Strategies for Success

Health Care NEWS

CMS issues inpatient proposed rule

by Tim Wolters, Springfield, twolters@bkd.com

The May 18, 2004, **Federal Register** includes the Medicare hospital inpatient PPS proposed rule that would generally take effect October 1, 2004.

The proposal includes significant changes in the way CMS adjusts payments based on geographic area, as well as implementing other MMA provisions.

Payment rate changes proposed

The basic inpatient payment rate is increased by the 3.3% market-basket factor, with various budget neutrality adjustments; under MMA, no separate rates are published for large urban areas.

Another MMA provision requires CMS to publish separate rates for hospitals in areas with wage index values below 1.0, with the labor share of those rates set at 62% of the total, compared to 71.1% for hospitals in areas with values above 1.0.

Also under MMA, separate rates are published with a 0.4% reduction for hospitals not participating in the quality initiative.

Hospitals can go to **qnetexchange.org** and click on the HDC tab to learn more in the "Reporting Hospital Quality Data for Annual Payment Update Reference Checklist."

Wage index/MSA changes proposed

As in prior years, new wage index values have been published based on the most recent wage index surveys, currently fiscal year 2001.

Corrections to the average hourly wages and wage-index values were posted on CMS's web site (**cms.hhs.gov/**) in late May. The values are weighted by 10% of the impact of incorporating the occupational mix data submitted by hospitals in February 2004.

The proposed method of including the occupational mix data results in a slight improvement in the wage index values for most rural areas.

CMS also proposes to incorporate changes in urban and rural areas based on OMB's revised MSA definition and 2000 census data.

This proposal results in some

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CAHs can manage critical issues

by Tom Watson, Houston, twatson@bkd.com

As the number of CAHs grows, so does the legislative and regulatory attention they receive. In addition to favorable reimbursement changes, CAHs occupy a prominent spot in OIG's **2004 Work Plan**.

As a result, there are a number of critical issues CAH administrators must learn to manage. Following are some of the key items you need to consider.

Report nonallowable costs

Now that so many hospitals have converted to CAH status, you can expect Medicare auditors to dust off old audit programs from a time when all hospitals were cost reimbursed.

PPSs have shifted the audit focus of many FIs from cost-

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dramatic fluctuations in the wage index values used to pay hospitals, with CMS estimating that 227 hospitals will see a decrease of at least 5% in their wage index, while 182 will see an increase of at least 5%.

CMS proposes to allow urban hospitals that would lose their urban status to maintain it for three additional years, not losing it until October 1, 2007.

After that date, these hospitals will have to meet applicable geographic reclassification rules to maintain urban status or wage-index value.

CMS does not address the issue of rural hospitals that may lose SCH, MDH or CAH status because their county is now considered urban (197 rural hospitals will become urban).

Some such hospitals that may be negatively affected by becoming urban may apply to be treated as rural under the regulations at 42 CFR 412.103.

Changes in urban areas may also affect a hospital's geographic reclassification for fiscal year 2005 and later years. Hospitals should review their classification in Table 9A to see how they may be affected by this issue.

Hospitals have 45 days from publication of the proposed rule to rescind their reclassification.

Table 9B lists those hospitals that successfully applied for and received reclassification under MMA's Section 508. CMS also has identified 98 counties qualifying as urban based on commuting standards and 2000 census data, compared to 28 counties previously qualifying.

Finally, CMS has identified hospitals in Table 4J of the proposed rule that qualify for a wage-index increase under new MMA commuting standards.

CMS proposes to automatically implement the wage-index increase for three years beginning October 1, 2004, unless a hospital has already been geographically reclassified under a different provision of the law.

CAH changes proposed

CMS proposes regulations to implement many of the changes in the CAH program included in MMA's Section 405. This includes increasing cost reimbursement from 100% to 101% of allowable costs for periods beginning on or after January 1, 2004.

Changes in urban areas may also affect a hospital's geographic reclassification for fiscal year 2005 and later years.

CAHs are allowed to bill outpatient services under the "method 2" billing option to receive 115% of the fee schedule for professional services for selected practitioners, while other practitioners perform their own billing. This provision is generally effective for periods beginning on or after July 1, 2004.

Cost reimbursement for on-call mid-level practitioners will be allowed for services furnished on or after January 1, 2005. Periodic interim payments are allowed for payments made on or after July 1, 2004.

Changes in bed size are also included, with CAHs now allowed 25 total beds for acute and/or swing bed patients, and distinct psychiatric and rehabilitation units of up to 10 beds each.

The December 31, 2005, sunset on receiving a state waiver of the CAH mileage requirement is also incorporated into the regulations.

Finally, despite considerable public comments, CMS is proposing no change to the requirement that CAH outpatient laboratory services are cost reimbursed only if the patient is physically present at the CAH for the specimen draw.

In response to these comments, CMS does request "verifiable documentation" of situations where this requirement has resulted in access problems.

Reduction of cap on residents

Implementing another MMA section, CMS provides a process to reduce a hospital's cap on residents by 75% of the difference between the current cap and actual residents claimed for cost reporting purposes, generally for the period ended on or before September 30, 2002.

This reduction applies to the cap used for both indirect and graduate medical education and will be effective July 1, 2005. Rural hospitals with fewer than 250 beds are exempt from this reduction.

Proposed regulations, and a proposed application process, are also included for hospitals seeking to increase their cap by obtaining some of the unused resident positions. Hospitals must demonstrate the likelihood of filling the new positions within three years.

Priorities in distributing the unused positions will be for hospitals in rural or small urban areas, or for hospitals with the only specialty program in the state.

Ten evaluation criteria will apply within each of the priority categories, except that no hospital can increase its cap by more than 25 positions. Applications are due March 1, 2005, with the increased cap effective July 1, 2005.

Other proposals

Among numerous other proposals, CMS proposes an increase in the outlier threshold from $31,000 to $35,085.

A payment adjustment is proposed for PPS hospitals with fewer than 500 discharges, provided they are over 25 miles from another PPS hospital. (MMA defines a low-volume hospital as one with fewer than 800 discharges; however, additional payments will only be made to hospitals with fewer than 500 discharges.)

The payment add-on is proposed to be .0005 times the difference between actual discharges and 500; thus, a hospital with 400 discharges receives a 5% add-on, while a hospital with 300 discharges receives a 10% add-on.

The post-acute transfer policy will be expanded slightly, adding DRG 430 to the list of DRGs subject to the policy. Also, CMS proposes replacing DRG 483, which was on the transfer list, with new DRGs 541 and 542, placing both of them on the transfer list.

To qualify for special reimbursement as a hospital-within-a-hospital, CMS proposes to delete several optional criteria and require such hospitals to meet the standard that at least 75% of admissions must be referred from a source other than the host hospital.

Finally, hospitals must provide a list of available home health or skilled nursing services in the area for those patients for whom such services are indicated at the time of discharge.

Hospitals must disclose any financial interest in any such home health agency or SNF and must inform patients of their freedom to choose from among available services.

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There are numerous other proposed changes not summarized above. Contact your BKD Health Care Group advisor for more information about the proposed rule's potential impact on your operations.❑

How to identify & monitor compliance risks

by Larry Fogel, Kansas City, lfogel@bkd.com

Let's face it: All health care organizations are exposed to compliance risks; however, some organizations either haven't identified them or haven't identified the right ones.

Where to begin

For this reason, OIG urges health care organizations to perform an annual risk assessment. Your compliance committee may be the ideal group to conduct it and can monitor risk throughout the year.

When assessing risks, be sure to go beyond those related to Medicare and Medicaid.

Consider potential exposure to other regulatory areas, *e.g.*, taxation, antitrust, employment and environmental law; ideally, these are areas that members of your compliance committee should already be familiar with.

To properly appreciate your organization's degree of risk, it may help if committee members have a general overview of the major regulatory provisions your organization complies with.

Distinguish between internal & external

It's important for your organization to distinguish between internal and external risks.

Internal risks are specific to every organization, including:

- ▲ Complaint patterns
- ▲ Denials
- ▲ Focused reviews
- ▲ Audits
- ▲ Surveys
- ▲ DRG trends

The challenge is to make your compliance officer and committee aware of them in a timely manner. For instance, if your organization had an adverse payer audit, your compliance officer should be aware of the results.

External risks are more general but apply to specific areas of the health care industry. OIG regularly issues alerts, including periodic fraud alerts when suspicious activity is reported.

It also issues advisory opinions on permissible yet problematic transactions and publishes an annual work plan of the areas they plan to emphasize over the next fiscal year.

Intermediaries and carriers issue local medical review policies, and CMS issues Medicare and Medicaid program policy notices.

Paying attention to published compliance settlements can provide additional insight on regulator's activities.

The challenge for many health care organizations may be how to select, organize, monitor and disseminate the information that is available.

Process requires self examination

There are many other potential areas of exposure, and it may be helpful to answer the following questions:

- ▲ Are your policies and procedures clear and current?
- ▲ Do any conflict with other policies?
- ▲ Does your plan require you to train and educate, and are you? Is training adequate to meet employee needs?
- ▲ Is the compliance plan outdated or unclear?

Possible areas of risk may seem endless to many health care organizations, but all potential sources must be thoroughly checked, identified and prioritized by their level of importance.

A word of caution

An effective way to prioritize areas of risk is for your compliance committee to evaluate them using a point scale of one to five, with one as the lowest level of importance.

Once every risk has a numerical value, prioritize by moving the fives and fours to the top of the list and include them on the coming year's work plan.

The committee should discuss time lines, who will execute required actions and who will provide deliverables. Decide if any audits or actions should be outsourced to an external party.

Issues to consider:

- ▲ Be careful not to over commit.
- ▲ Be clear about who will follow-up and when expectations must be met.
- ▲ Evaluate your compliance program on its ability to identify your organization's areas of greatest risk and on its ability to detect and prevent compliance violations.
- ▲ Do not overlook smaller departments that may pose high-level risks to the organization, *e.g.*, skilled nursing, home health, hospice, DME, physician practices, rural health clinics, etc.

Raise the bar, discuss results

For health care organizations to take risk assessments to the next level, OIG encourages organizations to establish a process individual departments can use to evaluate their regulatory exposure.

Many organizations have yet to implement this more intense risk assessment process that drills down to the department level.

After a department conducts a risk assessment, it should submit its findings to the compliance officer for the compliance committee's consideration.

The committee must constantly monitor the work plan and modify it if new developments make it necessary. If this happens, document why the work plan was revised, especially if existing items need to be deferred.

At year end, the committee will be able to evaluate its overall effectiveness, and the compliance officer can report its findings to senior management and the board of directors.

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Contact your BKD Health Care Group advisor for more information about risk assessment or about forming a compliance committee.❑

BKD Health Care Group Speakers' Bureau

Topic	Speaker/Office	Seminar	Location & Date
CAH Reimbursement Issues	**John Sheehan**, St. Louis; **Tim Wolters**, Springfield	National Rural Health Association CAH Conference	Kansas City 10/6-10/8
Rural Health Clinic Cost Reports	**John Sheehan**; **Tim Wolters**	Rural Health Clinic preconference	10/6

IRF classification criteria:

by John Britt, Holly Evans & Nicole Bierman, Louisville, jbritt@bkd.com, hevans@bkd.com, nbierman@bkd.com

Because IRF classification criteria will change, IRF providers have eagerly awaited results of a proposed rule announced by Medicare September 2003.

CMS estimates the final rule, published May 7, 2004, may result in Medicare program savings of $100 million per year or more, indicating serious consequences for IRF providers.

Rules bring change

The final rules require IRFs to make significant changes to the categories they use to meet the compliance threshold and will also introduce new rules:

- Graduated increase in compliance threshold percentage from 50% back to 75% (see "Compliance cost report period threshold table" at right)
- Deletion of polyarthritis from the 10 classification categories (conditions), to be replaced by three specific arthritis conditions
- One additional condition for meeting the compliance threshold
- A mechanism to allow patients' comorbidities to count toward the compliance threshold provided certain criteria are met, but only through July 1, 2007
- An administrative presumption allowing the facility's total population to meet the compliance threshold if the Medicare population does

Compliance cost report period threshold table

Cost report periods beginning:	Compliance Threshold
On or after July 1, 2004, and before July 1, 2005	50%
On or after July 1, 2005, and before July 1, 2006	60%
On or after July 1, 2006, and before July 1, 2007	65%
On or after July 1, 2007	75%

Medical conditions introduced

The final rule deletes polyarthritis as one of the conditions that meets the compliance threshold and will substitute it with four groups of arthritis-related conditions.

The first three include:

- Active, polyarticular rheumatoid arthritis, seronegative arthropathies and psoriatic arthritis
- Systemic vasculidities with joint inflammation
- Severe or advanced osteoarthritis involving two or more weight-bearing joints (shoulders, elbows, knees and hips)

Each of these conditions require evidence of patient functional impairment and a sustained course of outpatient therapy services or services in other less intensive settings immediately preceding the inpatient rehabilitation admission.

The final condition, which brings the total to 13, includes knee and/or hip-joint replacement during an acute hospitalization provided one of the three following criteria are met:

- Patient had bilateral knee- or hip-joint replacement surgery during the acute hospitalization immediately preceding the IRF admission
- Patient is extremely obese (as determined by a body mass index of at least 50)
- Patient is considered to be "frail elderly" as determined by the patient's age (85 or older)

IRFs should monitor FI publications for updated IRF information. Some FIs, such as Veritus, Riverbend and Mutual of Omaha, have already published inpatient rehabilitation-related draft LCDs.

Comorbidities a new addition

In addition to the principal diagnosis a patient has when entering the hospital, a comorbidity is an existing condition expected to require additional resources.

Health Care News glossary

ABN – Advanced beneficiary notice

ADL – Activities of daily living

ALOS – Average length of stay

APC – Ambulatory payment classification

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

HDC – Hospital Data Collection

HIPAA – Health Insurance Portability and Accountability Act

IPPS hospital – Inpatient prospective payment system hospital

IRF – Inpatient rehabilitation facilities

LCD – Local Coverage Determination

MDH – Medicare-dependent hospital

MMA – the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*

MSA – Metropolitan statistical area

NEMB – Notice of exclusions from Medicare benefits

OIG – Office of Inspector General

OMB – Office of Management and Budget

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

UPIN – Universal provider identification number

new rules become final

The final rule provides a mechanism that may allow a patient with a comorbidity to count toward the compliance threshold provided the following criteria are met:

- ▲ Principal diagnosis is not one of the 13 conditions that meet the compliance threshold
- ▲ Patient also has a comorbidity that is one of the 13 conditions
- ▲ Comorbidity has caused a significant decline in functional ability for the patient, such that— even in the absence of the admitting condition—intensive rehabilitation services unique to an IRF would be required

The provision to use a comorbidity to count toward the compliance threshold expires for cost reporting periods beginning on or after July 1, 2007.

Administrative presumption

The final rule instructs FIs to presume administratively that, if the Medicare population in the IRF meets the compliance threshold, then the facility's total population meets the threshold.

If the IRF's Medicare population does not meet the compliance threshold, FIs will be instructed to calculate the facility's total population to determine if the compliance threshold is met.

How IRFs will be affected

The final rule's implications for IRF providers are potentially very serious.

A number of IRF providers have relied for many years on the polyarthritis category to meet the compliance threshold. Over the last year, BKD has provided consulting services to assist them with the pending rule.

Common opportunities we have found include:

- ▲ Improved identification of IRF candidates in acceptable condition categories other than polyarthritis
- ▲ Improved documentation (by physician and others) to accurately capture (code) primary diagnosis and comorbidities
- ▲ Improved processes to accurately complete the PAI, which measures patient acuity, ultimately driving reimbursement
- ▲ Integration of levels of care offering less intense rehab services
- ▲ Revision of admission criteria to improve adherence to medical necessity guidelines
- ▲ Education of actual and potential referral services
- ▲ Improved management of the transfer payment policy (with an IRF being a transfer facility)
- ▲ Daily monitoring/management of the compliance threshold
- ▲ Integration of mechanisms to distinguish the IRF (specifically addressed in the final rule)
- ▲ Development of strategies for program and referral development

IRF providers should analyze their operations in the context of the final rule to assess both the potential opportunities and impact it will have for their facilities and develop short- and long-term strategic plans based on their findings.

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Contact your BKD Health Care Group advisor for more information about how to assess the final rule's effects on your facility and how to make the most of the changes it introduces.❑

In brief

Proposed 2005 home health rates published - CMS published proposed 2005 home health payment rates in the June 2, 2004, **Federal Register**. The proposed rates reflect a 2.5% increase from 2004, including a 3.3% estimated market basket update minus a 0.8% cut required by MMA.

At this time, CMS has deferred implementing changes in rural/urban areas based on the 2000 census data, choosing to wait until comments are analyzed related to the proposed changes included in the May 18 hospital proposed rule (see cover story).

Medicare announces instructions to implement outpatient hold harmless extension - CMS issued instructions recently for intermediaries to resume making interim outpatient hold harmless payments for eligible hospitals. By July 1, 2004, intermediaries should make a payment retroactive to January 1, 2004, for eligible hospitals.

Eligible hospitals include rural hospitals with up to 100 beds, effective for services on or after January 1, 2004, and rural SCHs with more than 100 beds, effective for cost reporting periods beginning on or after January 1, 2004. Hold harmless payments will expire for services on or after December 31, 2005.

Medicare announces payment increase for SNF residents with AIDS - CMS issued instructions recently to increase the PPS rate for SNF and swing bed residents with AIDS (diagnosis code 042) by 128%, effective for services on or after October 1, 2004.

Medicare announces long-term care hospital payment rates - CMS issued the final long-term care hospital prospective payment rates effective July 1, 2004, in the May 7, 2004, **Federal Register**. On average, payment rates will increase 3.1%. CMS announced 93% of long-term care hospitals have elected to receive payment based on 100% of the federal payment rate, foregoing the five-year transition period.

CMS clarifies provider enrollment process - To reduce possible fraud, CMS now requires all changes to "pay to" information for an existing provider to be approved via the 855 process through each contractor's provider enrollment unit. All changes of information to an existing provider's enrollment are supposed to be processed within 45 days.

In addition, CMS now requires all contractors to obtain a fully completed Form 855 from a provider before allowing any change to the provider's "pay to" information. Changes in "pay to" information include changing banks or bank account numbers, signing up to receive payments electronically when payments have previously been mailed or changing PO box numbers for receipt of hard copy remittance advice statements.

If a provider has never completed the Form 855, *i.e.*, provider existed before 1996 and has not had a change of ownership, then it must complete the entire Form 855 when making one of the changes identified above. If a provider or supplier already has Form 855 on file, it is allowed to submit a reduced version that includes only the provider's identifying information, authorized signature and the pages that have changed. ❑

SNF therapy services: should you outsource?

by Darryl Bueker, Springfield, dbueker@bkd.com

For a SNF to be financially successful today, it also must generally be successful in its Medicare Part A and Part B therapy operations.

If a facility with a good Part A and Part B therapy volume outsources its therapy services, it will often incur therapy bills exceeding $10,000 per month.

As a result, many SNFs consider bringing therapy operations in-house and using their own employees to provide the service instead of contracting an outside provider.

BKD has helped many SNFs evaluate this decision, and the answer is not always the same. Following are factors to consider:

If the contract is properly negotiated, the outside therapy provider will generally be paid a variable cost - This means the SNF will only incur the cost when it receives therapy services that can be billed to another party and generate therapy revenue.

Most of our clients have contracted their Part A services on a per-minute basis with limits for the amount of minutes to be provided in each rehab RUGs category.

Likewise, costs for Part B services are usually contracted at a percentage of the Part B fee schedule rate that applies to the services received.

If your SNF receives good rates in contract arrangements like these, the services will be provided at a variable cost and should be profitable to the facility for both types of services.

If your SNF employs its own therapists, it will generally be at a fixed cost that does not fluctuate with volume.

If you contract therapy, you should receive the three main therapy services - Your SNF should be able to offer all types of therapy services to your residents—physical, occupational and speech. When you bring therapy services in-house, it is often difficult to provide all three types.

For many SNFs, the volume for physical, occupational and speech therapy services can vary dramatically; therefore, an advantage to outsourcing is it generally provides access to all three types as needed.

Ability to locate and hire qualified therapists and keep them properly educated - Finding qualified staff and providing continuing education programs can be an important consideration for an individual SNF or small chain that's separated by geographic distance.

This is often a common problem for SNFs that employ their own therapists.

Pay attention to contract details; consult an attorney - Contracted therapy providers generally carry professional liability insurance to cover their services.

It's critical for outside therapy providers to know and understand SNF Part A and Part B coding and service issues; otherwise, they may provide services Medicare will not pay for.

A contract between the SNF and the outside therapy provider should include indemnification clauses for applicable therapy services.

This will protect SNFs from paying for services not covered or for any that were administered in error by the outside therapy provider.

How steady is the SNF's therapy volume? If all therapists are kept busy and productive (80% or more billable hours, for example) it may be to the SNF's financial advantage to have in-house therapy.

Potentially, the SNF could provide therapy at a lower per-minute cost, making outsourcing more expensive.

Often, a SNF's therapy volume is neither high nor predictable, but when several chain facilities are located in close proximity to each other, it can be to their advantage to hire therapists and rotate them among each facility.

Corporate compliance and other regulatory issues can have an impact - Every SNF must evaluate if and how contracting with an outside, independent therapy provider would affect compliance issues.

Whether or not a SNF decides to employ therapists or contract with an outside provider, it should closely review its Part A patients - This offers an opportunity to check Part A patients' *clinical* days against their percentage of *therapy* days.

BKD reviews many facilities' operations and often finds more than 80% of a SNF's Part A days are therapy days. Our SNF consultants recommend that percentage be between 60% to 70% of Part A days.

Generally, nontherapy Part A days can be profitable because the costs for these services are fixed and no outsourcing costs apply.

A SNF also should consider the use of Rehab Low (RL) RUGs payment levels to be properly paid for their restorative services.

* * *

If your SNF is deciding whether to outsource therapy services or provide them in-house, contact your BKD Health Care Group advisor for assistance.❑

Revenue cycle improvements begin at registration

by Carey Deal, Tulsa, cdeal@bkd.com

The revenue cycle consists of many routine tasks that, individually, are rather simple; however, errors in any area can cause significant cash flow delays.

Many of these tasks must be completed well before services are provided to patients.

Avoid pitfalls

There are ways to handle these issues before they result in denials, delays and slow or lost payments.

Many common errors are caused by oversights in such routine tasks as gathering accurate demographic information.

To verify the accuracy of pa tient information, always ask the patient for identification and do not assume that demographic data has not changed.

It's important to verify all parts of the information with the patient each time he/she visits your facility.

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CAHs can manage. . .

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related items to those with greater impact on hospital payments.

As such, some of the old attention on allowable costs has waned. CAHs bring the old cost-based reimbursement issues (and accounting challenges) to the forefront.

Filing a cost report that does not properly identify nonallowable costs can result in inaccurate payments at best and accusations of fraud and abuse at worst.

Throughout the year, track and remove nonallowable costs (see "Common Nonallowable Costs" below) from your cost report to avoid potential fines, penalties and Medicare audit surprises.

Combine bill services

CAHs have the option to combine bill for outpatient hospital and physician services. Instead of submitting a bill to both the FI and the carrier, electing hospitals submit one bill to the FI.

As a bonus, CAHs that elect this method receive 115% of the Medicare fee schedule for the physician service. For a moderately busy emergency room, a 15% difference can result in much-needed additional cash flow.

The MMA removed some onerous restrictions on the combined billing option by eliminating a requirement that a CAH must combine bill for *all* physicians providing outpatient services if it elects the optional method.

Effective for periods beginning on or after July 1, 2004, CAHs may elect to combine bill for selected physicians practicing at the hospital, *e.g.*, ER physicians.

This solves the problem many hospitals had when it proved impractical to combine bill for community physicians or out-of-town specialists who only occasionally practiced at the hospital.

To elect this method, you must have a valid assignment agreement with each physician for whom you wish to combine bill, and you must notify the FI at least 30 days before the beginning of your cost reporting period.

On approval, you can begin combined billing at the start of your cost report year. You will include the physician fee charge on the UB-92 and the FI will pay the fee schedule amount plus 15% in addition to regular hospital service payments.

Common Nonallowable Costs

- Alcoholic beverages
- Lobbying expenses
- Gifts and donations
- Promotional items
- Sports and other tickets
- Entertainment
- Advertising (to increase utilization)
- Marketing salaries and related costs
- Excess costs of related entities
- Most physician recruitment costs and physician guarantees
- Patient telephones/televisions
- Physician offices (including cost of rented space)
- Gift shops/vending machines
- Meals for guests
- Personal use of autos
- Fines and penalties
- Country club dues
- Spousal travel and education not related to patient care
- Costs of drugs sold to nonpatients

CAH approval requirements

To qualify as a CAH, a hospital must meet certain distance requirements from other hospitals or be designated as an essential hospital by the state.

The state designation has allowed many hospitals to become CAHs that would not have been able to meet the distance rules.

The MMA will remove a state's ability to designate essential hospitals for CAH purposes after January 1, 2006. Hospitals should keep this date in mind if they are considering CAH conversion but can't meet the distance rules.

Add distinct part units

CAHs will be able to add distinct part psychiatric or rehabilitation units with up to 10 beds each for cost reporting periods beginning on or after October 1, 2004. Patients in these units will not be included for purposes of the CAH bed limitation or 96-hour length-of-stay rules.

If a CAH elects to add a unit, the reimbursement system applicable to that unit type will be used. For instance, psychiatric units will be paid based on TEFRA-limited cost principles until a PPS is implemented sometime in 2005. Rehabilitation units will be paid under the existing rehab PPS rules.

While CAHs may find these units profitable, it is important to determine their impact on cost reimbursement for the rest of the hospital before adding one.

In many cases, significant fixed costs will be allocated to these units that would otherwise go to cost-based portions of the hospital. If these costs are significant, the additional profit expected from the distinct part unit may be limited.

Include ER physician fees

Many CAHs are able to include a large portion of their ER physician fees on their cost report as a reimbursable cost. Generally, stand-by or availability payments are reimbursable; for how to qualify, see Section 2109.3 of the **Provider Reimbursement Manual**.

Among other items, the manual requires CAHs to document that alternative methods for obtaining coverage, *e.g.*, straight fee-for-service arrangements, have been explored each time an existing emergency room contract is renewed or a new one negotiated.

Evidence of this can include advertisements placed in appropriate professional publications. Without documentation, availability costs could be disallowed.

* * *

CAHs have many unique reimbursement considerations; the legislative and compliance activities related to CAHs make it imperative to continually review your reimbursement situation.

Call your BKD Health Care Group advisor to find out how to take advantage of new opportunities and limit future risks at your hospital.❑

Check out. . .

Health Care NEWS @ bkd.com

Revenue cycle improvements. . .

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At admission, it's prudent to make a photocopy of the patient's insurance card(s). This can eliminate billing confusion later in the revenue cycle process.

If precertification is required, route the patient's information to the proper personnel within the time frame stated on the patient's insurance card.

Remember that an insurance card doesn't guarantee insurance coverage. Providers should verify patient benefits directly with the insurance company.

Know if a service is covered before providing it. The patient's coverage might exclude certain services, *e.g.*, pre-existing conditions, maternity care, high-tech radiology services, chemotherapy.

If it isn't, you may need to have the patient sign an ABN; only certain services qualify, which Medicare summarizes on its web site: **cms.hhs.gov/**.

For Medicaid patients, verify benefits with the state, either directly or through approved vendors.

Make improvements

Appropriately identify primary and secondary payers; billing the wrong insurance provider as primary is a common error that can cause reimbursement delays and poor customer satisfaction.

File claims in a timely manner, work them as they are processed and continually follow up with the payer. A denials-management process is critical to capturing reimbursement.

Improve the revenue cycle at your facility by implementing the following:

- ▲ Internal-audit processes
- ▲ Denial-management processes
- ▲ Fixed schedule for working patient accounts
- ▲ Regularly scheduled training and education

Training staff to always complete these relatively simple steps will help streamline your registration process.❑

Internal control helps provide assurance

by Dave Mason, Fort Wayne, dmason@bkd.com

Where are your most significant business risks and how do you limit or prevent your exposure to them? Begin by implementing a sound internal control structure.

An internal control structure is designed by an organization's board, management and personnel to provide reasonable assurance in the following areas:

- ▲ Effective and efficient operations
- ▲ Reliable reporting of financial, management and operating information
- ▲ Compliance with applicable laws and regulations
- ▲ Adequately protected resources
- ▲ Meeting goals and objectives

A control is a step within the process to help provide feedback on the accuracy or value of each task being performed.

Example: Blank check stock is maintained in a secure area accessible to only one individual. To obtain a check, the individual must access the stock and log out the sequential number of the check before distributing it for processing.

With this particular control structure, management is able to limit access to the negotiable checks, easily identify any missing checks and compare the check log to disbursements records for unusual items.

Implementing a sound internal control structure depends on assessing risk throughout your organization.

It is probably impossible to eliminate all risks, especially in a cost-efficient manner. Management should evaluate the company's risk areas and address those most vulnerable.

Once these key risks are identified, establish and implement mitigating controls to reduce the chance of malfeasance or misstatements.

Internal controls are instrumental in providing management the tools and information necessary to ensure financial statements are reported accurately and company assets are properly protected.

* * *

Contact your BKD Health Care Group advisor for help assessing your internal control needs and for more information about our internal control assessment expertise.❑

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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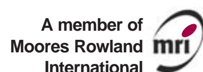

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