

# Health Care NEWS

Strategies for Success

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## Rules, rules, rules

by Tim Wolters, Springfield,  
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**C**MS recently issued a number of final rules, along with several proposed rules; this article summarizes the more significant provisions. As always, check with your BKD advisor for specifics on the impact each will have.

### Inpatient PPS

The August 11, 2004, **Federal Register** included the final inpatient PPS rule, generally effective for discharges on or after October 1, 2004. The final rule implement-

ed most of the changes described in the May 18, 2004, proposed rule (see June 2004 **Health Care News**).

The basic payment rate increase is based on a 3.3% market-basket adjustment. CMS estimates the average impact of the final rule on urban hospitals will be a 5.7% increase in payments, while rural hospitals will see a 6.2% increase; however, the rural impact is somewhat overstated because it includes a full 1.1% impact of geographic reclassification, as if no hospitals were reclassified in fiscal 2004.

CMS also includes an estimated 1.5% increase for all hospitals

because it has reduced the outlier threshold to \$25,800. CMS acknowledges it has effectively underpaid outlier payments by 1.5% using the fiscal 2004 threshold of \$31,000.

### Changes in status & wage adjustments

Probably the most significant changes in the final rule relate to the implementation of the new core-based statistical areas (CBSAs) based on the 2000 census.

CMS finalized its proposal to allow an urban hospital losing its **continued on page 5...**

## NFP hospitals & class-action lawsuits: the public is watching

by Scott Crabtree, Little Rock,  
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**T**he Scruggs Law Firm recently filed a series of class-action lawsuits against more than 300 not-for-profit hospitals, alleging they have not fulfilled their obligation to provide charity care in return for tax-exempt status.

According to an August 26 article in **Tax Analysts**, 44 suits have been filed across the country since June, including one filed recently against the AHA. The lawsuits also chal-

lenge the way not-for-profit hospitals bill their uninsured patients.

Scruggs, known for its multi-billion-dollar suit against the tobacco industry, alleges defendants charged uninsured patients unfair and unreasonable rates, harassing those who cannot afford to pay. The suits also allege these rates exceed the discounted amounts insured patients are charged.

One hospital system, a codefendant with AHA, criticized the suit saying, "This lawsuit, disguised as an attempt to change health care policy, is simply unnecessary litigation designed to enrich

plaintiffs' lawyers conspiring to attack nonprofit faith-based health care providers." An AHA spokeswoman called the suits "baseless and misdirected."

Whatever your take is on the recent rounds of litigation, one thing is certain—Congress, the IRS and other entities have these institutions on their respective radar screens.

Hospitals must closely monitor developments in this area. BKD also will closely monitor the progress of these lawsuits and the effect they could have on your institution. □

# OIG compels HHA accountability

by Karen Vance, Springfield,  
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**M**0175 is the OASIS data element collected during a home health comprehensive assessment that asks, "From which of the following inpatient facilities was the patient discharged **during the past 14 days?** (Mark all that apply)."

Since early 2003, M0175 has received much attention from OIG after regional home health intermediary (RHHI) audits estimated \$17 million in overpayments to

HHAs, attributing them to errors in answering M0175.

Early speculation about the overpayments prompted a CMS recommendation that RHHIs use this information as an educational tool to help HHAs to improve the accuracy of their M0175 responses.

Then, CMS upped the ante. As overpayment estimates grew, CMS instructed RHHIs to:

- ▲ Recover the overpayments found in sample claims
- ▲ Review, identify and recover overpayments from the balance of the claims

- ▲ Institute an automated system for identifying and correcting overpayments
- ▲ Conduct annual post-payment data analysis to detect and recover overpayments
- ▲ Provide education to HHAs for accurate data collection

Details for these instructions were published October 24, 2003, in **Transmittal 13**. A plan to phase in a three-stage recovery of the overpayments is anticipated, which will account for approximately \$25 million for fiscal years 2001, 2002 and 2003.

In response, the industry has pointed out errors in answering M0175 also have resulted in underpayments to HHAs. Because the audit system for identifying errors is automated, a request was made to identify and return underpayments to HHAs, including overpayments recovered by CMS.

## Story behind headlines

CMS published a modification to **Transmittal 13** July 30, 2004, with the intention of identifying "both overpayments and under-

# DAVE reviews could negatively affect SNF revenues

by Monte Aspelmeier, Springfield,  
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**M**edicare-certified nursing facilities across the U.S. are beginning to experience the financial impact of CMS's Data Assessment and Verification (DAVE) project.

DAVE was created to assess

the reliability of assessment data submitted by SNFs (MDS) and HHAs (OASIS).

In 2003, DAVE inspectors visited 127 facilities and reviewed more than 1,200 assessments. At the same time, the project included offsite reviews on 580 facilities.

The following looks at the SNF portion of the DAVE project.

Shelley Gold, project manager of the DAVE team, and CMS's Angela Brice-Smith say the DAVE project will involve all states and encompass approximately 2,000 facilities during the 2004 fiscal year.

As of June 2004, more than 1,200 facilities had been contacted, with 700 record reviews complet-

ed. Before September 30, DAVE teams plan to visit the remaining 800 facilities.

## How it's working

The project's original goal has been expanded, and reviews are resulting in Medicare payments being negatively adjusted. Results of the offsite reviews are being reported to CMS, FIs, surveyors and program safeguard staff.

This summer, facilities have begun to receive adjustments based on DAVE project reviews involving the entire patient stay.

Facilities selected for an onsite DAVE team review can expect a report from DAVE within 60 days. Offsite record reviews involve only one or two record reviews per facility.

Facilities will not receive a DAVE report unless a payment adjustment is indicated. Notification of the adjustment comes from the facility's FI.

The DAVE project does not include payment reviews during the onsite visit, but if the DAVE

**continued on page 8. . .**

## Prepare your facility

**H**ow do providers prepare for a review conducted by DAVE?

- ▲ Get to know DAVE very well; educate yourself and your staff on project specifics. A good information source is the CMS web site: [www.cms.hhs.gov/providers/psc/DAVE/Homepage.asp](http://www.cms.hhs.gov/providers/psc/DAVE/Homepage.asp)
- ▲ Appoint a small group or have an outside consultant review samples of Medicare records (opened and closed); compare MDS information with supporting documentation.

- ▲ Calculate your facility's risk of a DAVE review: Determine the percentage of Medicare A days billed to each rehabilitation RUG III vs. clinical RUG III categories. If the facility has more than 90% of the days in a rehabilitation category, this may elevate your risk of a review.

- ▲ Review CMS's report, "DAVE Onsite Review Results," for common reasons discrepancies occur in documented record information and the MDS:  
[www.cms.hhs.gov/providers/psc/DAVE/DiscrepancyReport.asp](http://www.cms.hhs.gov/providers/psc/DAVE/DiscrepancyReport.asp)

- ▲ Compare UB-92s for the Medicare Part A claims with the MDS assessments, therapy logs and nursing documentation. Your goal is accuracy; determine if medical record documentation justifies and supports the services billed.

\* \* \*

Contact your BKD Health Group advisor to help your SNF prepare for a DAVE review. □

# for M0175 - Part 1

payments resulting from inaccurate reporting of inpatient discharges for federal fiscal years 2001, 2002 and 2003.”

For claims in 2004 and beyond, Medicare will only identify overpayments because it believes the industry understands the importance of correctly completed M0175s and now has the resources to do so.

HHAs will be expected to self-audit for underpayments and seek refunds through individual claim corrections. January 3, 2005, the implementation date for the change, applies to episodes ending on or before September 30, 2003.

## Collecting data

To correctly complete an M0175, HHAs depend on referral sources and patients for accurate information about when and where a patient came from before HHA admission; however, this information can be difficult to get.

Referral sources are often too hurried or unaware of such details to share them during an intake call. To date, the primary source for many M0175s’ data is the patient or his/her caregiver, sources often described as “unreliable historians.”

M0175 also has two phrases that are problematic for completing an accurate OASIS assessment: “during the past 14 days” and “mark all that apply.”

A patient’s “past 14 days” begins the day *before* HHA admission. This detail can be very important. In addition, the primary reason for OIG audits is HHAs don’t always mark *all* the inpatient facility discharges during that 14-day period, just the one or two reported by the patient.

## Points at stake

These errors draw attention because of the points assigned

when M0175 is scored with a rehab or SNF discharge without a hospital discharge.

If a patient is discharged within the past 14 days from a rehab or SNF facility instead of a hospital, the difference in points translates to an approximate payment difference of \$200 to \$500, depending on expected therapy needs.

The table below defines the points allocated to the HHRG depending on the discharge location.

Hospital discharge	0 points
No hospital discharge	1 point
Rehab or SNF discharge	2 points

\* 3 points raises the payment category

Your HHA pays for the M0175 errors it makes, either with Medicare adjustments or underpayments, and it is incumbent on your HHA to correct underpayments from 2004 forward. But why not get it right the first time?

Following are clinical strategies to help your HHA do just that.

## Dig for information

Have your intake staff consistently ask referral sources for:

- ▲ Exact admission, transfer and discharge dates and locations
- ▲ All pertinent history and physical reports
- ▲ Possible prior inpatient stays that can be found electronically by searching Medicare’s common working file (CWF)

Become familiar with facilities in your area. Do they include rehab, skilled units or swing beds (an acute bed or a skilled bed)? Distinguish the free-standing rehab hospitals from long-term care hospitals, which are considered “hospitals” on M0175.

Instruct staff to probe for more information from patients and caregivers by asking:

- ▲ Did you move to a different room or floor in the hospital?
- ▲ Did you eat your meals in a different room? (signs of a rehab unit)
- ▲ Did you get therapy? (signs of rehab or skilled units)
- Any clues in the patient’s home?
- ▲ Did you spot any discharge instructions from a facility not listed on the referral?
- ▲ Does equipment in the home bear a tag from “XYZ Rehab Unit”?
- ▲ Do home exercise programs bear the name of an unaccounted-for facility?
- ▲ Compare it to the patient’s actual LOS
- ▲ Is there a significant difference between the diagnoses listed in M0210 and M0190, one that requires a longer stay or sub-acute transfer?
- ▲ Contact the hospital billing department for transfers within the hospital and the dates they occurred

Record the correct information on the intake form. Put the dates on a calendar and do the math. Do they fall within 14 days of the HHA admission? Check again for suspicious hospital LOS.


\* \* \*

Follow up on unanswered questions, mysteries or date discrepancies. Be aware of possible gaps in the picture and pursue information to close them:

- ▲ Is the hospital LOS suspiciously long for the diagnosis?
- ▲ Have a list sent to you containing the most frequent DRGs and the LOS for each

Sometimes, M0175 errors will occur no matter how hard you try to apply the correct billing strategy on the front end, but your HHA can implement certain safeguards when it’s time to file claims.

Billing strategies will be the subject of **Part 2**. Contact your BKD Health Care Group advisor for more information. □

 <b>BKD Health Care Group Speakers' Bureau</b>			
Topic	Speaker/Office	Seminar	Location & Date
Operational Improvement of the Revenue Cycle	<b>Angela Morelock, Jennifer Fielding,</b> Springfield	National Association of Community Health Centers	San Francisco 9/20
FQHC Cost Reports & PPS Issues	<b>Jeff Allen, Mike Schnake,</b> Springfield	NACHC	9/21
No More Write-Offs! Managing Receivables Effectively	<b>Brian Hickman, Derek Hunter,</b> Springfield	American Health Care Association	Miami Beach 10/3-6
E/M Coding & Billing, Managed Care Contracting	<b>Sandra Soerries,</b> Kansas City	American Academy of Physician Medicine & Rehab	Phoenix 10/4-5
Practical Strategies for Management of Billing/Accounts Receivable	<b>Aaron Little,</b> Springfield	National Association for Home Care & Hospice	Phoenix 10/24
Full Episode Thinking: The Journey to Outcomes	<b>Karen Vance,</b> Springfield	NAHCH	10/24

# Accurate documentation & coding at heart of encounter phase

by Darla McGinnis, Wichita,  
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**Editor's note:** "Revenue Cycle Improvements Begin at Registration" (June issue, page 6) covered the revenue cycle's front end. This issue covers the encounter phase, and the December issue will cover the revenue cycle's back end.

Authored by three writers, these articles were originally scheduled to appear together, but space limitations required separate publication.

For a June- or September-issue PDF, go to: [www.bkd.com/news/Newsletters.htm](http://www.bkd.com/news/Newsletters.htm). □

**T**he revenue cycle's encounter phase begins when patient medical records are created from the physician's notes that document the episode of care and the treatment provided. Billing codes are based on this documentation.

As the old saying goes, "Documentation isn't just a part of patient care, it *is* patient care. If it isn't documented, it wasn't done."

Documentation and coding have an impact on the revenue cycle. In fact, documentation and proper International Classification of Diseases 9th Edition Clinical Modification (ICD-9-CM) code as-

signments are at the heart of accurate billing and reimbursement.

## What is ICD-9-CM coding?

Coding is the numeric or alphanumeric designation given to the verbal descriptions of diseases, injuries or procedures.

Codes for inpatient services are entered into the DRG data-classification system; outpatient services are reported with HCPCS/CPT codes linked to payment amounts per procedure.

Therefore, assigning the accurate code is critical and significantly affects the revenue cycle

and the financial health of your facility.

## Case management, utilization review & education are vital

Case management and utilization review play a vital role in the charge-capture process.

Utilization review focuses on managing patient resources, such as procedures and diagnostic tests.

Case management cost effectively monitors patients through all segments of the health care continuum without compromising quality of care. It also helps maintain the necessary balance between patient, provider and payer.

Facilities must educate physicians about the importance of accurate documentation, not only for reimbursement purposes but for data collection and to evaluate patient care processes and outcomes. Remind physicians that documentation must accurately reflect the patient's current condition and the treatment provided.

Quality documentation and coding go hand in hand. Detailed and legible point-of-service documentation helps facilities receive accurate reimbursement and prevents claims denial on the revenue cycle's back end.

Your facility's coding staff also must be highly trained and highly skilled. Provide continual in-service coding education and implement monitoring mechanisms to evaluate coding accuracy.

## Charge capture & billing process must be accurate

The next step of the cycle is the charge capture and billing process. A critical component of

...continued on page 8

## Health Care News glossary

**ABN** – Advanced beneficiary notice

**ADL** – Activities of daily living

**AHA** – American Hospital Association

**ALOS** – Average length of stay

**APC** – Ambulatory payment classification

**CAH** – Critical access hospital

**CBSA** – Core-based statistical area

**CMS** – Centers for Medicare and Medicaid Services

**CPT** – Current procedural terminology

**DHHS** – Department of Health and Human Services

**DME** – Durable medical equipment

**DPU** – Distinct-part unit

**DRG** – Diagnosis-related group

**DSH** – Disproportionate share hospital

**FI** – Fiscal intermediary

**FQHC** – Federally qualified health center

**FTE** – Full-time equivalents

**HCPCS** – Healthcare common procedure coding system

**HDC** – Hospital Data Collection

**HHA** – Home health agency

**HHRG** – Home health resource group

**ICD** – Core-based statistical area

**IPPS hospital** – Inpatient prospective payment system hospital

**IRF** – Inpatient rehabilitation facilities

**IRS** – Internal Revenue Service

**LCD** – Local Coverage Determination

**LOS** – Length of stay

**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

# Rules, rules. . .

continued from page 1. . .

urban status to retain its urban wage index for three years.

Rural hospitals, newly designated as urban, may be able to apply under 42 CFR 412.103 to retain rural status if it is more beneficial, such as to retain SCH status.

CMS provides an additional transition for hospitals disadvantaged by their CBSA wage index, allowing them to receive 50% of the CBSA wage index and 50% of the wage index based on MSA boundaries used in fiscal 2004.

CMS also finalized its plans to implement Section 505 of MMA related to wage adjustments based on employee out-migration.

Hospitals have three different urban and three different rural wage-index tables to refer to in the final rule, as well as a table of Section 505 adjustments and three additional tables listing reclassifications for fiscal 2005.

Because of technical errors in the tables, CMS posted corrected tables on its web site August 31, 2004 (<http://www.cms.hhs.gov/providers/hipps/ippswage.asp>). Table 2 shows each hospital's wage index effective October 1, 2004.

With minor changes, most of the provisions proposed for CAHs to implement various sections of the MMA were finalized in this rule.

One significant change relates to CAHs newly classified as urban under the CBSA criteria. CMS will allow these CAH to apply for rural status under 42 CFR 412.103, through December 31, 2005.

## Impact of other MMA provisions

CMS also implements another MMA provision by finalizing an application process for teaching hospitals to apply for an increase in their resident cap, obtaining

unused resident positions taken from hospitals not using their full resident allocation.

Applications for unused resident positions will be due December 1, 2004, or March 1, 2005, depending on whether or not a hospital's resident count is undergoing audit.

CMS effectively removed any possible benefit from an MMA provision that would have given low-volume PPS hospitals an add-on to their inpatient payment rate.

MMA authorized this payment for hospitals with up to 800 discharges. The May 18 proposed rule limited the adjustment to hospitals with up to 500 discharges.

In the final rule, CMS limits the adjustment to hospitals with no more than 200 discharges, acknowledging very few hospitals will qualify for the adjustment.

## Other final rules

**SNF PPS** - The SNF PPS final rule, published July 30, 2004, generally provides for a 2.8% increase in payment rates effective October 1, 2004. CMS has opted not to use the new CBSAs developed from the 2000 census at this time.

Citing the numerous areas of concern from the hospital community, CMS states it wanted to wait until the hospital rule was finalized and then publish a new proposed rule for SNF PPS if they propose making changes to the SNF PPS in this area.

**Rehab PPS** - The July 30, 2004, **Federal Register** also included the rehab PPS final rule effective October 1, 2004. The rule provides for a 3.1% market-basket increase in payment rates.

As with the SNF PPS final rule, CMS is not adopting the new CBSA definitions for rehab hospitals and units at this time; thus, a hospital could be considered urban

for inpatient and outpatient PPS, while deemed rural for its SNF and rehab units.

**Ambulance fee schedule** - The July 1, 2004, **Federal Register** included an interim final rule implementing several MMA changes with regard to the ambulance fee schedule.

The provisions have differing sunset dates but are all generally effective for services on or after July 1, 2004, including:

- ▲ A 1% increase in urban payments and a 2% increase in rural payments, through December 31, 2006
- ▲ A 25% increase in the mileage rate for miles exceeding 50 on any trip, through December 31, 2008
- ▲ A regional fee schedule providing a floor for the ground ambulance base rate; the regional fee schedule will transition back to a national fee schedule over five years, with a December 31, 2009, sunset
- ▲ A 22.6% increase in the ground ambulance base rate through December 31, 2009, for trips originating in a qualified rural area, *i.e.*, an area ranked in the lowest 25% of all areas in the country, based on population density

## Other proposed rules

**Outpatient PPS** - The August 16,

2004, **Federal Register** contained the proposed outpatient PPS rule, with rates effective January 1, 2005.

The rule proposes a 3.3% market-basket increase for outpatient PPS services. Considering changes in drug payments and other MMA changes, CMS estimates the overall impact on hospitals will be an increase of 4.6%.

CMS proposes using the CBSA areas implemented for inpatient PPS to assign a hospital's wage index for outpatient PPS.

**Physician fee schedule** - In the August 5, 2004, **Federal Register**, the proposed 2005 physician fee schedule calls for a 1.5% increase, as mandated by MMA.

This avoids what would have been a 3.7% decrease in the fee schedule under previous law.

The proposed rule implements various MMA provisions, including a 5% incentive payment for doctors practicing in physician-scarcity areas, and new benefits for preventive medical services.

\* \* \*

There are numerous other provisions included within the rules mentioned above. Contact your BKD Health Care Group advisor for more information on how they will affect your operations. □



**BKD Health Care Group  
Writers' Bureau**

Article	Author	Publication	Date
"Making the Commitment to Compliance"	Larry Fogel & Joe Watt, Kansas City	HFM	June 2004
"Critical Access Hospital Status"	Sue Brammer, Kansas City	Reimbursement Journal	July 2004
Management Principles Guide Change	John Britt, Louisville	HFM's Executive Insights Newsletter	September 2004

# IME 101: what teaching hospitals must learn

by Brent Beaulieu, Little Rock, [bbeaulieu@bkd.com](mailto:bbeaulieu@bkd.com)

Under Medicare's IPPS, hospitals with residents in an approved graduate medical education (GME) program can receive an additional payment for a Medicare discharge.

This additional payment—called an indirect medical education (IME) adjustment—is intended to reimburse hospitals for the higher indirect costs associated with operating a teaching program. (Many hospitals also receive payment for Direct Graduate Medical Education, which is outside the scope of this article.)

The IME adjustment, which is an add-on to the federal DRG payment, is computed using a standard formula that considers the number of full-time equivalent residents, bed size (for operating DRG amounts) or average daily census (for capital DRG amounts).

The operating IME adjustment factor is based on a hospital's ratio of full-time equivalent residents to the average number of beds available during a given cost reporting period.

Obtaining a correct count of available beds is important, as small changes in this measure can have a significant impact on payments, as shown in the table accompanying this article.

The capital IME adjustment factor is computed differently because it is based on a hospital's ratio of full-time equivalent residents to the average daily census during a given cost reporting period.

When determining the average beds available and the average daily census, beds and patients associated with the following are excluded:

- ▲ Generally, beds in units not payable under IPPS
- ▲ Beds in excluded distinct-part units (psych and rehab units)

- ▲ Beds used for SNF, swingbed, outpatient observation and labor/delivery services

- ▲ Beds or bassinets in the healthy newborn nursery

- ▲ Custodial-care beds

The following guidelines apply when determining the number of resident FTEs needed to calculate the IME adjustment factor:

- ▲ Resident must be in an approved teaching program

- ▲ Resident must be assigned to an IPPS or outpatient department of the hospital

- ▲ Resident may be in a nonhospital setting if certain requirements are met

- ▲ FTE status is based on the total time necessary to fill a residency slot

- ▲ No individual may be counted as more than one FTE

The *Balanced Budget Act of 1997* (BBA97) imposed a cap on the number of resident FTEs that can be used to determine the IME adjustment based on the hospital's resident FTEs reported in its 1996 cost report. A different computation is used to cap programs started after 1996.

The regulations contain certain provisions for adjustments to the cap. For example, rural track programs, programs in areas where another hospital closed a program or programs in an affiliated group may be able to have their individual caps adjusted.

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* added a new provision to reduce the cap for hospitals not using their full cap allotment.

If a hospital has fewer residents than its cap allows, CMS will redistribute these to hospitals that can use the residency slots. This provision excludes rural hospitals with fewer than 250 beds.

Contact your BKD Health Care Group advisor for more information about IME adjustments

and how IME can affect your hospital. □

## IME Adjustment Factor Sample

	Hospital A	Hospital B
Resident FTEs	10	10
Average beds available	150	160
IME Adjustment Factor (2005) based on factors above	0.0376	0.0353
National base operating DRG payment	\$4,555	\$4,555
Medicare discharges	4,000	4,000
Operating IME payment add-on	\$685,174	\$643,107
Difference	\$42,067	

## IRS rules on joint ventures

by Tim Snavely, St Louis, [tsnavely@bkd.com](mailto:tsnavely@bkd.com)

When the IRS issued **Revenue Ruling (Rev. Rul.) 2004-51** in May, it provided long-awaited guidance on ancillary joint ventures between tax-exempt organizations and for-profit entities.

The ruling addresses whether an exempt organization continues to qualify for tax exemption when it contributes a portion of its assets to—and conducts a portion of its activities through—a limited liability company (LLC) formed with a for-profit corporation.

The second issue the ruling addresses is whether the exempt organization is subject to unrelated business income tax (UBIT) on income derived from the LLC.

According to a Treasury Department release, the revenue ruling was in response to requests of tax-exempt organizations for guidance in structuring joint ventures when the joint venture repre-

sents only an insubstantial part of the exempt organization's activities.

Although the ruling involves a situation where a university undertakes a joint venture, the same principals also should apply to health care organizations' joint venture arrangements.

First, tax-exempt organizations considering participation in "ancillary" joint ventures with for-profit entities should take comfort from **Rev. Rul. 2004-51** that such participation will not threaten their continued entitlement to Section 501(c)(3) status—but **only if** the activities conducted by the joint venture do not constitute a substantial part of their overall activities.

Second, the ruling indicated it is possible to avoid adverse UBIT consequences when structuring these joint ventures. Be sure governing documents provide information about the joint venture's charitable, scientific or educational

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# FSR planning can protect CHC funding

by Jeff Allen, Springfield,  
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**T**he Bureau of Primary Health Care (BPHC) is placing increased emphasis on finance issues for CHCs.

The possibility that unobligated grant funds will be carried forward into the next grant budget period seems less likely than ever before.

All federally funded CHCs are required to file a financial status report (FSR) within 90 days after the federal grant budget period expires.

The FSR is an official claim for federal reimbursement of expenditures; therefore, it is one of the most important documents CHCs are required to file.

Although relatively short, the FSR contains a variety of unique complexities and is often misunderstood. If it is not completed correctly—or if proper planning is incomplete—precious federal grant monies may have to be repaid or deducted from future grant awards.

Successful FSR completion depends on planning ahead for the end of the federal grant budget period. The following may help your CHC avoid unexpected problems.

## Avoid year-end reporting of unobligated funds

After the audit has been completed and the books are closed, have you ever been informed your FSR includes an unobligated balance of federal grant funds?

As you wait for news from BPHC about your carryforward request, what you thought was a great year is taking a sudden turn. You may ask, “How did this happen? Is there something we could have done to avoid this situation?”

Once the budget period is over, only limited actions can be taken to affect the FSR positively. One of the best ways to avoid this problem is to plan before the end of the federal grant budget period.

If a problem is discovered in the interim, proactive measures can be taken to reduce the possibility unobligated funds will be reported on the FSR at year end.

Although FSR planning can be completed at the end of any interim period, the one closest to the end of the federal grant budget period is usually more beneficial because projections are based on more accurate historical data; however, if FSR planning is completed too close to the end of the budget period, you may not have enough time to remedy your situation.

Generally, a good time to complete FSR planning is nine to 10 months into your budget period. That’s because, by then, you have sufficient historical data to project amounts to year end, and there is still time left to make needed changes.

## Planning requires careful consideration

After you select your interim period, generate accurate internal financial statements. FSR planning is generally useless unless accurate interim financial statements exist.

Expense accruals, valuation of accounts receivable, estimates for cost report settlements—these items can have a significant impact on the FSR; therefore, carefully consider them before continuing.

The next step is to project (as accurately as possible) the financial results for the rest of the budget period. The focus of this projec-

tion is on revenue and expense amounts; however, significant changes to balance sheet accounts also can affect the outcome.

If you expect operations to be relatively consistent for the rest of the budget period, all that is necessary is a simple calculation to annualize routine financial statement items, such as patient revenues and salary expenses.

**Generally, a good time to complete FSR planning is nine to 10 months into your budget period.**

On the other hand, if you anticipate operations will be different in the remaining budget period because of a peak time of the year or other issues, factor this into your projections.

Also, be aware of annualizing financial statement items that should not be annualized. For example, if you have received a large grant or contribution that has been fully recognized at the end of your interim period, annualizing that amount will overstate revenues and lead to a misleading analysis of the FSR.

Once projections have been made, complete the FSR form just as if it was year end.

## Be proactive

If the interim FSR projects the possibility of unobligated funds at the end of the budget period, then take proactive measures to prevent this from happening.

The most popular approach, and, perhaps, the most fiscally prudent, is to establish reserves authorized by the board of directors.

Reserve payments are considered allowable outlays on the FSR and also provide much-needed reserve funds should the need arise.

Examples of items that increase allowable outlays on the FSR include:

- ▲ Prepayment of recurring, nonsalary costs
- ▲ Early extinguishment of capital-related debt obligations
- ▲ Cash purchases of fixed assets

Is your calculation of net realizable value of accounts receivable too optimistic in your financial statements?

If you think it is, then increasing your allowance for doubtful accounts will, in effect, decrease program income and could have a positive impact on your FSR.

## Planning is priceless

It is impossible to list every type of transaction and how it affects the FSR; however, the important thing is to know your financial situation before the end of the budget period.

An old adage says, “An ounce of prevention is worth a pound of cure.” Compared to the potential loss of grant funds, the resources expended to complete FSR planning is relatively small and worth its weight in gold.

\* \* \*

For assistance with FSR planning, or for more information, contact your BKD Health Care Group advisor. □

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# DAVE reviews could negatively affect. . .

**continued from page 2. . .**  
team identifies a potential payment problem, such as unsupported RUG III category utilization, an off-site review will be conducted.

So far, the offsite reviews have involved records from April to May

## IRS rules. . .

**continued from page 6. . .**  
activities, including particular details of conduct subject to the tax-exempt organization's control.

**Observation:** While the joint venture described in the ruling was controlled by the exempt organization, the ruling's application for determining whether an activity creates UBIT keyed on the traditional view that the nature of the activities is the determining factor.

The presence or absence of the tax-exempt organization's control over those activities is not required to avoid UBIT if the actual activities are, in fact, substantially related to exempt purposes.

\* \* \*

Contact your BKD Health Care Group advisor to discuss tax issues related to existing joint ventures or those being considered. □

2003, and all records have involved Medicare stays.

### DAVE reviews: who is at risk?

CMS has stated all facilities that receive onsite and offsite reviews are selected at random; however, a vast majority of these facilities have one thing in common: a high percentage (greater than 90%) of all Medicare Part A days for claims submitted fall within one of the rehabilitation RUG III categories.

It also is interesting to note that from January to May 2004, all onsite reviews took place in Illi-

nois, Massachusetts, Ohio, Pennsylvania, Tennessee and Virginia, but offsite reviews occurred nationwide.

Even though financial impact results released by DAVE have been limited thus far, substantial repayment amounts have been requested by FIs based on the limited reviews DAVE has completed and issued.

When offsite reviews result in payment adjustments, the facility is often placed on focused medical review by the FI until they are comfortable accurate assessments are being submitted.

The DAVE project currently

shares site-review information with facility FIs, and payment adjustments to prior claims are being made at an increasing rate; this is expected to continue for some time to come.

In addition, the SNF industry should be aware DAVE is formulating processes to provide information to state agencies to incorporate into ongoing survey operations.

The effect this will have on the nature of certification surveys is unknown; however, the focused review activity clearly directs more attention to assessment information accuracy and the need for supportive documentation. □

## Accurate documentation. . .

**continued from page 4. . .**  
the charge capture process is the charge description master (CDM).

In the patient accounting system, the CDM is an electronic list of patient services; it includes a price, as well as a revenue and HCPCS code.

It is critical for your facility to annually review its CDM, not only to verify each charge is assigned the appropriate HCPCS code for outpatient services but to be sure each service line-item description

matches the CPT and UB-92 revenue codes assigned.

Charge entry and charge capture can affect the revenue cycle. If not appropriately maintained, billing errors and loss in revenue can occur.

In the charge-entry process, determine how each line item is used and whether this is consistent with the service the patient has received.

During the charge-capture process, verify that the order in

which information is entered maps to the appropriate chargemaster line item.


Compliance issues, claims denials and significant loss of revenue can result if charges are not supported in the medical record documentation or services are inappropriately or incorrectly billed.

\* \* \*

Contact your BKD Health Care Group advisor for help in improving your revenue cycle. □



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