

Receive HCN via e-mail

An e-subscription to HCN may be just what the doctor ordered, and it's free, fast and easy.

Don't change a thing if you're happy with your current subscription, but to receive your next issue electronically, follow the sign-up instructions at <http://www.bkd.com/enews/>.

Log on to choose your delivery option: receive HCN via print **and** e-mail or via e-mail only. Change your option any time (including the return to a print-only subscription) by simply clicking the appropriate option. □

In this issue

- ▶ Fraud: easier to identify & reduce risk than recoup losses
- ▶ MedPAC considers revisions to CAH program
- ▶ New CMS pressure ulcer regulations put pressure on SNFs
- ▶ SNF PPS consolidated billing update
- ▶ Re-evaluate your compliance training & auditing processes
- ▶ Will your IRF measure up to threshold?
- ▶ HIPAA security: time's up
- ▶ Update your strategic planning steps

Vol. 23, No. 1
April 2005



Fraud: easier to identify & reduce risk than recoup losses

by David Bowden, Springfield,
dbowden@bkd.com

When employees decide to commit fraud, they act on a decision to misappropriate their employer's assets. When it comes to fraud prevention, changing the attitudes and actions of owners and managers may be more important than knowing what a dishonest employee is about to do.

As an owner or manager, you may unknowingly create situations that not only invite embezzlement but help perpetrators get away with it.

Though you may be used to looking at reports and asking questions about the figures you see on paper, how well do you understand what goes on behind the numbers?

Your employees are behind the numbers, including trusted individuals who you'd never think could pose a fraud risk to your organization.

The more you know about your risks, the better able you are to help your organization save thousands of dollars by sealing opportunities employees can use to commit fraud.

The basics

First, to reduce the risk of embezzlement, you must accept that it can and does happen inside any entity that handles money. **If you think it can't happen to you,**

then you only increase the risk it will occur.

We all like to think we're good judges of character, but the most common words a fraud investigator hears are "I didn't think he/she was that type of person."

Decision makers are devastated when an employee betrays them. When we place great trust in another human being, we let our guard down and often fail to take basic precautions.

This puts perpetrators in the best possible position where they

can inflict the most damage.

Second, just because you can't see it now, doesn't mean that embezzlement hasn't happened. Such crimes can take place undetected for several years.

Third, if something doesn't seem quite right, pay attention to your "gut feelings." Perhaps it's the explanation you receive about a questionable expense report item, a payable or a receivable.

Don't be tempted to accept an explanation if something seems

continued on page 6 . . .

MedPAC considers revisions to CAH program

by Tom Watson, Houston,
twatson@bkd.com

Following are comments, statistics and suggestions on CAHs from a March 10 meeting of the Medicare Payment Advisory Commission (MedPAC).

What statistics reveal

MedPAC reported the number of CAHs has grown from 139 in 2000 to 1,070 at the start of 2005; of these, 151 were closer than 15 road miles to the nearest hospital.

In 2003, 17% of the \$2 billion spent on CAH services was paid to hospitals closer than 15 miles to

another hospital, while another 15% was paid to CAHs more than 35 miles from the nearest hospital. The other 68% was paid to CAHs located between 15 and 35 miles to the nearest hospital.

MedPAC also noted outpatient payments at CAHs grew 69% faster than payments for similar services at traditional PPS hospitals, though this is likely because payments to CAHs increased from far below costs in 1998 to today's rate of 101% of costs.

Swing-bed payments at CAHs averaged slightly more than \$1,000 per day, which is far more

continued on page 6 . . .

New CMS pressure ulcer

by Sherri Routh, Springfield,
srouth@bkd.com

Your SNF may soon feel the pressure of a new regulation that includes significant changes to clinical standards of practice, regulatory interpretations and compliance expectations.

Effective November 12, 2004, CMS issued a new section to the **State Operations Manual (SOM)**, "Appendix PP," replacing (in its entirety) the current tag "F314-Pressure Sores."

F314 now indicates "A resident

who enters the facility without pressure sores, does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable."

Potentially, the intent of this new requirement is that the SNF provides care and services to promote prevention of pressure ulcers, promote healing of existing ulcers and prevent development of additional ulcers.

How to comply

The new regulation will require providers to update facility policies

and procedures and communicate any changes to practitioners and staff.

SNFs also should implement quality-assurance measures to verify:

- ▲ Accuracy of assessments
- ▲ Individualized care approaches
- ▲ Updates to care approaches as indicated
- ▲ Consistency of clinical documentation
- ▲ Staff is comfortable communicating this information with surveyors

The survey records review will now include increased scrutiny of the Minimum Data Set (MDS), Resident Assessment Protocol System (RAPS) and a care plan for each resident targeted during survey.

The surveyor is then directed to verify consistency of care through other areas of the medical record, including physicians' orders and progress notes, nurses' notes and pharmacy and dietary documentation.

Interviews with health practitioners, *e.g.*, physicians and nurse

SNF PPS consolidated billing

by Gary Phillips, Springfield,
gphillips@bkd.com

Certain statutory and regulatory exclusions of services—those beyond the scope provided by SNFs—were key issues for SNFs in the final rule for Medicare PPS and consolidated billing (CB).

These excluded services are updated annually, though some revisions occur quarterly. Over the years, these updates have generally been positive for the industry.

What are excluded services?

Some SNFs have been required to pay for "otherwise excluded CB services" because some of their

Medicare Part A patients received excluded services from providers (and/or at locations) that did not meet the requirements for exclusion from the CB provision of Medicare SNF PPS.

CMS's transmittal instructions clearly outline which services are excluded or included, as well as the provider and location where excluded services can be obtained.

SNF PPS excluded services are listed under "Major Categories" and are based on the Medicare certification and location of the provider.

For example, for them to be excluded from SNF PPS CB, services listed under Major Category I can only be provided in a hospital or CAH outpatient setting.

The services are divided into five major categories. Instructions in the CMS transmittals identify the provider and/or location where these services must be rendered if they are to qualify for CB exclusion. Services and/or devices are excluded only when rendered by the specific noted provider type.

Example: A SNF representative recently asked BKD about a particular procedure code that would have been excluded had it been provided in an outpatient hospital setting.

The procedure (and device) in question was performed in a physician's office; therefore, the SNF was liable for payment for the procedure. The fee schedule reimbursement for the procedure and device exceeded \$13,000.

The location where a procedure is performed also must comply with the regulation. If a SNF simply identifies a procedure code from the excluded services list, it will not prevent it from being held liable for payment. This is a major issue SNFs must monitor closely.

Who pays?

BKD also has received inquiries within the past few months about charges for Medicare Part A SNF patients who have received chemotherapy and/or radiation therapy.

Apparently, some oncology clinics have "unbundled" services Medicare considers to be included in the global payment rate. These unbundled services were billed to the SNF at the provider's customary charge rate.

In other instances, the oncology clinics have billed the SNF for the chemotherapy or radiation therapy services at their customary charge rate instead of billing Medicare for these services.

The providers BKD spoke to said they would bill Medicare but only if the SNF did not pay the charges—charges the SNF did not owe and should not pay.

The 2005 annual updated HCPCS codes of excluded services are included in **Transmittal 360**, issued November 5, 2004.

There also is an updated quar-



**BKD Health Care Group
Writers' Bureau**

Article	Author	Publication	Date
"Reimbursement Policies and OIG Guidance"	Larry Fogel, Kansas City	Dennis Barry's Reimbursement Advisor	March 2005, Vol. 20, No. 7

regulations put pressure on SNFs

practitioners, may be required if the level of care ordered and/or provided appears inconsistent with recognized standards of practice.

Compliance with F314 must include **all** of the following:

- ▲ Accurately assess each resident's skin integrity
- ▲ Identify each resident at risk for development of pressure ulcers
- ▲ Identify and address all risk factors for each resident
- ▲ Implement prevention interventions, individualized as outlined in the resident's overall plan of care

- ▲ Provide clinical justification for the unavoidable development of pressure ulcers (it is inadequate to have only the physician's documentation that ulcer development was unavoidable)
- ▲ Provide appropriate interventions to minimize infections for each resident with a pressure ulcer
- ▲ Implement interventions to treat existing wounds according to current policies and procedures
- ▲ Notify the physician of the resident's condition and/or change of condition
- ▲ Identify and apply relevant policies and procedures for pressure ulcer prevention and treatment

The key elements for receiving an F314 "severity determination" include either the *presence of* or the *potential for* harm or negative outcomes, which can result from a lack of appropriate treatment or because the degree of harm (actual or potential) related to the non-compliance fails to receive the required correction in time.

Changes in citation severity levels

The severity level of citations also has been altered with this amended rule, including:

Examples of Severity Level 4 now include (1) development of an avoidable Stage IV pressure ulcer, (2) residents admitted with a Stage IV pressure ulcer that has not shown signs of healing or shows signs of deterioration, (3) Stage III or IV pressure ulcers with associated soft tissue or systemic infection and (4) extensive failure in multiple areas of pressure ulcer care.

Examples of Severity Level 3 now include (1) development of an avoidable Stage III pressure ulcer, (2) development of recurrent or multiple avoidable Stage II pressure ulcers and (3) failure to implement the comprehensive care plan for a resident who has a pressure ulcer.

Examples of Severity Level 2 now include (1) development of a single avoidable Stage II pressure ulcer that is receiving appropriate treatment, (2) development of an

avoidable Stage I pressure ulcer and (3) failure to implement an element of the care plan for a resident who has a pressure ulcer; however, no evidence can be present of a decline or failure to heal, as well as failure to recognize or address the potential for developing a pressure ulcer.

Note: Because it is considered more than minimal harm, a facility that fails to provide appropriate care and services designed to prevent or heal existing pressure ulcers will no longer be cited Severity Level 1 but will instead receive a 2, 3 or 4.

To comply with CMS's new regulations and avoid negative survey ramifications, SNFs will be required to place more emphasis on monitoring this key patient care issue.

* * *

Is your facility ready for F314 survey scrutiny? Contact your BKD Health Care Group advisor for assistance. □

update

terly transmittal that includes the excluded services for chemotherapy and radiation therapy. **Transmittal 449**, the latest quarterly update, was issued January 21, 2005, with an effective date of April 1, 2005.

Avoid negative consequences

In addition to following the directions of the HCPCS excluded services transmittals, each SNF should negotiate a consolidated billing agreement with every outside provider that may render services to its Medicare Part A patients.

CMS has posted guidelines (and sample agreements) for consolidated billing provider agreements on the **MedLearn** web site:

www.cms.hhs.gov/providers/snfpps/bestpractices.asp.

SNFs must properly monitor these critical issues to avoid unnecessary losses. Contact your BKD Health Care Group advisor for more information about this complex area. □

Health Care News glossary

APC – Ambulatory payment classification

CAH – Critical access hospital

CB – Consolidated billing

CDM – Charge description master

CMS – Centers for Medicare and Medicaid Services

CPT – Current procedural terminology

ER – Emergency room

FI – Fiscal intermediary

HCPCS – Healthcare common procedure coding system

HHS – U.S. Department of Health and Human Services

ICD-9-CM – International Classification of Diseases 9th Edition Clinical Modification

IGC – Impairment Group Code

IPF – Inpatient psychiatric facility

IRF – Inpatient rehabilitation facility

IT – information technology

MDS – Minimum Data Set

MedPAC – Medicare Payment Advisory Commission

NHII – National Health Information Infrastructure

OIG – Office of Inspector General

OP – Outpatient

PAI – Patient assessment instrument

PPS – Prospective payment system

RAPS – Resident Assessment Protocol System

SCPG – Supplemental Compliance Program Guidance

SNF – Skilled nursing facility

SOM – State Operations Manual

Re-evaluate your compliance training & auditing processes

by Sandy Soerries, Kansas City, ssoerries@bkd.com

When was the last time your hospital evaluated its compliance training and education? When was the last time you critically assessed your monitoring and auditing processes?

Now may be the perfect time to re-evaluate these processes because the OIG published its “Supplemental Compliance Program Guidance” for hospitals (SCPG) in the January 31, 2005, **Federal Register** (see “In Brief” at right).

SCPG guidelines provide a detailed explanation of what the federal government expects from providers.

Appropriate training & education

According to the SCPG, hospitals that fail to adequately train and educate their staff risk liability for the violation of health care fraud and abuse laws.

The purpose of conducting a training and education program is to ensure each employee, contractor or any other individual who functions on behalf of the hospital is fully capable of executing his/her role in compliance with rules, regulations and other standards.

In reviewing your training and education programs, ask the following:

Do qualified trainers conduct annual compliance training for staff, including general and specific training pertinent to varying levels of responsibility?

Do you annually evaluate training and education program content to determine if the

subject matter is appropriate and sufficiently covers the range of issues that confront your employees?

Do you keep up with changes in federal health care program requirements and adapt your education and training programs accordingly?

Does your education and training program content take into consideration the results of audits and investigations; results from previous training and education programs; trends in hotline reports; OIG, CMS or other agency guidance or advisories?

Is your training format appropriate in terms of session length; whether it’s delivered via live instructors or via computer; session frequency; the need for general and specific training sessions?

Do you seek feedback after each session to identify shortcomings in the training program? Do you administer post-training testing to ensure attendees understand and retain the subject matter delivered?

Have you provided your governing body with appropriate training on fraud and abuse laws?

Do you document who has completed the required training?

Have you assessed whether to impose sanctions for failing to attend training. Do you offer appropriate incentives for attending?

Internal monitoring & auditing

The SCPG states auditing and monitoring plans will help hospitals avoid submitting incorrect



BKD Health Care Group Speakers' Bureau

Topic	Speaker/Office	Seminar	Location & Date
Strategies to Identify and Monitor Compliance Risks	Larry Fogel, Joe Watt, Kansas City	HFMA Annual National Institute	Las Vegas 6/26 - 6/29
Beyond MMA: Rural Hospital Medicare PPS Update	Tim Wolters, Springfield	HFMA Annual National Institute	Las Vegas 6/26 - 6/29
The FQHC Solution - Managing the Federally Qualified Health Center	Mike Schnake, Jeff Allen, Springfield	HFMA Annual National Institute	Las Vegas 6/26 - 6/29

claims to federal health care program payers.

Take time to develop a detailed annual audit plan designed to diminish the risks associated with improper claims and billing practices. Consider these factors:

- ▲ Do you annually re-evaluate your audit plan; does it address the proper areas of concern, e.g., findings from previous years’ audits, risk areas identified as part of the annual risk assessment and high-volume services?
- ▲ To help identify the root cause of billing errors, does your audit plan include a billing systems assessment in addition to claims accuracy?
- ▲ Is the auditor’s role clearly established, and are coding and audit personnel independent and qualified with the requisite certifications?
- ▲ Should the need arise, is the audit department available to conduct unscheduled reviews, and is there a mechanism that allows the compliance department to request additional audits or monitoring?
- ▲ Has your institution evaluated the error rates the annual audits identify?
- ▲ If your error rates are not declining, have you investigated other aspects of your com-

pliance program to determine hidden weaknesses and deficiencies?

- ▲ Does the audit include a review of all billing documentation in support of a claim, including clinical documentation?

Respond consistently to deficiencies

By consistently responding to detected deficiencies, your organization can develop effective corrective action plans and improve overall compliance.

When evaluating the way your institution responds to a deficiency, use the following checklist:

- ▲ Use a response team that includes representatives from the compliance, audit and other relevant functional areas who are able to quickly evaluate deficiencies
- ▲ Investigate all matters thoroughly and promptly
- ▲ Implement a corrective action plan that addresses the root causes of each potential violation
- ▲ Conduct periodic reviews of problem areas to verify corrective action is successfully implemented to eliminate existing deficiencies

...continued on page 8

Will your IRF measure up?

by Wendy Wiley, Little Rock,
wwiley@bkd.com

Will your inpatient rehabilitation facility (IRF) measure up? Issued February 18, 2005, CMS's **Transmittal 478** clarifies the process it will use to determine if an IRF meets the classification criteria.

According to the **CMS Manual System**, two basic requirements must first be met:

- ▲ Services must be reasonable and necessary (in terms of effi-

cacy, duration, frequency and amount) for treatment of the patient's condition

- ▲ The level of care a patient requires must be at an inpatient hospital's level, rather than at the level provided in a less-intensive setting, such as a SNF, or on an outpatient basis

This means an intense rehabilitation program is necessary, one that requires a coordinated multidisciplinary team approach. Determination of medical necessity is based on an assessment of each beneficiary's individual care needs.

There are two ways an IRF admission can qualify and be counted in the percentage threshold requirement:



- ▲ The reported Impairment Group Code (IGC) is one of the 13 classification categories identified by CMS (Item 21 on the PAI), or

- ▲ An ICD-9-CM code reported as either the "etiologic diagnosis" (Item 22 on the IRF-PAI) or a "comorbid condition" (Item 24a-j on the IRF-PAI) matches one of the codes listed in "Appendix A" of the transmittal

Transmittal 478 contains guidelines for determining the compliance review period, which are based on your cost reporting period and the compliance percentage threshold that must be met during each compliance review period.

To identify your review period, see **Transmittal 478's** "Table of Compliance Review Periods." To comply with the threshold, BKD recommends your IRF:

- ▲ Perform ongoing internal rehab coding reviews each month on a preset percentage of total discharges
- ▲ Use periodic external coding and billing audits to ensure internal reviews identify all issues
- ▲ Provide rehab coding personnel training that pertains to coding and billing guidelines
- ▲ Provide rehab physicians a review of the importance of clear and concise documentation so services/procedures can be correctly coded for reimbursement
- ▲ Monitor FI publications for updated IRF information
- ▲ Daily monitoring of the compliance threshold

For more information about **Transmittal 478** and how it could affect your IRF, contact your BKD Health Care Group advisor. □

In brief

OIG supplemental guidance - The OIG published its supplemental compliance program guidance (SCPG) for hospitals in the January 31, 2005, **Federal Register**.

These guidelines supplement but do not replace the OIG's compliance program guidance of February 28, 1998.

The SCPG covers the following risk areas:

- ▲ False Claims Act
- ▲ Stark Law
- ▲ Anti-kickback statute

In addition, the SCPG recommends two methods for evaluating the effectiveness of a compliance program.

The first method is to evaluate outcomes indicators such as overpayments, denials, billing and coding errors, audit results, etc.

The second method is to evaluate the seven core elements that constitute an effective compliance program.

The SCPG applies to all

hospitals participating in federally funded health care programs. Therefore, it is important all compliance officers and compliance committees read and understand these guidelines.

Federal sentencing guidelines - The U.S. Sentencing Commission approved amended guidelines submitted to Congress in November 2004.

These guidelines were more stringent than the previous ones for meeting the standards to be an effective compliance program.

The amended guidelines required, among other things, that boards be knowledgeable about the contents of compliance programs and exercise reasonable oversight over the effectiveness of the compliance programs.

In January 2005, the U.S. Supreme Court declared the federal sentencing guidelines unconstitutional. However, federal judges may continue to take them under advisement and government agencies, such as the OIG, may continue to rely on them.

Therefore, health care organizations should understand the major elements in the amended guidelines and ensure they are properly addressed in their compliance programs.

Psych PPS emergency adjustment - An inpatient psychiatric facility (IPF) will receive a 12% add-on to the first day's reimbursement when the IPF has a qualifying emergency department.

For hospital-based IPFs, the add-on does not apply to patients discharged to the IPF from the hospital.

A hospital that believes it has a qualifying emergency department must notify its intermediary. While CMS has left it to individual intermediaries to determine the notification requirements, generally notification should occur at least 30 days before the start of the hospital's first cost report subject to IPF PPS. □

Fraud: easier

continued from page 1 . . .
unusual. Search for supporting documentation and follow up. It takes a little extra time, but it can pay large dividends.

Pay attention: Does an employee's lifestyle match his/her income? Does an employee frequently work after hours? Does someone with many responsibilities skip vacations? **If an activity**

seems wrong, investigate immediately.

Internal controls a must

You can implement a number of internal controls to reduce your risk of fraud. Two of the best: **Divide key responsibilities between employees and check your employees' work unannounced.**

Criminal suspects often admit being able to do practically anything because of their access to so many records and because no one ever looked at what they were doing.

When was the last time your organization conducted a fraud check up? It may be worth the expense to have an experienced professional periodically investigate

your internal controls for improper structuring or questionable transactions.

It costs far less to assess risk and maintain sound internal controls than it does to recover losses after they've occurred.

What to do if fraud discovered

If you discover you are the vic-

MedPAC considers revisions. . .

continued from page 1 . . .
than payments for similar services in freestanding nursing homes or PPS hospital swing-bed units; however, it was noted swing-bed days decrease inpatient acute reimbursement by spreading fixed costs across more patient days.

This results in net payments to

CAHs for swing beds that are \$100 to \$200 more per day than payments to other nursing facilities for similar services.

Revisions under consideration

Based on its review, MedPAC floated several suggestions for

revising the CAH program:

- ▲ MedPAC asked for discussion on requiring all CAHs to be at least 15 miles from another hospital. Reasons for this suggested change included curbing unnecessary duplication of services and improving the quality of patient care by having patients go to larger hospitals.
- ▲ Set swing-bed rates in CAHs equal to those paid to local SNFs.
- ▲ To encourage CAHs to control costs, as well as encourage local community investment in hospitals, MedPAC asked for comments about paying CAHs a return on equity instead of 101% of costs. If implemented, highly leveraged CAHs or those with few net assets could see a reduction in payments.
- ▲ MedPAC asked for comments on converting CAHs from a cost-based payment system to a PPS system, plus a fixed annual "subsidy" to offset losses, pay for emergency room coverage, etc. Because the current reimbursement system penalizes CAHs that care for charity patients by lowering Medicare costs, the thinking is that this revision would encourage CAHs to provide more charity care, and it also would help control costs.

Generally, commission members supported the existing program's structure because it has provided small rural hospitals a way to stay open and, therefore, has accomplished what it was supposed to.

In addition, commissioners also stated they had seen no evidence CAHs had not cared for charity patients.

What future holds

MedPAC will discuss additional CAH issues at their next meeting; their report on the CAH program must be submitted to Congress in June.

While MedPAC does not have rule-making authority, CMS and Congress will review (and may be swayed by) their reports.

As always, CAHs should regularly communicate the benefits of the CAH program to their elected officials to be sure the real benefits of the CAH program are understood.

Contact your BKD Health Care Group advisor for more background information about MedPAC and the impact its proposed revisions could have on your facility. □

Does your hospital plan to convert to CAH status?

A hospital that seeks to convert to CAH status—based on its state designation as a necessary provider of health care services to area residents—**must complete the conversion by December 31, 2005.**

After that date, hospitals may only convert to CAH status based on certain federal mileage criteria to the nearest hospital.

Questions have been raised about whether a CAH can retain its state designation and maintain its CAH status if it builds a new facility after December 31, 2005.

Though CMS has not offered clear and consistent guidance on this issue, its representatives have commented CAH status could be questioned if new and existing facilities are not located on the same campus.

On March 21, 2005, CMS administrator Mark McClellan commented on this issue at the National Rural Health Association's Policy Institute. McClellan indicated CMS's position on the status of CAHs that relocate after 2005 will be clarified in the inpatient PPS proposed rule to be issued in May.

Though not subject to inpatient PPS, CAHs are advised to pay close attention to this and other CAH information likely to be included in the proposed rule. □

to identify. . .



HIPAA security: time's up

tim of fraud, do you confront the employee you suspect?

Stay calm, but have a plan of action. **To avoid further loss you must act quickly, but you also must act correctly.**

If you have a fidelity bond—which is the best-case scenario—contact your insurer and also speak with an attorney when you discover the theft and get legal advice.

A mishandled confrontation and/or investigation can result in further losses if the suspect sues your organization because it can't prove its case.

Yes, that happens, so carry out the interview and investigation professionally. **To avoid being victimized twice, it's critical to respect the rights of the accused.**

Conducting such an interview takes extensive preparation and an understanding of how people react in interview settings.

Entities sometimes confront a suspected employee who may confess; however, the suspect may only divulge what he/she thinks you already know. You may not learn the true extent of the crime or your losses.

Suspects often try to minimize the damage they've caused by seeking sympathy, offering apologies or promising to make restitution, which you may never receive.

Another common problem is obtaining what some fraud examiners call a "blanket confession." This is where the suspect *generally* explains what happened but does not confess to a specific crime.

Example: An employee tells you he/she stole \$10,000 from your organization. You might think this a satisfactory confession, but it won't stand up in court if the indi-

vidual doesn't identify specific fraudulent transactions, how, when and where the crime was committed, what was done with the money, etc. **Tie confessions to supporting records.**

How you document what is said or done during a confession can affect the way a suspect's statement can be used in court by your private attorney or a prosecutor.

Prosecuting fraud demands skill & experience

Remember, not everyone speaks the language of your health care organization. A major challenge in investigating white-collar crime is to translate a complex set of facts and supporting documents into an understandable product a jury will find interesting and easy to follow.

If a jury loses interest, or the presentation is too complex, the purpose is defeated. **Working successfully with the legal system takes experience and skill.** That's what certified fraud examiners bring to the process.

BKD's Forensics & Dispute Consulting (FDC) team includes certified fraud examiners from diverse backgrounds and is skilled in using forensic computer services to gather and analyze evidence.

Members of our FDC team can help you assess risk, which can help reduce your chances of becoming a victim of fraud. If you already are a victim, they can conduct interviews, prepare reports and testify for you in court.

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



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

Are you one of the many providers, clearinghouses or payers not ready for the **April 20 security deadline**? No extension is anticipated. Indeed, the need for health care security compliance is ever more urgent.

IT initiatives gain momentum

Improvements in the adoption, interoperability and security of health care IT is critical.

Nearly every federal initiative related to health care quality, safety and cost includes an IT component. IT is a key tool to further national health care objectives:

- ▲ Only one third of hospital ER and OP departments and fewer than 20% of physician's offices use an electronic health record; the Secretary of HHS and Congress are formulating recommendations to raise awareness of health care IT benefits
- ▲ New York has included IT investment as part of its plan to reform the state Medicaid system
- ▲ National Health Information Infrastructure (NHII) legislation was introduced in February to create incentives and more standards for health care IT adoption

The HIPAA Security Rule is subject to the provisions of the May 2003 interim enforcement rule, authorizing HHS to impose civil monetary penalties (CMP) on entities that violate the HIPAA regulations. It is time to commit resources to security compliance.

Steps to take now

If you have done little to nothing so far, it is unlikely you will be fully compliant by April 20, but a late start is better than none. **Here**

are steps to take now:

- ▲ Appoint an information security officer with the authority to lead compliance efforts
- ▲ Establish a work group with a clear charter to assist the security officer
- ▲ Recognize that the final outcome is an ongoing security program; the administrative safeguards were designed with this in mind
- ▲ Identify obvious gaps between current practice and the regulation (note the summary chart at the end of the final rule)
- ▲ Create a preliminary action plan to begin addressing those gaps, which in large part will start with formal policies and procedures and work force training
- ▲ Begin the process of formal risk assessment as required by the regulation; in the process, you'll gain valuable information to help you prioritize identified compliance gaps and develop an incident-response plan and other contingency-planning strategies
- ▲ Continue to monitor and refine your action plan

As with privacy, your security-compliance efforts will eventually advance from compliance *projects* to an ongoing security *program*.

At this point, not only will you reduce your risk of civil penalties, but you also will more effectively manage the business risks associated with IT. This will support your own efforts to use IT to improve quality, patient safety and cost containment efforts.

Contact your BKD Health Care Group or BKD Technologies advisor for assistance with HIPAA compliance, including implementation, compliance audits and risk assessments. □



Re-evaluate your compliance. . .

continued from page 4. . .

- ▲ Consult with legal counsel if a detected deficiency results in an overpayment to the organization to determine your repayment options
- ▲ Include legal counsel early in

the process when you are concerned about a potential violation

Outdated CDMs can potentially create significant compliance risks for hospitals. Because HCPCS codes and APCs are regularly up-

dated, your hospital also must update its CDM to assign the correct codes to outpatient claims.

Implement timely updates and properly use modifiers and correct associations between procedure codes and revenue codes.

Contact your BKD Health Care Group advisor for more information about OIG's compliance regulations and for assistance in how to effectively train employees and monitor high-risk areas. □

Update your strategic planning steps

by Don Andrews, St. Louis,
dandrews@bkd.com

The traditional approach to strategic planning involves intensive data analysis, participation by a broad base of constituent groups, multiple levels of strategic initiatives and detailed implementation plans.

If your organization's strategic planners find this approach cumbersome, there is a way to efficiently develop meaningful plans that focus on priorities and are flexible enough to respond to unanticipated opportunities and challenges.

New planning steps can help

In addition to shaping your organization's core beliefs (its mission, vision and values), your strategic planners must carefully select the steps that best fit current planning needs.

For example, your organization may be trying to develop a specific clinical service that is already recognized as a priority, or it may be trying to find the best way a challenging key strategic issue can be brought to the table.

Regardless of the current issue you face, the following planning steps may prove effective for individuals in charge of planning:

Conduct focused interviews - Start using a series of one-on-one discussions with vested individuals to help clarify an issue, validate an opportunity or provide a framework for subsequent planning efforts.

Strengthen discussions with targeted analyses and related metrics to help participants better understand the issue.

Perform SWOT analysis - Many health care leaders recognize this acronym and have experience

applying it.

"Strengths are to be leveraged, Weaknesses fixed, Opportunities pursued and Threats dealt with" provides an efficient framework that is easily understood, helps organize a plan of action and keeps it top of mind.

Set priorities - Often, organizations are confronted with more issues and opportunities than the resources needed to address them.

If this is a problem for your organization, try integrating assessment criteria (specific to the focus area) into the planning process and give participants the opportunity to apply them.

This can help build ownership around the identified priorities and serve as a rationale to push important resolutions out into the organization.

Use these steps to help determine a strategic plan for your

health care organization. Strategic planning will help you narrow your focus on the right issues and identify a logical framework for resolving the challenges you face. □

About Health Care News

The content in this newsletter comes from sources BKD believes are reliable and authoritative; however, to apply specific information to your situation requires careful consideration of all the facts and circumstances. Please consult your BKD advisor before acting on any matter covered in this newsletter.

To change your mailing information or to add your name to our mailing list, call the communications specialist at the BKD office nearest you or call our administrative office at 417 831-7283. To inquire about topics covered in this newsletter, contact your BKD advisor or Jan House at 417 831-7283 or jhouse@bkd.com.

©2005 BKD, LLP All rights reserved



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

For a complete list of our offices and subsidiaries and their contacts, visit bkd.com or contact the communications specialist at the BKD office nearest you.

A member of Moores
Rowland International

PSRST STD
US POSTAGE PAID
SPRINGFIELD MO
PERMIT #801

Address Service Requested