Net Revenue Matters

November 2010

Welcome to the November 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, "A 'Cold Case' Case," Executive Vice President Jack Duffy discusses hospital business office process improvement.

Also, we hope that you'll appreciate the information presented in "Charge Auditing: There is Always More," "PECOS: Don't Miss the Date," and "CPT Coding Q&A: EGD vs. Enteroscopy."

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

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A "Cold Case" Case

Recent travels have taken me to business offices at hospital locations in Indiana and Georgia. The purpose was to review process and make suggestions to improve performance. The lesson learned was to again be faced with the high degree of structure in a contemporary business office and the lack of effective process options when accounts fail to pay. Hospitals may want to take a page from law enforcement and create specialized functions to accept follow-up responsibility when traditional approaches fail to resolve the issue.

Today we find some type of account selection process imbedded in almost every software tool. These work, or call, lists vary from the highly sophisticated, which use complex logic to match the problem with a best employee, to the simple date or balance ranges. All of these systems fail after the call begins and the insurance company's call screener begins to explain that they have no reason why the claim was not adjudicated and has no idea when they will release a definitive response. Too often we either thank the person for this non-response and move the claim forward 30 days, or we ask to speak to a supervisor, hoping to find an intelligent life form, only to be told that they are not and never will be available.

The above scenario can continue for months; see your accounts over 150 days. It consumes pages of notes and makes each subsequent call require more preparation time to read these non-effective responses. This continues until the account reaches an unnatural death as an unintended bad debt.

There may be a better way:

- Use Internet tools to check account status the night before a work list is created. Post these results to the patient accounting system and train staff members to use this as the starting point. The conversation then begins, "I can see that the account in question is unpaid. What I need to determine today is why and what your company is going to do to change this status."
- If the hospital has completed

requests for additional information and one status call has been made, do not repeat the same step. Rather, move that account to the "cold case" desk where the hospital will avoid the insurance call center and go directly to a designated problem solver. Don't have a designated problem solver? Then you need to negotiate for one for every significant insurance relationship.

- This process is repeated using a different resource, so that at step three or four the account becomes the responsibility of the CFO. The CFO will treat the account as a breach of contract and deploy the full suite of dispute resolution tools negotiated in the original contract. A lesser approach will always yield inconsistent results.

The fact is that a business office worker will always have limitations on what they can do or say. Best practice suggests that a well-crafted account migration strategy will yield superior results. As the insurance industry removes the last vestige of provider service from their business plans, hospitals must continue to develop a more sophisticated, thoughtful business office approach. ▲

Charge Auditing: There is Always More

As a charge auditor, you look at the chart and ask, "***what is…?***" The chart is the accumulation of all the documentation that tells a story of the patient's encounter.

Auditing for correct charges involves review of the physicians' order and verification that this order was completed. Orders are not always handwritten. They can be in various forms and places in the electronic world. They still need to be specific for the patient and signed off by the physician. As an auditor, you are reviewing the order for completeness. Documentation that supports the charge on the itemized bill includes dictated reports, nurses' notes, progress notes, lab and x-ray results, ancillary staff documentation, and the MAR (medication administration record).

Other documents not included in the medical record that assist with justifying charges, especially supplies, include the CPM (Charge Protocol Manual) and the DPCs (Doctor Preference Cards) from surgery, as major examples.

Another important role of a charge auditor is to ask, "***what if?***" If the documentation for an infusion stop time was in the record, the charge could be added. This is not only pertinent for infusions, but other missed charging opportunities as well. Compiling the "what ifs" into the observation log creates the foundation of many process improvement initiatives: financial or clinical improvements.

Look beyond what is and ask what if. This is the next evolution of a charge auditor. Suggest items that should be chargeable. Learn about other clinical areas within the facility and suggest a focused audit to be sure all charges are being captured correctly. As a new service is being introduced, be part of the charge capture process, ensuring complete charge capture. Ask clinical departments where they think they need help. There is always more.

Growth lies in "***what if?***" ▲

PECOS - The Provider Enrollment, Chain & Ownership System

Don't Miss the Date

The **Provider Enrollment, Chain and Ownership System** (PECOS) is a new way for physicians and other healthcare practitioners to modify their provider file online. Physicians and non-physician practitioners must enroll with the system to use it. Non-physician practitioners are: Physician Assistants, Certified Clinical Nurse Specialists, Nurse Practitioners, Clinical Psychologists, Certified Nurse Midwives, and Clinical Social Workers.

Prior to the PECOS system, physicians enrolled with their A/B MAC or Local Carrier to submit claims to be paid by Medicare. In 2008 the PECOS system was implemented. This system gives physicians the ability to enroll online and update their application via the internet. The PECOS system was made available to physicians in December, 2008 and later to group practices in April, 2009. Medicare required registration with the PECOS system by July 6, 2010 to prevent claim denials for prescribed items.

Medicare will use the PECOS system to validate claims for prescribed items and services. When claims are submitted by ancillary providers (DME, etc.) the PECOS database will be checked to ensure that the referring physician is enrolled in the program. If the physician is not found, the claim will be denied.

Use of the PECOS system has been voluntary until now. Most physicians are not aware that it exists. According to CMS, the local Medicare contractors have been updating the PECOS system when they receive updated CMS 855 forms from the physician.

Beginning January 4, 2011 any claims for items or services that have been prescribed by a physician or non-physician practitioner will be denied if not in the PECOS system.

This applies to Medicare claims only. ▲

CPT Coding Q&A: EGD vs. Enteroscopy

Q: What is the difference beween the 43235/ 43239 (EGD) and 44360/44361 (enteroscopy) codes? If an endoscopic diagnostic exam or biopsy of the jejunum is performed, how do we know which code to assign? Also, when would the 44376 or 44377 (enteroscopy involving ileum) codes be used? Are there upper GI scopes that can reach all the way to the ileum?

A: CPT Assistant Spring 1994 Page 7 provides some explanation of the difference between the 4323x and 4436x upper GI endoscopy codes. The relevant passage follows.

"Code 44360 specifically mentions that the ileum is not included because new codes have been added that do include the ileum. Code 44360 would be appropriate when, for example, a pediatric colonoscope might be used as an upper endoscope, its extra length used to reach beyond the second portion of the duodenum. Typical upper endoscopy does not reach beyond this point. Code 43235, 'upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum...'is worded to account for routine upper endoscopic procedures in patients with altered anatomy following surgery, such as Billroth II or Roux-en-Y reconstructions, which place a loop (or loops) of jejunum within reach of a conventional upper endoscope."

In other words, 43235/43239 is for conventional EGD where examination is up to first or second part of the duodenum in normal anatomy or to examination of gastrojejunal anastomosis or jejunal Roux limb in surgically altered anatomy.

44360 or 44361 would be assigned for examination or tissue sampling of the small bowel in normal anatomy that extends beyond the second portion of the duodenum and into the jejunum. A pediatric colonoscope may be used to reach the third or fourth duodenal portions or proximal jejunum in such cases.

Getting beyond the proximal jejunum and all the way into the ileum in normal anatomy via oral approach is very difficult, hence the growing popularity of capsule endoscopy. However, capsule endoscopy doesn't allow for tissue sampling or removal of lesions in the deep small bowel. Recently, push endoscopy (PE), single balloon enteroscopy (SBE), or double balloon enteroscopy (DBE) devices have been created that can provide access beyond the proximal jejunum in normal anatomy via oral approach and that allow for biopsy and other procedures to be performed in these areas. These devices provide some other instances where 44360 and 44361 or 44376 and 44377 could come into play. Still, even with SBE or DBE scopes, getting deep into the ileum is not always possible, so you won't be assigning 44376 or 44377 that often. ▲

http://www.asge.org/WorkArea/downloadasset.aspx?id=4166&LangType=1033

Client Corner

New $1M Club Member

Congratulations to Trinity Health's RID for reaching the coveted $1Million Club milestone. Under the leadership of Priscilla Frost, and executive sponsors John Kutch and Kevin Seehafer, this dedicated group reached the $1Million Club in six months. The department's continued success in charge capture, denial management, and new process improvement opportunities will ensure success in the remaining months of this fiscal year, as well as future years. ▲

Trinity Health Revenue Integrity Department

And Another!

IRM welcomes SGMC's Revenue Integrity Department (RID) to our acclaimed $1Million Club. Under the leadership of Jane Stephens, Jeff Sherman, and executive sponsor Greg Hembree, the RID achieved $1 million status in six months. The team is already poised to exceed its first year goals through recognized improvement in charge capture, code assignment, denial management, CDM accuracy, and implementation of systemic process improvement.

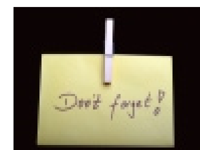
Congratulations, South Georgia Medical Center!

Save the Date!

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

Please mark your calendar and plan to attend next year's Best Practice Forum in beautiful downtown Austin. More information to follow. ▲

Don't Forget!



All CBR (Code-Based Reimbursement)/CCDR (Compliant Coding and Documentation Review) activity for the month must be entered into the CBR/CCDR Software applications, including DRG Catalyst, prior to the 10th of the following month.

Be sure to follow the steps below so that results from retrospective CBR/CCDR audits translate onto the Executive Summary:

Inpatient (DRG Catalyst)

- The rebill checkbox must be checked. (Please make sure that you send the checked accounts to PFS for rebilling!)

Outpatient (CBR Database)

- The completion date must be entered under the CBR/CCDR Utilities tab, and
- The rebill checkbox must be checked. (Please make sure that you send the rebill accounts to PFS for rebilling!)

Before the database closes each month, IRM recommends that you complete the following checklist:

- Confirm that all completed retrospective audits for the month have an end date entered into the CBR/CCDR database.
- Check the rebill box in the CBR/CCDR database or DRG Catalyst for each retrospective claim that has been approved for rebilling.
- Complete a Summary of Audit Findings form for any projects you closed this month and submit it to the coding Subject Matter Expert (SME).
- Ensure that data is entered for all accounts audited for the current month. ▲

Upcoming Webinars

Client RMD/RID Webinars 2010

Dec 7: RAC Forum: RAC & CDI Updates
14: CCDR Forum: 2011 CPT Updates
16: CA Forum: Wound Care Clinics

Potential Topics

Consumer-Driven Healthcare/Pay for Performance

Medicare Managed Care

Auditing ICU Accounts

How to Handle Adversity

Silent PPOs

How to Update and Maintain the CPM

How to Interact with Internal Customers

Write-Off Analysis

Software Data Entry and Process

Software Reporting

Injections and Infusions

Introduction to Inpatient Audits

Inpatient Mechanical Ventilation

POA and HAC

Observation and One-Day Stays

Device Dependent APCs

Wound Care

Pain Management

Outpatient Orders

Spine Surgery

Chemotherapy

Pathology

Brachytherapy

Moderate Sedation

Radiology Imaging

Erythropoiesis Stimulating Agents

Discharge Dispositions

Interventional Cardiology and Electrophysiology

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:
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