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THE REIMBURSEMENT ISSUE

AHA fights outpatient PPS implementation date

Hospitals should be prepared for system this month

Implementation time for the outpatient prospective payment system (PPS) is here. Are you prepared? You might have more time to get ready if the American Hospital Association (AHA) in Chicago has its way.

The AHA is fighting the Health Care Financing Administration (HCFA) in Baltimore for a delay in the implementation of the final rule.

"This new payment system will significantly change how hospitals are reimbursed for outpatient services under Medicare," wrote **Rick Pollack**, AHA executive vice president, in a letter to association members. "But while HCFA took more than a year and a half to issue its final regulation, hospitals and health systems will have less than 90 days to make sweeping system changes."

In a letter to HCFA Administrator Nancy-Ann DeParle, the AHA expressed "grave concern" that the agency's schedule is too short to implement the new system accurately. "Medicare beneficiaries could receive conflicting financial statements from hospitals and the intermediaries, which could confuse them and also harm the reputations of hospitals in their communities."

On May 23, HCFA revealed its contingency plans for the Medicare outpatient PPS, according to the AHA. If claims are processed under outpatient PPS using the new systems more than three weeks after July 1, HCFA will make accelerated payments to providers requesting them. Payments would be 70% of the estimated Medicare payment and would be made biweekly. Adjustments would be made once outpatient PPS becomes operational, and

(Continued from cover)

DRG Coding Advisor

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THE REIMBURSEMENT ISSUE

other payers would be told of the Medicare payments for each claim, allowing them to pay providers additional amounts. Similar payments would be made up to eight weeks after July 1 if individual providers can't submit bills compatible with outpatient PPS.

Even with the efforts of the AHA to delay implementation of the outpatient PPS, hospitals should be ready for the regulations to go into effect this month.

"Hospitals that have prepared as far as looking at their coding accuracy, impact analysis, and flow processes for the billing cycle are in a much better position than those that have to do all that plus look at their data and information systems from the perspective of the new rule," says **Sue Prophet**, RHIA, CCS. She is the director for coding policy and compliance at the Chicago-based American Health Information Management Association (AHIMA).

The final rule requires hospitals to refine their implementation plan. "They need to fine-tune and understand exactly what goes into the APCs [ambulatory payment classifications] and some of the things that have been added, such as new drugs that have pass-through payments," Prophet says.

Darice Grzybowski, RHIA, national manager of HIM industry relations with 3M HIS in Salt Lake City, offers two points of advice for preparation for the outpatient PPS:

1. Ensure you have appropriate software.

"You have to make sure you have software that groups your patients into APCs. You have to have software that allows you to calculate what you are going to get reimbursed," she says. "It's one thing to group them, but another thing to project your reimbursement. You have to have the ability to store that information and generate reports on it so you can analyze the data such as profit and loss."

2. Make sure your processes are reviewed and modified to be able to accommodate the work flow changes necessary to support APCs.

This allows the health information management (HIM) department to review both the charge-generated HCFA common procedure coding system codes as well as the ICD and common procedure terminology codes. "If you are not looking at them together, how are you going to see the big picture?" Grzybowski asks.

"Another example would be the ability to do a final APC grouping after all charges are entered, even late charges, which may not be available at the time of HIM coding. You need to look at those type of process issues and your interfaces to your data back to your systems." ■

Hospitals struggle through HCFA's E/M instructions

Facilities must decide what coding system to use

When industry analysts reviewed the final outpatient prospective payment system regulation, one portion seemed to universally catch them by surprise: instructions for evaluation and management (E/M) coding.

The rule, published in the April 7 *Federal Register*, stipulates that the Health Care Financing Administration (HCFA) in Baltimore will hold each facility responsible for developing and following its own system for coding clinic and emergency department visits. HCFA says that the system should map the provided services or combination of services for assigning the different levels of HCPCS (HCFA common procedure coding system) codes.

"As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill," the rule states. HCFA also says it does not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility.

"The E/M coding is one of the hot debate items [in the rule]," says **Darice Grzybowski**, RHIA, national manager for HIM industry relations with 3M HIS in Salt Lake City. She says she had expected the rule to say that hospitals would have to use the physician documentation definitions for the E/M coding. **(For information about other debated items in the final rule, see story, p. 101.)**

The final E/M decision most likely resulted from feedback that HCFA received from the proposed rule, says **Sue Prophet**, RHIA, CCS, director for coding policy and compliance at the Chicago-based American Health Information Management Association (AHIMA). "I know there were a lot of concerns and comments about the fact that the E/M codes and the CPT [common procedure terminology] coding system were developed to capture the physician work involved in taking care of a patient, which is significantly different than the type of resources expended by a facility."

In a medical visit to a hospital emergency department, patients can receive care that wouldn't take place in a doctor's office, and that doesn't reflect on the doctor's time, such as X-ray, nursing, and registrar services, Grzybowski says. "[E/M coding guidelines] were designed to measure physician treatment, time spent with patients, and physician office visits, but HCFA was not using it for that intent."

Sitting in limbo

Although Grzybowski and Prophet say they are pleased that HCFA recognized the problem and responded to industry concerns, they know the current rule leaves the E/M coding situation somewhat in limbo.

"There are mixed feelings from hospitals," Prophet says. "There is certainly some sense of relief that they don't have to use the physicians guidelines for assigning the codes. On the other hand, they are left wondering how they are going to assign them."

In addition, hospitals are concerned about how to determine if the system they use is reasonable. "Is the OIG's definition of reasonable going to be the same as HCFA's and the same as the hospitals? What does reasonable really mean?" Prophet asks. "Just because you think your system is reasonable doesn't mean the government will think the same thing. People might feel more secure if everyone had a standard system to use."

AHIMA's first preference was for HCFA to offer another mechanism for developing the ambulatory payment classifications for medical visits other than the physician's E/M codes. "The problem is that there really wasn't a system available for them to use that relates E/M codes to facility resources," she explains. HCFA has said it

plans to work with the American Hospital Association in Chicago and AHIMA to develop appropriate facility-based patient visit codes before the next proposed rule.

"HCFA will probably look around to see who has developed the best system of how to determine the relationships between the E/M codes and the facility resources and ultimately adopt a system," Prophet says.

What should hospitals do now?

While hospitals wait for HCFA to propose a standard E/M coding system, they can choose one of three options in response to the agency's current recommendations, says Grzybowski:

1. **Continue handling E/M coding the same way they do now.**

Some hospitals may continue to enter the codes in the chargemaster as a result of how much time and acuity measurements the nursing visit is spent on the patient, Grzybowski says. Others may handle the codes based on documentation criteria — how many items are marked off the record.

Hospitals may have less change and, therefore, less stress if they continue handling the E/M coding as they have been. "[Not changing] also may allow consistency in your audit results," she adds. "If someone were auditing you against how you were doing things previously, you're going to come up with the same answer. It helps protect you from a compliance perspective."

Given the way ambulatory payment classifications are formulated and the way the E/M codes are going to be used, however, hospitals may be getting potentially less revenue than they are due. "People tend to be sloppy with their current systems, and they don't have very objective criteria," Grzybowski says. "It is a little more subjective in some places. It's a potential cash-flow risk."

Prophet says she has concerns that many providers don't have a formal system to handle E/M coding. Many hospitals just assign the lowest code, since that brings no risk of payment penalties or ramifications. "A lot of facility coders, therefore, are not familiar with or have had education on the proper assignment of E/M codes. So they do not have any system to do it the same old way."

These hospitals, then, must choose from the two remaining options.

2. **Adopt the physician documentation standards as HCFA originally intended.**

"To do that, you would have to revise your documentation processes and realize that it's very intensive for the physicians to document that way," Grzybowski says. In addition, hospitals must take sides in the debate about whether to use the 1995 CPT rules or the 1997 rules.

"According to HCFA, right now for physician reimbursement, hospitals can choose either set of criteria," she explains. "Most stick with 1995 because it is easier."

Big change for hospitals

Hospitals would likely undergo the most dramatic change to adopt these standards, she says. "You may optimize your revenue, but on the other hand, you may not, depending on the quality of documentation you get back from the physicians." Switching to this system changes other processes — not just the method to capture E/Ms. "How do the doctors get their documentation? Are they dictating? Are they using template check-off boxes? Who is doing the coding? Is it the HIM department or is it going to be a different department?" Grzybowski recommends the health information management department do that type of review since that is in its area of expertise.

3. **Develop new criteria.**

Hospitals can also begin doing their E/Ms based on whatever they want. The coding can be based on some form of documentation, some type of formula they have developed based on coding, or other types of time spent and acuities.

Developing a new system may not be as dramatic a change as switching to the physician documentation standards, but it will still require educating staff. "That takes time," Grzybowski says, "and July 1 is rapidly approaching." The last two choices also don't give hospitals consistency in their coding methods.

If hospitals choose to maintain their present system of E/M coding, she recommends that one more set of actions be taken. "I would add some audits to make sure I was doing it as objectively as possible to ensure proper reimbursement." ■

Categories, copayments are other hot PPS topics

Inpatient-only list may discourage advances

Evaluation and management (E/M) coding guidelines aren't the only topics of discussion regarding the final outpatient prospective payment system regulation. Providers are also talking about the inpatient-only procedures list and the limit in beneficiary copayments.

In the proposed regulations, the Health Care Financing Administration (HCFA) had a list of procedures that would only be paid if they were performed on an inpatient basis. These procedures were chosen because of their invasive nature, the need for postoperative care, or the underlying physical condition of the patient requiring the surgery. In the final rule, 195 of these procedures were moved into the outpatient category, where they would be covered under ambulatory payment classifications (APCs). The procedures that were moved to the outpatient setting include laparoscopic cholecystectomy, partial mastectomy, and coronary and noncoronary angioplasties.

Hospitals will need to be aware of which APCs will be paid on an outpatient basis and which will be paid on an inpatient basis, says **Darice Grzybowski**, RHIA, national manager for HIM industry relations with 3M HIS in Salt Lake City. "Certain patients, based on medical necessity, better meet inpatient criteria, and some may better meet outpatient criteria. Insurance companies and HCFA may have different guidelines on what status patients should be in to meet insurance payment criteria, but this is different than medical necessity criteria.

"The bottom line is that the physician's order and hospital criteria for admission must indicate what status a patient is directed to, and payment is based on that documentation in the medical record," she adds.

Other industry analysts were pleased HCFA removed some procedures from the inpatient-only list. "Technology and the settings regarding how things are done are changing all the time and certainly at a much faster rate than HCFA's policies could ever keep pace," says **Sue Prophet**, RHIA, CCS, director for coding policy and compliance at the Chicago-based American Health Information Management Association. "My concern is that the inpatient-only list might actually hold back some of those technological changes."

For example, a technique for a particular procedure might be developed so that it would be performed only on an outpatient basis. If these hospitals were only going to get paid if they do the procedure on an inpatient basis, they are going to continue admitting those patients, Prophet says.

"A medical review of medical necessity on an after-the-fact audit basis would be a better method of making sure that hospitals were performing procedures in the setting that is the safest and most appropriate for that type of procedure, rather than just making a blanket statement that 'This procedure has to be done on an inpatient basis until we say otherwise,'" she says. "I think more of that should be left to the clinical judgments of the providers."

Change was a response to feedback

HCFA's decision to move some of the procedures back to the outpatient list was a response to some of those concerns, Grzybowski says. "I feel HCFA listened to the comments about that and responded appropriately."

The agency seemed to carefully consider comments relating to the inpatient-only list as well as to the E/M coding guidelines, she adds. "That's why it took them so long to release the final regs. To me, it has been a good and natural process." **(For more about E/M coding, see story, p. 99.)**

Now that the final regulations list procedures that must be done on an inpatient basis only, hospitals need to get their software in place, Grzybowski says. "You need to make sure you have a list available or software that screens patients at registration that says, 'This procedure is inpatient only.'"

HCFA also has used the final rule to limit what Medicare beneficiaries pay in copayments. "HCFA has recognized that Medicare patients have been paying an inappropriate share of co-insurance or copayment to the hospitals," she says.

Current rules stipulate that Medicare beneficiaries pay 20% of billed charges. When HCFA pays a reduced rate to insurance companies, though,

the remaining balance isn't based on the reduced rate but is prorated from the initial charges. That could mean that beneficiaries could spend 50% or more on copayments for certain procedures. HCFA capped the amount beneficiaries would pay for a copayment so they would not end up paying a disproportionate amount.

The final rule includes a provision designed to eventually transition the copayment to the desired 20%. Hospitals have the option of discounting the total price of the copayment before HCFA does and using that discount as a marketing tool to attract more patients. With reimbursement reduced in so many areas, however, Grzybowski says she doesn't expect many hospitals to offer the discount — or that patients will switch hospitals just for that reason. "Patients are loyal to their doctors."

As with the inpatient-only procedure list, hospitals need to ensure that their software can handle the new calculations of the copayments, she says. "That's something hospitals are going to have to get used to [evaluating]." ■

Prepare by department for APC implementation

Here is a checklist, broken down by department, of how to prepare for Health Care Financing Administration (HCFA) ambulatory payment classifications (APCs). The list was compiled by 3M HIS in Salt Lake City.

Information system/technology/decision support

- Identify new hardware and software requirements.
- Review requirements of Outpatient Code Editor (OCE).
- Determine process and timing of where APC and related data will be stored (such as stand-alone system, decision support, live billing system, etc.).
- Ensure interfaces exist between HIS vendor and selected APC grouper products including:
  - — importing charge item detail into coding / abstract for complete assignment;
  - — importing charge item detail into billing systems for final APC assignment and OCE checks;
  - — importing APC data into selected decision support system;
  - — issuing enough systems space for data storage, reports, etc.
- Consider Health Insurance Portability and Accountability Act of 1996 requirements for data storage.
- Design data reports for analysis if needed.

Health information management (HIM)

- Review coding / payment implications of APCs including the National Correct Coding Initiative (NCCI), the OCE, modifiers and evaluation and management (E / M) coding / documentation.
- Develop a methodology of adding modifiers either at the time of HIM coding or by ancillary department during order / charge process.
- Develop a process for coding the full range of medical visits with E / M codes.
- Train physicians about implications of the new system (i.e. documentation, superbill use, etc.).
- Select a grouper to identify expected payment.
- Design reports related to processing and timing of coding review.
- Develop process for implementing quarterly changes to OCE and NCCI.
- Improve the skills of outpatient coders.
- Provide resources (internal or external) to train and educate staff on new coding regulations and appropriate use of modifiers.
- Ensure that coders have appropriate reference materials and access to ongoing education.
- Implement a process of reviewing charge line item detail during coding process against source document (medical record) for all outpatients.
- Evaluate the potential / appropriateness for assuming coding responsibility throughout the facility.
- Determine method / criteria to be used for E / M assignment of medical cases.

Billing

- Ensure date of service, revenue code, units of service HCPCS (HCFA common procedure coding system) code, modifiers and items can display on each line item charge detail.
- Ensure that the billing system will accept the required changes such as modifiers.
- Review requirements of OCE.

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DRG CODING ADVISOR®

Does your coding pose a compliance problem?

Electronic records make it easier to get caught

As the government and payers institute stricter reimbursement policies and electronic medical records make it easier to check for compliance, it's more important than ever for your practice to improve its coding performance. If you're not coding correctly, you could face a government review and stiff fines — even if it's an honest mistake.

Proper coding is important because it's how you communicate what you've done, points out **Todd Welter**, MSM, CPC, coding consultant for the Medical Group Management Association in Englewood, CO. It's getting easier to get caught if your coding isn't correct. The federal Office of Inspector General and local Medicare carriers are conducting pre-payment and post-payment reviews comparing you with others in your specialty, he says.

"In the government's eyes, if you bill for a 99213 and all you documented was for a 99212, it's the same thing as saying you did four bypass graphs when you did only two. The government looks down on that," he says. "If you do more of a particular code than your peers, they may randomly ask you to send in documentation of some patients. Such a letter is the beginning of an audit."

If you do get a letter requesting more documentation, take it seriously, he adds. "A lot of those letters requesting documentation look benign but they can get doctors in a lot of trouble."

Welter cites three reasons for coding correctly:

- **Compliance.**

Your practice can prove it provided the services it billed for.

- **Reimbursement.**

Each code has a dollar figure applied to it. If you code correctly, you'll get the correct amount of reimbursement.

- **Statistical analysis.**

Coding shows the acuity of your patients. This is important in a lot of managed care situations. You'll need that information if you are going to enter into any kind of capitation arrangement.

Most health plans, including government programs, use the CPT code as a method to determine the payment you'll receive. If you're going to get paid correctly, you have to submit the correct code.

"Although there are a number of software products and tools that can help, there's really no substitute for a good background in coding principles," says **Rita A. Scichilone**, of Woodbine, IA, practice manager of coding products and services for the American Health Information Management Association in Chicago.

Is your software getting you in trouble?

Coding software sometimes gets physician practices in trouble, particularly if it suggests certain code combinations or tends to maximize billing, Scichilone says. However, other software may have useful segments, such as showing if the CPT code is correct for Medicare coverage or if you have to add additional codes, she adds.

If, in your practice, the physicians check off codes on the encounter form, they should be aware of the rules and guidelines that affect code choices, she points out. "The best situation is to have the physician select the code and the billing and coding specialist validate the code choices to make sure the codes are complete,

accurately represent what was performed and what was documented, and [contain no] conflicts with health plan reporting requirements."

She suggests having anyone in your practice who deals with coding attend an educational seminar to make sure his or her skills are up to snuff. Or your practice can hire a consulting firm to review your records and provide one-on-one instruction on coding principles, coding guidelines, and improvement of documentation.

Conduct your own audit

Your practice may decide to conduct its own audit. A good coding review includes checking to see if the documentation meets the criteria laid out for the particular code. Welter suggests compiling a year's worth of utilization data by doctor, broken down by code. Then ask for 10 randomly selected evaluation and management (E/M) notes and accompanying billing forms for each physician. Break the E/M notes into subpieces and compare them with the coding criteria. Look at coding per practice and per physician. If physicians' coding varies from the norm, see whether they have sicker patients or aren't coding correctly.

When Platte Medical Clinic in Platte City, MO, conducted a coding audit, the staff took the physicians' office notes and compared them with what was billed to see if the level of services the physician billed matched the documentation.

In addition to beefing up the practice's coding compliance, the audit discovered the practice was losing revenue because some physicians were undercoding, says **Lori Norris**, FACMPE, former practice manager at Platte Medical and current physician recruiting and marketing director for North Kansas City (MO) Hospital, which owns the practice.

"I encourage every practice to have it even if it has to outsource. Not only do you need a coding audit for compliance, but you can find a lot of missed revenue," she says. ■

Performance improvement can help the bottom line

Involve the entire staff in the process

Platte Medical Clinic was operating at a loss of about $20,000 a month when the hospital that owned the practice hired a management firm to find ways to turn the situation around. The consulting company mandated that each practice develop a plan to improve its financial performance. The goal was to reach break-even status.

"They asked each manager to come up with ways to cut expenses and maximize revenue at the same time," says **Lori Norris**, FACMPE, physician recruiting and marketing director for North Kansas City (MO) Hospital, formerly practice manager for Platte Medical Clinic in Platte City, MO.

Platte Medical Clinic is a member of Meritas Health Corp., a group of seven clinics owned by North Kansas City Hospital.

Norris says she started by listing projects she believed would help the practice meet its objectives of cutting expenses and maximizing revenue. Then she sat down with the physicians in the practice to discuss why it was important to improve the practice's financial performance and to ask for their suggestions.

She repeated the process with the office staff. "Everyone in the practice had to understand that this wasn't going to be easy and it wasn't going to go away. We needed them to be committed and to buy into the performance improvement process," Norris says. She solicited ideas from everyone in the practice on how they could increase revenue and efficiency and minimize expenses.

The staff originally came up with about 20 expense-reduction projects and about 20 revenue-enhancing ideas. These were honed down to eight to 10 projects in each category. The ideas ran the gamut from new methods for appointment scheduling and patient check-in to ways supplies could be given out and how claims could be paid.

Projects that lacked support were dropped

"We looked at the entire operational process. That's why it's important to involve everybody in the practice. A lot of people have different perspectives," Norris says.

Some ideas were rejected from the outset. For instance, if the physicians were reluctant to take on a project, it was eliminated from the list. "There was some trial and error. If the buy-in wasn't there, we knew we weren't going to realize the results no matter how much effort and

CCS and CCS-P certification signifies expertise among coders

Q. What are CCS and CCS-P certifications?

A. Professional certification has long been a symbol of competence and achievement. Certification provides both personal validation and confirmation to employers and consumers of professional expertise. The Certified Coding Specialist (CCS) and Certified Coding Specialist — Physician-based (CCS-P) are skills-based credentials for individuals with hands-on knowledge of coding practice.

CCS certification recognizes hospital-based clinical coders who pass an exam measuring their competence in the ICD-9-CM coding systems, the surgery section within the CPT coding system, and knowledge of medical terminology, disease processes, and pharmacology.

CCS-P certification recognizes physician-based clinical coders who pass a mastery level exam measuring their competence in CPT, ICD-9-CM, and HCPCS Level II coding systems.

Q. What are the exam and application dates?

A. The next exam will be held Sept. 16. The early application deadline is July 21; late application deadline is Aug. 11.

Q. What organization sponsors the certifications?

A. The 40,000-member American Health Information Management Association (AHIMA) in Chicago, which has been certifying health information management and related professionals for more than 60 years, is the sponsor.

Q. Who should be contacted for more information?

A. **Applied Measurement Professionals Inc.**, Lenexa, KS. Telephone: (913) 541-0400. Request AHIMA's CCS or CCS-P Certification guide. The guide can also be downloaded off of the association's Web site at www.ahima.org by following links to "Certification."

Theresa Reynolds, Public Relations Associate, American Health Information Management Association, Chicago. Telephone: (312) 233-1159. Fax: (312) 233-1459. E-mail: theresar@ahima.org. Web site: www.ahima.org.

cost we put into a project," she adds.

The planning process took a couple of months. Some changes were implemented right away, and others took time. "It was pretty easy to implement. We went through the initial training with the managers then repeated it with the physicians and staff," Norris says.

To track progress, she created a spreadsheet showing the projects and goals, allowing progress to be checked at any time. "As we worked through the plan, we realized that some goals weren't achievable. If they weren't realistic, we had to back off," Norris says. For instance, the plan called for increasing net patient revenue by $5 per patient. A more realistic figure would have been $1 to $2 to start with, she adds. "We originally set our goals too high. I encourage anyone else who starts such a plan to take baby steps."

Staff hold quarterly meetings when everyone is accountable for what has been happening

with the plans. "If they aren't looking at them everyday, they aren't going to be successful," Norris says. ■

ID reimbursement problems before they appear

Coding staff can spend a lot of time talking with third-party payers about denied claims, partial reimbursements, or late payments, so it's more efficient to develop processes to identify potential problems before they appear, says **Andy J. Hetrick**, administrator of the Decatur (AL) Ambulatory Surgery Center.

Identify potential problems when the patient is scheduled for surgery, Hetrick advises. "Our billing and coding people have developed a close relationship with the office staffs of our physicians, so whenever they have a question about a scheduled procedure, they pick up the telephone and call for more information," he says.

One of the potential problems is a procedure that Medicare and other third-party payers don't recognize as a reimbursable procedure for an ambulatory surgery center. "If it is considered minor and able to be performed in a physician's office, we won't be reimbursed," says Hetrick. Even if a lesion is small enough to remove in a physician's office, some of Hetrick's physicians don't have the capability of handling the procedure in the office. When this situation arises, he approaches it two ways. "First, we contact the payer and explain that if it can't be performed in our surgery center, the physician will have to perform it in the hospital at much higher rates. Many times, the payer agrees to allow the procedure to occur in our facility."

However, this approach won't work with Medicare, which will only pay if the lesion is on its list of CPT codes, coding experts point out.

When the payer refuses to reimburse the surgery center for a certain procedure, the billing staff talk with the patient and explain that the procedure is not on the approved list and that the nonreimbursed costs will need to be collected upfront. Medicare patients are given written notice, as required.

A typical situation is that a lesion on the approved procedures list is scheduled along with a smaller lesion that isn't on the list. "The physician doesn't want the patient to come into the office for one lesion removal and the surgery center for the other removal, so the removal of both will be scheduled at the same time," Hetrick explains.

Another key to identifying potential reimbursement problems upfront is to ask the third-party payer the right questions when verifying coverage, says Hetrick. "We don't just ask if the patient is covered. We specifically ask if the patient is covered for the procedure that is scheduled."

This step helps the surgery center staff identify a procedure that is excluded due to pre-existing conditions. "Some plans have anywhere from a 30-day to 180-day waiting period before a pre-existing condition is covered," he says.

Delay surgeries for approval, if possible

If staff discover that the patient won't be covered for another week or month, someone contacts the physician's office to see if the procedure can be delayed.

Frequently, hernia repair and knee arthroscopy fall into this category, says Hetrick. If the procedure is required because a work-related situation aggravated the pre-existing condition to the point that surgery is needed, workers' compensation comes into play and the procedure can be covered. If, however, the payer doesn't agree to cover the procedure and the patient still wants to proceed, the surgery center staff work out a payment agreement, he adds.

When talking with the third-party payer, Hetrick's staff also verify that the surgeon has received pre-certification for the procedure. "If the physician's staff haven't obtained pre-certification, we call the physician's office," says Hetrick. "If the procedure has been pre-certified, we get the pre-certification number and include it in our files in case there is any question about the claim later."

The staff at Decatur Ambulatory Surgery also collect all copays, deductibles, and uncovered charges upfront, says Hetrick. If the patient is undergoing a procedure for which the third-party payer isn't covering any of the charges, a financial plan is arranged that includes an upfront amount and a billed amount that can be paid over an agreed-upon time, he adds.

About 60% of patients are paying all charges not covered by third-party payers upfront, and the remaining 40% of the patients are billed, explains Hetrick. ■

(Continued from page 102)

- Work with the data processing area to install OCE software.
- Prepare to change software to accommodate the new Medicare coinsurance.
- Provide training resources (internal or external) to educate financial services staff on the new billing requirements under the outpatient prospective payment system.
- Outline a process to correct problem claims if errors are identified form grouper program.
- Verify that all line items include a HCPCS code.
- Verify that there is a process for including all claims from the same day on a single claim:
  — multiple medical visits with condition code G0;
  — multiple sites-of-service on a single claim;
  — correct use of modifier 25 for medical and significant procedure visits.
- Verify that all services that are coded and submitted for billing are included on the final claim.
- Create a process for identifying OCE edit errors and correcting them before submitting the claim.
- Determine the impact of late charges and create a process to reduce or eliminate them.
- Work to streamline submission of adjusted and corrected claims.
- Determine the need for a grouper in the patient accounting/billing information system.
- Resolve any conflicts between HIM coding and Chargemaster coding.

Reimbursement

- Determine strategy if you will reduce beneficiary coinsurance payments in anticipation of greater market share.
- Complete evaluation of the financial impact of the new system.
- Assess impact of the outlier and transitional payments.
- Make adjustments for contractual allowances if losses are expected.
- Update Chargemaster to ensure it is current.
- Update Chargemaster for coding of drugs, new technology, blood and blood products.
- Ensure accuracy of charge detail master including accurate HCPCS assignment, modifiers, and revenue codes.
- Design reports related to outpatient reimbursements. If rural hospital under 50 beds, consider grant application for subsidy.
- Analyze potential problems related to provider-based regulations.
- Update superbills used in provider-based clinics.

Legal and compliance

- Assess the liability from changes in provider-based requirements and Emergency Medical Treatment and Active Labor Act requirements.
- Ensure that all departments have access to and are familiar with any new transmittals from HCFA as well as the final regulations.
- Discuss integration of the compliance process and software with APC processes and software (including databases). ■

Knowledge of denials is power for hospitals

With data, health system holds payers accountable

Health information management personnel know that improving reimbursement requires a team effort across an organization. Such an effort took place at Baycare Health System in Clearwater, FL, where key players from patient access, case management, and patient financial services came together to develop a denials database.

This database is helping to correct misconceptions about lost reimbursement and is putting pressure on physicians and other clinicians to become part of the solution, says **Martine Saber**, CHAM, regional director of access management.

The new system has shown that, by far, the most payment denials — in number and in dollar amount — are for clinical reasons, such as medical criteria not being met, rather than for technical reasons, such as access personnel not calling for authorization, Saber says.

Armed with the information the database provides, hospitals throughout the 10-facility system are setting goals for reducing write-offs and denials, and clinical departments are joining the effort, she adds. **(For more information about how Baycare is using the database to improve reimbursement, see story, p. 109.)**

"Once [facilities] learn they're doing services

for free, they say, 'Of course we won't do that,'" Saber says. "It's really an education issue."

Already the hospital has brought to the table one large managed care company and said, "We expect payment on these denials that we consider to be unjustified," says **Donna Miller**, MHS, special projects coordinator for Baycare's continuum department. "We're moving forward in our communication with managed care companies. We realized that a lot of the issues we thought were related to the hospital service side turned out to be related to the physicians."

One example is when physicians cover for each other over the weekend and don't feel comfortable discharging someone else's patient. Another is when patients are admitted who don't meet the criteria for an inpatient, Miller adds.

Looking for answers

Saber notes, in some cases, physicians are giving access personnel the wrong authorization number for a procedure. "Just because they got an authorization to do a consultation doesn't mean it will cover the procedures ordered [as a result]."

The continuum (case management) department began the effort on the denials database by wanting to look at the patient days in the hospital that were avoidable — those that occurred, for example, because a procedure wasn't ordered in a timely fashion, Miller explains.

"We came up with a list of 30 reasons we have avoidable days," she says. "We code those and run a report every month. Then we asked, 'How often are avoidable days costing us? How often are we being denied reimbursement for that day we identified as being avoidable?'"

Baycare has identified the top 10 reasons for avoidable days and is working to reduce those as part of its quality improvement focus this year, Miller says.

Meanwhile, patient accounting was "starting to feel the brunt of managed care denials, but there was no central place where they could be processed, reviewed, documented, and worked," she says. "Since we didn't have a united front in fighting denials, we were not very successful at showing, (1) that we needed to be paid for a day or, (2) that we agreed with the managed care company and accepted responsibility."

There also was no tracking mechanism that allowed the continuum department to know how successful it was in getting denials turned around through the appeals process, Miller says. Through the database, she discovered that in many cases her department had been writing letters and submitting appeals for denials on accounts that had already been written off by patient accounting. "There was no central way for everyone to communicate."

The denials database works this way:

1. Whoever receives the denial enters the information in a special field in the registration system, which is from Malvern, PA-based SMS. The account is tagged with an "X" for a technical denial and a "Y" for a clinical denial.

2. At midnight, the SMS system populates the database with all the accounts that were denied.

3. A list automatically is sent to the database: the names of the primary care physician and the insurance company, expected charges for the account, expected reimbursement, the amount outstanding from the insurance company, and how much is written off.

4. The continuum department manually enters its findings on whether or not the denial was justified, and how many patient days met medical criteria and how many did not.

5. Anyone working on denials can go to the database and see actions taken — for example, that for one case the continuum department has already decided the denial was justified, and for another, an appeal letter has been written.

6. If an employee identifies a denial and calls the insurance company or corrects an authorization number, that person tags the account as a rebill account, which alerts patient accounting to reissue the bill.

7. If it's determined that an error was made and the denial is justified, staff in patient accounting know to write off the bill immediately, thus reducing accounts receivable days.

Gaining doctors' cooperation

The database has illustrated that "there are a lot of opportunities for physicians to partner with us when trying to determine a discharge plan for the patient," Miller says. When physicians fail to properly classify a patient, it puts the hospital in a position where it is not allowed to get an authorization number, she notes.

"The physician is responsible and accountable for the correct authorization," Miller says. "The managed care company might say [to the physician], 'We'll pay you for that as an observation [account] even though we initially gave you an inpatient authorization.'"

The physician can change that designation and still be paid, she says, but according to Medicare rules, a hospital cannot change a patient status for reimbursement purposes only.

"We've been trying to get a determination from the Health Care Financing Administration as to whether we can change [an account] from inpatient to observation as long as we're looking for a lesser payment," Miller adds. ■

Provider gets a grip on payment denials

Payers, physicians brought in line

Armed with the findings of its comprehensive denials database, Baycare Health Systems in Clearwater, FL, has begun taking some aggressive strategies for avoiding and, if necessary, challenging third-party payment denials. **(For more information about the database, see story, p. 107.)**

Baycare now requires physicians to have authorizations for most outpatient procedures by 10 a.m. the day before the scheduled service, says **Martine Saber**, CHAM, regional director of admitting for the 10-hospital system. "If they don't, we ask for the procedure to be rescheduled."

Emergent cases are excepted, of course, and the cooperation of the health system's clinical departments has been crucial in that regard, she says. "If we notice that a [supposedly emergent] case was scheduled two weeks ago, I'm not in a position to argue, but the clinician is."

Baycare is looking into going one step further, and is refusing to schedule nonemergent outpatient procedures without an authorization, Saber says. "We did a survey within our county and found that no other hospital has such a policy. But when we said we were considering doing it, they said, 'Great. If you do, we will.' [The problem is that] no one wants to be the first one."

A concerted effort at physician education already has had dramatic results in increasing the number of procedures scheduled with authorizations, she says. Although the improvement is anecdotal at present, the health system's denials database soon will provide hard evidence, Saber notes.

Outpatient surgeries and cardiac catheterizations rarely have to be rescheduled because the physicians have a strong incentive to get the authorization. Unlike other outpatient procedures, if physicians don't get the approval, they don't get paid, she explains.

Even with the surgeries and cardiac catheterizations, her department would like to be informed of the authorization in a more timely manner, Saber says. "What happens is the physicians book the procedure before authorization, which they're not supposed to do, and we usually have to make one or two phone calls." That's a decrease, however, from the 10 or more phone calls it took previously, she adds.

"We now call [the physician's office] at preregistration and ask for the authorization, and again one day before [the service date]," she says. "If we don't get it then, we tell them we'll reschedule."

Her department also is increasing its use of faxes to obtain authorizations from physicians, and has an on-line connection with Blue Cross Blue Shield that allows registrars direct access to authorizations that already have been obtained by physicians. Plans are under way to set up similar connections with other insurers, Saber adds.

For the most part, physicians have been cooperative with the efforts to reduce denials, and much progress has been made, she says. The ongoing frustration is that "the insurance companies are playing so many games with us. We're spending so much money fighting to get paid."

Finding out the hard way

As part of compiling a "managed care cookbook," Saber says her department requested insurers send a comprehensive list of services that require authorization. "Very few wanted to do that. They said, 'We don't have a list. You just have to call.' So we're making our own list, finding out through getting denied."

Through information gleaned from the denials database, Saber says her department is discovering

past mistakes and finding ways to correct them. For example, there were 10 designated codes for tagging a denial, with 0 indicating a patient didn't provide proper information and therefore was not eligible for the service; 1 meaning the authorization was never obtained; 2 meaning the insurance company was notified too late; and so on, she explains. "We really didn't do a good job of tagging denials correctly, and it is important to know those reasons. Some were tagged as denials, and they were not really denied."

As a result, Baycare is now creating a tool, which includes an explanation of the codes with examples so that whoever is tagging a denial will do it correctly, Saber explains. "If it's tagged because of medical necessity, we [in access] don't work it; utilization review will. But if it's tagged because there is no authorization, we will work it." Before, personnel wasted time determining who should handle a particular case.

Another benefit of the denials database is that it compiles information from all 10 Baycare hospitals, making for more compelling challenges to the third-party payers, she says. "We're working right now with two of the biggest insurance companies, CIGNA and Aetna. We now can combine all of the information, drop it in their laps, and say, 'You denied us this. You need to pay us.'" The argument is more convincing when it involves more than $1 million, as opposed to $100,000, she adds.

Bring on the lawyers

Although Baycare's managed care contracts specify that it will be notified within so many days if a new procedure goes on the "must be authorized" list, insurance companies do not always comply, Saber points out. When they do send notice of changes, they often send them to the wrong person, she says. "They do it on purpose. What we're doing now is putting it into the contract that they must notify us of changes by registered letter." The health system is hiring legal counsel to enforce the requirement, she notes.

"We're getting better at the contracting level," adds **Donna Miller**, MHS, special projects coordinator for Baycare's continuum department. "The people who write our contracts are getting very savvy in the ways in which managed care companies find opportunities to deny us. We're trying to work out contractually that if we're providing care at the direction of the physician, who is their agent, it is not our job to police their physician. We are only the provider of the care that physician orders. We can't admit or discharge without an order from a physician."

Correctly designating the patient's level of care continues to be a challenge that often leaves the health system caught between the demands of managed care companies and the requirements of the Health Care Financing Administration (HCFA), says Miller.

The issue revolves around whether a person is deemed an inpatient or an observation patient, Miller notes, with the latter theoretically requiring a lesser level of care for which hospitals receive a lesser reimbursement.

"The real problem has been that a patient may come in with chest pain or abdominal pain and be admitted as an inpatient through the emergency department," she adds. "We do some diagnostic tests and may decide the patient can go home that day or the following day. The managed care company decides the patient didn't meet acute care criteria and wants them categorized as an observation patient. It sends a letter saying it will pay the observation rate but not the inpatient rate."

> *"There are literally millions of dollars sitting out there that is our money. It's almost like the managed care companies have figured out a way to hold onto it. They know we can't change patient status, but they ask us to."*

The dilemma is that the hospital may decide after having provided treatment that the patient meets observation criteria. Medicare guidelines don't allow switching patients from one status to another, especially after discharge, Miller explains.

"Our corporate compliance director has made a stand that we won't treat patients differently — we won't change their status — because of payer

source," she says. "It gets a little gray when there is a contractual agreement and we are willing to accept a lesser payment. What has happened is we have all of these accounts that we agree should have been observation, but we can't change them, and the managed care companies won't send us money because they want a bill that says 'observation.'"

As a result, she notes, "there are literally millions of dollars sitting out there that is our money. It's almost like the managed care companies have figured out a way to hold onto it. They know we can't change patient status, but they ask us to."

Avoiding risks

Although some facilities do change the patient status, they are risking sanctions from HCFA by doing so, she adds. "We have an interpretation that says if you can determine within 12 hours that a patient has been inappropriately identified as an inpatient, and if a physician writes a clarifying order, you can [change the status]. But our director of corporate compliance is not comfortable with that."

Another complication of changing patient status is that the bill would have to be re-coded, which means hospital statistics would change, she points out. "Even though we treated a patient and provided care, that wouldn't show up to the same degree [in the statistics]."

In one instance, a managed care company questioned the inpatient designation. The patient, who had a history of colon cancer, spent three days in the hospital getting a work-up, was in severe pain requiring an analgesic pump, and was experiencing rectal bleeding, Miller says. "[The managed care company representative] asked, 'How much rectal bleeding?'"

The tracking, trending, and reporting database that Baycare created to help manage its denials is so effective, the health system may make it available to other hospitals, she says. "We're still tweaking it, but we're very close to being able to offer it."

The software has made it possible for various hospital departments to measure avoidable days and devise action plans for how to reduce them, Miller adds. "The continuum department has goals related to avoidable days, denials, and write-offs, as do patient accounting and patient access services. This is part of 'Impact Care,' our measure of service, outcomes, and cost, for which we set goals every year." ■

NEWS BRIEFS

Web site will let providers bid on patient care

Seraphim Inc., a health care consulting firm based in Kenosha, WI, has announced the formation of an Internet company and Web site that would allow health care providers to bid on patient care. The site, PatientWise, would allow

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patients to compare provider quality and cost for proposed treatment of serious illnesses and chronic conditions, officials say.

Bradley Engel, Seraphim president and CEO, says the company would secure more than $100 million in funding to launch the site by the end of the year. "All the care will be included in a single cost that the patient will be able to see immediately, in advance of committing to the care," Engel says. More information is available at www.patientwise.net. ▼

Confidential data loss through e-mail up 170%

More than one out of four employees (27%) surveyed in a new study about personal e-mail use have received confidential company data from outside their company. This figure has nearly tripled from when the first study was conducted one year ago.

The study was commissioned by Elron Software in Burlington, MA, and was conducted by NFO Interactive, a Greenwich, CT-division of NFO Worldwide. A total of 576 people with desktop Web and e-mail access from work responded to the survey. The study evaluated employee Internet usage throughout the United States from varying types of organizations and job titles. ▼

AHIMA endorses the Privacy Commission Act

The American Health Information Management Association (AHIMA) in Chicago has endorsed an act that would establish a bipartisan, 17-member privacy protection commission to review all issues pertaining to the protection of an individual's personal privacy.

The bill, the Privacy Commission Act, HR 4049, was introduced by Reps. Asa Hutchinson (R-AR) and Jim Moran (D-VA).

Hutchinson and Moran say the commission would have 18 months to:

- study the current laws relating to the protection of individual privacy and existing efforts addressing this issue;
- conduct hearings around the country to receive comments from the public, business leaders, and the community;
- identify potential threats to individual privacy in the "cyber age" and submit a report to Congress and the president on its findings, including any legislative recommendations for the reform or augmentation of current laws and regulations.

A copy of HR 4049 is available on AHIMA's Web site at www.ahima.org, following the links "Washington Report" to "Issues and Legislation" and then to "Current Legislation." ▼

Penalties for HIPAA fraud finalized

The Office of Inspector General in Washington, DC, has published new civil monetary penalties for fraud. The fines were established in conjunction with the Health Insurance Portability and Accountability Act of 1996. The final rule codifies new penalties for excluded individuals retaining ownership or control interest in an entity, for upcoding and claims for medically unnecessary services, for offering inducements to beneficiaries, and for false certification of eligibility for home health services.

The final rule increases the penalty from $2,000 to $10,000 per item or service improperly claimed or prohibited practice. The regulations went into effect on April 26, the date of their publication in the *Federal Register*.

To view the regulations, go to: www.hhs.gov/oig/new.html. ■