

# Net Revenue Matters

February 2011

Welcome to the February 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, "Clinical Integration in a Siloed World," Executive Vice President Jack Duffy discusses the integration of hospital and physician services.

Also, we hope that you'll appreciate the information presented in "2011 CPT Wound Care Debridement Guidelines," "Tools that Work," and "Guidance on Hospital Inpatient Admission Decisions."

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

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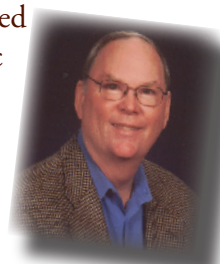
## Clinical Integration in a Siloed World

Many healthcare organizations are making massive investments to integrate professional and hospital services in order to meet current and future requirements as outlined in the recent healthcare reform legislation. While many of these goals are positive, the amount of work that will be required to complete these tasks is substantial. Some examples from real-life experiences are found below. I would strongly suggest that organizations that are investing in these new strategies identify non-competing partner organizations with similar goals to form mutual support groups for both clinical and administrative issues.

## Software and System Support

The integration of the hospital (technical) and professional components is very complex. Software vendors who promote integrated products are often designing as they install, with many areas not fully developed. For example, revenue codes for the same encounter can change depending on whether the

service was provided in a hospital clinic or in a physician's office. This means that the charge process must be built in "tiers" to define these codes based on site of service. The blending of registration, charging, and bill presentation rules can lead to many conflicts that then have to be resolved, thus suppressing revenue for extended periods.



## Coding and Workflow

One of the decisions associated with an integrated process is the assignment of ICD-9, CPT or procedure codes. Coders have traditionally worked in one environment or the other and now are faced with an "integrated" EMR. Organizations must be prepared to make a significant investment in training and auditing the coding process until a stable, accurate product can be achieved. Another factor is the bill editing and release process that can find a high-value hospital bill on hold for a much smaller physician charge. Even if the hospital bill met all edits, the physician may have 15 or more days under cur-

rent medical staff rules to submit his or her record for coding. The back-and-forth holds and edits can add millions of dollars to DNFB.

## Registration and Financial Counseling

Once again, there are enough differences in historical practice to cause these activities to be a challenge in an integrated environment. Hospitals have depended on frequent re-registrations to keep the database accurate while physicians have been able to depend on frequent patient interactions to correct any deficiencies. Similar problems exist with consents, Medicare Secondary Billing questionnaires, and other documents. If the hospital standards are adopted, the cost of an office visit can increase significantly. If the office standards are used, the hospital may lack support for future audits. Physician offices can often manage the patient's payment responsibility by collecting the visit co-payment. Hospitals have more complex calculations and usually wait for the insurance company's payment in order to fully understand the patient's responsibility. In an integrated environment, finding the best path for financial counseling is definitely more difficult.

*“The above items are but samples of the many issues that must be overcome on the road to becoming an integrated healthcare organization.”*

The above items are but samples of the many issues that must be overcome on the road to becoming an integrated healthcare organization. Careful planning and an honest discussion with software suppliers will reduce the financial risks and shorten the learning curve for all impacted departments. ▲

Jack

## Tools that Work

Working smarter, not harder, is the mantra for everyone in the healthcare field these days. A fast-paced, ever-changing, do-more-with-less environment is what we all experience. With this in mind, be sure

to get the most out of the tools and time you have at your disposal.

*“The charge audit database is a robust tool when used to its full potential.”*

The charge audit database is a robust tool when used to its full potential. The amount of detail entered into the database determines the end result of information available at the end of the month.

- ▶ To illustrate, sub audit area easily added to each audit type. These categories can isolate focused audits to allow the charge auditor an easy method of retrieving data from a subset of auditing. As an example, a focused review of respiratory charges can determine charge capture fractures in over- and/or undercharges. Auditing 100% of all inpatient respiratory charges for 30 days has the potential of providing a large enough audit sample, depending on revenue and usage reports, to determine if further investigation of the respiratory department's charge master, documentation, workflow, and charge capture process improvement is warranted.
- ▶ As a new service area or department is added to the facility, it is prudent to conduct a sample audit for a pre-determined length of time to ensure charge capture practices are complete, functional, and accurate.

Data fields already available when entering transactional findings include “location,” “department,” “reason code,” and “error caused by.”

- ▶ **Location** utilized accurately when entering findings in the charge audit database adds to the depth of drill-down capability. When a charge transactional error is identified, the location where it occurs is just as important as the department. For example, a medication is from the department “Pharmacy.” However, the location where the error occurred could be in “Pre-op holding area.” The service area of the encounter identifies from where the patient was discharged, such as Med-Surg floor. But, again, the error location could be the “pre-op holding area.”
- ▶ **Department** field is linked to the CDM (charge

description master) line item; this is not an optional field. Many reports can be utilized from this department information.

- ▶ **Reason code** is a predetermined list of reasons to identify major categories of transactional errors. Utilizing the most precise reason for the error assists the team when reviewing reports tied to this data field.
- ▶ **Error caused by** provides the auditor additional free text space to enter a brief note (the space is limited). This text is captured when reports that include a reason code is utilized. I would consider this an opportunity to expand on a reason code.

Utilizing the above enhancements in the database allows analyses of greater depth. I encourage each of you to expand your utilization of these fields as a team. Consistent reporting of all findings lends credence to all audit findings. Do not hesitate to reach out to IRM for assistance to utilize these elements to their full potential. ▲

Happy auditing!

*Dawn*

## Guidance on Hospital Inpatient Admission Decisions

If you struggle with the process for determining proper inpatient admissions and are worried about the RAC/MAC/FI/CERT, you are not alone. To assist, CMS issued MLN Matters SE1037 on January 25, 2011.

There are several screening tools available to help determine medical necessity, however, in all cases the reviewer needs to use his or her own clinical judgment to make a determination based on medical record documentation.

CMS directs us to prior policy guidance.

First is the Medicare Program Integrity Manual, Chapter 6, Section 6.5.1 and 6.5.2. A screening tool is to be used by contractor reviewers as part of the review process for inpatient claims. CMS does not require the use of specific criteria or screening tools,

however, it does require that the reviewer must use their own clinical judgment in making determinations. According to CMS, the reviewer is to use the following when making a determination:

- ▶ Admission criteria
- ▶ Invasive procedure criteria
- ▶ CMS coverage guidelines
- ▶ Published CMS criteria
- ▶ Other screens, criteria, and guidelines (practice guidelines which are well accepted by the medical community)

Second is the Medicare Benefit Policy Manual, Chapter 1, Section 10. A patient who is admitted as an inpatient with the expectation that they will remain at least overnight and occupy a bed, is considered an inpatient. “The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors. . .” When making the decision to admit, the factors to consider are:

- ▶ The severity of the signs and symptoms exhibited by the patient.
- ▶ The medical predictability of something adverse happening to the patient.
- ▶ The need for diagnostic studies that appropriately are outpatient services to assist in assessing whether the patient should be admitted.
- ▶ The availability of diagnostic procedures at the time when and at the location where the patient presents. ▲

### CMS links for this information:

Guidance on Hospital Inpatient Admission Decisions  
<http://www.cms.gov/MLNMattersArticles/Downloads/SE1037.pdf>

Chapter 1, Section 10 of the  
Medicare Benefit Policy Manual  
<http://www.cms.gov/manuals/Downloads/bp102c01.pdf>

Chapter 6 of the  
Medicare Program Integrity Manual, Section 6.5  
<http://www.cms.gov/manuals/downloads/pim83c06.pdf>

# 2011 CPT Wound Care Debridement Guidelines

Is your physician documenting correctly? Concurrent audits can assist in getting it right the first time!

As we roll into our second month of new guidelines for wound debridement coding, it is important to perform a concurrent audit of what is being documented and coded according to the 2011 CPT coding guideline and code description changes.

Per CPT guidelines, the language in the physician's report must include the depth (example: subcutaneous, muscle/fascia, etc.) of tissue that is removed and the surface area measurement of the wound in sq cm measurements. These services may be reported for injuries, infections, wounds and chronic ulcers.

When performing debridement of a single wound, the physician should report the depth using the deepest level of tissue removed.

For multiple wound debridement, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths.

Additionally, CPT codes 11040 and 11041 have been deleted. In order to report debridement of skin, epidermis, and/or dermis only, refer to code selection 97597 and 97598. The descriptors for this code selection have also changed. Reviewing the new codes and code descriptions with your physician will assist in accurate compliant reporting as well as compliant coding.

Do not report 97597-97602 with 11042-11047 for the same wound. If there are multiple wounds: to differentiate between the wounds treated, assign modifier 59 as appropriate, but only if another modifier to describe the service does not exist.

***“Remember that the clarity of the physician’s dictation is the key...”***

Remember that the clarity of the physician's dictation is the key to complaints, as well as proper code assignment. ▲

## CLIENT CORNER

### Plan to join us!

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

We are in full swing making plans for this year's event. You won't want to miss the chance to learn, share, and have fun in beautiful, downtown Austin. And be sure to put some thought into what your presentation will be! ▲

### 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. ▲

# UPCOMING WEBINARS

## Client RMD/RID Webinars 2010

Feb 24: Managed Care Forum

Mar 1: 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



**Integrated  
Revenue  
Management**

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

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