Billing and Coding
EDDA November 2022

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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

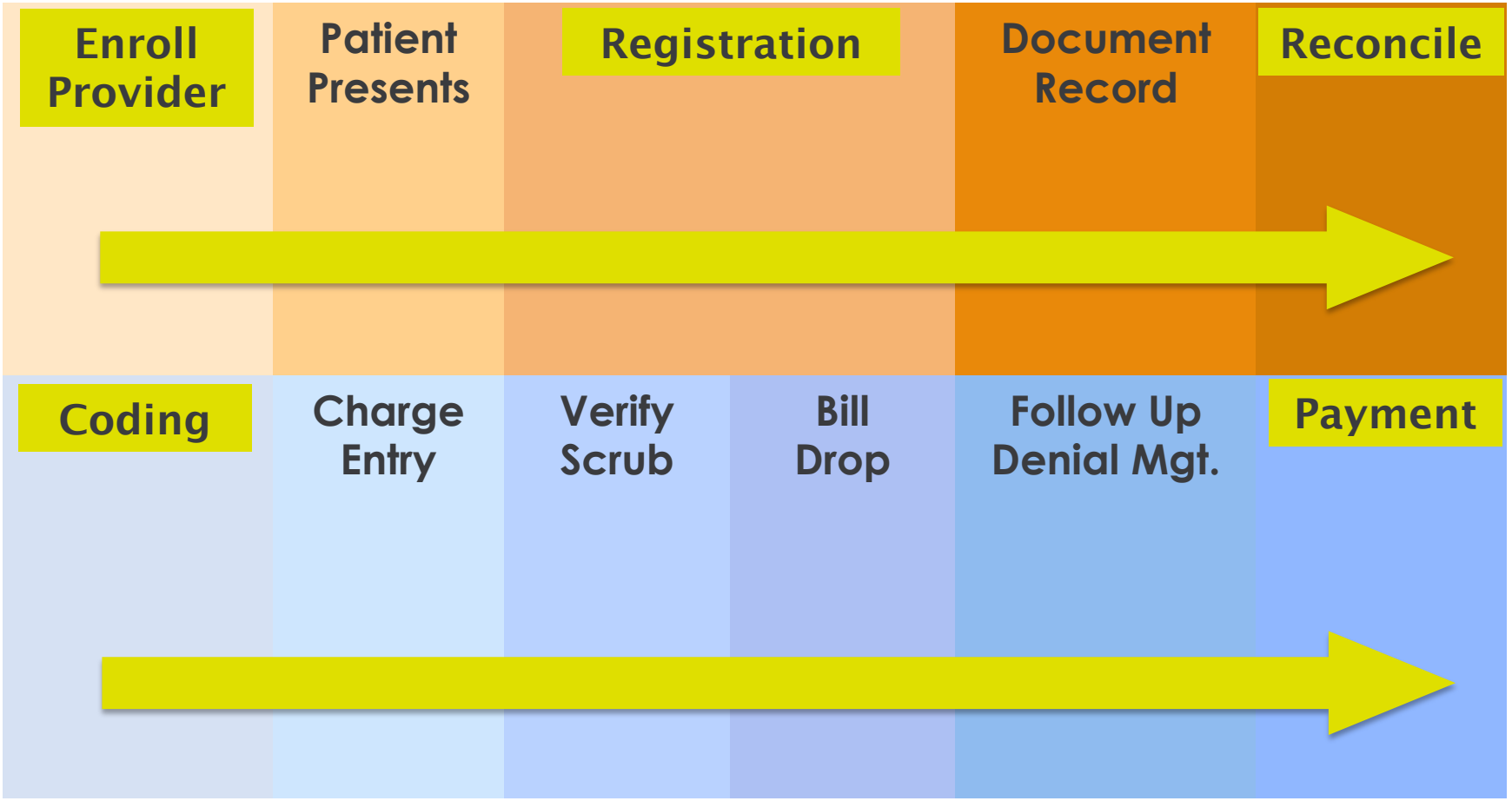
- Allow time for accounts to mature
  - 6 month look back

- 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**

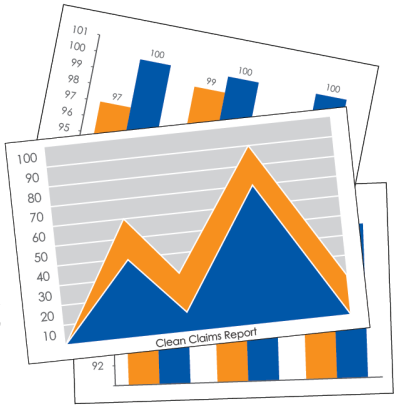


Chart Reconciliation Report

- 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

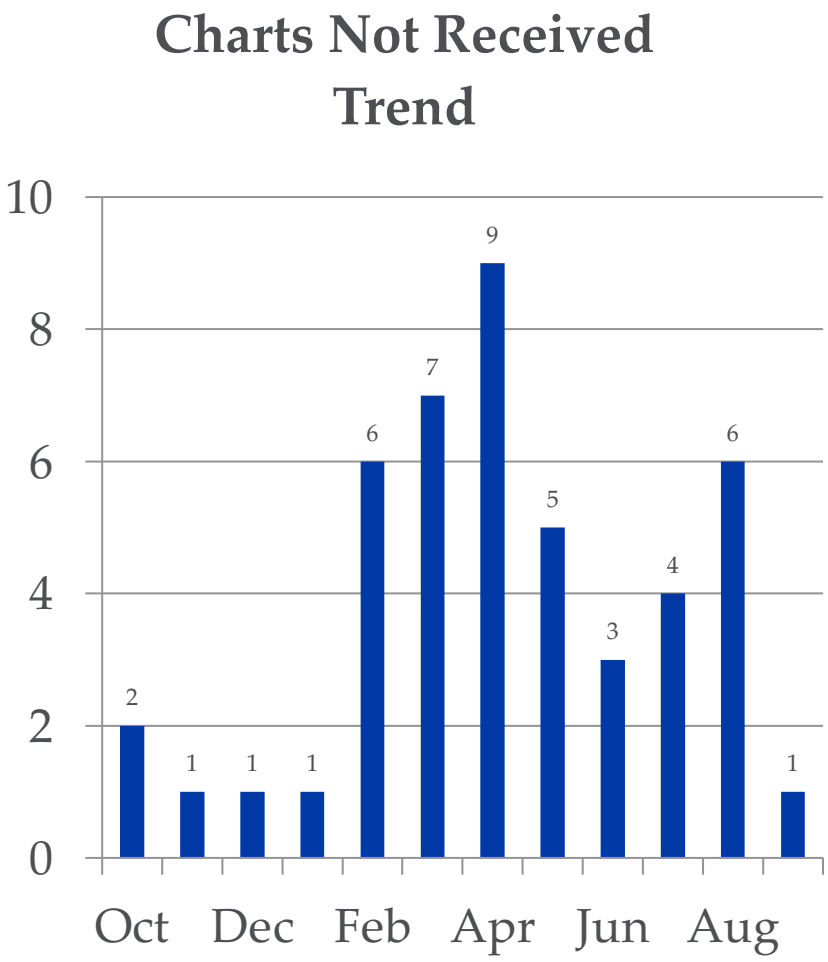
Benchmark: MISSING SHOULD BE < 0.25% at 1 month

At 30 days >99.75% of records received

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

- 91 Billed
- 4 Purposely not billed
  - 2 Suture Removals
  - 1 Private MD
  - 1 LWBS
- 3 Sent back to doctor (incomplete)
  - 1 Dr. Jones April 14
  - 1 Dr. Smith April 15
  - 1 Dr. Green April 15
- 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 Accurate Coding

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

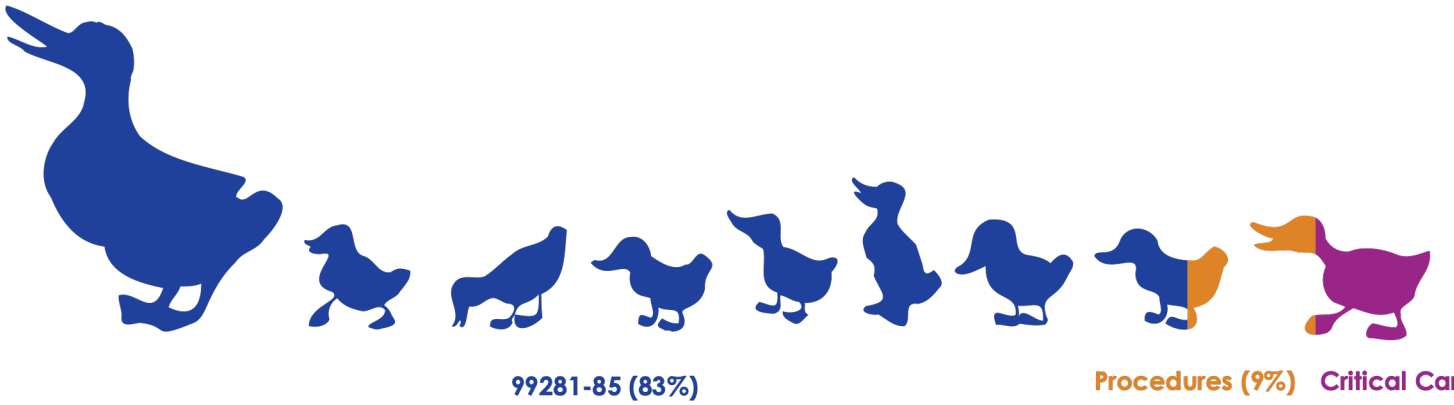
Your documentation must empower/allow the coder to accurately report the work performed

Who Does the Coding?

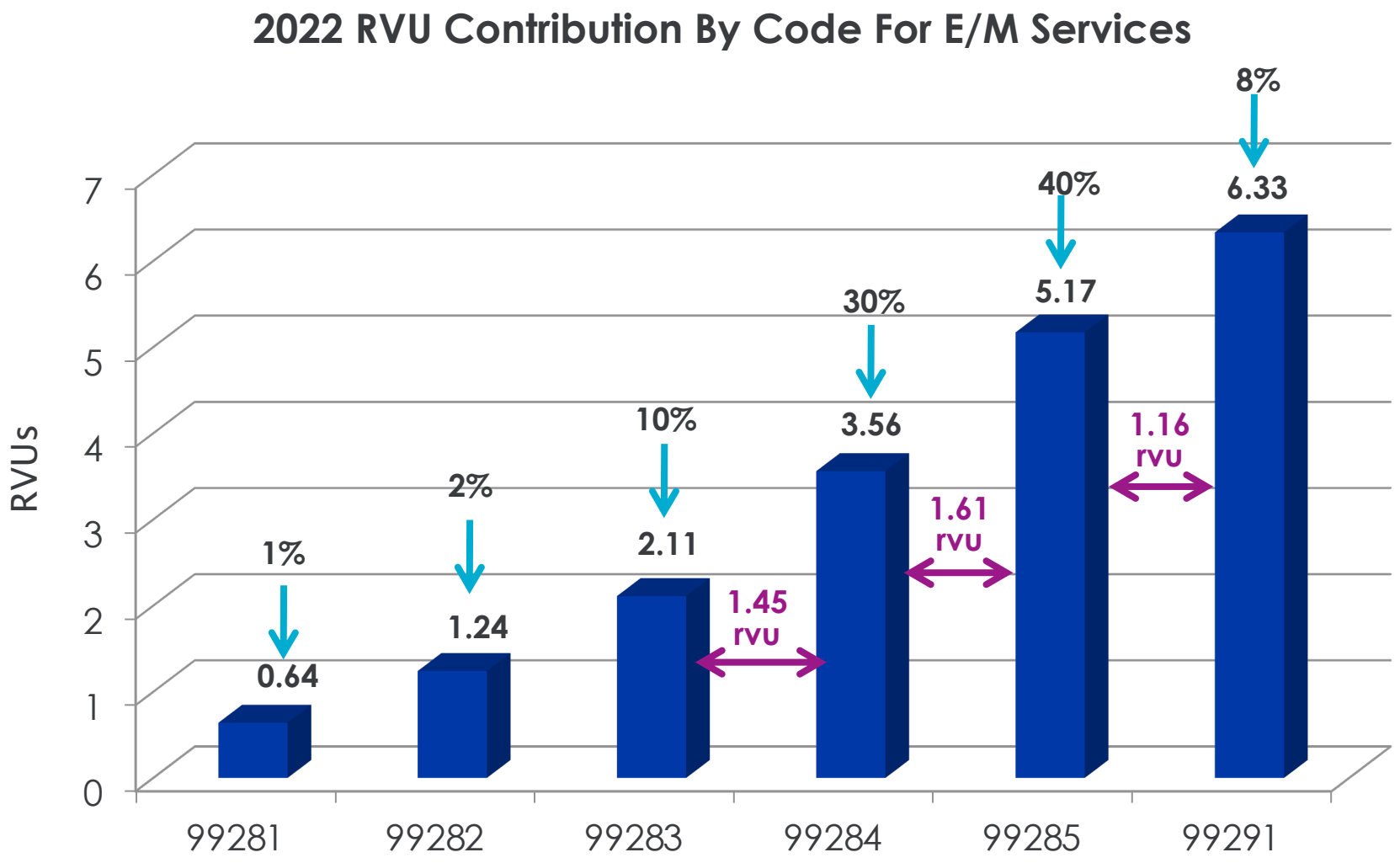
- Hospital – traditionally not focused on ED coding
  - Low charges, signs and symptoms
- Physicians – typically not trained in coding rules, inefficient use of time
- EHR- lowest common denominator
- Experienced professional coders
- Cannot allow a coding back log
  - Weakens communication with docs
  - Undermines education
  - Decreases RVUs

Where Are the RVUs?

- 83% of typical ED doc's RVUs 99281-99285
- 8% from critical care
- 9% from procedures



Drill Down on the RVUs



The 2023 Documentation Guidelines- Game Changer

Headwinds of the 2023 New Documentation Guidelines

- The intent of the 2023 Documentation Guideline changes was NOT to decrease the coding
- Large industry studies show a 5% -10% decrease in RVUs with the new guidelines
  - $160 collected per patient: $8- $16 decrease per patient in collections
  - All payers impacted
- Financial impact to the group 60,000 visit ED
  - $8 per patient X 60,000 visits = **$480,000**
  - $16 per patient X 60,000 visits = **$960,000**

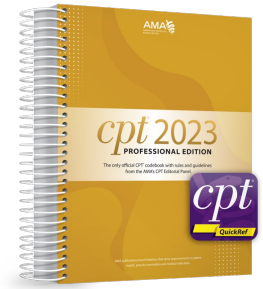
July Release: 2023 CPT E/M Guidelines for the ED

CPT® Evaluation and Management (E/M)

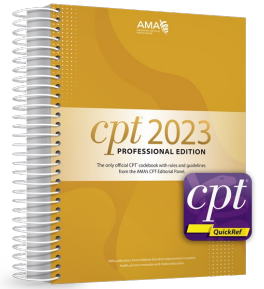
Code and Guideline Changes

effective January 1, 2023:

- **Revision of Emergency Department Services E/M codes 99281-99285 and guidelines**



Released July 1st



2023 ED: History and Physical Exam Don't Score

- **"The nature and extent of the history and/or physical examination is determined by the treating physician reporting the service."**
- **The extent of history and physical examination is NOT an element in selection of codes.**
- **"The main purpose of documentation is to support care of the patient by current and future health care team(s)."**

2023 CPT E/M Descriptors and Guidelines July 1 Release

How Will the ED Be Scored? For the Office: Medical Decision Making (MDM) or Time Determine Code Choice

"The CPT code changes allow clinicians to choose the E/M visit level based on either medical decision making or time."

CMS Physician Final Rule Press Release

1. Requires performance of **history and exam only as medically appropriate**

2. Allows clinicians to choose the E/M visit level:
   - Medical Decision Making; OR
   - Time (appendix)

ED and Time: Long Standing AMA CPT Principle

Time noted **NOT** to apply in the ED!

*"Time is not a descriptive component for the **emergency department levels of E/M services (99281-99285)** because emergency department services are typically provided on a variable intensity basis, involving multiple encounters with several patients over an extended period of time."*

AMA CPT 2023 Descriptors and Guidelines July 1 Release

Leaves the ED with MDM!

2023 ED Codes Will Be Based on MDM Alone!

2023 ED: It Really Is All About the MDM

2023 CPT E/M Descriptors and Guidelines July 1 Release

▲99281	**Emergency department visit** for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
▲99282	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
▲99283	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
▲99284	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
▲99285	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

99285 2022

99285

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

2023 Brand New ED MDM

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99281	**N/A**	N/A	N/A	N/A
99282	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99283	**Low**	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

Office Code MDM Construct Drove the ED Construct

2023 Overview of Office and ED MDM

No MDM	Office level 1	99281
Straight forward	Office level 2	99282
Low	Office level 3	99283
Moderate	Office level 4	99284
High	Office level 5	99285

2023 New ED MDM Requirements by Level

Level	2022 MDM	2023 MDM
99281	Straight Forward	None
99282	Low	Straight Forward
99283	Moderate →	Low
99284	Moderate	Moderate
99285	High	High

2023 ED MDM Components

The New Way: 2023 ED MDM Three Components

- Still uses 3 components for MDM- now more concrete in some areas
- MDM still scored by the highest two of three components:
  1. Number and Complexity of **Problems** Addressed
     - Previously – the Number of diagnoses or management options
  2. Amount and/or Complexity of **Data** to be Reviewed and Analyzed
     - Very quantitative
  3. **Risk** of Complications and/or Morbidity or Mortality of Patient Management
     - Incorporates components of the risk table as examples

MDM Component (Data) Operational Example

Moderate Medical Decision Making

(Must meet 1 out of 3 Categories)

Category 1: Tests, documents, or independent historian(s)

Any combination of 3 from the following:

- Review of prior external note(s) from each unique source
  Review of the result(s) of each unique test
  Ordering of each unique test
- Assessment requiring an independent historian(s)

Category 2: Independent interpretation of tests

- Independent interpretation of a test performed by another qualified health care professional (not separately reported)

- **Category 3: Discussion of management or test interpretation**
  External health care professional/appropriate source

MDM Component (Risk) Highlights

Risk of Complications and Morbidity/Mortality

- Based on previous table of risk – Highest element of risk prevails
- Key new changes
  - Moderate Risk
    - New - Diagnosis/Tx significantly limited by social determinants of health
    - New- Prescription drug management considered
  - High Risk
    - New - Decision regarding hospitalization

Social Determinants of Health Sample Detail

- Z55 Problems related to education and literacy
  - Not literate or low level literacy
- Z56 Problems related to employment and unemployment
  - Unemployed
- Z59 – Problems related to housing and economic circumstances
  - Homeless or inadequate housing
- Z64/65 Problems related to psychosocial circumstances

Overview 2023 Key ED Medical Decision Making Elements

Documentation Tips

- Review of external notes (NH, EMS, DC Summary)
- Independent historian (parent, guardian, spouse)
- Independent interpretation of test
  - EKG, X-ray, CT Scan
- Decision regarding hospitalization
- Testing considered if not performed (CT Scan)
- Treatment considered if not performed (Antibiotics)

Case Studies

Case Examples: 99283 or 99284?

Base Case

- 14 year old with temp. 100.5 wet cough. Covid negative. Influenza negative.
- Final diagnosis: Acute Bronchitis

Using All The Tools

- 14 year old with temp 100.5…
- History gathered from patient and **independent historian**: (Mother)
- **Consideration of prescription for antiviral/antibiotics:** Testing negative patient looks well, lungs clear. D/W mother not indicated.

Case Examples: 99284 or 99285?

Base Case

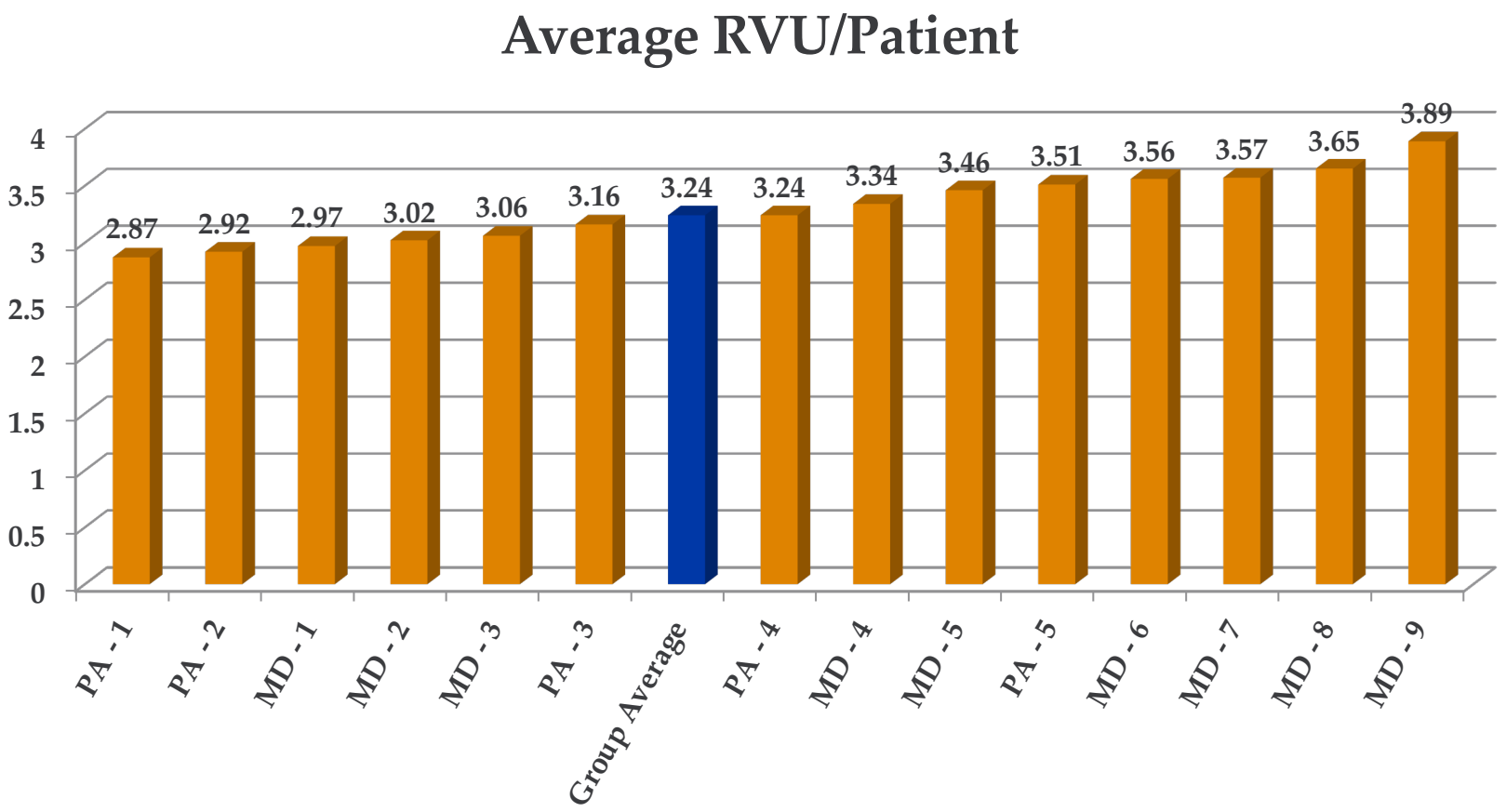
- 52 y.o. with COPD presents with wheezing and tachypnea. Receives several rounds of nebs. CBC, chem 7, CXR negative. Patient ultimately improves.

- Disposition: Discharged home with PCP follow up.

Using All The Tools

- 52 y.o. with COPD…
- **CXR Independent interpretation:** Chronic changes no infiltrate
- **External note reviewed:** Prior admission baseline O2 sats 92%
- **Consideration regarding hospitalization:** Patient reassessed; still with moderate wheeze, may require inpatient care. Continue nebs and reassess.
- Disposition: DC home and PCP follow up

Weekly Coding Reports: Average RVU/Patient



Conclusion and Best Practices

- Days in AR **<40 days**
- Bill drop **3 days**
- **Submit electronically**
- Net Collection Ratio: **>98%**
- **Steady** cash flow
- $ collected/patient **stable**
- **100%** providers credentialed
- **> 98%** clean claims

- **99.75%** of charts received within 30 days
- No coding backlog
  - Charts coded **48 hours**
- Protect your RVUs
  - **Robust 2023 education program**
  - **Significant 2023 preparation**

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