Revenue Cycle Landmines in Interventional Radiology & Cardiovascular Services

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Session Objectives

**Interventional Radiology & Cardiovascular Revenue Cycle**

- National Trends with Special Procedure (SP) Coding with Examples
- Common Problems with Special Procedure Coding
- Reasons Problems Exist
- Steps to Improvement
- Questions & Answers
National Trends

- Review of over 250,000 billed Outpatient Medicare claims since August 2000
- Review Included
  - UB-04 (previously UB-92) and Medicare Remittance Advice (all CPT codes, modifiers and pass through device codes)
  - Documentation in the permanent medical record (physicians dictation, hand written notes, nursing log)
- And on a portion of claims
  - Department entered charges
  - HIM entered codes

Missing all HIM codes from Final Bill

[Medicare Standardized Intermediary Remittance Advice]
### Charging 2 Defibrillators (Who’s looking at the Final Bill?)

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### Coding and Charging same procedure via different Revenue codes

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*Images of the documents are included.*
### Charges and HIM codes Doubling Service Units on Bill

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### Cardiology Charges for Radiology Procedures

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Common Problems with SP Coding

- Revenue cycle analysis of a large volume of claims in error revealed:
  - Root cause of errors were consistent in facilities across the nation
  - Everyone at the facility thought they were doing the right thing
  - No one department caused all errors (no department was without errors)
  - No one knew errors were occurring
  - No one looked at the whole process
  - No one involved in the process reviewed the final remittance advice

SP Coding- Not a Simple Matter

- Multiple Service Locations
- Vascular Surgery
- Interventional Radiology
- Interventional Cardiology
- Interventional Nephrology
- Everyone involved
- Knowledge
- Systems
- Work Process
- Coding
- Documentation
- CDM & Charging
- MD’s Nurses Techs
- HIM
- Software, Scrubbers
- Timing
- Charge Master
- Techs
Reasons Problems Exist

1) Multiple clinical departments performing procedures
2) Multiple departments can impact a bill
3) Departments don’t talk to each other
4) System set up can impact a bill
5) Charge tools affect accuracy of charges
6) Work processes can cause errors
7) Charge entry vs. documentation creation timing
8) Scrubbers result in changes to codes & charges
9) No one looks at the final product
10) No one is ultimately responsible for the entire bill
11) No Single Point of Accountability

Multiple Department Impact

- 90+% of Hospitals Split Coding Responsibility
  - HIM Codes Major Surgical Codes (10,000 - 69,999 Series)
    - They don’t usually have the capability to review charges
    - Codes are based on physician dictated report
  - Clinical Staff Codes (via Charging) S&l/Technical Codes (70,000 & 90,000 Series)
    - Clinical area doesn’t know they are “coding” or the impact of their charges
    - Charges/codes are entered prior to physician documentation
    - Clinical staff has no formal training or certification for coding
    - Varies from clinical department to department
- Scrubber edits often “fixed” in business office
  - Everyone thinks “billing issues” are the responsibility of the business office
## System Impact

- RIS charges must accurately map to CDM
- RIS or CDM may have “exploding” charges
- Encoder has tables defining UB-04 revenue code to look for on bill
- Billing system has protocols set to determine hierarchy of codes on bill (HIM vs. CDM)
  - Billing system protocols established by UB-04 revenue code and can be in conflict with encoder rules

## Charge Tool Impact

1. Charge sheets are outdated
2. Charge sheets are inaccurate
3. Charge sheets do not have complete code descriptions
4. Charge sheets are limited or difficult to use
5. Charge sheets be available but not used
6. Charge sheets are just the starting point for accurate procedural coding
7. Charge sheets may be based on hospital specific charge codes, not on CPT codes which makes it difficult to correlate with code specific rules
8. Charge sheets are filled out by busy physicians who may not be up to date on the latest coding rule updates and changes
9. Charge sheets are based on what was visually seen occurring in the lab, not on what was documented in the permanent medical record (dictated report)
10. Charge sheets differ from department to department
Bill Scrubber Impact

- Scrubbers can result in changes to original codes
- Modifier -59 usually not CDM-driven, so edits are encountered
- Usually edits are “fixed” by someone in the billing office without knowledge of Special Procedure coding rules
  - Appropriate codes are written off
  - Inappropriate codes are appended -59
  - Inappropriate codes may not be scrubbed as they do not create a CCI edit
  - Edits may be referred back to the clinical departments instead of HIM

Departments Interaction Impact

- Clinical area doesn’t know they are “coding” - “Coding is HIM’s responsibility”
- HIM doesn’t question department about charges submitted – “HIM doesn’t charge”.
- Business office changes charges and codes and may not communicate back to the source – “Billing is the Business Office’s responsibility”
Work Process Impact

- What Goes “Out the Door” Does Not Reflect Coding or Charging
  - Charges are removed
  - Codes are removed
  - Codes may be changed
  - Codes may be duplicated
  - Modifiers may be added, deleted or missing altogether
- Everyone did what they were supposed to, but the end result was failure
- No one department or person is responsible for the final product

4 Steps to Improvement

- Review Current Processes
- Implement Changes to Processes & Systems
- Validate
- Educate
### Review Current Processes

#### Charge Description Master
- Review CDM line items for CPT code, revenue code and description accuracy
  - Verify that surgical codes are not in the CDM if HIM is coding them
- Review explosion tables
- Analyze charging process
  - When are charges determined?
  - How are charges determined?
  - Who enters charges?
  - What reconciliation is performed?

#### Charge Tools
- Determine last date charge tools were updated
- Review charge sheets to verify they are accurate
  - Are all procedures performed listed?
  - Are items grouped in a manner that facilitates accurate charging?
  - Are charge code descriptions/mnemonics accurate for the item described
  - If RT & LT modifiers are in the CDM does the charge sheet list both right and left options
Review Current Processes

IT Systems
- Review mapping of CPT codes to UB-04 revenue codes in encoder
- Review billing protocols for handling of codes coming from the encoder
- Review mapping of RIS charge items to CDM
- Identify problem cases and trace them through the revenue cycle

Review Current Processes

Workflow
- Determine how HIM identifies the codes that should be “soft” coded
- Determine who can make changes to charges
- Determine who can change HIM codes
- Determine who fixes “scrubber” edits
- Determine if anyone reviews the final bill against the physician report prior to submission
Implement Changes

Charge Description Master and Charging

- Update with changes identified
- Establish a resource for the clinical area to keep current on:
  - Coding rules
  - CPT codes
  - HCPCS Level II codes
  - CCI edits

Implement Changes

Charge Tools

- Update or create new charge tools
- Get commitment from clinical areas to review charge tools at least annually. Use consistent tools within different clinical departments
Implement Changes

IT Systems
- Modify tables in encoder if revenue codes are incorrect
- Modify billing protocols for handling of codes coming from the encoder if necessary
- Revise mapping of RIS charge items to CDM when found in error
- Inactivate “exploded” charges

Implement Changes

Workflow
- Establish a team to be the “Single Point of Accountability” for all Special Procedure billing
  - 2 – 3 Individuals
  - Compare SP claims to physician report immediately prior to submission
  - Responsible for all revisions when incorrect
  - Communicate back and help education any area causing the correction
  - Only ones that can revise a bill, to include scrubber edits
  - Only ones to add most modifiers
Implement Changes

Workflow

- Establish a team to be the “Single Point of Accountability” for all Special Procedure billing
  - Responsible for staying current on coding rules
  - Responsible for educating departments, MD’s, etc
  - Review paid claims to verify reimbursed accurately
  - Location near the clinical areas allows interaction
  - Develop a team approach with clinical areas, HIM and billing office to manage the process. Consider involving the physicians and their office coders/billers

Validate

- Review changes implemented to verify they are accurate
  - CDM
  - Systems
  - Charge tools
- Review process changes as they may need further revision if not working as well as expected
- Review claims to verify all billed codes are on the RA and paid as expected
Education

- Educate clinical staff in coding rules so charges are accurate as possible (techs, nurses and MDs)
- If single point of accountability includes coders:
  - Educate coders on use of 70,000 and 90,000 series of CPT
  - Educate coders on interventional radiology component coding system
  - Allow coders to observe procedures in angio/cath labs
  - Coders to discuss documentation with physicians
- Maintain competency of single point of accountability through continued educational opportunities, reference material and other sources