



## Office Operations – *“Best Practices”*

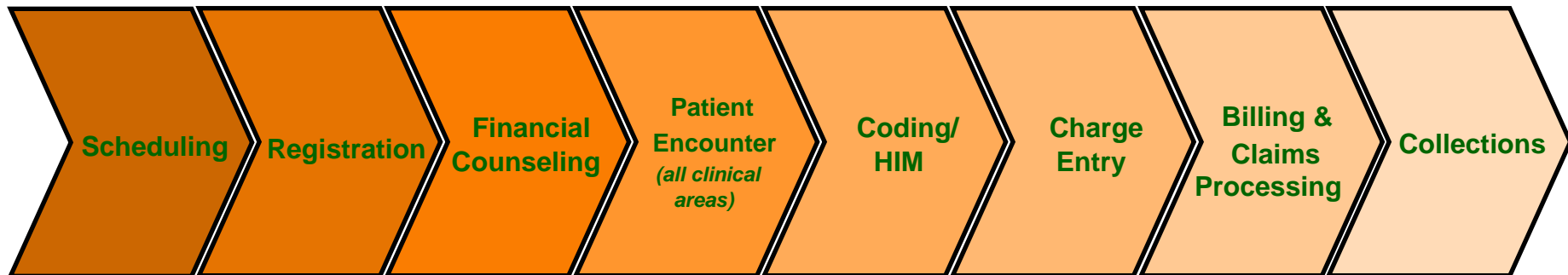


November 4-5, 2009

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**Wipfli Health Care Practice**

# Revenue Cycle Defined

- The revenue cycle is the process that begins when a patient makes first contact with a practice and it includes all activities that must occur to deliver and collect for the services.
- There are many people, systems, and activities that have to work – and work fairly seamlessly – for clinics to collect what they are owed.



- Most medical practices have addressed expense issues...

...but, many haven't looked enough at revenue cycle opportunities.

- Those that have typically focus on A/R (business-office processes).
- The “front end” of the revenue cycle is often not considered...

- Registration - information integrity
- Charge capture tools
- Coding - data capture process
- “Compliance” (read: “revenue”) monitoring
- Ongoing education

# Registration/Reception

- The “Merry-Go-Round”:
  - The insurance card shows the insurer’s address on the back, but claims are to go to another address
  - The card does not show co-pay
  - The card doesn’t ID the plan is PPO
  - Patients carry an old card
  - Patient’s family status has changed
  - Patient’s employment status has changed
  - **And most common: we don’t consistently check...**



## Actual Example:

1. \$34 office visit claim submitted.
2. Claim denied: *“Plan terminated.”*
3. Call the patient: *“Yes, I still have the same insurance.”*
4. Call insurance (Trudy): *“Yes, terminated.”*
5. Call patient: *“I swear I still have the same insurance!”*
- 6&7. Call insurance (Sally, then Bob): *“Yes, terminated.”*
8. Call Manager (Joan): *“Yes, terminated. Patient now has COBRA and the new policy number is...”*



- Most practices could do better at:
  - Collecting co-pays and account balances when the patient is standing in front of them (key issue with increasing number of HSAs)
  - Communicating with patients (early and often) about their role, to minimize surprises

## Data capture process solutions

- Ensure the right people are doing the job
  - Consider registration be done by “business-office” staff (appropriate in some practices, not in others).
  - Or, use BO staff just for pre-registering new patients and entering insurance information changes.

- Ensure people are doing the job right
  - Require that open-ended questions be asked at every visit. Verify it's happening - eavesdropping is OK!
  - Train employees to request current insurance cards at every visit.
    - Copy front and back at initial visit
    - Compare at all subsequent visits
  - Practices should completely re-register patients every year (print information for patient's review and signature).

- Be consistent
  - If you're trying to improve time-of-service collections (co-pays, old balances, today's service payments), **EVERY** patient should **ALWAYS** stop at the check-out desk.
  - Providers must support this.

- Education solutions
  - Formalize the registration process with policies and procedures
  - Teach registration staff using these P&P; do not use the “mentor” method
  - Incorporate a strong business office component in registration staff training – they should attend each other’s meetings
  - Institute job sharing or, better yet, trading
  - Begin a weekly “tip of the trade” (developed by them)

- Return registration errors (denials, mail returns, etc.) to the source for resolution

*Most people sincerely believe they aren't contributing to the problem (it must be someone else). When we fix Jane's mistakes, she continues to believe she's not making them and she will continue to make them...*

# Encounter Forms (Charge Tickets)

## Encounter Forms (Charge Tickets)

- Charge tickets are the primary billing tool; their design can make or break revenue cycle efforts
- Every year, carefully think through improvements to make them more useful charge capture tools
  - Go beyond simply updating codes
  - Involve virtually every functional area of your practice in updating charge tickets every year (e.g., charge ticket committee)
- Provide a “Coding Advice” area on the charge ticket

- Typical problem areas
  - E/M sections
  - Preventive medicine
  - “Nursing” or ancillary staff sections
  - Insufficient (or nonexistent) prompts
  - Modifiers
  - ICD-9 diagnosis section
    - Insufficient ability to link
    - Missing prompts
    - Insufficient room for writing
    - Biggest problem: preprinted lists limit the choices

- Practices should institute a process to assess charge ticket accuracy and completeness as close to the site of service as possible.
- Better performing practices use a nurse/provider team approach to ensure charge tickets (paper or electronic) are correct before releasing them.

- Tickets should be complete and accurate (with proof of pre-review) when they get to coding/charge entry.
  - Basic demographic information
  - Visit code indicated
  - Referring physician
  - Diagnosis tied to each CPT code
  - Drug and administration code marked for injections/immunizations
  - Etc. (defined by your practice)

- Agree that if this fundamental information is missing or unclear, tickets will be returned to the provider/nurse team.
  - Coders and/or business office employees should **NOT** seek out answers (e.g., pulling charts, making coding assumptions) or change coding.
  - This is not punishment – it's education (painful at first, but then it goes away...).

- Once entered, manual and automatic claim checks should be performed to ensure there are no glaring errors with claim submissions (service, gender, age mismatches).

# Coding Process

- The right balance of coding oversight is necessary.
  - **Too little: Charge tickets are taken at face value**
    - Potential compliance and/or revenue issues
  - **Too much: “Production” style or a coder extrapolates codes**
    - Most often, creates revenue issues

- The best medical practices focus on:
  - Identifying the right balance, given their practice make up (specialties, sizes, locations, etc.)
  - Identifying potential problems before they occur (“disease” prevention)
  - Making continual improvements (maintaining well-being).



- Physicians should be responsible for the information on claims.
- **Physicians** should be responsible for the information on claims (not a typo).

## REVENUE CYCLE SNAPSHOT ANALYSIS

Sampling: One week period (**BEFORE**)

### Documentation Review

### Missing Charge Analysis

CPT code	Description	Volume/ units	Total \$
11056	Trim Callus	1	\$117
17110	Destruction lesion	1	\$190
20610	Injection joint	1	\$225
36415	Venipuncture	6	\$108
90471	Immun administration	4	\$112
96372	Injection admin	8	\$224
92567	Tympanometry	1	\$72
93000	EKG	4	\$600
94640	Nebulizer (treatment)	1	\$69
99211	EM, Level 1	4	\$168
J0702	Celestone (drug)	2	\$60
J2790	Rhogam (drug)	1	\$188
L3485	Heel cup (supply)	2	\$15

*24 physician,  
primary care-based  
multispecialty  
practice.*

<b>Total (weekly)</b>	<b>\$2,148</b>
<b>Monthly</b>	<b>\$8,591</b>
<b>Yearly</b>	<b>\$111,687</b>



NOTE: These results only consider missing charges, not E/M coding discrepancies.

## REVENUE CYCLE SNAPSHOT ANALYSIS

Sampling: One week period (two months **AFTER**)

**Documentation Review**

**Missing Charge Analysis**

CPT code	Description	Volume/ units	Total \$
90471	Immun administration	1	\$28
95115	Allergy inj	1	\$26
99211	EM, Level 1	1	\$42
J0702	Celestone (drug)	1	\$60

<b>Total (weekly)</b>	<b>\$156</b>
<b>Monthly</b>	<b>\$624</b>
<b>Yearly</b>	<b>\$8,107</b>

NOTE: These results only consider missing charges, not E/M coding discrepancies.

## REVENUE CYCLE SNAPSHOT ANALYSIS

Sampling: One week period (one week **BEFORE**)

### Charge Ticket Review

#### Issues Resulting in Ticket Returns

# of Cases

Diagnosis missing or inconsistent with service	24
New/established patient code incorrect (mostly one provider)	16
No level of service chosen (16 from one provider)	29
Other (no box checked, insurance info incomplete)	<u>3</u>
<b>Total returns (one wk):</b>	<b>72</b>

## REVENUE CYCLE SNAPSHOT ANALYSIS

Sampling: One week period (one month **AFTER**)

### Charge Ticket Review

#### Issues Resulting in Ticket Returns

#### # of Cases

Diagnosis missing or inconsistent with service	7
New/established patient code incorrect (mostly one provider)	0
No level of service chosen (16 from one provider)	1
Other (no box checked, insurance info incomplete)	<u>1</u>
<b>Total returns (one wk):</b>	<b>9</b>

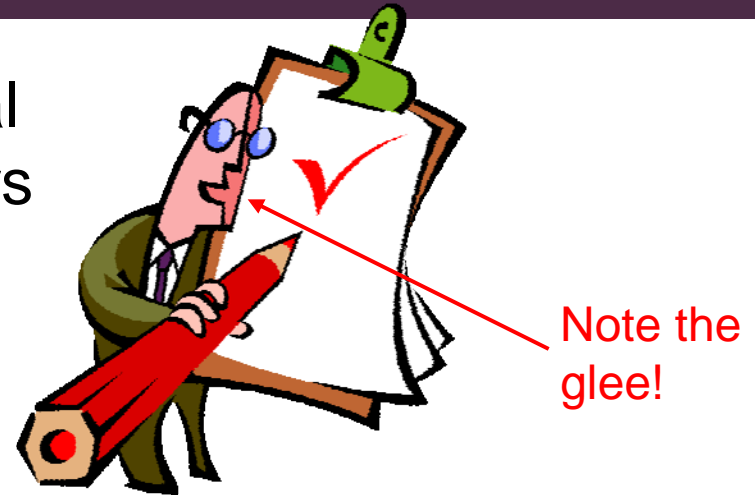
- By moving the work intensity to the FRONT END, clinics create the ability to communicate, mentor, and fix problems before they become deeply ingrained, thereby eliminating “chasing down” the same information later.

- In most practices, we advocate that coders:
  - Briefly review every “charge ticket” for completeness and accuracy (after the clinical check and balance is done)
  - Select unusual or potentially problematic cases to “audit” the documentation
  - Be available to respond to cases marked by providers “coding review”
  - But, **spend most of their time** monitoring coding outcomes and training clinical staff.
- **Coding Educators** can be most effective if they are located in the clinical areas.

# Daily Process and Monitoring

- Rather than putting out fires (which will never end), get “daily!” Implement systematic, daily processing:
  - “**Charge tickets**” submitted daily (get in the routine). Eliminate late submissions (more than 24 hours after service).
  - Post **charges** daily
  - Submit **claims** daily
  - Post **payments** daily
  - Respond to **payer requests** within 24 hours

- Many practices conduct an annual “audit” and then report to providers about where they are failing.



- Better: a proactive program that continually assesses, educates, and mentors – one that prevents coding and billing problems before they start.



- Practices should:
  - Compare their coding/billing patterns to:
    - Their own patterns over time
    - Same-specialty peers' patterns
      - Within the practice
      - Outside the practice
  - Communicate results...
  - Conduct REGULAR internal (and periodic external) reviews of **process** and **outcomes**, consistent with the compliance plan.

## Assess CPT frequency reports

- Are codes used that don't match the way you provide services?
- Are modifiers appended to the right CPT codes?
- Do volumes "add up" (e.g., low venipuncture volumes)?
- Are E/M usage patterns consistent with norms?

**ABC Family Practice Clinic (11 Providers)**  
**Change in Revenue: E&M Code Utilization (12/1/08 - 1/31/09)**  
*Established Patient Office Visits*

**ACTUAL UTILIZATION**

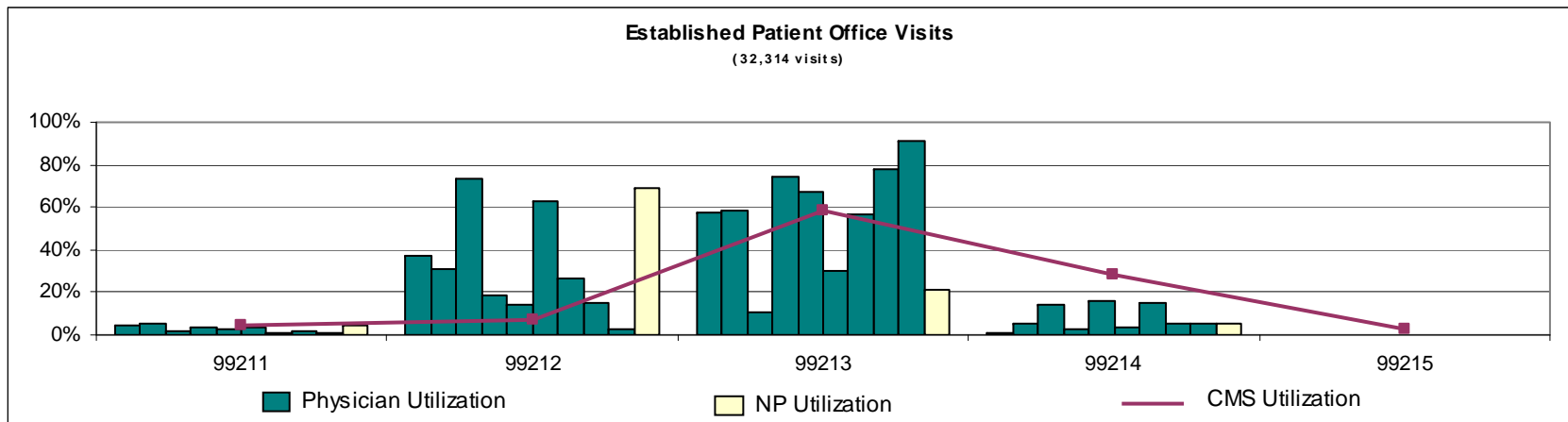
**REDISTRIBUTED UTILIZATION**

**VARIATION**

<u>CPT</u>	<u>Fees</u>	<u>Units</u>	<u>ABC %</u>	<u>\$ Prod</u>	<u>Units</u>	<u>CMS%</u>	<u>\$ Prod</u>	<u>\$ Prod</u>
99211	\$30	989	3%	\$29,670	1,275	4%	\$38,254	\$8,584
99212	\$48	9,129	28%	\$438,192	2,047	6%	\$98,236	(\$339,956)
99213	\$68	19,876	62%	\$1,351,568	17,846	55%	\$1,213,537	(\$138,031)
99214	\$103	2,090	6%	\$215,270	10,223	32%	\$1,052,923	\$837,653
99215	\$162	230	1%	\$37,260	924	3%	\$149,621	\$112,361
		32,314	100%	\$2,071,960	32,314	100%	\$2,552,572	\$480,612

**TOTAL VARIATION \$480,612**

SOURCE: CMS National E/M Utilization Summary Report; Family Practice January through December 31, 2007  
SOURCE DATA: RPT Proc Analysis



# Example E/M Findings – Code Category Utilization

"Surgery R Us"		Type of Service	CMS - Surgery	
Volume	% Util		Volume	% Util
<b>4,500</b>	<b>7%</b>	<b>New Patient</b>	<b>379,937</b>	<b>8%</b>
<b>55,000</b>	<b>91%</b>	<b>Establ. Patient</b>	<b>3,402,953</b>	<b>68%</b>
<b>1,000</b>	<b>2%</b>	<b>Office Consult</b>	<b>1,230,641</b>	<b>25%</b>
<b>60,500</b>	<b>100%</b>		<b>5,013,531</b>	<b>100%</b>

## Documentation Reviews (internal “audits”)

- Practices should:
  - Assess “bread and butter” services
  - Create a schedule and stick to it (even if it’s only two cases per month per provider)
  - Keep it simple (or it won’t get done)
  - Communicate results (good and bad)
  - Be consistent and follow through with findings
  - Document successes!!

## An Effective Implementation Schedule

- Conduct E/M coding utilization analyses every six months
- Conduct internal documentation reviews regularly
- Return coding-related payment denials to the coder to research (ongoing education) regularly
- Report payment denial trends to providers quarterly.

- **Outside reviews** should be done:
  - Simply to verify that the internal process is working – “review the reviewer” studies (**every one or two years**)
  - or*
  - If the practice does not have the resources or expertise to perform regular internal reviews (**every six months**)

# Education

- Because providers should be responsible for information on claim, careful attention should be paid to their education.
- Consider that providers typically don't understand the process (after their part in it).



**“I have no clue  
what happens  
after I’m done  
with the charge  
ticket.”**

## Define Scope of Education

**(“Provider Coding Education” is not enough)**

- New provider orientation (soup to nuts: internal tools and policies and technical coding training on a variety of topics the provider will face)
- Initial E/M coding training (very detailed)
- Follow-up E/M coding training (includes short cuts)
- Regular review follow-up (can cut through to the dirt)
- Focused review (potentially sensitive)
- New policies and procedures (might not even be “coding” discussion)

## Staff (business office, front desk, clerical)

- Meetings and classes
- Memos
- E-mails
- Daily tidbits (300+ bits of information!)

- Consider co-education when appropriate (learn “the other side”)
  - Multidisciplinary meetings
  - Job sharing
  - Training (not just exposure) by other departments
- Education should be policy driven (not Sue teaching Jane how she’s “always done it”)

- Clinical staff are rarely offered coding and billing education
  - Easiest and most effective: meet with nurses and ancillary staff to discuss what each item on the charge ticket represents and how it applies to them
- External classes should always lead to internal sessions
- Err on the side of teaching too many people

# Other Recommendations

- Watch for front-end related payment patterns by the top payers. Keep a log of issues and problems, categorized by payer. When the patterns break, call payer contact (or identify the internal error source and educate).
  - Trend outright denials and non-payments (that float in la-la land)
    - Create a log when researching non-payments, by payer, to identify the hold ups

- Maintain a folder for each of your major payers. Drop in copies of inappropriate denials, low payments, and other details of your relationship with that payer. These examples will come in handy during the next round of contract negotiations.

- Develop uniform adjustment buckets, by payer, to allow for detailed monitoring of denial type and significance (\$ impacted).
  - Coding issues (separate CPT from ICD-9 issues)
  - Registration issues (top part of claim)
  - Claims information (bottom part of claim: units, POS, referring physician, etc.)
  - Other
    - Timely filing
    - Medical necessity issues
    - Requests for additional information

# Other Recommendations

## Denial Management Report

### Summary, by Denial Type, by Payer

7/31/2009

Pt.	DOS	\$	DOD	Payer	Reason	Date	Action		
							Issue/Action	Result	
1	3/13/2009	\$ 424	3/29/2009	BC/BS	7	3/30/2009	Requested documentation	Pending	
2	3/13/2009	\$ 123	3/29/2009	BC/BS	7	3/30/2009	Requested documentation	Pending	
3	3/17/2009	\$ 75	3/24/2009	Medica	2	3/25/2009	Wrong dx on lab; resubmitted	Paid	
4	3/17/2009	\$ 245	3/24/2009	Medica	3	3/25/2009	Wrong ins; forwarded to Registration	Pending	
5	3/17/2009	\$ 175	3/24/2009	Medica	4	3/25/2009	Referring physician missing; refiled	Paid	
6	3/17/2009	\$ 245	3/24/2009	Medica	3	3/25/2009	Wrong ins; forwarded to Registration	Pending	
7	3/22/2009	\$ 125	3/31/2009	Medicaid	7	4/1/2009	Requested documentation	Pending	
8	3/22/2009	\$ 75	3/31/2009	Medicaid	5	4/1/2009	Timely filing; write off	Wrote off	
9	3/22/2009	\$ 232	3/31/2009	Medicaid	3	4/1/2009	Wrong Ins #; forwarded to Registration	Pending	
10	3/15/2009	\$ 125	3/25/2009	Medicare	1	3/26/2009	Missing -25. Resubmitted.	Paid	
11	3/15/2009	\$ 125	3/25/2009	Medicare	1	3/26/2009	Missing -25. Resubmitted.	Paid	
12	3/15/2009	\$ 75	3/25/2009	Medicare	4	3/26/2009	Provider number inconsistent w/svc; typo	Pending	
13	3/15/2009	\$ 232	3/25/2009	Medicare	2	3/26/2009	Screening dx on lab; to Coding; resubm.	Paid	
14	3/15/2009	\$ 75	3/25/2009	Medicare	2	3/26/2009	Screening dx on lab; to Coding; resubm.	Paid	
15	3/12/2009	\$ 153	3/21/2009	PrefOne	3	3/22/2009	Wrong Ins #; forwarded to Registration	Paid	
16	3/12/2009	\$ 75	3/21/2009	PrefOne	4	3/22/2009	POS filed as inpt; corrected	Paid	
17	3/16/2009	\$ 125	3/23/2009	UCare	3	3/24/2009	Wrong DOB; forwarded to Registration	Pending	
18	3/16/2009	\$ 325	3/23/2009	UCare	2	3/24/2009	Screening dx on lab; to Coding; resubm.	Pending	

SUMMARY:	Number of occurrences	%
1. CPT coding issues	2	11%
2. ICD9 coding issues	4	22%
3. Registration issues (top part of claim)	5	28%
4. Claims information (bottom part of claim: units, POS, referring physician)	3	17%
5. Timely filing	1	6%
6. Medical necessity issues	0	0%
7. Requests for additional information	3	17%
	18	100%

Do analysis by \$ and #

Source: EOB review from 1st quarter 2009

- Formulate good relationships with key payers. Meet with them at least every six months.
  - Talk over the timing of payments, confusing denials, or other key issues (from your folder).
  - Bring copies of relevant documents or correspondence so you can talk about real facts instead of anecdotes.
  - Be sure to point out the positive **AND** the negative!

- Expose all functions to their role and their responsibility in the revenue capture process.
- Everyone must understand
  - They each have a role and certain responsibilities in the revenue capture process
  - How their function relates to the big picture
  - What happens if they “drop the ball.”
- No one should be thinking “the next person in the chain will fix it.”

- My purpose here today was to help you:
  - Prevent problems, not fix **and re-fix** them
  - Minimize the checking and rechecking, and rechecking...
  - Be proactive – to keep looking for “better ways of doing things”
  - Create a culture in which **everyone** understands they have a responsibility in the revenue flow process...  
  
...then provide them the education to carry out that responsibility.

What happens (or doesn't happen)  
on the front end affects the back end...  
and that's where we should be focusing.

# Questions



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*The information presented and responses to questions posed are not intended to serve as coding or legal advice. Many variables affect coding decisions and our response to the limited information provided in a presentation session is intended only to provide general information that might be considered in resolving coding issues. All coding must be considered on a case-by-case basis and must be supported by medical necessity and appropriate documentation. Therefore, Wipfli recommends considering a variety of sources to determine appropriate coding and claim submission.*

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