Collaborate with Nursing Leadership to Enhance Revenue Cycle Performance in the ED

HFMA NJ and Metro Philadelphia Chapters Annual Institute
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Agenda

• Introduction
• Creating a business case for nursing's enhanced role in RCM
• How the finance professional can help improve engagement and outcomes
• Clinically modified RCM—what’s relevant in the ED?
• Making a case for case management in the ED
• Q&A, discussion
About LYNX Medical Systems

• **Founded** in 1984, LYNX became an Ingenix/Optum company in July 2010; we provide revenue management solutions for outpatient hospital and physician services
• **25 years** experience aligning outpatient health care services with proper reimbursement
• > 1,200 clients
• > 30 million patient encounters annually
• **Outsourced** outpatient coding labor solutions

LYNX is now OptumInsight, part of Optum—a leading health services business

Optum—An Aligned Health Care Services Platform

One of the largest health information, technology and consulting companies in the world

The leader in population health management serving the physical, mental and financial needs of both individuals and organizations

The pharmacy management leader in service, affordability and clinical quality

Market leaders within a dynamic health services market
"Health care is difficult, and we need to help each other learn and grow"

Mary Taylor, FHFMA, 2010-2011 president of the New Jersey Chapter, HFMA

Creating a Business Case for RCM in an ED Clinical Setting

• ED nursing leadership is challenged to manage the delivery of not only excellent clinical care and outcomes but also solid financial performance
• Barriers and challenges make achieving positive ED financial outcomes difficult, but not impossible
• One of those barriers is a less-than-optimal focus on important revenue cycle management processes in this outpatient setting
• Focused ED attention on revenue cycle processes will help pave the road to financial health
• Finance leaders have the background, knowledge, and experience to support nursing leadership’s efforts
• I challenge each one of you to collaboratively engage in new ways with ED nursing leaders to help create a financial win for the hospital
Nursing Leadership’s Collaborative Role: Partnering with Others to Oversee ED Revenue Cycle Processes

- A working understanding and the ability to “speak the language” will facilitate collaboration with others whose job it is to directly manage RCM processes.
- By understanding and actively engaging in these RCM processes, nursing leaders can identify issues and drive change if improvements are needed.
- Understanding will also allow the ED nursing leader to communicate these important revenue concepts and expectations to ED staff and physicians whose support is essential.
- If ED revenue enhancement is a goal, pushing RCM into the clinical arena is one approach to attain it.
Finance Can Lead the Way!

Strategy, Approach and the Political Climate

- Establish leadership; it will vary along the way—nursing vs. finance
- Obtain the support of top management and buy-in from key others
- Communicate your interest—share your time, knowledge and expertise
- Provide clinically relevant RCM 101 discussions/education sessions for nursing leadership
- Work with nursing to develop a plan, set goals; formal vs. informal?
- Understand how RCM components can be adapted and applied in the ED clinical setting
- “Pilot projects” offer a non-threatening approach to explore solutions to problems
- Recognize that, given constraints, successful collaboration involving patient access, HIM, nursing, physicians, compliance and finance will be a challenge, behind the scenes lobbying 1:1 may be required
- Be aware of and proactively address challenges
Challenging Issues

- RN’s lack of knowledge, information, and tools to monitor ED revenue cycle business processes
- Tight nursing resources, conflicting priorities
- Traditional “silo” approach to functional hospital management and other political issues
- Belief that the work of ED clinical and management staff and ED clinical processes should not be “tainted” by involvement in functions traditionally owned by the hospital’s finance group
- ED nursing leaders can overcome these challenges as they gain knowledge, educate staff, and, through partnership with others, begin to affect improvements in ED revenue performance

Let’s Talk About “Clinically Modified” RCM
Revenue Cycle Management

- The HFMA and others define RCM as the coordination of “all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue”
- These functions support generation of a clean claim, help optimize reimbursement, and are often the focus of compliance efforts
- RCM offers a systematic and practical approach to looking at the revenue side of ED profitability, which will appeal to analytical nursing leaders
- Drafting process flow diagrams identifying the tasks within each RCM process and how they interrelate will help the nurse leader gain understanding as well as identify opportunities for improvement
- With slight modifications in what is included and how processes are communicated, the revenue cycle model can be easily understood and adopted by clinical leaders
- Nursing leaders will not, in most cases, be revenue cycle process owners but they still should understand the processes, goals, and optimal outcomes and they must be willing to demand excellence at every step along the way

Use RCM as a Framework to Educate Nursing Leaders about ED Financial Performance

[Diagram showing the Revenue Cycle Management processes: Patient Registration, Documentation, Monitoring, Charging, Billing, Coding, and Follow up]

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Patient Registration

• Goal: recognize the value of and ensure accuracy in this first step of the ED revenue cycle process
• Inaccurate and insufficient demographic and payer information is one cause of denials and lost revenue
• Best Practices:
  – Have ED registration staff report to Patient Access
  – Provide and maintain up-to-date written policies and procedures
  – Establish clear expectations for accuracy and the extent of information obtained
  – Require that registrars receive ongoing training based on policies and expectations
  – Ensure that the automated registration system is as efficient as possible and that input of necessary data elements is required
  – Periodically audit the registration staff’s work; error tracking and feedback are success factors
  – Establish an expectation for excellent customer service to set the stage for a positive patient experience; patient volume is a driver of ED revenue

Documentation

• Goal: optimize documentation to support clinical care, medical-legal interests, data needs, reimbursement and downstream revenue cycle functions
• Documentation in the ED record captures facility resource utilization and establishes medical necessity for services provided
  – MN is a payment rule requiring that a billed service be reasonable, necessary and appropriate for the diagnosis or treatment of a patient’s illness or injury, i.e., justification for payment
  – On audit, payment will be denied for a service that is deemed not medically necessary
• Excellent nursing and physician documentation are required for optimal ED revenue capture
Documentation Best Practices

- The EHR is the preferred documentation format: it prompts physicians and nurses to document required data elements for clinical care, charging, coding and billing
- "Hardwire" documentation prompts into paper clinical records
- Provide nursing documentation education, especially as it relates to the internal guidelines for determining the ED visit level
- Provide physician documentation education on E/M services, procedures, diagnoses, quality measures and other hospital documentation requirements
- Clinical documentation improvement programs are frequently implemented to improve inpatient clinical documentation; add CDI capability in the ED through CDI consultants, the hospital’s CDI nurses or an ED case manager
- Establish an ED query process
- Audit records and provide feedback on documentation quality and any deficiencies; quantify lost revenue because of deficiencies

Charging

- Goal: submit complete and accurate charges for all billable ED services before the designated drop cycle deadline
- Charging vs. coding
  - Charging is usually completed in the clinical area by an RN or charge analyst and includes identification of the correct CPT codes for the visit level, nursing procedures, and supplies
  - Coding is typically performed in HIM by a professional coder and includes identification of additional CPT procedure codes, modifiers, ICD-9 codes, and other reportable information such as treating physician and quality measures
- Ancillary charges for ED encounters are entered into the billing system as other departments complete their charging process
- ED charges include 1) visit levels, 2) procedures and 3) supplies
Charging: Visit Levels

- There are no specific national guidelines or standards that direct hospitals how to differentiate between the ED levels of service
  - CMS has published eleven general guidelines and has instructed hospitals to develop their own guidelines
  - Chosen method applies to all patients in the ED or Clinic where implemented
- ED facility visit levels are usually reported with one of five E/M CPT codes, 99281-99285, or Critical Care, 99291
- Medicare differentiates between two types of ED beds: Type A and Type B
  - Type A ED beds meet the EMTALA definition of a dedicated ED and are open 24 hours a day seven days a week per the CPT definition of an ED
  - Type B ED beds also meet the EMTALA definition of a dedicated ED but these beds are open and available less than 24 hours a day
    - Often called fast track beds
    - Visit levels for Type B ED beds include G0380 through G0384 for levels 1 through 5

Charging: Procedures

- Procedures include medical, surgical, diagnostic and nursing procedures
- Each type of procedure must be ordered by the physician, be medically necessary and sufficiently documented; procedures are “coded” using CPT codes and these codes must be included in the ED chargemaster
- There are approximately 350 to 450 different procedures performed in EDs
  - Surgical procedures such as wound repairs and fracture care are coded based on physician documentation that is consistent with the CPT code descriptor
  - Medical procedures such as CPR or moderate conscious sedation are usually coded based on a combination of physician and nursing documentation
  - Diagnostic procedures such as ECGs are generally coded based on the physician documentation and orders
  - Nursing procedures include IV infusions and injections, intramuscular and subcutaneous injections, Foley catheters and others and are coded based on nursing documentation and CPT and CMS directions
- Procedure payment is usually made in addition to the ED visit payment
Charging: Supplies

- Supply charges are captured in a variety of ways:
  - Electronic capture using bar codes or an automated check out system based on the chargemaster
  - Manual charge tickets or sticky labels; charges are then keyed into the billing system
- Some supplies are accounted for in the procedure charge—it depends on the hospital's model for establishing fees
- Other supply items may be separately charged based on payer direction; splints, crutches and other ortho supplies are three examples

Charging Best Practices

- Determine who will perform the charging function—nurses, coders, or charge analysts and provide them with ongoing education and monitoring
- Implement a process to reconcile each record with the ED patient log to ensure that all encounters are charged
- Designate a tight timeframe or drop cycle within which all ED charges must be uploaded or entered into the billing system
- Develop charging procedures with ED-specific guidelines for visit, procedure and supply charging to ensure consistency
- Annually review and validate the visit level method making sure it accurately captures resource utilization and complies with CMS’ 11 guidelines
  - Educate staff on the visit level methodology’s documentation requirements
  - Integrate the visit level methodology into an EHR linking it with documentation
  - Have a copy of the methodology available for auditors and request that they use it if the ED’s records are audited
Charging Best Practices, continued

• Optimize the chargemaster/CDM—revenue codes, charge codes, CPTs and descriptors, and fees; review it annually for accuracy and completeness
  – Request a CDM code addition any time a procedure is performed/documentated that does not have a corresponding CDM number
• Establish a process for charging procedures performed by non-ED providers
• Audit the accuracy of visit, procedure and supply charges and provide feedback to staff; compare with expected levels and report revenue variance
• Keep a current copy of the CPT book in the ED
• Implement a query process for questions and resolving deficiencies
• Implement an electronic charging system interfaced with the billing system to support an accurate, efficient charging/billing process

Coding

• Goal: accurately report ICD-9 diagnoses codes, modifiers, surgical CPT codes and other required data elements for each ED encounter within a designated timeframe
• Accurate coding meets data needs, optimizes reimbursement and supports medical necessity for ED and ancillary charges
• Coding or abstracting is the process of converting clinical information in the ED record into data that is recognizable by payers and their information systems
  – When coding an ED record both the MD and nursing documentation are reviewed
  – The most sophisticated coding systems work with EHRs and employ a strategy called computer-assisted coding or CAC
  – Using CAC, inputs for coding some or all of the visit level, procedure, and ICD-9 codes are abstracted from documentation in the EHR; a coder reviews the documentation and system assigned codes to validate them for accuracy
  – Other coding systems allow a coder to review the ED record, either on-line or in paper, for evidence of resource utilization for the ED visit level, procedure detail, and diagnoses; the coder selects the appropriate codes based on on-line search capability or books
• ED nursing leaders should have a high level understanding of the coding process, ICD-9 and CPT, quality measure reporting, and coding tools—coding systems, editors, and abstracting
Coding Best Practices

• Coordinate the charging and coding processes; coding “drops” the bill in most billing systems
• Implement an EHR and tools for CAC
• Provide coders with continuing education, current coding references and payer information
  – Include lists of payer required diagnoses that support medical necessity for ancillary services—NCDs, LCDs
• Implement a query process for questions and resolving deficiencies
• Establish a process where coders review and validate ED charges, especially if completed by busy ED nurses
• Audit coding accuracy and provide feedback to coders
• Designate a tight timeframe or drop cycle within which all coding is completed

Billing

• Goal: accurately complete the billing process within a designated timeframe in order to increase ED revenue and decrease denied claims
• Start the billing process in the ED: consider point of service payment and optional financial counseling
• After charging and coding data flow into the billing system pre-billing edits validate claim information and ensure accuracy and readiness for payer processing
  – Some edits create deletion of line item charges
  – Some accounts that fall out of the edit process will end up in a “discharged not final billed” or DNFB report
• ED staff or managers can work with finance to resolve clinically oriented edits
• The ED should be kept informed about unbilled accounts, downcodes and denials
Billing Best Practices

• Obtain information re: what terms are included in major payer contracts and government payment policies for ED services—what they do and do not pay for
• Partner with finance to learn about billing issues and where clinical staff can support the process
• Ensure that system edits are accurate and up-to-date
• Reconcile patient accounts on the DNFB report and take steps to prevent recurrences of identified problems
• Consider implementing a discharge desk where registration, demographics, documentation and discharge information can be reviewed and verified
• Provide access to financial counselors prior to ED discharge
• Provide an option for point of service payment collection—co-payments, deposits or the entire bill
• Make sure someone in PFS or compliance establishes relationships with representatives from the Medicare contractor and major payers

Monitoring

• Goals: ensure “clinical” RCM processes are working efficiently and outcomes are positive and consistent with industry standards; identify problems and opportunities for improvement
• Monitoring efforts include auditing, evaluating process efficiency and outcomes, comparing ED performance in designated areas with benchmarks, and analysis of internal management reports
• Dashboards offer a customizable automated display of performance indicators and can facilitate the monitoring process
Monitoring: Audits

- Auditing of registration, documentation, charging, and coding should be completed on a periodic basis
  - Evaluate the quality of registration information
  - Identify documentation deficiencies including signatures and physician orders
  - Determine accuracy rates and timeliness for charging and coding
  - Provide feedback and education based on audit findings, quantify $ losses, track and trend results to show improvement
  - Start to finish audits should incorporate the claim and Remittance documents showing the outcomes of charging, coding and billing
- Document audit results as part of the ED’s compliance plan
- Audit findings will generate “spin off” projects that require follow-up

Monitoring: Key Performance Indicators

- Select KPIs for each step of the revenue cycle; examples of ED indicators include:
  - General: ED patient volume, wait times, time to provider, number of patients leaving without being seen, satisfaction scores, patient complaints
  - Registration: data accuracy rate, % denials for inaccurate demographic/payer information, productivity, copies of insurance/id info included with ED record
  - Documentation: signatures present per policy, orders present for applicable services, % completed charts, deficiencies resulting in coding below expected visit level
  - Charging: visit level frequency distribution, the percent of records charged and coded each day compared with patient volume, number of late charges
  - Coding: productivity, number of accounts on DNFB list, number and % of records audited, accuracy rate on audits
  - Billing: collection of ED payments before dc, screening for uninsured patients, financial counseling offered
  - Follow-up: process and outcome improvements, number of denied claims, appealed denials overturned, number of patient complaints
- After KPIs selected, determine optimal/targeted performance analytics for each
Monitoring: Benchmarking

- A benchmark = best practice target = optimal performance outcome
- Research local and industry benchmarks in selected KPI categories and work to meet or beat them
- With comparison data of actual vs. optimal in hand:
  - Examine variances and determine the reasons; if they occur more than infrequently it almost always goes back to a process that could be tightened up
  - Identify road blocks, bottlenecks and other areas where improvement opportunities exist—where there is a gap between the ED’s performance and an identified best practice or benchmark
- General ED benchmark categories include clinical and revenue cycle outcomes, patient experience/satisfaction, quality of care, time metrics, costs, and productivity
- Display KPIs, actual performance data and benchmarks on dashboard for management (and staff where appropriate!)

Monitoring: Internal Management Reports

- Determine the ED’s data needs and priorities that are consistent with KPIs and other internal goals
- Nursing leader or designee needs to understand how to run routine reports from various systems, how to generate ad hoc reports and how to analyze the data
- Meet monthly with a PFS analyst to review data and get questions answered
- Where applicable, establish access to key metrics in a dashboard format
Monitoring Best Practices

• Establish a monitoring plan for each component of the revenue cycle
• Assign the monitoring role to an ED case manager
• Determine relevant indicators/issues to monitor and an efficient means to report them
  – KPIs and the hospital's internal requirements will define monitoring content
  – Dashboards are the way to go
• In the process of monitoring, be obsessive about documenting problems, potential opportunities for improvement and issues needing follow-up

Follow-Up

• Goal: resolve inefficiencies and concerns in any "clinical" revenue cycle category with less than optimal performance
• Follow-up for nursing leadership includes:
  – Assisting with appeals of payment denials and downcodes, payer audit defense, and resolution of patient complaints
    • Immediate and ongoing concerns will often be related to billing follow-up issues
  – Analyzing and resolving identified problems
  – Improving processes to reduce ongoing "fire fighting"
  – Communicating information to ED staff and physicians:
    • Informing them of efforts and outcomes
    • Motivating them to engage in process improvement and corrective actions
    • Congratulating them on successes
Follow-Up: Payer Denials and Audits

- Reasons for payer denials generally fall into three categories: registration errors, clinical issues, and billing errors; ED can assist with or resolve the first two.
- Denied ED claims usually involve one or more accounts where the visit level or an ancillary test is questioned.
- Audits usually involve a group of ED claims that the payer believes were coded incorrectly.
  - The audit set is often based on outliers discovered via data mining.
  - Concerns are usually related to visit levels coded higher than expected; lack of medical necessity is often cited as the reason.
- The payer will provide the hospital with patient names and account numbers.
- Send records asap within the timeframes specified in the demand letter.
- Include the hospital’s ED visit leveling method; request that it be used in the audit.

Follow-up: Appealing an ED Audit

- Review payer policies, methods and concerns.
- Coordinate an internal audit of the same records to evaluate coding accuracy.
  - If correct, and PFS decides to appeal, the ED and/or HIM should prepare a clinical response supporting that the claim was correct.
  - Document the “story” for each record: substantiate medical necessity by documenting factors supporting the patient’s severity of illness and intensity of service.
  - Defend the level of service from a clinical perspective and be able to demonstrate that the visit level methodology was accurately applied.
  - Consider ED medical director involvement.
- Many payer auditors are unfamiliar with ED coding, especially visit levels; view the audit discussion as an education opportunity.
- If initially unsuccessful, there is usually an appeals escalation process.
Follow-Up: Patient Complaints

- Patient complaints about bills usually occur because the patient believes that the fees were too high
- The ED or HIM should audit the medical record to determine if the coding was correct
- If the coding was correct, HIM or nursing should provide a written explanation as to why the level of service was correct
- Under certain circumstances the fee may be reduced but the correct CPT code should not be changed to misrepresent the service provided
- If the complaint involves some type of medical misadventure, a quality of care issue, or a public relations issue, forward to risk management

Follow-Up Best Practices

- Finance and clinical leaders should work collaboratively to provide immediate attention to payer issues, audits, downcodes and denials
- Identify drivers of issues creating a need for follow-up; solve problems, identify improvement opportunities and then modify processes to reduce future concerns
- When process and KPI outcomes vary from benchmarks investigate why, determine a solution and make improvements where needed
- If available, involve an ED case manager to research issues, drive improvement efforts, monitor progress and communicate liberally
ED Case Management and Compliance

Case Management in the ED?

- The CM role is more commonly employed in inpatient settings for coordination of care and discharge planning, utilization management, carepathway monitoring, and clinical documentation improvement (CDI)
- Consider adding a case manager to the ED staff to support and monitor RCM processes and affect improvement in “feeder” clinical issues
- The case manager’s role can include support for ED coordination of care, analytics, utilization management and reimbursement
- An RN case manager has the ideal skill set to support nursing leadership in the provision of revenue cycle management in the ED
The ED Specific RN Case Manager Role

• The CM can “operationalize” RCM and help drive financial performance improvements
• Examples:
  – Assist with ED disposition decisions
    • Identify medical necessity and admission criteria for appropriate level of continued care—observation vs. inpatient
    • Support ED nurses by providing discharge planning and assisting them to resolve social issues that delay discharge or affect patient safety
  – Provide clinical documentation improvement analysis and education
    • Validate chart completion with clinical content and signatures
    • Ensure presence of diagnoses, POA status and quality measures
  – Respond to patient concerns including complaints about bills
  – Coordinate audits and effective rebuttals in response to payer audits
  – Generate reports and provide data analysis

A Few Words about Compliance

• The ED nursing leader needs to be mindful of compliance when managing the ED and more specifically when looking at processes and outcomes related to revenue and reimbursement
• Non-clinical compliance issues are related to registration, documentation, charging, coding, and/or billing
• ED management can help ensure compliance through effective systems, policies/procedures and processes, education, audits and monitoring
• Knowing the rules and having established policies and procedures as well as an internal compliance plan will provide an excellent foundation for compliance
• Drafting an ED specific compliance plan that incorporates RCM components will be a useful exercise
• The nursing leader can partner with the hospital’s compliance team, as well as finance, to gain information and assistance
Leadership, Commitment, Collaboration and Communication are the Keys to Success

• A knowledgeable ED nursing leader working closely with finance, HIM and compliance can integrate RCM processes into the ED and improve financial performance
• A case manager can coordinate the work effort
• Key success factors:
  – Nursing assuming leadership in the effort; getting staff/MD buy-in
  – Developing relationships and partnering with the hospital’s financial, HIM and compliance professionals
  – Communicating the value and setting expectations
  – Educating the team
  – Fully implementing clinically oriented RCM and making it a priority
  – Establishing performance benchmarks, monitoring, and implementing changes to hit targets if missed
• Celebrate success when targets are hit!

Questions?

Contact information
Candace E. Shaeffer, RN, MBA, RHIA
1877-542-4451
candace_shaeffer@picis.com