Anticipate & educate to navigate murky healthcare reform waters

Anxiety over changes in healthcare delivery and payment systems has permeated hospitals and ambulatory surgery centers (ASCs). Administrators are concerned about how the Affordable Care Act (ACA) and other initiatives will hit the organization’s bottom line. Increasingly, perioperative services leaders are being drawn into discussions in these areas.

“The OR is a place where we have very costly, complex procedures,” says Keith Siddel, PhDc, JD, MBA, CHC, an attorney and healthcare finance expert based in Creede, Colorado. “That’s why reimbursement is more critical there than anywhere else in the hospital.” If hospitals or ASCs don’t get reimbursed, administrators are less likely to have the cash flow to authorize purchasing of requested equipment for the OR. In addition, ORs may see surgeons—and patients—shifting from 1 hospital or ASC to another as the ACA results in more restricted provider networks.

Greater financial pressure can also be attributed to loss of cost shifting. In the past, Siddel says, Medicare would pay providers, including hospitals, a base rate. The hospitals would overbill insurance companies by about 30% to 40% and use the extra money to cover insufficient Medicare payments and patients who didn’t pay. “Now,” he says, “the ability to cost shift has virtually gone away. If you can’t make money on Medicare payments, you won’t survive.”

All this adds up to the need for OR managers to keep their view broad-based. “It’s becoming more and more important that we aren’t functioning just as a department head, but instead we understand the whole picture,” Siddel says. He cites 4 key areas that may have a significant impact on the bottom line: ACA, the 2-midnight rule, changes in the outpatient prospective payment system (OPPS), and implementation of ICD-10.

Reality of ACA

Siddel says the thinking behind the ACA was that by insuring everyone, unreimbursed costs could be controlled. Some key concepts of ACA to keep in mind include:

• For insurance exchanges, a formula based on age and income level is used to determine how much federal credit individuals will receive to help them pay for their health insurance.
• Insurance companies are required to cover preexisting conditions without an increase in premiums, which in many cases has led to a rate increase for everyone.
• Insurance companies have been incentivized to set up narrow provider networks to help control costs.

Originally it was thought that across-the-board health insurance would mean increased patient volume, full reimbursement, and a healthier patient population. The reality, Siddel says, is much different. “Not everyone has signed up, the cost of the system is much more expensive than anyone ever imagined, and the networks are much narrower than anyone anticipated.”

This reality has created several challenges, beginning with basic costs. Siddel cites the example of someone who earns $25,000 per year and buys a silver plan that has
a premium of $100 per month. The out-of-pocket expenses for that plan are $4,500, well beyond the person’s means. (The maximum out-of-pocket cost for any kind of insurance plan is $6,400.)

Instead of signing up for insurance, this person could choose to simply pay the $100 annual fine for being uninsured. However, if the person required hospital care and couldn’t pay for it, the hospital or ASC would have to try to collect the payment or write off the charges as a charity expense. Siddel believes many patients will be surprised by the high out-of-pocket expenses.

A corollary to this problem is the required 90-day grace period for premium payments. If a patient paid in January, but not February or March, a hospital would still receive payment for care delivered. However, if after 90 days the patient still hadn’t paid, the exchange health plan could take back the payment previously made to providers.

“Everyone is trying to figure out how to manage this,” Siddel says. One option could be for the hospital to pay the patient’s premium, but he says the Centers for Medicare & Medicaid Services (CMS) “strongly discourages” this practice. Organizations would also have to decide whose premium gets paid, when to pay or not, and how to pay, along with a multitude of other thorny problems.

Another challenge posed by the ACA is that many insurance companies no longer cover any out-of-network services. In the past, coverage was provided at a reduced percentage, and a patient could choose to pay the extra amount. Siddel recommends hospitals and ASCs ensure that patients lacking out-of-network coverage understand before receiving services that they will have to pay the entire cost. Otherwise, obtaining payment could be difficult.

What if your hospital is out of the patient’s network, and the patient can’t afford to pay? “You can try to bill them or try to collect, but these patients are just like the uninsured,” Siddel says. “The difference is, you can’t get them covered under any other supplemental plan because they already have insurance.”

**Bundling is king for OPPS**

A significant change in OPPS is ambulatory payment classification bundling. “Most clinical laboratory diagnostic tests performed on the same day as the surgery, for example, and ordered by the same primary physician will no longer be paid separately,” says Siddel. The only exceptions are molecular pathology lab tests.

Drugs, biologicals, and radiopharmaceuticals such as contrast agents are also now bundled when they are used in a surgical procedure. The only exceptions are the very few items that qualify for “pass through” status such as TheraSkin and obinutuzumab injections. Although CMS claims that these charges are now bundled into payment for procedures, Siddel says in many instances the reimbursement actually has been “wiped out.”

ORs must continue to analyze their bundled charges and time for procedures to ensure that everything is included and the associated costs have been taken into account. This is particularly important for device-dependent procedures, defined as procedures that require an expensive device. Because hospitals previously weren’t billing properly, Medicare initially had to implement device-dependent audits, and now CMS has decided to bundle everything required for a device-dependent procedure into 1 payment.

Other newly bundled items include device removal, repair, or replacement procedures, and procedures described by add-on codes. In essence, CMS is paying providers for the primary procedure only, and all related items and procedures are no longer paid separately.
Although some of the most dramatic bundling changes won’t go into effect until 2015, Siddel advises hospitals to prepare now. “This year, you should be modeling all of the bundling of these device-dependent procedures so that you know what the impact is and what you need to do,” he says.

OR managers should think about questions such as:

• Are your charges structured right?
• Do you have all your billable items in the charge master?
• What’s your cost for supplies, space, or staff, and how is that captured?

“These have always been important, but the more CMS bundles payments, the less room there is for errors,” Siddel notes.

CMS is also starting to standardize payments across delivery systems, so the reimbursement will be the same regardless of whether the procedure is performed in a hospital or an ASC. “Hospitals that are providing more complex services are losing money, and those providing less complex services on an outpatient clinic basis are making money,” Siddel explains. Hospitals are now competing for the same reimbursement dollars as ASCs and even physician offices, yet hospitals’ cost structures are much higher.

2-midnight rule still on hold
CMS has determined that if patients spend 2 midnights in the hospital, they’re considered inpatients in terms of level of care; if less than 2 midnights, they’re considered outpatients, in most instances, regardless of severity of illness or level of care provided. The 2-midnight time period is called a “medical utilization day” or “MUD.”

CMS has several times delayed enforcement of the 2-midnight rule, and on March 31, Congress voted to delay enforcement until March 31, 2015. Nonetheless, Siddel suggests surgical services directors work with surgeons and schedulers to ensure that “there is a better understanding of level of care and the elements required in the order because it will absolutely affect reimbursement.”

Historically, the challenge for OR managers has been surgical patients who undergo additional inpatient-only procedures and are then discharged as outpatients. Because they’re not considered inpatients, providers aren’t paid for the additional procedures.

Siddel says the new 2-midnight rule exempts inpatient-only procedures, and those patients are now automatically considered inpatients.

Surgical services directors have tried to be sure surgeons and staff understand that if an unplanned procedure is done, it’s important to verify the patient will be an inpatient, but as Siddel says, it’s a “burdensome problem.”

Under the 2-midnight rule, physicians must write specific admission orders including key care elements. To facilitate correct documentation, some hospitals have created a template for surgeons to complete and sign. The template includes the reason for inpatient care, the anticipated length of hospital time that will be required, plan for care after discharge, and a statement that the physician has completed a note detailing why the patient needs to be an inpatient (sidebar.)

Adding to the challenge is the fact that the assignment of all Medicare appeals is on hold for 2 years. “If you don’t like what Medicare paid, you’re out of luck for at least 2 years,” he says.

More information about the 2-midnight rule is available from the American College of Surgeons website: http://www.facs.org/ahp/two-midnights.html.
Why care about coding?

“Coding now plays a key role in many areas—reimbursement, quality, and outcomes,” says Siddel. “At a minimum, OR managers need to understand what’s changing.” Although surgical services directors and business managers are not directly responsible for coding, the coding drives an organization’s ability to achieve revenue goals, and this will ultimately affect its service line. “We’re all in this together,” Siddel says.

The major coding change coming sometime in the future is the implementation of ICD-10. On March 31, the Senate passed bill HR 4302, Protecting Access to Medicare Act of 2014, which prohibits the US Department of Health and Human Services from adopting ICD-10 as the standard until at least October 1, 2015, a reprieve from the October 1, 2014, planned implementation.

Siddel says the unexpected delay has divided the provider community. “Those who were behind in their preparations or are currently installing their electronic health records are happy with the extra 12 months. Those who were prepared and had invested significant resources into the preparation are very disappointed.”

In any case, the transition to ICD-10 is likely inevitable so OR leaders still need to understand the new standard and its challenges.

ICD-10 brings a vastly increased level of complexity to coding. “What used to take 5 ICD-9 codes may now take 10 ICD-10 codes,” Siddel says. For example, the suture of an artery in ICD-9 has 1 code, but the same procedure has 276 codes in ICD-10.

As many as 30% of coders, whose average age is over 50 years, will retire instead of learning the new system, meaning a crop of inexperienced coders will encounter a complex new system—an electronic perfect storm. “There is a game-changing event going on,” Siddel says. It’s expected that productivity in coding could drop as much as 50%.

ICD-10-CM (clinical modification) codes will be used for all inpatient and outpatient diagnoses, ICD-10-PCS (procedure coding system) codes will be used by hospitals for inpatient procedures, and CPT (current procedural terminology) codes will be used by healthcare providers for outpatient procedures. Although ICD-10 diagnosis codes have been used previously in other countries, the PCS coding is an untested, completely new coding methodology.

Effective documentation will be vital to avoid delays in reimbursement. In the past, missing documentation may have not affected the revenue cycle, but now claims must be sent back to the physician to answer queries before those claims can be submitted. By helping to ensure a completed document is obtained initially, perioperative services leaders can reduce reimbursement delays.

Siddel suggests OR managers talk with the health information management department to determine which surgeons’ claims tend to be held and why. Then revise documentation as needed to ensure all information is obtained during the initial event. Other strategies include:

• taking a basic course on ICD-10 to learn the terminology
• providing education to perioperative nurses (most facilities are offering between 1 and 3 hours of education)
• ensuring surgeons receive education
• having an electronic medical record
• having a clinical documentation improvement program.

Siddel also recommends OR managers get involved with test coding so they know what OR documentation needs to be revised. “Even if you do all of these things, there will still likely be a 13% to 15% loss in productivity [for coders],” he says.
No easy solution
Siddel uses an example to illustrate how the healthcare system will continue to be challenged because Medicare is not “prepaid” by those contributing to it. A patient born in 1944 who started working at age 21 in 1965 and worked until age 65 (2009) paid $64,000 into the Medicare system.

The average benefit for a Medicare beneficiary in 2008 was $11,000. Of that, the patient had to pay some out-of-pocket costs, so the actual benefit was $9,000. Assuming a person retires at age 65 and lives until age 83, the value of the benefit is about $173,000—far more than the person paid into it.

Siddel asks, “If people are paying around $64,000 into the system for an actual benefit of $100,000 more than what they paid into it, how long can that system sustain itself? We’ve committed to a level of care we can no longer afford.”

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Reference
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