



Chapter 5 - An Overview of Processes Associated with Healthcare Delivery Within Provider Organizations: Focus on the Ambulatory Setting

Healthcare Information Technology Exam Guide for CompTIA Healthcare IT Technician and HIT Pro Certifications

by Kathleen A. McCormick and Brian Gugerty

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Chapter 5: An Overview of Processes Associated with Healthcare Delivery Within Provider Organizations: Focus on the Ambulatory Setting

Michael Stearns

In this chapter, you will learn how to

- Be able to explain the workflow associated with scheduling a patient for a visit to an ambulatory healthcare facility
- Understand the workflow associated with the patient encounter within the electronic health record
- Be able to explain additional workflows that are associated with managing clinical data

An Overview of Key Process Associated with Healthcare Delivery in the Ambulatory Setting

Until recently, the rates of adoption of information technology by ambulatory healthcare facilities in the United States were the lowest of any industrialized nation. A survey of physicians published in 2007 reported that only 4 percent of physicians had a fully functional EHR and 13 percent had a basic system.^[1] In 2011 the percentage of ambulatory physicians using any form of electronic health record rose to nearly 57 percent^[2] in 2011, and that number continues to grow, in part because of the stimulus funds tied to the meaningful use of EHRs. This has created a demand for training programs that educate information technology professionals about the operational requirements of ambulatory practices tied to technology. This chapter will review the roles, workflows, and related operational requirements of ambulatory practices.

The number of physicians and other healthcare providers, including nurse practitioners and physicians assistants, varies from solo-practitioner clinics to groups of several hundred providers, but a typical ambulatory practice in the United States may have two to three providers supported by approximately nine to twelve staff members. Ambulatory practices can be roughly divided into surgical and nonsurgical specialties of medicine. Nonsurgical specialties include primary care (e.g., family medicine, internal medicine, and pediatrics) as well as a number of related specialties such as cardiology, dermatology, neurology, endocrinology, oncology, pulmonology, psychiatry, and others. Surgical specialties include general surgery, otolaryngology, orthopedic surgery, neurosurgery, cardiothoracic surgery, obstetrics and gynecology, and others. Workflows, clinical-care requirements, and documentation of the encounter tend to vary substantially depending on practice type, the EHR that is being used, and the level of sophistication of the users. This chapter will present some common workflows and clinical documentation requirements but is not meant to be all-inclusive.

^[1]DesRoches, C. M., et al. (2008). Electronic health records in ambulatory care: A national survey of physicians. *New England Journal of Medicine*, 359, 50–60.

^[2]Health information technology in the United States: Driving toward delivery system change. (2012). Accessed on July 30, 2012, from www.rwjf.org/files/research/74262.5822.hit.ex.summary.final041612.pdf.

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Initiating a Visit with an Ambulatory Provider

Scheduling a visit with a practice has traditionally required the patient or their representative to call the office and speak with a staff member. Increasingly patients are scheduling visits through patient portals, which are electronic tools that allow patients to remotely access the clinic's scheduling software to book an appointment. In either case, the practice will have scheduling software that may be a stand-alone application or one that is integrated with other electronic tools such as a practice management system or an EHR.

Several hundred ambulatory practice scheduling tools are available in the U.S. market with a variety of capabilities and levels of integration with other software applications. The majority of the more sophisticated EHR and practice management applications have a fully integrated scheduling tool that is essentially a component of the whole system. In other cases, the scheduling software may communicate with the EHR or practice management software through an interface.

Ambulatory scheduling applications need to accommodate a number of requirements that are essential to workflow in the clinic. These include the need to create slots for different types of visits, including new patient visits, follow-up visits, and procedures. They also need to accommodate the preferences of individual providers, who may prefer different time intervals for visits of varying types (e.g., a follow-up visit with a patient with multiple complex medical conditions may take longer than a visit for a patient with single medical problem such as hypertension). The scheduling application may or may not support scheduling at multiple facilities and can be a feature that differentiates enterprise-capable EHRs from other products.

The workflow associated with scheduling a visit is fairly straightforward. If the patient is new to the clinic, in most cases they will call the clinic to schedule the visit. A receptionist or scheduling professional will then use the scheduling tool to schedule the actual visit as a new patient visit type. In some instances, the patient visit is scheduled by another clinic that may be referring the patient, and an emerging trend is allowing clinics to schedule patients in other clinics through an electronic process. A third method is through the patient portal, which has the advantage of not requiring any involvement of the clinic staff and is available when the clinic is not open.

Upon arrival at the clinic, the patient will go through a check-in process at the front desk with a member of the clinic's staff, in most cases a receptionist. When automated, a check-in module will initiate the visit process for that encounter. The tools may alert the staff member to get key information from the patient that may be demographic or clinical information. The patient will then be asked to complete forms that are most often paper-based, including their demographic information (e.g., age, gender, preferred language, race, ethnicity, address, phone numbers, marital status, and health insurance information). Some clinics have adopted kiosks that allow patients to enter this information electronically in the waiting room, and some accomplish this by allowing the patient to add or modify their demographics through patient portals or personal health records. Another merging trend is to have patients perform as much of their own data entry as possible through personal computers and mobile devices, including applications designed specifically for this purpose. Some applications will allow the patient to enter a reason for visit and other clinical information.

The patient is often asked to provide medical information during the paper or electronic intake process, which may include the reason for the visit, past medical history, allergies, medication, current symptoms, social history, and family history. If this information is obtained on paper, a clinic staff person, usually a medical assistant or a nurse, will enter the information into the electronic health record (or paper chart if the clinic is not on EHR). If the information is entered electronically by the patient, it will be available in the EHR in most cases.

Tip Be sure that a clinically knowledgeable person reviews any clinic data entered by a patient during the scheduling process within a reasonable period of time to avoid potential delays in treating acute medical conditions such as chest discomfort.

The final step prior to the patient being seen by the provider often involves having the patient taken to a triage station or examination room. Some additional history may be obtained by a staff member with clinical training such as a medical assistant who may also obtain vital signs such as height, weight, basic metabolic index (BMI), heart rate, respiratory rate, temperature, and blood pressure. This information will be recorded on paper or entered directly into the electronic health record.

A number of EHR applications have dashboard-like tools that track the location and status of patients in the clinic, how long they have been waiting in the clinic's waiting room, what room they have been placed in, if they are actively being seen by a provider, if they are in the lab or radiology department of a clinic (when these are present), and if they have been checked out of the clinic. They also may record status information about the patient's visit, such as when the medical assistant has completed the intake process and the patient is ready to be seen by the provider. During each transition within the clinic, the appropriate staff member enters the patient's change in location or status.

Tip It is fairly common for clinics to combine paper intake processes with electronic data entry, creating hybrid workflow models that are often inconsistent with the training and intent of the EHR designers. It may be in the best interest of the clinics to gradually move toward a higher-level usage of the EHR.

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The Clinician Visit

The provider will review the clinical information that has been obtained through the check-in and triage process. In most settings, this information will be used to create or update information in what is usually referred to as the *health summary*, *face sheet*, or another similar name that typically exists as a distinct container of the electronic health record. It contains patient-specific health information that may be stored as unstructured data, structured data, or codified structured data. For the purposes of this discussion, unstructured data typically means free text that is not supported by a specific designated field. An example of this might be paragraphs of text entered into a very general category such as "History of present illness." The term "structured data" is often used for data that is entered into a specific field (e.g., last name) or for data that is stored in a codified format. An example of codified data might be a field titled "Past medical history" that contains a code that indicates the patient has a specific medical condition such as multiple sclerosis. The EHR will store the code in the database, but the graphical user interface will express the concept as free text.

Codified data aids downstream processes tied to the information needs of the patient visit, such as alerts and reminders tied to patient care (e.g., a medication contraindication), clinical decision support, population queries, research, and interoperability with other applications such as health information exchanges.

The sections of the health summary component include patient-specific information in the following categories.

The Problem List

This is often used to identify past and existing illnesses the patient has had.^[2] Definitions vary, however,^[3] and some providers may broaden this to include information that is relevant to patient care such as ongoing marital discord. Different specialists may have different problem lists for the same patient, reflecting their areas of expertise and focus. The problem list is a requirement for stage 1 of meaningful use, and the EHR needs to be able to represent the problem list concepts as codified data.^[4] The codified data elements need to be represented either as ICD-9-CM or as SNOMED CT codes, the two terminologies that have codes that represent disease entities. The EHR application needs to allow for the problem list to be updated manually or through an automated processes via an interface to a health information exchange (HIE) or another mechanism whereby problem lists can be imported and consumed as codified data that can be used to create or maintain problem lists. The format most typically encountered at this time is the continuity of care document (CCD), but other methods may be used.

The Medication List

This consists of an active list of current medications, and some applications may allow the display of what medications the patient has taken in the past. It often includes prescription drugs and drugs that can be purchased over the counter. Besides the name of the drug, the medication list generally supports additional prescribing information, including the strength of the medication, the form (e.g., pill, tablet, liquids, inhalants, etc.), how frequently it should be taken, the amount prescribed, the route of administration, a start date, an end date when appropriate, and other information as needed (such as not to drink alcohol while taking a specific medication). Medication concepts are usually codified at the key ingredient level so that they can be used by the application to support electronic prescribing.

Electronic Prescribing Applications

An electronic prescribing application is a key component of the majority of EHRs and usually provides clinical decision support (CDS) assistance to providers. For example, it may suggest medications to use for specific conditions and recommended dosages and frequencies. CDS for medications usually requires the e-prescribing application to communicate with a third-party drug database resource. Since new medications are frequently added and others are retired, the drug database needs to be updated fairly regularly. The CDS capabilities of e-prescribing applications vary, but they may have the ability to identify a number of potential interactions and alert the provider before the medication is provided. These include alerts related to the following:

- Drug combinations that might be contraindicated
- Drugs that the patient may be allergic to
- Drugs that are contraindicated with certain diseases such as kidney disease
- Drugs that are contraindicated based on a lab value
- Drugs that are contraindicated based on the patient's age, including children and the elderly
- Warnings about the drug, related to whether it is covered by the patient's insurance plan

E-prescribing can be performed from within the health summary tool or from the medication or plan sections of the progress note. From a technical standpoint, medications must be given a concept code that can be recognized by the applications. The medication name, dose, frequency of administration, form, duration, route, and number of refills are essentially always displayed and may or may not be represented in the EHR database by codified or even structured data. Alternative medications, the associated copay, and whether the drug is formulary compliant with the patient's insurance carrier may also be displayed. In most systems, the provider is able to print, fax, or e-prescribe the medications.

The Past Medical History

In the health summary view, this section is a record of all past and current illnesses, hospitalizations, injuries, operations, and other procedures performed on the patient. It may or may not be represented by codified data. The past medical history is closely aligned with the problem list, although they differ in that the problem list is primarily a subset of the past medical history.

Allergies

This section details medication and other allergies (e.g., latex allergies). It may also provide the clinician with information about the severity and nature of the allergic reaction.

Immunization History

This is a chronological record of the patient's immunization status. It may have age-specific content and features along with the ability to order immunizations from this section of the EHR. Alternatively, the immunizations may be contained within a separate module that is not within the health summary container. The immunizations tools generally allow the provider to enter immunization type, date provided, location provided (e.g., upper arm), and lot number. The immunization tools may provide guidance and recommendations tied to the administration of immunizations.

The Family History

This section captures the medical history of relatives of the patient, emphasizing inheritable diseases. This section may or may not contain codified data and may be limited to free text entered into designated fields.

The Social History

This refers to the patient's use or nonuse of alcohol, illicit drugs, tobacco products, and related potentially harmful substances. The frequency and amount of usage are typically recorded for each component. This

section also documents the patient's occupation, marital and family status, living situation, whether there is any high-risk sexual behavior (when relevant), and a number of other data elements. The information may be stored as codified data or free text.

Others

Since this is usually the first screen the clinician will review in a patient's record, a number of other items may be available on the health summary screen or presented in another way. These include the following:

- Recent lab results.
- Recent radiology results.
- Recent diagnostic study results (e.g., an EKG result).
- Recent hospitalizations.
- Pending studies.
- Studies that have been ordered and their status.
- Interventions that are needed for the patient (e.g., mammogram, colonoscopy, immunizations, etc.). This is often considered part of alerts and reminders that may be available from multiple areas of the clinical record.
- A section that addresses communications with the patient or about the patient.
- A summary of highly pertinent information about the patient.

[3]45 CFR Part 170 health information technology: Initial set of standards, implementation specifications, and certification criteria for electronic health record technology; final rule. Accessed on July 30, 2012, from www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17210.pdf.

[4]Holmes, C. (2011). The problem list beyond meaningful use. *Journal of AHIMA*, 82, 32–35

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Workflows vary, with some providers reviewing the health summary information, reason for visit, and vital signs prior to entering the examination room, or more commonly once they enter the examination room and start interacting with the patient. At this point, the provider in a traditional visit will obtain a history, perform an examination, review any additional values, develop an assessment, and formulate a plan. The intake method when using an EHR varies considerably. Many providers will document at least a portion of the encounter while in the room with the patient. This may be done through a mobile device such as a tablet or a fixed workstation. Some providers prefer to take physical or mental notes on paper during the encounter and then enter the information at a workstation in their office, in the hallway, or in an alcove. The use of scribes who shadow providers and enter information into the EHR is another method used by some providers.

EHRs may support the ability to import prior-visit notes or portions of prior-visit notes into the EHR. If used properly, this increases the efficiency of documentation and reminds the provider to address outstanding issues from the previous visit. However, if not used properly, it tends to import information that was either not relevant or not accurate for that visit.

Tip The process of importing visit notes from prior visits to be used as “template” for the current visit is supported by many EHRs; however, if not used carefully, it can lead to inaccurate or even fraudulent documentation and billing. It is important that this capability be used with caution during EHR documentation.

Many electronic health record applications are based upon the guidelines published by the Centers for Medicaid and Medicare Services (CMS) in 1995^[5] and 1997.^[6] The guidelines define several sections of the records that are used to create a progress note or history and physical. The following sections are defined.

The Chief Complaint

This is a brief statement that identifies the primary reason for the patient visit. The definition provided by CMS is as follows: “The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words.”^[7] It often includes demographic and pertinent information such as “The patient is a 44-year-old white male with a history of diabetes and hypertension who presents for blood pressure management.”

The EHR will often have a section of the chart that automates the importation of the demographic information to create a portion of the sentence. The rest of the opening sentence can be created by entering free text or through the use of templates that contain dropdown menus or other methods of choosing the data elements. Often a medical assistant or other nonprovider staff member will complete this section of the note prior to the point where the provider sees the patient.

A similar approach is often used for other sections of the progress note. The EHR may or may not support codified data at this level of documentation. If it does, the codified data may be used to suggest the use of other templates for other sections of the note generation process. For example, the use of the term “hypertension” might be tied to a codified data element that represents hypertension. Templates are used by many EHRs to help with text entry. The EHR would then suggest hypertension-based templates or defaults for that to facilitate the documentation process. One of the features that differentiates EHRs is their approach to template usage, creation, and modifications, because approaches and levels of usability vary widely.

The History of Present Illness (HPI)

This is a more detailed history of the patient's presenting problem and often includes a discussion of chronic diseases when present. It is defined by CMS as follows: "The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present."^[8] The documentation guidelines suggest that the providers obtain at least four of the following eight "HPI elements" regarding the presenting problem: location, duration, severity, quality, timing, context, modifying factors, and associated signs and symptoms. The HPI may or may not have the ability to capture codified data, and if it does, it may be limited to a few concepts that are needed to help with evaluation and management (E&M) coding that will be explained in more detail later in this chapter. The HPI may consist of a brief paragraph or several paragraphs. All relevant subjective information is documented in this section of the record. This is an area of the record where voice recognition is particularly popular given the need for prose that has less predictability than other sections of the record.

Past, Family, and Social History (PFSH)

This section is self-explanatory and basically contains sections of the health summary described earlier reproduced in the progress note. However, in this view, the past medical history tends to include all historical data (e.g., medications, allergies, immunizations, etc.) with the exception of the family and social history, but approaches in EHRs vary. The CMS definition of the PFSH is as follows:

The PFSH consists of a review of three areas: past history (the patient's past experiences with illnesses, operations, injuries and treatments); family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and social history (an age appropriate review of past and current activities).^[9]

Many EHRs will pull relevant information from the health summary and place it in the corresponding section of the progress note. Some systems may require this information to be added manually. In general, the past history includes diseases, injuries, allergies, medications, hospitalizations, and other pertinent historical information other than what is contained within the family and social history sections of the health summary. Modifications to information in this section may or may not update the corresponding fields in the health summary, depending on the EHR's capabilities. The information can be captured as free text or as codified data, depending on the EHR that is being used. The addition of information may be template-driven or free text.

Review of Systems (ROS)

The ROS is typically the next section of the record and often the last section of the historical portion of the progress note. The CMS definition reads as follows: "A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced."^[10]

Body systems include such items as eyes, cardiovascular, and others. Systems often allow the user to use default negatives for this section; here are some examples:

- **General** Denies weight changes, loss of appetite, or fatigue
- **Respiratory** Denies cough, shortness of breath, or wheezing
- **Cardiovascular** Denies chest pain, palpitations, or swelling in extremities

The user may start with negative defaults that can be changed to positives through a dropdown menu of alternative choices stored within templates, through a more hard-coded process, or via free text modifications. Free text can also be used either alone or in conjunction with templates. The symptoms and their positive or negative value may or may not be captured as codified data. To support accurate E&M coding, the tools need to identify which ROS sections contain data and use this as one of the components to determine the overall level of service for the encounter. It is not uncommon for the patient to complete ROS information on a written intake form while they are in the waiting room, and the workflow needs to manage the process of getting this

information into the electronic health record. The medical assistant or provider may take on this role. Some EHRs may allow the patient to enter their own ROS data via a kiosk, patient portal, or the personal health record. In all cases, this information will need to be reviewed by the providers. A mismatch between information captured in the HPI and the ROS is a relatively frequent occurrence that can lead to documentation errors. For example, documenting a history of chest pain in the HPI and accepting default negative including "denies chest pain" in the ROS can occur when defaults are used. For this reason, the use of codified concepts in both the HPI and the ROS may allow the system to recognize when the same concept (e.g., chest pain) is documented in both sections and alert the provider that there is a potential documentation conflict.

The Physical Examination

This section of the record documents findings related to direct observation and inspection of the patient and is normally conducted after the history is obtained. The examination typically contains an evaluation of body systems driven by the nature of presentation and the specialty of the provider.

The first section is usually the vital signs. These values may have been obtained during the triage process by a member of the clinical staff, and this data is then often pulled forward into the vital signs section of the progress note. Alternatively, the vital signs may be obtained by the provider who would then enter or modify data using various tools provided. In addition to the typical vital signs (i.e., weight, height, blood pressure, respiratory rate, BMI, temperature, and pulse), the system may also support the review of growth charts, pulse oximetry, and other information that is typically reviewed at this stage of the encounter. Some systems support interfaces with third-party vitals workstation devices that automate the recording of blood pressure, pulse, and temperature.

Following the vital signs, the provider will observe and inspect body systems and areas that are relevant to the presenting problem or reason for visit. Many EHRs will have prepopulated content that uses templates or fixed fields to document normal and abnormal findings. There are typically a fairly limited number of default normal findings that are documented per body system during a routine visit, such as the following:

Cardiovascular Examination: Auscultation: Regular rate and rhythm, no murmurs, rub, S3 or S4.
Pulses: carotid pulses 2+ without bruits, radial pulses 2+, pedal pulses 2+. No peripheral cyanosis or edema noted.

Each of the previous normal findings could be replaced by one or more abnormal findings identified during the examination. In many instances, there are dozens of abnormal findings that could be documented for each normal finding. Many systems will store the abnormal findings as available choices within a template or another mechanism, allowing them to be selected during the documentation process. The tools should also allow the provider to enter free text and to remove and modify findings as appropriate.

Complex rules exist regarding how physical examination documentation is used to determine the level of service for the encounter for E&M coding purposes that are beyond the scope of this chapter but documented elsewhere.^[11] In general, an EHR system that supports automated E&M coding will need to record what physician examination systems contain findings. The tools need to recognize patterns of documentation that support different levels of service, which range from "problem-focused" to "comprehensive" physical examinations. These are based upon what physical examination systems are documented and, depending on which CMS guidelines are used, how they match to specialty-specific examination types.^[7] Given the complexity of the rules, the ability of an EHR to help the provider determine the level of service based on what is documented in the physical examination section of the record can have significant value. The physical examination concepts captured during documentation may be codified data elements or free text. Many systems support the use of a drawing tool that allows for freehand drawing or template anatomic images that can be drawn upon to aid documentation.

Diagnostic Test Results

Many systems allow for the incorporation of test results in the progress note. This section may reside after the HPI, before or after the physical examination, or as part of the assessment section of the encounter note, but is most often found after the physical examination because, like the physical examination, it is considered to be objective information. It allows for the manual entry or importation of laboratory results, radiology results, and results of other diagnostic studies such as electrocardiograms. The tools may also support interfaces to

radiology images that are stored at another location such as the hospital via a picture archiving and communication system (PACS) interface or those stored within the EHR's database.

The Assessment

The provider utilizes this section of the record to summarize their findings and render diagnoses. They may be entered manually, or the EHR may assist them by suggesting diagnoses based on documentation to that point in the encounter. The provider may add free text manually, use templated text to add diagnoses, or use other tools to create or expand upon a discussion regarding each diagnosis. An example is provided here:

Assessment:

1. Classical Migraine: This is the most likely diagnosis at this time given the family history, age of onset, visual aura, associated nausea and photophobia, and time course. Abortive therapies are indicated at this time, and if this is not effective, prophylactic management will be considered.

The assessment is often codified so that the diagnoses can be passed forward to a billing application. The majority of clinics in the United States submit claims to payers that must first be reviewed by a billing specialist and then forwarded to a clearinghouse. This requires the use of specific codes from the assessment section of the visit tied to the diagnoses or the reason for the visit. Some systems suggest alternative diagnoses to the provider for their consideration. These may be alternative diagnoses they may want to consider or more specific diagnoses that could help with clinical documentation and reimbursement.

The Plan

The provider may elect to discuss management of the condition in the assessment or in the next section referred to as the plan. In general, the plan provides specific actions related to the treatment of the patient. The EHR may support the documentation of the plan through templates or other tools. Many of the plan items consist of orders that require subsequent action and impact workflow in the office.

Laboratory Orders

The clinician may order tests on blood, urine, fluid drained or expressed from a space, stool, or other substances, or the clinician may have obtained these during the encounter. At this point, the workflow needs to support obtaining or packaging the sample and delivering it to the laboratory for analysis. The steps will vary depending on the type of sample and whether the clinic has an in-house laboratory facility. The staff will need to be notified that a lab request is being made. In some clinics, the staff, usually a medical assistant, will obtain or package the sample and then send it to the laboratory. In other situations, the patient will be asked to travel to the laboratory. The EHR may have the capacity to generate an electronic order that can be sent to clinic staff for management of the order or via an interface directly to the laboratory. If there is no outbound ordering interface, the EHR tools may support the creation of a paper requisition that the patient will carry to the laboratory.

Radiology Orders

Some clinics, in particular orthopedic practices, routinely include radiographs as part of their workflow and have on-site radiology capabilities. The image is usually taken while the patient is in the office as a component of the visit. The workflow includes the generation of an order from the EHR, which is then conveyed via a staff member or electronically to the radiology department. The order will need to contain specific information about the radiology study that is requested. Once it has been completed, the image must be returned to the provider. In centers with digital radiology capabilities, this may be handled through the EHR. The provider would be alerted that the image was available for review. For the image to be read by the provider, minimum standards for resolution of the image should be adhered to (DICOM),^[12] and this may require specific hardware and settings. The majority of clinics do not have radiology facilities on-site, and the orders are managed in a process that is similar to laboratory requisitions.

Other Tests

Other diagnostic studies and interventions that are ordered in the plan section may have similar workflows. Some studies and procedures are performed in the clinic during the visit, or they may be scheduled for a subsequent visit. For example, a patient may be scheduled for a cardiac-monitoring study in the same clinic or facility, but it cannot be performed during that visit. The order will need to be transmitted electronically to a

scheduling tool and then scheduled by the staff (or the patient-driven scheduling is supported). Once the patient returns and the test has been performed, the provider who is interpreting the study will need to be alerted that the study is ready for interpretation. In many cases, this requires that an image, video, tracing, or other media be presented to the provider for digital or paper-based review. The interpreting provider will then need to generate a report through a report-generating tool if available in the EHR. A result will need to be generated in the form of a report and then transmitted to the provider who originated the order.

The clinician may also perform or schedule an outpatient procedure (e.g., a skin biopsy). This requires the plan section in the EHR to communicate the necessary information about the patient, their insurance information, and any needed details about the procedure to the person responsible for scheduling.

Medications

Prescriptions are usually generated from the plan section of the EHR using an e-prescribing tool. Even clinics that are not using an EHR often use a stand-alone e-prescribing tool. The e-prescribing requirements for meaningful use are detailed in the Final Rule for stage 1 meaningful use. (The features of an e-prescribing tool were described in the section titled "Electronic Prescribing Applications.") In addition, an e-prescribing application may also suggest medications of equal effectiveness based on cost and whether they are in a specific insurance carrier's formulary. The copay the patient has to pay when they obtain the medication may also be displayed, allowing the provider to warn the patient about the amount they will be expected to pay and potentially allowing the provider to choose an alternative drug of equal efficacy that is lower in cost to the patient.

Use Case 5-1: Using E-prescribing to Avoid Drug-Drug Contraindication

A 40-year-old male with a heart condition was prescribed a drug called Amiodarone to control his heart rhythm. While traveling, he developed a sinus infection and visited an urgent-care facility. The provider prescribed the antibiotic erythromycin for the sinus condition through an EHR with an e-prescribing tool. The e-prescribing tool alerted the provider that the use of Amiodarone and erythromycin together was contraindicated, because it could cause a potentially fatal disturbance of the patient's heart rhythm. The provider then chose a different antibiotic that was not contraindicated. For this to have occurred, the provider's EHR had to be aware that the patient was taking Amiodarone and have access to a drug-drug contraindication database.

Clinics often experience significant gains in efficiency with e-prescribing and in particular the medication refill process. Clinics usually require the patient to call the clinic when requesting a refill and place a request with a clinic staff member. This is then written down and given to the provider once the paper chart is pulled. The provider will need to review the request and create a handwritten prescription or have a staff member call the pharmacy to phone in the prescription. The patient's chart is then refilled by a staff member. With an EHR that includes a portal, many manual processes that involve ancillary staff can be eliminated. A common workflow would be for the patient to enter a medication refill request via the patient portal. This is then transmitted as an automated message to the provider who can review the request in the context of the patient's full medical record. The provider can then create a refill, send it electronically to the pharmacy, and notify the patient of this action through the patient portal. They can also manage the medication request in other ways, such as instructing the patient to come to the clinic for a visit, deny the refill request, or change the patient to a different dose or a different medication.

Immunizations

Immunizations can be ordered from the plan section, from the health summary module, or from an independent immunization module.

Patient Instructions

An important part of the plan includes information that is provided to the patient in the form of instructions and educational materials. This can be addressed through templates with preformatted text, free text, and linkages to third-party educational content that can be provided to the patient. This information is usually printed and given to the patient. The provider may also be able to send information to the patient electronically through a patient portal or a personal health record.

Referrals and Letters

The plan section is also where providers generate referrals to other providers or provide feedback to other caregivers, often in the form of a consult letter. Specialists in particular need to generate letters to referring providers. The EHR may support the ability to message electronically to other providers via an interface, or it

may require the referral or consult letter to be sent via fax or printed and mailed.

Follow-up Appointments

The EHR may allow direct access to the scheduling module, allowing the patient's next visit to be scheduled by the provider, or the tools may allow for a follow-up recommendation to be generated in the plan section and then transferred to the scheduling application, if there is integration or an interface is present between the EHR and the scheduling tool.

Note Conclusion

At this point, the provider has likely completed all the documentation and generated orders and referrals. The EHR may have already identified candidate billing codes for the visit. They will usually consist of the following: disease or reason for encounter codes from the International Classification of Diseases (ICD-9-CM), procedure codes from the Current Procedural Terminology (CPT) code set, and items and services delivered during care from the Healthcare Common Procedure Coding System (HCPCS). Many EHR systems will provide coding assistance, allowing the user to review the suggested codes and making changes as needed. Once approved by the provider, the codes are then sent to the billing (practice management) application electronically. This may occur via an interface if the EHR is not a single-database EHR/practice management software application.

A specific type of coding, referred to as E&M coding and touched on in the section "The History of Present Illness (HPI)," is of particular importance because it represents the majority of revenue generated by ambulatory practices in the United States. E&M codes are a form of CPT codes. They essentially represent the level of complexity or the amount of time spent with the patient, with higher levels or reimbursement tied to more complex encounters. The rules regarding the determination of E&M codes are complex and benefit from the computational assistance provided by EHRs. The majority of providers see an increase in their coding levels and reimbursement after they start using EHRs, and this has led medical insurers to start looking at computer-assisted coding in more detail. Large fines and even criminal charges can result from overcharging government healthcare insurance carriers via inflated E&M coding in particular (Medicare, Medicaid, and others). For this reason, providers need to be fully educated on how to use E&M coding tools provided by EHRs.

To meet stage 1 meaningful use requirements, the provider will need to generate a clinical summary of the visit.^[13] This summary needs to be printed and handed to the patient. This has created some workflow challenges related to the process of generating a printed document after each encounter, because the document contains HIPAA-protected information and most clinics do not have a printer in each examination room.

^[5]Department of Health and Human Services. 45 CFR Part 170, op. cit.

^[6]Documentation guidelines for evaluation and management services. (1995). Accessed in August, 2012, from www.cms.hhs.gov/MLN.pdf.

^[7]Documentation guidelines for evaluation and management services. (1997). Accessed in August, 2012, from www.cms.hhs.gov/MLN.pdf.

^[8]Ibid.

^[9]Ibid.

^[10]Ibid.

^[11]Grider, D. (2011). *The medical record auditor*. AMA Press.

^[12]DICOM standards. Accessed on July 30, 2012, from <http://medical.nema.org/standard.html>.

^[13]CMS meaningful use guidance, core criteria 13: Clinical summaries. Accessed on July 30, 2012, from www.cms.gov/Regulations-and-

Guidance/Legislation/EHRIncentivePrograms/downloads/13_Clinical_Summaries.pdf.

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Chapter 5 - An Overview of Processes Associated with Healthcare Delivery Within Provider Organizations: Focus on the Ambulatory Setting

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Transitions and Coordination of Care and Additional Workflows

An area of significant focus in healthcare is how HIT can support transitions of care between healthcare organizations, such as when the patient is being seen by multiple providers in the community, or when the patient is discharged from the hospital. There are a number of considerations tied to HIT best practices for managing information that have the potential to improve the continuity of patient care.

Document Storage and Messaging

Providers receive information from within the clinic and from outside entities via electronic messages, faxes, and paper. EHRs vary in how they manage this but may provide the ability to capture this information in an electronic form and deliver it the provider. Electronic messages from within the clinic may be managed by applications that function in ways similar to e-mail, including the ability to assign tasks to individuals. Faxes are often managed electronically, and paper records received by the clinic are scanned either before or after they are reviewed by the provider. Much of the information received from external parties needs to be stored in a patient-specific documentation storage tool that may be integrated with the EHR. This may include images, text files in multiple formats, videos, and other formats. These files are then available for review as needed.

Increasingly, information will be shared between healthcare enterprises via health information exchanges. The Direct Model^[14] for health information exchange uses a format that is similar to e-mail to send secure messages between providers. Systems that are able to integrate direct messages into the standard messaging workflow will offer advantages over those that don't. Over time, messages sent via health information exchanges will be standards-based, allowing codified information generated by other EHR applications to be imported into the receiving EHR. A leading example of this is the continuity of care document, an XML-based standard that contains an expansive array of demographic, health summary, and other information about the patient. As standards mature, increasing amounts of codified clinical data will be exchanged between healthcare stakeholders, including the patient. This will present technical challenges related to system design and the preservation of data integrity.

Coordination of Care

This is a central construct of the patient-centered medical home and the accountable-care organizations and is defined as "a function that supports information sharing across providers, patients, types and levels of service, sites and time frames."^[15] A relatively fully functioning EHR and HIE are required for the true coordination of care. Transitions of care, in particular discharges from hospitals and subsequent outpatient management of patients at risk for readmission, are a priority of HIT efforts. The electronic health record, health information exchanges, patient portals, and home-monitoring applications will play an essential role in facilitating interactions between healthcare providers, case managers, and the patients themselves in a manner that will allow more effective outpatient management. The amount of data that will need to be consumed by providers in order to effectively monitor patients is growing rapidly and has created concerns that it may overwhelm providers. Additional healthcare professionals, such as case managers, will likely play a greater role in U.S. healthcare.

Tip Care coordination depends upon relatively seamless access to data across multiple sites of care. This will depend upon a greater level of interoperability between disparate HIT platforms. This in turn is tied to an increase in the level of adoption of standards, many of which are under development.

Clinical Decision Support

The most common form of clinical decision support (CDS) exists in e-prescribing tools. Applications may aid physician decision making by helping them with patient-centric management such as alerting them about when a preventative maintenance study is needed (e.g., a patient is due to have a colonoscopy) while the patient is being seen in the office. They can also aid with population management, such as running a query that demonstrates all patients who are overdue for an immunization based on established guidelines.

Report Generation

Various tools are used to generate clinical and financial reports based on data that has been entered into the system. Examples of these reports include the status of compliance with meaningful use requirements such as the clinical quality measures and general compliance with the core and menu set items. An EHR may have hundreds of preformatted financial and clinical reports that are used to assess a variety of business and clinical measures.

Order Tracking

Practices that order tests have some level of responsibility that they are performed and that the results are returned to the ordering providers. Tests results can be lost, confused with another patient's name, or misfiled before being reviewed by a provider. Order-tracking modules make sure that each test or referral that is ordered by the clinic is tracked. The practice can usually monitor all tests that have been ordered and identify the ones that are overdue, allowing them to investigate the reason.

[14]The direct model. Accessed on July 30, 2012, from <http://wiki.directproject.org/specifications+and+service+descriptions>.

[15]Meaningful measures of care coordination: NCVHS presentation. (2009). Accessed on July 30, 2012, from www.ncvhs.hhs.gov/091013p9.pdf.

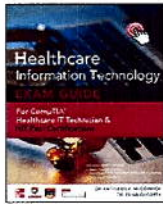
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Chapter Review

This chapter reviewed some fairly common workflows, roles, and documentation requirements related to patient care in an ambulatory setting on an EHR. Providing healthcare in ambulatory settings is dependent upon multiple workflows that vary considerably depending upon the size and the specialty of the practice and on provider preferences. The implementation of HIT in practices can result in substantial improvements in efficiency and can generate additional revenue for the practice, if the tools are used in an effective manner.

The starting point is the scheduling process, which may be performed through a traditional phone call, at the end or the prior visit, or through a patient portal. The data requirements for scheduling a patient include a tool that can capture demographic information in the form of structured data, including insurance information.

Once the patient arrives for the visit, they go through a check-in process that often requires that the patient enter clinical information on paper or via a kiosk or patient portal. This information is then used to complete the health summary portion of the patient's clinical record, including a problem list, current medications, allergies, and the past medical, family, and social history of the patient.

The next step is the clinical encounter and a fairly detailed description of how a visit note is created by the provider. The sections of the note each have unique clinical, functionality, and data requirements. The plan section is by far the most complex section from a workflow standpoint. This is where the majority of the orders are generated.

This chapter also provided a discussion of continuity of care and how the EHR and HIEs are essential for making sure that patients receive care that has continuity. Current efforts are targeting the prevention of unnecessary hospital admissions through better outpatient management of chronic medical conditions.

Questions and Answers

To test your comprehension of the chapter, answer the following questions and then check your answers against the list of correct answers at the end of the chapter.

1. Which of the following is *not* one of the methods commonly used by patients to schedule an appointment to a clinic? ?
 - A. Patient portal
 - B. In person during the prior visit
 - C. Over the phone
 - D. Via their personal e-mail
2. Which of the following is generally *not* considered demographic information? ?
 - A. Age
 - B. Allergies
 - C. Address
 - D. Insurance carrier
3. Which of the following is *not* a component of the health summary component of the EHR?

- A. The history of present illness (HPI) ?
- B. The problem list
- C. Allergies
- D. The medication list
- 4. Which of the following items is *not* true regarding the immunization record? ?
 - A. It is used exclusively for children up to the age of 18.
 - B. It contains a field for the lot number of the immunization used.
 - C. It provides a chronological history of immunizations that have previously been provided.
 - D. It allows for the site of administration to be documented.
- 5. Which of the following statements is *not* true regarding the problem list in the health summary component of an EHR? ?
 - A. It contains currently active diseases.
 - B. For meaningful use stage 1 EHR certification, the problem list items must be codified using ICD-9-CM or SNOMED CT.
 - C. It contains pending orders.
 - D. It can be edited.
- 6. Which of the following statements is *not* true regarding patient clinical data entry? ?
 - A. Patients often fill out intake forms on paper that are later added to the EHR by a clinic staff member.
 - B. Patients may access tools that allow them to enter clinical information through a patient portal, a personal health record, or a kiosk in the waiting room.
 - C. Patients may enter information related to their past medical history including allergies, current medications, and the reason they are requesting a visit.
 - D. Patient-entered clinical information helps improve the efficiency of the data entry process, because it allows the clinical staff to defer reviewing it until the patient arrives for the visit.
- 7. Which of the following statements is true regarding the social history? ?
 - A. It contains details about the patient's family structure and living conditions.
 - B. It contains demographic information such as addresses and phone numbers.
 - C. It contains the patient's prior history of medical conditions.
 - D. It contains the same information as the family history.
- 8. Which of the following statements is *not* true? ?
 - A. The number of providers who are using EHRs in the United States in ambulatory settings was less than 20 percent in 2006 but now exceeds 50 percent.
 - B. The rapid increase in adoption of EHRs and related technologies has created a strain on available resources that have the technical skills to manage EHR implementations and support.
 - C. Standards that allow for seamless interoperability between healthcare organizations have been implemented throughout the United States.
 - D. The current trend is to move toward greater levels of codification of clinical concepts in EHRs.
- 9. Which statement regarding the chief complaint section of the encounter note is *not* accurate?

- A. It may contain the reason for visit in the patient's own words. ?
- B. It may contain demographic information about the patient.
- C. It is often used to record a detailed history of the patient medical problems, complaints, associated signs and symptoms, and prior responses to treatment.
- D. It may be template-driven and include codified data.
- 10. Which statement regarding the history of present illness (HPI) is *not* accurate? ?
 - A. Guidelines published by the Centers for Medicaid and Medicare provide specific details regarding what information should be captured in this section of the encounter note.
 - B. HPI documentation may be assisted by the use of templates that provide dropdown menus (and other formats).
 - C. The HPI is not used to document responses to prior treatments.
 - D. The HPI is one of the sections of the record that is used to determine the overall level of service and E&M code for the visit.
- 11. Which of the following statements about the physical examination section of the encounter note is *not* accurate? ?
 - A. The amount of content stored within EHR templates that record the physical examination findings is relatively low compared to other sections of the encounter note.
 - B. The rules regarding how to determine the level of service (E&M) coding within EHRs based on what is documented in the physical examination are complex and benefit from computer-assisted coding tools.
 - C. The information captured in the EHR varies markedly between specialties of medicine.
 - D. The physical examination may contain codified data, in particular data elements that support the calculation of E&M coding.
- 12. Which one of the following items is *not* typically a component of the plan section of the encounter note? ?
 - A. The assessment
 - B. Medication orders
 - C. Radiology orders
 - D. Patient instructions
- 13. Which of the following statements is most accurate? ?
 - A. Workflows within ambulatory practices tend to be relatively standard with low levels of variability between practices, regardless of their size or specialty.
 - B. Practices frequently combine paper documentation processes with electronic documentation, resulting in a hybrid form of EHR implementation.
 - C. Pulling notes forward from prior encounters and using them as templates for the current visit need to be performed carefully to avoid inaccurate or even fraudulent documentation.
 - D. The EHR may have an interface to a PACS radiology service, but diagnostic interpretation of images should be performed on DICOM standard-compliant equipment.
- 14. Which of the following is *not* accurate regarding continuity of care? ?
 - A. Continuity of care efforts focus on patient care activities that are limited to the practice site.
 - B. Health information exchange is a key requirement needed for continuity of care efforts to be successful.

- C. Continuity of care efforts strive to prevent patients from being admitted to the hospital when it otherwise could have been prevented.
- D. The continuity of care document allows for key clinical information to be shared between healthcare organizations.

15. Which of the following statements is *not* accurate?

?

- A. Order tracking is an important consideration in the workflow of any practice, because test results that are positive and not returned to the practice or otherwise mishandled can lead to significant patient safety issues.
- B. Clinical EHR workflows may need to be customized for the practice, for the specialty, and for the level of sophistication of the users.
- C. Full EHR implementations are unlikely to result in significant changes in revenue for a practice.
- D. Mobile devices, including tablets and custom applications, are making significant inroads into clinical medicine.

Answers

1. **D.** The use of personal e-mail is generally not used to schedule patient visits for privacy and security reasons. The other three methods are used commonly, with the convenience of online scheduling through the patient portal gaining in popularity in recent years.
2. **B.** Allergies are generally not considered demographic information, which is used to capture the patient's age, race, address, contact information, insurance carrier, primary-care providers, and other relevant nonclinical information about the patient. Allergies are a component of the clinical data that is obtained on the patient, typically with a health summary module.
3. **A.** The health summary section of the EHR, which may also be called the *face sheet* or by another name, contains a problem list, allergies, past medical history, past family history, and social history among other components. It does not include the history of present illness, which is a component of the encounter note.
4. **A.** Immunizations are an important component of adult medicine, including a record of vaccinations against tetanus, meningitis, pertussis, pneumococcal pneumonia, and a number of different infectious diseases.
5. **C.** The problem list contains disease entities that need to be have codified data, as per stage 1 meaningful use requirements. It does not contain orders that are pending for the patient.
6. **D.** Patients may enter urgent symptoms that require emergent evaluations, and they may not be scheduled to be seen for several days. It is important that clinical staff review any patient-reported histories within a reasonable time frame so that no delays in recommending a intervention (e.g., telling the patient to call 911) will occur.
7. **A.** The social history records the patient's substance use, employment, social habits, family status, and living situation (e.g., lives at home with wife and two children, ages 3 and 1).
8. **C.** Standards that would allow for true interoperability are not in place in most of the United States, and this is an area of focus in HIT at this writing.
9. **C.** The history of present illness (HPI) is used to capture a detailed history from the patient and from other sources.
10. **C.** The HPI is where responses to prior treatments are typically documented.
11. **A.** The amount of clinical content needed to support the numerous normal and abnormal physical findings that may be present on any given examination is large, making the physical examination section of templates one of the more content-intensive components of an EHR application.
12. **A.** The assessment is a separate section of documentation that usually immediately precedes the plan and is where the diagnoses are recorded and discussed.
13. **A.** Workflows vary markedly between practices based on their size, specialty, level of experience with EHRs, and level of motivation of the providers.
14. **A.** Continuity of care refers to the overall management of the patient regardless of the practice setting, so it is not clinic-centric but rather healthcare community-centric.

15. C. A full implementation of an EHR tends to increase per provider revenues significantly based on improved coding accuracy, better charge capture, and improvements in efficiency.

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Chapter 6: An Overview of Processes Associated with Healthcare Payment Within Ambulatory Provider Organizations

Robert M. Tennant

In this chapter, you will learn how to

- Understand the business of a physician practice
- Identify the main ways to derive revenue
- Define the claims revenue cycle
- Recognize the standards and regulatory requirements necessary in a physician practice
- Define the steps in the claims revenue cycle
- Understand the resources necessary to maximize revenue including staff and health information technology

A physician practice is a business. For that business to continue to treat patients, it must generate revenue. The majority of this revenue is derived from contracts for professional services with government and commercial health plans and the patients themselves. However, to receive these payments, the practice must navigate a complex process known as the *claims revenue cycle*. Successful practices are those that understand the intricacies of this process, understand the intersection of government standards and requirements, utilize staff expertise, and leverage health information technology (HIT) to maximize revenue.

In recent years, much of the attention in the HIT environment has been focused on its ability to improve the clinical care provided to patients. At the same time, however, federal standardization efforts combined with practice adoption of HIT can produce significant efficiencies in the administration of patient care in physician practices. This chapter will outline the physician practice claims revenue cycle and how standards and automation are helping to streamline healthcare administration.

Foundational Standards Impacting the Claims Revenue Cycle

The movement toward automating the claims revenue cycle dates back to the inclusion of Subtitle F of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA named certain types of organizations as covered entities, including health plans, healthcare clearinghouses, and certain healthcare providers, and required them to adopt a wide range of administrative simplification standards as well as new privacy and security requirements. Of particular relevance to the claims revenue cycle, HIPAA required the issuance of regulations to create standard transactions for electronic data interchange of healthcare data. The transactions named in HIPAA that impact physician practices (and their X12N numeric designation) include the following:

- Eligibility for a Health Plan Inquiry/Response (270/271)
- Health Care Claim (837)
- Health Care Claim Status Request/Notification (276/277)

- Referral Certification and Authorization (278)
- Health Care Claim Payment/Remittance Advice (835)

Tip If a physician practice or other covered entity conducts any one of the HIPAA transactions electronically, they must use the adopted standard and must adhere to the content and format requirements of each transaction.

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ACA Administrative Simplification Provisions

The Patient Protection and Affordable Care Act (ACA) of 2010 included a number of provisions that will directly impact the claims revenue cycle. Written to improve on the standards originally mandated under HIPAA and to accelerate a number of provisions of HIPAA that were never promulgated, Section 1104 of the ACA requires the adoption and regular updating of a number of critical standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purposes of financial and administrative transactions.

Operating Rules

Although the implementation of the X12N 4010 A1 version of the HIPAA 837 claim standard in 2004 was expected to significantly improve automation of the claims revenue cycle, the design of the transaction standards permitted considerable variance in how health plans interpreted the data content requirements. Because of this variance, health plans created in excess of 1,000 “versions” of the one standard through publication of proprietary “companion” implementation guides. As a result, physician practices encountered continued challenges and additional cost in conducting each of the HIPAA electronic transactions. In 2006, the Council for Affordable Quality Healthcare (CAQH) created the Committee on Operating Rules for Information Exchange (CORE) to develop voluntary operating rules (business process standards) to help address the variation in health plan standards interpretation and to enhance the functionality of the HIPAA standards. Eligibility verification and claim status were the first two sets of operating rules developed by CORE.

Note These operating rules build on the existing standards to make the HIPAA transactions more predictable and consistent. CORE issued operating rules that included the identification of the rights and responsibilities of all parties in the transaction, security requirements, transmission standards and formats, response time standards, and specific data content requirements critical to practices such as establishing patient financial responsibility in real time. Due in part to their voluntary nature, these operating rules were not embraced by all HIPAA covered entities and their supporting vendors.

The ACA transforms these operating rules from voluntary to mandatory for health plans. Defining operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications,” the ACA set specific timetables for the implementation of operating rules not just for insurance eligibility verification and claim status but for the other HIPAA standards and electronic fund transfer (EFT) as well.

Note The ACA requires the establishment of a standard for an electronic fund transfer transaction that is effective no later than January 1, 2014, and requires the development of a standard and single set of operating rules for electronic health claim attachments no later than January 1, 2014.

National Identifiers

HIPAA mandated the implementation of a number of national identification numbers for use in the HIPAA administrative transactions to make the claims revenue cycle more efficient. (HIPAA also mandated the development and implementation of a standardized national patient identifier. Because of privacy concerns, Congress has prohibited HHS from developing this identifier.) The current HIPAA national-identified mandates for use in the HIPAA administrative transactions include the following:

- **Employer identification number (EIN)** The EIN, issued by the Internal Revenue Service, was selected as the identifier for employers and was effective in 2002.
- **National provider identifier (NPI)** The NPI is a unique identification number for covered healthcare providers mandated for use in 2005. The law requires that all covered healthcare entities must use NPIs in all the administrative and financial transactions adopted under HIPAA. The NPI is a ten-digit number with no intelligence (i.e., the number does not contain information about the healthcare provider, such as the state in which they live or their medical specialty). The Centers for Medicare and Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign standard, unique identifiers to healthcare providers.

Tip Practices can access the NPPES to assign an NPI to a provider, maintain and update the information about the practice's providers, or locate the NPI for another provider for a referral transaction.

There are two categories of healthcare providers for NPI enumeration purposes. Type 1 providers are *individual providers* who render healthcare (e.g., physicians, dentists, and nurses). Sole proprietors and sole proprietorships are Type 1 (individual) providers. *Organization healthcare providers* (e.g., practices, hospitals, home health agencies, and ambulance companies) are considered Type 2 (organization) providers. Type 1 NPIs are assigned to providers one time regardless of whether the provider changes location or specialty. Practices typically will also have the organization itself receive a Type 2 NPI. Note that a practice may determine that its business needs require multiple Type 2 NPIs. These "subpart" Type 2 NPIs most commonly apply to practices that provide different types of healthcare or have separate physical locations where healthcare is offered.

- **Health plan identifier (HPID)** It has been long recognized that clear identification of the health plan in the claims revenue cycle is critical to reducing administrative burden for physician practices and others. In recognition of this need, HPID regulations were originally mandated in HIPAA but supporting regulations were never issued by CMS. As a result, the HPID was again mandated in Section 1104 of the ACA. On September 5, 2012, CMS published a Final Rule adopting the HPID for health plans. As with the NPI, the HPID will be assigned to health plans by the NPPES. As well, similar to the NPI subparts described above, this rule allows for Health Plans to have more than one HPID. A "controlling health plan" *must* obtain an HPID for itself and *may* obtain an HPID for a subhealth plan of the controlling health plan or direct the subhealth plan to obtain an HPID from the NPPES.

Tip In general, if any of these separate locations conducts any HIPAA-standard transactions on its own (e.g., billing separately from the parent organization), it then must obtain and use its own Type 2 NPI.

In an effort to accommodate those entities who are not eligible for an HPID but perform certain healthcare functions (i.e., clearinghouses), CMS also adopted an Other Entity Identifier (OEID). The OEID will also be assigned by the NPPES. An "other entity" may obtain an OEID if it needs to be identified in one or more of the HIPAA electronic transactions, is not eligible for an HPID or NPI, and is not an individual.

Note It is hoped that implementation of the HPID and OEID will enable a higher level of automation for practices, particularly for the processing of billing and insurance-related tasks, eligibility responses from health plans, and complete descriptions of healthcare claim payments.

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Healthcare Information Technology Exam Guide for CompTIA Healthcare IT Technician and HIT Pro Certifications

by Kathleen A. McCormick and Brian Gugerty

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Practice Management System Software

Practice management system software (PMSS) is used in the physician practice to record and manage patient registration information, including demographics and insurance coverage, and to conduct patient billing and collections as well as potentially a wide variety of other operational functions. PMSS systems vary widely in their functionalities; some software is billing-specific, while other software incorporates other practices operations such as patient scheduling and registration. The most comprehensive software automates virtually all of the key practice functions and leverages the numerous HIPAA and ACA electronic transaction standards and operating rules. In addition, the more comprehensive PMSS systems can maintain large amounts of data as well as track and issue reports based on these data. Medical code sets, health plan-specific payment policies, and a list of referral physicians are typical of the types of data maintained by a PMSS.

In addition to the traditional client-server PMSS approach, practices now have another option. Application service provider (ASP) software, hosted on the vendor's web site, has become a popular option for many practices. The monthly-fee ASP model offers the benefit of not relying on the vendor to update server-based software, and in some cases the ASP approach reduces practice cost by eliminating the need for up-front costs to purchase PMSS software. These Internet-based solutions can facilitate practice access to health plan online patient eligibility verification and authorization systems and real-time claims payment systems. Security can also be enhanced, because the vendor remotely backs up all practice data on a regular basis.

Tip Some ASP-based systems have the capability of evaluating claims based on health plan contract terms, fee schedules, and payment policies, while taking into account variables that impact reimbursement, such as site-of-service differentials and edits due to services being "bundled" for payment purposes. This approach can decrease many of the expenses related to compiling and sending billing statements.

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The Claims Revenue Cycle

The claims revenue cycle can be defined as all administrative and clinical functions that contribute to the capture, management, and collection of revenue for patient services. This cycle starts even before the patient arrives and ends only when all charges are accounted for. Efficiently and effectively managing this revenue cycle is a critical component of a successful physician practice.

Patient Scheduling

The first step in the claims revenue cycle is to set an appointment for the patient to be seen in the practice. While many organizations employ a manual approach involving sometimes multiple staff answering telephones, others have moved to a more automated process.

Automating patient scheduling permits the practice to take advantage of the information being provided by the patient. For example, receiving demographic and insurance information online and in advance of the appointment allows the practice to prepopulate the PMSS in order to run an insurance eligibility verification transaction and identify the patient's financial responsibility prior to the actual visit. Some PMSS products provide a direct linkage to the billing system, ensuring that all patient financial charges are captured in the system.

Integrated into the practice workflow, preregistration, preferably occurring at least a week in advance of the appointment, can be completed manually through the mailing of forms to the patient or via the practice web site, should the organization have that capability.

Patient Intake

Practices take a number of different approaches to patient intake. For new patients, typically the office will e-mail or mail a set of forms for the patient to complete prior to their first visit. Some practices have incorporated increased web site functionality and include downloadable forms on their web site for patients to print, while others have the capability for the patient to complete these forms and submit them online through the practice's web site.

These forms include demographic data, family history, previous medical history including allergies and medications, and insurance information. This is particularly true for primary-care organizations and some specialties. Established patients, depending on the length of time between visits, may also be asked to submit these forms again to ensure that their information is up-to-date.

Note Medical specialties other than primary care may forgo much of the patient history if it has no relevance to the medical issue bringing the patient to the office.

The practice is also required to provide a Notice of Privacy Policies and Procedures (NPP) to all patients and have the patient sign an acknowledgment of receipt of the NPP. This NPP is to be given to patients when first seen in the practice and rewritten and redistributed to all patients upon request should there be material change to the practice's policies (i.e., adoption of an electronic health record [EHR] or participation in a local health information exchange). In addition, the practice must post the NPP in a clear and prominent location in the facility and on the organization's web site, if it has one.

Patient Identification Cards

Health plans commonly issue beneficiary identification (ID) cards that can aid in the intake process. Practices will often request the ID card each time the patient is seen by the practice to ensure that the patient has not switched health plans or has an expired card. There is a distinct lack of automation in the area of patient ID cards, with most practices copying or scanning these ID cards. Once the card is copied, practice staff then must enter the insurance data into the PMSS. This manual data entry process can lead to keystroke errors, which results in the claim being rejected by the health plan. This claim must be reworked to identify the error and resubmitted for payment.

Patient ID cards currently in use today have no mandated federal standards to rely on for format or content and most have no machine-readable elements. Many cards are inconsistently designed and feature photos, illustrations, and dark backgrounds that make legible photocopying difficult.

Use Case 6-1: Installing a Kiosk to Streamline the Intake Process

The Medical Group Management Association has identified significant costs associated with using a nonstandard, non-machine-readable patient ID card. The waste attributed to the additional time required to register the patient with a nonstandard ID card at the time of service at the practice as well as the staff time spent to correct errors and resubmit claims that have been rejected because of incorrect patient demographics in practices without card readers is estimated to be more than \$2.2 billion a year.^[1]

While typically it is the practice patient registration staff that handles intake, more advanced practices have started installing registration kiosks as a convenient method of streamlining the intake process for both the practice and the patient. While the functionality of the kiosk varies depending on the vendor, these kiosks can often capture demographic, medical, and insurance data as well as scan identification cards and even process payments for copayments and deductibles.

Note The hope is that an increasing number of health plans will issue machine-readable cards to their beneficiaries. Machine-readable cards, linked to the practice's computer systems via a card reader, would lead to automatic, accurate, and cost-effective collection of patient information with the simple swipe of a magnetic stripe or scan of a bar code.

Insurance Eligibility Verification

Verifying patients' insurance eligibility and establishing patient financial responsibility are critical parts of the claims revenue cycle and, if not completed properly, can result in a significant number of claim resubmissions. For many practices, verifying patient insurance eligibility is often a manual process that can involve multiple phone calls and visits to health plan web sites. However, new standards and the related operating rules described earlier in this chapter offer the promise of a significantly streamlined insurance eligibility verification process.

Prescreening a patient's insurance eligibility will determine the patient's financial responsibility and should be completed for all patients. Some practices have the check-in staff ask the patient whether their insurance has changed since they have last been to the practice. However, should the patient forget that their employer changed health plans or if the coverage has lapsed, the result could be a denied claim. With certain health plans, Medicare being a good example, eligibility verification can be conducted on a yearly basis. The exception, of course, is if the practice will be performing a non-routine service. In these cases, even for Medicare patients, eligibility should be determined prior to every service rendered. By determining what the health plan will cover and what it will not, the practice can significantly decrease the number of denied claims because of lack of insurance coverage.

The purpose of determining in advance, or at a minimum at the time of service, insurance eligibility verification is to decrease claim denials, resubmissions, and outstanding patient balances. Once the patient has left the practice, getting those unpaid balances becomes more difficult and costs the practice more money.

It is clear that determining insurance eligibility for all of your patients who are enrolled in one type of health plan product or another adds a layer of complexity to the practice workflow. This complexity increases as the number of health plan products the practice contracts with also increases. However, the investment the practice makes in incorporating the necessary technology and staff training to conduct eligibility verification transactions, especially the leveraging of the HIPAA standards and CORE operating rules, offers a significant payoff.

For many practices, eligibility verification is conducted via the phone through a health plan's automated voice response system or via the health plan's web site. With this approach, the practice enters the patient's health plan identification number and receives the appropriate voice or web response. While this approach can be effective for a small number of patient eligibility verifications, it remains cumbersome and labor intensive.

Tip Prior to deciding to invest in the practice management system technology that has comprehensive and automated eligibility verification capability, practices should perform the following calculation. Compare the cost of the technology to the cost for the practice for the staff time required to rework and resubmit denied claims, send patients letters and follow-up communications regarding delinquent accounts, process bad-debt information, engage with one or more collection agencies, and determine how much bad debt the practice was forced to write off.

With the appropriate technology in place, practice staff has the ability to check eligibility at multiple points, including pre-arrival, check-in, and charge entry. This realtime eligibility and benefits verification functionality combined with the claims valuation engine often incorporated into the PMSS technology (or offered on the health plan's web site) permits the practice to calculate the patient's financial responsibility before or at the time of service.

Adding to the efficiency, comprehensive PMSS systems can automatically generate an estimate of the patient's out-of-pocket financial obligations after determining the health plan allowance and applying any remaining deductibles or coinsurance. Armed with this information, practice staff can advise patients of amounts due prior to procedures and collect prepayments. Because patient estimates will be more accurate, the number of patient refunds and resubmission of claims will be reduced.

Tip Not only will identifying patient financial responsibility up front capture payments efficiently and reduce the need for back-end patient collections, but it can also enhance patient satisfaction. Providing patients with service estimates based on their latest deductible, coinsurance, and benefits information improves the provider-patient relationship, while helping the group maximize cash flow and minimize payment delays.

Changes to Patient Insurance Coverage

A persistent challenge in the claims revenue cycle is the process by which a patient's insurance coverage changes. For practices to receive notification of a change in a health plan enrollee's eligibility status, the enrollee's employer must notify the health plan, which, in turn, must notify the practice. Some employer-health plan contracts stipulate a reporting often on the first or last day of the month. A problem occurs when some employers do not notify their health plans of benefit status changes for days, weeks, or even longer. A health plan, in turn, may not notify the practice until weeks after receiving this information from the employer. Further, it is not uncommon for patients who change jobs or health plans to neglect to inform the practice.

As a result, after "successfully" verifying insurance coverage, the practice provides medical services to plan beneficiaries but who are later deemed by the health plan as no longer eligible to receive health plan benefits. Claims submitted for payment will thus be denied.

Use Case 6-2: Designing an Effective Eligibility Verification Workflow

Town Center Primary Care Clinic (TCPCC) determined that insurance eligibility was a critical component of the claims revenue cycle. Critical goals of the practice include preventing the organization from providing services to ineligible health plan enrollees and minimizing denied claims and resubmissions. TCPCC implemented the following workflow process to ensure patient eligibility for services:

1. **Process the patient's insurance card** In the past, TCPCC patient intake staff photocopied every patient's insurance card (front and back) on every visit, not just new patient visits. They then moved away from this manual process and incorporated scanning capabilities (again, front and back of the card), capturing this information directly into their PMSS. Staff also ensures that the card's expiration date has not passed. With more and more of their contracted health plans now offering machine-readable patient identification cards, TCPCC purchased a swipe terminal that permits them to read and download demographic and insurance information directly into their PMSS.

Note Other health plans are making these cards available to patients on the plan's web site for downloading and printing. Still other health plans are e-mailing "virtual" patient identification

cards for use on smart-phones and other mobile devices. If possible, the practice should be able to take advantage of each of these options.

2. **Communicate with the patient** TCPCC takes the opportunity when patients call or e-mail to make appointments or when the practice confirms the appointments to inquire about the status of their insurance coverage. This alerts the practice ahead of time if there has been any change in coverage status.
3. **Correctly integrate data into the PMSS** Most importantly, TCPCC staff ensures that the patient's demographic and insurance information is correctly integrated into the PMSS. This takes additional staff time but pays off nicely for the practice with a reduced number of denied claims.

Note It is not uncommon for practices to experience rejected claims because of incorrect demographic or insurance information improperly transcribed for the patient identification card or a photocopy of the card. MGMA estimates that about 5 percent of rejected claims are due to errors in the demographic information or the health plan enrollee/member number.^[2]

4. **Review capitation lists** TCPCC contracts with a number of health plans under a capitation arrangement. TCPCC regularly receives capitation lists from these health plans and reviews them immediately and carefully. If the patient's name does not appear on the capitation list, TCPCC staff confirms coverage through some other eligibility verification approach.
5. **Leverage the 270/271 HIPAA transactions and supporting operating rules** TCPCC has determined that implementing HIT and fully automating its practice patient eligibility verification process has resulted in significant administrative efficiencies. TCPCC staffs have found that whether they are generating a single eligibility transaction at the time of service or conducting a "batch" transaction the day before with multiple patients, automating the process has resulted in a significant improvement to the practice's cash flow by establishing insurance coverage and patient financial responsibility before or at the time of service. While not all the health plans that contract with TCPCC offer a standardized, real-time eligibility verification option, the practice takes full advantage of those plans that do.

The most appropriate approach to this issue is to address it effectively well in advance. Health plan contracts should clearly stipulate that the health plan is responsible for absorbing these types of losses or, at a minimum, will share the financial responsibility with the practice. In addition, eligibility verifications should be conducted for every patient. Finally, the contract should include language that describes the procedure in place and the process to contact those ineligible patients for whom the health plan will not pay and collect the outstanding balance.

Verifying patient eligibility takes significant practice staff time and effort on the front end of the process. However, utilizing a robust eligibility verification approach at this stage will result in considerable efficiency and cost savings on the back end of the process.

Medical Coding

Clinicians are paid for their professional services based on the documentation of the patient encounter. This documentation forms the basis of the two codes typically required for payment. Licensed by the American Medical Association (AMA), Current Procedural Terminology (CPT) codes describe the services and procedures performed by the clinician and are most often used as the basis for individual patient claims and provider-health plan contracts. There are three categories of CPT codes: physician procedures and services, performance management, and emerging technologies. CPT codes are five digits long, with category 1 codes numeric and category 2 and 3 codes alphanumeric with a letter in the last field.

The AMA has also developed a number of modifier codes that can be added to CPT codes to permit a better definition of the services provided by the clinician. These two-digit numeric or alpha codes are generally employed if the provider service was increased or decreased or when site-of-service on the patient (i.e., that it was the left hand that sustained the injury and was treated) identification is warranted.

Tip The use of modifier codes is not standardized, with some health plans requiring them in certain circumstances and others refusing to pay claims that include modifier codes.

CMS created an additional set of procedure codes in 1978 known as the Healthcare Common Procedure Coding System (HCPCS). HCPCS Level 1 codes are CPT codes, and Level 2 HCPCS codes describe products, equipment, and supply codes (i.e., durable medical equipment such as crutches and ambulance services).

Created by the World Health Organization and modified for use in the United States by the Center for Health Statistics and CMS, the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes are used on the claim to identify the diagnosis. Selecting the appropriate diagnosis code takes considerable expertise, and having expert coders on staff or on contract is extremely important to ensure accurate claims submission.

Note On September 5, 2012, CMS published a Final Rule requiring all covered entities to use the latest revision, ICD-10-CM, in all healthcare transactions by October 1, 2014.

Moving to ICD-10-CM is expected to add considerable complexity to the billing process and require significant reengineering of practice workflow. Currently, there are more than 13,000 ICD-9-CM numeric codes divided into categories of diagnoses, moving to more than 68,000 alphanumeric codes with ICD-10-CM. To prepare for this change, physician practices will need to complete an internal review of all IT systems and workflow processes that use ICD-9-CM, upgrade or replace all software that utilize these codes, and provide ICD-10-CM training for all clinical and administrative staff impacted by this new code set.

Claims Submission

Practices employ a number of approaches to submitting and resubmitting claims for payment. Some smaller practices send health plans the CMS-1500 paper directly, while others utilize a clearinghouse for this purpose. Clearinghouses typically convert the CMS-1500 into the 5010 version of the 837 HIPAA electronic transactions standard prior to sending it to the appropriate health plan for payment. Other practices, typically larger organizations with robust HIT, have the ability to send their 837s directly to the health plans. The use of clearinghouses by practices, particularly small to medium-sized organizations, is necessitated by the lack of comprehensive PMSS in the practice and the fact that health plans have adapted proprietary interpretations of "required" and "situational" data elements on the 837 electronic claim. Clearinghouses can also offer practices additional services to assist in streamlining the claims revenue cycle.

Practices can also employ what is known as *scrubbing* software. Scrubbing software is added to PMSS and permits the practice to apply pre-adjudication edits to the claims to identify and correct any problems prior to submission. At a minimum, scrubbing software can incorporate edits derived from diagnosis and procedure code denial data provided by health plans. However, as technology has improved, the software can also incorporate medical necessity and bundling edits and health plan medical coverage and review policy. As health plan payment policies change regularly, to be most effective scrubbing software must be updated at least quarterly.

Real-Time Claims Adjudication (Negotiations Toward Settlement)

A number of health plans offer practices the option of real-time claims adjudication (RTCA), allowing for the billing of services at the time the patient is in the practice. With the appropriate software in place or access to the health plan's web site, the practice not only can bill for the service while the patient is in the office but also can receive an estimated payment and, most importantly, a detailed account of the patient's financial responsibility. At the same time, RTCA presents certain challenges for practices to implement. Charge data must be ready at the time of patient service, and practice staff must manually key in the claims data to the software or appropriate web site. From a workflow perspective, conducting RTCA is challenging because staff must focus more on "front-end" billing requirements and less on "back-end" processes.

Tip Because not all health plans offer this as an option and even the ones that do offer the service may not adjudicate more complex patient encounters, at this point RTCA may be best suited for submitting small numbers of "simple" claims.

^[1]Swipe it home. Accessed on September 15, 2012, from www.mgma.com/swipeithome.

^[2]Swipe it waste. Accessed on September 15, 2012, from www.mgma.com/swipeitwaste.

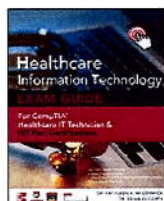
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Payments and Denial Management

Physician practices contract with health plans to receive payment for providing patient services. The process of receiving and processing that payment is complex even in the best-run practices, and successful management of this area of the claims revenue cycle is vital to the financial viability of the organization.

Explanation of Benefits/Remittance Advice

If the practice does not have the capability of accepting an explanation of benefits (EOB) or remittance advice (RA) from health plans in an electronic format, typically then the EOB/RA is mailed to the practice along with the check. Staff must then manually record the payment.

Although the practice may “charge” the health plan a certain amount for a patient encounter, the health plan may apply an edit or payment discount. Plans will cite a number of reasons for the reduced payment amount including that the patient portion of the bill is higher and the practice must recover the additional funds from them, that another health plan (known as a *secondary payer*) provides health insurance for the patient and payment is due from them, or that the practice–health plan contract stipulates a lower amount. Practice billing staff should enter all health plan payments and adjustments as soon as the payments come in so that secondary claims can be filed in a timely manner. For example, some married couples have coverage from both of their employers, or a Medicare recipient has a supplemental coverage. Accurate posting also provides the practice with current status on patient balances and insurance balances, which is critical in order to appropriately manage cash flow.

In some cases, the EOB/RA will not include a payment because the claim has been denied by the health plan. There are numerous potential reasons for a claim to be denied, including that the health plan has imposed a noncontractual adjustment to the claim. The problem could be either on the health plan side or on the practice side. For instance, there could have been errors in the registration process, the practice may have submitted the claim past the filing deadline, there was a lack of authorization (or appropriate referral), the service performed was not a covered benefit, or the service was deemed “not medically necessary” by the health plan.

Once the claim has been adjudicated, the health plan sends an EOB/RA back to the provider detailing what the health plan paid for and how much they paid. The 835 HIPAA transaction is the electronic version of the paper remittance advice (ERA). The 835 contains an explanation of claims payments, claims denials, and other financial information necessary for practices to reconcile patient accounts. To assist in explaining the payment amount, health plans include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) on the ERA. The CARCs and RARCs identify standard reasons why the payment may be different from the charge submitted by the practice. CARCs and RARCs are mandated by HIPAA, and the code definitions cannot be changed by any health plan. In general, CARC definitions tend to be generic, while RARC definitions provide more information related to adjudication of the claim. HIPAA requires that for every five CARCs displayed on the 835 ERA, at least one RARC must be returned as well to provide clearer information when claim payments are reduced or denied.

In many instances, practices have the ability to correct simple errors on the claim and resubmit or lodge a formal appeal of the claim denial. In the case of the former, the practice must implement a workflow process to identify and correct the problem and resubmit the claim for payment. Typically, these “simple” problems include such issues as the health plan subscriber identification number is incorrect or missing, the ICD-9-CM diagnosis code is not identified to the level required by the health plan, the claim contains insufficient documentation to support adjudication, or the subscriber’s name used on the claim does not match the information in the health plan’s system.

Denial Management Software

Denial management software can be extremely helpful for the practice to manage this portion of the claims revenue cycle. Under normal circumstances, the percentage of claims denied by health plans should be quite low. Denial management software can track statistics such as the following:

- Percentage of claims denied by health plan and resubmitted (by health plan)
- Most common reasons for denials by health plan
- Percentage and amounts of claims ultimately paid by plans and percentage written off

Once the practice has implemented denial management software and the appropriate workflow, the task for the practice is to identify the reasons for the denial, correct the individual claim issues, resubmit for payment, and also identify and correct any systemic and potential health plan-specific issues that are causing claims to be denied.

Electronic Funds Transfer

Electronic funds transfer offers an excellent opportunity for a practice to automate a manual process and achieve significant efficiencies. In many practices today, payment is received from the health plan in the mail, and administrative staff members copy the check, manually post the information, and then take time out during the workday to go to the bank to make the deposits. As the workplace has embraced direct deposit of pay checks, healthcare is now moving toward broader use of EFT, although the lack of standards and uniform business rules has slowed wide-scale adoption. The government has recently made efforts to require health plans to implement a series of standards to significantly increase the number of physician practices accepting EFT payments.

Tip The requirement that health plans adopt EFT standards and associated operating rules is included in Section 1104 of the ACA. Standardizing this transaction will require all health plans to offer EFT, and practices should adopt PMSS systems that support EFT transactions.

Patient Collections

With some exceptions, most patients arrive at the practice with health insurance that requires some financial responsibility on the part of the patient. The amount owed by the patient varies widely from relatively low copays for primary-care visits to high-dollar deductibles for surgical procedures. In recent years, there has been significant growth in the number of patients selecting high-deductible health plan products. As discussed earlier, it is critical for the practice to establish what the patient financial responsibility is before the visit and attempt to collect that payment prior to the delivery of services. Should that not happen or should the patient financial responsibility change or not be established subsequent to the visit, the practice will have to implement a collections process.

Tip The longer these outstanding balances remain in accounts receivable, the more difficult it is for the practice to collect them. The patient collection workflow should prioritize collections based on the date of service and the amount owed by the patient.

Outstanding balance letters should be sent to the patient as quickly as possible once the balance has been established. Should these not be paid, practices will typically then call patients as the next step in the collections process. It is critical, however, that practice staff be appropriately trained and follow strict guidelines in terms of what to say, payments options to present to the patient, hours to call, and sensitivity to financial hardship issues.

Tip Patient collections is an area where practices can implement technology to automate what has typically been a manual process. Software is available that allows the organization's billing team to easily produce a standardized appeals letter that includes the pertinent details of the appealed claim.

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