Revenue Enhancement for Outpatient Surgery

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DISCLAIMER

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ABOUT US

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Jennifer A. Asencio, CHC, CPC, CPCO, CPMA has over 20 years of healthcare compliance, documentation, and coding experience spanning academic medical centers, community hospitals, and private practices. She conducts educational and training seminars and has overseen comprehensive coding compliance programs. Jenn also has a successful record of compliance program operations including providing guidance and education to physicians and non-physician practitioners, clinical department leaders, and others regarding compliance with federal and state rules, regulations, and laws on physician billing and business practices and organizational policies and procedures.

Garfunkel Health Advisors, Inc. (GHA) is healthcare consulting company providing strategic and operational advice to the healthcare industry.

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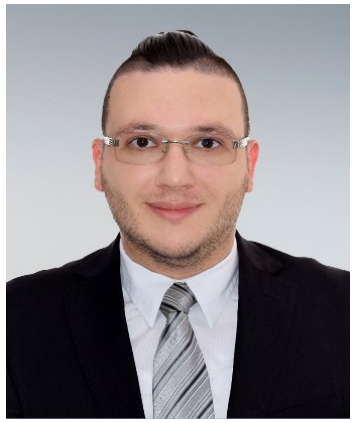

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Simon has extensive experience in business and healthcare administrative operations. His areas of expertise include revenue cycle integrity, documentation and coding, medical auditing, billing processes, payer policies, workflow development, and compliance. Additionally, he works closely with clients on business advisory services of all sizes including hospitals, ACSs, and physicians in areas of revenue cycle, coding and billing, and regulatory compliance. He provides in-depth analysis and assists providers with understanding best practices and how to identify opportunities while mitigating the risk of improper payments.

Simon holds a Bachelor of Business Administration in Finance. He is also credentialed as a Certified Professional Coder (CPC) and a Certified Professional Medical Auditor (CPMA) through the American Academy of Professional Coders and a Certified Revenue Cycle Executive (CRCE) through the American Association of Healthcare Administrative Management.

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OBJECTIVE

As healthcare evolves, the industry is facing increasing challenges from regulatory shifts, patient expectations, and technological advancements. Consequently, the importance of a robust Revenue Cycle Integrity has never been more significant.

Revenue Cycle Integrity ensures that each stage of the revenue cycle, from patient registration to account reconciliation, functions with efficiency, precision, and in full compliance with the highest standards.

What are the typical challenges faced by outpatient surgery departments and what enhancements can be employed to realize a high-performing revenue cycle?

OVERVIEW OF THE REVENUE CYCLE INTEGRITY

Front-End Processes

Pre-registration, Registration, and Scheduling

- Execution of consent forms,
- Verification of insurance,
- Collection of copay/coinsurance/ deductible,
- Financial counseling

Middle Processes

Point of Care

Medical Record Documentation

- Provider Documentation
- Ancillary Staff Documentation
- Medical Necessity

Charge Capture

- Documentation finalized
- Computerized Provider Order Entry
- Charge Description Master
- The Coding Process

Back-End Processes

Claim Production

Claim Submission

Adjudication

Remittance Process Claim Reconciliation

Denial Management and Follow ups

SCHEDULING AND PRIOR AUTHORIZATION

Scheduling and Appointment Management

- This is the process of booking appointments and managing the timing of patient visits.
- It may also include referral management.
- Proper scheduling ensures that patients are seen by the appropriate providers and that the services provided are correctly billed.

Insurance Verification

- Healthcare organizations need to verify each patient's insurance coverage and benefits to determine the extent of coverage for the services provided. This step helps avoid claim denials and billing issues later in the revenue cycle.

Prior Authorization

- In some cases, certain medical procedures or treatments require prior authorization from the patient's insurance company. Front-end staff may need to work with physicians to obtain these authorizations before services are rendered.

PRE-REGISTRATION AND REGISTRATION

Patient Pre-Registration

- Collecting patient information prior to the appointment such as name, address, date of birth, and insurance information.

Patient Registration

- Collecting copy of patient ID, insurance care, and any necessary authorizations or consent forms.

Co-Pay and Deductible Collection

- Front-end staff collect these payments either before or directly after the services are provided.

Financial Counseling

- Front-end staff help patients understand and navigate the financial aspect of their medical care, such as insurance coverage, financial assistance, and payment options. More recently, it also involves cost estimation and other efforts to increase price transparency for patients seeking medical care.

HOW CAN YOU IMPROVE FRONT-END OPERATIONS?

- Staff should ensure at **each** patient encounter that there have been no changes to the patient's insurance and that the most up-to-date insurance card is scanned into the medical record.
- Staff should ensure that the consent forms are signed, dated, and up-to-date at **each** patient encounter.
- Establish internal protocols on how to obtain consent forms in the event that the patient requests a telehealth encounter.
- Implement digital pre-registration and self-service kiosks at check-in.
- Implement automated insurance verification tools.

THE IMPORTANCE OF PROVIDER DOCUMENTATION

The operative report serves as proof of service(s) rendered in order to receive reimbursement for the facility, surgeon and surgical team.

The operative should contain:

- **Heading**
  - **Patient Information**
  - **Date of Service**
  - **Facility**
  - **Surgery Information –** Name of the primary surgeon, co-surgeons, and/or surgical assistants; type of anesthesia; name of anesthesiologist/CRNA; use of special equipment (microscope, robotics, etc.) and/or implants; complications; and estimated blood loss
  - **Pre-operative and Post-operative Diagnoses** *(List all applicable diagnoses to support medical necessity.)*
  - **Procedure(s) Performed**
- **Patient Past Medical History/Indications for Surgery**
- **Body**
  - All procedures from the beginning (prepping) to the end (closure and dressings) MUST be documented
  - Approach (open or endoscopic)
  - Implants
  - Use of robotic or microscopic assistance
  - Specimens collected or frozen sections performed
  - Intraoperative monitoring or testing
  - Any portions performed by another surgeon
- **Findings and Follow-Up**
  - Summarize the findings of the surgery
  - Any complications or absence of complications
  - Follow-Up Treatment or Future Procedures

HOW CAN YOU IMPROVE CHARGE ENTRY/CHARGE CAPTURE?

Standardize charge capture processes:

- **Automate the process:** The information automatically flows into the practice management billing side based on what the provider puts in their documentation
  - Streamlines processes
  - Reduces manual entry errors
  - Ensures timely submission
- **Utilize technology:** Coding tools, smart edits
- **Conduct regular audits:** Conduct regular audits of charge capture processes to identify and correct any issues or errors. Use data analytics and reporting tools to monitor performance and identify areas for improvement.

CLAIMS SUBMISSION

For a claim to be processed by an insurance carrier, it must be considered a “clean claim”, meaning all the required information has been entered.

Claims should be “scrubbed” to verify that the information is complete and accurate, based on predetermined edits, before being submitted to the clearinghouse.

The claim will then go through another series of edits. Once the claim passes these edits, it will then be transmitted to the health plans.

When using a clearinghouse, it is imperative to review acceptance reports to verify that claims were received (by the clearinghouse), sent to the payer, received, and accepted by the payer.

Submitting accurate information is essential to clean claim submissions and speed up the payment process.

MASTERING THE MAZE: OVERCOMING CLAIMS SUBMISSION HURDLES & ENHANCEMENTS

Common Pitfalls

- Incorrect insurance carrier information – wrong policy, inactive insurance, not verifying insurance eligibility
- **Missing or invalid CPT code** – CPT codes are updated annually at the beginning of each year
- **Incorrect Modifiers** – e.g., assistant at surgeon by MD vs PA,
- **Missing charges** – late entries, missing NDC#'s, etc.
- Procedure lacks a diagnosis
- Rendering provider does not match the medical record
- Missing Authorization Number
- Timely Filing
- The health plan did not receive the submitted claim

Enhancements in Workflow

- Run reports regularly to ensure providers are completely documentation timely.
- **Claim Scrubbing Systems**: Before submitting, review claims for errors to ensure they are accurate and increase the likelihood of first-time acceptance
  - **NCCI (National Correct Coding Initiative) edits**
  - **MUE (Medically Unlikely Edits)**
  - **OCE (outpatient code editor)**
- **Real-time Error Reporting:** Use systems that offer immediate error feedback on claims, enabling quick corrections and resubmissions
- **Education and training** – ensure staff attend webinars by medical societies, billing groups, CMS, and compliance programs

HIPAA SIMPLIFICATION – DATA ELEMENTS ON CLAIMS

In an ASC site, two types of claim forms are submitted: the CMS-1500 (837P) for professional services and the UB-04 (837I) for technical charges. The Standards for Electronic Transactions and Code Sets ("Transactions Rule") include:

Data Elements	Description
Patient Demographics	Name, Address, Date of Birth, Sex, and Telephone Number should match exactly as they appear on the insurance policies (avoid using nicknames or unofficial information).
MRN # and Account #	Unique health record number and account number that the provider assigns to identify the patient; the account number differentiates the specific episode of care, date of service, and type of service.
Subscriber Demographic Data	The Insurer's Name, Group Number, Address, Telephone, Payer ID Number, unique Subscription Policy Number, and so on.
Preauthorization # (Percert.)	Approval number obtained from the insurance carrier before providing service to the patient
Provider Demographics	Provider Name/Entity Name, National Provider Identifier (NPI), Address, Telephone Number, Taxonomy Code
Date of Service	Date when services was rendered to the patient
Diagnosis Code(s)	International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
Procedure Code(s)	The Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) Level II Codes
Revenue Code(s) [UB-04 only] **Type of Bill [UB-04 only]**	Four-digit code identifying specific accommodation, ancillary series, or billing calculations related to the services billed. Four-digit alphanumeric code provides three specific pieces of information (Type of Facility, Bill Classification, and Frequency)

DENIAL MANAGEMENT AND FOLLOW-UP PROCESS

Claim denial occurs when an insurance company declines a request from a provider to cover the costs of health care services received from a health care professional.

Effective management of claim denials is pivotal to an organization's financial health, as inefficiencies can result in revenue loss.

To reduce the financial uncertainties tied to claim denials, healthcare facilities/providers emphasize denial management. The objectives of such a program include reducing the number of denials and the related lost revenue, transforming initial denials into payable claims, and refining processes to preempt future denials.

The industry standard benchmark for FPRR is typically set at 90%.

ENHANCEMENT TO THE DENIAL AND FOLLOW-UP PROCESS

Dedicated Team of Professionals

- Designate a specific team or individual to address denials, ensuring both accountability and a timely resolution of claims.

Categorization of Denials

- All denials should be categorized based on the reason for denial. Examples are clerical errors, missing information, or policy-related issues.
- For best practices, it is important to keep track of denials in a tracking system.
  - Implement an automated system to track the status of each denied claim, including dates, contacts made, and any correspondence received.
  - The tracking system will allow to create key performance indicators for the denials.

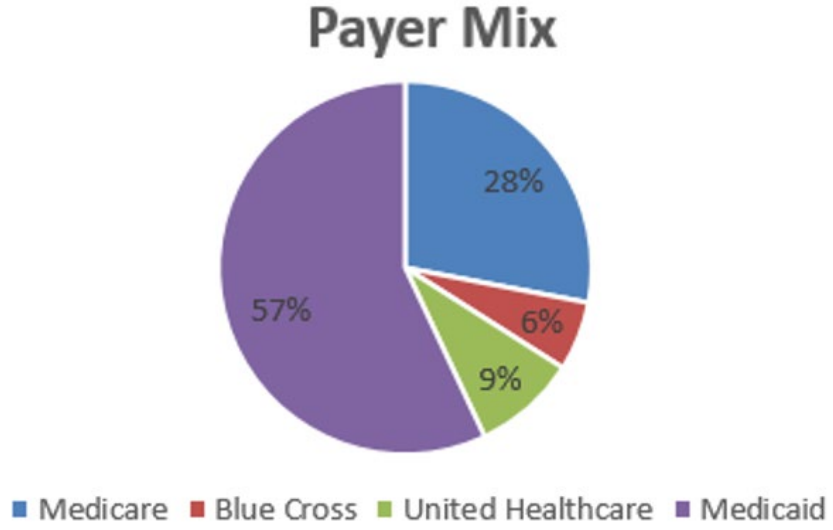
Root Cause Analysis

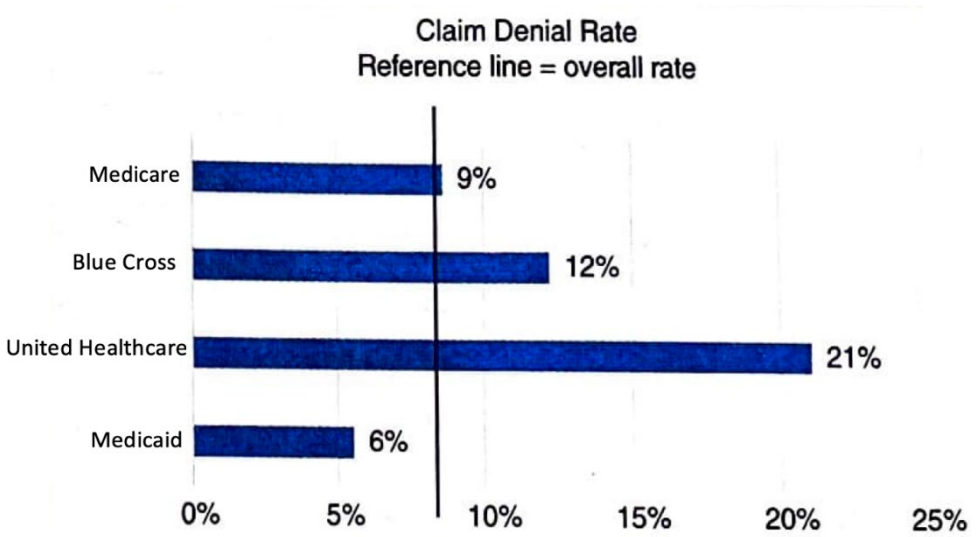
- Conduct regular audits of the denial management process to identify areas for improvement
  - **Administrative Denial** – when insurance carrier denies for a front-end denial or technical denial Examples are incorrect coding, missing preauthorization, registration issues, etc.
  - **Clinical Denial** – when insurance carrier denies for clinical aspect of the service. Examples are not medically necessary, incorrect site of service, etc.

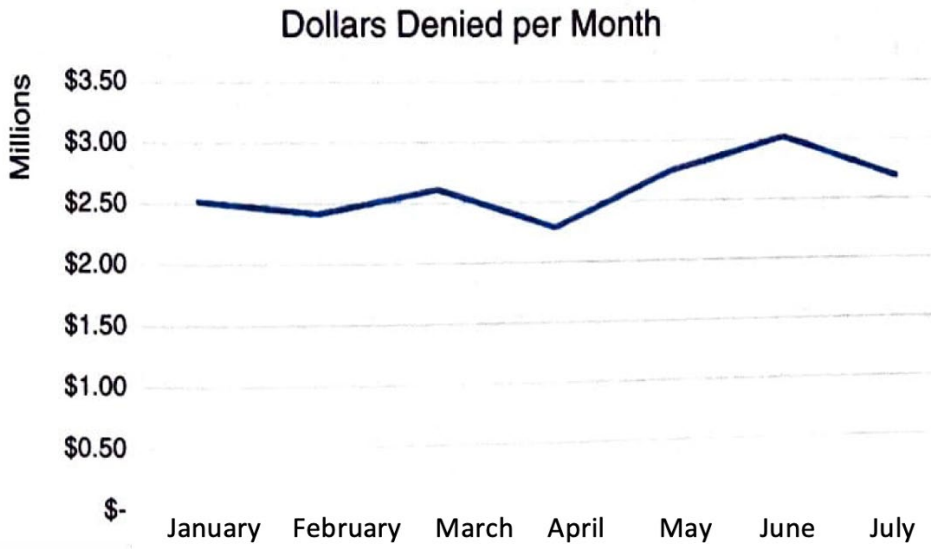
Education and Training

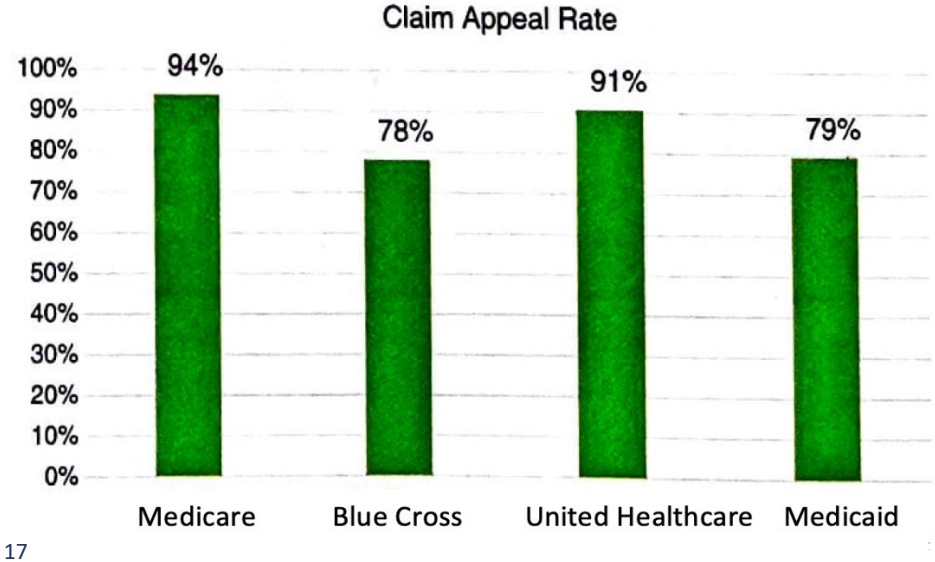
- Provide comprehensive education and training on denial management to front-end staff and providers. This will help reduce the number of denials, ensure successful appeals of denied claims, and boost revenue.

SAMPLE DASHBOARD OF DENIAL MANAGEMENT METRICS









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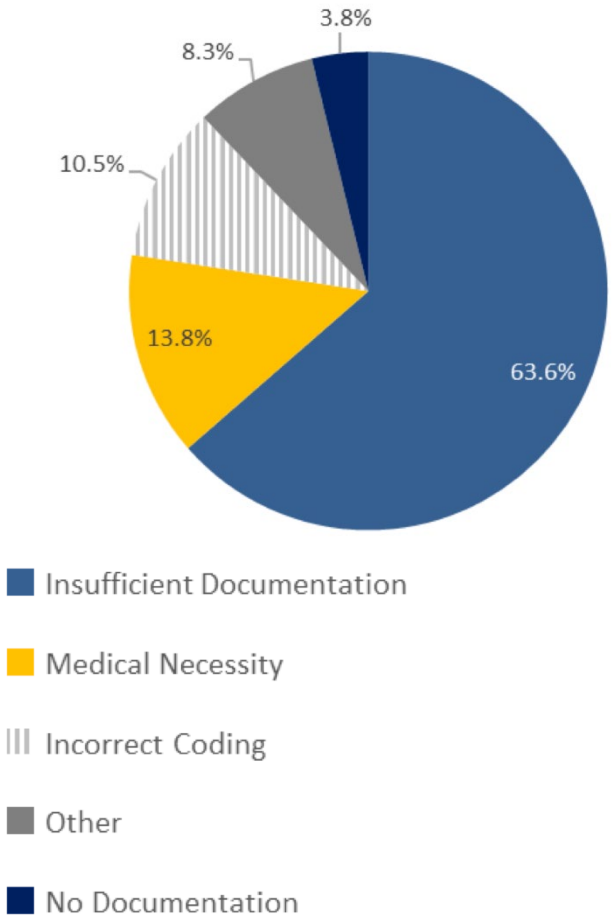
RECOMMENDATIONS AND TAKEAWAYS FOR SUCCESS

Improper Payment Rate Error Categories by Percentage of 2022 National Improper Payments



Enhancements to Reduce Financial Risk and Boost Revenue:

- Adopt modern medical billing software that integrates with electronic health records (EHR) systems for more accurate billing data extraction
- Develop an appropriate lag time for coders to receive complete medical records
- Implement a robust quality assurance procedure to guarantee that claims are submitted accurately and error-free the first time.
- Establish a rigorous quality assurance system to ensure claims are submitted without errors on the initial attempt.
- Conduct periodic internal audits to check for billing accuracy.
- Ensure “smart edits’ are in place.
- Benchmarks and key performance indicators

RESOURCES

- **Ambulatory Surgical Centers (ASC) Center:** https://www.cms.gov/Center/Provider-Type/Ambulatory-Surgical-Centers-ASC-Center
  - Coding and Billing
  - ASC Payment Systems
  - ICD-10-CM
  - Educational Resources
  - CMS Manuals & Transmittals
  - Polices/Regulations
- **Ambulatory Surgical Centers (ASC) Center:** CMS Manual System, Medicare Claims Processing Manual, Chapter 14, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf
- **CY 2024 Ambulatory Surgical Center Payment System Proposed Rule:** https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center