First Illinois Speaks
HFMA's First Illinois Chapter Newsletter
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Believe to Achieve

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Captured Events & Updates

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Interview with the C-Suite: Cherilyn G. Murer J.D., C.R.A.: Founder, President and CEO of the Murer Group

BY DAN YUNKER, VP & CFO, METROPOLITAN CHICAGO HEALTHCARE COUNCIL

With so much continuing to advance in light of the changing healthcare landscape, I checked in on Cherilyn Murer who presented to the HFMA CFO committee last fall. Here is what she had to say.

How has health care reform impacted revenue opportunities?

The reform law impacted just about everything in the American health care system. One of its stated goals was to lower costs, and so naturally it influenced how the Federal government will spend its money in the coming years. It also created programs on care coordination that will hopefully yield some savings.

It is also interesting how the law influenced pre-existing programs designed to provide financial help to providers. For instance, it expanded the types of hospitals eligible for the 340B drug discount program. Now certain children hospitals, free standing cancer centers, critical access hospitals, rural referral centers and sole community hospitals can all participate in the program. Health care reform also provided additional funding for FQHCs.

There are some revenue opportunities that have been affected in a more subtle way. Payments under the EHR Incentive Program have not been directly affected. However, the reform law places great emphasis on improvement through technology, and so it may have an effect on the definition of meaningful use requirements. Also, rules for provider-based reimbursement were in no way altered, but, given the massive amount of new regulations and programs, CMS has been forced to make auditing and enforcement of provider-based rules a lesser priority.

Cherilyn G. Murer J.D., C.R.A.: Founder, President and CEO of the Murer Group

Why is it important to continue to look for new revenue opportunities?

It is not news to anyone that costs are rising while payers, both public and private, are trying to reduce

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payments to providers. Even after the recent reform law, it is widely acknowledged that some hospitals will have to close because they are not financially viable in the long-term. Indeed this may be the most difficult business we have ever seen for health care providers. As such, all providers have to pursue every possible avenue to ensure that they are getting all the monies available to them. This is not a matter of profit but a matter of survival.

Is the FQHC program a good opportunity to increase revenue?

Technically speaking, the FQHC does not really do much to enhance revenue. Instead, the primary benefit comes in the form of cost avoidance. It is very common for some patients to use hospital emergency departments as the principal means of primary care. This is, of course, very expensive for hospitals to provide. The primary benefit of FQHCs is that they move this patient population out of the emergency department and into a venue far more appropriate to their health care needs. FQHCs lower costs because they provide primary and preventative care to patients regardless of the ability to pay. This helps to ameliorate the "frequent flyer" problem at emergency rooms. There is grant money available, but it is primarily intended to compensate for the fact that FQHCs must take patients regardless of ability to pay.

Is it difficult to obtain the grant money?

To receive grant money, facilities must be of a designated type, for example a community health center. They must also meet other requirements regarding patient population, types of services provided, operations, and governance. What keeps most facilities from obtaining grant money is not the criteria related to patient population and the like. Rather, it is because they do not fall within the list of facilities eligible for the grant money. These facilities are called FQHC look-alikes, and although they do not get grant money, they do receive special Medicare and Medicaid payments.

What is the 340B Drug Pricing Program?

It is a program designed to help certain health care facilities by providing discounts on covered outpatient drugs. Facilities normally see a 20-50% reduction in the cost of pharmaceuticals. For hospitals that qualify, the reduced cost of outpatient drugs can save a hospital or a system millions of dollars. A provider can see even greater savings by including employees in the program, and thus lowering its health care expenses for its own workers.

Has health care reform affected the 340B program?

Yes, by expanding the types of providers that are eligible for the program. These include certain children's hospitals, free standing cancer centers, critical access hospitals, rural referral centers, and sole community hospitals. Before the reform act, hospitals were pretty much only eligible for the program if they were disproportionate share hospitals. This meant they had to be paid under the Medicare Prospective Payment System, and so facilities, such as a CAH, that are excluded from the PPS were ineligible for the 340B program. Of course, these facilities will still have to meet the other requirements for participation.

Can you explain what the EHR Incentive Program is all about?

Nearly everyone agrees that using electronic health records is preferable to the paper system. EHR systems can be expensive to implement, however, and the transition can be strenuous in other ways. So, the Federal government created an incentive program whereby it would pay money to providers that made meaningful use of certified EHR technology. This can amount to millions in payments for a single hospital and thousands for an individual practitioner. There are actually two programs, one for Medicare and one for Medicaid. Doctors can only participate in one, but hospitals can receive payments under both, thus generating even more money.

Is the program actually incentivizing providers to adopt EHR systems?

It depends on which providers you're talking about. The program is extremely popular with hospitals due to the large amounts of money they can receive. It is not clear whether it is the program itself that is driving them to make the switch to EHR, however. Most hospitals realize the importance of transitioning from the paper-based system and so would probably do so of their own accord. The incentive program probably has accelerated the process, though. Another reason hospitals are making the switch now is that providers who do not use EHR will see reduced Medicare payments starting in 2015.

With doctors it is somewhat different. For them, potential payment under the program is, at most, around $65,000, which would hardly begin to offset the cost of an EHR system even if it was just for a physician's office. So, in many cases hospitals will bear the cost in return for the doctor assigning their incentive payments to the hospitals. Also, some physicians frankly do not have a significant amount of Medicare patients and so the payment reduction hardly matters to them. What we are finding is that physicians tend to participate in the program as a group.

Your firm does a great deal of work in establishing provider-based clinics. Can you explain the benefits of converting facilities to provider-based?

The primary benefit is that it allows the subordinate facility, usually an outpatient clinic, to bill just like any other part of the hospital. This usually means it is reimbursed at a higher rate in order to contribute to hospital overhead. One of the less appreciated benefits of provider-based status is that it, by its very nature, promotes integration and coordination. These subordinate facilities essentially become part of the hospital and so there is more sharing of information. This is critical to providing patients with better care at lower cost.

Do you see this as a growing opportunity?

For the most part, yes. More providers are taking advantage of this designation. The resulting increase in reimbursement has not gone unnoticed by the Federal government. It is highly unlikely that the payment designation will be abolished or that the qualification criteria will be altered in any significant way. Rather, CMS will likely place greater

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emphasis on ensuring that those facilities claiming to be provider-based actually merit such a status.

I found it interesting that review of provider-based status was dropped from the 2012 version of the OIG Work Plan. This suggests that it is not receiving much emphasis these days regarding audit and compliance. This may be true in so far as CMS is less likely to actively search for facilities that bill as provider-based without meeting the requirements. Still, it is carefully reviewing attestations, which most hospitals make anyway.

Where does care coordination fit into all of this?

Some people say that, in the long-term, care coordination is really the only way to make health care sustainable. It can take many forms, such as Medical Homes, ACOs, payment bundling, or clinical comanagement, but they are all essentially different strategies to reach the same goal. The idea is that providers work as part of a team in order to improve a patient's health while lowering cost.

Like the other programs we have discussed care co-ordination is a method providers can use to improve their financial viability. There are some important differences, however. All of the other opportunities I have mentioned thus far are strictly defined, meaning they apply to certain providers who must do certain things in order to gain a certain benefit. They are specific programs rather than general concepts.

With care coordination, on the other hand, providers are largely free to chart their own course. There are some programs where Federal government has tried to set forth specific rules, such as ACOs, but aside from that the area really gives providers a lot of freedom. There are payment bundling programs that provide basic rules but pretty much leave it up to providers how to design the system. Likewise, clinical co-management arrangements, because they are defined by contract, essentially let providers start from scratch. This is where I see the most chance for innovation.

Do you see clinical co-management as the most promising method of care coordination?

It definitely could be. Aside from allowing the most flexibility, I think co-management agreements do a very good job of aligning incentives in such a way that providers are able to generate savings. These agreements usually involve a group of physicians who form a limited liability company (LLC) which in turn contracts with a hospital to provide specified services and meet specific quality-improvement goals. Cost savings are shared as long as quality standards are met, and so physicians naturally have an incentive to figure out ways to bring down costs without compromising care.

One of the other things that sets co-management agreements apart from other methods of care coordination is the way it can get even greater buy-in from physicians. Like those other methods, physicians share in the savings generated. Unlike those other methods, however, co-management allows physicians greater control of care delivery and more input into administrative issues. This provides extra incentive to enter into and maintain these agreements.

How optimistic are you on these shared savings programs?

I am cautiously optimistic. Accountable Care Organizations were not met with as much enthusiasm as one might have hoped, although certain payment bundling initiatives seem to have more interest from providers. Likewise, many of the governments-sponsored pilot programs have seen mixed results, and so it remains to be seen whether these programs will be able to achieve everything that was promised. I think the most important thing for shared savings programs is to let providers experiment and find out what works.

What do you see as the biggest challenges to the financial viability of providers going forward?

There are specific issues, such as the "doc fix" or financial penalties for not meeting Federal mandates that are lurking in the background and causing a great deal of worry for providers. These are certainly important, but it is necessary to treat the disease rather than just the symptoms. At its most basic, the problem is that providers are expected to do more with less. Certainly there are ways in which they could be more efficient, but unless there is a serious discussion about what we, as a society, can reasonably expect from our health care system, providers will always be under pressure to take advantage of all possible revenue streams.

Dan Yunker

VP & CFO, Metropolitan
Chicago Healthcare Council

President's Message

As we are getting close to the end of the First Illinois HFMA Year (it ends May 31st), I wanted to review with you the many accomplishments of the Chapter this year. Some of the highlights are:

- The development of two **new programs** – Operational Improvement /Supply Chain in September 2011 and Facilities Planning in January 2012
- The development of 12 chapter sponsored webinars
- Another record year in support from our chapter sponsors and meeting sponsors
- Another record year for membership and educational hours
- The development of a chapter sponsored certification study group
- The launching of our new updated website and newsletter
- Great participation by the provider community, especially senior healthcare executives
- Having more fun, with additional social outings and social networking after our educational programs
- A greater awareness of thanks and recognition to all who help make this chapter a success this year

Many thanks to our chapter officers, board members, committee co-chairs and their teams for all of their hard work. It is my hope that you found being a member of First Illinois HFMA a rewarding experience and will continue on into the 2012-2013 year.

Again, my thanks to all of you for a truly enjoyable and successful year!

Very truly yours,

Patrick M. Moran
2011 – 2012
Chapter President,
First Illinois HFMA

Legislation Connection

BY ANDREW DIGATE, HEALTHCARE CONSULTANT, PBC INC.

Typically, an election year brings little if any major legislative activity, either on the state or national front. Politicians are focused on getting re-elected and not creating waves with constituents. However, in this era of increased belt tightning at the state and local level, with concerns about the economy and healthcare reform, previous assumptions can be discarded.

There are many bills at the State level that we are monitoring. While the ILMGMA represents a slightly different constituency than the First Illinois Chapter HFMA, we all share a similar agenda and have issues of commonality.

The biggest bill of concern right now is the **HB 5823 "Lien Act"** which would restrict the legal rights of health care providers in seeking payment for their charges for services provided to an injured person. This bill seeks to repeal this right by limiting the amount of any lien to the reimbursement rate established by the injured party's health insurance company even though this insurance company is not responsible for payment of the claim.

The bill was originally sponsored by Andre Thepedi (D: Chicago) and placed on the docket with the **Judiciary I - Civil Law Committee.** The ILMGMA along with other concerned organizations provided a joint resolution asking for a "NO" vote on this bill. Unfortunately, the bill passed successfully out of the Committee and is now in the House awaiting discussion, debate, and a potential vote sometime in the next few weeks.

While we can't predict the direction of the bill right now, we do know that it has momentum in Springfield since it has garnered additional sponsors and co-sponsors upon passage out of Committee. Additionally, the bill has the backing of the Illinois Trial Lawyers Association. **Whether you are an administrator running a practice or a CFO overseeing a hospital, this is a bill that needs to be defeated.** The bill would also reduce the amount of a lien or other claim that a party would have on an award if the injured party is found to be partially at fault. Whether or not the injured party contributes to their own injury is irrelevant to a legitimate claim for payment of services rendered. In this instance, HB 5823 also requires a lien holder to pay a pro rata share of the injured party's attorney's fees and litigation expenses and bars the pursuit of any unpaid balance. Lien holders should not be responsible for another party's expenses. It should be noted that the Health Care Services Lien Act currently protects a plaintiff's overall recovery because the total of all health care liens cannot exceed 40% of the recovery.

For the latest on this bill, please visit www.ilga.gov and enter "HB5823" in the bill look up field on the left side of this page. Feel free to contact me at 630-928-5228 if you have any questions on this bill.

Other Legislation of note in Springfield:

HB 4478 and SB 2821 ("Physical Therapy Direct Access" bill) – A licensed physical therapist may provide physical therapy without a referral only if the physical therapist is at least 21 years of age and holds a master or doctorate degree or has completed at least 2 years of practical experience as a licensed physical therapist. The bill does stipulate that a physical therapist shall refer a patient to a physician, dentist, advanced practice nurse, physician assistant, or podiatrist if the physical therapist has (i) reasonable cause to believe that symptoms or conditions are present that require services beyond the scope of the practice of physical therapy or (ii) provided physical therapy treatment and upon examination or re-examination the same condition that the person sought physical therapy does not demonstrate objective, measurable, functional improvement within a period of 90 consecutive days.

On the House side, the bill has been sponsored by Angelo "Skip" Saviano (R: Elmwood Park) and has a co-sponsor in Franco Coladipietro (R: Bloomingdale). The bill has moved around a bit since it was originally introduced in January and currently is in the Rules Committee. The Senate version of the bill was sponsored by Iris Martinez (D: Chicago) and has moved around a bit as well since being introduced in January.

SB 2915 ("Surgical Tech" bill) – This bill was sponsored by Maggie Crotty (D: Oak Forest) . Essentially, the bill provides that every hospital and every ambulatory surgical treatment center must employ a surgical technologist or contract for the services of a surgical technologist. While many of these entities already employ surgical techs, we feel that mandating certain staffing models opens the door for additional mandates. Like the Physical Therapy bill, this bill does not appear to be scheduled on any Committee calendar.

The Can Got Kicked…

As we reported in our last column, we surmised that the drastic Medicare cuts would not go through on January 1, 2012. Instead there was a temporary fix that expired on March 1, 2012. A subsequent deal was cut whereby Congress deferred steep physician payment cuts under the Medicare program until 2013. It has left in place a pay formula that could slash physician rates by an estimated 32% next year. The "Super Committee" had debated allocating unspent overseas war funds to cover the more than $300 billion cost to repeal the SGR altogether, but lawmakers could not find enough support for the idea. The temporary doctor pay freeze in the approved package will be paid for by a $5 billion reduction to a federal prevention fund set up under the health system reform bill, reduced payments to hospitals for patients' bad debt, and pay cuts to clinical laboratories (Payment rates for clinical lab services will be reduced by 2% starting in 2013, which will reduce spending by $2.7 billion).

The Department of Health and Human Services and the Government Accountability Office must also issue reports to Congress this year to find a long-term solution to the SGR. The can is getting too big to kick, so we hope that meaningful dialogue will ensue over these months and a beneficial solution is provided to Congress.

In Memorium

BY VINCE PRYOR

David Golom

Our chapter lost a very dear friend, colleague and resource recently when Dave Golom passed away in February of this year. Throughout his long career in healthcare, Dave became an expert in reimbursement that many of us relied upon for guidance and teaching. His ability to find opportunities for additional reimbursement was second to none that I have ever worked with in our industry. More importantly, Dave worked and lived with a passion to succeed while being a very caring and compassionate individual who had a smile and kind word for everyone.

Dave's work with our chapter spanned three decades as he was a Board Member twice, organized facilities for our education programs for several years and most recently worked on the annual membership directory for several years. In recognition of his many years of service, First Illinois recognized Dave with the Medal of Honor in 2007, the most prestigious honor we can bestow upon a chapter member.

Dave was an avid golfer who loved to play, whether that was on the course or the driving range. As you would expect he played well and tended to keep everything straight and down the middle, just the way he lived his life.

I personally feel very blessed that I knew Dave and worked together with him at Ingalls Memorial Hospital and HFMA. He was an individual that was always willing to give of himself to benefit others. Please keep his wife Adrienne in your thoughts and prayers during this difficult time.

Finally, let me just say a very thoughtful "thank you" to Dave Golom, a friend who meant a great deal to me, our chapter and the industry. You will be missed, God Bless.

Optimizing Claim Reiumbursement:
Tips for Liability Claims

BY CLAUDINE NESHEIWAT, DIRECTOR OF BUSINESS INITIATIVES AT CLAIM ASSIST, LLC

It is a widespread goal nationally for hospital leaders to increase financial performance in a changing healthcare financial climate. One subset of business often underrepresented is the liability claim.

Liability claims comprise Motor Vehicle Accidents, Worker's Compensation injuries, and General Liability claims (for example, slips and falls at a grocery store, or dog bites on another's property).

Many times, these claims are more complicated than true health claims, as there may be attorneys involved, insurance investigation, and long-term treatment plans, particularly in cases of traumatic injuries.

Internal hospital resources must understand the way these claims are filed, and how to optimize reimbursement. These types of claims often are not part of the core competencies of the business office staff. The typical biller is an expert with Medicare, Medicaid, and commercial health payers.

Hospital registration

Short of payment acquisition, the account classification is the most critical step in the entire process for liability claims:

- Do not have staff default questionable injuries into Self-Pay buckets. Millions of dollars may be impacted by registrars defaulting an account to Self-Pay erroneously.
- Garner as much **insurance data** as possible from the patient up front. Have staff conduct **bedside interviews** where appropriate. The line of questioning should be helpful to the patient; a stance of patient advocacy is key.
- If possible, create a **patient accident brochure.** This is becoming increasingly popular to patient education on liability claim processing.
- **Run exception reports** based on liability accounts that were misclassified by the registrars. Use **Occurrence Codes** on the UB, as well as **External Cause Injury codes (E-codes).**

Understanding coding

Many times, the story of the accident is in the medical records, documented by clinicians. This information is extracted and coded by hospital medical coders. PFS staff should understand these codes in a basic sense, as a liability situation often may appear in these codes. For instance, Occurrence Code "04" in Box 31 on the UB indicates a work-related injury. Any E-codes in the diagnosis code area, including Box 72, might show an external force causing the injury; for instance, E927.0 indicates "overexertion from sudden strenuous movement." E-codes may also indicate location; for instance, E849.3 indicates "place of occurrence, industrial places and premises."

In the event of Motor Vehicle Accidents, the coding is actually even more specific and finite. Occurrence Codes 01, 02, 03, and 05 represent Motor Vehicle Accidents. For conditions, bear in mind, each ICD-9 gets so specific for MVAs, that the decimal-point figures can tell you the role the patient played in the accident (driver, passenger, bicyclist, pedestrian, unspecified, etc.) For instance, E812.0 represents "Other Motor Vehicle Accident," where the patient is the driver.

Claim Processing

- A philosophy of **close examination** of accounts is key. Each account is unique, and requires more detailed attention than normal. Many times, a vendor strategy that frees up internal staff often works very well to ensure close handling of liability claims.
- Learning **insurer workflows** is important. Insurance carriers examine every liability bill very carefully for many reasons, with the primary goal to save the business money. Every hospital and large physician practice must learn to jump through the hoops that are created. The hospital must verify every stage of the claim's life: receipt of claim by the insurance company, claim status, and payment.
- **Conference call the payer and patient at the same time** so information is heard all at once. This must be done particularly in appeals or stalled claims scenarios, where both parties may simultaneously provide information to move the claim closer to resolution. Patients become especially appreciative of this advocacy as well.
- **Send claims to insurance carriers in multiple ways** – paper, fax, registered mail. Certain states have electronic mandates for Worker's Compensation claims. Keep those electronic submission records on file. Escalate to the State Insurance Department when a payer has inordinate delays or is uncooperative.
- One month to follow up on the insurer's receipt of the claim is too long. **Follow up a few days later** to ensure receipt.
- **Follow coordination of benefits.** For Motor Vehicle Accidents in tort (negligence) states, you must submit the claim to either the patient's auto policy or the at-fault auto policy, depending on what you know first. For no-fault states, the injured party's own auto policy (Personal Injury Protection) kicks in first, regardless of negligence. The insurers will subrogate from each other, depending on ultimate financial responsibility and negligence. **The key is to grab auto dollars first, not health at Day One.** Then submit residual balances to the health carriers. Send conditional notices and bills to health payers (except Medicare. With Medicare, open a segment with their COB department for secondary billing.) For Worker's Compensation, COB practices do not come into play unless the injury is denied by the insurer as not work-related. Therefore, the next action is to pursue the patient's health plan. In the event the patient conducts a tort suit against the employer, see if a lien can be filed in this case.

Lien Filing

- Have a healthcare attorney available to the organization for questions and advice for specific **county filing rules.**

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Optimizing Claim Reimbursement... (continued from page 7)

- **Take a mini "mass mailing" approach with liens.** Send a copy to everyone that is pertinent – the patient, patient's attorney, at-fault attorney, payers, and of course, keep a copy on hand at the facility.
- **File a lien at a certain balance** (not under $250, unless desired by your facility.)
- The lien is an enforcement mechanism to guarantee hospital payment. The lien must be perfected with all appropriate recipient data. First, check county ordinances to see if hospital lien filing is allowed, and what data makes a truly valid lien. Don't nullify forthcoming settlement dollars that your hospital is due to an imperfect lien.

Much more can be said on optimizing liability claim handling. In summary, **have consistent registration practices, identify liability payers, submit claims in multiple ways, and follow correct coordination of benefits guidelines.** File liens in MVA situations where you know a settlement will occur.

These claims are often very complex, and have a longer shelf life than commercial claims. Have the important internal discussions regarding how to dig deeper in the future, and what your future claim handling strategies will be.

Claudine Nesheiwat

ClaimAssist, LLC is a division of The CCS Companies, specializing in enhanced revenue recovery of complex liability claims for hospitals nationwide. To learn more about our No-Cost Financial Impact Analysis, call Rick Roos at 847-918-8602, or Claudine Nesheiwat at 617.965.2000, Ext. 2353.

Revenue Cycle Performance Excellence:
Targeting pre-admission processes to improve billing

BY RICHARD GREENHILL, MBA, MHA, FACHE, CAPM, LEAN SIX SIGMA BLACK BELT

Performance excellence and process improvement were historically seen as tools that primarily fit only in manufacturing. Several models are relevant with TWO taking the healthcare community by storm: Lean and Six Sigma (LSS). Lean is a well documented tool that involves decreasing waste through streamlining processes. Six Sigma can be applied to lean processes to decrease variation, thereby enhancing efficiency. Many critics of LSS often cite the lack of production of a product in healthcare as the reason for their doubt. While there are no widgets or jet engines being produced as in manufacturing, healthcare has a myriad of complex processes that could benefit from tools such as LSS. The truth is that where there are metrics-based processes LSS has broad application. Lean as a tool to decrease waste has utility in several departments that contribute to management of the Revenue Cycle. The principles of lean include eliminating the eight deadly wastes: ***Transportation, Defects, Over-processing, Over-production, Underutilization (employees, etc), Waste, Motion and Inventory.*** So where would a financial manager begin looking to improve processes (i.e., Lean)? The depiction below of the Revenue Cycle shows a high-level view of the main parts.

Under pre-admission, the access department resides and its processes have a monumental impact on billing and collection. By some accounts incorrect/inadequate information gathering in the department are considered the single greatest impediment to accounts receivable collection. Tools such as Lean provide a means to standardize these processes, which would in turn improve the billing process.

The Revenue Cycle

How many steps are involved in your processes? The comparisons on the next page show a complex process before and after applying Lean. In the pre-Lean process, red boxes are steps that would be considered non-value added to the process, the yellow are mandatory steps (such as those required by law), and the green are value added to the process. The post-Lean process shows a more streamlined set of steps needed after removing wasteful steps. After a period of measurement, the post-Lean process can be reviewed and tweaked for variation using Six Sigma concepts.

So maybe you are thinking, "There are other areas in which we have inefficiencies, how do be know which tools to use?" Some clues on which tools are appropriate are provided:

LEAN: This tool is appropriate when there are obvious wastes as listed above and the problem is **KNOWN.** Also this tool is appropriate to redesign broken processes. Examples could be patient check-in/out process, patient flow, transaction/patient claims processing.

SIX SIGMA: This is an advanced tool used when there are well defined processes with metrics where there is variation/deviation and the problem is **UNKNOWN.** Examples could be patient bed days of care-surgical, medicine; performance indicators, wait times, business process cycle times.

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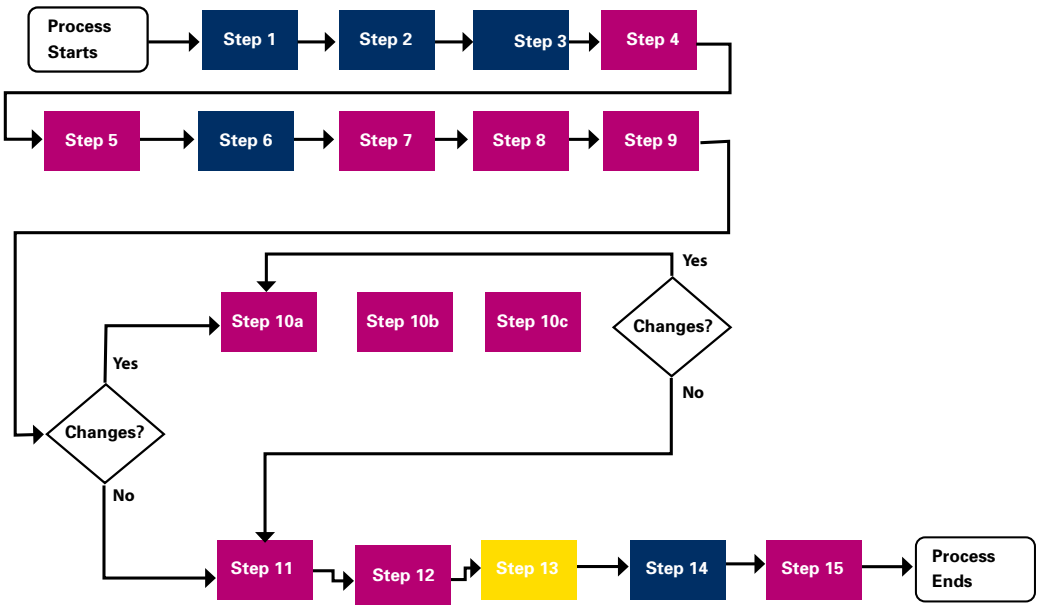
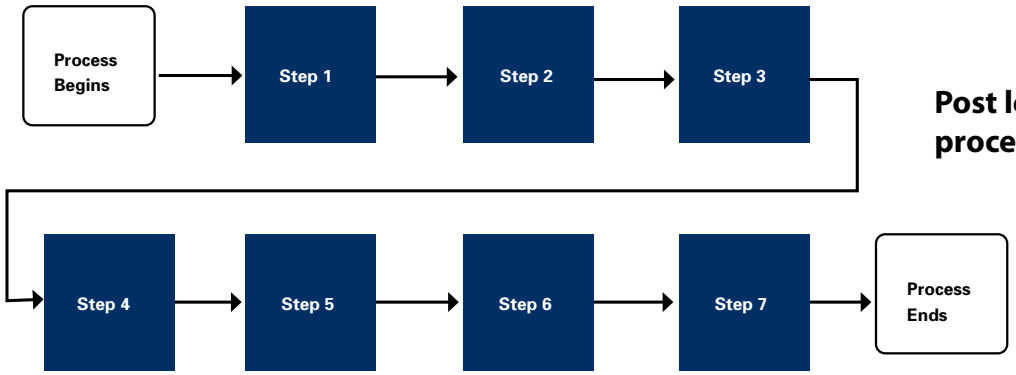
Pre-lean process





Post lean process

Use of these tools requires trained practitioners, leadership support, and a culture of performance improvement/excellence that is non-punitive. It is helpful to note that these tools work, and will only be successful with a systematic approach to implementation and follow-up. Other industries have successfully used these tools and have dramatically improved their efforts and bottom line.

Richard Greenhill
MBA, MHA, FACHE, CAPM, LEAN SIX SIGMA BLACK BELT

2012 OPPS and CPT Changes:
Have You Updated Your CDM?

BY ELIZABETH SCHAUB-DEBLOCK

Hard to believe that 2012 is here already, but it is, and as you read this article, your CDM should have already been updated and financial models been run to estimate the impact that the 2012 changes will have on your 2012 financials. If you haven't done it, do it now. There is no longer a "grace period" for the first quarter to implement any HCPCS changes, and if you are using deleted or outdated codes, you will not be reimbursed. Just a reminder of what is NOT paid under OPPS: Ambulance, Physical Therapy, Occupational Therapy, Speech Therapy, Screening and Diagnostic Mammography, Annual Wellness Visits and Clinical Labs. These continue to be paid under a fee schedule.

Here is an overview of the important changes and updates for 2012:

Conversion factor: There is a final market basket increase of 1.9%. There will continue to be two national conversion factors. One for hospitals that meet the quality reporting requirements, which increases in 2012 to $70.016 from $68.876 and one for the hospitals that do not meet quality reporting requirements, which increases to $68.616 in 2012 from $67.530. This differential emphasizes the importance of adhering to the quality reporting requirements of CMS. The 2012 outpatient deductible is $140.00.

Medicare Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Payment Rate Increases: The RHC upper payment limit is increased from $78.07 to $79.48, effective 01-01-12. The FQHC upper payment limit per visit for Urban FQHCs is increased from $126.22 to $128.49 effective 01-01-12.

Therapy Cap Values for Calendar Year 2012: The BBA of 1997, P.L. 105-33 set annual caps for Part B Medicare patients. Therapy caps for 2012 will be $1880. Remember this is $1880 for physical therapy and speech language pathology combined and then $1880 for occupational therapy.

Status Indicators: Look for HCPCS codes with Status Indicator D, which represents deleted codes for 2012. Many deleted codes have replacement codes, so check to see if this is the case. Status Indicators (SI) are assigned to CPT/HCPCS codes and define how and if the codes are paid under OPPS.

Major code group changes: There were changes that need to be addressed with your clinical staff to the following CPT groups: Audiology, Cardiology, E&M, General Surgery, Neurology, Ophthalmology, Orthopedics, Pain Management, Pathology, Pulmonology, Radiology and Vascular Surgery.

2012 CPT Manual: Read the green text in each section, which highlights the changes that have been made within that section. There are new and expanded tables in the 2012 CPT manual to aid in the coding of the following:

- Evaluation and Management pp.xx-xxiii
- Pacemaker/Implantable Cardioverter-defibrillator pg.171
- Central Venous Access Procedures pg.201
- Qualitative Drug Screening pg.400
- Cardiac Catheterization pp.493-495

Additionally, there is an expanded number of "Coding Tips" found throughout the 2012 Manual. Many codes have been re-sequenced as well.

Molecular Pathology: One of the biggest changes for 2012 is the addition of an entire new section of the CPT Manual, Molecular Pathology. "Molecular pathology procedures are medical lab procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (e.g., constitutional disorders) or somatic (e.g., neoplasia) conditions, or to test for histocompatibility antigens (e.g., HLA)." There are 92 new codes that are designated Tier 1 and an additional 9 new codes designated Tier 2. Lab management should be included in any decisions as to whether a new CDM needs to be developed for Molecular Pathology.

Vascular Injections: There are new and expanded guidelines for diagnostic studies of AV shunts, which now include access and imaging. There are four new codes for selective catheterization of renal arteries for renal angiography, which should be brought to the attention of the clinical staff in Interventional Radiology.

Cardiology: Radiology S&I is now included in all Pacemaker and Cardioverter-defibrulator codes. There are seven new codes specific to dual/multiple leads.

Pain Management: There are new guidelines for Pain Management that includes the use of fluoroscopy, the placement of catheters, and endoscopic assistance during open surgical procedures.

Radiology: There is a new code, 74174, for CTA of the Abdomen AND Pelvis; this complements the new codes added in 2011 for CT

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2012 OPPS and CPT Changes...

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of the abdomen and pelvis. There is some thought that there will be new codes added in 2013 for CT of the Chest, Abdomen and Pelvis when performed at the same session. Three new codes for abdominal Paracentesis (49082-49084) now include imaging guidance. Radiation Oncology: There are three new codes for intraoperative radiation treatment, as well as new guidelines for Treatment Management.

Hydration, Injections and Infusions: There have been revisions to the definitions for Initial, sequential and concurrent infusions; new examples of infusions have been added for clarification purposes; hydration is further defined, and E&M codes that can be reported in addition to infusion codes are specified.

Other changes or additions to be noted are: a new series of casting and strapping codes (29582-29584); 18 new codes that cover biopsies performed during thoracotomy and thorascopscopy codes; audiology evaluation and therapeutic codes have been revised to include time; many pulmonary function testing codes have been bundled together, producing 10 deleted codes and 4 new codes; and last but not least the definition of New and Established Patients for E&M coding have been revised and the definitions for Observation now include "typical times."

Remember, all hospitals are responsible for updating their billing systems each year, specifically in regard to the quarterly changes to HCPCS codes, including the addition of new codes. Don't forget that CMS makes quarterly changes (January 1st, April 1st, July 1st and October 1st) to the HCPCS codes. Make sure that the financial and clinical departments maintain open communication regarding the addition of new services and procedures so that they can be accurately reflected in your CDM and the hospital is reimbursed both efficiently and most importantly compliantly.

BESLER Consulting provides a variety of customized services that can provide the appropriate mix of experience and audits to help with your CDM review. For more information please contact Laureen A. Rimmer at 732.839.8226 or lrimmer@besler.com or visit us at www.besler.com.

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[1]MLN Matters : MM7533, 11-4-11; Medicare Rural Health clinics (RHC) & Federally Qualified Health Centers (FQHC) Payment Rate Increases.

[2]CMS Pub. 100-04 Medicare Claims Processing; Transmittal 2351; 11-18-11.

[3]2012 CPT Professional Edition; pg. 407.

Hospitals of the Future: First IL HFMA, BOMA Present Facilities Program on CFO Capital Decisions

BY VICKIE AXFORD AUSTIN

First Illinois HFMA Chapter members and guests were invited to peer into the future as Gordon Soderlund, senior vice president of Lend Lease DASCO, moderated a morning panel with healthcare executives who offered insights into facilities, capital planning and other issues at the first "CFO Capital Decisions, A Facilities Program" held in downtown Chicago on January 19. Vince Pryor, CFO of Edwards Hospital, Chuck Weis, CFO of Sinai Health System, and Brian Walsh, CFO of Northwestern Medical Faculty Foundation, were the panelists.

This event was offered in conjunction with the Building Owner Managers Association (BOMA) and sponsored by Thompson Coburn, who also hosted the event as well as the networking cocktail hour following the day-long program. Pat Moran, First IL HFMA president, welcomed the capacity crowd and Rosalyn Ryan from CCG LED Solutions, who helped coordinate the event, introduced Gordon.

Gordon lobbed his first question to the panel, "What are we doing about healthcare reform?" and Vince Pryor quipped, "Praying a lot." He said while we may not know what 2014 looks like, "we know it will be less." According to Vince, a hospital's job is to: 1) enhance efficiency; 2) improve quality and 3) grow market share. Hospitals are moving toward outcomes-based healthcare and partner with the people—primarily physicians—who decide how the care is given. In short, he said, hospitals will become more profitable by doing less.

Regarding the Supreme Court decision affecting the healthcare mandate, Chuck Weis said "it just may work," and he emphasized hospitals will have to have capital in order to compete as they transition from fee-for-service. Brian Walsh added that from the practice management perspective, physicians need to get the hospital involved in order to realize efficiencies and improve the use of technology. Hospital/physician integrations can grow market share, he added, pointing to the Northwest Medical Faculty Foundation's recent expansion to Lake Forest.

Gordon asked, "What would happen if the Court decides the mandate is unconstitutional—can we 'reverse the train?'" Chuck responded, "It's moving so quickly, there's no going back." Vince added that insurance companies have geared up to provide their product on the healthcare exchange, "changing the paradigm to narrow the network" and thus making insurance less costly and more attractive to younger, healthier patients.

Chuck mentioned some demonstration projects in the state of Illinois and cited Sinai's national urban healthcare model treating children with asthma, a project which reduced emergency room and hospital visits by 80%. He shared that the Sinai Urban Institute had launched a "block by block" program to get into homes of community members affected by diabetes, people who had no physician, limited access to medical care and who were largely uninsured.

When asked "What's the most difficult feat to achieve as hospitals and physicians integrate?" the panelists agreed it's a question of trust, especially when physicians aren't used to "the red tape" that hospitals experience. Also, communication around working with the payors is an issue and physicians have to work harder to get the same or less reimbursement. According to Vince, it's a different market than it's ever been, adding that Edward has just completed a major integration with DuPage Medical Group as one of their major strategies. "There's more collaboration [anticipated]," Vince said, "and a large portion of my job is to talk with the docs."

How do these healthcare executives create a five-year plan that means anything? "As CFOs," Gordon asked the panelists, "what are you doing to be prepared for the future with all this uncertainty?" Chuck drew a laugh from the audience when he said that at Sinai, they have a 15-day window for planning, adding that at best they can look out three years. Because of the age of their facilities, their biggest question is "Do we build or renovate?" Often they have to improve what they've got and depend on increased efficiencies. Vince shared that his hospital just completed its five-year plan, putting forth its best estimate based on three percent growth in volume. He emphasized again that volume growth will be a function of market

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Hospitals of the Future... (continued from page 15)

share, efficiency and quality. Brian said that as a medical faculty they aren't invested in bricks and mortar but rather in the clinical and research aspects of their business with five percent revenue projections. The physicians and the hospital share a common strategic plan which he said needs to be done every two years.

The discussion turned to facilities and the concept of healthcare retailing at places like WalMart, something that is "no longer a fad but rather a strategy." In the end, they agreed, there's the question—where's the tie to the physician? The panelists said that in this complex market, organizations will continue to be affected by economic woes including decreases in elective procedures, reduced birth rates, a state budget crisis and Medicare cutbacks. Trends will continue to fluctuate with year-end volume increasing due to high-deductible plans, especially in outpatient services.

The CFO panel was followed by presentations about the legal side of facilities planning featuring attorneys from Thompson Coburn, solutions to help reduce facilities cost with presentations by representatives of CCG LED Solutions, Honeywell and Environmental Systems Design, and an overview of the new Rush Hospital facilities program complete with building schematics and a history of the project.

All attendees were given a jump drive with copies of slide decks from each of the presenters. For copies, contact Roslyn Ryan at r.ryan@ccgled.com.

Vickie Austin, founder of CHOICES Worldwide, is a business and career coach and a professional speaker based in Wheaton, Illinois. She is honored to be a contributing writer for First Illinois Speaks, HFMA's First Illinois Chapter's newsletter. You can contact her at 630-510-1900 or vaustin@choicesworldwide.com.

Managed Care: Not Just Another Year March 8, 2012

MC Denise Cameron and Cathy Peterson

MC Joel Shalowitz

Game Changing: The Clinically Focused Revenue Cycle February 9, 2012

Tricia McGinn

Chris Meyers

Dan Powell and Kevin Shrake

John Orsini and Patrick McDermott

CFO Capital Decisions, a Facilities Program January 19, 2012

Chuck Weis Brian Walsh and Vince Pryor

Jay Ramirez Rosalyn Ryan and Cameron Allen

Mission Impossible: Compliance in a Changing Environment January 26, 2012

Bo Martin and Kristofer Swanson

Laura Hoey and David Tolley

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L. Peterson, R. Berg, S. Garcia-Houchins, A. Tomich, C. Glover

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sunday

7:45 PM – 10:45 PM

POST-WELCOME RECEPTION AT HOUSE OF BLUES

Enjoy free admission as well as cocktails and hors d'oeuvres at the House of Blues in Mandalay Bay. This is an opportunity to continue your networking with other 2012 conference attendees after the Opening Reception. Must have a 2012 ANI registration badge to attend. No one under the age of 21 will be admitted.

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monday

7:00 PM – 10:00 PM

ULTIMATE VEGAS PARTY AT EYE CANDY NIGHTCLUB

Join your fellow Conference attendees for this exciting networking event at Eye Candy Night-club, located right in the middle of the Casino floor at Mandalay Bay. Registered attendees will be treated to complimentary beverages and hors d'oeuvres, and will be able to mix, mingle and be entertained by special guests Elvis, Marilyn, and the Rat Pack. Must have a 2012 ANI registration badge to attend. No one under the age of 21 will be admitted.

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wednesday

6:00 PM – 10:00 PM

ANNUAL CHAIR'S RECEPTION AND BANQUET

Join us for the Annual Chair's Reception and Banquet, one of the most memorable events of ANI. Enjoy dinner and entertainment, installation of HFMA's new Board of Directors and the presentation of the Frederick C. Morgan Individual Achievement Award, the Association's highest honor for career-long contributions to healthcare finance and HFMA.

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- First Timers Get-Acquainted Session
- Sunday Opening Reception
- Certification Lounge (current Certified members only)
- Forum Networking Lounge (current Forum members only)
- Interactive Early Riser Sessions
- Lunch and Learn
- Exhibit Hall Receptions (Monday and Tuesday)

HFMA Event Promotions

2012 Events

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Join us for ANI 2012

Register now for ANI: The Healthcare Finance Conference at the Mandalay Bay Resort and Convention Center in Las Vegas. ANI will take place June 24-27, 2012.

ACOs, Round One: Slow coming out of the gate, but what are the potential impacts to your practice?

BY JIM WATSON AND CHAD BESTE

Accountable Care Organizations (ACOs) represented less than two pages of the 2000 page healthcare reform bill, but the concept of ACOs has gotten more attention than any other provision of the bill. Why? Because it stoked the fires of the imaginations of healthsystem and physician leaders around the country as to how they could gain and control marketshare from their competitors through these integrated networks. But there is more fallacy than fact, more legal fees than revenue being generated in the ACO space.

Response has not been exactly overwhelming to the ACO opportunity. CMS recently announced that only 65 ACOs have been approved, with another 150 applications under review. Why the low interest? Because once you get past the initial infatuation of control and total marketshare domination, the reality is that there are more questions than answers, and these are quite expensive answers to pursue with little promise of payback, control or marketshare growth, and frankly, it's a lot of work. Not to mention hesitancy in investing millions of dollars and thousands of hours of time on a strategy that may ultimately be ruled unconstitutional.

Healthsystems pondered several key questions in deciding whether to proceed with an ACO filing: Will ACOs lower cost? Why weren't hospitals or healthsystems identified as an eligible ACO (yet represent the majority of those that filed)? Why does the FTC continue to threaten anti-trust enforcement of ACOs, seemingly with an itchy trigger finger and seemingly in complete conflict with HHS goals in creating/enabling ACOs? How can we manage populations of patients who can't know that's what we are doing via the "patient attribution" model that replaces the requirement of active enrollment in a PCP? What are the practical implications of that if PCPs are allowed to join only one ACO? Are we building this empire only for Medicare patients or will commercial payors contract with us through our ACO as well? And if so, do we need to meet the FTC's definition of "clinical integration"? And the list of questions and uncertainties goes on and on.

So before we can sit down and determine how to split up all those shared savings earnings across 500 physicians representing 33 different practice specialties, and a hospital that is paying the total cost for the ACO party, it is practical that your practice be ready in case someone comes asking you to join their "ACO." Moreover, it is smart to understand the implications of healthcare reform models and ACOs. Here are a few pointers:

- **The importance of an EMR:** ACOs and other forms of "systems of care" will require an EMR for participation so that patient information can be exchanged across the organization. If you have not selected and implemented an EMR by now, it is mission critical that you do so ASAP. If you have been waiting for your affiliated hospital to save you either by providing this EMR to you, or buying your practice to save you from oblivion, that isn't going to happen if it hasn't happened by now.

- **Alignment for Payor Contracting:** While the value proposition of the Medicare ACO continues to be debated, while we wait for the Supreme Court ruling on the constitutionality of the health reform bill, and while we wait to see if anything changes with the November elections, understand that the commercial insurance industry is moving forward with its own flavor of "pay for performance" contract arrangements, some requiring clinical integration and some requiring financial integration. Some payor contracts you will still be able to hold directly with the payor, but for other contracts you will need to participate via an "upstream" entity (i.e., an IPA or PHO that should be clinically integrated and able to manage risk). Your practice will need to participate in and manage fee-for-service contracts, risk contracts, shared savings programs, global payments, bundled payments, episodic payments, commercial contracts, governmental contracts; a significant change to the current payor contract landscape. Knowing both how your practice is ready to manage these agreements and knowing your upstream IPA/PHO alignment options and strategy are critical: Who can bring you the best value with the least amount of effort, cost and risk?

- **The expansion of "mid-level providers":** Think now about your current and future state strategy for mid-level practitioners and patient coaches and nurse navigators to help patient throughput and compliance with clinical protocols and patient engagement requirements. These two pieces of the care continuum when combined with care coordination tools are central to the concepts of "accountable care" or "patient centered medical homes."

- **The changing relationship with referral consultants:** Specialists will be able to participate in multiple ACOs, but Primary Care Physicians can only participate in one ACO. So PCPs need to know their options before signing up for any given ACO. Establish your strategy early for maximizing relationships with your referring specialists; you will have higher expectations about consultant follow-up, care coordination, and other things you didn't have to worry about before. For example, you will need to ensure that you and your referral consultants coordinate care "in network" and manage costs and payor quality metrics together. You may be also challenged in keeping track of which patients you can refer to which specialists, so scheduling and office workflow may be affected.

- **Patient Engagement:** Patients may or may not like the idea of being in an ACO, so you will have to work with your ACO about patient communications strategies that heretofore had really been defined by you and your relationship with the patient. Additionally, you will find yourself having different kinds of conversations with patients, about things like preventive care, lifestyle choices and the potential ramifications of "non-compliance." You will be incentivized to pursue "patient engagement" or "patient

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ACOs, Round One... (continued from page 20)

activation" strategies with your patients and your patient population.

- **Additional technology and workflow changes:** Other technology tools may also be required in lieu of or in addition to EMRs (i.e., patient registries, other data exchange and access platforms). ACO patients will certainly need to be managed differently than other patients, if only in referral and paperwork requirements of the ACO and/or affiliated payor.

- **Defining your long term strategy:** If you feel like your "alignment" options are limited, and you do not want to be employed by a hospital or healthsystem, consider merging with other physicians in your specialty. Recent market experience nationally has shown that large, single specialty medical groups are the most successful model in the physician practice spectrum today, and are more adaptable to the emerging payor contract models and administrative management requirements.

The future is now, and the industry is rapidly changing. Regardless of what happens in the November election or the Supreme Court ruling, healthcare will continue to be a top 3 issue in this country for years to come. Whether you view this as a good or bad thing, the healthcare industry represents 22% of the GDP; there are enormous amounts of money in this industry. Your future success is largely dependent upon successful positioning in the industry and in your marketplace. Successful positioning and long term success begin with a good understanding of the forces driving this unprecedented transformation in the American healthsystem and the industries it represents so that you can develop, execute and maintain the appropriate strategic plan in response.

Jim Watson and Chad Beste are Partners at PBC, Inc., an Oak Brook, Illinois, consulting firm specializing in practice management and strategy. PBC works nationally with medical groups and health systems on physician alignment and ACO/Clinical Integration strategy development and implementation. They can be reached at 630-571-6770 or info@pbcgroup.com.

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A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

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In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

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Publication Date	Articles Received By
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October 2012	September 10, 2012
January 2013	December 10, 2012
April 2013	March 10, 2013

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2012

For a current listing of all upcoming First Illinois HFMA Chapter events, please visit: http://firstillinoishfma.org/events/calendar-of-events/

Friday, April 27, 2012
CFO Breakfast

Tuesday, May 8, 2012
Webinar: FirstSource - Healthcare Reform and its impact on Revenue Cycle

Saturday, May 14, 2012
Golf Outing

Tuesday, June 12, 2012
Webinar: TBD

Friday, June 22, 2012
CFO Breakfast

Tuesday, July 10, 2012
Webinar: TBD

Thursday, July 19, 2012
Recognition Dinner: Petterino's

Tuesday, August 14, 2012
Webinar: TBD

Thursday, August 16, 2012
HFMA 101

Thursday, August 21, 2012
Social Outing: White Sox Game

Tuesday, August 28, 2012
Webinar: TBD

Tuesday, September 11, 2012
Webinar: TBD

Wednesday, September 12, 2012
Golf Outing: Gleneagle Country Club

Thursday, September 20, 2012
OI Supply Chain

Tuesday, September 25, 2012
Webinar: TBD

Thursday, September 27, 2012
Revenue Cycle 101

Friday, September 28, 2012
CFO Breakfast

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