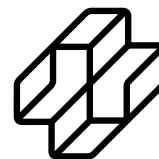


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Regulatory Alphabet Soup: Financial Implications of RACs, MACs, and HACs

By Kathy Johnson

Some of the newest regulations from the CMS deal with RACs, MACs, and HACs. Understanding the requirements and putting processes in place can help hospitals ease the transition to implementation.

New regulations from the Centers for Medicare & Medicaid Services (CMS) may sound like a spoonful of alphabet soup, but recovery audit contractors (RACs), Medicare administrative contractors (MACs), and hospital-acquired conditions (HACs) can wreak havoc on electronic record initiatives, organizational structure, work flow and processes, communication, and education among unprepared hospitals and health networks. Many financial challenges exist, but healthcare organizations can avoid pitfalls and capitalize on new opportunities by proactively preparing for these regulations. Healthcare financial executives should continue to evaluate their organization's preparedness to comply with the regulations and take steps to make the necessary changes as seamlessly as possible.

Financial executives should first determine which regulations pose the greatest threats and which require the most process and procedural overhaul. On the bright side, much of the effort spent preparing for one set of regulations will lay the groundwork required to comply with others, since the transitions happen simultaneously with some working toward the same end. Preparations for RACs, for example, will help prepare organizations for MACs, and preparation for present-on-admission (POA) regulations can help smooth the way for HACs.

RACs

Of these government initiatives, RACs have received the most attention, and organizations should already have this transition behind them or be well on

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COMING IN NOVEMBER

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their way to being prepared for the associated financial and compliance threats. CMS developed the RAC program to identify and correct past improper Medicare payments, reduce future improper payments, and improve its error rate.

During the three-year demonstration project, CMS collected \$900 million in overpayments and just \$38 million in underpayments, demonstrating the high stakes RACs represent for hospitals and health networks. However, although financial incentives for RACs were initially awarded only for overpayments, those incentives now include underpayments as well. It is hoped that this means RACs will provide a more level opportunity for hospitals and health systems moving forward.

Still, inpatient and outpatient claims through March 2008 cost hospitals for the following inaccuracies:

- > Incorrectly coded claims: \$331.8 million
- > Medically unnecessary services: \$391.3 million
- > Missing or insufficient documentation: \$74.3 million
- > Other, such as duplicate claims and unbundling: \$160.2 million

The RAC program is being rolled out by regions. RACs took effect in the first group of states in March 2009, and most hospitals should already be proactively reviewing the claims data to identify and correct risk areas. RACs can affect the entire organization, and finance executives should look to their RAC and health information management groups to ensure proper preparations are being made. Here are a few key strategies:

- > Appoint a RAC point person or liaison—someone who is able to work effectively across department lines as well as up and down the organizational structure.
- > Establish a workflow process using a tracking tool to ensure time-sensitive steps are not missed.
- > Monitor one-day stays for medical necessity, clear physician order for inpatient or outpatient status, and proper billing.
- > Establish an ongoing coding review process of RAC targets, such as excisional debridement, infusion and injections, reversal of colostomy/colostomy take-down, and transbronchial biopsies.
- > Engage a physician champion to educate medical staff members on clinical documentation practices and report the impact of clinical documentation efforts.
- > Periodically conduct accuracy audits for outpatient units billed.

Although the task may seem daunting, especially with more regulations to follow, much of the work done to prepare for RACs will also pay dividends for the MACs rollout.

MACs

Once in effect, MACs will replace fiscal intermediaries and should be fully operational by March 2010. The MAC program aims to improve customer service for hospitals and health systems by offering a single CMS point of contact and increasing provider education and training to improve claims accuracy. Similar to RACs, the MAC program also aims to increase payment accuracy and is expected to generate approximately \$1.4 billion over five years. Also similar to RACs, the MAC program rollout will happen in stages over various regions, and national jurisdictions are configured the same way as RACs. Unlike RACs, however, the MAC program is focused on current, individual claims, rather than retrospective and aggregate claims data.

The MAC program restructures how hospitals and health systems process claims, and during an organizational transition to accommodate MACs, many departments will be affected. Because MACs focus so heavily on the claims process, executives should look to their patient financial services and revenue cycle departments to ensure that necessary adjustments have been made. Here are a few key strategies:

- > Keep abreast of any claims submission or code changes, such as the new patient status code 21 that goes into effect Oct. 1, 2009. Patient discharge status code 21 usage includes transfers to incarceration facilities such as jail, prison, or other detention facilities. Note that for inpatient prospective payment system (IPPS) hospitals, the post-acute transfer payment policy will *not* apply to claims that contain discharge status code 21.
- > Review and educate on revenue codes, clarifying the types of bills each revenue code may be used on.
- > Conduct periodic checks of interfaces to avoid errors due to failure of data to

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Revenue Cycle Strategist is published 10 times a year by the Healthcare Financial Management Association, Two Westbrook Corporate Center, Suite 700, Westchester, IL 60154

Presorted standard postage paid in Chicago, IL 60607.
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Volume 6, Number 9

Subscriptions are \$110 for HFMA members and \$165 for other individuals and organizations. Subscribe online at www.hfma.org/rcs or call 1-800-252-HFMA, ext 2. To order reprints, call 1-800-252-HFMA, ext. 387.

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Revenue Cycle Strategist is indexed with Hospital and Health Administration Index and the HealthSTAR database.

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ISSN 1549-0858

cross from one application to another—from the health information management abstracting to claims or from the emergency department electronic record to the billing application.

- Include monitoring the MAC web site for your jurisdiction in the responsibilities and duties of a designated role.

By the March 2010 target, 19 MACs will be in place to handle claims for Medicare Part A, Part B, and durable medical equipment suppliers. As these new contacts take over, hospitals and health systems have the opportunity to start fresh and build key relationships with their CMS representatives. With just 19 MACs nationwide, executives should take advantage of any face time to ensure open communication and transparency with their contact.

HACs

Just as preparation done for RACs can help organizations prepare for MACs, previous POA regulations should give hospitals and health systems a leg up on HACs.

In October 2008, CMS got much tougher with HACs. CMS no longer provides reimbursement over and above the typical IPPS rate for care required to battle several types of HACs. Under these new regulations, CMS emphasizes value-based purchasing, holding hospitals accountable for and compensating on the basis of the value of care they provide patients. Therefore, any cost of treating a condition acquired during an inpatient hospital stay that was reasonably preventable is the hospital's responsibility and will not be paid by Medicare or the beneficiary. CMS made no changes to the list of HACs for FY10. (See a list of HACs at www.hfma.org/rcs.)

For example, catheter-associated urinary tract infections (CAUTIs) are the most common nosocomial infection and

account for approximately 40 percent of HACs, according to the National Center for Health Statistics. One out of four hospitalized patients will have a urinary catheter placed during their hospital stay, and a single incident of CAUTI will add \$500 to \$1,000 to the direct costs of acute-care hospitalization. Additionally, CAUTIs are the second most common cause of nosocomial bloodstream infection, which on average costs hospitals \$26,839 for each affected patient, according to 2006 research.

Although Medicare will not reimburse for the initial HAC, it will pay for physician and other covered items or services needed to treat the HAC, including the costs of post-acute care that would not have been needed for the patient's initial medical problem but is needed because of the HAC.

CMS maintains a list of "never events"; the agency will never reimburse a hospital or health system for unnecessary procedures related to these events (www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863). Examples of never events include surgery on the wrong body part, surgery on the wrong patient, or the wrong surgery on a patient. Unlike the HAC provisions, which affect only payments to hospitals for inpatient stays, the national coverage determination for never events may affect payment to hospitals, physicians, and any other health-care providers and suppliers involved in the erroneous surgeries.

Organizations that prepared for POA regulations should be well positioned to manage HACs. POAs are defined as any condition being present at the time the order for inpatient admission occurs, and beginning in October 2007, all IPPS hospitals were required by CMS to submit POA indicator information for all primary and secondary diagnoses. From

WEB EXTRA!

See list of HACs at www.hfma.org/rcs.

January 2007 to March 2008, CMS processed POA indicator data and educated IPPS hospitals on reporting errors. Since April 2008, however, CMS has been returning all claims lacking proper POA reporting.

HACs have the potential to cause enterprisewide impact and should be addressed as such. Executives should be working to address the issue from the point of care through coding, making sure physicians and other individuals affected understand the regulations, their role in managing them, and potential implications. For example, many may be surprised to learn that certain conditions are not classified by POA requirements as HACs. Any conditions acquired in an outpatient setting, such as the emergency department, just prior to the inpatient admission, are not classified as HACs, but hospitals may not receive entitled reimbursement in this situation if, for instance, coders misrepresent these outpatient developments as HACs.

Like any transition, preparing for RACs, MACs, and HACs causes anxiety and requires the time of many throughout the organization. RACs, MACs, and HACs can positively or negatively affect many hospital initiatives, but the efforts to prepare for these various regulations should never occur in a vacuum. By looking at the whole, rather than the sum of the parts, financial executives can alleviate stress and put processes in place to make the transitions easier for everyone. ☞

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Reprinted from the October 2009 issue of **revenue cycle strategist**.
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