BKD Health Care NEWS

Beyond Your Numbers • May 2006 • Vol. 24, No. 2

SOX holds practical ideas & value for health care organizations

by Bryan Bodnar, bbodnar@bkd.com

The purpose of the *Sarbanes-Oxley Act of 2002* (SOX) is to enhance corporate accountability and responsibility and to strengthen regulatory oversight of public companies.

While its only legal application is to "issuers," as defined in the *Securities Exchange Act of 1934*, many SOX best practices are being considered by nonpublic entities, including health care organizations.

Though many beneficial business practices have resulted from SOX implementation by larger organizations, full-scale adoption is not required (and is probably not practical) for most nonpublic health care organizations.

Adopting business practices

By implementing some of the business practices SOX promotes, your health care organization may be able to:

- Demonstrate its commitment to corporate governance to underwriters, rating agencies and other stakeholders
- Improve its financial reporting reliability
- Enhance the tone at the top and help build a culture of compliance
- Develop or improve documentation and understanding of controls, policies and procedures that aid in training and performing day-to-day responsibilities

Two of the biggest changes made by SOX are Sections 302, *Corporate Responsibility for Financial Reports*, and 404, *Management Assessment of Internal Controls*. These and other sections provide the impetus for some of the practices many health care organizations have adopted or are considering adopting:

- Require CEO and CFO certification of financial reports
- Conduct internal control assessments
- Create a formal audit committee
- Rotate the partner who conducts the audit review
- Develop or amend conflict-of-interest and code-of-ethics policies

Following is a summary of the practices listed above.

Certifying annual and quarterly reports - The potential best practices here are twofold: (1) Require CEO and CFO certification in connection with the financials (a relatively easy-to-implement best practice of SOX) and (2) implement quarterly or more frequent reporting requirements. A summary of each follows.

- ***Certification -*** SOX requires CEOs and CFOs to certify:
  - ✔ They have reviewed the report, which does not contain any untrue statement of material fact or material omission, and the financial information is fairly presented.
  - ✔ They are responsible for establishing and maintaining internal controls, which have been designed to ensure material information is made known.
  - ✔ They will disclose any fraud (material or not) and all significant deficiencies in the design or operation of the internal controls.
  - ✔ They will evaluate the effectiveness of internal controls and have presented their conclusions.
  - ✔ They will indicate any significant changes in internal controls subsequent to the date of evaluation,

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Proposed rule contains major DRG changes

by Tim Wolters, twolters@bkd.com

At presstime, CMS published its fiscal 2007 proposed rule, updating inpatient PPS rates effective October 1, 2006. It significantly restructures DRG weights based on hospital costs rather than charges.

Unlike inpatient nursing units, hospital ancillary areas tend to have higher markups, so restructuring tends to improve weights in medical DRGs (those with a heavy nursing component) and reduces them in surgical DRGs (those with heavy ancillary components).

Impact of DRG weight change

CMS estimates the impact of this DRG weight change will range from a negative 1.5% for urban hospitals with more than 500 beds to a positive 5.8% for rural hospitals with fewer than 50 beds. The effect is even more dramatic on selected high-volume DRGs.

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including any corrective actions with regard to significant deficiencies and material weaknesses.

Entities that have voluntarily adopted some form of CEO/CFO certification believe it makes high-ranking individuals responsible and accountable above and beyond current financial reporting considerations. In turn, this tends to improve the credibility, accuracy and reliability of financial reports and is considered by some health care organizations an easy way to adopt at least one SOX provision.

- ***Quarterly reporting -*** The certifications above are required for annual and quarterly reports for public companies. The audit committees of some nonpublic entities, including health care organizations, are considering quarterly "hard closes" and, to provide limited assurance, an interim review of the financial statements by the external auditors.

  The benefit of these quarterly procedures must be weighed against the workload capacity of the internal accounting staff and the costs of an external review.

Management's internal controls assessment - Under SOX 404, each annual report must contain management's internal control report that (1) states its responsibility for establishing and maintaining effective internal control over financial reporting and (2) contains its assessment of and conclusion about the operating effectiveness of the entity's internal control over financial reporting as of the balance sheet date. SOX then requires the independent auditor to audit and report on management's assessment.

Partner Rotation Considerations

Advantages	Disadvantages
Provides a "fresh look" at the engagement	Knowledge is lost (about the client, the business and the environment it operates in), information essential to the quality of both audit and nonaudit services
Helps discourage forming a "comfort level" with management that could inadvertently influence professional skepticism	Will take longer; with rotation, a different partner will need more time to acquire adequate knowledge
Enhances the *appearance* of auditor independence	Increases costs with more time-consuming, less-efficient processes during the learning curve

Implementing SOX 404 is no small task. It so overwhelmed public companies that the SEC twice extended the initial compliance deadline and is currently considering exempting all but the largest issuers from most or all of the SOX 404 requirements.

It's up to each individual health care organization to assess the costs vs. the benefits of adopting policies similar to SOX 404. The process is expensive and can easily result in internal and external costs that reach hundreds of thousands—or even millions—of dollars.

In reality, only the largest health care organizations are likely to fully implement SOX 404 because of the associated costs. Applying it on a smaller scale or over a longer period may be a viable option for some organizations.

Audit committees - An audit committee is typically comprised of a subset of board members. It serves as an oversight function of the entity's accounting and financial reporting processes and the audits of its financial statements.

Many health care organizations already have an audit oversight function at the board or finance committee level, though it may not be formalized as an audit committee per se. SEC rules generally require all members to be independent of management.

Establishing a formal audit committee is quickly becoming a best practice in the health care industry. Drafting a formal charter is recommended, one that becomes a living document for the committee instead of one placed on a shelf until its annual review.

One component of a formal charter is to ascertain if at least one audit committee member is a "financial expert" as defined in SEC rules and, if not, list why.

While a primary task of an audit committee is managing the relationship with external auditors, a health care organization's audit committee often has several other functions, including monitoring the internal audit process, discussing accounting policies with management and establishing procedures to receive and investigate complaints about accounting, internal control, auditing and ethical matters.

Many health care organizations already have hotlines in place as part of their corporate compliance program; the same hotline also could fulfill the audit committee's needs.

- ***Audit and nonaudit services -*** The most common audit committee task is to work with the external auditors, including engaging the independent auditors, discussing the audit process with them and receiving their report. Under SOX, the committee must pre-approve each auditor engagement for both audit and nonaudit services and decide if it's appropriate for him/her to perform the nonaudit service.

In reality, only the largest health care organizations are likely to fully implement SOX 404 because of the associated costs. Applying it on a smaller scale or over a longer period may be a viable option for some organizations.

  In health care organizations, audit committees often establish a fixed-dollar threshold for nonaudit services. Projects for nonaudit services that would exceed this predetermined fee require the committee's pre-approval, and many committees have found this a practical way to apply the spirit of these rules.

  The rules for permitted nonaudit services vary for governmental and nongovernmental entities and can be confusing. **For example, some health care organizations have asked if the preparation of the Medicare and/or Medicaid cost report by the audit firm is a prohibited service. It is permitted as long as the audit firm follows certain rules and safeguards**.

  The committee must understand these rules because there are often advantages to the auditor performing certain nonaudit services. Using two different firms is not always the best answer. Significant knowledge may be obtained during an audit that enhances a nonaudit service and improves the efficiency of providing it.

Audit partner rotation - SOX requires an issuer's audit firm to rotate partners (the lead partner and concurring reviewer) every five years. Don't confuse this with audit firm rotation; it is important to make this distinction. **SOX does not require audit firm rota-**

tion. Also, generally accepted auditing standards do not require partner rotation for entities not subject to SOX.

A concurring review is a second review by a partner or manager not otherwise involved in the engagement. Possible alternatives to achieving the objectives of partner rotation without losing your primary partner or manager's history and knowledge include:

- ***Perform a designated review***. A different partner or manager performs the primary review function of the lead partner, including the planning, fieldwork and reporting components of the audit; however, the lead partner remains involved in services provided to your organization, including provision of certain nonaudit services and meeting with management, the audit committee and board.

  Using this approach, the historical knowledge of the lead partner on reimbursement issues, financing matters or general corporate strategy is maintained while the organization has the benefit of a "fresh set of eyes" to review the audit.
- ***Rotate the lead partner with the lead partner performing the concurring review***.
- ***Rotate the concurring reviewer***, including use of a concurring reviewer from a different office in the audit firm.

Nonpublic companies across all industries are questioning whether partner rotation is a best practice they want to adopt. (See "Partner Rotation Considerations" sidebar for a few of the advantages and disadvantages.)

Conflict-of-interest and code-of-ethics policies - SOX requires each issuer to disclose if it has adopted a code of ethics, and, if not, the reasons why. Many health care organizations already have conflict-of-interest and code-of-conduct policies. As organizations look to adopt certain aspects of SOX as best practices, there may be opportunities to enhance existing policies:

- ***Add an active compliance program*** that extends beyond billing practices and other arrangements subject to Medicare's rules and regulations.
- ***Provide or revise guidelines*** on where conflicts of interest may arise.
- ***Require annual conflict-of-interest declarations*** from all directors, managers and other employees.
- ***Develop a formal process*** for resolving any such conflicts.
- ***Develop an enforceable code of ethics***, *e.g.*, build clarity around penalties/consequences once a policy is violated.
- ***Monitor policies and procedures***.

Decide which aspects to adopt

The basic principles of SOX center on auditor independence, corporate responsibility and enhanced financial reporting and disclosure.

While these requirements don't apply to nonpublic health care entities, some bond-rating agencies indicate they will consider a health care organization's implementation of them as a part of the rating process. ■

Reasonable compensation can still result in intermediate sanctions

by Tim Snavely & Troy Lindsey,
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If a tax-exempt organization pays for a disqualified person's personal expenses, *e.g.*, a vacation or the personal use of a car, and it doesn't substantiate the benefit was paid as consideration for services, the payment may be an *automatic excess benefit* transaction and subject to penalties.

Such penalties result from intermediate sanctions. A disqualified person includes an officer, director or such other person in a position to exercise control over the tax-exempt organization.

IRS rules for expressing intent

The IRS says even if the benefit was reasonable (and total compensation would be reasonable if the benefit had been taken into account) the receipt of the benefit without documentation that it was for services can be automatically subject to intermediate sanctions.

The IRS's enforcement position was published in its FY 2004 continuing professional education text and indicates an economic benefit received from a tax-exempt organization is considered compensation for services performed for the organization ***only* if it "clearly indicated its intent to so treat such benefit."**

The industry has generally held that this intent can be satisfied by including the benefit as compensation on Form W-2 for an employee or on Form 1099 for a board member or other nonemployee. In addition, intent is expressed if the disqualified person reports the item as income on his/her tax return for the year.

There are a number of expense types to consider when reviewing these issues, including:

- Spousal travel
- Personal use of assets, such as automobiles and cell phones
- Club memberships
- Business-related travel

Document personal expenses

Whether an expense is personal or business depends on the particular facts. A benefit, such as the business use of a car, may be disregarded as an item of compensation because it's a working condition fringe benefit; however, personal use is not disregarded.

If neither the individual nor the organization reports the personal use as compensation, the benefit will be an automatic excess benefit transaction.

If an individual has use of a business vehicle, keep auto logs to document business vs. personal use, *e.g.*, commuting to work, family trips, etc. If personal use is reported as compensation for services, then that benefit, along with other included compensation, will be aggregated to determine if compensation is reasonable.

Substantiating expenses

One of the many areas subject to enhanced IRS scrutiny during examinations is the substantiation of the business purpose for expenses incurred by employees:

- To adequately substantiate travel away from home, an employee must establish the amount, time, place and business pur-

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Exceptions allowed as outpa

by Gary Phillips, gphillips@bkd.com

Section 4541 of the *Balanced Budget Act of 1997* required CMS to impose financial limitations on outpatient physical therapy (including speech-language pathology) and occupational therapy services.

Implemented in 1999, these financial limitations, or caps, were applied to all outpatient providers of rehabilitation therapy services except hospital outpatient and emergency room services. In the years that followed, a moratorium on the caps was imposed (except for a short period in 2003 before the moratorium was extended).

The moratorium expired December 31, 2005, and the therapy caps were reinstated beginning January 1, 2006. The total dollar limit for calendar year 2006 for each of the two caps is $1,740, computed by aggregating the gross physician fee schedule payment amounts assigned to the procedures performed. Providers will not be paid by Medicare once services exceed the caps.

However, Congress did allow for exceptions to these caps, which may be granted when providing additional therapy services is determined medically necessary. There are two categories of outpatient therapy cap exceptions:

Automatic exception - An automatic exception is allowed for certain conditions or complexities that would result in a negative patient outcome if additional therapy services were not provided. These conditions or complexities must be clearly documented in the patient's medical record.

Information describing the ICD-9-CM codes and clinical complexities identified as qualifying for the automatic exception is included in the **Medicare Claims Processing Manual, Publication 100-04,** Chapter 5, Section 10.2.

Some FIs and carriers have noted "most of the conditions or complexities included on the list would not ordinarily result in services exceeding the cap. The mere fact that a patient has a diagnosis on the list does not qualify them for the exception."

It appears intermediaries and carriers could begin to aggressively monitor these automatic exceptions to confirm medical necessity. The requirements for the therapy cap exceptions are found in **Transmittal 140, CR 4364**, February 15, 2006, available at **www.cms.hhs.gov/Transmittals/**.

Manual exception request - In the event an outpatient rehabilitation therapy course of treatment is expected to exceed the cap and doesn't meet the criteria for an automatic exception, a written request for additional

Revenue code changes coming in 2006 for RHCs & FQHCs

by Marla Dumm, mdumm@bkd.com

Do you currently file claims to your FI for services provided in an RHC or FQHC? If you do, the latest revenue code update from Medicare will affect your practice or facility.

Codes affected

CMS reviewed the revenue codes currently reported for RHCs and FQHCs and those that will be affected include:

0520 - Free-standing clinic and/or FQHC

0521 - RHC

0522 - Rural health home-visit settings

CMS determined redefined or additional categories were needed to accurately reflect the type of service, the site where service is rendered and the identity of the performing practitioner.

Effective for dates of service on or after July 1, 2006, report these revenue codes:

0521 - Clinic visit by member to RHC/FQHC

0522 - Home visit by RHC/FQHC practitioner

0524 - Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF

0525 - Visit by RHC/FQHC practitioner to a member in a SNF (not covered in a Part A stay), NF, ICF/MR or other residential facility

0527 - RHC/FQHC visiting-nurse service(s) to a member's home when in a home health shortage area

0528 - Visit by RHC/FQHC practitioner to other non-RHC/FQHC site, *e.g.*, scene of accident

CMS has clarified revenue codes **0519** (FQHC supplemental payment), **0900** (Medicare outpatient mental health treatment limitation) and **0780** (telehealth originating site facility fee) will continue to be accepted with no revisions.

How to prepare

Tips to help you prepare for these changes include:

- Review current services to determine how they will fall into the new code scheme
- Teach your providers and billers when to use the new codes
- Educate coding and billing staff
- Update your chargemasters and encounter forms or charge slips with the new codes

Using the correct revenue codes will help you avoid FI payment delays or denials.

For more information

- **CMS Publication 100-04**, **Medicare Claims Processing Manual**, **Transmittal 820** (February 1, 2006)
- **MedLearn Matters No. MM4210**, "Change Request 4210," (February 1, 2006); online: **www.cms.hhs.gov/MLN MattersArticles/**. ■

tient therapy caps reinstated

treatment days for each therapy discipline can be submitted to the intermediary or carrier, not to exceed 15 days per request.

If granted, payment for services provided beyond the $1,740 caps will be allowed. Most intermediaries and carriers have developed exception request forms that specify the documentation required to support the exception request, including an evaluation and certified plan of care, certification, progress report, treatment notes and an explanation justifying medical necessity.

Even though retroactive approval can be granted, providers are encouraged to submit the manual exception request before exceeding the caps because the beneficiary is liable for any services provided beyond the caps if the request is denied.

If the intermediary or carrier doesn't respond to the provider within 10 business days of receipt of the request, the provider is to be paid for up to 15 treatment days. The 10 business-day limitation doesn't apply if there is evidence of provider fraud, misrepresentation of facts or inappropriate billing.

* * *

To indicate the provided outpatient therapy services meet the guidelines for an automatic exception—or that a manual exception has been approved—providers are required to add a modifier "KX" to the Medicare Part B therapy claim. Intermediaries and carriers began processing outpatient therapy claims with the therapy cap exception modifier KX on March 13, 2006.

In most instances, claims submitted after March 1, 2006, are being held until the exception process is fully implemented. Claims submitted between January 1 and February 28, 2006, may require resubmission to be paid. ■

How 'psyched' is your facility?

by Brent Beaulieu & Wendy Wiley, bbeaulieu@bkd.com & wwiley@bkd.com

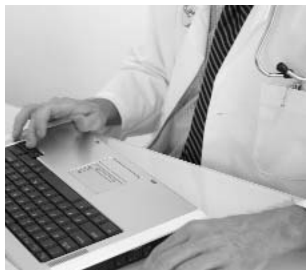
On November 15, 2004, the final rule for Medicare's PPS for IPFs was published in the **Federal Register**, becoming effective with cost-reporting periods beginning on or after January 1, 2005. The rule is available at **www.cms.hhs.gov/quarterlyproviderupdates/**.

Under IPF PPS, facilities are reimbursed by a standardized, federal per-diem payment with adjustments based on patient age, DRG, comorbidities, length of stay, wage index, geographic proximity, availability of 24/7 ER services, teaching adjustment and electroconvulsive therapy (ECT).

With IPF PPS entering its second year, providers now have a better idea of what life will be like under this payment system. A few areas of concern expressed by providers include:

Inadequate education - Those involved in the IPF PPS process require appropriate training, including the director and staff of the psychiatric unit, physicians involved in the care of psychiatric patients, the HIM staff responsible for coding psychiatric stays and business office staff responsible for billing psychiatric claims. In some facilities, the HIM staff may not be aware the IPF PPS exists.

Incomplete physician documentation - To receive proper reimbursement under IPF PPS, complete and accurate physician documentation is critical. Physicians must be as specific as possible when documenting a diagnosis.



For example, if a patient has diabetes that isn't in control during his/her stay, the physician must document it as "uncontrolled diabetes," not "diabetes mellitus" or "DM."

Comorbidities not coded - Not coding all comorbidities will reduce a provider's payment. In many cases, some comorbidities have been missed. CMS has identified 17 comorbidity categories that allow facilities a per-day payment adjustment factor ranging between 3% and 17%.

IPFs may only receive one adjustment factor for each comorbidity category; however, if a patient has multiple diagnoses in several categories, the adjustment factors for each separate category will be applied.

Comorbidity codes don't reach UB-92 - Most encoders will rearrange codes according to acute inpatient PPS, which sometimes causes conditions with unreported payment-adjustment factors to not wind up on the UB-92, resulting in missed reimbursement.

Because the UB-92 only allows you to report nine diagnoses, have a process in place to monitor and ensure IPF PPS comorbidity codes are included on the claim form.

Cost-report settlements - Transition to IPF PPS will occur over a four-year period for existing facilities, whereas new IPFs will be reimbursed 100% IPF PPS once they enter the program. As a result, a portion of the reimbursement for existing IPFs will continue to be based on cost for three years.

Interim payments for the cost-based portion of reimbursement are made using a per-discharge amount intermediaries calculate based on prior-year cost reports. Some providers have found significant errors in these interim rates that could result in significant settlements on the cost report.

In addition, because this is a per-discharge payment, significant shifts in a provider's average length of stay can result in large settlements on the cost report. These items should be considered for cash flows and cost report estimate purposes.

* * *

The initial IPF PPS implementation period is January 1, 2005, through June 30, 2006, with the first update July 1, 2006. The final rule for this first update was published in the May 9 **Federal Register**. ■

Medicare Part D's impact on SNF admissions

by Gary Phillips, gphillips@bkd.com

Since it became effective in January, the confusion surrounding the initial implementation of the Medicare Part D PDP has been the subject of several national news media broadcasts. While media attention may have waned, the reality is just starting for SNF providers.

Plan options are available

Beginning January 1, 2006, Medicare beneficiaries experienced confusion in getting the correct medications, followed by more confusion about which Part D plan to enroll in. BKD Health Care Group advisors spoke to a number of seniors about the plan they joined and their reasons for joining it.

We routinely hear about seniors who are considering a PDP, or have already joined one, based on its low monthly premium and/or annual deductible. Some join plans introduced by providers with name recognition, while many others say they are confused and hesitant to join for a variety of reasons.

The deadline for enrolling in a Medicare Part D plan without penalty was May 15, 2006. Two types of plans are available.

PDP basics & MA plan basics

In brief, the PDP is designed for the Medicare Part A/Part B beneficiary to receive assistance with his/her drug costs while continuing to receive traditional Medicare benefits.

When beneficiaries join a PDP, their Part A and Part B Medicare benefits continue to be administered through the Medicare intermediary while the Medicare Part D drug benefits are through the particular PDP they joined.

MA plans are Medicare-qualified managed care plans similar to commercial insurance large-group health plans. To qualify, beneficiaries must be enrolled in both Medicare Part A and Part B, the benefits of which are assigned to the commercial insurance company to administer.

Therefore, beneficiaries no longer have traditional Medicare Part A and Part B benefits but instead fall under the guidelines of the insurance company's managed care plan.

There are significant advantages and disadvantages to both options; however, it is extremely important for the beneficiary—and particularly the SNF provider—to have a clear understanding of the requirements for accessing payment for health care services under the guidelines of these two different options.

Confusion can be costly

Though there is considerable advertising from plan sponsors, explanations about the difference between a PDP and an MA plan are in short supply. Some of the Medicare beneficiaries who joined an MA plan did so thinking they were only joining a PDP.

Some SNF providers have admitted patients who assured them they had traditional Medicare Part A and Part B, as well as Part D benefits; however, with further investigation, the SNF determined the patient had actually joined an MA plan.

A major hallmark of MA plans is they do not pay if the SNF (or other provider) fails to obtain **prior approval** for the admission. This situation has caused some SNFs to write off "No Pay" days because a patient or his/her family assured the SNF the individual had not joined an MA plan when selecting a Part D provider.

As a SNF provider, it's your responsibility to determine the payer source of all Medicare-qualified admissions. Skip this procedure, and the negative financial ramifications could be significant.

For example, a recent list of Medicare Part D providers obtained from CMS for the state of Missouri shows 17 companies authorized to offer 41 separate PDPs. Missouri also lists 11 companies offering MA plans. Some companies offer both PDP and MA plans.

In reviewing the promotional literature from insurance companies that offer both plans, it's difficult to determine if the beneficiary is enrolling in a PDP or an MA plan.

* * *

SNF patients who enrolled in a PDP or MA plan can change their decision during the annual open enrollment period, which will be from November 15 through December 31 each year. ■

Speakers' Bureau

Seminar: **HFMA Annual National Institute (ANI), Orlando, Florida, June 19-21**

Topic: Strategies to Improve Critical Access Hospital Margins
Speaker: Larry Fogel & Joe Watt

Topic: Outpatient Therapy: What Every CFO Should Know
Speaker: John Britt & Chris Roszman
Date: June 19, 2006

Topic: Rural Hospital Medicare PPS Update
Speaker: Tim Wolters
Date: June 20, 2006

Topic: Demystifying the Federally Qualified Health Center
Speaker: Jeff Allen

Topic: Opportunities for Medicare Home Health Revenue Recovery
Speaker: Aaron Little & Mark Sharp
Date: June 21, 2006

* * *

Seminar: **NACHC - Reimbursement Conference, San Diego, California, June 21-22**

Topic: Preparing the Medicare FQHC Cost Report
Speaker: Michael Schnake

Topic: FQHC Billing – What You Need to Know
Speaker: Patricia Priest
Date: June 21, 2006

CMS softens reporting guidelines for 2006 observation services

by Paula Archer, parcher@bkd.com

CMS made it difficult to bill for injections and infusions in 2006, but it softened its reporting guidelines for observation services.

In the OPPS final rule, published in the November 10, 2005, **Federal Register**, CMS defines observation care as "a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment, before a decision can be made about whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

Changes in observation coding & reporting requirements

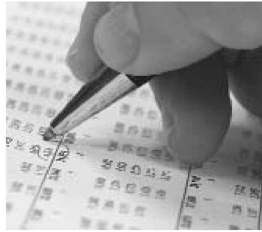
Based partly on provider comments about the burden of billing for observation services, CMS made two changes in observation coding and reporting requirements for Medicare observation services in 2006.

The following HCPCS G codes were discontinued:

G0244 (observation care by facility to patient) assigned to APC 0339

G0263 (direct admission to observation for patients with CHF, chest pain and asthma)

G0264 (direct admission to observation for assessment other than CHF, chest pain, asthma or separately payable observation APC requirements not met)



CMS directed the following two HCPCS G codes be used to report **all** observation services, whether separately payable or packaged:

G0378 (hospital observation services per hour) for observation services provided to **any** patient admitted to observation status, regardless of diagnosis, time in observation or whether payment is packaged or paid; the units of service reported will be the hours the patient is in observation status

G0379 (direct admission for hospital observation status; directly admitted without associated emergency room, clinic or critical care visit; unit of service will always be "one")

While reporting codes were changed, the previous diagnosis requirements for being paid for observation services remain the same. Patients must have a diagnosis of CHF, chest pain or asthma before separate payment will be made.

By now, your hospital should be enjoying the decreased burden as the outpatient code editor logic now determines if criteria are met in generating payment for the separately payable observation APCs.

For changes outlined in the final rule, be sure to complete these action steps:

- Be alert to and continue to monitor new transmittals about observation billing and coding
- Examine the final OPPS 2006 rule for more detailed information
- Review new information and provide it to the revenue cycle team
- Test your systems and processes to be sure observation edits occur as expected
- Provide your staff continual education and training
- Monitor the impact of all changes ■

Glossary

APC – ambulatory payment classification

CCI – Correct Coding Initiative

CDM – charge description master or "chargemaster"

CEO – chief executive officer

CFO – chief financial officer

CHF – congestive heart failure

CMS – Centers for Medicare & Medicaid Services

CPT/HCPCS codes – current procedural terminology/healthcare common procedure coding system codes

DRG – diagnostic-related group

ECT – electroconvulsive therapy

ER – emergency room

FI – fiscal intermediary

FQHC – federally qualified health center

FY – fiscal year

HCPCS – healthcare common procedural coding system

HIM – health information management

HSP – hospital-specific payment

ICD-9-CM – International Classification of Diseases, 9th Edition, Clinical Modification

ICF/MR – intermediate care facility for the mentally retarded

IPF – inpatient psychiatric facility

IPPS – inpatient prospective payment system

IRF – inpatient rehabilitation facility

IRS – Internal Revenue Service

IT – information technology

MA – Medicare Advantage

NF – nursing facility

OIG – Office of Inspector General

OPPS – outpatient prospective payment system

PDP – prescription drug plan

PFS – patient financial services

PPS – prospective payment system

RC – revenue cycle

RFP – request for proposal

RHC – rural health clinic

RHIA – registered health information administrator

SEC – Securities and Exchange Commission

SNF – skilled nursing facility

SNU – skilled nursing unit

SOX – *Sarbanes-Oxley Act of 2002*

UB-92 – uniform billing claim form 1992

Reasonable compensation. . .

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pose of each expenditure.

- To adequately substantiate entertainment, an employee must establish the amount, time, place, business purpose and business relationship of the people he/she entertains, including sufficient information to establish the business relationship between the employee and the guest.

While asking employees to substantiate the business purpose and to also collect other required documentation may not seem difficult in theory, actually getting employees to follow these rules can be difficult and cumbersome.

Let's face it, compared to for-profit organizations, standards for compliance are much greater for tax-exempt entities. For-profits only face a payroll risk with noncompliance, but tax-exempts risk that *and* intermediate sanctions.

Example - In addition to a $375,000 annual salary, assume a tax-exempt organization provides a key executive the personal use of a car and a country-club membership. The fair market value of the salary, car and country-club membership is $400,000, an amount determined reasonable for this individual's services.

Also, assume this executive incurs travel and entertainment expenses of $20,000 for business purposes, expenses not adequately documented under IRS standards. The W-2 issued for the year reflects only the $375,000 of salary. Form 990 also reflects only the $375,000 of taxable compensation.

Under IRS audit guidelines, the unreported $25,000 of taxable personal benefits, and the $20,000 of unsubstantiated travel and entertainment expenses would constitute automatic excess benefit transactions subject to a 25% penalty with an additional 200% penalty if the excess benefits are not corrected, *e.g.*, repaid to the organization within a reasonable time.

There also is a 10% penalty imposed on any organization manager (potentially to include board members) who knowingly participates in the excess benefit transaction.

Review reporting practices

Automatic excess benefit rules raise the stakes for various transactions and substantiation procedures of all tax-exempt organizations, including those in the health care industry.

Therefore, review compensation reporting practices, including the taxable fringe benefits and expense documentation your organization reports (or does not report) on Forms 990, W-2 and 1099. Remember, the risk of intermediate sanction penalties exists even when overall compensation is reasonable. ■

Inpatient proposed rule. . .

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For example, CMS proposes 30% decreases in DRGs 556 and 558 and 10% increases in DRGs 88 and 89. Because of these wide variations, hospitals should study the weights in Table 5 of the proposed rule and assess the potential impact on their reimbursement.

CMS proposes the DRG list be expanded from 526 to 861 severity-adjusted DRGs, with implementation more likely in fiscal 2008. It also proposes a general 3.4% market basket update for DRG payments; implementation of *Deficit Reduction Act of 2005* changes, primarily for Medicare-dependent hospitals; and various other changes in payment policy.

Comments on the proposed rule are due June 12, 2006. For an in-depth review of its provisions, visit **www.bkd.com**. For hospital impact files and other tables, visit **cms.hhs .gov/AcuteInpatientPPS/FFD/list.asp**. ■

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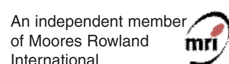

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