Effective Emergency Medicine Chart Reconciliation Ensures Lowest Risk of Lost Revenue

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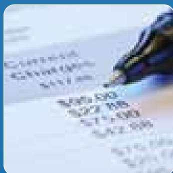

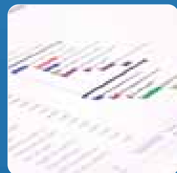

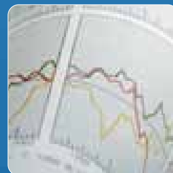

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PHYSICIAN BILLING — PRACTICE MANAGEMENT

Most emergency medicine practices may readily admit that chart reconciliation is an important process to perform in order to prevent lost charges for services provided. Many practices may not be aware that even small miss rate percentages of charges can create large pockets of revenue loss. If implemented and maintained, chart reconciliation allows emergency medicine practices to fill in gaps on lost charges and thus reduce risks for lost revenue. Many emergency medicine practices and third-party billing vendors claim 100 percent chart reconciliation, but there are many pieces to consider before this claim can be made accurately. Undergoing consistent interpretation of patient logs and source documents is necessary during the front-end of the process, while billing entry, auditing and reporting are necessary steps in closing the loop on the back-end to ensure that the chart reconciliation system is running efficiently and correctly. To assure the best approach, emergency medicine practices must consider automation, the source of the logs, and quality assurance as pieces fitting into a comprehensive chart reconciliation system that will reduce risks.

Chart Capture Versus Chart Reconciliation

In order to explore chart reconciliation, it is prudent to begin with a definition and a contrast to chart capture. Chart capture is simply the act of capturing the charts that are sent to the billing office from the various facilities and inputting these into the billing system. Chart reconciliation is the act of reconciling from a solid facility source log to the billing system to assure all billable patient visits performed by the emergency providers were truly entered into the billing system. The reconciliation process is not completed until a second chart reconciliation is performed assuring any missing charts that have been requested have in fact been received and entered into the billing system.

Automation

Due to its laborious nature, many practices and billing companies do not conduct a full reconciliation but instead conduct occasional spot audits. However, an effectively designed automated process to efficiently identify missing charges frees up labor to focus only on the exceptions. This is why the recommended methodology behind the chart reconciliation process incorporates automation. In an automated process a biller will usually obtain electronic logs from the hospital's IT department, and an automated program will scrub or compare that daily log against what was entered in the billing system.

The most important facet of automation to keep in mind is it allows the biller to only work the exceptions and errors, meaning if 95 percent of the charts were matched accurately in the reconciliation report, then the biller knows to only work on the remaining 5 percent, which is more effective. A sound automation system will ultimately allow for a biller to work just the exceptions or errors later in the reconciliation process, which in turn removes the human error factor, creates tremendous time savings, and provides greater efficiency in the revenue cycle.

Know Where the Source Lies

Chart reconciliation is the process of accounting for billable patient visits performed by the emergency providers to assure all charts are accounted for, based on the source data available. In the simplest of terms, chart reconciliation is the process of ensuring that every patient who presented to the emergency department (ED) and had billable services is accounted for.

The source of the visit or audit log can minimize some set-up frustration and ongoing maintenance in the chart reconciliation process. There are typically three sources of logs in emergency medicine; 1) the ED charting system currently in place in the department, 2) the hospital's IT system post billing, or 3) a triage or registration log . In emergency medicine, as with most specialties, it is always better to get a log from what was billed rather than what was "ordered." In this case it is based on patients that merely presented or showed up in the emergency room because not all patients who walk through the doors actually have a billable service. As is very typical in an emergency room setting, patients frequently leave without being seen by a provider. These patients are commonly referred to as LWBS, or "left without being seen." A second very common occurrence in the ED that can complicate ED patient reconciliation is when patients leave AMA, or "against medical advice." In these circumstances, patients were in the process of being seen and left the ED or hospital against the medical advice of a physician.

The reason for understanding these frequent occurrences is the implications to chart reconciliation. In the first instance, patients who LWBS will most likely appear on a registration log, but not on a log generated by the hospital's billing system (from IT) because they had no services rendered to them. This might create false positives that the biller will need to account for.

In the second instance, the AMA patient may or may not have been present in the ED long enough to have received billable services from the providers. For example, a patient might present to the ED complaining of dizziness and headache, and would receive a substantial work up, but they might then later decide that the process is taking too long, or that they feel well enough to leave the department. There could be a dozen reasons as to why the patient left AMA, however the importance lies with understanding that a patient may or may not have received billable services depending on the circumstances of the encounter and how much work was performed on the patient. As a result the biller will need to fully research each case, along with the ED coder to determine if a billable service was rendered.

Quality is Never an Accident

Martin Van Buren once said of quality, "It is easier to do a job right than to explain why you didn't." If a quality assurance system shows error rates from the initial exception report that are anything north of 2 percent to 3 percent, then it is important to understand why those errors are occurring. Finding the errors in data and setting up an effective quality assurance scrub from the beginning saves the practice both time and money.

There are, however, pitfalls where the identification and entering of missing or inaccurately recorded charts are concerned. Suppose for example the biller accurately identifies a missing chart and goes through the process of personally requesting the missing chart from the hospital, but no one verifies whether or not the chart was ultimately obtained and actually billed. Due to this scenario, a second reconciliation must occur to assure all the exceptions have been tracked down and entered into the billing system.

The bottom line: it is the doing it that matters. A biller can identify errors and request what is missing, but what is most important is to make sure that what is missing has been verified and entered, which is the true quality assurance piece of the chart reconciliation process. Quality assurance means the process is verified, error rates are looked at, and there is an understanding of why error percentages may have increased so as to compare data and improve. A monthly error rate analysis is often a part of a thorough quality assurance program, but going beyond finding the errors is the most important quality-related facet of chart reconciliation as it assures optimized revenue.

Reporting Requires Scrutiny for Remedies

Aligning closely with standard quality assurance practices is the analysis of data and reporting of error rates. Reporting on the practice's chart capture data and error rates is dependent on the scrutiny of three sources of information; 1) "what was billed" log, 2) exception report trends, and, 3) source logs. For example, if exception errors on patients who left the department against medical advice are identified as a gap within the exception process, then a biller can go back to the emergency medicine practice and highlight the service and showcase the data in its analysis. This, in turn, allows the emergency medicine practice and the biller to benchmark all ends of the process and make improvements to problem areas.

The Third-Party Advantage

With a third-party billing company such as Medical Management Professionals, Inc. (MMP), a practice can be assured that 1) people with the necessary skill sets are assigned to individual segments of chart reconciliation, and 2) that advanced automated processes have been put in place. A synergy of people and technology is often the key to assuring 100 percent chart reconciliation is met. Once a missing chart is identified, it can be obtained from the hospital or ED charting system quickly. Third-party billing companies have the ability to efficiently demand and obtain charts once missing charts are detected as they typically have individuals dedicated to this function. Ideally, a chart comes back to the person in charge of the manual reconciliation to enter into the billing system. In conjunction with people who have specific roles, it is also important to remember that automation of the process is critical because the human error factor is reduced. Daily logs can be compared and thoroughly scrubbed for accuracy with automation. If a practice's chart reconciliation system is run in-house, it would be wise to make sure there is little room for misinterpretation or mistakes and allow for more time efficiency to work the exceptions.

Lost Revenue is Risky Business

The ultimate goal of a chart reconciliation program is to lower or eliminate risks on lost revenue. The dollar impact of a 1 percent to 2 percent miss rate could result in a significant amount of lost revenue annually for a practice. Another factor is the overall impact on practice metrics, such as days in accounts receivable (A/R). There is little debate that having an efficient chart capture process will speed along the billing process so physicians receive revenue quicker with notable decreases of days in A/R.

Just to drive home the importance of this process, if the typical loss rate is about 3 percent, a practice's average collections per visit and annual volume can be plugged into the following hypothetical scenarios to determine its estimated loss and performance.

A	B	C	(A x B x C)
Annual Volume	Loss Rate %	Collections Per Visit	Estimate Revenue Loss
50,000	3%	$90.00	$ 135,000
75,000	3%	$90.00	$ 202,500
125,000	3%	$90.00	$ 337,500
200,000	3%	$90.00	$ 540,000

Doing the math might be an exercise in futility if a practice is unsure what it is missing, but assuring the right chart reconciliation pieces are in place is the key to reducing even the smallest risks.

Andrew Casselberry, MBA serves as a vice president of operations for the West region of Medical Management Professionals, Inc. (MMP) and is based in Tulsa, Oklahoma. He has 17 years of healthcare experience specializing in all aspects of billing and revenue cycle management including managed care contracting, third-party reimbursement, denial management and process improvement. Mr. Casselberry obtained his bachelor's degree in business management from Gettysburg College, and earned his master's of business administration degree from Loyola College in Baltimore, Maryland.

About MMP

Medical Management Professionals, Inc. (MMP) was founded in 1993 and is a provider of billing and practice management services to emergency medicine physicians. MMP's flexible solutions range from billing-only services to full-practice management services. For more information about MMP, visit www.cbizmmp.com.

For additional information please call **1.877.541.9690** or email **emergency@cbizmmp.com**