Billing and Coding
EDDA June 2023

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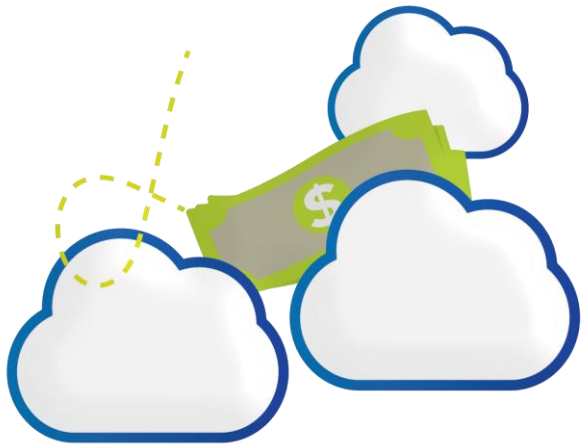
American College of Emergency Physicians®

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

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

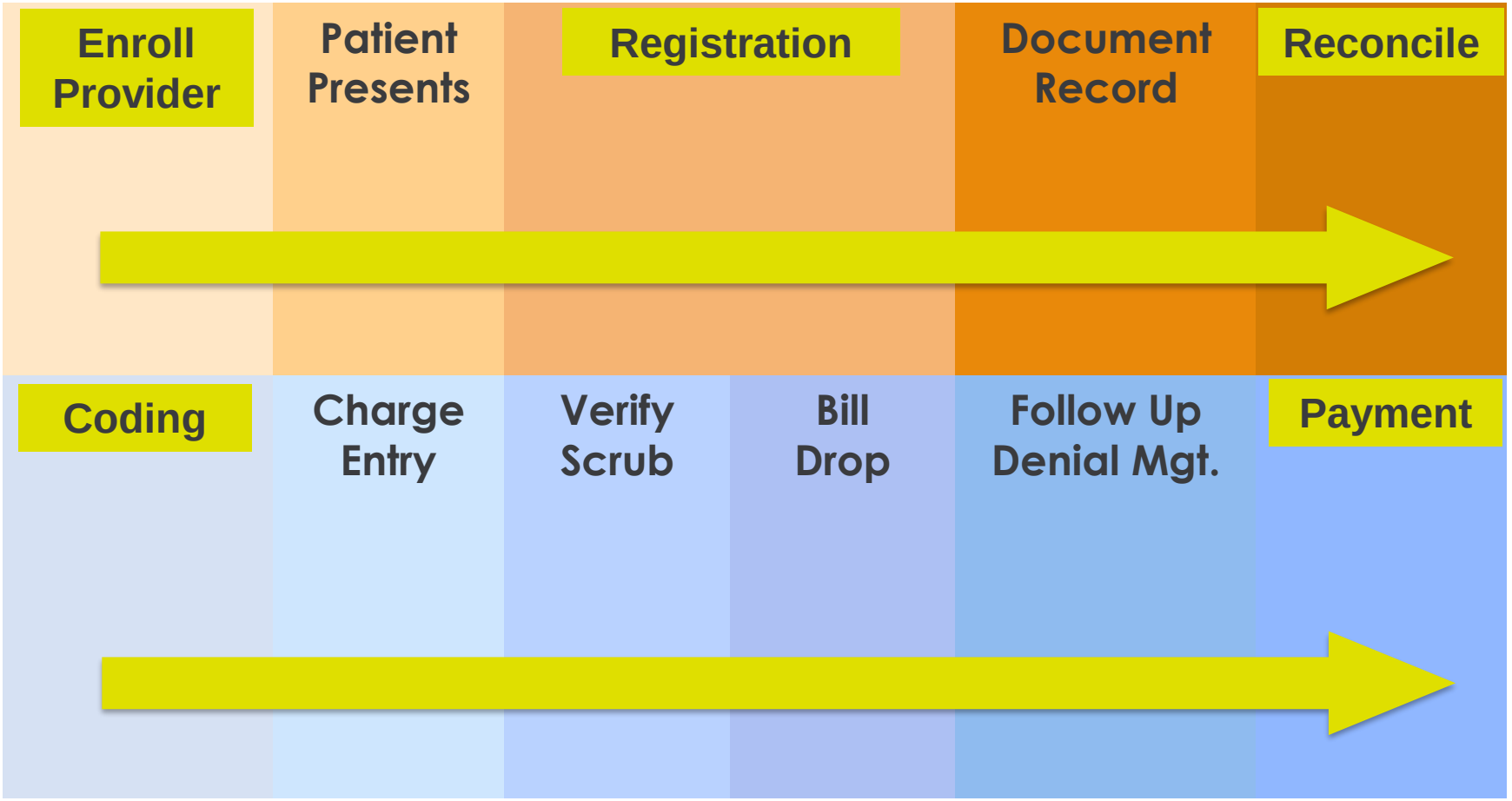
- Allow time for accounts to mature
  - 6 month look back

- 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!

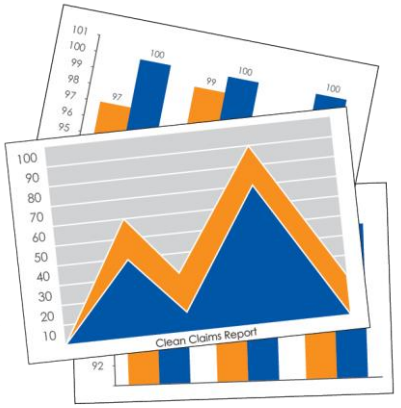
The Revenue Chain



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

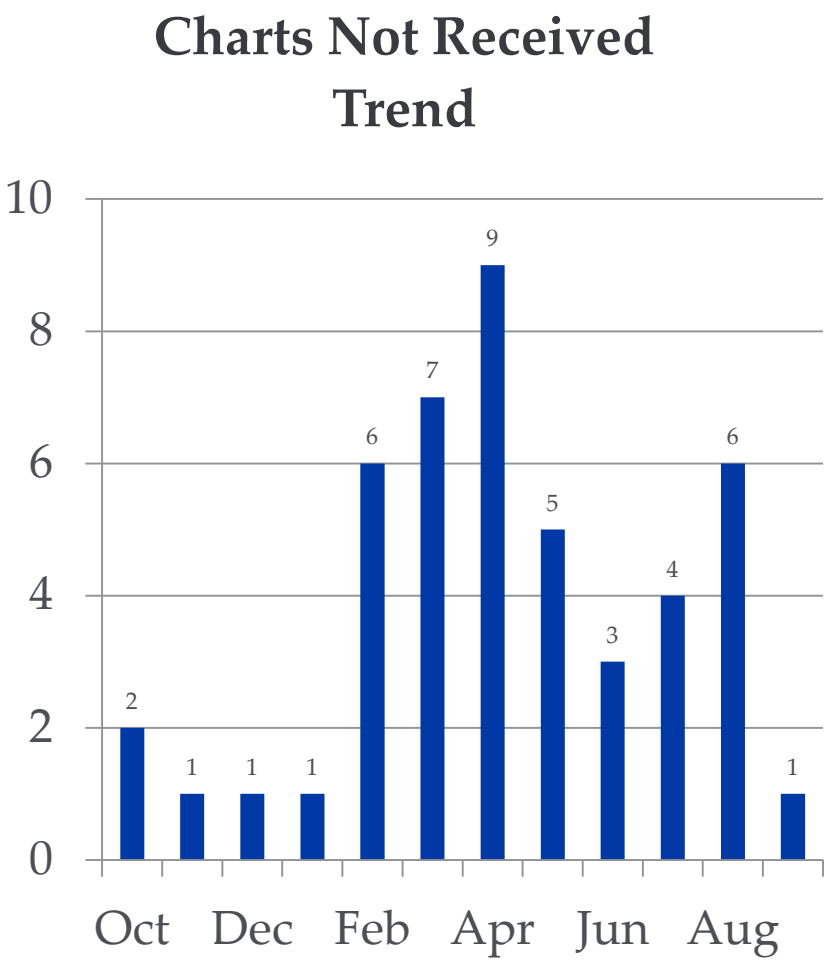
Benchmark: MISSING SHOULD BE < 0.25% at 1 month

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

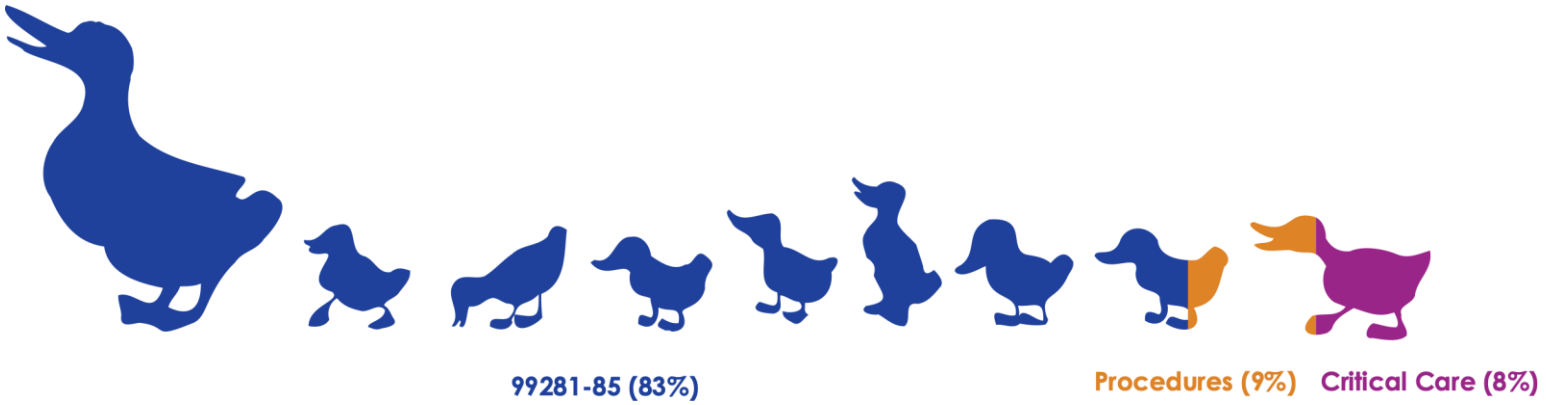
Your documentation must empower/allow the coder to accurately report the work performed

Who Does the Coding?

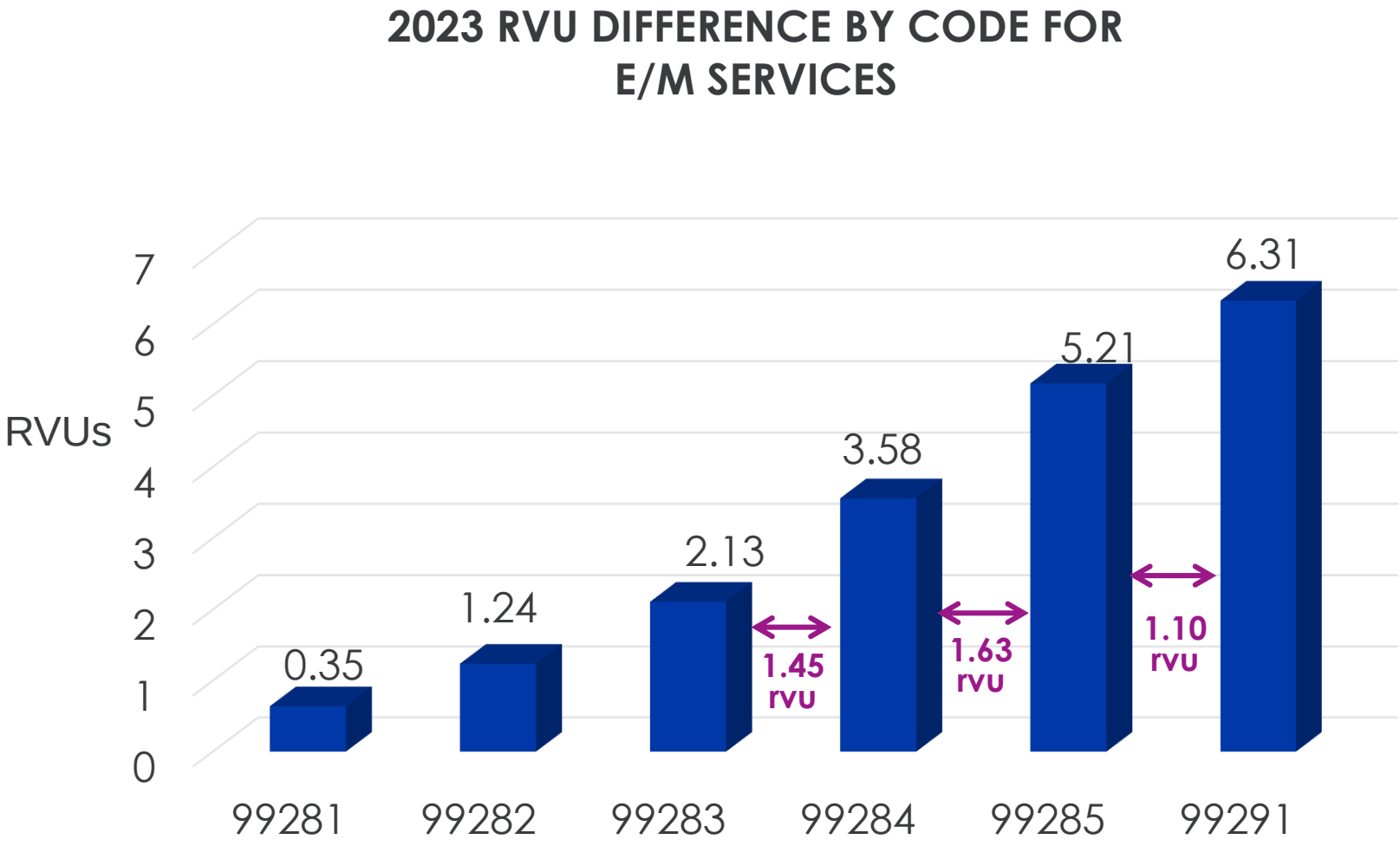
- Hospital – traditionally not focused on ED coding
  - Low charges, signs and symptoms
- Physicians – typically not trained in coding rules, inefficient use of time
- EHR- lowest common denominator
- Experienced professional coders
- Cannot allow a coding back log
  - Weakens communication with docs
  - 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 2023 RVUs

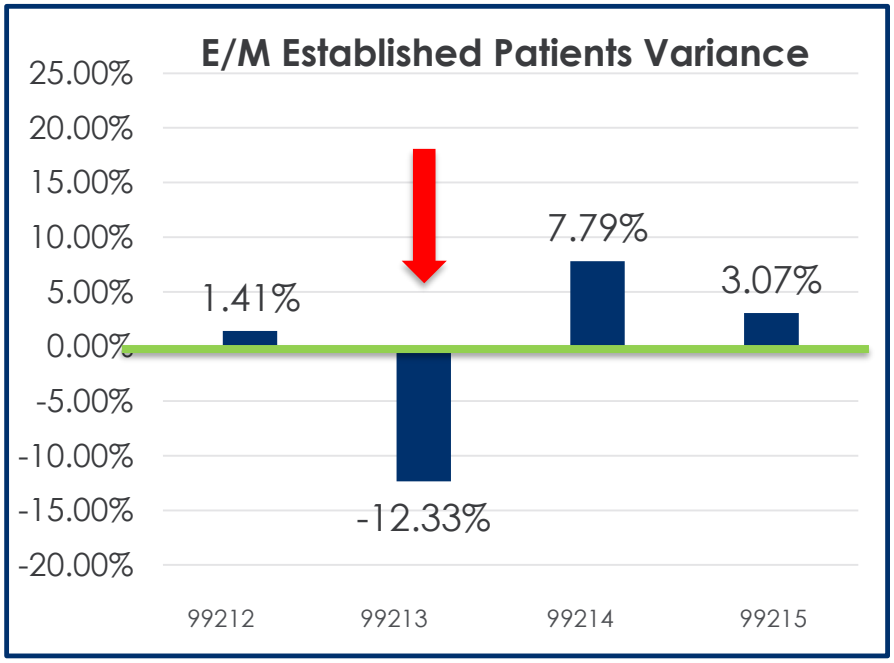


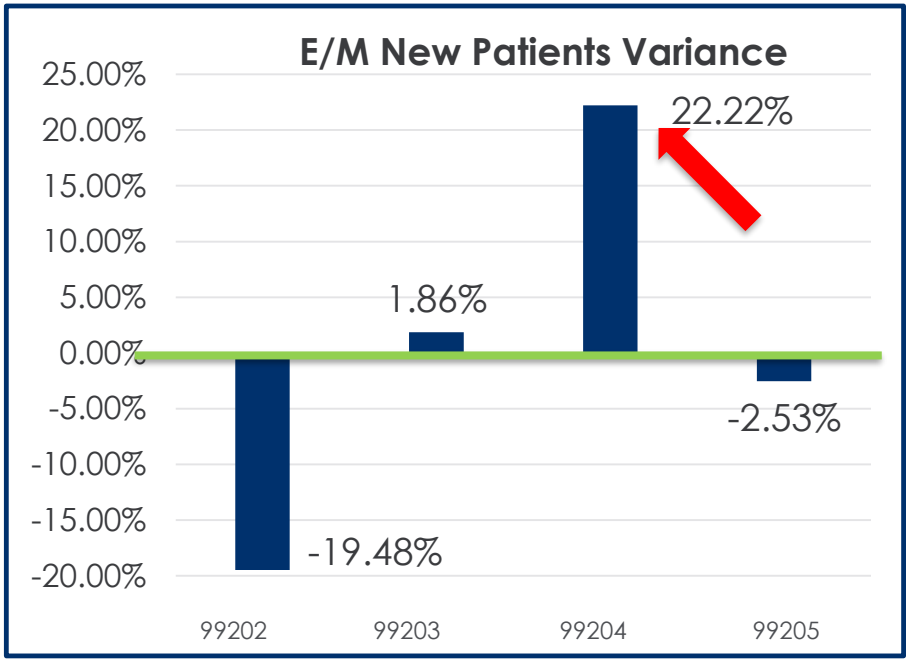
The 2023 Documentation Guidelines- Game Changer

AMA Guidance: Documentation Guidelines Coding Distribution Shift

Early Results of Top Performers

After examining initial results, some trends are starting to emerge. Well-prepared organizations are showing a shift to level four visit utilization based on the new E/M guidelines. Here are initial results from one organization:

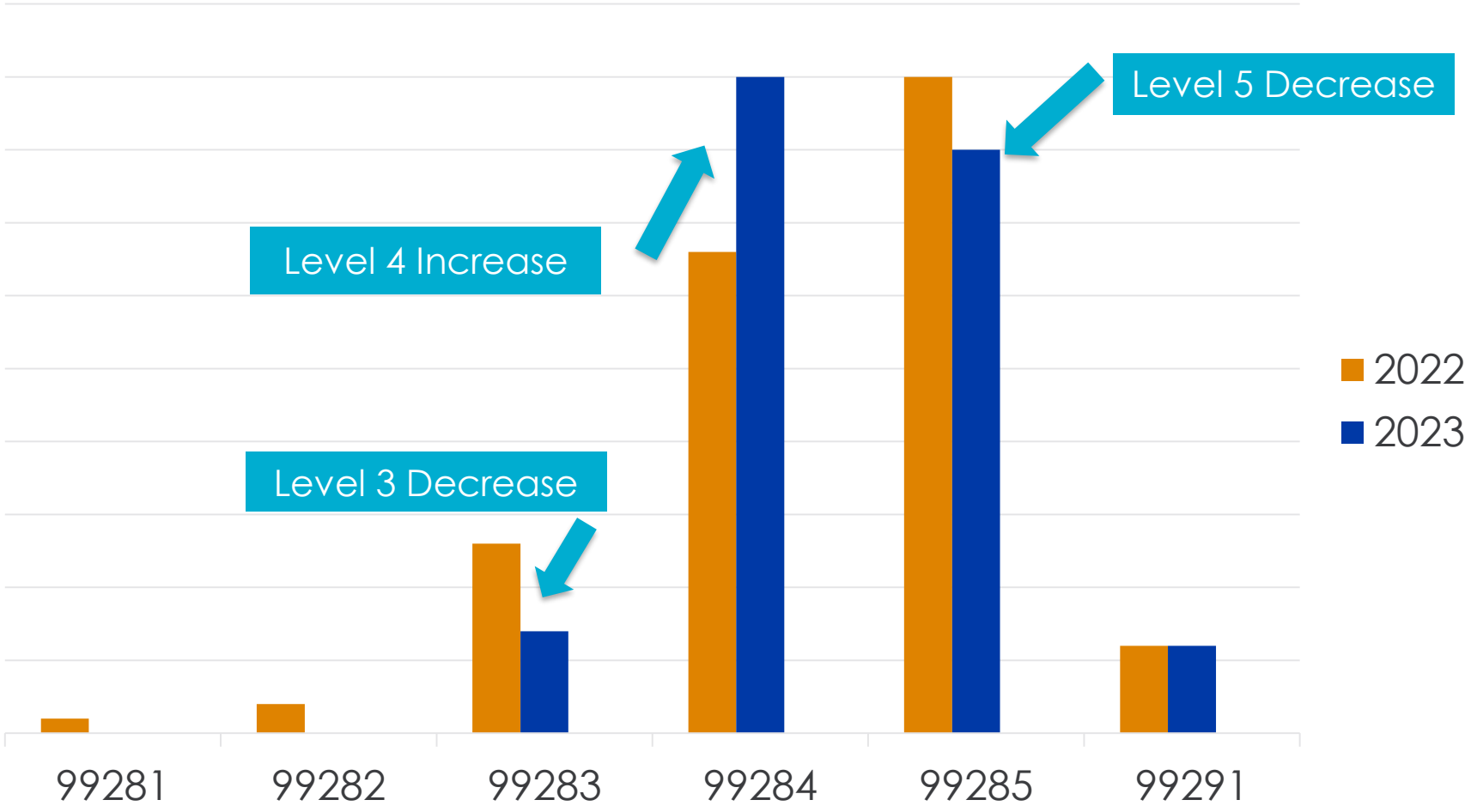




2023 Getting the Coding Right

- Case Study: "Effectively Prepared Group" fully ready for 2023 DG changes
  - Resources to digest new policies
  - Develops sophisticated expertise
  - Updates the EHR
  - Preparation: Physician didactics, lectures, newsletters and webinars
  - Ongoing education, monitoring, auditing, and chart feedback

2022 vs 2023 E/M Distribution



Consequences of Sub Optimal Preparation

- Case Study: "Somewhat Prepared Group" less ready for the 2023 DGs
  - Coding policies are found to be complex
  - Can't engage resources
  - Resources lack ED expertise
  - Coders lightly updated
  - Level 5s go down significantly
  - Appropriate 3 to 4 transition doesn't take place
  - .3 RVU/patient decrease
    - 60,000 visits X $45/RVU X .3 RVU/patient = $810,000

2023 ED:
Level Assignment Is All About the MDM

2023 CPT E/M Descriptors and Guidelines July 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.

Do I Still Need to Document a History? Think Clinical

History

48 y.o. male presents with left sided chest pain, worse with exertion, associated with diaphoresis.

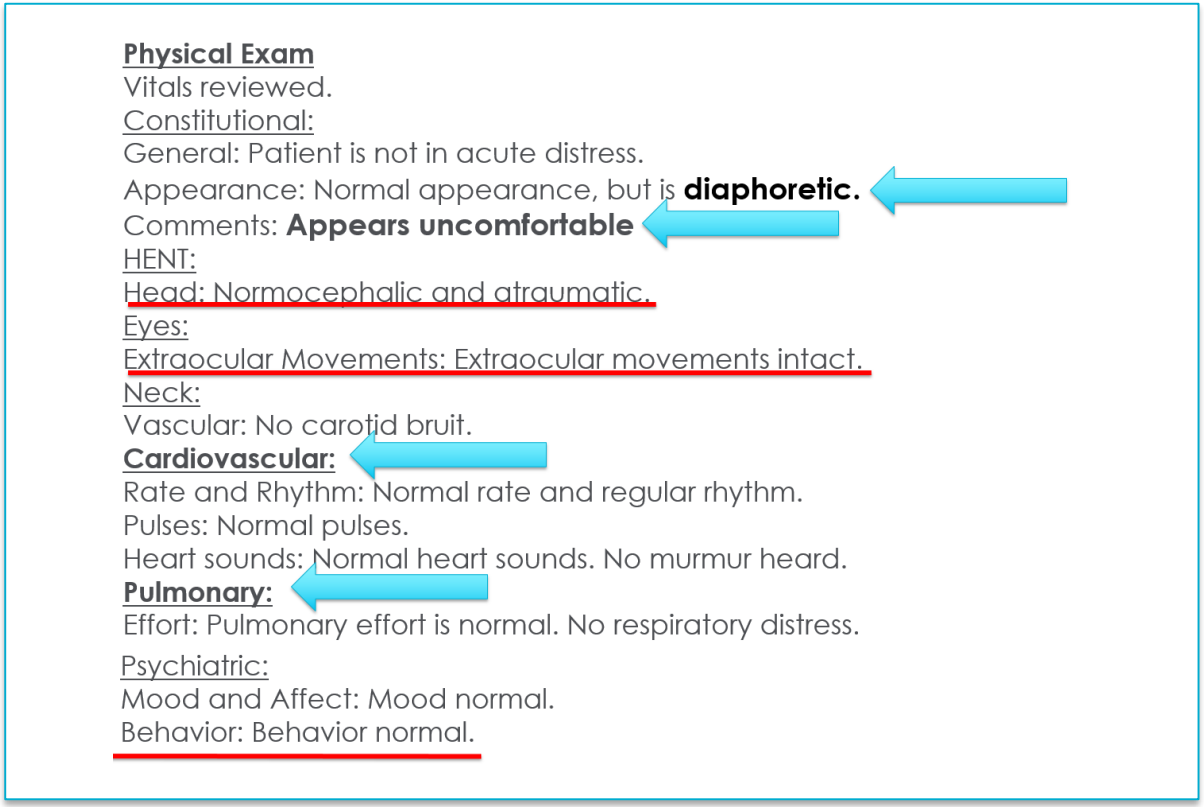
Episodes last 2-3 minutes and are relieved by rest.

(Clinically Important)

Decreased Documentation Burden: Physical Exam Think Clinical

Physical Exam

Key Area of Note Bloat



Physical Exam
Vitals reviewed.
Constitutional:
General: Patient is not in acute distress.
Appearance: Normal appearance, but is **diaphoretic.**
Comments: **Appears uncomfortable**
HENT:
Head: Normocephalic and atraumatic.
Eyes:
Extraocular Movements: Extraocular movements intact.
Neck:
Vascular: No carotid bruit.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds. No murmur heard.
Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Psychiatric:
Mood and Affect: Mood normal.
Behavior: Behavior normal.

2023 MDM Elements Determining Code Choice

- Number and **Complexity of Problems Addressed** at the Encounter
- Amount and/or Complexity of **Data** to Be Reviewed and Analyzed
- **Risk** of Complications and/or Morbidity or Mortality of Patient Management

Need to Satisfy Two Out of Three Elements for a Given Level

2023 ED MDM Element: Problems Addressed

Number and Complexity of **Problems Addressed** (COPA)

- Actually less numeric now and more qualitative
  - Acute, uncomplicated illness or injury
  - Acute illness with systemic symptoms
  - Chronic illnesses with severe exacerbation
- Differential Diagnosis, clinical considerations and responses to treatment are supportive

Practical Application:
High COPA Presenting Symptoms & Final Diagnosis

High COPA (99285): 1 acute or chronic illness or injury that poses a threat to life or bodily function.

46 yo male with no past history presents with substernal CP, centrally located with nausea and diaphoresis while at rest.

DDX: ACS, GERD, musculoskeletal.

ED Course: Serial ECGs and troponins negative. Pain relieved by GI cocktail. HEART score 2. DC with outpatient follow up.

Final Dx: GERD.

MDM Component 2 Data: Dependent on Physician Documentation

Moderate Medical Decision Making

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

Data Category 1: What and How?

Progress Notes, Medical Decision Making and Critical Care *.procdoc .edmdcc*

76 year old presented with altered mental status, fever, and tachycardia. Sepsis order set was initiated, concern for UTI or pneumonia.

ED Course as of 02/16/23 1625

Thu Feb 16, 2023

1600	External records reviewed: pt admitted here, 2/2022 for ACS workup. Echo at that time showed an EF of 55%. Will order a 30 ml/kg bolus. [ET]
1617	CBC noted, 22K, and lactate 2.4. Pt reassessed, BP 105 systolic, HR 110. [ET]

External record review

History of Present Illness

Triage note:
"Intoxication per EMS"

30 year old presents via EMS for evaluation of altered mental status. History is limited due to the acuity of condition.

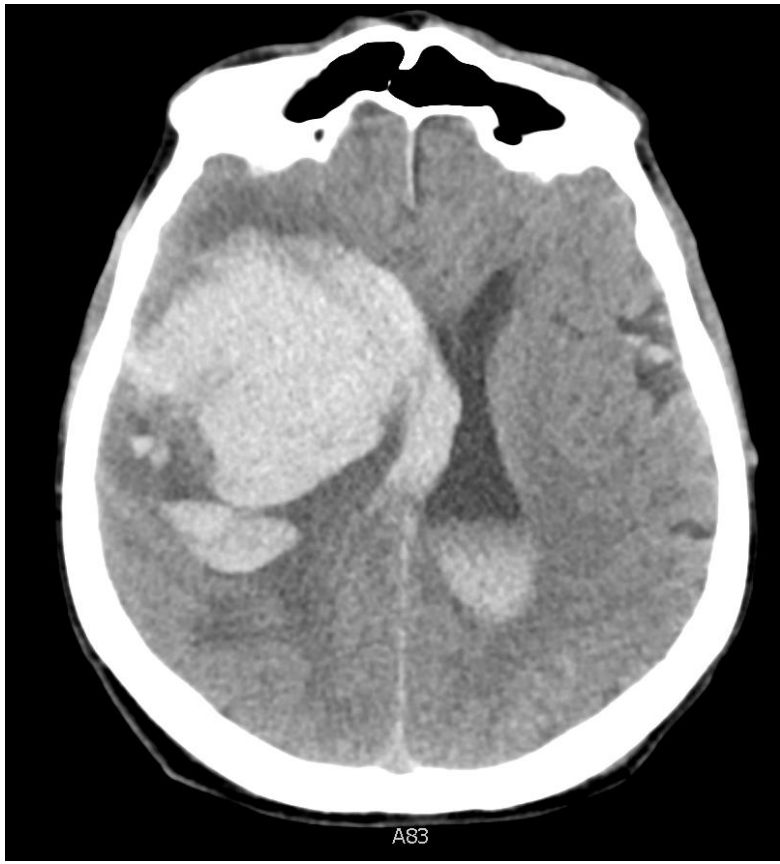
Independent Historian:

Independent Historian

EMS: arrived at the scene of a young male laying on the sidewalk. Collar placed. Glucose en route 160. Responds to painful stimulus and makes incomprehensible sounds/speech.

Data Category 2: Independent Interpretations

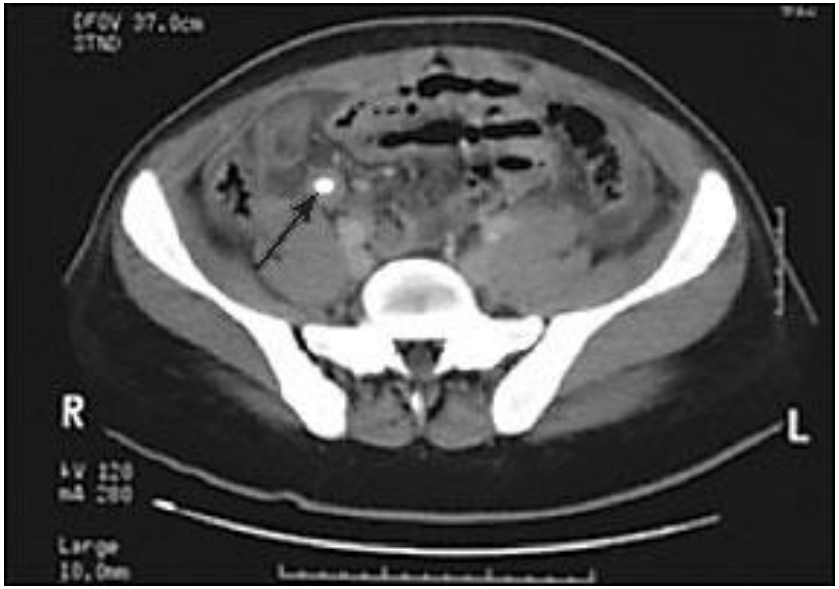
- Not held to the standard of a billable interpretation
  - "Xray, interpreted by me, no infiltrate or pneumothorax"
  - "Per my interpretation of head CT, large ICH, neurosurgery consult initiated."
  - "CT abdomen per my independent interpretation, no free air or significant hemoperitoneum."



Data Category 3: Discussion of Management with External Physician

Patient with continued pain, repeat exam still with focal RLQ tenderness. CT consistent with acute appendicitis. Have discussed with G- Surg who will admit, requests NPO and will take to the OR.

-AB 1/25 1930



2023 MDM Element: Risk

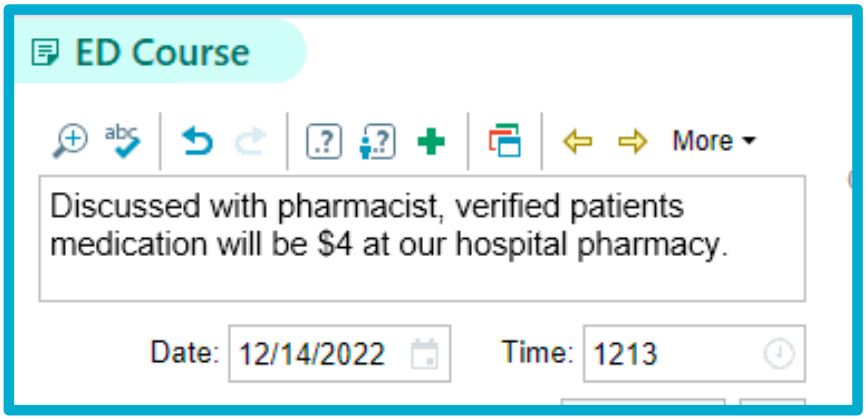
Risk of Complications and Morbidity/Mortality

- Key new changes
  - Moderate Risk:
    - Diagnosis/Tx significantly limited by social determinants of health
    - Prescription drug management appropriately considered
  - High Risk:
    - Parenteral controlled substances continues
    - Medication requiring monitoring
    - Decision regarding hospitalization
    - Decision to de-escalate or escalate care

How Do I Document Social Determinants of Health?

2023 MDM Grid Moderate Risk:
Diagnosis or Treatment significantly impacted by Social Determinants of Health

28 y.o. with dysuria. UA shows nitrate + with 2+ bacteria. HCG negative.
Plan outpatient antibiotics.
d/w patient and she is recently unemployed and without health insurance to cover treatment.
Patient's care was significantly impacted by a social determinant of health.



Low Acuity Vignette – All the Tools

Progress Notes, Medical Decision Making and Critical Care *.procdoc .edmdcc*

15 year old with 2-3 days of non-productive cough. Also complains of sore throat. No known sick contacts. No change in appetite. His mother adds he had a fever yesterday, 100.5, that resolved with ibuprofen.

Independent Historian (Mother)

COVID and RVP panel negative.

Clinical condition most consistent with viral etiology. Discussed with mother, antibiotics not indicated as likelihood of bacterial infection is low. Discussed need for close outpatient follow up.

Consideration of prescription for antiviral/antibiotics

High Acuity Vignette – All The Tools

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 admission. Continue nebs and reassess.
- Disposition: DC home and PCP follow up

Key 2023 MDM Drivers

1. Discussion of management with other providers
   - Hospitalist (admission), consultant (GI, neuro, social work), PMD

2. Independent interpretations
   - EKGs, plain X-rays, CT scans, Ultrasounds

3. Review of external records
   - Inpatient hospital, office records, nursing home

4. History obtained from an independent historian
   - Parent, caregiver, EMS

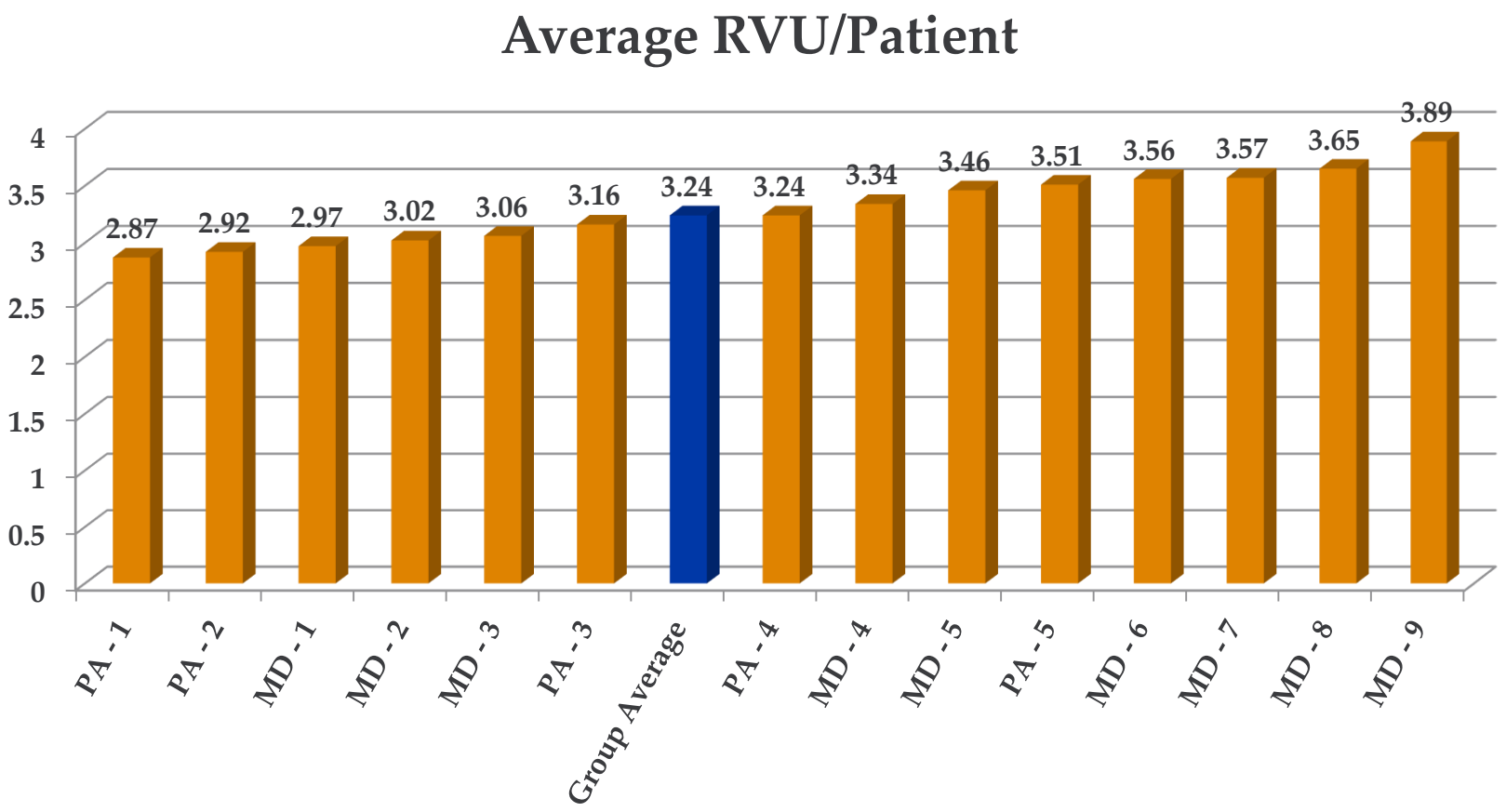
Key 2023 MDM Drivers

5. Prescription medications or testing appropriately considered
   - Antibiotics, antivirals, X-Ray, CT Scan

6. Care affected by social determinants of health
   - Homeless, literacy, access to medical care

7. Appropriate consideration of hospitalization or de-escalation
   - Chest pain, COPD, asthma, hyperglycemia

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**
  - **No RVU change**

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