Welcome to the July edition of Net Revenue Matters, a publication of Integrated Revenue Management, Inc. We hope that in this issue you'll find several topics of interest.

In his article, “The COBRA Imperative,” Executive Vice President Jack Duffy discusses how to use analytics to leverage a strategic decision process.

Also, we hope that you'll appreciate the information presented in “July 2009 Update to Hospital OPPS and Outpatient Code Editor,” “RAC Complex Reviews,” and “CDMCache.”

Finally, please note our partner updates, client corner, and upcoming events. We don't want you to miss anything!

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The COBRA Imperative

How to use analytics to leverage a strategic decision process.

The Strategy:

- Full Workers Comp
  - 100% Margin
- Managed Care
  - 30% Margin
- Dominant Payer
  - 10% Margin
- Medicare
  - Break Even
- Medicaid
  - 30% Loss
- Self Pay
  - 60% Loss
- Charity
  - 100% Loss

Impact of Loss of Coverage

Floyd Medical Center was awarded second place for their work in creating a revenue source for the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) conversions in the Best Process Improvement Initiative category at IRM’s 2009 Best Practices. Floyd will shortly exceed $1,000,000 in cash collected on COBRA accounts. Please hold the date of August 19, 2009 for a webinar hosted by IRM, in which Greg Polley and his team will share their $1M story and will be available to answer questions. A highlight of what is to come follows.

The Solution:

Once a hospital understands that only a small portion of total patients provides the majority of income above cost, defending that revenue stream becomes a working imperative. Fortunately, the federal government has provided tools to assist in that process. Specifically, a tool called COBRA, which includes a program for extended health insurance coverage and, more recently, federal subsidies to help pay for this coverage. For the past 23 years, workers have been able to continue health insurance coverage and pay premiums out of their own pocket. The bad news is that $800
per month premiums do not fit into a budget in which unemployment compensation is the principle income and little can be done except to try to save the house and car.

Next, we understand that hospitals cannot afford to let all previous high margin dollars fall to charity. To combat this double loss, hospitals must create an effective program to identify at-risk current or future patients who have lost coverage within the previous 60 days. Once identified, and coupled with a complete health risk assessment, hospitals can provide COBRA support from one to as many as 18 months.

We already provide COBRA support to selected patients. While many hospitals have this option “on the books,” the number of actual annual interventions can often be counted on one hand. This program, if deployed at the high impact level, requires several key components. Specifically:

► Trained community outreach workers who can present the program and complete the paperwork and payment within the specified time limits.

► Liaisons with community groups such as churches, social service agencies, small employers, and physicians to identify at-risk patients before their COBRA benefit expires.

► Awareness training for hospital staff that includes ER staff and a dedicated COBRA intake desk, and focused training for social workers, discharge planners, and other team members who have patient and family contact.

Does it work?

Floyd Medical Center took the above steps, and more, to create an additional one million dollars in revenue that probably would have, with no intervention, been classified as charity care. If their county continues to lose 500,000 jobs per month (over one million covered lives) this program can be expected to double by year end.

Is it valuable?

At the prototype hospital, expected reimbursement is budgeted to yield a 1000% return on the COBRA support investment. Other values that cannot be expressed in cold dollars are the lives saved, pain avoided, disabilities avoided, and the long-term impact on patients and families for life. The hospital that the people of the community supported over the past 50 years stepped up during the patient’s darkest hour when health care coverage was terminated and family income was decimated so as to avoid the under treatment of health care issues.

Save the Date: IRM’s Virtual Roundtable

Topic: The COBRA Imperative
Date: Wednesday, August 19, 2009
Time: TBD
Registration: Required

Please join us to learn how an IRM client expects to yield a 1000% return on their COBRA support investment and how they have helped their community’s families deal with mounting unemployment. This free webinar will include a live question and answer session.

Registration is required to attend the webinar. Further information to follow.

July 2009 Update to Hospital OPPS and Outpatient Code Editor

Under the OPPS, updates are released each quarter to reflect changes to the Integrated Outpatient Code Editor (I/OCE). These changes may include:

► New or deleted modifiers
► New APCs
► New HCPCS codes
► HCPCS code description changes
► Changes to edits or status indicators
This article addresses several I/OCE changes effective July 1, 2009.

Added APCs as of July 1, 2009

<table>
<thead>
<tr>
<th>APC</th>
<th>APC Description</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>01268</td>
<td>Xyntha, injection</td>
<td>K</td>
</tr>
<tr>
<td>01269</td>
<td>Alloskin skin substitute</td>
<td>K</td>
</tr>
<tr>
<td>01270</td>
<td>AlloDerm skin substitute</td>
<td>K</td>
</tr>
<tr>
<td>09250</td>
<td>Artiss fibrin sealant</td>
<td>G</td>
</tr>
<tr>
<td>09251</td>
<td>Injection, C1 esterase inhibitor</td>
<td>G</td>
</tr>
<tr>
<td>09252</td>
<td>Injection, plerixafor</td>
<td>G</td>
</tr>
<tr>
<td>09253</td>
<td>Injection, temozolomide</td>
<td>G</td>
</tr>
<tr>
<td>09360</td>
<td>SurgiMend, Neonatal</td>
<td>G</td>
</tr>
<tr>
<td>09361</td>
<td>NeuroMend nerve wrap</td>
<td>G</td>
</tr>
<tr>
<td>09362</td>
<td>Implant, bone void filler-strip</td>
<td>G</td>
</tr>
<tr>
<td>09363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>G</td>
</tr>
<tr>
<td>09364</td>
<td>Porcine Implant, Permacol</td>
<td>G</td>
</tr>
</tbody>
</table>

Added HCPCS codes are listed below. Drugs and biologicals marked with an asterisk (***) have been granted pass-through status as of July 1, 2009.

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Description</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>0199T</td>
<td>Physiologic tremor record</td>
<td>00215</td>
<td>S</td>
</tr>
<tr>
<td>0200T</td>
<td>Perq sacral augmt unilat inj</td>
<td>00049</td>
<td>T</td>
</tr>
<tr>
<td>0201T</td>
<td>Perq sacral augmt bilat inj</td>
<td>00050</td>
<td>T</td>
</tr>
<tr>
<td>0202T</td>
<td>Post vert arthrpst 1 lumber</td>
<td>00000</td>
<td>C</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal vacc, 13 val im</td>
<td>00000</td>
<td>E</td>
</tr>
<tr>
<td>C9250*</td>
<td>Artiss fibrin sealant</td>
<td>09250</td>
<td>G</td>
</tr>
<tr>
<td>C9251*</td>
<td>Inj, C1 esterase inhibitor</td>
<td>09251</td>
<td>G</td>
</tr>
<tr>
<td>C9252*</td>
<td>Inj, plerixafor</td>
<td>09252</td>
<td>G</td>
</tr>
<tr>
<td>C9353*</td>
<td>Inj, temozolomide</td>
<td>09253</td>
<td>G</td>
</tr>
<tr>
<td>C9360*</td>
<td>SurgiMend, Neonatal</td>
<td>09360</td>
<td>G</td>
</tr>
<tr>
<td>C9361*</td>
<td>NeuraMend, nerve wrap</td>
<td>09361</td>
<td>G</td>
</tr>
<tr>
<td>C9362*</td>
<td>Implant, bon void filler-strip</td>
<td>09362</td>
<td>G</td>
</tr>
</tbody>
</table>

The following modifiers were added July 1 and took effect January 1, 2009. The addition of these modifiers signal CMS’ continuing effort to pursue its pay-for-performance model. The new modifiers will allow improved tracking of poor quality care.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>Surgical or invasive procedure on the wrong body part</td>
</tr>
<tr>
<td>PB</td>
<td>Surgical or invasive procedure on the wrong patient</td>
</tr>
<tr>
<td>PC</td>
<td>Wrong surgery or invasive procedure on patient</td>
</tr>
</tbody>
</table>

The following modifiers took effect on April 1, 2009.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PI</td>
<td>PET tumor init tx strategy</td>
</tr>
<tr>
<td>PS</td>
<td>PET tumor subsqnt tx strategy</td>
</tr>
</tbody>
</table>

Updates to OPPS Pricer Logic

The July updates also contain updated pricer logic to correct programming errors that were present in the January 2009 OPPS Pricer. Claims possibly affected by the errors include those containing:

- Certain blood products eligible for the blood deductible
- HCPCS codes J1441, J1740, J2505, and J7513

In order to determine whether rebilling the affected claims is warranted, review the detailed information located in the July 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS), located at the following website.


In addition, the complete OCE update for July 1, 2009 is located at the following website.

**RAC Complex Reviews**

The Centers for Medicare & Medicaid Services (CMS) has stated that hospitals shouldn’t expect complex RAC audits, which require the review of the medical record, until late 2009 or early 2010.

In the coming months, hospitals should finalize their process for submitting medical records to the RACs whether it is electronic copies or paper copies. CMS has released a document outlining the Medical Record request limit for the RACs. For an inpatient hospital, Inpatient Rehab Facility (IRF), or a Skilled Nursing Facility (SNF), the RAC can request 10% of average monthly Medicare claims per 45 days up to the maximum of 200 records.

There are also restrictions on the types and dates of claims that the RACs can review. CMS has defined a claim review period for all RACs. No claims processed prior to October 1, 2007 will be reviewed, regardless of when your RAC begins. Going forward, RAC will not be able to look back more than three years after the claim processing date, but no earlier than October 1, 2007. Keep in mind the claim review period exclusions are based on paid claim date, not discharge date.

To prevent duplicate reviews, CMS also excludes previously audited claims from RAC review. CMS and RACs will submit selected provider and claim data to a web-based application called the RAC data warehouse. All RACs should check the RAC data warehouse for exclusion status prior to requesting a medical record. Claims are excluded from RAC review if it meets one of the following criteria.

- If a claim has been reviewed by another entity, it will be deemed “excluded.” This is a permanent exclusion.
  - Previously evaluated by an “Affiliated Contractor” (QIO, FI, MAC, Pt B or DME Carrier)
- If a claim is currently part of an ongoing fraud investigation, it will be deemed “suppressed.” This is a temporary exclusion.
  - Currently being investigated as part of potential fraud cases by Benefit Integrity Contact-

For more information please review the CMS Medical Record Request Limit document, which can be found at the following link: http://www.cms.hhs.gov/RAC/Downloads/RAC%20Medical%20Record%20Request%20Limits.pdf.

**CDMCache**

**Pharmacy Chargemaster Considerations**

The hospital pharmacy is a complex department with numerous variables that should be considered when building, editing, and auditing the CDM file.

- **Revenue code:** Pharmacy drugs may be classified into several different revenue code ranges dependent upon whether they do or do not require HCPCS codes or were self-administered by the patient. For example, revenue code 0636 is used for drugs that require HCPCS/CPT codes. Drugs that are self-administered by patients are classified to revenue code 0637. Charges for drugs without separate APC payment are reported on a single line under revenue code 025x without the HCPCS code.

- **Dosage:** Drugs rarely arrive in the same dosage as they are given, and the amounts distributed for use on patients do not often match the dosage listed in the narrative description of CPT/HCPCS codes. For this reason, dosages given to the patients must be converted to the appropriate number of units of a given CPT/HCPCS code. For example, a patient was given an injection of 2 mg of midazolam HCl. The HCPCS code for this substance is J2250, but has a dosage of 1 mg. In order to report the amount given, 2 units of HCPCS code J2250 should be reported.

Medicare regulations regarding drugs and biologicals may be found in the following:

- Medicare Benefit Policy Manual, Chapter 1, section 30, and additionally in Chapter 15, section 50.
New Webinar Series: The RAC Audit Pro™

Beginning July 23, 2009 Integrated Revenue Management will offer a monthly webinar series titled, The RAC Audit Pro™.

The RAC Audit Pro is a culmination of education, best practices, and technology. It is an integrated solution that is designed to help our clients and prospective clients stay on top of the industry’s single largest process change in years, the Recovery Audit Contractor review (RAC). RAC will have a direct impact upon virtually all providers in the healthcare delivery chain and the goal of The RAC Audit Pro™ is to give you the tools, knowledge, and processes to stay ahead of the game.

As part of the rollout of The RAC Audit Pro, we are launching a series of timely educational webinars featuring expert speakers from the financial, regulatory, and coding disciplines. Upcoming agenda topics will include:

► Preparing for a RAC Audit
► What Your Legal Department Needs to Know
► Lessons from the Field
► Records Retrieval and Management

The RAC Audit Pro will also feature an online resource center on IRM’s website and a weekly blog posting. Please visit our website for updates and registration information: http://www.irminconline.com/news/news.htm.

RACoverity Toolkit™, your complete RAC Audit solution, now on Twitter.

Visit us on Twitter for all your RAC news: http://twitter.com/RACoverityToolkit.

Don’t Forget!

All CBR activity for the month must be entered into the CBR Software application/DRG Catalyst prior to the 10th of the following month. Be sure to follow the steps below so that results from retrospective CBR audits translate onto the Executive Summary:

Inpatient (DRG Catalyst)

► The rebill checkbox must be checked. (Please make sure that you send the checked accounts to PFS for rebilling!)

Outpatient (CBR Database)

► The completion date must be entered under the CBR Utilities tab and
► The rebill checkbox must be checked. (Please make sure that you send the checked accounts to PFS for rebilling!)

Before the database closes each month, IRM recommends that you complete the following checklist:

► Confirm that all completed retrospective audits for the month have an end date entered into the CBR database.
► Check the rebill box in the CBR database or DRG Catalyst for each retrospective claim that has been approved for rebilling.
► Complete a Summary of Audit Findings form for any projects you closed this month and submit it to the coding Subject Matter Expert (SME).
► Ensure that data is entered for all accounts audited for the current month.
Upcoming Events

Client RMD Workshop

Webinars 2009

(Workshop webinars have replaced TCG webinars)

March
11: How to Analyze CBR Project Findings
23: How to Quantify PI Results
26: Defense Data Entry

April
3: Bilateral Procedures and Managed Care Payers

June
29: Observations and Process Improvements

July
30: The PCDA Form (new date)

Other topics (dates to be announced)

- Managed Care Database on Contract Negotiations
- Analyzing & Presenting Trended Findings
- Consumer-Driven Healthcare/Pay 4 Performance
- Medicare Managed Care
- Medication Administration
- Auditing ICU Accounts
- How to Handle Adversity
- Silent PPOs
- How to Update and Maintain the CPM
- How to Interact with Internal Customers
- Write-off Analysis
- Defense Negotiation
- Software Data Entry and Process
- Software Reporting

Please watch for your e-mail invitation approximately three weeks prior to the scheduled event.

Client Code-Based Reimbursement

Project Rollout Topics 2009

Live webinars begin at 11:30 Pacific

August
19: Inpatient Excisional Debridement

November
18: J Codes

Available Project Rollout Topics

- Injections and Infusions
- Introduction to Inpatient Audits
- Inpatient Mechanical Ventilation
- POA and HAC
- Observation and One-Day Stays
- Device Dependent APCs
- Wound Care
- Pain Management
- Outpatient Orders
- Spine Surgery
- Chemotherapy
- Pathology
- Brachytherapy
- Moderate Sedation
- Radiology Imaging
- Erythropoiesis Stimulating Agents
- Discharge Dispositions
- Interventional Cardiology and Electrophysiology
- Emergency Department
- Vascular Access Devices
- Neurostimulators
- GI Endoscopy
- Tracking and Trending CCI Edits

For more information, contact your subject matter expert (SME) at IRM:
Linda Schwab

Thank You

Net Revenue Matters is a monthly publication of Integrated Revenue Management, Inc. (IRM), and is offered as an informational service. Due to the nature of this publication, examples cited and advice given must often be general in nature and may not apply to a particular facility or situation. Thus, IRM does not warrant or guarantee the information contained will be applicable or appropriate in all situations. Each facility will have to evaluate its specific opportunities and take such action as to best meet its business needs. To find out more about a given subject or for information tailored to your specific circumstances, contact an IRM professional.

If you have questions or would like to submit information for a future newsletter, please contact:
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