

Net Revenue Matters



September 2011



Welcome to the September 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, "CMS Begins to Flex Its Power" Founder & Executive Vice President Jack Duffy discusses CMS' revalue of its prospective payment system.

Also, we hope that you'll appreciate the information presented in "FY2012 IPPS Final Rule" "Medicare Updates," "Coding Conundrum," and "What To Do about Waste."

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

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CMS Begins to Flex Its Power

A few days ago, the skilled nursing industry learned that CMS had revalued its prospective payment system, which has resulted in more than an 11% decrease in reimbursement. The skilled care industry has in recent years been increasing the amount of care provided to patients and, thus, billing higher value codes. This increase in acuity is most likely the result of hospitals needing to manage DRG-based patients as close to the discharge line as possible. Your organization may sponsor SNFs and other post-acute facilities for the very reason that you need a clear path to facilitate timely discharges.

As the population ages and margins are compressed, we expect acuity to continue to increase and the pressure discharge patients to increase. The balance between quality care that does not promote readmissions and economic survival is getting very close. The organizations that thrive in this environment will be those that fully embrace the need to manage each patient within published guidelines and document this

level of compliance. The limiting factor will be variation in treatment plans and outcomes.

Contemporary planning agendas need to include a systematic review of variation at all levels of care. High-efficiency care teams must mentor those who fall short of best practice. The consequences of sustained practice variation will cause increased external audits and loss of reimbursement.

The financial teams in our hospitals and healthcare centers have a unique skill set that allows for the rigorous examination of variation using statistical process control tools and skilled analytical staff. These tools should be available to all process improvement teams and, in particular, those who study outcomes and resource consumption. There will be a time when it will be the acute care hospital headlined in *Modern Healthcare* having just suffered a reduction in reimbursement similar to skilled nursing. When that day comes, it will be those organizations that spent their time wisely to reduce variance and increase compliance with practice



standards that will serve the healthcare needs of their communities.

A word about keeping up to date: if you did not know about the dramatic decrease in SNF reimbursement, you may not be faithfully reading the publications that strive daily to keep us up-to-date. In a few minutes a day you can review breaking stories on your smart phone, tablet, or laptop. This investment of time will give you the advantage to help lead your organization to prepare for next time CMS flexes its power. ▲



FY2012 IPPS Final Rule

On August 1, 2011 the Centers for Medicare & Medicaid Services (CMS) issued a final rule to update Medicare policies and payment rates for inpatient services furnished by acute care hospitals in fiscal year (FY) 2012.

Under the final rule, most general acute care hospitals will receive an increase in payment rates of 1.0 percent, compared to the payment decrease of 0.5 percent that was estimated in the proposed rule.

The difference between the proposed and final payment rate updates is due mainly to the adoption of a higher market basket, a lower multifactor productivity adjustment based on more recent data, and a prospective documentation and coding adjustment of -2.0 percent instead of the -3.15 in the proposed rule.

CMS projects that this rate increase, combined with other policies in the final rule and projected utilization of inpatient services, will increase Medicare's operating payments to acute care hospitals by \$1.13 billion, or 1.1 percent, in FY 2012 compared with FY 2011.

As required by Medicare law, hospitals that do not successfully participate in the Hospital Inpatient Quality Reporting Program will receive a 2 percentage point reduction from the market basket, yielding a final payment update of -1.0 percent.

Some of the coding updates include five changes to the MS-DRG classifications:

- ▶ Autologous bone marrow transplant – currently has no severity assigned to MS-DRG 015. It is now being moved into new MS-DRGs 016–017 and classified as with or without CC.
- ▶ Excisional debridements – CMS is removing them from MS-DRGs 573–578 and moving them into the newly created, lower paying MS-DRGs 570–572.
- ▶ Rechargeable dual array deep brain stimulation system – this is being moved from MS-DRGs 040–042 to the higher paying 023–024.
- ▶ Thoracic aneurysm repair – the two codes for repairing a thoracic aneurysm or placing a stent are being moved from MS-DRGs 237–238 and placed in MS-DRGs 219–221, which pay more.
- ▶ Nutritional and Metabolic Diseases – MS-DRGs 640–642 have had the titles updated to better reflect the cases that are assigned to these MS-DRGs.

As we prepare for ICD-10, a code freeze has been implemented.

- ▶ October 1, 2011 is the last regular annual update to both ICD-9-CM and ICD-10-CM.
- ▶ For FY2012 there are 168 new codes, most of which are due to adding a fifth digit to the 33 invalid codes, along with a few completely new codes. There were also 41 revised diagnosis code titles. The CC/MCC list was updated to reflect the changes to these codes. There were minimal changes to the procedure codes: 23 revised titles, 1 invalid, and 19 new.
- ▶ On October 1, 2012 there will be only limited code updates to both ICD-9-CM and ICD-10 code sets to capture new technology and new diseases.
- ▶ There will be no updates to ICD-9-CM on October 1, 2013 as the system will no longer be a HIPAA standard. There will be only limited code updates to ICD-10 code sets on October 1, 2013 to capture new technology and new diseases.

- ▶ On October 1, 2014 regular updates to ICD-10 will begin.

There are too many important updates to discuss here. Be sure to visit the CMS website at the path below to download the final rule and all of the associated files. ▲

<http://www.cms.gov/AcuteInpatientPPS/FR2012/list.asp#TopOfPage>

Medicare Updates

Magnetic Resonance Imaging in Medicare Beneficiaries with FDA-Approved Implanted Permanent Pacemakers for Use in an MRI Environment

Effective for claims with dates of service on or after July 7, 2011 CMS believes that the evidence is adequate to conclude that magnetic resonance imaging (MRI) improves health outcomes for Medicare beneficiaries with implanted Permanent Pacemakers (PMs) when the PMs are used according to the FDA-approved labeling for use in an MRI environment. Other contraindications that may be present in any given beneficiary would continue to apply in patients with PMs. These other contraindications are listed in section 220.2.C.1 of the National Coverage Determinations (NCD) manual and referenced in CR 7296.

Implementation of a Correction of Initial Default Values for Medically Unlikely Edits

CR 6712 requires that contractors apply Medically Unlikely Edits (MUEs) to claims with a date of service on or after the beginning effective date of an edit and before or on the ending effective date.

Further, CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the value in column 2 of the MUE table. Pub. 100-08, PIM, chapter 3, section 3.5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors. However, since claim lines are denied, denials may be appealed.

CR 6712 requires that appeals shall be submitted to local contractors and not the MUE contractor, Correct Coding Solutions, LLC.

Note that, quarterly, the NCCI contractor will provide files to CMS with a revised table of MUEs and

CR 6712 requires that contractors download via the Network Data Mover.

Furthermore, if Medicare contractors identify questions or concerns regarding the MUEs, CR 6712 requires that they bring those concerns to the attention of the NCCI contractor. The NCCI contractor may refer those concerns to CMS, and CMS may act to change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals. ▲

Coding Conundrum

Are you a coder that is caught in a coding conundrum? Over the past few months, IRM has conducted multiple quality reviews for our clients. From a coding perspective, one of the most frequently identified issues is related to the physician's dictation. Lacking documentation of anatomy and specific location of the procedure is eminent. Interventional radiology cases, for example, reflect omitted documentation by the physician for the catheter placements and what was imaged. Language such as selective catheter placement and a description of where that catheter terminated during the imaging is paramount. Also noteworthy is any anatomical variant, such as, what is the variant? This information is important to the coding process.

RAC is continuously looking for new issues to emerge and just because something isn't on the RAC radar today does not mean that it won't be on the radar tomorrow. Lack of documentation has consequences. If you are a coder and are assigning codes because you may think you know where the physician terminated the catheter because there is documentation of what was imaged, but the dictation does not support selective catheter placement, the facility could be at risk. Many areas in the arterial system can be seen from a single catheter placement. Therefore, if the physician doesn't say that the catheter was selectively placed, where it terminated, and doesn't provide documented imaging in the anatomic location with an impression of that anatomic location, then you can be assured that the code should not be assigned. So what should you do? Incomplete documentation should be addressed with the physician who is supplying it. In many cases, the physician may not realize

that the documentation is missing information that is pertinent to the coding process. If documentation is incomplete and you're working on a concurrent project, put your claims on hold and query the physician to obtain an addendum. Start a documentation improvement process. Provide education to the physician from a coding perspective. The final outcome of taking the time to educate will lead to compliant documentation which includes key language necessary to accurately code the highest level of specificity, as well as stop the revenue leak in the facility. In addition, obtaining compliant documentation will deflect any audit. ▲

What To Do about Waste

Do you know what your facility's policy is for charging or capturing the cost of a wasted implant or sterile supply?

Implants that have been opened, placed in the patient, and then not used are considered wasted. The facility should have a policy to account for the cost of this implant. With proper documentation in the physicians' dictation or nursing notes, these wasted implants can be charged on the itemized statement. The facility may choose to track this charge as a non-billed item. The payer contracts may have language that addresses how these wasted implants will be reimbursed. Compliance to these contracts is crucial.

Similarly, charging for a supply that was opened and then dropped, the wrong item was opened, or an opened item was not used is called wasted. Charge auditors need to comply and be consistent when auditing to identify a wasted item. Items can be wasted in any area of the facility. We are all most familiar with surgical supplies; however, be sure to consider any clinical area where sterile supplies are utilized.

The first tool you will need is a policy that applies to the handling and charging of wasted items. This policy needs to apply consistently to all areas of the facility, or make the exceptions very clear. Be sure it gives specific circumstances when these items should not be charged and who has the authority to waive this policy.

The following questions should be answered with this policy:

- ▶ When the item is contaminated, is it charged?
- ▶ When it does not function properly, is it charged?
- ▶ When the physician insists on opening a sterile item to have it available immediately, is it charged?
- ▶ When the wrong implant is opened, is it charged?

The next challenge is how to charge. Charging also needs to be clarified in the wasted supply/implant policy. Clarification that should be considered in your policy includes:

- ▶ Is the item resterilized, so not truly wasted?
- ▶ Do you charge the entire charge or use a different formula for mark-up of wasted items and charge only the cost of the item?
- ▶ Is there a different cost center, revenue code that is not reported on a UB-04 (such as 0999), or a different tracking mechanism for identifying the wasted item?

How does a charge auditor determine what is wasted? Documentation can be found in the physicians' dictation, nursing notes, on charge sheets or specific wasted item charge sheets, supply logs from an Omni cell or Pyxis machine, or supply chain records.

In order to understand how much waste occurs in the facility, the waste must be documented to include the implant information, the physician, clinical staff, and department. Information pertaining to why the implant was wasted is also important. Trending the reasons will help identify what department has a waste issue, if there a specific implant problem, or if a specific physician is responsible for the waste. With such data, process improvement projects can be initiated in order to stop, or at least curtail, this loss of revenue.

Develop a team of experts to help with this project. You will need to include the clinical area directors, the CFO, compliance, materials management, cost accounting, patient financial services, the CDM analyst, process improvement, and the RMD director.

Please contact your IRM representative should you require assistance with this issue. We are always glad to help. ▲

Happy auditing!
Dawn

CLIENT CORNER

Where Money Hides – Looking Beyond the Revenue Cycle



One of our clients found over \$30,000 in money held by the state that had been escheated under state laws. Our client was able to successfully recover these dollars. All firms doing business in a state are required to return to the state any unclaimed money and that requirement is called escheatment. These dollars represent bank accounts that have been inactive, checks that have not been cashed, proceeds from settlements or other legal action that have not been disbursed, etc. Hospitals regularly escheat monies related to refunds when the party to be refunded cannot be located.

States in the U.S. make it fairly easy to locate funds that are being held on behalf of citizens. It's held in the general fund and the state will sometimes run newspaper ads letting people know that they have money available. States also make a point of saying that you should never pay anyone to find this money for you. It is public information and all you need is the name and tax payor id number. You also need patience to fill out the forms and wait.

We encourage all of our clients to review state Web sites, as well as sites of surrounding states if you are in a border area, in order to determine if a state is holding any of your money. The hard part will be finding all of the corporate names that have been used over the years and the related tax payor ID numbers. This can sometimes be a chore.

The largest amount we have ever heard of being recovered? John Garcia, Kathleen Craig, and Jack Duffy recovered over \$800K for a 500-bed acute care hospital when IRM was just a dream and the RMD at the facility was in its formative years.

***How much money can you find?
Let us know.***



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

- Sep 20: Coding Forum: FY2012 IPPS Updates
21: Process Improvement Forum: Drug Wastage
Oct 4: Managed Care 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.

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