White Paper
Advanced Charge Capture and Compliance Rolled Into One Solution

The implementation of the MedAptus Charges In Hand™, Code Assist™ and Coding Reference™ solutions at University Physician Associates of New Jersey, Inc. (UPA), resulted in operational improvements including a 13% increase in gross charges per encounter, reduction in average days-to-payment by 15 days and most importantly, assisted UPA in enhancing its comprehensive coding and compliance program designed to monitor their compliance with the numerous Medicare and Medicaid medical billing rules.

University Physician Associates of New Jersey (UPA), the faculty practice plan of New Jersey Medical School, has been a leader in the healthcare community for 19 years. In 2002, its executive team recognized the need to decrease administrative costs for billing and coding, while at the same time expanding its comprehensive compliance program based on the Medicare and Medicaid regulations. UPA believed that billing and coding compliance could cost more than $1 million per year in lost productivity and compliance monitoring. Additionally it recognized that physicians are mobile and needed a comprehensive, but easy to learn mobile application that provides them with knowledge at the point of care regarding national, state, and local billing and coding requirements.

Background: Healthcare Billing and Coding Compliance

The Social Security Act section 1128C, as established by the Health Insurance Portability and Accountability Act of 1996, created the Health Care Fraud and Abuse Control Program, a far-reaching program to combat fraud and abuse in the health care industry. During the past seven years, (2003 marked the seventh year of the Program) over $2.9 billion has been returned to the Medicare Trust Fund. In 1999, the Trustees of the Medicare Trust Fund extended their estimate of the financial life of the fund by 30 years. One of the primary contributing factors cited by the Trustees was "the continuing efforts to combat fraud and abuse."[1]

The government's healthcare compliance program has saved the Medicare program $2.9B in the past seven years and enabled the prosecution of 840 cases in 2003

In addition to HHS/OIG's role in bringing about judgments and settlements based on fraud and abuse of the Medicare, HHS acted on HHS/OIG recommendations and disallowed $124.45 million in improperly paid health care funds in 2001. HHS/OIG continues to work with CMS to develop and implement recommendations to correct systemic vulnerabilities detected during HHS/OIG evaluations and audits. These corrective actions often result in health care funds not expended (that is, funds put to better use as a result of implemented HHS/OIG initiatives). In 2001, such funds not expended amounted to more than $16 billion -- nearly $13 billion in Medicare savings, and $3.1 billion in savings to the Medicaid program.

HHS/OIG conducted or participated in 840 prosecutions or settlements in 2001, of which 664, or 79 percent, were health care cases. A total of 3,756 individuals and entities were also excluded, many as a result of criminal convictions for crimes related to Medicare or Medicaid (682); or to other health care programs (66); for patient abuse or neglect (309); or as a result of licensure revocations (1,846). This all time high in exclusion actions is the result of increased outreach and collaboration with State licensing boards and MFCUs. The primary objective of criminal prosecution efforts is to ensure the integrity of our nation's health care programs and to punish and deter those who, through their improper activities, adversely affect the health care system and the taxpayers.

[1] Trustees Annual Report, 1999

Given the government's role in identifying healthcare fraud and abuse, medical billing "compliance" has become and will continue to be an issue that commands the attention of all healthcare professionals. Media coverage of recent investigations into violations of the False Claims Act has become more commonplace. Given this, it has become clear why 81% of Healthcare Executives stated that medical billing compliance with Medicare, Medicaid, and other health plans were one of their highest priorities.[2] According to Dr. Frohman, "We understand the importance of insuring accurate billing and correct coding in the effort to reduce the potential for billing errors, fraud and abuse. Thus, UPA determined that the MedAptus system would add considerable value to our current compliance plan."

> 81% of Healthcare Executives stated that medical billing compliance with Medicare, Medicaid, and other health plans were one of their highest priorities

In submitting medical claims for payment, particularly to Medicare and Medicaid, UPA executives were aware of potential liability if these claims are perceived to be inappropriate or fraudulent. UPA learned that HHS/OIG's national 5-year analysis indicates that over 70 percent of the claims that did not meet reimbursement requirements were attributable to unsupported and medically unnecessary costs - two areas that will receive ongoing monitoring by the government.

> The average compliance program costs between $10,000 and $15,000 per physician per year in administrative costs and lost productivity

For UPA, these developments have heightened the importance of developing a comprehensive and effective system to monitor their compliance with the myriad of changing requirements. UPA also understood the continued refinement of a manual, paper intensive, "compliance program" that meets the OIG's seven "voluntary" compliance program elements is expensive and time consuming. According to Michael Saulich, CEO of UPA, "the average compliance program costs between $10,000 and $15,000 per physician per year in administrative costs and lost productivity." Additionally, a 2002 study by AC Group, Inc. indicated that the average physician under-codes for actual services rendered by an average of 8-13% because of their overall fear of the government's anti-fraud program. These numbers have been reflected in an internal study conducted by UPA.

The solution:

In September of 2002, UPA initiated implementation with MedAptus (a healthcare information technology company) to provide all of their 350 clinically active physicians with a comprehensive suite of mobile workflow and billing compliance enhancing solutions including **Charges In Hand™** a solution that combines intelligent workflow management with real-time coding edits and coding support. Although increased financial benefits were impressive, even more important was the risk mitigation and improvement in compliance monitoring for physician billing and claims submission.

The first group of 100 physicians has utilized MedAptus' Code Assist™ and Coding Reference™ to access the most current coding and compliance rules and regulations for CPT-4 and ICD-9 codes. Using a handheld PocketPC, the physicians have immediate access to all current diagnostic and procedure codes, including Evaluation & Management (E&M) coding assistance, medical necessity checking, subsequent Advance Beneficiary Notification (ABN), and Medicare and bundling/unbundling rules. UPA selected the MedAptus solution suite in part because of the modular design, which allows the faculty to select the application functionality most applicable to their operating environments. In addition, the modular nature of MedAptus software allowed faculty the flexibility to incrementally implement solutions, thus minimizing clinical disruption and ensuring maximum adoption.

Each day, UPA physicians receive inbound feeds of patient appointment/admission data from the practice's McKessonHBOC Infinity scheduling system and the hospital's McKessonHBOC HealthQuest admitting and registration system. Each morning the physicians synchronize their individual mobile device on the MedAptus network via a cradle or wireless connection. Throughout the day they receive updated scheduling and demographic information. After the physician evaluates a patient in an outpatient office, surgery suite or in the hospital, the physician enters coding and billing information directly into his or her PocketPC. The MedAptus software then immediately checks the recorded diagnostic and procedure codes against quarterly updated

[2] Annual Report from the Faculty Practice Solutions Center – Volume I, December 2002

billing regulations to insure that the patient encounter information will be compliant with Medicare, Medicaid, and other reimbursement rules. Potential coding issues are identified immediately, and the physician is able to correct or add additional information required for compliant coding. The MedAptus solution reviews physician charges against a comprehensive set of billing regulations to enhance compliance and reduce denials based on insufficient information and improper coding.

Study Results:

After the first three months, UPA experienced a 13.9% increase in gross charges per encounter and was able to reduce days-to-bill by 15 days. A sampling of the physician users determined that the average physician captured an additional $38,000 in gross charges during the three month study period. Additionally, UPA is expected to dramatically decrease operating costs since it now can now electronically submit and monitor physicians' charges. According to Dr. Frohman, a full-time Neuro-ophthalmologist and President of UPA, "The compliance aspects of MedAptus are one of the greatest benefits. For my practice we have been able to take compliance training to a new level. The physicians are more engaged than ever." Additionally, since the MedAptus system automatically compares each physician's encounter billing data to applicable regulations, compliance for the entire practice is improved and billing anomalies are tracked. And finally, due to the placement of billing rules at the "front-end" of the charge capture process, UPA's coding-related billing denials have been significantly reduced.

Conclusion:

Given the complexity of medical billing and increased regulatory scrutiny, everyone in the healthcare industry must establish medical billing compliance programs or run the risk of significant fines and penalties if or when they face a compliance audit. The emergence of new mobile solutions, like those delivered by MedAptus, allow practices and practice managers the opportunity to support their physician billing compliance initiatives in ways that were not possible in the past. Providing access to patient, billing and compliance data at the point-of-care has enabled UPA physicians to make more informed and accurate coding decisions resulting in improved compliance and at the same time reduced costs and created a more efficient revenue cycle. For UPA, the decision to deploy MedAptus Charges In Hand™, Code Assist™ and Coding Reference™ solutions is proving to be invaluable, saving it time and resources, while improving reimbursement. Overall, UPA expects to improve its yearly collections by more than $5 million, and because of the immediate cash flow improvements, UPA projects it will be able to justify the cost of its system in less than 6 months.

More about the Author:

Mr. Mark R. Anderson, CPHIMS, FHIMSS is one of the nation's premier healthcare IT research futurists. He is a leading national speaker on healthcare and has spoken > 300 times since 2000. He has spent 30+ years focusing on Healthcare – not just technology questions, but strategic, policy, and organizational considerations. He tracks industry trends, conducts member surveys and case studies, assesses best practices, and performs benchmarking studies. He also assists vendors in their Business Strategies, Market and Customer Strategies, Competitive Analysis, and Product Profiling.

Prior experience includes Corporate CIO at 5 IDN's, consultant to > 200 hospitals, 50 healthcare payer organizations, and 70 Physician/Clinics. He has 17 years with multi-facility Health Care organizations, 15 years Administrative Executive Team experience, 6 years as a member of the Corporate Executive Team, and 9 years in healthcare turnaround consulting. Mr. Anderson received his BS in Business and is completing his MBA in Health Care Administration.