Back-End Revenue Cycle:

Charges, Billing, Collections, Denial Management, and Reporting

Nebraska Hospital Association Revenue Cycle Residency Program – Session 4/5

March 14, 2024

Presented by:

Bob Paskowski, CPA – Principal, PYA, P.C.

Carine Leslie, CCS, RHIA – Senior Manager, PYA, P.C.

David Hall, MBA – Senior Manager, PYA, P.C.

© 2024 PYA, P.C.

WE ARE AN INDEPENDENT MEMBER OF HLB—THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

Today's Agenda and Schedule

9:00 – 9:15	Introductions and Ice Breaker	All
9:15 – 9:45	Program Overview	Bob
9:45 – 10:30	Charge Description Master and Charge Capture	Carine/Dave
10:30 – 10:45	Break	
10:45 – 12:00	Billing, Coding, and Documentation	Carine
12:00 – 1:00	Lunch	
1:00 – 2:15	Managed Care Contracting and Payer Relations	Bob
2:15 – 2:30	Break	
2:30 – 3:15	Payments and Denials	Bob/Dave
3:15 – 3:45	Reporting	Dave
3:45 – 4:00	Closing, Q&A	All

Speaker Introductions

Bob Paskowski

CPA

Principal

With nearly four decades of experience, Bob has extensive healthcare expertise in payer strategy, finance, reimbursement, and data analytics.

He has senior-level experience with national and regional managed care organizations (MCOs) and integrated health systems. Bob has a proven record of accomplishments in financial performance, business growth, and operational excellence.

He specializes in building and reviewing payer and provider relationships under various arrangements.

Speaker Introductions

Carine Leslie

CCS, RHIA

Senior Manager

Carine serves as a senior manager on PYA's Revenue and Compliance Advisory Services team. She is a subject matter expert in ICD-10-CM/PCS, CPT-4, inpatient, hospital outpatient, physician Evaluation and Management (E/M) coding, and Clinical Documentation Improvement (CDI).

Her inpatient experience ranges from inpatient acute medical and surgical to rehabilitation to behavioral health. Carine's outpatient experience spans outpatient surgical, ancillary services, drug administration, emergency department, observation, behavioral health services, and Evaluation and Management.

Carine is a Registered Health Information Administrator (RHIA), a Certified Coding Specialist (CCS), and a member of the American Health Information Management Association (AHIMA) and the Georgia Health Information Management Association (GHIMA).

Speaker Introductions

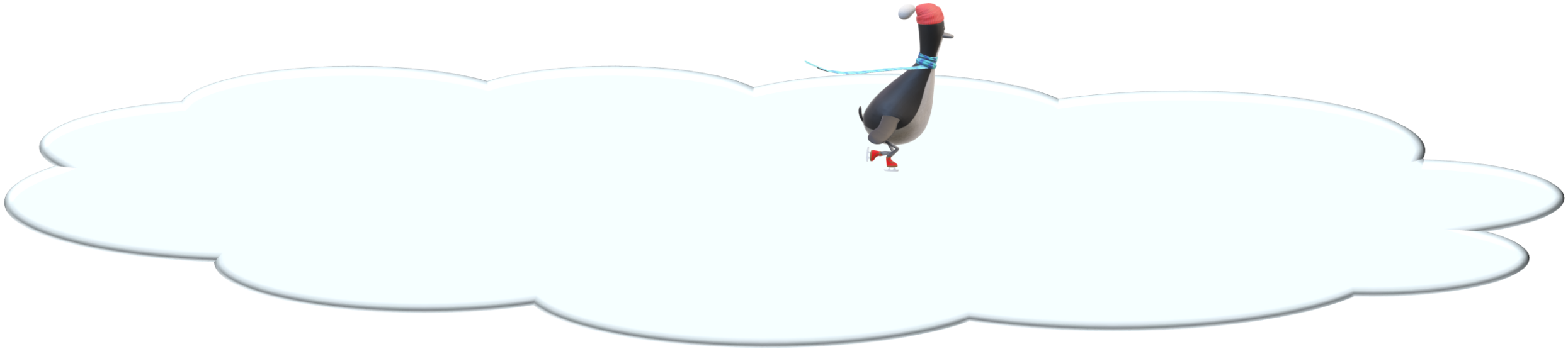
David Hall

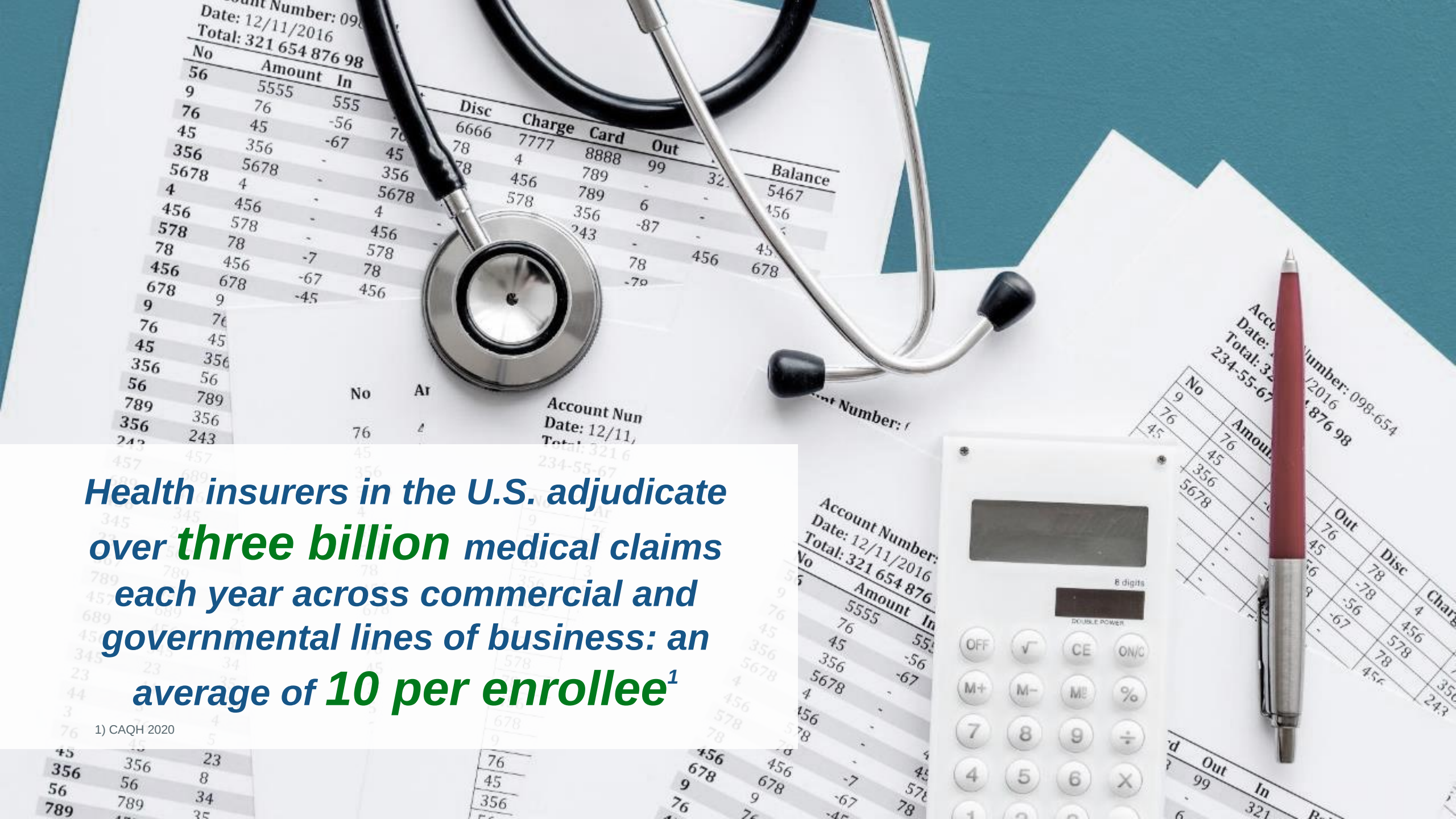
MBA

Senior Manager

David has more than two decades of experience advising healthcare businesses on optimal alignment—clinical to financial, provider to payer. His managed care and revenue cycle experience affords innovative consulting expertise to PYA clients seeking guidance on revenue cycle, payer strategies, contract negotiations, and reimbursement analysis.

Ice Breaker





Health insurers in the U.S. adjudicate over three billion medical claims each year across commercial and governmental lines of business: an average of 10 per enrollee[1]

1) CAQH 2020

Approximately 11,000 seniors age into the Medicare system daily…that is 1 every 8 seconds!

Did You Know? Fun Facts in Healthcare…

Beards are the **fastest growing** hair on the body

Everyone has a unique smell… **except identical twins**

It is **impossible** to tickle yourself

Fingers **do not** contain muscles

The fastest growing nail is the **middle finger**

Sneezes regularly exceed **100 mph**, while coughs register about **60 mph**

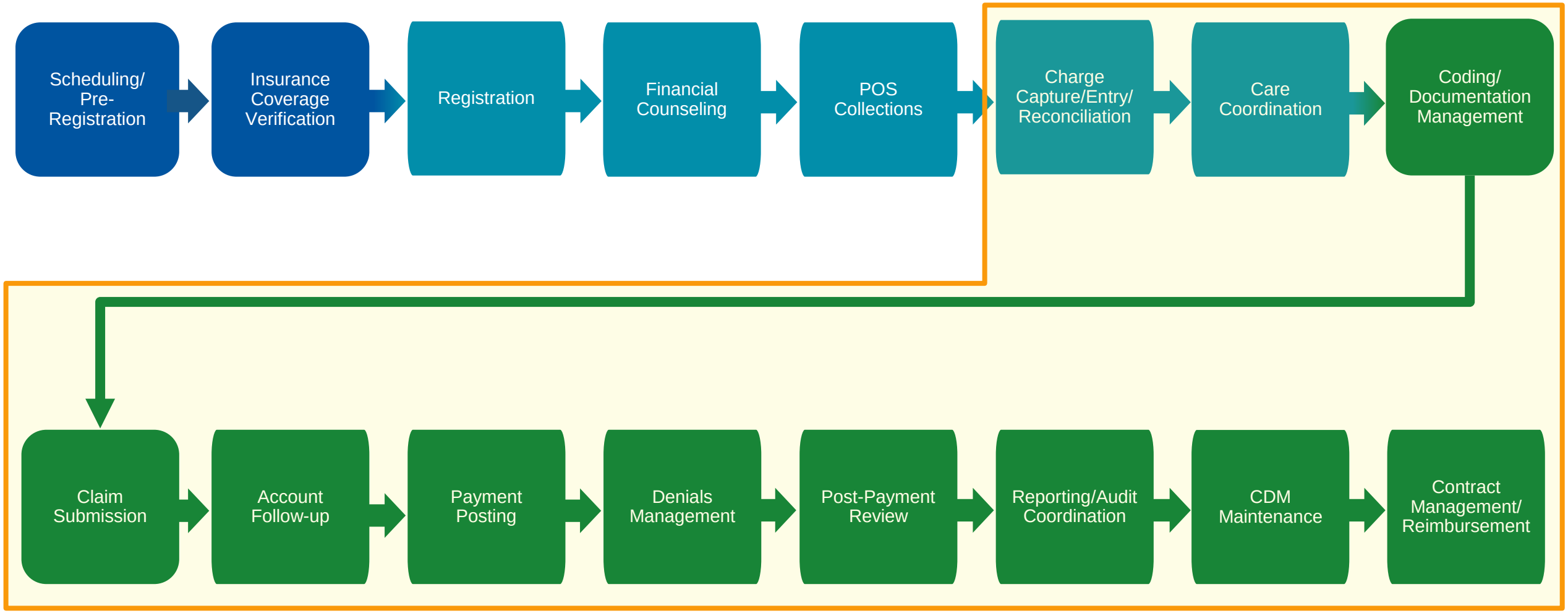
Chewing gum makes you **more alert**

If you're an optimist, it could help you **live longer**

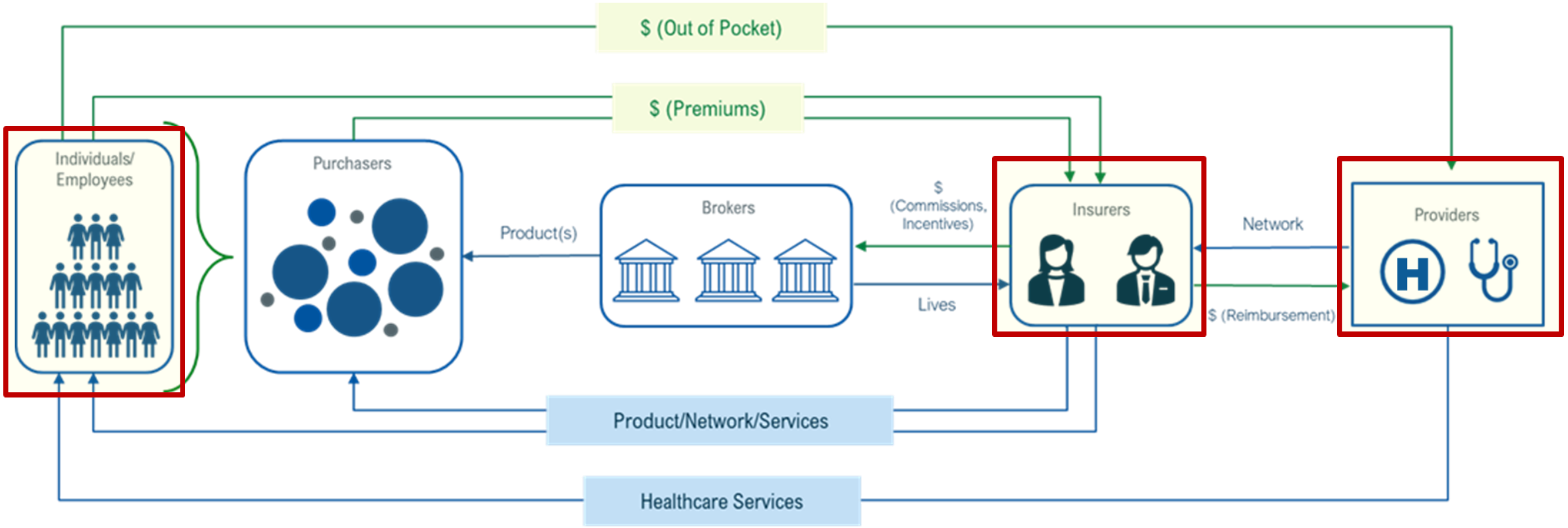
Handwriting things can **help your memory**

Program Overview

Program Overview – The Revenue Cycle



Program Overview – The Cast of Characters



Genie Wish List

Hospital 1

- A developed Registration “Bible” – Our registration staff could really use a handbook available to reference when registering new patients. This guide would have example insurance cards and how each is registered. It would outline how to determine COB when a patient presents with multiple coverages.
- Timeliness restrictions on Insurance Recoupments – just like we have timely filing deadlines for claims. Insurance companies should not be able to recoup payments past a certain time frame.
- An in-house EMR expert. We went through an EMR conversion in August and on the financial side of things it has been a huge mess. It is hard to get a competent EMR representative as they all seem very young and inexperienced. Whenever we think we take one step forward it seems like we take 10 steps back!

Hospital 2

- I would like to see payer plans that utilize a re-pricing organization to not be able to have their own policy. For example, XXX re-prices claims for many insurance companies. Repricer has its own policies; however, the payer can have their own policies that would override any of Repricer’s policies. This is particularly a concern with Payer utilizing Repricer.
- I wish all payers would have to follow the same guidelines. Should services be bundled or unbundled. Example: we are seeing many payers deny a venipuncture charge as not separately payable. Can’t all payers follow the same guidelines or at least be accountable to follow CMS policy?
- Third-party payers would not be available for payers to submit payment.

Genie Wish List (*cont.*)

Hospital 3

- Best practices for following CMS guidelines – No Surprises Act, Good Faith Estimates
- Blueprint for maintaining revenue integrity and compliance.
- How to: have efficient billing and coding processes.

Hospital 4

- **Higher standards** for **insurance companies** (timely reimbursement, denials, eligibility)
- **Streamlined Prior Auth Standards/Appeals** across all payers
- Tools/Resources to **educate patients on their health coverage**

Hospital 5

- **Standard audit checklist or KPI** metrics for Patient Access Staff
- Any best **practice policy templates** or list of policies that should be in place
- **Denials dashboard** with top avoidable denials and education on how to tackle them

Hospital 6

- **Standard rules** for Prior Authorization, claims processing and payments/remits.
- **Get rid of Medicare Advantage** plans or require them to work like Medicare.
- Somehow simplify the process of **provider enrollment**. One website for all new providers.

Charge Description Master and Charge Capture

Charge Description Master (CDM)

- Suggest policies and procedures (P&Ps) for all elements below:
  - Mechanism for **adding/adapting charge lines**:
    - Ensure charge lines available for all common charge types
  - **Hold charges** pending requested update?
    - Have a clear method agreed to hold and release
  - Nearest available?
    - ***Not recommended***
  - Mark-ups
    - Keep consistent – based on **cost** or **list price**?
    - **Ensure accuracy – check regularly**
  - RHC/CAH Chargemaster issues
    - Relationship with Medicare Cost Report?

CDM (*cont.*)

- Pharmacy
  - National Drug Code (NDC) codes?
    - Prices within CPT can vary – NDC pricing is benchmarked and consistent and varies each month
      (*e.g., Wholesale Average Cost (WAC)*)
- Locations
  - Defined by the system or non-location charges, such as in EPIC (*e.g., wards or radiology departments)*
  - Department tracking – **allocation of gross charges to department budgets**

- Lesser language
  - **Be aware and check regularly**
  - **Know which managed care contracts have this clause**
- Global rate updates:
  - Which elements to focus on and what to leave alone?
  - Managed Care contracts may limit the rate increase.
- **Charge to cost ratio – keep it consistent if possible**

Charge Capture

- Every charge needs a method to drop the charge
- Documentation to support charges/codes – accuracy is critical
  - Clear process
  - Check and authorize
- **Clear**, **repeatable process**
  - Consistent training
  - Validate/check
  - Document **why**
  - P&P
  - Clear ownership
- Test and validate
  - Testing, especially for new charges, is critical – ***validate that the process works***

Charge Capture (*cont.*)

Editable charges

Exploding packs!

Non-charge items

(e.g., low-cost pharmacy, bandages)

Covered charges?

Reverse erroneous charges

Do not delete!

System edits

Be aware.

Use them.

Keep them updated.

Break

Billing, Coding, and Documentation

Medicare – Government Financed Insurance

Medicare Part A

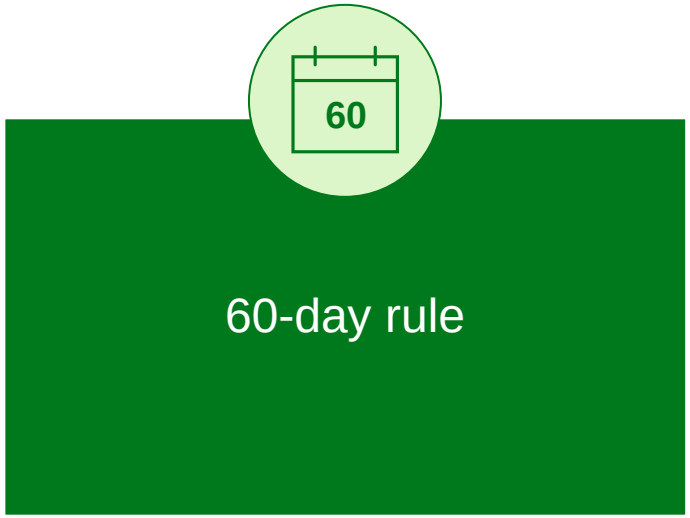
- **Hospital insurance** plan for the elderly
- Financed through social security taxes
- At age **65 years**, patients who have paid >10 years into SSI are **automatically enrolled**
- Those <65 years of age who are **totally and permanently disabled** may enroll after 24 months of disability
- Those with **ESRD on HD** usually enrolled without wait period

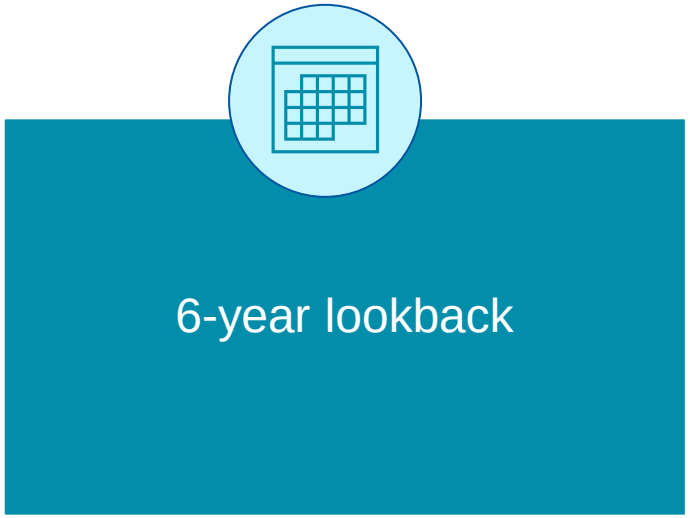
Medicare Part B

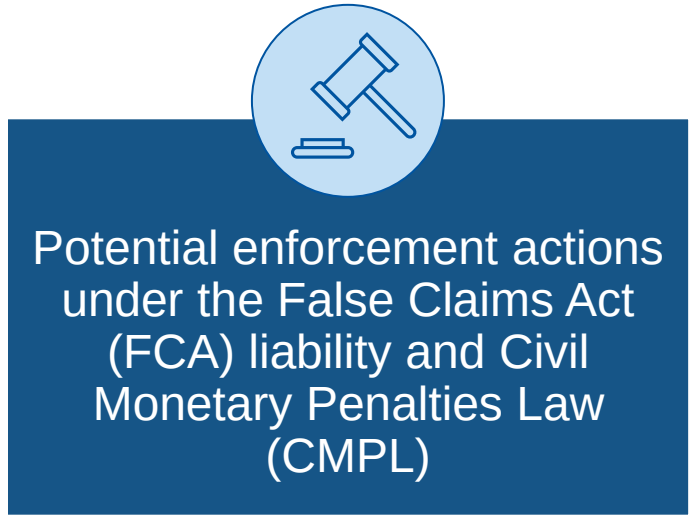
- Insures the elderly for **physicians' services**
- Financed by federal taxes and monthly premiums from beneficiaries
- Available to those eligible for Medicare Part A who elect to pay the Medicare Part B monthly premium

Why is Medicare So Important?

- Medicare is typically a **primary payer** for many hospitals, physicians, and pharmacies. In some cases, it **could be the largest payer in an organization's payer mix**.
- Medicare's **fee schedules are publicly available and published annually** (with updates), so they are a **reliable and available source of information** to compare against.
- Medicare is also a **source of risk** to the organization, related to appropriate billing practices and the identification, repayment, and remediation of errors.

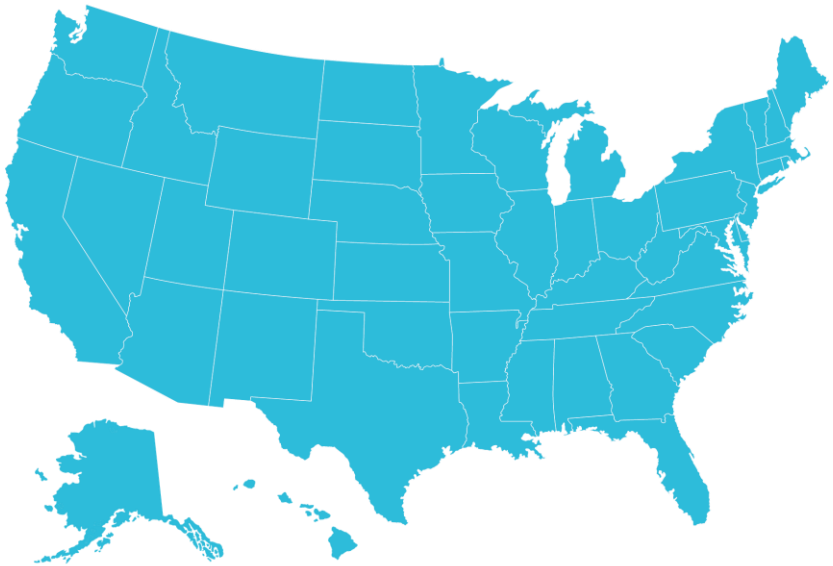






Medicaid – Government-Financed Insurance

- **Medicaid varies by state**
  - Federal program administered by the states
  - Federal financing for low-income patients
  - Federal government:
    - Pays a percentage of total Medicaid costs
    - Requires that a broad set of services be covered, including hospital, physician, laboratory, x-ray, prenatal, preventive, nursing home, and home health services



  - **EACH STATE** has its own Medicaid program and fee schedule(s).
  - Medicaid is generally an undesirable payer for physicians because the reimbursement is typically less than Medicare, sometimes 70 – 80% of Medicare, or lower.

Types of Healthcare Codes for Reimbursement

Professional

- **CPT (Current Procedural Terminology)**
  - **Five-digit, numeric code (19364)**
  - Used by physicians to describe the procedures they perform.
  - Determined by the AMA and may include payment for all supplies used during the procedure.
  - Includes Evaluation & Management (E/M) codes
- **HCPCS (Healthcare Common Procedure Coding System)**
  - **Five-digit, alphanumeric code (S2068)**
  - Used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Additional

- **ICD-10-CM (International Classification of Diseases – Clinical Modification)**
  - **3- to 7-digit, alphanumeric code (T84.043)**
  - The current system used to identify signs, symptoms, injuries, disease and conditions in the US.
- **ICD-10-PCS (International Classification of Diseases – Procedure Coding System)**
  - **7-digit, alphanumeric code (0SRB019)**
  - System published by the United States for classifying procedures performed in hospital inpatient health care settings.
- **Modifiers**
  - **2-digit, may be letters, numbers, or both**
  - Used to enhance the level of specificity for a given service or supply that has been provided.
  - When reported correctly, modifiers can add or decrease work RVU values.
  - Modifiers can also have the same impact on payer reimbursement.

E/M Codes

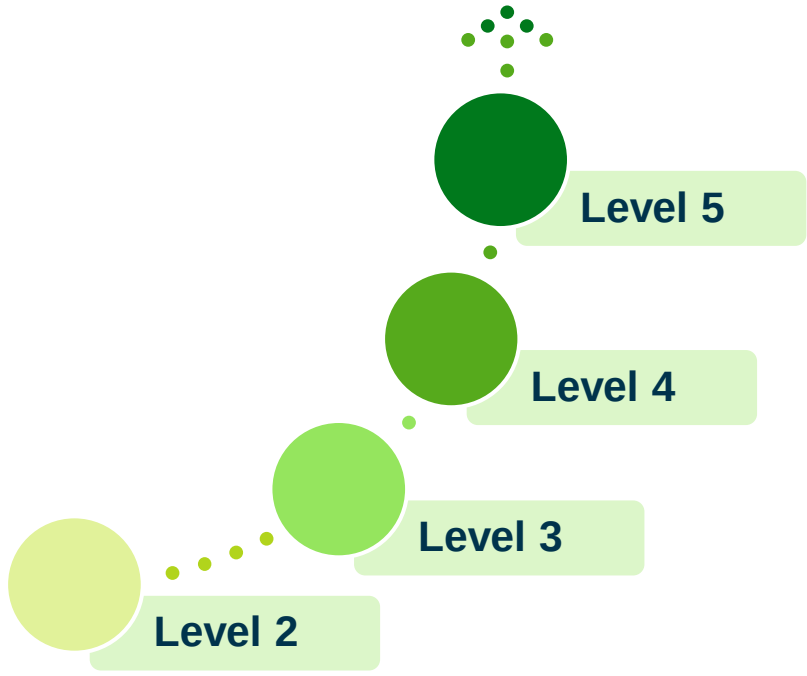
- E/M codes represent physician face-to-face evaluation and management services with a patient.
- Specific based upon:
  - Type of patient
  - Length/effort of visit
    - Medical Decision Making (MDM), time
  - Setting
    - Office, hospital, emergency dept., etc.

Source: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

E/M Codes (*cont.*)

- Significant changes to E/M code assignment methodology began in January 2021 and continued in 2023.
- These changes have a downstream impact on physician compensation models that are based on work Relative Value Units (wRVUs) which measure effort required by the service.
- Often referred to by "level" based on last digit
  - 99202, 99212 – "level 2 visit"
  - 99203, 99213 – "level 3 visit"
- Different E/M codes for office/outpatient and inpatient/observation.
- Typically, professional services only

The higher the code within each series, the greater the work, effort, and reimbursement.



Source: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Resources to Assess Compliance Risk

The OIG Work Plan

Each month, the most recent additions to the OIG Work Plan items are published at https://oig.hhs.gov/reports-and-publications/workplan/updates.asp

How to Utilize the OIG Work Plan

Frequently check the Active Work Plan Items list.

- At minimum, once or twice a month

Determine if the Recently Added Items of the OIG Work Plan are relevant to the organization.

- If so, include in the organizational Compliance Work Plan

Inform executives and the Board of relevant OIG Work Plan items that will be included in the organizational Compliance Work Plan.

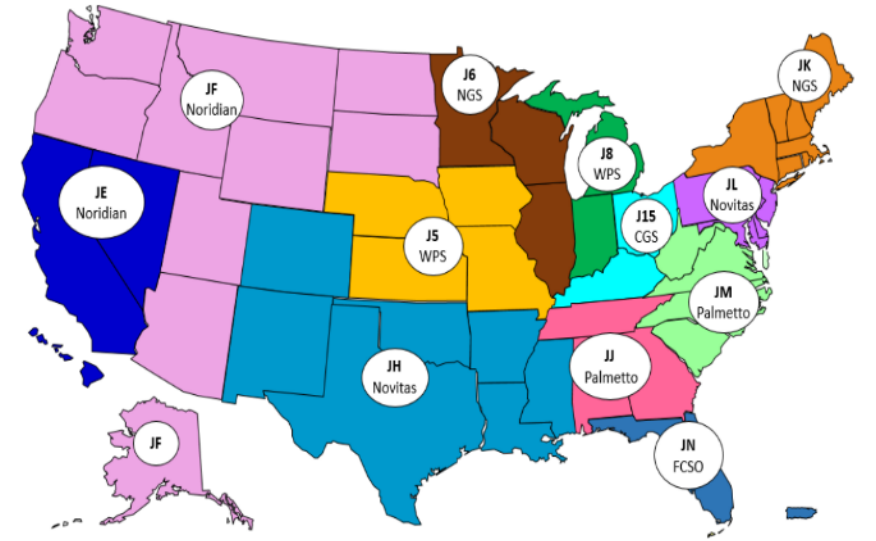
Program for **E**valuating **P**ayment **P**atterns **E**lectronic **R**eport

- Compliance officers use PEPPER to:
  - Review hospital- or facility-specific data statistics for target areas identified by CMS as at high risk for improper payment
  - Identify areas of potential overpayments and underpayments
  - Help prioritize areas for compliance auditing and monitoring
  - Access data tables and graphs displaying billing activity over time, in comparison with other hospitals/facilities

Source: https://pepper.cbrpepper.org/

Medicare Administrative Contractor (MAC)

A/B MAC Jurisdictions



WPS GOVERNMENT HEALTH ADMINISTRATORS

Policies Guides and Resources

Featured Guides and Resources related to policies

Local Coverage Determinations (LCDs) and Billing and Coding/Policy Articles
Access LCDs and Billing and Coding/Policy Articles from one location.

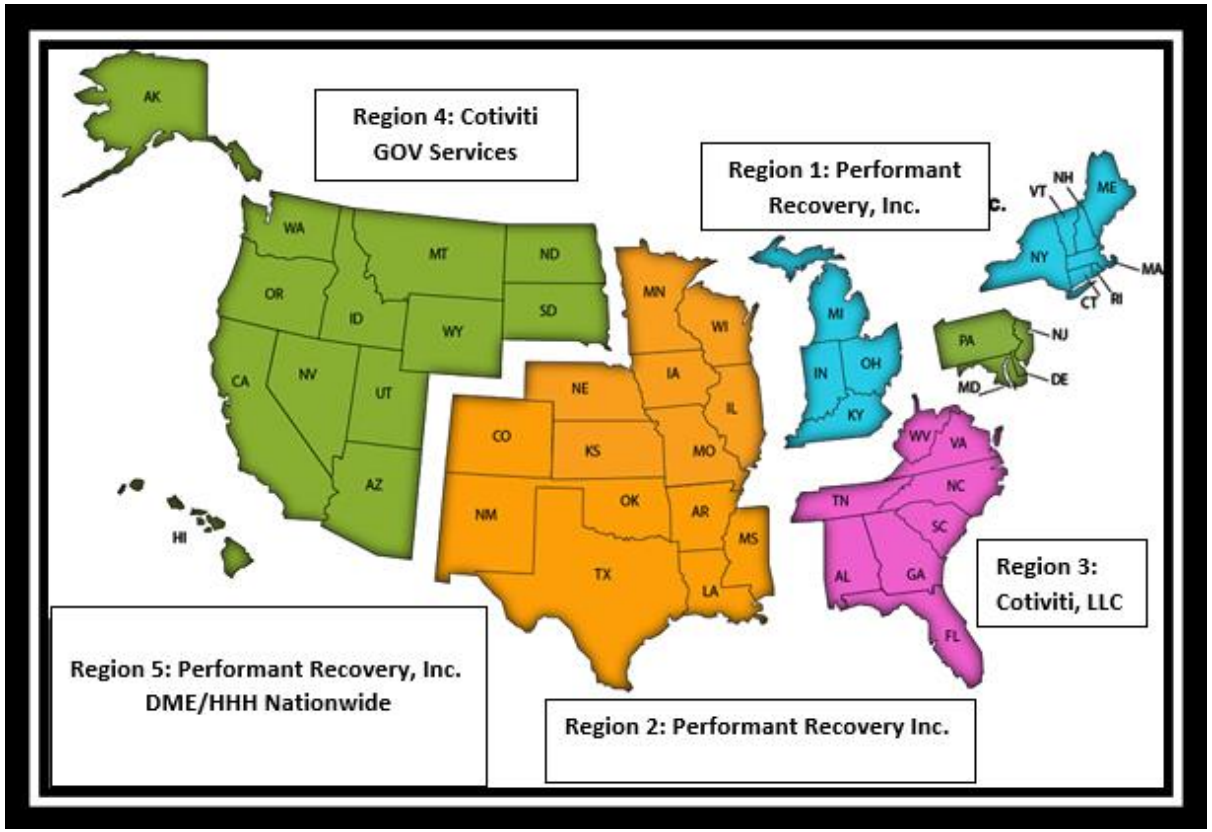
Proposed/Draft Local Coverage Determinations (LCD)
Proposed/Draft LCDs provide advance notice and a comment period for interested parties to provide feedback.

Self-Administered Drug Exclusion List (SAD List)
List of drugs considered usually self-administered.

The LCD and NCD Reconsideration Processes
WPS Government Health Administrators has a formal process for LCD reconsideration.

Source: https://med.wpsgha.com/topics/policies/guides-resources

Recovery Audit Contractors (RAC)



PERFORMANT

03/28/2023

On March 24, 2022, CMS awarded Performant Recovery, Inc., the new Recovery Audit Contractor (RAC) Region 2 contract. RAC Region 2 includes the following Medicare Administrative Contractor (MAC) jurisdictions: J5, J6, and JH.

Sources:
https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program
https://performantrac.com/cms-rac/cms-rac-resources/cms-rac-provider-resources/default.aspx

Unified Program Integrity Contractor (UPIC)

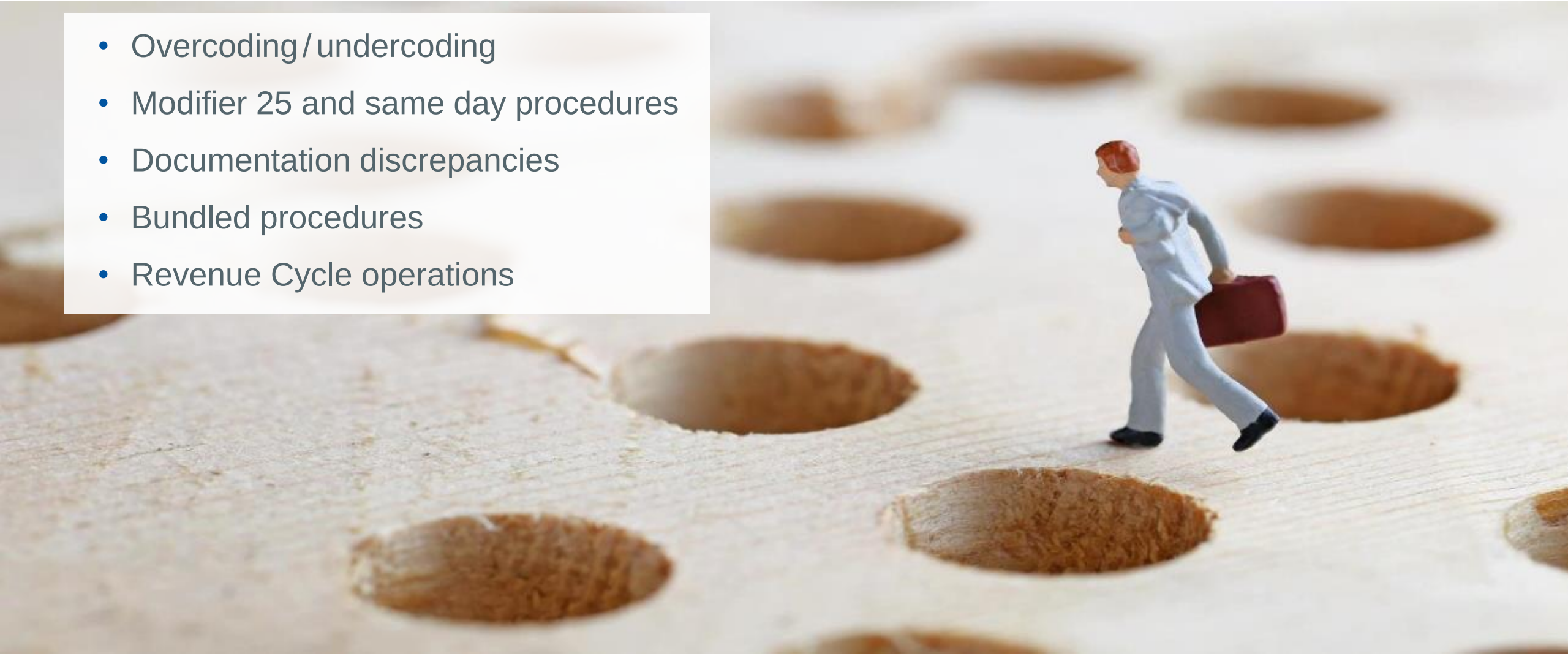
CoventBridge (USA) Inc. holds the UPIC MW contract that was awarded by CMS in 2016. The UPIC MW contract performs program integrity functions to detect fraud, waste and abuse in Medicare Parts A, B, Durable Medical Equipment (DME), Home Health, Hospice, Medicaid and the Medicare-Medicaid data match program in the states of Iowa, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin.

COVENTBRIDGE GROUP
THINK TRUTH

Source: https://coventbridge.com/midwest-upic/

High-Risk Areas and Frequent Coding/Documentation Errors

- Overcoding / undercoding
- Modifier 25 and same day procedures
- Documentation discrepancies
- Bundled procedures
- Revenue Cycle operations



Billing Considerations

Incident-to

- Is a Medicare billing concept and only **applies to office/clinic setting** E/M services (99202 – 99215)
- **Physician direct supervision requirement** (Medicare)
- Only applies to established patients with established problems
- Commercial payers may vary
- Allows NPPs to bill under Physician's NPI
- Maximizes revenue per claim

Split/Shared

- In 2024, CPT definition published and adopted by CMS
- Billing concept only **applies to facility (outpatient/inpatient hospital and SNF)** E/M services
- Require **face-to-face patient services** by either the physician or NPP on same calendar day
- Documentation/regulatory requirements have been in transition from 2022 through 2024 which represents retrospective risk.

Billing Considerations (*cont.*)

Standard Payment Method

- **Cost-based facility services with professional services billing**
  - Under the standard payment method, the physician or practitioner bills their outpatient professional medical services under the Medicare Physician Fee Schedule (MPFS).
  - Payment for professional medical services furnished in a CAH-to-CAH outpatients is made by the A/B MAC (B) on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a hospital outpatient department.
  - Payment for professional medical services, under the cost-based CAH payment plus professional services billed to the A/B MAC (B) method should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Provider Reassignment

- Providers performing outpatient services in a CAH cannot submit services separately to Part B Medicare when billing reassignment has been signed over to the CAH.
- The Office of Inspector General (OIG) report identified improper Medicare payments to CAHs and healthcare professionals for the same CAH services.
- As stated in CMS *Internet-Only Manual, Medicare Claims Processing Manual Publication 100-04, Chapter 4, Section 250.2*: practitioners must sign an attestation that clearly states that they will not bill Medicare Part B for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH.
- CMS Medicare Learning Network (MLN) Information for CAHs provides correct billing, compliance requirements and references to follow for healthcare professionals providing outpatient services in a CAH.

Case Study – Coding Review

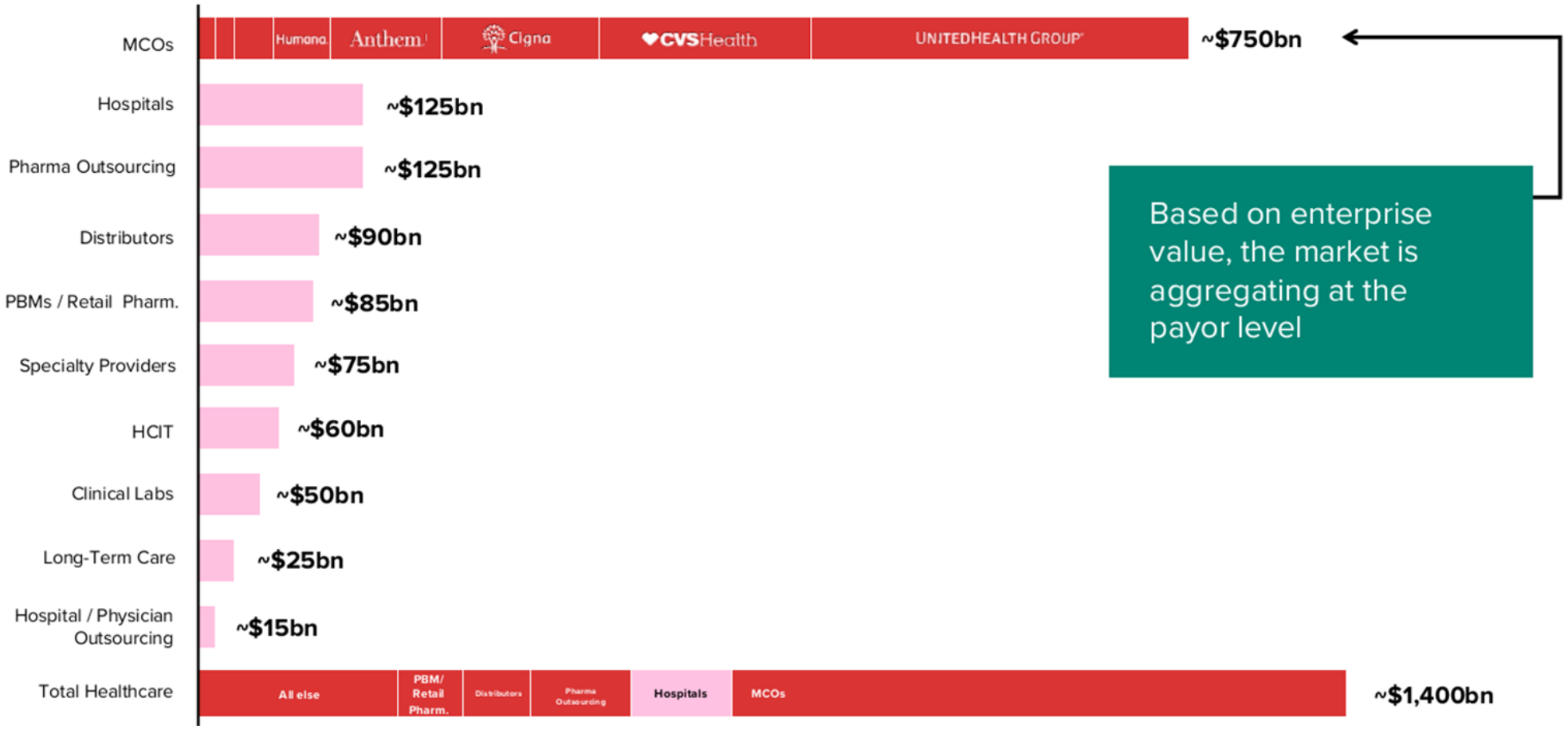
- **Medicare Part B overpaid, and beneficiaries incurred, cost-share overcharges of over $1 million for the same professional services**
  - Findings:
    - CAHs and health care practitioners each submitted an equal number of claims:
      - Number of claims audited: **40,026**
      - Number of claims that complied with federal requirements: **20,013**
    - Overpayment Identified by Medicare Administrative Contractors (MACs) to providers: **$907,438**
    - Specifically, MACs overpaid:
      - CAHs: **$331,448 for 12,156 claims** that were associated with services provided by healthcare practitioners who had not reassigned their billing rights to the CAHs
      - Healthcare practitioners: **$575,990 for 7,857 claims** even though the healthcare practitioners had reassigned their billing rights to CAHs.

Lunch

Managed Care Contracting and Payer Relations

Power of the Payers

The conglomeration of healthcare



Source: Centerview Partners

Managed Care Contracting – Basic Elements

- **Contracting Parties** – connected at the Tax Identification Number **(TIN)** level
  - **Providers** – connected at the **NPI** number level (credentialing)
- **Term** and **termination**
- Adherence to payer Utilization Management and Administrative **policies**
- Timeline for **billing** of claims
- Timeline for **payment** of “clean” claims
- Timeline for **disputed** payments and appeal filings
- **Products** included
- Fee schedules for **reimbursement**
  - Include **value-based incentives**

Managed Care Contracting – Price Transparency

Facility Name: All

Hospital Type: Short Term Acute Care Hospital

Payer Class: Commercial

Payer Name, Plan Name: All

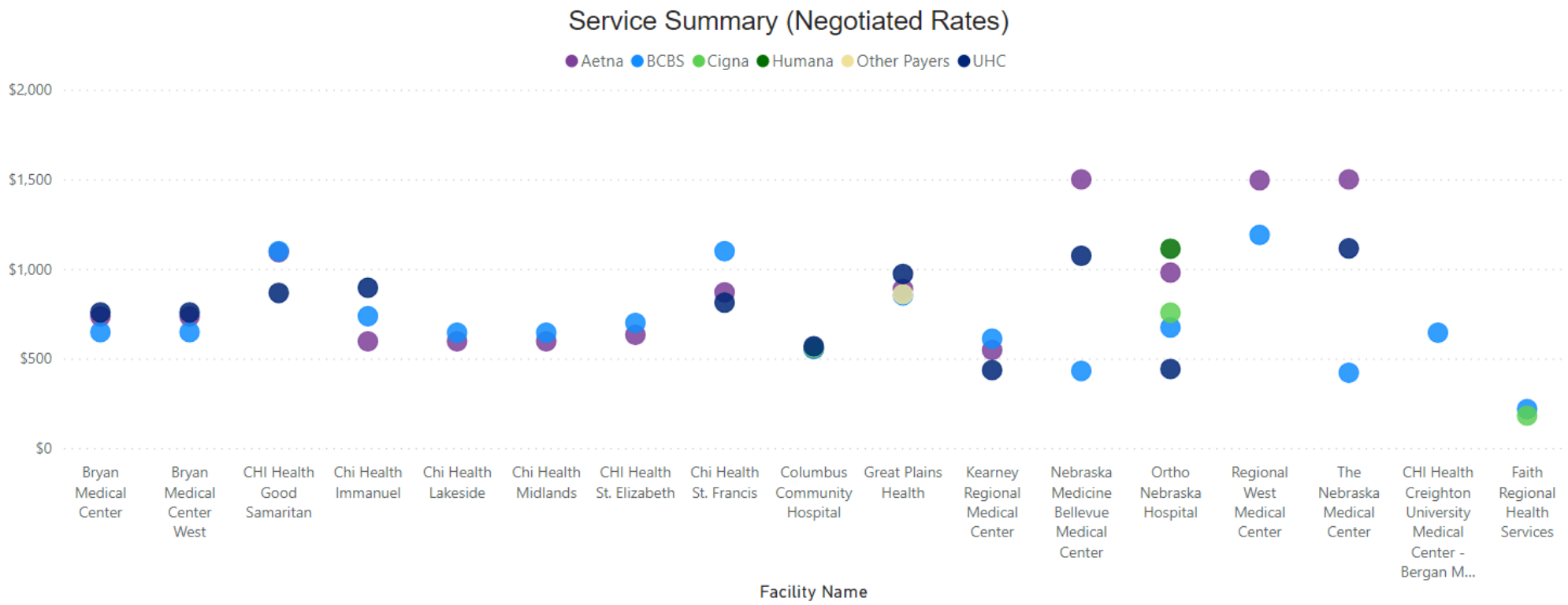
Service Description: 99284 - Emergency department visit for the evaluation and management of a patient, which requires these 3 k...

Code Type: All

Confidence Interval: 0 – 85

Negotiated Rates

Minimum	Maximum	Average
$182	$1,500	$777



Payer Relations

Know your payers – products, market share, network, pain points

Understand **services and access points** in your market

Identify **site of service** trends

Analyze your payer mix and historical trends

Talk to teammates – revenue cycle, care management, discharge planning, pharmacy, legal

Consult with your **hospital peers** across the state

Develop **value proposition** and strategy

Payer Relations – “Wishes”

Break

Payments and Denials

Payments

- **Posting payments** via automation
- Avoid any **manual data** inputs
- **P&Ps** – write-offs and adjustments
- Closing/balancing batches
- Statements and patient responsibility
- **Denials**
- Underpayments
- Overpayments
- **Staff training** and cross-training

Denials

Fatal vs. Non-Fatal Denials
Hard and Soft Denials

- **At a high level,** there are two types of basic denials**: hard (fatal) denials and soft (non-fatal) denials.**
- A **hard denial** represents a firm refusal by the payer to pay the claim – can be appealed.
- **Soft denials** are those denials in which the payer contests one or more data points in the claim.

Why was the claim (or part) denied?

- Regularly (each month):
  - Group denied claims by volume and dollars – **dig and keep digging**
- Even soft denials cost money to overturn, and **hard denials lose revenue that you had earned.**

How to Avoid Denials

Top 13 reasons for claims denials (*January 23, 2023*)

1. Authorizations – align with codes
2. Provider eligibility – not credentialed?
3. Code inaccuracies – CPT codes and ICD-10 codes
4. Incorrect modifiers – they tell the story
5. Failure to meet submission deadlines (timely filing)
6. Patient information inaccuracy – align with the insurance card and on-line information
7. Missing or inaccurate claim data
8. Not enough staff to keep up – *is this you?*
9. Formulary changes
10. Changing policies
11. Procedure changes
12. Improperly bundled services
13. Service not covered

Source: https://www.beckershospitalreview.com/finance/13-top-reasons-for-claims-denials.html

How to Avoid Denials (*cont.*)

1.

Get it right the first time.

2.

Learn from previous denials:

Identify the key root causes.
Fix ‘em! Keep ‘em fixed!

3.

Monitor denials monthly:

Work to KPIs – beat ‘em!

4.

Take pride in success – celebrate avoiding denied claims!

5.

Create a culture of monitoring, learning, supporting, teamwork, and celebration:

Be vigilant – hold people accountable, escalate with the support of leaders.
Be persistent and consistent.

6.

Challenge the payers!

Be the squeaky wheel!

Meet with them, update contract language, fight back!

Source: https://www.beckershospitalreview.com/finance/13-top-reasons-for-claims-denials.html

Reporting

Keys to Effective Reporting

- Reporting that shows measures that are **impactful to the organization**
  - Avoid reporting for the sake of reporting
- **Consistent data** that is understood and trusted – same source and methods over time
  - Change if needed, but communicate the impact of the change
- **Automated data pulls** with minimal manual manipulation
  - Automated pulls are normally more trusted that manual pulls – plus cost less
- **Able to track initiatives** (e.g., denials root causes)
- Understand **data limitations** (e.g., reporting tails and data lags)
- GIGO (*Garbage in, garbage out*) – only as useful as the data captured
- **Communication**
  - Internally and externally
  - Celebrate success!

Examples for Discussion			Advisory Board Benchmarks (2021)		
KPI	**Client A metric**	**Client A Benchmarked Performance Level**	**Low Performance**	**Median Performance**	**High Performance**
A/R days	38 days	High	54.2 days	47.3 days	44.0 days
Denials Write Offs	1.4%	Median	1.9%	1.5%	0.9%
POS Cash Collection	0.2%	Low	0.3%	0.5%	0.9%
Bad Debt Write Off	3.7%	Median	6.5%	3.3%	1.5%
DNFB (2015)	8.3 days	Low/Median	11.6 days	7.1 days	5.7 days
DNFC (2015)	0.9 days	High	7.0 days	4.1 days	2.1 days

Other Reporting Considerations

- Capacity to dig to the right level:
  - Understand which payers/plans are driving trends
  - Peel the onion
  - “Slice and dice”
- Data/reports that address concerns and key business metrics:
  - Limit reporting to key areas – expand out when needed
  - AR looks good – but it masks issues with Payer A
- Commit resources to reporting and to remediation.
- Use the “out of the box” reports where they are meaningful.
  - Be aware of the functionality of your applications
  - Work with user groups

Questions?

Thank you!

Bob Paskowski
CPA
Principal – PYA, P.C.
bpaskowski@pyapc.com

Carine Leslie
CCS, RHIA
Senior Manager – PYA, P.C.
cleslie@pyapc.com

David Hall
MBA
Senior Manager – PYA, P.C.
dmhall@pyapc.com

PYA | NHA | NEBRASKA HOSPITALS | AAHAM American Association of Healthcare Administrative Management The Premier Organization for Revenue Cycle Professionals | hfma nebraska chapter healthcare financial management association