



## Board responsibility & governance for compliance

by Larry Fogel, Kansas City

In the wake of recent corporate scandal, with major fraud and abuse cases blemishing the health care industry, it has

**To satisfy their duty-of-care obligations, boards should make reasonable inquiries of management to obtain the information they need.**

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never been more critical for boards of directors to clearly understand their role in preserving the integrity and reputation of the organizations they serve.

"Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors" was published in April 2003 by the Office of Inspector General (OIG) of the Department of Health and Human Services.

Cosponsored by the American Health Lawyers Association, this compliance resource was designed to help boards more clearly understand their oversight duties and responsibilities. (For more information, visit the Health Care Compliance Association's web site: <http://www.hcca-info.org/index.>)

### Fiduciary responsibility to provide oversight

To satisfy their duty-of-care obligations, boards should make reasonable inquiries of management to obtain information.

Because the health care industry is subject to myriad fraud and abuse laws, as well as federal and state laws, it is essential for health care organizations to establish effective compliance programs.

A board's fiduciary responsibility is to provide oversight of the corporate affairs of institutions and abide by the duty-of-care principle, which requires them to act in good faith with the care that a prudent person would exercise under similar circumstances.

### Compliance risks invite disaster

Health care is one of the most heavily regulated industries in America, and risks associated with failing to comply have increased dramatically for health care organizations over the past decade.

The False Claims Act alone authorizes the imposition of damages up to triple the amount of the fraud, plus civil monetary penalties of \$11,000 per claim.

In addition to criminal and civil monetary penalties, providers convicted of committing fraud may be excluded for a minimum of five years from participation in Medicare, Medicaid and other government health care programs.

### Develop effective program

To encourage and support lawful behavior, a growing number of health care organizations have developed active compliance programs.

According to a recent Health Care Compliance Association survey, health care organizations with active compliance programs have grown from 55% to 87% from 1999 to 2002.

To help organizations develop and maintain effective compliance programs, OIG published a series of compliance guidance documents to help identify risk areas and improve internal controls.

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**T**he second in a series concerning corporate integrity, this article addresses responsibility and governance for compliance issues for boards of directors serving health care organizations.

Health care is one of the most closely regulated industries in America, and compliance issues demand boards and management work together to strengthen the organizations they serve.

The focus for future articles includes:

- ▲ Appropriate roles of corporate codes of ethics and regulatory compliance
- ▲ Audit committee roles

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# Board responsibility & governance. . .

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**Operational issues**

## Code of conduct

Incorporate the code of conduct into corporate policies; monitor how well it's understood and accepted.

The board confirms all employees have received a copy of the code and training on the standards of conduct they are to follow.

## Policies and procedures

To address areas that may present compliance risks, health care organizations should implement policies and procedures that are current, clear and in sufficient detail to be understood and followed; periodic reviews will help determine their effectiveness and if they need revision.

Ideally, policies should incorporate OIG guidance concerning specific high-risk areas.

## Compliance infrastructure

To effectively administer compliance programs, the compliance officer should have:

- ▲ Authority to review all documents
- ▲ Open communication between senior management and board
- ▲ Sufficient personnel and financial resources
- ▲ A compliance committee to help accomplish program objectives

Compliance-related tasks should be assigned across the organization's infrastructure. Management plays an important role in integrating compliance at

the departmental level, though *all* employees should be held accountable individually for abiding by the compliance program's rules.

## Prevent violations

It's management's responsibility to evaluate compliance training and education to determine effectiveness and customize areas that pose the greatest potential risks.

Boards can help prevent violations by:

- ▲ Being alert to industry and regulatory risk developments
- ▲ Reviewing new regulations and published fraud alerts
- ▲ Informing new board members of major laws and regulations affecting health care organizations
- ▲ Knowing how "at risk operations" are assessed

Auditing and monitoring are effective ways to identify potential compliance risks, and regular internal and external audits of high-risk areas can help evaluate compliance with applicable laws and regulations.

## Responding to violations

It's easier for the board to respond to an organization's suspected compliance violation if it knows what policies and procedures are in place to investigate allegations of misconduct, including:

- ▲ Encourage employees to ask questions, report concerns without fear of retribution
- ▲ Time frame for initiating an investigation

- ▲ Policy for reporting violations to the government; is it followed and enforced
- ▲ Appropriate actions; does the organization follow and enforce
- ▲ Policy for retaining counsel; is organization's response consistent with counsel's guidance

Management must understand the board's expectations for receiving timely reports on an investigation's status, including the organization's response to the investigation.

## Ask right questions

Today, boards can't assume the organizations they govern maintain effective compliance programs, capable of detecting and preventing compliance violations.

Boards must be proactive and develop an ongoing understanding of the industry's inherent risks. Boards also must understand the importance of compliance programs and how they work within and assist health care organizations.

Boards have a fiduciary responsibility for oversight activities to promote an environment of corporate responsibility and integrity. A board can accomplish this provided its members ask the right questions and oversee the appropriate areas.

\* \* \*

Contact your BKD Health Care Group advisor for information about your board's fiduciary responsibilities for oversight activities. □

## Understanding structural issues

To understand an organization's compliance program, how it operates and what it's intended to provide, boards should pose the following questions to management:

- ▲ *How is the program structured, and who are the key employees responsible for its success?*

To provide oversight for compliance activities, the board may want to create a compliance committee

- ▲ *How does the reporting system work?*

The board should receive regular reports covering past compliance results and plans for the future

- ▲ *What are the program's goals?*

Practical, realistic program goals and objectives are easier to understand and accomplish. For example, it would not be realistic to assume the program could

prevent all wrongful conduct

- ▲ *Does the program address the organization's serious risks?*

Conduct a comprehensive risk assessment to identify areas of exposure and to develop a work plan to monitor them

- ▲ *How much will the program cost to implement and operate?*

Effective programs include training, auditing and continuous monitoring, all expensive, time-consuming operations

Management and the board need a clear understanding of the resources necessary to accomplish the organization's compliance goals.

Establishing a process to measure the effectiveness of the compliance program will help the board evaluate the return on its investment. □



## BKD Health Care Group Speakers' Bureau

Topic	Speaker/Office	Seminar	Location & Date
Rural & Critical Access Hospital Regulatory and Reimbursement Update	Eddie Marmouget & Tim Wolters, Springfield	Healthcare Financial Management Association Annual National Institute	Baltimore, June 22-26

# New CMS CoPs focus on quality improvement

by Joan Cisna, Kansas City

**E**ffective March 25, 2003, several new requirements will raise quality assurance standards for hospitals, according to new guidance published by CMS.

The new conditions of participation (CoPs) don't actually measure quality but help hospitals establish minimum requirements to systematically examine quality and implement specific, ongoing improvement projects.

Enforcement standards also have been raised, including:

- ▲ Programs now must demonstrate actual *improvement*, not just quality *assurance* measurements
- ▲ There must be cross-functional, interdisciplinary involvement, not limited to one department or activity

▲ Hospitals must document the rationale for the specific scope of the quality improvement (QI) program and monitor indicators

▲ Required focus on *outcomes* of care, eliminating unnecessary *procedural* requirements

Specific indicators for a quality improvement program are not prescribed but are determined by each hospital based on what is appropriate for the patient population, scope of services, available resources and other variables.

Hospitals are expected to follow external benchmarks established and published by quality sources, *e.g.*, the Quality Improvement Organizations, Joint Commission on Accreditation of Healthcare Organizations, the National Patient Safety Foundation or the Healthcare Cost and

Utilization Project.

BKD Health Care Group's clinical consultants can assist hospitals establish and conduct a QI program that adds value and meets the requirements of the new CoPs.

Our consultants can help with QI program enhancements, including:

- ▲ Educate staff in the new requirements, their implications and implementation
- ▲ Define terms and quality improvement concepts
- ▲ Fine tune organizational structure for QI
- ▲ Structure a QI framework throughout the hospital
- ▲ Enhance existing QI programs
- ▲ Research and facilitate adoption of appropriate indicators

▲ Develop tools for implementation

▲ Identify potential quality improvement opportunities

▲ Design and implement an action plan

▲ Perform follow-up monitoring to determine degree of success of the interventions

▲ Facilitate an ongoing QI program, including documentation

▲ Address state agency survey requirements

BKD Health Care Group's experience with QI programs in many different environments gives us insight into what works, what doesn't and how to demonstrate the desired results effectively and efficiently. Contact your advisor for more information. □

# Stolen insurance checks create heavy losses

by Angela Morelock & John Sherrick, Springfield

**T**he diversion of checks received or checks disbursed is one of the most common fraud schemes according to Sherri Schornstein, an assistant attorney in the U.S. Attorney's Office for the District of Columbia's Economic Crimes Section.

After years of investigating embezzlement cases, BKD agrees with Sherri and can confirm her findings.

Members of our Forensics & Dispute Consulting division have helped numerous health care organizations that have suffered heavy financial losses because insurance checks were relatively easy for employees to divert.

## Protect the checks

While many organizations

diligently protect their cash, the same level of control doesn't always exist for payments received by check. Treat and protect checks exactly like you would cash.

Once an employee gains access to a check, it's easy for it to be misappropriated and turned into cash, provided the account can be written off or adjusted.

BKD has investigated several cases of employees writing off the account and depositing insurance checks into personal bank accounts.

## Limit employee access

The only way to protect an organization from this type of loss is to limit employee access to both incoming payments and accounts receivable.

This can usually be accomplished even with a small staff. In addition, managerial and supervisory employees should never handle cash or checks.

## Survival tips

Sound daily processes are critical and will lessen your risk for embezzlement. Consider the following tips:

- ▲ **Never allow** the same person access to both incoming payments and accounts receivable
- ▲ Restrict access to the mail room **without exception**
- ▲ **Regularly test** contractual adjustments for validity
- ▲ Process **all** payments according to established processes **without exception**
- ▲ **Do not** pass payments



through the offices of supervisors or managers

- ▲ Send monthly statements on **all** accounts
- ▲ Post and deposit all incoming payments **the same day**
- ▲ Implement **sound and reliable** balancing procedures

Make sure your organization's internal control structure mirrors your operation requirements. Contact your BKD Forensics & Dispute Consulting advisor for help in tailoring your internal controls, and reducing the possibility of fraud. □

# Be ready when

by Sherri Routh, Springfield

**D**AVE, CMS's new Data Assessment and Verification initiative, is gearing up in 2003.

CMS and the Computer Sciences Corporation (CSC) will use established protocols to identify MDS coding errors that compromise resident care and payment integrity.

In 2002, CSC tested DAVE in 120 sample nursing facilities in Indiana and Georgia. With testing completed, CMS is now implementing DAVE nationwide, adding states incrementally.

CSC, a CMS program safeguard contractor, is authorized to assess and verify the accuracy and reliability of MDS data and make observations relative to fraud and abuse; payment policy; health and safety and quality care.

A combination of onsite and offsite procedures will be used to

collect and report findings to CMS and, when indicated, to the FI.

## DAVE to facilitate improvements

The stated CMS objective for the DAVE initiative is to improve both MDS accuracy and assessment data by identifying trends related to inaccuracies.

CMS has emphasized its desire for facilities to improve data quality and subsequent resident care. However, the DAVE contractor has been instructed to report any resident health and safety or payment issues to either CMS or the FI.

The DAVE review can be conducted onsite or by submitting requested medical records to CSC. For example, a letter requiring submission of medical records reads:

**"We selected your facility for medical records review through analysis of the MDS data submitted to the National Repository.**

**The residents identified on the enclosed attachment have been scientifically selected for review. You are required, under your Medicare provider agreement, to submit all documentation necessary to support claims for service. In this respect, if certain records supporting the services rendered are at another facility, as the billing provider, you are responsible for obtaining those records for our review."**

On average, 10 resident records are requested, including the UB-92 claim form. The information is used to determine MDS assessment accuracy and whether or not it's validated by the medical records.

## Onsite reviews

Initial data analysis may lead to additional requests for medical records, or CSC may feel an onsite DAVE review is warranted, for which facilities receive one week's notice.

There are two types of onsite reviews. One is called the Two-Stage Verification Protocol, in which the DAVE clinician completes an MDS assessment on a resident who has recently been assessed by the facility.

The second review is called the Retrospective Medical Record Review, which entails a detailed review to determine if the assessments submitted by the facility are supported by the medical record.

## DAVE affects coding patterns

The DAVE initiative will focus on many aspects of MDS coding patterns and resource utilization.

For example, for a patient who had pneumonia during two or three consecutive assessments, it would be reasonable to expect the pneumonia to be resolved in this time frame.

RUGs, such as Rehabilitation Ultra High (RU) and Rehabilitation

# Medicare margin analysis spells improvement

by DeInda Dellacca, Indianapolis

**D**o you know your Medicare margin for inpatient, outpatient, home health and other types of services? Are improvements in order?

A Medicare margin analysis (MMA) may help answer the following questions:

- ▲ Do you know what your Medicare margins are by business line?
- ▲ How do your Medicare margins compare to hospitals within your service area?
- ▲ What driving factors are behind your Medicare margins?

MMA's can be performed with information from your Medicare

cost report. Obtain the cost reports of your peers from the FI via the Freedom of Information Act.

After completing an overall MMA, you can begin to identify factors that may be contributing to differences in performance:

- ▲ Which DRGs are losing money?
- ▲ What is the average length of stay for each DRG classification by physician?
- ▲ Which cost center(s) is contributing to the high cost per patient?

For example, if a hospital's case weighted average length of stay is above its peer group's, the variance cause could be evaluated.

In reviewing utilization, many hospitals use MMA's to evaluate operating performance and can develop improvement plans from

the information. MMA is a proven tool for identifying areas of opportunity. □

## MMA Example

The chart below is an example of the data elements included in an MMA for acute care hospital inpatient services.

	Hospital A	Hospital B
Medicare Margin Amount	\$(152,226)	\$157,274
Medicare Margin Percentage	-4.30%	3.87%
Medicare Margin per Discharge	\$(181)	\$156
Medicare Days	4,298	4,877
Medicare Discharges	843	1,005
Length of Stay	5.10	4.85
Total Discharges	1,114	1,875
Medicare Discharges to Total Discharges	75.67%	53.60%

# DAVE visits your SNF

Very High (RV), might be analyzed according to the volume generated.

## Preparing for DAVE

What can providers do to prepare for DAVE? Consider implementing self-audits, and institute a focused quality improvement plan to address the accuracy of all MDS assessments your facility completes.

Continued education for facility staff members should focus on

areas of concern discovered during the audit process.

Some suggested tips for self-audits include:

- ▲ Choose residents whom reviewers might target, *e.g.*, those



with decubitus ulcers, pain, weight loss, recent falls, those on intake and output and those in the two highest RUG-III groups (RV & RU).

- ▲ Audit therapy logs for days and minutes of therapy provided during the assessment reference period, and compare them to the MDS completed assessment.

Do the days and minutes match what was coded on the MDS?

Note the resident's level of function as documented on the CMS 700 form (therapy evaluation), and determine if goals for improvement are reasonable.

- ▲ Review facility documentation standards; documentation in the medical record, including

all physical and cognitive data, should support information on the MDS.

An auditor should be able to read the resident's medical record and have an accurate description of the resident's abilities and deficits.

- ▲ Review residents who need assistance with activities of daily living (ADL) as documented in the nursing notes. Compare them to the coding of Section G on the MDS, and focus attention on areas of bed-mobility, transfers, eating and toileting.

These four ADL scores make up the final component of the RUG-III group. "A" reflects a more independent resident. "B" reflects that the resident requires moderate staff assistance. "C" reflects that

the resident requires extensive staff assistance.

It may benefit the facility to self-audit the "A" level residents who receive RV or RU group therapy services, especially if they are returning to their home after therapy.

Finally, gather copies of UB-92s for the Medicare Part A stay and compare them to the MDS assessments, therapy logs and nursing documentation. Does the documentation in your medical record justify services billed? The goal should be accuracy, not undercoding or overcoding.

\* \* \*

Contact your BKD Health Care Group advisor for help preparing for DAVE. □

# Bridging the coding & reimbursement gap

by Trisha Priest, Springfield

**T**hough the majority of FQHCs and RHCs (health centers) code and bill services directly from the encounter form, the codes identified by billers may not always match the information in providers' notes for the encounter.

Documentation assessments performed in various health centers reveal differences between the documented visit note and the encounter form:

- ▲ Diagnosis, signs and symptoms documented are different
- ▲ Procedures performed are not accurately stated on the encounter form
- ▲ Reasons for ordering ancillary tests do not meet medical necessity

If a health center has a high claims denial rate because diag-

noses do not meet medical necessity and/or fails to identify procedures performed because the provider didn't indicate the service on the encounter form, reimbursement may be lost.

Inappropriate reimbursement may result if patient diagnoses coding is consistently inaccurate because the proper codes do not appear on the encounter form.

The gap between coding and reimbursement is in the provider's documentation. To bridge this gap, the coder or biller should compare the provider's visit note to the encounter form before billing.

The importance of accurate coding has broad applications. Statistics are gathered from health care databases, and case mixes are derived from this data for specific geographic areas. Physicians use the same data when relocating, and insurance companies use it to

identify which providers to contract.

The encounter form is a tool for assisting different functions within the health center. As such, coding and billing staff should not depend on this document alone.

When a third-party payer requests documentation to validate a claim for payment (or when a health center is audited by Medicare or Medicaid), the health center is asked to submit a copy of the encounter form and complete supporting documentation for the billed services.

It is critical for your health center's coding and billing staff to understand that proper coding and billing of services are based on the provider's notes, the encounter form and other supporting documentation.

To improve billing and coding services at your health center, implement a review process with-

in your organization or hire outside assistance. The OIG and other auditing agencies will appreciate your health center's commitment to bill appropriately.

In summary, the goal for all health centers is to obtain payment as quickly as possible. Adjusting to a new process of coding and billing may include waiting for the provider's dictated or handwritten note, which may disrupt the first month's reimbursement flow.

After your health center makes the adjustment, claims will be billed more accurately, and your cash flow may improve because additional services are identified and billed accurately.

\* \* \*

For further information about how to improve billing and coding services at your health center, consult your BKD Health Care Group advisor. □

# New guidance on provider-based status

by Tim Wolters, Springfield

**C**MS issued Program Memorandum (PM) A-03-030 April 18, 2003, to provide further guidance on the revised provider-based rules.

Treatment of a facility as provider-based can, in certain circumstances, result in higher reimbursement than for freestanding services.

This could include:

- ▲ Outpatient clinics that receive higher reimbursement under

APC rates than the physician fee schedule

- ▲ RHCs in hospitals with fewer than 50 beds exempt from the RHC cost limit
- ▲ Outpatient rehab clinics that, if considered hospital-based, are exempt from the Part B therapy cap

The new rules for on- or off-campus facilities include requirements related to licensure, clinical integration, financial integration, public awareness and general hospital obligations with regard to

providing and billing for services.

Off-campus facilities also must meet additional requirements, such as demonstrating ownership and supervision by the main provider and close proximity to the main provider.

Grandfathered facilities, defined as those facilities treated as provider-based as of October 1, 2000, are subject to the new rules for cost-reporting periods beginning on or after July 1, 2003. New entities are already subject to the rules.

The PM provides a sample attestation that providers can submit to document compliance with the rules.

If providers do not submit an attestation, and CMS determines the provider-based rules are not met, inappropriate payments will be recovered retroactive to the opening of the facility, if new, or to the date grandfather status expires.

If an attestation is submitted but denied, payment recovery will be retroactive to the date the attestation was submitted. □

## In brief

**CMS to gather occupational mix wage data** - CMS has published a draft survey form to gather wage data for calendar year 2002 grouped into various occupational categories.

CMS has verbally indicated it expects the survey form to be finalized and sent to hospitals other than CAHs this summer. Hospitals will have 30 days to complete the survey and return it to their intermediary.

BIPA requires CMS to collect this data by September 30, 2003, for use in computing wage index values effective October 1, 2004.

The survey form would require hospitals to group employees into one of 12 broad occupational categories, such as registered nurses, clinical technologists and technicians, food preparation workers and house-keeping, etc. Definitions are provided for each category.

Within each category, wages and hours would be reported for employees with salaries under \$15 per hour, \$15 to \$29.99 per hour, \$30 to \$44.99 per hour or \$45 and over. CMS estimates 160 hours per hospital to complete the survey.

The effort's intent is to

determine whether the current hospital wage index penalizes hospitals with fewer specialized employees in higher wage categories.

Hospitals with more specialized employees to treat higher acuity patients are rewarded through a higher case mix index and higher prospective payments.

An occupational mix adjustment would standardize the wage index for hospitals based on wages paid for the same types of employees. It is important that hospitals carefully complete this survey.

**Medicare proposes 2.9% increase in SNF payment rates** - CMS issued the proposed SNF PPS rule in the May 16, 2003, **Federal Register**. The proposed rule calls for a 2.9% increase in payment rates effective October 1, 2003.

CMS also proposes no change to the RUGs case mix system at this time. This decision leaves in place the 20% add-on to selected RUG categories and the 6.7% add-on to the rehab RUG rates.

**Medicare proposes 3.3% increase in inpatient rehab payment rates** - CMS issued the proposed inpatient rehabilitation facility (IRF) PPS rule in the May 16, 2003, **Federal Register**. The

proposed rule calls for a 3.3% increase in payment rates effective October 1, 2003.

IRFs are required to serve an inpatient population of whom at least 75% required intensive rehabilitation services for 10 serious medical conditions, including stroke, spinal cord injuries, amputations, etc. FIs enforce compliance with this requirement. Because of concerns over inconsistent enforcement, CMS suspended enforcement of this requirement in July 2002. CMS is reinstating the enforcement requirement effective for cost-reporting periods beginning after September 30, 2003. Based on what CMS acknowledges may be incomplete data, CMS estimates that as many as 87% of all IRFs may be noncompliant with this requirement.

**OIG advisory bulletin targets joint ventures** - The OIG issued an advisory bulletin in April addressing potential problems with contractual joint venture arrangements.

The OIG's concern is that such arrangements may reward providers for improper patient referrals in violation of the federal antikickback statute.

An example of such an arrangement would be a hospital

that establishes a DME subsidiary, contracting with an existing DME company to manage and operate the subsidiary.

The OIG is concerned this could lead to inappropriate referrals from the hospital to its new subsidiary, potentially resulting in overutilization of services, as well as freezing out competitors in the area.

**OIG issues advisory opinion on management fees** - The OIG issued Advisory Opinion No. 03-8 on April 3, 2003, addressing a proposed management fee arrangement.

The arrangement involved a proposed contract whereby a management company would manage inpatient rehabilitation units in exchange for a management fee calculated on a per patient day basis.

The management company would provide the medical director for each unit. Each medical director also might have a separate medical practice and might refer patients to the unit.

The OIG's specific concern was that a management fee computed on a per patient day or similar basis could encourage overutilization of services. □



# Revenue from doctors not UBI

by **Tim Snavely, St. Louis**

**T**he IRS has ruled that revenue received by a tax-exempt hospital from a program that uses physicians employed by a taxable subsidiary will not be taxable unrelated business income (UBI).

In PLR 200309031, the IRS ruled that revenue received by the hospital for services provided by the physicians is not income from unrelated trade or business under Section 513. This is because the income comes from an activity substantially related to the hospital's exempt purpose of promoting the health of residents in its service area.

## Ruling fact pattern

The IRS based its ruling on the following scenario:

- ▲ The hospital is an exempt

501(c)(3) community hospital

- ▲ The hospital is wholly controlled by its parent corporation, also a 501(c)(3) entity
- ▲ One of the parent's direct subsidiaries is a taxable corporation that has several taxable subsidiaries of its own
- ▲ One of the subsidiaries provides physician services

*Observation:* Many hospital-owned physician corporations were originally formed as taxable corporations because of certain restrictions relative to employee benefits for exempt entities, such as 401(k) plans.

- ▲ The hospital proposes to operate a provider-based clinic offering a broad range of services provided by physicians currently employed by the taxable subsidiary
- ▲ While some physicians will stop working for the subsidiary and become employees of the hospital, others will remain subsidiary employees, with the hospital paying the subsidiary an arm's-length fee for their services
- ▲ Under either arrangement,

doctors will accept patients regardless of their ability to pay and will be required to treat Medicare and Medicaid patients

- ▲ Total compensation for each doctor hired by the hospital will not exceed the customary

range for the geographic area they practice in or the branch of medicine practiced

\* \* \*

Contact your BKD Health Care Group advisor if you have questions about your own physician subsidiary. □

## Health Care News glossary

**APC** – Ambulatory payment classification

**BBA '97** – Balanced Budget Act of 1997

**BIPA** – Benefits Improvement and Protection Act of 2000

**CMS** – Centers for Medicare and Medicaid Services, formerly Health Care Financing Administration (HCFA)

**DME** – Durable medical equipment

**DRG** – Diagnosis-related group

**FI** – Fiscal intermediary

**FQHC** – Federally qualified health center

**HCPCS** – Healthcare Common Procedure Coding System

**HIPAA** – Health Insurance Portability and Accountability Act

**IRS** – Internal Revenue Service

**MDS** – Minimum data set

**OIG** – Office of Inspector General

**PHI** – Protected health information

**PPS** – Prospective payment system

**RHC** – Rural health clinic

**RUG** – Resource utilization group

**SNF** – Skilled nursing facility

# Proposed change in outlier payment determination

by **Tim Wolters, Springfield**

**C**MS has issued a proposed rule in the March 5, 2003, **Federal Register** to revise how outlier payments are computed.

Outlier payments provide additional reimbursement to hospitals for high-cost cases, typically with long lengths of stay. The additional reimbursement for a case is computed by multiplying charges for the patient by a cost-to-charge ratio (CCR), deducting the normal DRG payment and a "fixed-loss threshold" currently set at \$33,560.

The remaining unreimbursed cost is multiplied by a marginal cost factor of 80% to determine the final outlier payment.

CMS is concerned the CCRs used to estimate cost are several years old and may result in overestimating a hospital's costs for these cases.

The proposed rule would require use of updated CCRs to estimate the cost of outlier claims. These ratios would be taken from the latest cost report the intermediary has either tentatively or finally settled.

The statewide floor for CCRs

would be eliminated for those hospitals with extremely low ratios.

The proposed rule also includes a provision that intermediaries may reconcile outlier payments based on actual CCRs for the relevant cost report.

This provision is vaguely worded, in that it does not provide specific criteria to determine under what circumstances such reconciliation would occur. It also would be difficult to implement, as it would require reprocessing all claims during the cost-report period.

This provision would add

uncertainty to the process of determining final reimbursement for Medicare claims because hospitals would potentially not know until the cost report is settled whether claims would be reprocessed by their intermediary.

While these proposed changes would likely result in a reduction in outlier payments for most hospitals, CMS does not propose any change in the fixed-loss threshold to offset some of the lost reimbursement.

The rule would be effective for discharges on or after the effective date of the final rule. □



# Medicare bad debts: don't leave money on table

by Brian Hickman, Springfield

**M**edicare allows providers to claim coinsurance and deductible amounts as bad debts on year-end Medicare cost reports, but only if related documentation proves the amount could not be collected.

## When bad debt claims are allowable

Bad debt claims are allowable if they meet the following criteria:

- ▲ The debt must be related to covered services and derived from deductible and coinsurance amounts
- ▲ The provider must be able to prove collection efforts were reasonable and similar to those used to collect comparable non-Medicare accounts, e.g., timely issuance of initial

and subsequent bills and collection letters, telephone calls or personal contacts constituting a genuine, not token, collection effort; hiring a collection agency to recover delinquent non-Medicare accounts must also be a means of collecting Medicare deductible and coinsurance amounts

- ▲ The debt may be deemed uncollectible if it can be established the beneficiary is either indigent or medically indigent (providers can deem Medicare beneficiaries indigent or medically indigent if they also are determined eligible for Medicaid as needy individuals, either categorically or medically); otherwise, providers must maintain specific documentation proving the individual's indigence
- ▲ Sound business judgment concludes there is little likelihood of recovery
- ▲ The debt may be deemed uncollectible if reasonable and customary attempts have been made to collect payment, and the debt remains unpaid more than 120 days from the first bill's mailing to the beneficiary
- ▲ Medicare deductible or coinsurance amounts for Medicaid

recipients are not allowable as bad debts under Medicare if a state is obligated by statute or under the terms of its plan to pay all or any part of them; any portion of the amount the state is not obligated to pay can be included as a bad debt under Medicare provided the other requirements are met

- ▲ The provider's collection efforts should be documented in the patient's file by including copies of bills, follow-up reports, reports of telephone and personal contact, etc.

It is important to note Medicare will **not** reimburse coinsurance or deductible bad debts for services paid under charge-based fee schedules. This includes therapy and ambulance services, and most other services paid under Medicare Part B.

## Maintain adequate documentation

Recently, bad debts claimed on cost reports have been the focus of Medicare FIs engaged in

Medicare audits. Therefore, it's important providers maintain adequate documentation to support bad debt claims.

Unfortunately, providers often lose money on uncollected coinsurance and deductibles. This may be the result of inattention, misdirected collection attempts or

**...it's important providers maintain adequate documentation to support bad debt claims.**

because collection efforts for bad debts claimed on the Medicare cost report lack documentation.

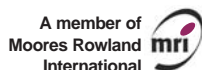
Cash flow is critical to the success of health care providers, especially in a period of Medicare and Medicaid reimbursement cuts. If your institution has proper billing and documentation procedures, eligible coinsurance or deductible amounts can be at least partially reimbursed through the Medicare cost report.

\* \* \*

Contact your BKD Health Care Group advisor for more information concerning Medicare bad debts. □



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