Newscast

Volume 43 Issue 3 November 1- January 31, 2010

Joseph A. Levi
51st Annual Institute

February 25-26, 2010

The LaGuardia Marriott Hotel

East Elmhurst, NY

Healthcare Reform:

Balancing Cost, Quality, Access and Care – Putting it All Together and Making it Count

Presented By the Metropolitan New York Chapter
Healthcare Financial Management Education Foundation

14.75 Educational Credit Hours

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Gail Spiro

Class of 2010

Paulette DiNapoli
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Robert Jacobs
Stacey Levitt
David Woods

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2004-2005	John M. Scanlan, FHFMA
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Daniel Sisto, President, Healthcare Association of New York State
Kenneth E. Raske, President, Greater New York Hospital Association
Kevin W. Dahill, President & CEO, Nassau-Suffolk Hospital Council

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Marty Abschutz, CPA, *Assistant Editor*

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Ken Sheridan
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Cynthia Strain, FHFMA

Contents

President's Message

Happy New Year and welcome to the second "green" edition of our chapter's member communication, ***Newscast.*** Thank you to everyone who sent in constructive feedback on our last edition. We are working hard to re-structure and re-format as we continue our new e-version of ***Newscast.***

Earlier in the year I spoke about a survey that National HFMA was going to randomly distribute to a portion of our membership. The survey was issued in October 2009 with the final results being collected at the end of November. For those members who participated, thank you for your candid and timely responses. I am pleased to report that the results were issued this week and the Metropolitan New York Chapter received an overall highly satisfied response of 57% percent which placed us above the National average of 54%, a fantastic achievement for our chapter. As Chapter Leaders we use the results from this survey during our strategic planning to deliver to the membership what is needed for the upcoming year.

Times are changing and we have tried to stay ahead of the curve and anticipate your membership needs. During these economic times we are aware of the financial constraints on the employer and on each member. To assist in alleviating some of this burden, while providing high quality educational sessions, to date we have offered several free seminars to our members and a two day seminar priced at the level of a one day event. Hopefully you were able to take advantage of this educational opportunity. The electronic information highway is today's generational format for communication and education. As a result Metro NY debuted our first Webinar, free to all members. Due to the overwhelming success we are currently working with the other Chapters in our Region for additional webinars in 2010. We have also partnered with National HFMA to promote all of the free seminars that they support which offer continuing education hours to all members who participate. I was very excited to be able to promote National HFMA's first Virtual Conference which was held January 12-13, 2010. It was an opportunity to earn up to 8 continuing education hours without leaving your office and it was free to all members. It was a truly amazing opportunity and many Metro New York members were able to participate.

The Annual Institute committee has hit the mark once again this year with the Joseph A. Levi 51st Annual Institute being held February 25-26, 2010 at the LaGuardia Marriot. Our premier event: ***Healthcare Reform: Balancing Cost, Quality, Access and Care-Putting it All Together and Making it Count,*** will focus on healthcare reform from a national and local perspective. Day one will give you the opportunity to listen to panel discussions where local CEO's and CFO's will participate. On day two enjoy breakfast while listening to Cam Marsten discuss ***" Four Generations in the Workplace: Searching for the Common Ground".*** Cam will discuss today's workforce which is experiencing a new phenomena of four distinct generations at work, many times in equal leadership positions. After breakfast join us for a presentation by **James G. Sheehan, NYS Medicaid Inspector General** who will present us with an up to the minute summary of what the OMIG has been working on and where it will focus in the future. Mr. Sheehan will then participate in a question and answer session. **Congressman Jerrold Nadler** will speak late morning on the impact of the upcoming Healthcare Reform bill in Congress and how it affects the Healthcare Industry.

The General Education committee has kicked into overdrive this year. As of date we have offered 15 local seminars totaling over 120 continuing education hours. Our events have ranged from back to basics to senior financial executive topics however; we are not done yet! There are two great seminars confirmed and a few more in the planning stages before I mark the official end of the educational year. **MARK YOUR CALENDARS-** March 18, 2010…Insurance Violations will be held at the LaGuardia Marriott hotel. Registration is now open and this is one seminar you do not want to miss. March 24, 2010…PQRI Updates and E-Prescribing will be held in Manhattan at Information Builders. Registration for this seminar will be open shortly, please check your mail and our website at www.hfmametrony.org for information.

I am pleased to report that we have secured an additional venue in Manhattan that can accommodate our larger seminars. I know that many of our members have asked for alternate locations in addition to the LaGuardia Marriott. The Education committee has offered a variety of venues this year from Long Island to Queens and Manhattan. All of these locations are supported by public transportation.

On October 17, 2009 we held our Past Presidents Dinner Dance honoring our Immediate Past President, Mary E. Kinsella, FHFMA. Over 140 guests danced the night away at The Carltun in Eisenhower Park. Please go to our website at www.hfmametrony.org to view pictures of the evening. It was a night to remember and a fantastic way to honor one of the best Presidents our Chapter has had.

On October 23, 2009 we held our annual Day at the Races at Belmont race track. Over 70 members and their guests spent an afternoon networking during the last races of the season at the track. A great time was had by all.

Our committees never stop planning educational and networking events. Please know that the organization is here to support your professional development and we strive to meet your goals. For many of us, we have gained professional knowledge as well as developed lasting friendships another value that the organization brings. We are bringing the topics to you, at reduced cost and convenient locations and it is up to you to take advantage of these opportunities and attend our events. I promise that you will find it worthwhile and you will walk away with valuable information.

I look forward to seeing you all at the Annual Institute on February 25-26, 2010

Best Regards,

Cynthia A. Strain, FHFMA
President
Metropolitan New York Chapter HFMA

Joseph A. Levi 51st Annual Institute

Thursday, February 25, 2010

7:30 – 8:30 AM **Registration and Continental Breakfast**

8:30 – 8:45 AM **Welcome and Opening Remarks**
Cynthia A. Strain, FHFMA, President, Metropolitan New York Chapter, HFMA
David Evangelista, Chairman, Joseph A. Levi 51st Annual Institute

8:45 – 9:15 AM **National HFMA Chairman's Remarks: Making it Count**
Speaker: Cathy Jacobson, CPA, FHFMA, 2009-2010 National HFMA Chairman

9:15 – 10:30 AM **Latest From Washington**
Updates out of Washington DC, including Medicare and Capital Hill, and how it is expected to impact the healthcare sector specifically, hospital reimbursement.
Speaker:
Leslie Norwalk, Esquire, Strategic Counsel to Epstein, Becker & Green, Former Administrator CMS

10:30 – 11:00AM **Networking Break and Vendor Fair**

11:00 – 12:30 PM **Financial Leadership: CFO's Taking the Lead**
A moderated discussion by Hospital CFO's confronting significant issues of leadership with respect to financing, payment vehicles and health care delivery. Our panel will explain their unique view of the expanding role of a Hospital CFO, given the current economic state of the nation and likely Healthcare Reform considerations.
Moderator: Raymond Sweeney, Executive Vice President, Healthcare Association of NY State
Panelists:
Jerry Haas, CFO, Senior Vice President Finance, South Nassau Communities Hospital
Cathy Jacobson, CPA, FHFMA, CFO & Treasurer, Senior Vice President of Strategic Planning & Finance, Rush University Medical Center, Chicago, Illinois
Phyllis Lantos, FHFMA, Executive Vice President, CFO & Treasurer, New York Presbyterian Hospital
Donald Scanlon, Executive Vice President of Business & Finance, CFO, The Mount Sinai Medical Center
Robert Shapiro, CPA, Senior Vice President & CFO, North Shore-LIJ Health System

12:30 – 2:00 PM **Networking Lunch with Dessert in Vendor Fair**
Presentation on the benefits of HFMA Membership

2:00 – 2:15 PM **National HFMA Update and Perspective on Healthcare Reform**
Speaker: Richard Clarke, DHA, FHFMA, President & CEO, HFMA

2:15 – 3:45 PM **Leading Within the New Landscape of Healthcare Reform- A CEO's Perspective**
Hear from industry leaders on the highly debated topic of health reform; their reactions to proposed legislation, their strategies for adjusting to a potentially new delivery system and their thoughts on navigating the rough terrain ahead.
Moderator: Richard Clarke, DHA, FHFMA, President & CEO, HFMA
Panelists:
Stanley Brezenoff, President & CEO, Continuum Health Partners
Michael Dowling, President & CEO, North Shore-LIJ Health Systems
Robert Levine, President & CEO, Peninsula Hospital Center
Joseph Quagliata, President & CEO, South Nassau Communities Hospital

3:45 – 4:30 PM **Networking Break and Vendor Fair**

4:30 – 6:00 PM **"Operating in the Red": The Impact of Healthcare Reform on NY State**

Join us for a presentation on the implementation of healthcare reform in New York State. Hear about the New York State Executive budget deficit and the key points that will effect all health care providers. What will be the impact of Federal Healthcare Reform on New York State.

Moderator: Irwin Birnbaum, JD, Senior Advisor RWJ Clinical Scholars Program, Yale University

Panelists:

Deborah Bachrach, JD, Former Deputy Commissioner for the New York State Health Department's Office of Health Insurance Programs (OHIP)

Betsy McCaughey, PhD, Founder and Chairman of Committee to Reduce Infection Deaths. Former Lieutenant Governor of New York State

Kenneth E. Raske, President & CEO, Greater New York Hospital Association

Daniel Sisto, President, Healthcare Association of New York State

6:00 – 7:30 PM **Social & Networking Event: Chapter President's Reception**

Friday, February 26, 2010

7:30 – 8:15 AM **Registration**

8:15 – 8:30 AM **Welcome**

Edmund P. Schmidt III, President-Elect, Metropolitan New York Chapter, HFMA

8:30 – 9:30 AM **Breakfast Presentation:**
"Four Generations in the Workplace: Searching for the Common Ground"

Today's workforce is experiencing a new phenomena-four distinct generations at work, many times, in equal leadership positions. Cam Marston has studied the collective histories and traits of each generation to uncover what makes the Matures, Baby Boomers, Gen X-ers, and Gen-Yers tick.

The author of ***Motivating the "What's In It For Me?" Workforce***, Marston helps bring out the best in your employees and colleagues.

Speaker: Cam Marston, Multi-Generational Relations and Workplace Communications Expert

9:30 – 11:15 AM **New York State Office of the Medicaid Inspector General Update**

Participants will be provided with an up-to-the minute summary of what the OMIG has been working on and where it will focus in the future. You can't afford to miss this timely session that will supply information that will impact all attendees. Interactive discussion to follow presentation.

Moderator: Lynn Stansel, Esquire, Vice President & Counsel, Compliance, Montefiore Medical Center

Speaker: James G. Sheehan, NYS Medicaid Inspector General

11:15 – 11:45 AM **Networking Break and Vendor Fair**

11:45 – 12:45 PM **Congressional Update on Healthcare Reform**

Congressman Jerrold Nadler will be speaking on the impact of the upcoming Healthcare Reform bill in Congress and how it affects the Healthcare Industry. Interactive discussion to follow presentation on Healthcare Reform and other Healthcare related areas of interest.

Speaker: The Honorable Jerrold Nadler, United States House of Representatives

12:45 – 2:30 PM **Lunch Presentation: Case Study: Healthcare Reform Readiness Assessment (HRRA)**

A case study will be presented with the results of a Healthcare Reform Readiness Assessment (HRAA) conducted with multi-hospital systems, community hospitals and academic medical centers in 2009 and 2010. The HRRA was designed to assist health systems in self-assessing their preparedness for healthcare of the future in seven areas related to reform. A CFO participant will join the panel to show how the assessment aided the system in organizing to prepare for reform.

Speakers:

Wayne Cafran, Managing Director, KPMG

Susan Davis, Director, KPMG

1:30 - 1:45PM **Closing Remarks**

Palmira Cataliotti, CPA, FHFMA, Co-Chair Joseph A. Levi 51st Annual Institute

Highlighted Annual Institute Speakers

CAM MARSTON

Multi-Generational Relations and Workplace Communications Expert

Cam Marston has spent more than a decade studying workforce dynamics, with a keen focus on how generational biases play out from the stock room to the boardroom. One of a handful of experts dedicated to conquering the generational divide, Marston has shared his insight with hundreds of organizations eager to make sense of the changing business landscape.

Through relevant presentations that capture and maintain audience interest, Marston shares his personal experience, research findings and proven strategies for successfully navigating a multi-generational business world. His powerful message of generational context promotes understanding and motivates leaders to adapt their management styles to meet the needs of the rising generations in the workforce – while staying true to their own values.

Since 1996, when he began revealing the effects of generational bias in the workforce, Marston has created a strong following as clients repeatedly bring him back to reach further and deeper within their organizations. His message of understanding and respect resonates at all levels.

Clients such as General Electric, American Express, the Food Marketing Institute, Professional Convention Manager's Association (PCMA), and the US Army have engaged Marston to inform both management and staff about the importance generational views have on sales, hiring, retention and overall performance – the core issues companies tackle on a daily basis.

His insight has also been shared through worldwide news channels, including Good Morning America, the BBC, the *Chicago Tribune*, the *Philadelphia Inquirer*, *New Zealand Herald, Entrepreneur Magazine, Business Week, Money Magazine, Fortune Small Business (FSB), HR Management Today* and the *Edward Lowe Report*; as well as numerous trade journals and city business journals throughout the United States.

Marston's presentations are continually met with rave reviews, not only for his engaging style, but his ability to tailor the message to a specific industry or organizational dilemma. With a professional background in sales and research, Marston understands the reality of business from many angles – and his presentations demonstrate this with action-oriented solutions to recurring business problems.

His book, Motivating the *"What's in it for me?" Workforce: Managing Across the Generational Divide*, demonstrates the individual characteristics and motivating factors each generation brings to the workforce, accompanied by management tactics applicable to any business setting.

Through large group presentations, intimate workshops and his published works, Marston gives his audience a series of lenses through which they can see the business world from each generation's perspective. Along with this understanding he delivers tactical guidelines that help individuals and organizations improve the performance of all generations in the workforce today.

Save the Dates...

REGION 2 INSTITUTE – BUFFALO!

October 13-15, 2010
Adam's Mark Hotel in Downtown Buffalo

120 Court Street, Buffalo, NY 14202 • (716) 845-5100

Presented by HFMA Region 2 Chapters:

Central New York Hudson Valley NY Metropolitan New York
Northeastern NY Puerto Rico Rochester Regional Western New York

Visit www.adamsmark.com for hotel information.
Visit the chapter website at
www.hfmametrony.org
for up to date conference information

Chapter Member News

The Nominating Committee is pleased to announce the proposed slate of Officers and Board of Directors for the 2010/2011 HFMA Year for the Metro NY Chapter:

President: Edmund P. Schmidt, III (automatic)
President Elect: John Coster
Vice President: Palmira Cataliotti, CPA, FHFMA
Treasurer: David Evangelista
Secretary: Wendy Leo
Immediate Past President: Cynthia Strain, FHFMA (automatic)

Class of 2010:

Paulette DiNapoli
Robert Jacobs
Stacey Levitt
Richard Nagy, FHFMA
David Woods

Class of 2011:

James G. Fouassier, JD, Esquire
James Petty, FHFMA
Meredith Simonetti, FHFMA
Donna Skura
Gail Spiro

As per the chapter's bylaws the membership will vote on the entire slate of Officers and Board of Directors at the Annual Business Meeting to be held Wednesday, May 5, 2010, 5:45pm
The Inn at New Hyde Park,
214 Jericho Turnpike, New Hyde Park, NY 11040 • (516) 354-7797

Please join us in congratulating the slate of officers and directors.

Calendar of Events

February 25-26, 2010	**The Joseph A. Levi 51st Annual Institute** LaGuardia Marriott Hotel Go to www.hfmametrony.org to register NOW!!
March 18, 2010	**Insurance Violations: What You Need to Know to Get Paid** LaGuardia Marriott Hotel Go to www.hfmametrony.org for agenda and registration information
May 5, 2010	**Annual Business Meeting** The Inn at New Hyde Park Go to www. hfmametrony.org for updated information and registration

Chapter Member News

The Metropolitan New York Chapter of HFMA Proudly Welcomes the Following New Members!

Submitted by: Paulette DiNapoli, Membership Committee Chair

Metropolitan New York HFMA is pleased to welcome the following new members to our Chapter. We ask our current membership to roll out the red carpet to these new members and help them see for themselves the benefits of HFMA membership. Encourage them to attend seminars and other Chapter events. We ask these new members to consider joining a Committee to not only help the Chapter accomplish its work, but to expand their networks of top notch personal and professional relationships. See the list of Metropolitan New York HFMA Committee Chairs, along with their contact information, listed on our website (www.hfmametrony.org).

Jeffrey J. Zupa
Principal, Battalia Winston International

Ivrose Bamba
Administrative Director, Mount Sinai Hospital

Neil Levinbook
Financial Medical Systems, Inc.

Crystal D. Marino
Auditor, Ernst & Young

James W. Rockett
Senior Auditor, Ernst & Young

Michael Sangregorio

Kevin A. Nelson
Project Manager, North Shore - LIJ Health System

Joseph P. Morello
Senior Manager - Assurance Services,
Ernst & Young LLP

Danielle C. Hurlburt
Auditor, Ernst & Young

Jill M. Embler
Director, Financial Planning,
Continum Health Partners, Inc

Kamla Persaud
Patient Financial Services,
New York Presbyterian Healthcare System

Jay Prabhu
Managing Partner / CFO, Summit House Inc.

Chi Izeogu

Mark P. Fauth
Director, Finance,
North Shore Long Island Jewish Health System

Nancy Waung

Daniel J. Burns
Senior Vice President, Aon Risk Services

Joshua Sclair
Manager Audits and Special Projects,
Medisys Management, LLC

Roberta Lynn Bosanko
Chief Executive Officer, Paradigm Coding LLC

Sarah Giannone
Client Executive, Surgical Information Systems

Roy Cordes
Healthcare Consultant, Deloitte and Touche

Joseph Dicks
Contracting Manager, MetroPlus Health Plan

Monique Morris
South Nassau Communities Hospital

Sonya Henderson
Vice President, Compliance and Audit, HealthFirst

Evan M. Resnick
Assistant Vice President- Financial Reporting,
Catholic Health Services of Long Island

Daryl J. Melancon, Jr.
Contracting Associate, Affinity Health Plan

Cheryl E. Kilkenny
Director, Internal Audit, SUNY Downstate

Molly E. Eagan
Senior Director, Affiliate Operations,
Planned Parenthood Federation of America

Brian Restivo
Sr. Reimbursement Analyst,
North Shore LIJ Health System

Jason Ganci
Healthcare Consultant, Jzanus Consulting, Inc.

Kathleen L. Hajek
Partner, McGahey Group, Inc.

Melissa A. Passo-Weirich
Account Manager, Amerisourcebergen

Peter Salisbury
Vice President of Development, Kurron

Joseph S. Moscola
Sr. Administrative Director,
North Shore LIJ Health System

Donald J. Denton, Jr.
Managed Care Coordinator,
John T. Mather Memorial Hospital

Michele Salituro, CPA
Vice President of Finance,
Saint Vincent Catholic Medical Centers

Nicholas M. Scalera
Accounting Manager,
Saint Vincent Catholic Medical Centers

Shaw A. Rietkerk
Region Vice President, MedQuist

Christian W. Burdick
Analyst, Winthrop University Hospital

Osmar Torres
Grants Accountant, New York Eye & Ear Infirmary

as of 12-31-09

Certification News…… take the Challenge

Enhance your career potential by becoming a Certified Healthcare Financial Professional (CHFP).

HFMA's certification program provides you an opportunity to earn this designation when you meet the following requirements:

- Be an HFMA member for a total of two years and be a current active member
- Have two years of professional experience in the healthcare finance industry
- Successfully complete the HFMA Core certification exam and one of the specialty exams – Accounting and Finance, Patient Financial Services, Financial Management of Physician Practices, or Managed Care
- Obtain a reference from an elected HFMA chapter officer and your CEO or supervisor

All active members are eligible to take the certification exams. The proctored on-line exams are available 24/7. A list of eligible proctors for your chapter is on the HFMA web page at: http://www.hfma.org/site/certification/proctors.cfm. Schedule a time with your proctor and then submit to HFMA National an exam application available on-line at: (http://www.hfma.org/login/index.cfm?script_name=/site/certification/exam_application.cfm).
The two requisite exams must be successfully completed within 24 months of passing the first exam.

To prepare for the exam, you can use the corresponding self-study course available on the HFMA website or contact our Certification Chair Jim Petty at jpetty@nshs.edu or myself at Cyndy65@aol.com to obtain a copy from our Chapter's resource library. Study guides are lent out on a first come first serve basis therefore; please submit your request quickly. You can also participate in an Instructor led coaching course offered by HFMA National at ANI please see the HFMA website at www.hfma.org for further information. This year's ANI is being held in Nashville, Tennessee.

Once you meet the requirements for becoming a CHFP, submit a CHFP application to HFMA National within 24 months of successfully completing the first exam, there is a one- time fee for the application process. You will then receive a certificate through your chapter that you can proudly display and will be entitled to use the CHFP designation after your name.

As a CHFP, you are on your way to becoming a Fellow of HFMA (FHFMA). Fellowship is available upon meeting the following requirements:

- 5 years of total HFMA membership
- Bachelor's degree or 120 semester hours of college credit required references
- Demonstrated volunteer activity in the healthcare finance field.

You will retain your CHFP or FHFMA designation as long as you remain an active member of HFMA and show proof of earning 90 professional education hours every three years. This maintenance requirement helps you remain current in your field and will also be an asset to your career. You can meet this requirement through participating in structured learning activities offered though the Metropolitan New York Chapter of HFMA, National HFMA, your employer, or other professional organizations. Visit our chapter website at www.hfmametrony.org for a list of the programs that we are offering locally. More information about the maintenance requirement is available on the HFMA website at www.hfma.org.

The Metropolitan New York Chapter supports you efforts in becoming HFMA certified by offering our ***Certification Challenge*** program. The Metro NY Chapter will pay for any of our chapter members to take the certification exam(s), pass or fail we will pay. For more information on this program please email the Certification Chairs: Jim Petty, FHFMA at jpetty@nshs.edu or John Scanlan, FHFMA at jscanlan@maimonidesmed.org. You can also email me directly, Cindy Strain, FHFMA, Chapter President at Cyndy65@aol.

Already Certified? Certified Members join the Certified Member Get-A-Certified Member Campaign. Our HFMA membership shapes the future of our industry. With your help, we can recognize healthcare financial management executives who have reached an enhanced level of knowledge and proficiency and by doing so, continue to develop our industry.

Whenever you refer 2 applicants who apply for the Certified Healthcare Financial Professional (CHFP) exam between January 1, 2009 and April 1, 2010 you will win 1 $25.00 Visa fuel card. Just make sure your name appears in the "Sponsor" area of the certified member application in order to receive proper credit.

For more information, contact Shirley Heavlin 800-252-4362 XT 311

Submitted by: Cynthia A. Strain, FHFMA, President

Metropolitan New York Chapter Certified Members

Edward J. Anderson, FHFMA, CPA
Rick Annis, FHFMA
Morris J. Annunziato, FHFMA
Kiran N. Batheja, FHFMA
Jeffrey G. Blumengold, FHFMA, CPA
Palmira M. Cataliotti, FHFMA, CPA
Kwok L. Chang, FHFMA
Sherwin Chue, FHFMA, CPA
Joseph P. Cianciotto, CHFP
Lewis Z. Cohn, Jr., FHFMA, CPA
Richard G. Crowley, FHFMA
James R. Curcuruto, FHFMA
Arthur Cusack, FHFMA, PhD
Allan P. DeKaye, FHFMA
Richard J. Donoghue, CHFP, CPA
Thomas W. Egan, FHFMA
Natale J. Falanga, FHFMA, CPA
Lawrence J. Friia, FHFMA
Justice Q. Gaba, FHFMA
Christopher R. Giuliano, FHFMA
Richard B. Griffel, FHFMA
Patricia A. Grubee-Puetz, CHFP
Karim A. Habibi, FHFMA
William C. Hammond, CHFP
Rachele I. Hashinsky, FHFMA
Richard J. Henley, FHFMA, FACHE
Yikyun Lisa Kang, CHFP
Arnold I. Katz, FHFMA, CPA
Mary E. Kinsella, FHFMA
Leon W. Kozlowski, FHFMA
Phyllis F. Lantos, FHFMA
Kevin F. Lawlor, FHFMA
Bruce B. Levin, FHFMA, MHA
Michael J. McGrath, FHFMA
Donna M. McGregor, FHFMA,CPA
Mark T. McQuillan, FHFMA
Ted Meroe, CHFP
Donald P. Minarcik, FHFMA, CPA
Dennis W. Mitchell, FHFMA
Sara M. Mooney, CHFP
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Cynthia A. Strain, FHFMA
Howard Tepper, FHFMA
Regina B. Vogelman, FHFMA
John W. Welborn, CHFP
Sydney J. Woogen, FHFMA
Charles J. Zambuto, CHFP

Tidbits...

All the miseries of mankind come from one thing: not knowing how to remain alone.

Blaise Pascal

The best thinking has been done in solitude.

Thomas Edison

The cure for boredom is curiosity. There is no cure for curiosity.

Ellen Parr

Doubt is not a pleasant state, but certainty is a ridiculous one.

Voltaire

No one should form an acquaintance with one who has an evil character. A piece of coal, if it is hot burns, and if it is cold, blackens the hands.

Hitopadesa

Courtesy is the one coin you can never have too much of or be stingy with.

John Wanamaker

I slept and dreamed that life was beauty. I awoke and found that life was duty.

Ellen Sturgis Hooper

Through pride we are deceiving ourselves. But deep down below the surface of the average conscience a still, small voice says of us, "something is out of tune".

Carl Gustav Jung

Nothing in the world is more dangerous then sincere ignorance and conscientious stupidity.

Martin Luther King Jr.

Consultants are people who borrow your watch and tell you what time it is, and then walk off with the watch.

Robert Townsend

No one has the right to destroy another person's belief by demanding empirical evidence.

Ann Landers

Change is inevitable. Change for the better is a full time job.

Adali E. Stevenson

If you are not criticized, you may not be doing much.

Donald H. Rumsfeld

Committee Meetings

Are you interested in participating?
Please email the committee chairs for further information.

General Education:		**3rd Wednesday of each month**	
	Chairperson	Rachele Hashinsky	hashinsr@mskcc.org
		Stacey Levitt	slevitt@lenoxhill.net
		Meredith Simonetti	meredith.simonetti@chsli.org
Finance:		**4th Thursday of the month**	
	Chairperson	Rich Nagy	rangy@notes.cc.sunysb.edu
		Mario DiFiglia	mario.difiglia@chsli.org
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Audit/Compliance:		**3rd Tuesday of the month**	
	Chairperson	Ann Amato	aamato@snch.org
		Lori Radler	radlgr2004@yahoo.com
Patient Financial Services:		**1st Thursday of the month**	
	Chairperson	Gail Spiro	gspiro@maimonidesmed.org
		David Woods	dwoods@nyee.org
		Jason Gottlieb	jag9064@nyp.org
HUIM/UR:		**last Thursday of the month**	
	Chairperson	Annie Lemoine	alemoine@jzanus.com
MIS:		**TBD**	
	Chairperson	Bill Delaney	Delaney@nyc.rr.com
		Nicole Terrenzio	nterrenzi@blumshapiro.com
Managed Care:		**2nd Wednesday of the month**	
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		Donna Skura	dskura@lihn.org
Medical Group:		**TBD**	
	Chairperson	Jackie Namwila	jnamwila@gmail.com
		Josephine Vaglio	Josephineatpba@yahoo.com
Continuing Care		**TBD**	
	Chairperson	Gary Carpenter	gcarpenter@hrcpa.com
		Al Conti	conti14@msn.com
Annual Institute		**Bi-weekly**	
	Chairperson	David Evangelista	devangel@jhmc.org
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New York Medicaid Changes Inpatient Reimbursement

Submitted by: D. Patrick Redmond, Ph.D.

On December 1, 2009 New York's Medicaid program will use a new system for reimbursing hospital fee-for-service inpatient stays. The new system is All Patient Refined Diagnosis Related Groups (APR-DRGs), a proprietary system for grouping inpatient stays into clinically related categories. The intent of this system is to better align payments to resource utilization -- higher payments would go to cases requiring high levels of utilization and reduced payments would go to clinically less complex cases.

Further, NY Medicaid would like to improve the value of its purchases by getting better quality outcomes, so Medicaid is discussing the possibility of reducing payments for potentially preventable conditions (those not present on admission to the hospital but could have been avoided with evidence-based medicine) and potentially preventable readmissions. Program representatives have stated that they hope to save over $225 million in inpatient payments annually with the change to the APR-DRG classification system.

The State is joining a broader movement to APR-DRGs for payment purposes. The first broad-based effort to use this grouper for payment is in the State of Maryland's all payer system. In Maryland, the Health Services Cost Review Commission adopted this new grouper to better align payments to resource requirements for the State's patients. Since Maryland began to use the APR-DRG grouper, several states in addition to New York have adopted APR-DRGs for their Medicaid programs, especially as Medicare's MS-DRG system is not altogether suited for Medicaid populations. Medicaid programs in Mississippi, Montana, and Pennsylvania have also developed payment systems based on the APR-DRG severity-based logic.

Unlike the old Medicaid DRG system and unlike MS-DRGs, APR-DRG and Severity of Illness (SOI) assignments are driven by complete coding. While Medicare uses fixed lists of secondary diagnoses to assign comorbidities and complications (and now major comorbidities and complications as well), APR-DRGs enlist a unique logic for each APR-DRG. An 18-step algorithm examines secondary diagnosis and procedure codes to determine the SOI for the case. Cases are classified into four severity-of-illness categories (minor, moderate, major, and extreme) within each DRG, and the relative weights that determine payments for each case can step up dramatically for each severity category with a DRG. Proper and complete documentation and coding is necessary to capture an accurate SOI classification (and payment) for the case within each DRG.

NY Medicaid's adoption of this new payment system brings challenges. Because all payers are under the same payment structure, hospitals must deal with multiple groupers. In New York, with only Medicaid moving to APR-DRGs, hospitals will need to have a special focus to be reimbursed properly under this system. Also, the proprietary APR-DRG grouper is expensive, so hospitals will need to employ their resources judiciously to maximize the return on investment.

For hospitals with substantial Medicaid fee-for-service populations, implementation of a program for improving documentation and coding within the organization offers the best option for managing these changes. Further, Medicaid managed care and commercial payers are likely to look at APR-DRGs in the future. Hospital experience in Maryland shows that a coding and documentation initiative that engages both physicians for more complete documentation and coders in learning the new system yields the best performance under an APR-DRG payment system. With the State's adoption of this new payment system, the time for action is now.

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The Perennial Problem Discharge-

How it Hurts the Patient, the Provider, the Payer and the Health Care System

Submitted by: James G. Fouassier, Esquire

This is the second of a 2 part series. Originally published in the Health Law Journal of the Health Law Section of the New York State Bar Associates, Winter 2009 (Used with Permission) addressing pitfalls and opportunities in APC revenue. Look for the second article focusing on outpatient surgery and a third on clinic visits..

Two additional avenues of legal redress present themselves. The first is a summary proceeding for eviction which, in New York, is governed by section 713(7) of the New York Real Property Actions and Proceedings Law. This is the standard "landlord-tenant" proceeding. The second is a plenary action for trespass, with an application for preliminary injunctive relief, enjoining the patient from further refusal to accept an appropriate placement.

Under the common law as applicable in most states the patient is at best a licensee of the hospital, with no possessory interest.[19] When the license terminates or is revoked and her or she refuses to remove from the premises such person is deemed to be a trespasser and is subject to eviction by self help, without any recourse to the courts.[20] A hospital obviously should not employ such a heavy-handed procedure: besides being poor policy, most states and many participating facility agreements establish some degree of "due process" for patient discharges generally, and Medicare patients also are entitled to separate notice and appeal procedures commonly known as "HINN"[21]; all of this effectively precludes self help. Eviction should contemplate the technical revocation of the patient's "license" on adequate notice to the patient and the family, along with appropriate appeal information. The hospital then may institute a summary proceeding for possession in the local equivalent of a "landlord-tenant" court[22]. The hospital may seek the appointment of a guardian ad *litem* (GAL) to represent the patient during the pendency of the proceeding if there is any indication that the adult patient is "incapable of adequately prosecuting or defending his rights" (New York Civil Practice Law and Rules 1201). If the patient retains his or her own counsel it is questionable whether the court will discern the need for a GAL but strategically it may be preferable to deal with someone other than the patient directly.

The summary proceeding will result in a quick hearing[23]. Unfortunately, in most states the jurisdiction of a local landlord-tenant court to fashion an appropriate remedy is limited.[24] Landlord-tenant courts are not designed to accommodate the unique needs of persons with significant medical issues. All those courts usually can do is grant possession of premises and ancillary relief in the form of money damages; they cannot compel the patient to accept any kind of placement. Thereupon the patient may continue to refuse to cooperate. The hospital's only remedy then would be to secure an order of eviction and seek the assistance of the Sheriff, who literally will put the patient out at the curb. Only in the clearest case where there is no foreseeable need for assisted care is this acceptable. Alternatively, the hospital may have made arrangements for an ambulette to take the patient home, or to a subacute facility or SNF which previously extended acceptance, or anywhere else the patient wanted to go. What if the patient flatly refuses to leave? Does the hospital staff strap him onto a gurney and roll him out the door? In addition, the admitting facility almost certainly will require an affirmative acknowledgment of consent to an admission, if for no other reason than to secure a guarantee of payment or authorize the facility to bill a third party payer. What if the patient refuses to sign the admission papers and the facility declines to accept him? Since the hospital cannot facilitate an unsafe discharge it has secured a pyrrhic victory at best.

The other alternative is a plenary action for trespass, with a request for a preliminary injunction prohibiting the patient from refusing the next viable placement, and the possible assistance of a guardian ad litem. This sounds

complicated but, upon contemplation, may be the preferable way to proceed. In New York the failure of the patient to vacate upon revocation of the "license" is a de facto trespass[25], and is actionable as such. The public policy implications of a refusal to vacate a much needed acute care bed, together with the "continuing nature" of the trespass and the insufficiency of any remedy based on money damages should satisfy the equitable requirements for injunctive relief notwithstanding that the trespass remedy is legal in nature. This procedure, in the specific context of hospital discharges, initially was adopted in New Jersey[26] and in the federal courts in Washington, DC[27]. More recently a New York court also adopted the "trespass and injunction" procedure. (*Wyckoff Heights Medical Center v. Rodriguez,* 191 Misc 2d 207, 741 NYS2d 400 (Sup Ct Kings Co. 2002)). The Syracuse Law Review cited the *Wyckoff Heights* case in its nationally recognized "Survey of New York Law" as follows:

> "Finally, of particular importance to acute care hospitals, a New York court authorized hospitals to discharge patients who refused to leave. This decision is significant for acute care hospitals because it marks the first time that a New York court has recognized the authority, and even the duty, of a hospital to compel patients who no longer need its services to leave, so that it can keep its services available to the acutely ill."

53 Syracuse L Rev 629 (2003)

The *Wyckoff Heights* procedure has since been followed in Connecticut.[28] One important caveat: The New York court made much of the fact that the proper discharge and appeal notice requirements set out in regulations[29] were "meticulously followed". Strict compliance with every notice and due process requirement is essential. All acute care general hospitals should be familiar with the Medicare "HINN" procedures and the "NODMAR"[30] or equivalent notice and appeals processes applicable in their jurisdictions or which may apply pursuant to their contracts with particular plans and payers. (Remember that just because the plan cuts off payment does not mean that other contract provisions respecting member notices and appeals no longer apply.)

In the context of eviction or injunction a guardian ad litem may be of particular assistance in reaping the practical benefits of any court order. It is not beyond possibility that the patient will refuse the mandate of the court to accept the next available placement, even if threatened with a contempt citation. The court will not compel a medically unsafe discharge. In the exercise of its equitable and general jurisdiction, however, a court could invest the GAL with the authority to consent to any discharge planning and admission as otherwise would be appropriate, upon the court's direction. Most courts of general jurisdiction are empowered to appoint a referee or receiver to act on behalf of a party who is unable or unwilling to comply with its orders.[31]

An Interesting Footnote and a Dose of Reality

On Sunday, August 3, 2008, in a front page story entitled, "Deported, by US Hospitals", the New York Times reported on several noteworthy cases in which hospitals faced with the crushing costs of unreimbursed hospital care effected the discharge of seriously disabled patients to their home countries. The subjects of the lead, Luis Alberto Jiminez and Martin Memorial Medical Center, are parties to litigation which, when finally resolved, may bear upon the issues raised in this article. The intermediate appellate decision of the Court of Appeal of Florida, Fourth District, is entitled, *Montejo Gaspar Montejo, as Guardian of the Person of Luis Alberto Jiminez v. Martin Memorial Medical Center, Inc.*, 935 So. 2d 1266; 2006 Fla App LEXIS 14039 (8-23-08). The underlying facts are as follows.

In February 2000, Luis Alberto Jimenez, an undocumented native of Guatemala who was living and working in Florida, sustained brain damage and severe physical injuries as a consequence of a car crash. Jimenez was transported to Martin Memorial Medical Center and remained there until June 2000, when he was transferred to a skilled nursing facility. The injuries suffered by Jimenez rendered him incompetent and a circuit court judge appointed a guardian of Jimenez's person and property. On January 26, 2001, Jimenez was readmitted to Martin Memorial on an emergency basis and, as of November 2001, was still incapacitated and still receiving medical

care at Martin Memorial. The guardian then filed a plan indicating Jimenez would require twenty-four hour care at a hospital or skilled care facility for the next twelve months. The costs of Jimenez's medical care were mounting; he was indigent and Medicaid refused to pay because he was an undocumented alien.

The hospital convened a discharge planning committee for Jimenez, and it determined that the next level of care he needed was traumatic brain injury rehabilitation. Qualified facilities in Florida would not accept Jimenez because he was indigent and did not qualify for Medicaid. The treating physicians had determined that Jimenez had reached a "therapeutic plateau," that remaining at the hospital would not improve his condition, and that the hospital, as an acute care facility, could not provide for his long-term therapy needs. Consequently the hospital intervened in the guardianship proceedings, claiming that its acute care facility was not appropriate for long-term rehabilitative care, and sought permission from the guardianship court to discharge the patient and have him transported to Guatemala for further care.

The hearing court found that federal law required the hospital to demonstrate that the discharge plan was medically appropriate.[32] In attempting to meet this burden, and over the hearsay objections of the guardian, the hospital offered a letter from the Vice Minister of Public Health in Guatemala which stated: "[T]he system of the Rehabilitation and Orthopedic Hospital 'Dr. Edwin Harold von Ahn,' is ready to give the necessary care to Mister Luis Alberto Jimenez, 28 years of age and originally from the City of Antigua Guatemala, Sacatepequez [sic] and will do so as soon as he arrives to this country. We will evaluate and transfer him to the most appropriate facility for the treatment of his condition. The medical treatment to be available will be without any cost to Mister Jimenez."

Following a hearing the guardianship court granted the hospital's request to effect the discharge over the guardian's objections and authorized the hospital to provide transportation and an attendant at the hospital's cost. Subsequently, and on the same day that his motion for a rehearing was denied, the guardian filed a notice of appeal as well as an application to stay the guardianship court's order. The hospital's response was due by 10:00 a.m. the following day but sometime before 7:00 a.m. the hospital took the patient to the airport via ambulance and transported him by private plane to Guatemala.

In an opinion issued on May 5, 2004, the appellate court reversed the order of the guardianship court that had authorized the hospital to transport Jimenez to Guatemala. In the opinion's final paragraph, the panel wrote that it was reversing not only because there was insufficient evidence that Jimenez could receive adequate care in Guatemala, but also that because of the collateral involvement of federal immigration authorities the guardianship court lacked subject matter jurisdiction to authorize the transportation of the patient.[33]

Arguing that the effect of such a ruling was to render the transfer order *void ab initio*, the legal guardian then instituted suit for false imprisonment and unlawful detention. The trial court dismissed the action, finding that the guardian had no standing, the hospital had absolute immunity by virtue of the prior court order allowing it to act, and that because of that prior order the plaintiff as a matter of law could not establish at trial that the detention was unlawful. The appellate court again reversed, finding that the underlying order was void as a matter of law.[34] Such a void order (as opposed to one merely voidable) could not confer immunity, especially when the subject of the order was a private right or benefit rather than a public one. At trial, it held, the plaintiff could show that the detention and subsequent actions by the hospital were unwarranted and unreasonable under the circumstances. In particular, and most relevant for our purposes, the appeals court made much of the fact that it earlier had vacated the initial order allowing the hospital to act because the proposed discharge might have been unsafe, citing its earlier decision in the same case.

The hospital also had argued that the appeal was moot because the patient was gone and federal immigration law precluded his readmission. The court turned that argument back against the hospital, however, by using it to bolster its finding that the guardianship court had no subject matter jurisdiction to authorize the hospital to

transport the patient to Guatemala in the first place because federal immigration law preempts deportation.[35] In addition, the mootness argument obviously is only possible because the hospital itself effected the departure before the court could rule on the pending motion for stay.

As to the merits, the guardian had argued that there was no substantial competent evidence to support the discharge from the hospital. At the evidentiary hearing the hospital attempted to satisfy the federal discharge requirements, as well as the hospital's own discharge requirements, by offering into evidence the letter from the consulate. The guardian objected to this letter as hearsay, but the trial court admitted it. The letter constituted the only basis upon which the guardianship court issued its decision. The letter was not admissible in evidence under any exception to the hearsay rule, the court found, and the hospital in its brief had not responded to the argument that it was precluded. Even if the letter had been admissible, the court held that it lacked the relevant degree of specificity necessary to satisfy either the federal regulations or the hospital's own discharge procedures. In fact, the court found that the only admissible evidence as to whether appropriate care would be available in Guatemala was the testimony of the guardian's expert, to the effect that that there were no public healthcare facilities providing traumatic brain injury rehabilitation in Guatemala.

Not reported in the decisions but buried in the news article is the fact that the hospital had arranged for Jimenez' transfer not just to his home town but specifically to a local hospital that would have been able to care for his needs. It was that local hospital, not Martin Memorial, that later effected the arguably improper discharge to his home.

The suit finally went to trial in July of this year. On July 23rd it went to the jury, and on July 27th the jury came back unanimously in favor of the hospital. As of the date of this writing the guardian's attorneys have not decided whether to appeal.

Conclusion

At the end of the day the hard decision as to whether to "evict" a patient (yes; evict is the way it will read in the newspaper and evict is the word that will be used on the 10 PM news) will require a careful analysis of all of the financial, legal and ethical questions presented by the particular patient in a specific clinical context.[36] It should not even be considered unless the provider has in place a comprehensive, properly adopted policy addressing the several most likely circumstances under which such a decision might become necessary, and unless the provider is certain that all of the patient's due process has been meticulously observed, especially whatever prior notice and appeal rights are established by law, regulation and the provider's own procedures.

Footnotes:

19 New York Real Property Actions and Proceedings Law section 713: "Grounds where no landlord-tenant relationship exists. A special proceeding may be maintained under this article after a ten-day notice to quit has been served upon the respondent in the manner prescribed in section 735, upon the following grounds: * * * * * 7. He is a licensee of the person entitled to possession of the property at the time of the license, and (a) his license has expired, or (b) his license has been revoked by the licensor, or (c) the licensor is no longer entitled to possession of the property; provided, however, that a mortgagee or vendee in possession shall not be deemed to be a licensee within the meaning of this subdivision".

20 See, e.g. Wales v. Giuliani, 916 F. Supp. 214, 1996 US Dist LEXIS 1433 (EDNY), citing Livingston v. Tanner, 14 N.Y. 64 (1856): "Nor could the owner, before entry, maintain an action of trespass against [a tenant at sufferance] (4 Kent, 117; 2 Black. Com., 150; Cruise's Dig., tit. 9, ch. 2.) But the owner could enter upon the tenant at sufferance and dispossess him by force, and reap the crops, and thus determine the tenancy, and the tenant could have no remedy by action. (Wilde v. Cantillon, 1 Johns. Ca., 128; Hyatt v. Wood, 4 Johns. R., 150; 2 Black. Com., 150.) This was upon the general principle that where one had no interest or property in the soil, and no exclusive possession, trespass quare clausum fregit could not be maintained. There can be no doubt whatever that, before our statutes on the subject of notice to tenants at will and by sufferance, the plaintiff might have either entered upon the defendant and dispossessed him, or brought ejectment and recovered possession without any demand or notice whatever."

21 "hospital issued notice of noncoverage"; see Social Security Act secs 1154(a), 1154(e), 1879; see also 42 CFR 411.404, 412.42(c), 489.34

22 after the ten day notice to quit has been served; see New York RPAPL 713, supra.

23 In New York the hearing or trial may not be adjourned more than ten days from the initial return date without the consent of both sides. NY RPAPL 745(1).

24 In New York these courts of limited jurisdiction may award possession and an incidental judgment for money damages to abide the possessory interest awarded (RPAPL 747) but not injunctions generally (see NY Civil Court Act sec 209 (b) and parallel provisions in the New York Uniform District, City Town and Village Court Acts).

25 Wyckoff Heights Medical Center v. Rodriguez, 191 Misc 2d 207, 741 NYS2d 400 (Sup Ct Kings Co. 2002))

26 Jersey City Medical Center v. Halstead, 169 NJ Super. 2, 404 A.2d 44 (Superior Ct Chancery 1979)

27 Lucy Webb Hayes National Training School v. Geoghegan, 281 F.Supp 116 (DC Dist Columbia 1967))

28 Midstate Medical Center v. Doe, 49 Conn Supp 581, 898 A. 2d 282 (2006).

29 10 NYCRR 405.1

30 "notice of discharge and Medicare appeal rights", required to be given to the Medicare beneficiary when the hospital determines that acute care no longer is required or that the hospital no longer can deliver the appropriate level of care to the beneficiary; 42 CFR 422.620

31 In New York see, eg., Civil Practice Law and Rules (CPLR) section 5106; CPLR Article 64

32 As a Medicare provider, the hospital was required to comply with federal discharge requirements contained in 42 U.S.C. section 1395X(ee) and 42 C.F.R. section 482.43. Under 42 C.F.R. section 482.43(d), the patient can be transferred by a hospital only to an "appropriate facility" where the patient would receive post-hospital care. Such a facility is defined as one which can meet the patient's medical needs. 42 C.F.R. § 482.21(b)(2). 59 Fed. Reg. 64149. An argument can be made that the appellate court took these sections out of context, in that they apply only to Medicare beneficiaries and are not intended to affect the discharges of all acute care hospital patients.

33 Montejo v. Martin Mem'l Med. Ctr., Inc, 874 So. 2d 654 (Fla. 4th DCA 2004).

34 Montejo v. Martin Mem'l Med. Ctr., Inc, 935 So. 2d 1266 (Fla. 4th DCA 2008).

35 Federal immigration law apparently preempts deportation while certain activities are pending. The court cited to Florida Auto. Dealers Industrial Benefit Trust v. Small, 592 So. 2d 1179 (Fla. 1st DCA 1992), an ERISA preemption case, in support of its holding that federal immigration law, like ERISA, completely preempts state courts of subject matter jurisdiction to grant orders which may result in "deportation". This is a curious line of reasoning based on a convoluted interpretation of federal preemption and its application to the facts, effectively denying the guardianship court subject matter jurisdiction over issues falling squarely within its statutory jurisdiction under state law because of the supposed existence of a "federal question". A guardian court is charged by law with supervising the activities of incapacitated persons who cannot act for themselves. If, after a full hearing, it allows any discharge plan, be it to an SNF, a rehab facility, or to home (here in the US or anywhere else), it is making a decision which cannot be presumed to be against the patient's interests. The court's decision to allow the hospital to send the patient to a hospital in his own home town is legally that of the patient himself, and cannot constitute an involuntary deportation.

36 An excellent analysis of the interaction of the law, medical ethics and clinical needs in effecting problem patient discharges is presented by Robert Swidler, Terese Seastrum and Wayne Shelton in "Difficult Hospital Inpatient Discharge Decisions: Ethical, Legal and Clinical Practice Issues", The American Journal of Bioethics, Vol 7(3):23-28 (2007).

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Ambulatory Surgery: High Stakes for APC Revenue

Author: Sheri Modell, RN, MBA, CCS-P

This is the second of 3 articles addressing pitfalls and opportunities in APC revenue. Look for the third article focusing on clinic visits.

Medicare's Outpatient Prospective Payment System (OPPS) has made the billing of ambulatory surgery procedures a more complex and cumbersome process. Every year CPT and HCPCS codes are revised, and increasing numbers of services are bundled into a surgical APC (ambulatory payment category) encounter. With more and more surgical procedures being performed in the outpatient setting, "getting it right" when billing surgical cases is critical for hospitals.

Following are key pitfalls and some strategies for performance improvement:

UNDERSTAND THE SOURCE OF ALL CHARGES

In most cases, the bill for an outpatient surgical procedure includes charges from several different hospital departments and systems. It isn't always clear to all key staff how the charges get to the bill nor is it obvious when they are omitted.

Charges can be generated by:

- Health Information Management (HIM) for diagnosis and procedure codes
- Radiology for procedure codes and intraoperative radiology supervision codes
- Laboratory for pathology and frozen section codes
- Ancillary departments such as Respiratory Therapy and EKG
- Chargemaster for device codes

HIM Codes

The first and most important source of charges is Health Information Management (HIM). Their coders usually are responsible for assigning all procedure codes in a surgical encounter. They also are responsible for assigning all diagnosis codes that the documentation supports AND for querying physicians when the documentation does not support a clear choice of diagnosis or procedure code(s). Coders must be aware of the "Medicare Only" codes that differ from the CPT code book methodology.

Even when HIM coders get all the diagnosis and procedure codes correct, some hospitals still are hampered by a compromised interface between the HIM abstracting and billing systems that may not transmit ALL of the HIM assigned codes to the bill – perhaps just the first one appears.

The impact of some codes not crossing to the bill can be significant, as illustrated in Exhibit 1 (Note: All exhibits reflect OPPS national rates).

Exhibit 1
Issue: Only One Surgical Code Crossing to the Bill

Bill Detail				HIM Abstract Detail			
Code	Procedure	Status	Payment	Code	Procedure	Status	Payment
29880	Arthroscopic Repair of Torn Meniscus	T	$ 1,943	29880	Arthroscopic Repair of Torn Meniscus	T	$ 1,943
88304	Pathology - Level 3	X	$ 35	29879	Arthroscopic Abrasion Chondroplasty	T	$ 972
				29876-59	Arthroscopic Major Synovectomy	T	$ 972
				88304	Pathology - Level 3	X	$ 35
	Total Payment:		**$ 1,978**		**Total Payment:**		**$ 3,922**
	Variance in Payment:		**$ 1,944**				

Another reason for lost revenue is surgical procedures performed outside of the operating room setting and thus not assigned to HIM for coding. These problem areas may include:

- Endoscopy
- Lithotripsy
- Cystoscopy

When procedures are performed in an area away from the main operating rooms such as the endoscopy suite or lithotripsy suite, secondary procedures in addition to the primary surgery may not be coded if HIM coders do not have the opportunity to read the documentation.

A frequent area where procedures can easily be missed is GI endoscopy. If the person assigning the procedure codes is not an experienced coder (e.g., selecting codes from a pre-printed charge form or screen), he/she may not know to look for specific techniques for polypectomies, or for tattooing of the procedure site.

The lithotripsy suite is another area where procedures can easily be missed. Charge forms may include only the lithotripsy codes, and may not include the option to add a code for procedures such as ureteral stent insertion.

Performance Improvement Plan -

- Audit current bills to assure that HIM abstract codes match the billed codes.
- Review a sample of cases on a monthly basis to evaluate the accuracy of data entry.
- Perform a quality clinical review of surgical procedures for coding accuracy.
- Verify that the Medicare specific procedure codes appear in the hospital's chargemaster and have been used for the appropriate procedures on Medicare patients.
- Determine how procedures performed outside of the operating room are coded and billed.
- Establish a policy that all surgical procedures are to be coded by HIM.
- Assure that HIM coders are in-serviced on annual CPT and HCPCS code changes and Medicare specific codes.

RADIOLOGY AND GUIDANCE CODES

Interventional Radiology cases require both surgery and radiology codes for correct billing. The radiology codes that are components of numerous surgical procedures can be either "guidance" to enhance procedures such as catheter placement, or intra-operative status images to determine the successful completion of a procedure such as joint repair. As a rule, HIM does not assign radiology codes; they are usually selected by charging staff in the Radiology Department. But Radiology staff conversely do not assign the surgery codes to the procedures that are performed in Interventional Radiology. So it requires a collaboration to get these bills rights

Radiology codes can have the following impact:

- ❑ Some radiology codes are paid in addition to the surgery component code. An example is retrograde urography (code 74420) performed during a cystoscopy with ureteropyelography which pays an additional $174.
- ❑ Even though some radiology codes have been bundled into the APC payment, it is still necessary to include these codes in bills. In those instances where the accompanying surgical procedure is cancelled or cannot be performed, the otherwise bundled radiology procedure might generate a payment. A common example is an angiography of an arteriovenous fistula prior to a scheduled angioplasty of the fistula. If both procedures are performed, the payment for the angiography is bundled into that for the angioplasty. If only the angiography is performed, it is payable.
- ❑ Many Medicare edits require that both the radiology code and surgery code be billed in order for the encounter to be paid at all. For example, in a CT guided liver biopsy, if just the CT code (77012) is billed without the procedure code 47000, the encounter will not be paid at all.

Performance Improvement Plan -

- Conduct a monthly review of surgical cases performed in the Radiology Department to make sure that all radiological and surgical codes reach the bill.
- Conduct a review of routine radiology procedures to verify the accuracy of the department's data entry.

PATHOLOGY AND DEVICE CODES

In many cases, some or all Pathology charges may not reach the bill. Errors may be incorrect units of specimens or missing charges such as frozen sections. While the payment for each unit of Pathology service may be low, missing Pathology charges may be indicative of a problem for every surgical case where tissue is removed. Exhibit 2 is an example of a real New York hospital case with both missing charges and unit errors.

Exhibit 2
Issue: Errors and Omissions in Pathology Charging

Incorrect Bill				Accurate Bill			
Code	Procedure	Status	Payment	Code	Procedure	Status	Payment
19302	Partial Mastectomy with Lymph Node Dissection	T	$ 2,677	19302	Partial Mastectomy with Lymph Node Dissection	T	$ 2,677
88307	Pathology - Level 5	X	$ 54	88307	Pathology - Level 5 (x2)	X	$ 108
88331	Frozen section, First Slide	X	$ 35	88331	Frozen section, First Slide	X	$ 35
				88305	Pathology - Level 4 (x2)	X	$ 69
				88332	Frozen section, Two Add'l Slides	X	$ 33
	Total Payment:		**$ 2,766**		**Total Payment:**		**$ 2,922**

Variance in Payment: $ 156

While the impact of a missing Pathology charge may have a minimal impact on the total payment for a procedure, a missing device code can result in no payment whatsoever.

On a quarterly basis, as part of its OPPS updates, Medicare issues a revised list of its "device-to-procedure" and "procedure-to-device" edits. In essence, if certain procedures appear on a bill without a specific device code, or if a device code appears without the designated procedure code, Medicare will not pay for the surgery.

The following (Exhibit 3) is an example of a surgical procedure where the device code was omitted:

Exhibit 3
Issue: Missing Device Code

Payment Without Device Code				Payment With Device Code			
Code	Procedure	Status	Payment	Code	Procedure	Status	Payment
33213	Insertion of Dual Chamber Pacemaker	T	$ -	33213	Insertion of Dual Chamber Pacemaker	T	$ 7,200
				C1785	Dual Chamber Pacemaker	N	$ -
	Total Payment:		$ -		Total Payment:		$ 7,200
	Variance in Payment:		$ 7,200				

Although pacemakers are the most familiar example of this edit (since the cost of the pacemaker unit is such a significant line item) other surgeries are also reliant on a device code being present to get paid. Lesser known ones include:

- Angioplasty
- Sling operation for stress incontinence
- Neurostimulator implantation

Performance Improvement Plan -

- Review a sample of surgical cases on a monthly basis to assure that the coding of Pathology service and units is accurate.
- Assign responsibility for updating the chargemaster with the quarterly device to procedure and procedure to device updates from Medicare.
- Institute a policy that all high dollar charges cases with a device code are reviewed prior to billing to assure that the correct procedure and device codes have been assigned.

BILL WHEN DOCUMENTATION IS COMPLETE

In the interest of cash flow, HIM coders are under pressure to code and drop bills quickly, often before the operative and pathology reports are available. Coders may resort to selecting diagnosis and procedure codes based only on the scheduling information or the brief operative note, thus leading to incorrect and missed codes. By waiting to code and bill surgery until both the operative report and pathology report are available, cash flow may be slowed initially, but overall revenue will increase.

Because the OPPS methodology for reimbursement often pays for more than one procedure code, making coding determinations before complete information is available can result in an incorrect payment. Certain types of surgery are very complex (e.g., orthopedic and vascular) and often can require additional codes based on the documented surgery. A common example of a procedure code that might be "undercoded" if the case is billed without a complete operative report is an arthroscopic shoulder repair. The physician would likely refer to the surgery as "a rotator cuff repair" – and only by reviewing the complete documentation would the extent of the surgery be clear. The difference in payment between the procedure coded and billed without and with the operative report is as follows:

Exhibit 4
Issue: Coding Before an Operative Report Is Complete

Payment w/o Complete Documentation				Payment w/ Complete Documentation			
Code	Procedure	Status	Payment	Code	Procedure	Status	Payment
29827	Arthroscopic Rotator Cuff Repair	T	$ 3,251	29827	Arthroscopic Rotator Cuff Repair	T	$ 3,251
88304	Pathology - Level 3	X	$ 35	29826	Arthroscopic Acromioplasty	T	$ 1,626
				29824	Arthroscopic Distal Clavicle Resection	T	$ 972
				88304	Pathology - Level 3	X	$ 35
	Total Payment:		**$ 3,286**		**Total Payment:**		**$ 5,884**
	Variance in Payment:		**$ 2,598**				

Complete documentation is also essential to facilitate accurate ICD-9 diagnosis coding. Meeting Medicare's medical necessity requirements for surgical procedures is just as critical as coding the surgery correctly to assure appropriate payment.

Important information to support a procedure might be present in a pathology report, for example, that will enable a coder to query a physician and code a diagnosis that will get the claim paid. The tissue type identified in a pathology report also may prompt a coder to question if an additional procedure was performed.

For example, when coders note that tissue was malignant they will be able to code a detailed diagnosis that will support medical necessity. If they note that tissue was removed from more than one site, they will look for additional procedures such as lymph node sampling or a more complicated closure of the operative site.

Performance Improvement Plan -

- Establish a policy that no surgical procedure can be coded without operative and pathology reports.

BUILD A TEAM TO ADDRESS DENIALS

HIM and Finance need to work together to prevent and eliminate payment denials. By forming a task force to review denials, both groups become aware of the payer requirements for documentation and can work toward the system modifications that will get claims paid.

The team also can assume responsibility for problem solving the cases that are suspended and cannot be billed. Members can work together to solve the data entry, missing data and incorrect information problems that can hamper the hospital's cash flow.

This collaboration is especially important when dealing with emerging technology procedures. In these instances, it is necessary for both HIM and Finance to understand what the procedure is and what the relevant payer policies are. Armed with the necessary information, coders will be better able to select the diagnosis and procedure codes for these new and often expensive procedures. Finance will be able to make sure that the device codes appear in the chargemaster and on the bill as needed. The hospital is thus less likely to see denials of the bills for these procedures.

Performance Improvement Plan -

- Establish a team consisting of representatives from Finance, HIM, IT and Case Management to address denials.
- Review all suspended cases to identify the system problems and documentation issues that caused the denial.

KEEP PHYSICIANS IN THE LOOP

Physician documentation is the cornerstone of accurate coding and billing. By querying physicians when documentation is not clear hospitals can improve both the quality of their data and their reimbursement.

Physicians should always be informed of documentation requirements for medical necessity and specific surgery detail that will enable cases to be coded correctly.

Another strategy to facilitate improved physician documentation is to develop forms that simplify the process and provide detailed options to describe the surgery. A high volume procedure that benefits a great deal from a documentation form is bronchoscopy. A well developed form encourages physicians to indicate the exact site of lesions (thus helping to improve the quality of diagnosis coding) and to check off what procedures are done in each area of the lungs.

Exhibit 5 shows the potential impact of documentation detail revised from a form.

Exhibit 5
Issue: Improved Documentation with Bronchoscopy Form

Routine Documentation "Bronchoscopy"				Improved Documentation w/Form "Bronchoscopy with needle aspiration biospy, bx additional lobe, brushing"			
Code	Procedure	Status	Payment	Code	Procedure	Status	Payment
31629	Bronchoscopy with Needle Aspiration Biopsy	T	$ 674	31629	Bronchoscopy with Needle Aspiration Biopsy	T	$ 674
				31633	Bronchoscopy with Needle Aspiration Biopsy, Add'l Lobe	T	$ 337
				31623	Bronchoscopy with Brushing	T	$ 337
	Total Payment:		$ 674		Total Payment:		$ 1,348
	Variance in Payment:		$ 674				

Other high volume procedures whose documentation can greatly benefit from a documentation form include:

- Arthroscopic knee procedures
- Arthroscopic shoulder procedures
- GI endoscopies

Performance Improvement Plan -

- Develop tools to facilitate better documentation of surgical procedures.
- Share information on patterns of denials and documentation requirements with the medical staff.

HEED THE "INPATIENT ONLY" PROCEDURE LIST

Hospitals are still experiencing denials by failing to heed Medicare's "Inpatient Only List." These procedure codes will not be paid on an outpatient basis. And when the hospital receives a denial it is not afforded the option to re-bill the case as an inpatient.

One strategy to prevent this problem is to build a table in the hospital's information system that classifies procedures as inpatient or outpatient and that blocks inpatient only procedures from being scheduled on an outpatient basis. In this way, the problem will be at least partially solved before it occurs.

Some of these inpatient only procedures that are confusing as to their status and can be mistakenly scheduled as outpatients include:

- Some procedures for breast reconstruction such as TRAM flap
- Partial removal of a vertebra
- Toe joint transfer
- Excision of a rectal prolapse

Performance Improvement Plan -

- Require a CPT code for the planned surgical procedure at the time the case is scheduled.
- Distribute the inpatient only list to all providers.
- Include a table of "Medicare Inpatient Only" procedures as part of the operating room booking software in order to identify these procedures and prevent them from being booked as outpatients.

CONCLUSION

Ambulatory surgery billing is a complex process that requires a coordinated effort by hospitals. To realize the payment a hospital has earned for providing ambulatory surgery services, it must monitor its own information and billing flows to assure that all services provided are accurately billed. It must develop collaborative approaches among its departments to identify and resolve coding and billing issues.

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