

Net Revenue Matters



October 2010



Welcome to the October 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, "Understanding Today's Interest in Hospital/Physician Relationships within the Context of Federal Strategy," Executive Vice President Jack Duffy discusses the hospital/physician organization.

Also, we hope that you'll appreciate the information presented in "Accountable Care Act," "Some Clarification on Radiopharmaceutical Coding," and "CDM Quick Tip."

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

Inside this issue:

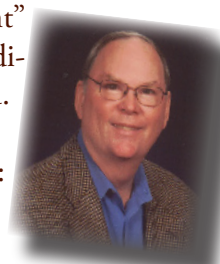
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Understanding Today's Interest in Hospital/Physician Relationships within the Context of the Federal Strategy

A number of well-positioned hospitals have expressed a renewed interest in sponsoring some form of hospital/physician organization. In some communities this is expressed through an aggressive program of direct employment. For others, service organizations can be focused on managed-care contracting, integration of health information, or exploring the requirements to establish medical homes for patient populations. Independent of which model is being considered, hospitals must save a place at the planning table for state and federal government. Without this perspective, the risks can be enormous.

As reported in previous newsletters, Medicare has promised **41 trillion dollars** in future benefits for which no current source of payment exists. These promises come due over the next 40 years and we can see already the strategy that will

be used to "prevent" the demise of Medicare and Medicaid. Let's list some of the known factors:



- ▶ Hospitals have already agreed to reduce future payments by 155 billion dollars. This is to "offset" the new income gained by reduced uninsured. The problem is that the newly insured will be paid at Medicaid rates which in many states do not cover costs.
- ▶ Physicians have been under a pay reduction cloud for years. An administration that stops printing trillions of dollars in worthless paper currency can be expected to pull this trigger to help reduce runaway deficits.
- ▶ CMS is encouraging experiments in global payments. That is a single payment that is somehow shared with both hospital and physician services. I strongly suggest that you study the capitation experiment of the 1990s. This multi-billion dollar loss was caused by too few dollars chasing too many services. The insurance companies were

allowed to retain 100% of their traditional profits guaranteed. Pharmaceutical prices inflated over 15% each year with no increase in payments. Patients began to sue hospitals for denial of service (remember that virtually no one can be denied service under the current healthcare legislation). Physicians demanded their fair share of the premium, often leaving hospitals with insufficient funds to provide required care. Adverse selection concentrated the sickest patients in the richest plans which led to financial failure. Finally, the number of patients in a system was insufficient to adequately spread the risk.

“If these factors do not cause your organization to plan carefully, consider...”

If these factors do not cause your organization to plan carefully, consider that physicians have not had an inflation-adjusted increase in reimbursement in ten years. This pent-up demand could make negotiations extremely difficult.

There remain some areas of great potential that do merit consideration. As the density of electronically stored records increase each year, the potential to share those records on a community-wide basis increases. Access to records can reduce redundant testing, reduce adverse drugs reactions, and improve outcomes. The body of knowledge that supports quality indicators also increases each year. Physician organizations that reach beyond the traditional medical staff model can increase the acceptance of quality indicators.

“The bottom line is that these decisions require careful planning that includes the agendas of all the players.”

At some point in time, both hospitals and physicians will fully install all of the tools associated with standard transaction sets. If managed at a best-practice level, these tools can reduce administrative costs and increase acceptance rates for claims.

The bottom line is that these decisions require careful planning that includes the agendas of all the players. Be sure to reserve a seat at the planning table for government, industry, and other stakeholders. ▲

Jack

Accountable Care Act

September 23, 2010 represented a new day for American consumers in our nation's healthcare system. There are a series of new rights, benefits, and protections under the Affordable Care Act now in effect. How does this effect your hospital's revenue cycle? How informed are your financial counselors of these new changes?

Consumers in new health plans will be able to:

- ▶ Use the nearest emergency room without penalty.
- ▶ Receive cost-free preventive services.
- ▶ Choose a primary care doctor, ob/gyn, and pediatrician.
- ▶ Keep young adults on a parent's plan until age 26.

Insurers will no longer be able to:

- ▶ Deny coverage to kids with pre-existing conditions.
- ▶ Put lifetime limits on benefits.
- ▶ Cancel a policy without proving fraud.
- ▶ Deny claims without a chance for appeal.

Hospitals do benefit from some of these changes. Banning lifetime limits and policy cancellation will allow hospitals to continue care for severely ill patients. Many of the nation's uninsured young adults will be able to extend coverage to age 26 on their parents' plans.

Inform the hospital, inform the RID staff, and, most important, inform your patients and prospective patients. ▲

Some Clarification on Radiopharmaceutical Coding

Unit assignment for I-123 Sodium Iodide

IRM has addressed several questions over the last month regarding the HCPCS codes appropriate for I-123 Sodium Iodide assignment. In addition to the appropriate HCPCS codes, the units to be assigned has also been a repeated inquiry.

“IRM has addressed several questions over the last month regarding the HCPCS codes appropriate for I-123 Sodium Iodide assignment.”

Two HCPCS codes exist for description of Sodium Iodide I-123. HCPCS A9516 with descriptor: Iodine I-123 sodium iodide, diagnostic, per 100 microcuries, up to 999 microcuries, and HCPCS A9509 Iodine I-123 sodium iodide, diagnostic, per millicurie.

A9516 would be assigned if the patient received 300 microcuries in their study dose. This would also be indicated as three units due to the descriptor associated with this code. If it were 400 microcuries then the code would be accompanied by four units. It is when you get into the amount over 999 microcuries when the code changes to the A9509 which describes millicuries.

“In addition to the appropriate HCPCS codes, the units to be assigned has also been a repeated inquiry.”

Example: if the patient was having a whole body scan and the coder needed to assign 1500 microcuries then the dosage would be assigned in millicuries instead of microcuries. The appropriate HCPCS code would be A9509. If the patient received 1500 microcures, then the amount equates to 1.5 millicuries. Appropriate code assignment would be A9509 with two units; not A9516 with 15 units.

For additional documentation regarding radiopharmaceutical descriptions and uses, the Medlearn Nuclear Medicine Coder is a great resource. ▲

CDM Quick Tip

The Charge Description Master (CDM), or charge-master, is a comprehensive listing of items that could be billed to a patient, payer, or healthcare provider and is a critical component of billing compliance. The CDM is an instrumental revenue tool that continuously needs to be updated and monitored for accuracy and compliance.

“Standardizing your CDM descriptions assists clinicians as well as non-clinicians...”

Standardizing your CDM descriptions assists clinicians as well as non-clinicians in choosing the appropriate charge to represent the service provided, supplies, and medication administered during a patient encounter. It is important to remember to check these descriptions annually to ensure they accurately reflect the service being provided and billed.

“The recommendation is to have consistency and an appropriate standard description for each department procedure/item.”

When descriptions are not standardized, it is common for supply items, procedures, and medications to be in the CDM several times because the description is vague, abbreviated, incomplete, or inaccurate. This can cause multiple line-item charges for the same item with different prices.

Recommendations

Implant Devices: List the type of implant first, then size or abbreviated vendor name.

Examples:

PM (Pacemaker) Dual Chamber

BS Stent, drug-eluting is Boston Scientific stent, drug eluting

Pharmacy: Medication descriptions require the correct dispensing dosage, type – tablet, injection, suspension – and generic name.

Examples:

Inj, Meperidine 50mg/ml

Tylenol 250mg

Procedures: Procedure descriptions can be challenging. When a procedure is added to the CDM and the description does not reflect the CPT definition, multiple procedure CDM charge codes may be added with the same CPT code. This occurs when the descriptions are not standardized and easily located to verify if there is a current CDM number that can be used.

Examples:

Insertion of Pacemaker

Revision of Lead

Central Supply/Material Management: In the Central Supply department it is easiest to put the item name first, then size or type.

Common items:

Dressing, Bandage, Suture, Pack, Tray, Stent, Catheter, IV, Filter, Tubing, Screw, Plate, GW(guide wire), Sheath, Introducer, Lens, and PM (pacemaker).

Examples:

Dressing, Tegaderm 6x8

Suture Prolene 6.0

Catheter, Hickman 2.0

Filter, blood

Angio Cath 1.5G

The recommendation is to have consistency and an appropriate standard description for each department procedure/item. The standard descriptions are usually limited to 29 characters in the CDM file.

“In an effort to have a clean, easy, and user-friendly CDM, it is best to standardize descriptions.”

In an effort to have a clean, easy, and user-friendly CDM, it is best to standardize descriptions. By standardizing the descriptions in the CDM it will facilitate maintaining and updating the CDM. The CDM is used by clinical and non-clinical staff. An optimal CDM is compliant and accurate for charging, bill presentation, and reimbursement. ▲

CLIENT CORNER

Best Practice Forum 2011

Plans are underway for next year's Best Practice Forum and we'll be sure to keep you posted regarding details as they're finalized. We hope that you'll be able to join us!

See you in 2011. ▲

Don't Forget!

All CBR activity for the month must be entered into the CBR Software application/DRG Catalyst prior to the 10th of the following month. Be sure to follow the steps below so that results from retrospective CBR 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 Utilities tab, and
- ▶ The rebill checkbox must be checked. (Please make sure that you send the checked 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 database.
- ▶ Check the rebill box in the CBR 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

Oct 21: Charge Audit Forum: Respiratory Therapy

Nov 2: RAC Forum

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.

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