

Net Revenue Matters



May 2011



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, "Some Thoughts on Software Conversions," IRM Founder/Executive Vice President Jack Duffy discusses points to consider surrounding conversion.

Also, we hope that you'll appreciate the information presented in "Drug Wastage: Did You Know?" "Tools that Work: Reports," and "If It Isn't Documented, It Didn't Happen!"

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

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Some Thoughts on Software Conversions

As many of you may know, I have been assisting a Midwest health-care system during the first several months of a software conversion. The software vendor is not material, but understanding the level of complexity is.

"For many of us, the decision to purchase or upgrade electronic medical records will also influence the choice of financial systems."

For many of us, the decision to purchase or upgrade electronic medical records will also influence the choice of financial systems. The government's needs to bend the cost curve will drive the discussion related to ACOs and other risk sharing payment schemes. What are some of the factors to be considered when these topics are discussed at your organization?

► Don't change the current financial system. If you have one

that works and is 5010 qualified, leave it alone. It will be less expensive to interface it to the clinician's than to change it out. Conversions cost millions of dollars and not withstanding marketing promises, are very difficult to recover the costs.



- Healthcare systems are very attracted to the concept of integration. As physicians align closer to their hospital partners, either through employment or other structures, the desire to have single-file solutions becomes attractive. I recommend that these goals be closely examined to determine if the changes are worth the costs. My current assignment had two corporate goals, those being a single registration and single statement to the patient that represented both hospital and physician services. Both of these goals could have been accomplished without the requirement to convert the software.
- Be aware of the shift in software development. Today some of the

best software is being developed for Internet distribution as a SaaS product. Some would suggest that server-based software will become an artifact. SaaS tools can be incredibly focused and can support accuracy and productivity at very high levels. When considering the next generation of tools, review focused solutions as an alternative to a conversion. Many organizations will discover that they can maintain current systems for years and add the contemporary tools needed to be a best practice organization.

- ▶ Design from the workstation forward. The most important tool in the revenue cycle process will always be the human resource. There are no machines that can match the power of an employee trained to solve complex problems. The first question must always be, “How does the solution make these employees better?” Too many times the tools are so convoluted and complex that valuable time is wasted mousing and clicking around the screens. The solution deployed needs to maximize the amount of information that can be imported and positioned from external sources to provide support for the effective use of the employee’s time.
- ▶ Select solutions that complement Medicare and commercial contracts. Each major source of payment has a unique set of transaction requirements and data flow. Systems that are tuned to monitor this flow at every important step, using automated tools, complement our employee’s efforts. The highest value is the ability to match the most important account with the best skilled employee at the earliest possible date. These systems may be more likely to be found in expert SaaS tools than in traditional systems.

The bottom line is to spend the time to really understand the value statement related to converting software. Also, not to skip the critical steps of visiting multiple organizations that have been successful using a specific software configuration to achieve superior results. If the reference is not at best practice standards, it may be impossible for your organization to reach that level using a similar set of tools. ▲



Drug Wastage: Did You Know?

Did you know that drug wastage for single-use vials must always be documented in the patient’s medical record? The documentataion must have the date, time, amount wasted, and a reason for wastage. Any discrepancy between the amount administered to the patient and amount billed can and will be denied as non-rendered unless the wastage has all documentation: date, time, and amount wasted. All amounts billed as “wasted” must never be administered to another patient or billed.

A **single-dose or single-use vial** is intended for injection or infusion that is meant for use in a single patient for a single case/procedure/injection. The vial is labeled as such by the manufacturer and typically lacks an antimicrobial preservative, such as ketorolac (injection), and kefzol (IVPB), etc.

A **multi-dose vial** is intended for injection or infusion that contains more than one dose of medication. These multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria, e.g. Insulin.

This policy does not apply to multi-use vials.

“Familiarity with medication waste policies is crucial for all clinical staff, as well as auditors, to ensure accurate billing.”

Familiarity with medication waste policies is crucial for all clinical staff, as well as auditors, to ensure accurate billing. CMS has strict guidelines for payment on discarded amounts of drugs, which are adopted by many payers.

More information can be found at the following links.

The related *MLN Matters* article:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5923.pdf>

The official instruction (CR5923):

<http://www.cms.bhs.gov/Transmittals/downloads/R1478CP.pdf>

Medicare Claims Processing Manual, Chapter 17:

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

TrailBlazer Health

[http://www.trailblazerhealth.com/Publications/Job%20Aid/](http://www.trailblazerhealth.com/Publications/Job%20Aid/Drug%20Wastage.pdf)

[Drug%20Wastage.pdf](http://www.trailblazerhealth.com/Publications/Job%20Aid/Drug%20Wastage.pdf)

Mary Reed ▲

Tools that Work: Reports

In the charge audit database are a number of audit activity reports that can be run to give the RMD/RID information about the results captured by the audits performed on a daily basis.

These reports can be drilled down by audit type, concurrent, retrospective; by date range; by auditor; sub audit type; service area and revenue code. Accounts rebilled or not can also be selected. Most reports can be viewed by detail or summary.

Productivity is reviewed by auditor reports, either by summary or detail. These reports also provide a good overview of overcharges and undercharges.

Drill down to what areas of the hospital have the greatest fractures in charge capture will entail the service area and department reports. Once a department or service area has been identified with acute transactional errors, attention can be given to help restore accurate charge capture by meeting with the departments, sharing the detailed information available in these reports, and collaboratively seek solutions to the charge capture errors. These new processes can in turn be monitored for compliance by the charge auditors and lead to additional process improvement initiatives.

The greater the detail used when entering the findings, the greater the amount of information that will be available from these reports. Reason reports are extremely dependent on how precise the auditor is when choosing a reason for a particular error. If the auditor has utilized the “error caused by” field when entering the findings, these comments appear

on these reports. It is possible through these reports and the error field to identify a specific individual responsible for documentation errors, should this be warranted.

“I encourage all RMD/RIDs to discuss findings as a group on a regular basis...”

I encourage all RMD/RIDs to discuss findings as a group on a regular basis, utilizing these reports. This gives everyone an overall picture, helps identify trends, and avoids the silo effect. Planning educational meetings with clinical areas to discuss the charge audit findings can also be initiated by this meeting.

Happy Auditing!
Dawn ▲

If It Isn't Documented, It Didn't Happen!

In the healthcare setting, this is a commonly known phrase. However, obtaining all documentation necessary to appropriately assign current procedural terminology (CPT) codes to a claim continues to be a challenge for coders.

All documentation should be concise and legible. Dates and times of occurrences often reflect gaps in the description of what is happening with the patient. For example, the patient came to the emergency department via ambulance with chest pain and, while being assessed, stopped breathing and Cardiopulmonary Resuscitation (CPR) was initiated. Due to the level of care this patient received, the evaluation and management would fall under critical care. However, since CPR was initiated, it is very important for the events that took place during this patient's care be legibly documented of what was performed and the date and time it was performed. When did CPR start and end? Due to the fact that critical care, CPT codes reflect time, the coder must be able to calculate how much time was spent in critical care to assign the correct code(s) for the encounter. As such, the coder would also need the documentation of the CPR time-

frame to subtract CPR time from the critical care time and assign the CPR CPT code 92950.

CPT Assistant provides the following example: Emergency services November 2007 pp 5, 7.

Code 92950, Cardiopulmonary resuscitation (eg, in cardiac arrest), has never been bundled into the hourly or global critical care codes. This service is not provided to the typical patient receiving these services and their value have not been added to this code. However, since the critical care codes for patients older than 24 months are time-based, it is not appropriate to report the time spent performing cardiopulmonary resuscitation as critical care when also reporting 92950. It is important to point out that CPR does not include treatment for apnea or a need to provide ventilatory support to the neonate or child. Rather, this code is used to describe procedures in response to a failure in cardiovascular function and perfusion leading to the need for cardiac support in the form of chest compressions.

Additionally, new guidelines for critical care have been implemented for 2011 for the facility setting. If you haven't already, be sure to review the guideline additions. Further information regarding evaluation and management can be reviewed at the following website:

http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

And remember, if it isn't documented, it didn't happen and you cannot code for it. ▲

Become a Detective

Have you ever wanted to know what it would be like to be a detective like Sherlock Holmes? Well, we are in essence detectives in our everyday life and in our work. In life, we may wonder, who really took that last piece of chocolate cake that we were saving for a late night snack? You could ask...is there anyone with cake on their face? What evidence, if any, was left behind?

Well, charge auditing is similar to detective work. As auditors, we are looking metaphorically for that

missing piece of chocolate cake. We audit the medical record looking for clues: physician orders, services and procedures, other documentation, etc. We also go to the source, the departments, to validate the charges billed. How can something be billed without the necessary documentation or orders? Well, this is when you bring out your magnifying glass and start looking for clues. Remember that not all documentation is available at the time of audit. Contact departments for the missing pieces. You may even find charges that were never billed during your investigation. And that can lead to process improvements and extra revenue for your facility.

So don't give up the search for clues, as it may lead to the documentation of the charge were searching for or it may lead to a dead end. In the case of a dead end, you will be led to educate departmental staff on proper documentation or how to improve their current process. Be the detective you always wanted to be and always send out clean claims.

In the words of Sherlock Holmes, "It is a capital mistake to theorize before you have all the evidence. It biases the judgment."

Mary Reed ▲

Q&A: CPT Coding on Reporting Lasix or Benadryl Administration with Blood Transfusion

Q: We have been coding for drug administration of substances such as Lasix and Benadryl with blood transfusions since not everyone receives them each time. If they are ordered and given we have been reporting the drug administration code with the 59 modifier appended along with the blood transfusion code. There is a debate at our facility as to whether this is appropriate. Can you help give guidance on this?

A: Some facilities routinely administer Benadryl prior to and Lasix subsequent to a blood transfusion to prevent transfusion reaction and volume overload, respectively. In that context, the Benadryl and Lasix

administration would be associated with the transfusion service and reporting the drug administration codes separately with 59 modifiers would not be justified. The only reason these patients are receiving the Lasix and Benadryl is because they are also receiving concurrent blood transfusion. Whether these are done for every patient is not the issue. It is the purpose behind the Benadryl and Lasix administration that determines whether it can be separately reported. If and when these drugs are administered concurrently with blood transfusion, if they are being given to prevent transfusion reaction or transfusion-associated volume overload, then the services are related to the blood transfusion and the infusion administration code should not be assigned.

On the other hand, if there are separate therapeutic indications for the Benadryl and Lasix unrelated to the transfusion service, then assigning the drug administration codes with 59 modifiers would be warranted since there are actual conditions present that would require treatment with these medications, even if concurrent blood transfusion had not been done. There may be specific payer policies regarding these scenarios. ▲

Q&A: CPT Coding on Tibioperoneal Trunk Intervention

Q: Patient had atherectomy of the right tibioperoneal trunk, right posterior tibial artery and right peroneal artery. Seeing that the tibioperoneal trunk is right at the bifurcation leading to the peroneal artery and then leading down to the posterior tibial would this be considered atherectomies in two sites 37229, 37233 or would it be considered three sites for each atherectomies: 37229, 37233, 37233?

A: The CPT Manual states the following in regard to involvement of the tibioperoneal trunk in interventional procedures:

The common tibio-peroneal trunk is considered part of the tibial/peroneal territory, but is not considered a separate, fourth segment of vessel in the tibio-peroneal family for CPT reporting of endovascular lower extremity interventions. For instance, if lesions in

the common tibio-peroneal trunk are treated in conjunction with lesions in the posterior tibial artery, a single code would be reported for treatment of this segment.

Thus, while the tibioperoneal trunk could be reported with a code in the tibioperoneal territory if the tibioperoneal trunk is the only area of that territory treated, if there is intervention in any of the three recognized tibioperoneal vessels (i.e., peroneal, anterior tibial, posterior tibial), as well as in the tibioperoneal trunk, the intervention in the tibioperoneal trunk would be considered part of the intervention within the recognized tibioperoneal artery or arteries and not reported separately. For your example, then, you would report 37229 and 37233 for the atherectomies of the peroneal and posterior tibial arteries; the atherectomy in the tibioperoneal trunk would be considered part of the other interventions and not separately coded. ▲

Q&A: Use of Balloon Catheter to Achieve Hemostasis during Vascular Procedure

Q: We have a case where a patient was encountered for a lower extremity vascular bypass. During the course of the bypass, there is mention of bleeding vessels being dilated by balloon catheter. There has been some discussion among the coders regarding whether an angioplasty code should be reported along with the main code for the vascular bypass. What are your thoughts on this matter?

A: The use of the balloon does not constitute an angioplasty in this instance. During the course of the procedure, the surgeon had trouble achieving adequate hemostasis in some of the vessels. Hemostatic control can be achieved via extraluminal (e.g., vascular clamp) or intraluminal (e.g., balloon catheter, etc.) methods. The extraluminal technique is generally preferred, but certain factors may be encountered that necessitate using an intraluminal method such as a balloon catheter. The balloon is used for hemostatic control to facilitate the main vascular procedure in your example, not to perform therapeutic angioplasty; therefore, an angioplasty code would not be separately reported here. ▲

CLIENT CORNER

See you there!

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



Our Best Practice Forum is upon us. We look forward to seeing you next week in beautiful downtown Austin.

To view a more detailed agenda, please visit our website:

http://www.irminconline.com/news/news_bestpractice.htm

Oh, and be sure to pack your dancing shoes! Tuesday evening we'll enjoy line dance instruction and tunes by Jukebox Rodeo.

Master of Ceremonies

Jack Duffy

IRM Founder/Executive Vice President

Presentations

- ▶ IRM: *"It Is Time to Reassess Your Clinical Documentation Program"*
- ▶ Guest: Velocette, Denial Management Experts
- ▶ IRM: *"Process Improvement and Bill Presentation"*
- ▶ IRM: *"Vascular IR and Cardiac Cath Highlights"*
- ▶ Guest: Integris Health
- ▶ Keynote: HFMA, *"Reform and the Revenue Cycle"*
- ▶ IRM: *"Bundled Payments"*
- ▶ Guest: EpsteinBeckerGreenWickliff&Hall, *"Accountable Care Organizations"*
- ▶ Panel Q&A: *"Accountable Care Organizations"*
- ▶ Guest: Our Lady of the Lake Regional Medical Center, *"CMS Outpatient Quality Measures"*
- ▶ Guest: Floyd Medical Center, *"Cost Saving and Revenue Leakage"*
- ▶ Clients: *Process Improvement Initiatives* ▲



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 7: 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:
Cynthia Hufferd ☎ 760-448-1034 ✉ chufferd@irminconline.com*