

Net Revenue Matters



August 2011



Welcome to the August 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, "The Perfect Opportunity," Founder & Executive Vice President Jack Duffy discusses healthcare's state of constant change.

Also, we hope that you'll appreciate the information presented in "IRM Launches RevComply™" and "Physician Orders, or Lack Thereof, Impact Reimbursement."

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

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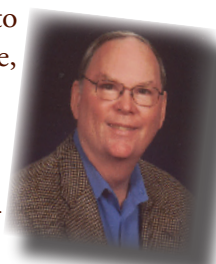
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The Perfect Opportunity

The next person that describes the future of healthcare as the *Perfect Storm* is in real trouble. Healthcare has been in the state of constant change since the Greeks first laid hands on a patient. Today and tomorrow are not different except for the magnificent new tools that we can bring to bear in our quest to better serve our patients. A review of available tools can give us the confidence to understand how we are going to navigate the next twenty years when the majority of the "baby boom" generation will use 90% of their total lifetime healthcare services. They include:

- ▶ Intelligent coding support tools that identify medical impressions from either transcription or the EMR. Such tools improve accuracy and increase productivity by 200-4000%. The conversion to ICD-10 is not there to fear, but to embrace.
- ▶ Although many hospitals will just squeak under the wire in December, the upgrade in the HIPAA code sets is a generational opportunity to finally achieve the promise of this legis-

lation. If used to its highest value, the new codes will save thousand of hours in non-productive follow-up repairing and rebilling flawed claims. The new codes are expected to reduce total hospital accounts receivable by eight billion dollars. We need to be sure each of our hospitals gets its share of this benefit.



- ▶ After resting in their respective silos for decades, the Materials Management process is about to meet the Charge Description Master. This departmental confluence, although often reporting to the CFO, will show huge opportunities to create a closed loop when all chargeable items are accounted for. This will allow for more accurate pricing. When coupled with tools that allow for standard nomenclature across multiple supplies and alerts to monitor the best prices, savings as high as 30% have been reported.
- ▶ The Thursday's Wall Street Journal, 08/04/2011 featured, in the Business Education section,

a review of Business Intelligence and how several top-tier graduate schools have begun to offer certificate and degree programs in this discipline. IBM is also mentioned as having spent \$14 billion since 2005 to purchase analytics companies. Investments at this level are a pointer as to how healthcare will be managed in the future. To make these tools practical, the Internet had to mature to the point where massive amounts of information originating from several discreet systems could be merged, scrubbed, and returned to the user in an easily understandable format.

Above are just four examples of many that support the hypothesis that healthcare's best days are still ahead. Although the amount available to treat the individual patient may decrease, the way we deploy both human capital and technology will deliver improved service at a lower unit cost. ▲



IRM Launches RevComply™

In December 2010, IRM launched RevComply™, a service to provide a comprehensive review of closed balance accounts and cash collections on all verified payment discrepancies. This service also identifies and documents performance and process improvement opportunities and concludes with an educational summary of where the underpayments occurred for correction on future claims.

IRM recognizes that the total available “auditable” revenue may be lost to statute, billing, and coding errors, and processing issues. We also recognize that hiring additional hospital team members may not be feasible during these tough economic times; therefore, we created RevComply™ to augment current collect efforts.

RevComply™ adds a layer of quality payment review for all closed balance claims by analyzing accounts through a series of queries to compare the actual reimbursement to the expected contractual allowable in order to identify potentially underpaid cases. Once variances are found, the IRM team conducts

the research, review, and assessment of each variance claim. IRM tracks and aggregates reoccurring underpayment risk areas to stop the trend, moving forward.

RevComply™: Review Summary

IRM's internal team adds a layer of quality payment review for closed balance claims that have discharge dates within the past 18 to 24 months and have not been previously reviewed by your RMD team. IRM runs the accounts through a series of queries to compare the actual reimbursement to the expected contractual allowable, which identifies potentially underpaid cases. Once variances are found, the IRM team conducts the research, review, and assessment of each variance claim.

What are the costs to and supporting requirements of RevComply™ clients?

- ▶ Front-end support includes administrative and IT system access and ongoing assistance for any clinical document requests, such as medical records and explanations of benefit.
- ▶ A 30% contingent fee for any collected revenue on claims reviewed.

What are the client benefits?

- ▶ Increased revenue between \$250-\$1M in additional annual revenue from closed AR.
- ▶ A summary detailing what the areas of risk are and how to avoid them moving forward; this provides ongoing process improvement-based revenue.

How does RevComply™ work?

The comprehensive review steps are as follows:

- ▶ Confirm appropriate insurance, contract, payor details, and any ad hoc agreements to verify the appropriate discount from the billed charges.
- ▶ Receive requested data to review all closed balance accounts.
- ▶ Create potential underpayment list for research and review.
- ▶ Review the necessary documents to confirm lost revenues (i.e. System notes, Explanation of Ben-

efits, Operating Reports, UB-04, and/or Itemized Bill detail, etc.).

- In order to research and review, IRM needs remote access to systems, which must include the ability to print UB-04, itemized bills, and coding summaries.
 - IRM must have a point-of-contact to request implant and drug invoices, when applicable, as well as medical records, unless these documents can be received via remote access.
- ▶ When an underpayment is confirmed, IRM appeals the claim with all necessary, supporting documents.
- ▶ All IRM underpayments must be flagged on the hospital patient accounting system so that the facility employees know that IRM is actively pursuing additional payment.
- ▶ IRM conducts follow-up on all appealed revenue disputes until reimbursement is received.
- ▶ On a weekly basis, IRM receives a payment posting report from the hospital for any IRM claims that has received additional payment.
- ▶ On a monthly basis, IRM invoices the facility for contingent amount. The invoice includes line-by-line account collections with a bottom line roll-up of the contingency amount. IRM also invoices for pass-through costs, such as travel.

During and concluding our review, IRM will:

- ▶ Analyze audit findings and identify trends and patterns that may indicate opportunities for process/performance improvement. IRM will provide a lost revenue list of all confirmed underpaid cases. In addition, we will track and aggregate any reoccurring areas in which underpayments occurred and provide suggestions as to how to stop the underpayment trend moving forward.
- ▶ Present summary reports to educate the hospital staff. These reports will provide the impacted and/or vulnerable areas. Risk occurs due to trended errors in coding, charge capture, billing, and/or documentation practices. The report will summarize recommendations for changes to current systems and/or implementation of new procedures.

Additional Project Scope and Document Request

In order to develop a project plan, IRM will need the following items from the hospital:

Data Download - Inpatient and Outpatient Closed Balance Reports (Full report specifications will be provided to hospital IT personnel.)

- ▶ All patient demographics
- ▶ Insurance Transaction Report (insurance carrier, codes, total payments)
- ▶ Contract Mapping details
- ▶ Clinical Details
 - MS-DRG (when applicable)
 - Revenue Codes 274-279, 636 aggregate charges by revenue code
 - First 10 ICD-9-CM procedure codes
- ▶ HCPCS/CPT Details
 - Vertical file of all patient-specific HCPCS, charges codes, etc.
- ▶ Charge Master file

Remote Access to Systems

- ▶ Patient accounting system access
- ▶ Online scanning systems – EOB, correspondence, implant, and drug invoices
- ▶ Access to and printing ability of Itemized Bills and UB-04s

To learn more, please visit:
<http://www.irminconline.com>. ▲

Physician Orders, or Lack Thereof, Impact Reimbursement

As we continually move forward into the realm of documentation integrity and defense audits, it is more important than ever to have clear, concise documentation for what is being coded and charged to Medicare, as well as other insurance companies. The

CLIENT CORNER



Don't Forget!

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. ▲

physician's intent is becoming more and more of a buzz word; however, the physician's intent must be documented in the patient's medical record and not be just a thought in the physician's mind.

Let's take Observation, for example. Conduct a physician documentation evaluation. Look for the physician's orders in order to evaluate and calculate observation hours. What are these orders telling you? The orders need to clearly reflect what the physician intends to do with the patient. Simply stating the word "Observe" is not enough. If the patient happened to have a surgical procedure that day and the doctor wrote "Observe," then that could really mean extended recovery, which would not be reported as observation. The physician may write observation orders for a patient who had a surgical procedure on the same day an extenuating circumstance took place, which would require observation care. However, again, documentation is everything.

The physician should be documenting the following on the orders: observation status and a timeframe of the expected length of stay; example: 24hrs. The orders must be timed and dated in order to calculate the appropriate time spent in observation status. Discharge orders must also be timed and dated in order to calculate the correct hours of observation.

"It doesn't matter if the orders are electronic or hand-written..."

It doesn't matter if the orders are electronic or hand-written; they need to clearly contain the required elements in order to code correctly for the observation hours. Retrospective orders may not be written after the patient is already in observation care; they must be written prior to the patient going into observation status. Otherwise, the time cannot be counted and coded for reimbursement.

With changes in hospital systems and the ever evolving healthcare challenges, it is very important to keep a pulse on what is going on with your physician orders and documentation of the patient's care. Most likely, there will be room for compliance process improvements, which in turn will lead to additional reimbursement. ▲

UPCOMING WEBINARS

Client RMD/RID Webinars 2011

Aug 18: Managed Care Forum
25: 5010 and the Revenue Cycle
Sep 6: RAC 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:
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