Strategies for Success

Health Care NEWS

New year brings RHC changes

by Phil Brummel, Kansas City, pbrummel@bkd.com

On December 24, 2003, CMS published a final rule implementing a provision of the *Balanced Budget Act of 1997* (BBA97), requiring RHCs to requalify for their special payment status under Medicare every three years.

RHCs receive special payments under Medicare. To qualify as an RHC, a clinic must be located in a medically underserved shortage area and provide primary-care services to patients through the use of both physicians and midlevel practitioners.

Under prior law, once a clinic received RHC designation, it could maintain its status permanently if it met Medicare's conditions of participation. BBA97 changed the permanent status provisions.

Under the new law, if an area where the RHC is located lost its "shortage-area" designation, any RHC in that geographic area also would lose its RHC status.

RHCs will have to requalify

Though the above BBA97 provision was never implemented, CMS published a proposed rule in early 2000 to implement the applicable BBA97 statute; however, it was not put into final form until now.

To retain RHC status, the area where the RHC is located must have had a shortage designation in one of the last three years. If the RHC no longer meets the qualification criteria, CMS will notify it.

RHCs no longer eligible under the new rules can qualify as an essential primary-care provider by applying for a three-year exception to the provisions. To qualify, the RHC must meet one of the following criteria:

Sole community provider – Must be the only Medicare and Medicaid provider within a 30-minute distance

Major community provider – Medicare, Medicaid and uninsured utilization rates greater than 51% or Medicaid and uninsured utilization rates greater than 31%; the clinic also must see a higher percentage of such patients than other clinics within a 30-minute distance

CMS has indicated a community may have more than one major community provider; however, an entity operating multiple RHCs must prove each location meets the exception criteria.

Specialty clinic – Sole or major source of pediatric, OB/GYN or mental health services within a 30-minute distance and with low-income utilization rates greater than 31%

Extremely rural community provider – Accepts Medicare, Medicaid and uninsured patients and is located in a frontier county, *i.e.*, fewer than six people per square mile

Take action if you're disqualified

Disqualified RHCs have 120 days from notification to request reconsideration of the shortage-area loss. They also have a 120-day protection period while requests are being processed and evaluated. During this period, no action will be taken on their loss of status.

Disqualified RHCs have 180 days from notification to apply for one of the exceptions. CMS terminates ineligible clinics 180 days after the final notice of ineligibility; therefore, it's possible a year or more could pass between the time the original notification was issued and the effective termination date.

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Check out. . .

Health Care NEWS @ bkd.com

What story does your SNF Medicare cost report tell?

by Brian Hickman, Springfield,
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SNF providers are aware of the requirement to file an annual Medicare cost report; however, many SNFs don't realize the cost report's value as an effective management tool.

A Medicare cost report can reveal information your management team can use to help identify significant trends, problems and opportunities to improve reimbursement and compliance, including:

- ADL needs of therapy patients
- Care needs of Medicare patients the facility serves
- Nursing vs. therapy for Medicare days' mix
- Extent of therapy provided to Medicare patients
- Therapy cost per minute compared to therapy revenue
- Average cost-per-Medicare day for drugs (and other ancillaries)
- Average hourly employee wage by department
- Average length of stay for Medicare residents
- Average Medicare rate received
- Average cost-per-Medicare day

In addition, the SNF Medicare cost report can help you identify other issues and opportunities, including:

- A high percentage of Medicare Part A days that fall within Rehab RUG III categories could indicate facility staff may not be taking appropriate credit for the nursing services provided.

  Accurate completion of the MDS forms may qualify additional patients for Medicare coverage.

  The facility may be providing appropriate therapies but may be failing to cover additional patients who would qualify for Medicare coverage based on the need for daily skilled nursing services.

  Frequently, facilities fail to cover nontherapy patients because of improper assessment. The nursing care is probably being given, but, by undercoding the services, the facility collects a private-pay or Medicaid rate instead of the appropriate, higher Medicare rate.

  The payment differential is often more than $100 per day. A high percentage of rehab Part A days also could invite scrutiny from the Medicare FI or CMS.

- A percentage breakdown of rehab patients' ADL scores might be inconsistent with the distribution of days within the rehab RUG III categories.

  For example, a facility with a case mix of heavier-care therapy residents might have ADL scores that indicate the rehab patients have little need for ADL assistance.

  Failing to properly capture appropriate ADL needs on the MDS assessments of your therapy residents could result in significant underpayment from Medicare.

- Many facilities have few Medicare Part A days that fall within the Rehab Low RUG III categories.

  Using a restorative nursing program in conjunction with a therapist's supervision, the facility could benefit from additional Medicare-covered days, better patient care and improved financial results.

  Again, the restorative nursing care is probably being given but is being reimbursed at a much lower non-Medicare rate, often at a differential of $100 per day or more.

- A low number of Medicare Part A days in the SE RUG III categories could indicate the SNF is failing to record documentation of medical services provided in the hospital look-back period, which might qualify the patient at a higher reimbursed RUG III classification on admission to the SNF.

  A low number of Part A days in the SE RUG III categories also could indicate undercoded ADL scores.

- A low percentage of Medicare days as a percentage of total patient days could indicate improper assessment of patients (this could result in Medicare Part A coverage of

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ABN replaces denial letters

by Derek Hunter, Springfield,
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CMS has directed SNFs to issue advance beneficiary notices (ABNs) to residents instead of denial letters and noncoverage notices.

CMS issued the requirement as part of the new **Medicare Claims Processing Manual** and did not issue providers any other type of transmittal or notification.

What is SNF ABN?

ABN is a CMS-approved model for the written notices SNFs give Medicare beneficiaries–or their authorized representative–before extended-care services or items are furnished, reduced or terminated.

ABNs are issued when the SNF, the utilization review entity, the quality improvement organization or Medicare contractor believes Medicare will not pay for—or will not continue to pay for—physician-ordered extended care services furnished by the SNF.

Use of the SNF ABN was technically required when it was published October 1, 2003, but compliance was impossible.

The ABN form was not issued by CMS until early November, and FIs still have not issued guidance on its use; some FIs advise the use of denial letters until further guidance is issued.

The SNF ABN replaces the five model denial letters with one notice form; however, two additional forms also are required: the NEMB for technical denials and the ABN-G for noncertified beds.

The SNF ABN is applicable for traditional Medicare-A residents only, not for Medicare managed-care residents (for whom CMS is implementing a new, different coverage notice).

In addition, the SNF ABN does not replace the Part-B ABN (form CMS-R-131) for services that can be paid under Part B in a SNF.

What to do

It is important to issue some form of denial, either the old denial letter or the new SNF ABN form. At some point, though, providers must transition to the new SNF ABN form. The transition date should depend on your FI and your organization.

Contact your BKD Health Care Group advisor for more information about converting to the new form.❑

DSH payments: unidentified Medicaid days

by Dennis Peare, Indianapolis, dpeare@bkd.com

Since May 1986, Medicare DSH payments have been critical to qualified acute-care hospitals. Recent legislation and interpretations have made these payments more important and applicable to previously ineligible hospitals.

Most recently, the *Medicare Modernization Act of 2003* increased the ceiling of these payments to 12% for all rural hospitals and urban hospitals with fewer than 100 beds. There is no ceiling for rural referral centers and larger urban hospitals.

Use Medicaid days statistic to compute DSH

One of the more important and controversial variables of the DSH fraction used to qualify for DSH is Medicaid days. For this fraction, Medicaid days is defined as hospital patient days used by patients who, for those days, were eligible for medical assistance under a state plan approved under Title XIX (Medicaid) but who were not entitled to Medicare Part A.

Hospitals have generally used either the state's data or internally generated data as the source for the Medicaid days statistic used to compute DSH payments. Both sources, while readily available, are widely recognized in the industry as less than accurate for a variety of reasons.

For example, neither of these sources may include claims where Medicaid is second or third in line behind a primary payer (common for the working poor).

Another example might include the omission of claims for Medicaid-eligible auto accident victims or any number of other examples involving subrogation or coordination of benefits.

Medicaid eligibility days may even be left out when the states' detailed claims data is reconciled claim by claim to the hospitals' records.

BKD is using a third source for Medicaid days that appears to be more accurate and less controversial. With assistance from Medicaid eligibility transaction service vendors, we are able to electronically compare hospital records to the respective state's Medicaid eligibility database.

By filtering the database of claims, through the state's electronic eligibility records, hospitals may identify incremental Medicaid days that are in neither the hospital's Medicaid data nor the state's report of Medicaid paid claims.

There are several reasons why omissions occur, including incorrect financial class assignment at registration or the state's report excluding claims when Medicaid is secondary.

* * *

BKD has assisted many hospitals in the reconciliation of hospital records to the state's Medicaid eligibility database. Contact your BKD Health Care Group advisor for more information.❑

340B eligibility expanded

by Brad Brotherton, Springfield, bbrotherton@bkd.com

With the recent change in the DSH payment percentage calculation specified in the *Medicare Modernization Act of 2003*, more hospitals will now be eligible to participate in the 340B drug discount program.

The program requires pharmaceutical companies that participate in Medicaid to give specified discounts on covered outpatient drugs purchased by qualifying health care providers.

Qualifying providers include high-volume DSHs (with a payment percentage of at least 11.75%) that are publicly owned or contract with a state or local government to provide uncompensated care, certain federally qualified health centers, AIDS drug-assistance programs and various other specific treatment clinics.

According to studies cited by the Public Hospital Pharmacy Coalition (PHPC), pharmaceutical prices available through the 340B program are significantly lower than retail and wholesale prices.

A recent analysis of 200 popular outpatient drugs found 340B prices are, on average, 54% lower than the average wholesale price. Another survey found 340B prices to be approximately 24% lower than the prices available to group purchasing organizations.❑

IPPS policy changes

by Maggie Gambill, St. Louis, mgambill@bkd.com

Changes to the transfer payment policy became effective October 2003. Only IPPS hospitals are subject to this policy, but many health care providers still have questions about how the changes will affect them.

Why change policy?

Medicare expanded its definition of a "transfer" to include all patients admitted to another IPPS hospital on the same day they are discharged from an IPPS hospital.

This was done to address concerns that hospitals were incorrectly coding such transfers as LAMA cases, which are currently considered a discharge that prompts full DRG payment.

The exception to the rule is if the first (transferring) hospital can demonstrate their treatment was completed at the time of discharge from their hospital. OIG found one inappropriate LAMA discharge per hospital, per year, which prompted its action.

To ensure compliance, Medicare has applied additional processing systems edits, to identify transfers inappropriately coded as discharges. Going forward, the accuracy of your discharge status information will be crucial.

Define language

The final rule deleted the existing language from the definition of a transfer, *i.e.*, Section 412.4(b)(2), "discharge from one inpatient area of the hospital to another area of the hospital."

In essence, an intrahospital transfer is not a transfer under the current definition in the transfer payment policy.

Another important component of the final rule is the expanded postacute care transfer policy to include additional DRGs. On or after October 1, 1998, CMS treats as a transfer any qualified discharges from one of the following DRGs to a postacute care provider

- ▲ DRG 14 Stroke

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HIPAA: Where

by Rod Walsh, BKD Technologies, Kansas City, rwalsh@bkd.com

Transaction and code set regulation is the core of HIPAA's administrative simplification provisions; it specifies the EDI format and required content of the new standard transactions.

If you are processing any of the identified transactions electronically, you *must* transmit them in the prescribed HIPAA format or use a clearinghouse.

If you are one of the many providers, clearinghouses or payers not ready for the TCS deadline, then you probably heaved a sigh of relief when CMS invoked its contingency plan.

How contingency plan works

The contingency 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 lessen operational disruption while trading partners not compliant on October 16, 2003, work with Medicare for full compliance. Blue Cross and Blue Shield and many other payers have implemented similar plans.

CMS is closely following progress on HIPAA compliance and will end its contingency when feasible.

CMS has recently announced noncompliant claims submitted on or after July 1, 2004, will be held an additional 13 days prior to payment.

It's important to continue to submit your electronic transactions in the HIPAA-compliant formats for these reasons:

- To be prepared when Medicare and other compliant payers discontinue their contingency plans
- To lessen the effect 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

Which transactions?

Although there are eight standard transactions, most providers focus on only a handful of common transactions for initial compliance and will continue to process the other transactions manually for now.

The most common transactions include:

- 837I – Electronic claim for institutional providers (replaces the UB-92)
- 837P – Electronic claim for professional providers (replaces the CMS-1500)
- 835 – Remittance advice
- 270-271 – Eligibility inquiry and response (the least common at this point)

The remaining provider transactions, such as authorization and referral and claims status inquiry and response, will be valuable to your organization but are not typically supported electronically by most vendors at this time.

Implementation tips

HIPAA compliance is your responsibility. Take the initiative with your software vendor, clearinghouse and payers.

To help you through the final stages, consider your arrangements with software vendors, your clearinghouse and payers.

Have your software vendor(s) help you:

- Obtain the latest HIPAA TCS updates
- Update master files with current code sets
- Train staff on new fields and screens necessary for HIPAA
- Understand new edits before you submit your files

If you use a clearinghouse, obtain the 837 transaction data file format from your vendor and test it with your clearinghouse

Ask your clearinghouse and/or payers to provide:

- Testing schedules and requirements
- Companion guides that describe any unique or situational requirements you must follow
- Listing of payer-testing status, as well as its contingency plans for payers that did not accept the 837 on October 16

What's next with HIPAA?

Areas receiving increased attention include:

TCS compliance & enforcement – CMS issued a TCS compliance document July 24, 2003, and will target enforcement based on complaints.

Introducing HIPAA-Watch for Security from RiskWatch

To serve clients with information security needs, BKD Technologies has teamed with RiskWatch, software developer of some of the world's leading security risk-assessment applications.

As a selected RiskWatch reseller, BKD Technologies will offer the publisher's timesaving HIPAA-Watch for Security software to help organizations with HIPAA security compliance initiatives and solutions.

The primary focus is to provide comprehensive compliance services for health care organizations working to meet HIPAA requirements.

RiskWatch software meets federal and audit standards in line with HIPAA's mandated emphasis on the security and privacy of information technology.

The combined resources of BKD Technologies and RiskWatch offer customized assistance with software implementation, training and support; compliance project management; and ongoing information security risk management.

"What attracted us to use RiskWatch's HIPAA-Watch for Security software as a compliance tool is its ability to simplify the assessment process for our clients," says Mike Burlew, partner in charge of BKD Technologies.

"It saves us analysis time and allows us to offer services that establish ongoing information security compliance such as policy and controls development, training and monitoring."

For more information, contact your BKD Health Care Group or BKD Technologies advisor.❑

are we now?

Following notification of a CMS complaint, an entity will have the opportunity to:

- ▲ Demonstrate compliance
- ▲ Document its good-faith efforts to comply with the standards, and/or
- ▲ Submit a corrective action plan

Avoid penalties with continued good-faith efforts and progress.

Security – HIPAA security is on the horizon, its primary focus on safeguarding information and systems that store, process and transmit that information.

The major provisions of the ruling involve administrative, physical and technical safeguards. Compliance must be met April 21, 2005, and will be an ongoing effort as systems are upgraded and new systems are added.

2004 is the year to perform and remediate HIPAA security risks. Risk assessments are required by the HIPAA security rule and should be included in your 2004 budget.

Once the assessment is completed, take time to correct any issues, a process that could prove long and time consuming. As with HIPAA privacy and transaction and code sets, documentation of decisions and good-faith efforts will help you defend complaints.

National provider identifier (NPI) – On January 23, 2004, DHHS issued its final rule, "Standard Unique Health Identifier for Health Care Providers," announcing the adoption of the national provider identifier (NPI) as that standard.

The rule's effective date is May 23, 2005; health care providers may apply for NPIs no earlier than that date. The compliance deadline for all covered entities is May 23, 2007, and the deadline for small health plans is May 23, 2008.

On implementation, covered entities will use only the NPI to identify providers in standard transactions.

Legacy numbers, *e.g.*, Medicare and Medicaid provider numbers, UPIN, TRICARE, etc., will not be permitted after the compliance deadline. Providers will no longer have to keep track of different identifying numbers for different payers.

Privacy again? – HIPAA privacy also should be an ongoing effort. Be sure protected health information (PHI) is shared appropriately per the privacy policy, and verify the use and disclosure of PHI and your privacy notice by periodically auditing all departments. There are other ways your entity can maintain compliance.

More rules?

DHHS continues to propose and finalize HIPAA-related rules, with these for 2004:

- ▲ Due in September, a proposed rule to establish standards for claims-attachment transactions
- ▲ Due in September, a proposed rule to modify existing electronic transactions and code-sets standards
- ▲ Due in September, a final rule to require, with limited exceptions, electronic submission of Medicare claims
- ▲ Proposed rule to establish a national payer identifier; no scheduled due date

For more information, visit http://www.cms.hhs.gov/providers/edi/, and contact a BKD Health Care Group or BKD Technologies advisor for assistance in meeting your HIPAA-compliance efforts, including implementation, compliance audits and risk assessments.❏

Impairment of investments: new disclosures

by Mike Wolfe, Springfield, mwolfe@bkd.com

The Emerging Issues Task Force (EITF), was formed in 1984 to help the Financial Accounting Standards Board (FASB) improve financial reporting through the timely identification, discussion and resolution of financial accounting issues.

A recent EITF consensus requires new disclosures for certain investments of for-profit and not-for-profit health care providers.

Providers must disclose the aggregate unrealized losses and current fair values of debt and equity securities with cumulative unrealized losses (impaired investments) for years ending after December 15, 2003.

Separate disclosure is required by category of investment (debt securities, equity securities, etc.) and by length of continuous impairment (greater than or fewer than 12 months). Providers must also disclose the nature, cause and extent of the impairment.

Example: September 15, 2003 – A calendar year-end, for-profit hospital purchases common stock for $10,000.

December 31, 2003 – The fair value of the stock is $8,000. The investment has been impaired fewer than 12 months.

December 31, 2004 – The fair value of the stock is now $9,000. The fair value of the stock was not above $10,000 at any point during the year. The investment has been impaired greater than 12 months.

This example assumes the impairment is not "other-than-temporary." Had the fair value recovered during 2004 but declined to $9,000 at year end, the investment would be considered impaired fewer than 12 months.

Each investment security must be evaluated separately. For providers with significant investment portfolios, this analysis will be time consuming. As a result, we encourage you to begin tracking this information as soon as possible.

On the horizon

Health care providers record unrealized losses on most investments outside the performance indicator. This practice is appropriate if the losses are not other than temporary. Other-than-temporary losses must be reported within the performance indicator.

The phrase "other than temporary" is not clearly defined. The above disclosures are part of a broader EITF project on impaired investments in which the EITF will provide a model to identify other-than-temporary impairments.

The result of this project may require providers to record extended unrealized losses within the performance indicator.❏

Part 3: Revenue cycle processes

Cash-receipt processes require strict procedures

by Angela Morelock, Springfield, amorelock@bkd.com

In the last of a three-part series about revenue cycle processes, the focus turns to effective ways you can make process improvements in the revenue cycle.

Use technology

Post and deposit cash receipts intact the same day they are received and don't hold checks. Maintain proper internal controls over incoming payments.

Many technological solutions currently exist to improve the efficiency and flow of revenue-cycle information and documents.

Many health centers have not yet taken advantage of some of the following efficiency-improvement technology:

- Electronic encounter forms
- Automated verification of coverage
- Electronic billing
- Electronic payment and posting
- Automated contract monitoring

The fewer papers you shuffle, the more claims you can process and bill in a timely manner.

Be aware

Having efficient and effective processes throughout the revenue cycle functions of a health center is critical. Implement daily procedures to ensure smooth flow of information, documents and people.

Lack of sufficient processes can result in backlogs, inadequate patient care, long wait times and sluggish cash flow.

The following actions can result in process improvement:

- Gain a detailed, thorough understanding of each process by interviewing personnel about day-to-day processes and procedures, including a step-by-step review of the revenue cycle processes from beginning to end
- Examine documentation regularly used as part of each process, including the supporting documentation related to each process—forms used, balancing procedures, etc.
- With the help of regular reviews, identify problem areas, as well as opportunities for improvement; act on your findings
- Implement processes and improvements using a detailed action plan (include time requirements) based on the industry's best practices

A detailed review of daily processes can expose problems and deficiencies and lead to improvements and better productivity. Increasing efficiency often means fewer employees are needed to do the same work.

* * *

Process improvement in the revenue cycle is an important focus for many health centers because improved processes affect the bottom line. Contact your BKD Health Care Group advisor for more information.❑

BKD Health Care Group Published Articles

Article	Author	Publication	Date
"Symptoms of an Ailing Compliance Plan"	**Larry Fogel & Joe Watt,** Kansas City	**Nursing Homes Long Term Care Management**	November 2003
"SNFs Must Monitor Qualifying Three Day Hospital Stay Issue"	**Darryl Bueker**, Springfield	**LTC Advisor**	Winter 2004

SNF Medicare cost report. . .

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fewer days than are allowed).

It also could indicate a need to increase the number of Medicare-certified beds in the facility. Many SNFs establish a minimum goal of 10% to 12% of Medicare Part A days to total patient days.

- A low ALOS for Medicare patients could indicate a facility is not covering all patients who could qualify for Medicare Part A services.

  Because Medicare days and revenue rates are generally much higher than other patient types, the facility may be receiving less revenue than is properly available.

These are just a few of the opportunities uncovered by a closer review of the Medicare cost report. It also emphasizes the importance of preparing an accurate cost report.

Contact your BKD Health Care Group advisor for help reviewing your SNF Medicare cost report.❑

BKD Health Care Group Speakers' Bureau

Topic	Speaker/Office	Seminar	Location & Date
Operational Improvement of the Revenue Cycle	**Angela Morelock & Jennifer Fielding**, Springfield	National Association of Community Health Centers 29th Annual Policy and Issues Forum	Washington, D.C. 3/23-3/26
Special Payment Issues for Rural Providers	**John Cooper**, Springfield; **John Sheehan**, St. Louis; **Leslie Herrmann** with von Briesen & Roper, s.c.	American Health Lawyers Association Institute on Medicare and Medicaid Payment Issues	Baltimore 3/31-4/2
Evaluating the Pros and Cons of FQHC Certification	**Mike Schnake & Jeff Allen,** Springfield	National Rural Health Association 27th Annual Conference	San Diego 5/26-5/29

Corporate ethics start at the top

by Larry Fogel, Kansas City,
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The old saying, "practice what you preach," applies to corporate ethics. It all starts with setting the right tone at the top, with the board of directors and senior management.

From the very top of the organization to the very bottom, a message should be sent to always do the right thing.

Having a code of conduct helps to articulate the importance of ethical and moral conduct for everyone involved with the organization. . .

Where to start?

It's a foregone conclusion that every organization needs competent employees who possess character and integrity. The hiring process should include interviews and background checks.

Background checks must carefully screen applicants to uncover any prior incidents involving candidates that would disqualify them from employment.

Having a code of conduct helps to articulate the importance of ethical and moral conduct for everyone involved with the organization—employees, independent contractors, physicians, etc.

The code should promote corporate ethics in every aspect of the organization's business and establish consistent rules and expectations.

BKD has conducted corporate integrity assessments for many organizations. We interview members of every employee level and ask if the board and management are serious about compliance.

When the board and management are serious about complying with an established code of conduct, it is often because:

- ▲ The compliance program is successful
- ▲ Board and management emphasize the importance of being honest and ethical in how the organization conducts its business
- ▲ When a mistake is made, resolution and corrective action is expected

Put it in writing

Your board and management should lead the way in establishing a system that promotes the organization's values and ethics.

The board should actively participate and help develop a code of conduct. Management's responsibility is to introduce the code and train employees to comply with its code standards.

When assessing honest and ethical behavior in your organization, consider using this checklist:

- ▲ Were all verbal (written and oral) communications truthful and honest?
  - ▲ Were patients and insurers properly charged for services?
  - ▲ Were records prepared accurately and honestly?
  - ▲ Were mistakes corrected in a timely manner?
- ▲ Were conflicts of interest properly disclosed?
- ▲ Were transactions for personal gain or private benefit avoided?
- ▲ Were records maintained as required and not prematurely destroyed?
- ▲ Was confidential information properly disclosed?
- ▲ Were gifts and gratuities to induce referrals or business avoided (payment or receipt)?
- ▲ Were patients treated with honesty and respect?
- ▲ Were employees encouraged to report complaints or improprieties without fear of retaliation?

* * *

The top of an organization sets the tone for its code of ethics; however, the responsibility to do the right thing belongs to the top, the bottom and to everyone in between.

Contact your BKD Health Care Group advisor for more information about conducting a corporate integrity assessment of your organization.❑

Health Care News glossary

ADL – Activities of daily living

ALOS – Average length of stay

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

DHHS – Department of Health and Human Services

DME – Durable medical equipment

DPU – Distinct part unit

DRG – Diagnosis-related group

DSH – Disproportionate share hospital

EDI – Electronic data exchange

FI – Fiscal intermediary

FQHC – Federally qualified health center

HCPCS – Healthcare Common Procedure Coding System

HIPAA – Health Insurance Portability and Accountability Act

IPPS hospital – Inpatient prospective payment system hospital

IRF – Inpatient rehabilitation facilities

IRS – Internal Revenue Service

LAMA – Left against medical advice

MDS – Minimum data set

NEMB – Notice of exclusions from Medicare benefits

OIG – Office of Inspector General

PAI – Patient assessment instrument

PHI – Protected health information

PIP – Periodic interim payment

PPS – Prospective payment system

QAPI – Quality assessment and performance improvement program

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

TRICARE – (Formerly CHAMPUS) health services and support program for active duty service members and retirees, and their families

UPIN – Universal provider identification number

IPPS policy changes. . .

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- DRG 113 Amputation for circulatory disorder
- DRG 209 Major joint surgery
- DRG 210 Hip procedures w/ complications
- DRG 211 Hip procedures w/o complications
- DRG 236 Fracture, hip/pelvis
- DRG 263 Skin graft w/complications
- DRG 264 Skin graft w/complications
- DRG 429 Mental disorders
- DRG 483 Tracheostomy w/ ventilation

Effective for discharges occurring on or after October 1, 2003, DRGs 263 and 264 are removed from the list, but 21 additional DRGs are considered transfers to postacute care providers, including:

- DRG 12 Nervous system
- DRG 24/25 Seizure/Headache
- DRG 88 Chronic obstructive pulmonary disorder
- DRG 89/90 Pneumonia
- DRG 121/122 Acute myocardial infarction
- DRG 127 Heart failure and shock
- DRG 130/131 Peripheral vascular disorders
- DRG 239 Pathological fracture
- DRG 277/278 Cellulitis
- DRG 294 Diabetes
- DRG 296/297 Dehydration
- DRG 320/321 Urinary-tract infection
- DRG 395 Red blood cell disorders
- DRG 468 Surgical procedure unrelated to principal diagnosis

What does this mean for you? Your hospital will need a system in place to ensure the accuracy of DRG assignments. Documentation and identification of the principal diagnoses and pertinent secondary diagnoses will be essential.

* * *

BKD Health Care Group can assist you in the assessment and evaluation of current data and related processes. We can help you receive appropriate reimbursement. Contact your advisor for more information.❑

In brief

Guidelines for reporting hospital-quality data – Under Section 501 of the *Medicare Modernization Act of 2003*, hospitals must submit data for 10 quality measures or face a 0.4% reduction in their Medicare inpatient payment rate update on October 1, 2004.

CMS has announced hospitals should sign up to participate by June 1, 2004, and begin submitting data by July 1, 2004. Hospitals will have a grace period until August 1, 2004, to complete the data submission.

More information is available at CMS's web site: **http://www.cms.hhs.gov/quality/hospital**. To participate, go to **http://www.qnetexchange.org** for more information.

CMS transitions to web-based manuals – Effective October 1, 2003, CMS began the process of replacing various Medicare paper manuals with web-based manuals.

The new system, called the CMS Online Manual System, is located at **http://www.cms.hhs.gov/manuals**.

This web site includes a crosswalk section to see where old paper manual sections are now included on the web-based manuals.

The web-based manuals are organized along functional lines; thus, sections from the old **Hospital Manual**, **Home Health Agency Manual** and **Skilled Nursing Facility Manual** (Publications 10, 11 and 12, respectively) each crosswalk to multiple web-based manuals.

For now, the old paper manuals are still available on the CMS web site. CMS suggests checking both manuals for current policy and procedures.❑

New year brings. . .

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What's QAPI?

Another provision of the recently published final rules replaces the annual program assessment (previously required of all Medicare-certified RHCs) with a quality assessment and performance improvement (QAPI) program.

A QAPI program's objective is to improve patient outcomes; it must include objective measurements to evaluate organizational processes, functions and use of such services.

Compliance will be evaluated by the state licensing body during the periodic program survey. Contact your BKD Health Care Group advisor for assistance.❑

For a complete list of our offices and subsidiaries and their contact information, go to bkd.com or call Director of Communications at 417 831-7283.

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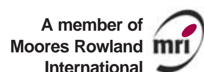

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