Welcome to the August edition of Net Revenue Matters, a publication of CentraMed.

In his article, “Troubling News on the Self-Pay Front,” Executive Vice President Jack Duffy discusses the idea of healthcare as merchant status.

We hope that you will appreciate the information presented our additional articles: “NCCI Edits by Managed Care Payers,” “Medicare Fee-For-Service Recovery Auditor Prepayment Review Demonstration,” “Confused About Coding?,” “CDM Tip of the Month,” and “Reporting Department Expenses Reminder.”

Also, please be sure to note our client corner and upcoming events. We don’t want you to miss anything.

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Troubling News on the Self-Pay Front

Congress is stirring because of interest raised by the Minnesota Attorney General and collection practices used by contract revenue cycle providers. Part of the story relates to renewed interest in enforcing the Fair Debt Collection Practices Act. For those who have not read this law, it has many more rules and obligations than most healthcare organizations deploy in their current practice.

As I have shared for many years, since 1971, it’s time for healthcare to become a merchant and claim the same debt collection status as all the other merchants in their community. The most efficient way to do this is to enter into a retail installment agreement with the customer/patient. This contract defines the economic relationship in clear terms and spells out each party’s rights and obligations.

As an exercise, I suggest you read the contract you signed when acquiring your last credit card. Then, compare that contract to your current version of “conditions of admission,” in which most hospitals devote only a sentence or two to describe the patient’s financial obligations. Which document better defines the desired financial relationship? If the overhead associated with converting to a retail installment contract seems too daunting, I suggest that this process be undertaken by healthcare associations or group purchasing organizations. Consolidators can hire the legal expertise and account processing resources to ensure a professional product. For patients who prefer not to have another credit type of product, payment at the time of service would always be acceptable.

Time may be running short to make these changes. If left to the government, healthcare may be burdened with hugely restrictive limitations, grossly increasing the amount of free care we are forced to provide each year. By taking the proactive role of joining every other merchant in our communi-
ties, healthcare providers can have a shield that offers some protection from acquiring another more onerous version of the current emergency room collection restrictions. Remember in this election year how much legislators like to protect the people by enacting laws that cost them nothing by project consumer value.

NCCI Edits by Managed Care Payers

There has been an increase in the number of Managed Care payers that are applying NCCI edits to outpatient claims. These payers are primarily following Medicare guidelines with NCCI edits; therefore, to ensure maximum contractual reimbursement, providers need to apply the same edits to these Managed Care outpatient claims as they do to their Medicare outpatient claims. If the outpatient claims that payers put through the NCCI edits are not going through a second-look edit process, as your Medicare claims do, you are leaving money on the table. Have you checked your payments from these payers lately to ensure CPT codes are not being bundled or disallowed based on NCCI edits?

Medicare Fee-For-Service Recovery Auditor Prepayment Review Demonstration

On November 15, 2011 CMS announced three demonstration projects aimed at reducing fraud, waste, and abuse. Of these projects, the Prepayment Review Demonstration, is set to begin on August 27, 2012.

This demonstration will be applicable to seven fraud and error-prone states (FL, CA, MI, TX, NY, LA, and IL) along with four states which have high volumes of inpatient stays (PA, OH, NC, and MO). These reviews will be DRG based, not provider based. At this time eight MS-DRGs have been put on the list to be reviewed:

- MS-DRG 312 Syncope & Collapse
- MS-DRG 069 Transient Ischemia
- MS-DRG 377-379 GI Hemorrhage
- MS-DRG 637-639 Diabetes

On August 9, 2012 CMS had an open forum call to review details and hold a question and answer session. Below are some highlights from this call:

- The purpose is to prevent improper payments before they are made and lower the error rate.
- These will not replace the MAC prepayment reviews.
- The letters will come from the FI/MAC. Providers will have 30 days to send the requested documentation and the auditors will send the determination within 45 days along with a detailed review results letter.
- These claims will be off-limits from future post-payment reviews by a CMS contractor.
- Requested charts will be reviewed in totality – for coding, medical necessity, to determine if everything on the claim is correct. As they refine their edits in the future, the review may become more jurisdiction- or provider-specific due to error rates.
- Letters will be sent to the current provider point-of-contact and will indicate that they are for this demonstration.
- Louisiana and others going through an FI change may have a delay in receiving these letters. It will be necessary to keep an eye on the CMS website for updates.

An audio recording and transcript of this special open-door forum will be posted to the special open-door forum website. The material will be accessible for download beginning on or around August 16, 2012 and will be available for 30 days. www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp

For more information, please go to:

http://go.cms.gov/cert-demos
Confused about Coding?

Are you confused about coding a fine needle aspiration and core biopsy during the same encounter? If so, you’re not alone. This has been one of our frequently asked questions here at CentraMed. Please see authoritative guidance from the National Correct Coding Initiative.

According to the Medicare NCCI Manual, Chapter 3: “FNA (10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g. needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI associated modifier.

Happy Coding!

CDM Tip of the Month:

Accurate charging to a patient’s account relies on the accuracy of the charge master file. Consistency in assignment of revenue codes is a good place to start. Let’s start with the 027X series.

To review:

- 0270 - General supplies. A HCPCS code is not required for this code. These items are considered packaged.
- 0271 – Non-sterile supplies. Does not require a HCPCS code; considered packaged.
- 0272 - Sterile supplies. HCPCS are not required, however when they are present may be granted pass through payment if appropriate. Many sterile supplies are packaged into an APC payment.
- 0273 - Take home supplies.
- 0274 - Prosthetic/orthotic devices- not used with implantable devices. DME devices such as crutches are billed to the DMERC and require a special provider number.
- 0275 – Pacemaker. Requires a HCPCS code for correct billing and reimbursement, device-to-procedure code edits also affect this revenue code.
- 0276 - Intraocular Lens (IOL) used for the lens. Using the appropriate HCPCS code, when billing for the cataract removal surgery as well.
- 0277 - Oxygen, take home. Used for MCR outpatient billing.
- 0278 - Other Implants. NUBC’s definition implantable are explained in the Uniform Billing Expert by Ingenix. When an appropriate HCPCS code is used with this revenue code, additional reimbursement is usually expected.
- 0279 - Other Supplies/Devices.

Best practice for CDM revenue code assignment is to develop policies that define chargeable, nonchargeable, sterile, nonsterile, orthotics, and implants. This will assist the CDM analyst with proper assignment of revenue codes. Once this is established, reports should be run to determine if supplies are consistently assigned the correct revenue codes. As an example, all balloon dilator catheters, regardless of manufacturer or revenue-generating department, should be assigned the same 0272 revenue code.

“A facility needs to be aware...”

A facility needs to be aware when assigning miscellaneous charge codes that the appropriate revenue code is assigned when billing. Often, reimbursement is not optimized when the incorrect revenue code is used for total joint implants.

It is recommended that this reconciliation should occur annually or more frequently as required by your facility.

Consistency and accuracy is the key for the integrity of the CDM.
CentraMed Client Reminder: Reporting Department Expenses

If your facility reports the actual RMD/RID department expenses incurred each month, it is important that CentraMed receive the department expenses each month to ensure the accuracy of the expenses reported on monthly and quarterly executive financial summaries.

The expenses should be submitted to CentraMed upon receipt from the facility’s accounting department.

We are aware that expense reports may not be received until very late in the month for the prior month. Should this occur, we request that the RMD/RID leadership coordinate with their CentraMed Director for an alternative plan to report the expenses for a given month. If expenses have not been received from those facilities reporting actual monthly costs, a reminder requesting the expenses will be sent to the RMD/RID leadership by CentraMed’s data integrity team.

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Expenses should include costs related to salaries, department education, CentraMed fees, and other administrative costs applicable to managing the RMD/RID. If the RMD/RID Director is responsible for other departments, the Director’s salary should be prorated in proportion to the time spent with the RMD/RID.

Please Note

All CBR (Code-Based Reimbursement)/CCDR (Compliant Coding and Documentation Review) activity for the month must be entered into the CBR/CCDR Software applications, including DRG Catalyst, prior to the 10th of the following month.

Be sure to follow the steps below so that results from retrospective CBR/CCDR audits translate onto the Executive Summary:

Inpatient (DRG Catalyst)

• The rebill checkbox must be checked. (Please make sure that you send the checked accounts to PFS for rebilling!)

Outpatient (CBR Database)

• The completion date must be entered under the CBR/CCDR Utilities tab, and

• The rebill checkbox must be checked. (Please make sure that you send the rebill accounts to PFS for rebilling!)

• Before the database closes each month, we recommend that you complete the following checklist:
  ◦ Confirm that all completed retrospective audits for the month have an end date entered into the CBR/CCDR database.
  ◦ Check the rebill box in the CBR/CCDR database or DRG Catalyst for each retrospective claim that has been approved for rebilling.
  ◦ Complete a Summary of Audit Findings form for any projects you closed this month and submit it to the coding Subject Matter Expert (SME).
  ◦ Ensure that data is entered for all accounts audited for the current month.
UPCOMING WEBINARS

Client RMD/RID Webinars

Sept 4: CA Forum
Sept 18: IPPS Updates Forum

Potential Topics

Consumer-Driven Healthcare/Pay for Performance
Medicare Managed Care
Auditing ICU Accounts
How to Handle Adversity
Silent PPOs
How to Interact with Internal Customers
Write-Off Analysis
Software Reporting
Injections and Infusions
Introduction to Inpatient Audits
Inpatient Mechanical Ventilation
POA and HAC
Device Dependent APCs

Observation and One-Day Stays
Pain Management
Outpatient Orders
Spine Surgery
Chemotherapy
Pathology
Brachytherapy
Moderate Sedation
Radiology Imaging
Erythropoiesis Stimulating Agents
Discharge Dispositions
Emergency Department
Vascular Access Devices
Neurostimulators
GI Endoscopy
Tracking and Trending CCI Edits

Please watch for your e-mail invitation approximately three weeks prior to the scheduled event.

Thank You

Net Revenue Matters is a monthly publication of CentraMed and is offered as an informational service. Due to the nature of this publication, examples cited and advice given must often be general in nature and may not apply to a particular facility or situation. Thus, CentraMed does not warrant or guarantee that the information contained within will be applicable or appropriate in all situations. Each facility will need to evaluate its specific opportunities and take such action as to best meet its business needs. To find out more about a given subject or for information tailored to your specific circumstances, contact a CentraMed professional.

If you have questions or would like to submit information for a future newsletter, please contact:
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