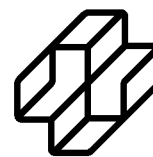


HFMA's Patient Friendly Billing



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Preparing for “No-Pay” Events

Hundreds of hospitals across the country have pledged or been ordered to stop charging payers and patients for costs associated with serious, preventable medical errors, such as fractures caused by patient falls and objects left in during surgery. The movement is being echoed at the federal level. In October, Medicare will stop paying acute care hospitals for eight so-called “never events” that are not present on admission.

How do those pledges and mandates translate to a patient’s bill? Leaders at two hospitals on the front lines of this issue share their processes for figuring this out.

A Collaborative Approach

Fairview Health Services, a seven-hospital system based in Minneapolis, served nearly 3 million patients last year. Of those, 23 experienced adverse events that were reported to the state health department.

“It’s a very small number compared to the number of people you see in a given

year,” says Mike Seitz, Fairview’s vice president for risk management and vice president for revenue cycle. “But you take it seriously.”

Minnesota hospitals, led by the Minnesota Hospital Association, were the first in the country to initiate legislation that requires public reporting of preventable adverse events. In addition, Minnesota is the first state in which hospitals agreed to jointly develop billing policies related to adverse events.

Since 2003, Minnesota law has required hospitals to complete the following:

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- > Publicly report any of the now 28 adverse events defined by National Quality Forum (NQF), which includes wrong-site surgery, use of contaminated drugs or devices, and hospital-acquired pressure ulcers. (Visit www.qualityforum.org for a complete list of NQF adverse events.)
- > Conduct a root cause analysis and prepare a corrective action plan for all reported events.
- > Share the analysis and corrections with other hospitals so similar problems can be averted in the future.

“It’s [The Minnesota public reporting] a very powerful and effective tool to improve safety in hospitals,” says Bruce Rueben, the association’s president.

While the list of reportable events is clear cut, how to handle billing issues related to them is anything but. It is, of course, appropriate for a hospital to charge for medical care delivered to a patient unrelated to an adverse event. Parsing out exactly what charges are appropriate for billing is the challenge.

“We want to do the right thing,” says Seitz. “But what is the right thing? This sets up many, many questions for us as providers.”

For example, it is obvious that a hospital should not charge for a second surgery required to remove a sponge left during a procedure. But pressure ulcers that do not require an extended hospital stay present a less clear billing issue. How should hospitals bill for admissions related to adverse events that happened at another hospital? And what about adverse events with patients whose care is billed as a diagnosis-related group (DRG)?

“We can’t change a DRG,” says Seitz. “How do we communicate this to the payer so that we are up front about it?”

To answer these questions, the Minnesota Hospital Association has convened meetings between payers and hospital leaders to develop an adverse event billing policy that spells out terms and protocols. (See the exhibit on page 10 for the draft policy.) When the policy is finalized later this year, Seitz expects it to be incorporated in new contracts between payers and providers.

Currently, when an adverse event occurs in the Fairview system, a team (including representatives from risk management and performance improvement, along with the relevant nurse manager and service unit vice president) conducts an investigation. That team also flags the patient’s account so no bill is prepared until the investigation is complete.

The risk management department and billing department review the patient’s bill to determine which, if any, charges should be removed from the bill. Any event that is reported to the state database is discussed with the patient, even though the patient’s name is not reported.

Historically, patient bills associated with adverse events have been handled on a case-by-case basis. In some cases, the patient’s bill was adjusted, but in other cases, it was not. Seitz says that is no longer acceptable. “We want to move towards a standard communication process whenever we adjust a bill,” he says.

A Proactive Approach

In February, all 57 hospitals in Oregon agreed to a policy that ensures no patient or payer will pay for hospital care related to any of 24 preventable adverse events. (The list of adverse events is available at www.oahhs.org).

The statewide policy, initiated by the Oregon Association of Hospitals and Health Systems, says hospitals will not seek payment if any of the following is true:

- > The event results in an increased length of stay, level of care, or significant intervention.
- > An additional procedure is required to correct an event in the previous procedure.
- > An unintended procedure is performed.
- > Readmission is required as a result of an event that occurred in that same facility.

Kathleen Dowling, of Providence Health & Services, rattles off the list of questions about the state policy that immediately come to mind. “How do I identify these no-pay events when they occur within the hospital?” says Dowling, associate administrator for health information management and access services at the seven-hospital system. “What is our source of these data? How do we estimate the cost of this event? How would we account for this on the bill—is it a contractual adjustment?”

Providence Health & Services had already convened a steering committee to

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standardize its billing procedures for adverse events before the Oregon policy went into effect. The steering committee, chaired by the system’s chief medical officer, includes representatives from finance, quality management, decision support, clinical, health information management, and nursing. The committee assigned three subgroups to think through the myriad issues:

- > A sentinel events subcommittee, which is responsible for objects left behind in surgery, air embolisms, and delivery of incompatible blood or blood products.
- > A nursing subcommittee, which is handling in-hospital injuries and hospital-acquired ulcers.
- > An infections subcommittee, which includes representatives from nursing and infection control.

Each of the subcommittees is responsible for identifying the kinds of adverse events that are occurring and how they can be avoided in future, as well as how

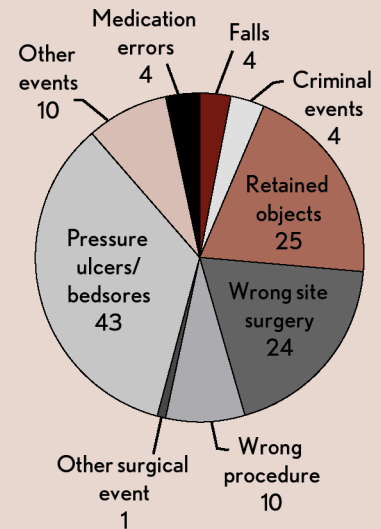
they are reported, coded, and billed.

Dowling expects the committee to draft and pilot a new policy by this summer.

Dowling says one thing is clear: Hospitals should not simply omit the charges associated with the adverse event from the bill. Rather, the bills should indicate that gross charges have been adjusted to reflect the fact that some care is not being charged. Another option: The hospital could make a pre-bill adjustment so that the bill a patient receives would be net of the charges associated with the adverse event. Regardless of how the charges are presented to the patient, the important point is that hospitals that do not record charges associated with adverse events will pass up an opportunity to understand the full ramification of the events

“Charging is how hospitals track the resources consumed for a particular patient,” says Dowling. “You need to understand what the cost to health care is.”

Reported Adverse Health Events in Minnesota, Oct. 7, 2006–Oct. 6, 2007



Source: *Adverse Health Events in Minnesota, January 2008*. Minnesota Department of Health. Reprinted with permission.

Pressure ulcers and bedsores generated the most adverse health events reported to the Minnesota Department of Health in the 2006-2007 fiscal year.

Who's Who in Consumerism

The Center for Studying Health System Change

Who: The Center for Studying Health System Change (HSC), a nonpartisan policy research organization, focuses on changes in the financing, delivery, and quality of health care in the United States, with a particular emphasis on the policy implications of these changes. The center is headed by economist Paul B. Ginsburg, PhD, and includes other respected researchers whose work appears in *Health Affairs* and other peer-reviewed journals.

What: HSC researchers primarily focus on four areas:

- > Health insurance coverage and costs
- > Access to care
- > Quality and care delivery
- > Healthcare markets

Affiliated with Mathematica Policy Research Inc. and funded in part by the Robert Wood Johnson Foundation, HSC also conducts research consistent with its mission for other organizations, including foundations and government agencies.

Significance to Consumerism: After analyzing data from the 2007 Community Tracking Study site visits, Draper and Ginsburg reported that, although consumer-directed health plans have not gained widespread adoption, “other developments—including a heightened emphasis on prevention and wellness, along with nascent provider cost and quality information—are advancing healthcare consumerism.”

The ultimate impact of that trend remains to be seen. “Concerns exist about whether these efforts

will slow cost growth enough to keep care affordable or whether the growing problem of affordability will derail efforts to decrease the rising number of uninsured Americans and stymie meaningful healthcare reform,” wrote the researchers.

In a January/February 2008 *Health Affairs* essay, Ginsburg cautioned that a slowdown in the growth of personal healthcare spending may be temporary. “For the most part, we have not seen qualitative evidence to suggest that the slowing of cost trends will continue,” he says. “Indeed, some developments in local health markets signal concern about accelerating cost trends in the future.”

For more information, visit www.hschange.org.