

INSIDE THIS ISSUE:

CHARGE CAPTURE 1

POOR COMMUNICATION 1

AMA, AHA WARY OF CMS NONPAYMENTS 2

FILLING THE GAP 2

CHARGE CAPTURE

As we focusing our attention to 2009, hoping better days lie ahead we must also take a look at what 2009 could mean for our business.

Although they focus on healing, hospitals are businesses and management must concentrate on surviving in these tough financial times.

Auditors are the facilities first line of defense against misstated financial results. In addition to reviewing financial reports, gathering audit outcome stats, auditors must ensure that the central billing office runs effectively as possible. It is apparent that auditing must be conducted in all departments on a monthly basis to assure the organizations financial well being. Identifying potential lost revenue and charge issues before claims are submitted for improved billing compliance, and gross and net revenue

capture must be an essential part of any organization.

How to improve charge capture...

One of the common causes of overlooked revenue is related with missed charges. These are charges related to supplies, devices, services and procedures that were rendered but never billed. Missed charges may prevent the hospital from accumulating enough dollar value to hit an outlier, which also results in missed revenue opportunities.

The key to improving charge capture and reducing the revenue loss is to insure that proper charging protocol is being followed initially. There are several ways to identify where charge capture needs to be improved.

Staff Education:

Having dedicated and knowledgeable staff will go a long way toward improving charge capture, especially for clinical staff. Nurses are trained to care for patients but no one has really taught them details about charges and why it is so important to document proper charges.

Audit Department:

Creating a separate revenue and audit department staffed by an experienced nurse auditor with strong clinical and billing experience to look for charge capture issues on a daily basis. As well as meeting with department managers to determine cause for over and under charges and corrective actions that will need to be taken by the departments to rectify proper charges.

Continued on pg. 3—Charge Capture...

QUOTE OF THE MONTH...

“ I AM NOT BOUND TO WIN, BUT I AM BOUND TO BE TRUE. I AM NOT BOUND TO SUCCEED, BUT I AM BOUND TO LIVE BY THE LIGHT THAT I HAVE. I MUST STAND WITH ANYBODY THAT STANDS RIGHT, AND STAND WITH HIM WHILE HE IS RIGHT, AND PART WITH HIM WHEN HE GOES WRONG.”

ABRAHAM LINCOLN

POOR COMMUNICATION HURTS MORALE

Keeping employees up to speed may be the best way to boost their moods during hard times, according to a survey by Accountemps. In a poll of 150 senior executives from the nation’s 1,000 largest companies, nearly half said better company-wide [communication](#) is the best remedy for low morale, the California-based staffing firm said. Despite the tough economy, just 13 percent of respondents said monetary awards were the best fix. At the same time, 33 percent of

respondents said a lack of open, honest communication in the workplace had the most negative effect on workers’ attitudes. Micromanaging, excessive work, and failure to recognize achievements were also cited as practices that can damage employee morale. The study said companies can create more positive and productive working environments by ensuring managers are available, willing

to listen, and dedicated to getting workers involved. “When people are concerned about [job security](#) and company performance, updates on corporate news are essential,” Max Messmer, the firm’s chairman, said in a statement. “By keeping employees informed, managers can address anxiety and ensure workers are focused on meeting objectives,” he said.

AMA, AHA WARY OF CMS NONPAYMENT PROPOSAL

Two of the nation's largest healthcare lobbying groups have raised questions over proposals from the CMS that would eliminate Medicare payments when surgeons operate on the wrong patient, the wrong body part or perform the wrong procedure altogether.

In comments made to the CMS, the American Medical Association said that the federal agency should not use its National Coverage Determination process, which dictates what procedures Medicare will and will not pay

for, to fight wrong-site, wrong-patient or wrong-procedure errors. The AMA said that the federal agency should instead "develop a clear payment policy outlining the circumstances which surgery claims would not be payable by Medicare."

The American Hospital Association said that the CMS must first better define the surgical events, more clearly determine what costs or services would not be covered, and discuss how it would assign accountability for an error.

In 1999, the Institute of Medicine predicted that up to 98,000 patients die each year from preventable medical errors. Instances of wrong-site or wrong-patient surgeries are extremely low. Still, a recent study said that they can be expected to occur "once each year in a 300-bed hospital."

"These types of surgical errors can cause serious injury or death to beneficiaries and result in increased costs to Medicare due to the need to treat the consequences of the errors," acting CMS Administrator Kerry Weems said in a written statement. "The proposed national coverage policies for certain types of surgical errors are important steps for Medicare in working to reduce or eliminate their occurrence and their associated payments." -- by [Matthew DoBias](#) *Modern Healthcare* December 3, 2008

FILLING THE GAP BETWEEN OBSERVATION UNITS & THE WARDS

Somewhere between the emergency department observation unit and the medicine wards of most hospitals, there's a group of patients who aren't a perfect fit for either setting. These individuals may be a little too sick to go home in 23 hours, but they're not so complicated that they warrant prime-time admission for a four-day stay.

To address these "gray-zone" patients—individuals who end up staying in the hospital for less than 72 hours—the hospitalists at Northwestern Memorial Hospital in Chicago came up with a novel solution: a short-stay unit. According to Matthew Landler, MD, the unit's medical director, the goal was not only to provide better care for these patients, but to improve throughput in the ED and the wards.

In most facilities, these patients end up in ED-

managed observation units. That's not always ideal, though, because as soon as patients develop issues that fall outside the scope of ED physicians, the hospitalists are called in to consult. "If something goes outside of what's expected, like a borderline stress test," says Dr. Landler, "they end up calling us anyway."

Northwestern, which is running close to capacity much of the time, had created an observation unit to reduce ED congestion. But administrators were looking for another strategy to wring more throughput out of the system. That's when they decided that a short-stay unit might not only free up beds in the observation unit, but in the medicine unit as well. No shortage of patients

Research showed that there was no shortage of patients

who would qualify for such a unit, Dr. Landler points out. Of the roughly 21,000 patients discharged from Northwestern Memorial between September 2006 and May 2007, more than half had a length of stay (LOS) of 72 hours or less. Of those, about half were general medicine patients.

In January 2008, Northwestern opened the 30-bed short stay unit. Dr. Landler explains that the unit is ideal for patients with conditions like uncomplicated chest pain or atrial fibrillation, a straightforward pneumonia, a moderate asthma or COPD exacerbation. Patients who have few, if any, comorbidities are also a good fit.

While Northwestern's hospitalist group has almost 50 physicians, the short-stay unit is staffed during the day by two hospitalists working 10- to 12-hour shifts, as well as two patient care coordinators and a nurse practitioner. Overall, the unit draws from a pool of eight hospitalists who are dedicated to the unit. The group's nocturnists cover nights with help from hospitalists who work evening shifts to handle admissions.

A typical day in the unit starts for hospitalists at 7 a.m. They hold multidisciplinary rounds at 10:30 a.m., reviewing the day's workload with patient care coordinators, case managers and social workers. Hospitalists begin discharging patients early in the morning as they prepare for the next wave of patients. The unit's hospitalists were chosen in part for their interest in working with less acute patients and in working closely with nursing staff and social workers.

Continued on pg. 3—Filling the gap...

CHARGE CAPTURE...CONTINUED FROM PAGE 1

Concurrent Audits:

Hospital should develop a program to perform concurrent audit (complete audit on non-disputed accounts within 30 days of patient discharge). The sample must include both inpatient and outpatient accounts.

Focus Audits:

Every so often hospitals should perform audit or charge capture review on revenue generating departments. Such as pharmacy, radiology, OR, ER.

Based on each hospital, departments that are going to present the greatest opportunity for missed charges are going to vary.

Charge Protocol:

Maintaining and developing charge protocol and policies in all revenue producing departments in order to insure proper implementation of all corporate charge protocols are in place and are being followed.

Charge Audit Committee:

Hospital should designate a formal Chart Audit Committee

attended by Chief Financial Officer, Nurse Auditor, Patient Financial Manager, Business Office Manager and Department Directors. This committee which should meet monthly to review monthly summary of the audit findings by the nurse auditor and address the trend of over and under charges and discuss corrective action that will need to be taken by department managers with excessive errors.

In the end whether the solution involves instituting new procedures, improving staff education, implementing concurrent and focus audits, the benefits are obvious. Accurate charge capture means improving cash flow which translates into increase revenue for the facility.

Julie Doumad RN, BSN, CMAS

Director of Audit Services

[\(American Healthcare Audit Professionals, Inc.\)](#)

FILLING THE GAP...CONTINUED FROM PAGE 2

But Dr. Landler adds that he also looked for hospitalists with good LOS data. "They had to show," he says, "that they were efficient doctors who had a good handle on throughput." Dr. Landler also notes that it did not take a hard sell to interest hospitalists in working on the unit. "There was," he says, "more interest than there were available spaces."

Liberal admission criteria

While observation units tend to use fairly tight admission criteria, Northwestern's short-stay unit accepts a range of 13 diagnoses. The list includes the usual suspects and some not-so-common ones, like uncontrolled diabetes, moderate cellulitis, hypertensive urgency and diarrhea/constipation. Dr. Landler says the unit decided to accept a wide

range of diagnoses so it could handily fill the 30 beds. "Sometimes people fail when they open a new unit because they're a little too selective. The hospital then says, 'You're supposed to be opening beds for us, so if you're sitting on empty ones because you only take three diagnoses, there's no point.

The unit doesn't accept patients who have already been admitted to other units in the hospital; exceptions include patients from the ED and those who have undergone procedures like interventional radiology and GI. The unit also does not allow external transfers or direct admissions from clinician offices.

Dr. Landler acknowledges that because these patients often show up with no advance testing, they can be

a bit of a mystery to the hospitalists. "Sometimes you get surprises, like patients who are misidentified as 'short stay' but who end up taking a lot of time and have to be transferred to a different unit or level of care," he says. "One or two of those can put the whole unit behind."

Getting the message to the ED

While the premise of a short-stay unit is fairly simple, Dr. Landler says that it took a while for the ED physicians to understand exactly which patients were good candidates. "We knew that we were looking at a big pool of patients," he explains. "The issue early on was whether we could identify them on the front end as they come through the ED." Hospitalists had to "reset the ED docs' barometer," for instance, on which pneumonia patients were appropriate for short stay. While a previously healthy patient with low-severity pneumonia should be in the unit, he says, the pneumonia patient with a malignancy discharged from the hospital a week earlier should not. In the end, Dr. Landler recalls, the hospitalists "got everyone on track" by persuading ED doctors to think in terms of "less sick" rather than about the primary diagnosis itself.

A drop in LOS

By all accounts, the unit has been a success. Average length of stay dropped 13% across all medicine units initially—and has remained there—from an average of 5.46 days to 4.75. More impressively, the short-stay unit reduced ED observation

Continued on pg. 4—Filling the gap...

www.AHAPInc.com

**AMERICAN HEALTHCARE
AUDIT PROFESSIONALS**

27068 La Paz Road, Suite 316

Aliso Viejo, CA 92656

Phone #: (949)-448-8296

Fax #: (949)-203-2298

E-mail: info@ahapinc.com

Web: www.AHAPInc.com



We are a premier Medical Consulting and auditing firm which provides Medical Chart Auditing, Certified Coding, and Consulting Services. With the help of our highly experienced Nurse Auditors and Certified Coders, we help our clients obtain specific goals in the areas of:

- *Medical Chart Auditing*
- *Hospital Bill Audit*
- *OIG Audits*
- *Certified Coding*
- *Contract Auditing*
- *Case Review & Preparation*
- *Expert Witness Testimony*
- *Consulting Services for Attorneys & Healthcare Providers*
- *Worker's Compensation Reviews*

MAKING A DIFFERENCE WHERE IT COUNTS...

FILLING THE GAP...CONTINUED FROM PAGE 3

volume by up to 60% in the first seven months of operation.

While the unit hasn't met its objective of discharging patients on average by 1 p.m., Dr. Landler figures that the current 2 p.m. average is "close enough, and just might be optimal. Even if a patient goes home at 5 p.m., that's better than 8 the next morning."

Early data also indicate that patient outcomes are good, at least from the standpoint of readmissions.

Problems with patient flow

Despite the unit's early success, Dr. Landler says that challenges remain, particularly in areas like staffing. Admission-volume fluctuations can wreak havoc. While having two hospitalists during the day works out in principle, problems develop when ED patients begin flooding the inpatient units in the afternoon. On a busy day, the short-stay unit

will handle 10 to 15 admissions. "We can't predict flow to the unit," Dr. Landler says, "but it tends to be toward the afternoon, because of the way our ED—or any ED—works. By the time patients get triaged and tested, it's afternoon. Our goal is to push our discharges earlier in the hope that it will push our admissions earlier." Two nurses who work for the unit as patient care coordinators (not floor nurses) play a key role in that effort. Besides commandeering the timing of tests, the coordinators help manage discharge planning and instructions and provide disease-specific patient education.

Having coordinators has been "a major contributor to the unit's success," Dr.

Landler notes. The unit recently added a nurse practitioner to help hospitalists during crunch times and to work independently with lower-acuity patients.

Making the case for more staff

The unit has also had to overcome nursing staffing issues as well. Nursing managers often assign night coverage nurses based on unit census at 3 p.m., so the short-stay unit ends up shortchanged during a late afternoon spike in admissions. To avoid being understaffed, Dr. Landler performed an ADT (average daily admissions/discharges/transfers) analysis to make the case for more nurses. The data showed that the unit's ADT index was 50% higher than on the medicine units, and that the unit's admission volume was 42% higher. By focusing the conversation on patient turnover instead of on the number of empty beds, the unit was able to make a convincing case for more nursing support.

One other challenge, albeit minor, is that administration has upped the stakes as far as its goals for the unit. The initial objective was to do a better job with the gray-area patients between ED observation and medicine. Now the hospital wants the hospitalists to take on more of the ED-observation patients, so the hospitalists are taking another look at criteria.

by Bonnie Darves

Published in the December 2008 issue of Today's Hospitalist