AT A GLANCE

Healthcare finance professionals and other employees from departments involved with a hospital’s revenue cycle can work together in many ways to minimize denials, delays, and write-offs:

> Verifying medical necessity when a patient is first seen, rather than when the patient arrives for service, so that an advance beneficiary notice can be issued and signed at the time of service

> Ensuring that the proper codes and modifiers are assigned before a claim is submitted

> Augmenting software compliance tools with human expertise in compliance and internal education programs to reduce errors over time before they reach the billing department

The saying, “If you want something done right, do it yourself,” doesn’t apply when it comes to ensuring clean claims.

One person—even one department—is hard pressed to take on this challenge in today’s environment, where the task of coding and billing claims gets more difficult every quarter, possibly every month. That’s how often payers update the rules that govern coding and compliance.

To keep up with ever-changing regulations, patient financial services departments are reaching out to other departments and experts within the hospital to ensure claims are sent correctly the first time. Today, each functional department along the revenue cycle is sharing in the responsibility for reducing the number of days a claim remains in accounts receivable—a difficult task, to say the least.

Reducing Back-End Fixes and Rework

To come up with new ways to reduce the number of claim denials and the amount of time that staff spend fixing claims after the fact, PFS professionals are looking not only at the benefits of front-end medical necessity compliance, but also the value of improving processes before bills hit a claims scrubber.

To drop a clean claim, PFS departments often must undertake the time-consuming process of consulting with multiple departments in order to confirm that the appropriate documentation exists to support adding modifiers or changing current procedural terminology or Healthcare Common Procedure Coding System codes. Worse yet, if the claim scrubber triggers an edit, a decision may be made to simply write off the charge assuming that its value is not worth the trouble of rework to fix the problem. Or the claim will be submitted knowing that it will be denied and will need to be corrected later by denials management staff.

Back-end fixes and rework require that billing or coding staff:

> Manage a worklist of unresolved edits

> Pull charts
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- Compare diagnosis and procedure code pairs manually against local fiscal intermediary rules
- Communicate with physicians or departments to check for additional documentation
- Ensure the appropriate use of modifiers
- Relay their findings and fixes back through the abstracting process, returning the claim to the billing department to rescrub

The end result may be cleaner claims, but back-end fixes and rework require a significant investment of time and labor, resulting in lost productivity and increased accounts receivable days.

An alternative approach would be to create a proactive integrated team made up of representatives from PFS, medical records coding, patient access, ancillary and clinical staff, and compliance, with responsibility for:

- Performing retrospective review of claim errors that occur throughout the revenue cycle
- Assigning responsibility for fixing the source of the identified problems
- Determining accountability for error resolution
- Reviewing new and upcoming regulations to determine financial impact and implementation implications
- Approving new services to be added to the chargemaster

This team of experts would review all hard- and soft-coded CPTs, revenue codes, and ambulatory payment classifications for editing, making it possible to track errors and pinpoint problems that occur repeatedly. After defining the impact of various problems, the task force could then address issues that have a significant financial impact or compliance exposure, as well as those that are simply easy to fix.

Although this approach involves a substantial process change for most facilities, it can have far-reaching benefits. Staff resources would be used more efficiently as PFS, ancillary, and coding staff members become more knowledgeable about each other’s area of expertise and how they can best work together to effect change.

**Taking the Detective Work Out of Coding**

There are numerous variables that can have an impact on coding compliance. The Centers for Medicare and Medicaid Services has issued national coverage determinations that affect countless procedures. Local carriers contribute to the maze of information with their own local medical review policies (now known as local coverage determinations). Correct coding edits that regulate which pairs of codes can and cannot be billed together are added and modified frequently. Often the detective work involved in discovering potential problems and avoiding coding errors is overwhelming.

New software and web-based technologies are making this task more manageable. Many electronic or online solutions are designed to quickly and automatically identify specific edits that will derail a claim, thus allowing coders to incorporate this information early in the initial coding session. For example, technology can immediately identify situations in which application of modifier –CA would be appropriate. This modifier, indicating that a procedure payable only in the inpatient setting was performed in the emergency department on an outpatient who died prior to admission, allows the hospital to be paid for the encounter. Without the modifier, the entire claim would be denied.

The latest software solutions improve upon current “pass/fail” claim scrubbers, which furnish the provider with basic information that a claim has an error without offering clues to the specific problem. Newer applications give edit guidance and direct links to the LMRP in question, so that reviewers can examine the policy, identify the problem—such as lack of a diagnosis to support the need for an electrocardiogram—and take immediate steps to fix it. Users are no longer
required to search through endless web pages or make numerous telephone calls to the payer in order to identify LMRP requirements to resolve errors. Using technology during the coding session to help ensure compliance can promote a seamless workflow that all but eliminates the need for back-end fixes.

Preventing Errors Before Billing
Sometimes a claim can be delayed for two weeks or more when an error requires that it be returned to medical records for review and rework. The patient’s file must be pulled a second time; often a physician must be pressed for more information about a patient seen days before, and policies may need to be researched in order to modify the claim.

Verifying CPT/revenue codes and performing pre-scrubber medical necessity and outpatient code editor checks may appear to extend the time between providing service to the patient and receiving payment for services rendered. However, by using the full bill hold period (usually up to five days) set aside for coding and charge capture, hospitals can decrease their A/R days simply through reduced rework later. The bill hold period provides a window of time in which facilities can implement a prescrub LMRP/OCE audit process against the full medical record, with time to contact a provider for additional documentation, if necessary. Once process deficiencies are identified and corrected, the number of edits and errors requiring correction should decrease substantially.

Preventing errors before they reach the billing department can be a key factor in reducing payment rejections, rework, and write-offs. This type of process improvement can have a tremendous impact on a hospital’s bottom line. It not only helps generate optimal payment from Medicare and other payers, but also allows the facility to pinpoint instances that require the patient to sign an advance beneficiary notice so that noncovered services can be billed rather than written off.

Reduce Repetitive Mistakes Through Education
As important as it is to provide staff with the tools they need to correct coding and compliance errors, it is even more valuable to implement process improvements that help to eliminate mistakes from occurring in the first place.

Too often, information learned during the process of cleaning up bad claims is never relayed back to the appropriate physicians, staff members, and ancillary departments that commit the coding, charging, and compliance errors. Providing education to prevent repetitive mistakes is in the best interest of these constituencies, because claims data are eventually used to evaluate and measure outpatient service mix, most and least profitable APCs, expected versus actual pay, and physician performance.

Repetitive mistakes often require only simple process changes. For example, ancillary departments may be unaware that charges must be backdated when posted after the date the service was provided. Failure to backdate charges can result in tremendous amounts of rework to address date of service edits at the back end. With the appropriate education, the required process change can be easily attained.

Software solutions are available with built-in reporting capability, allowing revenue cycle and compliance professionals to develop education programs that update key stakeholders about current coding requirements and communicate error prevention information across departments, from registration to billing to clinical staff, physicians, ancillary departments, and chargemaster coordinators. This type of information exchange is vital to any hospital’s compliance plan as well as to the facility’s overall quality improvement efforts. Over time, this effort can lower
error rates and increase efficiency at each point along the revenue cycle.

Enterprisewide support requires gradual implementation, patience, and cooperation. Integration of proactive medical necessity and payer-edit testing prior to a bill hitting the claim scrubber necessitates process changes across many hospital departments, from registration to ancillary departments, physician practices, and billing.

What is the best way to obtain enterprisewide buy-in? The first step is to align the priorities of the departments represented on the revenue cycle team, so that all areas understand how front-end process change supports the goals of each function. A formal plan for the team should be developed that outlines goals, expectations, responsibilities, and accountabilities. This plan should have the active support of top management so that process recommendations from the team are given priority importance.

Second, ancillary, coding, and billing staff should be well-informed regarding the positive impact that accurate coding and compliance checking have on a hospital’s revenue cycle. Accurate coding is the lifeblood of healthcare organizations. Day-to-day responsibilities of the coding staff are perhaps most directly and dramatically affected by a shift from back-end fixes to a proactive, front-end approach to coding and billing compliance. Initially the challenge may seem daunting, but technology solutions can help make the task more manageable.

The third step is to conduct a rigorous evaluation of available technologies to make sure they meet institutional objectives. Important factors to consider include:

- Is the new technology compatible with the software and systems currently utilized by revenue cycle teams? Can it be tailored to provide the level of functionality required by each department?
- Is the software easy to use? Can it be seamlessly integrated with existing systems and adapted to workflow patterns already in place, such as in-house versus remote-based coders?
- Is the vendor available to help facilitate the incorporation of new systems and technologies? Does the vendor recognize the impact this process change will have and assign responsive experts to help tailor solutions and streamline integration?
- Does the technology provide access to the information needed by registration, ancillary, coding, and billing staff in order to align medical necessity with services provided and to minimize rework?
- Does the system allow the hospital to bring specific departments and functions online in a reasonable and manageable time frame?
- Does the solution provide reports and data that allow ongoing coding, charging, and compliance problems to be corrected? Does it include features that help track recurring issues and provide a platform to educate physicians, clinical staff, and ancillary departments about compliance issues?

After choosing a solution that encompasses these features and benefits, hospitals can redirect resources to better address problems with medical necessity coding. Over time, modifying workflow processes will greatly improve a hospital’s ability to submit clean claims the first time, enhancing the organization’s revenue cycle.

Finding the Right Approach for Your Organization

Healthcare finance professionals agree: There must be a better way to verify medical necessity and achieve clean claims. There are a number of issues as well as emerging technologies that hospitals should consider in determining how to strengthen their medical necessity compliance programs. Together, departments from each step along the hospital revenue cycle can significantly minimize denials, delays, and write-offs—and come up with a winning combination for their healthcare team.

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