Editorial

Chennai Connexions has been a great tool that connects all our local members. Each issue covers issues and update from the industry experts.

This issue talks about some of the important updates that would affect most of us. We welcome you to contribute articles to the newsletter and share your knowledge and expertise with all the other members.

We hope you find this edition useful. Happy reading!

Do you have an article for the next edition of Chennai Connexions? Please send it to secretary@aahamchennai.org!

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**Autonomous Coding and Cloud Computing**

**AUTONOMOUS CODING:**

1. Medical coding completely performed with Human power. Whereas Autonomous coding are performed by tool with AI-Features infused.
2. Autonomous coding results in accurate coding within seconds for larger majority of Records.
3. This tool automatically analyses and close the coding part, if it has any complexity in coding then it will move to the Coding-Expert.
4. It gives opportunity to perform at their highest level and reduce coder’s workload at the same time.
5. Autonomous medical coding is like Autonomous driving. Self-Driving car need human assistance, likewise you will need Human assistance with different autonomy levels to improve the quality of the medical coding.
6. Organizations can assign coding professionals to more complex coding challenges, clinical documentation improvement initiatives, or other critical areas where human expertise is crucial. The optimization of coding resources in this manner, can lead to cost savings and improved assignment of more skilled coding staff.

**CLOUD COMPUTING IN HEALTH CARE:**

1. Cloud computing in healthcare provides benefit to both patient and provider in reducing costs, enhanced privacy and facilitating better patient care through collaboration and interoperability are just few of the benefits of leveraging cloud systems for healthcare.
2. Cloud computing in healthcare is where the business outcomes of healthcare providers and patient are aligned in large manner.



1. The below listed are the benefits provided while using cloud computing in healthcare.

**Reduced Data Storage Cards:**

Establishing on-site storage requires an up-front investment in hardware and requires purchasing hard drives to store data on, and additional IT infrastructure to keep that data secure and accessible at all times.

Providers of cloud-based healthcare solutions handle the administration, construction and maintenance of cloud data storage services, enabling healthcare providers to reduce their initial costs and focus efforts on the things they do best: caring for patients.

Keerthika Jayakumar CRCP



**SUPERIOR DATA SECURITY:**

In past, Physicians who used to fill cabinets to store patient records with significant risk of data theft or damage. Paper records can be easily lost or stolen, and it can be completely destroyed in natural calamities. The lack of security surrounding these documents was a significant risk to patient safety.

Once the EMR mandate was established, healthcare provider could establish their own that are knowledgeable in data security to ensure that patient data was protected.

**Evolving into Artificial Intelligence (Ai) in Medical Billing**

In recent years, the integration of Artificial Intelligence (AI) into various industries has brought transformative changes. One such area is in Medical Billing where AI is revolutionizing the way healthcare organizations manage their revenue cycle for the following.

* Efficiency and Accuracy
* Streamlined Workflow
* Faster Claims Processing
* Enhanced Revenue Cycle Management
* Real-Time Analytics
* Enhanced Fraud Detection

**Medical Billing Companies who have implemented AI**

**Cerner: AI-powered Revenue Cycle Solutions** created artificial intelligence-driven revenue cycle management systems that automate billing operations from claim creation to payment collection.

**Change Healthcare: AI-Enhanced Claims Processing** implemented AI technology to handle medical claims much efficiently. The AI algorithms analyze medical data, identify relevant billing codes, and evaluate claim correctness.

**McKesson's: Intelligent Denial Management** AI-driven rejection management solutions used predictive analytics to anticipate future claim denials and handle billing issues proactively, reducing revenue leakage for healthcare providers.

**Optum’s: AI-Enabled Charge Capture** by analyzing patient interactions and medical documents, AI technologies allowed automatic charge capture, ensuring correct and comprehensive invoicing for services given.



**Medical Billing Coding Tool**

**Medicodio** is an AI-powered medical coding tool that reduces medical coding costs and improves efficiency by up to 45%. A great fit for RCM companies and hospital billing departments, CODIO suggests medical codes (CPT, ICD10, HCPCS, modifiers) by reading patient demographic info from EHR systems and Physician Notes/Chart. After the medical coder makes a selection from the list of suggested

codes, CODIO sends your codes to the billing system.

While AI holds immense promise for transforming medical billing practices, it’s essential to strike balance between automation and human expertise.

**Opportunities and Obstacles in Ai**

**Opportunities:**

* Eliminates human error & risk
* 24/7 Availability
* Unbiased decision making
* Repetitive Work
* Cost Reduction
* Data acquisition and analysis

**Obstacles:**

* Costly implementation
* Lack of emotion and creativity
* Degradation
* No improvement with experience
* Reduced jobs for human
* Ethical problems



**AI in healthcare market size worldwide 2021-2030**

In 2021, the artificial intelligence (AI) in healthcare market was worth around 11 billion U.S. dollars worldwide. It was forecast that the global healthcare AI market would be worth almost 188 billion U.S. dollars by 2030, increasing at a compound annual growth rate of 37 percent from 2022 to 2030.

**Agnel Amaldass CRCP**



Source: https://www.knowledge-sourcing.com/report/ai-in-medical-billing-market

https://medicodio.com/5-best-ai-medical-coding-software-a-comprehensive-buyers-guide/

<https://www.statista.com/statistics/1334826/ai-in-healthcare-market-size-worldwide/>

**Focus On Errors To Minimize Denials**

“What goes out, comes back.” This adage is applicable more specifically to healthcare billing. What providers fill and send out on the claims decides what they will get from the insurance. The Centers for Medicare and Medicaid Services (CMS) for instance reports that in 2020, 18% of in-network claims submitted, resulted in claim denials. These denial rates vary from individual providers as well.

**Common Denial Codes in Medical Billing**

1. CO-4: The procedure code is inconsistent with the modifier used.
2. CO-11: The diagnosis is inconsistent with the procedure.
3. CO-197: Precertification/authorization/notification/pre-treatment absent.
4. CO-198: Precertification/notification/authorization/pre-treatment exceeded.
5. CO-16: Claim/service lacks information or has submission/billing error(s).
6. OA-18: Exact duplicate claim/service.
7. CO-22: This care may be covered by another payer per coordination of benefits.
8. PR-26: Expenses incurred prior to coverage.
9. PR-27: Expenses incurred after coverage terminated.
10. CO-29: The time limit for filing has expired.
11. CO-167: This (these) diagnosis (es) is (are) not covered.

All the denials mentioned above are either because of entry errors or information missed out from being captured or were not gathered.

**CO-4**

Insurance companies send out denial code CO-4 when a required modifier is missing, or the procedure code is inconsistent with the modifier used. This may be because either the modifier was not entered or incorrectly entered.

In the CMS1500 claim form the modifier will be reflected along with the procedure code on the block 24d and in the UB-04 claim form on block 44. The modifier shall be reviewed before being submitted to the insurance.

Review to see if the coding team really did use the incorrect modifier or perhaps forgot to apply it. If the team missed adding the correct modifier or added an incorrect modifier, update the mistake, and submit the claim.

**CO-11**

CO 11 stands for a claim with a diagnosis code that does not match with the procedure. An incorrect diagnosis code is likely the culprit, so the first thing to do is to check for that.

In the CMS1500 claim form the diagnosis and procedure codes will be reflected on the blocks 21 and 24d; in the UB-04 claim form they will be on blocks 67 to 67q, 69 and 70a to 70c and block 44. Review the diagnosis and the procedure codes before submitting the claims to the insurance.

If there is an error or a diagnosis that is missing, use this information to correct the claim and submit it.

**CO-197 or CO-198**

These denial codes means that either the claim entered misses an authorization number or has a wrong authorization number for a service or a procedure.

In the CMS1500 claim form the authorization number will be reflected on the blocks 23; in the UB-04 claim form on blocks 63.

Review claim to see whether the team submitted a prior authorization request. Recheck the respective block 23 in CMS1500 or block 63 in UB-04, for any errors. If a prior authorization number was obtained and was either missed out or entered incorrectly, update the same in the respective blocks and submit the claim. If the pre-authorization information is not available anywhere, attempt to get a prior authorization for the procedure.

**CO-16**

Denial code CO-16 is probably one of the most common denial codes. Some reasons for CO 16 include:

* Demographic errors.
* Invalid Clinical Laboratory Improvement Amendments (CLIA) number

For Demographic errors, providers may refer to blocks 1a to block 13 of CMS1500 or blocks 8, 9, 10, 50 to 65 of UB-04.

For Invalid CLIA number, providers may refer block 23 of CMS1500 or block 63 of UB-04.

To avoid CO 16 claim denials, providers should pay attention to the entries in the respective blocks and make changes accordingly.

**OA-18**

Payers use the denial code OA-18 with RARC N522 to deny duplicate claims, which happens if either provider,

* Submits the same claim twice for a service, medication, or treatment.
* Resubmits a claim without letting the insurance company know that it was corrected.
* Provides the same service multiple times on the same day without a modifier.

In case of a CMS1500 claim form, providers need to refer blocks 22 and 24a to 24j; in case of a UB-04 claim form blocks 42 to 47, block 4 and block 64 are to be referred.

**CO-22**

When the secondary insurance companies are billed before the primary payers, they will deny the claim and send back with denial code CO-22. To avoid this denial code, submit the claim to the primary health insurance plan first. After that, the claim can then be sent with the remaining balance to the secondary or tertiary payers.

On the CMS1500 claim form the blocks 9 to 9d, 11 to 11d can be referred for correct insurance information before submission. On the UB04 claim form the blocks 50 to 65 are to be referred. Any errors found are to be corrected before the claim is submitted to the payor.

Another way to avoid running into denial code CO 22 is to make sure patients’ insurance information is up to date as well as coordination of benefits information.

**CO-27**

The denial code CO 27 can be expected when a patient undergoes services or treatment after their health insurance expires. Unfortunately, this denial code is pretty difficult to resolve. That is why it is important to perform insurance eligibility verification checks before seeing the patient.

However, providers can consider the following:

* Confirm the insurance policy’s effective and expiration dates.
* See if the patient has any secondary insurers.
* If the patient doesn’t have active insurance, bill them directly.

**CO-29**

Denial code CO 29 means that a claim was sent after the submission deadline. Each health plan has its own claim submission timeframe. So, make sure to be familiar with the payers. Refer the clearinghouse report periodically to identify any rejected claims and correct the incorrect entries and resubmit as soon as possible.

**CO-167**

Payers will use denial code CO 167 to reject the claims that don’t fall under their coverage.

To avoid denial code CO 167,

**Anand S CRCP**

* Review (ICD-10) diagnosis codes
* Contact the payer to find out which diagnoses are not covered.
* Make any adjustments necessary, then submit the claim.

In case of the CMS1500 claim form the block 21 can be referred. In case of the UB-04 claim form, review the diagnosis entered in blocks 67 to 67q, 69 and 70a to 70c and block 44 before submitting the claims to the insurance.

The above measures may not be fool proof in avoiding denials. However, these can avoid the number of denials and hence the leakage of the revenue.

Source: <https://etactics.com/blog/denial-codes-in-medical-billing>

**No Surprise Act - Independent Dispute Resolution (IDR) Process**

**No Surprise Act Overview:**

Patients are protected from receiving surprise medical bills resulting from out-of-network care for emergency services and for certain scheduled services without prior patient consent.

Patients who do not have insurance to pay for care have a right to receive a good faith estimate of their potential bill for medical services when scheduled at least three days in advance.

Individuals with federal insurance plans are not covered under the No Surprises Act because these federal insurances have existing protections in place to minimize large, unforeseen bills.

**No Surprises Act (NSA) Dispute Resolution Process:**

The Biden-Harris Administration has released a [proposed rule](https://public-inspection.federalregister.gov/2023-23716.pdf) to improve the independent dispute resolution (IDR) process for surprise billing by addressing payer-provider communication and adjusting open negotiation policies.

The surprise billing proposals address the open negotiation process for independent dispute resolutions, batching, and eligibility determinations.

The No Surprises Act established a 30-business-day open negotiation period to allow disputing parties to agree on a payment rate without using the federal independent dispute resolution (IDR) process.

Payers must also use standardized codes to communicate whether a claim for an item or service furnished by an out-of-network provider is subject to the No Surprises Act’s surprise billing provisions and the IDR process.



The Departments proposed to include new content elements in the open negotiation notice, including plan type, location of service, and claim number, according to a fact sheet.

The new proposals would:

* Impose new requirements on plans and issuers to disclose certain information along with the initial payment or notice of denial of payment for medical services covered by the surprise billing protections in the No Surprises Act.
* Require plans and issuers to communicate information by using claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), when providing any remittance advice to an entity that does not have a contractual relationship with the plan or issuer.
* Amend certain requirements related to the open negotiation period preceding the IDR process, the initiation of the IDR process, the IDR dispute eligibility review, and the payment and collection of administrative fees and certified IDR entity fees.
* Define bundled payment arrangements, amend requirements related to batched items and services, and amend the rules for extensions of time frames due to extenuating circumstances.
* Require plans and issuers to register in the IDR portal.

The policies in the proposed rule aim to streamline the federal IDR process for payers and providers, reduce the administrative burden that accompanies the process, and continue to protect patients from unfair medical billing.

 **Fatima Lourdudoss CRCP**

Source:<https://revcycleintelligence.com/news/surprise-billing-proposals-aim-to-streamline-idr-process>

<https://tax.thomsonreuters.com/news/prop-regs-clarify-no-surprises-act-dispute-resolution-process/>