

Net Revenue Matters



May 2008



Welcome to the May 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, "Revenue Management...A Product Line Approach," Founder and Director Jack Duffy discusses a possible RMD value-add.

Also, we hope that you'll appreciate the information presented in three additional articles: "Recent Release of FY2009 IPPS Proposed Rule," "Are You Ready for the CMS Recovery Audit Contractor (RAC)?" and "The ABCDs of SLAMming Patients."

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

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Revenue Management... A Product Line Approach

While working last week with hospital teams, several situations arose that reminded me of the three years I spent in the 1980s establishing product and service lines for a large Midwest hospital. The leaders of the hospital team were advanced practice nurses and exhibited extraordinary communication skills. During the time that I worked with these leaders, each of their assigned areas thrived and the hospital team became the regional powerhouse.

The work included several hours spent on how to position a hospital to successfully introduce a comprehensive program for the management of an observation service. The program needed to meet regulatory requirements, be successful as a clinical tool, and, finally, be a successful economic contributor. Using the blind men and the elephant management system, it was suggested that we approach the problem from the perspective of getting the bill correct so it could be paid. Another approach discussed was to

make the program a coding project since everyone knows that codes have to be correct. Yet other ideas were discussed, each borrowing from our historical experience and expertise.



"So, today's question would be, 'do our revenue management teams collectively possess the expertise, energy, and focus required to successfully lead new clinical initiatives?'"

However, it may be that the best possible approach would be to first recruit a clinical entrepreneur. This is one of those special people who can translate patient care opportunities into a successful business. I remembered how the nurse service line managers would organize their efforts to first envision what would determine success. As with all clinical programs, timely, appropriate care for the patient was the first consideration. After that, the issues related to resources, medical staff, contracts, and the myriad of details

that makeup the fabric of an American community hospital. The service line manager would then “go to school” to learn all of the required components or to recruit subject matter experts to provide needed structure. Serving in the role of conductor, the service line manager would bring all the pieces together to create a successful program.

So, today’s question would be, “do our revenue management teams collectively possess the expertise, energy, and focus required to successfully lead new clinical initiatives?” Several examples from our best practice events indicate that hospitals have already come to the conclusion that a revenue management department (RMD) can be a very valuable tool. Let’s consider for a moment the composition of an RMD. Skills including nursing, coding, manage care contracting, charging and the charge master, use and design of metrics, and process improvement expertise. Many team members have also developed relationships with clinical care areas and the physicians who use them in the process of solving existing challenges. This note is intended to evoke some thought the next time a product expansion arises at your hospital. As an RMD matures, there should be less reliance on individual transactions to project future value. Extending the challenge for an RMD to be a critical part of new services development could be great value-add for your hospital.



Recent Release of FY2009 IPPS Proposed Rule

Summary of Changes

On April 14, 2008, CMS released its proposed changes to the hospital inpatient prospective payment system (IPPS) for FY2009. The proposed rule was published on the CMS website on April 30, 2008, in

the Federal Register, Volume 73, No. 84. Highlights include:

- ▶ Minor revisions to the current Medicare Severity DRGs (MS-DRGs), complication/comorbidities (CCs) and major CCs (MCCs).
- ▶ Major expansion of hospital quality measure reporting initiatives
- ▶ Major expansion of hospital-acquired conditions (HAC) list

In addition, the list of approved changes to ICD-9-CM diagnosis and procedure codes effective October 1, 2008 is attached to the Proposed Rule in the Addendum, Section V, Tables 6A – 6F.

MS-DRG Changes

After last year’s complete conversion from CMS DRGs to MS-DRGS, hospitals will not experience significant changes to the MS-DRG descriptions for FY2009 if the proposed changes become final. Two MS-DRGs with proposed revisions are:

- ▶ MS-DRG 245 (AICD lead and generator procedures) to be subdivided into two MS-DRGs. MS-DRG 245 will include AICD generator procedures and MS-DRG 265 to include AICD lead procedures
- ▶ MS-DRGs 870, 871, and 872 to have the words “or severe sepsis” added after the word “septicemia” to their descriptions, which currently read “Septicemia with/without mechanical ventilation, 96+ hours, with/without MCC.”

Hospital Quality Measure Reporting Changes

CMS proposes to add 43 new quality measures to the current 30 measures hospitals must report in order to receive their full annual update to Medicare inpatient payment rates. The additional measures include: Surgical Care Improvement Project (SCIP), hospital readmissions, nursing care, patient safety and inpa-

tient quality indicators by AHRQ, venous thrombo-embolism, stroke, and cardiac surgery measures.

Hospital Acquired Conditions Expansion and Present on Admission (POA) Indicators

Effective October 1, 2008, Medicare will no longer pay hospitals at a higher rate when certain conditions develop during the hospital stay. The original list of 8 conditions remains the same as stated in the final rule for FY2008, with a revision to the pressure ulcer description. Only Stage III and Stage IV pressure ulcers will be subject to reduced payments if not present on admission.

FY2009 proposed additions to conditions not paid if they are hospital acquired are:

- ▶ Surgical site infections following certain elective procedures
- ▶ Legionnaires' disease
- ▶ Extreme blood sugar derangement
- ▶ Iatrogenic pneumothorax
- ▶ Delirium
- ▶ Ventilator-associated pneumonia
- ▶ Deep vein thrombosis/pulmonary embolism
- ▶ Staphylococcus aureus septicemia
- ▶ Clostridium difficile associated disease

Present on admission indicator U (unknown) will indicate that any of the above-listed conditions will not be paid at a higher rate, as well as POA indicator N (not present on admission).

ICD-9-CM Changes

The ICD-9-CM Coordination and Maintenance Committee met March 19-20, 2008 to finalize the list of changes to ICD-9-CM codes included in the Proposed Rule for FY2009. A few of these changes are as follows:

- ▶ New diagnosis codes will be subdivided to allow more detailed reporting in several areas including leukemia in remission, types of headaches and migraines, and exposure to hazardous materials.
- ▶ To allow for tracking of HACs in FY2009, a new ICD-9-CM code has been introduced for ventilator-associated pneumonia (VAP), 997.31.
- ▶ Also related to HAC reporting, new pressure ulcer codes will be added. The new codes are 707.20 (unspecified stage), 707.21 (stage 1), 707.22 (stage II), 707.23 (stage III), and 707.24 (stage IV).
- ▶ A welcome change to the ICD-9-CM procedure codes includes the ability to distinguish open gastrointestinal procedures from laparoscopic ones.

Public comments may be submitted to CMS by the deadline, 5 p.m. EST, June 13, 2008. Release of the final rule is expected on or before August 1, 2008. The complete rule is available at www.cms.hhs.gov/AcuteInpatientPPS/IPPS, Reg. No. CMS-1390-P

Are You Ready for the CMS Recovery Audit Contractor (RAC)?

Is your hospital prepared for CMS' permanent Recovery Audit Contractor program? Does your hospital know in what areas it risks potential exposure or what the potential financial impact may be? Are you ready to manage the RAC process, including Medical Record Requests?

“The permanent RAC program will be an enormous adjustment for every hospital.”

The permanent RAC program will be an enormous adjustment for every hospital. Integrated Revenue Management (IRM) can assist your hospital in preparing for and managing the RAC process.

The first step is to identify your high-risk areas and estimate the financial impact. IRM can assist you by conducting a RAC pre-audit. IRM's The Coding Group will conduct a coding and documentation audit of inpatient and outpatient records with a focus on areas of risk as identified by CMS's RAC program. The RAC pre-audit will assess your hospital's performance in the following areas:

- ▶ ICD-9-CM diagnosis and procedure code accuracy
- ▶ MS-DRG accuracy
- ▶ POA indicator accuracy
- ▶ Accurate CPT/HCPCS procedure code assignment
- ▶ Appropriate medical necessity for services
- ▶ Appropriate patient status for observation accounts, inpatient-only procedures and one-day inpatient stays

Please contact Kristi Stanton @ 303-506-8719 if you are interested in a RAC pre-audit.

The second step is implementing a process to manage the RAC audits. IRM's RAC Trac database is the tool needed to manage the RAC process. The RAC Trac database offers the following

- ▶ It tracks all RAC letters by giving your hospital a central location to collect and store detailed RAC account information.
- ▶ Manages the Medical Record request and submission process by tracking all deadlines and alerts you of overdue medical records.
- ▶ It tracks all submissions of medical records to the RACs including the date the Medical Record was sent, the method of submission, and tracking number.
- ▶ RAC Trac aggregates your data to allow for simple analysis and understanding of the financial impact of your RAC audits. This data aggregation assists in identifying areas for process improvement or focused education. It allows you to review the

financial outcomes of the audits by attending physician, coder, reason, service area, etc.

- ▶ It assists in managing the appeal process by tracking appeal deadlines as well as the outcome of each level of appeal.

Please contact Dena Bengson @ 760.448.1015 if you are interested in IRM's RAC Trac database

2008 CBR Projects

Calls begin at 11:30 a.m. Pacific

May

28 *Forum Call*

June

13 *Project Rollout: Spine Surgery*

25 *Forum Call*

July

2 *Project Rollout: Pathology*

23 *Forum Call*

August

6 *Project Rollout: Brachytherapy*

27 *Forum Call*

September

3 *Project Rollout: Moderate Sedation*

24 *Forum Call*

October

1 *Project Rollout: Radiology Imaging*

22 *Forum Call*

November

5 *Project Rollout: J Codes*

26 *Forum Call*

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

The ABCD's of SLAMming Patients

One of the best things about performing hospital evaluations is a best practice nugget or two that we can take back and share with our clients.

This month, golden nuggets come from Holy Name Hospital in Teaneck, New Jersey. Craig Hersh, M.D., along with Maritza Gonzalez and Jill Vladick in the Case Management and Documentation department, developed an easy method for discharge planning and denials management. In addition to reviewing the industry normative SOAP notes (Subjective, Objective, Assessment, and Plan) methodology of documentation during the patient's course of care, Dr. Hersh and his team have added the following.

SLAM(Screening, Living Arrangement, ADLs, and Mobility)

Patients are *slammed* at the time of admission, as well as throughout their hospital stay, to assure that the discharge planning process is well planned, thorough, and timely for appropriate patient discharge.

The *screening* process begins with welcoming the patient, discussing the pre-discharge plan, and assuring the patient that the hospital will work on making sure that the transition from the hospital will be smooth.

The case manager next talks with the patient about the *living arrangement*. For example, is the patient living at home, at an assisted living center, or in a skilled nursing facility? Case management will begin to consider the likely discharge location – return to the original location or an intermediate or permanent alternative placement based on the patient's current and expected condition.

Case management next considers the patient's *ADLs* (activities of daily living). Is the patient able to dress, bathe, and prepare meals independently or with

assistance? Is it expected that home health, social services, or other assistance may be needed?



Finally, case management considers the *mobility* status of the patient. Did the patient arrive with a cane, walker, or wheelchair? Are there stairs or other limiting factors that may need to be considered for DME (durable medical equipment) or placement needs? The SLAM method is an easy way to streamline the early discharge planning process.

ABCD (Acuity, Behavior, Communication, and Discharge Plan)

Denials management is a function within Holy Name Hospital's case management department. Dr. Hersh and his team take a methodical approach to a denial that is similar in structure to their discharge planning program.

Denials are approached with ABCD. The *acuity* level of the patient is considered. If the acuity, course of care, and length of stay is determined to meet medical necessity, the case management team's *behavior* (whether to appeal in part or full) will be determined.

“One of the best things about performing hospital evaluations is a best practice nugget or two that we can take back and share with our clients.”

If an appeal is decided to be the appropriate course of action, the case management team will *communicate* the course of care, *discharge plan* or other factors influencing the status of the patient, and the denial and appeal plan with the patient's attending physician. This will set the foundation for the appeal plan and process.

IRM wishes to thank Dr. Hersh and his team for their time and willingness to share their program ideas. We enjoyed spending time with this high-energy case management team – and, who knows; they may join us in the future for an IRM Best Practices forum.

Upcoming Events

TCG Audio Conferences 2008

Conferences begin at 10:00 a.m. Pacific

May

29 *Intro to Medicare Reimbursement Series: APC 101*

June

17 *OB-GYN Procedures*

26 *Orthopedic Series: Shoulder Arthroscopy*

July

15th *Orthopedic Series: Knee Arthroscopy*

29 *Bill Presentation*

August

12 *Cystoscopies*

28 *Screening Tests*

September

16 *ICD-9-CM Updates for 2009 (Part 1 of 2)*

18 *ICD-9-CM Updates for 2009 (Part 2 of 2)*

October

23 *Vascular Interventional Radiology Series: Catheterization Procedures*

30 *Vascular Interventional Radiology Series: Imaging Procedures*

November

11 *Vascular Interventional Radiology Series: Vascular Transcatheter Procedures*

20 *OIG Work Plan for 2009*

December 2008

16 *CPT/HCPCS Updates for 2009*

18 *OPPS Updates for 2009*



To register, call us or visit our web site:

www.IRM-TCG.com

760.448.1022



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If you have questions or would like to submit information for a future newsletter, please contact:

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