

Outpatient Revenue Cycle Challenges Part 2



2011
NMHIMA and
HFMA Annual
Convention
"Leading the Way"

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Your Outpatient Formula

Staying Ahead of ALL Federal Auditors

**ACCURACY + RELIABILITY +
SUPPORTIVE x (VALUE) =
REVENUE INTEGRITY &
FEDERAL PROOFING**



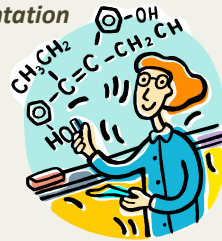
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Your Outpatient Formula

- **Accuracy of**
 - HCPCS selection and charge capture comprehensiveness
- **Reliability of**
 - Data transmission through systems to produce “clean” claims
- **Supportive.....**
 - Sufficient and complete medical record documentation
- **Value X.....**
 - Price facility puts on this formula
 - Education, Technology, Expertise, Audits

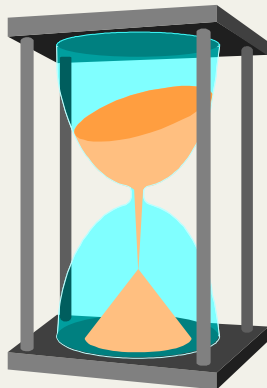


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So Many Issues & Implications.... So Little Time



*Steps Towards Your
Facility's own
Outpatient Audit
Model*

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Overwhelming Odds.....

OP Coding Complexity HIM/CDM

+

Lack of Supportive Documentation

+

OP/APC Revenue Management

+

Regulatory and Compliance Initiatives

+

Operational Challenges

+

ICD-10 Initiatives

+

Technology Advancements



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Outpatient Revenue Cycle Challenge - Ambulatory Surgery

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Inpatient versus Outpatient

Cross Training or “Niche” Specialty

Inpatient Specialist

- ICD-9-CM DX & PX
- MS-DRG Grouping
- POA
- Compliance with supportive documentation
- Coding Complexity
- Inpatient # Days
- Credentials

Outpatient Specialist

- ICD-9-CM DX, PX & CPT with modifiers
- APC grouping & CDM
- Charging & RC reporting
- Compliance with supportive documentation
- Coding Complexity = Medical Necessity
- Increased Volume
- AMB SURG, ED, & OPD
- Credentials

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Cross-Training the Universal Coder?

➤ *Cross-training:* How far should we go? Is it realistic based on regulatory landscape?

- MS-DRG versus APC reimbursement
 - Volume of outpatient encounters
 - OP Coding Rules
 - CDM expertise
 - Charge posting, if applicable
 - Professional billing
 - Medical necessity issues
 - Communication skills between departments



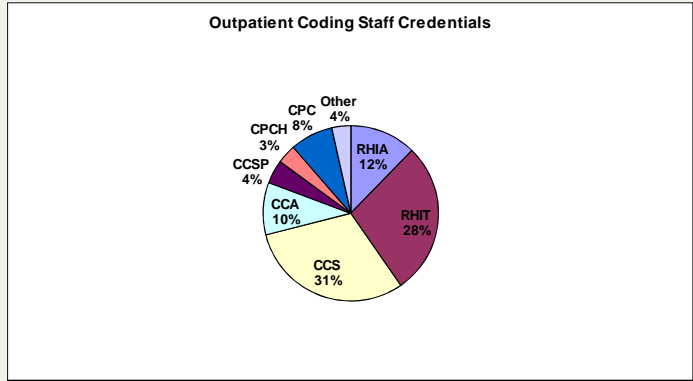
- *Motivation of staff?*
- *How often are staff rotated through both INPT and OUT? Are skills sharp or rusty?*
- *Burn out factor*
- *Retention of staff*
- *Accuracy Rate of both INPT and OUTPT ?*

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Outpatient Challenge – ASU

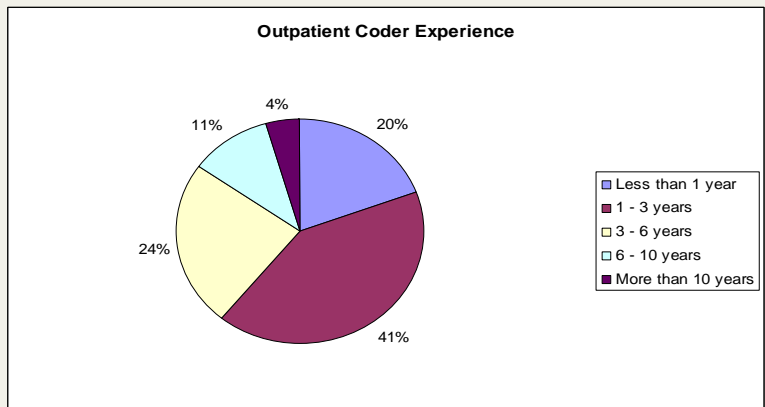


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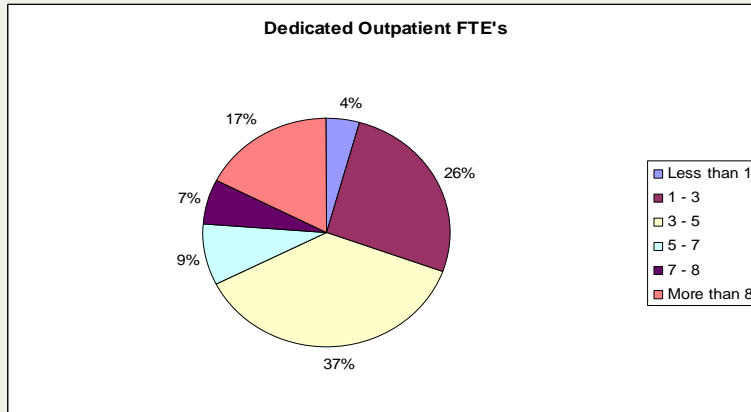


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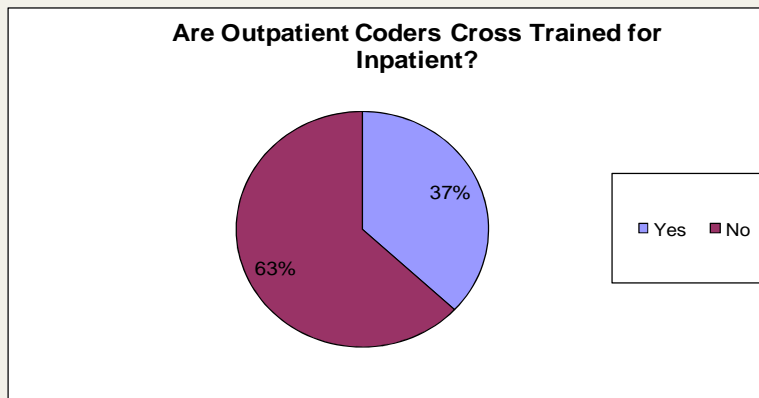


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Outpatient Challenge – ASU



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OP Productivity/Accuracy/Compliance ASU Encounters

- Outpatient National CPT Accuracy Rate –
 - *Is it conceivable to reach 95-100%?*
- Providers have set their own coding accuracy standards for their staff.
- Issue with setting a national standard is that there is also no standard method for determining error rates
 - For example, some organizations look only at number of records (a record with at least 1 coding error is counted as 1 error – even though multiple codes might be incorrect).
 - Other organizations base the coding accuracy rate on each code.
 - And some of these organizations weight certain errors as being more serious – principal diagnosis selection, coding the CCs that affect the DRG assignment, etc.
- AHIMA and the coding benchmarking group is reviewing national standards

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OP Productivity/Accuracy/Compliance ASU Encounters

- Accuracy evaluation criteria:
 - Accurately assigns codes for all diagnoses and procedures
 - ICD-9-CM
 - CPT
 - Modifiers
 - Each code assigned is substantiated by documentation in the medical record
 - Physician documentation
 - Sequencing is correct according to guidelines
 - Abstracts coded data accurately



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Nation-wide CPT Accuracy Rates

ASU Encounters

- **ASU** – Total CPT coding accuracy rate ranges between 70-75%
- **ASU** – Revenue Accuracy rate ranges between 80-85%
- **50 Medicare Audited claims -**
 - CPT range 10000 through 69999/ modifiers/ physician documentation
 - Nation-wide Average
 - Facility size
 - Encoder versus manual usage
 - *Body System Weakness - Integumentary, Musculoskeletal, Urinary and Cardiovascular*



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Why You Ask? Continued Issues Identified from 2001 to present

- Minimal to Basic understanding of CPT coding guidelines & conventions
- Minimal/Basic application of modifiers
 - Modifier 59 and anatomical
- Encoder Dependency
 - Lack of CPT manual usage
 - Lack of reading CPT Asst
 - Jumping straight to technology
- Diverse levels of CPT coding expertise within the OP coding staff
- Reporting codes w/o source document
- Over-looked technical information in the body of the OP report
 - Code assignment from NAME of operation
- Limited OP resources or budgeted education
- CDM and HIM duplication
- Aggressive OP billing schedule requirements
- Productivity Concerns
- Accepting insufficient physician documentation
- Improved technology however lack of usage understanding
 - CDM and LCD



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Outpatient Challenge – ASU

➤ *Principal DX - FL 67*

- If post operative diagnosis is different than preoperative diagnosis – assign post operative diagnosis.
- Pathology available @ time of code assignment

➤ *HCPCS codes – FL 44*

- Operative Report available @ time of code assignment ?
- Code assignment from operative note versus operative report?

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Outpatient Challenge – ASU

➤ *Secondary Diagnosis Assignment*

- FL 67 a- h or up to eight DX identified by MAC
- Although we have 17 in total; only the principal (1) and top (8) = 9 are recognized
- *Watch your internal medical necessity software*
- Once completed with “pertinent secondary’s” – assign chronic conditions that may effect care/treatment of patient during ASU event – See Outpatient Coding Guidelines
- Utilize H&P, consultant H&P or anesthesiology H&P to achieve the needed data to strengthen case mix and support medical necessity of ordered test(s) *on the same day as ASU*
 - Review Past History to include Surgery Events
 - Review Medication List for V58.61, V58.63, V58.66
 - No Arrows translated into DX
 - No “one word” translated into DX i.e. “Thyroid”
 - Look for Third Quarter Coding Clinic 2009

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Next Steps – Your Own ASU Review

Service Line P&L - Outpatients Only - MC Only	Encounters
Principal Procedure CPT Code and Name	
45385-COLSC FLXPROX SPLE NIC FLXR RMVL LES SNARE TQ	849
43239-UPPER STOMACH-INTESTINE SCOPE FOR BIOPSY	575
66984-CATARACT REMOVAL, INSERTION OF LENS	526
45378-SCOPE OF COLON FOR DIAGNOSIS	496
64483-NJX ANES&S TRD TF RMLE DRL LMBR/SAC 1 LVL	431
G0105-COLORECTAL SCRNI; HI RISK IND	296
G0121-COLON CA SCRNI NOT HI RSK IND	295
62311-NJX C+DX/THER SBST EDRL/SAR ACH LMBR SAC	264
45380-SCOPE OF COLON WITH BIOPSY	200
64475-NJX ANES&S TRD JT NRV LMBR/SAC 1 LVL	169
43235-UPPER STOMACH-INTESTINE SCOPE FOR DIAGNOSIS	146
36561-INSJ TUN CTR CTR VAD W/SUBQ PORT AGE 5 YR/>	142
64622-DSTRJ NULYT P VRT FACET JT NRV LMBR/SAC 1 LVL	126
75790-ANGRPH ARVEN SHUNTRS&I	100
43450-OPENING OF ESOPHAGUS	99
43248-UPR GI NDSC INSJ GD WIRE DILAT ESOPH >GD WIRE	91
49505-RPR 1ST INGUN HRN A AGE 5 YRS/> REDUCIBLE	86
62310-NJX C+DX/THER SBST EDRL/SAR ACH CRV/THRC	72
35476-TRLUML BALO ANGIOP PRQ VEN	61
66982-XCAPSL CTRC RMVL INSJ LENS PROSTH 1 STG	61
36581-RPLCMT COMPL TUN CVC W/O SUBQ PORT/PMP	55
50590-LITHOTRP XTRCORP SHOCK WAVE	54
19125-EXC BRST LES PREOP PLMT RAD MARKER OPN 1 LES	44
36558-INSJ TUN CTR CVC W/O SUBQ PORT PMP AGE 5 YR/>	40
58558-HYST SC BX ENDOMETRIUM&POLYPC +-D&C	40

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Next Steps – Your Own ASU Review

➤ Do your own “complex” review –

▪ **Outpatient Surgery Review**

- Top 25 Frequently Reported Medicare Procedures
- Unit = 1
- HIM CPT Code Accuracy with Modifier application to include 59
- Transference of CPT codes from Encoder Product thru to UB04 claims submission
- **Remember** - HIM CPT/HCPCS Accuracy for 50 claims – 70-75%
- **Remember** - HIM Revenue Accuracy for 50 claims – 80-85%

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Accuracy and RAC Threshold ASU Cases Reviewed

	DOS	Accuracy	APC Impact			Paid	Corrected	Rac
	Audited	Rate	Neutral	Positive	Negative	Amount	Amount	Threshold
ASU	9	33.333%	3	5 \$5,394.39	1 (\$504.74)	\$14,965.77	\$19,855.42	32.672%
Cardiovascular	1	0.00%	0	1 \$641.22	0 \$0.00	\$89.74	\$730.96	714.534%
Digestive	1	0.00%	0	1 \$157.29	0 \$0.00	\$370.81	\$528.10	42.419%
Integumentary	5	60.00%	3	1 \$767.83	1 (\$504.74)	\$8,999.71	\$9,262.80	2.923%
Musculoskeletal	2	0.00%	0	2 \$3,828.04	0 \$0.00	\$5,505.52	\$9,333.56	69.531%
Total	9	33.333%	3	5 \$5,394.39	1 (\$504.74)	\$14,965.77	\$19,855.42	32.672%

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Outpatient Surgery Issues LCD Concerns = Medical Necessity

- **Cataract Removal**
 - LCD and complex review
- **Colonoscopy – Excess Units**
 - LCD and complex review

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Outpatient Challenges ASU with CDM Issues

- Physician Orders for additional ancillary test(s) – *Revenue Impact*
 - Radiology
 - Lab
- PAT combined on same claim as ASU
- Nebulizer Treatments – pre/post surgery – *Revenue Impact*
 - 94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)
 - 94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
- GZ modifier reporting – *Revenue Impact*
 - LCD utilization and medical necessity requirements
- Fluoroscopy during procedures
 - 76000 and 76001
 - *No Revenue Impact – data quality*
- Observation following procedure – G0378 – *No Revenue Impact*

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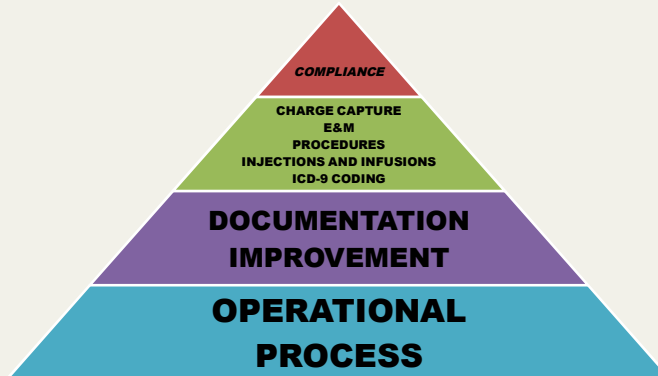
Outpatient Revenue Cycle Challenge - Emergency Department

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Again – the bottom line revolves around the operational process to achieve Revenue Integrity

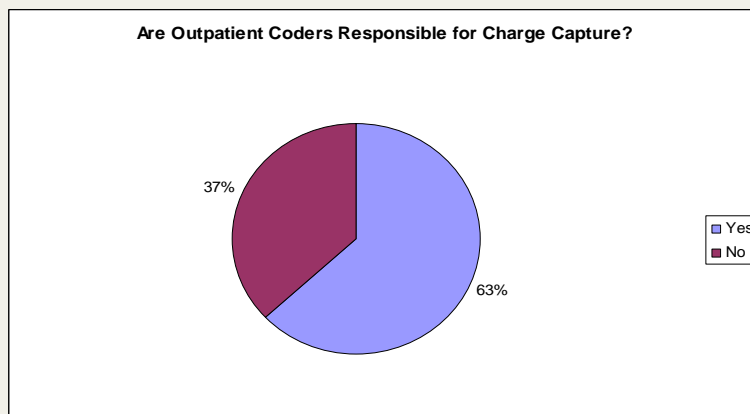


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Outpatient Challenge Emergency Department (ED)

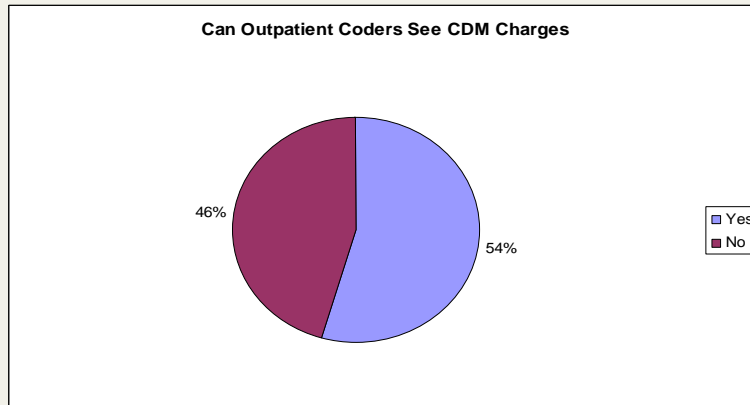


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Outpatient Challenge Emergency Department (ED)



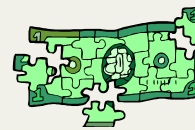
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Outpatient Challenge Emergency Department (ED)

- Contributing to your auditing - ED Claims Accuracy
- *Operational models vary from hospital to hospital*
- Think when asking questions –
 - CPT Assignment...
 - Charge capture....
 - Both of the above....
 - HIM to validate.....
- ED E/M Facility Level and modifier 25
- ED CPT procedure (10000 through 69999) and modifiers
- ED Infusion/injections and modifiers
- ED CDM (70000 through 99999)
- ICD-9-CM diagnosis policy to include reason/primary and secondary's



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Outpatient Challenge Emergency Department (ED)

- “Hot” = topic chosen based on national audit results
- “Mess” = typically problematic operations and claims submission for all hospitals
- Turn your own “Hot Mess” into revenue integrity for your outpatient revenue cycle initiatives.
- *Why is ED DX reporting such a “hot mess” and the need to turn it around –*
 - Evaluate the current landscape of outpatient ICD-9-CM diagnosis coding for ED encounters
 - Strengthen your facility ED case mix
 - Secure valid and compliant diagnosis (es) to ensure medial necessity
 - Lessen the amount of ancillary test denials

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“Tid-Bits” from Coding Clinic and AHA Outpatient

- Use of Arrows = Assignment of Diagnosis (es)
- *Question provided to AHA –*
 - Outpatient encounters only – If a physician documents chronic conditions with arrow symbol up or down, for example ↑ lipid, ↑ chol or ↓ thyroid can we code “hyper” or “hypo” – please clarify with answer.
 - *Letter dated 11/06 -*
 - Diagnosing the patient’s condition is solely the responsibility of the physician, therefore is it not appropriate for a coder to report a diagnosis based on up and down arrows.
 - The physician should be queried regarding the significance and request appropriate documentation.

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“Tid-Bits” from Coding Clinic and AHA Outpatient

- **Official Outpatient Coding Guideline -**
- **For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.**
- **Do not assign I9 DX from the BODY of radiology report**
- **Do not assign I9 DX from HEADER of radiology report**

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“Tid-Bits” from Coding Clinic and AHA Outpatient

- **Coding Clinic – Third Quarter 2005**
 - Narrative phrases as documented in the *INTERPRETATIONS* or *FINAL IMPRESSION*
 - “Consistent with”, “compatible with”, “indicative of”, “suggestive of”, and “comparable with” – terms fit the definition of a probable or suspected condition which are not coded – cod the conditions(s) to highest degree of certainty.
 - **New terminology – “evidence of cerebral atrophy”, “appears to be a nasal fracture” – are being reviewed @ the National Level for final determination of code assignment - Answer provided and will be published 3rd Quarter 2009 Coding Clinic –**
 - **“appears to be....” use the R/O definition**
 - **“evidence of.....” can be reported as established**

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“Tid-Bits” from Coding Clinic and AHA Outpatient

- *ICD-9-CM Official Guidelines for Coding and Reporting -*
 - Signs/Symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by classification
 - Additional signs/symptoms that may not be associated routinely with a disease process should be coded when present
 - Particularly for ED cases -
 - **KIDNEY STONES**
 - Abdominal Pain, Abnormal urine color, blood in urine, chills, excess urination@ night, fever , flank or back pain, nausea, vomiting , groin pain, painful urination, testicular pain, urinary frequency,/urgency, urinary hesitancy.

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Outpatient Challenge Emergency Department (ED)

- *Patient Reason Visit*
 - FL 70 a-c
 - Requirement of one ICD-9-CM DX; may be opened to three (3) – contact FI/MAC before the beginning of the year
 - RC 45X – Unscheduled outpatient visits
 - Describes the PATIENT’S STATED “reason’ for seeking care
 - Code should represent the patient ‘s distress, injury, poisoning or a reason/conditions for seeking treatment or care
 - HIM coders’ need to be consistent – which/where it is going to be assigned

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Outpatient Challenge Emergency Department (ED)

- **Principal DX Assignment**
 - Multiple ED forms along with dictated reports
 - Be sure consistency of where HIM coding staff is securing this DX
- **Secondary DX Assignment**
 - “Pertinent Secondary's”
 - Chronic conditions that affect care/treatment of ED patient
 - Imperative to support medical necessity of test(s) ordered in the ED
 - Past History authenticated by physician
 - If nursing history used, physician MUST STATE reviewed information
 - DO NOT report DX from nursing documentation only i.e. RN, LPN
 - *Coding Clinic Fourth Quarter 2004* – only nurse practitioners or physician assistants (NP, PA) can diagnose; not RN, LPN.
 - Do not forget V58.61, V58.63, V58.66,. V58.67

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Outpatient Challenge Emergency Department (ED)

- **Secondary Diagnosis**
 - After pertinent secondary's and chronic conditions
 - Test(s) available @ time of code assignment and interpreted by MD
 - EKG
 - CT
 - Radiology
 - **NO LAB RESULTS**
- **Adjusted off claim or GZ to non column??**



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Emergency Department (ED) Audit Issues “So After it is Said and Done”

- Evaluation and Management Visit Levels
 - **Accuracy 20/51 = 60%**
 - Lack of nursing documentation – i.e. triage and nursing assessment/notes
 - ED levels -
 - Levels upgraded/downgraded due to above
 - E/M criteria – lack of policy and procedure to determine “how to use it”
- Data Transference and charge capture
 - **E/M level appears on UB with quantity of 2**
 - Coding summary reflects E/M level and procedure code
 - “System” or “human” - rolling units

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Outpatient Auditing History of Critical Care – Facility

- **Transmittal 1139 January 2007 OPPS Updates**
- ***“Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.”***
- **From the CPT book 2010 -**
- ***“Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (eg, participation in administrative meetings or telephone calls to discuss other patients). Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time.”***

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Outpatient Auditing History of Critical Care – Facility

- **Federal Register effective for January 1st, 2009 OPPS Updates –**
- ***“...hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically with respect to CPT code 99291, hospitals must follow the CPT instructions related to reporting that CPT code. Any services that CPT indicates are included in the reporting of CPT code 99291 should not be billed separately by the hospital. In establishing payment rates for visits, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for visits according to the standard OPPS methodology for packaging costs.***
- **April 1st, 2009 - Full set of CCI edits incorporated under OPPS**

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Critical Care for 2011 - OPPS

- **2011 CPT code definition/guidance for critical care has changed!**
- **Last sentence added states – “Facility may report the above services separately.”**
- **Good news in terms of hospitals being able to report these services separately, BUT CMS will not pay for these separately until sometime in the future since its current critical care APC payment rate “has been developed to include costs associated with these ancillary service”.**
- **SI Q3 will be assigned to the ancillary services to indicate that payment for them is packaged into a single payment for specific combination of services**
- **Ancillary services included in the definition of critical care prior to CY 2011 will be considered “conditionally packaged” by CMS when reported on the same day as critical care services so that CMS does not end up double paying.**
- **CMS is requesting comments on this issue so hospitals should weigh in...otherwise who knows whether we’ll ever see separate payment!**

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Emergency Department (ED) Audit Issues

“So After it is Said and Done”

➤ Critical Care – 3 Claims

- Reported without documentation to support
 - Time based CPT code
 - Definition of “Critical Care”
 - Reporting other services
 - Services included in code 99291
 - Separately reportable services
 - Time involved in other services must be deducted (CPR)
 - Requires documentation of ED staff time

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Emergency Department (ED) Audit Issues

“So After it is Said and Done”

➤ Drug Administration

- Under reporting of hydration and therapeutic drug infusions - when start and stop time documented.
- Over reporting units for hydration and therapeutic drug infusions without stop time.
- Over reporting pushes in conjunction with other services
- *Defaulting to IV push code with generic “IV” and no stop time.*



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Drug Administration Rumors Abound

Let's try to clear them up

- We are assigning injection and infusion services during CPR and critical care services – that's OK – right?
- CCI Manual Instructions starting from 10.3 and forward -
- "In keeping with the policies outlined previously, procedures routinely performed as part of a comprehensive service are included in the comprehensive service and not separately reported. A number of therapeutic and diagnostic cardiovascular procedures (e.g., CPT codes 92950-92998, 93501-93545, 93600-93624, 93640-93652) routinely utilize intravenous or intraarterial vascular access, routinely require electrocardiographic monitoring, and frequently require agents administered by injection or infusion techniques; accordingly, separate codes for routine access, monitoring, injection or infusion services are not to be reported."
- Review your operational practice and discontinue with the guideline as listed above.

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CPR and Injections/Infusion PLUS Critical Care

Vital Signs						IV Therapy						
Time	BP	Pulse	Resp	Temp	O2 Sat / SpO2	Pain/Concept	IV	Time	Size #	Site	Lock / Solution	Rate
0559	120/80	90	20	98.6	94	None	1	0555	27	venous	Removal	
							2	0555	27	NS	7	W/O
							3					
							4					

Time	Medication / Dose / Route	Site	Int.	Time	Medication / Dose / Route	Site
0555	1 amp D50	IVP		0604	1 amp bicarb	IVP
0557	epi 1mg	IVP		0610	1 amp bicarb	IVP
0600	Atropine 1mg	IVP		0601	Atropine 1mg	IVP
0600	epi 1mg	IVP		0603	1mg Epi	IVP

Time	Notes
0555	Pt brought to room # [redacted] Report given to: [redacted] Eval. by: [redacted] (MOP/AMP) Time: [redacted]
0555	PR in [redacted] CPR started pt intubated prior to arrival
0555	ESRS 246 multiple IV attempts, attempt (C)
0555	Removal of venous femoral line placed labs drawn and sent. head as above
0557	on monitor, no pulse, med as above.
0559	no cardiac movement via ultrasound.
0600	CPR continued.
0600	med as above
0600	Respirator not done by [redacted]
0600	no cardiac movement till CPR continued
0600	U/S done but no (R) gain

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Drug Administration Rumors Abound

Let's try to clear them up

- We continue to have trouble with incomplete clinical documentation to include start and stop times and appropriate abbreviations. We developed an internal list to assist with what drugs can be pushed, infused and the associated time frame. Is this sufficient documentation to support our CPT code(s) and charge capture even if the clinicians information is incomplete?
- If in your mind the following words are triggered based on incomplete clinical documentation on a continued basis ...
"I believe we are; Fairly accurate; presuming; in the ballpark; estimating; assuming; guessing; connecting the dots; using protocol or instructions; using an interdepartmental list; downgrading to be safe; giving up"
- **WOW – can you spell RISK and potential CERT and RAC initiatives**

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Rumors Abound

Let's try to clear them up

- In the most simplistic terms –
- “Time units are calculated based on how long the fluids have infused. (**PERIOD**) The documentation must have both start and stop times recorded to justify the amount of time billed.” (**AND REVENUE RECEIVED**)
- **“Time-Based”** CPT codes require **“Time-Frame”** documentation
- No ifs, ands, buts or sometimes...this is the rule; not the exception.
- **Your MAC may say it is OK – however Medicare and RAC will not abide by your MACS directions**

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Rumors Abound Let's try to clear them up

Medicare Contractor Beneficiary and Provider Communications Manual (Pub 100-09), Chapter 6, section 30.1.1

Providers are responsible for determining the correct diagnostic and procedural coding for the services they furnish to Medicare beneficiaries. CSRs shall not make determinations about the proper use of codes for the provider. When providers inquire about interpretation of procedural and diagnostic coding they shall be referred to the entities that have responsibility for those coding sets.

The coding questions appropriately answered by the PRRS are those concerning the underlying Medicare payment or coverage policy. Pure coding questions (not related to a Medicare payment or coverage policy) shall be answered with referrals to the correct organizations such as the American Medical Association and the American Hospital Association's Coding Clinic.

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Real Time Documentation You are the Auditor – Pretend...

NURSING PROCEDURE: IV (7:47 MGH)
 TIME: Patient's identity verified by, [redacted] stating name [redacted] Indications for procedure: medication administration, Procedure performed at 0730, IV established, 22 gauge catheter inserted, into left, metacarpal vein, #1 site, in 1 attempt, Saline lock established, Flushed with normal saline, amount 5cc. After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, Patient tolerated procedure well, Procedure done by Rosemarie, RN.

NURSING PROCEDURE: NURSE NOTES (7:47 MGH)
 TIME: Time: 0730, Ancef 1GM IV infusing as ord by [redacted] [handwritten signature]

Medication Orders		
Date/Time	Medication	MD Signature
7/11	Ancef 1gm IV x 1	[handwritten signature]

ANCEF – NO STOP TIME OR TIME DOWN indicating completion – based on protocol of drug administration typically 30-60 min which is NOT a push nor can you use PROTOCOL as a defense – work with EHR and nursing staff to ensure reliable documentation to show the work involved – GET PAID FOR YOUR TIME AND RESOURCES

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Real Time Documentation

You are the Auditor – Pretend...

IV saline lock
IV solution rate

Time	Medication / Dose / Route	Site
1800	1 L NS NS E 2 Gram MgSO4	
	1 amp MVI, 1 mg Folic, 100 mg Thiam	

Time ordered ALLERGIES / REACTIONS noted Td 0.5 ml IM

5th ASD NS + 1mg plate + 100mg Thiamine
+ 1 amp MVI + 2g Mg sulfate

Patient stayed 12 hours in the ED. A « banana bag » started @ 6 pm. Patient discharged @ 6:00 am. A typical composition of a banana bag is Thiamine 100 mg + Folic acid 1 mg + MVI 1 amp to 1 Liter of normal saline. One to two grams of Magnesium Sulfate may also be added to the mixture. The solution is typically infused over four hours. OPTIONS of code selection below based on documentation above -

IV	Time	Size #	Site	Lock / Solution	Rate
1	1700	B50	(B) Thiam		
2					
3					
4	1200	10			

TOTAL INTAKE: 1 L NS
TOTAL OUTPUT: 400 + DR

- A. NONE = BUPKIS = NADA = ZIP = NILL = ZILCH
- B. 96365 x 1 (they must have given at least one hour, right?) = \$128
- C. 93674 - no downtime so default to a push = \$36
- D. 96365 x 1, 96366 x 3 – standby the PROTOCOL and hope for the best = \$152
- E. Need to provide feedback to nursing staff regarding RISK and opportunity base on complete documentation 96365 x 1, 96366 x 11 = \$392

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ED Revenue Accuracy

	DOS Accuracy		APC Impact			Paid Amount	Corrected Amount	Rac Threshold
	Audited	Rate	Neutral	Positive	Negative			
ED	51	37.255%	19	6 \$1,048.52	26 (\$2,189.30)	\$22,652.31	\$21,511.53	-5.036%
Auditory	1	0.00%	0	0 \$0.00	1 (\$40.66)	\$520.56	\$479.90	-7.811%
Critical Care	3	0.00%	0	1 \$655.47	2 (\$259.10)	\$1,494.77	\$1,891.14	26.517%
Digestive	4	100.00%	4	0 \$0.00	0 \$0.00	\$3,893.01	\$3,893.01	0.00%
Integumentary	8	37.50%	3	0 \$0.00	5 (\$677.29)	\$3,517.99	\$2,840.70	-19.252%
Medical Visit Only	1	100.00%	1	0 \$0.00	0 \$0.00	\$0.00	\$0.00	
Musculoskeletal	6	33.333%	2	0 \$0.00	4 (\$299.60)	\$1,979.67	\$1,680.07	-15.134%
Nervous	1	0.00%	0	1 \$65.84	0 \$0.00	\$800.46	\$866.30	8.225%
Respiratory	4	50.00%	2	1 \$69.91	1 (\$100.97)	\$1,459.44	\$1,428.38	-2.128%
Urinary	23	30.435%	7	3 \$257.30	13 (\$811.68)	\$8,986.42	\$8,432.04	-6.169%
Total	51	37.255%	19	6 \$1,048.52	26 (\$2,189.30)	\$22,652.31	\$21,511.53	-5.036%

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Outpatient Revenue Cycle Challenges Part 2

Questions??

And

Thank You



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