Billing and Coding
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Michael Granovsky MD, CPC, FACEP

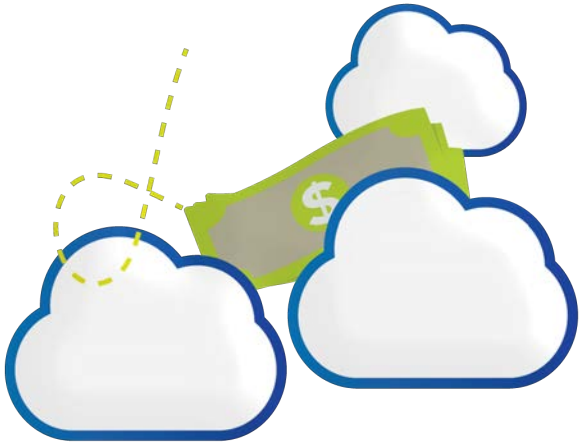
President, LogixHealth

The Safety Net - Now The Front Line

We are both the safety net and the front line.

Billing Terms-Accounts Receivable

- Accounts Receivable A/R- services that have been billed for, but $ not collected
  - Patient seen and treated
  - Chart coded
  - Bill sent



Money not received yet… "It's out there."

Days In Accounts Receivable

- **Days in A/R- The average number of days it takes to collect on a bill.**
  - Total $ in AR/Average daily charges
  - $2,000,000 AR/$50,000 daily charges = 40 days
  - Benchmark for how long it takes to collect your money
- **Best Practice now < 40 days**
  - Many variables: payer mix, registration data, chart flow, coding turnaround, billing efficiency

AR Report: Ideal Example

	Apr 20XX	May 20XX	Jun 20XX	Jul 20XX	Aug 20XX	Sep 20XX	Oct 20XX
Charges	$1,109,679	$976,023	$988,565	$1,148,619	$981,894	$986,410	$961,432
Collections	$246,484	$217,510	$240,462	$253,666	$235,618	$229,865	$242,700
# of Pts	2,695	2,650	2,623	**3102**	2,713	2,709	2,672
Refunds	$81	$893	$295	$669	$486	$405	$279
Cont Adjs	$292,752	$246,678	$272,409	$282,819	$265,494	$257,069	$246,261
Free Care	$2,370	$3,253	$2,214	$1,175	$3,573	$3,830	$2,373
Bad Debt	$62,478	$56,971	$63,463	$55,653	$63,134	$88,699	$44,236
A/R*	$1,895,113	$1,847,617	$1,897,928	$2,073,904	$1,928,465	$1,896,412	$1,851,553
Days*	37	38	37	**41**	40	38	38

Billing Terms: Aging Analysis

- Aging Analysis- lets you know how old your A/R is in 30 day increments:
- 0-30, 30-60,60-90,90-120…
- May even be broken down by payer:

  Aged Trial Balance

  - Medicare may run 21 days
  - Medicaid 30-90 days (variable)
  - Self-pay 120 days
  - Worker's comp. 150 days
- Depends on optimizing clean first pass claims

Days To Bill Drop

- The number of days from the date of service until a bill is sent to the patient or insurance carrier
- **Benchmark 3 days**
- **3 days** maximizes practice cash flow
- Many steps:
  - Chart completion
  - Data file transfer
  - Coding (is there a back log)
  - Data entry (should no longer exist)
  - Demographic verification
  - Claim scrubber (maximize clean first pass)
  - Bill sent

Dunning Cycle

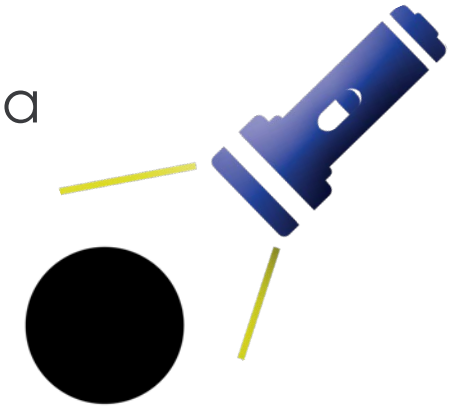
- Schedule of claims and statements
- Payer specific cycles enhance cash flow
  - Medicare processes Wednesday
  - BCBS processes on Tuesday
  - **Best Practice Submit directly electronically and receive by EFT**

The longer "it's out there"…

the harder it is to collect!

Shine a Light On The Black Hole of Billing

- **FILE** and **POST** Electronically – discrete steps
  - Medicare, Medicaid, BCBS, Aetna, Cigna
  - 837 electronic claim submission
  - 997/999 claim received
  - 835 electronic remittance
    - (EOB shows payment and denials)
  - Electronic Funds Transfer (EFT)- direct deposit
- **Best Practice: All electronic process**



Gross Collection Ratio

- **$ Collected/Total Charges (as a %)**
- **Not "apples to apples"**
  - Impacted by pricing structure
  - Impacted by payer mix
  - 99283 charge $180
    - HMO reimburses $60 ….30% Collection Ratio
    - Comm. reimburses $90…50% Collection ratio
- Whole state of MD runs 42% (vague term)

Net Collection Ratio

Net Collection Ratio:

Total $$ charged minus contractually mandated discounts

- all the collectible $

See 50 HMO patients coded 99283 ($180 charge)

Contracted rate $60

Total charges	$180 X 50 = $9000
Total collectibles	$60 X 50 = $3000
Receive payment on 48 patients	48 X $60 = $2880
Gross collection ratio	$2880/$9000 = 32% ***?bad***
Net collection ratio	$2880/ $3000 = 96% ***good***

Good indicator of **billing performance**

Benchmark > 98%

Apples to Apples
$ Collected per Billed Visit

- The ultimate distilled measure of revenue for each visit

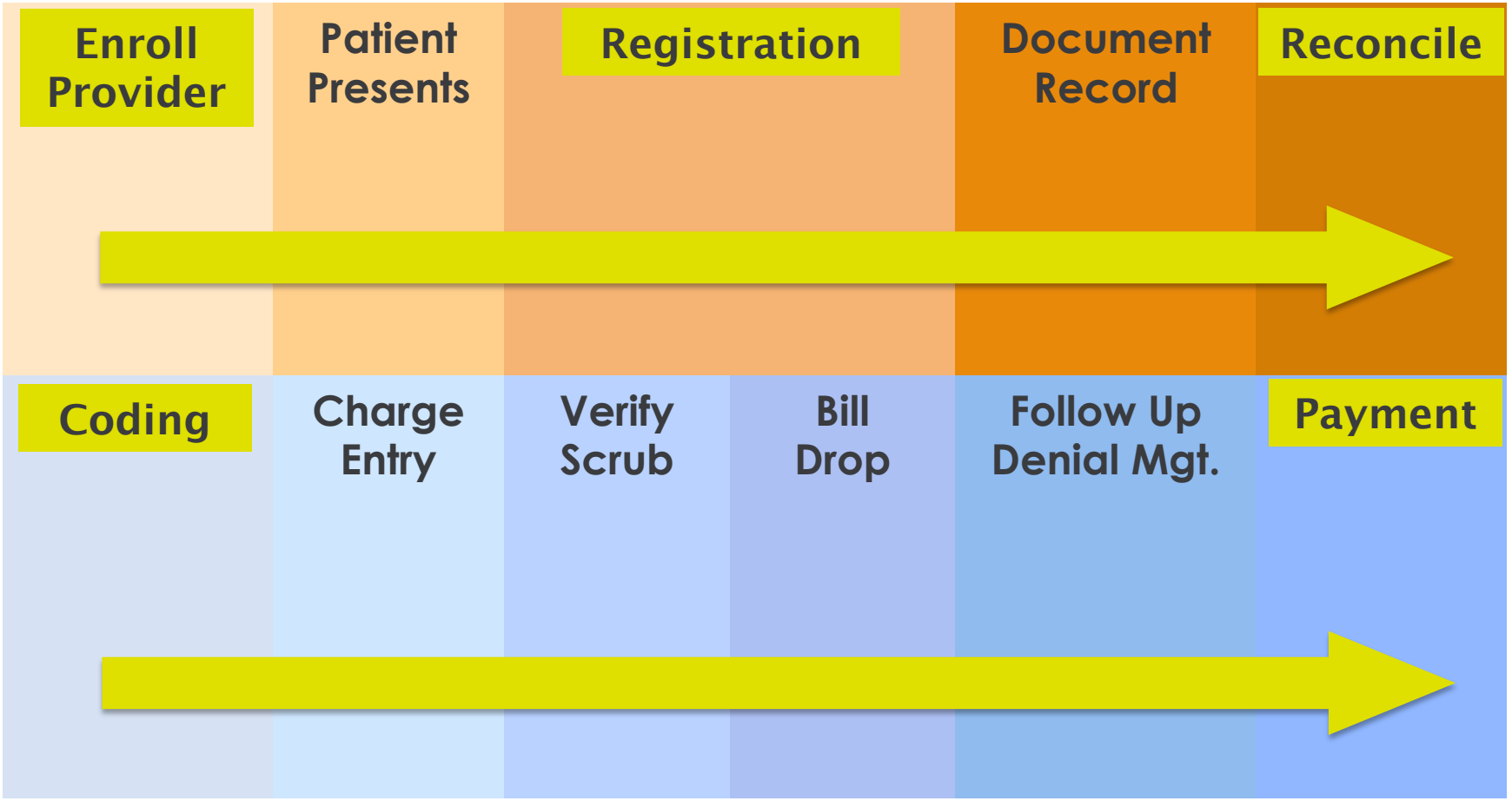
- Allow time for accounts to mature
  - 6 month look back

- High End $200
- Suburban $150
- Urban $90 hospital subsidy

Billing Functionality: Best Practices and Benchmarks

- Days in AR: AR/Avg. daily charges **<40 days**
- Bill drop **3 days**
- **Submit electronically** to all enabled payers
  - No Clearing House
- Net Collection Ratio: $ collected / All the collectible money **>98%**
- $ collected per patient maximized
  - Track trends
- Steady practice cash flow!

The Revenue Chain



Provider Enrollment

- Tight timeline
- Robust provider enrollment team
  - Full software package
- Off the shelf application package
  - **Project**
- Measure turnaround time from providers
  - 1-2 wks. max
- How much revenue is waiting for provider numbers?
  - Missing Provider Number Receivables Report
- No provider numbers = no pay!
  - **Benchmark 100% credentialing**

Hospital Registration Data

- Measure the amount of bad insurance info.
- Get detailed insurance data crosswalks
  - Not just "BCBS" use insurance dictionary from the hospital - over 1,000 discrete payers
- Clean Claim Report:
  - **Benchmark > 98% first pass clean claims**
  - Track denial reasons: Patient ineligible
- Billing agent should work closely with:
  - Hospital IT re-query/real time updates
  - Registration staff scripting **Project**
  - **Best Practice: Direct Electronic Download**

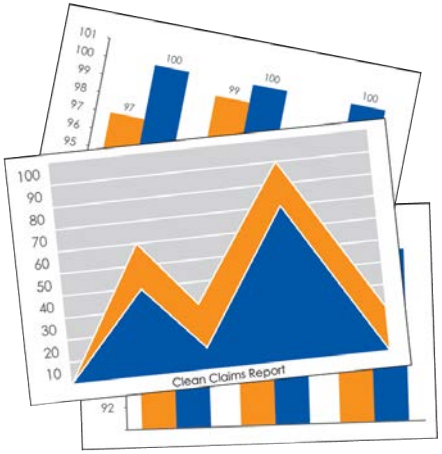


Chart Reconciliation Report

- Account for every chart! Lost record > $100
  - 5 hours of clerical time
  - ED registration log = the denominator
  - Electronic download and weekly aged reconciliation **Project**
  - Purposely not billed: Private physician, LWBS
  - Missing: (Often admissions and transfers)
  - Incomplete: Sent back to the provider pending additional documentation
  - **Best Practice: electronic download of the ED log and daily updated reconciliation reports**

Reconciliation Formula

Formula- account for 100% of records

#Billed

#Purposely not billed

#Incomplete

+ #Missing

#Patients on ED Log

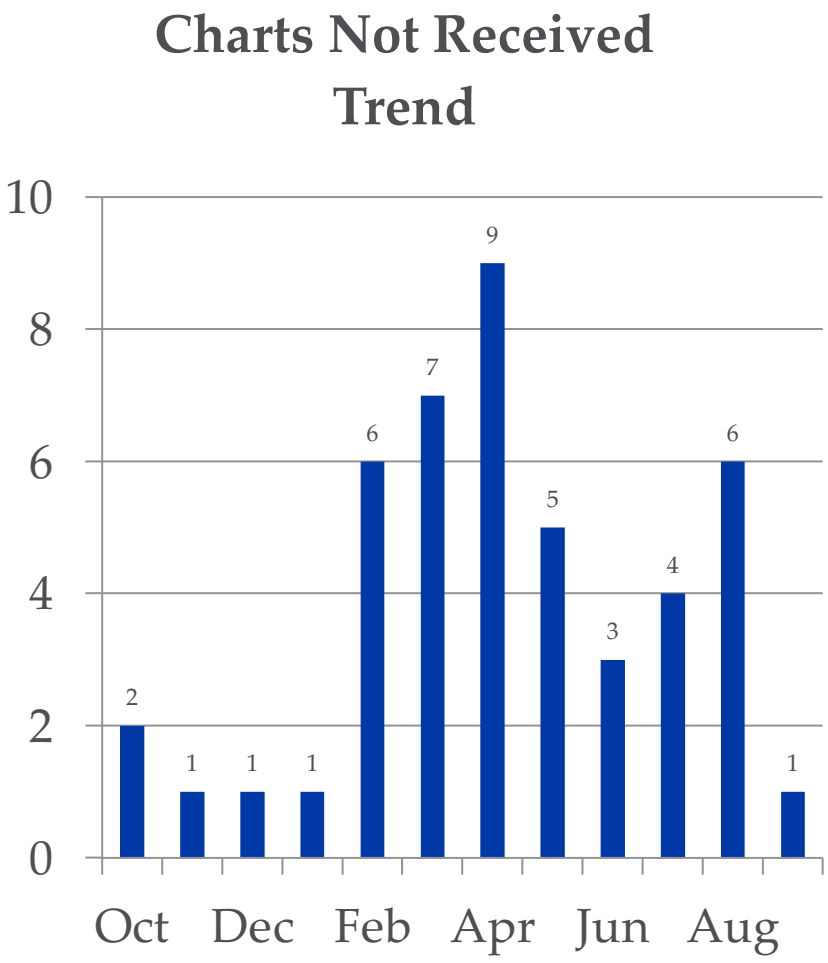
Benchmark: MISSING SHOULD BE < 0.25% at 1 month

At 30 days >99.75% of records received

Reconciliation Report Detail: 100 Patients on ED Log October 3rd

- 91 Billed
- 4 Purposely not billed
  - 2 Suture Removals
  - 1 Private MD
  - 1 LWBS
- 3 Sent back to doctor (incomplete)
  - 1 Dr. Jones October 15
  - 1 Dr. Smith October 17
  - 1 Dr. Green October 17
- 2 Still missing

Reconciliation Reports - Trend Monthly



ED Log Reconciliation Value

Let's do a little math:

- 3 charts per day
  - 365 X 3= 1,095 charts per year.
  - (1,095) X ($150/chart)=$164,250 per year.
- How many unbilled charts do you have?

Best Practice/Project: Daily Reconciliation report.

Useful reports enable important changes!

Billing Processes: Best Practices and Benchmarks

- Tight enrollment process
  - **100%** enrollment providers
- **98%** Clean first pass claims
- Direct electronic downloads:
  - Accurate ED Census Log
  - Full daily electronic reconciliation
  - **99.75%** of charts received within 30 days

The Importance of Provider Documentation/Education

Coding- Why Does It Matter?

- Coding and documentation is simply the process of **communicating to the payer your concerns and thought process**
- The payer does not have the following:
  - The chart
  - The patient's perspective on the tx. received
  - The ability to talk to the treating physician
- The payer receives (electronically) a series of 5 digit codes representing your care

Your documentation must empower/allow the coder to accurately report the work performed

Who Does The Coding?

- Hospital – traditionally not focused on ED coding
  - Low charges, signs and symptoms
- Physicians – typically not trained in coding rules, inefficient use of time
- EHR- lowest common denominator
- Experienced Professional Coders

Documentation Guidelines: Focus on Complex Cases

Level	HPI	ROS	PFSoc	PE
1	1	0	0	1
2	1	1	0	2
3	1	1	0	2
4	4	2	1	5
5	4	10	2	8

History of Present Illness

- Location – left sided chest pain
- Context – while shoveling snow
- Quality – sharp chest pain
- Timing – worse at night
- Severity – moderate chest pain
- Duration –10 minutes
- Modifying Factors – worse with exertion
- Associated Signs and Symptoms – diaphoresis

This is the case specific detail that makes the patient "come to life" …antidote to "cloning"

HPI Killers

LEVEL	99281	99282	99283	99284	99285
# HPI	1-3	1-3	1-3	4	4
RVUs	0.64	1.24	2.09	3.55	5.18

HISTORY OF PRESENT ILLNESS
CHEST PAIN. This started yesterday.

History of Present Illness:
HPI Comments: Low o2 sats at home poor respiratory effort in er.

The history is provided by the patient and a caregiver.

The Big Cost of HPI Errors

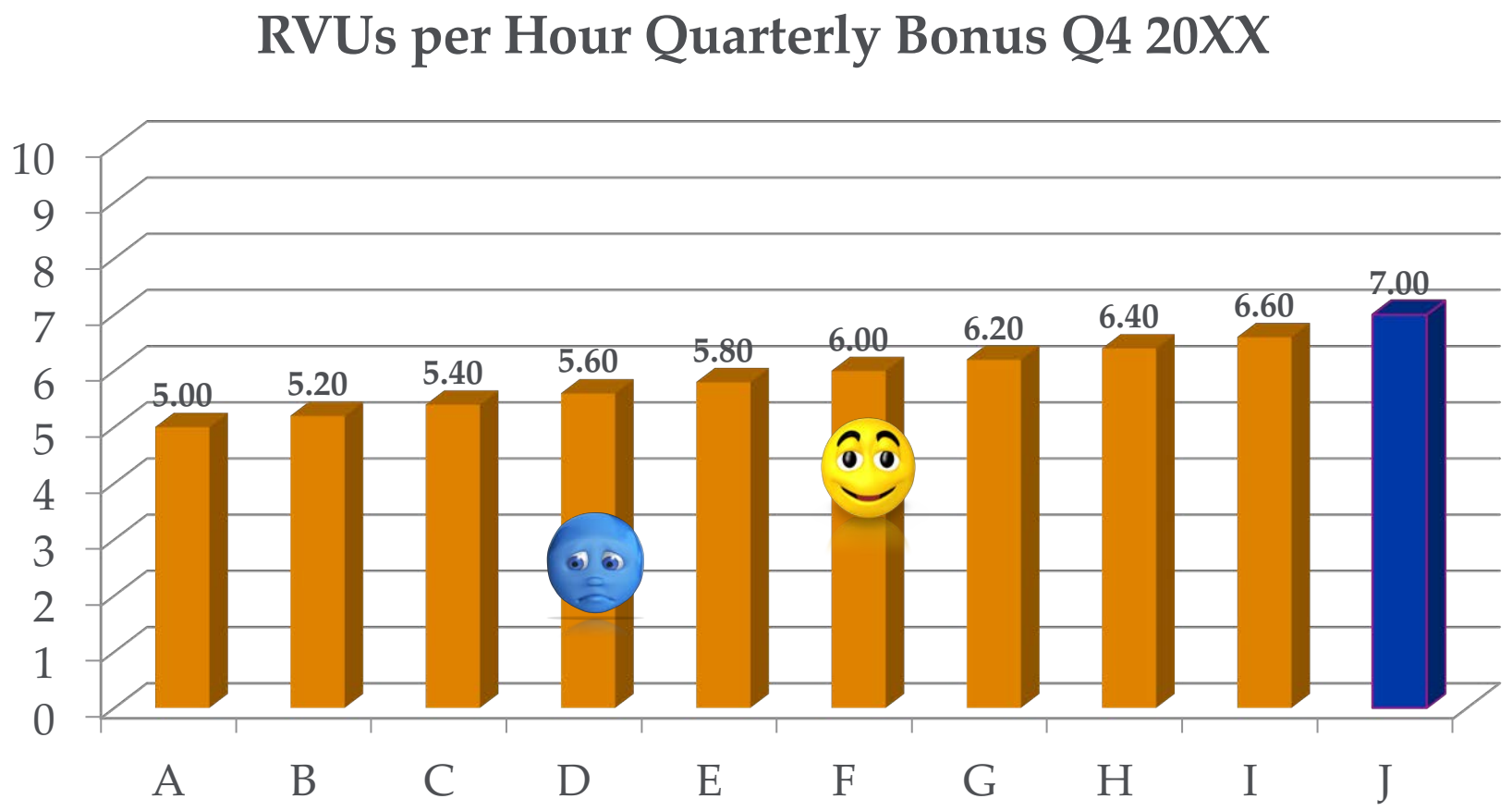
- Some basic math:
  - 8 hour shift
  - 2 patients per hour ⟹ 16 patients
  - 3 RVUs per patient ⟹ 48 RVUs
  - **6.0 RVUs per hour**

  Or 1 HPI Downcode: 5.18 to 2.09 RVUs

  Loss of 3.09 RVUs - ⇩ .4 RVUs/Hr

  Down to 5.6 RVUs/Hour!

Coding Reports: RVU/Hour



Documentation Tools: CMS Documentation

History Caveat:

"If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstances which precludes obtaining a history."

CMS 1995 Documentation Guidelines

History Caveat

- NH patient with advanced dementia and DKA:

> **History: Unable to obtain due to altered mental status.**

- 73 year old Poor historian with UTI, fever, and dehydration

> History: Patient presents with 2 day history of fever and decreased PO intake. Pt is a nursing home resident, with history of dementia, was sent in by PMD for possible UTI. **Unable to obtain** the remainder of the History due to dementia.

Documentation Tools: CPT Documentation

The Acuity Caveat:

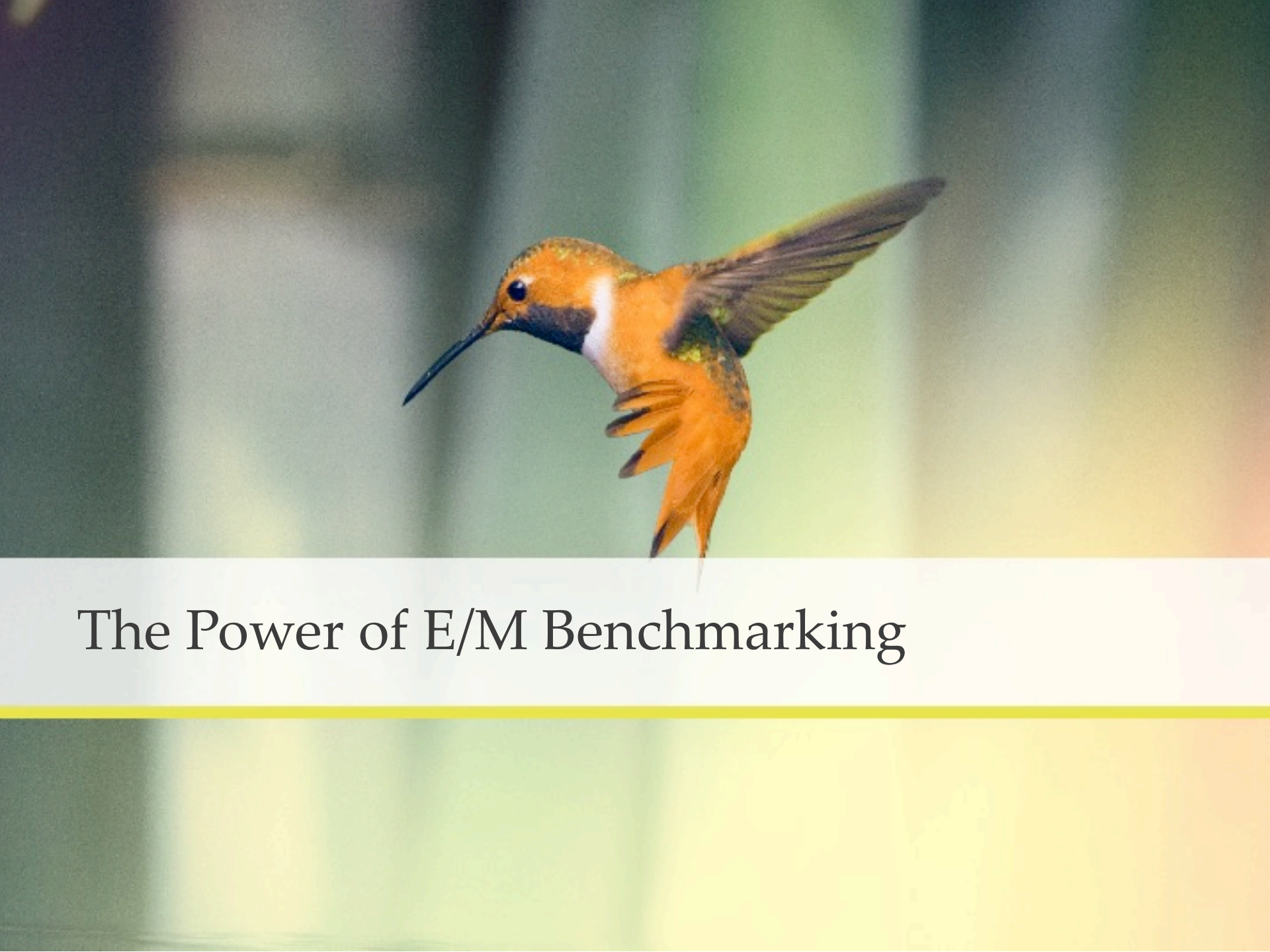
- 99285 requires:
  - Comprehensive History
  - Comprehensive Exam
  - High Level Medical Decision Making

☑ 99285

Emergency department visit *for the evaluation and management of a patient, which requires these three key components* ***within the constraints imposed by the urgency*** *of the patient's clinical condition and/or mental status*:

Documentation Best Practices

- 4 HPI with **case specific** detail
- Recognize high complexity cases
- Beware overuse of ROS and PE macros
  - Include pertinent positives and negatives
- Document Past/Family/Social Hx
- Cleary state history caveat
- Utilize the acuity caveat

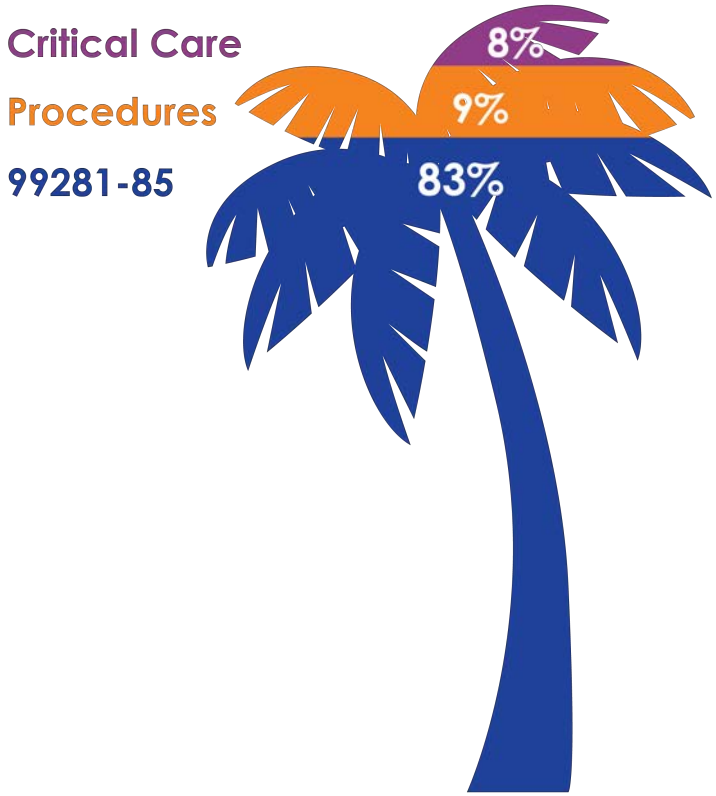


The Power of E/M Benchmarking

Where Are The RVUs?

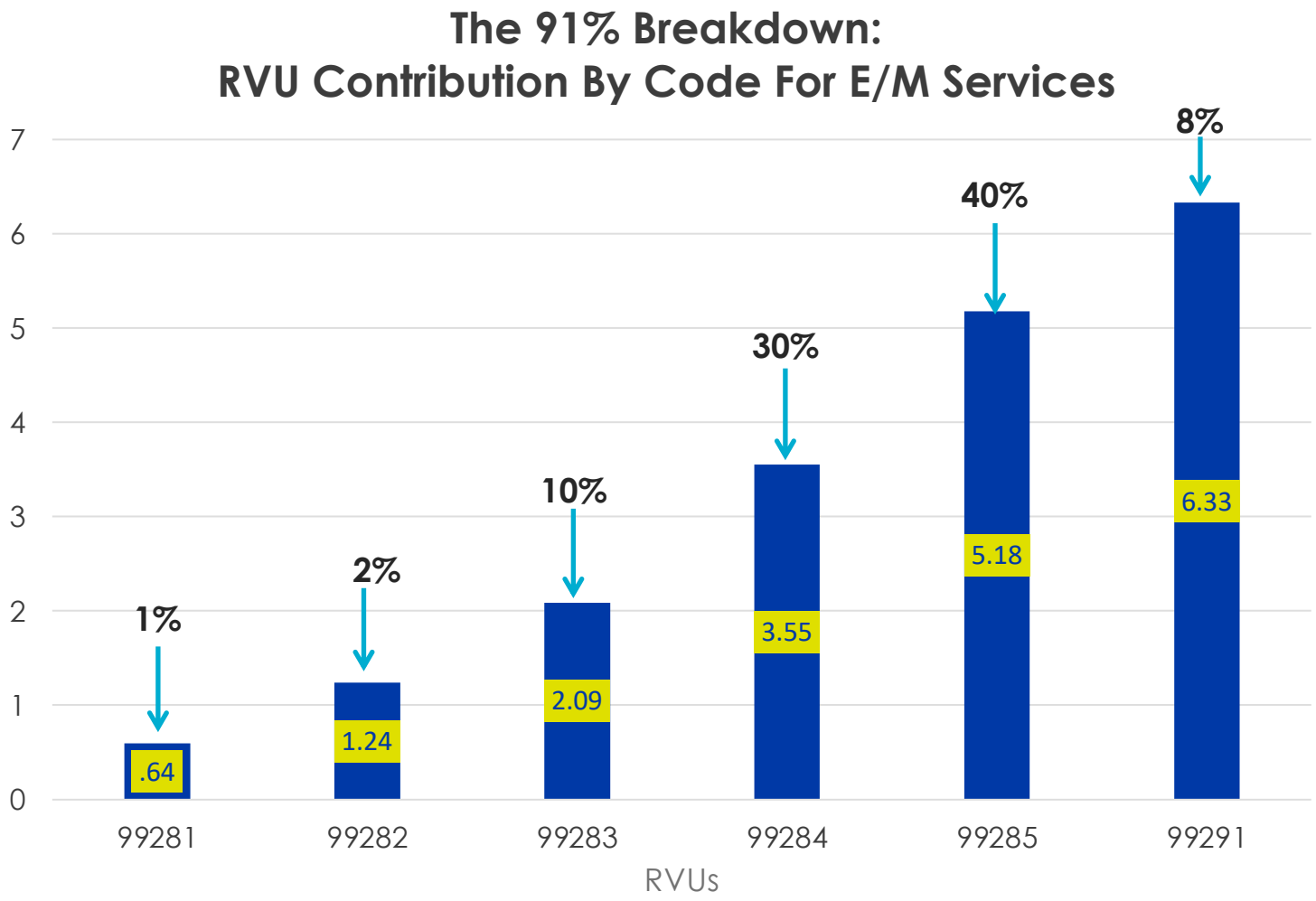
- 83% of typical ED revenue

  99281-99285 - track key metrics
  - E/M distribution
  - Average E/M
  - Feedback report
- Critical Care brings up to 91%
- Widen the lens to 100%
- RVUs per patient
  - Includes procedures



Track the important metrics!

2021 Drilling Down on E/M RVUs



Benchmarking Your Coding

- Majority of revenue derived from appropriate E/M levels
- Benchmark data **Project**
  - Acuity predictors
- Common admission benchmark as 85s
- 55/45 split between 99284 and 99283
- 99281 and 99282 low due to high copays
- Critical care benchmarking
  - 4% - 6% for most groups
  - .2 - .3 X the admission rate

Benchmarking Example

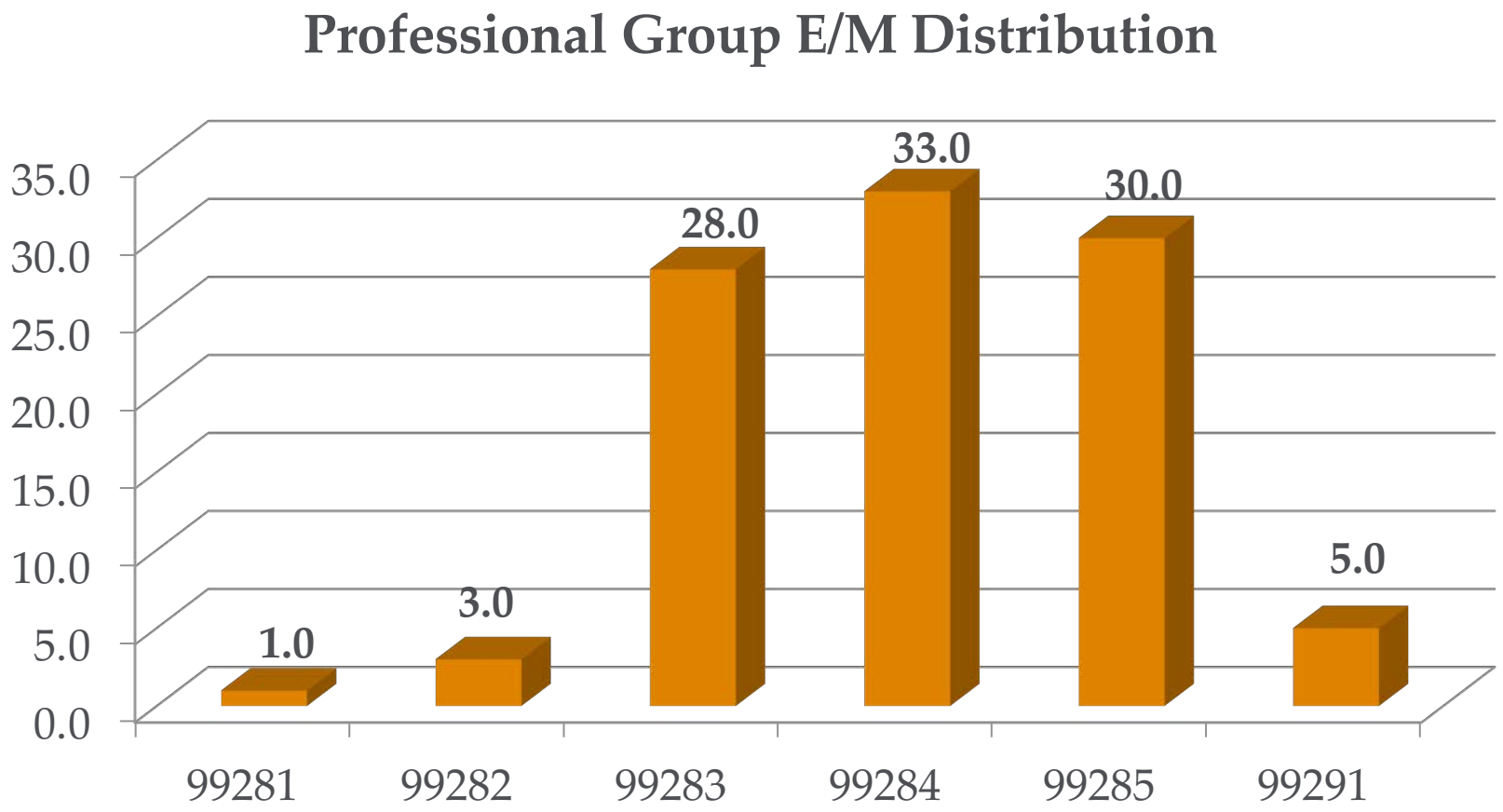
- 40,000 visit ED, level 2 trauma, Cath Center
- Admit Rate 24%
- Sample E/M Distribution:

99281	1%	99284	33%
99282	3%	99285	30%
99283	28%	99291	5%

PROJECT:

Compare and benchmark your E/M distribution

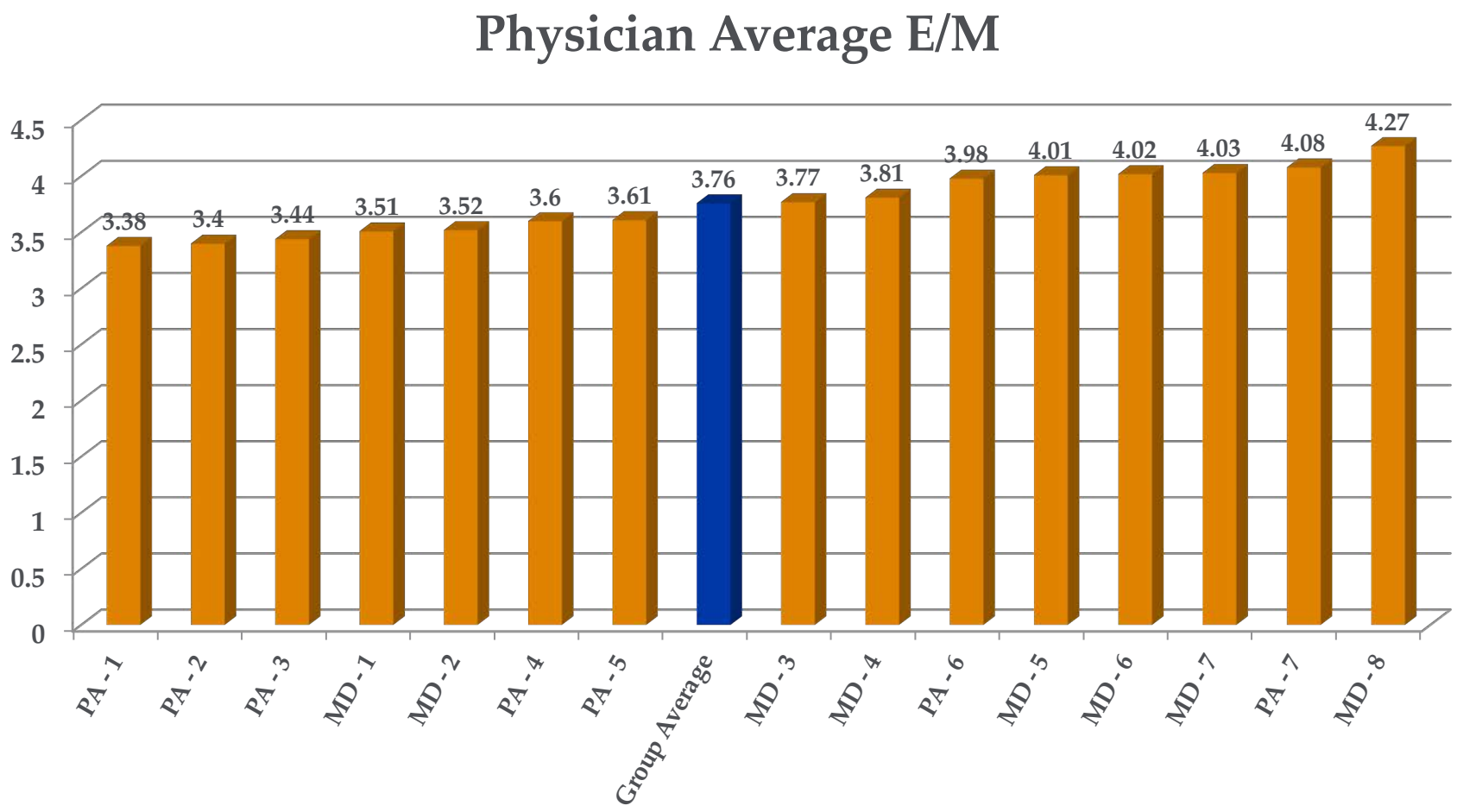
Benchmark E/M Distribution



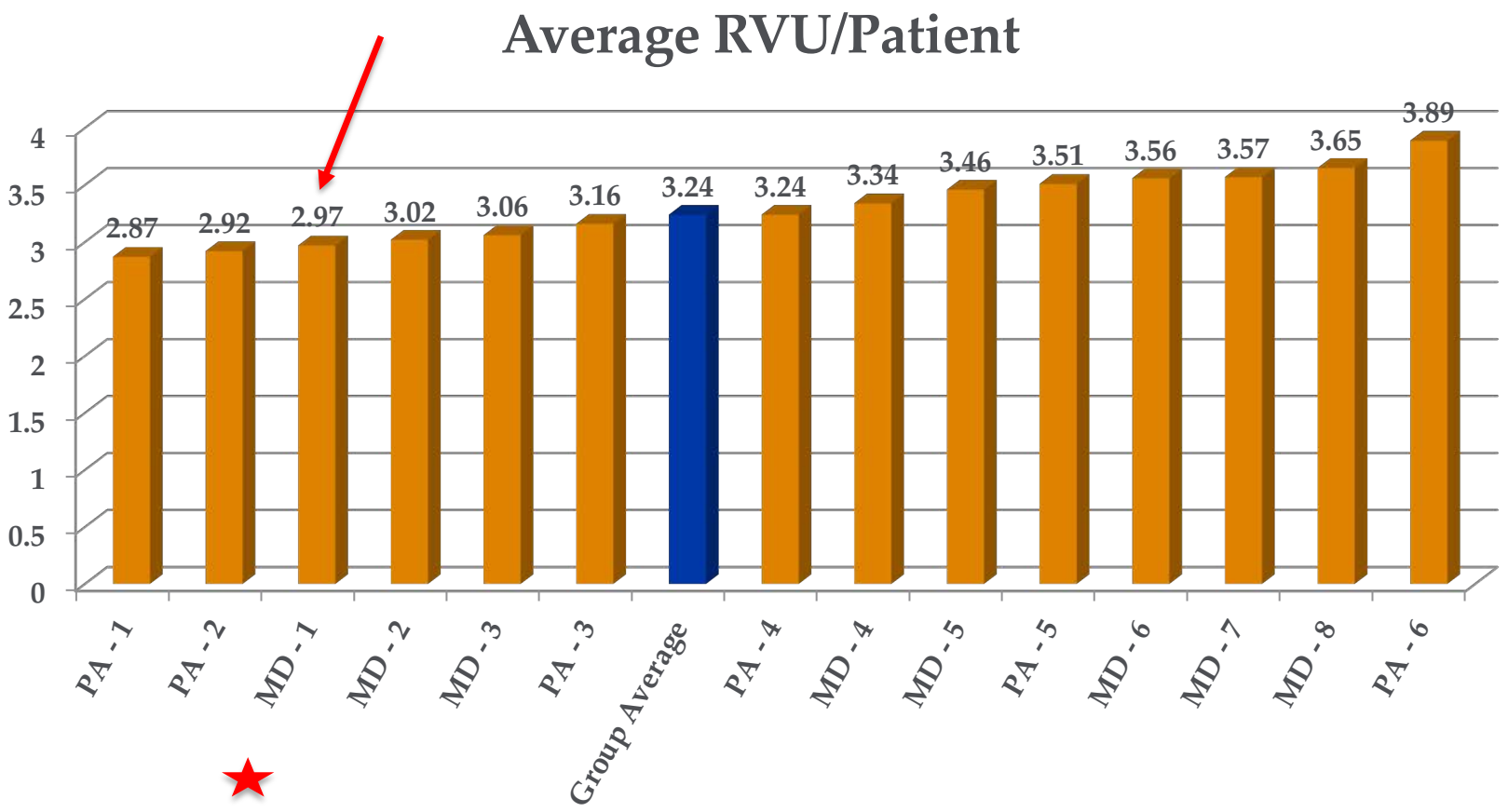
E/M Trends Drive Charges
Benchmark Against Yourself: Rolling 12 Months

Evaluation & Management Distribution Analysis							
CPT	Jun	Jul	Aug	Sep	Oct	Nov	12 Month Average
99281	1%	1%	1%	1%	0%	1%	1%
99282	3%	2%	3%	5%	3%	2%	3%
99283	27%	27%	29%	29%	28%	27%	28%
99284	33%	31%	32%	34%	33%	34%	33%
99285	30%	29%	29%	32%	29%	31%	30%
99291	5%	5%	5%	4%	5%	5%	5%

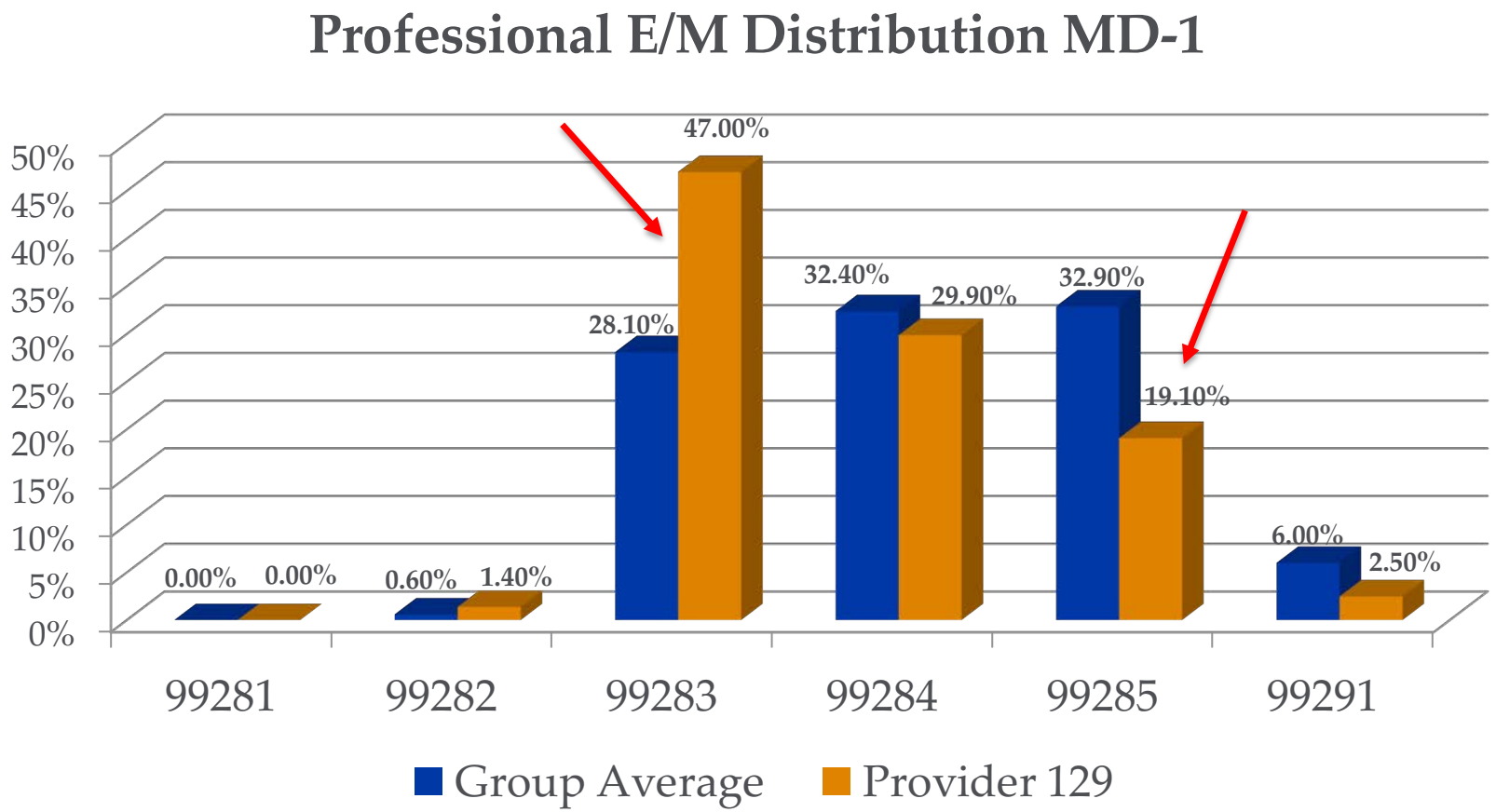
Coding Reports: Average E/M



Coding Reports: Average RVU/Patient



Benchmarking Provider E/M Distribution



Provider Education

Managing Documentation and Coding: Effective Provider Education

- Documentation/Coding are a key vulnerability in the revenue chain
- Effective provider education - creates the required foundation to optimize revenue
- Need a recurring education program
    - Example records returned to individual physicians
    - Formal didactics
    - Track provider feedback
- **Best Practice: RVU and feedback reports monthly**

Coding Reports: Documentation Feedback

- Feedback reports by provider
  - HPI
  - ROS
  - PFSH
  - PE
- Critical Care Feedback
  - Possible Critical Care Cases
    - Acute MI

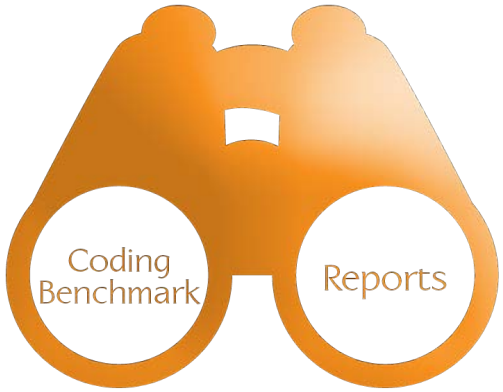
Educational Feed Back and Follow Up

Provider Documentation Three Month Trend

Provider	June	July	August
Provider A	√	√	√
Provider B	ROS	ROS*	√
Provider C	CC	ROS*	√
Provider D	ROS	ROS, Exam*	ROS, PFSHx
Provider E	PFSHx	√	√

Coding Benchmark Reports to Watch

- Overall E/M Distribution
- RVUs per patient for the group and by provider
- Average E/M per patient for the group and by individual provider
- Feedback Report

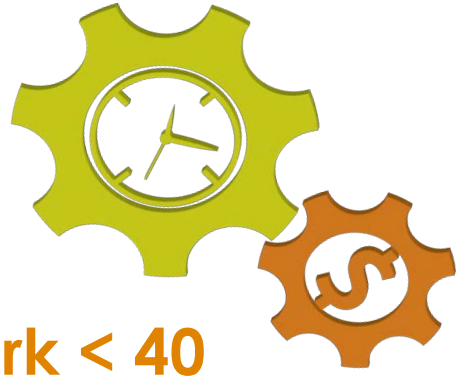


Coding: Benchmarking and Best Practices

- E/M Distribution Benchmarks
  - Benchmarking 85s
  - Benchmarking Critical Care
  - **PROJECT**
- Solid education and feedback program
- Need sophisticated coding methodology
- Accurate physician documentation
  - No Downcodes
  - Utilize all documentation tools!

Billing-Turning Your Hard Work Into Revenue

Managing The Billing Process



- Track the important metrics
- Overall size of the AR
  - 40K visits runs ~ $2m
  - Days in AR-look for trends… **benchmark < 40** increasing days = danger sign!
  - Follow Gross and Net collection ratio
  - Maximize $ collected per patient
    - Allow accounts to mature
- Gross monthly revenue should be steady!
- Watch gross **charges** as an early warning sign

Billing Report: Mastering The Terms

Executive Summary: Charges, Collections and A/R Analysis						
	Aug	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
Charges*	$1,770,746	$1,822,473	$1,768,146	$1,703,243	$1,851,191	$8,415,799
Collections*	$716,148	$770,177	$777,442	$748,679	**$702,914**	$2,315,360
# of Patients*	3,052	3,425	3,212	3,158	3,512	15,759
Refunds*	$3,846	$3,799	$3,723	$4,043	$3,325	$8,098
Cont. Adjs*	$629,306	$608,797	$669,277	$659,878	$670,200	$2,837,457
Free Care*	$4,875	$3,585	$3,535	$4,979	$3,471	$16,570
Bad Debt*	$101,845	$108,090	$74,814	$103,341	$119,915	$579,006
A/R*	$2,114,447	$2,186,279	$2,031,080	$2,020,489	$2,145,504	$2,035,504
AR Days*	39	39	37	36	38	36

Billing Practice Performance Reports: Date of Service Analysis

Date of Service Analysis						
CPT	**March**	**April**	**May**	**June**	**July**	**Total**
Total Charges	$1,808,884	$1,821,390	$1,815,147	$1,465,803	$1,852,778	$8,664,002
# of Visits	3,219	3,313	3,304	**3,030**	3,276	16,242
Avg Chg/Pt.	$462	$463	$459	$460	$461	$461
Collections	$650,452	$643,591	$644,899	$624,791	$690,779	$2,634,511
Avg Collect/Pt.	$189	$189	$188	$190	$191	$189

The 6-month look-back

Metrics to Monitor

- **Days in AR** - Should not trend up
- **Contractual adjustments** should not spike up
- **Monthly collections** should be steady
- **Average charge per patient** – small variations
- **Dollars collected per patient** – tight range
  - Allow accounts to mature
- Watch gross charges and your E/M distribution

Aged Trial Balance (ATB)

- Aging Analysis- a table displaying the A/R age by payer
  - 0-30 days, 30-60 days, 60-90 days, 90-120 days
  - Increase $$$ = warning sign!
  - Un-credentialed physicians
  - Clearing House failure
  - Billing company data file transfer failure
  - Alarm bells- monitor top 5 payers
    - Private pay increasing 45,60,75,….
    - BCBS
    - Medicare increasing

We Have a Problem!

ATB Warning Signs Increase $$$ Far Out

Payor Category	0 - 30	31 - 60	61 - 90	91 - 120	*121 -150	151 - 180	Total
Blue Shield	$66,567	$23,476	$18,325	$5,567	$632	$67	$107,025
Medicaid	$7,928	$2,261	$2,051	$1,408	$781	$232	$16,521
Aetna	$23,439	$37,338	$48,116	$72,184	**$111,360	$3,744	$297,116

My Cash Is Down

- Go Back 60 – 120 Days
  - Volume
  - Charge per patient …E/M Distribution
  - Provider Enrollment
  - Electronic Submission process
- Carrier Specific Issues
  - Contracted vs Non Par Rates

My Cash Is Down

- Payer Policy changes
  - Inappropriate bundling (EKGs)
- Discounting of E/M with procedure
  - Not honoring 25 modifier
- Coding has drifted downward
- E/M diagnosis downcodes

BCBS Down-coding 99284/99285

To: Physicians and Other Health Care Professionals

Subject: Clinical Editing Policy - Evaluation and Management Coding

BlueCross BlueShield

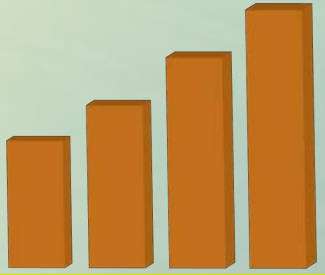
The Centers for Medicare & Medicaid Services has identified Evaluation and Management (E/M) coding as an area that has significant opportunity for increased accuracy. Effective with dates of service on and after

Excellus BlueCross BlueShield will adjust the level of E/M codes when appropriate.

Diagnosis codes will be used in determining the appropriate E/M level, using all diagnoses on the claim. If the diagnosis codes submitted do not support the level of E/M billed, the E/M code will be automatically adjusted to 1 or 2 levels lower at the time of adjudication based on the diagnosis code allowing the highest level.

Auto-Downcoding simply based upon Diagnosis!

Coding and Billing
Benchmarking and Best Practices



- Electronic processes
  - No clearing house
- 100% Enrolled Providers
  - Project
- 99.75% of records received at 30 days - Project
- 3 days to bill drop
- Consistent charges and monthly cash flow
- Days in AR < 40 days
- Maximized $$$ collected per patient
- Net Collections ratio 98%
- 98% clean first pass claims
- Benchmark group E/M distribution- Project
- RVUs/Patient
  - Group and provider
- Feedback Report
- Billing Reports
  - Executive summary
  - Date of Service

Michael Granovsky MD, CPC, FACEP

mgranovsky@logixhealth.com

781.280.1575

www.logixhealth.com