Financial and Coding Terms for Clinical Cardiovascular Program Leaders

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Providing new cardiovascular services as well as maintaining existing programs has taken on significant importance in most healthcare organizations' in light of the doubling of the population of Americans that are over age 65. This is relevant since it is known that the incidence of cardiovascular disease (CVD) increases with age. Current estimates are that 1 in 5 people have some form of cardiovascular disease, which has been the leading cause of death since 1900[1]. Supporting the projected need for CVD services, a report from the Center for Disease Control trends the number of hospital discharges for Coronary Heart Disease as an upward progression that is expected to continue well into the 21st century. This data and market demand projections influence healthcare administrators who acknowledge that providing cardiovascular care services is vital for acute care hospitals.

Many healthcare administrators view the provision of advanced cardiovascular services such as open-heart surgery and interventional cardiac catheterization programs as the key to their organization's future success. Given the natural market situation, hospitals are challenged to manage the growth opportunity.

One proven method that aids in controlling the costs of cardiovascular services is to establish a financial management process that includes attention to reimbursement as well as resource allocation. Responsibility and oversight for financial processes should be jointly owned by the CV administrator and a key individual within the finance department. A joint effort should be applied by these individuals to develop methods that expedite rapid financial/ business responses for the cardiac program. The process goals are to accommodate the ever changing cardiovascular inventory environment and facilitate accurate data and charge entry at the unit level to capture all due reimbursements. This communication forum can be enhanced when clinical leaders have an understanding of the financial language and reimbursement processes. Financial learning opportunities for the CV clinical leaders can be hindered by a lack of easily accessible financial references defining financial terms and processes and an unclear appreciation of the organizational impact of the CV program. Often, the CV clinical leaders remain focused on clinical care issues and not the relevant financial aspects. One of the first steps to bridging this gap in knowledge is for clinicians to understand and grasp the significance of hospital finance/reimbursement jargon.

Medicare, the forerunner of the prospective payment system has been responsible for the implementation and acceptance of common financial terminology in healthcare organizations. The importance of compliance with the regulatory guidelines is two fold for the organization with mandatory compliance a requirement for reimbursement or substantial fines and legal action will be taken against the organization. Secondly, denial of reimbursement from inaccurate claims can significantly impact financial solvency.

Figures 1, 2 and 3 provide a simplistic outline of the most frequently used financial and coding terms. Understanding these terms can increase the CV administrators and clinical managers' business knowledge, ultimately facilitating communication with finance and medical coding personnel.

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In summary, the market for cardiovascular services is projected to grow rapidly due to the aging population. Providing a comprehensive cardiovascular program is frequently one of the most expensive endeavors a hospital undertakes, requiring a return on the investment within a reasonable timeframe to offset expenses. Cardiovascular programs need to maintain a favorable contribution margin since they typically account for the organizations' highest volume of admissions. To accomplish the organization's financial cardiovascular goals CV administrators and clinical leaders must recognize the financial impact of the services. By developing a thorough understanding of finance and coding processes, CV administrators and clinical leaders will experience:

- Ability to network with the financial department and become viewed as a needed component during cardiac financial discussions
- Organizational confidence that CV expenses are controlled without comprising clinical quality
- Improved accuracy of medical coding resulting in reduced claim denials and full reimbursement capture

Cardiovascular program managers who blend clinical and financial understanding are key to a financially sound cardiovascular program. •JCM

References

1. American Heart Association. 2002 *Heart and Stroke Statistical Update*. Dallas. Tex.: American Heart Association; 2001.

Figure 1. General Terms

Term	Definition	Comment
CDM	Charge Description Master. The individualized hospital computer file that lists all the hospital procedures, services, supplies and drugs. The CDM is used at the clinical unit to enter the patient's procedures and charges	CDM needs to be current and accurate or reimbursement may be lost. Some facilities hardcode the procedures to interface with the medical coding process.
Indirect Costs	All costs that are not directly used for patient care such as heating, lighting, security the "overhead costs"	Needed to determine the cost/case
Direct Costs	All costs directly involved in patient care such as drugs, consumables, personnel time, and equipment used.	Needed to determine the cost/case
Contribution Margins	The difference between revenue minus expenses	Financial indicator used to determine the value the service provides to the organization

Figure 2. Inpatient Terms

Term	Definition	Comment
MDC	Major Diagnostic Categories divides all DRGs (by similar anatomic system) into 25 groups	MDC-5: Diseases and Disorders of the Circulatory System (DRGs 104-145, 478-479, 514-518)
DRG	Diagnostic Related Groups. A prospective payment system (PPS) in which patient conditions are grouped into categories by principal diagnosis. The facility is paid what the assigned DRG payment is, not actual cost.	Reimbursement per DRG is assigned according to region, facility type, and third party payor contracts and is not a universally assigned rate. New 2002: Five DRGs added to Cardiac: 514, 515, 516, 517, and 518.
Case Mix	A method of distributing inpatients into various acuity groups based on their care requirements. A higher case mix indicates a higher acuity level and a higher payment to the organization.	Each hospital is given a predicted case mix index that is their expected average acuity level based on historical and population data by the payor at the beginning of the contract. The organization tracks actual case mix and reports to payors. If the actual case mix is below or over predicted level, payments may be adjusted.
RW	Relative Weight. An assigned percent associated with each DRG used as an indicator of the resource consumption needed to care for that patient. RWs are predetermined by the payors and reflecting conditions or procedures carried out during the admission.	The higher the RW the greater the payment. Documentation to support the higher RW must be present before the record is assigned to the higher weight.

Figure 3. Outpatient Terms

Term	Definition	Comment
APC	Ambulatory Payment Classification. Medicare's outpatient payment system. APCs are a service classification system designed to explain the amount and type of resources used in an outpatient encounter. These are pre-set, capped payments.	Additional pass-through codes can be applied when appropriate. These codes are explained below.
HCPCS	Healthcare Common Procedure Coding System (pronounced "hix-pix") a uniform system for coding procedures, services, items, or supplies. It is a three-level coding system.	Level I – CPT Level II – National Codes updated periodically by the Centers for Medicare and Medicaid Services (CMS). Supplements the CPT for non-physician procedures such as ambulance services, durable medical equipment (DME), specific supplies, or drugs. Level III – Local Codes specific procedures or supplies for which there is no national code or CPT. Used within a small region. If a local code applies to the procedure it is prioritized first.
CPT	Current Procedural Terminology (CPT) describes physician services. A different code is assigned to every service and procedure a physician performs.	These codes are used by the physician's office or the hospital to authorize payment. A procedure or diagnostic test may have several codes for different components of the testing. For example, echocardiograms have a technical component (performance of the examination) and a supervision/ evaluation component (physician interpretation and report). The hospital will code for those components performed by the hospital and the physician will code for the components they perform. For the inpatient; the hospital will be paid the DRG reimbursement but a CPT code may be used to authorize a higher relative weight.
C-Codes	Pass Through/ New Device Technology codes assigned to an APC payment that allow the institution to regain the costs of expensive single use medical devices or pharmacological agents.	Each device or pharmacological agent has their own independent numbers which are not interchangeable. The codes are authorized by HCFA and available from the vendor or Medicare. If a new device has not been assigned a c-code, then this additional reimbursement cannot be obtained.
Revenue Code	Needed on the billing form (UB-92) to represent or describe the type or service provided. Completion of this field is required for Medicare billing, usually linked to a HCPCS/CPT code	Describes the type of procedure or visit such as laboratory, radiology, pulmonary but not always an indication of procedure location.
ICD-9	Internal Classification of Diseases- Ni h Revision. Diagnostic Codes that provide the documentation of the necessity for the procedure.	Change to ICD-10 expected to occur by mid decade. Provides the documentation or justification for the procedure or test.
Modifiers	These further explain the procedure done and help to eliminate duplicate billing. Not all procedures require a modifier.	Modifiers add information regarding anatomic site, i.e. right, left or bilateral. They are two digit alphanumeric characters. Up to two modifiers may be reported on each service line.
Status Indicator	Distinguishes payment methodologies for services performed under the APC.	Categories: H – Device G – Current Drug J – New Drug S – Significant procedure not reduced when multiple procedures performed. T – Significant procedure, multiple procedure reduction applies. V – Visit to Clinic or ED X – Ancillary service