



There Is No Such Thing As Easy Money

There is no such thing as easy money, but in these difficult financial times with decreasing healthcare reimbursement, hospitals need to carefully evaluate their charging processes to make sure they are not leaving money on the table. Two areas that hospitals often overlook are: the charging of injection and infusion services for observation patients and the medical necessity of laboratory tests. Hospitals may not pursue these areas of charging because both can be challenging and time-consuming. They often require dedicated staff to accomplish; however, even with the extra costs, the pay-off may be worth the effort.

Why So Difficult?

In billing for infusions and injections, it is not as simple as adding the charge codes to your chargemaster and asking staff to enter charges when an infusion or injection is performed. The CPT rules for charging infusions and injections are complex: generally only one initial service should be billed per episode of care, there is an hierarchy for determining the correct initial service, codes are time-based and documentation must include start and stop times - just to name a few of the rules. Since the "initial service" rules apply to a complete episode of care, a review of the entire record is required to make sure charges from a combined ED / observation stay are correct. The record should also be carefully reviewed for complete documentation to support the charges, especially the time component.

Obtaining information to support the medical necessity of laboratory tests is not as complex, but can be time consuming. If diagnostic information to support the medical necessity of a laboratory test is not provided by the ordering physician on the laboratory requisition, someone should contact the physician and see if additional diagnostic information can be provided. Additional diagnoses must be appropriately documented, present in the medical record, and coded on the claim to support reimbursement. Challenges are getting in touch with the physician, getting the physician to understand the need for more information, and getting appropriate documentation for your record. Hospitals could consider adding such a process to a clinical initiatives program. They

could also involve members of the medical staff that lead a physician integration program.

Is It Worth It?

Obviously there are several factors that will determine a return on investment for these charge processes: the volume of observation patients and laboratory tests, the types of services usually provided to your observation patients, and the volume of laboratory tests that are denied or written off for failing to meet medical necessity requirements. Before billing for any service, hospitals should always evaluate for appropriate utilization considering quality standards, best practices and the "better not more" mindset of healthcare in the future. Hospitals should do an internal analysis of the financial impact of both areas. You may even want to consider a limited "trial run" to determine the resources required, the challenges and the benefits of the process.

One large Alabama hospital implemented a process to charge for injections and infusions on Observation patients over a year ago and has seen a calculated reimbursement of over \$1M for FY 2009 as a result of the program. The reimbursement was calculated using average reimbursement percentage for all payers based on charges. In considering whether to implement such a program, the hospital performed pilot projects: first, they selected an RN who had some knowledge of coding, billing, and payer reimbursement issues. The RN was then trained on the coding and billing rules for injections and infusions. The hospital utilized internal personnel already knowledgeable on coding injections and infusions to perform the training with additional guidance from an outside consultant with expertise in injection and infusion coding. The RN then reviewed all observation patient records for one week, assigned the appropriate injection/infusion codes, and calculated reimbursement based on the Medicare APC rate. The hospital realized not all payers pay at this rate, but this method was used to determine a potential financial impact. Two pilot projects were done and both indicated potential reimbursement of \$250 - \$300 per Observation patient.

The calculated reimbursement since full implementation of the process has actually been approximately \$160 per Observation patient. Based on their experience, the hospital projects one FTE per 250 Observation patients per month is needed to adequately implement such a program. The hospital states the major keys to success of their program have been:

- Dedicated personnel to perform the tasks. Employees must be knowledgeable and organized.

continued on page 19

- Utilizing an RN to perform the process. An RN has the clinical knowledge and experience to interpret and understand documentation and to make clinical judgments regarding medical necessity.

- A thorough understanding of the guidelines and rules for coding and billing injections and infusions.

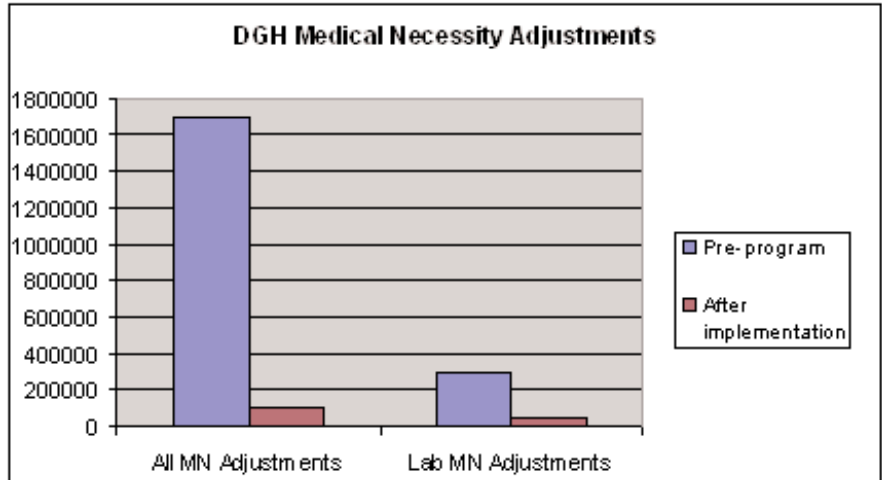
- Oversight of the program. Regular audits are performed by the Compliance department.

- Support of hospital Administration and other departments, especially Nursing.

The biggest challenges the hospital has faced relate to appropriate documentation, especially documentation of start and stop times for infusions; following all the CPT rules; and the time it takes to adequately review the records. The hospital has committed to holding all observation claims until the review for injection / infusion charges is complete. This takes an average of 10 days post discharge to allow time for all documentation to be complete and in the record. It has been a struggle to get everyone to understand the need for more accurate and consistent documentation. That is why the support of Administration, Nursing, Information Services and other departments has been critical.

Other hospitals considering implementing such a program need to consider several factors such as their overall number of observation patients, the types of services provided to observation patients, the medical necessity of the services provided and the availability of resources such as dedicated staff. And although the task may seem daunting, consider the payoff if your hospital has similar results to this hospital – for an average of 250 Observation patients per month and employing one RN to execute the program with associated training and oversight costs, there is the potential for \$480,000 of reimbursement annually for an investment of less than \$100,000.

Hospitals often ignore denied laboratory tests because the reimbursement rates are low. However, there is often a large volume of lab tests and enough volume of even low-paying lab tests could result in a substantial financial benefit. Decatur General Hospital in Decatur, Alabama chose to include laboratory tests when implementing a process to address medical necessity denials. Prior to implementation of the program, all medical necessity adjustments totaled over \$1,700,000 including radiology and laboratory tests. Obviously, the higher priced radiology tests accounted for most of this amount, but lab tests were almost 20% of the total



adjustments. Since the process was put in place, there has been a 94% decrease in the amount of medical necessity adjustments.

Decatur General took several steps initially to ensure the success of their program but has also made adaptations as needed to improve the process along the way and ensure continued success. They started by creating a task force comprised of representatives from Accounting, Physician Marketing, Health Information Management (HIM), Patient Financial Services (PFS), Information Services, the Emergency Department and Compliance. This ensured support throughout the hospital and allowed the process to be designed to meet the needs of all departments. They eventually decided an RN was best suited to perform the process due to clinical knowledge and the ability to receive verbal orders. They also invested in marketing the program to physicians' offices through Physician Office Managers' luncheons and physician newsletters. This created physician buy-in. The RN works as a team with the physicians and their office staffs. Good, respectful communication between the RN, physicians, and their staff has been key to the program's success.

Initially, the process was performed manually but now billing software produces a daily Medical Necessity Report. The RN reviews the report, the patient account history, and contacts the physician's office to determine

continued on page 20



if additional diagnoses are available to support the medical necessity of the test(s). If additional diagnostic information is available, the RN documents it on a “diagnosis revision form” and faxes it to the physician’s office for the physician’s signature. The signed form becomes part of the patient’s medical record and HIM revises the diagnosis coding as appropriate. The RN also works with the billers to assure accurate billing (appropriate use of modifiers, etc.); addresses code sequencing issues with the coders when there are more than nine diagnoses on a claim; and reviews denials, submitting appeals when appropriate.

Increased reimbursement has been the biggest impact of the program. Obviously, radiology procedures have the largest impact due to their larger reimbursement rates. But at Decatur General, approximately 3,900 laboratory tests a year fail to meet Medicare coverage requirements. The medical necessity review process has been able to obtain covered diagnoses on 75% or more of these. Considering the top laboratory tests that fail medical necessity at Decatur, the average laboratory test reimbursement rate is around \$21.00. If medical-necessary diagnoses are obtained for 3,000 of the 3,900 lab tests, this would result in increased reimbursement of \$63,000 per year for just the lab tests. Since the RN also addresses medical necessity for other types of tests and performs the other duties as described above, this is a significant return on investment.

Physician education concerning Medicare coverage requirements has also been a benefit; over time this has resulted in a reduced number of tests failing medical necessity initially. Patients and physicians are pleased when tests meet Medicare’s medical necessity requirements and the patients do not have to sign an ABN to assume financial liability.

The biggest challenge of the program has been obtaining the support of all physicians. Potential challenges that need to be addressed for others considering implementing such a program are obtaining the support of hospital Administration and other hospital departments and being sure there is appropriate oversight of the program for coding and billing compliance. At Decatur, the

HIM Director oversees documentation/coding questions and the PFS Director reviews for billing compliance issues with an outside consultant serving as a final resource for tough questions. Per Decatur General, the process requires “an interest in decreasing denials, a commitment to learn the process and the patience to see it through.”

Be Very Careful

Instituting charging processes for these areas can result in appropriate reimbursement if done correctly. Follow the suggestions below to ensure compliant processes:

- Know the rules. Understand the CPT guidelines for the billing of injection and infusion services. Be careful when asking physicians for additional diagnostic information – do not suggest diagnoses that would cover the test in question and be prepared to accept the answer that there are no additional diagnoses.
- Consider dedicated staff to manage the process. Because of the complex rules, one person or a few people to understand the rules and apply them appropriately may be necessary.
- Be sure the documentation in the medical record is complete and supports your charges and diagnosis coding.
- Verify appropriate utilization and that the services are medically necessary.
- Establish metrics to ensure success of the program. Institute on-going processes to monitor return on investment at least annually.
- Educate to make the process easier going forward. For example if start and stop times are not being documented, provide education to nursing staff on appropriate documentation to support infusion charges. And although you can’t “code steer” physicians on diagnoses to support a lab tests, you can share medical coverage policies with the physicians for their review. As physicians become more knowledgeable of the policies, they should start providing appropriate diagnoses at the time of order.

**- Debbie Rubio, MT (ASCP)
Manager of Regulatory Affairs and Compliance
Medical Management Plus
Birmingham, AL**

Ms. Rubio may be reached at drubio@mmplusinc.com