

Net Revenue Matters



April 2011



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, "NextGen Case Management," Executive Vice President Jack Duffy begins a new series of discussions.

Also, we hope that you'll appreciate the information presented in "Tired of Collecting 26% of Outstanding Patient Receivables?" and "Injections and Infusions Hierarchy."

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

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NextGen Case Management

This article begins a series that will highlight the changing requirements for point-of-service control of orders and related assignment of level of care. The federal and state audit processes continue to move compliant documentation requirements towards greater emphasis on outpatient care. This movement has both economic and patient care issues. The expected outcomes have not changed, but the mix of resources clearly has. For the past 75 years, it was sufficient for a physician to write an order and for the hospital staff to try its best to determine what it meant. "Admit Patient" covered the bases. However, in today's environment, that order without a clear understanding of underlying criteria is the equivalent to a request to audit that claim.

"Hospitals are now considering options to meet this challenge."

Hospitals are now considering options to meet this challenge. Options involve significant retraining of the medical staff with con-

tinuous review.

The alternative is to position highly trained and skilled nurses in the ER to monitor incoming patients 24/7 and assist the physician to get the orders correct at the point of first contact. This process will be tied to criteria-based healthcare and will be referenced back to InterQual and M&R.

The added cost of this tactic will exceed one million dollars for many hospitals. The cost of not taking these steps can be several times that amount. In subsequent articles, I will explore how to write a business plan and make a case for this resource even when experiencing reduced reimbursement. I will also look at the skills and personalities needed to be successful in the emerging role and if this is part of the revenue cycle.

I look forward to expanding this initial piece over the next few months and providing our readers a detailed outline of how to manage in this ever-changing world of healthcare. ▲



Jack

Tired of Collecting 26% of Outstanding Patient Receivables?

Integrated Revenue Management (IRM) is pleased to announce our partnership with Payment Clinic. Payment Clinic is an efficient and cost-effective way to increase payments (money to your bottom line) on patient-pay accounts before they end up in bad debt, are sent to collections, or are simply written-off. Payment Clinic has helped major acute care hospitals increase patient-pay cash flow by as much as **40%** in less than 120 days in certain patient-pay segments, and has helped incentivize patients to pay their small-balance accounts promptly.

“Payment Clinic is a simple, no-cost way to convert patients into happy, paying consumers.”

Payment Clinic is a simple, no-cost way to convert patients into happy, paying consumers. The platform is a format that patients are used to: an online web portal. Patients access the site and are incentivized by the “potential” of a discount on their bill if they pay immediately. The psychology is tremendous.

Patient-pay bills are challenging to collect in today’s economic environment. We, like you, know the national average for patient-pay collection is only 26%. In addition, many hospitals write-off patient-pay balances less than \$200-\$500 because of the time, cost, and effort of trying to collect them.

Payment Clinic lets you decide the discount you are willing to accept for certain bill amounts, patient types, or bill dates. Those “rules” that YOU set are entered into the decision engine. Patients don’t know what you are willing to accept, but their competitive spirit and desire to “get a deal” encourages them to pay immediately.

Payment Clinic sees more than **70%** of the patient-pay consumers who are directed to the site pay their bill immediately.

What does this mean to you?

- ▶ Thousands of dollars of immediate cash flow to your hospital
- ▶ Decreased number of accounts sent to collections, where you see pennies on the dollar (avoid collections and write-offs)
- ▶ Happy patients who will want to return to your facility
- ▶ No upfront costs

Considering that Payment Clinic is web-based, it is easy to implement with no upfront costs or long-term contracts required. You do not need to allocate millions of dollars in a new HIS system, or implement a completely new practice management or revenue cycle software system to realize the benefits of Payment Clinic. And even if you have very sophisticated systems, Payment Clinic becomes an additional channel: a new tool in your toolkit helping you to improve your patient-pay cash flow. ▲

For more information, please contact

Ina Masten

(760) 448-1030

imasten@irminconline.com

RAC Semi-Automated Reviews

Up until recently, there have been two types of RAC reviews. Automated, which occurs when a RAC makes a claim determination without human review of the medical record, and complex reviews, which occur when a RAC makes a claim determination utilizing human review of the medical record.

“Now there is a third type: semi-automatic review, a two-part process.”

Now there is a third type: semi-automatic review, a two-part process. First, the RAC conducts an automated review of claims data. Then, if he or she identifies any potential billing aberrancies, a notification letter is sent for a complex review. The time to respond with supporting documentation is 45 days. If submitted documentation supports the billed claim,

it will not be sent for adjustment and the provider will receive notification that the review has been closed. If documentation does not support the claim, or the provider does not submit documentation, it will be processed for adjustment and a demand letter will be sent to the provider.

The differences between these reviews are as follows:

- ▶ Automated reviews can occur only if no **certainty** exists as to whether the service is covered or correctly coded.
- ▶ Complex reviews occur when requirements for an automated review are not met or the RAC is unsure as to whether or not the requirements for an automated review are met. There is a **high probability** that the service is not covered.
- ▶ Semi-automated reviews occur when there is a **possibility** of claim errors. ▲

Injections and Infusions Hierarchy

Is your facility following the injections and infusions hierarchy?

There has been much confusion and discussion recently in regard to the injections and infusions hierarchy. In review, what we have found is that the hierarchy in many cases has not been followed by the facility staff per the CPT coding guidelines for injections and infusions. CPT guidelines are as follows:

“When these codes are reported by the facility, the following instructions apply. The initial codes should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services, which are primary to hydration services. Infusions are primary to pushes, which are primary to injections.” This hierarchy is to be followed by facilities and supersedes parenthetical instruction for add-on of a higher hierarchical position that may be reported in conjunction with a base code of a lower position. An example of this would be that the hierarchy would not permit reporting CPT 96376 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intra-

venous push of the same substance/drug provided in a facility (list separately in addition to code for primary procedure) with CPT 96360 intravenous infusion, hydration; initial, 31 minutes to 1 hour, because CPT 96376 is a higher order code, according to the guideline, IV push is primary to hydration. It is important to note that when reporting codes in which infusion time is a factor, the actual time documented over which infusion is administered is imperative for proper code assignment. Intravenous intra-arterial push is defined as: (a) an injection in which the healthcare professional who administers the substance drug is continuously present to administer the injection and observe the patient, or (b) an infusion of 15 minutes or less.”

When coding injections and infusions, it is recommended that the CPT book be available to review, along with IRM's injection and infusion tool kit and cards. This will assist the coder to determine the correct hierarchy in order to report these services. ▲

Information in this article includes excerpts from CPT coding guidelines.

Q&A: Direct Physician Supervision for Cardiac Rehab in the Facility Setting

Q: We understand that CPT codes 93797 and 93798 for cardiac rehabilitation require direct physician supervision. How does this requirement apply to the facility setting? Typically, a physician does not see the patient during cardiac rehabilitation at our hospital.

“There has always been some ambiguity concerning how this physician supervision requirement applies in the outpatient hospital setting.”

A: There has always been some ambiguity concerning how this physician supervision requirement applies in the outpatient hospital setting. CMS tried to clarify this in the OPSS Final Rule for CY 2010. Cardiac rehabilitation requires direct physician supervision. In the aforementioned Final Rule, CMS stated that for the outpatient hospital setting, this means a physician must be present somewhere on the hospital campus

and be close enough to render immediate assistance. It doesn't have to be the same physician who ordered the treatment and it doesn't mean that the physician has to be in the same room or even the adjacent room. There is no specific time interval given for what constitutes "immediately available." Generally, as an example, if the cardiac rehab is in the main hospital building, or even an adjacent building, with the hospital emergency room, the emergency room physician staff could be said to meet this requirement. However, while direct supervision for certain other services can be extended to some nonphysician staff, services such as cardiac and pulmonary rehabilitation do require that a physician be present on campus and close enough to render immediate assistance, if needed. For off campus cardiac rehabilitation, the physician supervision rules are more stringent.

The websites below helpfully summarize the 2010 OPSS Final Rule discussion of this topic.

<http://www.klgates.com/newsstand/detail.aspx?publication=6025>

http://www.hallrender.com/library/articles/546/HLW/article_11_13_09.pdf

http://www.kilpatricktownsend.com/en/Knowledge_Center/Alerts_and_Podcasts/Legal_Alerts/2009/12/Physician_Supervision_Requirements_under_the_2010_Outpatient_Prospective_Payment_System_Final_Rule.aspx

[http://www.trailblazerhealth.com/Tools_\(accept_the_agreement,_if_you_wish\)_and_then_navigate_to_LCDs.aspx?ID=2828&DomainID=1](http://www.trailblazerhealth.com/Tools_(accept_the_agreement,_if_you_wish)_and_then_navigate_to_LCDs.aspx?ID=2828&DomainID=1)

<http://www.cms.gov/manuals/downloads/clm104c32.pdf> (see sections 140.2 and 140.2.1 or pages 80-82 of the pdf file) ▲

RAC Updates

Below are the most recent RAC-approved issues updated for end of March, early April.

DCS Healthcare posts seven new issues for DRG validation claims:

- ▶ DRGs associated with all MDCs: MS-DRGs 984-986, 998, and 999
- ▶ MDC 25-human immunodeficiency virus infections: MS-DRGs 969, 970, and 974-977

- ▶ MDC 24-multiple significant trauma: MS-DRGs 955-959, and 963-965
- ▶ MDC 23-factors influencing health status and other contacts with health services: MS-DRGs 939-941, and 945-951
- ▶ Burns: MS-DRGs 928, 929, 934 and 935
- ▶ MDC 20-alcohol/drug use and alcohol/drug-induced organic mental disorders: MS-DRG 894, 895, 896 and 897
- ▶ MDC 19-mental diseases and disorders: MS-DRGs: 876 and 880-887

Connolly posts four new issues across three categories

- ▶ Outpatient billing: Infliximab (Remicade) billed with therapeutic injection/infusion. Infliximab (Remicade) is a monoclonal antibody agent. Infusion administration should be billed as a chemotherapy and other highly complex drug or highly complex biologic agent infusion administration. Some providers will bill with therapeutic infusion administration.
- ▶ DME while in hospice: Services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately.
- ▶ Hospice related services – Part B: Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.
- ▶ Add-on codes without primary codes: Certain CPT codes, by their definition (in each respective year of the CPT Manual) require billing to include both the primary and additional component codes. Providers are billing only the add-on codes without their respective primary codes resulting in overpayments.

HealthDataInsights posts four new issues across three categories

- ▶ Mohs surgery pathology billed by separate provider J1: If the preparation and interpretation of the slides of tissue taken during the Mohs surgery are performed by someone other than the surgeon or his or her employee, then Mohs surgery may not be billed.

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CLIENT CORNER

See you in May!

Best Practice Forum 2011
May 17-19
The Driskill, Austin, TX



We're looking forward to seeing you next month in beautiful, downtown Austin. To view a more detailed agenda, please visit our website:

http://www.irminconline.com/news/news_bestpractice.htm

Master of Ceremonies: Jack Duffy, IRM Exec VP

Presentations

- ▶ IRM: *"Is It Time to Reassess Your Clinical Documentation Program?"*
- ▶ Guest: Velocette, Denial Management Experts
- ▶ IRM: *"Process Improvement and Bill Presentation"*
- ▶ IRM: *"Vascular IR and Cardiac Cath Highlights"*
- ▶ Guest: Integris Health
- ▶ Guest: HFMA, *"Reform and the Revenue Cycle"*
- ▶ IRM: *"Bundled Payments"*
- ▶ Guest: EpsteinBeckerGreenWickliff&Hall, *"Accountable Care Organizations"*
- ▶ Panel Q&A: *"Accountable Care Organizations"*
- ▶ Guest: Our Lady of the Lake Regional Medical Center, *"OPPS Quality Measures"*
- ▶ Guest: Floyd Medical Center, *"Cost Saving and Revenue Leakage"*
- ▶ Clients: *Process Improvement Initiatives*

RAC Updates *continued from page 4*

- ▶ Mohs surgery pathology billed by separate provider J3: If the preparation and interpretation of the slides of tissue taken during the Mohs surgery are performed by someone other than the surgeon or his or her employee, then Mohs surgery may not be billed.
- ▶ Visits to patients in swing beds: If the inpatient care being billed by the hospital with swing bed approval is for nursing facility care, then the nursing facility codes apply.
- ▶ Acute inpatient hospitalization – red blood cell disorders without MCC: DRG 812. ▲



All CBR (Code-Based Reimbursement)/CCDR (Compliant Coding and Documentation Review) activity for the month must be entered into the CBR/CCDR Software applications, including DRG Catalyst, prior to the 10th of the following month.

Be sure to follow the steps below so that results from retrospective CBR/CCDR audits translate onto the Executive Summary:

Inpatient (DRG Catalyst)

- ▶ The rebill checkbox must be checked. (Please make sure that you send the checked accounts to PFS for rebilling!)

Outpatient (CBR Database)

- ▶ The completion date must be entered under the CBR/CCDR Utilities tab, and
- ▶ The rebill checkbox must be checked. (Please make sure that you send the rebill accounts to PFS for rebilling!)

Before the database closes each month, IRM recommends that you complete the following checklist:

- ▶ Confirm that all completed retrospective audits for the month have an end date entered into the CBR/CCDR database.
- ▶ Check the rebill box in the CBR/CCDR database or DRG Catalyst for each retrospective claim that has been approved for rebilling.
- ▶ Complete a Summary of Audit Findings form for any projects you closed this month and submit it to the coding Subject Matter Expert (SME).
- ▶ Ensure that data is entered for all accounts audited for the current month. ▲

UPCOMING WEBINARS

Client RMD/RID Webinars 2011

Apr 27: Charge Audit/CCDR Forum - Blood

May 3: RAC Forum: RAC Updates

5: Managed Care Forum

Potential Topics

Consumer-Driven Healthcare/Pay for Performance

Medicare Managed Care

Auditing ICU Accounts

How to Handle Adversity

Silent PPOs

How to Interact with Internal Customers

Write-Off Analysis

Software Reporting

Injections and Infusions

Introduction to Inpatient Audits

Inpatient Mechanical Ventilation

POA and HAC

Observation and One-Day Stays

Device Dependent APCs

Pain Management

Outpatient Orders

Spine Surgery

Chemotherapy

Pathology

Brachytherapy

Moderate Sedation

Radiology Imaging

Erythropoiesis Stimulating Agents

Discharge Dispositions

Emergency Department

Vascular Access Devices

Neurostimulators

GI Endoscopy

Tracking and Trending CCI Edits



Please watch for your e-mail invitation approximately three weeks prior to the scheduled event.

Thank You



Net Revenue Matters is a monthly publication of Integrated Revenue Management, Inc. (IRM), and is offered as an informational service. Due to the nature of this publication, examples cited and advice given must often be general in nature and may not apply to a particular facility or situation. Thus, IRM does not warrant or guarantee the information contained will be applicable or appropriate in all situations. Each facility will have to evaluate its specific opportunities and take such action as to best meet its business needs. To find out more about a given subject or for information tailored to your specific circumstances, contact an IRM professional.

*If you have questions or would like to submit information for a future newsletter, please contact:
Cynthia Hufferd ☎ 760-448-1034 ✉ chufferd@irminconline.com*