

3M Health Information Systems

Case study:

Uncovering reimbursement opportunities and compliance risk at “Health System”

Northeastern United States

Snapshot of Health System*

Located on the Eastern seaboard, Health System includes a flagship hospital and ambulatory care clinics serving more than 3,000 patients each day. With a foundation built on research and medical education, Health System provides primary care and specialty services at community-based facilities throughout the area it serves.

Health System has worked with 3M over many years to advance its coding and reimbursement processes and establish effective clinical documentation practices for both inpatient and outpatient services.

Step #1: Identify the challenges

Translating the physician’s narrative and power of clinical language into accurate coding and appropriate reimbursement are complex challenges—even more so today as the percentage of physicians employed by hospitals and hospital medical groups grows every year.

As professional fee coding operations become centralized and reporting structures change, responsibility for professional fee coding can rest with the medical group, a hospital’s HIM department or the revenue cycle team. Healthcare professionals concerned about coding accuracy should consider these questions:

- Are you confident that the coding of your professional services is supported by documentation in the record?
- Are the EMR systems used by your physicians robust enough to promote accurate and compliant coding?
- Are you obtaining all the reimbursement to which your organization is entitled?
- Have you done everything necessary to protect against an adverse audit?

Faced with these questions, Health System brought in the professional fee services coding and billing experts from 3M Health Information Systems (3M) to evaluate the accuracy and completeness of the organization’s professional services documentation and coding.



*Because of client confidentiality, this case study has substituted “Health System” for the actual organization’s name. The snapshot description is accurate and the facts and figures reported as results of the 3M analysis are true to 3M findings; only the institution’s name has been altered for privacy reasons.

Risk and loss are out there.

3M can help.

Thanks to 3M’s analysis, Health System recognized that it risked a potential adverse audit unless changes were made to current professional services documentation and coding practices. The organization was also missing opportunities to improve revenue.

But by putting 3M’s professional fee computer-assisted coding (CAC) solutions to work, Health System can:

- Achieve more consistent, accurate coding of E/M levels based on the documentation
- Reduce the potential of an adverse audit through more accurate coding
- Realize reimbursement that is missing because of inaccurate coding

Step #2: Conduct a Physician Services Review

3M consultants reviewed 200 professional coding records from Health System—100 records were randomly selected for review and an additional 100 records were selected for specific focus on levels of Evaluation and Management (E/M) services that could present opportunities for improved code selection and documentation.

In evaluating coding accuracy for both the focused and random samples, 3M consultants assessed the quality of documentation, including the accuracy and sufficiency of all documented E/M codes and CPT® coding of other services. Published guidelines from Medicare and the state’s Medicare Administrative Contractor (MAC) were applied to all services in the research samples. 3M’s Physician Services Review also used the Medicare Physician Fee Schedule and assumed that all services were paid in order to achieve consistency in analyzing the financial impact.

Once the analysis was complete, 3M provided Health System with comprehensive reports by clinic that detailed the reimbursement impact for the records reviewed, along with specific recommendations for change and improvement.

Opportunity and risk: Focused sample

Based on data provided by Health System, the services of 24 different physicians made up the focused sample, including a wide variety of specialties. This sample emphasized the higher level E/M services because incorrect coding of these levels poses greater audit overpayment risk due to the higher reimbursement rates.

Of the 91 E/M services reviewed, the 3M consultants found that 75 percent were accurately coded and sufficiently supported by the record. The remaining 25 percent, however, posed risk and opportunity to the organization.

Fifteen records in the sample were over-coded, as the documentation supported 1-3 levels of service lower than what was reported, while four records were under-coded and could have been reported at one level of service higher. *Figure 1* details the difference in reimbursement, both pre- and post-audit.

Focused Sample Variance
Paid amount compared to audit amount: 1.70%
A variance of less than 5% is an acceptable tolerance by the OIG.

Error Type	Count	Paid Amount	Audit Amount	Net Difference	Opportunity	Risk
Lower Level Supported	15	\$1742.85	\$1153.23	\$589.62	\$0.00	\$589.62
Higher Level Supported	4	\$183.97	\$304.53	\$120.56	\$120.56	\$0.00
Bundled With Other Service Provided	4	\$122.44	\$0.00	\$122.44	\$0.00	\$122.44
Procedure Supported But Not Coded	2	\$0.00	\$417.42	\$417.42	\$417.42	\$0.00
Total	25	\$2049.26	\$1875.18	\$1250.04	\$537.98	\$712.06

Note: This table includes only errors that impact payment amounts. The complete Detailed Variance Report was provided with other detailed reports of findings.

Figure 1. Focused sample variance findings for Health System

Opportunity and risk: Random sample

The services of 36 different physicians made up the random sample in the 3M review, again with a wide variety of represented specialties. Of the 26 E/M services reviewed, 73 percent were accurately coded and sufficiently supported by the record. The remaining 27 percent offered examples of under- and over-coding, as well as the selection of the wrong service code in several instances and services without supporting documentation.

The random sample also included a high number of surgical procedures. Of the 99 surgical and other ancillary

services reviewed, 85 percent were accurately coded and sufficiently supported by the record. The inaccuracies of the remaining 15 percent of services are detailed in *figure 2*, as well as the post-audit impact on reimbursement.

For Health System, the compliance and financial implications of the data were clear. With only a sampling of records, the analysis found that 17 E/M services were billed at least one level of service higher than what was supported by the record for an estimated payment at risk of \$712.66.

In contrast, five E/M services were supported by documentation at least one level higher than billed, resulting

in an estimated payment opportunity of \$181.26.

Figure 3 summarizes the financial impact of the data for both sets of sample records. While extrapolation of these results across the entire volume of encounters was not possible, it is likely that Health System's bottom line would be significantly improved when considering the impact of more accurate documentation and coding across all providers and many months of professional services rendered.

Random Sample Variance
Paid amount compared to audit amount: 4.89%
A variance of 5% or greater prompts an expanded audit by the OIG.

Error Type	Count	Paid Amount	Audit Amount	Net Difference	Opportunity	Risk
Lower Level Supported	2	\$446.77	\$323.73	\$123.04	\$0.00	\$123.04
Higher Level Supported	1	\$32.74	\$93.44	\$60.70	\$60.70	\$0.00
Not Documented	6	\$452.13	\$0.00	\$452.13	\$0.00	\$452.13
Time Not Stated	1	\$155.00	\$100.00	\$55.00	\$0.00	\$55.00
Alternate Code	4	\$283.32	\$491.43	\$208.11	\$219.94	\$11.83
Teaching Physician Requirement Not Met	1	\$655.00	\$0.00	\$655.00	\$0.00	\$655.00
Total	15	\$2024.96	\$1008.60	\$1553.98	\$280.64	\$1297.00

Note: This table includes only errors that impact payment amounts. The complete Detailed Variance Report was provided with other detailed reports of findings.

Figure 2. Random sample variance findings for Health System

Combined Sample Variance of E/M Only
Paid amount compared to audit amount: 7.44%
A variance of 5% or greater prompts an expanded audit by the OIG and possibly levying of sanctions and fines.

Sample	Total E/M/Count	Error Count	Paid Amount	Audit Amount	Net Difference
Focused Sample	68	23	\$8,755.66	\$8,168.26	\$587.40
Random Sample	26	7	\$2,536.91	\$2,283.70	\$253.21
Total	94	30	\$11,292.57	\$10,451.96	\$840.61

Note: This table includes only errors that impact payment amounts. The complete Detailed Variance Report was provided with other detailed reports of findings.

Figure 3. A summary of the financial impact for Health System

Step #3: Actionable data for promoting improvement

Based on the 3M analysis, Health System recognized that it risked a potential adverse audit unless changes were made to current professional services documentation and coding practices. The organization was also failing to take advantage of opportunities to improve revenue.

3M consultants recommended the following steps to reduce or mitigate the risk and institute best practices for promoting appropriate reimbursement:

- Review records where potential overpayments have been identified and refund all monies owed to the payer
- Consider providing focused educational sessions for all physicians whose services were included in the Physician Review analysis
- Consider conducting an annual external compliance review of each physician’s documentation, coding and billing practices
- Implement a professional fee computer-assisted coding (CAC) solution to promote more consistent and accurate coding of E/M levels based on the documentation

3M solutions built on compliance

As health care transitions to value-based care and providers are held accountable for cost and quality of the care delivered, healthcare delivery networks and large hospitals need to bridge clinical documentation and all coding workflows. To help, 3M offers professional fee coding solutions tailored to the specific requirements of your organization:

The **3M™ 360 Encompass™ System – Professional** brings

professional coding into the 3M™ 360 Encompass™ System, providing one platform that expands the power of computer-assisted coding, physician query capability and reporting to the professional fee coding world. The healthcare industry’s first encounter-based professional fee coding solution, 3M 360 Encompass System – Professional breaks down the barriers between professional and facility coding. It provides 360-degree visibility and communication to hospital and outpatient coders through a single application.

Used by many of the nation’s top hospitals, physician practices, billing companies, multi-specialty clinics and imaging centers, the **3MSM CodeRyteSM CodeAssistSM System** is an easy-to-use, web-based application that automates the coding process by automatically identifying billing codes and streamlining coding workflow. Rooted in 3M’s proprietary natural language processing (NLP), the integrated technology imports physician documentation from clinical reports and exports billing codes back into the organization’s billing system.

Call today

For more information on how 3M products and services can assist your organization, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at **www.3M.com/his**.



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