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Financial Best Practice Emergency Services Revenue Cycle

A Vitalware Webinar

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Presented By

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Agenda

- Review of the ED Revenue Cycle
- Discuss key elements of each phase of the Revenue Cycle
- Discuss the importance of charge capture routines
- Use of automated charge capture and post bill (837) routines
- Facility to Provider comparisons to identify charge leakage

Objectives

- Failure or success begins with first patient presentation
- Documentation can make or break charge capture
- Understand the difference between physician and facility charging requirements
- Create an internal audit process for root cause remediation

Importance of ED Revenue Cycle in Revenue Integrity

Two sources of true income for an institution

- Planned
  - Elective Procedures
  - Diagnostics
  - Therapeutics
- Unplanned / Episodic
  - Emergency Services
  - Non-elective procedures

ED constitutes the singular gateway to unplanned services for the facility and therefore a significant revenue risk

Polling Question #1

In your facility, which entity is responsible training and compliance with EMTALA?

- Compliance Officer / Committee
- Privacy Officer
- Medical Staff
- Nursing Staff
- Other

EMTALA

Big difference between planned services is the overarching requirements of EMTALA

- *https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/*
- CMS states:
  - "In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented."
    - [https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA]

EMTALA

Medical screening may not be delayed to enquire as to the patient financial status or insurance coverage

- Registration generally occurs in two phases
  - ”Short Registration” – just enough information to ensure an Medical Record can be created and orders performed
    - Generally, name, date of birth, address
  - Second phase or “full registration” to include insurance coverage, eligibility, guarantor and subscriber information
    - Generally performed bedside at the end of the encounter

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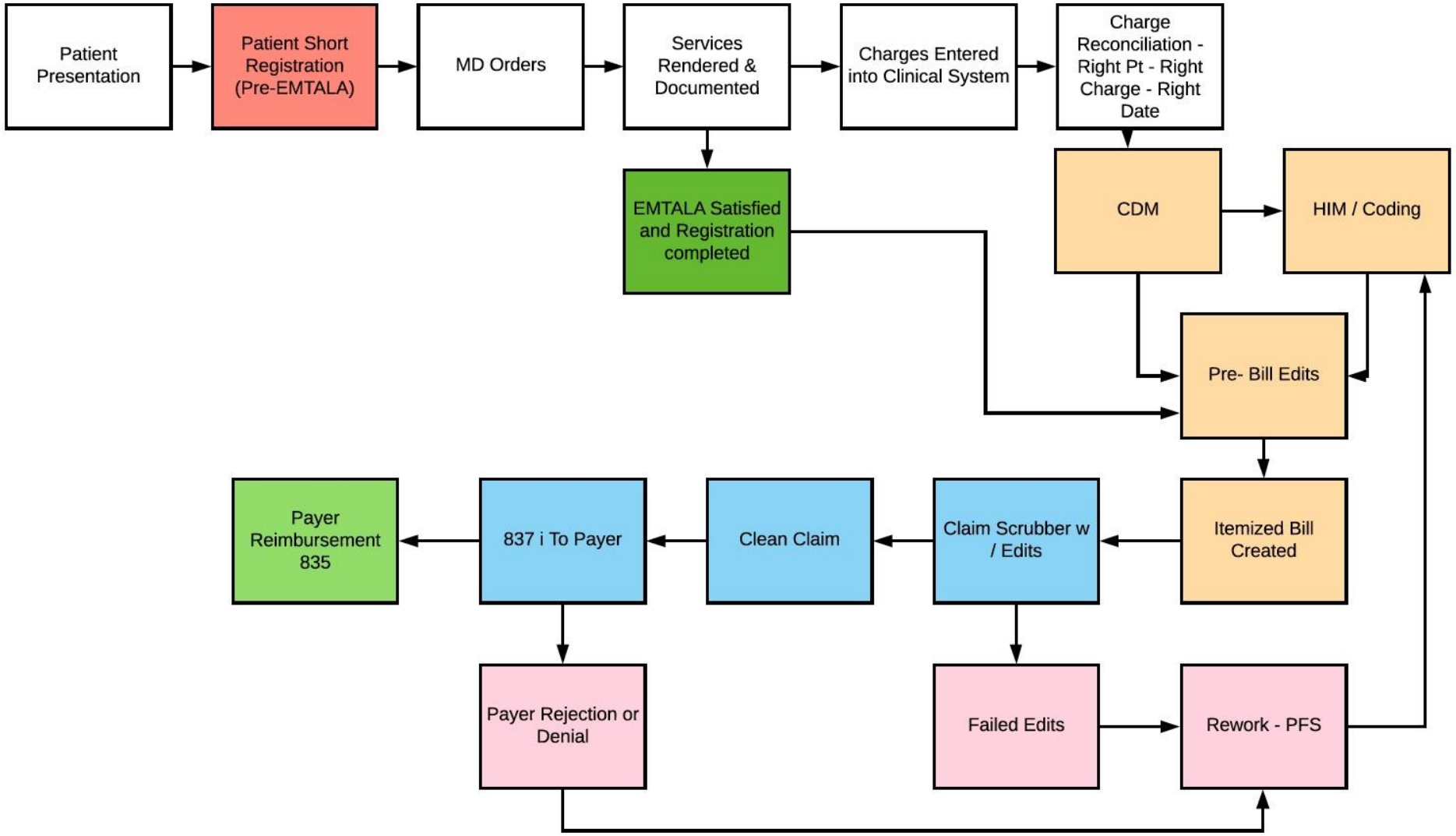
Revenue Cycle Phases and Key Takeaways

Overview of ED Revenue Cycle



Review the Revenue Cycle

ED Revenue Cycle Phases:

- Data Acquisition & EMTALA Requirements
  - Registration – Short Reg until EMTALA completed
- Clinical Provision of Care
  - Post EMTALA
    - Acquisition of Demographics – subscriber, guarantor
    - Authorisation
    - EMTALA – no requirement for medical necessity review until stable
- Charge Capture
  - Charge entry
  - Charge Reconciliation
  - CDM – softcoding (HIM) and hardcoding (CDM)

Review the Revenue Cycle

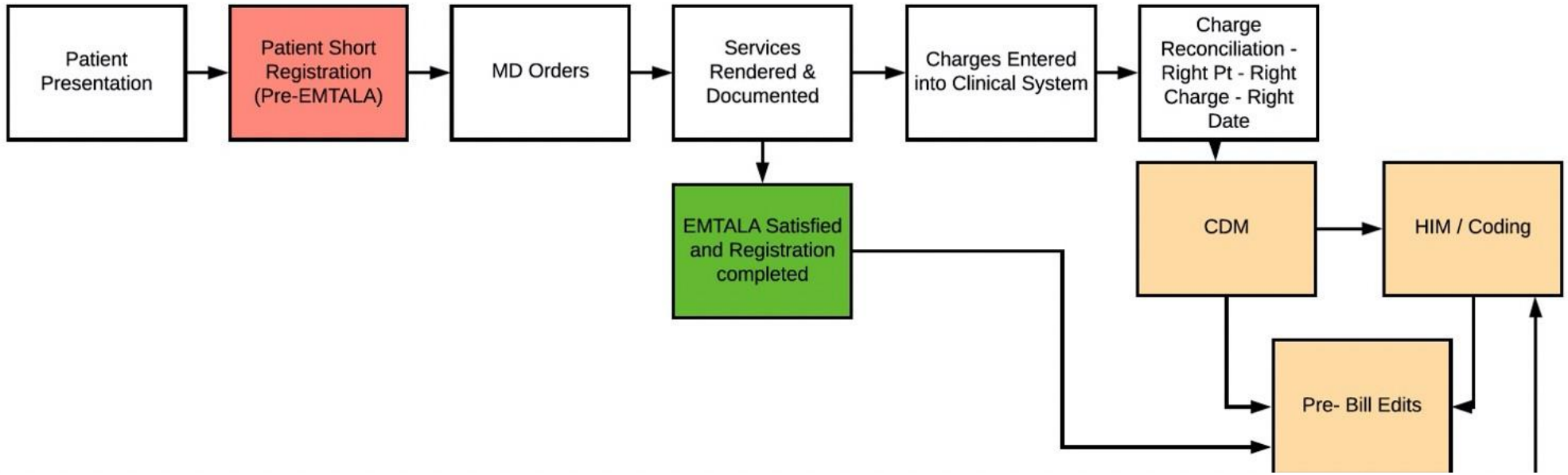
ED Revenue Cycle Phases:

- Billing
  - Pre Bill Edits
  - Itemized Claims
    - Pre-Bill Automated Reviews
  - Bill Scrubber
  - Creation of 837
    - Post-Bill Automated Reviews
  - Submission of Clean Claim to Payer
  - Payer rejection – back to provider
- Reimbursement
  - Payer acceptance
  - Ensure appropriate payment (review for under/overpayment)

Key Processes

- Complete and accurate documentation
- Complete and accurate charge capture
- Comprehensive (manual / automated) pre-bill review (itemized claims)
- High clean claim rate through bill scrubber
- Timely claim submission
- Timely reimbursement that is accurate (no overpayment / underpayments)

Charge Capture / Documentation



Polling Question # 2

In your facility the facility Evaluation & Management (Visit) is:

- Derived through an automatic points calculator in the system based on documentation
- Derived through chart review by coding or charge entry personnel
- Nursing enters the E & M level
- Other

Clinical Care & Documentation

Documentation of services / items provided is key:

1. Evaluation and Management Services
2. Surgical / Medical Procedures
3. Supplies
4. Medications

These 4 categories represent the categories for charge capture for the purpose of reimbursement

Clinical Care & Documentation

- **MSE must be completed and documented in the record**
- **Experiencing more "documentation driven" charge capture in the ED especially in Nursing**
  - Some systems will "calculate points" to determine the E & M based on the documentation of services rendered
- **Medication Administration Record (MAR) can drive charges for medications**
  - Some systems will include the "administration" charge as well once documented

Clinical Care & Documentation

Evaluation and Management: Key Differentiator

- Physicians will use E & M guidelines from:
  - CPT guidance
  - CMS (1995 or 1997 guidelines)
- Facility will use CMS and/or other payer guidance
  - CMS provides 11 points that should be met to determine the level
  - Guidance is provided in 2008 OPPS Final Rule
  - Humana – *different criteria than CMS*
    - https://dctm.humana.com/Mentor/Web/v.aspx?chronicleID=090009298276f34d&searchID=caf698cb-a59a-4c8c-9ee4-045a5c7fcf67&dl=1

2008 OPPS 11 Points – Facility E & M

1. The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code
2. The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources
3. The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits
4. The coding guidelines should meet the HIPAA requirements
5. The coding guidelines should only require documentation that is clinically necessary for patient care
6. The coding guidelines should not facilitate upcoding or gaming
7. The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.
8. The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
9. The coding guidelines should not change with great frequency.
10. The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
11. The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

Point System, Dx or Proprietary E & M

- **E & M must be assigned based on the 11 points or payor guidelines for facility**
- **Some caution should be applied with automated E & M calculators within the system:**
  - Does your facility have control over the calculations?
  - Can your facility adopt them to meet changing needs?
  - Is the system consistently making Level 4 and 5 the choice creating a potential for outside audit?
  - Internal audit of the calculations should be routinely performed against the documentation?

E & M

99281 – 99285

- Must follow 11 points or other proprietary guidelines of a payor
- CMS is concerned that there is a shift moving from Level 3 (99283) toward Level 4 – 5
- PEPPER report tracks Level 5 charges for outliers which is one of only a few outpatient categories
- Must be audited randomly to determine if the level assigned is supported in documentation
- Audit immediately after system upgrades that can affect documentation driven E & M levels.

Trauma Activation

- "In summary, revenue code series 68x can be used only by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons.
- Different subcategory revenue codes are reported by designated Level 1–4 hospital trauma centers.
- Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response can be billed a trauma activation charge."

Trauma Activation for Medicare

Has to meet the criteria based on CMS guidelines

- Trauma Activation with Critical Care – G0390
  - Needs to be at least 31 minutes of FACILITY based critical care
  - Not necessarily based on physician timing but includes time of face-to-face nursing and ancillary care.
  - Must use revenue code 068x
    - X= level of trauma certification from Amer. College of Surgeons
    - Ex. Level 1 trauma center = 0681.
    - Charges must reflect resources the facility consumed
- Trauma Activation without Critical Care
  - No HCPCS code
  - Apply a charge to the uncoded line item
  - Also charge the E & M level achieved with revenue code 0450

Trauma Activation for Other Payors

- **Many payors follow most of Medicare activation requirements.**
- **Patient must be registered as Trauma (FL 14) = 5**
- **One consistent non-Medicare requirement is:**
  - Requirement that **one** of the following be documented
    - Confirmed systolic blood pressure of <90mmHg in adults and age-specific hypotension in children
    - Respiratory compromise, obstruction or intubation
    - Use of blood products to maintain vital signs in patients transferred from other hospitals
    - Discretion of the emergency physician
    - Gunshot wounds to abdomen, neck or chest
    - Glasgow Coma Score less than 8 with mechanism attributed to trauma

Surgical and Medical Procedures

Concerns:

- There is no documentation driven charging
- Nursing fails to document procedures performed by physicians
- Lacerations – failure to document lengths, locations
- Templates within EMR are difficult to use and leave room for erroneous or incomplete documentation
- No designated procedure forms that will ensure capturing data required and coding professionals miss documentation in the volume of notes
- These represent reimbursement that is often higher than the visit level itself

Surgical Procedures (10,xxx-69,xxx)

Some of the ED most common Surgical Procedures include:

- Intubation – Emergent
- Laceration repairs – documentation of location, depth and length required
- Foreign Body Removal
- Anterior / Posterior Nasal Packing
- Gastric evacuation / Blakemore
- Casting and Splinting
- Chest Tube Insertions
- Intraosseous Line Insertion
- Central Line Insertion
- Incision and Drainage
- Live Birth
- Foley
- Lumbar Punctures
- Fracture manipulation / reduction

Surgical Documentation

System documentation:

- Many facilities create documentation templates for:
  - Cardiac Arrest / Code
  - Trauma Activation
  - Live Birth
  - Line Insertion
  - Pleural Tap / Chest Tube
  - Fracture Care

Medical Procedures (90,xxx)

Some of the ED most common Medical Procedures include:

- Infusions and Injections
  - Importance of documenting the site, start and stop time for infusions
- EKG
  - 12 lead
  - 3 lead rhythm strip
- Respiratory treatments / aerosols provided by Respiratory Therapy
- Pulse Oximetry
- Cardioversion
- CPR
- Temporary Transcutaneous Pacing
- Echocardiography – transthoracic
- Moderate Sedation

Supplies

- **Supplies are one category that charges are lost or late**
- **While this category does not represent significant reimbursement it does add to the cost of performing the service. As a result this does come into play with cost reports and future rate setting**
- **Usual culprit is an incorrect CDM or supply labelling process such that the charge entry person can make a mistake**
  - Bar codes are preferred as they are scanned accurately into the system
  - Also “preference card” charging could become inaccurate if the “supply link” is not accurate allowing for the wrong supply to be charged

Supplies

- **Supplies in the ED can be costly, voluminous and frequently come under the domain of supply chain**
- **Charge capture failures with supplies can be found in daily inventory**
  - Stocked = charged + remaining on shelf
  - If the supply consistently does not reconcile root cause should be determined
    - Is the supply linked incorrectly so that when it is charged it charges something else
    - Is there a failure to charge it in the first place
    - Determine the cause of the stock aberrancy and remediate

Pharmaceuticals

- **These are generally under the control of Pharmacy**
- **Pharmacy will review the medical order and ensure that the correct dosage is delivered (personally or by Pyxis)**
- **The errors in charge capture occur in the math !**
- **Billing units are seldom the same as dispensed units**
- **Failure to link from Pharmacy module to the MAR and then to the billing system where billing units are determined**
  - Frequent offender – Ondansetron 4mg vial = 4 units but frequently billed as 2 units (2mg/cc)

Pharmaceuticals

Charge capture depends upon the method of dispensing

- Directly from Pharmacy will likely be charged at time documentation of administration occurs in the MAR
- From the Pyxis could be charged either at time of removal from the Pyxis or at the time of medication documentation in the MAR.

Orders Matter

- **One of the key areas of charge capture failure is due to nursing providing a therapy but the physician failing to order what was verbally requested**
- **Medication errors used to occur due to "verbal" communication between nursing and physicians**
  - Now most MAR require the drug to be bar coded and the patient, the nurse, the drug must be scanned at time of delivery and must match the order
- **Another area of charge loss is the failure to order an orthotic only "apply splint to forearm" – needs more specificity**

Charge Capture

- **Difficulty arises when charge capture is more of a manual and not data / documentation driven process**
  - Nursing and Medicine become key to the documentation
  - Frequently “physician coders” and charge entry staff in the ED will enter the charges
    - Rarely are “charge slips” still in play except downtime procedures
  - Manual charge capture requires that there is charge reconciliation at the end of the shift / day
    - Make sure charges are correct and on the correct patient and account

Polling Question # 3

In your facility who is responsible for daily charge reconciliation and/or charge capture?

- The Department entering the charges
- A specific group of charge entry analysts
- The Patient Financial Services area (Business Office)
- IT
- Other

Charge Categories

- **These can be charged by the system, coding professional or charge entry staff**
- **These procedures can be:**
  - Hardcoded – when the charge is placed the CPT code is provided by the CDM as well as the patient charge
    - Evaluation & Management
    - Supplies
    - Medications
    - Medical Procedures (90xxx CPT series)
  - Softcoded – when the charge is placed only the patient charge is assessed. HIM coding professional would be required to place the CPT code on the charge line
    - Surgical Procedures

Coming in the House

Decision to discharge or bring into the facility is an important opportunity to ensure compliance is achieved

- If coming in the facility under “observation” status the MOON must be presented for Medicare patients
- For non-Medicare / commercial payor there is generally a requirement to provide notification within 24 hours – care management will need to be involved
- For patients discharged to home this is the opportunity to arrange for home health or physician follow up

Each of these decisions come with requisite requirements to ensure compliance and ensure reimbursement

Patient Discharge a Key Lost Leader

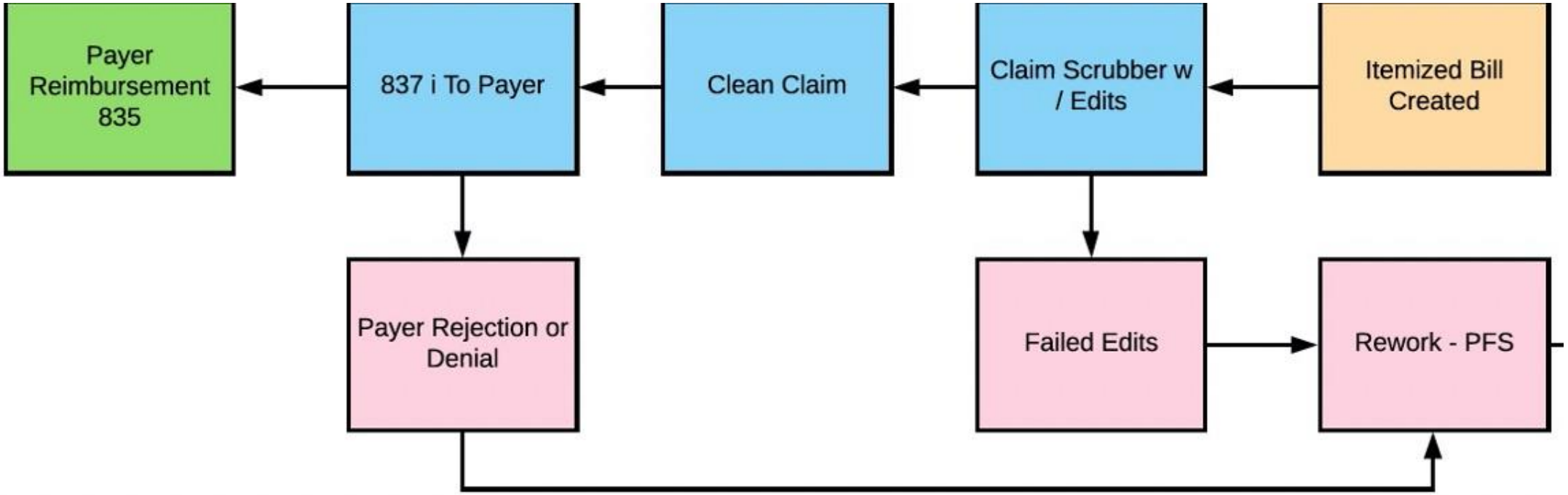
Full and complete registration must be completed prior to discharge

- Bedside is the standard of practice

Copayment / Deductibles can be collected at the time of discharge

- Failure to understand patient insurance can lead to failed co-payment collection
- This is benchmark practice at most facilities to capture earned revenue early in the cycle

Phase II Billing



Phase II Billing

- **Itemized bill has been created and will go through a series of "internal claim edits" doing first pass review**
- **The 837i will be created and sent to the "claim scrubber"**
  - Can be an internal scrubber
  - Can be an clearinghouse scrubber
- **If the 837i passes these two scrubs then the claim is sent to the a payor as a "clean claim"**
  - Goal is a clean claim rate of 98% or greater
- **Claim is then adjudicated by the payor**

Phase II Billing Failures

- **If the itemized claim fails the first set of internal claim edits or second set of scrubber edits it will require remediation**
  - If there is a pattern of failure then a “root cause” will be required
- **Post adjudication 837i software may be used for the detection of “patterns of behaviour for lost charges”**
  - Again rules based are the benchmark review for lost charges
    - There is a “trigger” such as a supply that looks for a “target” such as a procedure
    - Other trigger to target may include a procedure that requires an implant but no implant is on the 837i

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Fighting Charge Leakage

Causes of Charge Leakage

These are key areas of charge leakage:

- Late charges
- Charges not documented completely
- Documentation without a charge
- Failed Processes / Procedures
  - Incomplete education and auditing
- Systems Issues – EMR, Mapping, CDM
- Staff (the human component) – especially floats, per diem and casual staff
- Any combination of the above

Net Income Opportunity

- **HFMA and others have put lost charges at 1–5% of total charges**
- **While Medicare may not reimburse separately most facilities still have a percent of charge payor mix that cannot be ignored**
  - Example – Prosthetic and Orthotic ("L" Codes) for splints, air splint, knee immobilizer all of which are Status Indicator "A"
    - Not payable under OPPS but possibly under another fee schedule
    - For percent of charge payors having the charge on the claim will generate revenue
    - Note: Don't forget "splinting and casting" CPT codes here as well as they are frequently confuse with Prosthetics

Pre-Bill Edits – The Safety Net to Lost Revenue

- **Depending on the system there may or may not be a mechanism to set up "pre-bill edits"**
  - EPIC uses Revenue Guardian™
    - Series of facility generated and maintained rules
- **There are proprietary systems that use itemized bills to perform rule checks**
  - These systems have hundred of thousands of rules even millions that check combination of codes on the claim
  - For example: Supply of Endotracheal Tube is charged but there is not a CPT 31500 (Endotracheal Intubation) on the claim resulting in a lost charge for the procedure

Pre-Bill Edits – The Safety Net to Lost Revenue

Many systems use a pre-bill scrub of charges or software to:

- Identify lost charges
- Identify overcharges / excessive units
- Identify units of service that are below threshold or exceed an MUE
- Identify inaccurate supply to procedure combinations
- Identify medications charged with units less than clinically expected
- Duplicate charge identification

Goal: To ensure all charges are present for the documented service with the correct quantity and therefore clean to move into the billing cycle

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“A Day in the Life of Revenue Integrity”

Charge Capture Professional

- **Responsible for isolating and correcting missing, inaccurate and overcharges.**
- **This team may work in facility system and a additional proprietary system**
- **The differences between internal and external generally is the method of review of the itemized and 837i as well as the volume of edits and maintenance of the edits**

Day in the Life

- **Daily the professional will get either:**
  - Itemized Workque (Pre-Bill)
  - Post Bill Workque (837i)
- **These workque(s) are designed to evaluate the charges by a method best suited to review the charges based on the skill of the analyst**
  - Government versus Non-Government
  - Service Line (i.e. ED, Surgery, Radiology, Lab etc…)
  - High Dollar Claims
- **Generally service line expertise drives the review of the ED charges**

Setting up the WQ

- **Generally workque(s)are designed through "case routing" mechanisms**
- **The case routing takes a specific characteristic (payor, service line, dollar charges) and routes "like and kind" to a specific workque or a specific professional**
- **Key to case routing is that it is dynamic and can be changed based on situations:**
  - Ex: PTO / Holiday coverage / Staffing changes

Day in the Life

- **ED charge capture specialist will use “rules” or combinations of edits to analyse the 4 components:**
  - Evaluation & Management;
  - Surgical & Medical Procedures;
  - Supplies and
  - Pharmaceuticals
- **The method of review will consist of a rule identifying a “potential” charge aberrancy**
  - Missing Charge
  - Charges that “do not make sense” together
  - Duplicate charges or charge units that consistent with the supply or pharmaceutical

Day in the Life

Example:

- Level 5 E & M without any additional charges like radiology, lab or procedures
- Zofran billing units =10,000
- Laceration tray (supply) charge without laceration repair
- Trauma 05 in FL 14 without 068x revenue code charge
- Multiple E & M on same day of service
- IV / IM / SQ drug without administration charge
- Toxoid administration without toxin
- Endotracheal tube without intubation charge
- Thousands of different combinations to review

Day in the Life

Chart Review:

- The charge will be identified by the software
- Professional will review the identified charge against the medical record
- One of the following actions will ensue:
  - Accurate charge – no action
  - Inaccurate charge – correct the charge by crediting original and replacing with the correct charge
  - Duplicate charge – issue a credit
- Finalize the charges and move into the billing cycle for a final scrub

Post Bill Review

- **This is very similar to the pre-bill charge review.**
- **There are two places to obtain the data:**
  - 837 from the billing system and BEFORE the claim is sent to the scrubber
  - 837i as created post scrub and sent to the payor
- **837 from the system will allow for potential remediation before final scrub**
- **837i from the scrubber can isolate charge capture issues that slipped through the scrubber and likely require amendment to the "pre-bill" edits**

The Team

- **The team generally resides in:**
  - Revenue Integrity
  - PFS
- **Team members generally have experience in one area of specialty be it payor specific or service line expertise**
- **To fully perform the role the professional should have coding experience (not necessarily certified) or access to a coding professional**

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Summation

Summation

The ED Revenue Cycle provides:

- Significant source of volume and financial reimbursement for the facility
- Significant source of charge leakage that must be mitigated through a specialized charge capture team
- Charge capture losses / overcharges generally occur by hardcoded services not reviewed by coding
- Software that can identify aberrancies is the best defence against charge leakage
- Audit – Audit – Audit – to ensure charge capture sufficiency and avoid loss of earned revenue
- Discharge can represent a great opportunity to validate demographics and collect co-payment

Questions?

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