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healthcare financial management association

Patient Accounts Problem Solving and Program Committee
Oregon HFMA Spring Meeting

May 17th, 2017
(Pacific)
Conference Room:
Salishan Resort and Spa
Gleneden Beach, Oregon

Attendees:
Bickle, Tammy; Ceryance, Coon, Tammie; David; Davis, Brittany; Descmber, Terry; Eagles, Carla; Emerton, Mary; Fernandez, Gordon, Amanda; Jorge; Hans, Liana; Honzay, David; Howard, Teri; Humphrey, Tyler; Kernutt, Lori; Kimmel, Melony; Martin, Evan; Mitchell, Ken; Navigato, Matt; Rouse, Kathryne; Semeniouk, Diana; Shultz, Hollie; Sloan, Patrick; Stewart, Jeremy; Swank, Kristi; Tommer, Tara; Vos, Janet; Whitlock, Ruth

Time	Description	Facilitator
2:30pm	Welcome	Evan Martin
2:35Pm	Introductions of New Chairs and Co-Chairs:	Amanda Gordon
2:35pm	Patient Solving Questions and Answer Session	Evan Martin
4:00pm	Program Council Topic Session	Ken Mitchell

Patient Accounts Problem Solving:
Past Chair: Amanda Gordon angordon@lhs.org
New Chair: Evan Martin evmarti@lhs.org
Co-Chair: Brittany Davis: Brittany.davis@modahealth.com

Patient Accounts Programs:
Past Chair: Ken Mitchell Mitchken@ohsu.edu
New Chair: Kathryn Rouse Kathryn.Rouse@providence.org
Co – Chair: Amanda Gordon angordon@lhs.org

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1. **Is anyone billing deep sedation in their Emergency Room? If so have you had any problems.**

   Providence bills deep sedation in the Emergency. There were no related issues known. Using appropriate documentation and modifiers. Internal edit in Epic to error for 100% for the CDM person. Created a Rev Guardian edit check, to also trigger for another level of review. Regina Olson is a good person for follow up at Providence.

2. **For those who manage Coding/CDI areas……what is the typical best practice for coding (vs cdi) physician responses, etc.? (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**

   OHSU engages with Advisory Board. Matt will share this with Terrie. Matt will follow up with advisory board, to see if information can be shared. 93% response rate, average should be above 92%. Kelly Smith manages the CDI department right now.

3. **Point of Service best practices in our local community (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**
   a. **Requesting POS at all pt access/pre-reg areas**
   b. **Requesting prior balance payments**
   c. **Offering pmt plans (as well as Fin Assistance)**

   Willamette Valley-McMinnville offering payment plans and financial assistance prior to service. Upfront collections on all payer types. Also, offer a 20% discount for pre-payment. Goal is 2% of A/R.

   Peace Health- financial clearance- Angela hillbebrand is a good reference.

   Orthopedic Clinic, call ahead of time and tell them balance. Do offer payment plans.

   Asante- doesn't call ahead of time. Offer financial assistance and payment plans.

   Providence is looking to build a financial clearance center. Looking at bringing in any health score segmentation. Seems to be a lot of success with pre-reg on Saturdays

   Legacy- Goal to call five days in advance. Prompt payment discount of 10%, doesn't have to be paid at time of service, but one lump sum upon receiving statement.

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4. **Call Center best practice….hold times & abandoned rates (how to you define abandoned call)? (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**

   Providence-80% of calls within 90 seconds or less. IVR solution that is taking all calls by phone. Abandon rate 10% is less than 10%, usually about 5%. 7am-7pm Monday through Friday.

   Tara Toomer Salem health will provide data. Hold times less than 2 mins. Abonnement rate at 15 seconds, if caller hangs up prior to fifteen seconds, call not counted. For ambulatory after recorded message plays.

   Legacy-Abandon rate is 10%, everything counts towards abandon rate, two-minute hold time or less. Consistently around 90 seconds.

5. **Denial Mgmt – org structure and database for specific denials received outside of 835 – i.e. letters etc.….predictive analytics? (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**

   Denials for BX- pre-managed no more denials here. Denial for no signed physician order, denied for no electronic signature. Flagging the chart notes with a sticky. Needing to keep duplicated copies. No auth-attached the auth, had a fax that said received and fax back. Going through two different appeals process, one internal and one external.

6. **3D Mammo update (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**

   MODA-Medicare, OEBB, PEBB starting 4/1/17 (cover 3D). Plan to implement as covered of 1/1/18. Medicare/Medicare advantage. Everyone thinks that VA and Tricare, should be following by Medicare but doesn't appear to be happening. Blue cross Federal also covers 3D. All providers this creates huge public relations nightmares. Providers are writing charges off, and have an agreement with the imaging providers to write them off (reading fees).

7. **CODING AUDITS (data based to coordinate annual (etc.) provider audits and frequency, etc.) (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**

   HCC Programs off the ground. HRNW has been very helpful with education to coders, departments, education to providers. Helps providers understand how important HCC.

8. **How do other providers handle med necessity denials/cont adj based on social pt issues—where does it point to on their GL. (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**

   Medical necessity write-offs, everyone would like charity. However, currently they are writing this off to non-covered services. Each provider will follow up with their legal team.

9. **What types of training programs other organizations have, and how they are supported as far as from an FTE standpoint (Submitted by: Amanda Gordon, Dir Pt Access Telecom HIM, Legacy Health)?**

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Not Asked

10. **How are providers (other facilities) approaching DMAP CAWEM claims that are urgent transfers from other facilities? We are finding that CAWEM rejects our requests for additional claim review stating that these are not marked as Emergent admissions (Admission Type 1). These claims due to being submitted as an Admission Type 2, which indicates that the patient was an urgent transfer (perhaps having been stabilized at another facility but transferred to Legacy for an escalation in care needs). We understand that their system does not accept Admission Type 5, but what is the process other facilities are employing to argue their urgent admissions? (Submitted by: Mariam Baig, Manager, Hospital Billing & Follow Up, Legacy Health)**

    Angel is taking this to the Medical Director review board at the state. If it's an internal transfer, we will use the admission type. Take it as a denial and will write it off at that point in time. Add email info on minutes.

11. **We are holding patient that no longer qualify for inpatient services or obs status while looking for placement. How your organizations do handle the high dollars that are potentially lost? Do you count this type of denial towards charity dollars? Or do they simply end up as medical necessity write-offs? (Submitted by: Heidi Sheppard, Patient Business Services Analyst, Legacy Health)**

    All hospitals would prefer charity. However, currently they are writing this off to non-covered services. Each provider will follow up with their legal team.

12. **Moon Form how are you delivering MOON form to patients (Care/UR Mgmt or Patient Access)? What lessons learned would you have able to share? (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**

    All facilities concur they are having Care Management deliver these forms. OHSU has minimal involvement, but started out on a larger scale.

    Some organizations began with Patient Access, however there were too many questions related to status changes. Patient Access staff didn't feel equipped to handle these changes. Everyone concurs this is care related.

    OHSU, Salem Health, Legacy Health, Tuality, Willamette Valley, Providence, all have Care Management.

13. **For the payors in the room, how do you determine which CARC/RARC codes to use on a claim. Changes and inconsistency of codes complicate programing the system to take appropriate action without multiple touches (Submitted by: Carla Eagles, PFS Supervisor, Salem Health)**

    Salem Health to send over to MODA and different payors are using the same codes for different things and the remark codes provides that the denial is. Brittany (Moda) will follow up and provide information and

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payors don't have internal communication on this. OHHA had some of this work standardizing payors (Tammy B OHSU) will provided contract information

14. **CMS Ruling on Series Accounts as of January 1st, 2017: See attached handout. How are you responding to this? (Submitted by: Jenny Stewart, Compliance Manager, Legacy Health)**

    Just now coming onto the radar. The group believes ICD10 accounts may have led to this as there is more specificity. Group wonders if this has been communicated to patients as it would likely have an impact on their out of pocket. This could affect: PT/OT, Infusion, Wound Care, Bariatric, and Radiation Oncology. More to come at next meeting.

15. **Care Management- who do they report to? Do they report to Rev Cycle? Best practices on how they work together?**

    Engage the group work with trends on denials with CDI. Denials management taskforce. Diverse team including, nursing, providers, etc.

Roundtable Additional Topics:

16. OHSU- final draft for room and board policy, what is included in bed charges? Lots of discussion with labor and delivery. When billing delivery do you just move room charge? Are you charging for the additional staff during the actual delivery? Group concurs billing for both. Some are time based charges. If it exceeds 24 hours of labor.

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News & Analysis
Q&A: What's changed with recurring or repetitive claim payments?
May 10, 2017
Medicare Web
Q: Our billing office has noted that we have many recurring accounts that have seen a huge drop in reimbursement over the past couple of months. We have noted that our outpatient physical/speech therapy and speech-language pathologist accounts aren't affected, but our wound care accounts are. What changed?
A: This is the result of CMS changing the application of comprehensive APC (C-APC) packaging methodology at the claim level. CMS reminded hospitals in the 2016 OPPS final rule that only certain services designated as "repetitive services" would be exempt from these payment applications.
As noted in the 2017 OPPS final rule, packaging is now being applied at the claim level rather than for each date of service. Based on your question, you are billing wound care services on a recurring/series account. For example, if you billed a service (e.g., CPT code 11044 [debridement, bone; first 20 sq. cm. or less]) with status indicator J1 (hospital Part B services paid through a C-APC), all the services on the claim will package into the J1 service. If you bill a combination of status indicator T (paid under OPPS; separate APC payment) services, the standard status indicator T methodology will apply–the first service will be reimbursed at 100% and the remaining will be discounted 50%.
Providers have long viewed services such as wound care and chemotherapy administration services as "series" or "recurring" services, and in some respects this is a true statement. However, CMS has reminded providers that there is a specific list of services that are considered "repetitive" for claims processing purposes. While its claims processing system will allow monthly billing of other services that are not on the list, the definition of "repetitive" does not apply for actual adjudication of the claim. It will adjudicate the claim based on standard OPPS methodology.
CMS' list of defined repetitive services is located in the CMS Claims Processing Manual (Pub. 100-04), chapter 1, section 50.2.2.
Editor's note: Denise Williams, RN, CPC-H, senior vice president of revenue integrity services at Revant Solutions, in Fort Lauderdale, Florida, answered this question.
Need expert advice? Email your questions for consideration in the Revenue Cycle Daily Advisor. Note: We do not guarantee that all questions will be answered.
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