

# Net Revenue Matters



## Inside this issue:

CMS Expands RAC Program	1
Proposed Changes to Observation Payments	2
New and Continued IRM Partnerships	2
October is National Breast Cancer Awareness Month - Self Check!	3
Upcoming Events!	3
Client Corner Code-Based Reimbursement Project Rollout and Forum Call Calendar Blue Cross Underpayments New Monthly Procedure for Submitting Databases	4
Revvvvvv-Up Your Revenue! Zero Tolerance for Revenue Leakage Due to Silent PPOs - Part III	5

## CMS Expands RAC Program

The Centers for Medicare & Medicaid Services (CMS) recovery audit contractor (RAC) program was designed to ensure correct payments are made to providers and suppliers, therefore protecting the Medicare trust fund. The RAC program was implemented in California, Florida, and New York and was initially due to end in March 2008. Due to the success of the initial program, the Tax Relief and Health Care Act of 2006 (Section 302) allows CMS to expand the RAC program to identify Medicare under- and overpayments nationwide by 2010.

As a first phase, CMS has expanded the RAC program to include the Part A providers in South Carolina, Massachusetts, and Arizona. The expansion to the new states will only affect Part A inpatient and outpatient claims.

Given that the RAC program will be nationwide by 2010, all Part A providers should begin preparation.

First, providers can identify high-

risk/high-volume areas. Proactive audits could identify coding and documentation issues and allows the facility to self-correct before a RAC contractor becomes involved.

Second, a process of handling RAC audits should be discussed and implemented. This process should cover the following:

- ✓ How will RAC audits be tracked?
- ✓ Who will respond to audit requests?
- ✓ How will the facility ensure copies of medical records will be submitted by the 45-day deadline? Records submitted after 45 days result in disallowance of the entire claim.
- ✓ How will audit results be tracked and trended?
- ✓ How will the facility use these results to improve coding and documentation?
- ✓ How will appeals be handled?

For more on the RAC program, visit CMS' web site:

<http://www.cms.hhs.gov/rac/>



## Proposed Changes to Observation Payments

Total Medicare spending under the outpatient prospective payment system (OPPS) has increased at an average of 10% per year since 2002. It is projected that Medicare spending under OPPS will reach \$35 billion in 2008 (Federal Register, Vol. 72, No. 148, Proposed Rules, page 42650). Due to this rapid increase in OPPS spending, CMS introduced a packaging approach for numerous HCPCS codes in the CY 2008 OPPS proposed rule.

Included in this proposed packaging approach are observation payments (G0378). Currently, separate payments are made for observation care for three specified diagnoses meeting additional criteria for diagnostic testing and time limits. These three diagnoses are chest pain, asthma, and congestive heart failure. For all other diagnoses, observation payments are packaged. If the proposed change is made final, all observation payments will be packaged into the payment for the separately payable services with which it is billed. Below is an example of observation care payments unpackaged and packaged:

### Example of the Effects of CY 2008 Packaging

HCPCS Code	Short Descriptor	Sum of CY 2007 Payment (Some G0378 paid separately)	Sum of CY 2008 Proposed Payment (G0378 pkgd)
G0378 (under criteria for separately paid observation care)	Hospital observation per hour (dependant service)	\$442.81	\$0.00
99285	Emergency Dept. visit independent service)	\$325.26	\$348.81
<b>Total Payment</b>		<b>\$768.07</b>	<b>\$348.81</b>

The other areas included in the proposed packaging approach are as follows:

- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Diagnostic radiopharmaceuticals
- Contrast agents

The complete discussion concerning the proposed packaging approach can be found in the CY 2008 proposed OPPS rule, beginning on page 42648:

<http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1392p.pdf>

## New and Continued IRM Partnerships

The founders and staff at IRM pride ourselves in creating not only new partnerships with hospitals as they enhance their revenue management through our evaluation services or the creation of internal revenue management departments, but also in the continued relationships we have with current, valued IRM clients.



### Renewal RMD partnerships:

- Archbold Memorial Hospital, Thomasville, GA
- Columbus Regional in Columbus, GA
- Memorial Medical Center in Port Lavaca, TX
- Phoebe Putney Memorial Hospital in Albany, GA
- Sisters of St. Francis Health System, twelve hospitals in Indiana and Illinois

### New RMD partner:

IRM wants to welcome West Georgia Health System in LaGrange, GA to the IRM family. They will be developing an 8-person RMD under the executive leadership of Paul Perrotti, CFO.

### New IRM evaluation partner:

Gwinnett Hospital System in Lawrenceville, GA under the executive sponsorship of Tommy McBride, CFO.

As the IRM family grows, these partnerships continue to help us create a nationwide best practice community. To find out more about IRM's evaluation process and how to start your own RMD, visit our website or contact us!

## October is National Breast Cancer Awareness Month - Self Check!

Breast cancer is the most common cancer in women, but it can be successfully treated - one key is early detection. A breast self-exam (BSE) should be done once a month, several days after the last day of a woman's period, and should begin by age 20.



The American Cancer Society's recommended step-by-step technique for BSEs is as follows:

- ✦ *Lie down on your back and place your right arm behind your head. The exam is done while lying down, not standing up. This is because when lying down the breast tissue spreads evenly over the chest wall and is as thin as possible, making it much easier to feel all the breast tissue.*
- ✦ *Use the finger pads of the three middle fingers on your left hand to feel for lumps in the right breast. Use overlapping dime-sized circular motions of the finger pads to feel the breast tissue.*
- ✦ *Use 3 different levels of pressure to feel all the breast tissue. Light pressure is needed to feel the tissue closest to the skin; medium pressure to feel a little deeper; and firm pressure to feel the tissue closest to the chest and ribs. A firm ridge in the lower curve of each breast is normal. If you're not sure how hard to press, talk with your doctor or nurse. Use each pressure level to feel the breast tissue before moving on to the next spot.*
- ✦ *Move around the breast in an up-and-down pattern starting at an imaginary line drawn straight down your side from the underarm and moving across the breast to the middle of the chest bone (sternum or breastbone). Be sure to check the entire breast area going down until you feel only ribs and up to the neck or collar bone (clavicle).*
- ✦ *There is some evidence to suggest that the up-and-down pattern (sometimes called the vertical pattern) is the most effective pattern for covering the entire breast without missing any breast tissue.*
- ✦ *Repeat the exam on your left breast, using the finger pads of the right hand.*
- ✦ *While standing in front of a mirror with your hands pressing firmly down on your hips, look at your breasts for any changes of size, shape, contour, dimpling, or redness or scaliness of the nipple or breast skin. (The pressing down on the hips position contracts the chest*

*wall muscles and enhances any breast changes.)*

- ✦ *Examine each underarm while sitting up or standing and with your arm only slightly raised so you can easily feel in this area. Raising your arm straight up tightens the tissue in this area and makes it harder to examine.*

Doing a BSE regularly, and properly, is a way for women to know how their breasts normally look and feel and to more readily detect any noticeable changes. If a change occurs, such as development of a lump or swelling, skin irritation or dimpling, nipple pain or retraction (turning inward), redness or scaliness of the nipple or breast skin, or a discharge other than breast milk, it should be reported to a doctor or nurse right away.

Visit the American Cancer Society's website for a detailed guide on breast cancer:

[http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_6x\\_Breast\\_Cancer\\_Early\\_Detection.asp](http://www.cancer.org/docroot/CRI/content/CRI_2_6x_Breast_Cancer_Early_Detection.asp)

As an additional resource for self exams, the Susan G. Komen for the Cure website offers an online self exam tool. This tool assists in learning how to perfect self exam skills and is available in English, Spanish, and Hindi

<http://cms.komen.org/komen/AboutBreastCancer/EarlyDetectionScreening/BreastSelf-Exam/index.htm>

### Upcoming Events!

#### October 2007

*16th: Audio Conference, 10:00 a.m. Pacific  
All About Medically Unlikely Edits*

#### November 2007

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

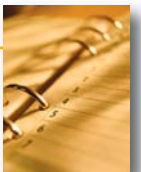
#### December 2007

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

*13th: Audio Conference, 10:00 a.m. Pacific  
Coding for 2008: CPT/HCPCS and OPPI  
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 October, 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:

### October 3 2007

Project Rollout, 11:30 a.m. Pacific

- GI Endoscopy

### October 24 2007

Forum Call, 11:30 a.m. Pacific

- GI Endoscopy
- Neurostimulators
- Vascular Access Devices
- Emergency Department
- Interventional Cardiology and Electrophysiology

### 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.

## Blue Cross Underpayments

Kathy Henson, Managed Care Auditor at Greenwood Leflore Hospital in Greenwood, MS, has reported a Blue Cross underpayment issue that is of interest to other RMDs. Greenwood Leflore's RMD discovered that Blue Cross is only paying the first physical therapy, occupational therapy, and speech therapy visit on recurring account claims.

The RMD has had discussions with their Blue Cross contracting contact who states that Blue Cross is aware of

the issue. Blue Cross does not seem inclined to speed to a solution, and suggested that the facility send appeals on the underpaid claims. Greenwood Leflore will continue to work with Blue Cross to find a solution, but is sending appeals on the underpayments in the interim.

All RMDs are urged to review their Blue Cross outpatient recurring accounts for physical therapy, occupational therapy and speech therapy to ensure accurate reimbursement.

Many thanks to Debbie Lea, RMD Director at Greenwood Leflore Hospital and her staff for this alert.



## New Monthly Procedure for Submitting Databases

As a reminder, IRM's latest upgrades to the Charge Audit, Managed Care, and Code-Based Reimbursement databases include a lock-out date which will occur on the 10th day (not business day) of each month. In order to validate your databases for data integrity, and to provide feedback prior to the lock-out date on the 10th of each month, we are requesting that each RMD do the following:

- By the 5th day of each month: In order to validate your databases for data integrity, IRM suggests that you transfer each database via the File Transfer Protocol (FTP) process by the 5th day of each month. IRM will review the databases and contact you to discuss any recommended changes to ensure accurate executive summary reporting.
- On the 10th day of each month: Submit each database again through the FTP process for executive summary preparation by IRM.

Be sure to contact Jennifer Huddleston (jhuddleston@irminonline.com), Data Integrity Manager, and your IRM Director of Revenue Management via email or phone when each transfer is completed.

IRM will provide email reminders twice each month for database transfers, and will also send a confirmation email notifying you that we have received your databases. Please share this process with the RMD staff member that performs the database transfer monthly. If you have any questions regarding this process, please contact Jennifer Huddleston or the Director Revenue Management assigned to your facility.

Thank you for your assistance with this new process!



## Revvvvvv-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. The focus for this installment will focus on education and training, job aids, and RMetrics Reports.

This series is 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) 448-1020 or contact your Director of Revenue Management at IRM.



## Zero Tolerance for Revenue Leakage Due to Silent PPOs – Part III

### Educating and Training RMD Associates, Patient Financial Services, and Clinical Staff

The RMD and/or PFS representative should plan a meeting devoted to training and discussion regarding contract provisions affecting claim reimbursement in existing contracts. All materials should be reviewed before presentation to the team members.



After making copies of contract provisions, highlight sections as described below and proceed with a discussion:

- Highlight provisions of current contracts prohibiting making available contracted rates to entities who are not directly contracted with the hospital.
- Highlight contract provisions that specify a discount may only be applicable if claims are paid on time per the contract. (Refer to state laws, rules and regulations, if applicable. Make copies of the sections of your state laws, rules or regulations that address payer reimbursement issues giving the hospital the right to collect claim balances.)

### Educating Hospital Collectors

- In preparation for collection calls to TPA’s (payers), the RMD and/or PFS representative should instruct collectors to coordinate the current payer contracts that are applicable to the erroneously paid claims. Examples should be provided that show claims that were paid at a less than contract rate.

- The RMD and/or PFS representative should create scripts for hospital collectors to dialogue with payers, and should be instructed to fax applicable contract provisions to payers. Scripts should include acceptable hospital terms for claim reimbursement including wire transfer information, overnighting funds, and when payment is accepted.
- IRM’s best practice recommendation is to have the trainer utilize role-playing scripts including methods to advance the conversation to the insurance claim’s supervisor. (See sample script on page 7)

### Specialized Collection Techniques

Collectors should be advised that the first payer representative often has the ability to only adjust routine claims. An unauthorized discount requiring the payer to make systemic changes and additional reimbursement usually involves a senior claims supervisors or manager.



Once the collector successfully reaches a claim supervisor, the collectors’ use of friendly language to make the point that the payer has taken an unauthorized discount and erroneously paid the claim will assist in resolution of the claim collection. At this point in the collection dialogue, the collector should offer to fax documentation to the supervisor. Collectors should be able to verbally provide the specific requirements to fully adjudicate the underpaid claim.

The following is an example of an inaccurately paid claim showing a \$32,500 unpaid balance due to an unauthorized

contractual discount taken by the payer, a workers compensation carrier:

**Example of Inaccurate Claim Payment:**


The trauma center (hospital) treated an injured worker. The hospital's total billed charges for the injured patient were \$45,000 for a 5-day medical stay and the hospital sent the bill to the patient's workers compensation carrier.

The major payer with a contract at the hospital sold access to its hospital-contracted rates to a TPA who also represents the workers compensation carrier. The workers compensation carrier uses the TPA's discounted rates to under pay the hospital. Therefore, the workers compensation carrier reimburses the hospital only \$12,500 using the major payer's rates:

\$45,000	Billed charges
- \$12,500	Workers comp carrier payment
<hr/>	
\$32,500	Revenue leakage due to silent PPO

There is \$32,500 lost revenue on this one claim if the hospital does not identify and pursue the unauthorized discount applied to the claim reimbursement.



 **Follow a script.** Based on the example above, the following sample script will assist the hospital collector in recovering the full economic value of the claim from the worker's compensation carrier:

"Hello, my name is John Smith from ABC Hospital calling about a claim balance. The issues are complicated and I need to speak with your claims supervisor, may I have the name of your supervisor please?"

Generally, before the transfer to a supervisor takes place, the collector will be asked to identify the claim, the patient, and the date of service. At this point the collector has a choice to provide the information. In the event the collector gets resistance to their request to speak with a supervisor, remember to keep the conversation as friendly as possible, but be specific with the next steps the collector is obligated to take:

"I respect your position; however, I am trying to do my job. If we can't reach an agreement during today's conversation, the hospital must contact both the patient and the employer to explain the situation to each party and request payment of the balance due. I would prefer to speak to the supervisor and not have to repeat the issues, please connect me to your supervisor."

If the collector gets continued resistance to their requests to speak with a supervisor, the collector can say, where applicable:


"I have copies of my contract and the state law that prohibits the use of the discount your company applied to the claim payment. I know the supervisor will have the ability to pay the claim balance once I explain and document the issues."

Once connected to the supervisor, the collector should introduce themselves again and thank the person for taking the call. The collector can then go on to say:

"ABC Hospital received an erroneous payment for this workers compensation claim. Your company paid the claim applying an unauthorized discount and the additional payment on this claim is 120 days past due. The additional balance to this claim is \$32,500. ABC Hospital requests the claim to be paid in full within 5 business days.

I am prepared to fax you sections of the contract and state law to document that the payment made was wrong. Therefore, the balance of \$32,500 can be pursued by the hospital. Will you send me a check in the amount of \$32,500 within 5 business days with this documentation?"

Offer a courtesy discount if necessary. Situations may arise where the payer requests either a discount for prompt payment or an extension of the 5-day payment request. Hospitals should provide guidance to their collectors for when these requests are made.

 **Finalize the details.** The collector should ask the payer for prompt payment in the form of an immediate hand drawn check.

🔍 **Prepare a statement.** After the call, the collector should prepare a note to file that includes the negotiated terms, any additional discounts, the exact dollar amount to be paid, and the date by which the payment is expected. A copy can then be faxed to the payer confirming the terms of the payment.

🔍 **Follow-up.** Each hospital should have clearly defined written policies and next steps outlined for a comprehensive collection process. Collectors must know the state and federal laws, rules, and guidelines for fair and acceptable collection practices.

## Metrics Tracking



### For the Collectors:

The collector should document collection calls, payer's responses in an appropriate system. Follow-up should be scheduled to determine and document if payments have been received per the terms negotiated.

### For the RMD and/or PFS Representative:

The trainers should document training dates, attendance and subjects covered. (Details on creating reference binders for distributed materials will follow in the November issue).

### For the Silent PPO Zero Tolerance Team:

Review the current list of reason codes in the existing denial tracking system to determine if "Silent PPO Activity" is an option to use for a denial reason. "SiPPO" (could be a home code for Silent PPO Activity) is more accurate and correctly identifies claim balances due to unauthorized silent PPO discounts than writing a claim off to bad debt.

- After reviewing the denial findings related to silent PPO activity with appropriate hospital staff, additional reason codes for silent PPO activity on denial management reports should be implemented if necessary.

- Include tracking and trending report information for the number of claims reviewed and identified as having balances due to silent PPO activity
- Track and trend the dollar amount of collections for balances due to silent PPO activity
- Track all implemented process improvement projects associated with silent PPO activity and track results.

As mentioned above, and because it is so important to the process of stopping revenue leakage due to silent PPO activity, we repeat: IRM's best practice for the Silent PPO Zero Tolerance Team makes it the responsibility of each member to share information and examples of silent PPO activity with their entire staff in each department including all shifts. Team members should pre-schedule department meetings and post information received at their team meetings. All departmental staff should be educated to universally implement the recommendations of the Silent PPO Zero Tolerance Team to stop the revenue leakage at the hospital.

*Educate,  
Collect,  
Track!*



*This concludes Part III of Zero Tolerance for Revenue Leakage Due to Silent PPOs. The fourth and final installment in November's Revvvvvv-Up Your Revenue column will feature the steps needed to create a job aid binder. IRM is available to assist with these activities. 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:*

*Jennifer Vansant, Marketing Manager ☎ 760-448-1036 ✉ [jvansant@irminconline.com](mailto:jvansant@irminconline.com)*