

# Net Revenue Matters



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## 2008 Will Be a Pivotal Year for Hospital, Physician Relations

*Notes from Jack Duffy, FHFMA, Founder and Director, IRM*



As hospital leaders, our physician partners are never far from our thoughts. Over the past 40 years, many strategies have been employed to ensure that our patients have access to quality medical care. Regionally, we have experimented with capitation as a payment methodology, with large scale practice purchases, and numerous forms of joint ventures. Most of these strategies ended up costing a hospital millions of dollars with limited benefits to both the organization and the community. An experimental program would then unwind and there would be a pause before the next idea was launched. Given the cyclical nature of these initiatives, why does 2008 appear to have more than the "normal" complexity in our physician relations?

been avoided by last minute deals for several years but the current arrangement will only last until June. Hospitals may expect large scale physician disenrollment from these programs, leaving few options for referring patients who are seen in the Emergency Room. Community access issues could pressure hospitals to hire more physicians to ensure an orderly discharge process.

- The complexity of coding and billing causes many physicians to seek alternatives. They increasingly look to their hospital partners for assistance. Hospitals, with their required emphasis on large balance accounts, are able to pay only limited attention to the "small balances" usually associated with physician services.
- The same dynamic in point 2, will cause physicians to compete for the limited coding resources

### What We Know

- Medicare and Medicaid are determined to impose a 10% payment reduction for physician services. This has



found in most communities. As insurance and government demand ever more compliant coding and billing, physicians can no longer rely on traditional “super bills” to accurately reflect their services.

- Many hospitals are investing in either or both primary care practices to help manage a fair mix of patients and specialty practices to offset the loss of voluntary on call coverage. These relations are often not self supporting and compete for scarce capital or operating dollars.
- The fluid situation around the build and payment for services at specialty hospitals further complicates our physician relationships.

### **Suggested Ways to Mitigate the Impact of These Changing Relationships**

- For those hospital that have invested in creating revenue management teams, there may some effective strategies that can be deployed
- Do an assessment of charging, coding and payment accuracy. This is the basic building block of any intervention.
- Contract with trusted advisors to assess any compliance issues related to the physician community.
- Start a coding school. While not an inexpensive option, having an adequate supply of diagnostic and procedural coders in your community may prevent rapidly escalating wages and the need to send your records all over the world perform this critical function. Properly sized, the availability of procedural coders could be a magnet for quality physicians and groups.
- Make a serious effort to reduce total administrative overhead for all parties. This is 2008 and we have the choice to replicate every key stroke for every health care service a patient receives or to use our technologies to reduce redundant processes. This problem is over 40 years old, but many hospitals lack the energy to create better processes. Of note, a physician and hospital bill share over 95% of total required characters. If more than one physician consulted on a case, the overlap is even more significant. We recommend that the hospital use its resources to reduce this waste of effort and benefit all members of the medical staff.

### **Summary**

For the past 8 years a select group of visionary hospitals have worked to create additional resources by establishing a focus on revenue management and in particular, the clinical skills required to get the best economic results. The same focus and many of the same skills can be further deployed to benefit our physician relationships in a time of rapid change and uncertainty.



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## **How Secure is Your Patients' Health Information? “HIPAA Police” to Launch Investigation**

On January 16, 2008, the Centers for Medicare and Medicaid Services (CMS) announced that they will begin performing onsite hospital audits to validate compliance with the security regulations associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This announcement came as CMS wrapped up its focus on outreach, education, and the publication of seven educational papers on HIPAA security.



HIPAA addresses both health information privacy as well as security. These audits will focus on the security portion of the law. CMS will begin by looking at large hospitals who have received security complaints. While most HIPAA-related complaints are related to privacy which is monitored by the Office for Civil Rights, another department of Health and Human Services (HSS) department, an investigation into a privacy violation can also uncover security issues, which are monitored by CMS.

Within the next nine months, Price Waterhouse Coopers, under CMS contract, will audit 10 to 20 hospitals. The audited facilities will be

allowed to comment on the findings and CMS will anonymously publish the results. Hospitals with major lapses in information security may be subject to fines.

CMS will publish a checklist of security issues prior to beginning the reviews. It is anticipated that they will focus specifically on remote access to data as well as portable storage devices, such as hand-held devices used by physicians for scheduling, ordering, and documentation. CMS will also interview the compliance officer, security officer, and other information technology personnel. They are also expected to request copies of facility security policies and procedures.

In order to prepare, facilities should work with their security officer to take proper safeguards to protect patient information. This includes ensuring that all policies and procedures are updated and enforced. Hospital employees or staff with remote access to patient information (e.g., medical staff) and those that use laptop computers or hand-held devices for storing patient information should be particularly vigilant. A great place to start in deciding how to prioritize security validation is to review the security information series available on CMS's website at:

[http://www.cms.hhs.gov/EducationMaterials/04\\_SecurityMaterials.asp#TopOfPage](http://www.cms.hhs.gov/EducationMaterials/04_SecurityMaterials.asp#TopOfPage)

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## Point of Origin Codes

With the release of Transmittal 1395 on December 14, 2007, the CMS announced significant changes to the Point of Origin Codes effective January 1, 2008. The new Point of Origin Codes replace the Admission Source Codes and appear on the Uniform Bill – 2004 (UB-04) at Form Locator 15. The values for the Point of Origin Codes are found in the National Uniform Billing Committee's (NUBC) Official UB-04 Data specifications Manual 2008.

First and foremost the definition of the Point of Origin field differs from the definition of Admission Source. The new definition of the Point of Origin Code is "A code indicating the point of patient origin for this admission or visit." The old definition read, "A code

indicating the source of the referral for this admission or visit." The new definition has essentially changed what is being measured. The new Point of Origin Codes are designed to focus on the patient's place, or point of origin, rather than the source of physician order or referral.

Facilities should ensure the new codes are implemented correctly and that all appropriate staff is aware of the new Point of Origin codes. All registration staff should be aware of the new codes and understand the definition of the new Point of Origin field. If coders are required to review and correct this field, they also should be aware of the new codes. If the definitions of the Point of Origin codes are truncated in the hospital information system, it is important that all staff have access to the complete definitions for each code.

Hospital administration, including the emergency department (ED) director, should be aware of the new Point of Origin codes as well as the new definition. Any statistics historically reported using admission source will likely change. Administration should understand that there has not necessarily been a change in admitting patterns, only a change in the meaning of the data. Facilities may find it necessary to utilize an alternative method of tracking the number of patients admitted through the ED.

Below are the new Point of Origin Codes which can be found in CMS Transmittal 1395.

<http://www.cms.hhs.gov/transmittals/downloads/R1395CP.pdf>

- Value 1- Non Health Care Facility Point of Origin
  - Inpatient: the patient was admitted to this facility upon an order of a physician.
  - Outpatient: The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). Includes non-emergent self-referrals.
  - Note: Includes patients coming from home, a physician's office, or workplace.
- Value 2 – Clinic
  - Inpatient: The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.

- Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services.
- Value 3 – Reserved for national assignment
- Value 4 – Transfer from a Hospital (Different Facility)
  - Inpatient: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or an outpatient.
  - Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of a different acute care facility.
  - Note: Excludes transfers from hospital inpatient in the same facility. For transfers from hospital inpatient in the same facility, see code. D.
- Value 5 - Transfer from a SNF or Intermediate Care Facility (ICF)
  - Inpatient: The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.
  - Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF or ICF where he or she was a resident.
- Value 6 – Transfer from Another Health Care Facility
  - Inpatient: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.
  - Outpatient: The patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.
- Value 7 - Emergency Room (ER)
  - Inpatient: The patient was admitted to this facility after receiving services in this facility's emergency room department.
  - Outpatient: The patient received unscheduled services in this facility's emergency department and discharged without an inpatient admission. Includes self-referrals in emergency situations that require immediate medical attention.
- Note: Excludes patients who came to the ER from another health care facility.
- Value 8 - Court/Law Enforcement
  - Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
  - Outpatient: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
  - Note: Includes transfers from incarceration facilities.
- Value 9 - Information Not Available
  - Inpatient: The means by which the patient was admitted to this facility is not known.
  - Outpatient: For Medicare outpatient bills, this is not a valid code.
- Value A - Reserved for national assignment.
- Value B - Transfer From Another Home Health Agency
  - The patient was admitted to this home health agency as a transfer from another home health agency
- Value C - Readmission to Same Home Health Agency
  - The patient was readmitted to this home health agency within the same home health episode period.
- Value D - Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer
  - The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.
- Value E - Transfer from Ambulatory Surgery Center
  - For Medicare bills, this is not a valid code.
- Value F - Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program
  - For Medicare bills, this is not a valid code.

## Payment for Brachytherapy Seeds Extended

On December 29, 2007 President George W. Bush signed the Medicare, Medicaid and SCHIP Extension Act of 2007. The new legislation extends the 2007 reimbursement policy for brachytherapy seeds until June 30, 2008. CMS announced in the Outpatient Prospective Payment System (OPPS) final rule that hospitals would begin receiving a fixed per seed payment for brachytherapy seeds beginning January 1, 2008. However, the new legislation prevents CMS from implementing the fixed per seed payments and hospitals will continue to receive payment for seeds based on their charges adjusted to their cost until July 1, 2008. CMS will provide new instructions at a later date for brachytherapy source payment effective July 1, 2008.

The codes for separately paid brachytherapy sources, long descriptors, status indicators, and APCs for CY 2008 are listed in Table 5, the comprehensive brachytherapy source table below. Note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand. See Transmittal 1259, CR 5623, issued June 1, 2007, for further information on billing for brachytherapy sources and the OPPS coding changes made for brachytherapy sources effective July 1, 2007.

CPT/ HCPCS	Long Descriptor	SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	H	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	H	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	H	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	H	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	H	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	H	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	B	NA
C2638	Brachytherapy source, stranded, Iodine-125, per source	H	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	H	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	H	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	H	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	H	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	H	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	H	2699

A summary of the Medicare, Medicaid and SCHIP Extension Act of 2007 can be found at the following link:

<http://thomas.loc.gov/cgi-bin/bdquery/z?d110:SN02499:@@D&summ2=m&>

# Client Corner

## Code-Based Reimbursement Project Rollout and Forum Call Calendar for 2008

Continuing in 2008, IRM will present one CBR project per month developed specifically for the CBR analysts, CDM analysts, and RMD Directors. The complete 2008 schedule for project rollouts, topics, and forum discussion calls is as follows:

### February 27, 2008

Forum Call, 11:30 a.m. Pacific

### March 5, 2008

Project Rollout, 11:30 a.m. Pacific  
• Wound Care

### March 26, 2008

Forum Call, 11:30 a.m. Pacific

### April 2, 2008

Project Rollout, 11:30 a.m. Pacific  
• Pain Management

### April 23, 2008

Forum Call, 11:30 a.m. Pacific

### May 7, 2008

Project Rollout, 11:30 a.m. Pacific  
• Outpatient Orders (Compliance project)

### May 28, 2008

Forum Call, 11:30 a.m. Pacific

### June 4, 2008

Project Rollout, 11:30 a.m. Pacific  
• Spine Surgery

### June 25, 2008

Forum Call, 11:30 a.m. Pacific

### July 2, 2008

Project Rollout, 11:30 a.m. Pacific  
• Pathology

### July 23, 2008

Forum Call, 11:30 a.m. Pacific

### August 6, 2008

Project Rollout, 11:30 a.m. Pacific  
• Brachytherapy

### August 27, 2008

Forum Call, 11:30 a.m. Pacific

### September 3, 2008

Project Rollout, 11:30 a.m. Pacific  
• Moderate Sedation

### September 24, 2008

Forum Call, 11:30 a.m. Pacific

### October 1, 2008

Project Rollout, 11:30 a.m. Pacific  
• Radiology Imaging

### October 22, 2008

Forum Call, 11:30 a.m. Pacific

### November 5, 2008

Project Rollout, 11:30 a.m. Pacific  
• J Codes

### November 26, 2008

Forum Call, 11:30 a.m. Pacific

For more information, contact your subject matter experts (SME) at IRM - Kristi Stanton or Sheldrian Leflore.

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## 2008 Best Practice Revenue Management Forum - See You There!

This year's Best Practice Forum will be hosted at the Floridays Resort Orlando, in beautiful Orlando, Florida. The Forum is February 19-21, 2008 and includes the annual PI Roundtable along with varied speakers and topics. This year's agenda looks to be a not-miss opportunity!

Travel safe, and we'll see you in Orlando!



# Upcoming Events! TCG Audio Conference Topic Schedule for 2008



## February 2008

- 14th: Audio Conference, 10:00 a.m. Pacific  
*RAC Update*
- 21st: Audio Conference, 10:00 a.m. Pacific  
*Coding Electrophysiology Studies*

## March 2008

- 13th: Audio Conference, 10:00 a.m. Pacific  
*Coding Pain Management Services*
- 27th: Audio Conference, 10:00 a.m. Pacific  
*Coding and Documentation of Wound Care Services*

## April 2008

- 15th: Audio Conference, 10:00 a.m. Pacific  
*Intro to Medicare Reimbursement Series:  
DRG 101*
- 24th: Audio Conference, 10:00 a.m. Pacific  
*Orthopedic Series: Casting, Splinting, Strapping*

## May 2008

- 13th: Audio Conference, 10:00 a.m. Pacific  
*Orthopedic Series: Knee Arthroscopy*
- 29th: Audio Conference, 10:00 a.m. Pacific  
*Intro to Medicare Reimbursement Series:  
APC 101*

## June 2008

- 17th: Audio Conference, 10:00 a.m. Pacific  
*OB-GYN Procedures*
- 26th: Audio Conference, 10:00 a.m. Pacific  
*Orthopedic Series: Shoulder Arthroscopy*

## July 2008

- 15th: Audio Conference, 10:00 a.m. Pacific  
*Orthopedic Series: Spine Surgery*
- 29th: Audio Conference, 10:00 a.m. Pacific  
*Bill Presentation*

## August 2008

- 12th: Audio Conference, 10:00 a.m. Pacific  
*Cystoscopies*
- 28th: Audio Conference, 10:00 a.m. Pacific  
*Screening Tests*

## September 2008

- 16th: Audio Conference, 10:00 a.m. Pacific  
*ICD-9-CM Updates for 2009 (Part 1 of 2)*
- 18th: Audio Conference, 10:00 a.m. Pacific  
*ICD-9-CM Updates for 2009 (Part 2 of 2)*

## October 2008

- 23rd: Audio Conference, 10:00 a.m. Pacific  
*Vascular Interventional Radiology Series:  
Catheterization Procedures*
- 30th: Audio Conference, 10:00 a.m. Pacific  
*Vascular Interventional Radiology Series:  
Imaging Procedures*

## November 2008

- 11th: Audio Conference, 10:00 a.m. Pacific  
*Vascular Interventional Radiology Series:  
Vascular Transcatheter Procedures*
- 20th: Audio Conference, 10:00 a.m. Pacific  
*OIG Work Plan for 2009*

## December 2008

- 16th: Audio Conference, 10:00 a.m. Pacific  
*CPT/HCPCS Updates for 2009*
- 18th: Audio Conference, 10:00 a.m. Pacific  
*OPPS Updates for 2009*

Check our website for more information and to register throughout the year, or call!

**www.IRM-TCG.com**  
**760.448.1022**

*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 any particular situation. Each facility will have to evaluate their specific opportunities and take such action as to best meet their 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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