REVENUE CYCLE
CODING STRATEGIES



Reimbursement Review: Don’t Let Any Money Slip Away

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Agenda

- Key Elements of a Charge Capture Operational Review
- Key Measurements & Metrics
- Implementing Change within an Organization
- Your Stories & Q&A



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What is Our Goal Today?

Walk away with a check list for your charge capture review to ensure things are as you think they are…or how you can improve them…

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Why Review?

- Identifies positive and negative areas of risk and opportunities for improvement
- Things may not be as they seem or how you intend them to be…

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Audits/Reviews

- Charge Capture Audit
  - Did we *charge* all the services?

- Compliance Audit
  - Did we *document* the services charged?

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Why are Charges Missed?

- Hospitals may have missed charges because:
  - –Lack of good systems for reconciliation
  - –Lack of training for individuals responsible for charge capture
  - –Incorrect mapping between RIS and CDM
  - –Lack of resources (personnel and systems)
  - –Lack of focus by administration

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Why Should We Care?

- $$$$$$$
  - –Buy equipment
  - –Justify staffing levels (if charges used for FTE calculation)
  - –Demonstrate profitability for the organization
  - –Payers match with physician charges (as appropriate)

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Why Aren't the Codes the Same?

- Hospital and radiologist codes have frequently differed because of:
  - –Differing coding processes
  - –Differing payment mechanisms
  - –Historically poor accuracy of hospital coding
  - –Legitimate exceptions

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Coding & Payment Mechanisms

- Traditionally, hospital and radiologist have used different processes for assigning procedure codes

- Payment mechanisms are also different

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Hospital Charge Process

- HCPCS codes are still in most cases generated by the chargemaster, with charge codes selected by the Technologist
  - –Does Tech select from CDM or RIS system?

- In most cases, the procedure codes are still not checked against the dictated report

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Hospital Charge Process

- There are no clear or significant financial consequences from incorrect HCPCS procedure coding on inpatient cases
  - Payment for these cases is driven by ICD-10-PCS codes (assigned in Health Information/Coding)

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Hospital Charge Process

- For outpatient cases, HCPCS codes drive the Medicare reimbursement, and outpatient coding accuracy receives more attention than previously; however—

- Many services (e.g., cath placement codes) are packaged (not separately payable)
  - –No strong/clear financial incentive to assign packaged codes correctly

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Radiologist

- Code assignment is typically a much simpler process
- Typical coding mechanisms include:
  - Manual (a coder reviews the report and assigns diagnosis and procedure codes)
  - Natural language processing (report is analyzed by computer and codes are assigned based on documentation)
  - Charge interface (charge data from the hospital are uploaded to the radiologist's billing system)

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Radiologist

- In most cases, the radiologist's code selection is based on the documentation
  - –If a service was done but not documented, it will not be coded
  - –On the hospital side, typically if the service was done, it will be charged, regardless of whether it's documented

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Hospital Coding Accuracy

- Historically, hospitals have had difficulty maintaining a high rate of accuracy in procedure code reporting

- The complexity of the charge process is a major barrier
  - –Multiple computer systems
  - –Multiple departments and personnel
  - –Poor feedback processes

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Acceptable Differences

- In some instances it is appropriate for the hospital and radiologist to submit different codes

- However, these typically account for only a very small % of hospital outpatient radiology claims

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Hospital vs. Physician Coding

- ✓Hospital and physician charges frequently do not match for radiology charges..
- ✓Which is correct?
- ✓Could be neither one!



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Payer Billing Guidelines

- In some instances the payer will instruct the two parties to report different codes
  - –payer instructions should be followed
- Examples:
  - –MRA w/ contrast, abdomen
    - Hospital: C8900
    - Radiologist: 74185
  - –Breast MRI
    - Hospital: Separate code for CAD, C codes for w/contrast only studies
    - Radiologist: Bundled codes

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Payer Billing Guidelines

- DRG window
  - –Hospitals are required by CMS to include charges for exams performed within 3 days of an inpatient admission on the inpatient bill
  - –The radiologist bills the PC of these exams as a hospital outpatient service

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Fluoroscopy

- The radiologist should not charge for fluoro unless he or she personally provided the service

- The hospital charges for the facility service (76000) regardless of the radiologist's involvement (if not bundled into another code)

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Other Non-Radiologist Services

- Interventional procedures may be performed jointly by a radiologist and another physician
  - –Example: Endovascular repair of AAA performed by radiologist and vascular surgeon

- Each physician reports the components he/she performed

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Professional-Only Services

- A few services are professional-only (charged only by the radiologist, not the hospital)
- Example:
  - –76140 Radiology consultation



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Technical Services

- Some services are charged only by the hospital, not the radiologist
- Examples:
  - –76000 Fluoroscopy



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What's the Extent of the Problem?

- Comparative claims studies have been very difficult because hospital and physician claims historically were processed by different Medicare contractors using different information systems
  - –These systems didn't "talk to" each other
  - –But then came the MACs

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Why is Consistency and Accuracy Important?

- Incorrect (or no) payment
- Claims reviews
- Audit risk



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Incorrect Payment

- In most cases, if the hospital's codes are not the same as the radiologist's codes, one party's codes are wrong
- Incorrect coding means incorrect payment and incorrect charges to the patient
  - –Lost revenue (underpayment) vs. compliance risk (overpayment)

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Claims Review

- Discrepancies between hospital and radiologist claims can lead to claims review for either or both parties
  - –Example: Radiologist reports different procedure code than hospital; third party payer requests copy of record from one or both parties
  - –This delays payment and increases costs

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Audit Risk

- The more frequent and drastic the discrepancies, the higher the risk of audit by Medicare or other payers

- This can result in inconvenience at best or financial penalties at worst

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Conduct a Review

- The organization can benefit from taking steps to evaluate the extent of potential problems with charge capture and accuracy
- Steps to take:
  - Initiate a dialogue
  - Evaluate the extent of the problem
  - Identify the causes
  - Develop an action plan
  - Implement ongoing monitoring

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Initiate a Dialogue

- Discuss goals with all involved parties
  - –Technologists
  - –Administration
  - –Finance
  - –Coders (HIM)
- Emphasize the potential benefits to all involved parties as well as to the patient

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Evaluate the Extent of the Problem

- Determine the best approach to evaluating the charge capture process
  - –Interventional vs. diagnostic services
  - –CT, MR, Nuclear Medicine/PET, Ultrasound, Other
- Is there an easy way to compare performed exams against captured charges?
  - –RIS?
- If not, how can you get that data?

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What is Your Process?

- At what point in the process is the procedure code selected? Before, During or After?
- Who is responsible for selecting the charge?
- What information is utilized for code selection?
  - Physician Charge Sheet?
  - Technologist? Info in RIS, CDM?
  - Coder?

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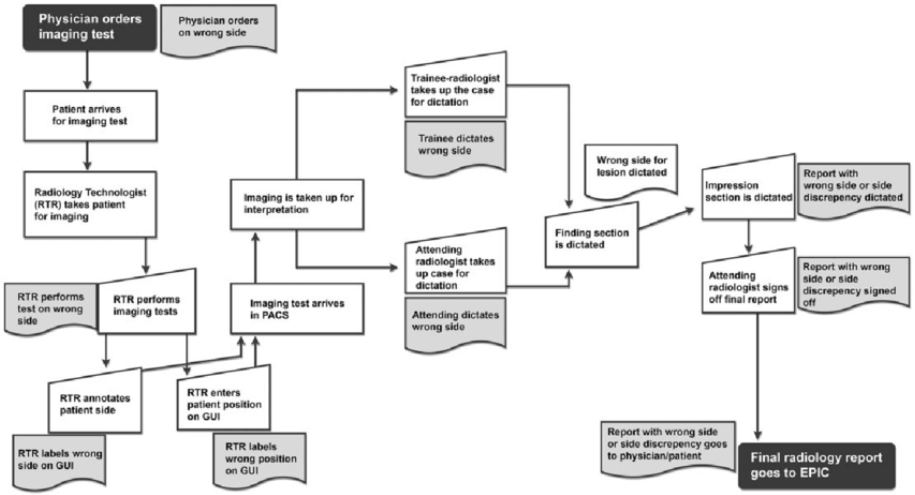
Document

- Document your process
  - Who does what?
  - What information do they use?
  - How specifically captures the charges?
    - Are you sure – what about the systems?
  - What about edits?
    - Who works those?
    - Do you get feedback?

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Document

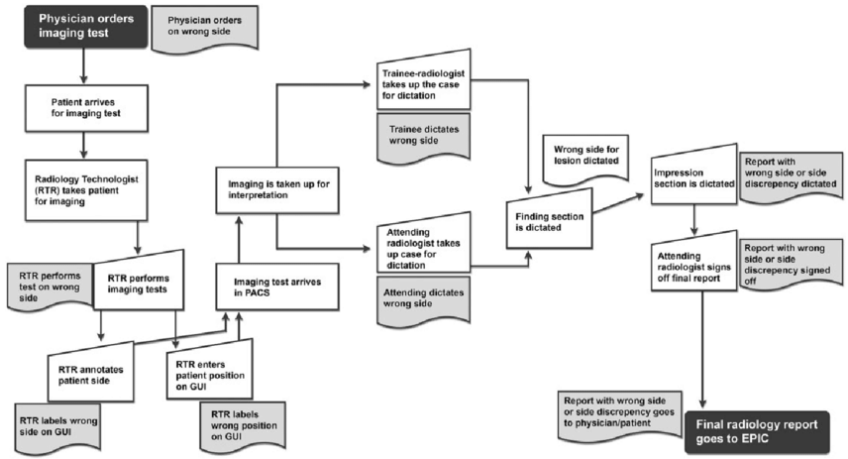
- Document your process
  - Who does what?
    - Technologist role
    - Other department staff
    - Finance: “Edit department”
    - HIM staff involved?
      - Interventions
      - Diagnostic services



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Document

- Document your process
  - What information do they use?
    - Scheduling?
    - Actual exam performed?
    - Dictated report?
    - Information from RIS?



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Document

- Document your process
  - How specifically captures the charges?
    - Are you sure – what about the systems?
    - Who updates RIS and links to CDM?
    - Directly in CDM or RIS?
    - Error reports between RIS and CDM?

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Document

- Document your process
  - What about edits?
    - Who works those? Department or Finance
    - Do you get feedback? When? How?
    - Modifiers

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Verify

- Verify that everyone has the same understanding that you do..
- Identify the exceptions
  - “Except Medicaid”
  - “Except for Dr. X”
  - “Except on Tuesdays when Mary is not in….”

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Now Start the Analysis

- Validate the process
  - Do a walk-through for a patient
  - Did the system work correctly?
  - Did all the charges get *correctly* captured?

- Time to move to a bigger analysis

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Evaluate the Extent of the Problem

- Potential methodologies:
  - Evaluate aggregate charge data
    - Compare RIS data to Revenue/Usage (Charge Data)
    - Add physician component if also a goal
  - Compare individual charges
    - Take one week's worth of procedures and compare

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Aggregate Data

- Compare CPT utilization over a one- to three-month period
  - –What is in the RIS system versus what was charged?
  - –Is it close?
    - It will never be exact but should be close enough for comfort.

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Aggregate Data

- If evaluating hospital versus physician…
  - How many times did each party charge each procedure code?
  - Are there differences in code distribution and utilization—for example:
    - Some codes are used frequently by one provider but not by the other
    - One provider is charging for significantly more or fewer exams than the other

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Aggregate Data

- Comparison between facility and physician is made more difficult by the factors discussed previously
  - –Different codes, different payer guidelines, etc.



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Compare Individual Charges

- Compare all charges for a given date or dates of service
  - –Are charges in the system for the performed procedures?
  - –Have the reports for these exams evaluated by technologists (and coders?) to determine:
    - What exam was performed
    - What exam is documented in the report
    - What exam should have been billed

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Compare Individual Charges

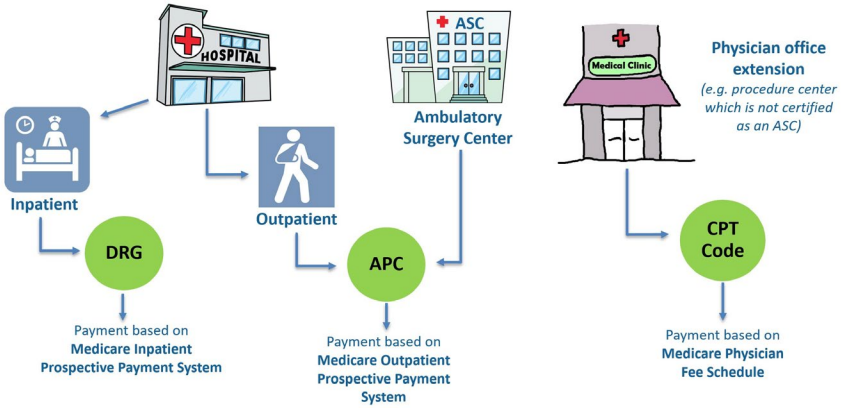
- If comparing hospital and physician
  -
    - Identify services that were charged differently by the two parties
    - Does any data seem out of place?



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Data Elements

- Procedure Codes
  - Physician – all codes
  - Hospital
    - Procedure codes only
    - Specific revenue codes
    - Devices and supplies
      - Device edits



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Data Elements

- Diagnosis Codes
  - Physician – accuracy and linking
  - Hospital – may or may not include



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Data Elements

- Provider Identification
  - NPI/PIN
  - Correct physician billed?
  - Incorrect use of extenders/non-physician practitioners?



Data Elements

- Date of Service
  - Accuracy
  - Bundling issues
- Place of Service
  - Block 24B of CMS1500



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Source Documents

- Physician's Dictated Report
  - Primary source of information for audit
- Other portions of the medical record
  - H&P
  - Progress notes
  - Sedation record

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Source Documents

- Claim Information
  - Access billing system or print a demand copy of the claim information
  - Need all claim data, not just procedure codes or info from RIS
    - Itemized bill for hospital services (procedure code listed?)

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Data Collection Tools

- Recommend that spreadsheet be created.
  - Customize format according to the type of provider that is being audited and the specific data elements that are to be captured.

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Data Collection Tools

- Patient ID
- Revenue code (hospital only)
- Billed procedure codes
- Charges
- Recommended procedure codes
- Charges (for rec'd code)
- Variance
- Type of variance

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Categorizing Errors

- Charge/Payment Impact
- Coder or Physician or Hospital
- Location of Service
- Revenue Code



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Charge/Payment Impact

- Undercoded
  - Lower reimbursement
  - Lower charge

  Example: Stent placed but only angiogram billed

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Charge/Payment Impact

- Overcoded
  - Higher reimbursement
  - Higher charge

  Example: Biliary stent placement coded but only cholangiogram documented.

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Charge/Payment Impact

- Other errors
  - Nonpayable services
  - Modifiers
- Identifies opportunities for improved reimbursement or potential refund obligations.

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Coder or Physician or Hospital

- What are you evaluating?
- Categorize errors by physician if they assign or you want to evaluate documentation
- Categorize by Physician or Hospital if trying to determine accuracy

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Analysis

- For areas of concern/errors
  - –Can you identify HOW it happened?
  - –Finding errors is easy… identifying how they happened is the real challenge!

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Classify Areas of Concern

- Chargemaster issues
- Charge process
- Physician documentation
- Lack of Staff training



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Chargemaster Concerns

- Errors?
  - Get them corrected ASAP
  - Not sure? – get assistance

- Who *owns* the CDM for radiology?

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Chargemaster Concerns

- –Compare CDM to RIS
- –In Excel map corresponding field
  - •Where are there gaps?
  - •Is every service reflected?
  - •Are there coding errors?
  - •What about duplicate entries?
- –Review with Lead from each section



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Charge Process Concerns

- What kind of error is it?
  - People
  - IT
- How can it be fixed
- If it can't – change the process to accommodate

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Physician Documentation

- Meet with physician stakeholders

- Determine how to best address
  - Physician education
  - Feedback to individual physicians

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Staff Training

–Who needs to be trained?

–What information do they need?

–How will you measure comprehension?

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Implement Ongoing Monitoring

- Perform small-scale comparative studies on a regular basis (semiannually or annually)

- Keep all informed of identified errors and action items

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Now…
How do we set up an ongoing charge capture process to ensure all charges are captured?

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Key Steps

Select a responsible individual (aka Champion!)



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Skill Set

- ✓Possess the qualifications and experience necessary to perform the ongoing assessments/audits
  - ✓Understand your processes and how they should work
  - ✓Substantial knowledge of IR & Diagnostic Coding Guidelines and Principles
  - ✓Current and up-to-date

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Skill Set

- ✓Credible with staff and physicians
  - ✓Competent and objective
  - ✓Lack of this may create conflict and delay corrective action.



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Skill Set

- ✓Access to resources
  - ✓RIS system(s)
  - ✓Medical records
  - ✓Bills and claims
  - ✓Current coding references
  - ✓payer policies



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Skill Set

- ✓Analytical skills to categorize audit findings in a meaningful way.
- ✓Determine the probable root cause of systemic errors.
  - ✓Documentation?
  - ✓Lack of training?
  - ✓System error?
  - ✓System limitations?

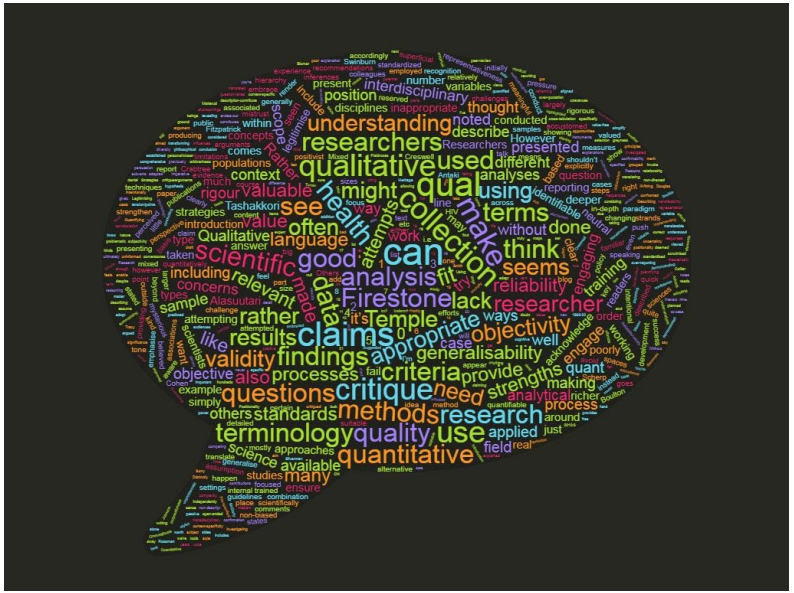
Skill Set

- ✓Ability to write reports (if needed)
- ✓Ability to present findings to physicians and/or administrators
  - ✓Group
  - ✓One-on-one
- ✓Comfortable with everyone!

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Quantifying the Results

- Error rates
- Financial impact
- Charge impact analysis
- Payment impact analysis
- RVU impact analysis



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Error Rates

- Expressed as a %
- For example, 12% error rate indicates that 12 out of every 100 services were captured incorrectly.
- To calculate you need the total number of errors and the total number of services billed.

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Error Rates

- The numerator (Errors) is divided by the denominator (sample size) to get the error rate.
- For example 10 errors in a sample of 90 services yields an error rate of 10/90 = 11%

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Error Rates

- Auditors sometimes use the number of encounters as the denominator.
- There are so many radiology codes that number of procedures is more meaningful.
- 50 cases with 257 procedure codes
  - 32 codes are incorrect – 32/257=12%

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Error Rates

- Categorize errors as undercoded or overcoded
- You need to determine how to deal with modifiers
  - Who is responsible?
  - Be realistic in counting

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Financial Impact

- What is the bottom line of the audit?
  - Charges
  - Payment
  - RVU

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Charge Impact

- Calculates the difference between the charges submitted on the claim and the charges that would have been submitted if the correct code had been assigned.

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Charge Impact

- Example
  - Report supports catheterization of the SFA (36247) but only 36245 was reported on the physician claim. Physician charge for 36245 is $735 but the charge for 36247 is $840. Therefore, the charge impact for this error is -$105.

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Payment Impact

- Calculate the difference between the payment that was received and the payment that would have been received if the correct code had been submitted.

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Payment Impact

- Example
  - Report supports catheterization of the SFA (36247) but only 36245 was reported on the hospital claim. This error has no financial impact since Medicare unconditionally packaged.

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Payment Impact

- Example
  - Similar scenario on physician side. If Medicare payment for 36245 is $243 but payment for 36247 is $286, the estimated payment impact for this error is -$43.

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RVU Impact Analysis

- Sometimes used for audits of group practices and freestanding facilities
- Calculate variances in RVU for audited procedures
- Helpful if physicians are using RVUs for productivity.

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RVU Impact

- Example
  - Under reporting of catheterization codes. RVU for 36215 is 6.69 but 36216 has 7.52 RVUs. Therefore, the RVU impact for this error is -0.83.

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Error Rate

- It is best to determine before the audit is started how you will calculate errors rates.

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What are the challenges at your facility?

Questions?
Comments?

Speaker Contact Information

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