Insights and actions for successful results

July-August 2014

# Revenue Cycle Strategist

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## The Buttons Tell the Tale: **Documentation Matters**

By J. Stuart Showalter

*A diagnosis alone is not justification for medical necessity. The record must explain why, given the diagnosis, the patient needs to be in the inpatient setting.*

Day Egusquiza loves buttons. Not the fasteners that join two parts of a garment, but the round, flat badges that pin onto a shirt or coat and feature a slogan or logo. Day's buttons say things like "Frickin Free!" and "RAC/MAC Attack" and "This is not optional."

With her buttons as props, Egusquiza spoke in March to the Health Care Compliance Association's annual meeting in San Diego. Her message was simple: We're in an era of audits and all payers are knocking on your door. If the medical record doesn't clearly spell out why the services provided are medically reasonable and necessary, then they're "Frickin Free!"

Egusquiza encouraged the attendees to focus as much money on "fixing" as they do on "fighting." Although a large percentage of denials ultimately get overturned on appeal, the process can take years, and all the while the government is holding onto the money.

"We should spend more time educating physicians and other clinicians about how to document care so the claims don't get denied in the first place," she says. "It's a cliché but it's true that you don't



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get paid for what you do; you get paid for what you document."

### Think in Ink

Wearing a button that reads "Think in Ink"—an expression coined by some of her physician advisors—Egusquiza uses the two-midnight rule as an example. Under the rule, if a Medicare beneficiary's inpatient stay spans two midnights it is presumed that the stay was reasonable and necessary. But a MAC auditor can still review the information available at the time of admission and second guess the attending physician's expectation of a two-midnight stay if there is evidence that someone is gaming the system.

While Egusquiza was speaking, a bill made its way to President Obama's desk that, among other things, delayed some aspects of the two-midnight rule. H.R. 4302 prohibits recovery audit contractors (RACs) from auditing for the rule through March of next year. "But this doesn't change much," Egusquiza says.

"The MACs will audit the two-midnight rule during prepayment review, so physicians still need to document and certify that their inpatient admissions are necessary."

"The medical record must tell the patient's story. It must clearly show why the patient needs to be an inpatient for two midnights," Egusquiza says.

Her "This is not optional" button underscores the point.

She adds that this requirement is not new; Medicare has always limited payment to services that are medically necessary. Care that is custodial or that is provided for reasons of convenience—such as when a certain test or procedure is not available on the weekend—is at

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## Eight Critical Steps for Two-Midnight Compliance

Revenue cycle departments should take these actions to ensure their organizations are abiding by the two-midnight rule.

*Embed questions from the optional certification form within electronic orders or use the manual form.* The form can be used at the initiation of care and after the first midnight to help physicians and utilization review (UR) staff answer two key questions: What is the reason for admit, and can the physician attest that the patient needs two medically appropriate midnights to resolve the condition?

*Empower UR staff to assist with compliance.* Don't rely solely on clinical decision support software guidelines. The two-midnight criteria trump those.

*Know which procedures are riskiest, such as cath lab procedures and outpatient surgeries that "stay the night."* Don't allow patients to stay the night for no other reason than "sleeping." Staying the night has nothing to do with inpatient status.

*Focus on physicians in the ED.* On average, 65 percent of patients admitted to the hospital come through the ED. The ED should be a trigger point for getting the patient status correct from the beginning.

*Hire internal physician advisers to assist with education.* They can help support the UR staff and educate other physicians on how to support the admitting physician's conclusion that a two-midnight stay is necessary.

*Understand the implications for transfers.* It is not possible to "split" the two midnights between two hospitals. If a patient is transferred from one hospital to another, the two-midnight "clock" starts again.

*Use internal audits to identify problem areas.* For example, if a physician attests to two midnights but the patient goes home after just one midnight, that patient can still be considered an inpatient. But that patient's "story" must be well documented. If it is not, internal audits can identify the problem before external auditors do.

*Learn from probe audits and then hammer the message home.* The findings from MACs' probe audits should be used to educate physicians and the UR team on any problem areas.

*Source*: Egusquiza, D., "8 Critical Steps for 2-Midnight Compliance," *hfm* magazine, February 2014.

risk for denial. "A nursing note that says 'resting comfortably, in no acute distress' doesn't by itself justify continued inpatient status, and the auditors will be happy to deny a claim for that admission," Egusquiza says. Documenting the reason for admit as part of the physician certification process goes a long way toward avoiding such denials, she says.

### Watch for Challenges to the Rule

Five hospital associations and a few individual hospitals filed a lawsuit on April 14 challenging the two-midnight rule. They allege that the rule "undermines medical judgment and disregards the level of care needed to safely treat patients," according to the American Hospital Association, one of the plaintiffs. The case will take considerable time to resolve.

In addition, there is some discussion of changes to the two-midnight rule in 2015 under the Inpatient Prospective Payment System (IPPS) rule.

### Ask Medical Necessity Questions

Whether the two-midnight rule stands, a diagnosis alone is not justification for medical necessity. The record must explain why, given the diagnosis, the patient needs to be in the inpatient setting. To do this, Egusquiza uses Sharon Easterling's 5-W concept that underscores clearly identifying medical necessity. Easterling, CEO of Recovery Analytics, Charlotte, N.C., says these questions should be asked to determine medical necessity:

- *What* is being treated (diagnosis)?
- *Where* is the treatment needed (inpatient/outpatient)?
- *Why* is the treatment needed in that setting (acute/chronic/risk)?
- *What* treatment are we giving (how are we treating)?
- *When* is the patient expected to get better (estimated length of stay)?

The Centers for Medicare and Medicaid Services (CMS) would likely agree. The following are highlights from a CMS frequently asked questions document:

> Expected length of stay and the determination of the underlying need for medical or surgical care at the hospital must be supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which review contractors will expect to be documented in the physician assessment and plan of care.
>
> It is up to the physician to make the complex medical determination of whether the beneficiary's risk of morbidity or mortality dictates the need to remain at the hospital, because the risk of an adverse event would otherwise be unacceptable under reasonable standards of care, or whether the beneficiary may be discharged. If, based on the physician's evaluation of complex medical factors and applicable risk, the beneficiary may be safely and appropriately discharged, then the beneficiary should be discharged, and hospital payment is not appropriate on either an inpatient or outpatient basis.
>
> If the beneficiary is expected to require medically necessary hospital services for two or more midnights, then the physician should order inpatient admission and Part A payment is generally appropriate per the two-midnight benchmark. Except in cases involving services identified by CMS as inpatient-only, if the beneficiary is expected to require medically necessary hospital services for less than two midnights, then the beneficiary generally should remain an outpatient and Part A payment is generally inappropriate.

### Use an Effective Certification Form

To help improve the documentation process, Egusquiza has developed a sample certification form that she recommends hospitals and physicians use (see the web extra box on this page). "I believe the Medicare auditors will like this form because it makes finding the required documentation elements very easy. It's a win-win for the hospitals and the auditors," says Egusquiza.

"For payers other than Medicare, the length of stay is tied to the precertification process, and that is payer specific," Egusquiza says. "We call ahead and get 'permission' to make the patient an inpatient, and the payer says how many days they will approve. So that varies by payer."

### Meet Compliance Goals

The goal of two-midnight compliance—and, for that matter, all medical record documentation—should be to gather as complete a patient story as possible. By providing more complete documentation for patients who will require at least a two-midnight stay, hospitals can set aside their worries and better protect their inpatient volumes.

WEB EXTRA

**Inpatient Admission Certification Form**
Download and adapt a sample Medicare inpatient certification form at hfma.org/rcs, July/August 2014 issue.

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By J. Stuart Showalter

# Understanding CMS's Appeals Delay

**The OMHA decision to postpone assigning new appeals to an ALJ for at least two years has been questioned as a possible denial of due process.**

The goal of the Centers for Medicare and Medicaid Services' (CMS's) audit program is to protect Medicare by identifying improper payments and potential fraud. But many believe a flawed process prevents CMS from achieving this goal.

The situation is compounded by the backlog in the Medicare appeals process at the administrative law judge (ALJ) level and the financial impact that this delay is having on providers. Although a recently approved budget may add staffing to the Office of Medicare Hearings and Appeals (OMHA) central office, it may be months before providers obtain a full resolution of their claims, according to Deonys de Cárdenas, an attorney with the law firm Womble, Carlyle, Sandridge & Rice in Atlanta, and Tracy Field, a partner with the firm.

During an OMHA forum in February 2014, providers and ALJs discussed, among other things, OMHA's unannounced decision last July to delay scheduling new appeals. OMHA did not give providers notice of the decision until last December.

The decision is often described as a "moratorium," but, chief ALJ Nancy Griswold said it is merely a new docketing process, say De Cárdenas and Field. When specifically asked about the legal justification for the moratorium, Griswold declined to answer the question directly but insisted that there is no "moratorium," only a "change in storage geography." This left the audience bemused but chuckling.

### Legal Issues Raised

The OMHA decision to postpone assigning new appeals to an ALJ for at least two years has been questioned as a possible violation of the Administrative Procedure Act or even a denial of due process under the U.S. Constitution. After all, by law, the appeals are supposed to be decided within 90 days.

The moratorium presents problems for providers and possible legal issues for CMS, says Michael R. Schulze, partner, Sullivan Stolier Knight, LC, Lafayette, La. "Federal law is supposed to provide a predictable set of uniform rules that everyone abides by in administrative matters before the government," Schulze says. "Unfortunately, OMHA and CMS changed the rules for appeals without notice or an opportunity for the public to comment, and they put providers in a serious financial bind because they haven't stopped the recoupment process."

If a provider files a timely appeal at the first or second level—denial by the MAC or RAC—CMS cannot recoup funds paid, Schulze says. But once the provider appeals to the ALJ level they have to pay money back to the government. "Then, because of the moratorium, they must wait more than two years for a case even to be put on the docket and longer still before it's decided. This is so, even though they are likely to win almost all of their appeals."

**The OMHA decision to postpone assigning new appeals to an ALJ for at least two years has been questioned as a possible violation of the Administrative Procedure Act or even a denial of due process.**

"The proper thing for CMS and OMHA to do would be to have a moratorium on recoupment for as long as there's a moratorium on assigning claims to the ALJ," Schulze says.

Another legal issue is OMHA's practice of allowing Medicare recovery auditors to appear and testify at ALJ hearings as "non-party" participants, say De Cardenas and Field. Although the recovery auditors are not official parties to the appeals, they have been allowed to testify without the opportunity for cross-examination by providers' counsel, and they are not subject to the usual rules of discovery. "Allowing non-parties to participate as witnesses without the opportunity for cross-examination of their testimony is arguably a violation of due process," Field says.

### Solutions Suggested

Regardless of the terminology, delays are evidence of a broken appeals process. By the end of last year, RAC appeals were arriving at a rate of 15,000 per week, and the case backlog was in the hundreds of thousands and growing exponentially. Field recalls the roughly $2 billion that CMS claims to have recovered as a result of its audit efforts, and she suggests CMS use some of that money to address the appeals backlog.

Schulze suggests another solution to the backlog: Continue to pay the RACs their contingency fee, but apply an accuracy rate to it. "For example, if a RAC was entitled to $100,000 as a bounty, but 90 percent of those denied claims were overturned, the RAC would only get $10,000."

Another possible approach is a court order requiring OMHA to comply with the 90-day time limit. In May 2014, the American Hospital Association and two hospital systems filed suit seeking a declaratory judgment that the delay violates federal law. They asked that their appeals be heard "forthwith" and asked the court to order the government to "comply with its statutory obligations in administering the appeals process for all hospitals."

### Actions Recommended

No matter what solutions CMS devises or the courts may order, providers should analyze their current claims and denials. By discovering ways to improve internal processes now, providers will be ready when the appeals moratorium ends.

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## Focus on Positives to Increase Staff Motivation

Helping employees focus on successes and positive experiences throughout the workday reduced staff stress levels and physical complaints by roughly 15 percent, according to the study, "Building Positive Resources: Effects of Positive Events and Positive Reflection on Work-Stress and Health," published in the *Academy of Management Journal*.

The study participants spent 10 minutes at the end of their workdays writing about three things that had gone well that day. They were asked to list big successes or small things that made their days easier and why those events had gone well. The experiences could be personal or work related.

Workers in the study had access to a website where they recorded their positive experiences, but managers can get similar results by asking employees to record their thoughts on paper or in an electronic word processing document.

The researchers found that in addition to reduced stress levels, employees experienced improved personal relationships, increased on-the-job motivation, and reduced blood pressure and mental health problems. The researchers concluded that organizations should place as much emphasis on increasing positive events as they do on reducing negative events.

Revenue cycle managers who want to take this exercise one step further can consider planning biweekly or monthly staff lunches when employees can share some of their ideas and their gratitude for their coworkers. For special contributions among staff members, employees can share thank-you notes or small-denomination gift cards for a local café or book store— if the department's budget allows for it—during these lunch periods.

If your staff is short on time at the end of the day to write positive reflections, ask them to record a tally mark for each positive experience throughout the day. Staff should then insert that number on their calendars and review monthly numbers to raise their awareness of positive events in the workplace.

*Source*: "A Simple Daily Intervention Decreases Employee Stress," Andrew O' Connell, HBR Blog Network/The Daily Stat, Jan. 28, 2014.



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By Karen Wagner

# Using Productivity to Improve Claims Throughput

By measuring performance and recognizing employee accomplishments, Blessing Hospital improved its ability to identify and retain high performers.

Implementing health information management (HIM) and patient financial service (PFS) productivity metrics has led to marked improvements for Blessing Hospital, a 250-bed facility in Quincy, Ill. From 2010 to 2012, Blessing's days in total discharge not final billed (DNFB) decreased from 6.71 to 5.53, an indication of better claims throughput. By reducing the amount of edits, the PFS department increased clean claim rates to greater than 90 percent.

Blessing's efforts were recognized with HFMA's MAP Award for Performance Improvement in Revenue Cycle.

**Each group within PFS has a daily target—segmented into commercial, Medicare, and Medicaid payers—for the number of claims sent and the dollar amount of claims. Plus, each employee in each group has an individual target.**

## Tracking Coders

To track HIM performance, the department monitors the number of charts completed per hour per coder on a daily basis. Charts are categorized, and each category has a target for the number of charts that should be completed per hour.

The metric is based on guidelines for coding productivity from the American Health Information Management Association, says Julie Duke, administrative director of revenue cycle for Blessing.

Charts are categorized into:
> Inpatient
> Observation and one-day surgery
> Clinic
> Emergency department
> Outpatient

## Identifying Wasted Tasks

Coding staff productivity is reviewed weekly. When productivity decreases, processes are reviewed to identify inefficiencies. "We want to look at how we can eliminate waste," says Laura Triplett, Blessing's director of HIM.

For example, if the target is to code 20 inpatient charts in a day, but the coder regularly completes only 15 charts, then the coder's workflow is evaluated to identify whether other tasks may be hindering productivity.

Specifically, Triplett searches for nonproductive tasks that are not part of the coder's primary work. Some work that hinders productivity, such as staff meetings, is necessary. Other tasks, such as second-level reviews, are not.

In a second-level review, a coder reviews a claim that has already been completed to determine whether codes can be adjusted to more accurately match the patient's risk of mortality or severity of illness. This is considered nonproductive work, Triplett says. Second-level reviews to adjust DRG codes to better reflect specific conditions, in addition to work performed by coders to resolve denials, are also considered nonproductive, she says. To reduce these kinds of nonproductive tasks, clinical staff are given further training or education on accurate coding and documentation.

There has been no need to adjust the coding productivity targets thus far, but the organization is prepared to adjust them when the transition to ICD-10 has an impact on the number of charts a coder can code per day.

## Tracking PFS Output

In PFS, improved performance in claims billed per day contributed to improvements in DNFB, as well, Duke says. By prioritizing edits to resolve issues faster, PFS staff were able to increase the number of claims billed per day from 1,790 per day to an average of 2,250 per day.

After experiencing success with an initial set of productivity metrics, the following PFS metrics were developed over the past two years:
> Daily claims billed per employee
> Daily accounts receivable (A/R) status calls to check on payment and request timely payment from insurance companies per employee
> Daily denial resolution per employee

Each group within PFS has a daily target—segmented into commercial, Medicare, and Medicaid payers—for the number of claims sent and the dollar amount of claims. Plus, each employee in each group has an individual target, says Nikki Harper, Blessing's director of PFS. Performance reports from the prior week are reviewed weekly, looking at daily averages per employee. In A/R follow-up work, group performance is measured by tracking the number of accounts that are followed up on every day and the number of denials that are overturned each day, for example.

To measure quality of staff work, a few accounts are randomly selected and reviewed by supervisors to ensure these accounts are resolved according to standards, Harper says.

## Using Metrics to Motivate

Performance metrics are also sometimes used to motivate staff. Developing individual metrics is useful in identifying and retaining high performers, Harper says.

"We want to boost morale," she says. For example, in PFS, leaders congratulate a weekly champion who has collected the most in cash collections. High performers also have the opportunity to train new employees, which is viewed with prestige, Harper says.

By Kim Felix

# Another ICD-10 Delay? Now What?

Performance is also transparent. Data is presented to staff on monthly scorecards. Individuals know their own scores, which are also posted anonymously, so one employee can benchmark personal performance against the group's and against high, mid, and low performers.

In HIM, DNFB metrics are released in a daily newsletter; coders also receive weekly statistics on their individual productivity so they can gauge whether they need to improve their output, Duke says.

### Setting Goals

Making productivity metrics clearly visible to staff on a regular basis serves as an ongoing reminder of where there's room for improvement and how to best prioritize accordingly. For example, if days in A/R for commercial accounts are too high, then staff can take more time to focus on those accounts, Harper says.

Overall, Harper and Triplett say that employing productivity metrics fosters accountability by giving employees tangible goals—and that is the genesis of organizational improvement. "Understanding the target we're trying to meet is key," Harper says.

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**Q.** What steps should our hospital take to respond to the recent delay in the ICD-10 conversion?

**A.** Some of us are probably still in shock after hearing about the recent ICD-10 implementation delay. Understandable! However, this is not the time to rest on our laurels and let time pass by. Most experts are recommending that hospitals continue with ICD-10 coding education and that is exactly what you should do. However, reconsider your training strategies. Here are some suggestions to keep education ongoing during these tenuous times.

*Slow down, but don't stop.* At this point in the conversion process, you have probably allocated a specific number of weekly hours for coders' ICD-10 education. Consider trimming those weekly hours. For example, cutting back from four hours per week to two hours keeps coders' ICD-10 skills sharp while allocating training budgets appropriately. Coders should touch ICD-10 weekly to avoid the dreaded "use it or lose it" scenario that requires retraining later on.

*Focus on PCS coding.* One of the most challenging parts of ICD-10 is procedures coding (ICD-10-PCS). A critical skill to master PCS codes is identifying the root operation. A close second would be the approach. It might be a bit too soon for complete dual-coding. An alternative is to set a day when coders review operative reports—while coding records in ICD-9—and decide what the root operation is. Choose another day and ask them to assign the appropriate approach. Don't spend time assigning an entire PCS code via the code book this early. Build on the ICD-10 education foundation and transition gradually. This will not only increase accuracy and confidence but also will increase speed in assigning ICD-10-PCS codes.

*Analyze the data.* We have the luxury of time, so take advantage of it. As a revenue cycle leader, you have probably taken a look at the top 50 DRGs, principal diagnoses, major complications or comorbidities (MCC), complications or comorbidities (CCs), and procedures and have identified some of the barriers to successful transitioning from ICD-9 to ICD-10. However, now is the time to dig a little deeper. Some of the more subtle changes may not change DRGs but certainly can throw a wrench into coder productivity.

**Cases in which patients present to the office for irrigation or lavage of non-impacted ear wax to be performed by either the nurse or the provider don't qualify for 69210.**

For example, noninvasive mechanical ventilation in ICD-10-PCS requires determining the number of hours for the procedure just like invasive mechanical ventilation codes. This is not a reimbursement concern but will certainly have an impact on coder productivity. Also, make sure respiratory therapy notes are concise. Many ICD-10-PCS radiology procedures that we often code on inpatient charts require the coder to know the type of contrast used. For example, adjunct cardiac catheterization procedures require the coder to identify the type of contrast used by clinicians. Make a tip sheet identifying which contrasts are "low" versus "high" osmolar contrast to remove the guess-work.

The delay has now made our race to ICD-10 implementation a marathon rather than a sprint, so put on your running shoes, slow the pace, and build your strength along the way.

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**Figure at a Glance**

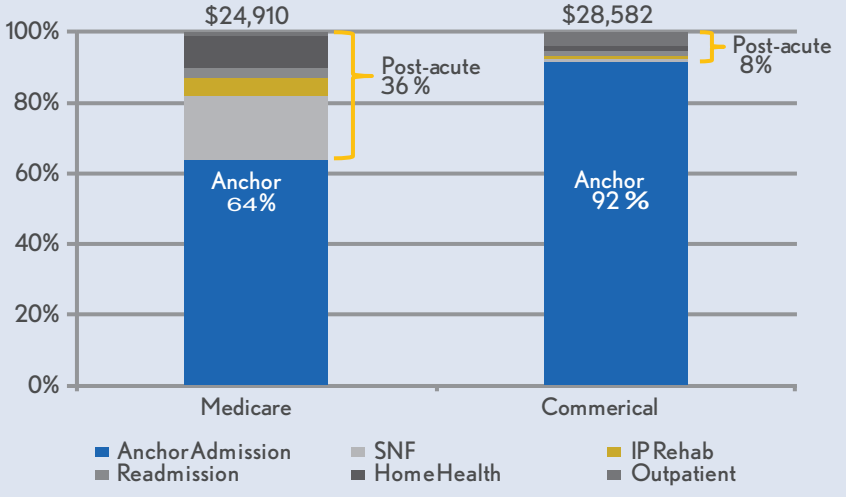
# Commercial Versus Medicare Bundled Payment Arrangements

The key to financial success under episode-based payment arrangements is dependent on the patient population. With predetermined DRG payment rates and more than one-third of an episode's payment occurring in the post-acute setting, proper management of skilled nursing, inpatient rehabilitation, and other post-acute services is imperative to succeeding under Medicare episode-based payment models.

However, in the under-65 population, 90 percent or more of an episode's payment is in the initial hospitalization, thus success under commercial bundled payments is dependent on negotiating appropriate DRG prices. Pricing and packaging of physician services is also important.

For more information, contact Tricia Eminger, senior consulting manager, payment reform (tricia.eminger@truvenhealth.com) or Kevin Miller, consulting manager, payment reform (kevin.miller@truvenhealth.com), Truven Health Analytics.

## Mean Medicare and Commercial Payment Allocation, Example: 30-Day Total Joint Bundle, Example Market




*Source*: CMS Limited Data Set Standard Analytical Files, 2011-Medicare beneficiaries residing in Phoenix-Mesa-Scottsdale, Ariz., Core-Based Statistical Areas; Truven Health MarketScan® 2011-2012 Commercial Data, Mountain Census Division.