BKD CPAs & Advisors

Health Care NEWS

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Communication helps board exercise duty of care

by Joe Watt, Kansas City, jwatt@bkd.com

With multiple areas to cover—personnel, physician, financial, operational, compliance—many health care managers struggle with this question: What kind of information do I provide our board, and how much does it need?

Borrow strategies used by high-profile regulatory bodies

Whether to share more information or less is a hotly debated issue within many health care administrative teams.

Though you could argue either side at length, health care organizations now have some guidance about the need to augment compliance-related communication with their boards.

For example, the United States Sentencing Commission (USSC) included recommendations for compliance-program effectiveness in its proposed revised **Federal Sentencing Guidelines**.

It said, "… an organization's governing authority shall be knowledgeable about the content and operation of the program to prevent and detect violations of law and shall exercise reasonable oversight with respect to the implementation and effectiveness of the program to prevent and detect violations of the law."

Though the U.S. Supreme Court recently found the USSC's revised guidelines unconstitutional, many believe they will still be used as sentencing guidelines by authorities.

Another example, **Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors**, was recently published by OIG and the American Health Lawyers Association (AHLA).

It also emphasizes the duty-of-care principle boards must follow: "… duty of care refers to the obligation of corporate directors to exercise in their decision-making process."

According to OIG and the AHLA, a board is responsible for: "… determining whether the directors acted (1) in "good faith," (2) with that level of care that an ordinarily prudent person would exercise in like circumstances and (3) in a manner that they reasonably believe is in the best interest of the corporation."

What your board must know

These examples suggest a board's fiduciary responsibilities are heightened in today's environment. Therefore, health care organizations must provide more training, more involvement and regular communications with their boards.

For your organization to communicate

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OIG clarifies cardiac rehab

by John Britt, Louisville, jbritt@bkd.com

OIG's recent release of a cardiac rehab report gives CMS feedback on its request that OIG audit outpatient cardiac rehab.

The mechanism(s) of how to meet the "physician supervision" requirement has been a source of ambiguity for many hospitals.

In its cover letter, OIG states: "We attribute this situation to inconsistent guidance in the **Medicare Coverage Issues Manual**, **Hospital Manual** and **Intermediary Manual**. This inconsistency was confirmed by our interviews with hospital officials, most of whom believed that the guidance in the vari-

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SNF PPS final rule for FY 2006:

by Monte Aspelmeier, Springfield,
maspelmeier@bkd.com

The industry has had mixed reactions to the August release of CMS's final rule for the refined RUG III case-mix classifications and per-diem payment rates.

Case-mix classification system update

SNF Medicare providers will continue to use the current 44 RUG III case-mix classification system with few changes through December 31, 2005. However, the RUG 53 classification system will be implemented effective with services provided on or after January 1, 2006.

As proposed earlier, the RUG 53 case-mix system will include an additional nine new Rehabilitation and Extensive Services RUG groups. CMS advises that MDS software vendors will be ready by November 22, 2005, to release the changes to SNF providers.

CMS plans to release training materials and billing instructions in a reasonable time to help providers make necessary system adjustments and training.

CMS advises that MDS software vendors will be ready by November 22, 2005, to release the changes to SNF providers.

New RUG payment rate update

The new payment rates for the current 44 RUG III categories go into effect October 1, 2005, increasing by 3.1%. In addition, all payment add-ons currently in effect (FY 2005) will continue to be included in the original 44 RUG system through December 31, 2005.

On January 1, 2006, all except one add-on will be eliminated with the implementation of the RUG 53 case-mix system. Thus, the payment rates for the upper 26 of the 44 existing categories will see significant decreases, while the nine new categories will be at relatively high payment rates.

The only add-on to remain in effect throughout FY 2006 is the separate 128% increase to the PPS per-diem rate for any Medicare skilled-nursing patient with AIDS. CMS states this add-on is temporary and may not be continued in FY 2007.

Effective October 1, 2005, CMS applied revised definitions of metropolitan statistical areas (MSAs) to SNFs. These new core-based statistical area (CBSA) definitions revise current definitions for MSAs.

CMS will phase in the new CBSA market area definitions using a 50/50 blended MSA/CBSA wage index approach in FY 2006 with full adoption of the CBSA-based wage index effective October 1, 2006.

How other key issues fared

In the proposed rule, CMS requested comments on key issues it was considering eliminating or clarifying. CMS decided not to eliminate:

- Requirements related to "look backs" into the acute-care hospital stay
- Use of grace days, which also won't be reduced
- The projection of estimated therapy minutes

This is positive for the SNF industry; however, CMS says it "… will continue to study these and other issues during the upcoming staff time measurement (STM) study and MDS 3.0 design initiative." Current regulations for meeting the qualifying Part A three-day inpatient hospital stay will remain in place for now.

CMS says, "Any potential changes in the SNF benefit's qualifying hospital stay requirement would need to be carefully evaluated, in order to ensure that they accurately reflect congressional intent in establishing the qualifying hospital stay requirement."

CMS also considered the need to provide additional clarification "… to help prevent the inappropriate provision of concurrent therapy in situations where it is not clinically justified." For now, the concurrent therapy rule will remain the same.

Focus on basics

With the addition of nine new RUG categories, **it's become increasingly more important for your facility's nursing and rehabilitation departments to work closely together**.

Collaborative effort will help SNFs obtain sufficient, accurate medical data for comprehensive assessments, allowing Part A Medicare beneficiaries to be placed in the most appropriate category. If implemented properly, this will ultimately result in improved quality of care for the resident and increased payments for the SNF.

In your approach to each assessment, focus on the basics. Before conducting onsite pre-admission assessments, answer the following:

- What key documentation does your FI require?
- Who is responsible for obtaining this documentation?
- What hospital information do you request?
- Who will complete the pre-admission assessment?
- After completing the assessment, what processes are in place to properly handle admission?
- Who makes admission decisions?
- Do you have a written form to guide the pre-admission process?

What about hospital "look-back" data? Have a clear plan about what information to request from a hospital because some hospital personnel may not understand a SNF's need for certain medical information.

Emphasize to hospital personnel that your SNF's correct MDS coding depends on patient-specific data that only the hospital can provide.

Key hospital medical records components to request include:

- Current history and physical
- Discharge summary
- Nursing notes
- Therapy notes
- Emergency room records
- Medication administration records (MAR)
- Lab reports

industry reaction mixed

- Radiology reports
- Consultant reports
- Vital sign worksheets
- IV flow sheets (if not on MAR)

Capture appropriate ADL activity

With the implementation of the nine new RUG 53 categories, it will be even more critical to establish an accurate ADL scoring process.

To establish an ADL activity, the beneficiary must require ADL assistance at least three or more times over a seven-day period. **The ADL activity can be captured using data from all three shifts.**

Documenting all required ADL assistance will help establish whether ADL scoring will be at or above 7, the lowest qualifying ADL score for the nine new RUG categories.

* * *

For additional information about the final rule, five CMS web-site links are listed in the box on page 9, including a brief description of what each offers. They also are available at **www.bkd.com/industry/Health_Care/**.

Contact your BKD Health Care Group advisor for more information about how we can help you implement the many complex rule changes this article describes. ■

HHA revenue recovery opportunities: you may qualify

by Aaron Little, Springfield, mlittle@bkd.com

Since Medicare home health became subject to PPS, many HHAs have unknowingly lost significant reimbursement in episode payments because of billing errors. PPS added many new challenges to the HHA billing process that may have allowed payment errors in your HHA to go unnoticed.

Such factors include significant change in condition payment adjustments (SCICs), partial episode payment adjustments (PEPs) and estimated therapy utilization.

SCIC adjustments

While the original intent of the SCIC was to allow additional payment for unexpected changes in patient status, the unique prorated payment formula sometimes results in significant payment reductions.

In addition to confusing billing guidelines, some HHA software systems add billing complexity by incorrectly computing estimated SCIC payments and by automatically coding episodes with SCICs based on OASIS assessment scoring, both of which can cause episodes to be billed incorrectly.

PEP adjustments

PEPs are made any time a Medicare patient is discharged and subsequently readmitted before the end of a 60-day episode period.

While a small percentage of PEPs should be expected, some are caused by the incorrect use of the patient discharge status code “06.” This status should only be used when it’s known the patient had a subsequent HHA Medicare readmission within the same 60-day episode period.

Therapy utilization

Estimated therapy utilization plays a significant role in the Medicare episode payment. If 10 or more therapy visits were estimated at the beginning of the episode but fewer than 10 were actually provided, Medicare will automatically downcode the episode to a nontherapy payment category.

However, if ***fewer*** than 10 therapy visits were expected but 10 or more therapy visits were provided, Medicare requires the HHA to evaluate why the therapy met or exceeded 10 visits. It’s then the HHA’s responsibility to take appropriate corrective action to ensure payment accuracy.

Qualifying for revenue recovery

With many layers of complexity in the billing process, many HHAs have found even a small number of billing errors can result in significant payment losses. Fortunately, HHAs have an opportunity to recover lost payments.

Industry benchmarks suggest only 1% to 3% of all episodes would normally be billed with a SCIC or PEP adjustment. If your HHA has billed a higher percentage of episodes as SCICs or PEPs, there is a strong possibility some episodes have been billed in error and you may have an opportunity for revenue recovery.

Identifying episodes where 10 or more therapy visits were provided but not coded as such can be trickier, as many software systems don’t provide this data. Because this situation is not technically a payment adjustment, reliable industry benchmarks are scarce.

Financial impact

The financial impact of billing errors has many variables, but HHA size and volume are ***not*** necessarily key factors. Industry reports indicate average recoveries range from $50,000 to $60,000 per HHA.

Take action

Currently, any episode ending on or after October 1, 2003, is eligible for correction; however, as of January 1, 2006, only episodes ending on and after October 1, 2004, are eligible for corrections.

It takes time to identify episodes billed in error, but the revenues recovered typically more than cover the costs incurred. As 2005 draws to a close, don’t miss your opportunity for Medicare home health revenue recovery. Contact your BKD Health Care Group advisor for more information or assistance. ■

Smart business decisions can enhance CHC mission

by Jeff Allen, Springfield, jeallen@bkd.com

Your federally funded CHC receives DHHS grants to provide primary health care services to individuals who otherwise might not have ready access to them.

Success of CHC mission linked to savvy business practices

CHC services are a critical part of the array of health care services available in the United States. More than 3,600 rural and urban clinics serve as the medical home and family physician for approximately 15 million people.

Nearly 70% of CHC patients have family incomes at or below the poverty level. As a CHC, your mission is to reduce the barriers to primary care that many of these patients encounter and provide access to services regardless of a patient's ability to pay.

CHC boards of directors and management teams generally succeed in emphasizing the CHC mission, but it's not the only area that needs your regular attention.

To succeed in fulfilling your mission of providing uninterrupted services, it's essential for the business side of your operation to receive its share of attention.

Don't neglect business side when making decisions

When making an important decision, CHCs usually consider the impact it will have on their mission, but the business ramifications also should play a significant role in the process.

Is your CHC considering the addition of a new service? What about a new location? CHCs regularly consider and make decisions like these. Your board and management teams may view them in terms of their potential to enhance the CHC mission, but don't overlook their financial implications.

If your CHC is considering a new location, perform the necessary due diligence to determine the financial impact it will have.

For example, a new clinic's payer mix might be different from your existing payer mix, which could have a direct financial impact on your overall organization.

Examples abound of CHCs that have agreed to "take over" the operations at a new site, such as existing clinics formerly operated by the local hospital or county government. When proper due diligence wasn't performed, the CHC's financial condition eroded.

This is certainly not the case in every situation because many CHCs partner successfully with other health care providers, such as hospitals, to the benefit of both providers. However, without proper due diligence, your CHC takes a gamble that might not pay off.

What about personnel issues?

Let's say a member of a CHC management team learns its most productive biller is being courted by another area health care provider using a higher salary as an incentive to switch employers.

In keeping with its mission, the CHC management team decides it can't afford to counter the competitor's offer with a salary increase that keeps the biller from leaving.

In losing this particular employee, the CHC also risks losing revenue from claim denials and cash flow issues from increasing days revenue in accounts receivable.

In making its decision, did the CHC management team give as much consideration to the situation's business implications as it did its mission-based concerns?

Paying the biller a higher salary may have been well worth it; in fact, it might have enhanced the CHC's mission by providing more revenues and allowing additional servic-

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In Brief

Outpatient PPS proposed rule – In the July 25, 2005, **Federal Register**, CMS proposes to update outpatient PPS rates effective January 1, 2006. The overall estimated impact of the update is 1.9% for all hospitals. Under Section 411 of the MMA, outpatient hold harmless protection expires December 31, 2005, for rural hospitals with 100 or fewer beds and all SCHs. This section also required CMS to study whether costs incurred by rural hospitals for outpatient services exceeded costs incurred by urban hospitals. CMS concludes costs incurred by rural SCHs do exceed costs incurred by other hospitals; to recognize this difference, it proposes a 6.6% add-on to the APC payment rates for rural SCHs.

OIG study of RHC program – OIG has issued a study of the RHC program. RHCs are clinics established in underserved rural areas that receive cost-based reimbursement from the Medicare program. OIG suggests changes to the way shortage designations are made and how RHCs are reviewed to determine if their location is still a shortage area. OIG was not critical of providers in this area but urged other government agencies to update their procedures to review RHC issues.

Provider-based and freestanding RHCs should stay tuned to this area, as new regulations are likely to be issued that may change the rules for existing and future RHCs.

Revised occupational mix survey released – CMS has issued a revised occupational mix

Physician recruitment incentives could benefit your NFP hospital

by Dave Mason, Colorado Springs,
dmason@bkd.com

When it comes to the competitive arena of physician recruiting, a physician group that partners with a not-for-profit hospital may have an advantage.

Physician groups and hospitals often offer some type of financial incentive when encouraging physicians to join their group or to practice in their geographic area.

One that's commonly used involves assistance with repaying medical school loans. A typical example might involve a primary care physician group that wants to recruit a new physician after he/she completes residency requirements.

A hospital serving the same geographic area might be willing to assist the physician group in its recruitment efforts and offer student loan assistance as a financial incentive.

Provided certain requirements are met, it's possible for the physician recruit to receive this assistance tax free. Student loans include those made by an organization exempt from tax under IRC §501(a) to refinance existing medical school or undergraduate student loans.

When a tax-exempt organization pays for all or a part of a physician's student loans—agreeing to forgive a portion of or the entire repayment obligation—the forgiveness may be tax free if the following criteria are satisfied:

- The hospital has determined its service area is underserved in the physician's specialty
- The physician is free to practice anywhere within the hospital's underserved service area
- The hospital makes a loan to the physician to refinance his/her current student loans
- The hospital agrees to forgive and discharge the loan to the physician
- The forgiveness is tied to a physician service requirement in the hospital's underserved service area
- The physician is not obligated to perform services directly to the hospital
- The physician is under the direction of the hospital
- The educational loan assistance is necessary to recruit physicians to serve the hospital's underserved service area

To determine if unmet needs exist in certain specialties in its service area, a hospital often prepares a needs assessment, which is necessary to avoid the possibility of any private inurement of the hospital's tax-exempt status.

The needs assessment also helps to satisfy many of the statutory requirements to achieve tax-free forgiveness of student loans.

Each recruiting agreement is different and should be individually analyzed to determine if any tax-favorable incentives are available for the recipient physician. ■

New Roth option available under §403(b) for 2006 plan years

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

A tax-sheltered annuity—otherwise known as a §403(b) plan—is a special type of retirement arrangement that enables certain tax-exempt and governmental employers to purchase annuity contracts or contribute to custodial accounts for eligible employees.

The two types of employers eligible to establish §403(b) plans are public educational organizations (public schools) and organizations tax exempt under IRS §501(c)(3), including many health care organizations.

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survey form that attempts to address concerns from the initial survey in early 2004, which was used with a 10% weighting factor to adjust the hospital wage index. If CMS believes the new survey more accurately reflects the mix of occupations among hospitals, it may give a heavier weight to it for the fiscal 2008 hospital wage index.

The new survey requests paid salaries and hours for four major occupational categories: RNs; LPNs; nursing aides, orderlies and attendants; and medical assistants. The RN and LPN categories are broken into subcategories of nursing administrator/director, nurse supervisor/head nurse and staff nurse/clinician. Nurses in SNF, rehab and psych units are excluded from the survey.

The survey will include employees and contract labor and will consist of data from January 1 to June 30, 2006. It will be due to intermediaries by July 31, 2006. CAHs will be exempt from the survey process. Comments on the survey process are due to CMS by December 13, 2005.

Hurricane Katrina provider issues – As we go to press, numerous developments have surfaced concerning providers in areas hit by Hurricane Katrina, as well as providers serving evacuees from the affected areas. For more information, providers can visit the CMS web site at **www.cms.hhs.gov/katrina/**. ■

Glossary

AIDS – acquired immunodeficiency syndrome

ADL – activities of daily living

APC – ambulatory payment classifications

CAH – critical access hospital

CBSA – core-based statistical area

CCI – Correct Coding Initiative

CDM – charge description master

CHC – community health center

CMS – Centers for Medicare & Medicaid Services

CPT – common procedural terminology

DHHS – Department of Health and Human Services

DRG – diagnosis-related group

FI – fiscal intermediary

FY – fiscal year

HCPCS – healthcare common procedure coding system

HHA – home health agency

IRA – individual retirement account

IRS – Internal Revenue Service

IRC § – Internal Revenue Code section

LTC – long-term care

MDS – minimum data set

MMA – *Medicare Modernization Act of 2003*

MSA – metropolitan statistical area

NFP – not-for-profit

NPI – National Provider Identifier

OASIS – Outcome & Assessment Information Set

OBRA – *Omnibus Budget Reconciliation Act*

OIG – Office of Inspector General

PEP – partial episode payment

PPS – prospective payment system

RHC – rural health clinic

RUG – resource utilization group

SCH – sole community hospital

SCIC – significant change in condition

SNF – skilled nursing facility

STM – staff time measurement

Communication helps. . .

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more effectively with your board, educate its members to be aware of:

- Significant laws and regulations that affect the organization
- How the organization is reimbursed for the services it provides
- Critical financial ratios
- Compliance activities

For your board to perform its duty of care, it must understand the issues your organization faces before it can make adequate and effective inquiries of management.

Management should proactively educate the board in areas critical to the organization's well being. For example, conduct an orientation for each new board member that includes:

- An operations' overview
- Health care industry background
- Explanation of financial statements
- Review of compliance programs

In addition, regularly update the board about legislative changes, compliance activities and reimbursement issues that affect payment for services. An update can be an overview of the most critical elements; any follow-up training or education sessions can be determined by the board.

Get board members involved

Another step in communicating more effectively with your board is to get members involved.

Before recent scandals and company failures shocked the nation, serving on an organization's board generally required little work or effort and was considered a privilege and a position of stature in the community.

Today, many organizations require board members to attend more than just the monthly meeting, and more is expected from the board, too—more involvement, more time and a more thorough understanding of the organization. This stems from the health care industry's complexity and the public scrutiny now placed on boards.

Directors are getting involved in more committees and spending a significant amount of time understanding the intricacies of the health care industry. Involvement like this allows management to work with a well-informed board, one that can make informed decisions on issues facing the organization.

It also allows directors to exercise the duty-of-care principle because they're able to ask management informed questions before decisions are made.

Communicate regularly

Regular communication with the board on important issues is critical. For example, provide your board a quarterly update on compliance activities and establish agenda items to cover at each quarterly report.

In addition, establish similar reporting timelines for other areas in your organization to help keep your board involved and in the know.

The bottom line: Your board of directors is ultimately responsible for your organization's overall conduct. To help it carry out its fiduciary responsibilities, educate, involve and regularly communicate with your board. ■

To stent or not to stent

by Trisha Priest, Springfield, ppriest@bkd.com

OIG's recently issued report, "Review of the Services Related to the Placement of Arterial Stents," reviews claims for services provided in calendar year 2002.

Outdated criteria can pose compliance risk

CMS has changed its payment requirements for CPT/HCPCS coding for stenting procedures and devices many times since the August 2000 inception of ambulatory payment classifications (APCs).

OIG noted some of the coding requirements date back to October 1996. Despite this, OIG and other reviewers continue to find many common coding errors, such as:

- Lack of medical necessity documented in the chart to support the services billed, resulting in overpayments
- Improper coding, resulting in overpayments
- Lack of established hospital internal procedures to ensure services billed meet Medicare requirements
- Lack of education covering proper billing practices for stent services

These issues pose a major compliance risk to hospitals and physicians.

What hospital administrators & physicians want

Stenting and other interventional radiology procedures are costly and use a lot of resources; however, when accurately documented and coded, they can be among the highest paying APCs at a hospital. (Some stent procedures are considered "inpatient only," which can affect the DRG payment.)

Hospital administrators and physicians want to receive the highest possible reimbursement they are entitled to for the patient services they provide.

To achieve this, you must navigate a tangle of payer regulations and coding changes that can change every year. For various internal reasons, it's not always easy to educate the coding and billing staff so it can keep up with these changes, and this can cause a domino effect in a provider's revenue cycle processes.

Appropriate reimbursement starts with accurate documentation and ends with coding expertise. Without these vital components, the highest possible reimbursement may not be possible.

Component coding & documentation can be tricky

Component coding for these procedures is very complex, and requirements can vary somewhat between different FIs. Some of the areas to closely monitor include:

- Reliance on the charge description master (CDM)
- Charging codes in the department before dictation
- Multiple points of accountability
- Work processes not tied to documentation
- Data flow and system mapping issues
- Multiple service locations

Be aware of other changes that could potentially create high error rates for coding:

- Emerging technology code changes (category III codes)
- Quarterly CCI edit changes
- HCPCS level 2 changes

Documenting these procedures can be a quagmire. Coding can be difficult if physicians don't clearly state their selective placement of catheters into second-, third- or fourth-order vessels. Any damage (residual stenosis or gradient, occlusion) to the vessels along with procedures performed must also be clearly stated.

There are coding combinations for specific procedures that—if not documented clearly—preclude accurate code capture of both procedures. Communication gaps between coding staff and physicians also can contribute to error rates. These issues can seriously affect reimbursement.

Medical necessity can be questioned when:

- A physician does not document a clear reason for procedures performed for particular vessels
- A physician does not document a clear reason for procedures related to a continuous lesion
- A physician does not document a clear reason why an angioplasty balloon was used before stent implantation.

The intent of the procedure should be clearly defined.

* * *

Interventional radiology is a highly specialized area. If your hospital or cardiology physicians' group practice is not sure accurate code capture is occurring, a documentation and coding assessment can help you locate any missing reimbursement. For more information, contact your BKD Health Care Group advisor. ■

Inpatient PPS final rule offers modest improvements

by Tim Wolters, Springfield
twolters@bkd.com

The inpatient fiscal 2006 PPS final rule published in the August 12, 2005, **Federal Register** included several changes from the proposed rule issued in May. Corrections to the final rule were published in the September 30 and October 4, 2005, **Federal Registers**. Changes are generally effective October 1, 2005.

The basic inpatient payment rate increase is 3.7%, compared to the 3.2% originally proposed. The increase is 3.3% for hospitals not submitting required quality data.

Considering other changes being implemented, CMS estimates the overall impact of the final rule will be a 3.5% increase in payments. CMS reduces the fixed-loss cost outlier threshold from $25,800 in 2005 to $23,600 for 2006. CMS had proposed to increase the threshold to $26,675.

Wage index issues

CMS continues implementation of CBSAs for geographic classification and wage index purposes. The full impact of the new CBSA wage index will be felt by hospitals on October 1, 2005, after a 50/50 hold harmless blend for the previous year. CMS does continue the three-year transition begun last year for urban hospitals that became rural under the new CBSA definitions.

CMS also clarifies transitional issues for hospitals receiving special MMA Section 508 reclassifications, which last from April 1, 2004, to March 31, 2007.

Hospitals that filed for regular geographic reclassification by September 1, 2005, and are approved will be eligible to receive the reclassification effective April 1, 2007, or turn down the Section 508 reclassification and receive regular geographic reclassification on October 1, 2006. Affected hospitals will need to make the appropriate election within 45 days of the fiscal year 2007 proposed rule's publication next spring.

Finally, CMS provides clarification for fiscal year 2006 and subsequent years: If CMS makes a technical error on a hospital's wage index assignment—and if the hospital notifies CMS of the error and CMS acknowledges the error before October 1—the error will be corrected October 1.

Transfer policy expansion

CMS is implementing a major expansion of the post-acute transfer policy. This policy potentially reduces the DRG payment for patients transferred to psych, rehab or long-term care hospitals/units, SNFs or HHAs.

CMS estimates this expansion will result in a 0.9% decrease in DRG payments for the average hospital. The expansion increases from 30 to 182 the number of DRGs subject to the policy. This is a slight improvement from the 231 DRGs CMS originally proposed to include in the policy.

Disproportionate share

As required under Section 951 of MMA, CMS will make Supplemental Security Income (SSI) patient data available for hospital cost reporting periods that include December 8, 2004.

Hospitals will be able to verify such data, possibly improving their disproportionate share reimbursement. A subsequent **Federal Register** notice will furnish details on data usage.

CAH relocation

The ability for a hospital to become a CAH based on a state designation of the facility as a necessary provider expires January 1, 2006.

If a CAH relocates after January 1, 2006, it will have to comply with new regulations included in the final rule to maintain its CAH status. A CAH can retain its status if it can document the new facility serves at least 75% of the same service area and provides at least 75% of the same services with at least 75% of the same staff.

CMS eliminated the proposed date restrictions that would have required the CAH to document the replacement facility planning process was underway on December 8, 2003, when MMA was signed into law.

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The final rule includes numerous other provisions not summarized above. For more information about the rule's impact on your operations, contact your BKD Health Care Group advisor. ■

Speakers' Bureau

Topic: Accounting Issues for Medical Group Managers

Speaker: Tom Cottrell & Mark Blessing, Fort Wayne

Seminar: MGMA National Conference, Nashville

Date: 10/24/05

Smart business. . .

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es to be provided to patients that need CHC services.

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The theme for many similar examples is the same: **Smart business decisions enhance the CHC mission**.

When you consider the financial implications of any decision, you protect your mission. As the adage goes, "Without money there would be no mission."

Several CHCs across the country no longer have a mission because they're no longer in business. Learning to be business savvy can help benefit the community and the patients your CHC serves. ■

Have you seen our ads in *hfm* magazine?

BKD Health Care Group is proud of our affiliation in chapters of Healthcare Financial Management Association. Look at your June, August, October and December issues for our ads and, watch for upcoming ads in 2006 editions of **hfm** magazine, as we support your efforts to go beyond your numbers and get to the heart of the business of caring. ■

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Visit CMS's web site for additional information about the SNF PPS final rule, including:

The full version of the Medicare SNF PPS 2006 final rule -
www.cms.hhs.gov/providers/snfpps/fy06finalrule.asp

Regular updates of SNF PPS information -
www.cms.hhs.gov/providers/snfpps/default.asp

CMS research on RUG refinements -
www.cms.hhs.gov/providers/snfpps/rugrefine.asp

Transmittal 640, which provides instructions to FIs for implementing updates to the SNF PPS payment rates, effective October 1, 2005 -
www.cms.hhs.gov/manuals/pm_trans/R640CP.pdf

The RUG-III version 5.20 grouper package, including the 53-group RUG model that will be used for billing Part A services effective January 1, 2006 -
www.cms.hhs.gov/medicaid/mds20/mdssoftw.asp

These links also are available at www.bkd.com/industry/Health_Care/

OIG clarifies. . .

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ous Medicare manuals was confusing."

The two primary points of confusion:

- Physician supervision at the hospital
- "Incident to" criteria

OIG has recommended CMS clarify national coverage criteria related to direct physician supervision and "incident to" criteria. It also recommends CMS direct FIs to educate providers on the clarified policy.

CMS's response: It will seek to clarify the criteria and develop and publish provider-education materials and **Medlearn Matters** articles. More information can be found at **www.cms.hhs.gov/medlearn/**.

Review your current physician supervision practices, integrate the "clarified" information once it's published and anticipate FIs to focus on this area. ■

Don't let thieves steal your organization's information

by Dave Bowden, Springfield,
dbowden@bkd.com

As a health care organization, what are your most valuable items? You might not think of information as one of them, but your organization and your patients depend on accurate, timely information.

Over the past decade, technological advances and the ability to communicate at increasingly higher speeds have led to better methods of gathering and using information.

Think about how you might be affected if the information entrusted to you by patients was stolen because of inadequate safeguards, a lack of planning or inappropriate employee use.

Identity theft can happen when sensitive, personal information isn't adequately protected, making it vulnerable to illegal use or transfer by criminals.

Stolen personal information is generally used to open fraudulent credit accounts and to obtain loans, but it's also used to:

- Obtain employment under a false name
- Obtain rental housing
- Throw authorities off the trail in the event of arrest or the issuance of a summons

Safeguarding personal information

Recent news coverage about the loss of customer information by large corporations underscores the potential for risk, including lawsuits and bad publicity.

Information can be stolen from either traditional paper files or their particularly susceptible electronic equivalent.

You could also be vulnerable to social engineering schemes, *e.g.*, people may enter your facility unchallenged or use a false story to pilfer offices for information or look for passwords.

"Pfishing," an electronic form of social engineering, uses e-mails containing links to legitimate-looking web sites that pretend to belong to familiar companies.

When "marks" arrive at the site, they're cleverly asked to submit sensitive information and some do.

Never respond to such e-mails and immediately report them to the company whose identity is used as a cover.

Criminals use other methods to persuade you to divulge passwords or other sensitive information. Beware of information-gathering phone calls from individuals pretending to represent legitimate-sounding entities. Conduct periodic staff training on how to respond to such calls.

Create a computer usage policy all employees must read and sign when they begin employment and review it annually. Restrict access to appropriate personnel and grant access to other employees as needed; revoke access when it's no longer needed.

Be sure to confiscate keys, identification cards and related items from terminated employees, and quickly eliminate their computer access. Remember to change system passwords regularly.

Create and execute a defense plan for reducing risk and develop instructions for how to respond if sensitive information is stolen:

- Designate a media contact
- With your attorney, develop advance plans for meeting potential legal issues and for notifying law enforcement and patients, whose information could be compromised
- Create and enforce data retention policies; destroy unnecessary data and properly store all other information

Tools of trade help hammer security risks

Simply deleting data doesn't remove it from a computer. Before you dispose of a hard drive, have a properly trained professional run a wiping program on the system to ensure all information has been disposed of.

Routinely assess your system's vulnerability to attack, and, if weaknesses are found, run tests to verify the areas most susceptible to intrusion.

Firewalls and data encryption can help reduce the risk of successful external attacks. As its name implies, an intrusion detection system can alert you to attempts to penetrate your system. For internal security, "key loggers" can monitor who accesses specific files and when.

Use other measures to protect information in paper form. When using a shredder to destroy documents containing personal information, use one that turns paper into confetti-sized pieces or consider using a commercial shredding service.

Monitor and restrict records' storage areas to employees who need access to them to do their jobs, and consider securing such areas during nonbusiness hours.

Background checks have limitations

New-employee background checks can help protect sensitive information concerning employees and patients, but their information can also be limited: Some only consist of a local record check with a local law enforcement agency. Therefore, they may not contain information about arrests and convictions outside your area.

A background check's timing can pose problems, too. Let's say an individual either (1) leaves an employer after committing a crime and starts working for a different employer or (2) changes employers while under investigation for a crime.

Any related investigation or resulting judicial process could continue for months, meaning an initial background check would probably not show a conviction.

As part of your hiring strategy, consult your legal advisor about running several checks during an employee's first year or two on the job.

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SNF immunizations & MDS Section W: what's required

by Jan Zacny & Derek Hunter, Springfield, jzacny@bkd.com & dhunter@bkd.com

CMS believes all nursing home residents should be vaccinated annually against the flu and periodically against pneumonia.

To improve immunization rates in LTC facilities, CMS is requiring that they collect immunization data on the new Section W of the MDS.

As of October 1, 2005, all MDS (OBRA and PPS) assessments must include the new CMS-required Section W (influenza and pneumococcal immunization information).

Section W includes W1 (provider's NPI ID number), W2 (influenza vaccine) and W3 (pneumococcal vaccine) questions.

Required actions

Section W1 requires the facility's 10-digit NPI number, **which—in most states—is an optional number until May 2007**. Therefore, W1 currently does not require a number, and MDS assessments should be accepted at state databases without one.

For state databases to accept the MDS, only valid numbers can be inserted in W1; otherwise, the MDS will be rejected. **Leave the number blank until you have a valid NPI number.** If you have problems submitting the MDS, contact your state's MDS coordinator. If you need additional assistance, contact your BKD Health Care Group advisor.

Section W2 and W3 (vaccine data) is required on all MDS assessments, including the discharge tracking forms. Both W2 and W3 are inactive on the re-entry tracking forms. The data can be submitted but will not be edited or stored in the state database.

Facilities must develop and implement immunization procedures, including an immunization history for each resident.

The information must be documented in the resident's medical record and indicate whether the resident received the immunization or if it was medically contraindicated or refused.

Refusals must reflect that the resident's responsible party received appropriate education about the benefits of the immunizations.

If your SNF doesn't yet have an NPI number, it should apply for a facility-specific NPI number immediately. Application information is available at CMS's web site: **www.cms.hhs.gov/hipaa/hipaa2/npi_provider.asp**.

Roster billing assists with vaccine reimbursement

Effective October 2, 2002, CMS removed the physician order requirement for influenza and pneumococcal vaccinations from the Conditions of Participation for Medicare- and Medicaid-participating hospitals, LTC facilities and HHAs.

In another positive move, CMS increased Part B immunization reimbursement rates for the administration of the vaccines from $8 to $18 beginning January 1, 2005.

The costs of the vaccines are reimbursed by the Medicare program on a cost basis. For Part B eligible residents, SNFs are allowed to "roster bill" (one bill listing several residents).

The financial implications of these changes are positive. Consider a SNF with 100 patients getting two immunizations per year. The vaccine administration fees would be $3,600, in addition to the reimbursement of the costs of the vaccines.

Given the ability to roster bill, billing will be much easier than submitting individual bills for individual residents.

Set charges appropriately

A key concern about charging for Part B vaccines is that a facility's charges must be set at an appropriate level to avoid a limitation of the reimbursement.

Medicare pays for administering the vaccines under Part B at the lower of the fee schedule amount or the facility's charges. BKD recommends SNFs establish vaccine charges at the fee schedule amount plus a 20% to 25% mark up.

The mark up allows SNFs to:

- Offer discounts to managed care organizations
- Avoid limiting Medicare reimbursement when the fee schedule amounts are changed (if the facility doesn't immediately increase vaccine charges)
- Recoup a small profit on private-pay patients

CMS believes "high-risk" residents should also be vaccinated against hepatitis B.

Summary

To summarize how your SNF must comply with the new rules:

- SNFs must apply for an NPI number
- SNFs are required to complete the new Section W of the MDS for state-required assessments—the 14-day assessment
- Vaccine costs are reimbursed by Medicare Part A and B
- Administration of the vaccines is reimbursed at $18 per immunization
- Vaccine charges should be set at 20% to 25% above the Medicare fee schedule amount
- Medicare Part B services can be roster billed, making the billing much more efficient

For more information about how Section W will affect you, contact your BKD Health Care Group advisor. ■

New Roth option available. . .

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Section 403(b) plans can be funded via any combination of employee salary reduction contributions, employer nonelective (matching) contributions or employee after-tax contributions.

Although it's been rare for a §403(b) plan to allow employee after-tax contributions, a recent change in the law will likely cause many plans to reconsider allowing such contributions.

The *Economic Growth and Tax Relief Reconciliation Act* (EGTRRA) added Code §402A, permitting employees that make elective contributions under a cash or deferred arrangement (CODA) to designate some or all of those contributions as Roth IRA-like contributions to the plan.

This concept has been around since 1997 in the form of Roth IRAs. Funded by after-tax dollars, the growth and contributions are not subject to taxation upon qualified withdrawal. The new law simply blends this familiar feature into the §401(k) and §403(b) environments.

Specifically, IRS §402A permits employers sponsoring §401(k) or §403(b) plans to offer participants the opportunity to make both pre-tax elective deferrals to a "traditional" §401(k) or §403(b) account and nondeductible contributions to a Roth §401(k) or Roth §403(b) account (with the total subject to existing overall contribution limitations).

In a traditional §401(k) or §403(b) plan, contributions are made pretax, earnings grow tax deferred, and withdrawals are treated as taxable income.

Contributions pursuant to Roth features of a §401(k) or §403(b) plan are made after tax and grow tax free. Withdrawals that take place after the fifth year of participation and after age 59½ also are tax free.

In a recent Hewitt Associates poll of 200 companies, 35% of the respondents indicated they may add a Roth feature to their existing plan.

Employers that choose to offer Roth contribution programs must amend their plan documents to add Roth provisions. They also will incur additional administrative costs because accounting for pre-tax and after-tax contributions, earnings and withdrawals must be done separately.

* * *

Roth §401(k) and §403(b) accounts are available for plan years beginning in 2006. For more information about the Roth §403(b) option, contact your BKD Health Care Group advisor. ■

Don't let thieves. . .

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New schemes and tools will always be on the horizon, looking for opportunities to steal sensitive information.

To reduce your odds of attack, periodically reassess your facility's computer system and upgrade your security measures. Be prepared to revise your plan of defense, which will help you to more effectively prevent new security risks and attacks.

Such measures can and do save money and can help you avoid costly problems that could potentially damage your reputation and financial well being.

* * *

Make the protection of sensitive information an ongoing part of your daily operations. BKD's Forensics & Dispute Consulting (FDC) team can help. Contact your BKD Health Care Group advisor for an introduction. ■

About Health Care News

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

For a complete list of our offices and subsidiaries and their contacts, visit:

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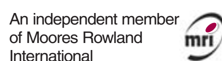

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