management (continued)

- Sample key performance indicators:

Co-pay collections as % of total co-pay office visits:	95%
EDI claims as % of total claims:	90%
Charge-entry lag period:	1 Day
Claims passing claim edits as % of total claims:	98%
Net A/R days (non-specialty practices):	40 Days
Collections as % of net revenue:	100%
Collections as % of gross revenue (non-specialty practices):	60%
Third-party A/R aging * 90 days from service date:	10%
Denials as % of net revenue (including "incident to" services):	2%
Claims with no activity * 90 days from last activity date:	0%
Credit balances:	2 A/RD

Source: HFMA

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Technical Billing Information

CMS 1450 Data Set Elements

Patient information:
- Demographic information
- Site of service (inpatient/outpatient)
- Date of admission/discharge/services etc.
- Type of admission (emergent, urgent, elective, etc.)
- Reoccurring service information
- Patient status code (discharged home or to SNF/hospice etc.)

What was done to the patient:
- Revenue codes
- Revenue code descriptions
- HCPCS codes
- Service dates
- Units of service
- Procedure codes and dates
- Charges
- Noncovered charges

Reason for treatment:
- Principal diagnosis
- Other diagnosis(es)
- Admitting diagnosis
- PPS code

Physician information (attending/operating and other)

Professional Billing Information

CMS 1500 Data Set Elements	
Patient information: Demographic information Site of service Date of service Hospitalizations related to current service Information on work status (unable to work) MA and related prior authorizations	What was done to the patient? HCPCS codes and modifiers Service dates Units of service Charges
Reason for treatment: Diagnosis(es)	Physician information: Referring physician information

Other information such as use of outside lab

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Understand Your Hospital

Critical Access Hospital Professional Billing:

- Standard method (Method I)
  - Professional services billed on 1500
  - Paid under the physician fee schedule

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Understand Your Hospital

Critical Access Hospital Optional Method Election:

- Optional method (Method II):
  - Request made by the hospital
  - Request must be made in writing 30 days prior to the start of the cost reporting period
  - Annual election no longer required. The election remains in place until the hospital submits a termination request
  - Professional services billed on UB-04
  - Reimbursed 115% of the physician fee schedule amount

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Understanding Data Elements

Quality View - Putting Claims Data to Use in Analyzing Your Hospital:

- Common billing errors:
  - ED professional and technical billing issue (CAH example)
  - EKG professional and technical billing issues (CAH example)
  - Anesthesia billing issues

Understanding Data Elements

Common Billing Errors - ED Example:

Levels	Description	Facility Fees Utilization	Pro Fees Utilization
99281	ER Level I	662	60
99282	ER Level II	1,000	646
99283	ER Level III	315	720
99284	ER Level IV	202	564
99285	ER Level V	125	4
Total		2,304	1,994

- A 310 visit discrepancy exists between E/M professional codes and ED facility fees charged.
- There likely should be a one to one (1:1) ratio between E/M professional codes and facility fees.

Understanding Data Elements

Common Billing Errors - EKG Example:

		Before	After	
HCPCS	Description	Global Fee Utilization	Facility Fees Utilization	Pro Fees Utilization
93000	EKG with interpretation and report	193	0	0
93005	EKG, tracing only, without interpretation and report	0	193	0
90010	EKG interpretation and report only	0	0	193
Total		193	193	193

Understanding Data Elements

Anesthesia Billing in CAH Facilities

Common Billing Errors - Billing for Anesthesia Services:

- **CRNA Pass-through exemption:**
  - Be geographically located in a rural area, or reclassed to a rural area
  - The hospital must employ or contract with a qualified non-physician anesthetist (CRNA)
  - Total hours of service may not exceed 2,080 hours per year. These hours represent total hours (not just in surgery)
  - Inpatient and outpatient surgical procedures requiring anesthesia services did not exceed 800 procedures, including procedures done elsewhere in the hospital

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Understanding Data Elements

Anesthesia Billing in CAH Facilities

Common Billing Errors - Billing for Anesthesia Services:

- **CRNA Pass-through exemption (cont.):**
  - Annual election
  - Must make a written request between October 1 and December 31 of each year
  - Based on anesthesia services between January 1 and September 30 annualized
  - The election is granted on a calendar year

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Understanding Data Elements

Anesthesia Billing in CAH Facilities (cont.)

Common Billing Errors - Billing for Anesthesia Services:

- **Billing with pass-through exemption:**
  - Do not include anesthesia in CAH all inclusive (Method II) election
  - Type of Bill – 85x or 11X

Revenue Code	Reimbursement
037X – Technical Services	Cost reimbursed for both inpatient and outpatient
0964 – Professional Services	Cost reimbursed for both inpatient and outpatient

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Understanding Data Elements

Anesthesia Billing in CAH Facilities (cont.)

Common Billing Errors - Billing for Anesthesia Services:

- **Billing <u>without</u> pass-through exemption:**
  - Anesthesia included in Method II election
  - Type of Bill – 85x
  - Inpatient professional services reimbursed on fee schedule

Revenue Code	Reimbursement
037X – Technical Services	Cost reimbursed
0964 – Outpatient Professional	115% x 80% (not medically directed, QZ modifier)
Billed on 1500 – Inpatient Professional	80% (not medically directed)

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Understanding Data Elements

Anesthesia Billing in CAH Facilities (cont.)

Common Billing Errors - Billing for Anesthesia Services:

- **Billing <u>without</u> pass-through exemption or Method II:**
  - No election made for anesthesia
  - Inpatient professional services billed on a 1500
  - Outpatient professional services billed on a 1500

Revenue Code	Reimbursement
Billed on 1500 – Inpatient Professional	80% (not medically directed)
Billed on 1500 – Outpatient Professional	80% (not medically directed)

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Understanding Data Elements

Anesthesia Billing in CAH Facilities (cont.)

Common Billing Errors - Billing for Anesthesia Services:

- **CRNA Professional Billing – Revenue Code 0964:**
  - Report the appropriate anesthesia CPT-4 code (00100 -01999) for the procedure performed
  - Report the <u>actual</u> anesthesia time in <u>minutes</u>. The minutes will be converted to units by Medicare
  - Multiple surgeries or multiple bilateral surgeries:
    - List the CPT-4 code with the highest base value
    - Report the total anesthesia minutes of all procedures in item 24G of the CMS 1500

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Understanding Data Elements

Anesthesia Billing in CAH Facilities (cont.)

Common Billing Errors - Billing for Anesthesia Services:

- **CRNA Professional Billing – Revenue Code 0964:**
  - Use the appropriate modifier. Modifiers are essential for the prompt and correct payment of the claim
    - QX – CRNA with medical direction by a physician
    - QZ – CRNA without medical direction by a physician
    - QS – Monitored anesthesiology services (can be billed by a CRNA or a physician
- **CRNA Technical charges– Revenue Code 037x**

CMS Revalidation

Medicare Revalidation:

- Do not send information for revalidation until you receive a revalidation letter from CMS
- Approximately 10,000 requests being mailed each month by CMS
- Adhere to the deadlines stated in the letter
- Advantages of using PECOS – Provider Enrollment, Chain and Ownership System
  - Faster than paper-based enrollment
  - Tailored application process
  - Easy to check and update information

CMS Revalidation

Recent changes to PECOS:

- E-Signature
- Payment can be made through PECOS
- Can authorize an outside party to update information on your behalf

CMS website for PECOS and other Revalidation questions:

- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

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