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Revenue cycle management starts with scheduling, ends with appeals

AM controls first step, but there's more to affecting the bottom line

Regardless of whether your hospital has embraced the methodology associated with the term "revenue cycle management," chances are you've heard the words bandied about. The crucial importance of accurate and efficient front-end operations to a health care provider's bottom line is certainly emphasized whenever there is a gathering of health care industry leaders.

What may not have crossed your radar screen, however, is the equally vital second phase, the part of the cycle that comes after the access department has performed the scheduling, precertification, insurance verification, preregistration, and registration functions that start the process.

"Charge capture" and "charge description master" are the operative terms for that second piece, explains **Joe Denney**, CHAM, director of revenue management at The Ohio State University Health System (OSUHS) in Columbus, an organization recognized for being on the cutting edge in its implementation of revenue cycle management. OSUHS has been designated by the University Health Consortium in Columbus as having a "best practice for reduction of late charges."

"We put a program together where we reduced late charges from over $3 million a month to less than $100,000 a month within the past 18 months," he says. The lower figure represents less than 1% of the organization's gross revenues, Denney adds.

OSUHS also received the best practice designation for denial management, he notes. It's important for access managers "to understand that everybody involved [in the revenue cycle] has an extremely important piece of the process," says Denney, who gained extensive experience in access management and patient accounting before assuming his current position. The full name of the area in which he works, he points out, is "department of access and revenue management," which gives special

emphasis to the importance of the front end.

"[Managers], who have responsibility for scheduling, preregistration and registration, and maybe precertification, need to understand how that fits in with the rest of the revenue cycle," he says. "It's not business office accounts receivable management anymore." Instead, Denney adds, the process extends from scheduling through charge capture and on to denial management. "We all have to work together as a team."

Below, Denney highlights the different steps in the revenue cycle as exemplified at OSU Health System.

"Traditionally, when you think 'accounts receivable management,' you think business office," he says, "but the key, as we've learned over the years, is that a lot of the responsibility of getting the claim out faster is on doing a good job up front in collecting data. That absolutely starts with scheduling."

The object of that first telephone call — probably from a physician needing to schedule a patient for a procedure — is to get just enough information to go to the second step, Denney says. That "minimum data set," as it is known at OSUHS, would be the information necessary to contact the patient, he adds.

The second step, then, in securing payment for the hospital is to call the patient to get insurance and guarantor information so that insurance verification — and, if necessary, precertification or authorization — can be done on the account, Denney says.

OSUHS is considering changing the process so the physician simply faxes the order for the procedure to the hospital and the patient calls at his or her convenience to do the preregistration, he notes. "The key there is they have to send the order to us in the first place."

The OSUHS computer system has the capability of running an Advance Beneficiary Notice (ABN) check on the case to see if the diagnosis the physician provided will stand up to Medicare scrutiny, Denney points out. "When the [access employee] is on the phone with the patient, [the employee] can let the patient know that the test or diagnosis is not supported.

Eliminating coverage surprises for patients

"The important piece is not to have a surprise for the patients when they show up," he adds. "If we can let the patient know up front that the test may not be paid for, then we have all the bases covered. What happens on the day of service is just verifying, getting the consents signed, and making sure we meet HIPAA [Health Insurance Portability and Accountability Act] requirements."

The up-front notification also prevents the waste of a scheduling slot should the patient decide not to have the procedure after discovering it is not covered by insurance, Denney says.

OSUHS has ordered a new ABN checker that also includes an on-line requisitioning system, he notes. The new product initially will be standalone, Denney adds, but eventually will be integrated with the patient management and patient accounting system.

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Editorial Questions

For questions or comments, call **Alison Allen** at (404) 262-5431.

Editor: **Melinda Young**, (youngtryon@mindspring.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Managing Editor: **Alison Allen**, (404) 262-5431, (alison.allen@ahcpub.com).
Production Editor: **Brent Winter**.

"There are two components [to the new product]," Denney says. "One is the ABN checker. You put in the ICD-9 diagnosis code and the test or procedure, and it searches for the local medical review policy to see if the diagnosis is a valid reason for the test. If not — and this is true just for Medicare patients — the system prints an ABN that the registrar can present to the patient."

With the second component, the on-line requisitioning system, a physician can — instead of writing by hand a consult for an X-ray — fill out an on-line requisition from his or her office, he explains. "[The physician] can say, 'Here's the diagnosis, here's my electronic signature,' click a button, and the people in radiology will have the order."

If the physician desires, he or she can initiate the ABN checker as well, determining the validity of the order before sending it, Denney adds.

Revenue management

At this point the process moves into the revenue management department. Denney and staff "work directly with [the health system's] 200-plus revenue-producing centers to make sure they have all of the charges necessary in order to properly bill for the services they provide," he explains.

"If there's a new supply or a new procedure, they contact us and we do research and set up a charge for that supply or procedure," he says. "We collect the cost information and then determine a proper price."

Within the charge description master, Denney says, there not only is a charge code for each item, but a related revenue code and CPT code.

If there is a mismatch in those codes, or if the chargemaster is not properly maintained so as to ensure accurate descriptions of procedures, claims could wind up being rejected as a result, he adds.

One of the things Denney did to facilitate charge capture was to lead a grass-roots effort to bring the various cost centers into ownership of the process. He educated lead people, who in turn worked with their centers to discover opportunities for increasing revenue, explains **Donna Madlener**, manager of the Apheresis Unit at James Cancer Hospital, a part of OSUHS.

"It was decided at the management level that we should know more about charges that were getting lost, about anything we were not capturing," she adds.

If all of the above steps have gone well, the result will be a clean claim, Denney notes, which can pass all the edits in the electronic billing system without being caught and without a biller having to touch the account.

"If this all happens properly," he adds, "the claim can go out the door and remittance will come in the door. If it all didn't happen correctly, you have another major piece of the revenue cycle." That piece begins, Denney notes, when the insurance company rejects a claim for one reason or another.

"We have a process that we are fully automating so that when a rejection comes into the business office, [the system] will sort it by activity code," he says. "It will say, for example, that the claim was rejected because it was not precertified or that there was no medical necessity for performing the service, or maybe that we billed too late."

Depending on the reason for the rejection, the business office immediately will notify the appropriate department, Denney says, and that department will research the account. "We will determine if we can submit a letter to explain [to the insurance company] what went wrong and if we can turn the rejections around."

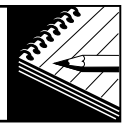
If the reason given for the denial was lack of precertification, for example, Denney's counterpart in access will have his or her staff investigate the matter, he adds. "Maybe they'll find that we did get a precert and the insurance company is wrong. If so, they'll issue a letter of appeal, and then log what has happened with the account into our electronic system."

Software generates work lists

Work lists in the system allow staff to see if it has been 30 days, for instance, and the hospital hasn't heard back from the insurance company, Denney notes. Revenue Management Workstation, the denial management part of Malvern, PA-based computer vendor SMS' admission/discharge/transfer system, gives OSUHS this electronic method of generating and using work lists, he adds.

"If we hear from [the insurance company] that a procedure is not medically necessary, [the information] gets fired off to the medical information management staff, who look through the records and see if they can get more documentation, he explains. "Then they will send a message back to the business office and say, 'Resubmit it.' There are no more manual work lists." ■

GUEST COLUMN



Arbitration a viable option for handling payer denials

It should be final step in appeals process

By **Linda M. Fotheringill**, Esq.
Fotheringill & Wade, LLC
Baltimore

In October 2002, HCA in Nashville, TN, won an $8.8 million arbitration decision against Humana Medical Plan Inc. of Florida for the late payment or nonpayment of 3,300 patient accounts at 16 hospitals in Florida. HCA alleged that Humana paid hospital bills for patients in HCA's HMO, preferred provider, Medicaid, and Medicare health plans as much as one year late, and that its hospitals sometimes had to re-bill the insurer three or four times to receive reimbursement.

This arbitration result should provide inspiration to other hospitals that are subjected to business practices similar to those alleged in HCA's arbitration proceedings. However, chances are that your hospital never has initiated arbitration against an offending payer. If so, your hospital has not taken advantage of one of the most effective tools in denial management.

Arbitration should be the final step in your appeals process because it allows your dispute to be decided by an impartial third party who is more likely than the payer to render a fair decision. More than likely, your contract with offending payers will specify that any disputes not settled in the appeals process are to be resolved by binding arbitration.

Arbitration vs. litigation

Arbitration should not be confused with civil litigation. Arbitration is a private, informal process, and generally is faster and less expensive than litigation. A hospital shouldn't wait until there is a multimillion-dollar problem with nonpayment and late payment issues before considering arbitration. Indeed, all disputes, such as unsuccessfully appealed claims denied for lack of medical necessity, delay of service, lack of authorization/precertification, untimely billing, and underpayments for contractual terms could and should be grouped for arbitration. Not only will net revenue be increased by overturning more denied or underpaid claims, but the payer will get the message that unacceptable claims-handling practices will not be tolerated at your facility.

Although arbitration hasn't been used much in the past, times are changing. Hospitals that care about their bottom lines and about the ability to enforce the mutually agreed-upon terms of their contracts are giving consideration to arbitration. In fact, some have made arbitration an automatic final step in the appeals process.

Market position may influence decision

Generally, arbitration proceedings are confidential, which prevents publication of the success rate for this activity. Before initiating arbitration, consideration on a payer-by-payer basis should be given to your hospital's market position and payer relationship, and to the revenue recovery opportunity. Your hospital may decide that enforcement of contractual terms should not be considered with certain payers due to market position, but definitely should be pursued with others. Even in instances where a decision is made not to pursue enforcement with a particular payer, there may be a change of heart as time goes by and wrongful denials continue or increase with that payer.

There are decision points where it is not worthwhile to continue a contractual relationship with a particular payer, and it would be advantageous to have the opportunity to go back and recoup money lost through abusive business denial practices.

Grouping a particular payer's low-dollar claim denials together and filing them in a single arbitration can achieve cost-effectiveness. A qualified law firm should be willing to pursue the arbitration on a contingency fee basis, thereby decreasing or eliminating out-of-pocket expense to your hospital.

Arbitration should not be confused with mediation. While they both are methods of alternative dispute resolution, mediation generally is associated with a non-binding procedure, in which a neutral third party facilitates the parties' settlement process. In non-binding mediation, the neutral facilitator can offer suggestions for resolution, but a resolution is not enforceable

in a court of law.

The parties can provide for arbitration of future disputes by inserting the following clause into their contracts (the bracketed language suggests possible alternatives or additions):

"**Arbitration.** Any controversy, dispute, or disagreement arising out of or relating to this agreement, the breach thereof, or the subject matter thereof, shall be settled exclusively by **binding** arbitration, which will be conducted in [city, state] in accordance with the [insert name of alternative dispute resolution organization of your choice]'s rules of procedure for arbitration and which, to the extent of the subject matter of the arbitration, shall be binding not only on the parties to the agreement, but on the other entity controlled by, in control of, or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof."

Arbitration of existing disputes where there is no existing arbitration clause in the contract may be accomplished by a separate written agreement that states the following: "We, the undersigned parties, hereby agree to submit to binding arbitration administered by the [insert name of alternative dispute resolution of your choice] under its commercial arbitration rules, the following controversy: [briefly describe the nature of the dispute]. We further agree that a judgment of any court having jurisdiction may be entered upon the award."

Single case can send deterrent message

There are a number of organizations that administer alternative dispute resolution procedures and provide published rules for the process. Three such organizations are the American Arbitration Association, the American Health Lawyers Association, and JAMS, a dispute resolution company. All three of these organizations have comprehensive, informative web sites that include their arbitration rules as well as downloadable forms.

The benefit of arbitrating against a payer should not be measured only by the potential monetary recovery. A single case can send a message to a payer that your hospital is not willing to tolerate unfair denial practices and is willing to enforce the terms of the contract, thereby deterring future abuses. ■

2003 CPT codes affect several critical areas

Changes take effect April 1

The 2003 *Physician's Current Procedural Terminology* (CPT) code set released Dec. 31, 2002, contained over 500 additions, revisions, and deletions. Getting updated by April 1 is no easy task, but should be a priority, as mistakes could result in lost reimbursement, says coding expert **Glenda Schuler**, RHIT, CPC, CPC-H, senior health care consultant at Ingenix in Salt Lake City.

The list of changes includes 189 additions — 107 in surgery, 27 in medicine, and 18 in Category III, which covers emerging technologies. Also, there are 281 revisions, including 124 in surgery, 55 in radiology, and 48 in medicine, as well as 34 deletions, including 14 in pathology and laboratory, 10 in medicine, and eight in surgery.

The goal between now and April should be to update the chargemaster and educate coders. Coders need to make sure all additions have been added to the chargemaster and all deletions have been removed from it, says **Nelly Leon-Chisen**, RHIA, director of coding and classification at the American Hospital Association in Chicago.

Additionally, she cautions, it is very important to pay close attention to revisions. "There may be an increase in services with the same code numbers," she says. "Delete or revise the existing charge or combine into one." Leon-Chisen stressed that coders should understand what the code does and what is represented by the code.

For example, there were significant revisions made to the surgical codes for 2003. Knee arthroscopy procedures may require both a CPT code assignment as well as Medicare's HCPCS code G0289/arthro, loose body + chrondoplasty. CPT code selections are still reportable from 29870-29889, and when documentation indicates, HCPCS code G0289 may be appropriate.

Category III codes, which cover emerging technologies, have been available for hospital reporting since January 2001, though hospitals are still not recognizing their importance and availability for reporting services provided, says Schuler.

Category III codes can be reported for services provided in laboratory, radiology, rehabilitation, labor/delivery, and surgical departments. Eighteen Category III codes are new for 2003 and

include antiprothrombin antibody, Dexa body composition study, magnetic treatment for incontinence, CT perfusion with contrast, and whole body photography.

HIM coders are challenged to assign CPT/HCPCS codes and ICD-9-CM diagnoses codes consistently for all types of services, for all payers. However, with the drastic difference in code requirements evidenced between Medicare and commercial payers, coders are beginning to see how code selection often is based on payer requirements and cannot be based solely on departmentally established procedures or coding guidelines.

It does not matter whether the CPT code originates from the chargemaster or is assigned by HIM coders, says Schuler, as long as the code reported on the UB-92 claim form for which the facility will receive reimbursement represents the procedure performed and documented in the medical record.

"Many hospitals use a combined approach by having some clinical areas contain hard-coded CPT codes, originating from the chargemaster, while other facilities have all surgical CPT codes assigned by HIM coders," she explains.

"Health care providers sometimes feel they need to wear roller skates to remain current with constant changing reporting requirements, CPT revisions, coverage rules, reimbursement and APC updates, staffing shortages, and increased demands on facility resources," Schuler says. "In spite of all the demands, however, it's very important to remember update your chargemaster by April 1." ■

Group therapy billing confusing for some

Watch how you bill for one-on-one time

Start asking questions about the way Medicare wants physical and occupational therapists to code group vs. individual therapy, and you'll get a plethora of contradictory answers and some heated opinions to boot. It's an issue; it's not an issue. It's wrong; it's right. It's confusing; it's clear as can be. It flies in the face of traditional therapy training; it's the way they've always done it. It's a financial blow for providers; it's not a problem at all.

That's if you can get people to talk to you at all. Ever since the Baltimore-based Centers for Medicare & Medicaid Services (CMS) issued Carriers Manual Transmittal 1753 last May, many providers have hesitated to publicly discuss their interpretations of group vs. one-on-one therapy. Behind closed doors, however, it's a hot topic. CMS officials themselves were unwilling to speak on the record, but their official position can be found on the web site www.cms.hhs.gov/medlearn/therapy, which contains a list — some say a long-awaited list — of frequently asked questions released in January. CMS also held an open-door conference call last September to answer questions on the topic (see an unofficial transcript of the call at www.amrpa.org).

All of this debate stems from Transmittal 1753, which CMS officials say was issued to clarify — not change — the rules. But the effect was to say that many claims for one-on-one therapy actually should be billed as group therapy, which results in significantly lower payment. The transmittal defines group therapy services (code 97150) like this: "pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be, performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required."

In general, if a therapist is billing for a 15-minute session of a service that is done one on one with the patient, the therapist cannot bill for any other one-on-one or constant attendance service during that same 15 minutes, according to a CMS official. If a therapist treats two or more patients simultaneously, the therapist should use the group code. If the therapist can document the time that he or she worked one on one with each patient, the one-on-one codes may be used as long as the total time billed does not exceed the total time in which services were provided.

"This is a huge issue. CMS' attempt to clarify a definition has really frustrated outpatient therapists," says **Bonnie Breit**, MHSA, OTR, president of BRB Consulting Inc. in Media, PA. "It's not a group in the traditional definition of therapy if you say a group is any two people at any one time doing two different things. For group, therapists generally expect that the patients

would be doing the same thing. Imagine what's happening to all the providers. This discussion not only affects the way patients could get treated, but because of the fee schedule, group therapy is considered less skilled, which translates into less reimbursement."

Therapists know when a patient needs undivided attention and when he or she might be encouraged by working alongside another patient, Breit says. "Physical and occupational therapists make those decisions all the time, and they don't need someone else defining if they ever walk out of that room from doing a massage or an ADL, now they have to bill group therapy," she says. "It's a reimbursement issue and a practice issue. This may also reduce access. If therapists are limited to four units per hour, they may not be able to take two patients at a time. They won't be able to afford the decreased reimbursement."

It's hard to argue the point with CMS, though, because if a provider admits to having used a different interpretation of individual or group therapy, they may fear retroactive retribution, Breit says. "Nobody wants to be caught on the wrong side of the definition," she says.

Some providers say they disagree with the notion that a therapist is conducting a group session when he or she moves among patients who are in the office at the same time but who may not have the same diagnosis or be performing the same tasks. Given that the approximate amount paid last year for the group therapy code was $17.74 (which is an untimed code that can only be billed once per day) and the approximate amount paid for the one-on-one therapeutic exercise code (97110) was $26.43 per 15 minutes, it's not hard to see why providers might complain.

HealthSouth blames losses on group code

Perhaps the loudest voice of complaint on this topic comes from HealthSouth Corp., the largest provider of outpatient surgery, diagnostic imaging, and rehabilitation services in the United States. The Birmingham, AL-based company has about 1,800 sites in all 50 states as well as Puerto Rico, Britain, Australia, Saudi Arabia, and Canada. In August, HealthSouth blamed the Medicare group therapy policy when it lowered earning estimates by $175 million. Shareholder lawsuits were filed questioning chairman and chief executive officer **Richard Scrushy's** sale of $25 million in HealthSouth stock before the earnings announcement, and the Securities and Exchange Commission is investigating the matter. The company has said an internal review found no wrongdoing.

Scrushy strongly disagrees with CMS' position that Transmittal 1753 did not change the way physical therapists bill for group therapy. He says physical therapists traditionally have moved from patient to patient when clinically appropriate in a practice commonly referred to as "dovetailing."

"When you change the rule from dovetailing, which is what all physical therapists are taught in every school in America and the way they have always worked in every practice in America, you've got a disaster of a rule," Scrushy says. "It's a magnificent waste of resources. Could you imagine telling doctors or dentists that they could only treat one patient at a time? We do practice group therapy when patients have similar problems and are all working on the same thing. But CMS is saying that if you are treating two patients, even if they have completely different problems and need completely different therapies, that if they're laying on a stretcher next to each other and you touch one while the other's stretching, you've got group therapy. It's absolutely ridiculous."

Forcing physical therapists to work with only one patient at a time means they can see only about six patients in one day as opposed to as many as 25, and that has the potential not only to reduce profits but also to reduce patient access to care, Scrushy says. "PTs can do some outstanding work and have some outstanding outcomes working with more than one patient at a time. This is a tragic waste of some really talented people," he says. "I have two daughters who are physical therapists, and they say they're spending a lot of their days now just standing around while Medicare patients are out in the waiting room. It's very inefficient and makes no clinical sense at all. This is going to cost the health care industry billions of dollars."

Scrushy says HealthSouth is complying with the policy 100%, but physical therapists still have a lot of questions about it. "Our PTs are being extremely conservative in our coding. They may have been a little too conservative in their concern that they don't violate any of the rules," he says. "It's a confusing situation."

Another problem Scrushy has with this system is the reimbursement amount itself. The Balanced Budget Act of 1997 required CMS to establish

uniform coding for outpatient rehabilitation services, which meant that providers went from cost-based reimbursement to the Medicare Physician Fee Schedule. "When we were under cost-based reimbursement, the reimbursement amount took into account rent and utilities and other overhead," Scrushy says. "Now that we're fee-based, they're using the same amount, but they didn't figure in all those other costs. CMS needs to re-price the fees."

APTA claims codes undervalued by 18%

The fee schedule is perhaps the only area of this argument in which the American Physical Therapy Association (APTA) would agree with Scrushy and HealthSouth. APTA, based in Alexandria, VA, supports CMS' interpretation of the group therapy code, but does have a couple of issues with CMS, including the fee schedule, says **Gayle Lee**, associate director of federal regulatory affairs. "We're working on other areas with respect to this fee schedule. We think the practice expense methodology that CMS uses is flawed," Lee says. "We think it significantly underestimates — by about 18% — the value of the codes in the 97000 series [physical medicine and rehab codes]. We've met with CMS on that issue. We're trying to get the payment increased for all of the codes. If they would go back up on that, it would help a lot with finances."

The 2003 Medicare Physician Fee Schedule final rule, published in the *Federal Register* on Dec. 31, does increase this year's payment to physical therapists by about 2%. But APTA points out that basic flaws with the fee schedule formula more than offset the increased physical therapy values.

On the issue of what constitutes group therapy, APTA agrees with CMS that any outpatient physical therapy services provided simultaneously to two or more patients constitutes group therapy. "We find it very difficult to say that you're one-on-one with more than one patient at the same time," Lee says. "The position CMS has taken is if you're not one-on-one, you can bill for all patients as group or you could go back and forth between the patients and bill for the time that you're one-on-one with each particular patient and aggregate your time. That's always been our understanding. From our understanding, this is not all that new."

APTA is concerned that some providers are having difficulty getting reimbursed if they bill both a group code and a one-on-one code for the same patient on the same day. CMS says you can bill both, but you must use a modifier. "We disagree with that edit," Lee says. "We think you should be able to do both of those services in the same session. We're trying to work with CMS on that. If they're going to advise people to use the group code, then they need to pay for it. There are some implementation issues out there, and we're focusing on those rather than making an argument that you can bill more than one patient at the same time."

Thomas Grissom, director of the Center for Medicare Management, sent a letter (available at www.apta.org/reimbursement/OneonOne_Group/cmsletter) to APTA in November expressing concern with the payment problems reported by APTA. He requested that APTA send specific information about these problems to CMS' division of practitioner services.

'They're throwing therapists to the dogs'

Scrushy of HealthSouth says APTA is making "a tragic mistake" by agreeing with CMS' interpretation of group therapy. He says they like the policy because it will increase the need for physical therapists. "APTA is burying its head in the sand," Scrushy says. "They are letting the industry down. They're throwing therapists to the dogs."

APTA, of course, doesn't see it that way. **Andrew Guccione**, PT, PhD, senior vice president of practice and research for APTA, doesn't buy the argument that this is the way therapists have traditionally worked.

"Traditional doesn't necessarily mean right," Guccione says. "It's done, but APTA has advised against it. It's been a longstanding principle in our code of ethics that you abide by the law, that you represent your services truthfully. If there's a discrepancy, we have the responsibility as a professional organization to advise people how to describe their services appropriately. We'll fight for your reimbursement if we think there has been a capricious denial. We are vigorous in promoting fair payment, but you can't fudge on the description."

Guccione says there's no uniform definition of dovetailing, which could either mean staggering patients' arrival throughout the hour or going back and forth between patients. He says the key is to look at whether the therapist is giving the patient divided or undivided attention. "In order to provide one-on-one services, which is the way

many of the CPT codes in the 97000 series are, that means I'm paying attention to you and you alone. That doesn't necessarily mean I will work with you for a half hour straight," Guccione says. "I may work with you for 12-14 minutes — one unit of one-on-one care — then I may ask you to rest or give you an unattended modality, and then I see the next patient, and then I may come back to you. That's different from group. The situation that has arisen is that if I call in three or four patients and I run around the room and speak to everybody, that's the divided attention. That has the characteristics for group. One-on-one is one-on-one and group is not."

This isn't Hollywood

As for the profit issue, Guccione says he's confident that many providers are following CMS' interpretation and doing just fine. "You may not be making money hand over fist," he says. "This isn't Hollywood. If you really want to get paid like a rock star, keep practicing the guitar. There is legitimate profit, but there is not overwhelming profit. It's a human service with an ethical basis. It's not the business to have enormous profits."

What about the issue of potential reduced access for patients? Guccione says it's true that physical therapists have to hustle, but they must continue to put the patients' needs above profits. "There is probably an optimal combination to provide care efficiently and still make money," he says. "But our code of ethics is very clear. You can't put financial gain above the patient. There are cost efficiencies; many clinics are billing this way and still making a profit. If you need to cut costs, look at your square footage, your mix of personnel, whether you've hired too many people, whether your productivity standards are too low. You also have to recognize what a reasonable profit is given your case mix."

The bottom line, Guccione says, is that this is the way it is. "When you enter into a contract with any insurer, you agree to abide by their rules. The rules say please use the CPT codes. That's what you agreed to do. You don't fudge. If you disagree, you argue with it."

Theresa Woodard, PT, director of rehabilitation services for St. Francis Hospital in Greenville, SC, says her institution tries to avoid billing the group code altogether. "Medicare allows it, but it has to be coded with a modifier, and you have to make sure the documentation supports it," she says. "Your note has to explain why they needed group and why they needed individual, what the difference was, and what the goal of each was. We try to avoid having to do that. It would be the exception, not the rule, that we would do group and individual on the same day. From a clinical standpoint it's hard to explain the difference in your documentation."

From a compliance standpoint, Woodard says it's just easier not to use the group code. "It's almost like they're asking you to fail," she says. "They've made it so difficult that it's next to impossible to comply. You can bill differently in the private sector, so that's going to complicate things even more. You have to think, 'Is this a Medicare patient?' and it can cause problems to treat them differently from other patients. It's cleaner all the way around to treat all patients the same."

Besides the documentation issue, billing group comes down to simple economics, Woodard says. "If we bill therapeutic exercise, it's something like $26 or $28 every 15 minutes, so if you see a patient for an hour, that's over $100 for the hour that Medicare is going to pay you," Woodard says. "For the group rate, they only pay $13, so you'd have to see six or seven patients in that same hour to get the same amount of money from Medicare. It's really just not cost-effective for us to get $39 for that hour with three patients when we could see just one patient and get $100, and that patient gets more individualized care."

Woodard says the CMS policy doesn't jibe with what she learned in PT school. "We were taught dovetailing where you have two patients at the same time. You might work with two patients at the same time where they're doing different things but they're in close proximity to you," she says. "You could let one rest and then spend a few minutes with the other one. Now, if you have two in the gym at the same time, that's group therapy. We've stopped doing that."

Dovetailing makes sense, Woodard says, because each patient has a different tolerance level. "If you were able to have two or three patients working in the same vicinity, then they could work at their own pace and take rest breaks, and they ultimately could probably do more," she says. "If you are confined to a 45-minute period, then you're going to try to cram everything in and make sure they're busy that whole 45 minutes. If I'm scheduling patients for one-on-one therapy, then if I give them a 15-minute rest break, I don't have anything to do. That's non-billable time for me." ■

Remote coding offers practical alternative

Eliminate staffing hassles

Remote coders can be used to bridge the gap created by staffing shortages and fluctuating workloads, but it's up to HIM managers to ensure that they follow the rules, says **Betty Hatten**, MHS, senior associate at PriceWaterhouseCoopers in Dallas.

"Health care providers should explore the options with remote coders and ensure the coders they hire have the proper credentials and training and apply the right quality assurance procedures to their work," Hatten explains.

Steep fines and lost revenue can result from ineffective documentation, cautions Hatten, a reimbursement consultant specialist in Medicare compliance. "The government is very serious about proper coding," she notes. "If someone accidentally or deliberately chooses the wrong code, it can result in lost revenue or overpayment."

An acute shortage of coders nationwide creates the need for alternatives, says **Leslie Ann Fox**, MA, RHIA, president and CEO of Care Communications Inc. "In the past several years, hospitals have been having problems keeping coding positions filled. Remote coding can help in two ways. First, contract or temporary coders who work remotely can respond more quickly to fluctuations in workload than coders who must travel to the hospital. Second, hospitals that offer their own coders the opportunity to work from home reduce their turnover of coders," Fox explains. "Hospitals that develop the capacity for remote coding also expand the pool of available coders for temporary coding and for their own coder recruitment."

Hatten agrees that remote coding is a good solution for unexpected backlogs related to staffing issues. "It can get help when you need it," she says. "It buys experienced help when you need it and costs nothing when you don't need it."

A critical component of the remote process, according to Fox, is having effective access to records. Methods to ensure this include using a bonded carrier to send copies of records, web-based remote coding systems for coders to access record images via the Internet, faxing, or direct access to the hospital's electronic medical record documents. If an HIM department uses the Internet, it's important that remote coders dial in to hospital information systems through a Virtual Private Network to enter codes.

Hatten cautions that remote coding makes privacy even more of a concern. "You're going to have to maintain privacy and confidentiality outside the hospital," she asserts. "Whenever information goes out of a health care provider, you've got to make sure you apply a firewall regulating privacy." ■

Use benchmarking to improve performance

Look at productivity as well as costs

When considering opportunities to improve financial performance, benchmarking may not immediately come to mind, but health care managers who have used benchmarking techniques to enhance the fiscal well-being of their institutions have found it to be invaluable.

"We use benchmarking to compare ourselves [to other institutions] in terms of productivity, fiscal performance, volume, quality of care, and patient satisfaction," says **Kevin Hammeran**, chief administrative officer of James Whitcombe Riley Children's Hospital in Indianapolis.

"Benchmarking is like a signpost to me. It indicates the areas I need to go look at in more detail or depth to determine if opportunities for improvement exist if I'm outside the benchmark," adds **Teresa A. Stroud**, RN, MSN, vice president, patient care services, at Kosair Children's Hospital in Louisville, KY.

"I start by looking at all benchmarks from both a quality and a financial framework," she continues. "Our mission as a pediatric hospital is to provide the best quality of care. That can be defined as clinical quality, but it is also entails a fiscally responsible level of care; we have to remain fiscally sound so we can continue to fulfill our mission."

"Financial benchmarking should be used as part of the performance improvement process, just like we use outcomes measures," asserts **Sharon Lau**, a consultant with Medical Management Planning (MMP) in Los Angeles.

Lau is quick to add that such benchmarking should not be viewed in a vacuum. She says she pictures health care as a three-legged stool comprising cost, quality, and speed of service.

"Take the laboratory as an example," she says. "Your productivity/financial indicators may include cost per billed test. Those numbers could be very low, leading you to conclude you are very productive. But what if it takes six hours to get a CBC with differential results, and 50% of them have to be redone? That's why you have to balance all three of those aspects."

You certainly can use your financial data to set targets for productivity or supply costs, she notes. "That's what we recommend, but you need to look at all three 'legs,' making sure you are well-balanced, and try to raise the bar in all three areas."

A wide range of applications

Both Stroud and Hammeran have employed benchmarking in a wide variety of applications. "When we first started working with MMP about eight years ago, we were really bad on supply costs per adjusted discharge," recalls Stroud. "Since that time, we've worked really hard on managing supply costs. We've been able to use benchmarks to give us direction, and since we've benchmarked a group of hospitals, they've given us ideas as well. In the process, we've been able to make improvements; we're now below the median [in costs]. We're not the best, but we were the worst out of 19 to 20 hospitals, and we've improved to within the top five."

Stroud has utilized measures such as total expense per adjusted patient day to assess performance at her 255-bed tertiary teaching pediatric acute care facility, which is affiliated with the University of Louisville. "We're part of a multihospital system, so there are expectations about our performance," she explains. "Because we're a pediatric hospital, there's not that much benchmarking data out there. The common practice would be to compare us to adult hospitals, so MMP [and its data bank of children's hospitals] helps me justify my staffing."

Hammeran faces a similar challenge. "We're an institution within Clarian Health Partners, a collection of facilities that includes the state's only university teaching hospital, its premier private care hospital, community hospitals, and us," he explains. "Like any other institution that is part of the system, we have to compete for resources. What we usually find is that kids are more expensive [to treat] than their adult counterparts, and children's hospitals have higher staffing ratios." Hammeran says children's hospitals typically staff eight FTEs per adjusted occupied bed, vs. five FTEs for a typical adult hospital.

When it comes time for the system to cut costs, the natural tendency is to treat all facilities the same. Benchmarking, however, enables Hammeran to demonstrate the distinct nature of his hospital. "It allows us to demonstrate that an FTE cut to us has a more profound effect than it would on an adult hospital," he observes. "We have consistently seen situations where if you look at systemwide benchmarks, we're in good shape, but compared to other children's hospitals we need to add staff."

Stroud has had a number of other occasions to use benchmarking to address financial issues. "We put together a performance improvement team for our emergency department [ED] and redesigned the patient flow process and developed an admission express unit. This reduced wait times for beds and offloaded workloads for the ED," she recalls. "We saw patients in a more efficient manner, but with the redesigned staffing, we actually decreased total costs per visit."

She says she also has benchmarked length-of-stay data for specific DRGs. She has one word of advice for those looking to do the same: "Revenue benchmarks, costs, and numbers in general can be pretty straightforward, but issues can be buried as well; you can't just look at the surface," she says. "During one benchmark project I had a blip on labor costs, and I had to go down behind the numbers and study the problem. What I found was that my psychiatric unit was markedly different from those in other kids' hospitals, so in that case it told me the higher labor cost was appropriate."

The two major areas in which Hammeran employs benchmarking are productivity and fiscal performance. His facility, a 262-bed hospital, is the only acute care children's hospital in Indiana.

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"We're highly specialized, which is reflected in the case mix index [CMI], the second highest among the members of the National Association of Childrens' Hospitals and Related Institutions," he says. CMI, Hammeran notes, is a measure of case complexity, but it also can be used as a proxy measure of acuity.

When it comes to productivity benchmarking, "We measure most major departments in terms of worked hours per patient day, and ancillary services by worked hours per test or procedure, and larger areas like support or maintenance in worked hours per square foot," he says. "These are the most relevant indicators of actual production or workload. While they are not adjusted for acuity, it is helpful to the extent you can cluster similar patients in each unit."

In fiscal areas, his staff looks at measures like cost per adjusted patient day and other indicators of fiscal health like profit before and after disproportionate share revenues. "We consider operating margin, what our salary and benefit costs are per FTE, benefits as a percentage of salary, number and vacancy rates per RNs, supply expenses, and energy costs per patient days," he notes. "This way we get some sense of how we're faring within the local market."

His competition is basically not other children's hospitals, but community hospitals in the surrounding area, he explains. "If we get too big a distance between us and them in our charges or in our costs per patient day, insurers will simply have patients sent someplace else," he says. "In theory, ultimately children's hospitals would become places where only transplants are done, and they will be the most expensive hospitals around. To avoid that, we depend on a certain amount of 'bread and butter cases,' and in turn we have to be reasonable on what these cases cost."

Accordingly, his hospital used benchmarking to help determine where its rate structure should be. "We wanted to be the most economic facility we could, despite our high case mix," says Hammeran. "Some insurers will refer patients out to us across state lines, because we are one of the best places to send patients for transplants. But our charges are probably some of the best in the country among children's hospitals, and our outcome survival rates are superior, so we are a very good buy."

Benchmarking can be used effectively as a way to identify opportunities for improvement in financial management, says Lau, but it's more effective if it becomes part of the culture. "Benchmarking is like any other tool; if you use it at the 11th hour, it will just be seen as a 'slash and burn' tool," she notes. "This makes frontline managers afraid of it."

You should keep your expectations reasonable, she adds. "We don't expect clients to get to the top right away," she says. "We set a reasonable target, say 80% of your ultimate goal, for the first year. Then, you can go for 90% the second year, and so on. But make it part of the whole culture of your organization; don't wait until you have a dire situation to use it."

Despite the undisputed value of benchmarking in financial endeavors, you shouldn't operate with blinders on, Hammeran warns. "One of the problems all administrators have is that they spend a disproportionately large amount of time on the fiscal end of the house and not enough on clinical care indicators," he says. "In a very real sense, if you do the right things clinically, economics will take care of itself. I prefer to look at what our measures are in the clinical realm compared to other children's hospitals — cardiac mortality rate, catheterization complication rates, five-year survival rates, and so on. If you don't have the best rates or you're not in close proximity to the best, you should be doing a gap analysis to find out why other institutions have better rates than you." ■

DRG CODING ADVISOR®

OPPS: The emergency department challenge

ED facility fees cause confusion

By **Deborah K. Hale**, CCS, President
Kathy Dean, CPC, CPC-H,
Emergency Department Consultant
Administrative Consultant Service, Inc.
Shawnee, OK

The Outpatient Prospective Payment System (OPPS) implemented on Aug. 1, 2000, was a significant turning point for hospitals, moving them from a cost-based reimbursement to a CPT-4 and HCPCS level II line item prospective payment methodology, referred to as Ambulatory Payment Classifications (APCs). Each APC has a pre-established prospective payment amount associated with it. The hospital can earn profits if costs are lower than the payment rate or face losses if costs are higher than the payments. Since that day, hospitals have struggled to understand the confusing and frequently changing OPPS guidelines for hospital outpatient departments.

The emergency department (ED) tops the list of challenges for most hospitals. This department generates a large percentage of outpatient revenues and also has complex coding and billing guidelines for facility fees. Frequently, numerous ancillary services are provided during the ED visit.

Before the implementation of OPPS, many facilities reported all clinic and emergency visits at the lowest level of service (such as CPT codes 99211, 99201, and 99281) simply to minimize administrative burden. For example, chargemasters might include only one level of service. Because the correct HCPCS code did not influence payment, there was little incentive to report the level of service correctly.

This situation changed with the implementation of OPPS, which requires correct reporting of services using HCPCS codes as a prerequisite to payment.

Beginning Aug. 1, 2000, the Centers for Medicare & Medicaid Services (CMS) instructed hospitals to use all CPT evaluation and management (E/M) codes to report clinic and ED visits. CMS told hospitals to develop their own mapping system or internal set of guidelines to report services represented by these codes. The only requirements were that the ED services be both medically necessary and documented, and that the mapping should reasonably reflect the intensity of the hospital's resources consumed.

Hospitals have struggled to create their own acuity systems. Initially, there were no specific guidelines for what could or could not be included in determining the E/M level, and hospitals did not have historical data to assess the impact of their mapping system.

Emergency department visits are charged by levels of service based on the acuity level of the patient and the intensity of supplies and services provided. Hospitals are to build six charges based on acuity and intensity of service using CPT codes 99281-99285 and 99291 for critical care. These codes were defined to reflect the activities of physicians. It is generally agreed, however, that they do not describe well the range and mix of services that facilities provide to clinic and emergency patients (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).

Some hospitals are reluctant to use the critical care code (99291) because of the CPT definition. Remember, that definition does not apply to the ED facility. While a physician can bill both critical care codes based on time, a single code (99291) will suffice for the entire critical care facility visit regardless of the time factor.

The most recent instruction was published in the *Federal Register* on Nov. 1, 2002 (66,793-66,794), for OPPS Final Rule for 2003. It reads as follows: "We [CMS] do not believe that facilities and physicians would be expected to bill similar levels of service for the same encounter. The resources used by a facility for a visit may be quite different from the resources used by a physician for the same visit. Facilities should code a level of service based on facility resource consumption, not physician resource consumption. This includes situations where patients may see a physician only briefly, or not at all."

CMS also stated that if hospitals set up these guidelines (mapping systems) and follow them, they would be in compliance with OPPS coding requirements for the visits.

An additional requirement added by CMS was that the distribution of E/M codes should result in a normal bell curve. If a facility is using an accurate emergency department acuity form to report the six levels of service, a bell curve should be the result when the code distribution is represented in a graph. To assess the appropriateness of your hospital's E/M mapping system for facility ED visits, display the frequency of billing for each E/M code in a graph format.

CMS used 2002 OPPS claims data (as published in the *Federal Register*, Nov. 1, 2002) to determine that well over 50% of ED visits were considered "multiple procedure claims" because the claim included services such as diagnostic tests (for example, electrocardiographs and X-rays) or therapeutic interventions (for example, intravenous infusions). The distribution of all emergency services was in a bell-shaped curve with a slight left shift because there were more claims for CPT codes 99281 and 99282 than for CPT codes 99284 and 99285. This pattern of coding is significantly different from physician billing for emergency services, which is skewed and peaks at CPT code 99284.

Furthermore, CMS announced that the agency will review the issue. CMS plans to set national guidelines for coding clinic and emergency visits. In the proposed rule published Aug. 24, 2001 (66 *Fed Reg* 44,672), CMS asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. These comments were compiled and presented at the January 2002 APC Panel meeting. CMS was unable to make a final decision based on the comments submitted and has now announced a plan to finalize uniform national facility coding guidelines in the proposed rule for the 2004 OPPS.

CMS has proposed to replace CPT Visit Codes with 10 new G codes for OPPS payment purposes for implementation no earlier than January 2004. CMS also plans to establish separate documentation guidelines for emergency visits and clinic visits to help facilities understand the difference between physician coding rules and facility coding rules, which hospitals have struggled with since the beginning of OPPS.

Emergency department procedure codes

In addition to E/M facility fees, hospitals must report CPT-4 codes and HCPCS level II codes for all procedures and services provided in the outpatient department setting in order to receive accurate reimbursement from Medicare.

CPT and HCPCS codes are required for reporting all of the following outpatient services to ensure additional payment for invasive procedures: radiology, other diagnostic procedures, clinical diagnostic laboratory services, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventive services, and immunosuppressive drugs identified in the *Medicare Hospital Manual*, section 422. The *Medicare Hospital Manual*, transmittal 747, revised the coding guidelines that apply as of Aug. 1, 2000.

What to do now:

- Review the Nov. 1, 2002, OPPS final rule (67 *Fed Reg* 66,717-67,046).
- Create a report showing the number of E/M levels provided over a 12-month period. Develop a graph to show current rate of billing for each of the E/M facility codes (99281-99285 and 99291) and determine whether it displays a normal bell curve.
- Evaluate your current ED acuity system and determine whether your existing system meets CMS requirements to reflect intervention and resource consumption. Make sure separately billable procedures and services are not used to determine the E/M level of care.
- Review a sampling of ED records using your current acuity system guidelines to ensure you are able to produce the same E/M level as the coder.
- Create a charge sheet for the ED to report procedures that are performed separately, e.g., injections, infusions, CPR, intubation, wound repairs, fracture treatment, burn care, etc.
- Keep the hospital's chargemaster up to date and have current chargemaster meetings to help with this process.
- Provide for an external audit of ED claims to get an outside perspective. ■