

A photograph of a doctor in a white lab coat and a yellow and blue striped tie, with a stethoscope around their neck. The doctor is holding an open book and looking down at it. The background is a blurred hospital room with a bed and medical equipment.

Improved Revenue Cycle Management for Epic

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Current Physician Practice 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

15% ▶ The portion of claims that are rejected or denied, necessitating rework and resubmission

\$25 ▶ The average cost per claim for rework and resubmission

\$68,000* ▶ The cost per physician per year in time spent interacting with payers*

* Medical Group Management Association study: “The Costs to Physician Practices of Interactions with Health Insurance Plans,” 2009.

What if There Was a Better Way?

Q: What if. . .

- *Clinical claims editing was integrated into your Billing System?*
 - ✓ Claim errors identified and edited before they are dropped into A/R
- *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 even the smallest physician practice?*



A: Your Practice's. . .

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

Ingenix ClaimsManager

- **Review claims before submission in order to reduce claim denial rates, shorten accounts receivable cycles, and increase the rate of collection.**
 - 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 practice's billing and reimbursement needs

Common Platform – Ingenix Claims Processing

- **One common platform across Ingenix claim editing solutions**
 - ClaimsManager is the Provider market solution
 - ClaimsManager Professional
 - ClaimsManager Facility
 - iCES is the Payer market solution
 - iCES Professional
 - iCES Facility

- **One common clinical knowledgebase**
 - Millions of coding relationship
 - Professional and Facility
 - Industry sourced

- **One common rules engine**

Benefits of the Shared Platform

- **Design emulates payer adjudication process**
- **All Payer product**
 - Medicare Rule set
 - Commercial Rule set
- **Fully customizable solution**
 - CES Knowledgebase open and customizable by line of business
 - Rules Creation Manager
- **Relational editing**
 - Lines within the Claim
 - Claim to Claim
- **Historical editing**
 - Duplicates
 - Global Periods, New vs. Established
- **Positive editing**
 - Identify un-billed services

Claims Form Edits vs. ClaimsManager

■ Claims Form Edits

(Typical Clearinghouse Edits)

- HIPAA Compliance & 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)

Power behind the system: ClaimsManager Knowledgebase

- **Comprehensive Commercial and Medicare KnowledgeBase**
 - Contain more than 9 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 30 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 Knowledgebase – Commercial Edit Sources

■ **AMA Guidelines**

- AMA Consulting
- CPT Assistant
- CMS Program Memoranda
- National Correct Coding Initiative (NCCI) - physician
- Medicare Physician Fee Schedule Database (MPFSDB)
- National Coverage Determinations
- Local Coverage Determinations
- Physician Specialty Panels

■ **Medical Societies**

- American College of Radiology
- American College of Surgeons
- American Physical Therapy Association
- American College of Cardiology
- American Academy of Orthopedic Surgeons
- American College of Obstetrics and Gynecology
- American Society of Therapeutic Radiologic Oncologists
- Society of Interventional Radiologists



ClaimsManager Knowledgebase – Medicare Edit Sources

- Medicare Physician Fee Schedule Database (MPFSDB)
- Federal Register
- CMS Program Memoranda
- National Correct Coding Initiative - NCCI-Physician
- Publication #100-02 Medicare Benefit Policy Manual
- Publication #100-04 Medicare Claims Processing Manual
- Publication #100-03 Medicare National Coverage Determinations Manual
- Local Coverage Determinations



ClaimsManager Knowledgebase - Specific types of editing (not all inclusive)

- Invalid modifier combination
- Modifier 26 not appropriate with code that does not have pro/tech split
- Modifier -25/26 required
- Rebundle to appropriate procedure code
 - Lab Panels billed as separate tests
- Commercial Unbundle Edits
 - Tachycardia Mapping can't bill 93609(standard mapping) with 93613 (3-D mapping)
- Medicare Physician Fee Schedule
 - Medicare Physician Fee Schedule
 - Bi-lateral procedure
 - Team, Assistant, Co-surgeon
 - PC/TC
- Patient age not valid for procedure/ICD9
- New vs. Established patient
- Anesthesia performed by non anesthesiology provider
- Global Follow Up
 - Provider/Specialty
 - Procedure 27330- 90 days
- LCD/NCD Local Carrier Policies
- Post-op unrelated service
- Place of service not typical
- Duplicate Line/Claim
- Medicare Unbundle (CCI)
- Positive Edits
 - Infusion therapy performed but medication not billed for
 - Cardiac Cath procedure performed but S&I not billed
 - Prolonged service billed but E/M service is missing
- E code reported as primary procedure

ClaimsManager Commercial Edits

(not all inclusive)

- **Decrease rejections and Increase Payments for Commercial Payers**
 - **Pre Op Procedure One Day Before Surgery (PRE, PRH)**
 - Definition for Example: Validate the Surgical Provider isn't billing for E/M service one day prior to surgery (if being seen for items related to the surgery)
 - Historical edit
 - Example: Patient comes in for an office visit 1 day prior to their meniscus surgical repair for service related to their surgery.
 - If E/M service was billed on a different claim than the surgery PRH would trigger
 - If E/M service is on same bill as the surgical procedure PRE is triggered
 - **Cardiac Cath Injection without Cardiac Cath (CCI)**
 - Definition for example: Occurs only when the injection service is found for the Cardiac Catheterization
 - Historical Edit & Positive Edit
 - Example: Cardiac Catheterization is a procedure where the physician inserts a long thin tube (catheter) in an artery or a vein in your groin, neck or arm, and threaded through blood vessels to your heart and an injection is performed into a coronary artery. The claim is evaluated but the injection code has only been reported . ClaimsManager will raise a flag to identify that the cardiac catheterization must be billed in addition.

Data Files- Medical Necessity Edits (LCD Part B)

(not all inclusive)

- **Decrease rejections and stay in compliance with Medicare Part B**
 - **Missing or Invalid LMRP Diagnosis (LBI)**
 - Definition for example: Validate that Diagnosis represents the need for Nail Trimming
 - ABN, Compliance Edit
 - Example: The patient presents with an ingrown toenail with an infection. The physician performs a nail trimming to treat the nail. The patient is also diabetic but when the physician bills the patient, he/she only includes the diagnosis code for the toenail infection 703.0. ClaimsManager does the analysis of the Diagnosis code 703.0 and determines that the diagnosis doesn't support medical necessity guidelines to support the payment for the patients foot care.

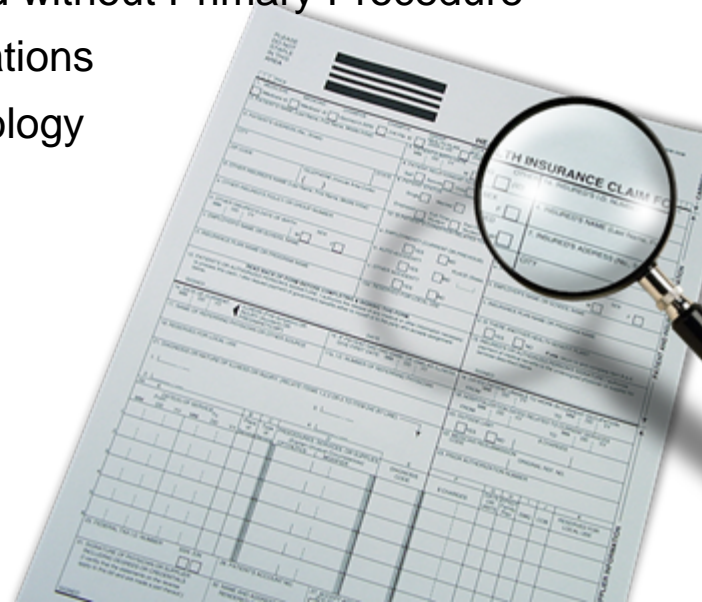
 - **LCD Part B Typical Frequency Exceeded (BFR)**
 - Definition for example: Validate that patient hasn't been seen for Nail Trimming within last 60 days
 - Historical Edit
 - Example: Diabetes patients struggle with Neuropathy and poor circulation, therefore routine foot care is necessary. Some Medicare Carriers have designated Routine Foot care to be 1 session every 60 days. If the patient comes in for additional foot care more frequently than the 60 days, ClaimsManager will flag to indicate that this has been billed outside the parameters of the policy.

Ingenix ClaimsManager

- **Identifying partially billed procedures before claims submission, results in complete payment for all services delivered**
 - Identify additional revenue sources – average group fails to capture 0.05% of potential revenue
 - Automatically detect missing related procedures
 - If an inject-able drug is billed, the associated procedure to administer the drug should be present
 - Add on Codes billed without Primary Procedure
 - Cardiac Catheterizations
 - Interventional Radiology

Prevea Health has gained \$2,112,859 by identifying service dollars that were previously not billed by making substantial use of ClaimsManager's positive editing ability.

**Prevea Health, Wisconsin. Results based on five year study (2005-2008).*



ClaimsManager Helps Increase Revenue -

Family Practice

Scenario : Patient is billed for a Prolonged Service.

Code	CPT Description	Reimbursement
99354	Prolonged physician service in office or other outpatient facility; face to face, 1st hour	\$115.57
Edit	Per CPT guidelines, codes 99354-99357 are used when a physician provides prolonged services involving direct patient contact that is beyond the usual service. This services is reported including other services, including E&M services at any level.	
99215	The claim is modified to include the code as noted in the edit. High level Office Visit	\$143.17



By adding the additional code, the total reimbursement increase by \$143.17, for a total of \$258.74.

ClaimsManager Medicare Edits

(not all inclusive)

■ Increase Payments for Medicare Services

– Medicare Venipuncture (mVP)

- Definition for example: Validates that both the Venipuncture and lab code was billed
- Positive edit
- Example: It is important to take a Hemoglobin A1C test annually to detect diabetes before symptoms start to manifest. When the Lab test is performed the physician should bill for both the drawing of the blood as well as the hemoglobin test. If only the Hemoglobin test is billed, ClaimsManager will flag the missed Venipuncture code. The addition of the code will result in additional revenue.

– Billing Established Codes for New Patients

- Definition of example: Validate that the patient is an Established patient and not New to Specialty
- Positive Edit
- Example: Patient comes into Orthopaedics office and saw Dr. Anderson 4 years ago when he blew his knee. Now, he is presenting with a shoulder issue. Dr. Anderson remembers this patient and bills him as an Established patient instead of a New Patient. The change between the Established Patient code and New code will increase reimbursement.

ClaimsManager – What Does It All Mean?

■ Unparalleled clinical content

- Commercial editing
 - 9.4 million Professional coding relationships
 - 1.5 million Facility coding relationships
- Medicare editing (including LCD and NCD)
 - 3.2 million Part B coding relationships
 - 4.0 million Part A coding relationships

■ Continuous investment

- Ingenix invests annually to 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
 - Medicare Physician Quality Reporting Initiative (PQRI) Edits and Rules
 - Medicaid

■ Leader in the industry

- Ingenix will be fully prepared for ICD10
- Significant financial investments will help guarantee ClaimsManager and its content will be ICD-10 compliant by the October 1, 2013 effective date.

ClaimsManager & EPIC

■ Long standing Epic – Ingenix relationship

- ClaimsManager Professional Real-Time interface to Resolute Professional and EpicCare (35+ sites)
- iCES (Payer Market) Real-time interface to Tapestry Managed Care
- Provide Data Files, Epic multiple integration support Cadence, Epic Care, Resolute (Facility and Professional), Radiant, ETC.
 - LCD Part A and B (Charge Entry and ABN editing)
 - CCI/OCE (Charge Entry)
- Epic Resolute Hospital interfaced to Ingenix WebStrat (Grouping/Encoding) at Parkland, Dallas with Resolute Hospital.
- Ingenix discussing integration with Epic for ClaimsManager Facility
- Ingenix Healthia, primary resource for PM, application expertise
- Support and Attend Epic National Meeting

Joint Epic - Ingenix ClaimsManager Customers



ClaimsManager / Epic Integration

- **Real time two way interface using Bridges**
 - End users stay within the Epic screens, providing enhanced productivity and minimal learning curve
- **Many integration points within Resolute and EpicCare**
 - Order Entry
 - Charge Entry / Charge Review
 - Claims Processing / Claims Edit
- **Edits routed via Charge Router Logic (Resolute Work queues, EpicCare Work queues)**
- **ClaimsManager is transparent to users**

Charge Entry Errors



Charge Entry

Encounter Details (1)

Enc form: Patient:

Account: Svc date: 8/31/2004 Visit:

Coverage: Claim info: Select

Svc prov: Bill prov:

Department: CENTRAL BILLING OFFICE POS: CENTRAL BILLING OFFICE

Referral: Referral src:

Price cntr: Reimb cntr:

Charges (3)

Code	Description	Modifier	Diagnosis	Qty	Ass	Self-pay	Ovd	Clm
1								

Documentation Providers (4)

Doc Prov	Function	Procedures
1		

Fast Payment (5)

Prev SP balance: Total: Self-pay total:

Pmt code: Source:

Amount: Ref #:

Options (6)

Pend Appt

Addl Docs

Receipt

Enter new charge. If charge has no errors the session will close and a new Charge Entry screen will automatically appear

Charge Entry

Hyperspace - CENTRAL BILLING OFFICE - Production

Desktop HIM Scheduling Billing Reports Tools Help

Charge Entry Charge Review Workqueue Charge Entry Report Encounter Form Control Report Transact

Home Chg Entry - 31145

Batch: 31145 Service Area Tier

Activities Charge Entry (adding new session)

Batch Info

Chg Entry

Encounter Details (1)

Enc form: Patient: Test

Account: Test Svc date: 04/01/10 Visit:

Coverage: Claim info:

Svc prov: Bill prov: Kladar

Department: GI POS: 22

Referral: Referral src:

Price ctr: Reimb ctr:

Charges (3)

Code	Description	Modifier	Diagnosis	Qty	Amount	Self-pay	Ovd	Clm
43121	Partial Esophagectomy, distal w or w/o pyloroplasty		2352	1				MCR

Documentation Providers (4)

Doc Prov	Function	Procedures
1		

Prev SP balance: Total: Self-pay total:

Fast Payment (5)

Pmt code: Source:

Amount: Ref #:

Options (6)

Pend Appt

Addl Docs

Receipt

Ctrl+J - Go Up
Ctrl+K - Go Down

Enter new charge. If a Front End Edit Occurs...

Edit Message Returned to Epic Charge Entry Screen

Ingenix offers enhancing features such as Historical claim checks

Charge Entry Validation Messages

Front-End Warnings:

Error ID: (PRH) Line 1- History Pre-Op E/M Service 99213 on Claim ID XXXX line 2 was billed one day before a Surgical Procedure Code 43121 is not allowed as part of the Global Surgical Package without an appropriate modifier.

Reason:

Comment:

Accept

If Charge hits a Front End ClaimsManager Error a message will appear immediately within Epic

PRH flag issued because E/M Code was billed one day prior to Surgical Code.

Charge Router- Claims Processing Work Queue



Questions and Answers

