

Net Revenue Matters



December 2007



Reflections from the Back of the Bus

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As IRM completes its eighth year of service to U.S. hospitals, I would like to take a moment and reflect on what our hospital's have accomplished and what the next year looks like after 1/3 of a century in healthcare finance.

To begin, the current IRM hospital teams are rapidly moving into their second billion dollars, yes that is billion with a "B," in net income improvements. This is a remarkable accomplishment given all the changes in coding and reimbursement that have occurred since the turn of the century. The vast majority of hospitals who have entered the world of revenue management with IRM, maintain active teams and many have extended their original agreements with an increased focus on metrics and education of the larger revenue cycle communities.

In 2006, hospitals earned a net income of over \$35 billion or 6% of patient income. This represents a historical high for many hospitals but, as always, there are

new and increasing challenges that will keep our teams focused in 2008. Specifically, government sponsored reimbursement continues to evolve, or devolve, at a startling rate. Our state and federal planners are committed to holding hospitals to ever higher standards of quality. In 2008 we will continue to see more financial risk associated with:



- Pay for performance
- Hospital errors and hospital acquired complications
- Over billing (under documented records)
- Quality measures from multiple quality think tanks
- Rapidly change coding conventions and standards
- Significant shifts in payments from procedures to medicine

To ensure the long-term financial success of our organizations, the IRM model will continue to evolve to meet these challenges. The staff is currently working diligently



on developing evidence-based metrics for the most critical revenue management KPI's. These enhanced reports and dashboards will be coupled with focused education, not only for the revenue management departments but also for staff members within allied departments including, patient financial service, access, health information, case management, and others. IRM believes this is the time to strongly move from a longevity-based review system to one with the full capacity to reward superior performance. Further, there is a growing national effort to excise the "clerical" designation for our key revenue management positions and create vital professional positions capable of attracting and retaining highly motivated, educated associates. IRM continues to invest planning and development resources to be able to offer the required support for hospitals moving in these directions.

One additional observed national trend is the desire to recruit and retain key employees who have the collateral skills in both coding and charge capture. IRM understands that some days it is difficult just to maintain production in the coding community, however best practice is becoming a professional that understands all components of bill presentation. I plan to continue to monitor these and other trends during 2008 and report the findings in the newsletter.

On behalf of the founders, leadership, and all employees of IRM, may the season be one of family, fellowship, and renewal for you and your families. We are looking forward to 2008 as another year of service to all of our hospital partners across the nation.



IRM Employee of the Year: Andy Miller!

Andrew (Andy) Miller was selected as the IRM 2007 Employee of the Year. Andy has a positive attitude and he puts forth sincere efforts to continually improve the IRM database products and provide quality service to both his internal and external customers. In his role as Programmer/Analyst, Andy has proven to be a valued member of the IRM organization. Join us in congratulating Andy on this award.

Observation Charges for OPPS 2008

In the Outpatient Prospective Payment System (OPPS) Final Rule for 2008, the Centers for Medicare and Medicaid Services (CMS) announced significant changes to observation payments in 2008. CMS believes that observation care is generally part of ancillary procedures and supportive care and is packaging observation services for 2008. However, in 2008 hospitals can receive payment for extended observation care for any diagnosis under two new APCs.

Below is a summary of the changes to observation for 2008:

- The diagnosis requirement for payment of observation services has been eliminated. As of January 1, 2008 claims that have any diagnosis may be eligible for payment of observation services.
- The observation codes G0278 (observation per hour) and G0279 (direct admit to observation) are still valid and have a status indicator of "N," denoting their packaged status.
- CMS has created two new composite APCs for patients who receive extended (more than 8 hours) observation care. In these instances, payment will be assigned for the additional observation care beyond the packaged observation payment.
 - 8002 - Level I Extended Assessment and Management Composite
 - Status indicator "V"
 - National payment rate = \$351.04
 - 8003 - Level II Extended Assessment and

Management Composite

- Status indicator “V”
- National payment rate = \$638.66
- The main difference between the two new composite APCs is where the patient was seen before observation admission.
 - 8002 - High level (level 5) hospital clinic visit or direct admission to observation reported with code 99205 (level 5 new patient), 99215 (level 5 established patient), or G0379 (direct admit to observation or admission from a clinic that is not hospital-based).
 - 8003 - High level (level 4 or 5) ED visit or critical care reported with code 99284, 99285, or 99291.
- Hospitals will be paid a composite APC if the following criteria are met:
 - The above codes are reported, as applicable.
 - The patient was in observation at least 8 hours (reported as code G0378 with units of service for hours in observation).
 - No procedures with a status indicator of “T” were billed on the day before or the day of the observation admission that has a status indicator of “T.”
- Payment will be determined by Medicare’s Outpatient Code Editor (OCE).
 - It will screen claims for criteria and if met, assign the composite APC.
 - If criteria are not met, the claim will be paid according to the other ancillary services on the claim, with packaged observation payment.
- Documentation requirements are the same as they were for CY 2007 and include:
 - Documentation of admission and discharge times.
 - Documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

According to CMS, the new observation payment methodology will require no changes to the reporting practices of hospitals, so there should be no associated administrative burden on hospitals. Even so, hospitals should begin preparing for these changes and ensure all applicable observation charges are captured. IRM’s January CBR project will address observation charges. It will cover audits for both

2007 and 2008 claims.

The complete discussion of this topic can be found in the 2008 OPPS Final Rule beginning on page 66810. A link to the Final Rule is provided below:

www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1392fc.pdf

Changes to “Inpatient-Only” List for 2008

CMS has identified procedures that are typically provided only in an inpatient setting and therefore are not paid under the OPPS.



This list is referred to as the inpatient-only list. Each year CMS reviews the list and recommends removal of certain procedures based on the following criteria:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that have already been removed from the list.
- It is determined that the procedure is being performed in numerous hospitals on an outpatient basis.
- It is determined that the procedure can be appropriately and safely performed in an Ambulatory Surgical Center (ASC) and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list.

CMS identified 15 procedures for possible removal from the OPPS inpatient-only list. The APC panel recommended that 13 of the 15 procedures be removed from the list (see table 46 shown on page 4). The panel recommended CMS obtain additional utilization data concerning two of the procedures, CPT Code 64818-Sympathectomy lumbar and CPT code 20660-Application of cranial tongs caliper, or stereotactic frame, including removal. This data will be presented to the APC panel at its winter 2008 meeting.

HCPCS Codes for Removal from Inpatient List and Their APC Assignments for CY 2008

HCPCS Code	Long Descriptor	CY 2008 APC	CY 2008 SI
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod.	0254	T
21365	Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches.	0256	T
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation).	0256	T
25931	Transmetacarpal amputation; re-amputation	0049	T
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure).	0050	T
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique).	0063	T
27722	Repair of nonunion or malunion, tibia; with sliding graft.	0064	T
50580	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus.	0161	T
51535	Cystotomy for excision, incision, or repair of ureterocele.	0162	T
58805	Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach.	0195	T
60271	Thyroidectomy, including substernal thyroid; cervical approach.	0256	T
61770	Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source..	0221	T
69970	Removal of tumor, temporal bone.	0256	T

Federal Register / Vol. 72, No. 227 / Tuesday, November 27, 2007 / Rules and Regulations, pg 66816

As most hospitals have experienced, one of the keys to abiding by the inpatient-only list is physician support and cooperation. During the comment period for the 2008 OPPS final rule, a commenter recommended that CMS consider implementing a code that would enable hospitals to indicate those cases in which the physician failed or refused to notify the patient that the procedure was on the inpatient-only list and would not be paid by Medicare if performed in the hospital outpatient setting. The commenter suggested that the physician could be held accountable for those cases, and Medicare could track physicians who repeatedly chose inappropriate admission status for procedures on the inpatient-only list.

The commenter went on to recommend that CMS implement financial disincentives for physicians who continue to perform inpatient-only procedures in an outpatient setting. The commenter asked that CMS consider expanding the ability of hospital staff and utilization review committees to overturn outpatient status orders when procedures on the inpatient-only list are performed and the services are not reported in a timely manner by the physician, or are not revised upon notification of the status conflict. Finally, the commenter recommended that CMS drop the inpatient-only list altogether if they are not willing

to refocus the payment policy associated with the inpatient-only list to address physician behavior.

Below is CMS' response:

"We appreciate the recommendations for improving the effectiveness of the inpatient list. We continue to believe that the inpatient list serves an important purpose in identifying those procedures that cannot be safely and effectively provided to the Medicare beneficiaries in the Hospital Outpatient Department. We are concerned that elimination of the inpatient list could result in unsafe or uncomfortable care for Medicare beneficiaries and, therefore, we will not discontinue our use of the inpatient list at this time."

They also state:

"Payment for physicians' services and monitoring of physicians' practice patterns are outside the scope of this OPPS/ASC final rule with comment period. We continue to believe that it is very important for hospitals to educate physicians on Medicare services covered under the OPPS to avoid inadvertently providing services in a hospital outpatient setting that are only covered during an inpatient stay."

Therefore the financial and educational burden of implementing the inpatient-only list remains with hospitals. Below are some helpful hints to ensure all inpatient-only procedures are performed on an inpatient basis.

- Review hospital admission policies. The policy should contain guidelines for Medicare patients being registered for inpatient-only procedures.
- Educate physicians, admitting staff, nursing, billing staff, and HIM staff. All staff should understand what an inpatient-only procedure is and how it affects reimbursement.
- Ensure all staff and physicians have a current listing of the inpatient-only HCPCS codes.

The complete discussion of this topic can be found in the 2008 OPPS Final Rule beginning on page 66815.

A link to the Final Rule is provided below:

www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1392fc.pdf

Best Practice Forum 2008 - Hotel Reservation Deadline: January 7

As a reminder, please make your hotel reservations for the 2008 Best Practice Forum soon. The deadline to guarantee the greatly reduced room rate is January 7.



This year's Forum will be hosted at the Floridays Resort Orlando, in beautiful Orlando, Florida. Along with the PI Roundtable, speaking topics will include overcoming operational challenges during the RAC audit process, OIG compliance, Medicare bad debts, managed care, and a motivational session from Gary Borgstede on the keys to building a high performing team. Our optional pre-forum workshops are a not-to-be-missed day as well.

The Forum outline for planning purposes is as follows:

Monday, February 18, 2008

Travel Day

Tuesday, February 19, 2008

Optional Pre-Forum Workshops

Welcome Dinner / Speaker

Wednesday, February 20, 2008

Full-Day Meeting

Thursday, February 21, 2008

½ Day Meeting

Friday, February 22, 2008

Travel Day

Visit our website for client registration information or contact Jennifer Vansant at 760-448-1036.

www.irminonline.com/news_bestpractice.htm

Upcoming Events!

December 2007

18th: Audio Conference, 10:00 a.m. Pacific
Coding for 2008: CPT/HCPCS and OPPS
Updates (Part I)

20h: Audio Conference, 10:00 a.m. Pacific
Coding for 2008: CPT/HCPCS and OPPS
Updates (Part II)

Register for both sessions and save 25% off the regular audio conference fee!

For more information, visit our website or call!

www.IRM-TCG.com
760.448.1022



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If you have questions or would like to submit information for a future newsletter, please contact:

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Client Corner

Code-Based Reimbursement Project Rollout and Forum Call Calendar for 2008

Continuing in 2008, IRM will present one CBR project per month developed specifically for the CBR analysts, CDM analysts, and RMD Directors. The complete 2008 schedule for project rollouts, topics, and forum discussion calls is as follows:

January 9, 2008

Project Rollout, 11:30 a.m. Pacific
• Observation and One-Day Stays

January 30, 2008

Forum Call, 11:30 a.m. Pacific

February 6, 2008

Project Rollout, 11:30 a.m. Pacific
• Device Dependent APCs

February 27, 2008

Forum Call, 11:30 a.m. Pacific

March 5, 2008

Project Rollout, 11:30 a.m. Pacific
• Wound Care

March 26, 2008

Forum Call, 11:30 a.m. Pacific

April 2, 2008

Project Rollout, 11:30 a.m. Pacific
• Pain Management

April 23, 2008

Forum Call, 11:30 a.m. Pacific

May 7, 2008

Project Rollout, 11:30 a.m. Pacific
• Outpatient Orders (Compliance project)

May 28, 2008

Forum Call, 11:30 a.m. Pacific

June 4, 2008

Project Rollout, 11:30 a.m. Pacific
• Spine Surgery

June 25, 2008

Forum Call, 11:30 a.m. Pacific

July 2, 2008

Project Rollout, 11:30 a.m. Pacific
• Pathology

July 23, 2008

Forum Call, 11:30 a.m. Pacific

August 6, 2008

Project Rollout, 11:30 a.m. Pacific
• Brachytherapy

August 27, 2008

Forum Call, 11:30 a.m. Pacific

September 3, 2008

Project Rollout, 11:30 a.m. Pacific
• Moderate Sedation

September 24, 2008

Forum Call, 11:30 a.m. Pacific

October 1, 2008

Project Rollout, 11:30 a.m. Pacific
• Radiology Imaging

October 22, 2008

Forum Call, 11:30 a.m. Pacific

November 5, 2008

Project Rollout, 11:30 a.m. Pacific
• J Codes

November 26, 2008

Forum Call, 11:30 a.m. Pacific

For more information, contact your subject matter experts (SME) at IRM - Kristi Stanton or Sheldrian Leflore.



Memorial Medical Center Joins the Million Dollar Club!

One year ago, Memorial Medical Center, a critical access hospital client in Port Lavaca, TX, implemented their revenue management department. In their first ten months, the team exceeded their first year goal and pushed past the \$1,000,000 mark in November 2007. Congratulations to Memorial Medical Center's RMD for all their hard work!

