

## Medicare prescription drug act's impact on providers



by John Sheehan, St. Louis, & Tim Wolters, Springfield

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**P**resident Bush signed the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (the Act) on December 8, 2003.

While the legislation creates a Medicare prescription drug benefit, there also are significant provisions that affect Medicare reimbursement to providers.

Following is a summary of key provisions.

### Rural provisions

Rural provisions affecting both urban and rural hospitals include:

**Standardized amount** - Congress has twice eliminated the "other areas" standardized amounts, mandating that all hospitals be paid the "large urban" standardized amounts. The most recent such legislation is effective through March 31, 2004.

The Act makes this change permanent and eliminates the other areas standardized amounts. This provision generally increases reimbursement for all hospitals except those in an urban area with a population of more than one million.

In addition, the Act requires the portion of the standardized amount subjected to wage index adjustment to be limited to 62%

(vs. the present 71.1%) for any area

where the wage index is less than 1.0. Unchanged is the percentage for areas with wage indices of 1.0 or more.

This provision is effective for discharges on or after October 1, 2004, and generally increases reimbursement for rural hospitals in 43 states, based on the most recently published wage indices, and also for hospitals in many urban areas.

These two provisions are by far the largest provider payment enhancements in the Act.

**Disproportionate share hospital payment** - This is the Act's third most expensive provider payment provision, enhancing DSH payments available to all hospitals except urban hospitals with 100 or more beds (payments remain unchanged).

Effective for discharges on or after April 1, 2004, the Act replaces the 5.25% DSH cap that applies to urban hospitals under 100 beds and to rural hospitals.

The Act provides that all hospitals will be paid DSH amounts under the formula applicable to large urban hospitals, but caps the DSH adjustment at 12% for all hospitals except rural referral centers and large urban hospitals.

**CAH provisions** - The Act contains some significant expansions of the CAH program, a significant tightening of the conversion criteria in two years and some reimbursement improvements for CAHs.

**Revision of bed limitation** - Under previous law, CAHs were limited to 15 beds, 25 beds if they were approved as Medicare swing beds, but a CAH could never use more than 15 beds for acute inpatients.

The Act removes all references to 15 beds and establishes a limit of 25 total acute care beds. This eliminated on page 10. . .

For a more complete summary of the Act, visit the House Ways and Means Committee "Medicare Resource Kit" online. A link to their site is available at [www.bkd.com](http://www.bkd.com).

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# Intermediate sanctions require effective compliance process

by Tim Snavelly, St. Louis

**F**iduciaries of tax-exempt hospitals and other health care providers should review the organization's transactions for any problem areas, such as private inurement and excess benefits provided to insiders.

Otherwise, stewards of such organizations risk severe penalties, negative publicity and potential damage to the reputation of the organization.

## Overview

Personal liability is imposed on any organization insider, also known as a "disqualified person," who receives excess compensation or sells property at an inflated price to an exempt organization.

A disqualified person is an individual, such as an officer, director, trustee or key employee, in a position to exercise substantial influence over the affairs of an exempt organization.

A 25% penalty is assessed on the excess benefit, with an addi-

tional 200% penalty if the excess benefit is not corrected, *i.e.*, repaid to the organization, within a reasonable amount of time.

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

## IRS enforcement

A tax-exempt organization's tax return (Form 990) now requires an organization to indicate whether any excess benefit transactions have occurred during the tax year.

This, of course, assumes the organization has a process in place to identify these transactions.

To ensure compliance, the IRS has instructed its agents to closely review responses to the questions on Form 990 and has hinted additional questions will be developed to force organizations to review their compliance with the intermediate sanctions rules.

IRS audit examinations now include steps to identify transactions that would impose penalties.

## Develop risk-management program

To address the risks associated with intermediate sanctions, exempt organizations should consider:

- ▲ Educating board members and key employees
- ▲ Identifying insiders in the organization using definitions included in the Act
- ▲ Reviewing specific transactions and compensation arrangements
- ▲ Implementing a structure to comply with the rebuttable presumption of reasonableness

The rebuttable presumption of reasonableness is met if an independent board or a committee approved by the board has

approved the compensation or other payment to an insider before the organization makes payment.

The board or committee also must use appropriate and comparable data and adequately document its determination of reasonableness.

The key advantage to obtaining the presumption is that penalty taxes can be imposed only if the IRS develops "sufficient contrary evidence" to rebut the presump-

**A 25% penalty is assessed on the excess benefit, with an additional 200% penalty if the excess is not corrected. . .**

tion.

Therefore, as a practical matter, the IRS would likely have to invest considerable extra effort to impose the taxes.

## Take action

Tax-exempt health care organizations should implement and monitor an intermediate sanctions risk-management program.

At the very least, such a program would include annual education of board members, officers, key employees and managers affected by intermediate sanctions.

It also would include a process to take full advantage of the rebuttable presumption of reasonableness.

Contact your BKD Health Care Group advisor if you have questions or need assistance with your own program. □

# Psych PPS regulations released

by Susan M. Miller, Little Rock

**C**MS released proposed PPS rules for psychiatric hospitals and units in the November 28, 2003, **Federal Register**.

Implementation of the final rule is expected to be effective April 1, 2004, with a three-year transition period. However, the expected implementation date may be delayed, as well as an increase in the transition period.

The prospective payment for capital and operating costs is

expected to be made per-diem. The federal portion of the payment will be determined using each year's transition percentage applied to a base per-diem rate proposed to be \$530 and adjusted for:

- ▲ Patient's age, diagnosis and comorbidities
- ▲ Wage index for the geographic area, a 16% add-on if the facility is located in a rural area and an additional adjustment if the facility has indirect teaching costs
- ▲ Higher per-diem payments for

initial higher cost days of a patient's stay

- ▲ Outlier adjustments for higher cost cases

A copy of the psych PPS preliminary rule from the November 28, 2003, **Federal Register** can be downloaded from:

<http://www.bkd.com.access.gpo.gov/nara/index.html>

For more information, contact your BKD Health Care Group advisor. □

# Corporate integrity: audit committee's role

by Phil Brummel, Kansas City

**C**orporate America continues to reel from the aftermath of scandal and the consequent demands for public redress and accountability.

While publicly held companies were the first to feel the effects of these issues, other companies are beginning to respond to the changing environment.

Because many health care organizations are structured as not-for-profit entities, the industry has yet to be directly affected by new mandates from the Securities and Exchange Commission (SEC), the Government Accounting Office (GAO) and requirements of the *Sarbanes-Oxley Act of 2002*.

However, it may be time for health care organizations and their boards of directors to be proactive and consider the important benefits of forming an audit committee.

Boards of directors have a fiduciary responsibility to oversee management and to set policy and strategy for an organization, including oversight of finances and reporting to stakeholders.

An effective means to improve the level of oversight is to organize the services of an audit committee.

## Oversight & assurance

Audit committees have responsibilities in two primary areas: financial reporting and corporate governance.

In financial reporting, an audit committee:

- ▲ Recommends the appointment of the external auditor
- ▲ Reviews and approves the scope of the financial statement audit
- ▲ Reviews and approves

accounting policies

- ▲ Reviews audit results with the auditor, including the management letter and internal control issues

- ▲ Assesses audit report's disclosures for completeness

In corporate governance, the committee makes sure the organization:

- ▲ Operates in compliance with laws and regulations
- ▲ Follows the corporate code of conduct
- ▲ Maintains adequate controls against conflict of interest and fraud

To accomplish these goals, it's important for members of the audit committee to have a strong background in financial matters as

well as a good understanding of the industry.

## Defines structure

The audit committee charter outlines the authority, responsibilities and structure of the committee and also can delineate the size, meeting schedule and goals of the oversight body.

## Monitors compliance & sets policy

Most health care organizations currently operate under the guidance of an RCP.

The RCP outlines the organization's goal to operate lawfully, in accordance with an established code of conduct.

An active audit committee can further this goal by monitoring activities of the organization's compliance function as well as setting policy.

## Encourages appropriate code of conduct

An audit committee can help encourage and support your organization's code of conduct and appropriate financial reporting and sends the message your organization will always "do the right thing."

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Contact your BKD Health Care Group advisor for information about forming an audit committee. □

# HUD 242 & capital financing

by Tom Watson, Little Rock

**M**any hospitals need to replace or significantly update their facilities in a time when financial performance has suffered because of BBA '97 and other pressures.

The needed level of capital financing combined with historical financial performance has made it almost impossible for some hospitals to obtain traditional financing at reasonable rates.

The HUD 242 Mortgage Program has allowed many hospitals to secure funding for significant capital improvements at rates approaching A-rated credit.

However, the process to obtain this funding has been rather tedious, especially in non-certificate of need (CON) states.

The *Hospital Insurance Act of 2003* (the Act) became law in October, removing the requirement that HUD involve state agencies in determining the need for a hospital in a non-CON state.

While this new law does not necessarily remove the requirement for a feasibility study, it does potentially simplify the process and could reduce the time needed to obtain HUD approval.

In addition, the Act also expands the availability of HUD

242 financing for CAHs, especially those with significant nonacute care inpatient utilization.

Hospitals unable to obtain traditional financing at reasonable rates should view HUD 242 financing as a viable option, especially in light of the Act.

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BKD has helped numerous clients with HUD 242 and traditional financings, including feasibility studies, financial advisory services and other financing matters. Contact your BKD Health Care Group advisor for more information. □

# Pros & cons of wireless

by Paul Doelling, St. Louis

Until recently, information technology (IT) successes have been limited to hospitals and large group practices, primarily because of

costs and the complexity of the technology.

However, today's more affordable IT products and systems are easier for many physicians to purchase and use, especially the wireless or mobile variety.

Following are some of the pros and cons of mobile technology in the current physician's practice.

## What is a wireless network?

Primarily, a wireless network is

a line of communication between one computer device and another through the medium of electromagnetic radiation.

Wireless networks are prevalent in the form of cellular phones, satellites and personal

## Proposed changes to inpatient rehabilitation facility classification

by John Britt & Nicole Bierman, Louisville

In the past year, CMS published proposed regulations about the classification of IRF, which will apply to both freestanding IRFs and those considered distinct part units.

The proposed regulation involves the 75% rule, a key topic in 2003 for CMS and the rehabilitation industry.

To qualify as an IRF, providers have had a long-standing requirement to prove 75% of their patients fall into these condition categories:

- ▲ Stroke
- ▲ Spinal cord injury
- ▲ Congenital deformity
- ▲ Amputation
- ▲ Major multiple trauma
- ▲ Hip fracture
- ▲ Brain injury
- ▲ Polyarthritis
- ▲ Neurological disorders
- ▲ Burns

In 2002, CMS learned FIs were inconsistent in their methods of evaluating an IRF's compliance with the regulations. In June 2002, CMS suspended the requirement until further notice.

Since then, CMS has researched the issue and has solicited public comments. The chart to the right compares provisions of the proposed rule to those of the current rule.

The proposed rule's comment

period ran through November 3, 2003, and the final rule is to be published after that date. The proposed rule applies for cost-reporting periods beginning on or after January 1, 2004, and has a provision to return to the 75% threshold in 2007.

## Implications for providers

In the past, some providers have interpreted the polyarthritis category in a manner too vague to classify a number of patients under this condition.

Now, providers will have to meet more highly defined arthritis conditions. The change to this portion of the rule may have a significant impact on providers that have relied heavily on their orthopedic population.

Even though some patients may no longer qualify within the 65% rule, they may still need those therapy services.

Providers should reassess their therapy resources across all levels of care, *e.g.*, outpatient, home health, swingbed or SNF, and begin to plan how they will meet their patients' needs. Both a revenue and cost analysis should be done.

Patient access to the correct care intensity and mix of therapy services is a process that's central to the discharge planner's role.

Consequently, discharge planners should be included and educated about the strategy and admission criteria defined by the provider.

The 65% rule should be monitored and managed daily. On any given day, providers should know where their facility is in relationship to the rule. This prevents surprises at the end of the year and allows the admissions team to appropriately regulate referrals that fall outside the 65% rule.

Given the importance of the primary and secondary diagnoses,

providers should ensure qualified coding personnel are involved in the coding and PAI process.

Physicians who routinely admit to an IRF should be educated to attend to the relationship of the diagnosis or diagnoses and the need for inpatient rehab services in their history and physical and subsequent documentation.

Providers should keep their fingers on the pulse of the IRF classification rule. If finalized as is, many IRFs may have to make significant changes to comply. □

## Proposed Rule Compared to Current Rule

Current	Proposed
▲ 75% of the patient population must be within the specified conditions	▲ 65% of the patient populations must be within the specified conditions
▲ There is no consideration for secondary diagnoses in terms of meeting the 75% rules	▲ Under certain parameters, a comorbidity (secondary diagnosis) may be included in the inpatient population that counts toward the 65% rule
▲ The 75% rule applies to all patients (Medicare and others)	▲ Establishes an administrative presumption that if the population of Medicare patients meet the 65% requirement, the total population meets the requirement
▲ Polyarthritis is one of the 10 conditions	▲ Polyarthritis is replaced with defined arthritis conditions. These conditions stipulate, however, that: <ul style="list-style-type: none"><li>✓ Very specific impairments must be present</li><li>✓ A less intensive course of therapy services, <i>e.g.</i>, outpatient therapy must precede the IRF admission</li></ul>

# networks for physicians

digital assistants (PDAs).

So, why would businesses and physician practices want or need wireless technology?

- ▲ Easier connectivity if access to multiple locations is required
- ▲ Mobility of users within a facility
- ▲ Cable is too expensive or difficult to install
- ▲ Wiring is not physically possible
- ▲ Remote connectivity required with the office

Many physicians that use mobile technology today do so because of the benefits it provides, including:

- ▲ More efficient capture of charges from remote locations, such as hospitals, nursing homes, etc.
- ▲ Faster bill processing
- ▲ Decreased administrative costs
- ▲ Improved efficiency performing patient rounds
- ▲ Increased quality of patient care

Currently, approximately 1% of physicians are on wireless networks. By 2004, it's predicted 20% of physicians will be wireless.

According to several technology surveys, "Physicians are continuing to integrate technology into daily routine." (**Manhattan Research**, May 2003.)

## Weigh benefits & risks

With increased Internet use, the development of wireless technology and the advances in computing devices, smaller practices now have options for deploying sophisticated technology.

This technology couldn't have come at a better time for physicians who are under more financial pressure from increased malprac-

tice premiums and decreasing reimbursement.

However, the proper assessment of the risks or disadvantages must be weighed to realize the incremental benefit available through mobile technology.

As with any new technology, it is advisable to evaluate the other side of the coin:

- ▲ Increased security risks
- ▲ Additional compliance with HIPAA privacy and security regulations
- ▲ No qualified technical support staff to handle wireless network
- ▲ Signal interference possibilities
- ▲ Increased possibility of hackers getting into computer system and database

One of the most classic wireless "hacked" systems occurred in New York in 2001. Technology experts identified 61 access points, or open wireless ports, in offices over six blocks away and also could enter the network very easily.

This technique, called "war driving," uses special software that searches for wireless networks to access.

There are many hacking tools and attacks that enable unauthorized persons to enter into a wireless network without any detection, primarily because of the software's lack of proper configuration to detect and prevent unauthorized entry.

Other security issues include:

- ▲ Theft or loss of mobile equipment
- ▲ Network stagnation, where updates are not applied to the network
- ▲ Improper security protocol on the home user or mobile device

- ▲ Inadequate physical controls

## HIPAA privacy concerns

Health care providers are mandated to implement measures to protect the privacy and confidentiality of protected health information of every patient per HIPAA privacy and security regulations.

Mobile technology requires additional security measures not



only to comply with HIPAA but also to protect the integrity of patient data.

Though identity theft is one of the fastest growing crimes today, some providers underestimate the need to establish an information security system.

If someone wants to steal an individual's identity, accessing mobile or wireless networks is one of the easiest methods.

Security experts recommend using "best practices" with mobile technology, including:

- ▲ Plan and prepare for the mobile network
- ▲ Be sure the equipment meets your security requirements
- ▲ Ensure secure communications with remote locations
- ▲ Install internet firewall software
- ▲ Close ports if not needed
- ▲ Perform internal and external penetration testing

- ▲ Monitor the activity and perform formal assessments
- ▲ Enforce security policies and procedures

Mobile technology can improve a physician practice's efficiency in many ways, but it should not compromise the integrity or confidentiality of patient data.

Wireless networks will continue to become more commonplace. It's important to consider the pros and cons before implementing any wireless network.

Be sure you are not compromising your ability to secure electronic patient data. Who wants to be the first HIPAA test case?

BKD can help. Contact your BKD Technologies or BKD

Forensics & Dispute division advisor for more information about wireless networks and risk prevention. □

## Part 2: Revenue cycle processes

# Improving cash flow

by Angela Morelock, Springfield

**A** health care provider's coding for an encounter must match the information in their notes.

However, many health centers experience differences between the actual documented visit notes and the encounter form, such as:

- ▲ 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

Reimbursement may be lost if you have a high claims-denial rate because diagnoses do not meet medical necessity and/or fail to

identify procedures performed (provider did not indicate the service on the encounter form).

Consistently inaccurate coding of patient diagnoses (proper diagnostic codes omitted on the encounter form) also may result in inappropriate reimbursement.

### Documentation is critical

The gap between coding and reimbursement is in the provider's documentation. To bridge this gap, personnel knowledgeable in encounter coding and billing should periodically review a sample of provider visit notes and compare them to encounter forms.

Use the information from this review to provide communication

and training on coding and billing issues.

Statistics are gathered from health care databases and case-mix indexes are derived from this data for specific geographical areas.

Physicians often use this information to choose locations in which to work and live. Insurance companies use this information to identify which providers they will choose to contract with.

The importance of accurate coding goes well beyond the desks of the personnel responsible for encounter coding and billing.

The encounter form is a tool to assist in different functions throughout 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 services billed.

Education of a health center's coding and billing staff in proper coding and billing of services based on the provider's notes, the encounter form and other supporting documentation is critical.

### Charges: get them all

Implementing a review process within a health center, or using outside assistance, is a step **continued on page 12 . . .**

## In brief

**SNFs required to report additional data** – Free-standing and hospital-based SNF payment rates were increased October 1, 2003, by 3% as a market basket increase, plus 3.26% to correct for forecasting errors made since 1998. Congress expects the additional funds provided by this 3.26% increase should be used for direct patient care and related expenses.

In response to this, CMS recently issued transmittals modifying the SNF and hospital cost-report forms to collect data on how funds provided by the increase in rates are actually spent. The transmittals are effective for cost-reporting periods beginning on or after October 1, 2003.

Providers should be prepared to identify where

increased costs have been incurred, and the amount of such costs, in staffing, recruitment, employee retention, training and other areas.

**Revised rates published** – CMS published revised SNF PPS rates September 29 and revised hospital rates October 6. The revised rates, effective October 1, 2003, incorporate corrections to the hospital wage index and various other technical errors.

Hospital rates for rural and small urban areas also were revised effective November 1, 2003, to incorporate recent legislation temporarily equalizing the national operating DRG rates for large urban and all other areas. Rates for all other areas will be increased through March 31, 2004, under current legislation.

**Revised occupational mix**

**survey proposed** – CMS published a revised hospital occupational mix survey September 19, 2003, with a 30-day comment period. CMS is required to collect this data to incorporate into wage index values effective October 1, 2004.

The revised survey would only collect data for seven major employee categories and 19 sub-categories, such as registered nurses, physical therapists, etc. When finalized, hospitals other than CAHs are likely to have 30 days to complete the survey and return it to their intermediary.

**Hospital outpatient and physician payment rates published** – CMS published 2004 hospital outpatient payment rates in the November 7, 2003, **Federal Register**. The rates are expected to result in a 4.5% average increase in reimbursement for

hospitals, before considering the expiration of hold harmless/transitional corridor reimbursement that was scheduled to occur December 31, 2003.

CMS also published 2004 physician payment rates in the November 7, 2003, **Federal Register**. Under the required methodology, CMS will update physician payment rates, which were scheduled to decrease by approximately 4.5% if not altered by additional legislative action.

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For more information about changes in inpatient, outpatient and physician payment rates, see the separate page 1 recap of provisions of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*. □

# Disbursements: How does your cash leave your company?

by John Sherrick, Springfield

## The Association of Certified Fraud Examiner's 2002 Report to the Nation

found more than 70% of the study's cash frauds are fraudulent disbursement schemes, which also are the most costly, with a median loss of \$100,000 per incident.

Under normal circumstances, the disbursement process represents the most common path for cash to exit an organization, making it more vulnerable to fraud.

Having investigated a number of fraudulent disbursement schemes for health care organizations, BKD believes in the old adage, "an ounce of prevention is worth a pound of cure."

The typical scheme lasts 18 to 24 months before detection, giving the "fraudster" time to inflict serious financial damage to a company before it has a chance to react.

## Billing schemes abound

Fraudulent disbursements are most often perpetrated through a billing scheme. BKD has investigated cases where employees have processed fraudulent invoices through their employer's accounts payable system.

The accounts payable area issues a check for the fake invoice, and the culprit diverts the payment for his/her own personal use. False invoices are often based on:

- ▲ Fictitious goods or services
- ▲ Overpriced goods or services
- ▲ Personal items

## Spot red flags

Fraudsters are always looking for opportunities and will compromise internal controls without hesitation. Be on the alert for red

flags that may be related to billing schemes, including:

- ▲ Lack of segregated duties in purchasing functions
- ▲ Unexpected increases in expenses, especially service-related expenses where no tangible goods exist
- ▲ Payment to unknown vendors
- ▲ Insufficient detail on vendor invoices such as the vendor's address, phone number and description of purchase
- ▲ Duplicate payments to a vendor could indicate an employee is rerunning invoices
- ▲ Unauthorized changes to vendor files could indicate that an employee is misdirecting disbursements

## Tips for fraud-prevention

Deterrence and prevention

are a company's best weapons to combat fraud, including:

- ▲ Segregate duties, including the segregation of purchasing, approval of purchases, receipt of goods and cash disbursement processes
- ▲ Independently verify purchases to prevent the acquisition of fictitious goods or services
- ▲ Review vendor purchases periodically and analyze for abnormal prices and quantities
- ▲ Independently verify receipt of goods to reduce the chances of non-existent items being purchased
- ▲ Match purchase orders, receiving reports and invoices before liability is recorded and paid

- ▲ Make sure liability recorder is independent of the purchasing function to prevent false entries that could conceal a fraudulent scheme
- ▲ Establish a control mechanism to check for duplicate invoices and purchase order numbers
- ▲ Maintain an approved vendor list and periodically review additions and modifications to vendors and addresses



Contact your BKD Health Care Group or Forensics & Dispute Consulting advisor for more information about preventing fraudulent employee disbursement schemes in your organization. □

## Health Care News glossary

**APC** – Ambulatory payment classification

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

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

**CAH** – Critical access hospital

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

**DME** – Durable medical equipment

**DPU** – Distinct part unit

**DRG** – Diagnosis-related group

**DSH** – Disproportionate share hospital

**FI** – Fiscal intermediary

**FQHC** – Federally qualified health center

**HCPCS** – Healthcare Common Procedure Coding System

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

**IRF** – Inpatient rehabilitation facilities

**IRS** – Internal Revenue Service

**MDS** – Minimum data set

**OIG** – Office of Inspector General

**PAI** – Patient assessment instrument

**PHI** – Protected health information

**PIP** – Periodic interim payment

**PPS** – Prospective payment system

**QRA** – Qualified rural areas

**RCP** – Regulatory compliance program

**RHC** – Rural health clinic

**RL** – Rehab low

**RUG** – Resource utilization group

**SCH** – Sole community hospital

**SNF** – Skilled nursing facility

**TCS** – Transaction and code set



## Knock, knock. Who's there? OIG...

by Joe Watt, Kansas City

OIG released its **2004 Work Plan**, which to no one's surprise, has targeted a long list of areas for review in the coming year.

OIG's objective is to evaluate vulnerable areas in the programs provided through the three major entities of the Department of Health and Human Services (HHS): CMS; the public health agencies; and the Administrations for Children, Families, and Aging.

The **2004 Work Plan** is a health care provider's first notice of what's on OIG's radar screen. It should prompt providers to investigate internally the areas listed as part of OIG's compliance-program activities.

The following review of the **2004 Work Plan** focuses on hospital providers; however, it addresses many other types of providers in Medicare.

Some targeted areas should be reviewed by providers if they are applicable to the providers' business:

- ▲ Inpatient capital payments will be reviewed for accuracy and the appropriateness of the CMS process for updating the capital rates. In addition, capital payments will be reviewed to see if hospitals have used the capital payments for their intended purpose.
- ▲ Inpatient PPS rate elements will be examined; factors included in the market basket updates will be analyzed to see if the updates adequately cover the elements of the PPS and represent fair increases in Medicare rates.
- ▲ Outlier payments for inpatient services will continue to be

reviewed, and OIG will determine if the payments were submitted in accordance with Medicare laws and regulations. In addition, OIG will review if the program has vulnerabilities in the current reimbursement policies for outlier payments, including the mechanisms used to establish the outlier threshold.

- ▲ A study will be conducted on long-term care hospitals operating as "hospitals-within-hospitals" to evaluate if they meet Medicare's requirements to retain a PPS-exempt status.
- ▲ Consecutive inpatient stays will be evaluated where Medicare beneficiaries received acute and postacute care through sequential stays at different hospitals.
- ▲ Medical necessity continues to be an OIG target that has had problems in the past. This year, OIG is focused on two areas:
  - Inpatient psychiatric stays will be reviewed to determine if any of the improper payments for the stays were due to medical necessity or coverage issues. PPS-exempt psychiatric units and specialty hospitals received more than \$2.8 billion for Medicare inpatient stays in 2000.
- ▲ CAH cost reports will be reviewed to determine if home-office costs and related party transactions were properly allocated and treated in accordance with Medicare requirements.
- ▲ To be assessed are DRG payment limits to hospitals by Medicare contractors for patients discharged from a PPS inpatient hospital and admitted to one of several post-acute-care settings. This limitation applies to certain DRGs.
- ▲ An update on DRG coding will examine DRGs that have a history of aberrant coding to determine whether some acute hospitals exhibit aberrant coding patterns. The PPS, or DRGs, for inpatient acute care depends on accurate coding of diagnoses and procedures. Inaccurate coding by hospitals can lead to Medicare overpayments.

- ▲ Diagnostic tests performed in the emergency room will be reviewed, and an assessment of the appropriateness of Medicare billings for these services will be determined. In addition, a determination will be made about medical necessity and whether the tests were interpreted contemporaneously with the beneficiary's treatment.
- ▲ Outpatient PPS payments will be reviewed to determine if the payments are in accordance with Medicare laws and regulations. OIG intends to review several aspects of the payment system, including multiple procedures performed during a single encounter and transitional pass-through payments.

In addition to the activities with hospitals, the **2004 Work Plan** also addresses issues related to home health agencies, nursing homes, physicians, medical equipment, drug reimbursement and many others.

As stated, providers should review the **2004 Work Plan** and evaluate the issues on OIG's radar screen internally before they are looked at by an outside regulator.

A copy of OIG's **2004 Work Plan** is available at <http://oig.hhs.gov/publications/workplan.htm>. □

## HIPAA-compliant electronic

by Rod Walsh, BKD Technologies, Kansas City

**C**ompliance with the TCS regulation for HIPAA was required by October 16, 2003. On September 23, 2003, CMS implemented its contingency plan. This article covers the plan and what actions to take.

If you are one of the many providers, clearinghouses or pay-

ers that was not ready for the TCS deadline, then you probably heaved a sigh of relief when CMS invoked its contingency plan.

The plan states Medicare will continue to accept and send standard and nonstandard versions and/or formats for any electronic transaction for a limited period beyond October 16, 2003. This is a temporary measure to maintain

provider cash flow and reduce operational disruption, while trading partners who are not compliant on October 16, 2003, work with Medicare to achieve full compliance. Blue Cross and Blue Shield, as well as many other payers, have implemented similar contingency plans.

The contingency is for a limited time. It is important you con-

# SNF therapy key issues

by Derek Hunter, Springfield

**T**he Part B therapy caps have been a “political yo-yo” for several years.

They went back into effect September 1, 2003, but were suspended again as part of the recently passed *Medicare Prescription Drug, Improvement and Modernization Act of 2003*, which will

## The calculation of the cap is based on charges at fee screen amounts, before deducting coinsurance or deductibles.

suspend the Part B therapy caps for 2004 and 2005.

This article addresses key issues while the Part B therapy caps were in place.

The cap limits Medicare coverage of therapies provided by SNFs, or rehabilitation agencies under Part B, to \$1,590 for occupational therapy (OT) and \$1,590 for physical therapy (PT) and speech pathology (SP) combined.

The calculation of the cap is based on charges at fee screen

amounts before deducting coinsurance deductibles.

SNFs or agencies that provide services greater than \$1,590 in therapy must collect the excess charges from the patient. Medicare will pay nothing toward the services.

Because many of the patients who receive therapies are Medicaid patients, and because many state Medicaid programs do not pay amounts beyond the normal daily per diem rates, there won't be funds available for such services. (You can collect from private-pay patients.)

The \$1,590 caps applied to services rendered September 1, 2003, through December 7, 2003.

## How to meet patient needs

One key way to meet the therapy needs of a SNF patient is the use of the rehab low (RL) Part A RUGs classes for your facility's restorative services.

Providing restorative services in the RL classes will

enable the facility to serve the patients therapy needs more completely under Part A before providing therapy under Part B.

Lengthening the Part A stay, and better meeting the therapy needs of the patient, is a win-win for the patient and the facility.

Many SNFs give the restorative nursing services but do not properly claim credit for it under Part A. These issues are important whether the Part B therapy caps are in place or suspended.

The minimum requirements for placing a patient into the RL RUG-III category is “Nurse rehabilitation at least six days per week plus two activities; therapy treatment at least three days per week 45 minutes per week.”

The patients that usually qualify for the RL groups are those receiving rehab therapy at a high-

## Properly used, the RL category also will increase the average length of stay for Part A patients.

er level, *i.e.*, rehab high, rehab very high, etc., and historically may have been discharged from Part A but continue receiving intermittent rehab therapy services under Medicare Part B.

Patients that require a few weeks of rehab/restorative nursing services after extensive therapy services have ended are good candidates for RL services. Properly used, the RL category will increase the average length of stay for Part A patients.

## Guide RL Services

We suggest the rehab therapy provider guide the RL services. The contracted therapist develops the plan of care for the RL services, the nursing department provides

the two separate modalities per day at least six days per week.

The nursing staff should be documenting the treatments on a service log similar to the one used by the therapists, to remain consistent in documentation.

Any nurse or nursing assistant can provide the nursing component of RL services if he/she has been specifically trained to perform those restorative therapy activities as discussed.

The registered therapist must see the RL patient at least three times weekly to determine if the rehab nursing program is effective and also to do return demonstration activities.

Any measuring or testing that is required to determine the effectiveness of the rehab-nursing program is performed during the three weekly visits.

For example, the St. Louis, Missouri, metropolitan statistical area Part A payment rates for the two RL categories are as follows:

RLB	\$248.85
RLA	\$209.17

Contact your BKD Health Care Group advisor for help with these key SNF therapy issues. □

## transactions

continue to take action to submit your electronic transactions in the HIPAA-compliant formats for several reasons:

- ▲ To be prepared when the Medicare and other compliant payers discontinue their contingency plans
- ▲ To reduce the affect on cash flow when contingency plans are lifted

- ▲ To prove you have demonstrated continued “good faith efforts” to comply, should complaints be made against your entity

At press time, there was no word from CMS about how long the contingency will be in effect. □

# Medicare prescription

...continued from page 1  
inates the requirement for swing-bed certification and allows a CAH to have up to 25 acute inpatients.

The elimination of the 15 acute patient limit will open the program to somewhat larger facilities and make managing patient care less complex for the busier existing CAHs.

**Enabling CAH DPUs** - The Act also permits CAHs to operate rehabilitation and psychiatric DPUs, effective for cost-reporting periods beginning on or after October 1, 2004.

The CAH is limited to 10 such DPU beds, and such beds are in addition to the 25 acute-bed limitation.

There are no special criteria or reimbursement provisions applicable to such CAH-operated units. The CAH-operated DPUs must meet criteria applicable to such units that are part of an acute care hospital, and Medicare will reimburse the DPUs under PPS applicable to such units.

**Eliminating necessary provider exception** - Under previous law, criteria for CAH certification required a hospital to be 35 miles from any other hospital, 15 miles in mountainous terrain or areas with only secondary roads **or to be state certified as a necessary provider**.

The Act eliminates the necessary provider provision for facilities certified as CAHs January 1, 2006, but has no effect on CAHs certified before that date.

For many states and areas of the country this means there will likely be no additional CAH conversions after January 1, 2006.

Hospitals for which the pres-

ent CAH reimbursement benefit is marginal will have a difficult decision in the next two years.

**Reimbursement improvements** - Effective for cost-reporting periods beginning on or after January 1, 2004, CAH reimbursements will increase from 100% to 101% of Medicare's defined reasonable costs.

Previous legislation gave CAHs the billing and reimbursement option of sending the FI one inclu-

## The outpatient PPS hold harmless provision that protected rural hospitals of 100 beds or less was due to expire January 1, 2004, but the Act extends it to January 1, 2006.

sive bill for outpatient facility services and professional fees.

Medicare reimburses the billings on a cost basis for facility services and 115% of the applicable fee schedule for professional services.

CMS requires that to elect this optional methodology, the CAH must use it for all outpatient services to Medicare beneficiaries, effectively requiring all physicians and practitioners providing services to the CAH's outpatients to assign their billing rights to the CAH.

The Act prohibits CMS from continuing to require this "all or nothing" criteria. Thus, the CAH could elect this method for emergency room physicians and increase existing professional fee payments by 15%.

The change is effective for cost-reporting periods beginning on or after July 1, 2004, unless the election was made before November 1, 2003, in which case the effective date is cost-reporting periods beginning on or after July 1, 2001.

CAHs are required to make available 24-hour emergency care.

This can be met by having physicians or certain other practitioners on standby within the facility or on-call.

On-call cost for other practitioners (physician assistants, clinical nurse specialists and nurse practitioners) is an allowable cost for services furnished on or after January 1, 2005.

**Permitting periodic interim payments** - The Act adds CAH inpatient services to the list of services specifically allowed to be paid under the PIP methodology effective July 1, 2004.

## Other rural provisions affecting hospital/ambulance reimbursement

### Inpatient payment adjustment for low-volume hospitals -

Roughly following a MedPAC recommendation, the Act creates a new payment adjustment for low-volume hospitals (non-CAHs located more than 25 miles from another hospital, with fewer than 800 acute discharges).

CMS will determine the adjustment, effective for discharges on or after October 1, 2004.

CMS is to study the relationship between the standardized cost-per-case and number of acute discharges for such hospitals.

Based on the relationship between incremental cost-per-case and volume of discharges, CMS is to develop a percentage add-on methodology. The add-on cannot exceed 25%.

**Changes to area wage index classification** - Two provisions affect the determination of hospitals' area wage indices:

▲ Effective for three years beginning with discharges on October 1, 2004, CMS will establish a wage index adjustment process to increase the

wage index of all hospitals in a county if significant out-migration of county residents to work at hospitals in higher wage index areas occurs; adjustment to be based on percentage of out-migration and the differences between the wage indices in other areas.

▲ CMS to establish a process by January 1, 2004, for hospitals not qualified for wage index reclassification to appeal present classifications by February 15, 2004; with no further administrative or judicial review, MGCRB will decide which reclassifications to grant under this one-time process, effective for three years beginning with discharges on April 1, 2004. Expenditures under this provision are limited to \$900 million.

### Extension & expansion of outpatient hold harmless -

The outpatient PPS hold harmless provision that protected rural hospitals of 100 beds or less was due to expire January 1, 2004, but the Act extends it to January 1, 2006.

In addition, it extends this provision to all rural SCHs with more than 100 beds. In an apparent drafting error, the bill specifies the expansion to larger SCHs is effective for cost-reporting periods beginning on or after January 1, 2004.

Thus, a large SCH with a June 30 fiscal year end might have the benefit of the outpatient hold harmless for only 18 months, from July 1, 2004, through December 31, 2005.

The Act also requires CMS to study whether costs incurred by rural hospitals under the outpatient PPS are higher than costs incurred by urban hospitals, and if so, to provide an appropriate rural payment adjustment by January 1, 2006.

**Ambulance & laboratory reimbursement** - CMS is direct-

# drug act's impact. . .

ed to identify qualified rural areas (QRAs) based on population density. Those areas with the lowest population density will receive an increase in the ambulance fee schedule base rate, to the extent the average cost per trip in these areas exceeds the cost in areas with the highest density.

The increase will apply for services furnished from July 1, 2004, through December 31, 2009.

QRA hospitals with fewer than 50 beds will receive cost reimbursement for outpatient laboratory services for two years beginning on or after July 1, 2004.

## Other provisions

**Provider overpayments** - If an overpayment causes a hardship on a provider (defined as an overpayment exceeding 10% of the amount paid to the provider during the year), the provider can request an extended repayment plan of at least six months but no more than three years.

In cases of extreme hardship, as determined by CMS, the repayment plan can last five years. Interest will accrue on all overpayments.

## Hospital payment updates -

The inpatient hospital payment update will be reduced by 0.4% for federal fiscal years 2005 through 2007 for hospitals that do not submit quality data to CMS.

The quality data consists of a set of 10 indicators established by CMS as of November 1, 2003. The data will be due in a form and manner and at a time to be specified by CMS.

## Medical education reimbursement

- The present indirect medical education reimbursement factor of 1.35 is increased to 1.47 from April 1 to September 30, 2004. The factor is reduced thereafter to a low point of 1.32, return-

ing to 1.35 as of October 1, 2007.

For graduate medical education (GME) programs with rates more than 140% of the locality-adjusted national rate, no inflation update will apply from 2004 through 2013.

Effective July 1, 2005, for the limitation on the number of GME residents, CMS is to reduce the cap on hospitals with fewer than the maximum number of residents, except for rural hospitals with fewer than 250 beds.

Such excess resident positions can then be redistributed to hospitals that apply, with a priority given to small and rural hospitals.

The Act clarifies congressional intent to allow an exception to the initial residency periods for approved geriatric training programs for periods beginning on or after October 1, 2003.

During 2004, the Act prevents CMS from changing treatment of volunteer services provided by teaching physicians in nonhospital locations for programs in existence on January 1, 2002. OIG is to study the issue and report to Congress within one year.

## Physician/therapy fee schedule changes

- CMS recently published a final rule to reduce 2004 physician fee schedule payments by 4.5% and provides that the payment update for 2004 and 2005 will increase at least 1.5% from 2003 rates, including the rates used to establish the Part B therapy fee schedule.

Also established is a floor of 1.0 on the work geographic index for 2004 through 2006, improving the incentive payment program for physician-scarcity areas.

**Specialty hospitals** - The

“whole hospital” exception to the Stark Law is suspended for 18 months from enactment for specialty hospitals that primarily or exclusively engage in treatment of cardiac, orthopedic, surgical or some similar specialized category of patients.

Specialty hospitals in existence or under development as of November 18, 2003, are grandfathered under the existing exception, unless the hospital adds additional physician investors or changes its services after that date.

## Moratorium on therapy caps

- The Part B therapy caps moratorium expired September 1, 2003. The Act reinstates the moratorium on the caps from the date of enactment through December 31, 2005.

CMS is required to submit several reports to Congress by March 31, 2004, related to alternatives to the cap and utilization patterns for

## The Act suspends the requirement to submit outcome and assessment information set data for non-Medicare and non-Medicaid patients. . .

outpatient therapy.

## SNF consolidated billing

**exclusions for RHCs & FQHCs** - Effective January 1, 2005, RHC and FQHC services are excluded from the SNF PPS consolidated billing requirements, to the extent such services would be excluded if provided by an individual not affiliated with an RHC or FQHC.

## Information on SNFs in hospital discharge plans

- CMS is to make available to hospital discharge planners information to identify SNFs participating in Medicare.

Within six months of the avail-

ability of such information, hospitals are to include information about SNFs in the service area in discharge plans for individuals likely to need SNF services.

## Home health changes

- For home health episodes and visits ending on or after April 1, 2004, and before April 1, 2005, reimbursement rates for services furnished in a rural area are increased by 5%.

Otherwise, reimbursement rates are reduced by 0.8% from April 1 through December 31, 2004, and rates are increased by the market basket minus 0.8% for each of 2005 and 2006.

The Act suspends the requirement to submit outcome and assessment information set data for non-Medicare and non-Medicaid patients until CMS issues a study of how such data can be used, and the value of collecting such data by small agencies compared to the burden related to such collection.

## Ambulatory surgery & outpatient laboratory fee schedules

- From April 1 through September 30, 2004, the ambulatory surgery center fee schedule will be updated by the consumer price index minus 3%.

From October 1, 2004, through December 31, 2009, the fee schedule is frozen. CMS is required to implement a new ambulatory surgery center fee schedule during 2006 or 2007.

The outpatient laboratory fee schedule is frozen from October 1, 2003, through September 30, 2008.

\* \* \*

The Act contains numerous other provisions affecting providers. Contact your BKD Health Care Group advisor for information on how the Act will affect your operations. □

# Improving cash flow. . .

. . .continued from page 6 toward compliance and indicates to oversight agencies, such as OIG, that a health center is attempting to bill appropriately.

One goal for all health centers is to obtain payment as quickly as possible. Designing a process to review and monitor coding and billing compared to the provider's notes should improve the quality and accuracy of coding, allowing the billing process to work more efficiently. Clean claims mean better cash flow.

Health centers can't bill for services that aren't documented or where documentation is lost. Providers should be trained to fully complete fee tickets and record appropriate levels of services.

Without training, providers often tend to undercode, resulting in lost revenue to the health center. Fee tickets must be carefully accounted for and charges posted in a timely manner.

Lost fee tickets is a common problem that results in missed revenue opportunities. Number fee tickets and evaluate numerical sequence on at least a weekly, if not daily, basis.

To facilitate timely billing and speed up cash flow, post all fee tickets within 24 hours of providing service.

## Billing: submit all payers

Billing departments frequently and inadvertently fail to bill certain accounts. Sometimes, claims become stuck as a result of system problems, and these problems have become more pervasive as electronic billing has grown.



Other times, the billing function fails because the billing staff lacks knowledge, which could result in large numbers of claims not being billed. Properly monitor the billing function to ensure all bills are sent. Don't leave money on the table.

## Denials can be easy money

Often, management may be unaware that denials result in claims not being paid. Monitoring and reducing denials is the best policy because denial follow-up is time consuming.

Make denial follow-up a priority; many such claims need a simple

correction to be paid, making them easy money. Improper handling of denials can significantly reduce cash flow. Therefore, rebill all denials within 10 days.

To avoid similar denials in the future, determine the reason for the denial and fix the problem at the source.

## Monitor accounts receivable

It's possible to pinpoint serious revenue cycle problems with diligent accounts receivable monitoring. Every month, produce and review an aging of accounts receivable by payer type.

A lack of regular accounts receivable review allows problems to go unchecked and become more costly to fix. Regularly monitor certain benchmarks related to accounts receivable. Most health centers monitor patient accounts receivable by the number of days an account remains outstanding.

To reduce the amount of time, regularly compute the number of days in accounts receivable by payer type, and provide incentives to achieve individual and departmental goals.

## Collection: money for the mission

Health centers should attempt

to collect amounts due from patients and have effective collection policies and account follow up. Every attempt should be made to collect amounts due at the time of service.

Where this isn't possible, the health center should have collection and follow-up policies to improve the chances of collection at a later date, including:

- ▲ At check in, referral of past-due accounts to a collection representative
- ▲ Monthly patient-statement mailings
- ▲ Sufficient collection staff
- ▲ The use of collection letters and phone calls

Health centers that emphasize patient collections and follow through on established collection policies are often successful in maintaining adequate cash flow.

\* \* \*

Part III will describe effective ways to make process improvements in the revenue cycle and the affect on an organization's bottom line.

Contact your BKD Health Care Group advisor for more information. □



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