Importance of Revenue Cycle Continuous Education

EHR – EMR – ICD-10

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Presentation Outline

• Definitions

• Best Practice for Quality Patient Outcomes and Revenue Integrity Is Integration / Activation

• Revenue Integrity / Health is only ‘shortly second’ to Quality Patient Outcomes

• How do we connect the dots between Clinical Operations and Financial Operations?
First, the definitions

Definitions

The Healthcare Enterprise

- Delivers Healthcare Services
  - Could be one facility but collaborative networks are needed for sustainability

- Delivers quantifiable quality Healthcare Services
  - Standardized transparent metrics to demonstrate Quality Care

- Integrates data for the benefit of the patient (EMR)
  - The era of only your physician can understand clinical data is no longer valid

- Creates interoperability of data for the evolution of medical care across the country (EHR)
  - Collaborative Enterprise reporting across the US will improve healthcare

- Collects appropriate revenues from Payers or Payers to sustain itself and forward Quality Outcomes
  - Two mutually agreeable goals: Deliver Quality Care AND receive remuneration for those services
Electronic Medical Records

- The legal record of the CDO
- A record of clinical services for patient encounters in a CDO
- Owned by the CDO
- These systems are being sold by enterprise vendors and installed by hospitals, health systems, clinics, etc.
- May have patient access to some results info through a portal – but is not interactive
- Does not contain other CDO encounter information

Electronic Health Records

- Subset (i.e. CCR or CCD) of information from various CDOs where patient has had encounters
- Owned by patient or stakeholder
- Community, state, or regional emergence today (RHIOs) - or nationwide in the future
- Provides interactive patient access as well as the ability for the patient to append information.
- Connected by NHIN

Integrated Documentation
The Healthcare Enterprise Operations

Clinical Operations
- Direct Care
- Indirect Care
- Support (IC, Quality, Risk Management)

Financial Operations
- Revenue Cycle Operations
- Budgeting and Accounting

IT Operations
- Hardware
- System Applications

The ‘three legged stool’ of a Healthcare Enterprise
The Collaborative Enterprise

System Applications – can no longer be acquired in a vacuum (Clinical, Financial or Reporting)

Clinical AND Physician Documentation needs to be structured and differentiated with appropriate links to Finance

Clinical Operations must be integrated electronically WITH the Revenue Cycle

Quality patient Care ALWAYS come first

Change is always difficult ... care needs to be taken to not lose a patient ... literally
Best Practices

Best Practice for Quality Patient Outcomes and Revenue Integrity Is Integration / Activation

Metrics

‘Normal’ Measurements
- DNFB
- Denials
- Days in A/R
- Payer acceptance of Clinical treatment plan (CM)
- IP admission / OP Registration errors
- Claim rejection turnaround

Focus Measurements
- Revenue Integrity
- Customization of the EHR/EMR by payor
- Strategize by Account type and dollar amount of the claim
- Amount of training by service type, by employee
### Where to start?

<table>
<thead>
<tr>
<th>Denial Name</th>
<th>Denial Definition</th>
<th>Annual total to Date</th>
<th>% of Total Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td>LoD</td>
<td>denials based on lack of documentation or incomplete documentation</td>
<td>5,457</td>
<td>38.2%</td>
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<tr>
<td>UT Filing</td>
<td>denials for untimely filing</td>
<td>2,557</td>
<td>17.9%</td>
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<tr>
<td>LoA</td>
<td>denials for lack of authorization</td>
<td>1,734</td>
<td>12.1%</td>
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<tr>
<td>LoMN</td>
<td>denials based on lack of medical necessity</td>
<td>1,077</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

### Where to start? (page 2)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Total Claims Denied</th>
<th>% Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCO</td>
<td>contractual carve-outs</td>
<td>577</td>
<td>4.0%</td>
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<tr>
<td>NPPS</td>
<td>underpayments under non-participating provider statutes</td>
<td>1,175</td>
<td>8.2%</td>
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<tr>
<td>EMTALA</td>
<td>Emergency Medical Treatment and Active Labor Act (EMTALA) disputes</td>
<td>86</td>
<td>0.6%</td>
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<td>ERISA</td>
<td>Employee Retirement Income Security Act (ERISA) benefits denials</td>
<td>104</td>
<td>0.7%</td>
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<tr>
<td>CoB</td>
<td>coordination of benefits</td>
<td>1,532</td>
<td>10.7%</td>
</tr>
<tr>
<td>TCD</td>
<td>Total Claims Denied</td>
<td>14,299</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Best Practice - Finance/Revenue Cycle Education

- National Standard for Education Best Practice
  - 80 Hours per New Hire per annum
  - 36 Hours per Existing Employee per annum
  - 34 Hours devoted in creation of one hour of Class Time

- Backward and Forward Training
  - For Finance/Revenue Cycle
  - For Operations (across the Enterprise)

Collaboration between Clinical Outcomes and Revenue Integrity

The EHR/EMR will make ICD-9 and ICD-10 coding easier

- EHR Physician & Clinical Documentation can easily:
  - Affirm the lab result indicating sepsis
  - Provide reasoning for ordering a given treatment
  - Indicate POAs avoiding a HAC situation
  - Reflect H&P adequately resulting in ability to code CCs or MCCs
  - Automate Coding and Charges

- Admitting, referring & consulting physicians can see what each ordered/determined as the appropriate clinical path
Successful EHR / EMR implementations require structured clinical documentation

- automate PDX and DDx – reduces data input

Review of structured clinical documentation is needed to achieve Meaningful Use (MU)

- Could reduce Medicare Payments

Physicians should not be Coders

With ICD-9 this was diagnosis code 474.02, but now? Who knows?
Quality Data / Revenue Integrity

- CPOE – why the physician ordered the test
- Lab Results – acknowledgement of test results
- Problem Lists – sequencing, cc/mcc, due to, POAs
- Demographics – age, sex, family, and social information
- Medications – indicates what is being treated
- Quality Stats – build for “if this then that” notifications [Decision Support]
- HIEs, NCHS, CDC, WHO and other organizations

CPOE – Real Time Decision Support Denial Reduction

Relational and specific inputs via CPOE: a means to improve or add clarity to orders

- Nebulizer and Oxygen for: Acute, Chronic, or Acute on Chronic COPD
- CXR to determine presence of: PN, COPD, etc.
- Treatment of Stage IV Ulcer: Present on Admission
Clearly identify Issues to be addressed, eliminate erroneous HACs

Inpatient POA reporting is mandated by the Deficit Reduction Act of 2005

- Codes for Principal Diagnosis and Secondary Diagnoses must include POA data

- A specific POA screen can be prepared to provide a listing of common POAs: Infections, Ulcers, Diabetes which can then be utilized as CCs or MCCs

- Patient Access invaluable for catching these items and eliminating the assignment of HACs

Missing POAs: Use the EHR Tool to Check Treatment vs. POAs

- Principal diagnosis
  - Intracranial hemorrhage or cerebral infarction (stroke) with MCC: MS-DRG 064
  - Secondary diagnosis
  - Stage III pressure ulcer (code 707.23 - MCC), POA: Y
    - Final payment: $8,030.28

- Principal diagnosis
  - Intracranial hemorrhage or cerebral infarction (stroke) with MCC: MS-DRG 064
  - Secondary diagnosis
  - Stage III pressure ulcer (code 707.23 - MCC), POA: N
    - Final payment: $5,347.98

* Example taken from the AHIMA CDIP course work.
So – Finance / Accounting Training Content

- Patient Access (276/277, POA)
- Concurrent Quality and Revenue Integrity
- DNFB
- Billing/Claims/5010
- Collections
- Denials
- Reporting – Backwards and Forwards

Finance / Accounting Training Content

- Training for reduction in Denials
  - Developing metrics by Payor Contract (terms)
  - Complete 276/277s (95% Benefits and Eligibility)
  - Triggers for Untimely Submission
  - Triggers for Notification of Benefit Max
  - POAs
  - Correct Patient Status
    - IP to Observation: An never event
    - Change of Status after discharge
Finance / Accounting Training Content

- Training for Coding Needs
  - POAs
  - ABNs
  - Presenting and Discharge Diagnoses
  - Concurrent Charging and Review
    - Triggers to re-Authorize
    - Triggers for Interim Payments
    - Recurring patients
    - Mis-Matched Orders and Status Trigger

Reporting

- Intra-departmental
- Internal
- External
- Regulatory
Meaningful Use Stage 2 and 3

- Will not be able to manually abstract charts in the future
  - All documentation must be entered in the EMR/EHR
  - There will be no paper charts with notes...
- MU Stage 3 – SNOMED ... use EHR to assist in standardizing now
- ICD-11
HIEs, NCHS, CDC, WHO and Other Data Seeking Organizations

The US is the **only** country using ICD Codes for billing purposes

- The focus should be on sharing information for improvement in care delivered
- HIEs sharing of critical medical history in a mobile society
- WHO Avian Flu and SARS

How is Healthcare Data to be Used?

![Aggregation Logics by domain rule-based aggregations](image)
ICD-10 is the Chassis of Any Car ...
What Has Rest of the World [Using ICD-10 for the Past 10-15 Years] Learned?

ICD-11 Builds on the ICD-10 Chassis
Getting to ICD-11 Requires Highly Specific Data Documented by Physicians

ICD-10 ‘proposed’ delayed to October 1, 2014

- Extra time to review and structure EHR screens and tables
- Extra time to work on CDI and standardizing language usage
- Extra time to truly strategize as a care delivery ‘enterprise’
- ICD-9 Codes and ICD-10 Codes are still frozen until 1 year after the actual Implementation date

Thank You!