



**MANAGING THROUGH THE MAZE OF CURRENT  
CHANGES:**

*The Impact from Listening to the Data Found  
in the Revenue Cycle*

**PART TWO**

# Introductions



Christian: BA – Director of Patient Accounts for Oneida Healthcare, Oneida, NY with almost 20 years of Revenue Cycle



Don: MBA – Health Industries Advisory Manager with PwC in Boston, MA with 12 years of Revenue Cycle experience



Lorrie: MA; CRCE-I; CRCS; CPC – President of Best Practice Training Institute with over 20 years of experience in various settings



Rob: MBA; FHFMA; CRCE-I – President of Best Practice Associates with about 35 years of Revenue Cycle Experience



Tim: MBA; CRCS; PMP – Deputy Director and Practice Leader for Altarum Institute with 15 years of Revenue Cycle experience

Healthcare Cost Trends

Metrics / KPIs

Risks & Impacts

ICD-10 Risk Planning

Case Mix  
Present on Admission  
Payor Perspective

Clinical Documentation  
Medical Necessity  
Present on Admission  
Case Mix  
Revenue Cycle Strategies

# Healthcare Cost Trends

## Inflators:

- Economic Upswing
- Specialty Drugs
- Physician Employment
- IT Investments

Increased consumer confidence = declining delayed care

Hospital acquisition of Physician Practices provide opportunity to escalate charges to higher hospital-rates

Reducing redundancies lowers operating costs and should counterbalance spending

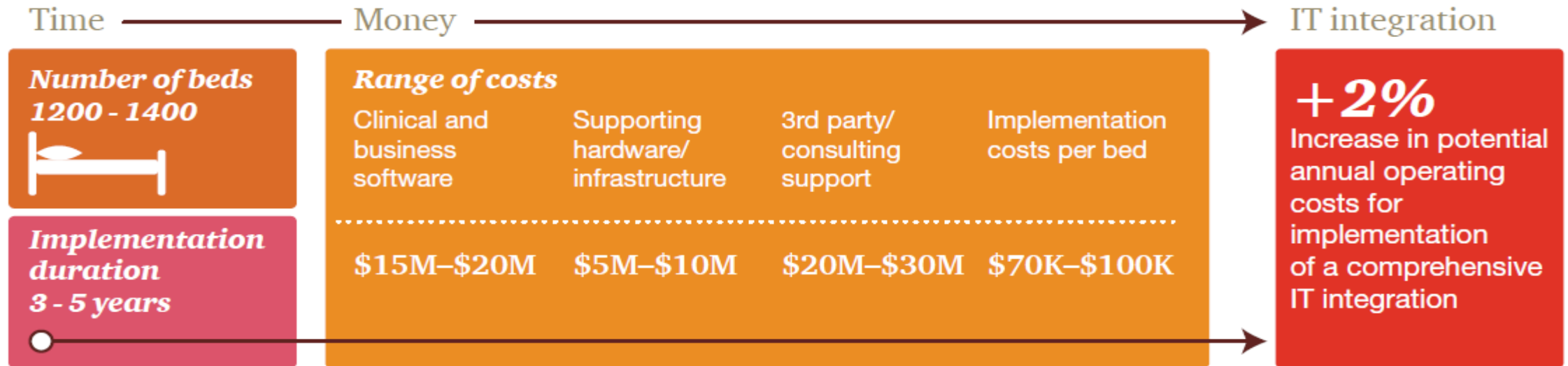
## Deflators:

- “System-ness”
- Healthcare Price Shopping
- Risk-Based Payments

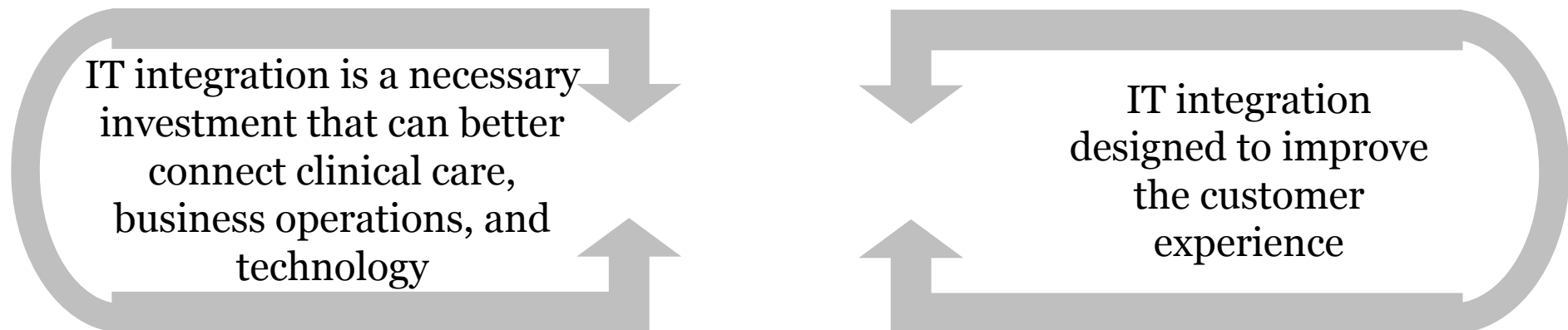
Savings experienced through holding physicians and health systems responsible for patient outcomes

# Healthcare Cost Inflater

Example costs and duration for an end-to-end IT integration



\*Does not represent complete range of costs. Numbers are representative.

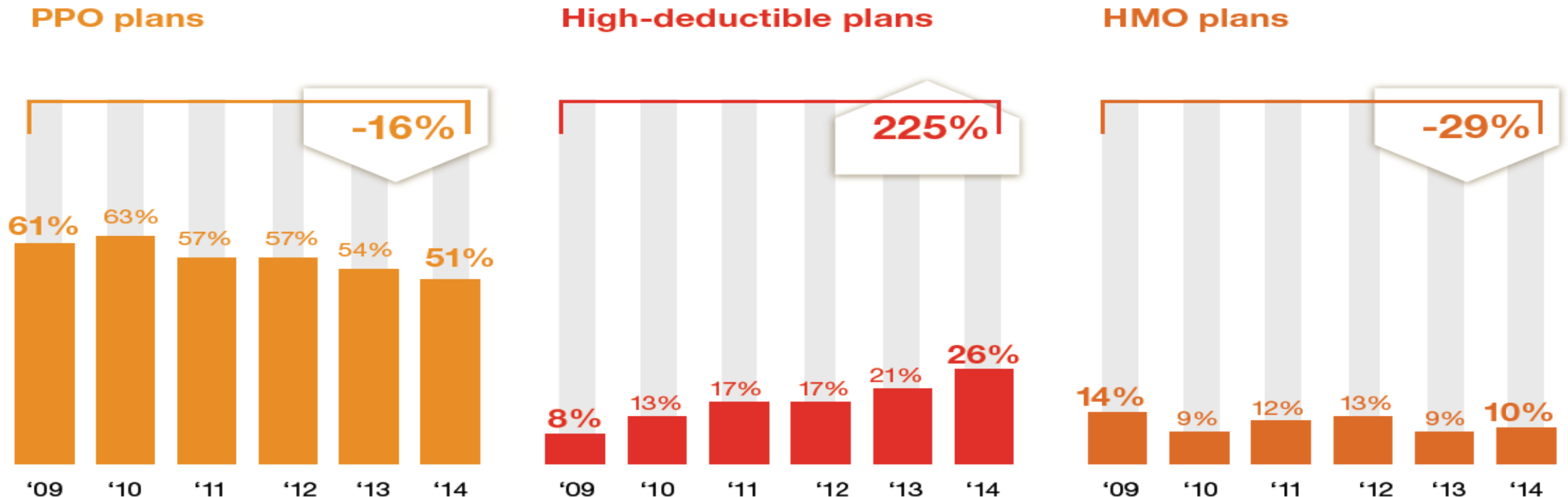


# Healthcare Cost Deflator

33% of employers across all industries are considering high-deductible plans as the only insurance option for their employees during the next three (3) years

According to a recent study, families in consumer-directed plans used fewer brand-name drugs, had fewer visits to specialists, and were hospitalized less

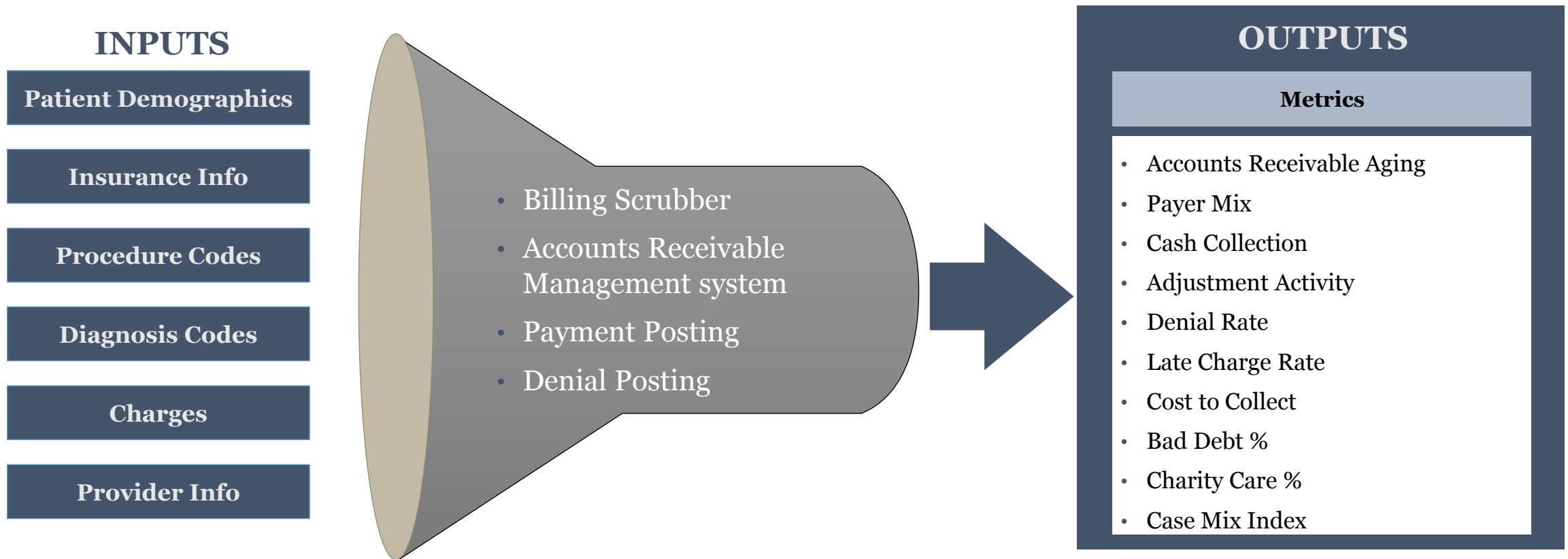
Enrollment in employer-sponsored health plans by type of plan, 2009–2014



Source: PwC's Health Research Institute – Medical Cost Trend: Behind the Numbers 2015

# Metrics = Performance

- Claims processing is transactional in nature and the measuring of metrics is critical to becoming a high-performing organization
- Comparing your metrics to a peer organization provides insight to performance levels and, consequently, where effort should be focused in order to improve



# Patient Financial Services – Management KPIs

Measure	Purpose	Value	Equation
Net Days in A/R	Trending indicator of overall A/R performance	Indicates revenue cycle efficiency	$\frac{N: (\text{Net A/R})}{D: \text{Avg. Daily Net Patient Service Revenue}}$
Aged A/R as a Percentage of Billed A/R	Trending indicator of receivable collectability	Indicates revenue cycle's ability to liquidate A/R	$\frac{N: (>30, >60, >90, >120 \text{ days})}{D: (\text{Total Billed A/R})}$
Cash Collection as a Percentage of Adjusted Net Patient Service Revenue	Trending indicator of revenue cycle to convert net patient services revenue to cash	Indicates fiscal integrity/financial health of the organization	$\frac{N: (\text{Total Cash Collected})}{D: \text{Average Monthly Net Revenue}}$
Bad Debt	Trending indicator of the effectiveness of self-pay collection efforts and financial counseling	Indicates organization's ability to collect self-pay accounts and identify payer sources for those who can't meet financial obligations	$\frac{N: \text{Bad Debt Write-Off}}{D: \text{Gross Patient Service Revenue}}$
Charity Care	Trending indicator of local ability to pay	Indicates services provided to patients deemed unable to pay	$\frac{N: \text{Charity Care Write-Off}}{D: \text{Gross Patient Revenue}}$
Cost to Collect	Trending indicator of operational performance	Indicates the efficiency and productivity of revenue cycle (RC) process	$\frac{N: \text{Total RC Cost}}{D: \text{Total Cash Collected}}$
Case Mix Index	Trending indicator of patient acuity, clinical documentation, and coding	Supports appropriate reimbursement for services performed and accurate clinical reporting	$\frac{N: \text{CMI}}{D: \text{Number of patients in the month}}$



# PFS – Revenue Integrity KPIs

Measure	Purpose	Value	Equation
Discharged Not Final Billed (DNFB)	Trending indicator of claims generation process	Indicates revenue cycle performance and can identify performance issues impacting cash flow	<u>N: Gross Dollar in A/R (Not Final Billed)</u> D: Average Daily Gross Revenue
Discharged Not Submitted to Payer (DNSP)	Trending indicator of total claims generation and submission process	Indicates revenue cycle performance and can identify performance issues impacting cash flow	<u>N: (Gross Dollars in DNFB + Gross Dollars in FBNS)</u> D: Average Daily Gross Revenue
Late Charges as a Percentage of Total Charges	Measure of revenue capture efficiency	Identify opportunities to improve revenue capture, reduce unnecessary cost, enhance compliance, and accelerate cash flow	<u>N: Charges with post date greater than three days from last service</u> D: Total Gross Charges
Net Days Revenue in Credit Balance	Trending indicator to accurately report account values, ensure compliance with regulatory requirements, and monitor overall payment system effectiveness	Indicates whether credit balances are being managed to appropriate levels and are compliant to regulatory	<u>N: Dollars in Credit Balance</u> D: Average Daily Net Patient Service Revenue

Source: HFMA MAP Key Category – Revenue Integrity

# PFS – Additional KPIs

Measure	Equation	Measure	Equation
Denial Write-Offs as a Percent of Net Revenue	<u>N: Total Denial Write-Offs</u> D: Net patient services revenue	Net Days Revenue in A/R	<u>N: Dollars in debit</u> D: Average daily net patient services revenue
	<u>N: Denial write offs for no authorization</u> D: Net patient services revenue		<u>N: Dollars in credit</u> D: Average daily net patient services revenue
	<u>N: Denial write offs associated with untimely filing</u> D: Net Patient Services Revenue		<u>N: Total Medicare +Medicaid billed A/R &gt;90 days</u> D: Total A/R
Cash Collections	<u>N: POS cash payments</u> D: Net patient services revenue	Aged A/R as a % of Billed A/R by Payer Group	<u>N: Total Commercial +Managed Care + “Other billed A/R &gt; 90 days</u> D: Total A/R
	<u>N: POS cash payments</u> D: Total patient cash collected		<u>N: Total Self-Pay Billed A/R &gt; 90 Days</u> D: Total A/R
	<u>N: Total gross cash collected</u> D: Net patient services revenue		<u>N: Total Billed A/R &gt; 90 Days</u> D: Total A/R
Days in Total Discharged Not Final Billed (DNFB)	<u>N: Dollars in A/R Not Final Billed or Not Submitted to Payer (DNSP)</u> D: Average daily gross revenue	Uncompensated Care	<u>N: Bad debt write-off</u> D: Gross patient service revenue
	<u>N: Dollars in Discharge Not Final Coded (DNFC)</u> D: Average daily gross revenue		<u>N: Uninsured discounts</u> D: Gross patient service revenue

Source: PwC Revenue Cycle Consortium – *Survey Metrics and Definitions*

# Potential for Healthcare Provider Impacts and Risks Summary

<b>BENEFITS</b>	<b>RISKS</b>	<b>RESULTS</b>	<b>RESOLUTION</b>
Better documentation for profiles, billing and research	Incomplete documentation; Lower clinical delivery rate	Physician queries delay billing an increase DNFB	Physicians must be retrained Clinical Documentation Improvement vital
Great reduction in nonspecific coding	Training & productivity challenges	Decreased coding productivity an increase DNFB; Increase in claims error rate; High training costs; Coder turnover	Educate coders over time Train a Trainer Individually address coder issues Train billers
Clearer code choices	Software issues	Encoder and/or abstracting software does not support both ICD-9 and ICD-10 code fields; Costs for hardware conversion	Communicate with vendors early Budget for hardware and software expenses Spend time testing
Operational efficiencies for more efficient claims processing	Coding errors & payor contract management	Higher claims error rate leads to billing delays and lower cash; Less accurate data for reimbursement trends	Work with payors to assess coding conversion payment plans Perform gap analysis coding with both ICD-9 and ICD-10

# Data Gathering and Outcome

	Data	Outcome
1.	Gather selected forms, order sheets, super bills, etc.	Recommendations to ICD-10 Committee on form revisions
2.	Identify all system vendors – focus on selected three	Contract issue and contact 3 for assessment of readiness
3.	Identify third party payers – focus on selected three	Contact three payers to determine their readiness and testing plan

# Effects of Case Mix and Reimbursement

Case Mix is a determining factor regarding the overall COST of services for inpatient care

Case Mix is a determining factor in aligning a dollar value for reimbursement for inpatient care

Reimbursement is generally based on the cost for hospital services

Reimbursement methodologies have been developed to strive to address both the cost of hospital services and avenues to reduce cost through higher efficiency

Reimbursement varies based on the severity of the case and the level of services addressing the quality of care

# Six dimensions for measuring Case Mix

## **Severity of Illness**

Levels of organ system loss of function

## **Treatment Difficulty**

Patient management problems

## **Risk of Mortality**

Likelihood of dying

## **Need for Intervention**

Consequences in terms of severity of illness

## **Prognosis**

probable outcome (improvement or deterioration)

## **Resource Intensity**

Services used in the management of illness

Case Mix



# POA Questionnaire

IN THE PAST SIX MONTHS, HAVE YOU HAD...

	YES	NO			YES	NO
ANY OPERATION				STOMACH PROBLEMS		
PAINS IN THE BACK				MIGRAINES		
LEG PAIN				HEAD PAIN		
DIABETES				NECK PAIN		
PNEMONIA				ARTHRITIS		
HEART CONDITION				BREATHING PROBLEMS		

# Payor Perspective

## People

- *Clinicians and medical reviewers will need to be fluent in both ICD-9 and ICD-10*
- *Training will be critical*

## Process

- *Medical policy will require an overhaul*
- *Organizations will have to invest the time to define how it will stratify ICD-10 codes for medical and reimbursement requirements*

## Technology

- *Pre-Cert and Approval systems will need to be able to record both code sets*
- *There will not be a single cross-walk solution*

*There are no holy grail crosswalks – Each Health Plan needs to decide for themselves how ICD-10 is interpreted in regard to medical necessity*



# Payor Implementation Impacts



Keep a log of each payor's approach

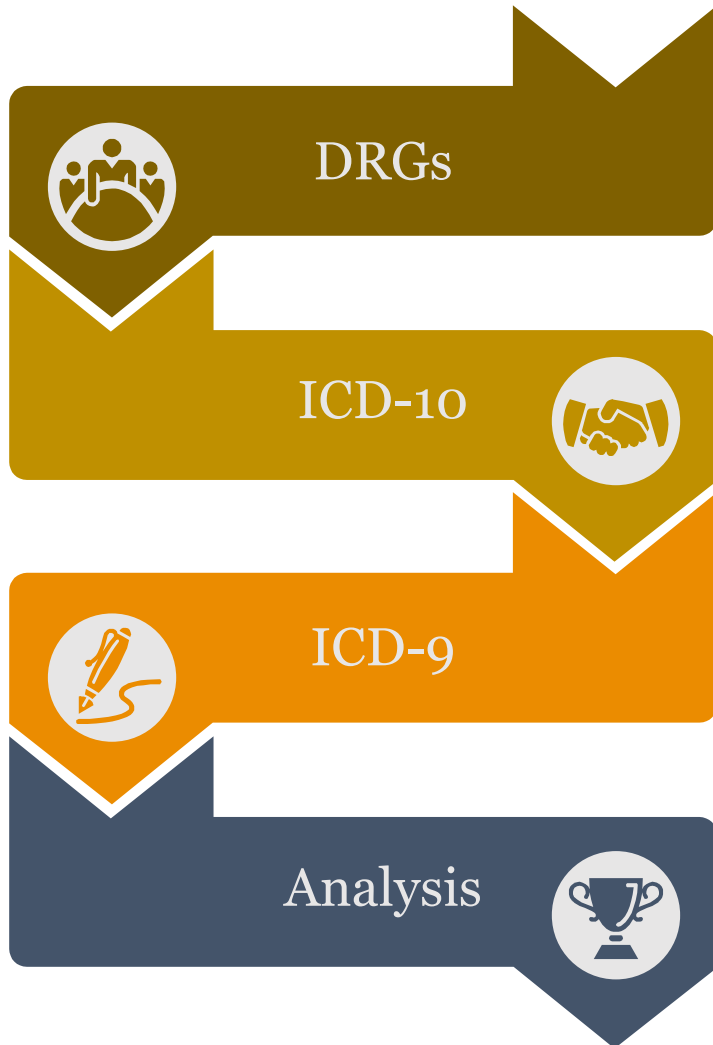


According to CMS there are 4 HIPAA compliant strategies that payors may employ:

- Crosswalk Strategy
- Minimum Upgrade Strategy
- Maximum Upgrade Strategy
- Upgrade and Crosswalk Hybrid Strategy

# ICD-10 Risk Planning for Success

# Awareness



It took three years for the initial DRGs (1983) to adjust the weights (based on improved coding)

Managed Care Companies are offering to “keep you whole” during the ICD-10 period of adjustment

Managed Care Companies will accept your ICD-10 codes but may pay you under ICD-9 methodology

Without a strong CDI program and a DRG Impact Analysis...You will never know!

# Contract Management and Insurance Verification

Building coverage patterns from Third Party Payor contracts

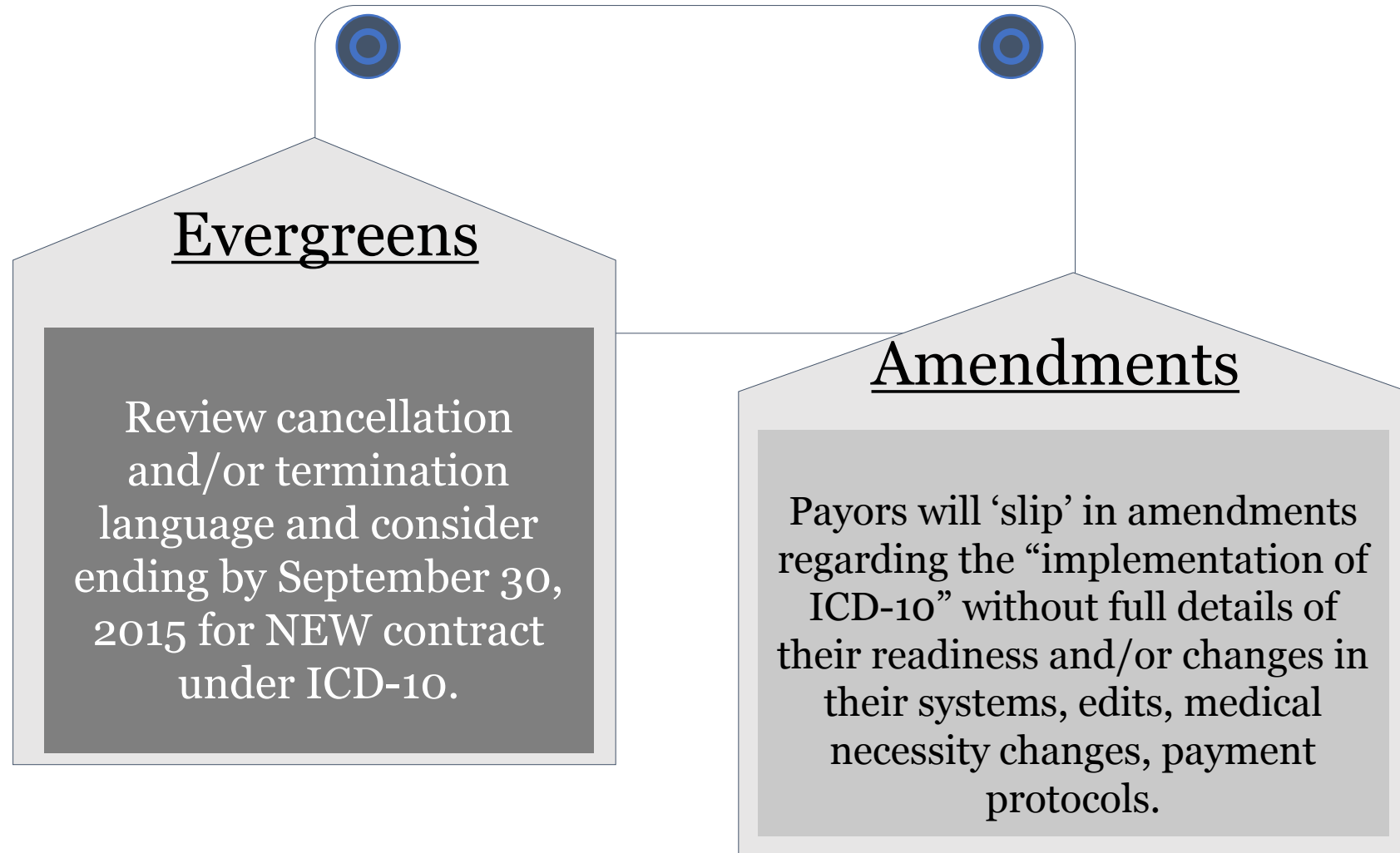
Specific specialty definitions of both CPT and diagnosis (Case Rates)

HIPAA Transaction sets

Educating and Training staff for optimum coverage in identifying both POA and principal reason for admission (medical necessity)

Third Party Payer systems monitoring

# Managed Care Contracts



# Language to Question!

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“In preparation for the implementation of ICD-10, we will process claims as usual and accept the submitted codes. The reimbursement for the year 2015 -2016 will be budget neutral, reflecting no impact on XXXXX hospital.”

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Similar language but with a twist – “...although our processing protocols may have changed due to ICD-10, reimbursement will be budget neutral for 2015 – 2016.”

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**YOUR ANALYSIS MAY SHOW DIFFERENT REIMBURSEMENT BENEFITS!**

# Language to Add to a Contract

With the discontinuation of ICD- 9 as of September 30, 2015, the auditing of historical claims will not involve any claims with initial DOS over three (3) years old from review request date.

As of October 1, 2017, no claims with ICD-9 codes will be available for audit.

Any open claims with ICD-9 codes must be resolved by January 1, 2018.

# Language to Consider!

All new and/or modified system processing changes to the payor system must be shown to the hospital /practice and explained by the payor.

This includes crosswalks, medical necessity edits, claim processing edits, etc.

As of October 1, all claims will be processed using ICD-10 codes and no crosswalks to ICD-9 will occur



# Contract Comparisons

Fiscal Year Data										
XYZ										
Hospital	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Allowed	71.8%	64.0%	51.4%	62.6%	60.3%	62.9%	59.3%	96.4%	95.8%	42.0%
Collected	60.5%	53.0%	39.8%	48.4%	46.4%	46.4%	40.6%	39.9%	52.2%	11.8%

## Inpatient Data

Fiscal Year Data										
XYZ										
Hospital	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
I/P Allow	57.0%	61.9%	38.7%	51.3%	39.6%	86.0%	30.3%	100.0%	100.0%	6.8%
I/P Coll	55.2%	59.4%	33.8%	45.8%	35.2%	78.6%	22.4%	59.0%	83.2%	5.2%

## Outpatient Data

Fiscal Year Data										
XYZ										
Hospital	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
O/P Allow	75.1%	64.5%	53.9%	65.5%	65.2%	55.8%	69.8%	95.7%	94.9%	46.6%
O/P Coll	61.7%	51.2%	41.0%	49.1%	49.0%	36.6%	47.3%	36.0%	45.7%	12.7%

# Inpatient Activity

## Allowed Coverage

<u>Allowed by Care</u>	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Total	71.8%	64.0%	51.4%	62.6%	60.3%	62.9%	59.3%	96.4%	95.8%	42.0%
Gen Med	55.6%	62.2%	46.5%	44.8%	45.2%	86.4%	15.6%	100.0%	100.0%	6.8%
Surgery	55.5%	60.9%	29.1%	59.4%	26.9%	97.4%	58.2%	100.0%	100.0%	n/a
Psychiatric	61.4%	68.6%	89.2%	n/a	93.2%	100.0%	33.4%	n/a	100.0%	n/a
Rehab	65.4%	63.2%	40.8%	n/a	37.8%	n/a	44.3%	n/a	n/a	n/a
OB/Gyn	69.2%	45.9%	n/a	40.0%	n/a	5.4%	n/a	n/a	n/a	n/a
Other	39.0%	62.7%	23.8%	34.9%	32.0%	n/a	50.1%	n/a	n/a	n/a

## Collected Data

<u>Collect by Care</u>	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Total	60.5%	53.0%	39.8%	48.4%	46.4%	46.4%	40.6%	39.9%	52.2%	11.8%
Gen Med	53.0%	60.1%	42.3%	40.5%	42.2%	79.3%	9.8%	58.1%	85.8%	5.2%
Surgery	54.3%	58.0%	24.0%	52.1%	22.9%	89.6%	45.9%	60.9%	76.6%	n/a
Psychiatric	59.3%	66.1%	79.0%	n/a	50.3%	65.0%	25.6%	n/a	78.9%	n/a
Rehab	62.2%	60.0%	38.1%	n/a	30.1%	n/a	35.4%	n/a	n/a	n/a
OB/Gyn	69.2%	45.7%	n/a	32.3%	n/a	5.4%	n/a	n/a	n/a	n/a
Other	39.0%	53.5%	18.0%	32.2%	17.4%	n/a	43.7%	n/a	n/a	n/a

# Plan Comparisons

## Allowed

<u>Allowed by Plan</u>	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Total	71.8%	64.0%	51.4%	62.6%	60.3%	62.9%	59.3%	96.4%	95.8%	42.0%
PPO	72.0%	64.3%	51.0%	65.4%	60.4%	63.8%	58.2%	96.6%	95.8%	n/a
HMO	76.1%	66.4%	52.4%	56.5%	59.9%	n/a	n/a	98.8%	n/a	n/a
Comp	74.1%	56.9%	53.5%	71.9%	67.1%	51.5%	88.3%	n/a	95.0%	n/a
ACO	63.6%	50.7%	31.1%	59.5%	69.5%	38.7%	61.7%	n/a	n/a	n/a
Secondary	67.3%	62.2%	62.4%	61.5%	33.9%	n/a	97.3%	n/a	n/a	n/a
Value	69.9%	65.9%	50.3%	74.6%	59.1%	n/a	67.2%	n/a	n/a	n/a

## Collected

<u>Collect by Plan</u>	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Total	60.5%	53.0%	39.8%	48.4%	46.4%	46.4%	40.6%	39.9%	52.2%	11.8%
PPO	60.7%	53.3%	38.4%	50.3%	47.8%	47.2%	40.6%	39.8%	53.4%	n/a
HMO	47.2%	37.2%	42.6%	44.6%	45.2%	n/a	n/a	46.4%	n/a	n/a
Comp	41.5%	45.9%	39.7%	51.2%	47.0%	41.1%	41.0%	n/a	34.1%	n/a
ACO	56.6%	33.0%	15.5%	42.6%	22.7%	27.2%	48.0%	n/a	n/a	n/a
Secondary	47.2%	53.7%	42.4%	41.0%	26.9%	n/a	97.3%	n/a	n/a	n/a
Value	33.8%	56.3%	35.5%	42.6%	38.9%	n/a	58.8%	n/a	n/a	n/a

# DRGs Allowed as a % of Medicare

DRG	Description	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
470	Major joint replacement or reattachment of lower extremity w/o MCC	398.5%	334.0%	63.2%	331.6%	74.9%	484.0%	137.2%	na	Na	na
885	Psychoses	294.9%	214.5%	187.8%	na	251.4%	40.8%	111.6%	na	na	na
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	173.5%	565.3%	na	na	na	na	9.5%	na	na	na
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	637.1%	349.9%	na	209.8%	54.2%	na	na	na	na	na
309	Cardiac arrhythmia & conduction disorders w CC	106.8%	161.9%	na	na	33.0%	na	24.0%	na	na	na
392	Esophagitis, gastroent & misc digest disorders w/o MCC	122.4%	235.0%	109.2%	131.2%	72.3%	na	na	na	462.3%	na
603	Cellulitis w/o MCC	241.3%	382.1%	251.2%	na	62.3%	193.6%	na	429.2%	na	na
292	Heart failure & shock w CC	na	na	na	na	318.3%	872.5%	na	na	na	na
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	282.0%	276.5%	208.5%	na	584.1%	320.3%	159.9%	na	149.6%	na
313	Chest pain	315.4%	171.1%	74.9%	224.4%	94.9%	261.9%	na	na	na	na
312	Syncope & collapse	217.4%	297.2%	na	248.7%	na	na	na	Na	na	na
343	Appendectomy w/o complicated principal diag w/o CC/MCC	265.3%	236.4%	na	na	na	595.4%	411.0%	Na	na	na

# DRGs Collected as a % of Medicare

		Collected as a Percent of Medicare									
		RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
DRG	Description	391.2%	321.3%	58.9%	315.5%	64.4%	462.4%	116.9%	na	na	na
470	Major joint replacement or reattachment of lower extremity w/o MCC	285.1%	206.6%	172.6%	na	15.6%	26.5%	74.0%	na	na	na
885	Psychoses	171.5%	544.3%	na	na	na	na	9.5%	na	na	na
247	Pericardiovascular procedure with drug-eluting stent w/o MCC	625.2%	344.6%	na	190.8%	38.1%	na	na	na	na	na
743	Uterine & adnexa procedure for non-malignancy w/o CC/MCC	104.3%	161.9%	na	na	33.0%	na	24.0%	na	na	na
309	Cardiac arrhythmia & conduction disorders w CC	110.1%	228.0%	109.2%	68.8%	59.8%	na	na	na	451.2%	na
392	Esophagitis, gastroenteric & miscellaneous digestive disorders w/o MCC	205.0%	351.9%	236.4%	na	56.1%	125.8%	na	117.5%	na	na
603	Cellulitis w/o MCC	na	na	na	na	318.3%	872.5%	na	na	na	na
292	Heart failure & shock w CC	273.1%	271.1%	202.4%	na	484.6%	208.2%	149.7%	na	135.6%	na
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	313.2%	166.7%	63.7%	174.3%	61.6%	198.7%	na	na	na	na
313	Chest pain	192.1%	275.7%	na	192.7%	na	na	na	na	na	na
312	Syncope & collapse	228.2%	168.9%	na	na	na	520.3%	346.2%	na	na	na
343	Appendectomy w/o complicated principal diagnosis w/o CC/MCC	198.3%	120.0%	74.6%	na	45.9%	271.0%	na	na	na	na

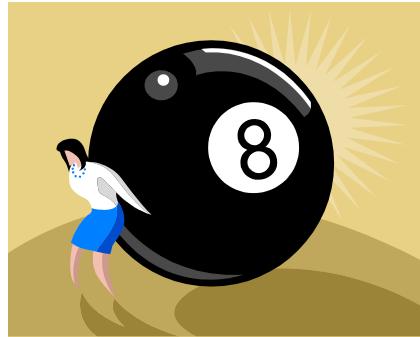
# CPT Allowed as a % of Medicare

Allowed by CPT	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
99213	153.6%	120.5%	134.0%	144.8%	140.1%	170.4%	89.1%	na	169.3%	na
99214	155.9%	117.8%	131.2%	138.0%	141.2%	186.6%	108.9%	na	169.9%	na
90471	380.2%	295.4%	267.0%	334.8%	185.2%	105.1%	364.7%	na	388.6%	na
97110	231.5%	211.2%	212.1%	261.4%	247.9%	188.5%	322.7%	na	470.1%	na
99211	166.1%	125.8%	112.6%	143.1%	221.3%	79.3%	113.3%	na	180.5%	na
99212	151.4%	121.1%	127.5%	144.9%	143.4%	116.3%	86.6%	na	170.1%	na
96372	410.8%	322.5%	295.4%	362.3%	469.2%	121.1%	393.0%	na	551.9%	na
71020	407.2%	310.3%	343.6%	377.8%	397.0%	177.3%	409.3%	na	455.5%	na
99202	157.0%	122.0%	117.3%	138.6%	138.0%	175.2%	19.1%	na	168.6%	na
99283	359.4%	294.0%	288.1%	304.8%	329.3%	165.4%	301.2%	na	398.7%	na
88305	710.9%	658.0%	682.4%	700.9%	853.0%	598.0%	616.9%	na	754.1%	na
97140	210.3%	155.8%	172.2%	285.4%	165.7%	282.8%	188.0%	na	367.6%	na
97001	143.3%	127.8%	129.2%	147.5%	137.6%	179.5%	146.9%	na	206.7%	na

# CPT Collected as a % of Medicare

Collected by CPT	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK33	Workers' Comp
99213	113.3%	88.7%	105.6%	85.6%	81.8%	92.9%	38.3%	na	91.3%	na
99214	118.7%	97.3%	102.3%	79.6%	83.0%	98.2%	51.8%	na	94.9%	na
90471	359.8%	289.0%	261.2%	262.7%	0.0%	93.2%	313.0%	na	197.9%	na
97110	173.5%	152.9%	146.8%	181.9%	178.9%	121.0%	258.0%	na	318.2%	na
99211	122.0%	94.0%	78.6%	92.7%	155.9%	43.7%	79.3%	na	100.0%	na
99212	115.3%	95.5%	95.1%	89.5%	94.5%	57.5%	54.2%	na	94.6%	na
96372	326.4%	260.9%	217.9%	265.7%	373.3%	67.5%	320.1%	na	344.3%	na
71020	311.8%	231.0%	236.0%	236.3%	288.4%	95.7%	215.0%	na	192.7%	na
99202	118.7%	89.1%	96.1%	82.9%	85.2%	88.8%	0.0%	na	92.9%	na
99283	247.0%	197.4%	197.8%	233.3%	200.1%	124.0%	241.0%	na	159.4%	na
88305	570.4%	531.1%	525.1%	504.6%	694.4%	374.8%	360.5%	na	218.6%	na
97140	169.8%	114.7%	115.5%	228.7%	126.5%	173.4%	143.3%	na	239.9%	na
97001	101.4%	87.8%	78.5%	95.3%	77.0%	96.3%	104.4%	na	62.0%	na

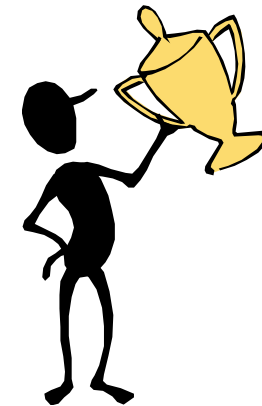
# So What is Next?



ARE YOU BEHIND THE  
EIGHT BALL?????

OR

AHEAD OF THE CURVE!!!





# The Maze Leads to Future Changes!!

- Quality Indicators will expand and tied to reimbursement
- Clinical documentation will increase and coders will code “everything”
- POA and Secondary Diagnosis will have a direct effect on payment
- ICD-10 codes MUST address Severity of Illness and Risk of Mortality
- Case Mix will change for many facilities
- Managed Care Contract language will become more “specific”
- APR-DRGs will become the national Grouper with reimbursement sub-classes

# APR-DRG Weight Comparison

<u>Future Methodology</u>							
				<u>APRDRGs</u>	<u>Weights</u>		
<u>MSDRG</u>		<u>Weight</u>	<u>APR #</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613	313	1.0621	1.6254	2.8176	7.0611
313	Chest pain	0.5404	203	0.3586	0.451	0.6973	1.9656
392	Esophagitis, gastroent & misc digest disorders w/o MCC	1.6921	220	1.2027	1.9353	3.4738	7.5539
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121	175	1.4546	1.6351	2.4993	3.8994
885	Psychoses	0.8899	751	0.4768	0.5508	1.4403	1.4765
603	Cellulitis w/o MCC	0.8178	383	0.484	0.6808	1.1808	3.0538
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.571	201	0.4231	0.6489	1.1315	2.6423
312	Syncope & collapse	0.7215	204	0.4192	0.5524	0.8874	2.302
303	Atherosclerosis w/o MCC	0.5681	198	0.3902	0.5022	0.8473	0.9198

# APR-DRG Rate Comparison

<u>Future Methodology</u>							
<b>Base Rate of \$5000</b>				<u>APRDRGs</u>	<u>Weights</u>		
<u>MSDRG</u>		Weight	<u>APR #</u>	1	2	3	4
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613	313	1.0621	1.6254	2.8176	7.0611
	REIMBURSEMENT	<b>\$ 10,306.50</b>		<b>\$ 5,310.50</b>	<b>\$ 8,127.00</b>	<b>\$ 14,088.00</b>	<b>\$ 35,305.50</b>
313	Chest pain	0.5404	203	0.3586	0.451	0.6973	1.9656
		<b>\$ 2,702.00</b>		<b>\$ 1,793.00</b>	<b>\$ 2,255.00</b>	<b>\$ 3,486.50</b>	<b>\$ 9,828.00</b>
392	Esophagitis, gastroent & misc digest disorders w/o MCC	1.6921	220	1.2027	1.9353	3.4738	7.5539
		<b>\$ 8,460.50</b>		<b>\$ 6,013.50</b>	<b>\$ 9,676.50</b>	<b>\$ 17,369.00</b>	<b>\$ 37,769.50</b>
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121	175	1.4546	1.6351	2.4993	3.8994
		<b>\$ 9,560.50</b>		<b>\$ 7,273.00</b>	<b>\$ 8,175.50</b>	<b>\$ 12,496.50</b>	<b>\$ 19,497.00</b>

# APR-DRG Rate Comparison

<u>Future Methodology</u>							
<b>Base Rate of \$5000</b>				<u>APRDRGs</u>	<u>Weights</u>		
<u>MSDRG</u>		Weight	<u>APR #</u>	1	2	3	4
885	Psychoses	0.8899	751	0.4768	0.5508	1.4403	1.4765
	REIMBURSEMENT	<b>\$ 4,449.50</b>		<b>\$ 2,384.00</b>	<b>\$ 2,754.00</b>	<b>\$ 7,201.50</b>	<b>\$ 7,382.50</b>
603	Cellulitis w/o MCC	0.8178	383	0.484	0.6808	1.1808	3.0538
		<b>\$ 4,089.00</b>		<b>\$ 2,420.00</b>	<b>\$ 3,404.00</b>	<b>\$ 5,904.00</b>	<b>\$ 15,269.00</b>
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.571	201	0.4231	0.6489	1.1315	2.6423
		<b>\$ 2,855.00</b>		<b>\$ 2,115.50</b>	<b>\$ 3,244.50</b>	<b>\$ 5,657.50</b>	<b>\$ 13,211.50</b>
312	Syncope & collapse	0.7215	204	0.4192	0.5524	0.8874	2.302
		<b>\$ 3,607.50</b>		<b>\$ 2,096.00</b>	<b>\$ 2,762.00</b>	<b>\$ 4,437.00</b>	<b>\$ 11,510.00</b>
303	Atherosclerosis w/o MCC	0.5681	198	0.3902	0.5022	0.8473	0.9198
		<b>\$ 2,840.50</b>		<b>\$ 1,951.00</b>	<b>\$ 2,511.00</b>	<b>\$ 4,236.50</b>	<b>\$ 4,599.00</b>

Readiness/Risk Planning Needs  
to Start NOW despite the  
postponement to Oct 2015



# Questions?



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