Improving
the Clinic Revenue Cycle

Through Cross-Functional Documentation

Introductions

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Objectives

1. Eliminate rework that is required when incorrect information is collected and/ or documented.
2. Develop practices that improve clinic-wide collection of accurate patient information.
3. Eliminate unnecessary delays from date of service to payment received.

Documentation Impacts Cash Flow

Paper versus Electronic

PAPER MEDICAL RECORD

- Often very limited documentation
- If it wasn’t documented in the record, we didn’t know about it
- The work was being done but the documentation didn’t reflect it

ELECTRONIC MEDICAL RECORD

- There may be an abundance of documentation
- Some documentation isn’t relevant to care being delivered during the visit
- Copy and Paste increases volume of documentation and may result in inaccurate documentation
- The electronic record keeps us more accountable

Why is Documentation Important?

- It facilitates inter-provider communications
- Provides evidence for legal health record
- Populates registry functions for management of patient population
- Necessary for billing and coding
- Improve quality of care for the patients

How is Documentation Used?

Complete and accurate clinical documentation is needed:

- To provide patient care
- To meet Meaningful Use requirements
- For Quality reporting (inc GPRA, PQRS, Managed Care, etc.)
- For value-based purchasing
- To respond to payment reform
- For fraud prevention and discussion

Does Documentation Quality Matter?

- High quality documentation provides a more accurate clinical picture of the quality of care provided
- Improved documentation leads to better coding
- Quality and performance reporting are more accurate with quality documentation
- Reimbursement is enhanced with quality documentation
- Severity-level profiles have improved accuracy with quality documentation
- Provider profiles more accurately reflect the care provided with quality documentation

Everyone Plays a Role

Intake/Registration

Obtain/confirm patient demographic information including these MU requirements:

1. Preferred language
2. Sex
3. Race
4. Ethnicity
5. Date of Birth

Payer Information

- Confirm patient eligibility
- Update patient record at the time of service
- Customer Service
- Insurance Verification
- Front Office Collections
- Scheduling

Medical Assistant Basics

- Document chief complaint
- Record patient vitals
    - Height/Length
    - Weight
    - Blood Pressure (age 3 and over)
    - Pulse
    - Respiration
    - SO2 (if needed)
    - Body Mass Index (BMI)
    - Growth Charts (age 0 to 20 years)

Medical Assistant – Doing More

- Review Reminders Due
  - Depression (PHQ2 and/or PHQ9)
  - DM check list (A1C, Urine Micro, eye exam, foot exam, labs
  - Domestic Violence
  - Alcohol (Audit C, CAGE
  - Intimate Partner
  - Tobacco
- Review/update Allergies
- Review/update medication list
- Immunization Record review

Providers

- Add/Edit problems to Integrated Problem List (IPL)
- Perform medication reconciliation
- Enter orders (Nursing, Lab, RX, Consults, Referrals)
- Enter and Sign SOAP Note
  - Chief Complaint(s)
  - Physical Findings
  - Assessment
  - Plan
- Enter visit codes (E&M and/or CPT)

Is It Timely?

- Progress notes should be written and signed at the time of service.
- Many providers complete the note before moving on to the next patient
- Best practice is that 99% of all progress notes will be written and signed on the day of visit
- It may be necessary to complete and sign a progress note on the following day but this should be the exception

Entering a Progress Note

Entering a Visit Note in RPMS EHR:

- Sign into RPMS EHR
- Select patient
- Select visit date
- Select template
- Accept default date and time
- Enter visit notes using clinic-approved format such as SOAP
- Use addendum later, if needed, to document labs and other information not available on the day of visit.
- Sign note

Late Entry of a Progress Note

Making a Late Entry in RPMS EHR:

- Sign into RPMS EHR
- Select patient
- Select visit date
- Select “late entry” note template
- Accept default date and time
- Enter visit notes using clinic-approved format such as SOAP
- Sign notes

Addendum

Adding An Addendum in RPMS EHR:

- Sign into RPMS EHR
- Select patient
- Select visit date
- Select note
- Click on “addendum”
- Enter necessary documentation
- Sign addendum

Assign the Correct E&M Code

- Why did the patient come in?
- What type of care did they require?
- What are the next steps to manage this patient?
  - Type of condition?
  - Severity of the condition?
  - What is the risk to the patient
- What was done? Was it needed?
- Work should be driven by the nature of the problem.
- It is not simply the number of problems. It is also how severe the condition is and whether it is unstable.

Evaluation and Management Codes

Are determined by the **COMPLEXITY** of service provided and **DOCUMENTED**

1. History
   - Chief Complaint/ History of Present Illness
   - Review of Systems
   - Past, Family, Social History
2. Physical Examination
   - Complete or focused?
3. Medical Decision-making
   - Number of problems
   - Complexity/type of data
   - Risk to the patient

Nursing

- Document care provided based on clinic protocol
- Document immunizations and injections
- Complete orders

Health Information Managers

- Verify note has been entered and is complete for each visit based on clinic policies and procedures
- Confirm clinic type
- Correct note title if necessary
- Confirm that SOAP note is complete
- Identify missing or unsigned
  - Progress notes
  - Purpose of Visit
  - Evaluation and Management (E&M)
- Merge/delete visits if needed

View Notes by Visit Date – Step 1

List Selected Documents

Status
Signed documents (all)
Unsigned documents
Uncosigned documents
Signed documents/author
Signed documents/date range

Max Number to Return
100

Author:
Richards,Susan P
Richey,Christopher H
Richter,Hazel J
Richter,Paula
Rimmer,William L

Beginning Date

Ending Date

Note Tree View
Sort Order
Chronological
Reverse chronological

Group By:
Visit Date

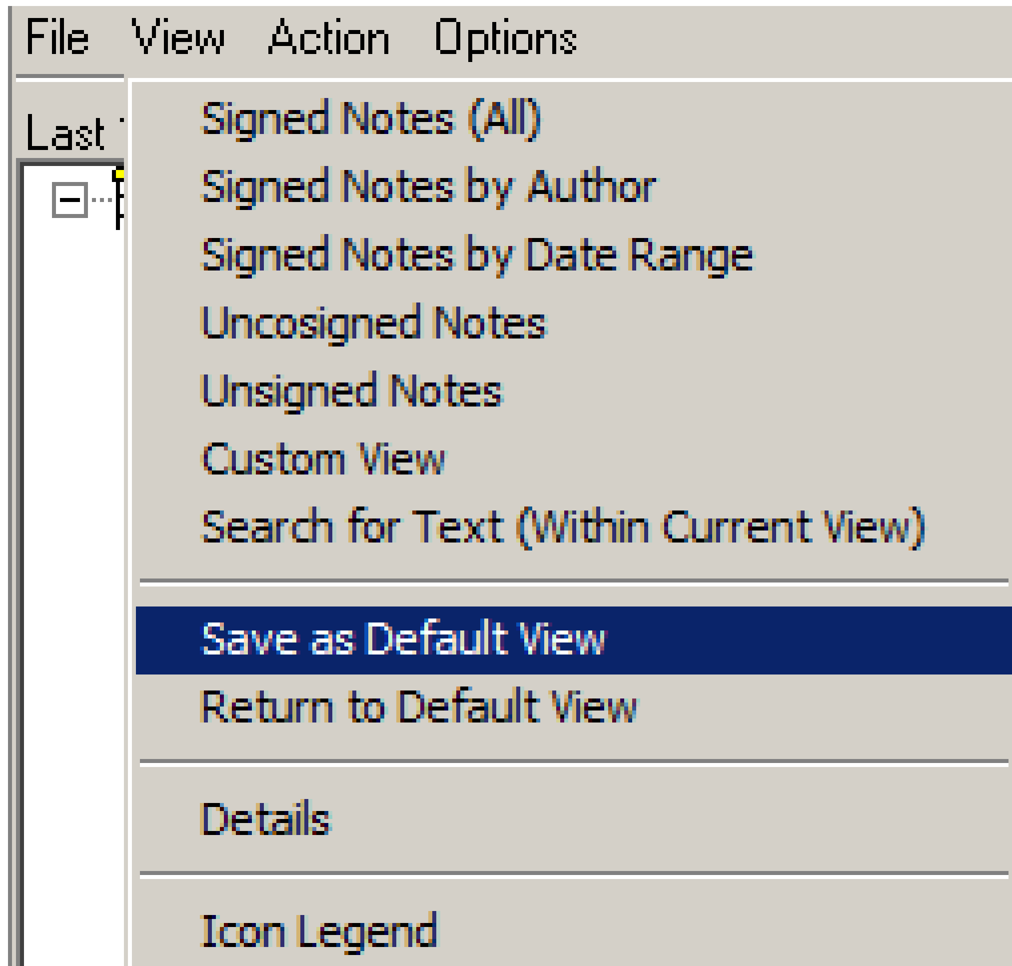
Sort Note List
Sort Order
Ascending
Descending

Sort By:
Date of Note
Show subject in list

Search
Where: Subject Title Diagnosis
Contains: One of All of

Clear Sort/Group/Search OK Cancel

Step 2 - Save View as Default



Step 3 – View "all signed notes"

File View Action Options

Last 100 Signed Notes

- All signed notes
  - Outpatient Notes
    - Visit: 05/20/14
    - Visit: 12/02/13
    - Visit: 11/27/13
    - Visit: 11/15/13
    - Visit: 11/12/13
    - Visit: 08/31/11
    - Visit: 08/15/11
    - Visit: 08/10/11
    - Visit: 06/14/11
    - Visit: 05/25/11
    - Visit: 05/19/11
    - Visit: 05/16/11
    - Visit: 05/12/11
    - Visit: 05/11/11
    - Visit: 04/17/11
    - Visit: 02/03/11
    - Visit: 11/09/10
    - Visit: 10/28/10
    - Visit: 10/01/10
    - Visit: 09/10/10
    - Visit: 05/12/10

All signed notes

Date	Title	Author	Location
May 20,14	GENERAL	Hess,Barbara	AAA DEMO
Dec 02,13	ER PROVIDER	Richards,Susan P	AAA DEMO
Nov 27,13	ER PROVIDER	Richards,Susan P	AAA DEMO
Nov 20,13	ER PROVIDER	Richards,Susan P	AAA DEMO
Nov 15,13	ER PROVIDER	Richards,Susan P	AAA DEMO
Aug 31,11	PC NOTE ADULT	Sneed,John F	OUTPATIENT URGENT CARE
Aug 15,11	CWWC CASE MANAGEMENT	Lossiah,Katie R	CWWC CASE MANAGEMENT
Aug 10,11	CASE MANAGEMENT	Durand,Angela	NURSE-BLUE/GEN
Jun 14,11	PC NOTE ADULT	Crigler,Joe W	OUTPATIENT URGENT CARE
May 25,11	SPECIALTY CLINIC	Menon,Ali S	CHART REVIEW
May 19,11	CWWC CASE MANAGEMENT	Lossiah,Katie R	CWWC CASE MANAGEMENT
May 17,11	Addendum to CODING NOTE	Lossiah,Katie R	CWWC-CABE
May 17,11	CODING NOTE	D'Alessandro,Steve G	CWWC-CABE
May 16,11	OUTSIDE LAB	Krisel,David	CHART REVIEW
May 12,11	Addendum to CWWC CASE MANAGEMENT	Carrillo,Peri F	CWWC CASE MANAGEMENT
May 12,11	CWWC CASE MANAGEMENT	Lossiah,Katie R	CWWC CASE MANAGEMENT

```
 LOCAL TITLE: GENERAL
STANDARD TITLE: GENERAL MEDICINE NOTE
DATE OF NOTE: MAY 20, 2014@16:31     ENTRY DATE: MAY 20, 2014@16:31:22
      AUTHOR: HESS,BARBARA         EXP COSIGNER:
     URGENCY:                            STATUS: COMPLETED
```

Step 4 – Click on Individual Note

NOTIFICATIONS | COVER SHEET | TRIAGE | PROBLEMS | PRENATAL | WELL CHILD | WELLNESS | MEDS | LABS | ORDERS | CONSULTS | NOTES | SUPERBILL | REPORTS | MORE ...

File View Action Options

Last 100 Signed Notes

- All signed notes
  - Outpatient Notes
    - Visit: 05/20/14
      - May 20,14 GENERAL
    - Visit: 12/02/13
    - Visit: 11/27/13
    - Visit: 11/15/13
    - Visit: 11/12/13
    - Visit: 08/31/11
    - Visit: 08/15/11
    - Visit: 08/10/11
    - Visit: 06/14/11
    - Visit: 05/25/11
    - Visit: 05/19/11
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    - Visit: 02/03/11
    - Visit: 11/09/10
    - Visit: 10/28/10
    - Visit: 10/01/10
    - Visit: 09/10/10
    - Visit: 05/12/10

Visit: 05/20/14

Date	Title	Author	Location
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     URGENCY:                             STATUS: COMPLETED
```

Coding

- Review visits in coding queue
- Assign appropriate codes (Diagnosis and procedure)
- Abstract data from note (BMI, Eye Exam, etc)
- Query provider if necessary
- Mark visit complete (or incomplete if missing required information for coding)

Coding/Billing Changes in RPMS EHR

- IMPORTANT: The provider narrative must be in sentence case (NOT all CAPS) so 3rd Party Billing can see the text
- Grant 3rd Party Billing access to see the PCC visit display (if they don't already have it)
- RPMS EHR Patch 13 removes coder ability to change provider narrative. Educate providers to select best possible SNOMED

Billing, Follow-up and Collections

- Claims Processing and Submission
- Claims follow-up
- Analyze detailed claims and resolve errors
- Post payments
- Patient statements and collections
- Contract management
- Answer patient billing questions
- Customer Service
- Reporting
- Month-end closing and reconciliation to finance

Disruptions in the Revenue Cycle

- What Happens when one of the previous processes does not work, or there is a disruption in the cycle?
  - Delayed Cash Flow
  - Potential Lost of Revenue
  - Unnecessary Rework
  - Inefficient and Ineffective Patient and Work Flow.

The Role of Management

- Management has the overall responsibility to ensure that the “Revenue Cycle” is not broken
- If it is broken, decisions to make process changes have to be made
- Must have an understanding and support the entire revenue generation cycle
- Third Party Resource and Internal Control Policy
- Ensure the necessary staff, space, training, and equipment is provided to “maximize revenue”.
- Training refers to Contracted Staff as well
- Marketing
- Auditing and Reviews

Establishing Rules/Benchmarks

"RULES" must be set and followed:

- Revenue Enhancement Meetings will take place once a week
- All Provider Documentation will be completed accurately within 24 hours of visit
- All Coding/DE will be completed within 4 days of OP Visit
- All claims will be dropped (approved and submitted) within 3 days of completed data entry and coding
- All Checks will be posted/deposited within 24 hours of payment
- All EOB's will be posted within 7 days of receipt
- All patient accounts will be closed within 60 days of billing

Benefits of Successful Implementation

- Accurate/Complete Medical Documentation
- Enhanced Provider Profiling Capabilities
- Reduced malpractice/tort action liability
- Improved Risk Management for Physicians
- Facilitated Quality Assurance/Accreditation mandates
- Cost Accounting/Reporting Capabilities
- COMPLIANCE with Rules and Regulations
- Quick Access to needed information
- Continuity of Care
- <u>IMPROVED QUALITY OF CARE</u>

It takes a team…

Working as a Team

- Come to consensus about process and responsibilities.
- Who is responsible for documentation?
- What is process when documentation is not completed?
- Avoid stress by being proactive.
- RPMS offers a variety of monitoring reports. Run the reports regularly and take action.

The Guiding Lights

- **Medical Staff Rules and Regulations:** Review and update annually.
- **Clinic Policies and Procedures:** Review and update annually
- **Workflows**: Make changes as new regulations and/or software come out

Clinic Workflows

1. Gather the entire team to workflow current or new procedures
2. Come to consensus about process and responsibilities
3. Assign responsibility
4. Corrective action when responsibilities are not met

New Workflows Needed

- Consolidated Clinical Document Architecture (CCDA)
- Personal health record (PHR)
- DIRECT messaging

Resources

Copy and Paste: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_042416.hcsp?dDocName=bok1_042416

Paper Persistence after EHR: http://www.healthit.gov/unintended-consequences/node/19/case-example.html

Communicating Change: http://www.healthit.gov/unintended-consequences/node/20/case-example.html

Continuous Quality Improvement: http://www.healthit.gov/providers-professionals/frequently-asked-questions/460#id129

http://www.healthit.gov/sites/default/files/tools/nlc_continuousqualityimprovementprimer.pdf

Questions and Discussion