

pay \$2.87 million in restitution. He was caught misdiagnosing patients with a rare vascular

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Value ~ Added

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CMS Proposes New Prospective Payment System for Hospital Services Provided in Inpatient Psychiatric Facilities & Certified Sub-provider Units of Acute Care Hospitals

In November, the Centers for Medicare & Medicaid Services ("CMS") released its proposed regulations for a prospective payment system inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals.

Most hospital inpatient services provided to Medicare beneficiaries are subject to the Inpatient Prospective Payment System (referred to as the "IPPS System"). Certain specialty hospitals though are paid based upon alternative prospective payment rates and/or recent cost. Hospitals/units that have been statutorily excluded from the IPPS System include:

- Psychiatric Hospitals and Psychiatric Units in Acute Care Hospitals ("IPFs")
- Long-Term Care Hospitals
- Children's Hospitals
- Rehabilitation Hospitals and Rehabilitation Units in Acute Care Hospitals
- Cancer Hospitals

CMS has already developed and implemented prospective payment systems for Rehabilitation services and Long-Term Care Hospitals. The remaining components continue to be paid on the system outlined in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA").

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The Benefits Improvement and Protection Act (“BIPA”) mandated that a new prospective payment system be developed for inpatient hospital psychiatric services. The Balanced Budget Refinement Act required that the system CMS develops for IPFs be a *per diem* prospective payment system that includes an adequate patient classification system that reflects the differences in patient resource use and costs among IPFs. The BBRA mandates that the system maintain its budget neutrality and gives CMS the authority to expand reporting requirements related to services provided in Psychiatric Hospitals and Units.

This system was to be implemented for cost reporting periods beginning on or after October 1, 2002. However, CMS required additional time to develop the patient classification system portion of their requirements. As such, they are currently proposing that this new prospective payment system become effective for cost reporting periods beginning on or after April 1, 2004. For most Hospitals in the Commonwealth, that will mean an effective start date of either October 1, 2004 or January 1, 2005.

As proposed, the IPF PPS system applies only to inpatient hospital services furnished by Medicare participating entities that are classified as Psychiatric Hospitals or Psychiatric Units and meet the specifications outlined in regulatory sections 412.22, 412.23, 412.25, and 412.27. For the most part, if your facility currently functions as a Psychiatric Hospital and/or a Psychiatric Unit of an Acute Care Hospital and is being reimbursed under the TEFRA system, you can assume that you meet the qualifications. We encourage you to revisit them to ensure that your compliance with all of the elements are properly documented.

The Basics

CMS is proposing a per diem payment system that incorporates the following elements:

- An all-inclusive base rate that reflects the (adjusted) average cost (routine, capital, overhead and ancillary costs) per day for services provided to Medicare beneficiaries in IPFs. CMS used 1999 MedPAR and HCRIS (i.e., cost report) data as a starting point for this base rate.

The base rate is adjusted to incorporate several indicators to reflect variances in the resource consumption of different patients. These adjustments are referred to as “Patient Level Adjustments” and “Facility Adjustments”.

- Patient Level Adjustments include:

- Age of the Beneficiary at the time of service delivery.
- Specified DRGs (i.e., *casemix adjusted* per diems).
- High Cost Comorbidity Categories
- Facility Adjustments include:
 - Area Wage Index adjustment
 - Rural Location adjustment
 - Indirect Teaching adjustment

The base rate is further adjusted to reflect:

- CMS’ research indicating that higher costs were incurred in the early days of the psychiatric stay (referred to as the variable per diem adjustments).
- Outlier adjustments to target greater payment to high cost cases.

In combination with the proposed adjustments, CMS believes several new policies are also required:

- In order to classify patients into the appropriate DRG, CMS is mandating that IPFs use only psychiatric diagnosis codes that appear in Chapter 5 of the ICD-9-CM. This is a deviation from current regulations that require an IPF admit only those patients who have a principal diagnosis that is listed in Chapter 5 of the ICD-9-CM *and/or* the Diagnostic and Statistical Manual of Mental Disorders (“DSM”). As proposed, CMS continues to allow facilities to use DSM for patient assessment but requires that all diagnosis be drawn from Chapter 5 of the ICD-9-CM.
- Because the variable per diem adjustment provides for higher payment for the initial days of a hospital stay, CMS has proposed instituting an “interrupted stay policy” similar to that

used in the long-term care hospital prospective payment system. Under this proposed policy, patients who have been “transferred” from a psychiatric facility to an acute care facility and who then return within 5 days to the same psychiatric facility will be considered to be in a continuation of their original admission to the IPF. A stay is considered “interrupted” even if the principal diagnosis for the psychiatric inpatient portions of the stay is different.

There will be a 3-year transition to the new system. During this time, IPFs will be paid based on a blend of the TEFRA and PPS systems as follows:

- Year 1: 75% TEFRA/25% IPF PPS
- Year 2: 50% TEFRA/50% IPF PPS
- Year 3: 25% TEFRA/75% IPF PPS

Unlike previous PPS implementations, the proposed rules DO NOT allow an IPF to choose to be paid at 100% of the IPF PPS. That is to say that the transition period is mandatory.

CMS does not anticipate a change in the current claims processing system. IPFs will continue to bill as they currently are (with ICD-9-CM and comorbidity codes). CMS’ contractors (i.e., the “FI”) will group and price the claim and remit payment to the IPF. It appears that, on an interim basis, payment will be based on the IPF PPS rate. The “blending” during the transition will presumably occur through the cost report.

Coding Specifications

Current Medicare regulations specify that psychiatric units of acute care hospitals admit only those patients with a principal diagnosis listed in the DSM or Chapter 5 of the ICD-9-CM. Medicare regulations however have not required psychiatric *hospitals* to similarly limit their admissions.

CMS’ review of the data has revealed multiple occasions where the principal diagnosis for patients in IPFs was not a “psychiatric condition as defined in DMS or ICD-9-CM”. In light of these findings, CMS has proposed extending the “principal diagnosis” requirement (while, as discussed above, limiting the diagnosis to those listed in the ICD-9-CM) to all IPFs.

In addition, Medicare re-asserts that patients who were admitted to IPFs must receive *active treatment* that is of an intensity that can only be furnished appropriately in an in-patient hospital setting. As such patients must be capable of participating in their treatment program.

Physician Certification

Current regulations require that a physician certify (and re-certify after 18 days of an inpatient stay), that inpatient psychiatric services are required: (1) for treatment that could reasonably be expected to improve a patient’s condition or for diagnostic study and (2) the provision of intensive treatment and related diagnostic services related to a plan for improving the patient’s condition are adequately documented in the IPF’s records.

CMS is proposing to change the timing physician re-certification requirement. Instead of 18 days, CMS is proposing to require re-certification of the continued need for *inpatient* psychiatric services by the 10th day of an inpatient stay.

DRGs

Medicare has selected 15 DRGs, which they believe (based on their analysis) are appropriate for treatment in an IPF. The prospective payment system that they are proposing only recognizes the following 15 DRGs:

- DRG 12-Degenerative Nervous System Disorder
- DRG 23-Non-Traumatic Stupor and Coma
- DRG 424-OR Procedure with the Principal Diagnosis of Mental Illness
- DRG 425-Acute Adjustment Reaction and Psychosocial Dysfunction
- DRG 426-Depressive Neurosis
- DRG 427-Neurosis Except Depressive
- DRG 428-Disorders of Personality and Impulse Control
- DRG 429-Organic Disturbances and Mental Retardation
- DRG 430-Psychosis
- DRG 431-Childhood Mental Disorders
- DRG 432-Other Mental Disorder Diagnoses
- DRG 433-Alcohol/Drug Abuse or Dependence, Left AMA
- DRG 521-Alcohol/Drug Abuse w/Complication or Comorbidity
- DRG 522-Alcohol/Drug Abuse w/rehabilitation therapy without Complication or Comorbidity
- DRG 523-Alcohol/Drug Abuse or Dependents without rehabilitation therapy and without Complication or Comorbidity

There were an additional 10 DRGs that showed up in CMS’ analysis. However, they did not believe that the frequency was sufficient to include them in the prospective payment system.

CMS has asserted that a majority of the diagnoses that are listed in Chapter 5 of ICD-9-CM can be mapped to

one of the included 15 DRGs. It is also important to note that CMS has indicated that they believe that the *majority* of the diagnoses in DSM can be linked to a Chapter 5 ICD-9-CM diagnosis. However, there are diagnoses in DSM that can be cross-walked only to diagnoses in other chapters of ICD-9-CM. Under the proposal, those diagnoses would not produce a patient appropriate for services in an IPF.

Each one of the aforementioned DRGs has a corresponding casemix weight. These range from a high of 1.22 for DRG 424 to a low of .88 for DRG 433. DRGs 426 (Depressive Neurosis) and 430 (Psychosis) have a casemix weight of 1.00. These two DRGs reflect the most common occurrences in the 1999 data used by CMS to develop the system.

Comorbidities

CMS has developed a list of 17 proposed categories for comorbidity. Based upon their aggression analysis, these comorbidity categories (each of which represents a “bundle” of ICD-9-CM codes) had a direct impact on the cost of care. The presence of these comorbidities will increase the per diem from 3% and 17%.

Age

Medicare covers both the elderly and the disabled. A large proportion of disabled beneficiaries are under 65. Not surprisingly, Medicare’s research indicated that the cost of care increases significantly with age. Therefore, they are including another adjustment to increase the per diem rate by 13% for IPF patients over 65.

Variable Per Diem

As previously, the proposed system includes a “variable per diem adjustment”. Essentially, Medicare will pay “enhanced” per diems during the initial 8 days of a hospital stay. The rate of enhancement is on a sliding scale:

- Day 1: the per diem rate will be increased by 26%.
- Days 2-4: the per diem will be increased by 12%.
- Days 5-8: the per diem will be increased by 5%.
- Days 9 through discharge: will be paid at the per diem without further adjustment.

Medicare’s research also indicates that Psychiatric *Units* have a higher per diem cost than Psychiatric *Hospitals*. According to the 1999 MedPar file, the average per diem cost for Psychiatric *Units* was \$615 compared to \$444 for Psychiatric *Hospitals*. While their research was able to identify this difference, the regression analysis did not provide sufficient information for CMS to develop a “site of service” adjustment in the system as currently pro-

posed. However, they have left open the opportunity to refine their research and to potentially create separate per diems for Units and Hospitals.

Outliers

The proposed system includes a high cost outlier payment adjustment. The payment adjustment will be evaluated against a high cost outlier threshold of \$4,200 (adjusted for the geographic wage index). It will be measured at the end of the stay, on a per case basis. The “loss sharing” ratio is variable based upon the length of stay of the case.

Budget Neutrality

Per legislation any proposed system is subject to budget neutrality. In developing the budget neutrality adjustment (a 19% reduction), CMS incorporated “behavioral offsets”. These adjustments reflect anticipated changes in length of stay, cost of care, acuity, and the incidence of comorbidities that are likely to occur (in CMS’ opinion) subsequent to the institution of the new prospective payment system.

Base Rate

After taking into account budget neutrality and the behavioral offsets, the proposed federal per diem rate would be \$530 per day. This rate varies based on the adjustments outlined above, including the area wage index.

After adjusting for the area wage index and assuming: (1) no comorbidities, (2) a patient age of greater than 65, and (3) the variability of the rate based on the average length of stay, we estimate that IPFs in the Boston MSA (for a casemix of 1.00) will experience rates that vary between \$691 per day and \$719 per day, depending on the length of stay (assuming 8 to 14 day stay).

Estimated Impact

CMS has estimated the aggregate impact of the proposed system on IPFs. Given the requirement for budget neutrality, there will be no aggregate overall nationwide impact. However, segments of the IPF industry will see dramatic changes in payments:

- Government IPFs: 14% increase reimbursement
- Psychiatric *units*: 1% decrease in reimbursement
- New England IPFs: 1% decrease in reimbursement
- Psychiatric *hospitals* with more than 400 beds: 19% increase in reimbursement
- Psychiatric *units* with less than 50 beds: 1% - 2% decrease in reimbursement



Top 10 Things to Consider in Response to Psych PPS

We offer the following “Top 10” list of suggested “*things to consider*” with regard to the proposed regulations.

- 1. Review prior or current year’s discharge data and quantify the estimated impact of these new payment rules.** We know - an obvious place to start. However, keep in mind that the new system is an acuity adjusted per diem system and includes a mandatory three year phase-in. During the phase-in period reimbursement will be a “blend” of the current TEFRA system and the new PPS payment methodology. We believe that the best place to start is to develop an estimate based on your historical data. We also recommend modeling on a *claim-by-claim basis, not in the aggregate*. Remember, the patients covered by this system are ONLY the patients in your current sub-provider unit NOT all patients with the covered DRGs (i.e., some of those DRGs could “show up” in your standard PPS units) - claim-by-claim is probably the only way to get at this data accurately.
 - 2. Review coding practices to determine if your current “system” is accurately capturing principal diagnosis (using ICD-9-CM).** The proposed system uses only principal diagnoses outlined in Chapter 5 of ICD-9-CM. The rule specifically excludes diagnosis codes drawn from the Diagnostic and Statistical Manual of Mental Disorders (“DSM”). This is a change from current regulations (which allow DSM listed diagnoses) and may be a change for some clinicians (who generally favor DSM). The principal diagnosis is the main driver of the DRG/Casemix component of the payment system and the primary determinant of payment. Selecting and documenting the correct diagnosis will be critical.
 - 3. Review coding practices for co-morbid conditions and complications.** CMS has proposed a payment increase reflecting the additional resources required to treat psychiatric patients with *selected* co-morbid conditions and complications. Not all co-morbid conditions will yield an increase in payments. You need to take steps to ensure that your current documentation systems allow for the capture, tracking and reporting of this information.
 - 4. Review your procedures for documenting both care and physician certifications of the need for care.** The proposed regulations change both the content and the timing of the physician certifications. New policies and procedures will be required to adopt these changes.
 - 5. Review your current method for billing and ensure that “interrupted stays” will be accurately captured.** The new system requires that any patients returning to an inpatient psychiatric facility
- (whether a free-standing hospital or a certified sub-provider) within 5 days of discharge (regardless of the reason for the second admission) be considered a component of the first stay. The system’s use of a “front-loaded” variable per diem payment (i.e., higher payments in the first 8 days of a stay) means that you will have to develop a method to identify these patients upon re-admission and segregate the patient days in order to properly record revenue.
- 6. Review your monthly reimbursement models and take steps now to make adjustments to recognize the changes stemming from this new system.** The new system’s proposed phase-in means that a portion of reimbursement for psychiatric services will be retrospective - requiring a settlement through the cost report at year end. This blending is a “wrinkle” that your monthly reimbursement models will need to consider.
 - 7. Consider developing or enhancing a log system to capture data necessary to ensure that claims are adjudicated correctly and that revenue is properly recorded.** We highly recommend creating a log system to capture revenue elements for patients serviced in these areas. While potentially cumbersome, a log may be the only way to track patients, particularly in the initial stages of implementation. A codicil to this point is to take steps to prepare for potential cash flows interruptions. This payment system will require some changes at the FI. History tells us that those changes can sometimes lead to delays in payment.
 - 8. Compare current coding practices and patient mix with the 1999 data that CMS used as its baseline.** If your facility has experienced significant changes in patient type/clinical mix, you should consider responding to CMS’ request for public comments regarding the appropriateness of the base data given the evolution of your unit since 1999.
 - 9. Review current cost assignments and ensure that all TEFRA unit expenses are appropriately classified and recorded, particularly during FY 2004.** Under the current proposal, FY 2004 will be the last year for most providers under full TEFRA reimbursement. A review to ensure that all expenses related to your psychiatric sub-provider are appropriately classified and recorded would appear warranted.
 - 10. Train and/or re-train your staff.** View the changes required by these regulations as an opportunity to educate and/or re-educate your clinical, operational and financial staff members concerning documentation, clinical pathways, guidelines for ancillary utilization, and the impact of this new reimbursement method on financial performance.

The Principals of Inpatient Coding

The majority of the problems in inpatient coding can be traced to errors in principal diagnosis and complication/comorbidity (CC) diagnoses. In face-to-face meetings with hospitals with Health Information Management professionals, these two issues always come to light.

There are two elements that need to be present to arrive at the correct ICD-9-CM code: sharp coding skills as well as clear and concise clinical documentation. In clinical coding, we assign an established set of numbers to diagnoses and procedures. Coders can only apply a code to a diagnosis or procedure that is well documented.

Coding skills are divided into basic and advanced. Basic skills are learned in a didactic milieu, and advanced skills are acquired through experience. Basic skills involve knowing what, where, how, and when to code. Advanced coding skills are developed by experience, the countless hours spent perusing medical records, and understanding all the nuances and myriad of clinical scenarios – understanding the underpinnings of the official coding guidelines.

Good Documentation Required

In addition to all of the above skills, clear and concise medical record documentation is needed to apply one's coding skills. Good documentation reduces gray areas in coding. It pre-empts misinterpretation and creative (a.k.a. assumptive) coding.

Medical record documentation encompasses notations from physicians, nurses, and other health care practitioners, as well as results of therapeutic and ancillary diagnostic procedures. For acute inpatient hospital stays, ICD-9-CM codes are only applied to diagnoses and procedures that are shown to have clinical significance as documented by the physician. It is imperative that physician documentation in the progress notes address the conditions a patient is ill with as well as the significance of results of laboratory and other diagnostic tests performed.

Diagnosis coding is a more difficult area than procedure coding because of the complexity of arriving at a diagnosis and the sequencing of diagnoses and this article will focus on these areas. The principles governing the correct code assignment and sequencing of diagnoses are based on the American Hospital Association's Coding Clinic guidelines, developed by the Cooperating Parties for ICD-9-CM. The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) receive assistance from the American Health Information Management Association (AHIMA), the American Medical Association (AMA), and the American Hospital Association (AHA) in determining official advice for interpretation of the basic principles intended by the classification systems.

Diagnosis Documentation Specificity

The documented diagnosis has to be specific. Case in point – pneumonia caused by specific bacteria should be documented as to the specific organism (e.g., pneumonia

due to *Klebsiella pneumoniae*). If the physician documents only "Pneumonia," even with positive sputum culture for *Klebsiella pneumoniae* and orders therapy with antibiotics to which the organism is sensitive, this will be coded to 486 – Pneumonia, organism unspecified, rather than 482.0 – Pneumonia due to *Klebsiella pneumoniae*. This constitutes a big difference in DRG payment – from a simple pneumonia DRG to a complex pneumonia DRG and is a frequent topper in the OIGs target list for possible fraud.

Coders Cannot Diagnose

It is important to note that coders cannot assume a diagnosis from clinical information in the medical record for acute inpatient hospital stays.¹ (Although the outpatient coding guidelines concur, there are some slight differences in the ICD-9-CM coding for diagnostic tests specific for outpatient services inherently because of the short patient encounter episode.)² "Clinical information" refers to laboratory and other ancillary results. The physician is required to clearly document the diagnosis in the medical record before the coder can assign the appropriate ICD-9-CM code. There are many factors and nuances that go into diagnosing patients that physicians have been educated and trained to recognize. Coders are not trained as physicians to distinguish false positive or negative diagnostic tests (e.g., culture & sensitivity tests, x-rays, pathology reports).

It is only the physician attending to the patient who will be able to recognize the intricacies that each individual case brings. He or she bears responsibility to document these fine points in the patient's medical record – not just for purposes of coding, but for continuity of patient care. Physician documentation should provide an accurate depiction of the patient encounter because it inherently affects quality of patient care. It has been said before – the medical record should be able to stand alone and provide a clear picture of the patient encounter. Contrary to the old adage, "*the less said - the better*," insufficient documentation only brings more inquiries and potential liability.

Principal Diagnosis (PDX)

This refers to the condition established after study to be chiefly responsible for occasioning the patient's admission to the hospital for care.³ The selection of principal diagnosis is determined by the circumstances of admission, diagnostic workup and/or therapy provided.⁴ The condition that best satisfies the three criteria is the principal diagnosis.

The documented circumstances of admission, diagnostic workup and/or treatment should support and reflect the principal diagnosis. Among the three criteria, the circumstances of inpatient admission always govern the selection of the principal diagnosis. Circumstances of admission refer to the chief complaint, as well as signs and symptoms of the patient on admission. The reason for the patient's admission has to be clearly identified. The principal diagnosis is the definitive diagnosis that was established and should relate to the chief complaint on admission. If it is



Inpatient Coding continued from page 6...

unclear, the physician should be queried and then corroborated with supporting documentation in the medical record.

Co-equal Principal Diagnoses

When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic work-up, and/or therapy provided (and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction), any one of the diagnoses may be sequenced first.⁵ For example, a patient presents with multiple problems: shortness of breath, fever, and chest pain. Chest x-ray demonstrates an exacerbated CHF, examination reveals acute bronchitis, and prior history and current EKG findings are consistent with unstable angina. The three conditions were treated with medications. All three diagnoses equally meet the criteria for the definition of principal diagnosis and the hospital can sequence any one as the principal diagnosis. But let's say this patient undergoes coronary arteriography revealing coronary artery disease (CAD) with 85-90% blockage of two prominent branches and has a percutaneous transluminal coronary angioplasty (PTCA). In this scenario, the workup and therapy criteria clearly distinguish CAD, identified as the etiology of the patient's unstable angina, to be the principal diagnosis.

Circumstances of Admission

Let's put another twist to a different scenario. A patient presents with fever, hypotension, and altered mental status. Impression on admission is sepsis. A few hours after admission, the patient develops chest pain. Work up shows the following significant findings: Blood C&S – Staphylococcus aureus; Cardiac enzymes – elevated CPK MB. Patient was treated with IV antibiotic to which the organism was susceptible and undergoes cardiac catheterization and coronary artery bypass graft (CABG). Impression documented in Progress notes shows Acute MI and Sepsis due to Staphylococcus aureus. The Final Diagnoses in Discharge summary lists in order, Acute MI and Sepsis due to Staphylococcus aureus. One may conclude that since the CABG far outweighs IV antibiotics, the AMI should be the PDX. However, the AMI developed after a few hours into the admission and does not satisfy the criteria of circumstances of admission. The circumstances of admission always govern the selection of principal diagnosis. Hence, Staphylococcus aureus sepsis is the appropriate principal diagnosis.

Other Diagnoses (ODX)

Also known as “secondary diagnoses,” or “additional diagnoses,” these are conditions that either coexist at the time of admission or develop subsequently and affect patient care for the current hospital episode. “Co-existing at the time of admission” means that the condition was present on or before admission but was not the main focus of the admission. For example, a patient with long standing CHF and/or COPD comes in with clinical evidence of sepsis. Although the CHF and/or

COPD may have affected patient care, sepsis occasioned the admission. “Affecting patient care” means the condition required either: clinical evaluation, therapeutic treatment, diagnostic procedures, extended the length of hospital stay, or increased nursing care and/or monitoring.⁶ Thus, when an additional condition incurs consumption of hospital resources it is considered a valid secondary diagnosis.

The Centers for Medicare and Medicaid Services (CMS), has developed a standard list of diagnoses that are recognized as complications and comorbidities (CC) for the DRGs. When a CC is present as a secondary diagnosis, it could affect DRG assignment. Those conditions that coexisted at the time of admission are called “co-morbid conditions,” while those that develop subsequently in the current hospital episode are termed, “complications.” Thus, we have DRGs with and without CCs. CCs are a type of other diagnoses (ODX) that statistically show a substantial increase in utilization of hospital resources. It has to be combined with a corresponding PDX to affect the DRG. Note that complications, in DRG terminology, do not only refer to errors in medical or surgical workup or treatment.

DRGs affected by the appearance of a CC show a substantial increase in utilization of hospital resources in the majority of cases. Only one CC is needed to change a DRG without CC to a DRG with CC. However, not all DRGs are with or without CCs. There are a number of stand-alone DRGs that are not affected by the presence or absence of CCs (e.g., DRG 014 – Specific Cerebrovascular Disorders Except Transient Ischemic Attack and DRG 015 – Transient Ischemic Attack and Precerebral Occlusions). With the stand-alone DRGs, the DRG will only change if the principal diagnosis is changed or a significant surgical procedure is introduced.

Contact Feeley & Driscoll

Please visit www.fdcpa.com/healthcare.htm to receive the latest health care news and the dates and agendas of our upcoming Reimbursement Roundtables for Hospitals and Long Term Care Providers

If you have any questions or would like to discuss further any of the issues discussed in Value Added with one of our health care specialists, please contact us at (617) 742-7788 or

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Compliance Corner

An update on recent activity by the Department of Health and Human Services Office of Inspector General (HHS-OIG)

The OIG is responsible for conducting audits, evaluations, and both criminal and civil investigations for all HHS agencies. These functions are performed by the OIG's Office of Audit Services (OAS), Office of Evaluation and Inspections (OEI), and Office of Investigations (OI), respectively.

Review of the State of Massachusetts' Efforts to Account for and Monitor Sub-Recipient's Use of Bioterrorism Hospital Preparedness Program Funds – This topic was introduced in 2003 and has been very popular with the OIG. Over thirty reviews have been conducted by the OIG on this subject.

The Centers for Disease Control and Prevention (CDC) has funded State bioterrorism preparedness efforts through cooperative agreements since 1999. More recently, the CDC has worked with State and local health departments to develop a performance guidance called, the Core Capacity Project, for bioterrorism preparedness. The CDC asked the OIG to assess State and local health department's bioterrorism detection and response capacity using these core capacities.

To read the report for Massachusetts, go to:
<http://oig.hhs.gov/oas/reports/region1/10301505.pdf>

State Strategies to Contain Medicaid Drug Costs – Medicaid drug costs have been a source of many OIG reviews. In December 2003, the OIG released an inspection report describing State strategies to contain their Medicaid outpatient prescription drug costs. Escalating Medicaid drug expenditures, combined with strained State budgets, have led States to seek such strategies to contain Medicaid drug costs. Fed-

eral Medicaid constraints prevent States from benefiting from some cost containment tools widely used by private purchasers.

States exercise some flexibility within Federal Medicaid parameters to employ three main drug cost containment strategies highlighted in this inspection report. Maximizing States ability to contain drug costs can provide a significant fiscal benefit to both State and Federal Medicaid budgets. However, States face significant challenges to maximizing drug cost savings, including lack of accurate drug price information and stakeholder opposition to cost containment efforts.

To read the inspection report, go to:
<http://oig.hhs.gov/oei/reports/oei-05-02-00680.pdf>

Ineligible Medicare Payments to Skilled Nursing Facilities – The OIG conducted seventeen reviews on this subject in 2003. The objective of each report was to determine the extent of ineligible Medicare Skilled Nursing Facility (SNF) payments contained in the OIG database.

The OIG found for most carriers reviewed, that the overpayments occurred as a result of the absence of an automated cross-check within the CMS Common Working File and the FI's claims processing systems verifying that a three consecutive day inpatient hospital stay occurred prior to SNF admission.

To read the latest report on the subject, go to:
<http://oig.hhs.gov/oas/reports/region5/50300071.pdf>

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