Meghan Yeager
Reimbursement week 7

Chapter 9 Outline and Learning Objectives

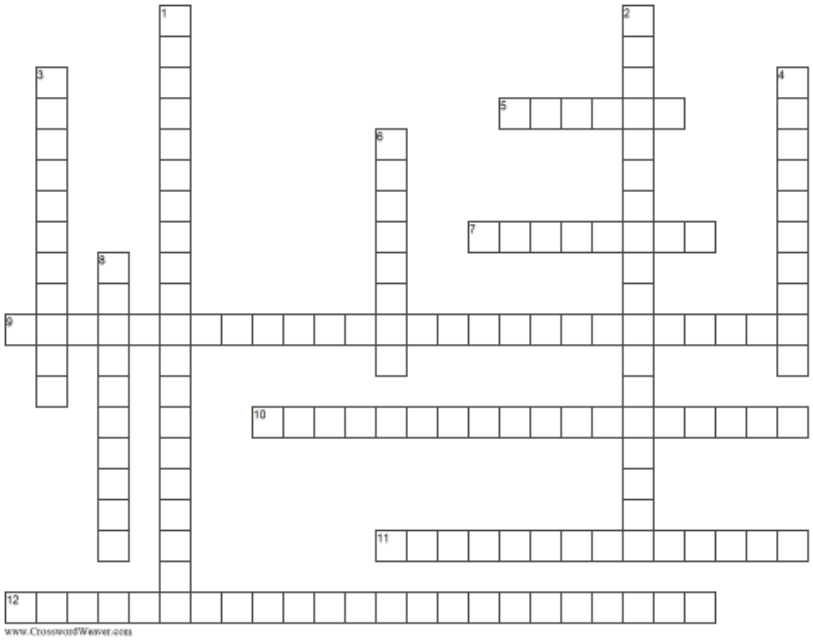
Application and Data Analysis Exercises

Application and data analysis exercises are provided at three levels of understanding. Basic exercises focus on Bloom's Taxonomy levels 1, Remembering and 2, Understanding. Intermediate exercises relate to Bloom's Taxonomy levels 3, Applying and 4, Analyzing. Advanced exercises are presented at Bloom's Taxonomy levels 5, Evaluating and 6, Creating. Intermediate and advanced exercises require critical thinking and analysis of data or scenarios.

Beginner Exercises

1. Key Term Crossword Puzzle (Level 1 – Remembering)
Fill in the crossword puzzle with chapter 2 key terms by using the provided hints.

Chapter 9 Key Terms



ACROSS

5 The price for a hospital service
7 Individual line of a CDM that is comprised of all the required data elements
9 Reimbursement and medical necessity policies established by MACs
10 Often monitored by 30 day increments
11 Hospital specific code that designates the third-party payer for a patient
12 Area identified for needed improvement through benchmarking and continuous quality improvement

DOWN

1 Logic within software that evaluates hospital outpatient claims data for inconsistencies and other errors
2 Documents used by CMS to communicate policies and procedures for prospective payment systems' program manuals
3 Four digit billing code that categorizes charges based on type of service, supply, procedure, or location of service
4 Uses of the CDM to code repetitive or noncomplex services
6 Internal claim auditing system used to ensure that claims are complete and accurate before submission to third party payers
8 Hospital specific code used to identify an item or service

2. Understanding the Revenue Cycle Components (Level 2 – Understanding)

Complete the following table using information from the text. To complete the Tasks and Example Employee Positions categories, brainstorm functions and positions that you believe would be included in the RC Component.

RC Component	Description	Tasks	Example Employee Positions
Pre-Claims Submission	Preclaims submission activities comprise tasks and functions from patient registration and case management areas.	This portion of the RC is responsible for collecting the patient's and the responsible parties' information for determining the appropriate financial class, for educating the patient about fiscal responsibility, collecting waivers, and for verifying data prior to services.	When a Medicare patient arrives for admission into the cardiology unit for services, the admitting representative is responsible for collecting the patient's demographic data and Medicare beneficiary identifier.
Claims Processing	Claims processing activities include the capture of all billable services, claim generation, and claim corrections.	All clinical areas that provide services to a patient must report charges for the services that have been performed.	A physician sees a patient in the hospital, and after 30 min of care and diagnoses with HTN. Bothe the HTN diagnosis and the 30 min of care translate into separate codes which are eventually submitted for reimbursement.
Accounts Receivable	The AR department manages the amounts owed to a facility by patients who receive services but whose payments will be made at a later date by the patient, the guarantor, the third-party payer.	Once a claim is received by the TTP, the insurance processing of the claim begins, in addition to processing the claim for payment, the TTPs prepare an explanation of benefits that is delivered to the patient. After the claim is processed by the TTP, a remittance advice is electronically returned to the provider with an electronic form.	A patient has services provided at the hospital. The next week the patient receives an itemized list of services provided and of what they cost. Then at the doctor's office they receive a RA via fax that tells the doctor's office what was covered.
Claims Reconciliation and Collections	The healthcare facility uses the EOB, MSN, and RA to reconcile accounts.	In this process the facility compares expected reimbursement to the actual reimbursement provided by the TTP and the patient.	A patient is treated for HTN. 2 weeks later he receives the bill for an appendectomy. The facility must review the ARs and to correct the claims error.

Intermediate Exercises

1. ABN Process (Level 3, Applying)

As a leader and manager, the health information administrator is responsible for communicating reimbursement policy and procedures. This responsibility requires the manager to interpret payer guidance documents and relate requirements to hospital-specific operations. Read the Medicare Advance Written Notices of Noncoverage booklet located at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf. Examine and interpret the guidance provided in the document.

Your local HIM association has been asked to present to new Medicare enrollees at Sensational Seniors community center in your city. Develop a presentation that educates new Medicare enrollees about the ABN process. The presentation should include what options beneficiaries have when they are provided with a notice of noncoverage, how to complete the form, and who to contact about noncovered services.

2. Incorporating New Codes into the CDM (Level 3, Applying)

Identify five new CPT codes for the upcoming calendar year. Create a workflow to ensure all data elements required in the CDM are identified, verified, and signed off on for inclusion in the CDM. Identify any compliance issues for these new CPT codes.

3. Impact of Coding Guidelines on Reimbursement (Level 4 – Analyzing)

You are a data analyst at Happy Hospital. The lead physician for the breast cancer center has asked you to examine reimbursement for breast cancer radiotherapy, chemotherapy and immunotherapy inpatient admissions. She is concerned that the reimbursement levels are incorrect. This assignment is Word document titled: Ch09 StudentWorkbookImpact of Coding Guidelines.AB202017. Access the file and complete the assignment. This assignment requires the calculation of case mix index, which was covered in Chapter 6, *Medicare-Medicaid Prospective Payment Systems for Inpatients.*

Impact of Coding Guidelines on Reimbursement

You are a data analyst at Happy Hospital. The lead physician for the breast cancer center has asked you to examine reimbursement for breast cancer radiotherapy, chemotherapy and immunotherapy inpatient admissions. She is concerned that the reimbursement levels are incorrect.

You have pulled the volume for breast cancer, chemotherapy, and radiotherapy MS-DRGs for the past year. Additionally, you identified Coding Guideline I.C.2.e.2 – Patient admission/encounter solely for administration of chemotherapy, immunotherapy and radiation therapy. This information is provided below.

Breast Cancer MS-DRG Data				
MS-DRG	**MS-DRG Description**	**RW**	**Volume**	**Weighted Volume**
597	MALIGNANT BREAST DISORDERS W MCC	1.8034	700	1262.38
598	MALIGNANT BREAST DISORDERS W CC	1.0876	650	706.94
599	MALIGNANT BREAST DISORDERS	0.8735	475	414.9125

	W/O CC/MCC			
600	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9569	550	526.295
601	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6294	800	503.52
846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.3771	400	950.84
847	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.2601	325	409.5325
848	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.9321	175	163.1175
849	RADIOTHERAPY	1.8	220	396
• Cases in MS-DRGs 846-847 has a secondary diagnosis in ICD-10-CM category C50, Malignant neoplasm of breast		**Total**	4,295	5,333.5375
			CMI	1.24180151

Coding Guideline I.C.2.e.2 - Patient admission/encounter solely for administration of chemotherapy, immunotherapy and radiation therapy.
If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or external beam radiation therapy assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence.
The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.
If a patient admission/encounter is for the insertion or implantation of radioactive elements (e.g. brachytherapy) the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis. Code Z51.0 should not be assigned.
Coding guideline I.C.2.e.3 - Patient admitted for radiation therapy, chemotherapy or immunotherapy and develops complications.
When a patient is admitted for the purpose of external beam radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.
When a patient is admitted for the purpose of insertion or implantation of radioactive

elements (e.g. brachytherapy) and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is the appropriate code for the malignancy followed by any codes for the complications.

Once you have reviewed this information, answer the following questions.

1. What is the CMI for this data set?

- 1.24180151

2. Based on the information in the coding guideline, list the questions that you will need to explore through data analysis to help determine if there is a coding issue.

A. Are secondary diagnosis codes (z codes) listed for cases MS-DRGs 597-599?
B. Were charge codes for chemotherapy procedures/drugs listed for cases MS-DRGs 597-599?
C. Were principle diagnosis codes correct for cases MS-DRGs 600-601?
D. MS-DRGs 600-601 charge codes for pathology services?
E. Does principle diagnosis differ from admission diagnosis for cases MS-DRGs 846-849?

3. Let's say that the data analysis showed that admissions in MS-DRGs 597-599 were incorrectly coded and should have been coded to MS-DRGs 846-848. The volume shifts are provided below. How does the CMI change? How does this CMI shift impact reimbursement?

Breast Cancer MS-DRG Data

MS-DRG	MS-DRG Description	RW	Volume	Weighted Volume
597	MALIGNANT BREAST DISORDERS W MCC	1.8034	630	1136.142
598	MALIGNANT BREAST DISORDERS W CC	1.0876	585	636.246
599	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.8735	428	37.3858
600	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9569	550	526.295
601	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6294	800	503.52
846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.3771	470	1117.237
847	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.2601	390	491.439
848	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.9321	222	206.9262
849	RADIOTHERAPY	1.8	220	396

• Cases in MS-DRGs 846-847 has a secondary diagnosis in ICD-10-CM category C50, Malignant neoplasm of breast	**Total**	4,295	5051.191
		CMI	1.1760630966

4. Reimbursement and Revenue Cycle Data Analysis Challenge (Level 4 – Analyzing)
This assignment is Word document titled: *Ch09 StudentWorkbookChapter 9Challenge.AB202017*. This assignment requires knowledge from coding courses and textbook chapters 1-9. This assignment is typically of analysis performed by revenue cycle analysts.

Advanced Exercises

1. Preparing an Audit Summary (Level 5 - Evaluating)
As a leader and manager, the health information administrator is responsible for planning and conducting audits. This responsibility requires the manager to execute audits according to budget and to report findings and ROI (return on investment) to senior executives.

You are the Coding Manager at Happy Hospital. You recently hired an outside consulting firm to perform an audit of 100 inpatient admissions from the last quarter of the fiscal year. Review the Excel file titled: Ch09 StudentWorkbookExercises.AB202017, tab titled: *Audit Results*. This spreadsheet contains the claim specific issues for each medical record included in the audit. After review and data analysis of the audit results, prepare an audit summary for hospital management. Your summary should include the following:

a. Overall statistics for the audit
    a. Error rate
    b. CMI changes
        i. Pre-audit CMI
        ii. Post-audit CMI
b. Discussion of the top 3 areas of concern
    a. Include plan of action for each area
c. Educational session schedule based on the audit results
d. Disciplinary action plan for each coder

2. Developing a Dashboard (Level 6 - Creating)
As a leader and manager, the health information administrator is responsible for monitoring and evaluating the performance of processes. This responsibility requires the manager to determine key performance indicators to be included in the monitoring and evaluation process.

You are the HIM Director at Happy Hospital. You are a member of the Revenue Cycle and are charged with monitoring and evaluating key HIM RC processes that impact the stability and health of the facility's revenue cycle.

Using HFMA's MAP Keys® for Hospitals and Health Systems, design a dashboard that can be used to monitor and evaluate **HIM RC processes**. MAP Keys are located at http://www.hfma.org/MAP/MapKeys/. Chose at least three indicators to be included in your dashboard. Your final product should include a description and rationale for each indicator

chosen for your dashboard, a mock-up of your dashboard (using fake data), and a plan of action for indicators when they do not meet the expected threshold.

Chapter 10 Outline and Learning Objectives

Chapter Outline

Learning Objectives
Key Terms
Value-Based Purchasing and Pay-for-Performance Systems
    Definitions
    Goals
    Background
    Advantages and Disadvantages
    Models
    Operations
Centers for Medicare and Medicaid Services-Linking Quality to Reimbursement
    Value-Based Purchasing
    Quality Reporting Programs
    Value-Based Purchasing Programs
    The Future of Value-Based Purchasing
References

Learning Objectives

- Describe the key characteristics of the value-based purchasing and pay-for-performance models
- Explain the structure and application of value-based purchasing programs implemented by the Centers for Medicare and Medicaid Services for various healthcare settings and payment systems
- Explain how compliance with the Centers for Medicare and Medicaid Services' value-based purchasing programs affects healthcare reimbursement for a facility, entity, or provider

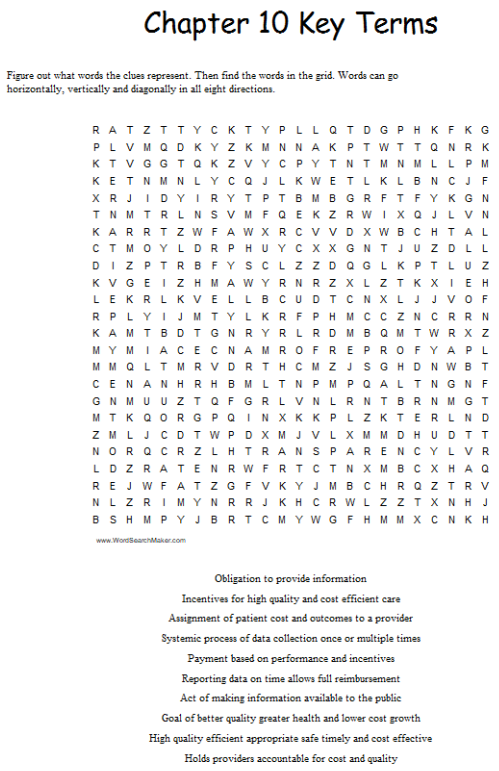
Application Exercises

Application and data analysis exercises are provided at three levels of understanding. Basic exercises focus on Bloom's Taxonomy levels 1, Remembering and 2, Understanding. Intermediate exercises relate to Bloom's Taxonomy levels 3, Applying and 4, Analyzing. Advanced exercises are presented at Bloom's Taxonomy levels 5, Evaluating and 6, Creating. Intermediate and advanced exercises require critical thinking and analysis of data or scenarios.

Beginner Exercises

1. Key Term Word Search (Level 1 – Remembering)

Use the clues to determine the key term from chapter 10, then find the key term in the grid.



Chapter 10 Key Terms

Figure out what words the clues represent. Then find the words in the grid. Words can go horizontally, vertically and diagonally in all eight directions.

R A T Z T T Y C K T Y P L L Q T D G P H K F K G
P L V M Q D K Y Z K M N N A K P T W T T Q N R K
K T V G G T Q K Z V Y C P Y T N T M N M L L P M
K E T N M N L Y C Q J L K W E T L K L B N C J F
X R J I D Y I R Y T P T B M B G R F T F Y K G N
T N M T R L N S V M F Q E K Z R W I X Q J L V N
K A R R T Z W F A W X R C V V D X W B C H T A L
C T M O Y L D R P H U Y C X X G N T J U Z D L L
D I Z P T R B F Y S C L Z Z D Q G L K P T L U Z
K V G E I Z H M A W Y R N R Z X L Z T K X I E H
L E K R L K V E L L B C U D T C N X L J J V O F
R P L Y I J M T Y L K R F P H M C C Z N C R R N
K A M T B D T G N R Y R L R D M B Q M T W R X Z
M Y M I A C E C N A M R O F R E P R O F Y A P L
M M Q L T M R V D R T H C M Z J S G H D N W B T
C E N A N H R H B M L T N P M P Q A L T N G N F
G N M U U Z T Q F G R L V N L R N T B R N M G T
M T K Q O R G P Q I N X K K P L Z K T E R L N D
Z M L J C D T W P D X M J V L X M M D H U D T T
N O R Q C R Z L H T R A N S P A R E N C Y L V R
L D Z R A T E N R W F R T C T N X M B C X H A Q
R E J W F A T Z G F V K Y J M B C H R Q Z T R V
N L Z R I M Y N R R J K H C R W L Z Z T X N H J
B S H M P Y J B R T C M Y W G F H M M X C N K H

www.WordSearchMaker.com

Obligation to provide information
Incentives for high quality and cost efficient care
Assignment of patient cost and outcomes to a provider
Systemic process of data collection once or multiple times
Payment based on performance and incentives
Reporting data on time allows full reimbursement
Act of making information available to the public
Goal of better quality greater health and lower cost growth
High quality efficient appropriate safe timely and cost effective
Holds providers accountable for cost and quality

2. State Delivery Systems (Level 2 – Understanding)

The patient-centered medical home (PCMH) is a model of value-based purchasing (VBP) and pay-for-performance (P4P) systems. As stated in the textbook, PCMH initiatives are often organized by health plans, states, payers, providers, or multi-stakeholder groups. Several states have adopted policies and programs to advance PCMHs. Go to the web site of the National Academy for State Health Policy (NASHP) to learn about medical homes and other programs offered by state:
http://www.nashp.org/med-home-map.

On the State Delivery System and Payment Reform Map three categories of healthcare delivery models are discussed: Health Homes, Medical Homes, and Delivery System Reform Incentive Payment (DSRIP) programs. For each category, choose a state that is participating in the program. Answer the following questions based on the information provided about the models/programs offered in the state you selected. The information is provided on the left-hand side of the page.

A. Health Homes: Click on a state highlighted in blue. What is the activity this state? Include information about target population, eligible providers, and measurement and evaluation.

-the activity in this state is The CMS has approved Six Health Home State Plan Amendments (SPA) in Maine, two for the state's Primary Care Health Home model, three for the state's Behavioral Health Homes Model, and one for the state's Opioid Health Home model.
- the target population is to include individuals with either A) two chronic conditions; or B) have one chronic condition and be at risk for another
-eligible providers are primary care practices (as health homes). Eligible providers are required to be recognized as NCQA patient centered medical homes, have an electronic medical record, and achieve 10 core expectations originating in the state's multi-payer patient-centered medical home program
-measurement and evaluation: The measures tied to four overarching goals are
-Reduce inefficient healthcare spending
-improve chronic disease management
- ensure evidence-based prescribing

B. Medical Homes: Click on a state highlighted in blue. What is the activity this state? Include information about qualification criteria, payments and supports, and metrics and outcomes. Indicate if the program is a multi-payer program.

- The Maine Patient-Centered Medical Home (PCMH) Pilot is a multi-payer demonstration. This began January 2010. Medicare participated from Jan 2012- Dec 2016.
-Six payers are participating in the PCMH Pilot:
-Maine care (Medicaid)
-Medicare fee-for-service
-anthem blue cross blue shield
-Aetna
-Harvard pilgrim
-Maine community health options
-CCTs receive PMPM payments. They support practices by providing additional support and care coordination services to the most high-risk and high-cost patients in the pilot. They receive $2.95 PMPM from Medicare and $.30 PMPM from commercial insurers. Maine care pays CCTs $129.50 PMPM for high risk high cost patients who are referred from practices participating.
-This is a multi-payer program

C. DSRIP: Click on a state highlighted in blue. What is the activity this state? Include information about goals, eligible providers, types of projects, measurement and evaluation, payment and supports and overall status.

-Oregon has the Hospital Transformation Performance Program (HTPP)
-Goals are to allow DRG hospitals to earn incentive payments by meeting specific performance objectives. The performance objectives are designed to advance health system transformation, reduce hospital costs, and improve patient safety. The concept is to create a mutually beneficial system for both hospitals and CCOs by reducing costs while improving quality
-Eligible providers are 28 urban DRG hospitals with a bed capacity of greater than 50
-The HTPP is not project-based it is however a standardized list of 11 performance measures that hospitals have to report
-Measurement and evaluation is captured in two overarching focus areas, hospital-focused and hospital-CCO coordination-focused
-hospital focused: readmissions, medication safety, patient experience, and healthcare-associated infections

-Hospital-CCO: behavioral health and sharing ED visit information
- Each hospital is eligible to earn $500,000 by achieving 9 out of 11 measures
-this program is still operational

Intermediate Exercises

1. Quality Reporting Programs (Level 3, Applying)
CMS has implemented quality reporting programs for several prospective payment systems. Review table 10.3 in the textbook. Select one of the quality reporting programs included in this table. Research the program (CMS website, most recent Federal Register for the applicable PPS, etc.). Prepare an educational presentation that outlines the reporting requirements for your medical director and quality department director. Provide examples of how this provision may affect the reputation and reimbursement of your facility.

2. Pioneer ACO project (Level 4 – Analyzing)
The Pioneer ACO project paved the way for the Next Generation ACO model. The CMS pioneer ACO model began on January 1, 2012. The project included an initial 3-year performance period and allowed for 2 additional option years. CMS used this model to test alternative model designs with ACOs that were already experienced in shared shavings (savings and losses) models. Thirty-two ACOs started the program in 2012. At the end of the program in 2016 only 8 AOCs remained. A final evaluation report and quality and financial results from this project are provided on the CMS website at: https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/. Review the information in the Final Evaluation Report and the Performance Year 5 data spreadsheet.

Pick one ACO from the Performance Year 5 spreadsheet. Then review information for Performance Years 1-5. Create a graphic that shows the ACOs performance throughout the project.

	A	B	C	D	E	F	G	H	I	J
1		ACO Name	Total Aligned Beneficiaries 1	Total Benchmark Expenditures2, 3	Total Actual Expenditures for Aligned Beneficiaries	Total Benchmark Expenditures Minus Total Aligned Beneficiary Expenditures4	Total Benchmark Minus Aligned Beneficiary Expenditures as % of Total Benchmark5	Earned Shared Savings Payments/Owe Losses6	Successfully Reported Quality7	Quality Score8, 9
2										
3	year 1	Allina Health	11,779	$113,878,272	$113,864,709	$13,564	0.01%	$0	Yes	P4R
4	year 2	Allina Health	11,255	$112,027,446	$110,160,896	$1,866,550	1.67%	$0	Yes	85.31%
5	year 3	Allina Health	12,774	$126,570,846	$124,555,880	$2,014,966	1.59%	$0	Yes	89.65%
6	year 4	Allina Health	14,475	$144,425,079	$140,838,499	$3,586,580	2.48%	$2,347,369	Yes	95.41%
7	year 5	Allina Health	26,110	$268,445,602	$263,218,691	$5,226,911	1.95%	$3,425,746	Yes	92.94%

Did the organization improve each year?
yes
What could cause an ACO to not meet expenditure benchmarks?
A number of the parameters of the original Pioneer Program did not create the optimal environment for an organization to be able to manage an at-risk population from a perspective of coordination of care across the continuum. The Medicare fee schedule differs based on geographical region and the difference in prices compared to the national average can help or hurt an ACO regardless of how it is changing care. Their

benchmarking methodology could be off if they serve sicker patients. For that they may have been penalized. Also if an ACO does not keep spending for a specified population below its benchmark they will not get to share in the Medicare savings.

Advanced Exercises

1. ACOs – Are they the solution? (Level 5 - Evaluating)
The concept of ACOs has been around since 2005. The ACA strengthened the commitment of CMS to expand ACO programs for Medicare. Currently, there are over 480 ACOs participating in CMS Medicare Shared Savings Program (MSSP). ACOs are responsible for the health outcomes for beneficiaries attributed to their organization. Therefore, ACOs will share savings (expenditures less than predicted) or return payments back to CMS based on their patient population.

Is it fair for CMS to hold providers accountable for the actions of their beneficiaries? For example, a physician counsels their patients about weight loss and healthy diet. Only a portion of their patients will change their eating and exercise habits. For those who do not, is it fair to hold the provider responsible for the patient's future healthcare expenditures? Should the patient be held accountable? How could CMS hold the patient accountable for their decision to ignore physician instruction?

2. Developing an Audit Plan (Level 6 - Creating)
The Hospital-Acquired Conditions Present on Admission (POA) Program designates diagnosis and procedures that are considered preventable in the inpatient setting. One condition applicable for FY 2018 is Stage III and Stage IV pressure ulcers (ICD-10-CM codes in category L89). To indicate whether the pressure ulcer was present when the patient was admitted or was acquired during the hospital stay, the hospital must report a present on admission code for L89 diagnosis codes on the claim form. Hospitals with HAC may have reimbursement for the admission decreased. Review figure 10.5 in the textbook.

Scenario: Stephanie is the coding manager at Happy Hospital. The coding professionals have been charged with applying the POA indicator code. Stephanie has collected data over the past six months for stage III and stage IV pressure ulcers. It is quite clear from the data that there is an issue with either the documentation of pressure ulcers, assignment of the POA indicator, or the quality of care provided at Happy Hospital.

POA Report for Pressure Ulcers (L89.x) October - March		
POA Code	**Description**	**Volume**
Y	Yes, present on admission	15
N	No, not present on admission	30
U	Unknown, insufficient documentation	45
W	Clinically undetermined	3
1	Exempt from POA reporting	0

Design an audit plan for this POA issue. When designing your audit consider the following questions to help you determine components that should be incorporated in

your plan:

What is the scope of the audit?
What are the goals of the audit?
What processes need to be evaluated?
What data should be collected during the audit?
    What data will determine if this is a documentation issue?
    What data will determine if this is a POA assignment issue?
What data will help you determine if this is a quality of care issue?
Who should be on the audit team to conduct the audit?
What rules/guidelines should be considered?
    HINT – see Official Coding Guidelines Appendix I, Present on Admission Reporting Guidelines and Official Coding Guidelines, Section I, C, Chapter-Specific Coding Guidelines, Chapter 12, Diseases of the Skin and Subcutaneous Tissue (L00-L99).

Check your understanding 9.1

1. In which component of the revenue cycle does order entry take place?

   -order entry is part of the claims processing activities portion of the revenue cycle. All clinical areas provide services to a patient must report charges for the services provided via the order entry process prescribed at their facility. Many facilities are physician offices have electronic order entry to complete this task

2. How are remittance advices utilized in the Claims Reconciliation and Collection component of the revenue cycle?

   -remittance advice files are reviewed to identify line items or claims that have been rejected or denied by the third-party payer. Facility reviewers then compare the claim information to the medical record documentation to determine if a correction is warranted.

3. What is the function of scrubbers in the claims processing component of the revenue cycle?

   -Scrubbers edit claims to locate and flag for correction any data that may contain errors, such as dates of service that are incompatible, inaccurate diagnosis and procedure codes, lack of substantiation of medical necessity, and inaccurate assignment of revenue codes.

4. List the basic data elements of a CDM, identifying which data elements are hospital-specific and which are nationally recognized.

-Charge code – hospital-specific
-Department code – facility-specific
-Description – facility-specific
-HCPCS code – nationally recognized
-Revenue code – nationally recognized
-Charge – facility-specific

5. When are the CPT and HCPCS Level 2 code sets updated?

   -January 1st annually

Check your understanding 9.2

1. Healthcare facilities should design key performance indicators so they _____.

   -can be measured to gauge performance improvement

2. Which component of the revenue cycle is measured in the KPI DNFB?

   -Claims Processing Activities includes the task of charge capture. Late charges are a significant issue as the prescribed protocol for charge capture was not followed.

3. What are three benefits of an integrated revenue cycle?

   -Reduced cost to collect, performance consistency, and coordinate strategic goals

4. What system is typically used to audit inpatient Medicare claims

   -The Medicare Code Editor (MCE)

5. In MS-DRG relationships reporting, MS-DRG families are examined for ____.

   -Complication and comorbidity (CC) and major complication and comorbidity (MCC) codes

Chapter 9 Review Quiz

1. Which component of the revenue cycle is responsible for determining the appropriate financial class for a patient? Why is this task important to the health of the revenue cycle?

   Pre Claims submission activities. This is important to the health of the revenue cycle because it is responsible for collecting complete and accurate patient information and educating the patient about financial responsibility for services and verifying data before costly procedures are done

2. What are two sources of new charge description master codes?

   The CMS releases updates to code and billing guidance, and performance of new services at the health care provider that require line items to be added to the system.

3. What risk areas are concerns when the charge description master is not properly maintained and revised?

   Reimbursement may be lost through claim denials and compliance violations may occur

4. How has HIPAA changed claims processing?

   By requiring all healthcare facilities to use standardized code set on electronic claims that contain standardized formats this changes the conventional submission of claims on paper form

5. What is the role of CDI in claims processing?

   Clinical documentation improvement enhances medical data collection to maximize reimbursement revenue and thus improve quality care in claims processing

6. List ways that discrepancies between submitted charges and paid charges are reconciled by the provider.

   Provider contracts the patient to collect outstanding debt the facility determines whether the claim can be correct and resubmitted accounting personnel can also check for denied claims to determine whether corrected claims should be submitted to the insurer.

7. How do providers decide what optimal performance is for units of their facility?

   Key performance indicators which represent areas that need to be improved are established by providers to define optimal performance unit of the facility

8. Facility A just completed an analysis of its alarmingly high denial rate. How could facility A identify the root cause of the high rate?

   Facility A could utilize root cause analysis, to determine the root cause of the high denial rate there are several tools and techniques within RCA to uncover cause problems such as an event and causal factor analysis, and management oversight and risk three analysis

9. Describe at least three sources of errors that cause claim denials.

   Outdated CDM codes used on claims, data entry errors, and inexperienced HIM coders

10. Describe how hard coding is different from soft coding (coding by coding professionals). Has the charge description master made soft coding by coding professionals obsolete?

    Hard coding is the use of the change description master to code repetitive services where soft coding is when codes are manually assigned by HIM coders. The CDM has not made soft coding obsolete because some situations will still require manual coding by HIM coders such as more complex visits and multiple diagnosis

Check your understanding 10.1

1. What three components do value-based purchasing (VBP) systems and pay-for-performance (P4P) systems typically link?

   -quality
   -performance
   -payment

2. What three reports provided the impetus for VBP/P4P systems?

   -To err is human: building a safer health system, Kohn, L. T., J. M. Corrigan and M. S. Donaldson, eds., Committee on the quality of Health Care in America, institute of medicine; Crossing the quality chasm: a new health system for the 21sst century, the committee on quality of health care in America of the institute of medicine; and rewarding provider performance; aligning incentives in Medicare, the committee on redesigning health insurance performance measures, payment, and performance

improvement programs, board on health care services of the institute of medicine

3. List two types of VBP/P4P incentives.

   -bonuses, penalties, bonuses to capitation or global payment rates, higher fee structures, shared savings and shared risk

4. What are the five functions and attributes of a PMCH?

   -Comprehensive care – meets most patient's healthcare needs including prevention and wellness, acute care and chronic care
   -Patient-centered – provides health care that is relationship-based and oriented towards the whole person
   -Coordinated care – coordinated elements of care across the continuum of care including specialty care, hospitals, home health, and community services
   -Accessible services – provides shorter waiting times for urgent needs, enhanced in-person hours and around-the-clock telephone or electronic access to a care team member. Additionally, alternative forms of communication are available, such as e-mail, telephone.
   -Quality and safety – demonstrates a commitment to quality care and quality improvement by engaging in evidence-based medicine and clinical decision-support tools

5. Describe the difference between Medicare shared savings program's track 1 and track 2.
   - Track 1 is one-sided and ACOs share in savings but not losses. Track 2 is two-sided and ACOs share in both savings and losses.

Check your understanding 10.2

1. List three service areas that participate in Medicare's quality reporting program.
   - Hospital inpatient, hospital outpatient, ASC, long term care hospitals, inpatient rehabilitation hospitals, hospice, home health, inpatient psychiatric facility, PPS-exempt cancer hospitals, and SNF

2. Which focus areas are included in the hospital readmissions reduction program?
   - Heart failure, acute myocardial infarction, pneumonia, chronic obstructive pulmonary disease, total hip arthroplasty and total knee arthroplasty and coronary artery bypass graft surgery

3. What four domains are included in the hospital value-based purchasing program?
   - Safety domain, clinical care domain, efficiency and cost reduction domain and patient and caregiver-centered experience of care/care coordination domain

4. List three of the domains used in the home health VBP program.
   - Clinical quality of care, communication and care coordination, patient and caregiver-centered experience, patient safety

5. What are the two tracks that providers can take in the QPP?
   - Merit-based incentive payment system (MIPS) and advanced alternative payment models (APMs)

Chapter 10 Review Quiz

1. What three fundamental characteristics do value-based purchasing (VBP) systems and pay-for-performance (P4P) systems share?

   The fundamental characteristics they share are measurement, transparency, and accountability

2. Why did VBP/P4P systems emerge?

   VBP and P4P were created to increase quality and safety in health care as well as to control the rising cost of health care

3. What is attribution, and by what other term is this process known?

   Is the determination of who rendered care so that the cares outcomes can be linked to its provider and that provides receives the reward or penalty other terms for attribution are enrollee assignment or beneficiary assignment

4. Describe the Medicare shared savings program.

   Program aims to improve beneficiary outcomes and increase value of care by providing better care for individuals better health for populations and lowering growth in expenditures

5. List the six national quality strategy domains.

   Patient safety, personal and family centered care, effective communication and care coordination, health and wellbeing, affordable care, prevention and treatment for leading cause of morbidity and mortality

6. What piece of legislation mandated that CMS develop a VBP program?

   The health reform ACA legislation mandated Medicare establish a hospital value-based purchasing program by 2012, in fact the deficit reduction act of 2005 already authorized Medicare to develop a plan to implement VBP for 2009

7. Describe CMS' quality reporting program.

   The development of quality measures is the first step in the establishment of a VBP program CMS allows a facility to maintain the full payment for services when it is successfully participates in a quality measure reporting program

8. How is the HAC POA program different from the HAC reduction program?

   HAC POA payment provisions is distinct from the HAC reduction program in the lhe latter authorizes centers for Medicare and Medicaid services to make payment adjustments to applicable hospitals based on risk adjustment quality measure while the former indicator reporting provisions requires a quality adjustment in Medicare severity diagnosis related groups mayent for certain HACs HAC POA payment provision also applies only to IPPS hospitals, the HAC reduction program is a Medicare pay for performance program that supports CMSs long standing effort to link Medicare payments to healthcare quality in the inpatient hospital setting

9. Define the term alternative payment model.

   A model through which physicians and other healthcare providers accept a measure of financial risk and are reimbursed

based upon prudent resource use and quality of patient's outcomes rather than on a piecemeal fee for service basis

10. Why are MSSP ACO Tracks 2 and 3 considered advanced APMs, but Track 1 is not under the QPP?

MSSP ACO tracks 2 and 3 are shared savings program, track 1 has to have qualifying advanced APM participant