

# Net Revenue Matters



April 2008



Welcome to the April edition of *Net Revenue Matters*, a publication of *Integrated Revenue Management, Inc.* We hope that in this issue you'll find several topics of interest.

In his article, "Preparing for a RAC Audit," Founder and Director Jack Duffy offers suggestions that we believe you'll find useful.

Also, we hope that you'll appreciate two additional articles, "Billing for Drug Wastage" and "RAC Demonstration Period Ends."

An article from the March 2008 issue of *hfm* magazine caught our eye and we chose to include it, "policing your commercial payments **staying in (or getting in) the black.**"

Finally, please note our client news and upcoming events. We don't want you to miss anything!

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## Preparing for a RAC Audit

By now every healthcare financial manager has spent some time considering how to respond to an audit by a revenue recovery contractor (RAC). Your mail box, both electronic and paper, is full of seminar offers and consulting assistance. While some form of external assistance may help, good internal preparation is still the best option. Some suggestions for those still in the waiting mode or those hospitals that are currently struggling with this process include:

- ▶ Appoint a team to manage the process. This is a serious audit with potential negative consequences that could amount to millions of dollars. The team should include:
  - The Revenue Management Department
  - Compliance
  - Health Information
  - Information Services
  - Legal office
  - Patient Financial Services
  - Information Services
  - Others as needed

- ▶ The first exercise can be a massive request for records. There needs to be designated copying resources to manage the request.



- ▶ Hospitals should consider installing a focused data base like the IRM RAC Management System that will be available by the end of April.

***"This is a serious audit with potential negative consequences that could amount to millions of dollars."***

- ▶ Network with hospitals that have already been audited and learn from their experience. Current lessons include:
  - It is easy to miss deadlines without a tracking system. Results of missing records can be extrapolated over several years of experience, making the loss even greater.
  - First level appeals are not resulting in a change in

audit findings. Some fiscal intermediary appeals show some movement, but not much.

- Hospitals should do all their work with the understanding that the process is most likely to be concluded at the Administrative Law Judge level.
- ▶ Of longer term importance, hospitals should be reviewing the cases that are the target of the audits (listed below). The point is to use all means to learn what the audit targets are and to reduce exposure whenever possible.
  - One-day stays that could be completed in an outpatient setting
  - Transfers to anywhere should be reviewed
  - Three-day stays to qualify a patient for long-term care
- ▶ As with most audits that involve site of service or level of care issues, the controlling factor is documentation. The only defense for this type of audit is a passion for excellent documentation. Hospitals that made significant investments in documentation improvements during the past few years are about to experience the payback in the form of reduced exposure. Although some in Congress have suggested a pause in the RAC process, the income is already part of the CMS budget. A prudent approach is to plan for a long-term exposure and prepare your hospital to fight at every appeal level to support the standard of care in your community. ▲

## Recovery Audit Contractor (RAC) Demonstration Period Ends

As most hospitals are aware, CMS' RAC demonstration period ended in March 2008. So what happens next? It will become permanent!

The RAC demonstration was authorized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) by Congress and was

required to be a permanent part of Medicare in the Tax Relief and Healthcare Act of 2006. CMS will enter into new contracts as the national program is implemented in the next year.

The permanent RAC program will be gradually implemented. The timeline is as follows:

- ▶ December 1, 2007, was the last day a demonstration RAC could issue medical record request letters.
- ▶ February 1, 2008, was the last day a demonstration RAC could issue Part B demand letters.
- ▶ February 15, 2008, was the last day a demonstration RAC could issue Part A informational letters.
- ▶ In the spring of 2008, CMS will announce the names of the companies chosen to be the permanent RACs for the four regions identified in the following map.
- ▶ In the spring/summer of 2008, CMS and the new RACs will conduct extensive provider outreach. CMS will work with provider associations to help facilitate outreach.
- ▶ To determine when your state will be included in the RAC program, please refer to "Appendix D – Permanent RAC Expansion Schedule" in the CMS FY 2007 RAC Status Document, which can be found at the following link: [http://www.cms.hhs.gov/RAC/Downloads/2007\\_RAC\\_Status\\_Document\\_vs1.pdf](http://www.cms.hhs.gov/RAC/Downloads/2007_RAC_Status_Document_vs1.pdf)

The following changes will be implemented during the permanent RAC program:

- ▶ The look-back period has been changed from four years to three years in the permanent program.
- ▶ In the demonstration, CMS did not give a maximum look-back date. In the permanent program, the RACs will not be able to look for any improper payments on claims paid before October 1, 2007.
- ▶ The demonstration RACs were not allowed to review claims during the current fiscal year, but

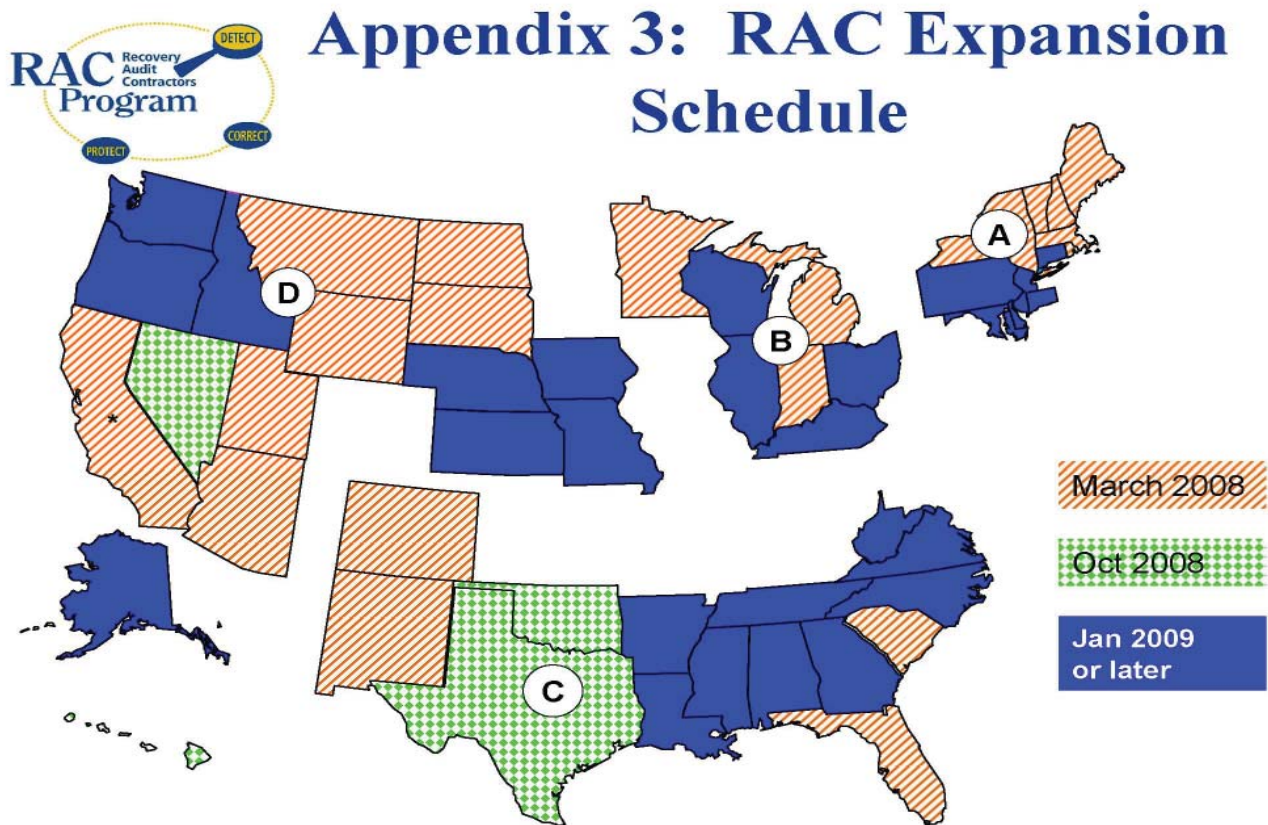
the permanent RACs will be allowed to review claims during the current fiscal year in the permanent program.

- ▶ Certified coders were not mandatory in the demonstration. In the permanent program, each RAC must have certified coders.
- ▶ Optional medical record limits were set by the individual RACs in the demonstration. The permanent program will have mandatory limits set by CMS.
- ▶ During the demonstration, discussion with the medical director regarding claim denials, if requested by providers, was optional. In the permanent program, it is mandatory.
- ▶ The demonstration called for limited reporting by the RACs on the problem areas they had identi-

fied. Frequent problem area reporting is mandatory in the permanent program.

- ▶ During the demonstration, the RACs only had to pay back the contingency fee if they lost at the first level of appeal. This has been changed to all levels of appeal for the permanent program.
- ▶ The RACs did not offer a web-based application that allows providers to customize addresses and contact information or see the status of cases during the demonstration. In the permanent program, each RAC must have this web-based application by January 1, 2010.
- ▶ During the demonstration, an external validation process was optional and it varied by state. The external validation process is mandatory for the permanent program and it is a uniform process.

For more information on the RAC program, visit CMS' RAC web page: <http://www.cms.hhs.gov/racl>



\*California claims will not be available for review from March 2008-approximately Oct. 2008 due to a MAC transition

## Billing for Drug Wastage

The Centers for Medicare & Medicaid Services (CMS) encourages hospitals to “schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.” However, if the remainder of a single use vial or single use package must be discarded after a drug/biological has been administered to a Medicare patient, Medicare will pay for the wasted amount along with the amount administered, up to the amount of the drug or biological as indicated on the vial or package label. Drug wastage must be documented in the patient’s medical record with date, time, amount wasted, and reason for wastage. This policy does not apply to multi-use vials.

Example given by CMS (Transmittal 1478): “A physician schedules three Medicare patients to receive botulinum toxin type A (J0585, botulinum toxin type A, per unit) on the same day within the designated shelf life of the product. Currently, Botox® is available only in a 100-unit size. Once Botox® is reconstituted, it has a shelf life of only four hours. Often, a patient receives less than a 100-unit dose. The physician administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient.”

To receive payment from Medicare for the discarded amount, your local fiscal intermediary (FI) may require the use of the modifier JW to identify the unused drug or biological. The JW modifier does not apply to drugs or biologicals provided under the Competitive Acquisition Program (CAP). Check with your state’s FI to determine the billing requirements specific to your hospital.

Hospitals may be able to receive payment for drug wastage from commercial payers. The hospital should have a drug wastage policy in place that clearly outlines how drug wastage is billed. A hospital may also have a policy stating all payers are managed and billed in the same manner. Such a policy would refer to CMS’ guidelines on billing for drug wastage. More information can be found at the following links. ▲

*The related MLN Matters article: <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM5923.pdf>*

*The official instruction (CR5923): <http://www.cms.hhs.gov/Transmittals/downloads/R1478CP.pdf>*

*Medicare Claims Processing Manual, Chapter 17: <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf>*

## policing your commercial payments

### staying in (or getting in) the black

The American Hospital Association (AHA) has reported that 25 percent of U.S. hospitals lost money during 2005 (AHA, TrendWatch Chartbook 2007, Trends in Hospital Financing, Chart 4.1). Healthcare leaders are all too aware that today’s healthcare industry is faced with rising costs and flat (or even declining) revenue. According to the AHA’s TrendWatch Chartbook2007, the average hospital’s operating margin was 3.6 percent in 2005; during the same timeframe, the average hospital’s patient margin was -2.8 percent (Chart 4.2: Aggregate Total Hospital Margins, Operating Margins, and Patient Margins, 1991-2005). Fortunately, hospitals often have revenue from nonpatient care operations to help offset these operating losses.

One way in which hospitals can increase revenue is by auditing payments from managed care programs with which they contract. In the December 2005 issue of hfm magazine, Martin D’Cruz and Terri Welter listed the need to audit commercial insurers’ payments for accuracy as one of the top five payment trends. “Underpayments and denials continue to erode the bottom lines of U.S. hospitals,” they write. “A recent survey shows that 8 percent to 14 percent of commercial revenue goes uncollected, and the number is much higher for hospitals that lack an effective audit function.” How (or if) hospitals respond to this issue can have a significant impact on their financial performance.

Unfortunately, many hospitals lack a structured program designed to audit managed care payments. Some facilities may consider their managed care volume to be too low to warrant special auditing; others may simply lack the resources to address this issue.

Nevertheless, developing a program for auditing and recovering managed care underpayments is very important – and doesn’t have to be overwhelming.

Hospitals can use software applications designed to identify underpayments, focus on a manual auditing process, or implement a combination of the two.

The recovery unit should call payers frequently regarding underpaid claims – at least every two weeks. Yet whom the representative calls is often more important than how often he or she calls.

### **Software Applications**

The managed care auditing program in many hospitals consists of a software program purchased to identify insurance payments that are below expected levels. The various types of software programs available – coding scrubbers, contract management systems, and reimbursement calculators – can effectively identify lost revenue. These systems work quickly, often without significant manual effort

Many of the leading patient accounting systems in use at hospitals include modules designed to identify underpayments. Other stand-alone applications are designed to interface with most hospital systems. Both types of systems can be effective; however, like any software application, these tools are only as good as their implementation and the data entered into them.

Despite significant progress in software development, these systems can often miss certain types of underpayments. For example, contract loopholes, silent preferred provider organization (PPO) activity, and interpretation issues can be difficult for software to identify. Typically, even the best software applications can miss underpaid accounts, which can add up to millions of dollars of lost revenue per year at larger facilities.

The primary advantage of software systems is their efficiency. A properly installed application can review thousands of claims at a time and identify discrepancies from expected reimbursement. Frequently, these discrepancies are automatically documented in the patient accounting system, and therefore are immediately available for billing and collection staff to pursue.

Also, despite their large price tag, software systems can generate significant value over time. When com-

pared with the expense of creating an auditing unit within the hospital's patient financial services department, the expense of a software system may be easily justified. Regardless of which software system is implemented, however, the hospital still needs staff to recover the identified underpayments. In some cases these collection efforts can be assigned to existing billing or patient financial services staff; in other cases, the hospital is required to assemble a dedicated collection team.

A hospital with significant managed care volume should still consider implementing a manual auditing process to review the results of any software application, as well as to identify underpayments that may otherwise have been missed.

### **Manual Auditing**

In manual auditing, every managed care account is reviewed by an individual who understands the various hospital reimbursement methodologies as well as managed care contracts. Each account's reimbursement should be reviewed, recalculated, and compared with the expected payment as dictated by the prevailing managed care contract. Although time-consuming, these steps can be very rewarding in terms of additional reimbursement to the hospital.

Given privacy concerns, many hospitals prefer to develop internal managed care auditing capabilities rather than consider outsourced options. Assuming that a hospital has qualified managed care auditing and management staff (or access to such individuals), the development and operation of an internal auditing team can be fairly straightforward to implement. Qualified individuals should have experience in medical billing, procedural coding, medical appeals, denial management, and/or medical collections.

Working within the hospital's patient accounting software, an internal auditing unit can manually review the transactions for all managed care accounts. To avoid overlap with normal collection efforts, the unit should review only accounts that have reached a zero insurance balance or that have been previously denied for additional payment. Accounts with outstanding patient balances should be audited for proper insurance payments. Waiting for patient-portion balances

to be fully paid will frequently result in exceeding a payer's timely appeal requirements.

Auditing staff should also review accounts for frequent underpayment types, such as a payer's failure to pay for contractual carve-outs such as implants. To facilitate a more accurate and efficient auditing process, the staff should develop and use contract matrixes that summarize the covered services and corresponding rates for each contract. These matrixes should be developed and maintained by individuals with experience working with contracts. No matter their experience, those responsible for the matrixes should always have someone else review the matrixes for accuracy, as well as their interpretation of the contracts' terms. A single contract misinterpretation can lead to auditors missing hundreds of thousands of dollars in underpayments.

Once an underpayment is identified, the auditing team should conduct a benefit confirmation call to ensure that the patient was covered by the payer indicated in the hospital's patient accounting system. Benefits frequently change, and if the registration process did not capture the patient's current plan, the underpayment may not be recoverable.

### **Recovery**

For any underpayments that have been identified and confirmed, the accounts can be returned to the regular billing staff (or, if the internal unit includes recovery staff, they can begin their collection efforts immediately). Collection efforts can be documented in the hospital's patient accounting system, or in commercially available software.

The recovery unit should call payers frequently regarding underpaid claims – at least every two weeks. Yet whom the representative calls is often more important than how often he or she calls. Most plans' customer service departments are ill-equipped to respond to requests for reprocessing or to questions regarding contract terms. Increasingly, these departments are out-sourced, often overseas, and lack the authority to effectively respond to demands for additional payment. Such requests should be taken to customer service supervisors, or to the facility's provider relations representatives.

Besides telephone calls, the recovery unit may also need to file written appeals on some underpaid

accounts. These appeals offer an opportunity for the recovery unit to outline the terms and provisions of the agreement that allow for additional payment, as well as to provide language from applicable state laws and statutes that support the request for additional payment or preprocessing.

The costs associated with developing an internal auditing and recovery unit are fixed, meaning that regardless of how much money is identified or recovered, the hospital's expenses will remain unchanged. Staff salaries, benefits, rent, computers, office equipment, and supplies will cost the same amount, whether the unit recovers \$1 million or \$25,000 per year. As a result, many hospitals hesitate to create a unit to manually audit their managed care accounts.

### **Outsourced Managed Care Auditing Firms**

If the effort and costs associated with developing an internal unit are more than the hospital is willing to take on, at least initially, then consideration should be given to an outside auditing firm. Firms that are structured and staffed specifically for the functions associated with managed care auditing can effectively operate as an extension of the hospital to help identify and recover underpayments. Some auditing firms specialize in silent PPO auditing, which presents specific challenges. Other firms audit for both standard managed care underpayments as well as silent PPO activity.

In addition to auditing and recovery, outside managed care auditing firms should be able (and willing) to provide a hospital with observations regarding potential loopholes in their managed care contracts, as well as recommendations for closing those loopholes.

Most managed care auditing firms charge hospitals a monthly fee, plus a portion of what they successfully recover. Depending on the underpayment volume, these arrangements can sometimes be more costly than developing an internal auditing unit.

However, some auditing firms are strictly based on contingency fees. These arrangements can be attractive to a hospital because they essentially eliminate the risk of spending money only to find that the hospital is being paid correctly, or is successfully

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## CLIENT CORNER

### 2008 CBR Projects

Calls begin at 11:30 a.m. Pacific

April

23: Forum Call

May

7: Project Rollout: Outpatient Orders (Compliance Project)

28: Forum Call

June

4: Project Rollout: Spine Surgery

25: Forum Call

### 2008 TCG Audio Conferences

Conferences begin at 10:00 a.m. Pacific

April

24: Orthopedic Series: Casting, Splinting, Strapping

May

13: Orthopedic Series: Knee Arthroscopy

29: Intro to Medicare Reimbursement Series: APC 101

June

17: OB-GYN Procedures

26: Orthopedic Series: Shoulder Arthroscopy

July

15: Orthopedic Series: Spine Surgery

29: Bill Presentation

### 2008 Best Practice

Best Practice was a great success and we would like to recognize our winners!

PI Roundtable

1st Place: Memorial Medical Center: "Free Babies - No Charge"

2nd Place: Archbold Medical Center: "Understanding Injections and Infusions"

3rd Place: Intermountain Healthcare: "Discharge Disposition - Collection from Medicare"

CBR Academy Awards

Most Completed IRM CBR Projects: Mercy Hospital and Medical Center

Most Completed CBR PI Initiatives: Archbold Medical Center

Biggest Financial Impact (Compliance or Revenue Enhancement): Intermountain Healthcare

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recovering underpayments on its own. If the hospital has purchased expensive software, this form of secondary review can be a risk-free method of generating a significant amount of additional revenue.

Failure to carefully audit every managed care payment, whether with software or manually (or both), can result in thousands or even millions of dollars of lost revenue every year at a hospital. In today's health-care industry with its razor-thin operating margins, this can mean the difference between a year in the red and a year in the black. ▲

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