Improving Hospital Outpatient Payment

Radiology department administrators are at a crossroads. Since implementing the Outpatient Prospective Payment System (OPPS) in 2000, they have worked diligently to improve outpatient payment outcomes, yet they have seen little positive impact on the bottom line.

This is not an insignificant issue for hospitals. According to national statistics, Medicare typically accounts for at least 40% of outpatient revenues. Meanwhile, demand for radiology services continues to grow. Overall volume is increasing, fueled largely by accelerating requests for higher-cost services such as MRI and CT. Unit costs within many department have increased as well.

Growth trends in imaging services were recently identified by the Medicare Payment Advisory Commission, yet many US hospitals report that average reimbursement for various radiology procedures has actually decreased during the last 3 yearsdespite increases in service delivery costs. Moreover, according to the Health Financial Management Association (HFMA), unless hospitals act to stem the tide, this trend will continue. What follows is an attempt to identify why this is occurring.

OPPS CHANGES EVERYTHING

Services paid under OPPS are assigned to Ambulatory Payment Classifications (APC). Each APC is linked to a payment amount representing the total reimbursement a hospital receives for the procedure. To provide additional funds for new medical devices not recognized by APC, a temporary “pass-through” payment process has been established. Following a proscribed period, the pass-thorough payment is bundled into the APC.

Table 1. Trends in improper CMS payments (by category). Source: US Department of Health and Human Services.

To accommodate OPPS requirements, hospitals have had to reengineer their Medicare outpatient billing methods. For example, under this new order, facilities must report by line item and by code each outpatient procedure they perform. Although physician practices have used this system for years, it is new to hospitals, especially at the clinical department level.

What does this mean for radiology administrators? As pass-through device payments are bundled into APC payments, hospitals will continue to grapple with reduced payments because of the averaging process that determines APC rates. Other factors add only complexity and uncertainty to the equation:

- OPPS rules are frequently updated, requiring constant vigilance by those submitting payment requests.
- Deeper expertise is required to understand OPPS’ ever-changing, detailed billing rules, and to interpret their applicability to radiology and imaging facilities.
- And increased procedure volume leaves fewer resources available to keep up with billing rules that are hard to track and seem irrelevant to patient care.

Not surprisingly, such extensive changes carry the potential for error. A 2001 report? by the US Department of Health and Human Services Office of Inspector General, “Improper Fiscal Year 2001 Medicare Fee-for-Service Payments,” (Table 1) revealed the three most common reasons for improper payment of hospital outpatient claims:

1) documentation errors

2) medically unnecessary services (usually based on documentation errors)

3) coding errors

Based on these facts, the prognosis for radiology departments looks grim. Unless improvements are made to a department's fundamental approach to reimbursement, expect to fight a perpetual uphill battle. How can a department turn the tide? The solution lies in establishing a system that aligns itself with sound clinical practices.

THE CLINICAL CONNECTION

Across the country, hospitals are coding inaccuratelyor not at allfor many radiology services. This means that they lose all or part of many Medicare payments they have earned. Furthermore, because CMS uses these claims to set payment rates, the inaccuracies lead CMS to base future payment schemes on faulty claims data. The system's integrity depends on the degree to which clinical staff members assume front-line responsibility for assigning accurate procedural and diagnosis codes. In fact, coding can be viewed as a natural extension of the clinician's role.

Figure 1. CPT and ICD-9 codes ensure payment is generated when properly linked.

Most physicians and clinical staff focus on ensuring proper testing as an integral component of good patient care. This wealth of clinical information is a precious asset the billing department can also leverage to maximize reimbursement levels. But clinical insight is the key. Without full and accurate representation of clinical information, revenue capture is seriously jeopardized.

CODING UP CLOSE

Because payments are based on codes reported, it is important to understand the essentials of code selection. Two primary coding systems are used to report services:

1) Current Procedural Terminology (CPT), which describes services or procedures rendered;

2) International Classification of Diseases, 9th Revision (ICD-9), which classifies thousands of diagnoses, conditions, and procedures.

When properly linked, CPT and ICD-9 codes ensure payment is generated. (See Figure 1)

For every imaging patient, clinical professionals must obtain accurate "front end" input to perform proper testing. Understanding the reason for a diagnostic examination is paramount to successful diagnosis and treatment. The same should hold true for coding. Both clinical staff and physicians can add value to the process without becoming overwhelmed by rules and details. Their role is to provide the initial code selection. The billing department can then step in with specialized expertise to verify that the code selection is accurate and applicable. This integrated communication flow creates a strong, informed check-and-balance process to minimize denial of payment.

A CLOSER LOOK

For perspective on how to approach this challenge, consider how a hypothetical? facility could improve the outcome of a recent case:

Case Study: An internist refers a patient to the radiology department for a pelvic ultrasound. The order states "pelvic ultrasound for pain."

- The receptionist schedules the examination using that indication.
- The sonographer performs a pelvic ultrasound.
- The patient provides no additional medical information.
- During the transabdominal pelvic examination, the sonographer notes a “suspicious area” and performs a transvaginal examination to investigate. She determines the suspicious area is artifact.
- When finished, the sonographer reports the CPT procedural code for a pelvic ultrasound (76856) and an ICD-9 code for pelvic pain (625.9-unspecified symptom associated with female genital organs).
- The physician dictates a report for both examinations with normal findings.
- The information is forwarded to the billing department.

There are three possible negative outcomes for this scenario:

1. If the billing department reports only the pelvic ultrasound, the medical center does not capture payment for a service that was performed for the right reason.

2. If the billing department reports both codes, one may be denied because the nonspecific code does not support both tests.

3. If the claim is audited, questions may arise from the lack of a written order for a separate transvaginal examination.

Analysis: This department has lost an opportunity to identify and correct the problem because numerous missteps occurred at the front end of the service. Examine the weak links in this chain of events.

Roadblock No.1: Diagnosis coding (ICD-9)

The referring physician indicated only that the patient complained of unspecified pain. This prompted the billing department to use the nonspecific ICD-9 code chosen by the sonographer. Nonspecific codes do not accurately reflect medical necessity. Therefore, payment will likely be denied, and the implications include:

- From a clinical standpoint, the sonographer probably could have tested more effectively if the physician had provided details about why he ordered the test. Useful information could have included physical examination findings or medical history notes.
- From Medicare’s perspective, without specific indications and findings, the test may not be medically necessary.

Roadblock No. 2: Procedural coding (CPT)

Two procedures were performed, yet the sonographer captured only one. Will the billing department revise her code selection? Specific concerns are:

- The radiology department’s protocol is to perform a transabdominal pelvic ultrasound unless the order also requests a transvaginal ultrasound examination. (Exception: If the sonographer requires clarification and better visualization or if it is required for certain pathology, a transvaginal examination is appropriate.) In this scenario, the sonographer performed both tests.
- Because the sonographer did not note any abnormalities, and the physician’s report confirmed her findings, she did not report the additional code for the transvaginal examination.

- The sonographer reasoned that, because she did not receive a specific order for a transvaginal examination, she did not need to provide a specific code. Fur-thermore, because the findings were normal, she was concerned that reporting it would signal unnecessary testing.

Roadblock No 3: Medical record documentation

There was a discrepancy between the examination order and the actual tests performed. The following specific concerns would arise in this circumstance:

- The physician made an interpretation based on two examinations because results of both were presented to him. However, the referring physician originally had requested only the transabdominal examination.
- The sonographer had included a note saying she had been concerned about the “suspicious area,” but the physician did not include this in his report.

If the transvaginal ultrasound payment is denied, the hospital will lose $83.38 (the national payment rate) in direct revenue from Medicare. And depending on the follow-up required, the department will face indirect labor costs to resolve open issues associated with this case. The cost avoidance potential for this submission seems relatively small. However, if the hospital’s error rate is high, the cumulative impact could be significant, considering all procedures the department conducts each year. And imagine the increased productivity and cash flow the facility would enjoy if it avoided even a fraction of these lost-income transactions annually.

LESSONS LEARNED

What specifically can be done to prevent this situation in the future? The various disconnects can be avoided by raising awareness and promoting interaction among physicians, clinical staff, billing staff, and reception personnel (see 11-Point Plan, below). As hospitals like the institution described struggle to do more with less, the bottom line dictates that they cannot afford not to help clinical staff embrace critical payment processes. Even an incremental improvement can have a dramatic effect.

11-Point Plan to Improve Reimbursement

The following11-point plan is designed to improve radiology department reimbursement effectiveness.

Education

1. Teach reception personnel how to identify indications that lack specificity (and are therefore denied payment). Encourage them to seek information about a patient's symptoms and relevant history.

2. Familiarize referring physicians with common examination indications and best practices in order submission.

3. Provide physicians with ongoing training about general rules of coding and documentation specific to their area of expertise.

4. Offer clinical staff ongoing training and publications about general rules of coding.

Communications

5. Facilitate collaboration among physicians, clinical staff, and reception and billing personnel to promote better understanding of each function's role in the process.

6. Routinely gather all team members to review relevant payor updates and code revisions.

7. Encourage ongoing communication between the billing department and physicians about the accuracy of medical record documents.

8. Devise and distribute reports that pinpoint differences between billing department submissions and codes selected by the radiology department.

Process

9. Update the chargemaster at least annually, especially when new codes are issued.

10. Create a system that documents clinical staff revisions to an order, changes to the protocol, and/or modifications to examination indications. Ensure that this information is accessible to the billing department.

11. To support code selection decisions, establish written policies about examination protocols and appropriate indications.

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