CASE STUDY

Southtown Medical Center

Dave Cash is the new CFO at Southtown Medical Center (SMC). Southtown provides dermatology services to an average of 90 patients each day. Dave's approach to management includes spending a day with each staff member in his department to understand that person's duties. After two days with the two billing clerks, he realized that nearly 50 percent of their typical day is consumed by reworking payment denials from insurance companies resulting from billing errors and resubmitting the charges to the insurance company. The rest of their day is spent handling patient telephone calls regarding their accounts. Dave noted that a large number of patient calls are from irate customers asking for an explanation of why the services provided by SMC were denied by their insurance payer. The remaining patient calls are requests for balances due or for explanations of outstanding charges on their accounts. Dave is quickly coming to the conclusion that thousands of dollars in insurance payments are being denied or delayed each week because of erroneous bills. He believes that in some cases, the insurance payment is never recovered, and either the patient or SMC is stuck with the bill. He is also very unhappy that a significant amount of his staff time is consumed with reworking billing errors. Something has to be done about this situation, and he is determined to investigate and find a remedy.

Federal laws require that "clean," or correct, electronically submitted bills be processed by the insurance company within 10 working days. Whether the bill is paid in full, partially paid, or denied, the reason for the action is stated on the explanation of benefits (EOB) from the insurance company. EOBs are mailed to both the patient and the provider of services, in this case, SMC.

Dave begins asking questions of everyone involved in SMC's billing process. Figure 11.21 shows flowcharts of the billing process. When a patient checks in to see a physician, a form is generated with the patient's demographic and insurance information. This form, known as an evaluation form, is placed on top of the patient's medical chart. When the medical visit is completed, the physician notes the patient's diagnosis and any procedures that are performed. The nursing staff then assigns a four- or five-digit International Classification of Diseases (ICD) code to the diagnosis and a five-digit Current Procedural Terminology (CPT) code to the procedure(s) performed. ICD and CPT are universal coding systems used by service providers and payers to describe, in detail, the procedure performed and the diagnosis that necessitated the procedure. The CPT code determines the fee, and it may be modified and additional charges added for more extensive procedures. The ICD code must support the need for the procedure, or the bill will be denied by the payer. An incorrect or missing digit in either code can result in a lower payment or complete denial of the bill.

The evaluation form is then given to the receptionist, who enters the codes into the patient's account on the computer system. The computer system does not have the capability to check the accuracy of the codes; it simply accepts whatever is entered. Bills are electronically submitted overnight to the appropriate insurance carrier. The process appears to be fast, yet it is not very effective because of the lack of quality checks in the process. Dave knows that he needs to dig further to determine exactly where breakdowns occur in the system.

Next, Dave meets with some of the nursing staff to learn their process for assigning ICD and CPT codes. One of the nurses explains that the members of the nursing staff are not really trained to assign ICD and CPT codes; they receive only one hour of formal instruction at the beginning of every year when the new codes are issued. The rest of their coding training comes from the more senior nurses in the department. She also fills him in on a secret: The nurses resent having to do the coding and sometimes just assign any code to get the paperwork out of their hands. Dave is astounded. The most important source of SMC revenue is being handled by inadequately trained staff members who resent the responsibility.

Dave goes back to his office to mull over this situation and determine his next step. He knows that he cannot justify hiring coding specialists at an additional cost unless he can first prove the existence of the problem with facts and numbers. He will also have to prove that coding specialists are necessary to correct the problem. Dave knows from previous experience that coding specialists can increase revenue by 10 to 20 percent on an ongoing basis by optimizing reimbursement through correct application of coding rules. Dave decides to call in Karen Coder, a coding consultant he has worked with previously, to conduct an initial study. She starts by sampling 20 bills each day over a 20-day period and comparing the billing information to the information in the medical chart. Figure 11.22 (on page 445) shows the results of

this study. The revelations from this study are startling, and Karen and Dave immediately develop a plan to study all of the bills over a 20-day period and determine the number of incorrect bills for each doctor's office. Table 11.12 (on page 446) shows the results of this study.

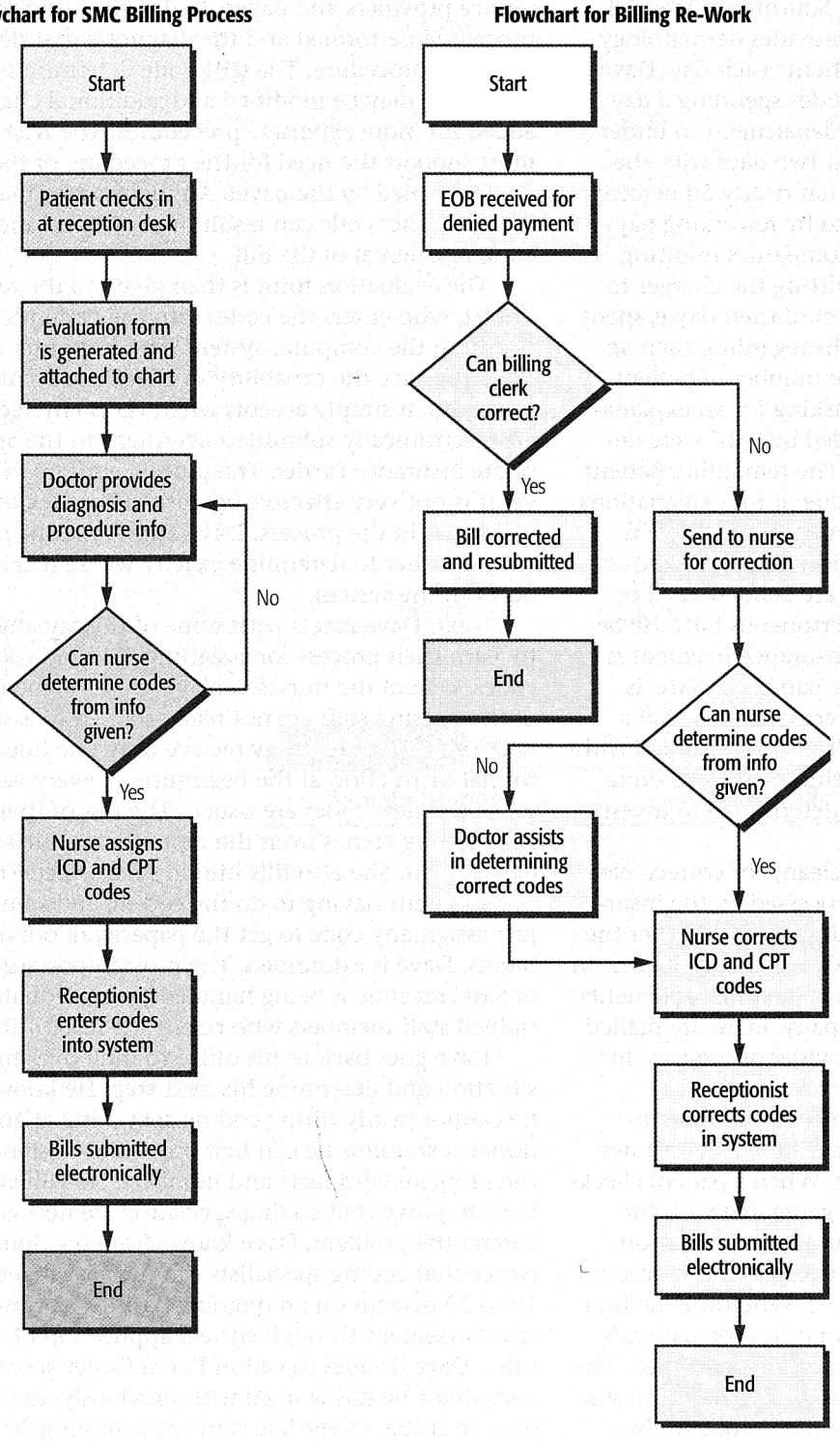

FIGURE 11.21

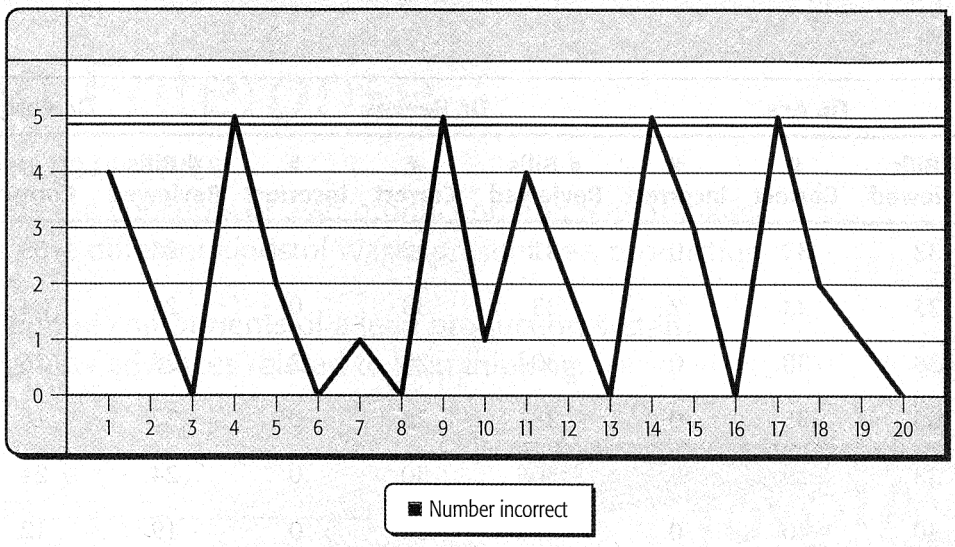

FIGURE 11.22

QUESTIONS

1. Analyze the data in Figure 11.22 and, using the appropriate control chart, determine whether the system is in control.
2. Using the data in Table 11.12, develop appropriate control charts to determine whether the coding process is under control for each doctor.
3. Suggest recommendations to reduce billing errors.