

Navicure – Payer Mayhem

Pamela: Hi, this is Pamela Moore from Physicians Practice. As anyone running a medical practice today knows, it is hard to get paid. Every payer seems to have their own billing rules and getting denied seems more likely than not.

Now, in the past your best solution to that complexity was to have a genius biller; somebody who could keep all those rules straight. But given all the variations in place today, that's pretty much impossible for a single human brain. Luckily computers are excellent at keeping track of that sort of trivia and here to help me explain how to reduce the chaos in billing is Brian Koch. He is Vice President of Strategic Services for Navicure. He's a graduate of Michigan State University where he got a BA in accounting and also became a certified Six Sigma Brown Belt. Brian has also held the position of Chief Operating Officer for one of the nation's largest anesthesia billing and practice management companies. He's also worked in revenue cycle management consulting for Ernst and Young and was Reimbursement Director for Texas Health Resources. Brian, thanks for helping us out today.

Brian: My pleasure and thank you for having me.

Pamela: Absolutely. So is it really so hard for a human brain, a biller, to keep things straight in the billing office?

Brian: Simply, yes. And you know, in my opinion, the coders and billers of this world are some of the more underappreciated components of the revenue billing cycle. And we take into account the vast volume of knowledge that a person has to consider in the development of a medical claim and it's quite impressive. Not only do they need to understand the medical terminology; they also have to distinguish the scribbles of most of the physicians and convert that scribble into some numeric and alpha type of conversion over into CPT code, diagnosis and modifier combination.

Pamela: Scribble to coding is hard enough as it is.

Brian: Yes, it is. So when you take all those complexities together it just provides an avenue for people just to make errors, and those errors can result in a number of things whether it's underpayments, a loss revenue to the practice by writing off the procedure in whole, or

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putting the physician at a compliance risk. So -- and to boot on all those things, all these governing boards whether it's the CCIs, the ICD9s, the CPTs, they're changing these requirements every year, deleting and adding codes. And looking into the future we have the ICD-10 for performance practices on the horizon. It's just going to make it that much more difficult so now's the time for practices to really start assessing the tool sets that they have, the front end edit systems, their clearinghouse edit sets to ensure that they can put in carrier specific edits that allow them to identify the errors or the missing modifiers, CPT diagnosis combinations. So they can optimize those revenues.

Pamela: Great. One of the really concrete examples that I can never figure out how anybody keeps straight are the different drug coding rules that every payer has.

Brian: Yes, that's one of the more difficult ones out there, and why that is because so many different drug codes and so many different requirements in the units of service column on the HCFA. A good example of that for example is J3487. In the units of service you must include a 4. For J2469, you have to have a 10 in the units of

service column. For J0894 you have to have a multiple of 25. So you can see in there there's many opportunities for a coder to misplace or miscode the numeric value in the units of service that's ultimately going to result in a denial.

Another good example of this is a consult for a new patient visit, and a consult by definition is an encounter with the physician where a request of opinion was given, there was a need for a consult and that the consulting physician provided a written report of findings to the referring physician. You know, CMS dictates for documentation for a physician that they have to have in quotations, this is direct from CMS, "Please examine the patient and provide me with your opinions and recommendations regarding his or her conditions." If those words are not included within your physician documentation and you are coding consults, you're potentially putting your physician at risk not only for overpayment, but coming back from an audit standpoint and incurring penalties and fees. So you know, a new patient visit is more -- is defined by -- is an evaluate and treat, or a transfer of care from one physician to another. So be very careful when you are either coding a consult or a new patient visit.

Pamela: So a lot of detail needed, and when you're talking about J codes it does sound like you're speaking a foreign language so it is pretty complex and so all these - - there's a whole raft out now of these so-called revenue cycle management products and I know that part of what they're designed to do is keep all those rules, all that detail, all that foreign language sort of in place to make it make more sense and be more easy to build correctly in the first place. But how does a revenue cycle management product, how does a computer know what all the edits are? It must be huge variations by state or even city, practice by practice. How does it work?

Brian: Yes, exactly. When you're looking at the national PM systems, I would say if you're on one of those national platforms whether it's NextGen or Allscripts, you probably have a better chance that they include the more global or national edit sets for these. But for the practices out there that are using, you know, the older systems are the ones that are not so globally. You have to be careful that they don't have your region specific edit sets. A majority of the ones that I've seen over the years actually don't even have CCIs or the LCDs in the systems

and they rely on that genius biller that you referred to earlier to be that brainpower to make sure those things are happening. So again, it results in a potential loss of revenue and then risk expansion for the practice.

Pamela: Okay. And CCI is the national Correct Coding Initiative, the national rules that may or may not be part of your practice management system, just to define our terms. And the LCD stands for Local Coverage, is it Determination?

Brian: Determinations, yes.

Pamela: And so more at the local level. So...

Brian: And excuse me for interrupting you, but you know, Medicare's a perfect example of that. They have the local coverage determinations that could be different in each one of the regions of the different intermediaries, so if you're practice management system is not bringing all the LCDs in, you could be governed -- you could be submitting your claims based on the downstate New York versus the upstate New York, for example.

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Pamela: I see. So then part of the promise of a revenue cycle management product is that you can really customize what edits you include and don't include.

Brian: Exactly. And here at Navicure what we do with our clients is we actually will develop carrier specific edit sets, practice specific edit sets, so what we do is we do an analysis of the top 80% of your patient mix -- I'm sorry, of your procedure mix -- that result in 80% of your practice revenue, and we build custom edit sets based on the denials that you receive, the front end rejections, or any contract specific requirements that the carriers have to minimize that backend work. So in real-time we identify those on the front end, shoot those back to the practice, let them fix those so they don't have to go through the appeal or denial process on the backend.

Pamela: Beautiful. Get it right the first time.

Brian: Exactly.

Pamela: And a great idea to focus where the largest amount of revenue is. So can you give us some examples of how doing that kind of editing on the front end can improve

the revenue picture for a given practice?

Brian: Sure. We had a practice out of Michigan who had an issue, or they performed a lot of procedures and it 96372 which is a injection to the subcutaneous or intramuscular for therapeutic reasons. That code, defined under CCI, is actually a separate and distinct code from an E&M level, or evaluation of management level. So out of an audit of 100-plus cases, we saw that the practice was not appending the 25 modifier in 99% of the cases, and out of the cases that they did not, the payment poster was actually writing off the procedure because it was being denied as a bundled service because the 25 modifier was not appended to the E&M level.

Pamela: Wow. So it's not even that the practice appealed and got the money later. They didn't even know they were missing the money.

Brian: Exactly. Exactly. So you know, and that's just one instance within that practice that resulted -- it would have resulted in additional \$8,000, \$8,500 in reimbursement to the practice but it was just one specific

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edit set that could have been implemented to eliminate that.

Pamela: Wow. Get two or three of those and you're talking a large amount of dollars.

Brian: Exactly. And one other quick example of that is the 59 modifier. It can apply to the same CPT code, the 96372, when you're billing it in a single level or a single instance you have to append the 59 modifier. When you're billing it at two or three more instances you have to append the 76 modifier. So there's just so many things that these billers and coders have to remember in order to optimize that. And if they don't bill it with those, typically the denial comes back and then it's up to your payment poster again to say should it have been paid or should it not? And in my experience, most payment posters don't have that knowledge to make those decisions. So front end edit sets, education to your billers and coders, keep them up to date with the regs and changes in all the governing bodies and you'll be in the best shape to optimize your revenue.

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Pamela: Excellent advice. Thank you to Brian Koch,
Vice President of Strategic Services for Navicure. Thanks
for your time today, Brian.

Brian: Thank you.

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