

Net Revenue Matters



November 2007



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Happy Thanksgiving to you and yours, and a wish for a bountiful 2008 from IRM!

American Diabetes Month

November is American Diabetes Month. According to the American Diabetes Association (ADA), nearly 21 million children and adults in the United States are living with diabetes, and another 54 million people are at risk. During the month of November, the ADA is highlighting those affected directly and indirectly by diabetes. Each week, the ADA is focusing on a specific group affected by diabetes:

- Week 1 – Caregivers
- Week 2 – Employees
- Week 3 – Diabetes around the world
- Week 4 – At-risk Population
- Week 5 – Youth and type 1 diabetes

Please see the American Diabetes Association web site to learn more concerning American Diabetes Month:

<http://www.diabetes.org/communityprograms-and-ocalevents/americandiabetesmonth.jsp>

Diabetes mellitus (DM) is a metabolic disorder characterized by the body's inability to transport sugar from the bloodstream into cells. The term of diabetes mellitus comes from the Greek word "diabetes," which means to pass through, and the Latin word "mellitus" for "honey" or "honey-sweet." The generic term diabetes refers to the state of frequent urination in diabetic patients. The word mellitus refers to the sweet smell and taste (according to Aristotle!) of the urine in diabetics.

There are two types of diabetes mellitus:

- Type 1, commonly and sometimes erroneously referred to as insulin-dependent diabetes mellitus (IDDM), is the result of failed production of insulin in the pancreas. Insulin is essential for survival. Type 1 DM most frequently develops in children and adolescents, although it is being increasingly noted late in life. Onset of type 1 DM is usually a viral infection or autoimmune disorder.

- Type 2, or non-insulin-dependent diabetes mellitus (NIDDM), results if insulin is not able to work properly (insulin resistance). Type 2 diabetes is much more common than type 1, accounting for approximately 90% of all diabetes cases. It is more common in adults over 40 than in children and adolescents, although the incidence among adolescents is rising because of the childhood obesity epidemic. Type 2 DM is rampant in obese individuals.



- Cases of patients with type 2 diabetes who are on long-term insulin treatment may be reported with code V58.67, Long-term (current) use of insulin. This code should not be used if insulin is given temporarily to control blood sugar during a visit.

Diabetes Coding Tips

- If a diabetic patient presented without any complications, a code from subcategory 250.0x, Diabetes without mention of complication, is assigned.
- Diabetic patients often present with more than one complication. In that case, assign codes from subcategories 250.1-250.9). The fifth digit assignment must be consistent among all diabetes codes. A patient cannot be both a type 1 and a type 2 diabetic. The status of controlled or uncontrolled applies to the diabetes itself, not the complication.
- Except for rare circumstances, diabetes with conditions such as renal failure, neuropathy, and PVD must have an established link documented by the physician. It cannot be assumed that such disorders are due to the diabetes without proper physician documentation.
- If a patient was admitted for a diabetic complication, a diabetic code is sequenced first. The only exception to this rule is in the case of pregnant patients, in which a code from Chapter 11, Complications of Pregnancy, Childbirth, and the Puerperium, is sequenced first.
- The use of oral antidiabetic agents is indicative of type 2 diabetes.
- A cause and effect relationship is assumed between diabetes and osteomyelitis unless another cause of the osteomyelitis is documented.
- Conditions listed in the index under the main term “diabetes” and the subterm “with” do not require a documented link between diabetes and the condition.

E Codes on the UB-04

Beginning October 1, 2007, Medicare providers are required to submit present on admission (POA) indicators for every diagnosis on all inpatient acute care hospital claims. “Present on admission” is defined as present at the time the order for inpatient admission occurred. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered present on admission. A POA indicator is assigned to principal diagnoses, secondary diagnoses, and the external cause of injury codes not included on the “Codes Exempt from Diagnosis Present on Admission Requirement” list. The list of exempt codes can be found in the ICD-9-CM Official Guidelines for Coding and Reporting Effective October 1, 2007, beginning on page 97.

External cause of injury codes (E codes) can be placed in form locators (FL) 67A – 67Q or 72A – 72C on the UB-04. However, page 121 of the Medicare Claims Processing Manual, Chapter 25, states that the codes in field 72 will be ignored. Therefore, for the purpose of the POA indicator, it is recommended that the E codes requiring a POA indicator be placed in FL 67 with the appropriate POA assignment. Those E codes exempt from the POA requirement should be placed in field 72.

POA indicator compliance is critical. Hospitals failing to provide the POA indicator for discharges on or after January 1, 2008, will receive a remittance advice remark code informing them of the missing POA indicator. Beginning with discharges on or after April 1, 2008, Medicare will return claims to hospitals if the POA indicator is not reported and the claim must be resubmitted with the correct POA indicator.

Best Practice Forum 2008 - Plan Now to Attend!

Each year, IRM hosts a Revenue Management Best Practice Forum for our RMD clients. Along with speakers who are varied experts in the healthcare arena, a key element of the Best Practice Forum is a roundtable format that encourages our clients to highlight their facility's highly successful Process Improvement Initiatives that have resulted from the efforts of their Revenue Management Departments. These initiatives show the successful impact on the economics, compliance, patient care and/or organizational structure of the facility and create a best practice community.

This year's Forum will be hosted at the Floridays Resort Orlando, in beautiful Orlando, Florida.



Along with the PI Roundtable, speaking topics will include overcoming operational challenges during the RAC audit process, OIG compliance, Medicare bad debts, managed care, and a motivational session from Gary Borgstede on the keys to building a high performing team. Our optional pre-forum workshops are a not-to-be-missed day as well.

The Forum outline for planning purposes is as follows:

Monday, February 18, 2008

Travel Day

Tuesday, February 19, 2008

Optional Pre-Forum Workshops

Welcome Dinner / Speaker

Wednesday, February 20, 2008

Full-Day Meeting

Thursday, February 21, 2008

½ Day Meeting

Friday, February 22, 2008

Travel Day

Be sure to make hotel arrangements by January 7, 2008! Visit our website for client registration information or contact Jennifer Vansant at 760-448-1036.

www.irminonline.com/news_bestpractice.htm

Of Note ... CMS Change Request 5208



In the October 22, 2007 Modern Healthcare magazine (page 36), it was noted that CMS is now requiring nine-digit, rather than five-digit, zip codes.

"... Medicare has been returning claims as "unprocessible" in some cases if providers failed to use the full nine-digit codes when billing under the Medicare Physician Fee Schedule or for anesthesia.

The change is intended to fix confusion that comes up when a provider's five-digit ZIP code includes more than one of Medicare's payment localities, which occurs in several hundred codes in 32 states. Providers in one of those places should make sure they've got an extended ZIP on file with the feds that matches their claims.

On returned bills, the CMS offers a few of its own digits to indicate the digit shortage, including 16 (an 'adjustment reason code') and MA 130 (a 'remark code'...)"

For more information, refer to CMS Change Request 5208:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5208.pdf>

Upcoming Events!

November 2007

*29th: Audio Conference, 10:00 a.m. Pacific
Compliance for 2008: The OIG Work Plan*

December 2007

*11th: Audio Conference, 10:00 a.m. Pacific
Coding for 2008: CPT/HCPCS and OPPS
Updates (Part I)*

*13th: Audio Conference, 10:00 a.m. Pacific
Coding for 2008: CPT/HCPCS and OPPS
Updates (Part II)*

For more information, visit our website or call!

www.IRM-TCG.com

760.448.1022

Client Corner



Code-Based Reimbursement Project Rollout and Forum Call Calendar

Continuing in November, we will present at least one CBR project per month developed specifically for the CBR analysts, CDM analysts, and RMD Directors. The upcoming schedule for project rollouts and forum discussion calls is as follows:

November 7 2007

Project Rollout, 11:30 a.m. Pacific

- Inpatient Add-on Procedures
- Inpatient Only Procedures

November 28 2007

Forum Call, 11:30 a.m. Pacific

- Inpatient Add-on Procedures
- Inpatient Only Procedures
- GI Endoscopy
- Neurostimulators
- Vascular Access Devices
- Emergency Department
- Interventional Cardiology and Electrophysiology

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

Intermountain Healthcare's Urban North Region Joins the Million Dollar Club!

The Urban North Region's Revenue Integrity Department of Intermountain Healthcare in Utah is the newest member of the Million Dollar Club at IRM. The Region implemented the in late July, 2007 and achieved this very important milestone on October 24. Chris Martinelli, Manager, recruited two impressive teams, and that is apparent from their hard work

Congratulations to the entire Intermountain team!



Halloween Team Building at IRM

For all of you who have participated in team building exercises with IRM staff during RMD training in the Carlsbad office, you'll appreciate the team building efforts made during Halloween from IRM staff. Presenting, Revenue Management MUMMYS and the IRM monster crew:



Mary Reed, Silvia Kelch, Dena Bengson, John Garcia, and Sheldrian Leflore - all good sports!



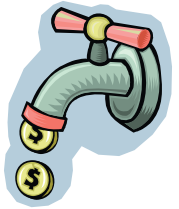
The IRM Monster Crew



Revvvvv-Up Your Revenue!

The Revvvvvv-Up Your Revenue column began in August with a series called “Zero Tolerance for Revenue Leakage Due to Silent PPOs”. This series highlights IRM’s best practices for preventing, detecting, and collecting revenue leakage due to silent PPO activity. Part I outlined how to create a Silent PPO Zero Tolerance Team and to prepare for the first team meeting. Part II included activities outlined which may be considered for individual process improvement projects in your RMD. Part II focused on education and training, job aids, and RMetrics Reports.

This series has been authored by Ina Gelfound, former Director of Client Services, and Jack Duffy, IRM’s Founder and Director. If you have questions, comments, or need further instructions to implement the activities, please call Jack Duffy at (760) 448-1011 or contact your Director of Revenue Management at IRM.



Zero Tolerance for Revenue Leakage Due to Silent PPOs – Part IV

The Silent PPO Binder: Creating a Job Aid and Reference Guide

The RMD should create a Silent PPO Binder. The binder will likely require use of a 4” D-ring binder with tabbed sections. The binder should be a permanent reference in each department having a representative on the Silent PPO Zero Tolerance Team and reviewed monthly by team members for payer additions and/or deletions and for contract changes.

- **Suggested binder sections:**

1. **Contract matrix.** Include all payer and direct employer contracts.
2. **Hospital payer codes.** Include two copies, one alphabetically sorted and one in numeric payer code order. Different colored paper can be used to identify the individual lists.
3. **Patient identification card samples from all payers.** Include all payer’s plans and descriptions of the individual plans sorted by payer in alpha order. Prepare sheets of payer identification cards. It was recommended in the previous installment that all ID cards should be scanned and attached to the hospital’s payer alpha code list for distribution to the Silent PPO Zero Tolerance Team members prior to the first team meeting. (Acquire this information by requesting it from each payer)



4. **Payer information for procedure authorizations and approvals, i.e. PATs, lab, and other required authorizations.** Can the patient use the hospital lab? What paper work does the payer require for proof of authorization or approvals? Is there electronic verification? The information can be requested from each payer.
 5. **Client lists for PPOs, TPAs and Insurance Carriers.** Payers must be required to send quarterly updates of changes deletions or additions of their client lists to the RMD managed care analyst. The managed care analyst should provide sufficient copies to the Silent PPO Zero Tolerance Team members and be prepared to review the changes at team meetings.
 6. **Payer list.** These binders will become a permanent job aid and reference book in all access/registration and clinical departments. The benefit of having payers send quarterly updates of their client lists is to have a document for the managed care analyst to review and determine if the insurance company is giving access to discounted rates. Once the payers who are prohibited from taking discounts for certain lines of business are identified, a payer list should be created and maintained in an additional tabbed section of the binder. This binder section will be an easy to access resource for all staff involved with stopping revenue leakage due to silent PPO activity.
- Giving documentation to department team members is the start of best practices for interdepartmental communications and education.

- Sharing information and distributing hard copy examples enables all staff to understand the magnitude of the issue and their role in the revenue cycle. Where and when each department can intervene to correct and stop the prohibited silent PPO activity are important lessons and the foundation of stopping revenue leakage.
- PFS and IS should work together to prepare RMetrics reports listing all suspected payers engaging in silent PPO activity. Reports should track and trend payers who consistently underpay claims using a declaration of “Usual and Customary Payment” on their EOBs. The list can also include those who apply discounts to claims where discounts could not be verified at the time of registration or when hospital staff verify eligibility and obtain authorizations or approvals.

Best Practice Standards



IRM best practice standards occur when managed care staff responsible for negotiating or implementing new contracts or changes in existing contract terms and conditions schedule educational meetings with all members of the business office and clinical department managers. The RMD and clinical department managers’ goal is to educate all staff on all shifts as to how the contracts effect reimbursement for clinical services.

The best practice standard for allowable discounts is to document the patient in-take sheet and scan, at time of registration, the patient’s ID card. By doing this, the hospital can capture all the allowable company logos and allowable discounts and each patient bill can then be generated with the correct expected reimbursement. If the claim is underpaid due to an unauthorized discount, the payer can be notified immediately that no discount is applicable because the discount was not identified at the time of patient registration per the contract. Contract language must specify that patient ID cards have a company logo for use of an applicable discount. If a payer respond that they cannot implement this request, suggest that small stickers replicating payer logos are inexpensive and can easily be dispensed to all covered subscribers and beneficiaries. The alternative is, without the logo at time of registration, absolutely no discount will apply to the claim and full charges will be required. Be clear that patients will be balanced billed.

Best practice standards for contract terms restrict payers

from applying discounts if patients’ identification cards do not clearly show what company the payer or TPA will access for a discount at time of registration. Additionally, contracts should specify that the allowable discount is only applicable when claims are paid on time. Contracts must contain language defining “timely payment.”

Educating Staff - Access Is Where It Starts



The RMD and the managed care analyst should educate all RMD staff and the Silent PPO Zero Tolerance Team on claim reimbursement information including the allowable contract discounts and when discounts are applicable for contracted payers - starting with Access/Registration.

- Access staff should be taught to review prior registration records, update and correct insurance information, add new carriers for workers compensation and auto coverage, and to make necessary changes. Instruct for Access/Registration staff should also include the importance of adding or deleting beneficiaries using family coverage.
- Train staff to recognize logos on ID cards of contracted payers. Teach staff to question patients and call companies with unfamiliar or suspect look-a-like ID cards. Many silent PPOs copy patient ID cards of well know contracted insurance companies with small differences. The intent is to get their member registered at your hospital to qualify for a discount. Uneducated staff can easily indicate an allowable discount at the time of registration if they are unfamiliar with the look-a-like copies of ID cards for companies with whom your hospital does not have a contract. For example, compare Aetna US Healthcare ID card to USA Healthcare ID. The appearance is very similar and when busy, the registration staff may not pick up the unauthorized ID. Collect all insurance information for health, workers compensation, and auto at the time of registration or ER admission. Verify all personal patient information, i.e. name, social security number, addresses, employer, secondary or supplemental insurance etc.
- At time of registration or verification, Access and eligibility staff should call the hospital’s Managed Care department or PFS if the binder does not

contain the name of the entity used on the patient's ID card to determine if a discount applies.

- A department supervisor should be notified of suspected silent PPO activity. The supervisor should immediately call the RMD managed care analyst so system-wide alerts can be implemented.
- When changes to payers' client lists occur, the hospital should initiate an immediate cancellation of any discount. The hospital may begin a termination process or schedule an education session with the hospital's Managed Care department and RMD managed care analyst. Access, eligibility, and authorization are the frontline departments and must be armed with current information to effectively catch and stop silent PPO activity.

Eligibility Verification

Eligibility verification is best done within 24 hours of treatment or admission. This step is designed to detect and prevent silent PPO activity before a bill is generated. Collecting health insurance information from patients presenting at the ER with a work-related injury or collecting supplemental or secondary insurance information is a *"must do activity."* All patients must be registered with "Who will pay the bill?" information on their intake sheet. The patient must have insurance information recorded within 24 hours of admission or hospital staff should start the process for charity care.



- This step is critical to the process of stopping revenue leakage. PFS and staff throughout the hospital may require patient insurance information for maximizing reimbursement and collecting payments in the shortest period of time. The more complete and accurate the insurance information is upon the initial registration sheet, the less time and expense is incurred to collect full and accurate claim payment.
- The Silent PPO Team should develop an RMetrics Dashboard report to track, trend, and measure findings and collections of all silent PPO activity data that comes from PFS and RMD collection staff.
- Reports should be distributed to executives and staff where and when appropriate

Negotiations

The stronger the hospital's contracts are worded, the better the ammunition to fight silent PPO revenue leakage.

Managed care contract negotiators, whenever possible, should try to include provisions in all contracts *"prohibiting sharing, renting, leasing or giving access to contracted rates to any entity, partner, affiliate or sponsor that is not the original party of signature on the contract."*

Additionally, the hospital can stop revenue leakage by negotiating contract provisions that allow the hospital to terminate individual, non-compliant payers by unilateral written notice, without cancelling the entire contract.

Summary of Previous Tips



Whenever possible, request client rosters from ALL contracted payer plans. Request that payers send you updated rosters when contracted payers enroll or delete clients. Payers should be requested to highlight the roster changes (try to make this a contract provision). Rosters should be distributed to the team and added to binders as updates for all departments and staff.



Learn state laws, rules and regulations and know the hospital's contract provisions.



Remember, the goal is to **maximize revenue collection** of erroneously or underpaid claims. Be prepared to impose payer timelines and financial penalties if permitted by laws, rules, regulations, and/or contract provisions. Send a facsimile of applicable provisions to self-funded payers, third party payers, insurance companies, re-pricing companies, and employers justifying the hospital's demand for correct and full claim payment.



Be aware of cherry-picking, stacking, misrepresentations, and arbitrary, erroneous claim payments in the name of "Usual and Customary Rates."

- There can be multiple companies and other entities engaged in reviewing the hospital's claims. Never agreed to arbitrary low rates which may be the amount the hospital receives as claim payment. This type of erroneous claim payment is another source of revenue leakage caused by silent PPO activity.
- Self-funded employers often use TPAs and re-pricing companies promising to save them money by applying low rates for hospital services. Re-pricing companies and TPAs access multiple rates from a nationwide data base. The TPA and re-pricing company cherry-pick the lowest

rate or the stacked rate from high to low for claim reimbursement, rather than the contracted applicable rate.

- TPAs and re-pricing companies typically do not use the hospital-specific contract provisions. Hospital contracts often have provisions for timely claim payment as a condition for applicable discounted rates. If that is the case and payment is untimely, than full payment of billed charges constitutes correct reimbursement. Always collect the **expected full rate** in such a case. Explain that patients will be balanced billed when permitted.
- TPAs and re-pricing companies defend their low, erroneous reimbursement by stating that they only pay “usual and customary charges.” They may state that, *“Your hospital’s charges are above the usual and customary charges, your hospital must accept the lower payment.”* Payers’ statements identifying the discount they accessed, or if they are applying usual and customary charges payment, may be found on most EOBs. Payers’ usual and customary charges statements are not necessarily true. Do not accept the TPA’s or re-pricing company’s defense for underpaying the hospital’s claim. That is silent PPO activity, and the hospital can stop it! Simply say, *“Our hospital contract does not have a provision permitting the use of usual or customary rates. The only applicable rates are those scheduled in the contract, and they are only applicable if the claim is paid in a timely manner.”*



Challenge the TPA or re-pricing company. Here is where knowing the terms and conditions and applicable contract rates pays off. The hospital can maximize claim collections and rebut the TPA or re-pricing company by sending them copies of applicable law and/or contract terms and conditions addressing when discounts apply or may be denied. Remember, TPAs and re-pricing companies generally have no knowledge of the hospital’s contract terms and conditions.



Request to speak to a payer’s claim supervisor and get the fax number to send copies of the contract provisions and applicable laws, rules, or regulations for the state in which the hospital rendered service. Explain to the supervisor that the payer is bound to abide by your specific State and contract provisions and must reimburse claims accordingly.



Once the supervisor reviews the faxed information (suggest a short time, 24 hours, for review and a decision), most often the claim will be paid correctly.



Happy hunting for all those silent PPOs! Consider implementing a process improvement project in the appropriate divisions of your hospital’s RMD to stop the revenue leakage and Revvvvvv-**Up Your Revenue!**



If you would like a complete electronic version of the four-part series Revenue Leakage Due to Silent PPOs, visit our website:

www.irminonline.com/news_revenue newsletters.htm

- Part I: August 2007
- Part II: September 2007
- Part III: October 2007
- Part IV: November 2007

If you would like to investigate IRM’s comprehensive managed care service offerings, contact Jack Duffy or your IRM Director of 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 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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