



Improved Revenue Cycle Management



Karen Cole, MBA, CPC
Sales Product Consulting



Ingenix Overview

Ingenix — The Markets We Serve



Our goal is to reduce the friction across the health care system.

The Company We Keep



Ingenix serves more than 250,000 diverse clients
Numerous federal/state agencies, 1,500 insurance companies,
Over 75 pharmaceutical and biotech firms, over 3,500 hospitals, 100-plus employers,
and more than 200,000 physician practices.

A photograph of two healthcare professionals in white coats. The woman in the foreground is a Black woman with curly hair, wearing a white lab coat over a pink shirt and a dark stethoscope. She is looking to her left and smiling slightly. The woman in the background is a white woman with dark hair, also in a white lab coat, looking towards the same direction. They appear to be in a bright, clinical setting with large windows in the background.

Ingenix ClaimsManager Facility Workflow

Current Facility Claim Workflow –

- **Code, click submit, then wait for. . .**
 - Rejections and denials
 - Manually edit claims and resubmit
 - Then the entire process starts over
 - Reimbursement

- **While all of this is taking place. . .**
 - Cash flow is unpredictable
 - Rejections and denials increase A/R days
 - Productivity suffers and costs escalate
 - Clearinghouses provide only limited technical edits – primary focus on connectivity

What if There Was a Better Way?

Q: What if. . .

- *Clinical claims editing happened prior to sending claims*
 - ✓ Claim errors identified and edited before they are sent to your clearinghouse
- *Regulatory and payer rules were automatically updated?*
 - ✓ Medicare and Commercial updates on a quarterly basis
- *Missed revenue opportunities were proactively identified?*
 - ✓ Identify partially billed services
- *The solution was affordable and within reach of all facility sizes*



A: Your Facility's. . .

- Denials and rejections would decrease
- A/R days would get lower
- Cash flow would improve
- Productivity would increase and reduce costs



Ingenix ClaimsManager Facility

Review claims before submission in order to reduce claim denial rates, shorten accounts receivable cycles, and increase the rate of collection.

- Submit cleaner claims the first time and speed payment
- Catch rework at the least costly point – before it leaves your business

ClaimsManager can help your facility:

- Help realize significant ROI through intelligent automation
- Reduce claim denials by pre-screening for billing and coding errors
- Stay current with new and changing guidelines
- Comply more easily with Medicare and commercial regulations
- Develop your own edits and customize system edits to meet your facility's billing and reimbursement needs

Common Platform – Ingenix Claims Processing

One common platform across Ingenix claim editing solutions for providers and payers

ClaimsManager is the provider market solution

- ClaimsManager Professional
- ClaimsManager Facility

iCES is the payer market solution

- iCES Professional
- iCES Facility

Design emulates payer adjudication process

- Fits with existing workflow

Fully customizable solution

- Rules-creation manager

One common clinical knowledgebase

Historical editing

- Global periods, new vs. established

Positive editing

- Identify unbilled services

Relational editing

- Lines within the claim, claim to claim

Over 15 million coding relationships

Industry sourced professional and facility editing

One common clinical knowledgebase

Medicare and commercial rule sets



**ClaimsManager Facility:
Knowledgebase / Edits**

Power Behind the System: ClaimsManager Facility Knowledgebase

Comprehensive Commercial and Medicare Knowledgebase

- Contain more than 15 million government and 3rd party industry edits
- Sourced at the code relationship level
- Supported by disclosure statements
- Updated Quarterly
- Date Sensitive at the code relationship level

Diverse Team of Medical and Clinical Coding Experts

- Team of over 40 experts supporting content development
- Team of Medical Directors, Specialty Panels, RN's, LPN's, RHIT's, RHIA's, CPC's, CCS-P and Legal Support
- Methodology reflects clinical research, comprehensive coding expertise and claims data analysis
- Clinical, Technical and End User customer support



ClaimsManager Facility vs. Typical Clearinghouse Edits

Claims Form Edits (Typical Clearinghouse Edits)

- HIPAA compliance and certification (WEDI SNIP levels 1-7)
- Presence of a field (provider, provider tax ID, insurance ID)
- Payer companion guide edits (loop, segment)
- Claim-level Medicare edits (CCI, MUE)
- Claim-level LCD
- Validation edits (CPT, HCPCS, ICD-9)

ClaimsManager's Clinical Edits

- CPT codes to DX to modifier relationships
- Sequencing of DX codes
- Appropriate use of modifiers
- Age, gender, frequency relationships
- Medicare unbundle (CCI)
- Medicare edits (MUE, globals, reductions)
- Non-covered services
- Commercial unbundle edits
- NCD/LCD
- Missing charges
- Duplicate charges
- Validation edits (CPT, HCPCS, ICD-9)

ClaimsManager Facility - Historical Based Clinical Editing

Invalid Use of Modifiers

- Modifier 25 may be required
- Modifier 27 may be required
- Modifier not appropriate with CPT code

Unbundling Across Claims

- Commercial Unbundle
- Medicare Unbundle (CCI)
- Will a modifier override an unbundle?
- Should component codes be transferred to a different code such as a lab panel?

72 Hour Rule

- Were Outpatient services rendered within 72 hrs of admission?

New vs. Established Patient

- Should an Established Patient be billed vs. New?

LCD/NCD Part A Edits

- CPT to Diagnosis appropriateness
- Sequencing of Diagnosis Codes
- Frequency allowed for Procedures
- Age/Gender Requirements
- POS or Modifier Requirements

Condition Codes

- Appropriate condition code billed with TOB
- Appropriate condition code billed with Modifiers

Overlapping Observation Periods

Partial Hospitalizations

Duplicate Line/Claim

Medical Necessity Edits (LCD Part A)* - Example

Decrease Rejections and Stay in Compliance with Medicare Part A

Missing or Invalid LMRP Diagnosis (LBI)	Definition	Validate that POS and diagnosis represents the need for hyperbaric oxygen therapy (HBO)
	Edit Type	ABN, compliance edit
	Example	<p>Medicare will only cover hyperbaric oxygen therapy in the setting of a hospital, either inpatient or outpatient. Also, patient must present with one of the following conditions:</p> <ul style="list-style-type: none"> • Acute carbon monoxide intoxication • Decompression illness • Gas embolism • Gas gangrene • Acute traumatic peripheral ischemia (ATPI) • Crush injuries requiring sutures • Necrotizing infections • Acute peripheral arterial insufficiency • Compromised skin grafts • Refractory osteomyelitis • Acinomycolosis • Cyanide poisoning • Diabetic wounds of lower extremities

* Not all inclusive

Appropriate Use and Sequencing of Diagnoses Codes - Example

Diagnoses Code Based on Medical Necessity

Chronic Airway Obstruction	Definition	COPD Code 496 <i>Chronic airway obstruction not elsewhere classified</i> is one of the few three-digit codes in the ICD-9-CM manual. The code includes a subcategory listing of “chronic obstructive pulmonary disease (COPD) NOS” and is both a not otherwise specified (NOS) and not elsewhere classified (NEC) diagnosis. Code 496 is a legitimate diagnosis but it lacks specificity.
	Edit Type	Diagnosis Sequencing
	Example	According to ICD-9-CM instructions, Code 496 should not be reported with chronic bronchitis (491.xx), emphysema (492.x) or asthma (493.xx). Just as shortness of breath normally should be integrated in the coding for pneumonia, COPD should be incorporated into categories 491-493 for other lung diseases listed.

Facility Compliance Editing - Example

Services Not Covered in the Facility Setting

Flu Vaccines 90654 to 90663	Definition	Many vaccines are not covered services in the facility setting. These include flu vaccines 90654 to 90663
	Edit Type	Compliance
	Example	When these services are billed with a “facility” location, Claims Manager will flag lines with 009NCS, “Facility Non-Covered Codes.”

Increase Payments for Medicare Services - Example

Multi Faceted Procedure Billing

Shoulder Arthroscopy Codes	Definition	Shoulder arthroscopy codes encompass two joints in the shoulder area: The glenohumeral joint (typically called the shoulder joint) and the acromioclavicular joint.
	Edit Type	Revenue Generating (Positive)
	Example	<p>The acromioclavicular joint is the smaller of the two and there are arthroscopy codes specific to it. When coding, two codes should be used as follows:</p> <p>1. <u>Excision of the Distal Clavicle</u> — Code 29824 Arthroscopy, shoulder, surgical; distal claviclectomy, including distal articular surface (Mumford Procedure), and</p> <p>2. <u>Decompression of the Subacromial Space</u> — Code 29826 Arthroscopy, shoulder surgical, decompression of sub-acromial space with partial acromioplasty, with or without coracoacromial release, which includes partial excision of the acromioplasty.</p> <p>In addition, add-on codes can be billed as follows:</p> <p><u>Arthroscop Debridement of the Labrum and the Undersurface of the Rotator Cuff</u> – Code 29822 Arthroscopy, shoulder, surgical debridement, limited.</p> <p>According to the May 2001 CPT® Assistant. Subacromial decompression includes arcomioplasty, arch decompression, excision of bursa and coracoacromial ligament release.</p>
In addition, when appropriate		

ClaimsManager Facility Edit – Example for OB/GYN Care

Scenario : Patient is seen for follow-up visit after delivery		
Code	CPT Description	Scenario
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	Billed for patient's total care
59430	800.765.6704 Postpartum care only (separate procedure)	Patient returns one week later for postpartum care
EDIT TYPE	Historical, CCI Unbundle	



Code 59430 is a component of the global code 59618 which includes all routine follow-up care.



ClaimsManager Facility: Knowledgebase Coding Relationships and Edits

Alternate Codes OPPS/Alternate Codes Medicare

Procedure 90386 (HCPCS)

RHIG, IV

Scope: Enterprise	Origin: System
--------------------------	-----------------------

Attributes [Deny Codes](#) [Alternate Codes OPPS](#) [Alternate Codes Medicare](#) [Associated Devices](#) [Associated Procedures](#)

<input type="button" value="Override"/>	<input type="button" value="Delete"/>			
Code Effective Date	Code Expiration Date	Origin	Status	
<input type="checkbox"/> 10/01/2001		System	Enabled	

ACTIONS

<input type="checkbox"/>	Alternate Medicare Code	Origin	Scope	Effective
<input type="checkbox"/>	J1563	SYSTEM	SYSTEM	10/01/2001
<input type="checkbox"/>	J1566	SYSTEM	SYSTEM	01/01/2006
<input type="checkbox"/>	J1567	SYSTEM	SYSTEM	01/01/2006
<input type="checkbox"/>	Q9941	SYSTEM	SYSTEM	04/01/2005

Revenue Code Payment Status

Revenue Code 0250

PHARMACY

Scope: Enterprise

Origin: System

Attributes

<input type="checkbox"/>	<input type="button" value="Override"/>	<input type="button" value="Delete"/>		
Code Effective Date	Code Expiration Date	Origin	Status	
<input type="checkbox"/> 08/01/2000		System	Enabled	

Attribute	Value	Origin	Scope	Effective	Expiration	Disclosure	Status
Revenue Payment Status	N - Incidental Service, Not Paid Under the APCs	System	System	08/01/2000		None	Enabled

Associated Devices / Associated Procedures

Procedure 25441 (HCPCS)

RECONSTRUCT WRIST JOINT

Scope: Enterprise	Origin: System
--------------------------	-----------------------

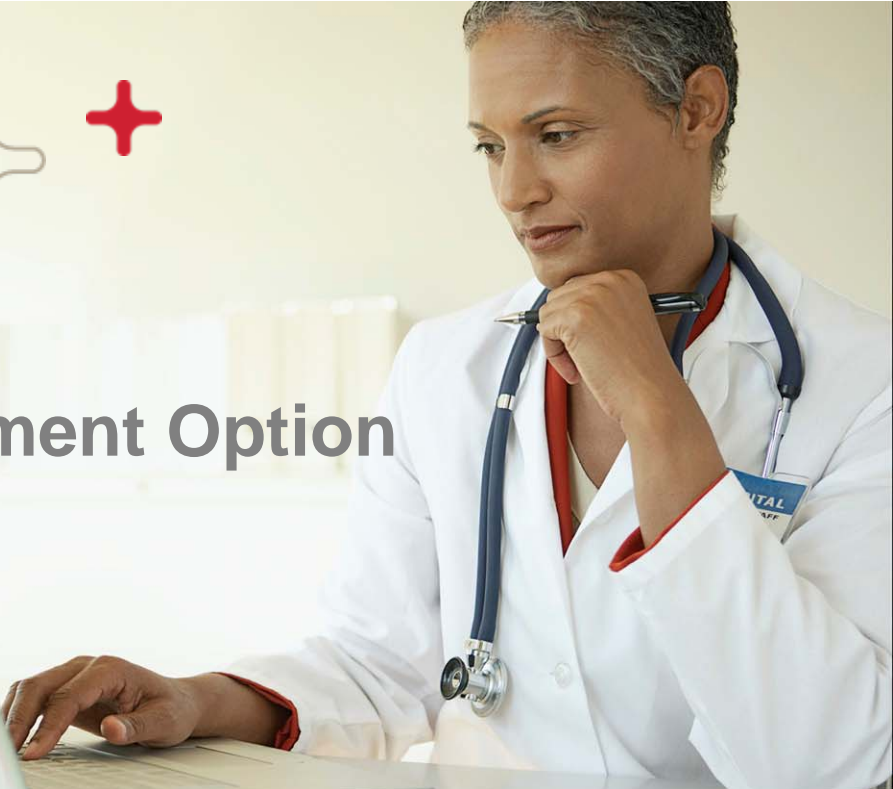
Attributes [Deny Codes](#) [Alternate Codes OPPS](#) [Alternate Codes Medicare](#) [Associated Devices](#) [Associated Procedures](#)

<input type="checkbox"/>	<input type="button" value="Override"/>	<input type="button" value="Delete"/>		
Code Effective Date	Code Expiration Date	Origin	Status	
<input type="checkbox"/>	01/01/2005	System	Enabled	

Attribute	Value	Origin	Scope	Effective	Expiration	Disclosure	Status
Proc Payment Status	T - Ambulatory Procedure Subject to Discounting	System	System	01/01/2005		None	Enabled
Bilateral Procedure	1 - Code is conditionally bilateral	System	System	01/01/2005		None	Enabled
Medically Unlikely Edit	2	System	System	10/01/2008		None	Enabled



ClaimsManager Facility – Deployment Option Benefits



ClaimsManager Facility Deployment Through Software as a Service (SaaS)



Available as a service, no server or IT staff required

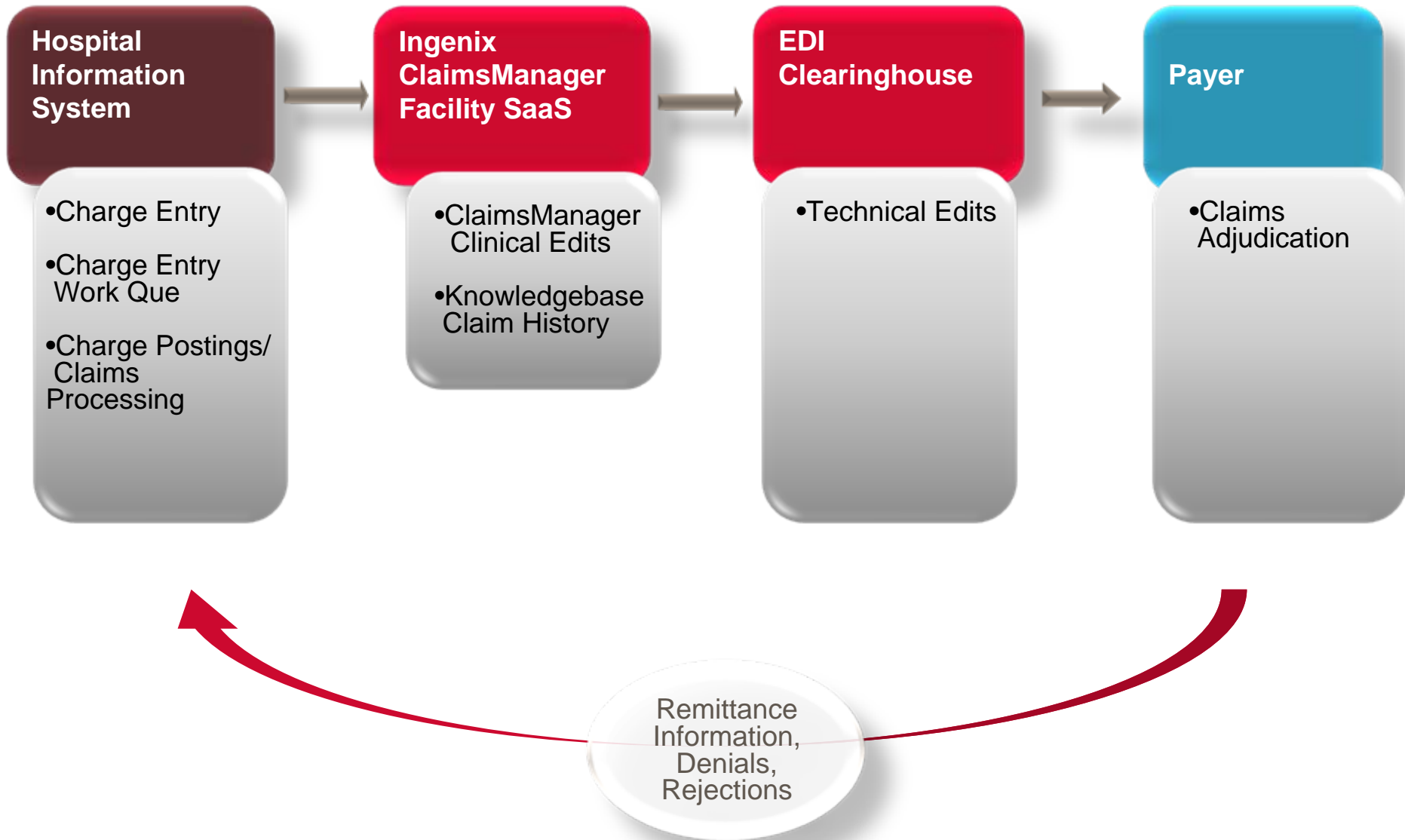
Get all the benefits of ClaimsManager Facility with a web-based service that provides instant access to rich content and functionality without the burden of installing or maintaining software or servers.



ClaimsManager Facility Deployment through SaaS provides:

- High availability rate— web based allowing for faster deployment.
- Reduced costs—subscription-based, no large up-front capital investment
- Automatic updates—Ingenix manages infrastructure, upgrades, and updates
- Streamlined implementation and integration—customized to meet your organizations needs
- A helpful client portal—a single entry point

ClaimsManager Facility SaaS Workflow



ClaimsManager Facility Deployment Through Netwerkes



Superior clinical editing features, integrated into existing claims management work flow.

Access all of the features and functionality of ClaimsManager Facility through Netwerkes. Ingenix's Web-based clearinghouse service. By reducing denials, decreasing rejections, and accelerating the accounts receivable cycle, Ingenix ClaimsManager Facility and Netwerkes help you maximize revenue potential.

ClaimsManager Facility Deployment through Netwerkes provides:

- Easy Implementation – Be up and running in a matter of weeks.
- Affordability with a one-time only implementation fee.
- Improved Process Workflow – Leverage one vendor for your clinical editing and EDI needs, eliminating the need to build an interface with your practice management system. ClaimsManager edits are integrated into the Netwerkes workflow.

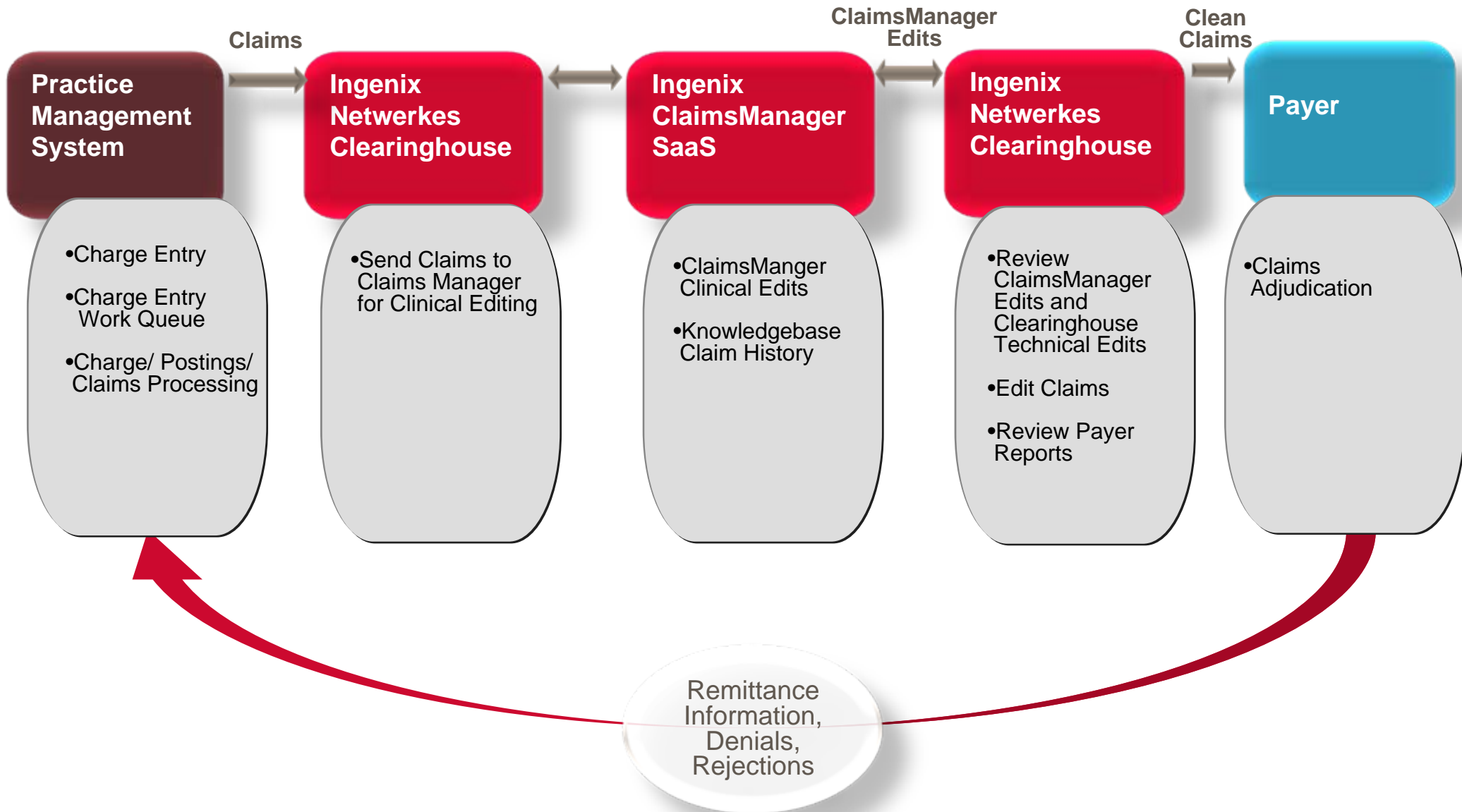
Netwerkes Overview



Netwerkes is a clearinghouse that enables the exchange and management of many important health care transactions between providers and payers. Supports most EDI transactions, including:

- Claims (837s)
- Remittances (835s)
- Eligibility inquiries/responses (270/271s)
- Claim status inquiries/responses (276/277s)
- Referrals/authorizations (278s)
- Inpatient notifications (278 I/Ns)
- Only charges for claims that are accepted by the payer and eligibility inquiries, only billing providers when they derive value.
- Makes billing secondary payers easy
- Offers patient statement, patient payment, and paper claim print/mail services.

ClaimsManager Deployment Through Netwerkes Workflow





ClaimsManager Facility: Industry Leading Solution

INGENIX.

What Makes ClaimsManager Facility Different?

Unparalleled Clinical Content

- Medicare editing
 - Over 14.1 million Part A coding relationships (including LCD and NCD)
 - Over 1.5 knowledgebase edits (excluding LCD and NCD)

Continuous Investment

- Resource and financial investments are made annually to help gather and maintain the content used in our editing and billing products
- Quarterly knowledgebase update / bi-monthly NCD/ LCD updates
- Yearly/ bi-yearly software new feature releases

Industry Leader

- Ingenix will be fully prepared for ICD-10
- Significant financial investments will help guarantee ClaimsManager Facility and its content will be ICD-10 compliant by the Oct. 1, 2013 effective date.



Questions and Answers