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Revenue Cycle Coding Strategies RCCS

NEVADA
Oncology Society

Presenter

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Why is financial analytics important?

Strong financial performance is associated with improved patient reported experience of care, the strongest component distinguishing quality and safety. These findings suggest that financially stable hospitals are better able to maintain highly reliable systems and provide ongoing resources for quality improvement.

→ Financial Analytics and Reporting

+

→ Strong Financial Performance

=

→ Maximize and increase resources to positively impact staff, patients, and community.

Who's Who?

FINANCE

Areas of Focus:

- Financial Health of the Organization
- Cash Flow

Staff Examples:

- CFO
- Financial Analyst
- Rad Onc Administrator with Budget Responsibility

REVENUE CYCLE

Areas of Focus:

- Front end reg, Ins. Verifications, Scheduling, Referrals, FC Authorizations
- Coding
- Claim Submission & Adjudication
- Patient Statements

Staff Examples:

- Front Desk/FC/Auth
- Director of Revenue Cycle
- Patient Access Manager

OPERATIONS

Areas of Focus:

- Effective and Efficient High-Quality Processes of the Organization
- Staff Satisfaction and Wellbeing
- Staff Productivity
- Patient Satisfaction and Care

Staff Examples:

- Practice Administrator
- Division Mgrs

CLINICAL

Areas of Focus:

- Patient Care
- Patient Experience
- Quality Care

Staff Examples:

- Physicians
- Radiation Therapists
- Nurses
- Medical Assistants

Staff Type & Corresponding Data

FINANCE

- Income statement
- Balance sheet
- Statement of Cash Flows
- Cost of Operations
- Budget
- Metrics/Analytics

REVENUE CYCLE

- Denials Reporting
- Accounts Receivable
- Call Volume
- Collections
- Controllable Write-offs
- Patient Experience Scores

OPERATIONS

- Mix of All Dept Areas
- Reporting/Measures
- Staff Turnover Rate
- Staff Productivity/Compensation
- Practice Benchmarks Against Industry

CLINICAL

- Charge Lag
- Patient Wait Time
- RVUs
- Patient Experience Scores
- Patient Readmission Rate

What measures are most important for your practice?

Measures & data all practices should analyze:

- Fee Schedule
- Medicare Reimbursement
- RVUs

Other types of data to consider based on practice priorities, opportunities, and future state:

- Revenue Cycle Related Metrics
- Patient Experience Metrics
- Patient & Staff Satisfaction Measures
- Productivity Measures

How does financial analytics relate to most aspects of a patient's experience with an organization?

Time to Bill, Time to Collect, Time to Start Tx – Important Metrics

Analytics Scope

NON-CONTACT PATIENT CARE

Activities include:

- Referral Coordination
- Authorizations

Financial Topics:

- Denials & Other Avoidable Write-offs
- Cost to Obtain Authorizations or Referrals vs. Profit on Services

NON-CLINICAL PATIENT CARE

Activities include:

- Patient Scheduling & Check-in
- Financial Counseling

Financial Topics:

- Time of Service Collections
- Patient Financial Responsibility Estimates and Collections

CLINICAL PATIENT CARE

Activities include:

- Appointment with Physicians
- Telemedicine

Financial Topics:

- Physician Compensation Structure/RVUs
- Clinical Related Denials (ex: Medical Necessity or Coding)

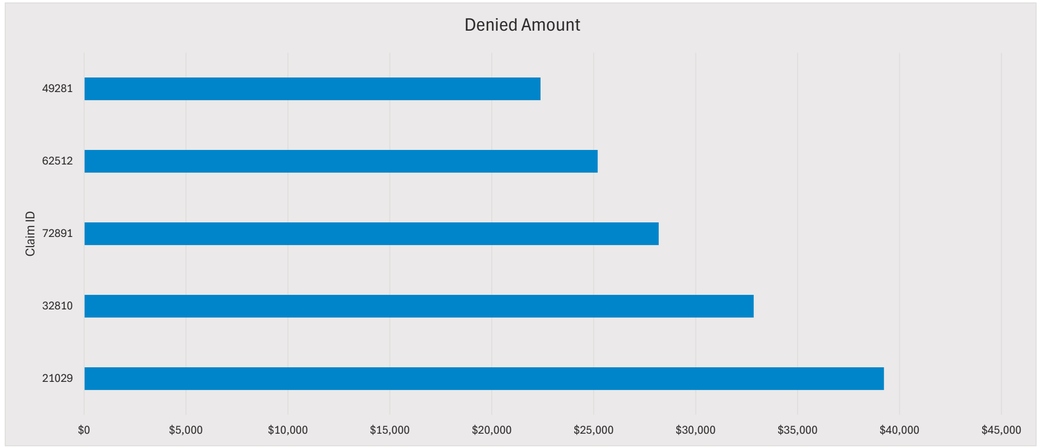
Determining Your Reporting Needs

When identifying reporting needs, every topic should have a what, how, and why. **This will enable you to get SUPPORT and BACK UP to the Improvements you are about to execute and monitor**. At times there may be detractors so you NEED SUPPORT up line!

There are an abundance of measures and metrics that exist today, but just because one exists, does not mean that you have to use it or that it is right for your practice.

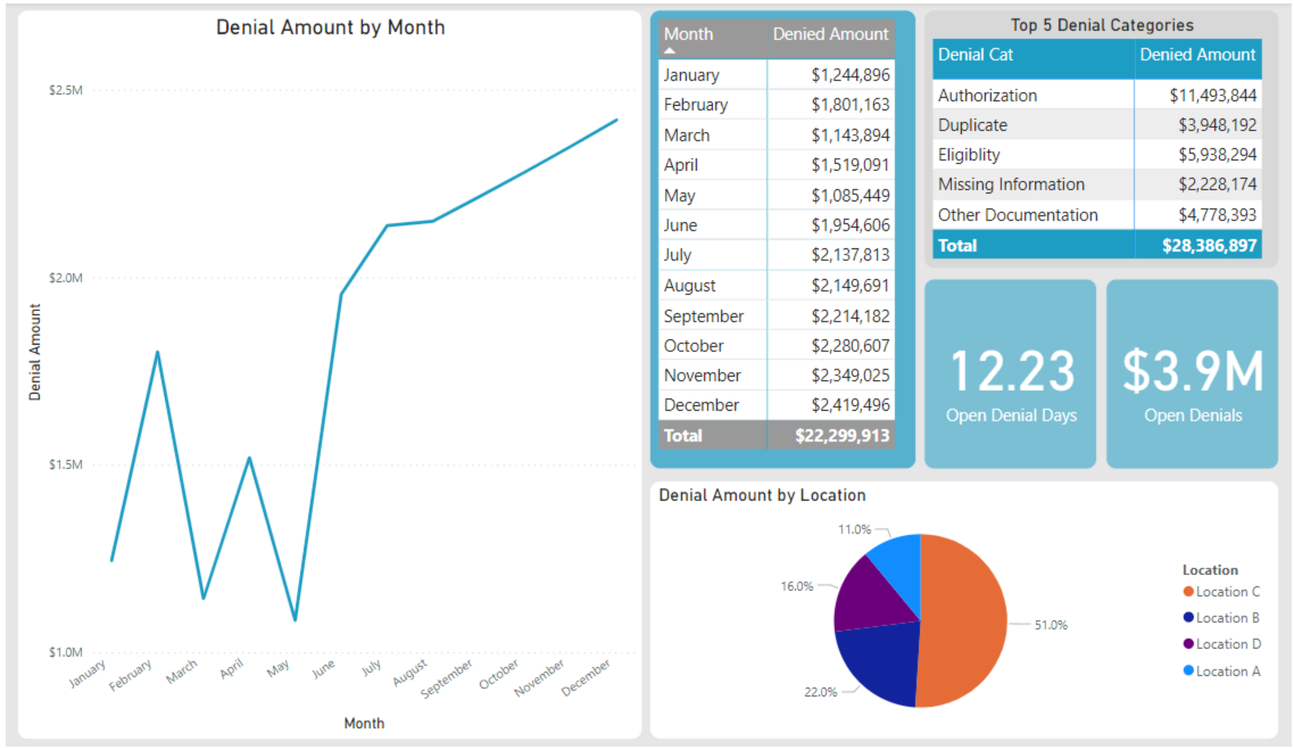
Report Creation & Root Cause Analysis

Example A



Top Denied Claims		
Claim ID	Denied Amount	Denial Category
21029	$39,239	Multiple
32810	$32,843	Authorization
72891	$28,183	Multiple
62512	$25,192	Credentialing
49281	$22,392	Duplicate

Example B



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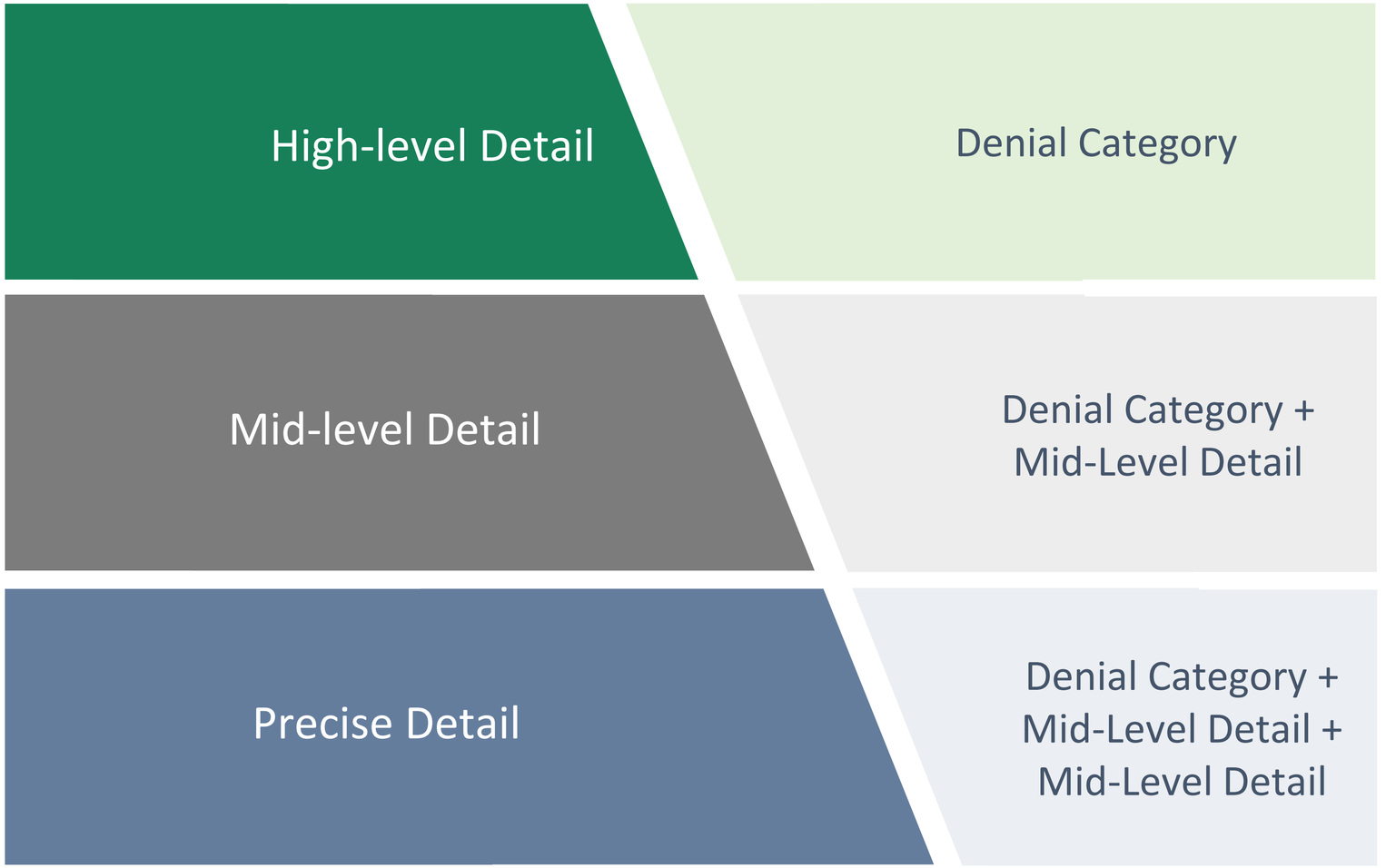
Report Creation & Root Cause Analysis

Effective reporting needs multiple level of detail to allow for trending as well as root cause analysis:

Examples of Mid-level Details:

- Top denied CPTs
- Top Denying Payers
- Remark Codes
- Location
- Physician



Root Cause Analysis

Start by identifying an opportunity

ASK QUESTIONS to answer one primary topic:
<u>Why does this opportunity exist?</u>

- What trends exist within this finding?
- Is this finding linking to one specific payer or financial class?
- Have there been any recent changes within the organization that would explain this outcome?
- Are there denial or remark codes associated with the data that can provide additional detail to the root cause?

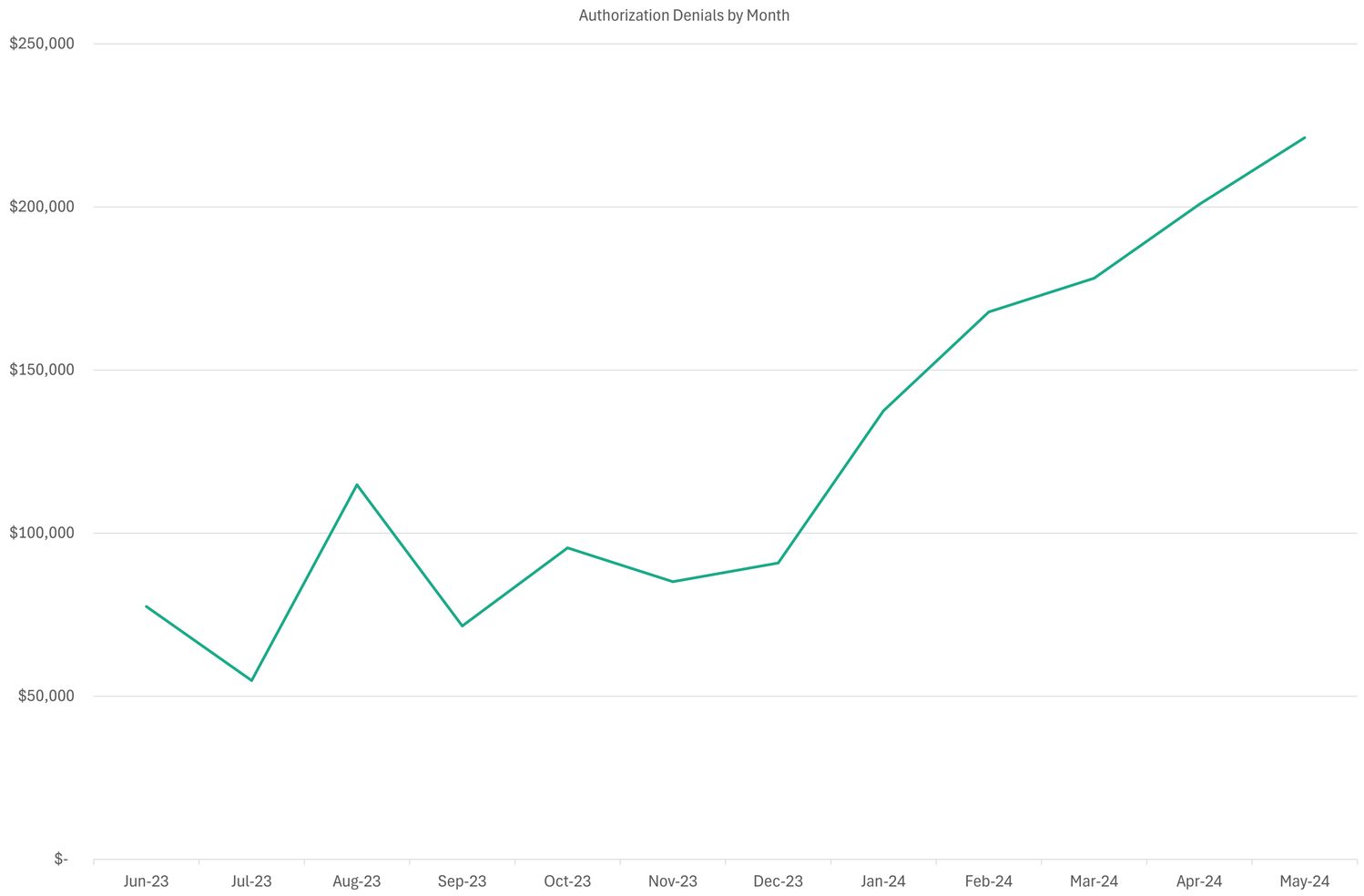
Example Case 1

XYZ Radiation Oncology Cancer Center

Case Background:

- XYZ Cancer Center is a practice that recently underwent a merger between three groups (Center X, Center Y, and Center Z) in August of 2023
- There are three locations
- The practice has experienced a significant increase in authorization denials after engaging a vendor to assist in obtaining authorizations.
- There is concern that the new vendor is linked to the spike in denials.
- Existing metrics available:
  - Denial amount by month
  - Denial amount by category
  - Open denial amount by month
  - Denial rate (quantity not $ amount)

Starting Point



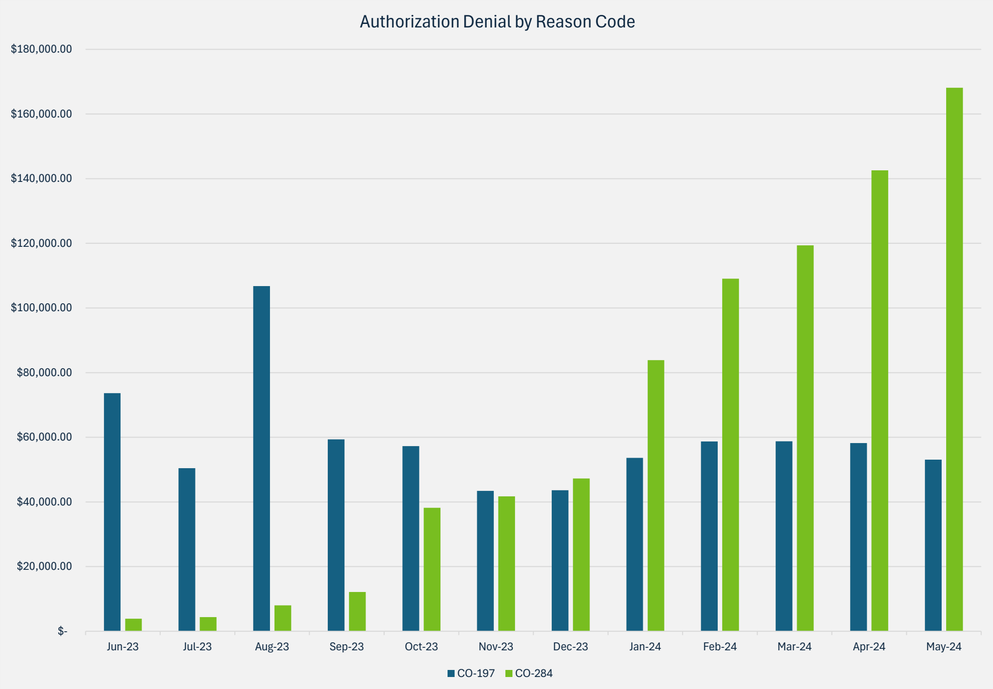
Starting point:

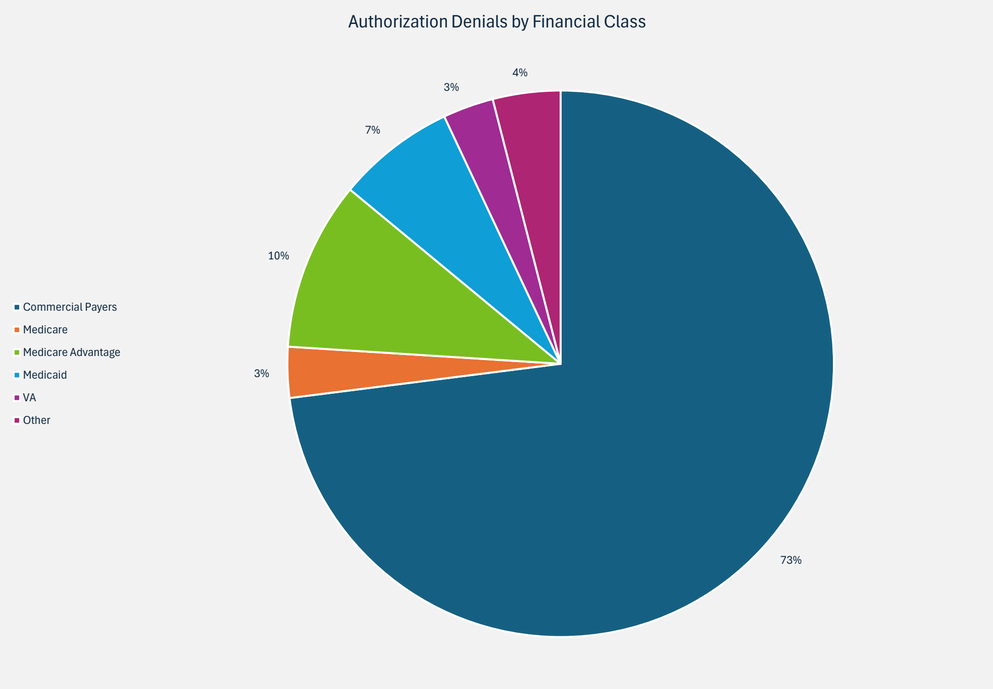
1. The practice had reports that showed increase in authorization denials, but it lacked the information needed to explain why this was happening.
2. A new vendor started assisting with authorizations in February of 2023.
3. The increase in denials appeared to begin prior to the new vendor start date.

Root Cause Analysis

Further data analysis showed an increase in CO-284 denials starting in October, and that the primary denying financial class were commercial payers.

CO-284: authorization is valid but does not apply to the services billed





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Root Cause Analysis

Data Analysis Findings:

CO-284 Denials

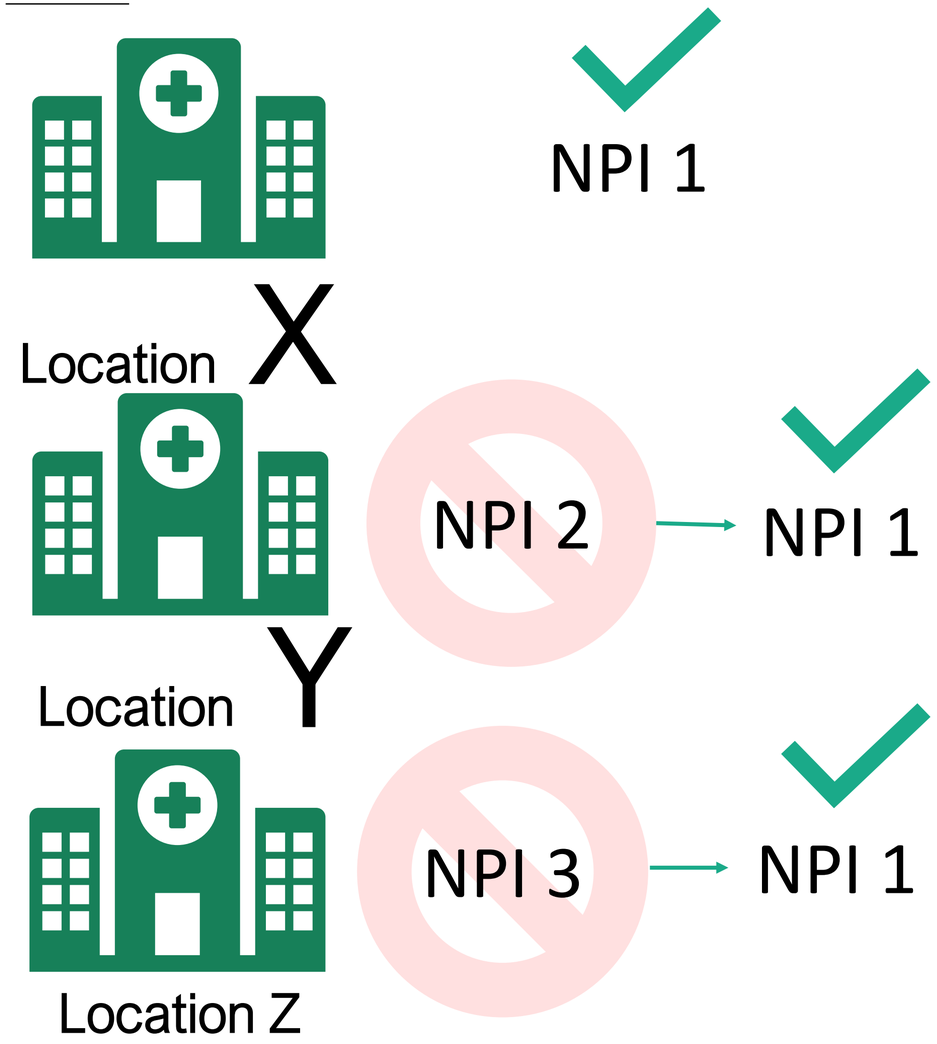
Commercial Denying Payers

Post Dates On/After October 2023

Next Steps Taken & Findings:

- Individual denied claims from October 23 onward were reviewed in detail
- All claims did have an authorization ID present, and it was for the accurate procedure codes
- There was a trend present of the same commercial payers denying claims
- Staff notes showed that the denials were linked to accounts where authorizations were being obtained from the same portal

Final Solution



Addressing the Opportunity:

- Calls were made to the payer portal to discuss the cause for the denials.
- Upon discussion, we learned that while the names of the various locations had been changed, all but one were listed under the incorrect NPI.
- After identification of the problem, the correct NPIs were updated within the payer portal to cease the authorization denials.

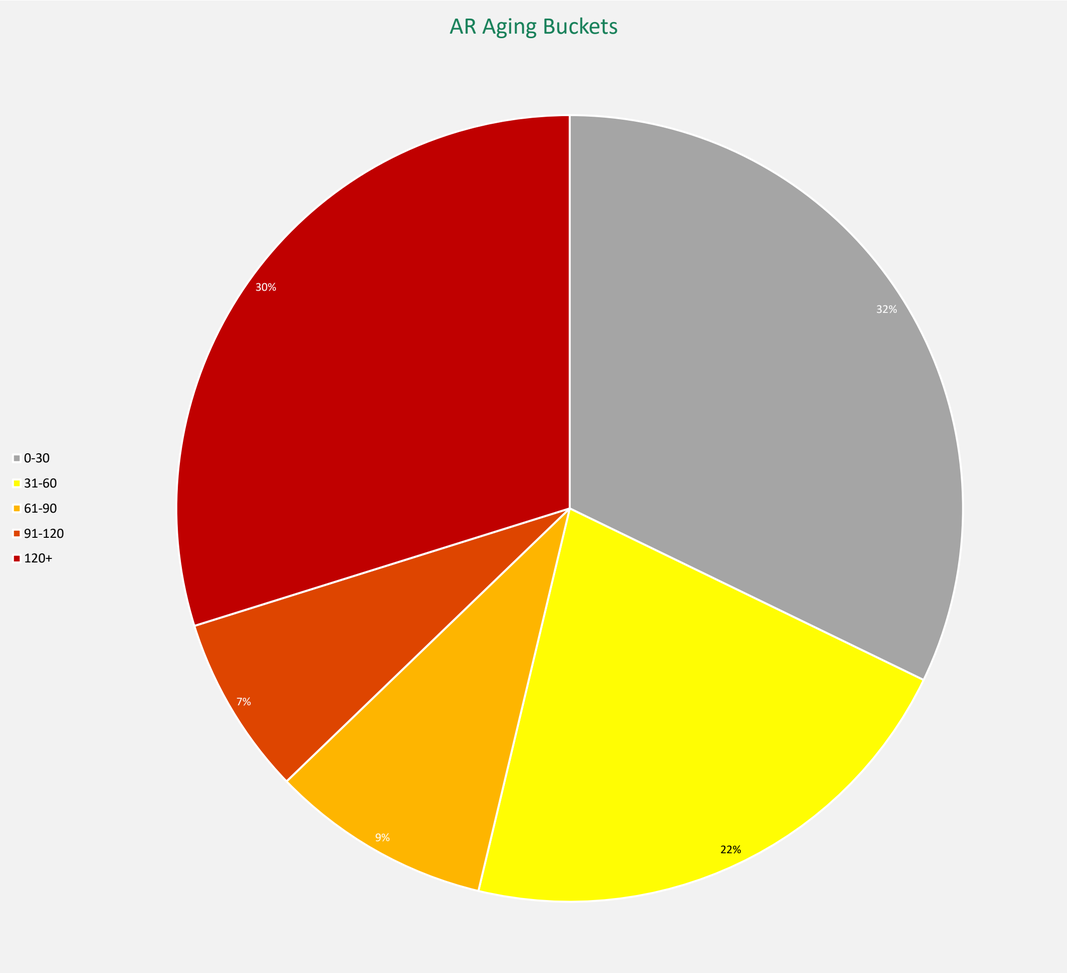
Example Case 2

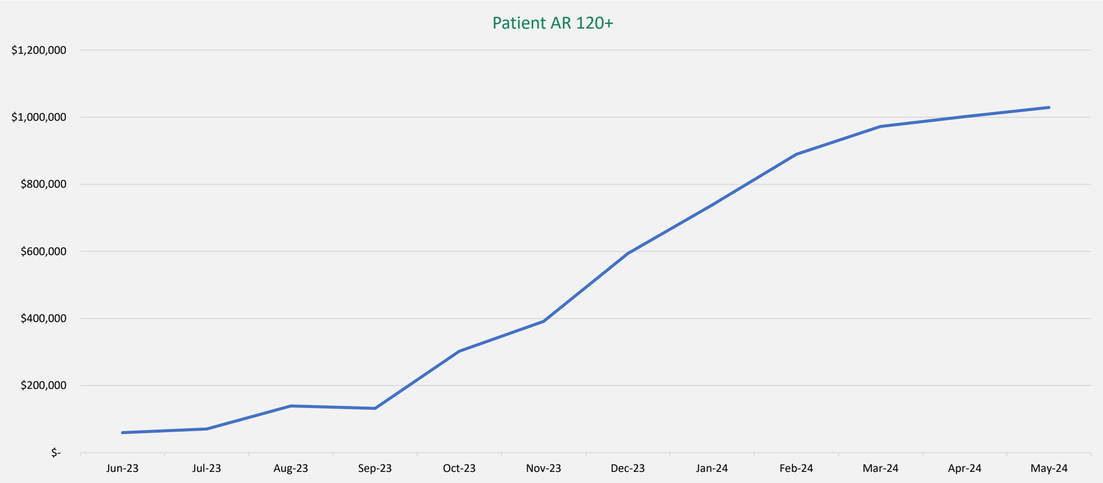
Cancer Care of ABC

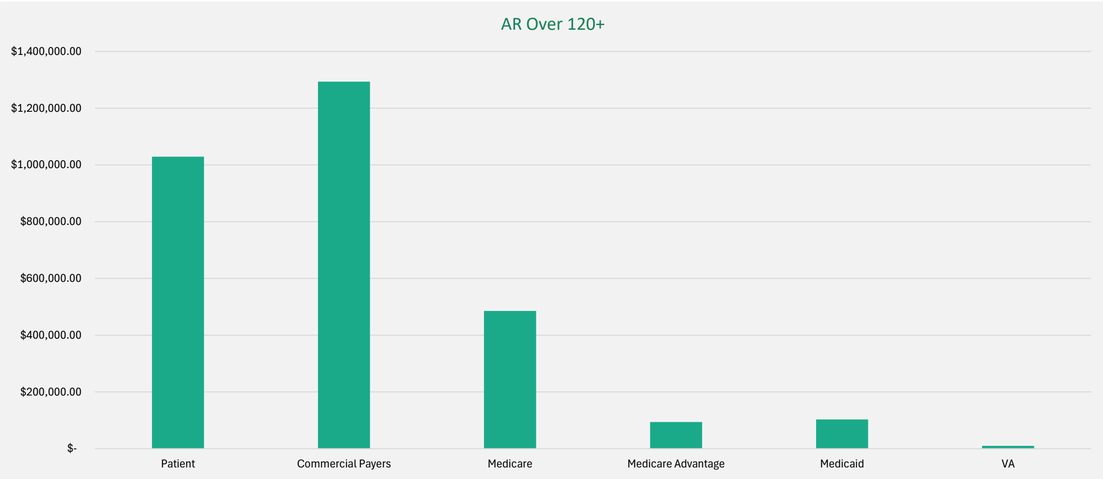
Case Background:

- Cancer Care of ABC has noticed that their patient accounts receivable balance over 120 days has significantly increased over the past few months.
- The staff is aware that the front-desk is collecting a co-payment at time of service.
- There is financial counseling available, but only for patients who request financial assistance.

Starting Point







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Root Cause Analysis

AR Data Findings:

- AR over 120+ is high
- One third of the 120+ balance is patient
- The patient AR over 120+ started increasing in November 2023

What is the root cause for the elevated patient AR?

Sometimes the data highlighting the opportunity does not allow for easy root cause analysis.

Root Cause Identification Next Steps:

- Analyze additional factors of the AR data (original financial class, charges associated with balance, etc.)
- Review some accounts with patient outstanding balances over 120+
- Look at all of the practices data inclusive of AR, transactions, and denials and identify if there are any trends that can be linked to the opportunity.

Root Cause Analysis

Additional AR Data Review

- Patient outstanding accounts all had the same few commercial payers as their original financial class

Account Sampling

- All accounts showed charges that received a non-covered denial where the code on the EOB had PR (patient responsibility) as opposed to CO (contractual obligation) listed

Full Data Analysis

- A full review of data highlighted an increase in non-covered denials for the same set of CPT codes

Credentialing and Contracting

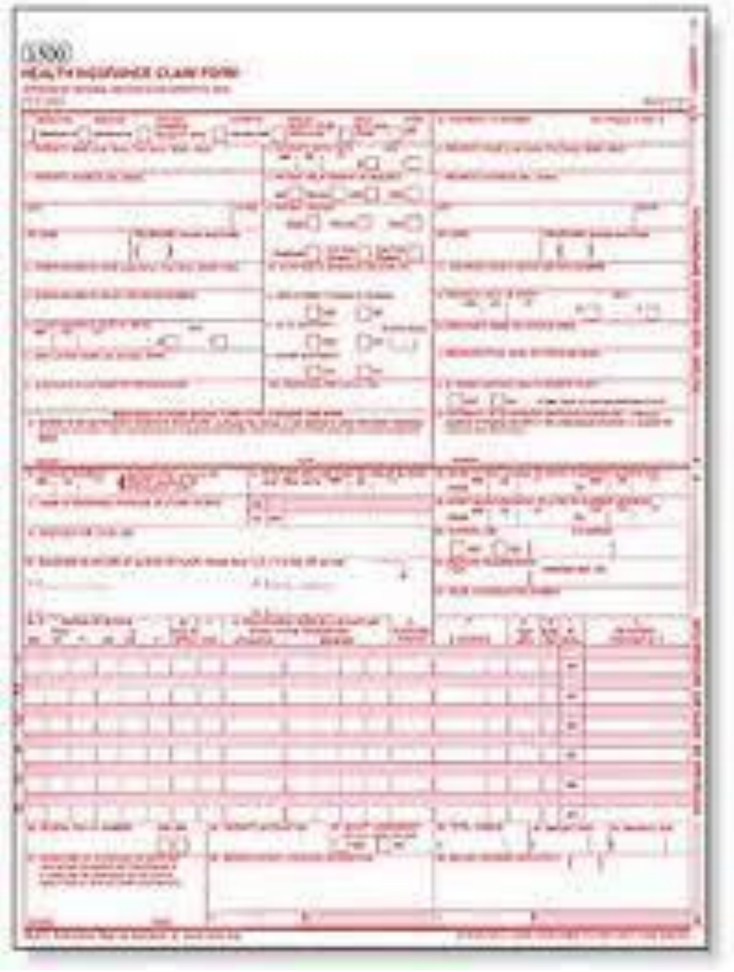
What is Credentialing? Verification of education, where you went to school, when and what residencies, fellowships, etc.

- Gather all documents and make copies each year of latest files and keep originals/copies in an easily accessible location. Keep an electronic folder ready for distribution. Second off-site location is also recommended, i.e., parents' computer, trusted family member etc.
- Current DEA
- Maintain contacts for each school you went to, be able to notify them you will need responses
- Hospital privileges required

What is Contracting? Negotiation of payment and terms…..

- This process can take 3-6 months and longer for some commercial payers.
- Lack of paperwork will slow the process down significantly.
- State Licensure required

CMS 1500



Submitting this form:

1. All True, Accurate and Complete
2. I've Familiarized myself with all applicable laws, regs, and program instructions from CMS MAC
3. I have provided or will provide all information necessary for CMS to make a payment decision
4. This claim submitted by me or my billing co. complies with all MC/Mcaid laws, regs, instructions including stark
5. The services on this form were medically necessary and personally performed by me or my employee under my direct supervision unless specifically expressed
6. Incident to is under the physician's direct supervision

Authorization Approvals

Regarding approvals given a date range effective on the date that Aetna begins their review instead of the date of the initial authorization request, they have a tendency to only list 1 of the proton codes on the approval such as 77525 instead of utilizing the information provided on the authorization request. In NJ, they review the approval once received & attempt to request correction of the approval to properly reflect the requested codes as well as corrected date ranges. Generally, Aetna will advise that they cannot change the information & a claims appeal will be required. This situation is not specific just to Aetna, it does happen with UHC, BCBS & other large payers as well. External appeal options have been dependent on patient specific policy.

Also- It is my understanding that availability for external appeals for prior auth denials will be determined based on the patient's plan. Most self-funded plans allow external review, but not all. In addition to the Aetna attachments sent previously, I have attached the following info found on Anthem and UHC.

Authorization Approvals/Details Ex.

Aetna authorizes approvals based on the appeal review date rather than the date that the auth request was originally submitted, which can cause the approved date range to be partially or fully outside of the treatment dates, resulting in claim denials for invalid authorizations for the services rendered and additional claims appeals that may or may not result in payment. For example, we had a patient treated from 02/02/24-03/04/24. NYPC requested auth with the payer on 01/26/24, which denied under internal appeal. IRO appeal occurred on 03/26/24, which began review by Aetna on 03/29/24, and was approved with a date range of 03/29/24-12/31/24. AFTER treatment. Provider attempted to have the approval dates changed to the date of the original request, which Aetna would not consider advising to appeal on the claims side. Claims are now beginning to deny for lack of auth which we will appeal based on the original auth request date. I have attached the information available online for Aetna's appeals process as well as the external review program.

Compliance

- **New York Presbyterian Hospital Pays Over $800,000 to Settle Claims that Physician Practices Improperly Billed Government Health Care Programs**
- **Government Alleged that Radiation Oncology Practices Failed to Properly Review Images Taken for Guided Radiation Therapy**
- "The defendants provided substandard care to cancer patients by not properly or timely reviewing medical imaging and then billed taxpayer funded healthcare programs for these shoddy services," stated United States Attorney Breon Peace. "My Office is committed to holding healthcare providers accountable for such conduct."
- The United States claimed that between 2012 and 2018, RTA and LEROS billed for images utilized in IGRT when such images were either not reviewed, or were not timely reviewed, and therefore were not reasonable and necessary. Further, the investigation found that initial consultation sessions at RTA were in some instances billed at a higher coding level than appropriate.
- Under the terms of the agreement with the United States and the State of New York, NYPH will pay a total of $801,000, with $694,999.71 going to the United States and $106,000.29 to the State of New York. These funds will go to the Medicare, Medicaid, and TRICARE programs.
- **https://www.justice.gov/usao-edny/pr/new-york-presbyterian-hospital-pays-over-800000-settle-claims-physician-practices**

Fee Schedules

Medicare Physician Fee Schedule (MPFS)

- In short, this is the payment system for PROFESSIONAL reimbursement for physicians working in a hospital **OR** in a physician or commercially owned free standing Radiation Therapy Center
- https://www.cms.gov/medicare/physician-fee-schedule/search/overview
- https://www.cms.gov/medicare/physician-fee-schedule/search

Hospital Outpatient Prospective Payment System (HOPPS or OPPS)

- This is the payment system set up for Hospitals and their associated TECHNICAL reimbursement
- https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps

RVUs

- The Conversion Factor value for 2024 is $32.74 2023 is $33.0607 – why does that matter? 2022 - $34.6062
- IMRT for LA County is 55.36 RVUs in MPFS = $2113.23 and $1814.38 Nationally
- Relative value units (RVUs) are **a measure of value** used in the United States Medicare reimbursement formula for physician services.
- RVUs are a part of the resource-based relative value scale (RBRVS) and are comprised of 3 different values
  - Physician Work
  - Practice Expense
  - Malpractice
  - https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-relative-value-files/rvu23b
- What is meant by Medicare Facility or nonfacility?
  - **Facility Services** are provided within a hospital, ambulatory surgery center, or skilled nursing facility.
  - **Non-Facility Services** are provided in outpatient clinics, urgent care centers, home services, PHYSICIAN'S OFFICE (RAD ONC CENTER) etc.

CMS Conversion Factor Over the Years

Year	Conversion Factor	Change	Year	Conversion Factor	Change
1998	$ 36.69		2012	$ 34.04	$ 0.06
1999	$ 34.73	$ (1.96)	2013	$ 34.02	$ (0.02)
2000	$ 36.61	$ 1.88	2014	$ 35.82	$ 1.80
2001	$ 38.26	$ 1.64	2015	$ 35.93	$ 0.11
2002	$ 36.20	$ (2.06)	2016	$ 35.80	$ (0.13)
2003	$ 36.79	$ 0.59	2017	$ 35.89	$ 0.08
2004	$ 37.34	$ 0.55	2018	$ 36.00	$ 0.11
2005	$ 37.90	$ 0.56	2019	$ 36.04	$ 0.04
2006	$ 37.90	$ -	2020	$ 36.09	$ 0.05
2007	$ 37.90	$ -	2021	$ 34.89	$ (1.20)
2008	$ 38.09	$ 0.19	2022	$ 34.61	$ (0.28)
2009	$ 36.07	$ (2.02)	2023	$ 33.89	$ (0.72)
2010	$ 36.87	$ 0.80	2024	$ 33.28	$ (0.61)

Conversion Factor Trend 1998 - 2025

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ACS Stats

- According to the ACS from 2014-2019:
- Black Americans have the highest incidence of Cancer and death rates of all groups in the United States
- Of the United States, the South and Appalachian regions have the highest Death Rates
- Those with lower socio-economic status or live in more rural areas vs higher socio-economic have shorter survival rates for people of All Races
- Lower education levels for all types of Cancers reduce survival rates across the board including breast, colon, and lung
- It is interesting and VERY UNFORTUNATE that older, uninsured, and racial minority groups are less likely to get
  - SBRT
  - IMRT
  - Protons
- Why is this?
- Do you see this in your locations?
- Is this something you as a dosimetrist suggest?
- Are you as clinicians aware of insurance coverage?
  - Would it matter if you did know?
  - You can help make a difference nationally.
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10090826/

What Can We Change?

- It is interesting and VERY UNFORTUNATE that older, uninsured, and racial minority groups are less likely to get
  - SBRT/IMRT
  - Expensive Drugs – Therapeutic and Non-Therapuetic
  - Protons
- Why is this?
- Do you see this in your locations?
- Is this something you as a dosimetrist suggest?
- Are you as clinicians aware of insurance coverage?
  - Would it matter if you did know?
  - You can help make a difference nationally.
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10090826/
- A study of more than 300,000 patients who had prostate cancer found that Black race was not associated with inferior prostate cancer-specific mortality in cohorts from National Cancer Institute-sponsored randomized clinical trials
- Black men with nonmetastatic prostate cancer appeared to have comparable stage-for-stage prostate cancer-specific mortality to White men.[15] This finding was similarly historically noted in an analysis of Radiation Therapy Oncology Group phase 3 randomized trials for prostate cancer.
  - Roach M, 3rd, Lu J, Pilepich MV, Asbell SO, Mohiuddin M, Grignon D. Race and survival of men treated for prostate cancer on radiation therapy oncology group phase III randomized trials. *J Urol.* 2003;169:245–250

Disparities

Cancer disparities are differences in cancer measures such as:

- Incidence (new cases)
- Prevalence (all existing cases)
- Mortality (deaths)
- Survival (how long people survive after diagnosis)
- Morbidity (cancer-related health complications)
- Survivorship (including quality of life after cancer treatment)
- Financial burden of cancer or related health conditions
- Screening rates
- Stage at diagnosis
- Cancer disparities can also be seen when outcomes are **improving overall** but the improvements are **not seen in some groups** relative to other groups.
- Population groups that may experience cancer **disparities include** groups defined by race, ethnicity, disability, gender identity, geographic location, income, education, age, sexual orientation, national origin, and other characteristics.
- https://www.cancer.gov/about-cancer/understanding/disparities

Wow! Just FYI

- Andrew Witty – CEO United
  - 2023 Compensation $23,534,936
- Gail Boudreaux – Elevance Health CEO
  - 2023 Compensation $21,889,039
- Karen Lynch – CVS Health
  - 2023 Compensation $21,615,034
- David Cordani - CEO Cigna
  - 2023 Compensation $21,047,255
- Sarah London – Centene CEO
  - 2023 Compensation $18,556,966
- Bruce Broussard – Humana CEO
  - 2023 Compensation $16,327,384

Yet have restrictive Authorizations/Insurance Verification, Appeals for Standard of Care

Analytics to increase Denials

https://www.fiercehealthcare.com/payers/unitedhealth-ceo-andrew-witty-was-2023s-highest-paid-payer-ceo-heres-what-his-peers-earned

- Without Insurance Screening and Well Visits don't occur at necessary levels
- Can't afford treatment
- Can't afford living expenses
- Choice between food and treatment
- Fear of burdening family
- Strong financial performance is associated with improved patient reported experience of care, the strongest component distinguishing quality and safety. These findings suggest that financially stable hospitals are better able to maintain highly reliable systems and provide ongoing resources for quality improvement.

THANK YOU

QUESTIONS?

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