TEAMHealth
EMERGENCY MEDICINE

WHITE PAPER

WHERE'S THE MONEY GOING?

SOLVING THE PROBLEM OF EMERGENCY DEPARTMENT REVENUE LOSS

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Today, we are faced with emergency department (ED) professionals who are required to treat more patients each day while potentially facing lower reimbursement levels. In this environment, it's vital that emergency departments take all possible steps to capture maximum legitimate revenue opportunities.

PATIENT CARE IN THE ED IS CHANGING

In 2009, as the economic recession spread across the country, more and more Americans sought healthcare services in hospital EDs. According to data from the Centers for Disease Control and Prevention, the number of ED visits hit 136 million that year, a nearly 10 percent increase from 2008 and the largest single-year climb on record.

Among the individuals visiting EDs, a greater share of patients were uninsured—19 percent compared with 15.4 percent in 2008—and fewer carried commercial insurance. A lack of insurance coverage as well as limited access to primary care often prompts patients to delay needed healthcare services, meaning EDs are not only seeing more patients than in years past, but the patients they're seeing now are sicker and less likely able to compensate the hospital for the cost of their care.

These dynamics require ED professionals to treat more patients each day while potentially facing lower reimbursement levels. In this environment,

it's vital that EDs take all possible steps to capture all legitimate revenue opportunities. Unfortunately, many EDs unknowingly undermine their ability to capture all the revenue they earn by employing inaccurate coding practices. Depending on the severity of the problem, faulty coding can add up to millions of dollars in lost revenue for an ED and can pose undue compliance risks.

This white paper discusses common mistakes that hospitals make in developing, using and defending their home-grown ED coding criteria; steps to identify whether your ED is making critical coding mistakes; and how enlisting the help of an expert ED coding partner can resolve those problems, enabling your ED to enjoy greater financial success.

The Complexity Challenge

Proper ED coding is vital for several reasons.

- Compliance with Centers for Medicare and Medicaid Services (CMS) regulations
- Capture of all appropriate ED revenues
- Accounting for all ED resource utilization (costs)

But the coding process in the ED is unique and can be highly complicated.

As outpatient departments, EDs are subject to the rules and regulations established by the Outpatient Prospective Payment System (OPPS), which is overseen and administered by CMS. EDs are instructed to use the same codes employed by emergency physicians to bill the technical component of the service. Listed in the CPT Manual under "Emergency Department Services," evaluation and management (E/M) level codes 99281, 99282, 99283, 99284 and 99285 reflect higher acuity as the numbers ascend.

Coders are given specific rules to follow when choosing E/M levels for physician services, but CMS has not defined specific criteria for EDs to follow in determining an E/M level. Instead, CMS provides general guidelines for EDs to use in developing their own criteria (sometimes called facility criteria) to guide coders in choosing an E/M level of service for billing. Although some EDs adopt criteria published by third-party organizations, a large percentage of hospitals task clinical staff with developing the facility criteria internally without offering formal training in the rules and regulations about coding and with little guidance on how to create and test optimal criteria that captures and reflects resources.

Consequently, many EDs deploy coding criteria that have little correlation to actual resources used to treat patients. In some cases, the facility criteria are designed in a way that results in high code selection levels for patients who require few resources or low code selection levels for patients who require many resources, both of which may cause the government to question a hospital's method for assigning codes.

Most frequently, a hospital's facility criteria design results in the selection of lower E/M levels for very ill, high-intensity patients who require extraordinary hospital resources. For example, consider an elderly patient who presents to the ED with a very high fever that requires multiple infusions of medications, hydration, many ancillary studies, CT scans, multiple assessments and re-assessments by the hospital's staff and transfer to another facility. If the hospital's facility criteria is developed in a way that under-reflects those resources, a moderate E/M level—generally in the range of 99283 to 99284—will likely be recorded and billed, and the hospital will be unlikely to collect revenue sufficient for covering the cost of caring for that patient.

Common Problems Associated with Poorly Designed Criteria:
lost revenue
inaccurate perception of acuity
compliance issues

Poorly designed facility criteria typically cause several problems for a hospital, such as:

- Lost revenue
- A inaccurate perception of the ED's patient acuity profile as a result of underreporting actual resources consumed—reflecting a misleading "moderate" acuity within the department given the predominance of moderate to low E/M codes billed (i.e., 99282s and 99283s)
- Compliance issues when the facility criteria are not clearly written or are misunderstood by staff responsible for assigning codes

Accurate procedure coding

In the past, a patient's bill listed every supply and medication used during an encounter. Payers often reimbursed based on a contracted rate or a percent of charges. Since the inception of OPPS, in addition to an E/M level, EDs are required to use CPT codes to bill for procedures performed during a patient's visit. An ED "charge-master" may contain as many as 300 to 400 procedure codes that represent services performed during an encounter (e.g., infusions, injections, laceration repairs, spinal taps, splints, straps).

There are several common pitfalls that occur when assigning procedure codes. Hospitals often rely on clinical or non-clinical staff to choose a charge or procedure code for billing. However, coding is an exceedingly regulated field and requires highly skilled professionals. Individuals who are not properly trained may inadvertently choose incorrect codes or miss coding a procedure altogether. In addition, a charge-master may contain outdated codes or incorrectly "crosswalk," resulting in an improperly billed code or charge.

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Incorrectly billed codes result in over- or under-payment to a hospital, which may not be discovered until a governmental or payer audit. In these situations, at best the hospital loses revenue, and at worst the hospital undergoes an audit that results in compliance issues with possible penalties and fines.

Pinpointing the problem

EDs that are noticing lost charges and flagging revenue will often focus efforts on improving efficiency and /or building strong patient volumes. They realize that they have a problem, but they don't go the extra step of investigating their coding practices to discover whether the cause is faulty coding criteria, choosing the wrong procedure codes, or omitting procedure codes.

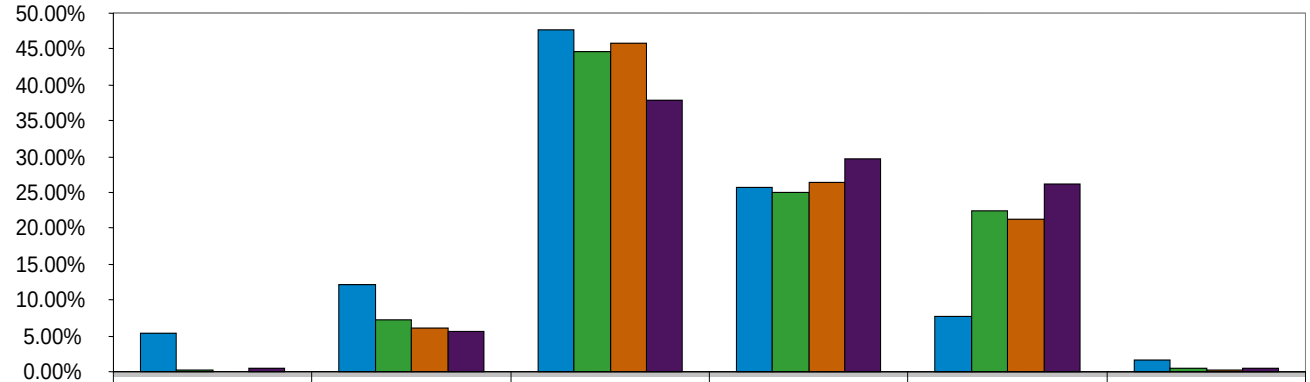
To identify the extent of a problem with facility-level coding, the ED should conduct a review of the department's E/M level distribution. This requires retrospectively tracking the number of times each E/M level was billed per month for the prior year, then calculating an average for the year. Findings should be tracked in at least two ways—for all patients treated in the ED and for all patients treated in the ED except those who were admitted to the hospital as inpatients.

An E/M distribution bell curve can signify missed revenue.

It is a misconception that all EDs should see a bell curve when distributions are displayed on a bar graph. In fact, when an ED sees that their distribution resembles a bell curve or has higher (or equal) concentrations of 99281s and 99282s and 99284s and 99285s, there is probably significant missed revenue and poorly developed or incorrectly applied facility criteria.

Similarly, the ED should analyze its procedure coding practices to identify any chronic problems. The easiest way to do this is to review past patient records, analyzing whether the proper procedure codes were selected. At times, this analysis will uncover multiple examples of omitted or incorrectly applied procedure codes that resulted in over- or under-payments.

Sample Hospital E/M Distribution Compared to Similar Facilities



	99281	99282	99283	99284	99285	99291
Sample	5.48%	12.07%	47.57%	25.67%	7.66%	1.55%
Hospital A	0.16%	7.35%	44.69%	24.89%	22.38%	0.53%
Hospital B	0.11%	6.16%	45.69%	26.48%	21.34%	0.21%
Hospital C	0.40%	5.61%	37.91%	29.57%	26.13%	0.37%

SOLUTION: IMPLEMENT PROVEN CODING PRACTICES

To eliminate the issues of lost revenue and compliance risk associated with incorrect coding practices, EDs should adopt proven coding criteria and methods. The benefits of this approach include:

- No staff time spent on redesigning coding criteria
- Increased revenue
- Proper capture of all expended resources
- Ensured coding compliance

ENLISTING AN EXPERT

Given the complex nature of ED coding, a hospital may want to consider enlisting the help of a partner that is an expert in ED coding and compliance. Such a partner can quickly conduct an analysis of the hospital's ED E/M distribution and procedure coding to roughly estimate how much annual revenue the department may be missing based upon its current coding practices. Through an outsourcing arrangement, this partner should also be able to come into the hospital's ED and assume responsibility for the coding functions.

Outsourcing of coding services is a common hospital technique for alleviating coding problems without adding or draining resources associated with training and education of existing hospital personnel. In looking for an appropriate outsourcing partner, the hospital should seek out a company that can quickly deploy an appropriate mechanism of coding criteria, practices, and the accounting of revenue that most accurately reflects the hospital's actual resource utilization. In addition, by using its own staff to perform the actual coding process, the outsourced company can ensure that coders are properly trained and able to select the most appropriate E/M code for the capture of all appropriate procedure codes. In addition, the outsourcing company should utilize services provided by its employed staff, allowing the hospital's ED to redeploy staff previously dedicated to coding to other areas of the department (in the case of nurses, redeployment to patient care).

In the end, a hospital should find that partnering with an outsourcing company that provides successful and proven coding and compliance services can reverse the revenue loss the hospital's ED experienced under its previous coding process. The additional incremental revenue generated should also sufficiently offset the cost of the coding partner's services with plenty of new revenue remaining.

CASE STUDY

For example, consider the case study of a small hospital ED with approximately 12,000 visits per year. Prior to bringing in an outsourced coding partner, the ED generated about $550 in revenue per patient visit based on its internally developed E/M criteria. Upon the outsourced review of the hospital's E/M distribution and criteria, the outsourced coding partner identified an additional $105 per patient visit that the ED should be billing. Over the course of a year, that $105 per patient amounts to more than $1.2 million in additional

incremental revenue generated by the ED. After commercial and governmental insurance contract discounts and the impact of the uninsured patient population are applied, the ED should collect about 25 percent of that additional revenue—or $315,000—which equates to approximately $26.25 in additional cash collections per patient visit.

$105 x 12,000 = $1,260,000 in additional incremental revenue

$1,260,000 x .25 = $315,000 in additional cash collected

$315,000 ÷ 12,000 = $26.25 per patient in additional cash collections

After deducting the cost for the coding services provided by the outsourced partner, a hospital ED can generally expect to retain more than 80 percent of the additional incremental cash generated.

Over the course of a year, additional revenue per patient amounts to more than $1.2 million in additional incremental revenue generated by the ED.

Conclusion

Hospital EDs across the country are facing increased pressure due to increased patient volumes and reduced reimbursements because of the declining number of patients with commercial insurance and the rising number of uninsured patients. In this environment, EDs must work smarter to optimize their revenue and minimize their risk exposure, ensuring that they optimize revenue and mitigate compliance risk.

Proper ED coding is a vital component for ensuring that a hospital ED receives all of the revenue legitimately owed to it. Enlisting the help of an outsourced coding partner who is an expert in ED coding can help a hospital identify exactly how much revenue the ED is overlooking and begin to bring in all of the revenue it should be collecting.