

Receive HCN via e-mail

An e-subscription to HCN may be just what the doctor ordered. It's free, just a click or two away and has live links to writers' e-mail addresses and to every URL referenced.

If you're happy with your current subscription, do nothing, but to receive your next issue electronically, follow the simple online sign-up instructions at <http://www.bkd.com/enews/>.

Your e-mail address and other personal information will **never** be sold to outside vendors or shared with anyone outside BKD. It will be kept, as always, in strict confidence. □

In this issue

- ▶ Managing toward HIPAA security compliance
- ▶ CMS ends 90-day grace period
- ▶ CMS releases final inpatient psych PPS rule
- ▶ OIG reports on LTC hospitals
- ▶ Moratorium on rehab rule enforcement
- ▶ Oncology programs see treatment changes
- ▶ Class-action lawsuits: hospitals charging practices questioned
- ▶ Revenue cycle completion: events in the income management process
- ▶ Do you know where your Medicare margins are?
- ▶ Employee fraud: crime of the 21st century
- ▶ IRS seeks to halt compensation abuses of tax-exempt organizations

Vol. 22, No. 4
January 2005
© 2005 BKD, LLP



Managing toward HIPAA security compliance

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

Health care providers, insurers and others have been struggling to implement HIPAA's administrative simplification section for the past several years.

Though most health care organizations have implemented the privacy rules, the industry is still struggling to comply with the transaction and code set EDI rules.

On the horizon is security. HIPAA's final security regulation was published in the February 20, 2003, **Federal Register**. Compliance is required by April 21, 2005.

Key components of the security rule include industry-standard approaches to sound technology management.

To ensure electronic PHI confidentiality, the final rule specifies the series of administrative, technical and physical security procedures all covered entities must use.

Standards are categorized as either *required* or *addressable*, and implementation specifications depend on which category a standard is assigned.

A required standard must be implemented exactly as the regulation specifies. An addressable standard can be implemented either according to the regulation or in any other way that accomplishes the security objective.

Covered entities will have more

latitude in complying with addressable standards but will have to decide what it will take to comply. They also will be required to document why they chose to comply as they did.

Security & privacy

The security standard's focus is to safeguard electronic PHI and the systems that store, process and transmit that information. Major

provisions affect the administrative, physical and technical safeguards necessary to accomplish that purpose.

Many organizations will discover they have already begun to address key elements of the security standards as they prepared for privacy.

Common areas where privacy and security standards overlap

continued on page 2 . . .

CMS ends 90-day grace period

by Michelle Burkett, Tulsa, murbkett@bkd.com

CMS has announced the elimination of the 90-day grace period for HCPCS codes.

Effective for services provided on or after January 1, 2005, the 90-day grace period will no longer apply for the annual HCPCS updates.

This includes both levels of codes:

- ▲ Level I codes copyrighted by the AMA's **Current Procedural Terminology, Fourth Edition** (CPT-4)
- ▲ Five-position alphanumeric Level II codes, approved and maintained jointly by the Alpha-Numeric Panel and Dental "D" codes copyrighted by the ADA

CMS has instructed Medicare carriers, DMERCs and FIs to return claims submitted with discontinued codes to the provider.

For more information, download **Transmittal 89, Change Request 3093** at: http://www.cms.hhs.gov/manuals/pm_trans/R89CP.pdf.

These changes also apply to mid-year coding changes. To avoid unnecessary billing denials or cash flow delays, you should proactively review all new Level I and Level II coding changes and adopt the new codes in your billing processes based on their effective dates.

Remember, the ICD-9-CM and HCPCS/CPT-4 codes you use must be effective on the date the service is rendered. □

CMS releases final inpatient psych PPS rule

by Stoney Oxford, Tulsa,
soxford@bkd.com

CMS has announced the new Medicare PPS for inpatient psychiatric services furnished in psychiatric hospitals and units exempt from the inpatient acute PPS.

The final rule, published in the November 15 **Federal Register**, is effective for cost reporting periods beginning on or after January 1, 2005.

It implements Section 124 of the BBRA and will replace the current reasonable cost-based payment system. Full implementation is scheduled after a three-year transition to the new PPS.

Transition period payment blends

The first year's payment blend will be 75% of the current TEFRA payment rate, and 25% will be based on the proposed inpatient

psychiatric facility (IPF) PPS federal rate.

The regulations published with the final rule indicate that the first year's blend actually applies for cost reporting periods beginning on or after January 1, 2005, and on or before June 30, 2006.

Thus, based on these regulations, many IPFs may have two cost reporting periods paid at a 75/25 blend before moving to a 50/50 blend.

A 50/50 blend will be used in the second year, and the third year blend will be a 25% TEFRA payment and a 75% IPF-PPS payment. In the fourth year, payment will be based entirely on the IPF PPS federal rate.

All exempt psychiatric facilities and units, except for new IPFs, will be required to participate in the three-year transition period, and no facility will be allowed to go directly to the full IPF PPS federal rate before the transition period ends.

CMS has warned it will not be able to implement computer system changes necessary for claims processing under the IPF PPS until April 4, 2005.

Claims submitted after January 1, 2005, will be paid as if the current TEFRA system was still in effect. Payments during this time will be reconciled later by FIs, with the appropriate IPF PPS amount.

New IPF providers will not participate in the three-year transition but will be paid entirely under the IPF PPS federal rate.

During the transition period, a new IPF is a provider of inpatient hospital psychiatric services that otherwise meets the qualifying criteria for IPFs and has a first IPF cost reporting period beginning on or after January 1, 2005.

Payment system changes

The IPF PPS implements a

per-diem PPS. Hospitals will receive a daily base rate adjusted for:

- ▲ Acuity
- ▲ Comorbidities
- ▲ Wage index
- ▲ Teaching status
- ▲ Rural location
- ▲ Patient age
- ▲ Outliers
- ▲ Emergency department
- ▲ Electroconvulsive therapy
- ▲ Interrupted stays

The federal per-diem base rate for 2005 will be \$575.95 and will not include the costs of bad debts and direct graduate medical education costs, which are paid outside the PPS.

BKD Health Care Group has developed tools to compute the impact of IPF PPS payment on providers. Contact your BKD advisor for more information about the new rule and its impact on you. □

Managing toward HIPAA. . .

continued from page 1. . . include:

- ▲ Assessing the PHI access needs of personnel
- ▲ Preventing incidental disclosures
- ▲ Restricting access to PHI
- ▲ Physically protecting PHI
- ▲ Training necessary personnel

Assess risk first

Now is the time to assess and remediate HIPAA security risks. As mentioned, the security rule includes required standards that must be implemented as specified in the rule, as well as addressable standards that can be implemented according to the rule or in any other way that accomplishes the

security objective.

The security rule will require you to base security decisions on a risk assessment, a very important formal procedure providing guidance, support and documentation for security compliance decisions.

The good news is the assessment will help you determine and implement the most appropriate security approaches for your organization. But don't delay—security compliance will take time and requires budget planning.

Ask your technology personnel when your risk assessment will be available for management to review.

Qualified resources

If you are already familiar with

the traditional basics of privacy, confidentiality and EDI issues, it is likely you have been able to rely on existing internal resources to lead your HIPAA compliance efforts.

However, the security rule may require expertise unavailable within your organization, but personnel brought in to assist with HIPAA security also must be familiar with the privacy and transaction and code set rules.

Security compliance will not be an isolated technical exercise; it must be implemented to complement and support the other rules.

Monitor compliance

Managing your organization's privacy and security concerns within the context of increased electron-

ic transaction standardization is now a way of life. It is now a legal imperative your patients and clients have come to expect.

Make sure your compliance team provides the information your organization needs to make informed management decisions.

More rules?

HHS continues to propose and finalize rules related to HIPAA. For more information, go to www.cms.hhs.gov/hipaa/hipaa2/. Information also is available at www.bkd.com.

Contact your BKD Health Care Group or BKD Technologies advisor for assistance. □



OIG reports on LTC hospitals

by Stoney Oxford, Tulsa,
soxford@bkd.com

OIG recently posted the results of a study of LTC hospitals located within a host hospital or hospital within a hospital (HWH).

The study's two primary objectives:

- ▲ Assess the rate at which LTC HWHs readmit patients discharged to the host hospital and test if it exceeds the 5% threshold for full Medicare reimbursement
- ▲ Document the nature and extent of CMS's controls to determine if HWHs meet the criteria for exclusion from Medicare acute care hospital PPS

Background

Medicare regulations define LTC hospitals as those with an ALOS of more than 25 days.

A LTC HWH is physically located inside an acute care hospital, referred to as the host hospital. Though it is located in the same building as its host, an HWH is different because:

- ▲ It is a separate hospital with its own Medicare number
- ▲ It is organizationally independent, with its own governing body, chief medical officer, medical staff and CEO
- ▲ It provides basic hospital functions and is financially independent
- ▲ At least 75% of its patients must come from a source other than the host
- ▲ No more than 15% of its total inpatient operating costs can be used to purchase services from the host

CMS guidelines

Between 1995 and 2002, the number of HWHs increased from 32 to 132, and Medicare payments to these facilities rose from \$135 million to \$817 million.

Because HWHs and host hospitals share the same building, there is concern about potentially inappropriate financial incentives, *e.g.*, the HWH can discharge patients to the host hospital and readmit them for additional care, or the host hospital can transfer patients to the HWH without completing their treatment.

To address this concern, CMS has set specific guidelines for patient discharge and readmission in its HWH regulations.

It also responded in a 1999 regulation. Without an intervening discharge to another setting, HWHs are allowed to re-admit up to 5% of patients discharged to the host. This is measured on the HWH cost reporting period.

Under the cost-based system, HWHs were paid, up to a ceiling, their average cost per discharge. If an HWH exceeded the 5% threshold, its payment was decreased by excluding these discharges from the reimbursement calculation.

DRG-based PPS

Effective for fiscal years beginning October 1, 2002, all LTC hospitals are paid under a DRG-based PPS, phased in over five years.

Under PPS, the 5% rule still applies as explained in Medicare Regulation 42 CFR 412.532(c): "If, during a cost reporting period, a long-term-care hospital (including a satellite facility) discharges patients to an acute care hospital co-located with the long-term-care hospital, as described in paragraph (a) of this section, and subsequently directly readmits more than 5 percent (that is, in excess of 5.0 percent) of the total number of its Medicare inpatients discharged from that acute care hospital, all such discharges to the co-located acute care hospital and the readmissions to the long-term-care

hospital will be treated as one discharge for that cost reporting period and one LTC-DRG payment will be made on the basis of each patient's initial principal diagnosis."

OIG's findings

As a result of its review, OIG found:

- ▲ At least once during their fiscal years ending in September 2000 through December 2002, 19 of the 87 HWHs reviewed exceeded the annual 5% threshold for readmissions
- ▲ CMS lacks a system to detect readmissions exceeding the 5% threshold
- ▲ Many readmissions involved high-cost DRGs.
- ▲ CMS provides limited oversight of HWH compliance with the exclusion criteria

OIG's recommendations

Because HWHs and host hospitals share their location, OIG believes the potential for improper

Medicare payments to HWHs demands strong oversight.

Based on its report, OIG made these recommendations:

- ▲ CMS must develop a system to monitor HWH compliance with the 5% readmissions threshold
- ▲ HWHs are required to demonstrate ongoing compliance with the organizational and financial independence criteria

CMS generally agrees with the findings and recommendations and is developing a program to enforce the 5% readmission threshold. It also plans to strengthen oversight of the independence criteria.

Though the proposed changes have not been published, LTC HWHs should review data related to these issues.

The complete report, "Long-term Care Hospitals within Hospitals, OEI-01-02-00630," is available at OIG's web site: www.oig.hhs.gov. □

Moratorium on rehab rule enforcement

by John Britt, Louisville,
jbritt@bkd.com

The American Hospital Association has reported that Congress has passed a "fiscal year 2005 omnibus spending bill that places a moratorium on enforcement of the 75% rule for inpatient rehabilitation services until 60 days after GAO completes a formal assessment of the rule's impact on access to the services."

The May 7, 2004, final rule caused considerable concern

throughout the inpatient rehab provider community because it changed the requirements for IRF classification.

Of particular interest:

- ▲ Removal of polyarthritis as one of the conditions
- ▲ Increasing compliance threshold from 50% to 75% by July 2007

The American Medical Rehabilitation Providers Society reports GAO is scheduled to release its report in late January 2005. □

Oncology programs see treatment changes

by Trisha Priest, Springfield,
ppriest@bkd.com

Oncology treatment centers—both hospital and provider based—are seeing a shift in what the government deems a facility fee.

As recently as 2002, little guidance existed to determine which services also are billable as facility fees. However, OIG has focused more attention on medical necessity issues.

Billing & coding changes

When it comes to hospital oncology programs, two scenarios are typically found. In the first

scenario, the patient is scheduled for physician-ordered chemotherapy treatments, either administered orally with medication or via radiation oncology treatment.

For this type of service, the only codes billed to Medicare would be the CPT/HCPCS codes representing the ordered services.

These codes have a certain level of work component built into their pricing structure to capture the nursing resources needed to administer medication.

Chemotherapy services also include laboratory tests to monitor patient blood levels during chemotherapy treatments.

Depending on which way the lab results fall within the given

treatment criteria, medication adjustment may be required, or chemotherapy may be delayed until the blood counts level out. Blood can be drawn from either a vascular access device (36540) or venipuncture (G0001).

As a result, chemotherapy administration codes are used to code a patient's visit for treatment. The change from 2004 to 2005 final rule administration codes can be found in table 29 of the August 16 proposed rule.

This table represents a cross-walk approved for 2005 OPPTS. As suggested in the November 15 final rule, using CPT codes that also have been used for transfusion and chemotherapy adminis-

tration services in a physician office is less burdensome for hospitals because all payers recognize them.

The CPT codes also facilitate development of more accurate payment rates for drug administration services for future years. HCPCS codes representing the drugs administered, as well as the appropriate unit per drug, also are reported.

A facility fee may not be considered medically necessary unless a service (separate from the ordered procedures) was identified and required an intervention.

In the second scenario, the patient is scheduled to see the physician/provider for a scheduled office visit (also provider-based).

In this scenario, the nursing staff typically provides, as a minimum, a substantial amount of patient history, present condition assessments and lab assessments.

A facility fee is generated that captures nursing-staff resources on the hospital side, though CMS has yet to produce what it considers a "facility fee" charge. As appropriate, physician/providers also bill their professional fees.

Be aware of the following compliance issues:

- ▲ Is nursing documentation clear about what services were provided?
- ▲ Is the charge-capture process consistent with updated policies and procedures?
- ▲ Are drug units reported appropriately?

What to do now

Hospitals continue to struggle with reimbursement methodologies, such as ambulatory payment classifications (APCs).

The final rule mandates a change of reporting chemotherapy drug administration codes, so hos-

...continued on page 8

Health Care News glossary

ADA – American Dental Association

AHA – American Hospital Association

ALOS – Average length of stay

AMA – American Medical Association

APC – Ambulatory payment classification

AR – Accounts receivable

BBRA – *Balanced Budget Refinement Act of 1999*

CDM – Charge description master CDM

CEO – Chief executive officer

CMS – Centers for Medicare & Medicaid Services

CFR – Code of Federal Regulations

CPT – Current procedural terminology

DHHS – Department of Health and Human Services

DMERC – Durable medical equipment regional carrier

DRG – Diagnosis-related group

DSH – Disproportionate share hospital

EDI – Electronic data interchange

EO – Exempt organization

FI – Fiscal Intermediary

GAO – General Accounting Office

HCPCS – Healthcare common procedure coding system

HDC – Hospital Data Collection

HHA – Home health agency

HIPAA – Health Insurance Portability & Accountability Act of 1996

HWH – Hospital within a hospital

ICD-9-CM – International Classification of Diseases, Ninth Revision, Clinical Modification

IPF – Inpatient psychiatric facility

IPPS hospital – Inpatient prospective payment system hospital

IRF – Inpatient rehabilitation facilities

IRS – Internal Revenue Service

LCD – Local Coverage Determination

LTC – Long-term care

NFP – Not-for-profit

OIG – Office of Inspector General

OMB – Office of Management and Budget

OPPS – Outpatient prospective payment system

PAI – Patient assessment instrument

PHI – Protected health information

PPS – Prospective payment system

RCP – Regulatory compliance program

RHC – Rural health clinic

SNF – Skilled nursing facility

TECEP – Tax Exempt Compensation Enforcement Project

TEFRA – Tax Equity & Fiscal Responsibility Act of 1982

Class-action lawsuits: hospitals charging practices questioned

by Scott Crabtree, Little Rock, scrabtree@bkd.com

Since June, the Scruggs Law Firm has filed more than 50 class-action lawsuits against more than 370 NFP hospitals across the country.

Filed on behalf of uninsured patients, the lawsuits allege the hospitals used improper billing practices and—as tax-exempt organizations—failed to fulfill their charity-care obligations.

What lawsuits claim

The lawsuits claim uninsured patients were often driven into bankruptcy by the tactics hospitals used to obtain payments from the uninsured at rates higher than those paid by Medicaid, Medicare or insurance companies for the same procedure.

The U.S. Judicial Panel on Multidistrict Litigation is a Washington-based committee of seven federal judges whose sole function is to decide whether to consolidate numerous federal cases involving the same issues.

The panel ruled October 20 against consolidating 28 of the class-action lawsuits in 25 states. “Centralization,” it said, “would neither serve the convenience of the parties and witnesses nor further the just and efficient conduct of this litigation.”

The hospital defendants affected by this ruling immediately applauded the decision because it forces Scruggs to file individual actions in their jurisdictions.

AHA President Dick Davidson has maintained the lawsuits are baseless and said in a prepared statement, “The panel’s decision means we can now move to the merits of the case; hopefully, this

decision will lead to a speedy and fair conclusion . . . so hospitals can fully focus their time and resources on the daily mission of taking care of their communities.”

Even baseless lawsuits can take a toll when health care dollars are tight. A Scruggs spokesperson shrugged off the ruling, saying it would only affect the tactical aspects of the lawsuits, not the legal merits.

Despite the complexity of the legal issues involved, Scruggs’ history as a crusader against big business—winning billions in class-action suits against asbestos manufacturers and the tobacco industry—has caused concern among embattled hospital administrators.

At least four of the lawsuits have been dismissed by courts in different regions of the country.

Settlement status

The sole settlement to date, decided August 5, awarded an estimated \$150 million in refunds, debt forgiveness, discounts or free care to more than 48,000 eligible uninsured patients treated by North Mississippi Health Services (NMHS) over the past three years.

Settling early was considered a cost-saving measure according to John Heer, NMHS’s chief operating officer, and the settlement was similar to what NMHS had planned to do anyway.

In an August 9 *Modern Healthcare* article, Heer said, “There seemed to be little reason to pursue lengthy litigation of the issue since the proposed discounts were very close to NMHS’ current policy; the actual amount the system [NMSH] would likely pay out is around \$200,000.”

This doesn’t include Scruggs’ legal fees, which are subject to judicial approval.

Hospitals must now realize real legal issues exist about their billing practices and how to quantify charity care.

Much of what’s at stake in the Scruggs’ litigation involve these issues. One outcome of the lawsuits may be standardization of these practices.

In June, numerous Congressional hearings (House Ways and Means, Senate Finance and House Energy and Commerce committees) were held about this subject, but a resolution has yet to surface.

Discounting principles created

On the other hand, AHA has created a set of discounting principles for the uninsured, including:

- ▲ Provide financial counseling to patients who need it
- ▲ Disseminate information about public and charity programs to help patients with their medical bills
- ▲ Educate staff about written policies on billing issues
- ▲ Define standards and scope of practices to be used by outside collection agencies

According to AHA, 2,600 hospitals have pledged to support the above principles.

Facilities make positive changes

In testimony before the Energy and Commerce Committee, leaders of five large health care systems said their facilities have taken major steps in recent months, including:

- ▲ Publicizing their prices
- ▲ Developing guidelines for patients that qualify for public assistance or charity programs and helping them locate the proper resources and information
- ▲ Easing collection efforts to prevent overly aggressive pursuit of debts

Government intervention or private litigation often forces an industry to reevaluate certain practices, and improvements are often the result.

The NMHS settlement is a case in point. The changes the health care industry voluntarily implements may provide far greater benefit to patients than endless litigation. □



**BKD Health Care Group
Writers' Bureau**

Article	Author	Publication	Date
“Medicare Time Record Requirements in Rural Health Clinics”	Sue Brammer, Kansas City	Dennis Barry’s Reimbursement Advisor	November 2004

Revenue cycle completion: events in the income management process

by John Britt, Louisville,
jbritt@bkd.com

The revenue cycle's completion involves many steps in the income management process, including:

- ▲ Claims generation
- ▲ Clearinghouse error messages
- ▲ Payment posting
- ▲ Accounts receivable (AR) analysis
- ▲ Denials management
- ▲ Nurse auditing
- ▲ Insurance follow-up
- ▲ Third-party collections

By the time claims are ready to be transmitted, either as electronic files or hard-copy versions, they should not contain any errors or omissions. If they do, the remainder of the revenue cycle can be plagued with rework.

This often reduces your anti-

ipated reimbursement because time and personnel are needed to find and fix the mistake and recycle the claim. Sometimes, hospitals are forced to write-off claims if rework efforts fail.

Prevent problems

To help prevent problems during the final phase of the revenue cycle, providers can reduce the amount of revenue cycle rework with proactive internal auditing, tracking and training.

These procedures can help identify the root cause of mistakes and help providers develop and initiate action plans to prevent them. Following are certain indicators to watch for:

Payment-posting phase - To help prioritize your efforts, develop an effective system of adjustment codes that will help you categorize and quantify claims by type, payer and service.

Denial management process

Once you have the data, look at problems systematically and identify flaws originating in the revenue cycle's first two phases.

Increasing AR - Why aren't these claims getting paid? Are payments timely? Again, if you have a systematic approach to denials, AR is a good barometer of your denial management system's effectiveness.

Information system updates

Is your information system able to support the denial management process? Evaluate your existing system. Are enhancements necessary? Should additional applications be purchased?

Identify causes

Identifying root causes and preventing mistakes will help you eliminate processes employed on the back end.

For example, do you have a

crew of nurse auditors to correct errors forwarded by the business office? Are they trying to satisfy medical necessity several weeks after the service has been rendered?

If the front-end capture of medical necessity information is improved, nurse auditors are no longer necessary.

How cost effective is your insurance follow-up staff? Do they spend more time and effort trying to get a claim paid than the claim is worth? Again, it is better to attack denials systematically than piecemeal.

When you are not reimbursed for a claim, what are your thresholds for referring an account to a third-party collection agency? Do you monitor the agency's performance? Do they know why the claim wasn't paid and how to rectify it?

Unfortunately, problems on the back end can potentially overwhelm all your other processes. By the time problems created on the front end or in the middle reach the back end, it is often too late for an easy fix. It is far easier to prevent them.

Corrective steps

What does your action plan look like? The following steps will help you conquer problems in every phase of the revenue cycle and help prevent them from happening again:

- ▲ Identify the problem
- ▲ Analyze the data
- ▲ Determine the corrective action
- ▲ Implement the action
- ▲ Monitor the situation

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

Do you know where your Medicare margins are?

by Dee Dellacca, Indianapolis,
ddellacca@bkd.com

Today's ever-changing Medicare regulations can make it difficult to monitor your facility's Medicare profitability.

Do you know where money is made or lost from treating Medicare patients? Do new reimbursement rules make certain programs no longer viable?

A Medicare margin analysis can help you answer questions like these.

To identify other reimburse-

ment or operational opportunities, a Medicare margin analysis using your facility's Medicare cost report will help define the relationship between your Medicare costs and related reimbursement.

The analysis will indicate whether you are covering your overall inpatient and outpatient costs, but it can help you study the Medicare margins of certain other departments as well.

Have you ever considered whether the Medicare margin of your facility's radiology or laboratory departments are where they could be? You might be surprised

at the results.

Other areas to review in margin analysis include home health agencies, distinct part psych, rehab units, hospice, renal dialysis, etc. A lot of data about these departments can be gleaned from the Medicare cost report.

Because of the many changes and proposed changes to noncore-service reimbursements, your facility may decide a service is too costly to provide, or it could become aware of an opportunity to add a service line.

What is your facility's ALOS?

continued on page 8. . .

Employee fraud: crime of the 21st century

by John Sherrick, Springfield,
jsherrick@bkd.com

Are your organization's assets adequately protected from crimes of deception?

According to a recent survey about fraud, 75% of the companies polled said they had been hit by fraud.

Statistics indicate your organization will eventually be the victim of fraud, probably from an employee. Are the right safeguards in place to prevent this?

Fight financial war's forgotten battle

News of Enron, WorldCom and HealthSouth's financial statement frauds was devastating, but so is the battle against employee theft that many organizations fight every day.

Although most embezzlements do not have the same financial im-

pact as financial statement fraud, they occur with greater frequency.

Primarily because of its liquidity, an organization's cash is the target of most employee theft. The U.S. Chamber of Commerce estimates the annual cost of employee theft at more than \$40 billion.

Embezzlement has been and is expected to remain corporate America's number-one financial crime. By the time an organization becomes aware of employee fraud, significant damage may have occurred with little chance of recovery.

Combat employee theft from trenches

Fraudsters use many clever methods to conceal fraud, but there are ways organizations can prevent it, including:

Hire the right people and periodically review your hiring policies

and procedures to be sure they keep people with questionable backgrounds off your payroll.

Segregate duties and know if your organization has appropriate access controls in place. This may help limit opportunities to commit fraud.

Perform independent bank reconciliations within 30 days of statement mailings. Thoroughly investigate all discrepancies regardless of size.

Conduct surprise audits and cash counts to examine the way your staff performs key procedures (the key to success is the element of surprise).

Protect your cash by reconciling your cash receipts every day, comparing them to your daily bank deposit. Restrict access to check stock and regularly account for all of it, used or unused.

Insure your organization to control risk and protect it from employee-dishonesty loss because it's unlikely you'll recover losses from the perpetrator. Meet with your insurance agent to be sure you have the right type of policy to address your risk areas.

It's up to you to protect your organization from fraud. Be proactive and put as many barriers as you can in the fraudster's path. Having sound internal controls can help eliminate many of the opportunities employees use to commit fraud.

* * *

Contact your BKD Forensics & Dispute Consulting advisor to review your organization's internal controls. We can help you lessen the chance of an employee running away with your organization's assets. □

IRS seeks to halt compensation abuses of tax-exempt organizations

by Scott Crabtree, Little Rock,
scrabtree@bkd.com

A recently announced Internal Revenue Service (IRS) enforcement effort is underway to identify and halt abuses by tax-exempt organizations that pay excessive compensation and benefits to their officers and other insiders.

Through this initiative—dubbed the Tax Exempt Compensation Enforcement Project (TECEP)—the IRS plans to contact approximately 2,000 tax-exempt charities and NFP organizations between now and next summer to determine how executive pay was set and whether it is excessive.

The IRS's specific concern is that some exempt organizations (EOs) may be abusing their tax-

exempt status through exorbitant executive compensation arrangements.

NFP hospitals must be prepared to demonstrate their salary range is within reasonable industry standards and that their executives bring measurable value to key areas of operation, including benefits to the community.

Hospital boards of directors are advised that failure to compensate CEOs at fair market rates could result in IRS scrutiny of boards and their members, especially if it can be proved individual members benefited from the NFP through lucrative contracts or other perks to avoid private inurement.

This IRS effort to more closely monitor the operations of exempt organizations may be a spillover from general Sarbanes-Oxley poli-

cy considerations that promote integrity of financial reporting and enhanced governance oversight of executive compensation decisions.

It also is consistent with today's emphasis on providing a board of directors all the information it needs to exercise its oversight obligations and evaluate the legal compliance risks facing a corporation or other business entity.

In addition, Congress passed legislation in the mid-1990s that has come to be known as "intermediate sanctions," which gives the IRS the authority to require overpaid charity executives to give the money back, including a 25% penalty.

IRS contacts will combine information gathering with enforcement and will focus on specific officers and types of transactions, e.g., loans, leasing and prop-

erty exchanges.

It also will focus on insider transactions, such as loans to officers, and will gather information on the way exempt organizations set compensation levels, how NFPs report compensation on 990 forms and educate organizations about compensation tax issues.

* * *

Contact your BKD Health Care Group advisor or BKD tax advisor for more information about how TECEP and compensation issues could affect you. □

Check out. . .

Health Care NEWS

-----@-----bkd.com

Oncology programs. . .

continued from page 4. . .
pitals will need to update their charge sheets and CDM charge codes.

Hospitals should not delete 2004 and earlier codes because this information will be necessary to process rejected claims for that time period.

All staff involved in charging services will need education about the new codes and how to report services appropriately.

In addition, there are new drug codes to be reviewed and updated in the pharmacy modules. Hospitals are urged to carefully review this rule for changes to oncology treatment and drug fees.

Do you know where Medicare. . .

continued from page 6. . .
What is it for your Medicare patients? Compare ALOS to your case mix. Is ALOS increasing and case mix decreasing?

Do you know which DRGs are loss leaders for your facility? How about the ALOS for each DRG by physician?

Your answers may indicate the need for medical staff education or

extended-care services, such as swing beds or SNFs.

When it comes to reimbursement, no facility wants to be in the dark, and a Medicare margin analysis can help shed light on these and other important issues.

For more information, or to begin the process, contact your BKD Health Care Group advisor. □

For physician clinics

On the physician side, CMS has issued an announcement for a "Demonstration of Improved Quality of Care for Cancer Patients Undergoing Chemotherapy." More information can be found at: www.cms.hhs.gov.

Office-based physicians or nonphysician practitioners who operate within their state's scope-of-practice laws, provide care for oncology patients and administer chemotherapy in an office setting are eligible to participate in this demonstration.

CMS wants to monitor three specific factors that are a big part of cancer patient care:

- ▲ Pain management
- ▲ Reducing nausea/vomiting
- ▲ Limiting fatigue

CMS believes if these factors are improved as part of a cancer patient's overall treatment plan, it may help reduce overall cancer-care costs by eliminating hospitalizations resulting from treatment complications.

Physician practices that report data about all three factors to Medicare will qualify for an additional \$130-per-encounter payment.

Fact sheet available

A fact sheet about the demonstration is available from the Community Oncology Alliance: www.communityoncology.org.

The final rule for the 2005 physician fee schedule also was released November 15, 2004. Physicians must be aware of drug cost and payment amount changes.


Some practices may want to shift their chemotherapy treatments to hospitals because of dramatic decreases in payments for chemotherapy drugs administered in a physician's office.

Before shifting chemotherapy care, consider analyzing physician fee payment and hospital payment for chemotherapy treatment and drug costs.

Contact your BKD Health Care Group advisor for more information about how the new rule will affect you. □



P.O. Box 1900
Springfield, MO 65801-1900

A member of
Moore's Rowland
International 

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.

PRSR STD
US POSTAGE PAID
SPRINGFIELD MO
PERMIT #801

Address Service Requested