

# THE EVERGREEN CONNECTION

Volume 24, Number 1

Winter 2010

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by Judy Veazie, CPAM

## CMS Alerts Providers to Key OIG WorkPlan Impacts:

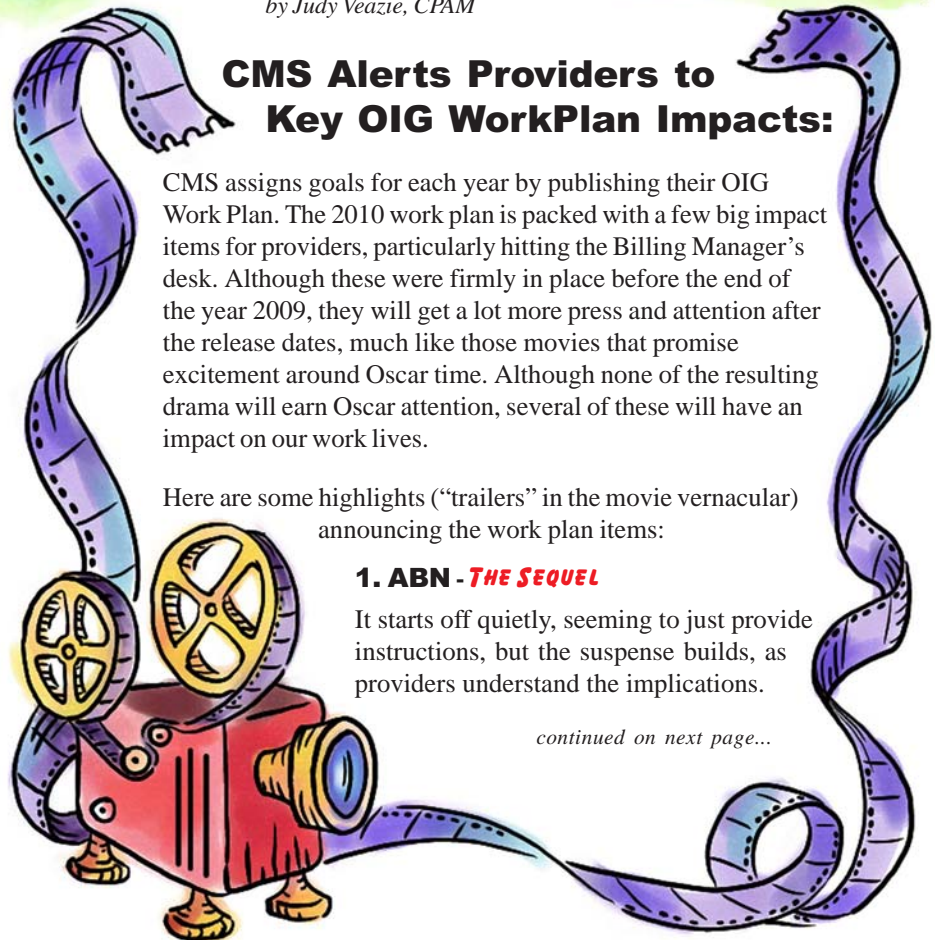
CMS assigns goals for each year by publishing their OIG Work Plan. The 2010 work plan is packed with a few big impact items for providers, particularly hitting the Billing Manager's desk. Although these were firmly in place before the end of the year 2009, they will get a lot more press and attention after the release dates, much like those movies that promise excitement around Oscar time. Although none of the resulting drama will earn Oscar attention, several of these will have an impact on our work lives.

Here are some highlights ("trailers" in the movie vernacular) announcing the work plan items:

### 1. ABN - THE SEQUEL

It starts off quietly, seeming to just provide instructions, but the suspense builds, as providers understand the implications.

*continued on next page...*



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*“This transmittal provides instructions regarding one new and one revised modifier for use in association with ABNs. It also provides revisions to clarify general non-covered charge instructions for institutional claims and relocates certain benefit-specific information in their associated chapters of the Claims Processing Manual.”*

EFFECTIVE DATE: April 1, 2010 (with IMPLEMENTATION DATE: April 5, 2010), this item requires providers to take a second look at the diagnosis used when serving an ABN. If the test results clarify the diagnosis, negating the need for a modifier, providers must go back and rebill the data, reverse the patient due portion and show the charges as covered charges. The trigger item on this change is the GA modifier. A new modifier –GX has been created with the definition of “Notice of Liability Issued, Voluntary Under Payer Policy.” The GX provides beneficiaries with a voluntary notice regarding services excluded from Medicare coverage by statute. This new focus really targets labs and puts the spotlight on providers who may appear to be a little careless in their diagnosis selection.

Note: Review Transmittal 1840; CR 6563.

### **Hospital Readmissions - *COULD BE THE HORROR EVENT OF THE YEAR***

Some hospitals, who are very familiar with the OIG genre of audit, have been waiting for this release for years. The numbers vary from hospital to hospital, but if we look at the Medicare readmits the same way that Medicaid readmits are monitored, you may have some very scary moments ahead.

### **Observation Services During Outpatient Visits - *HAVEN'T WE SEEN THIS PLOT BEFORE?***

Just in time for the 2009 Christmas season, CMS “clarified” their view of observation and pointed out that these services are “no different than an outpatient radiology service.” For many of us, the limits of payment for observation services is old news, but for some nursing managers, it was their first release of this theme. They were shocked to discover that there are limited or NO payment for many services for observation. This new OIG focus will continue to exploit that same story line, but we can



imagine the consequences. (Expect more features to be released.....or is it the sequel?)

### **Oversight of Hospital’s Compliance with EMTALA - *ANOTHER FAMILIAR PLOT LINE?***

Just when we thought you could not find a new approach to this old story, the OIG is back to the table to examine EMTALA compliance. This is a good area for self-audit to see how your policy and procedures (in practice/on the floor) play out. (A good story to play at home for the staff).

### **MSP and Provider Bad Debts - *THE HORROR GENRE SEEMS TO DOMINATE 2010***

Although examining the MSP and bad debt seems like an old issues, they are continuing theme for CMS/OIG. Look to have every dot carefully examined. For OIG, this wins the critic’s choice award.



### **FINALLY.....a potential sleeper hit.....**

### ***PAYMENTS FOR DIAGNOSTIC X-RAYS IN HOSPITAL EMERGENCY DEPARTMENTS***

This has long been a concern for CMS and other payers and more claims show spikes in use of expensive diagnostic testing in ER. While one group may point out the barriers to access for the Medicare patient seeking primary care, the ER is not the best place for their needs, and the most expensive solution in getting diagnostic and routine treatment.



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# President's Message

by Patti Peterson, CareMedic

Welcome to a New Year and your new board at Evergreen AAHAM. I am very excited to have been elected as your President and have the opportunity to work with such a great group of people not only on our board, but also with all of you.

This year's theme is, "2010 The Year of the Revenue Cycle." Our education committee is

already working on preparing our agenda's for upcoming meetings. I invite each of you to look at your operations and identify current processes that you feel are effective.

We want you share your success stories with us. We are also want to know topics that interest you and you think will help you improve.

We are also looking for new faces to join, not only AAHAM, but also our board committees.

If you would like to contribute to a

committee please contact me directly at 360-794-1058. There is much that can be done to help our organization.

Sometimes by doing small things that take little of your time, you can make a real difference:

- Solicit one of your vendors to support our chapter
- Submit an article for our newsletter – Becoming published looks good on a resume!
- Suggest speakers/or come tell your success

story at one of our meetings

Check out the AAHAM events calendar in this issue. Looking forward to a great year!



## Corporate Sponsors Make a Difference



Corporate Sponsorship is becoming more critical to the continued growth of the Evergreen Chapter. Sponsorship allows us to offer you low cost workshops and educational events every year.

The Evergreen Chapter is actively seeking corporate sponsors to join the list of our long-time supportive organizations. We welcome your help in recruiting new corporate sponsors for the Evergreen Chapter.

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If you have a good candidate for sponsorship please email [jenniferm@audit-adjustment.com](mailto:jenniferm@audit-adjustment.com)

## Welcome New Members

Amy Erickson  
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Cory Giles  
Cardon Healthcare Network, Inc.

Desta Graham  
Healthcare Resource Group

Bob Laskowki  
Great Lakes

Allan Long  
Puget Sound Blood Center

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[www.aahamevergreen.org](http://www.aahamevergreen.org)



## AAHAM UPDATE



from Caremedic Systems

### Provider One - 2010

We are currently planning our April 9<sup>th</sup>, 2010 workshop at Valley Medical Center that will include a session on ProviderOne. In the process of securing our speaker we were provided the following information from DSHS that might be helpful to you.

Effective 1/4/10, DSHS opened up ProviderOne to providers to verify sample or test claims are getting paid in ProviderOne. Only 165 providers are participating so far and an over-whelming majority of the claims (63%) are denying because providers are not using the new ProviderOne billing requirements as follows:

- 53% of the denied claims are due to missing or incorrect taxonomy
- 25% of the denied claims are due to missing or incorrect ProviderOne client ID
- 6 % of the denied claims are due to missing or incorrect National Provider ID
- 18% of the denied claims are a combination of other factors (duplicate, invalid service code, etc.)

All providers are *strongly urged to submit practice or test claims* to ensure they understand the new requirements and can get paid. Providers can key practice claims directly in ProviderOne, submit test claims through a 3<sup>rd</sup> party (billing agent/clearinghouse) or submit electronic (HIPAA compliant) test claims on their own behalf. For more information, providers can contact the ProviderOne help desk at 1-800-562-3022, option 2 for provider then option 4 for ProviderOne. We have a dedicated staff ready to answer the calls. Also, providers can sign up for free email notices about ProviderOne at

[Click Here](http://hrsa.dshs.wa.gov/providerone/providers.htm) <http://hrsa.dshs.wa.gov/providerone/providers.htm>

## Tri Care Clarifies ID Card Issues



by Tiffany Anderson, Sr.  
TriWest Healthcare Alliance

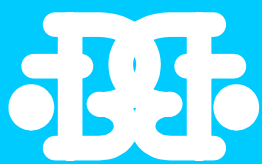
We want to clarify for TRICARE providers that they should validate a Service member's eligibility for TRICARE coverage. This clarification comes after some confusion of the associated penalties when allowing establishments to photocopy military ID cards to verify proof of military affiliation.

**The Department of Defense** has since reinforced that **TRICARE providers are allowed and advised to photocopy a TRICARE beneficiary's military ID card** to facilitate eligibility verification and for the purpose of rendering needed services.

We appreciate your inclusion of our TRICARE submissions; it enables us to share information and resources with providers caring for our military communities, in hopes of making their jobs a little easier.



Tiffany Anderson  
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TriWest Healthcare Alliance  
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Spring Target Half Day Meeting  
**Working Together  
Front to Back**

April 9<sup>th</sup>, 2010  
Valley Medical  
Center  
Mark your calendar!



# UPCOMING

## Evergreen AAHAM Meetings & Events

- Feb 24-26, 2010 ..... AAHAM/HFMA Vendor Fair - Sea Tac Hilton
- April 9, 2010 ..... Target Half Day - Valley Medical Center  
*Theme "Working Together Front to Back"*
- June 10, 2010 ..... Quarterly Full Day - Location TBD  
*Theme "Billing, Denials"*
- Sept 14, 2010 ..... Quarterly Full Day - Location TBD  
*Theme "Healthcare is changing & so is our day - Healthcare Update, collections, charity care"*
- Nov 5, 2010 ..... Target Half Day w/Board Meeting after - Location TBD  
*Theme "Customer Service"*
- Dec 10, 2010 ..... Quarterly Full Day - Embassy Suites, Lynnwood  
*Theme "Motivational"*



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- Revenue Cycle Consulting



# MEET ONE OF YOUR BOARD MEMBERS

by Darlene Wood, CPAM

## Janet Walthew, CPAM Education Committee member for the 2008-09 term

*As we start 2010, I wanted to provide a personal introduction to some of our new board members.*

*Although Janet Walthew is not new to AAHAM, nor new to the role as Board Member, she has returned to take on the key role of Education. I had a chance to interview Janet Walthew:*

**Q. Janet, what was your first job in Healthcare? What Healthcare jobs did you hold after that and up until your current position?**

Janet: I was a part time cashier at Virginia Mason Medical Center. I worked there 25 years, working my way up through the ranks. From there I worked at First Choice as Vice President Government Programs, then worked at Swedish Medical Center as Director of the Revenue Cycle. My next exciting job was as Vice President, Patient Financial Services at Airlift Northwest. I then worked as the Manager, Medicare at Group Health Cooperative.

**Q. What is your current title, where do you work and what are your areas of responsibility? How**

**long have you been in this position and to whom do you report?**

Janet: I started at Northwest Hospital & Medical Center January 2008 to turn around the PFS department after it has been outsourced for several years. The DRO went from 58 days to 42.4 in less than eleven months.

I report to Michael H. Smith, Senior Director, Revenue Cycle.

**Q. When did you first join AAHAM? What positions have you held? Are you certified? If yes, are you a CCAM or a CPAM?**

Janet: I joined AAHAM in 1973. I was the President of the Evergreen Chapter for the 1986-87 term and have served on many committees and on the Board. I am a CPAM.

**Q. Are you a member of HFMA and if yes, when did you join? What positions have you held?**

Janet: I am a member of HFMA and have served on many committees.

**Q. What is your biggest**

**challenge in your current position?**

Janet: My biggest challenge is hiring and keeping good people as well as maintaining the A/R at acceptable levels.

**Q. What are your hobbies outside of work?**

Janet: I manage a wheat farm in Eastern Washington that has been in my family over 125 years.

I have a husband of 42 years, Jim and two great kids, David Walthew and Sarah Walthew Bodine and am the proud grandmother of three.



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# Understanding The Transfer DRG Challenge

by Natalie Cataldo, CareMedic Systems

In 1999, the Centers for Medicare and Medicaid Services (CMS) initiated a reimbursement methodology related to certain Diagnostic Related Groups (DRGs) involving transfers to post-acute care facilities (e.g., SNF or rehab facility). Another category targeted by CMS is those patients who go home, but receive home health care.

Since CMS was paying the acute care facility at the full DRG rate, and subsequently paying the post-acute care facility or home health agency a full payment as well, CMS determined that inaccurate overpayments were occurring in many instances.

### CMS Takes Action

To address these inpatient overpayments, CMS chose to calculate the hospital's reimbursement for these cases based on a per diem rate, rather than reimbursing the hospital for the full DRG amount. "Transfer DRGs" (TDRGs) were established, with corresponding edits, checks and balances incorporated into the CMS payment systems.

Under the "transfer rule," a hospital receives a reduced reimbursement if the patient had a length of stay more than one day less than the geometric length of stay (LOS) for that particular DRG, and if the patient was transferred to another post-acute care facility (such as skilled nursing or home health). Initially, CMS identified 10 TDRGs. In October 2003, this was increased to 29; in October 2005, to 182; then in October 2007, that number increased to 273.

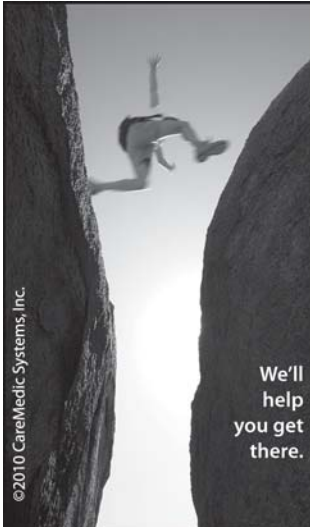
The OIG stated in its 2008 Work Plan that it will be reviewing patient discharges that should have been coded as transfers in order to identify potential overpayments. As a result, TDRG compliance issues and take-backs are becoming even more prevalent and important for providers. The potential negative impact on a hospital's reimbursement continues to grow.

At the same time, however, CMS takes the position that it is up to the provider to identify any under-payments.

To lower the risk of underpayment hospitals requires additional work, re-billing and potential unrecovered cash for acute care providers. The steps required to identify potential payment includes calling other providers, researching the patient's actual care post-hospital services and rebilling with corrected information to Medicare.



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**What's the Impact?**

Statistics show that (on average) 60 percent of hospital Medicare inpatient discharges are coded with a TDRG. At the same time, 33 percent of those discharges are related to an LOS less than the geometric LOS, representing potential underpayments. Of the TDRGs submitted, 10 percent have a coding error that result in recovered underpayments if discovered. This amount can be substantial, and well in excess of the cost of pursuing corrected payments.

**What can you do?**

If your facility is looking for new ways to recover more cash, it could be very

rewarding to examine the status of potential TDRG-related underpayments. You can choose to audit these transfers on your own or hire an outside vendor. If you look for outside help, be sure to select a

company that specializes in TDRG work. Understanding the complex nuances of this program can

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## MEETING NOTICE

★ Quarterly Meeting ★  
Full Day

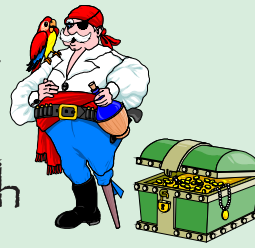
### Billing / Denials

Mark  
Your  
Calendar!

## June 10, 2010

Location TBD

## Share the Wealth



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## Inside This Issue:

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