APC Revenue Cycle: Tips for Success

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Practical Tools for Seminar Learning
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The faculty has reported no vested interests or disclosures regarding this presentation.
Arlene Baril is president of Baril & Associates Healthcare Consulting in Dallas, TX. Ms. Baril has over 29 years of experience specializing in revenue cycle management and HIM operations. Prior to starting Baril & Associates, she was executive vice president of HIM services at PHNS, Dallas. Arlene has also served as vice president of HIM and software services for UASI in Cincinnati, OH, director of HIM and coding services for Pyramid/The HealthCare Financial Group, and regional manager for PricewaterhouseCoopers, LLP. Ms. Baril is a frequent contributor to many HIM and healthcare financial publications and served as an editorial advisory board member of Briefings on Coding Compliance and Briefings on APCs. She has presented numerous educational seminars and state and national conferences around the country.
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## Presentation Objectives

- Identify the components of the Revenue Cycle
- Evaluate the role of each department
- Demonstrate the impact of coding and health information management (HIM)
- Denials in the APC system - Prepare a plan for auditing denials
- OPPS Audit Opportunities
- Sample Case Study
- Revenue Cycle Areas to Monitor

## Count the Silos:

- Organizational silos make it difficult to anticipate surprises
  - Various people have various pieces of the puzzle, but no one has them all
  - Silos disperse information & responsibility
  - Assume that someone has responsibility, but actually no one really does
Some Statistics to Ponder:

- Health care industry experts estimate that 25-30% of all health care claims are denied or rejected
- Providers typically lose 3-4% of their net revenue each year from denials
- The Health Care Advisory Board released a survey of hospital CEO’s that listed decreased claim reimbursement for services as their highest-priority financial concern (79% of those surveyed)
- Typically about 50% of denied claim amounts are not recovered
- Using technology can add about 20% to the bottom line of previously un-recovered amounts

Source: Health Care Advisory Board
Some Statistics to Ponder:

- Various reviews and surveys have shown that hospitals don’t collect between 4-12% of the monies due to them, because of:
  - Coding errors
  - CDM errors due to poor maintenance of the CDM
  - Insufficient documentation to support medical necessity

Some Statistics to Ponder:

- Outdated billing and collections systems and processes can delay payments for up to 75 days
  - Non-healthcare organizations average 28 days
- Examples of reasons that delay payment:
  - Authorization process failures
  - Poor coding methodologies based on a specific health plan's requirements
  - Poor charge capture methodologies
  - Billing follow-up failures
Components of the Revenue Cycle

What is the Revenue Cycle?

The processes by which a healthcare facility receives payment for services rendered - service point of entry to payment receipt/resolution.
What is the Revenue Cycle?

Visual

What is the Revenue Cycle?

Alphabet Soup
What Language Are YOU Speaking?

**ROI**
- Release of Information (HIM)
- Return on Investment (Finance)

**ADR**
- Additional Documentation Request (HIM/Business Office)
- Average Daily Revenue (Finance)

Players in the Revenue Cycle

- Admitting/Access Management
- Case Management/UR
- Charge Capture
- Health Information Management
- Unbilled Management
- Business Office/Patient Financial Services
- Finance
- Compliance
- Information Technology
Functions of the Revenue Cycle
Admitting/Access Management

- Verification
- Certification
- Registration
- Scheduling
- Collection of insurance information
- Collection of co-pays
- Consents/Notices
- Issuance of Advanced Beneficiary Notices

Functions of the Revenue Cycle
Case Management/UR

- Documentation Review-Medical Necessity
- MD/Provider Interaction/Education
- RAC Reviews-Assistance
- Critical Pathway/Guideline
- Concurrent MS-DRG Assignment
- CDI program

GOAL: MINIMIZE retrospective processes
Functions of the Revenue Cycle

Charge Capture

- Point of Care vs. Batch
- Linking to Order Entry
- Late Charges (non-existent under OPPS)
- Data Dictionary (Charge Master)
- Coding Updates (quarterly changes for OPPS)

Functions of the Revenue Cycle

Health Information Management

- Reconciliation of accounts vs. documentation received-Medical Necessity
- Processing Cycle Order and Timeliness
- Coding (only 21% in the OP environment)
- Physician Query Process
- Coding Accuracy Audits – Internal and External
- Requests for Records/ Documentation (ROI)-now includes RAC requests
- CDI Program
Functions of the Revenue Cycle

**Unbilled Management**

- RTP/ Denial Resolution
- Response to Business Office/ PFS Requests
- Edit Correction (OCE and Groupers)
- Policy Development Based on Corp Guidance
- Data Presentation
- Data Analysis
- Write Off Preparation
- Additional Documentation Requests (ADR’s)

Functions of the Revenue Cycle

**Patient Financial Services/ Business Office**

- Edits (Front End, Pre/ Post Billing)
  Generation and Resolution
- Bill Generation
- Denials/ RTP’s (Return to Provider)
- Posting (Remits, Payments)
- Additional Information Request Coordination
- Bill Hold Settings
- Charge Master Maintenance
- Appeals
Functions of the Revenue Cycle

Finance

- Case mix Analysis
- Patient Volume Data (MS-DRG Review)
- Service Line Analysis
- Decision Support
- Data Benchmarking
- AR Days
- Primary Data Source
- Administrative Representation of the Revenue Cycle Team

Compliance

- Legal Watchdog
- Regulatory Experts
  - Somewhat dependent on background
- Coding Accuracy Review Coordinator
- Typically the RAC point person
- HI PAA Enforcer
- External Audits
Program Development: The Revenue Cycle Team

1. Determine the need to have a Revenue Cycle Team. **YES, you need one!!!**
2. Determine who are the members of the Team
3. Assess what the Team knows (Baseline)
4. Determine if education of Team members is necessary at this point
5. Define Team Goals
6. Identify and Define Data Needs and Sources
7. Standardize Language and Data Reporting

Program Development: The Revenue Cycle Team

8. Develop Key Indicators/ Measurement along the entire Revenue cycle
9. Define Team and Facility Responsibilities
10. Determine What Functions are and are NOT being done (Gap Analysis)
11. Identify Appropriate Types of Issues for the Team to address
12. Prioritize Issues and Problem Areas
**Program Development: The Revenue Cycle Team**

13. Educate your Team
14. Educate your facility
   - Revenue Cycle Manual
   - Clinical Staff
   - Targeted Problem Areas
   - Annual Updates
     - Regulatory
     - Coding
15. Coordination of Upgrades/Updates
16. Your work is never done

**Sample Revenue Cycle Team Objectives**

- Identify issues resulting in increased A/R
- Prioritize issues to address
- Communicate issues to appropriate areas
- Solve problems collaboratively
- Develop educational materials and provide education (can be done with internal or external staff)
- Develop a “map” or “blueprint” on how to implement new services
- Review denials and actively discuss appeal process and success
- Discuss intermediate measurements/indicators
Revenue Cycle Team Notes

- Catalog what process are and are NOT being done and where
- Process recommendations/fixes based on problems resolution solutions
- Detailed multidisciplinary process analysis
- Determines measures/indicators for facility
- Provide Education
- Offer Revenue Cycle Guidance
- Determine Write Off thresholds
- Determine High Dollar threshold
- Review Appeal Responses (KEY for RAC)

Program Development
Unbilled Management - The HIM Role

- Liaison between all areas
- Coded Data Experts
- Coding Accuracy and Consistency
- Case mix Analysis
- MS-DRG/APC Experts
- Education
- Holder of the “Rework” Effort
- Coding a common focus
- RAC and CDI
Information Systems
Data Collection and Accessibility

Departments within the Revenue Cycle commonly “own” component systems.

- ADT System
  - Collects and stores registration information
  - Assigns MR and Account #s

- Billing System
  - Generate Bills
  - Generates Monitoring and Edit Reports

- Encoder/Grouper

- Abstracting Application
  - Account holds for Documentation issues

Measurements/Indicators

- DNFB $ (Discharged Not Final Billed)
- AR Days
- % and $ of Write Offs
- % of Clean Claims
- % of Claim RTP’s (Return to Provider)
- % of Denials
- % of Accounts Missing Documents
- # of Query Forms
- % of Late Charges
- % of Accurate Registrations
**Patient Registration - Opportunities**

- Develop standardized policies and procedures to:
  - Ensure authorization documents are obtained prior to service
  - Ensure all other documentation necessary for billing is timely and accurate
- Implement a POS program to collect co-payments for all clinic visits
- Implement fully functional compliance checker/medical necessity software to support ABN compliance

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**Patient Registration - Opportunities**

- Establish a central authority for all clinic registration to provide consistent management of:
  - Standardized documentation, process and data integrity for clinic registration
  - Training of new registrars
- Implement a comprehensive (financial impact-oriented) data quality audit program

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**Information Systems - Opportunities**

- Verify that the Medicare outpatient systems claim goes through all appropriate edits before final submission to the fiscal intermediary/MAC
- Determine the differences between billing edits in the internal system versus those utilized in the Medicare outpatient code editor
- Ensure that billing edits are working appropriately
- Program appropriate management reports so that the hospital can evaluate performance under OPPS

**Charge Capture Process - Opportunities**

- Develop a concurrent charge capture audit program to include:
  - Improved charge capture/increased revenue
  - A “built-in” clinician-to-clinician educational process to support each of the charging departments with specific feedback and selective training, as needed
  - Proactive audits for each charging area, identifying and correcting charge capture problems as they occur
  - Late charge problems identified and corrected prior to the initial bill being sent and corrective feedback to charging departments
  - Charging protocols maintained and updated, as necessary
Denials Management - Opportunities

- Implement a comprehensive denial management program that incorporates all functional areas of the revenue cycle and has formalized policies, procedures, and weekly results reporting by accountable area.
  - Denial Management “Team” would include representatives from key revenue cycle areas, including:
    - Patient Access
    - Health Information Management
    - Finance
    - Charge Capture
    - Patient Accounting
    - Utilization Review
    - Managed Care
    - Financial Counseling

Denials Management - Opportunities

- Form a denials recovery unit
- Appoint an authorizations clerk
- Maintain a denials database
- Consider automation of the process
- Do a comprehensive contracts review
**OCE Editor and CCI Edits**

The Outpatient Code Editor (I/OCE)

- Processes claims for all outpatient institutional providers including OPPS and non-OPPS hospitals
- Claim will be identified as ‘OPPS’ or ‘Non-OPPS’ by passing a flag to the OCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1
- This version of the OCE processes claims consisting of multiple days of service. The OCE will perform three major functions:
  - Edit the data to identify errors and return a series of edit flags
  - Assign an Ambulatory Payment Classification (APC) number for each service covered under OPPS, and return information to be used as input to a PRICER program
  - Assign an Ambulatory Surgical Center (ASC) payment group for services on claims from certain Non-OPPS hospitals
- The OCE will accept up to 450 line items per claim. The OCE software is responsible for ordering line items by date of service
**Purpose of the OPPS I/OCE:**

The (I/OCE) software combines editing logic with the new APC assignment program designed to meet the mandated OPPS implementation. The software performs the following functions when processing a claim:

- Edits a claim for accuracy of submitted data
- Assigns APCs
- Assigns CMS-designated status indicators
- Assigns payment indicators
- Computes discounts, if applicable
- Determines a claim disposition based on generated edits
- Determines if packaging is applicable
- Determines payment adjustment, if applicable
- Purpose of the non-OPPS I/OCE functionality

In addition, the I/OCE program screens each procedure codes against a list of approximately 2500 ASC procedures, and summarizes whether or not the bill is subject to the ASC limitation.

**The I/OCE Dispositions:**

There are currently 83 different edits in the OCE. The occurrence of an edit can result in one of six different dispositions.

- **Claim Rejection** - one or more edits present that cause the whole claim to be rejected. A claim rejection means that the provider can correct and resubmit the claim but cannot appeal the claim rejection.
- **Claim Denial** - one or more edits present that cause the whole claim to be denied. A claim denial means that the provider can not resubmit the claim but can appeal the claim denial.
- **Claim Return to Provider (RTP)** - one or more edits present that cause the whole claim to be returned to the provider. A claim returned to the provider means that the provider can resubmit the claim once the problems are corrected.
- **Claim Suspension** - one or more edits present that cause the whole claim to be suspended. A claim suspension means that the claim is not returned to the provider, but is not processed for payment until the FI/MAC makes a determination or obtains further information.
- **Line Item Rejection** - one or more edits present that cause one or more individual line items to be rejected. A line item rejection means that the claim can be processed for payment with some line items rejected for payment. The line item can be corrected and resubmitted but cannot be appealed.
- **Line Item Denials** - one or more edits present that cause one or more individual line items to be denied. A line item denial means that the claim can be processed for payment with some line items denied for payment. The line item cannot be resubmitted but can be appealed.
Sample OCE Edits

- 1 Invalid diagnosis code
- 2 Diagnosis and age conflict
- 3 Diagnosis and sex conflict
- 5 E-code as reason for visit
- 6 Invalid procedure code
- 8 Procedure and sex conflict
- 18 Inpatient only procedure
- 52 Observation does not meet criteria for separate payment
- 60 Use of modifier CA with more than one procedure not allowed

APC Opportunities

[Chart showing APC opportunities]
Common Missed Reimbursement Under OPPS

1. HIM vs. CDM/ Ancillary Charging
2. ER & Clinic Visits
3. Infusions and Injections
4. Modifier Usage
5. Observation Services
6. Drugs/ Pharmaceuticals
7. Wound Care Services
8. OCE/ CCI edits/ UB04 errors
9. Cardiology & Interventional Radiology Services
10. Transfusion services

Coding - Opportunities

- Reduce bill hold to industry standard of two-four days, and associated turnaround time for coding
- Track all uncoded accounts and report by reason and dollars to responsible areas
- Contract with third party to provide at least annual audits of facility coding
- Provide hardware and software capabilities for coders to reduce the need to “toggle back and forth” between systems
**Coding - Opportunities**

- Run all bill edits at one time, producing a report that identifies all reasons a bill fails an edit before it is sent back for correction
- Consider installing pre-bill edits on the abstracting system to allow coders to correct coding errors before the abstract is finalized; allow coders to view charges and associated Chargemaster codes at the time of abstracting
- Place responsibility on ancillary departments to correct codes by installing a “front end” product to screen for medical necessity and other coding errors

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**Coding - Opportunities**

- Review hospital charge description master (CDM) for compliance on an ongoing basis
- Evaluate coding practices of health information management versus coding through the CDM (internal and external reviews)
- Train HIM personnel on coding issues related to ambulatory payment classifications (APCs); provide access to all CMS materials
- Conduct assessment of hospital’s charging practices
- Enhance efforts to uniformly utilize modifiers and code for pass through items
- Develop a patient classification system for evaluation and management (E&M) services that is routinely used throughout your organization
HIM vs. CDM/ Ancillary Charging

- Who codes what?
  - Departmental vs. service lines vs. revenue codes
- Is the CDM updated at least on a quarterly basis?
  - APC/ CDM task force
  - How is a charge added/ amended?
  - Are all changes implemented through order entry?
  - How is staff trained/ updated on these changes?
- Are all components of a procedure coded?
  - Procedure
  - Supplies/ drugs
  - Covered ancillary tests

Interventional Procedures

- Nationally, the overall case error rate for complex Interventional Radiology is 82%. Interestingly, this trend since 2000 has only moved downward by about 5%
- Interventional Radiology--of the 82% of cases in error- 48% of the errors were the result of inappropriate undercoding, 20% resulted in over-coding and the remaining were coding compliance errors that had minimal effect on reimbursement
- Cardiology APC Coding errors average 45% nationally

Source: Health Care Biller
Interventional Procedures

- Be sure to code procedures to furthest level of specificity
- Code both the surgical component and the interventional radiology/cardiology component
- Code fluoroscopic, CT, MR or ultrasound guidance when appropriate
- If bilateral procedure is performed, be sure to append a -50 modifier for additional APC reimbursement

Transfusion Services

- CPT 36430 should be coded to identify the transfusion procedure
- Code all blood products under revenue code 038X or 039X
- Don’t forget all laboratory services!!
  - Type and cross match
  - Antibodies
  - RH factor testing
Billing Example: Blood Transfusion

Revenue code: 0391  
HCPCS code: 36430-36460  
Units: 1 (per day)  
Charges: Charges related to blood administration

The OPPS pricer will determine the blood deductible dollar amount for each line item.

Billing Blood & Blood Products

- A transfusion APC will be paid to the hospital for transfusing blood once per day, regardless of the # of units transfused
- Hospitals should bill for transfusion services using rev code 0391 and HCPCS codes 36430-36460
- The hospital may also bill the laboratory revenue codes (030X/031X) with the HCPCS codes for blood typing, cross match and other lab services
### Billing Example: Blood Charges

- **Blood processing, storage and other acquisition costs for purchased blood and blood products.** Charges should reflect (at a minimum) the acquisition costs.
  - **Revenue code:** 0380-0389
  - **HCPCS code:** Level II C or P codes as appropriate
  - **Units:** # of units infused

- **Blood processing, storage and other acquisition costs for blood and blood products that are NOT purchased.** This acquisition cost would be the processing charges imposed by the supplier (such as the American Red Cross). Providers then generally add their costs of processing and storing the blood to the acquisition cost.
  - **Revenue code:** 039X
  - **HCPCS code:** Level II C or P codes as appropriate
  - **Units:** # of units infused

- **Pre-transfusion lab testing are billed with the following codes:**
  - `86850-86999` pre-transfusion testing
  - `86920-86922` compatibility testing
  - `86850` antibody screens

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### Case Study - Actual APC Audit

![Image of a person at a computer]
The Audit – Selecting a Sample

- A quarterly audit is recommended due to the quarterly changes in CPT codes, transitional pass-through lists, OCE and CCI edits
- Make sure qualified, credentialed staff perform the audit
- Supplement any internal audits with a MINIMUM annual external audit, as recommended in the OIG Compliance Plan for Hospitals
- Report findings to your APC Committee & Administration and be sure to share feedback with your coding staff (we can’t fix it if we don’t know it’s broken)

The Audit – Selecting a Sample

- Be sure to include a mix of cases that represents all of your services currently reimbursed under APC’s
  - Ambulatory Surgery
  - Observation
  - Clinic Visits
  - ER
  - Endoscopy Lab
  - Cardiac Catheterization Lab
  - Interventional Radiology
  - Chemotherapy, Transfusions and Radiation Therapy
The Audit – What You’ll Need

- Complete Medical Record
- Copy of the final UB-04
- Copy of the itemized detail bill
- Remittance Advice Statement

The Audit – What to Look For

- Coding Errors - both HIM and CDM generated
- Modifier Errors - yes, you need to use them
- CDM Generated Errors - revenue code, invalid CPT/HCPCS code, units of service issues, descriptions, bundled services, etc.
- IS Errors - interface issues, different codes in the HIM abstract vs. the UB-04
- UB-04 Errors - duplicate charges, omitted CPT codes, CDM codes overriding HIM assigned codes
- FI Errors - we billed it, but didn’t get paid for it
Remittance Advice Statements (RA’s)

- Reason Codes
  - Refers to products, drugs, supplies or equipment
  - At least one reason code must be used per claim
  - Multiples reason codes may be used for each service or claim as needed
  - Code “93” must be displayed if there is no claim level adjustment made

Remittance Advice Statements (RA’s)

- Sample Reason Codes
  - 1 Deductible amount
  - 2 Insurance amount
  - 3 Co-payment amount
  - 7 Procedure code inconsistent with patient’s sex
  - 26 Expenses occurred prior to coverage
  - 40 Charges do not qualify for emergency/ urgent care
**Remittance Advice Statements (RA’s)**

- **Sample Remark Codes**
  - M2 Not paid separately when the patient is an inpatient
  - M20 HCPCS code needed
  - M24 Claim must indicate the number of doses per vial
  - M29 Claim lacks the operative report
  - MA10 The patients payment was in excess of the amount owed. You must refund the overpayment to the patient.

- **Remark Classifications are used for:**
  - Enrollment
  - Equipment/ Orthotic/ Prosthetic
  - Home Care
  - Justification for Service
  - Liability
  - Medical Test
  - Missing/ invalid information
  - Overpayment
  - Payment Basis
  - Place of Service
  - Responsible Provider
  - Secondary Payment
  - Separate Payment
  - Miscellaneous
Return to Provider (RTP)

- RTP claims and adjustments contain data errors. These claims and adjustments are returned to the provider to review, to correct the data error, and to resubmit for processing. The following are some of the reasons a claim or adjustment can be returned. This is NOT an all inclusive list:
  - "Billing errors/ edit rejects
    - "Inconsistency with Beneficiary/ HIC#
    - "Certain CWF errors
    - "Missing or invalid claim information
  - The OCE utilizes claim level and line item level information in the editing process.
    - The claim level information includes such data elements as “from” and “through” dates, ICD-9-CM diagnosis codes, type of bill, age, sex, etc...
    - The line level information includes such data elements as HCPCS code with up to two modifiers, revenue code, service units, etc...

Sample RTP OCE Edits

- 1 Invalid diagnosis code
- 2 Diagnosis and age conflict
- 3 Diagnosis and sex conflict
- 5 E-code as reason for visit
- 6 Invalid procedure code
- 7 Procedure and age conflict (Not activated)
- 8 Procedure and sex conflict
Audit Summary - Sample Audit

Table 1 - Audit Summary (Actual Review)

<table>
<thead>
<tr>
<th>OP Hospital Medicare Cases Reviewed</th>
<th>127</th>
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<tbody>
<tr>
<td>Cases with APC changes</td>
<td>50</td>
</tr>
<tr>
<td>% Cases with APC Changes</td>
<td>39%</td>
</tr>
<tr>
<td>Total # APC Changes</td>
<td>90</td>
</tr>
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<td>Overpayment Impact</td>
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<tr>
<td>Underpayment Impact</td>
<td>$12,306.05</td>
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<tr>
<td>Net/ Case with Error APC $$</td>
<td>$193.48</td>
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<tr>
<td>Net/ Case APC $$$</td>
<td>$76.17</td>
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</table>

Breakdown by Case Type/Errors

<table>
<thead>
<tr>
<th>Case Type</th>
<th>Total Cases</th>
<th>Total with APC Errors</th>
<th>Underpayment</th>
<th>Overpayment</th>
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</thead>
<tbody>
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<td>Angiogram</td>
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<td>$2305.44</td>
<td>$406.78</td>
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<td>$51.24</td>
<td>0</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>11</td>
<td>5</td>
<td>$618.63</td>
<td>0</td>
</tr>
<tr>
<td>ER</td>
<td>33</td>
<td>14</td>
<td>$1109.37</td>
<td>$188.47</td>
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<tr>
<td>Radiation Tx</td>
<td>5</td>
<td>2</td>
<td>$131.06</td>
<td>0</td>
</tr>
<tr>
<td>Surgery</td>
<td>31</td>
<td>13</td>
<td>$4746.78</td>
<td>$538.55</td>
</tr>
<tr>
<td>Wound Care</td>
<td>2</td>
<td>1</td>
<td>$48.29</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>112</td>
<td>50</td>
<td>$12,306.05</td>
<td>$2631.70</td>
</tr>
</tbody>
</table>
**Errors by Error Type**

<table>
<thead>
<tr>
<th>Error Types (Each case may fall into more than one error type)</th>
<th>Total # Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>No changes</td>
<td>23</td>
</tr>
<tr>
<td>Coding Issue</td>
<td>71</td>
</tr>
<tr>
<td>Modifier Issue (missing or incorrect)</td>
<td>33</td>
</tr>
<tr>
<td>Information Systems Issue</td>
<td>20</td>
</tr>
<tr>
<td>OCE/CCI Edits</td>
<td>18</td>
</tr>
<tr>
<td>Billing Issue</td>
<td>46</td>
</tr>
<tr>
<td>Charge Master (generated) Issue</td>
<td>29</td>
</tr>
<tr>
<td>UB-04 Error</td>
<td>29</td>
</tr>
<tr>
<td>Other Issues</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65</strong></td>
</tr>
</tbody>
</table>

**Annualized Financial Opportunity (Forecast)**

**Formula:**

- Cases audited were comprised of actual paid Medicare accounts, and the APC underpayment amount does not include any self-pay portions
- 75,000 ER visits X 24% Medicare = 18,000 APC cases
- 300,000 Hospital OP visits X 22% Medicare = 66,000 APC cases
- Total Hospital Medicare APC cases = 84,000
- 84,000 cases X 39% (sample with APC errors) = 32,760 cases
- 32,760 cases X $76.17 (net/ case APC $$) = 2.5 Million Potential Lost APC Reimbursement
Audit Findings - Sample Audit

- Discrepancies in HIM assigned ICD-9-CM and CPT-4 codes were discovered in 30% of the charts reviewed.
- Discrepancies in Charge Description Master (CDM) CPT and HCPCS codes were discovered in 29% of the charts reviewed.
- Some inconsistency found as to whether the CDM or the HIM department will take the responsibility for the code assignment resulting in some duplicate coding and missed modifier assignment.
- Inconsistency in the assignment of the Evaluation and Management (E/M) codes in the Emergency Department and in the Outpatient Clinic areas.
- Documentation levels within the main hospital were very good, but some inconsistency within the outpatient clinic settings was discovered.

After the Audit

- Summarize the data in a user-friendly format that everyone can understand
- Share information across the facility-don’t just focus on the coding staff
- Submit all necessary adjusted bills
- Make all necessary changes in the CDM
- Update charging tickets, order entry screens
- Train ancillary clinical staff on all the changes
- Monitor a sample of bills prior to submission to ensure the “fixes” are in place
Revenue Cycle Process: Areas To Monitor

- How are charges generated & input?
- Who maintains and updates the CDM?
- Are the revenue codes accurate?
- Are the line item descriptions correct?
- Are the departments accurately assigning charges?
- Are the CPT codes and modifiers updated?
- Are there unbundling risks?
- Are CDM changes made timely?
**Patient Accounts**

- What are the Coding protocols?
- Modifiers
- Coding changes
- NCCI bundling edits
- Monitor denials
- Review the remittance advice
- Refunds and adjustments

**System Issues**

- How accurate is the transfer of data?
  - Demographic information obtained at registration
  - Ancillary department charging to the bill
  - HIM assigned codes
- Data dropping off the bill to scrubber?
- Data dropping off the bill to the FI?
- Are new billing fields created timely?
- Maintenance of Grouping software?
- Interface issues?
**Things to Consider**

- Types of services and frequency
  - What are your facility’s top 25 APCs?
- Charges billed and cost of services
  - Which APCs present the most financial risk?
  - Are you calculating resource use accurately?
- Reimbursement rates among other payers
  - How does it compare with APC payments?
- Forecasting the future
  - “Budget neutral”

**Revenue Capture: Critical Success Factors**

*Physicians*

- Change physician perception of revenue importance
- Physician Orders
- Site of Service

*Improve Clinical Documentation of Care Provider*

- Visit Level Criteria
- Procedures
**Revenue Capture: Critical Success Factors**

**Patient Registration**

- Accurate collection of billing information
  - Demographics
  - Eligibility/ COB
  - Coverage/ ABNS
  - Referrals
  - Reason for visit (ICD-9 codes)
  - Consistent registration process
  - Centralized vs. decentralized

**Revenue Capture: Critical Success Factors**

**Clinical Department Operations**

- Accurate charge master
  - CPT codes
  - UB-04 revenue codes

- Effective charge capture
  - Documentation of services
  - Charge ticket/ order entry
  - Education

- Strong charge reconciliation process
  - Lost charges
  - Late charges
  - Validation of charges
Revenue Capture: Critical Success Factors
Information Systems

Active involvement in revenue capture process
- Accountability
- Problem resolution

Revenue capture cycle data integrity
- Order entry/billing/decision support
- Cross systems/interfaces

Revenue Capture: Critical Success Factors
Business Office

Effective claims adjudication process
- Hands free billing
- Billing edits

Aggressive denials management
- Line item rejections
- NCCI edits
- Process improvement feedback
Revenue Capture: Critical Success Factors

Claims Review

- Analysis of:
  - Physician order
  - Test results
  - UB-04 claim
  - Itemized detail bill
  - Remittance/EOB
- Focuses on whether services are billed correctly
- Analyzes integrity of data through revenue capture cycle

CONCLUSION:

- Mastering change is the key element for success
- OPPS continually offer new challenges
- Adequate planning, maintenance, and updating will increase probability of success under OPPS

Thank You for your participation!
Resource/Reference List

- CMS Transmittals: R1664CP, R1739CP, R1746CP, R1752CP, R1756CP, R1760CP, R494OTN,
- Medicare Claims Processing Manual 100-04, chapters 1, 2, 4, 21, 23, 25.

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FY10 ICD-9-CM Diagnosis Code Updates
September 10, 2009

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