Revenue cycle, UR, and access management

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News & Insights

A successful revenue cycle begins with a robust access management program. The admissions/registration team typically handles patient eligibility determinations, accurate capture of all demographics, and copay collection. The admissions/registration team is also integral to the utilization review (UR) process, because the UR process itself is often determined by the demographics collected and recorded in the registration process. If the information is not accurate or complete when it is collected initially, it will affect the rest of the process. Unfortunately, this problem is common. Based on the informal and unscientific surveys we've done at hospitals over the past 20 years, we estimate that 40% of face sheet information generated through the admissions office is incorrect. Most of the time, the UR specialist or case manager must stop what they are doing to correct the information, which unfortunately does not remedy the problem going forward. We recommend printing every example of incorrect demographic information on a regular basis and then sitting down with the director of admissions/registrations to review the work that had to be done to correct errors or complete missing information. Without that feedback, we have found that admission/registration leaders will report a high accuracy rate, because the UR specialists and case managers are correcting the data. Demographic inaccuracy is particularly problematic when it occurs in insurance information, patient's full name, or family contact information. Incorrect insurance information heavily affects the UR specialist's work because there is no way of knowing what the patient's insurer expects in terms of UR requirements. It also affects the work of case management as they plan transitions of care, which can lead to delays in discharge or transfer.

The UR process for a patient with original Medicare is generally quite different than that for a patient with Medicare Advantage (MA) or another commercial insurer. The regular Medicare UR process is typically quite stable, whereas every other insurer may have its own distinct process outlined in its provider manual. For example, regular Medicare patients must have medical necessity for hospital care documented in the medical record and reviewed by the UR staff, but payer notification isn't required. For MA plans, the notification requirements vary, with some requiring notification only for inpatient admission, some requiring notification for inpatient admission and outpatient (observation) stays of more than 24 hours, and some requiring notification for any hospital care.

Hospitals do not always do a good job of ensuring that every employee knows his or her role in the organization's revenue cycle. Even if a formal revenue cycle team does not exist in your hospital, every worker—especially the members of the UR/CDI team—should know the effect of his or her job on the revenue cycle. A consistent UR workflow is critical for a successful revenue cycle. Creating such a workflow means training everyone on the UR team on a standard workflow that includes all tasks necessary to confirm eligibility for admission and continuing stay. Too often, workflow depends on the individual's preferences and past experiences rather than on the program's goals and those of the hospital it represents. If steps are missed or tasks are forgotten, the revenue cycle may be compromised and reimbursement may be delayed.

***Editor's note**: This article is an excerpt from "The Hospital Guide to Contemporary Utilization Review, Third Edition" by Stefani Daniels, RN, MSNA, CMAC, and Ronald L. Hirsch, MD, FACP, CHCQM, CHRI.*

Related Topics:
Documentation improvement, Patient status

Take our Medicare survey for a chance to win a gift card

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What Medicare requirements do you struggle to comply with? Are you looking for more opportunities to obtain continuing education credits? What education methods and formats work best for your team? What do you like and/or dislike about HCPro's current offerings?

We want to hear from revenue cycle professionals like you about your Medicare education gaps and how we can help fill them. Click here to take our survey and share your thoughts on how we can improve our Medicare content, webinars, e-learning courses, boot camps, and more.

Your responses will help us better assist healthcare organizations in navigating and implementing complex Medicare requirements. All revenue cycle professionals, including those who do not have a *Revenue Cycle Advisor* subscription, are encouraged to complete this survey by April 1. Survey participants can enter a raffle for a $50 Amazon gift card.

Void where prohibited. See official sweepstake rules here.

CMS updates global surgery billing and coding guidance

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CMS recently updated its MLN Booklet on Medicare's global surgery package to provide additional information on transfer of care modifiers and new Healthcare Common Procedure Coding System (HCPCS) G-code G0559.

Medicare's global surgery package includes all necessary services usually provided by a provider before, during, and after a procedure, according to CMS. Physicians within the same group practice and specialty must bill as though they are a single physician.

CMS classifies global surgery packages into the following three groups:

- 0-day post-operative period (endoscopies and some minor procedures)
- 10-day post-operative period (other minor procedures)
- 90-day post-operative period (major procedures)

Organizations can use the Medicare Physician Fee Schedule look-up tool to identify covered surgical procedures and their post-operative periods.

The booklet details the services that are included in global surgery payment and those that are not. For example, any pre-operative visit after the decision to operate is included in the package, but a surgeon's first evaluation to determine the need for major surgery should be billed separately.

CMS updated its global surgery coding and billing guidelines to reflect changes in the 2025 Medicare Physician Fee Schedule (MPFS) final rule.

When providers agree on a transfer of care during the global period, they must bill with one of the following modifiers:

- -54 (surgical care only)
- -55 (post-operative management only)
- -56 (pre-operative care only)

CMS clarified that modifier -54 shows the surgeon transferred all or part of the post-operative care and is to be used in any case when a practitioner plans to provide only part of the global package. This includes but is not limited to when there's a formal, documented transfer of care or an informal, non-documented but expected, transfer of care, according to the booklet.

CMS added information on new HCPCS add-on code G0559 for post-operative care service provided by a practitioner other than the one who did the surgical procedure or another practitioner in the same practice. This code reflects the time and resources involved in post-operative follow-up visits provided by practitioners who did not provide the surgical procedure, according to the agency.

The booklet provides extensive guidance on pre-operative, procedure day, and post-operative billing and coding requirements, as well as special billing situations and assistant-at-surgery services. Revenue integrity professionals can find more information about these updates in the 2025 MPFS final rule. Read Chapter 12 of the *Medicare Claims Processing Manual* for more information on global surgery billing requirements.

Editor's note: This article originally appeared in Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Billing and reimbursement, Coding, Medicare news

Finding the “sweet spot” in clinical evidence

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HIM program leaders should work with physicians to outline clinical indicators and definitions for “controversial” diagnoses. These departments must ensure that any such information is part of ongoing coding and physician education and that it gets updated annually or at least as frequently as advances in regulations or healthcare standards demand. Although such efforts provide guidance to all parties, physicians can still determine a diagnosis based on his or her clinical judgment.

For example, when a patient presents with pneumonia, one of the clinical indicators would be an infiltrate on the chest x-ray. However, if the patient is severely dehydrated, the x-ray may not show an infiltrate. Similarly, if the patient is presenting with an acute exacerbation of congestive heart failure in addition to pneumonia, infiltrates may not be visible. In both of these examples, physicians can use their clinical judgment and assign a pneumonia diagnosis and treat accordingly.

Unfortunately, there is no exact answer when determining how much clinical evidence to include in a query. The key is finding the “sweet spot” wherein there is enough evidence to support a given diagnosis without overwhelming the reader.

Clinical evidence should generally include information from some or all of the following areas:

- Sign and symptoms with duration
- Diagnostic test results
- Lab findings
- Findings of consultants
- Treatment performed

For example, when writing a query for pneumonia, the following information should be included:

- Signs and symptoms: Fever 101°, green sputum, cough for a week
- Diagnostic test results: Chest x-ray with left lower lobe infiltrate
- Lab findings: White blood cell count of 14,000
- Treatment: Started on Levaquin intravenous (IV) piggyback

Notice that this example did not include multiple sets of vital signs, as the diagnosis of pneumonia is made primarily based on signs and symptoms and radiological findings. Some diagnoses are less straightforward and require more clinical evidence to write a compliant query.

For example, when writing a query for a suspected case of acute renal failure, more in-depth information may be needed, with the treatment and outcome tied together, such as the following:

- Signs and symptoms: Severe nausea and vomiting for one week and unable to keep down fluids. History of normal creatinine values prior to admission.
- Lab findings: Creatinine 3.6 at admission and decreased to 1.2 after 24 hours of IV fluid boluses.
- Findings of consultants: The nephrologist states “renal failure.”

Those new to the coding profession often struggle to determine the amount and type of clinical evidence to include with a query. *Coding Clinic for ICD-10-CM/PCS* states that such facility-specific policies can help provide instruction as to “when they should query physicians for clarification” (AHA, 2000, p. 12).

Even though *Coding Clinic* offers a variety of additional advice regarding when a clinical indicator (or lack thereof) may warrant the submission of a query, the 2019 AHIMA/ACDIS query practice brief *Guidelines for Achieving a Compliant Query Practice* warns that *Coding Clinic* is neither an “authoritative” nor “comprehensive” resource for determining when queries may be appropriate (AHIMA/ACDIS, 2019).

The brief states that a query should be considered when “it appears a documented diagnosis is not clinically supported” (AHIMA/ACDIS, 2019, p. 3). CMS also provided guidance published in its July 2011 *Medicare Quarterly Provider Compliance Newsletter*. In it, CMS instructs coders to do the following:

... refer to the Coding Clinic guidelines and query the physician when clinical validation is required. The practitioner does not have to use the criteria specifically outlined by Coding Clinic, but reasonable support within the health record for the diagnosis must be present (CMS, 2011).

Again, there is no magic formula for the amount of information to include in a query. AHIMA's 2008 guidance called "Managing an Effective Query Process" states the following:

Your [documentation] reviewer must use his or her professional judgment and discretion in considering the information contained on a hospital's physician query form along with the rest of the medical record (AHIMA, 2008).

Ultimately, coders need to think strategically and consider what the receiver of the information needs in order to make a clinical decision, using objective information that illustrates the true clinical picture. In general, as long as the diagnosis and treatment are consistent throughout the documentation, a diagnosis should be assigned. Remember, by documenting a diagnosis, the physician is accepting legal accountability for it. Nevertheless, if there is conflicting documentation and/or treatment, the attending physician should be queried to determine whether the condition was ruled in or out.

***Editor's note**: This article is an excerpt from "The Coder's Guide to Physician Queries, Second Edition" by Dr. Jillian Harrington, MHA, CPC, CPC-I, CPC-P, CCS, CCS-P, CEMC, MHP.*

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