the right moves for success with Medicare

The Medicare payment landscape is changing, and hospitals should be taking steps to ensure they receive appropriate payment. Here’s how.

New laws and regulations, ongoing federal reforms, and payer initiatives are altering the way hospitals and physicians are paid.

The Centers for Medicare and Medicaid Services (CMS) has adopted Medicare severity diagnosis-related groups (MS-DRGs), reshaping the payment landscape for providers nationwide. CMS estimates the transition to MS-DRGs will redistribute provider payments by $100 million in 2008 alone. Compliance pressures are compounding the effect of regulatory changes. In addition, the CMS recovery audit contractor (RAC) demonstration program recovered $371.5 million in improper Medicare payments to healthcare providers and suppliers in 2007. Hospitals also incurred significant costs in responding to RAC record requests and in appealing denied claims. Providers will also feel the financial impact from new federal and state pay-for-performance initiatives, value-based purchasing models, and the reporting of conditions present on admission (POA) for Medicare claims.

On the outpatient side, CMS is moving to package services within payment methodologies, as evidenced by the 2008 transition to prospective payment for ambulatory surgery centers and revised payment guidelines for interventional radiology and electrophysiology studies.

An Ounce of Prevention

There’s no question that regulatory changes are having a profound impact on the bottom line for many healthcare organizations. How, and how much, depends not only on case mix and coding practices, but also on an organization’s ability to analyze its data and address the changes. Hospitals with established programs for analyzing and addressing quality outcomes data are finding the move to MS-DRGs is having a positive impact on revenues. These facilities, often located in states where quality-based data are transparent and available to the public via hospital report cards, are already capturing and analyzing information about patient acuity and risk of mortality for performance reporting. The transition to severity-based payment is much less arduous for these hospitals, and many have actually seen an improvement in case mix index (CMI) under MS-DRGs.

Conversely, facilities that have not prepared for Medicare payment changes are paying the price through spikes in claim denials and time-consuming retrospective coding inquiries, which can substantially increase accounts receivable (A/R) days.
What can healthcare organizations do now to minimize the downside of payment reform and gain the payment to which they are entitled? Here are 10 action steps that can be taken immediately to meet payment reform challenges head-on.

**Analyze the Financial Impact of Payment Changes**

Severity-based payment will affect the relative profitability of individual hospital service lines and even individual physicians. By drilling down and analyzing the data by specific MS-DRG, providers can take appropriate action to ensure complete and accurate documentation and coding, thereby minimizing negative impacts to the bottom line.

The first step is to determine baseline impacts from the new MS-DRG rules to the organization’s revenue in aggregate. The impacts can be estimated by looking at the change in the organization’s CMI from CMS v24 to MS-DRGs, a measure that will likely change as inpatient cases are reclassified from DRGs to the new MS-DRGs. (Changes to capital payments within the blended rates and market basket updates will also influence hospital payment and should be analyzed in addition to case mix changes.) Changes will result from new computations of the relative values for MS-DRGs, changes to the list of codes considered complication and comorbidities (CCs), and codes now considered major complication and comorbidities (MCCs). CC and MCC changes and additions increase the need for full and complete coding of all secondary diagnoses and procedures to ensure that the appropriate MS-DRG is assigned.

Because payment changes will also affect the individual service lines, an analysis needs to drill down to identify trends across cost centers to determine which clinical areas will experience revenue gains or losses. This detail will provide a realistic picture of the impact on payment if no changes are made to current practices and areas where the best opportunities for improvement lie.

**Benchmark Performance Against Your Peers**

Hospitals should compare their facility’s performance under MS-DRGs with industry metrics (developed and available from many healthcare industry vendors and consulting firms) to determine areas for potential improvement.
A first step is to identify how frequently MCCs or CCs are captured within high-volume MS-DRG pairings or clusters.

Once baselines are established, hospitals should target high-volume, high-cost MS-DRGs for improvement. Targeted MS-DRGs can then be ranked against key metrics, as well as vetted to uncover any internal obstacles to improvement, such as lack of documentation or nonspecific documentation. At this point, specific MS-DRGs can be selected for a focused concurrent review and physician education by service line.

Next, hospitals should evaluate their facility’s outcomes against peer organizations of similar size and services or in a particular region or state. They should compare severity CMI (complexity) and determine whether the facility’s actual mortality is higher than expected. Why evaluate mortality? Unlike severity case mix, mortality scores don’t directly affect payment, but if a hospital’s customers choose to go to other facilities in reaction to published provider performance reports, the organization will certainly feel the impact on revenue.

A facility’s performance below peer performance leads to many questions:
> Is coding accurate?
> Is documentation specific or absent?
> Is quality of care an issue?

A regular review will identify ongoing opportunities for improvement and pinpoint areas where additional education is needed for physicians or coders. Hospitals should investigate variances to the industry and peer organizations by evaluating:
> Quality/consistency of coding
> Quality of physician documentation
> CC and MCC capture rates
> Severity of illness
> Risk of mortality
> Service-line performance

**Audit and Educate Physicians**

The underlying methodology supporting patient classification and payment according to MS-DRGs demands much more specificity in the physician documentation than was required under DRGs. Hospitals should assess coding accuracy, physician documentation specificity, and hospital-acquired conditions. Doing so will help quantify opportunities for improved payment and will identify specific areas for further analysis, help prepare for RAC audits, and assess the facility’s readiness for the October 2008 CMS initiative eliminating payment for certain conditions that are not POA.

A hospital’s health information management (HIM) and case management/utilization management (CM/UM) departments can offer a wide range of education options to physicians, helping them understand the new payment guidelines and what to watch for when documenting. For example, HIM can begin by auditing records where an MS-DRG is assigned without a major CC. Next, HIM should evaluate coding quality and lack of documentation by individual physician to uncover areas where greater specificity is needed. For example, a physician may document congestive heart failure as a secondary diagnosis, but neglect to specify whether the patient has acute or chronic, systolic or diastolic heart failure. Additional documentation will allow assignment of a CC or a major CC, leading to more appropriate payment.

Physician training should be focused by service lines and address frequently occurring issues identified in the facility’s record review. Providing examples of frequently omitted or unspecified documentation—and then demonstrating the impact on payment and severity and risk for mortality—is crucial to engaging the medical staff.
Implement a Concurrent Documentation Program

Relying on traditional, retrospective documentation review under the new payment regulations presents challenges from a compliance standpoint, because physicians are hesitant to provide late entries into the chart. Information added several weeks after discharge may appear out of context, and facilities may end up with accounts that can’t be billed at the severity level delivered.

Concurrent documentation review ensures that review and assignment of a working principal diagnosis code takes place concurrently with clinical evaluation. Physicians can be queried about inconsistencies during the inpatient stay, which improves the odds that a patient’s complete clinical status, including secondary diagnoses and complications, is documented and accurately reflected in the medical record, and thus more precisely coded and billed.

Most physicians realize that if they don’t use appropriate terms when they document, they may not be credited for the true severity of their patients. As a result, quality report cards may suggest the physician is providing substandard care if the mortality rate is higher than expected. Hospitals should focus physicians on improving quality outcomes data, including severity of illness, mortality risk, complication rates, and readmission rates, bearing in mind that outcomes reflecting severity are strictly tied to the MCC classification under MS-DRGs.

Establishing a concurrent documentation program may require changes to staffing and workflow processes. Different implementation models include integration into CM/UM or HIM or assembling a team of documentation specialists, including nurses and coders who report to either of these departments.

Before establishing a concurrent documentation program, hospitals should take the following steps:

> Quantify opportunity and determine focus areas from record review.
> Establish oversight committee, including as potential members HIM, CM/UM, and compliance leaders; physician leaders; vice presidents of quality, finance, or revenue cycle; the COO; and the CEO.
> Perform staffing analysis and determine where the program will be managed.
> Educate the team and medical staff around documentation improvement, Medicare rules/regulations, and frequently occurring issues.
> Develop a query process.
> Monitor process and data indicators.

Focus on Length of Stay

Cost reduction efforts in the 1990s led many healthcare organizations to focus on length of stay (LOS). Today, with the change from charge-based relative weights to cost-based relative weights, hospitals are focusing again on LOS to determine whether costs are higher than payment.

Facilities can use the published Medicare geometric mean length of stay (GMLOS) as a target, but severity-adjusted LOS is often better received by the medical staff since complexity of cases is influenced by the additional secondary conditions they must manage. For example, a diagnosis of heart failure and shock has an expected Medicare GMLOS of 3.1 days to 5.1 days. In using the all patient refined (APR) DRG classification system, for example, the severity-adjusted data could show lower than expected LOS in subclass 1, but higher than expected LOS in subclasses 3 and 4, when compared with GMLOS ranges.

Hospitals that detect a variance in LOS should audit records to determine whether the MS-DRG was correctly assigned. They should look for
conditions that lack specificity in the documentation and query the physician for more information. They need to correct the MS-DRG before determining the appropriate LOS. For example, a physician may document a diagnosis of decubitus ulcer, but fail to indicate a location of the sacrum. Adding this specificity to the documentation justifies the assignment of a major CC, leading to a significantly different expectation of LOS and payment.

Get Ready for RACs
With the success of the RAC demonstration program in California, Florida, and New York, CMS anticipates rolling out permanent RACs nationwide this year.

Addressing the RACs is not merely a compliance, clinical, or HIM issue, but a concern for the entire hospital. The money recouped from overpayments to hospitals in the demonstration states in FY07 alone accounted for 93.5 percent of the total overpayments received by CMS, or $321.8 million.

The RAC program, part of a larger initiative to determine improper Medicare payments, focuses on improving the accuracy of the Medicare fee-for-service (FFS) program. Although the RACs found only 0.2 percent of improper Medicare FFS payments during the three-year demonstration program, CMS anticipates that the rate of improper payments detected by the RACs will improve over time with permanent contractors in place. The current Medicare FFS improper payment rate is approximately 3.9 percent. With constraints on payment, hospitals can little afford to place almost 4 percent of their Medicare FFS payments at risk.

The RACs determine improper payments by data mining in both inpatient and outpatient claims with apparent errors. These automated reviews may result in denials without a review of the record, or for claims that likely contain errors, the RACs will request the medical record for review. Providers need to prepare now to address a larger number of requests for information as well as an expanded appeals process.

Protecting Medicare revenue in the face of increased compliance scrutiny can be accomplished by ensuring claims accuracy. Incorrectly coded claims and medically unnecessary claims accounted for the largest amounts of overpayments recouped from FY07 in the RAC demonstration program. Hospitals should monitor and audit coding, billing, and medical necessity as part of their compliance program, and request additional audits or tools to ensure the accuracy of their coded and claims data as well as accurate validation of admissions and services meeting medical necessity.

A first step to consider is the creation of a RAC response team, including a representative from patient financial services to monitor the denials and appeals process. Because RAC preparation may take employees away from other initiatives, senior management support is needed to ensure the necessary attention is paid to RAC preparation efforts.

The manpower required to respond to record review requests or research records for appeals will tax many organizations. Hospitals should consider the following key areas in determining whether to outsource some processes.

Clinical documentation improvement. This drives more complete documentation to justify services provided.

Release of information. Organizations that outsource this function need to ensure that their vendors can respond to RAC record requests in a
timely manner. During the CMS demonstration program, delayed record release and insufficient documentation accounted for more than $30 million in overpayments recovered by the RACs.

**Appeals process management.** Hospitals potentially face a much larger number of appeals under the permanent RAC program. Determining which claims to defend and managing the various levels of appeals is a time-consuming but essential process. Hospitals need to assess whether their facility has the in-house expertise to aggressively manage the appeals process for a successful outcome.

Implementing a RAC preparation and response strategy well in advance of the RAC rollout is time well spent. It may help your facility mitigate risk of improper payments, thus protecting your Medicare FFS revenue.

**Take Charge of Charge Capture**

Regulatory changes make it imperative that an organization’s chargemaster fully reflect the continuum of services it offers and is both accurate and compliant with payer requirements. This is not an easy task, given annual revisions to CPT/HCPCS codes and ambulatory payment classifications (APCs), along with quarterly updates to HCPCS Level II codes and OCE and NCCI edits. However, inaccurate codes can lead to improper payment, line-item denials, and returned-to-provider claims. Inaccurate codes can also lead to compliance issues if an error results in inappropriately billed items.

Errors often trigger edits in the claims-scrubbing process that may require manual intervention to correct or could result in write-offs. It’s not uncommon for a facility to achieve an 80 percent or less claim accuracy rate on the first pass through the claims processing system. In other words, 20 percent of claims may require manual intervention before release for payment. All of these issues contribute to an increase in A/R and additional funds (approximately $125 to refile a claim) to ensure a clean claim and appropriate payment.

Although the chargemaster is the backbone of the billing system, charge tickets, order entry screens, and other data capture documentation must also be complete, compliant, and consistent with the chargemaster. If the order entry screen or charge ticket does not match the line item to which it is linked in the chargemaster, significant errors and delay can result as the claim moves through the billing system.

Charge capture processes vary between ancillary departments, systems, and even personnel. Focusing on efficient and effective charge capture processes will help protect payment, and also prevent or reduce delays in receipt of payments. Each department should perform daily charge reconciliations by comparing the services actually performed with the charges entered in the billing system. Hospitals should verify that the charges entered flow from the clinical system to the financial system and ultimately to the actual bill to ensure that interfaces between the systems are working appropriately.

**Prevent Coding Duplication**

Review of the charge capture process is not complete without regular focused audits of medical records that track specific charges resulting from a physician order, through the claims process to final payment. Although a claims scrubber will detect many billing issues, some issues can be identified only through the use of audit procedures. For example, “lost charges” or incorrect charge selection will be evident only by comparing charges with the documentation and orders.

Outpatient services coded by the HIM department will occasionally duplicate code assignments.
driven by the chargemaster. Some scrubbing processes can detect this duplication before the claim drops and prevent incorrect payments or payment delays. Significant problems can occur, however, when duplicate code assignments result in different CPT codes submitted for payment, an error that might be identified only in the audit process. Corrective measures may include revising charge capture documents; modifying interfaces among order entry, chargemaster, and billing systems; updating the chargemaster; auditing charts; and/or providing additional coding education for the HIM and department staff, depending on the root cause of the error.

HIM staff and the chargemaster team should work together to determine accountability for code assignment to avoid duplication of efforts and any resulting inaccuracies. Accountability may be accomplished by an annual review of chargemaster tables in the billing system to determine which UB-04 revenue codes are assigned to HIM coding or “hard coded” in the chargemaster.

Additional physician education can also ensure that physicians partner with hospitals in providing accurate and comprehensive diagnosis codes when ordering outpatient procedures or services to support medical necessity and complete and accurate documentation for procedures performed to support accurate procedure coding.

Audit procedures and schedules should be defined. Feedback and education should be provided back to the affected departments. Audit effectiveness is best achieved when performed by an entity not directly responsible for charge entry.

**Conduct a Pricing Review**

Regulatory changes, increasing payer constraints, commercial contracting pressures, and growing calls for public price disclosure demand a pricing review. A comprehensive evaluation of prices and price structure, along with the establishment of price adjustment protocols, can help drive revenues necessary to support technology investment and service expansion in this changing payment climate.

In addition, an organization’s contract negotiation team needs accurate information on which to base contracting decisions. Market comparisons, market position, and charges consistent with payer provisions should be considered in conjunction with desired performance levels so informed decisions can be made on price adjustments versus cost containment and operational efficiency considerations.

Across-the-board price increases and even carefully timed and focused rate adjustments can be problematic due to the risk of negative exposure if increases are not based on a logical pricing structure. Although a full discussion of appropriate pricing is beyond the scope of this article, it is important to note that better, more defensible approaches can be employed to determine pricing of services. Each approach has its pros and cons, which should be carefully evaluated when selecting a methodology.

Some hospitals use cost accounting data to determine pricing. This can be an effective approach for facilities with an accurate and up-to-date cost accounting system. However, if the system is outdated and cost information is inaccurate, ultimately, pricing will also be inaccurate. Other pricing models incorporate the use of a contribution factor to determine prices based on utilization and volume, or use peer comparisons to establish pricing based on market position. Facilities should be watchful for price maximization with the former approach, and use caution in selecting peer competitors with the latter, ensuring that competitor facilities...
Given various options for developing a pricing strategy, a facility can determine the best approach by using a combination of several models to create checks and balances in the decision-making process.

**Validate Payment Reconciliation Processes**

Finally, protecting payment in this new era of regulatory change requires that an organization predict and monitor ambulatory performance under Medicare and other third-party contracts. Do you have an effective process in place to accurately estimate payment and monitor payments received? Healthcare organizations lose millions of dollars each year by failing to ensure that third-party ambulatory payments are made in accordance with contract terms. Claims are written off for lack of precertification and never appealed. Claims are written off for failure to meet medical necessity guidelines without review for additional documentation to support the service. Third-party payers “bundle” services inappropriately by applying proprietary edits

---

**CASE STUDY: APPROPRIATE PRICING**

A 450-plus-bed Midwestern facility had invested time and effort in negotiating contracts with payers. Due to “lesser of billed charges” logic written into its contracts, however, the hospital was losing revenue to which it was entitled. One of the most significant areas of loss was the Comprehensive EP Evaluation procedure. The actual charge established in the chargemaster was $4,000, although the negotiated commercial rate for the facility’s largest commercial payer was $6,800. The facility was losing $2,800 for each procedure based on the “lesser of billed charges” logic, resulting in a total loss of $834,400 per year. A revised price reflecting the negotiated rate of $6,800 resulted in full recoupment of this loss. Although the exhibit provides a specific example of one procedure, many considerations need to be taken into account to ensure an adequate and compliant pricing strategy.

---

### PRICING IMPACT CONSIDERATIONS

<table>
<thead>
<tr>
<th>APC Payment</th>
<th>Actual Existing Charge</th>
<th>Negotiated Commercial Rate</th>
<th>Market position, price transparency, contract negotiation considerations</th>
<th>Average Market Price for Peer Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,974.00</td>
<td>$4,000.00</td>
<td>$6,800.00</td>
<td>Lost revenue based on lesser of billed charges logic</td>
<td>$8,936.25</td>
</tr>
</tbody>
</table>

Evaluation Point: Does this price achieve the necessary profit margin to allow for sustainment and growth to meet emerging needs of patients in our community?

Knowledge transfer with contract negotiating team is a key ongoing need.

Based on this facility’s volume for this procedure and the utilization for this payer, the net revenue loss was $834,400.

If your revised charge is at least equal to the negotiated rate, then you recoup the dollars lost as a result of lesser of billed charges logic in the contract.

Evaluation Point: Does this price achieve the necessary profit margin to allow for sustainment and growth to meet emerging needs of patients in our community?
that are rarely challenged. The sheer volume of claims processed makes effective reconciliation challenging.

Establishing an effective outpatient claims management process is essential to protecting payment. Hospitals should begin by assessing patient financial system capabilities to ensure that expected payments are accurately calculated based on unique contract terms. This step also serves to validate that payments collected are consistent with contract language. Essential information related to contract requirements such as preauthorization numbers, updates, and additional approvals must be integrated into the patient financial notes so that information is readily available should an appeal be required.

Next, the hospital should establish acceptable payment variance thresholds and institute a process to challenge incorrect payments. For cases challenged, the hospital should measure the effectiveness of the appeals process and evaluate trends so it can implement preventive measures that may reduce appeal volumes. Results feedback should also be communicated with the contract negotiation team; contract language that is subject to interpretation should be prevented or corrected as soon as possible. (See case study, above.)

The Bottom Line
Taking a proactive stance in addressing payment reform challenges can also have a profound impact on a healthcare provider’s efficiency, quality of care, reputation, and profitability. And as competition gets tighter and the rules governing payment continue to evolve and change, meeting such performance objectives will help build market share and protect revenue—the two best hedges against evolving federal and state payment changes.

CASE STUDY: PREVENTING PROTRACTED PAYER DISPUTES

A 300-bed hospital asserted that it had underpayments or nonpayments of nearly $10 million for services provided to beneficiaries of a key payer. The payer, on the other hand, maintained that the amount owed was one-fourth of the hospital’s projection at best. Only after a lengthy dispute and significant time, budget, and staff resources devoted to retrospective claims auditing was the hospital able to adequately summarize the various reasons for nonpayment and offer an estimate to the payer for settlement purposes. The hospital determined reasons for nonpayment included lack of appropriate precertification documentation, incorrect claim payment by the payer, different interpretation of contract language provisions regarding payments for multiple procedures, incorrect application of proprietary edits, and incorrect payment estimation by the hospital.

In the end, the hospital incurred significant additional costs in the process of uncovering the necessary information required to resolve and settle the disputed amounts. Avoiding a large backlog of disputed claims requires a better approach that includes proactive reconciliation and management of claims payments, plus careful review of contract negotiations to eliminate potential inconsistencies or different interpretations of contract language.

About the authors

Garri L. Garrison, RN, CPUR, CPC, CMC, is a director, data monitoring services, 3M Health Information Systems, Atlanta (glgarrison@mmm.com).

D. Wayne Little, CPA, is director, ambulatory care services, 3M Health Information Systems, Atlanta, and a member of HFMA’s Georgia Chapter (wwlittle@mmm.com).

Copyright 2008 by Healthcare Financial Management Association, Two Westbrook Corporate Center, Suite 700, Westchester, IL 60154. For more information, call 1-800-252-HFMA or visit www.hfma.org.