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is your claim editor really working?

Complete, unquestioning reliance on an internal claim editor to ensure clean claims can be a costly mistake.

Many hospital financial leaders have a lot at stake in the accuracy of clinical claim editors. The purpose of these editors, also called scrubbers, is to analyze and ensure the technical and coding accuracy of patient bills before they are submitted for payment. Claim editors detect potential problems that cause claim rejection or reduction in payment by:

- > Performing charge analysis
- > Reviewing for medical necessity
- > Validating required data fields
- > Analyzing coding rules and regulations

Optimized reimbursement and regulatory compliance are often-cited benefits, attributed to the ability of claim editors to incorporate payer-specific editing rules (e.g., Medicare Outpatient Code Editor and Correct Coding Initiative edits). Users of the editors also have the ability to modify or customize editing rules to develop internal scrubbers that meet specific facility needs.

But are internal claim editors really completely reliable?

Evidence from a recent analysis suggests that it can be a costly mistake to trust that an internal claim editor will do everything that's necessary to ensure your claims are clean.

Claim-Editor Reality

To test the accuracy of common customized edits, we analyzed 15 selected areas from publicly filed 2004 Medicare outpatient claims to determine the degree that claim editors were allowing reimbursement to be lost. Reimbursement was determined to have been lost only in cases where there was no question of interpretation—that is, where it was clear that billing errors had been made. An analysis of Medicare claims can effectively address the reliability of claim editors because virtually all hospitals use these tools.

The findings of this analysis were dramatic: In just these few areas, our analysis disclosed that in 2004, the nation's healthcare providers lost more than \$327 million of reimbursement due to errors in claims that were missed by claim editors.

A Case in Point: Specimen Removal

The potential for lost reimbursement was greatest with claims that included billing for pathology exams. Often, these exams include a specimen-removal procedure, which must be coded or billed separately in the claim.

We found that 14 percent of all claims having a pathology exam code failed to include a procedure code for obtaining the specimen, resulting in a total loss of about \$171 million in Medicare reimbursement. A two-step process was used to arrive at this figure.

1. Identify all claims that included a surgical pathology examination code (CPT® 88300 – 88309) with or without a biopsy or specimen-removal procedure. There were 2,693,150 such claims in the national 2004 database of Medicare outpatient claims, of which 377,041 (14 percent) did not have a specimen-removal procedure on the claim.

Reference-lab claims that were designated as bill type 14X claims were excluded. Such claims have a specimen that is examined but do not require a specimen-removal procedure because the procedure could have been performed in a different setting.

2. Identify the appropriate specimen-removal procedure code. To calculate how much reimbursement was lost as a result of providers' failure to appropriately include a specimen-removal procedure code, we needed to identify which specimen-removal procedure code should have been included in each claim.

As an example, the most common surgical specimen-removal procedure in claims with a surgical-pathology exam was APC 0143 (Lower Gastrointestinal Endoscopy). In 2004, the national payment rate for this APC was \$452.62. Lost payment was then computed as \$452.62 for every claim having a surgical-pathology examination with no specimen-removal procedure.

The exhibit above represents a 2004 sample missing specimen-removal claim. Although other issues may be present in this claim, the major issue is the missed specimen-removal procedure. The lost reimbursement reflected in this claim amounts to at least \$447.68 (the wage index for this hospital is 0.9818). Additional payments could result from outlier payments.

Results of our analysis of 2004 Medicare outpatient claims submitted by hospitals suggests that many hospitals are losing significant reimbursement because of poor billing and coding edits in the 15 limited areas we reviewed. However, this lost reimbursement may be only the tip of the iceberg. Not only is there the potential for lost reimbursement in the areas we did not review, but also failure to properly bill and code in just the 15 limited areas reviewed would affect payment from other payers in addition to Medicare.

Many hospitals believe that their claim editors are identifying the types of errors we found, but this trust may not be warranted. So what should you do to make sure your claims are truly clean and you are reimbursed appropriately? Conduct frequent, independent

15 REVIEWED AREAS	
Drug Administration	Claim selected if a pharmaceutical item requiring injection or infusion was present without the administration procedure. This query excludes surgery, cardiac cath lab, and gastrointestinal service claims.
Specimen Removal	Claim selected if pathology exam was present without biopsy or specimen-removal procedure.
Venipuncture	Claim selected if laboratory test requiring venous blood draw was present without venipuncture.
Transfusion	Claim selected if blood product was present without transfusion procedure.
Emergency Department	Claim selected if revenue code 45X was present without an evaluation and management level.
Chemo Administration	Claim selected if chemotherapy drug was present without chemo administration.
Pharmacy Charge	Claim selected if drug-administration procedure was present without pharmacy charges by revenue code. This query excludes claims containing OR, cardiac cath, endoscopy lab, or ambulatory surgery charges.
Device Charge	Claim selected if device-dependent procedure was present without revenue code 27X or 62X.
Pacemaker Procedure	Claim selected if revenue code 275 was present without associated pacemaker procedure.
Supervision & Interpretation for Angiography/Atherectomy	Claim selected if supervision and interpretation service was present without the surgical procedure.
Angiography/Atherectomy Procedure	Claim selected if surgical procedure was present without the supervision and interpretation service.
Surgery Add-On Code with No Parent Code	Claim selected if surgical add-on procedure was present without an appropriate primary procedure.
Radiology Add-On Code with No Parent Code	Claim selected if radiology add-on procedure was present without an appropriate primary procedure.
Laboratory Add-On Code with No Parent Code	Claim selected if laboratory add-on procedure was present without an appropriate primary procedure.
Other Add-On Code with No Parent Code	Claim selected if other add-on procedure was present without an appropriate primary procedure.

reviews of your claims editing, focusing in particular on those coding and billing areas in which errors are most likely to occur. The 15 areas we reviewed pose the greatest risk. Typical risky areas include services where combination coding from health information management/medical records and the chargemaster occurs. However, review of your claim editor should not stop there. Facilities should also routinely conduct audits to ensure all outpatient code editor edits are updated and working correctly. ●

About the authors



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MEDICARE CLAIMS MISSING SPECIMEN-REMOVAL PROCEDURE, 2004

Facility: 00000A Sample Medical Center
Category: Pathology

PTN: 11000000 Principal Diagnosis: 211.3 Benign Neoplasm Lg Bowel

Revenue Code	HCPCS	Definition	APC	Status	Units	Charges	Cost	2004 APC Payment
250					3	\$ 172.86	\$ 34.57	\$ -
258					3	\$ 205.83	\$ 41.16	\$ -
272					18	\$ 2,585.00	\$ 578.52	\$ -
300	82962	Glucose blood test		A	3	\$ 61.80	\$ 16.95	\$ 9.81
310	88304	Tissue exam by pathologist	0343	X	1	\$ 214.60	\$ 58.88	\$ 24.91
370					6	\$ 228.90	\$ 192.75	\$ -
636	J2405	Ondansetron hcl inj 1 mg			4	\$ 121.95	\$ 24.39	\$ -
710					4	\$ 553.90	\$ 169.05	\$ -
762					21	\$ 470.75	\$ 143.67	\$ -
Totals						\$ 4,615.59	\$ 1,259.94	\$ 34.72
Outlier Payment								\$ 589.11
Total APC Payment								\$ 623.83

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