

HEALTH CARE

POSSIBILITIES



inside

- 2** Critical Access Hospital Items
- 3** Payment Adjustment for Medicare Disproportionate Share Hospitals
- 4** MS-DRG Changes for FY 2010
- 6** Changes Affecting Indirect Medical Education and Graduate Medical Education
- 7** 2010 OPPS Proposed Rule

Special Report—2010 IPPS Final Rule

CMS released its inpatient prospective payment system final rule for fiscal year (FY) 2010, which was published in the Federal Register dated August 7, 2009. This special issue contains articles summarizing the IPPS final rule. These changes are generally applicable to discharges occurring on or after October 1, 2009.



Critical Access Hospital Items

Clinic Diagnostic Laboratory Services

The 2010 IPPS final rule includes clarifications and changes for Critical Access Hospitals (CAHs). The first item affects billing for clinical diagnostic laboratory services, effective beginning July 1, 2009. The rule states that a CAH may bill and receive cost-based reimbursement for clinical laboratory services where the patient was not on-site at the CAH, as long as the patient was receiving outpatient services from the CAH on the day the specimen was collected, (registered outpatient of the CAH) or the specimen was collected by an employee of the CAH.

For skilled nursing facility (SNF) patients where an employee of the CAH may go to a SNF and draw a specimen, the rule stipulates that if the beneficiary is still within his or her Part A stay of the SNF, consolidated billing still applies and the CAH must bill the SNF for these services. However, if the Part A benefits are exhausted and/or the beneficiary has Part B, and an employee of the CAH draws the specimen, the CAH may bill and receive cost-based payment for the draw and the laboratory test.

CAH Optional Method of Payment for Outpatient Services

The final rule changes payment to CAHs that have elected the optional method of payment for outpatient services (Method II). Prior to the rule, CAHs that elected Method II and submitted bills for both the facility and profes-

sional services to their Medicare Administrative Contractor would receive 115 percent of the Medicare physician fee schedule and 101 percent of its facility costs. In the rule, CMS clarifies that payment for the facility costs should only be reasonable costs, meaning 100 percent, not 101 percent of the facility costs for those services which the CAH has elected to use the optional method (Method II) of payment. The change will be effective for cost reporting periods beginning on or after October 1, 2009.

Provider-Based Status Affecting CAHs

The 2010 IPPS final rule clarifies that independent clinical diagnostic laboratory facilities, which were previously exempt from provider-based determinations, must meet provider-based requirements at \$413.65, as of October 1, 2010, in order for a CAH to be eligible to bill and be paid 101 percent of reasonable costs for these services. If a CAH owns a clinical diagnostic laboratory facility established on or after January 1, 2008, the CAH will also have to satisfy the CAH distance requirements of 35 miles for the CAH to retain its CAH certification. ■



The 2010 IPPS final rule clarifies that independent clinical diagnostic laboratory facilities, which were previously exempt from provider-based determinations, must meet provider-based requirements at \$413.65, as of October 1, 2010, in order for a CAH to be eligible to bill and be paid 101 percent of reasonable costs for these services.



Brian Bertsch
Senior Manager
Eide Bailly LLP



Payment Adjustment for Medicare Disproportionate Share Hospitals

DSH Background

Section 1886(d)(5)(F) of the *Social Security Act* provides for additional Medicare payments to hospitals that provide services to a significant disproportionate share of low-income patients. The most common method to calculate the Disproportionate Share Hospital (DSH) adjustment is based on the hospital's geographic designation, the number of beds in the hospital and the level of the hospital's disproportionate patient percentage (DPP). Essentially, the DPP is a combination of the facility's Supplemental Security Income (SSI) percentage, which is furnished by CMS, and the percentage of inpatient days furnished to patients eligible for Medicaid divided by the hospital's total number of inpatient days for the same period.

Labor and Delivery Patient Days in the Medicare DSH Calculation

Under the existing regulations at §412.106(a)(1)(ii)(B), patient days associated with beds used for ancillary labor and delivery are excluded from the Medicare DSH calculation. Specifically, Medicare policy has been that: "A maternity patient in the labor/delivery room ancillary area at midnight is included in the census of the routine care area only if the patient has occupied an inpatient routine bed." No days of inpatient routine care are counted for a maternity inpatient discharged without ever occupying a routine bed. In applying this policy, a Medicaid patient in the labor room at the census-taking hour, who has not yet occupied a routine bed, would not be counted as an inpatient for DSH calculation purposes. Alternatively, if the same patient were in the labor room at census, but had first occupied a routine inpatient bed, the day would be counted for DSH purposes.

Inclusion of Labor and Delivery Patient Days in the Medicare DSH Calculation

CMS now believes that even if a particular labor and delivery patient day is not included in the inpatient routine care census, it may still be reasonably considered an inpatient day for DSH purposes, provided that the labor/delivery bed is located in an area that is generally providing services that are payable under inpatient PPS. Medicare's DSH policy for periods beginning on or after October 1, 2009, is to include these

patient days in the DSH calculation. In practice, this change in policy will not have a significant impact on DSH calculations because these patient days will be included in both the numerator and the denominator of the calculation.

Reporting of Medicaid Days for DSH

Existing CMS policy related to counting of Medicaid days used in the DSH calculation is that a hospital is required to report Medicaid inpatient days in the cost reporting period in which the patient was discharged. CMS now believes that this policy may create confusion due to varying ways in which hospitals count Medicaid days, as well as varying ways in which state Medicaid agencies count patient days.

DSH Changes—continued on page 5



MS-DRG Changes for FY 2010

The reductions to the MS-DRG weights that CMS had originally proposed for the anticipated documentation and coding adjustment will not be implemented. CMS had proposed a reduction of 1.9 percent in payment for 2010 to account for the, “effect of increases in aggregate payments due to changes in hospital coding practices that do not reflect increases in patient’s severity of illness.” There will actually be a 2.1 percent increase, according to the fiscal year (FY) 2010 IPPS final rule that CMS released July 31.

However, CMS states it will continue to research the effects of the MS-DRG transition, including performing a complete analysis of FY 2008 and FY 2009 data. The agency may consider phasing in future adjustments over an extended period beginning in FY 2011, according to a CMS press release.

The changes to the MS-DRG weights are developed from claims and cost report data. It is critical to submit the most accurately assigned ICD-9-CM diagnosis and procedure codes to assure the severity of illness indicators are available for the assignment of the MS-DRG weights.

Many PPS hospitals have implemented a Clinical Documentation Improvement (CDI) program to

closely monitor and improve physician documentation in hospital medical records. The goal is to improve the documentation so it accurately reflects the condition of the patient, the medical severity of the patient and the services and resources required to care for that patient. In turn, the most valid codes are then submitted to all third-party payers, resulting in accurate reimbursement per the rules and regulations of the payer system. The proposed documentation and coding adjustment would have had a sizeable negative financial impact for those facilities that have not begun a CDI program.

In addition, CMS expands the number of quality measures hospitals must report to be eligible for a full market basket update in FY 2011. New measures include Surgical Care Improvement Project (SCIP), Infection 9 (Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2) and SCIP INF 10 (Surgery Patients with Perioperative Temperature Management). There were no changes to the list of hospital-acquired conditions. CMS will, however, evaluate the impact of the existing policy on hospital practices and care.

There are no new MS-DRGs for FY 2010.

There are 12 additions to the Major Complication Comorbidity (MCC) list for 2010. These are primarily Obstetrical and Newborn codes. There are 37 additions to the Complication or Comorbidity (CC) list, which are primarily new codes to be implemented October 1, 2009.

Only one new technology add-on payment was approved for FY 2010. Spiration® IBV® Valve System (Spiration® IBV®). The Spiration®IBV® is a device that is used to place, via bronchoscopy, small, one-way valves into selected small airways in the lung in order to limit airflow into selected portions of lung tissue that have prolonged air leaks following surgery, while still allowing mucus, fluids and air to exit, thereby reducing the amount of air that enters the pleural space. The device is intended to control prolonged air leaks following three



The changes to the MS-DRG weights are developed from claims data and cost report data. As always, it is critical to submit the most accurately assigned ICD-9-CM diagnosis and procedure codes to assure the severity of illness indicators are available for the assignment of the MS-DRG weights.



specific surgical procedures: lobectomy, segmentectomy or lung volume reduction surgery.

This approval is on the basis of using the Spiration® IBV® consistent with the FDA approval. Add-on payments are limited to cases involving prolonged air leaks following lobectomy, segmentectomy and lung volume reduction surgery in MS-DRGs 163, 164 and 165. Cases involving the Spiration® IBV® that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 163, 164 and 165 with procedure code 33.71 or 33.73, in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41 or 32.49.

The maximum add-on payment for a case involving the Spiration® IBV® is \$3,437.50.

The following code updates are effective on October 1, 2009:

- New ICD-9-CM diagnosis codes: 313
- Revised ICD-9-CM diagnosis codes: 45
- Invalid ICD-9-CM diagnosis codes: 23
- New ICD-9-CM procedure codes: 14
- Revised ICD-9-CM procedure codes: 16
- Invalid ICD-9-CM procedure codes: 0

While the financial impact of the FY 2010 final rule has not produced the negative impact facilities had expected, hospitals should continue to place documentation and coding improvement near the top of the priority list for the coming year. FY 2011 is just around the corner! ■



Sue Roehl, RHIT, CCS
Manager
Eide Bailly LLP

DSH Changes—from page 3



Policy Change for Reporting of Medicaid-Eligible Days

Effective with cost reporting periods beginning on or after October 1, 2009, hospitals will be permitted to elect the methodology they employ for counting of Medicaid days. CMS will now allow one of three methods to be used: date of discharge, date of admission or date of service. Medicare insists there be consistency from one cost reporting period to the next, so a hospital must provide written notification that specifies the new methodology the hospital wishes to use, and the cost reporting period to which the requested change would apply. Written notification must be provided 30 days prior to the beginning of the cost reporting period to which the change would apply, and must specify the methodology to be used.

Reporting of Observation Beds and Patient Days for Medicare DSH Calculations

This policy deals with patients who receive outpatient observation services and who are subsequently admitted for acute inpatient care. Current CMS policy is to include these observation days in the available bed and patient day counts. Observation patient days for patients subsequently admitted are identified on the cost report and included in both the numerator (Medicaid days) and denominator (total days) of the DSH calculation.

Policy Change for Use of Observation Bed Days for Medicare DSH Calculations

Medicare considers a patient who receives observation services as a hospital outpatient, and must not be included in the inpatient DSH calculation. Effective for cost-reporting periods beginning on or after October 1, 2009, total observation bed days will be deducted from the total days count for DSH payment calculation purposes. Since this is considered a policy change, Medicare will not apply this change retroactively. ■



Jim Maxwell
Manager
Eide Bailly LLP

Changes Affecting Indirect Medical Education and Graduate Medical Education



In the FY 2010 IPPS final rule, CMS states that because a patient under observation in the hospital is considered to be an outpatient of the hospital and receives services prior to being admitted as an inpatient, observation days—even for a patient who is subsequently admitted—should not be considered inpatient days.

The final rule reflects changes to policies for counting beds in relation to the calculations for the Indirect Medical Education (IME) adjustment. The final rule changes the policy with respect to counting bed days for patients receiving observation services. Prior to October 1, 2003, CMS's policy had been to exclude all observation days from the available bed count. CMS clarified that if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the days that those beds are used for observation services are to be excluded from the bed day count (even if the patient is ultimately admitted as an acute inpatient).

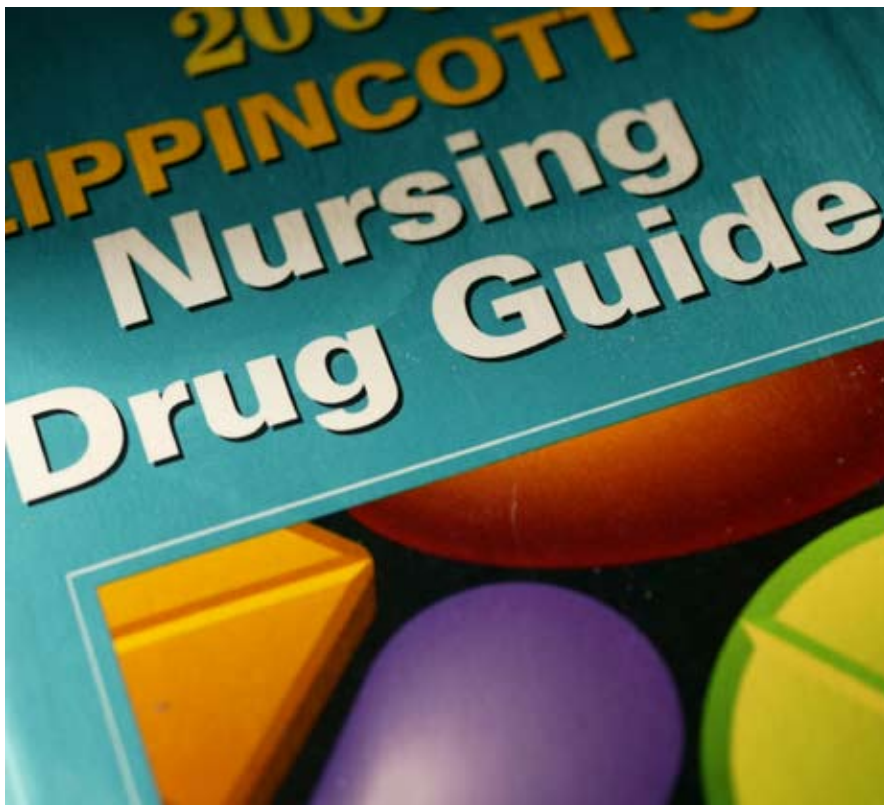
The FY 2005 IPPS final rule revised the regulations to specify that observation days are to be excluded from the counts of both available beds and patient days, unless a patient who receives outpatient observation services is ultimately admitted for acute inpatient care, in which case the bed days and patient days would be included in those counts.

In the FY 2010 IPPS final rule, CMS states that because a patient under observation in the hospital is considered to be an outpatient, and receives services prior to being admitted as an inpatient, observation days—even for a patient who is subsequently admitted—should not be considered inpatient days. Therefore, effective for cost-reporting periods beginning on or after October 1, 2009, hospitals will be required to report their total observation bed days so that the total observation bed days can be deducted from the total bed day count for IME and Disproportionate Share Hospital (DSH) payment adjustment purposes.

The FY 2010 IPPS final rule also provides clarification of the definition of a “new medical residency training program.” For purposes of determining direct graduate medical education (GME) and IME payments, the Medicare statute establishes a cap on the number of allopathic and osteopathic FTE residents a hospital may count; which, for most hospitals, is based on the number of allopathic and osteopathic full-time equivalent (FTE) residents the hospital was training in its most recent cost-reporting period, ending on or before December 31, 1996.

Section 1886(h)(4)(H)(i) of the *Social Security Act* requires the Secretary to prescribe rules for the application of the FTE resident cap in the case of medical residency programs that are established on or after January 1, 1995. Regulations were issued to permit adjustments to the FTE resident caps, under certain circumstances, for hospitals which establish new medical residency training programs on or after January 1, 1995. There has been a great deal of confusion in the industry as to what meets the definition of a new medical residency training program.

In the final rule, CMS clarifies the existing policy regarding the definition of a new medical



2010 OPSS Proposed Rule

Supervision Policy for Hospital Outpatient Therapeutic Services

In the 2010 Outpatient Prospective Payment System (OPPS) proposed rule, CMS further addresses the physician supervision issues that had been “clarified” in the 2009 OPSS final rule. In the 2009 OPSS final rule, Medicare “clarified” that direct supervision requires the physician to be present on the premises of a provider-based department, whether the department is on- or off-campus, and that hospital outpatient therapeutic services (i.e., infusions, chemotherapy) be provided under the direct supervision of physicians in the hospital and in all provider-based departments of the hospital; specifically, both on-campus and off-campus departments of the hospital.

In the 2010 OPSS proposed rule, CMS is allowing non-physician practitioners (NPP), i.e. physician assistants, nurse practitioners, clinical nurse specialists and certified nurse-midwives, to directly supervise all hospital outpatient therapeutic services that they may perform. The non-physician practitioner must perform within his or her state law, scope of practice and hospital-granted privileges. The non-physician practitioners will not be able to supervise the individual outpatient diagnostic tests that require physician direct supervision, cardiac rehabilitation services, intensive cardiac rehabilitation services or pulmonary rehabilitation services, all of which must be supervised by a physician.

The physician or NPP must be prepared to step in and perform the service, and not just respond to an emergency. This includes the ability to take over performance of a procedure and to change a procedure or the course of treatment being provided. Previously, Medicare had stated that the supervising physician need not be of the same specialty or in the same department as the ordering physician. CMS now states, “We believe the supervisory physician or non-physician practitioner must have, within his or her state scope of practice and hospital-granted privileges, the ability to perform the service or procedure.” Furthermore, CMS is requiring that the physician/NPP must be “immediately available without interval of time.” The physician/NPP could not be performing another procedure or uninterrupted service, or be so far away on the main campus that he or she could not intervene right away.

In the 2010 proposed rule, CMS also states that when outpatient therapeutic services are provided in a hospital or in an on-campus provider-based department, the supervising physician or NPP must be present on the same campus, in the hospital or in the on-campus provider-based department of the hospital. When providing supervision, the physician or NPP may not be located in any other entity. CMS states they may not be located in a “physician’s office, an independent diagnostic testing facility, a co-located hospital, a hospital-operated provider or supplier (i.e. skilled nursing facility), or any other non-hospital space co-located on the hospital’s campus.”

CMS further states that “in the hospital” means in the main buildings of the hospital that are under the ownership, financial and administrative control of the hospital, and that are operated as part of the hospital for which the hospital bills the services furnished under the hospital’s CMS certification number.

In the proposed rule, off-campus provider-based departments, direct supervision continues to require a physician/NPP to be physically in the off-campus department and immediately available to furnish assistance and direction throughout the performance of the procedure.

The proposed rule, if adopted, would take effect January 1, 2010. We recommend closely monitoring this rule to determine the impact on the practice patterns of hospitals.

Pulmonary and Cardiac Rehabilitation

To implement additional benefits authorized by MIPPA, CMS is proposing to establish OPSS payment for pulmonary and intensive cardiac rehabilitation services furnished to beneficiaries with chronic obstructive pulmonary disease, cardiovascular disease and related conditions. ■



JoNell Moore
Principal
Eide Bailly LLP

POSSIBILITIES is produced and published by Eide Bailly and distributed with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns as the contents of the publication are intended for general informational purposes only. Readers are urged not to act upon the information contained in this publication without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and information for publication can be submitted to your Eide Bailly representative or to the editors of the newsletter. Copyright 2009

To view this and previous issues of **POSSIBILITIES**, visit www.eidebailly.com/publications

Managing Editor: Liz Stabenow
Assistant Editor: Lisa Dahlen
Send comments to:
possibilities@eidebailly.com

**An Independent Member Firm
of HLB International**



4310 17th Ave S
PO Box 2545
Fargo ND 58108-2545

FORWARDING SERVICE REQUESTED

Medical Education—from page 6

residency training program. Under existing policy, to determine whether a program is new and whether a hospital qualifies for an FTE cap adjustment, a hospital should consider the following supporting factors:

- *Is the program director new?*
- *Is the teaching staff new? and,*
- *Are there new residents?*

In determining whether a particular program is newly established, it may also be necessary to consider factors, such as the relationship between hospitals (for example, common ownership or a shared medical school or teaching relationship) and the degree to which the hospital with the original program continues to operate its own program in the same specialty. In addition, the following factors could also be considered:

- *Has this program been relocated from a hospital that closed?*

- *If so, was this program part of the closed hospital's FTE cap determination?*
- *More generally, is this program part of any existing hospital's FTE cap determination?*

CMS would not consider a transferred program to be new if the program director, teaching staff and residents are the same as the program that closed in another hospital, if the first hospital remains open, or when an FTE cap associated with the first program is still available for use by an existing provider. ■



Sherry Schmitt
Manager
Eide Bailly LLP