

Net Revenue Matters



June 2011



Welcome to the June 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, "Notes from Our Best Practice Forum," Founder & Executive Vice President Jack Duffy discusses recent vendor offers.

Also, we hope that you'll appreciate the information presented in other articles, such as "ICD-10 Readiness Roadmap," "FY2012 IPPS Rule," "Drug Description," and "Self-Administered Drugs."

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

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Notes from Our Best Practice Forum

Well, our time in Austin was special. For some of us it was the first time and, for others, the tenth.

I would like to take a minute and review some of the incredible vendor offers that were extended to IRM partner hospitals.

- ▶ Wayne offered to review a year's worth of payments in order to provide valuable information as to the nature, degree, and trends of denials. You could pay \$25,000 for this information and it would not be at this level of quality. Please consider.
- ▶ Carl showed us our biometric future and offered a large discount to attendees. The technology has a return-of-investment based on reducing duplicate medical record numbers. It could save a life by not pulling the wrong chart. It also saves time at every registration.
 - How would you like to save 100,000 minutes?
 - How about a million minutes?

- ▶ Rebecca was the scariest presenter. What do we not understand about the 5010 conversion? At a recent billing group meeting, it was estimated that 65% of U.S. hospitals could not bill if the conversion was today. Washington Publishing Company would be glad to provide a web-enabled seminar for all IRM partners.



"I would like to take a minute and review some of the incredible vendor offers that were extended to IRM partner hospitals."

Please let me (or Cynthia) know of your interest in one or all of these opportunities. We will be happy to coordinate the required contact. ▲

Jack

ICD-10-CM/PCS Coding Readiness Roadmap

ICD-10-CM/PCS mandated conversion arrives October 1, 2013. In order to be adequately prepared for this major transition in code sets, facilities must phase in a comprehensive and carefully considered coding readiness program that encompasses assessment and reinforcement of coders' knowledge of the clinical foundations of medicine, identification of key physician documentation improvement issues, and intensive training in the ICD-10-CM/PCS coding classification systems themselves, as well as the corresponding coding guidelines and conventions.

A suggested roadmap for timely implementation of the aforementioned phases is outlined below.

2011

July - September: *administer Clinical Foundations Proficiency Assessment to coders.*

October - December: *implement Clinical Foundations Education to address discovered gaps in knowledge.*

2012

January - March: *continue to reinforce Clinical Foundations Education.*

January - March: *perform Medical Record Review to identify documentation improvement issues pertinent to ICD-10-CM/PCS for physicians.*

April - June: *provide summary of findings from Medical Record Review and begin ICD-10-CM/PCS Overview Education Training to key revenue cycle areas and physicians.*

July - September: *administer follow-up Clinical Foundations Proficiency Assessment and subsequent education, as needed.*

October - December: *perform follow-up Medical Record Review and continue ICD-10-CM/PCS Overview Education Training to key revenue cycle areas and physicians, as needed.*

2013

March - September: *administer ICD-10-CM/PCS Coder Training.*

IRM's Coding Readiness Program will expertly guide your facility through each important phase of the roadmap.

Phase 1: ICD-10-CM/PCS Clinical Foundations Proficiency Assessment

ICD-10 features a greatly expanded capacity to capture more specificity in clinical information. Coders will need to become familiar with clinical classification concepts (e.g., Gustilo and Anderson classification of open fractures, Neer classification of proximal humerus fractures, Glasgow Coma Scale, etc.) not currently accounted for in ICD-9-CM. In order to achieve this, coders will be required to reinforce their knowledge of the clinical foundations of medicine.

IRM can facilitate this process by providing a comprehensive clinical foundations proficiency examination covering four critical areas:

- ▶ Medical Terminology
- ▶ Anatomy & Physiology
- ▶ Pathophysiology
- ▶ Pharmacology

This examination has been carefully constructed to accurately reflect those clinical components most pertinent to ICD-10. Upon completion of the exam, coders will receive a gap analysis evaluation of their strengths and weaknesses within each of the four tested areas; subsequently, IRM will provide helpful and informative course materials custom tailored to remedy any identified deficiencies in these areas. Afterward, a follow-up proficiency examination will be given to ensure that coders have achieved sufficient mastery of the material to effectively prepare them for ICD-10.

Phase 2: Medical Record Review and Physician Documentation Improvement

Both ICD-10-CM and ICD-10-PCS will offer an unprecedented level of granularity compared to ICD-9-CM. While ICD-9-CM contains 13,000 diagnosis codes, ICD-10-CM features approximately 68,000. For procedure coding, the level of added detail is even more pronounced. ICD-10-PCS offers approximately

87,000 total procedure code combinations as compared to only 3,000 procedure codes in Volume 3 of ICD-9-CM.

However, one crucial fact will not change: regardless of the coding classification system used, coders can only report the level of detail that is reflected in the physician documentation. Just as coders will need to shore up their knowledge of clinical foundations, physicians will need to increase the specificity of their clinical documentation in order for coders to take advantage of ICD-10's superior granularity.

To assist with this process, IRM will provide a thorough and complete medical record review, identifying key documentation improvement opportunities. This will be followed by an education action plan, consisting of a detailed analysis of items needing to be addressed, extensive educational materials custom designed to facilitate improvement in these areas, and a follow-up review to ensure improvement goals are being achieved.

Concurrent with this step, IRM will institute regular ICD-10-CM/PCS training sessions for physicians and other important revenue cycle stakeholders, keeping everyone abreast of the latest information concerning ICD-10 conventions and guidelines and their potential impact on documentation improvement, compliance, and other significant revenue cycle components.

Phase 3: ICD-10-CM/PCS Coder Training

The ICD-10 code sets are not simply increased and renumbered ICD-9 code sets. They include greater detail, changes in terminology, and expanded concepts for injuries, laterality, and other related factors. The additional characters in the ICD-10 procedure code set allow for identifying the body system, root operation, body part, approach, and device involved in the procedure. The complexity of ICD-10 provides many benefits because of the increased level of detail conveyed in the codes. The complexity also underscores the need to be adequately trained on ICD-10 in order to fully understand reporting changes that will come with the new code sets.

As the 10/1/2013 implementation date draws closer, the third and final phase of the coding readiness

program, the intensive training of coding staff in the practical application of the ICD-10-CM/PCS codes themselves, becomes of paramount importance. IRM is uniquely well-equipped to prepare coders to master the daunting complexity of these new code sets through a meticulously detailed and highly informative series of online courses, including case studies and quizzes with rationales, covering ICD-10-CM body system chapters and ICD-10-PCS root operations. These courses may be customized for onsite training, as well. To further enhance this training, IRM also provides pre-recorded audioseminars and a help desk service to further clarify difficult concepts and to elucidate new or unusual topics not covered in the course material, making our educational offerings as varied and flexible as they are comprehensive and illuminating. ▲

Child Delivery Complications Are 5% of Hospital Costs

The Agency for Health Research and Quality released the results of a 2008 study that assessed the complications that occur during pregnancy and childbirth. The study concluded that maternal complications account for nearly 5% of all hospital costs. With mom and baby charges in annual excess of \$86 billion, below are some of the adverse event highlights from the study. Hospitals should run reports and conduct analysis to determine where they fall within these averages and what can be done to decrease the cost of care.

- ▶ Average length of stay with pregnancy-related complications tended to be longer at 2.9 days for non-delivery stays and 2.7 days for delivery stays. Delivery stays without complications are an average of 1.9 days.
- ▶ The cost of care rose significantly for maternal stays with complications. Complications increase cost approximately 50%, which brings costs to between \$3,900 and \$4,100 while delivery stays without complications is approximately \$2,600.
- ▶ Maternal stays with pregnancy and delivery-related complications accounted for \$17.4 billion, or nearly 5% of total hospital costs in the United States.

- ▶ Among non-delivery maternal stays, the following conditions occurred at a rate of 100 or more for every 1,000 hospital stays:
 - Early or threatened labor
 - Infections of the genitourinary tract
 - Hypertension, including eclampsia and pre-eclampsia
- ▶ Among maternal stays with delivery, the following conditions occurred at a rate of 50-99 for every 1,000 deliveries:
 - Umbilical cord complications
 - First- and second-degree perineal lacerations, previous C-section
 - Abnormal fetal heart rate or rhythm
- ▶ Patients 35 to 44 years of age accounted for 15% of maternal stays with complicating conditions (with or without delivery), but comprised only 1% of delivery stays. ▲

It's that Time of Year Again... CMS Proposed FY2012 IPPS Rule

The 2012 proposed rule for the inpatient prospective payment system was released on April 19. The comment period closes June 20 and the final rule should be released in early August.

The rule includes a few clarifications on prior rules, such as the three-day payment window and HACs vs. Never Events. On the subject of HACs, three existing HACs will have the coding modified and there is a proposal to add a new one – contrast induced kidney injury.

There is also information regarding how quality will impact payments. The Hospital Inpatient Quality Reporting Program will continue, with four proposed new quality measures being added in FY2014 and another 17 added in FY2015. A new program, the Hospital Value-Based Purchasing program, will be effective for FY2013. This program will reward hospitals for the *quality* of care provided, not just the *quantity* of services.

Some of the other highlights are three proposed new MS-DRGs for excisional debridement, which would include lower payments. The DCA, or Documentation and Coding Adjustment, will continue with an additional 3.15% reduction in payment.

The Hospital Readmissions Reduction Program (HRRP) is planned to begin in FY2013 and will use the National Quality Forum definition for readmission. The first year will include acute myocardial infarction, heart failure, and pneumonia, with a possible four more added in FY2015.

So, be proactive and prepare. Read the rule, review PEPPER, and run reports so you can then start evaluating where you may need to improve your processes. ▲

Self-Administered Drugs

Patients are often given Self-Administered Drugs (SAD) in hospital outpatient areas, such as the Emergency Department. These outpatient, self-administered drugs are excluded from Medicare coverage and, therefore, are the responsibility of the patient.

“Basically, self-administered drugs are those drugs patients would normally take on their own.”

What is a self-administered drug? Basically, self-administered drugs are those drugs patients would normally take on their own. According to CMS, a self-administered drug is a drug or biological given to an outpatient for therapeutic purposes and is not integral to the performance of a treatment or procedure. CMS considers a drug to be a SAD if Medicare beneficiaries give themselves the drug at least 50% of the time. This means given by the patient themselves, not by other individuals such as spouse, friend, family, or caregiver on an outpatient basis. This would include pills, suppositories, topicals, and some injectable drugs.

Fiscal intermediaries, carriers, and Medicare Administrative Contractors (MACs) are instructed to follow the CMS guidelines when applying the exclusion

for drugs that are usually self-administered by the patient. Each individual contractor must make its own determination for each drug. The carrier makes the determination to categorize a drug as an SAD by the drug itself, not the individual patient's condition. Contractors must provide on their Web site the criteria used to determine SADs and must include a list of injectable drugs that are subject to the SAD exclusion, including the data and rationale leading to that determination. Contractors must also provide a 45-day notice prior to the date that the drugs will not be covered. Contractors must not develop LCDs for this purpose, as the elaboration of "incident-to" and "not usually self-administered" are unnecessary.

"How should hospitals bill for SADs?"

How should hospitals bill for SADs? Revenue category 637 should be used to bill self-administered drugs and the patient should be billed for the non-covered, self-administered drugs. Choosing not to bill the patient could be seen as inducement by CMS. Many hospitals find the topic of charging for self-administered drugs to be controversial in their communities. Hospitals can avoid confusion by providing the beneficiaries with information on SADs during their visit. It is not appropriate to issue an Advance Beneficiary Notice because SADs are excluded from Medicare coverage. However, hospitals may provide other notification in order to inform the patient of financial responsibility. CMS has a free publication that explains in detail self-administered drugs and the responsibility of the beneficiary. A copy can be found at the following location:

<http://www.medicare.gov/Publications/Pubs/pdf/11333.pdf>

If patients have the Part D Medicare drug plan, these drugs may be covered and the patient can submit claims for the SADs to receive a refund. They must follow the instructions in their Medicare drug plan's enrollment materials or they can call their plans directly for instructions. Hospital pharmacies participating as in-network Part D pharmacies may bill the SADs to those contracted plans. Although it is a challenge for hospital pharmacies to become in-network Part D pharmacies, facilities may consider participation as a network pharmacy. More information can be found at the following location:

http://www.cms.gov/PrescriptionDrugCovContra/11_PartDContacts.asp#TopOfPage

Further instruction on billing self-administered drugs can be found in the following tip sheet provided by CMS:

<http://www.cms.gov/partnerships/downloads/11331-P.pdf> ▲

Deciphering the Drug Description

As we move into June 2011, IRM continues to realize that many hospitals have not updated their Charge Description Master (CDM) to reflect correct Healthcare Common Procedural Coding System (HCPCS) drug code descriptions. This is resulting in incorrect reporting of drug amounts used during patient care. Deciphering the drug description and billing the correct units on the UB-04 continues to be a challenge due to the CDM reflecting descriptions of the purchased descriptor versus the HCPCS descriptors for billing, therefore the amounts are not converting into the correct units when billed. Per Medicare, hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of an item described by a reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

"CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together..."

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration

(FDA) under the New Drug Application (NDA) process.

The following is an example from Medicare of what correct drug billing should look like. This example includes the use of the JW modifier, as well, for drug wastage. Remember that drug wastage must be thoroughly documented in the patient's medical record and once billed as a wasted drug, the drug cannot be used on any other patient. See last month's issue (May 2011) of the Net Revenue Matters Newsletter for documentation requirements.

A provider schedules three Medicare patients to receive Botulinum Toxin Type A 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 provider administers 30 units to each of the three patients. The remaining 10 units that must be discarded are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the provider had to discard 10 units at that point.

When processing claims for drugs and biologicals (except those provided under the Competitive Acquisition Program for Part B drugs and biologicals (CAP)), local contractors may require the use of the modifier JW to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological. For example, a single use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and 5 units discarded. The 95 unit dose is billed on one line, while the discarded 5 units may be billed on another line by using the JW modifier. Both line items would be processed for payment.

Remember: multi-use vials are not subject to payment for discarded amounts of drug or biological.

In addition to requirements applicable to all claims, the following applies to drug claims. On claims to Fiscal Intermediaries (FIs), the drug is identified by the appropriate HCPCS code for the drug administered and billed under revenue code 0636 unless specific instruction states otherwise.

- ▶ On claims to carriers, the drug is identified by HCPCS code.
- ▶ All drugs, including Prodrugs, are reported to DMERCS by National Drug Code (see §80.1.2).
- ▶ Where HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4.
- ▶ Where the National Drug Code (NDC) is required, units are entered in multiples of the units shown in the NDC label description. For example, if the description for the code is 50 mg., and 200 mg are provided, units are shown as 4.
- ▶ If the units provided exceed the size of the units field, or require more characters to report than spaces available in the format, repeat the HCPCS or NDC code on multiple lines until all units can be reported.
- ▶ Covered administration codes for injections may be billed to the carrier and FI in addition to billing for the drug. The drug maximum payment allowance is for the drug alone. However, if payment is under a PPS, such as OPPS, the injection would be included in the APC rate.

Remember, documentation is everything when coding and billing for services rendered.

Additional updated information effective July 2011 can be reviewed at the following:

<http://www.medicarefind.com/searchdetails/Transmittals/Attachments/MM7443.pdf>

<http://www.medicarefind.com/searchdetails/Transmittals/Attachments/R2234CP.pdf>

Reference:

<http://www.cms.gov/manuals/downloads/clm104c17.pdf> ▲

Charge Protocol Manual

The Charge Protocol Manual (CPM) is a tool that guides the auditor in the charging practices and policies of a facility. It is imperative to send out clean claims, and validating what is billable or not must be determined prior to auditing.

IRM has upgraded the CPM template to an Excel format that can be amended at anytime. This template is a starting point for both the clinical areas and the RID/RMD. Additional information specific to the facility may be added; be sure to include an effective date for each change. Updates to the CPM will inform the auditing staff when a new charge has been established or when changes in the charge capture process occur.

When adding information to the CPM, be as specific as possible. For example, when billing time charges, address how that time is to be billed: by the minute, hour, quarter hour, etc. Indicate grace periods that affect how additional time is calculated and billed. When capturing procedure charges, indicate what is included or not included.

For consistent auditing, the CPM should be placed on a shared drive for everyone in the RID/RMD department to utilize. Also, please be sure to send the updated CPM to IRM. It is everyone's responsibility to participate in the completion of this tool. Additional information such as charge sheets, specific written guidelines, charge tools, and lists of packs and trays (including items contained in the packs and trays) all help the audit process and, therefore, need to be added to the CPM.

Once the CPM has been completed, maintenance is the responsibility of the charge audit team. When changes in the charge capture process occur or new charge items are added, it is time to update the CPM. This should be done on an as-needed basis or at least twice a year to validate all charge capture processes. IRM utilizes the CPM for charging rules during quality reviews and a complete and up-to-date CPM could result in a positive quality review. Please take this opportunity to complete your CPM. ▲

Mary Reed

CLIENT CORNER

Best Practice Forum 2011 Wrap Up

Last month's event was fabulous! The weather in Austin was lovely, The Driskill hotel incredibly elegant, the local food choices abundant, and the attendees the best in the industry.

Our featured speakers this year presented a wealth of information, our client process improvement (PI) presentations were excellent, and it was tons of fun kicking up our heels Tuesday evening to the sounds of Jukebox Rodeo. We also received many compliments regarding our event sponsors, Siemens and PatientSecure.

Many thanks to our speakers:

- ▶ Greg Meyers, Integris Health
- ▶ Chad Mulvany, HFMA
- ▶ Mark S. Armstrong, EpsteinBeckerGreen
- ▶ Jennifer Artigue, Our Lady of the Lake
- ▶ Greg Polley, Floyd Medical Center

Congratulations to our client Process Improvement Presentation winners:

First Place

“Revenue Leakage Projects”

Chris Butler



Way to go, Chris!

Second Place

“Charge Audit Departmental Site Visits”

Scott Crawford & Brittany Calhoun

Third Place

“OBOP Optimizing Charge Opportunity”
Amy Canete & Joe Lewy

Huge thanks to all of our client PI presenters:

- ▶ Laura Davis, Satilla
- ▶ Tara Sartor, St Francis
- ▶ Amy Canete/Joseph Lewy, NYU
- ▶ Myesha Nichols-Turner, St Joseph
- ▶ Scott Crawford/Brittany Calhoun, West Georgia
- ▶ Priscilla Frost, Trinity
- ▶ Chris Butler, Floyd

Thank you to all who were able to attend and join in.
We'll see everyone next year! ▲

Another Revenue Integrity Department Featured on IRM's Million Dollar Wall



Congratulations to St. Francis Medical Center for achieving, within seven months, their first million dollars in cash and net revenue! The team's picture joins IRM's Million Dollar Wall in Carlsbad alongside all other Revenue Management Departments and Revenue Integrity Departments that have achieved this milestone.

St. Francis Medical Center is located in Monroe, Louisiana. The team is comprised of nine staff and is directed by Tara Sartor. The team received their Carlsbad training in November 2010. ▲



Congratulations, St. Francis Medical Center!



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

Jun 30: CCDR Forum: Stop the Modifier Madness!

*Jul 5: RAC Forum: RAC Updates
20: PI 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**

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 must 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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