

What You Need to Know to Monitor &
Audit the Revenue Cycle

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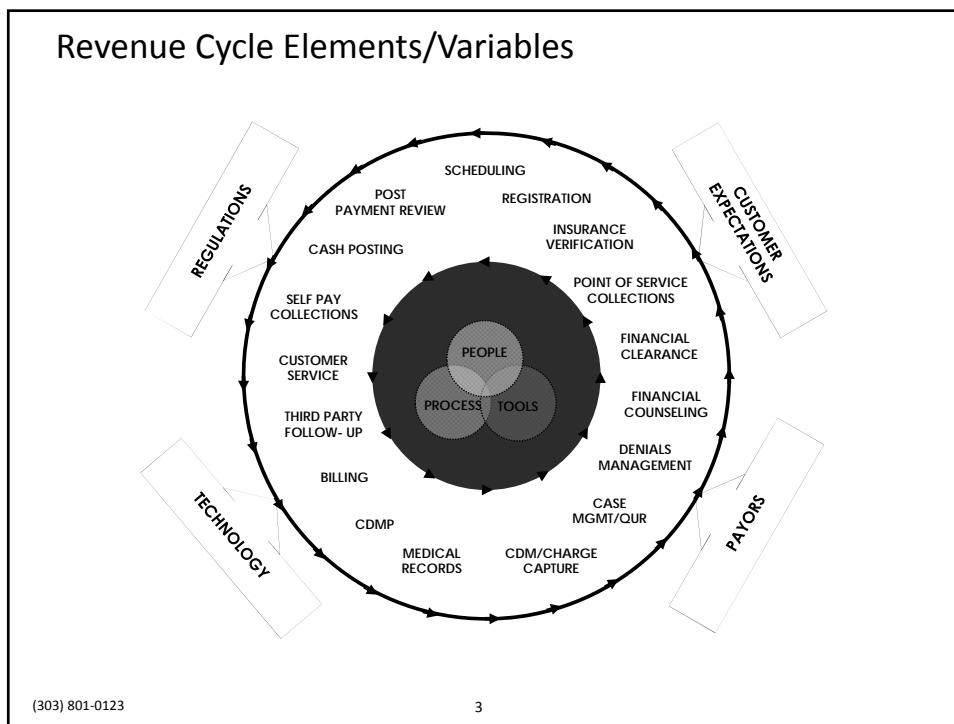
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What is the Revenue Cycle?

- All the administrative and clinical functions, processes, and software applications that contribute and manage the scheduling, pre-admission, registration, financial counseling, charge capture, coding, billing, payment and collections tasks associated with a patient encounter.
- Revenue cycle is the process that begins when a patient comes into the system and includes all those activities that have occurred in order to have a zero balance.

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- ### Medicare Payment Systems
- Acute Inpatient
 - Inpatient Psychiatric
 - Inpatient Rehab
 - Long Term Care Hospital
 - Critical Access Hospital
 - Hospital Outpatient
 - Skilled Nursing Facility
 - Part D
 - Partial Hospitalization
 - Professional Services
 - Home Health
 - Hospice
 - Ambulance
 - Durable Medical Equipment
 - Clinical Laboratory
 - Ambulatory Surgery Center
 - Medicare Managed Care (HCC)
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Medicare Insurance Basics/Benefits

Medicare is an insurance plan with covered and non-covered benefits. Medicare patients have Part A and Part B benefits with deductibles and co-insurances just like other insurance plans.

Part A Coverage

- Inpatient hospital, skilled nursing facility (limited number of days), and hospice
- Submitted on UB-04

• Little B Coverage

- Outpatient services provided in a hospital department
- Submitted on UB-04

• Part B Coverage

- Outpatient services provided in a free standing facility. Physician clinic, outpatient surgery center, outpatient radiology center, rehabilitative services (PT/OT,SP)
- Submitted on CMS1500

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UB04 – Where the Data Comes From?

Required Elements:

Required Billing Elements - Where do they come from?

50% - Patient Access, Registration	15% - Charge Entry Areas
15% - Medical Records	20% - Billing

Patient Demographic Data

- Patients last name, first name, and middle initial
- Patient address
- Birth date
- Male (M) or Female (F)
- Marital Status
- Admission date or start of care date

Encounter Specific

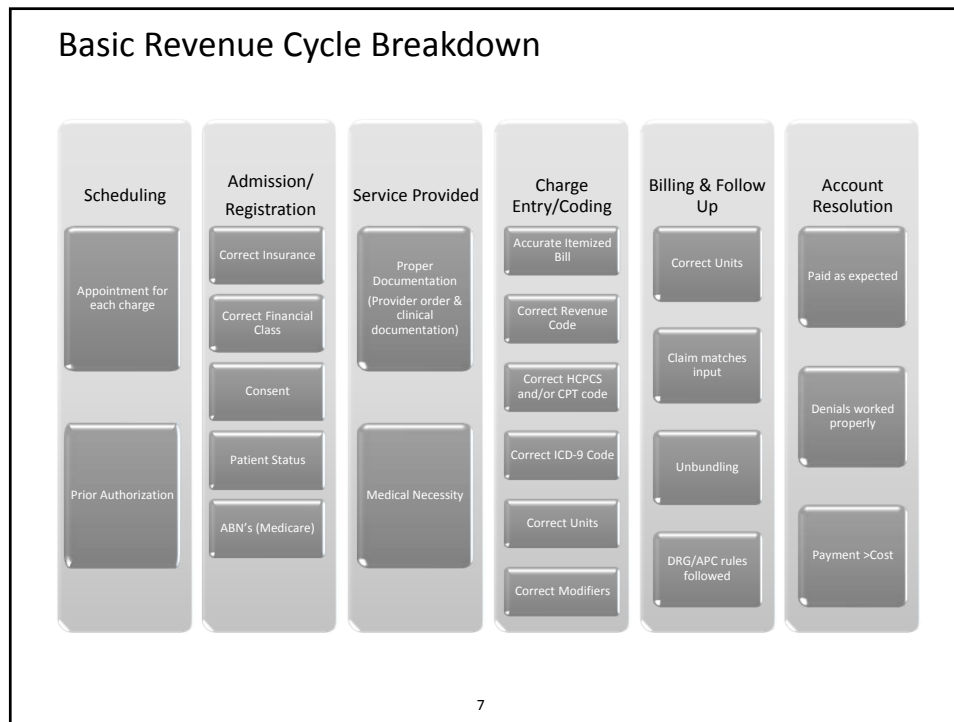
- Hour patient was admitted for inpatient or outpatient care
- Occurrence Codes
- Code indicating the priority of admission--1 indicates emergency; 2 urgent; 3 elective; 4 newborn; and 9 information not available.
- Code indicating the source of admission or outpatient service
- Provider has patient signature on file permitting release of data (Y or N)
- Principal Diagnostic Coding (ICD-10-CM code)
- Admitting Diagnostic Coding (ICD-10-CM code)

Insurance Information

- The name and number identifying each payer that payment is expected
- Assignment of benefits (Y) yes; (N) no
- The name of the patient or insured individual
- Relationship of the insured (person having insurance) to the patient
- Insured's identification number assigned by the payer organization
- The group name/plan through which the insurance coverage is provided
- The insurance group number
- Employment status code
- Employer's name and address

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Patient Access/Scheduling

- The “Front Door” to the organization and the first step in the revenue cycle process for the majority of patients.
- Important functions and information gathered in during scheduling include:
 - Centralized versus decentralized scheduling
 - Surgery, radiation oncology, therapy services are typically managed in the department
 - Identify the referring physician
 - Obtaining prior authorizations/certifications, physician orders and other required documents from the provider’s office
 - Pre-registration when possible/gather patient demographics and insurance information

Patient Registration

- May be centralized or decentralized
- The important functions and information gathered in Access include:
 - Insurance verification
 - Medicare Secondary Payer Questionnaire
 - Patient Class
 - Financial Counseling
 - Medicaid Eligibility/Charity Care
 - Consents/Assignment of Benefits
 - Point of Service collections (co-payments, self pay)

Patient Access & Registration 50% of claims data

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Medicare Secondary Payer Questionnaire

Part A Institutional Provider Responsibilities (Hospitals)

- Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, for information such as group health coverage through employment or non-group health coverage resulting from an injury or illness.
- Bill the primary payer before billing Medicare, as required by the Social Security Act.
- Submit MSP information on your Medicare claim using proper condition and occurrence codes on the claim. This is only submitted on a UB-04. **NO fields exist on the CMS1500 for the questions.**

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MSPQ (continued)

- The MSP questionnaire has a series of questions that vet out every possible primary payer. It is a lengthy questionnaire.
- The questionnaire needs to be completed every time there is an inpatient admission.
- The outpatient requirement is once in a lifetime; however, CMS expects the information to be kept current. Most hospitals update the MSPQ annually.
- If the beneficiary's MSP record in the Common Working File indicates another insurer should have paid primary to Medicare, Medicare will deny the claim.

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Patient Care Area

- Verify provider order
 - Consideration of local and/or national coverage determinations
- Document provided services
 - Ancillary services (nursing, lab, radiology, medications, etc.)
 - Provider services (physicians and mid-levels)
- Medical Necessity
 - Provider documentation of risk and plan

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Utilization Review

- Liaison between providers and health plans for authorization of inpatient and/or observation care.
- Reviews clinical documentation during or following an inpatient or observation admission to validate appropriateness of patient class.
- Should also be reviewing the physician's order to validate it is an acceptable order per regulations. For example:
 - Admit to inpatient and Admit to observation status are acceptable.
 - Admit to ICU, Admit to BH or Admit to OB/Labor are not acceptable orders; they are Levels of Care (LOC).
- Monitors progression of care and acuity in accordance with payer requirements.
- Assists with preparing medical necessity denials.

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Clinical Documentation Improvement

- Liaison between providers and Health Information Management/Coding.
- Performs medical record reviews during the stay to identify:
 - Gaps in documentation which would lead to delays in billing.
 - Signs/symptoms and/or tests for which a diagnosis has not been documented.
 - Performs concurrent queries to ensure the gaps are addressed prior to the patient being discharged.
- Educates providers on documentation required for coding.
- The program assists in preventing delays in billing by ensuring all conditions treated during the stay are documented appropriately.

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Charge Capture

- Occurs in patient care areas/departments
- Charge Capture fundamentals:
 - Charge codes are built in department's charge description master
 - Charges are either entered (manual) or generated off documentation
 - Order
 - Results
 - Completion
 - Flowchart
 - Charges are entered timely (within 24 hours of discharge) to avoid delayed claim submission and late charges
 - Charge scrubber used to identify charging errors
 - Charging errors sent to department for corrections
 - Ideally - Daily Charge Logs reviewed by department for completeness and logical (do the charges make sense?)

15% of claims data

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Charge Description Master (CDM)

The CDM is a master file that includes:

- "Hard coded" CPT/HCPCS codes that are selected at charge entry by patient care areas or automatically generated by electronic medical record documentation or activities. Modifiers may or may not be built with the hard code.
- Charge codes that need the CPT/HCPCS code and/or modifier added by a Coder
- May include non-billable codes used to track productivity
- Fee schedule
- **FOR UB-04 PROVIDERS ONLY:** A revenue code assigned to each billable charge code. The revenue code is used to "roll up" similar charges for reporting on the UB-04. It also creates the sub-categories on an itemized statement.

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HCPC (Healthcare Common Procedure Coding System)

- Based on the American Medical Association's Current Procedural Terminology
- With the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) use of the HCPCS for transactions involving health care information became mandatory.
- **Level I** consists of the American Medical Association's Current Procedural Terminology (CPT) and is numeric . Updated annually by AMA.
- **Level II** codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices,^[3] and represent items and supplies and non-physician services, not covered by CPT-4 codes (Level I). Updated quarterly by CMS.
- **Level III** codes, also called local codes, were developed by state Medicaid agencies, Medicare contractors, and private insurers for use in specific programs and jurisdictions.

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Level I: CPT Code Ranges

- Anesthesia: 00100–01999; 99100–99150
- Surgery: 10000–69990
- Radiology: 70000-79999
- Pathology and Laboratory: 80000–89398
- Medicine: 90281–99099; 99151–99199; 99500–99607
- Evaluation and Management: 99201–99499

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Level II: HCPCS

- A-codes (example: A0021): Transportation, Medical & Surgical Supplies, Miscellaneous & Experimental
- B-codes (example: B4034): Enteral and Parenteral Therapy
- C-codes (example: C1300): Temporary Hospital Outpatient Prospective Payment System
- D-codes: Dental Procedures
- E-codes (example: E0100): Durable Medical Equipment
- G-codes (example: G0008): Temporary Procedures & Professional Services
- H-codes (example: H0001): Rehabilitative Services
- J-codes (example: J0120): Drugs Administered Other Than Oral Method, Chemotherapy Drugs

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Level II: HCPCS

- K-codes (example: K0001): Temporary Codes for Durable Medical Equipment Regional Carriers
- L-codes (example: L0112): Orthotic/Prosthetic Procedures
- M-codes (example: M0064): Medical Services
- P-codes (example: P2028): Pathology and Laboratory
- Q-codes (example: Q0035): Temporary Codes
- R-codes (example: R0070): Diagnostic Radiology Services
- S-codes (example: S0012): Private Payer Codes
- T-codes (example: T1000): State Medicaid Agency Codes
- V-codes (example: V2020): Vision/Hearing Services

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Health Information Management

- Health information management (HIM) is the practice of maintenance and care of health records by traditional and electronic means in hospitals, physician's office clinics, health departments, health insurance companies, and other facilities that provide health care
- The important functions and information gathered in HIM include:
 - Providing and Managing Transcription Services
 - Coding services documented by Physicians
 - CPT codes (procedures)
 - HCPC (supplies, drugs, etc.)
 - ICD- 10 (diagnosis and procedure)
 - Validates codes accurately reflect patient care services
 - Assigns discharge disposition code
 - Educates, presents, and trains on opportunities to improve
 - Case Mix Index (CMI)
 - Manages storage and retrieval of medical record

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Hard Coded vs. HIM assigned CPT/HCPCS

- Not all CPT/HCPCS codes are selected by the patient care area during charge entry
- Codes with Status Indicators of S or T are typically placed on the account by Coders after the department enters charges
- Codes with S and T indicators are influenced significantly by how the physician documents the service which is why a Coder needs to assign the CPT or HCPCS.
- Codes with S or T indicators have charge codes built in the CDM with an associated fee. Given most of these codes are surgical procedures, the charge code is typically a called a "procedure charge level".

Responsible for 15% of claims data

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Patient Financial Services

- The important functions and information gathered in PFS include:
 - Charge Master
 - Billing
 - Overseeing Claims Edits to ensure “Clean Claim Submissions”
 - Employing tools to support accurate charge capture
 - Follow-Up with Insurance companies
 - Appeals
 - Denials
 - Un-paid Claims
 - Customer Service
 - Collections
 - Cash Posting
 - Subject Matter Experts
 - Government Billing
 - Commercial and Managed Care Billing
 - Employs and Oversees systems and vendors to enhance
 - Services provided to patients
 - Revenue
 - Cost to Collect

Responsible for 20% of claims data

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Assess Risks to Focus Resources

- High or low denial rates
- High utilization (provider CPT utilization)
- PEPPER Report
- Changes in Case Mix Index
- New or recently changed processes
- Patient or staff complaints
- Trend payer pre-payment reviews

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Monitoring Examples

- Scheduling
 - Prior Authorization (completion before appointment)
 - Registration Errors
 - Insurance Verification (completion prior to appointment)
 - Others?
- Registration
 - Insurance Verification (completed during check-in)
 - Medicare Secondary Payor Questionnaire
 - Assignment of Benefits
 - Registration Errors
 - Notice of Privacy
 - Others?

Monitoring Examples

- Utilization Review
 - % of admissions seen within 24 hours of admission
 - % of admissions sent to physician review for medical necessity
 - % of physician reviews maintained as an inpatient admission
 - Others?
- Charge Capture
 - Charging error reports sent to departments
 - Charging work queues
 - Charging errors identified or corrected by Health Information Management
 - Charges without orders
 - Others?

Monitoring Examples

- Health Information Management

- Coding
 - Coding Quality Management Program results
 - Number or % of coding changes made by Coding personnel (physician charges)
 - Productivity reports
 - Others?
- Records Management
 - Number or % of orders unsigned (EMR reports)
 - Average lag time for co-signing verbal orders (EMR reports)
 - Number or % of incomplete records, types of reports, etc.
 - Quality Management Program for misfiled or comingled patient records
 - Others?

Monitoring Examples

- Patient Financial Services

- Claims Submission
 - Scrubber rejection data and trending
- Denials Management
 - Tracking denial codes by payor, provider, specific segments of the revenue cycle
- Payment Posting
 - Adjustments due to denials
- Others?

Monitoring Using Data

- **Physician Billing**
 - Billing utilization report analysis
 - E/M bell curves, Critical Care & Discharge levels of service.
 - “Impossible Day” – are RVUs and visit/procedure volumes realistic compared to number of days in time period, patient base or other factors impacting volumes?
 - Hot topic risk areas
 - Are frequency of services compliant with coverage policies?
 - Are frequency of visits, compared to physician specialty typical for routine monitoring of pain diagnoses?
 - Are areas with provider and process changes supportive of services?
 - Denial report analysis
 - Are avoidable denials present?
 - Are claim scrubbing edits in place to address potential denials before submission?

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Monitoring Using Data

- **Inpatient**
 - DRG volumes compared to expected averages and patient type
 - High utilization of diagnoses unexpected in patient population
 - Encephalopathy
 - Marasmus and Kwashiorkor’s (severe malnutrition)
 - Case Mix Index changes
 - Denial report analysis
 - Are avoidable denials present?
 - Are claim scrubbing edits in place to address potential denials before submission?

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Denials Management

- **Two types of denials**
 - Clinical Denials require more expertise on the denial process. You may have to engage a physician or nurse for assistance initially and then bridge the gap in communication by pulling in members of the coding department. Examples:
 - Local or national coverage determinations
 - Payer policies
 - Technical Denials are typically more straightforward and can be managed by members of the AR follow up and/or coding department. Examples:
 - Incorrect primary insurance/coordination of benefits
 - Outside coverage dates

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Denial Tracking Best Practices

- Denial trending completed at time of posting payments & adjustments.
- Track denials by:
 - Type of denial
 - Provider and/or specialty department
 - Insurance
- Assign staff to work denials by “bucket” (type) or work queue.
- Prevent future denials.
 - Implement processes to avoid these same denials in the future based on trends.
 - Educate providers, clinic/ancillary staff, billers & coders.

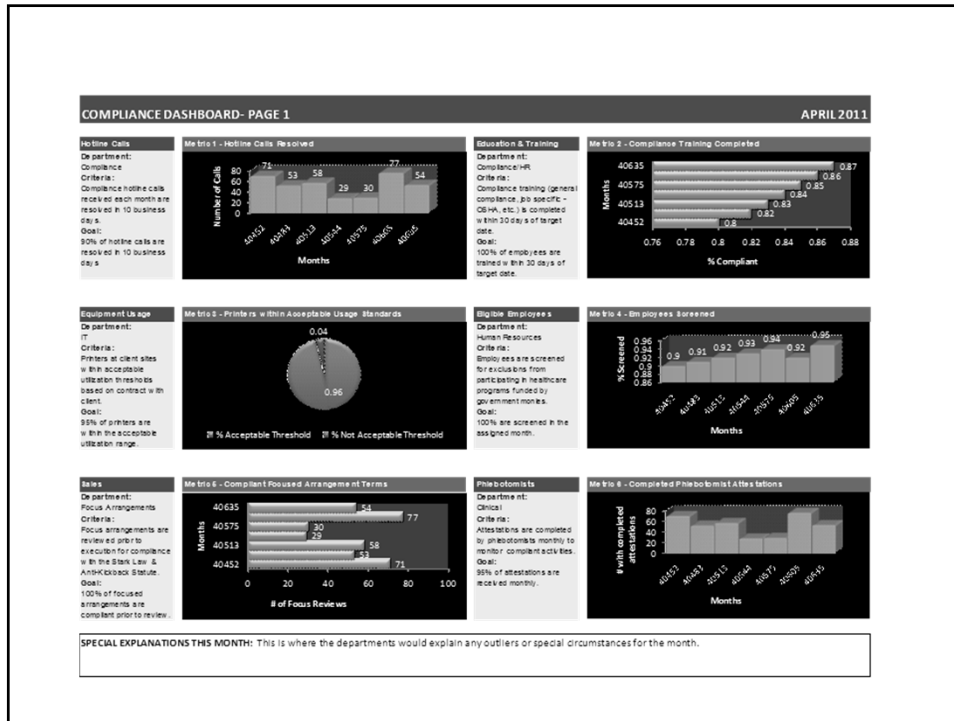
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Audience Participation

- Brainstorm what might be monitored by management in these areas in the following outpatient areas.
 - Laboratory
 - Radiology
 - Pharmacy
 - Emergency Department
 - Outpatient Surgery
 - Infusion services
 - Supply Chain Management (supplies)

Reporting

- Once risks are identified and monitoring needs are determined, need to develop an easy tool.
- Consider Excel because it can easily convert data to graphs (management and committees like this).
- Determine “how many” monitoring elements should be reported and how often to report information to senior management and board. Information may be different based on audience (detailed versus high level).



Questions

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