



What you need to know about NPI

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Health care providers began to apply for the National Provider Identifier (NPI) May 23, 2005, the effective date of the final rule. The NPI number is now the established identifier all health care providers are eligible to receive.

All entities covered under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) must obtain and use one, with compliance for all but small health plans required May 23, 2007, and May 23, 2008, for small health plans.

NPI: what it is & who needs one

The NPI is a 10-digit number, which will make it possible to create enough unique number combinations over the next 200 years to allow for significant growth in the number of health care providers.

NPIs also are intelligence free, meaning they do not carry other information about a provider, such as its location or medical specialty.

Use the NPI for all standard HIPAA transactions that require a provider identifier; it will eventually replace all other provider identification numbers currently required for government and commercial insurance plans.

All health care providers must obtain an NPI: Individuals (physicians, nurses, dentists, chiropractors, physical therapists or pharmacists) and organizations (hospitals, HHAs, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, HMOs, suppliers of DME, pharmacies, etc.).

In other words, any business entity with a tax-identification number that submits standard HIPAA transactions must have an NPI.

How do I obtain my NPI?

Each individual provider must apply for the NPI. The online application is free and available at www.NPPES.cms.hhs.gov.

As a physician, can the hospital obtain an NPI for me?

With permission, an organization may submit a request for the NPI on behalf of a provider via an electronic file. The larger organization must apply to be recognized as an electronic file interchange organization (EFIO).

Once approved, it can download files in a specified format to receive individual as well as facility NPI(s). An EFIO also may be used for updates and deactivations if permitted by the providers.

As a physician, should I ask the hospital to obtain my NPI?

Discuss the long-term impact of this decision with the hospital and understand the limitations it may put on you in the future. The appropriate maintenance of associated demographics over the years to come will be critical to your ability to bill and collect payments.

If you change locations, practices, specialties, or if other related changes occur, you want to ensure you can control your NPI updates. You may choose to apply for the NPI on your own to maintain personal control of your information.

Why should I apply now?

Applying now will facilitate the testing and transition processes and decreases the possibility of any interruption in claims payment.

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MA for IPPS & CAHs: be aware of details when

Negotiating MA contracts under IPPS

by Tom Watson, twatson@bkd.com

As Medicare Advantage (MA) plans begin to include mandatory drug programs and receive higher payments from CMS, their popularity with beneficiaries and their geographic reach are expected to grow.

As a result, hospital leaders in areas not currently subject to Medicare managed care plans may soon find a proposed contract on their desk.

What to analyze & why

When analyzing the proposed contract's impact on your hospital, inventory what Medicare currently pays for traditional Medicare beneficiaries and compare it to the proposed payments. When reviewing Medicare inpatient payments, consider several components as you analyze the equivalent managed care payment:

Base federal rates - Under IPPS, hospitals receive an acuity-adjusted base rate for operating costs that's adjusted by inflation factors and changes in the area-wide wage index each year.

In some cases, changes in the wage index can result in significant payment changes from one year to the next. In future years, consider partially tying rate adjustments to the normal Medicare IPPS inflation rate and to increases in the wage index at your hospital.

DSHs - The Medicare DSH add-on is a substantial payment adjustment for many hospitals, often adding 10% to 25% to the base federal rate. If a rate offered by an MA plan is based solely on the federal rate, and your hospital has a high DSH percentage, there could be a significant reduction in cash flows under the new contract.

Indirect medical education (IME) - A hospital with a teaching program receives an adjustment to the federal rate based on its ratio of residents to available beds. This payment adjustment also can be applied to

MA patients; however, for the add-on to be computed, you must bill a "simulated DRG" to Medicare.

If you receive IME payments and are entering a new MA contract, set up a system to bill the simulated DRG for the managed care participants. The MA IME payment will be based on the same formula as the IPPS payment.

Hospital-specific payments (HSPs) - Some SCHs and MDHs receive an additional payment based on their HSP rate. The aggregate HSP is compared to the cumulative federal rate (base rate + DSH + IME + outlier payments), and the SCH or MDH receives the higher of the two amounts. When negotiating a contract based on Medicare rates, consider any HSP rate difference.

Capital payments - Under IPPS, hospitals also receive a separate capital payment with each discharge, based on a national standard rate adjusted for cost differences among geographic areas.

The capital rate also is subject to IME and DSH adjustments. **If you are an SCH or MDH, remember the capital DRG payment is paid in addition to the HSP payment.**

Deductibles & coinsurance - Medicare beneficiaries are required to pay deductibles and coinsurance for many services they receive, and hospitals must try to collect these amounts from patients.

However, if the debt remains unpaid after a prudent collection effort, Medicare generally reimburses the hospital 70% of the bad debt amount.

In many hospitals, approximately 12% to 15% of Medicare deductibles and coinsurance are not collected from patients. Under managed care plans, bad debts cannot be included in the Medicare bad debt claim on the cost report.

When reviewing an MA contract, compare how much you'll be required to collect from patients to what you must collect under IPPS. Determine if the health plan will reimburse

you for a participant's unpaid amounts (similar to Medicare's IPPS methodology).

Graduate medical education (GME) - A hospital with a teaching program may receive payment for direct GME costs, which are roughly based on the number of approved residents working in your hospital, times a predetermined per-resident amount.



Medicare pays hospitals its share of this amount based on the ratio of Medicare days to total days. Days for patients in MA plans will qualify for this payment provided the days are properly counted and included on your hospital's annual cost report.

When reviewing an MA contract, you also may need to consider other, less common payments, including:

- CRNA pass-through payments
- High-percentage ESRD payments
- Cost-based payments for medical education, *e.g.*, nursing schools and paramedical education programs

Review impact of acute-care transfers

Many hospitals have separate programs for swing beds or distinct-part SNUs, psychiatric units or rehabilitation units. In many cases, patients initially admitted into the acute-care area of the hospital will be transferred to a subacute setting, which will help cover the costs hospitals must pay for high LOS patients.

When reviewing the proposed MA contract, **review the impact of patients that transfer to swing bed or SNUs.** If the proposed MA contract does not allow a separate payment for these services, you may see a higher reduction in payments than initially indicated.

Medicare currently pays for these subacute services:

negotiating MA plan contracts

- Swing bed and SNU (acuity-adjusted per-diem payment based on MDS scoring)
- Rehabilitation units (prospective payment per admission based on patient diagnoses)
- Psychiatric units (acuity-adjusted per-diem payments)

Not all hospitals elect to contract

Hospitals must elect whether to contract with an MA plan. Most providers that elect not to are considered “out of network,” which generally results in the MA plan paying at the regular Medicare rates but with increased cost sharing by the beneficiary.

Cost sharing could be substantially higher than the normal Medicare deductible or coinsurance and would not be eligible for bad-debt

reimbursement through your cost report. This also may result in patients electing to use a different network provider.

Some MA plans could seek CMS approval to designate a noncontracting hospital as an “essential” hospital under the MA plans. While the method for obtaining this status is beyond the scope of this article, hospitals with this designation receive certain benefits:

- Even though they have not contracted with the MA plan, they are considered in-network hospitals for beneficiary cost-sharing purposes.
- Essential hospitals will receive payments at their normal Medicare rates.
- For inpatient claims, essential hospitals

that can demonstrate the costs of caring for MA patients exceeds the Medicare Part A payment from the MA plan may receive “wrap-around” payments to cover this shortfall.

For 2006, these payments will be funded by a \$25 million fund established by CMS. In future years, the essential hospital fund is scheduled to increase based on the hospital market basket inflation factor.

Before signing an MA contract, it's important to have legal counsel review it. It's also important to know how total inpatient payments will be affected. Much of the data you must analyze can be found in your Medicare cost report. ■

MA for CAHs: standard contract provisions require negotiation

by John Harris, jharris@bkd.com

With the MMA's passage in 2003, CMS embarked on a plan to encourage more providers and beneficiaries to contract with commercial insurance providers under a new MA, Medicare Part C.

What MA insurers' contract goals include

The goal of MA insurers is to contract with both providers and beneficiaries in a regional, if not national, service area. Because MA insurers haven't had much success in contracting with rural hospitals to provide required coverage under their agreement with CMS, they have been allowed to designate certain hospitals as “essential hospitals.”

This entitles essential hospitals to receive a potential additional reimbursement if their costs for providing inpatient services exceed the payments received from an MA insurer.

It also allows the beneficiary to be treated “in network” for cost sharing on inpatient services only; however, CAHs are not eligible for the essential hospital designation.

Therefore, CAHs are at somewhat of a disadvantage if they don't contract with an MA insurer, at least for the cost-sharing implica-

tions to beneficiaries relative to inpatient services, which creates the potential for negative public relations and erosion of community support.

This assumes enough beneficiaries have signed with an MA insurer for Medicare Part C to create a problem. While it may not seem like a huge risk, there will likely be more beneficiaries in the future who look more favorably to these types of policies.

In addition, it may be in every CAH's best interest to say an attempt was made to contract with an MA insurer.

Address legal & reimbursement issues

As with any contract, there are a number of legal issues to consider, and, from a reimbursement standpoint, there are quite a few issues a CAH should negotiate:

- Request cost settlements for inpatient, outpatient, skilled swing bed, RHC and HHA (if cost is better) be based, at a minimum, on the same methodology as Medicare.
- Request reimbursement for bad debts at 100% based on the same methodology as Medicare.

- Include language that defines skilled swing-bed services in the inpatient section of the contract.
- Request coordination of billing language included in the billing manual coincide with the contract. Primarily, this relates to the timing of filing and paying claims in a manner similar to current Medicare methodologies.

In addition to negotiating reimbursement, some standard contract provisions may require modification. For example, a significant contractual provision in one MA insurer's basic contract is a requirement for the hospital to maintain \$10 million of insurance coverage, but many rural providers don't maintain that amount of coverage.

There are many other contractual issues that should be evaluated, and BKD strongly recommends your legal counsel assist with this review process.

As with any managed care contract, there are a variety of considerations for providers. Before agreeing to any proposed contract, it's essential you know what you are really agreeing to. ■

Part B therapy caps & edits affect providers

by John Britt, jbritt@bkd.com

Providers of outpatient therapy services may be significantly affected by two regulatory changes effective January 1, 2006.

Changes end two-year therapy cap moratorium

Section 221 of the *Balanced Budget Re-finement Act of 1999* placed a two-year moratorium on what are now referred to as therapy caps. Except for a brief period in 2003, the moratorium was extended and kept in place until the scheduled regulatory changes became effective in January.

Change Request 4115 from CMS describes the financial limitations (therapy caps) applied to therapy services provided on or after this date. Annual limits include:

- Outpatient physical and speech therapy

combined -
\$1,740

- Outpatient occupational therapy - \$1,740

The limits apply to all outpatient and skilled nursing Part B therapy services except hospital outpatient. However, with the caps reinstated, hospital outpatient therapy services are once again subject to the provider-based rules and should be in compliance with those requirements.

If you are a provider subject to this change, review Change Request 4115 and implement processes to track and manage your patients within these new constraints.

As we go to press, Congress is poised to pass the *Deficit Reduction Act*. It is expected to include a process to apply for exceptions to the therapy caps during 2006 on a case-by-case basis if these services are determined medically



necessary. If CMS does not deny an individual exception request within 10 business days, it will be considered approved.

How CCI edits will change

Also effective January 1, 2006, all Part B therapy providers will be subject to the Correct Coding Initiative (CCI) edits.

Hospital outpatient therapy services have been subject to the edits since their inception; however, in 2006, they also will apply to:

- SNFs
- Comprehensive outpatient rehab facilities
- Outpatient providers
- HHAs

Providers subject to these new rules should be prepared to meet these new documentation and billing requirements. ■

What you need to know about NPI. . .

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Must I share my NPI?

Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction.

Examples include referring physicians or any provider with whom you do business, such as pharmacies, health plans or organizations where you have staff privileges.

How will the transition work?

From January 3, 2006, through October 1, 2006, Medicare systems will accept claims with an NPI, but an existing legacy Medicare number, *i.e.*, your current Medicare provider number, also must be on the claim.

Beginning October 2, 2006, through May 22, 2007, Medicare will accept NPI as the primary number; however, if there is any problem with the NPI number, claims may not be paid.

Medicare strongly recommends providers, clearinghouses and billing services continue to submit the Medicare legacy identifier as a secondary identifier. Beginning May 23, 2007, CMS systems will only accept NPI numbers.

What about identifier crosswalks?

Each health plan may create its own crosswalk to crosscheck NPI and legacy identifiers. **CMS stresses the importance for health care providers to enter their current identification numbers on their NPI application. This is to facilitate Medicare's building of identifier crosswalks (for Medigap and secondary payer purposes).**

What other preparations should I make?

- Watch for information from the health plans you do business with about their implementation/testing schedule for the NPI.
- Check with your billing service, software vendors and clearinghouses about NPI compliance and how you can assist in facilitating the process. You may need to obtain updates to your billing software to be able to submit claims using the NPI.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims, as well as electronic transactions.

- Each health plan may create its own crosswalk. As stated above, health care providers should record their current identification numbers on their application to facilitate health plans building crosswalks.

Anticipated issues

How will you obtain NPI numbers from the numerous referring physicians whose names and unique physician identification numbers (UPINs) are currently required?

Begin now to develop a plan to obtain the referring physician's NPI, which will replace the current UPIN. This could include a mass mailing or e-mail request. NPIs should be requested for all referrals received on or after January 3, 2006.

If the hospital submits your application as an EFIO, must you always submit your information through that hospital even if you relocate? Yes. BKD recommends each individual physician apply for and maintain his/her individual NPI.

For more information, visit the CMS web site: cms.hhs.gov/NationalProvIdentStand/. ■

IRS increases Form 990 information disclosures

by Rita Worster, rworster@bkd.com

The IRS released a draft of Form 990 in November for public comment. At press time, the draft had not been finalized, but changes to the draft are not anticipated.

Following are information disclosures the IRS has added to Form 990:

- Explanation of any family or business relationships between any officers, directors, trustees, key employees, highest compensated employees or highest compensated professional and other independent contractors
- Explanation of compensation arrangements between organizations, whether tax exempt or taxable, that are related to the organization through common supervision or common control. The explanation must include the amounts paid to any officers, directors, trustees, key employees, highest compensated employees or highest

compensated professional and other independent contractors

- The total number of officers, directors and trustees permitted to vote on organization business at board meetings
- A question about whether the organization has a written conflict-of-interest policy
- Information about certain transactions with **former** officers, directors, trustees and key employees involving compensation, loans and advances, contributions to employee benefit plans and deferred compensation plans, expense account and other allowances

Schedule A, which is completed by 501(c)(3) organizations, has an additional section to disclose the five highest-paid independent contractors for other services. Previously,

The IRS continues to focus on compensation issues and transparency, which refers to the ability of outsiders to review data concerning the organization's finances and operations.

only independent contractors for professional services were disclosed.

The IRS continues to focus on compensation issues and transparency, which refers to the ability of outsiders to review data concerning the finances and operations of a tax-exempt organization. The additional information required on the Form 990 is an example of how the IRS is carrying out its desire for transparency.

It also will continue to focus on excess compensation (especially in the health care industry) and various types of compensation arrangements, such as deferred compensation, loan forgiveness and nonaccountable expense plans. ■

In Brief

Budget legislation pending - As we go to press, Congress is about to pass significant legislation to implement the federal fiscal year 2006 budget. As mentioned in John Britt's "Part B Therapy Caps & Edits Will Affect Providers," page 4, an exception process is expected to be implemented there.

Other provisions the final bill is likely to include:

- Expand quality measures hospitals must report to get a full PPS inpatient payment update and an increase in the amount of the reduction in the update factor applicable to hospitals not reporting data from 0.4% to 2.0%
- Continue restrictions on new specialty hospitals pending CMS developing a plan to address concerns about physician investment in such hospitals
- Retain the 60% threshold for the phase-in of the rehab 75% rule for an additional

year; increase threshold to 65% in 2007 and 75% in 2008

- Extend for five years the Medicare-dependent hospital program and improve it by (1) providing an option for an additional base year using 2002 data, (2) increasing the potential DRG add-on from 50% to 75% of the difference between the hospital-specific and federal rates and (3) removing the 12% cap on disproportionate-share payments (all MDH changes are effective October 1, 2006)
- Extend for three years the outpatient hold harmless payments for rural hospitals with 100 or fewer beds but reduce payments by 5% in 2006, 10% in 2007 and 15% in 2008. All SCHs have been excluded from this provision because they now receive a 7.1% add-on to outpatient payments
- Freeze physician payments at 2005 levels, avoiding a 4.4% reduction in payments under prior law

- Reduce reimbursement 30% for SNF bad debts except for those beneficiaries that are dually eligible because of Medicaid plan limitations
- Freeze 2006 home health payments at 2005 levels; implement a 2% reduction in the payment update starting in 2007 for agencies not reporting quality data but reinstate the 5% rural add-on for 2006
- Starting in 2007, limit payments for free-standing imaging services to the outpatient PPS payment for the same service
- Limit free-standing ambulatory surgery center (ASC) payments to the outpatient PPS rate until a new ASC fee schedule is developed

The legislation is expected to contain numerous other provisions not recapped here. ■



What's on OIG's radar so

ten agreements between teaching hospitals and dental schools.

Nursing and allied education payments - OIG will audit FI and provider records to determine the appropriateness of payments for provider-operated nursing and allied health programs, which are reimbursed on a reasonable-cost basis. Apparently, OIG will determine the validity of payments made by the FI.

Inpatient PPS wage index - OIG will determine the impact of incorrect wage data on DRG reimbursement. OIG believes wage index data could be significantly influenced because of information reported by a single hospital in an urban area.

IRF payments - OIG will review the payments to IRFs under PPS to determine if they are in accordance with Medicare laws and regulations. The specific focus will be whether IRF admissions were proper and if the billings were submitted correctly. OIG also will review outliers and the cost of services and LOS of rural IRFs.

IPF payments - OIG will review the payments to inpatient psychiatric hospitals to determine if they comply with Medicare laws and regulations. It appears OIG will concentrate on outlier payments, interrupted stays and the LOS and cost of services of rural psychiatric hospitals.

CAHs - OIG will review hospital cost reports to examine the administrative and other costs claimed before and after conversion to CAH status. In particular, OIG may be concerned with related-party costs, home-office costs, management fees and purchased service costs.

Rebates paid to hospitals - OIG will determine if hospitals correctly reported rebates as separate line items on the cost report. Medicare rules require rebates be offset against the specific cost centers for which they apply. OIG intends to review several large vendors to determine the amount of rebates paid to hospitals and examine the hospital cost reports to determine how they were reported.

Outpatient payments - OIG will review payments for outpatient services to determine if they were in compliance with Medicare regulations. Specifically, OIG will review multiple procedures, repeat procedures and global surgeries to determine if they were appropriately billed and paid.

Unbundling of outpatient services - OIG will review outpatient services that should be bundled according to Medicare regulations. Medicare prohibits hospitals from unbundling services that should be bundled and billing for them separately.

Inpatient-only services performed in an outpatient setting - OIG will determine if hospital outpatient claims have been properly denied for services listed by CMS as "inpatient only" that were performed in an outpatient setting. This list is updated annually in the Outpatient PPS rules. Hospitals are prohibited from billing for "inpatient only" services on an outpatient basis.

DRG codes - OIG will continue to audit DRG codes to determine whether some hospitals are using aberrant coding practices; this is one of OIG's longstanding concerns because of the potential for overpayments caused by inaccurate coding.

Medicare HHAs

HHA outlier payments - OIG will determine if outlier payments were made according to Medicare regulations. OIG will evaluate how frequently outlier payments are made, whether they cluster in certain home health groups or geographical areas and whether the outlier payment methodology is equitable to all HHAs.

Enhanced payments for therapy - OIG will determine if an HHA's therapy services meet the threshold for higher payments according to the Medicare regulations by analyzing the number and duration of therapy visits provided per episode period.

HHA survey and certification deficiencies - OIG will review trends and patterns related to survey and certification deficiencies. Every 36 months, the *Social Security Act* requires CMS conduct a survey of quality of care and ser-

by Larry Fogel, lfogel@bkd.com

OIG's 2006 Work Plan has something for just about every type of provider, including fraud- and abuse-preventive safeguards under Medicare Part D intended to protect the interests of Medicare beneficiaries.

The safeguards also are intended to avoid fraudulent and abusive practices particularly in kickbacks, false statements and services not rendered.

Because the 2006 Work Plan's scope is broad, this article focuses on some of the initiatives related to hospitals, nursing facilities, HHAs and physicians. However, BKD recommends providers review the complete publication for other OIG initiatives that could affect their organizations.

Selected highlights

Following are selected highlights of OIG's 2006 Work Plan:

Medicare hospitals

Payment for observation services - OIG will review whether hospitals have been admitting patients for dialysis services when they should have been providing observation services.

OIG's concern is that DRG payments are paid at a much higher rate than observation services. Presumably, OIG will review if the physician's order specified an admission or observation care.

Medical education payments - OIG will review the appropriateness of including podiatry and dental residents in a hospital's FTE resident count for purposes of GME and IME payments. OIG also plans to review the writ-

Screen for 2006

vices provided by HHAs based on indicators of medical, nursing and rehabilitative care. OIG also will determine if certain HHAs show cyclical noncompliance with certification standards.

Medicare nursing facilities

SNF rehab and infusion therapy services -

OIG will determine if SNF rehab and infusion therapy are medically necessary, adequately supported and are actually provided to Medicare beneficiaries. These services are provided to Medicare beneficiaries because of multiple medical and post-surgical conditions. Medicare rules require these services be ordered by a physician and performed in the facility by its nursing staff.

Consecutive patient stays - OIG will examine SNF care provided to patients with consecutive inpatient stays. The review will focus on beneficiaries that had three or more consecutive stays, including at least one SNF stay. Presumably, OIG is concerned about whether the stays were medically reasonable and necessary.

Day of discharge - OIG will determine if Medicare is inappropriately paying SNFs for the day of discharge. Under Medicare rules, the day of discharge should not be billed and reimbursed.

Consolidated billing - OIG will determine whether Medicare is overpaying providers for services because of duplicate billings under the consolidated billing rules. OIG claims it previously identified millions of dollars of improper payments in 1999 and 2000, which were associated with outpatient hospital, ambulance, laboratory and radiology services. OIG will determine if any improper payments were made for 2001, 2002 and 2003.

MDS assessments - OIG will review the type, frequency and severity of nursing home deficiencies relating to MDS assessments and care planning. OIG previously identified deficiencies in comprehensive assessments, care planning and the services provided in connection with the care plan.

Imaging and laboratory services - OIG will

audit for medically unnecessary or excessive billings for imaging and laboratory services to nursing home residents. OIG is concerned that Medicare pays over \$200 million a year for imaging and laboratory services. OIG plans to review a sample of claims and examine the utilization patterns for these services.

Medicare physicians

Billing service companies - OIG will review relationships between billing companies and physicians. OIG plans to assess the types of arrangements with billing service companies and the impact on physician billings. One possible reason for this initiative could be incentives for upcoding or overbilling services to Medicare.

Care plan oversight - OIG will evaluate Medicare payments for care plan oversight claims submitted by physicians. The focus will be on physician supervision of patients in hospice care. OIG is concerned that care plan oversight payments have increased from \$15 million in 2000 to \$41 million in 2001.

Physician pathology services - OIG will conduct a review of pathology services performed in the physician's office. OIG's review will focus on whether the laboratory services comply with Medicare Part B payment rules. Presumably, OIG is interested in the relationships with physicians and outside pathology companies.

Cardiography and echocardiography services - To determine if they were billed properly for their professional and technical components, OIG will review cardiography and echocardiography services provided by physicians. Evidently, OIG is concerned about the use of Modifier 26 when the physician performs the interpretation separately.

Physical and occupational therapy services - OIG intends to review therapy services provided by physical and occupational therapists to determine if the services were reasonable and medically necessary and certified by physician certification statements.

Use work plan as valuable resource

OIG's **2006 Work Plan** offers providers an

excellent opportunity to conduct risk assessments and develop their own work plan for the year or update their existing plans with OIG's initiatives for 2006.

As a valuable resource for identifying OIG's targets for 2006, wise providers will use the **2006 Work Plan** to determine if they have potential exposure in any targeted areas and—if they do—conduct internal compliance audits during 2006.

As the old expression goes, the first step in resolving a problem is to determine if one exists. After all, no one likes surprises. Knowing what's on OIG's radar screen for 2006 and monitoring these areas may help avoid some costly surprises. ■

Writers' Bureau

Article: Minding Your Business

Author: John Britt, Louisville

Publication: hfm

Date: December 2005

Article: Re-evaluate Your Compliance Training & Auditing Processes

Author: Sandy Soerries, Kansas City

Publication: Health Care Compliance Association's (HCCA's) **Compliance Today**

Date: December 2005

Article: OIG's Roadmap for Effective Compliance Programs

Author: Larry Fogel & Joe Watt, Kansas City

Publication: HCCA's **Compliance Today**

Date: January 2006

Applying trending techniques to compliance & reimbursement

by Marla Dumm, mdumm@bkd.com

Do you use physician-data trending techniques to track reimbursement outcomes?

This approach also can help you identify areas of risk, establish the focus of internal audits and develop compliance education programs. Here's how.

Trending helps establish baseline

OIG's "Final Compliance Program Guidance for Individual and Small Group Physician Practices" (65 FR 59434, October 5, 2000) recommends practices use trending methods to establish baselines to effectively monitor coding and billing activities.

OIG indicates baseline statistics provide the opportunity to "reduce or eliminate potential areas of vulnerability" and "allow a practice to chart its compliance efforts by showing a reduction or increase in the number of claims paid and denied."

Internally reconciling and tracking reimbursement outcomes is part of an effective practice management system.

Use billing software to generate reports that categorize paid and rejected claims by certain variables, including:

- Payment received
- Adjustments
- Insurance carrier
- Denial remark code
- Billing provider
- ICD-9-CM or CPT code

By grouping claims according to these variables and comparing them to statistical benchmarks, business office or coding department staff can easily identify claim denial patterns or trends, *i.e.*, risk areas, that could potentially affect the practice.

If you manage a physician practice office, analyze any indication of coding and/or billing trends:

- Consistent use of the same or high levels of service

- Unbundling of diagnostic or surgical procedures
- Incorrect modifier use

Claim denials are a national concern, and some current reports estimate their rate at 14%. Incorrect modifier use is a common reason for denying claims and one that federal programs are currently analyzing. CMS tracks the use of modifiers -25 and -59 as part of its prepayment audit process.



What trending can identify

Another example of analysis is the **OIG's 2006 Work Plan**. A focus area for physician *continued on page 12*

Glossary

ADL – activities of daily living

CAH – critical access hospital

CCI – Correct Coding Initiative

CHC – community health center

CMS – Centers for Medicare & Medicaid Services

CPT/HCPCS codes – current procedural terminology/healthcare common procedure coding system codes

CRNA – certified registered nurse anesthetist

DME – durable medical equipment

DRG – diagnosis-related group

DSH – disproportionate-share hospital

EFIO – electronic file interchange organization

E/M – evaluation and management

ESRD – end-stage renal disease

FI – fiscal intermediary

FTE – full-time equivalent

FY – fiscal year

HDHP – high-deductible health plans

HHA – home health agency

HHS – Department of Health & Human Services

HMO – health maintenance organization

HRA – health reimbursement arrangement

HSA – health savings account

HSP – hospital-specific payment

IPPS – inpatient prospective payment system

IRF – inpatient rehabilitation facility

IRS – Internal Revenue Service

LOS – length of stay

LTC – long-term care

MA – Medicare Advantage

MDH – Medicare-dependent hospital

MDS – minimum data set

MMA – Medicare Modernization Act of 2003

NPI – National Provider Identifier

OIG – Office of Inspector General

PPS – prospective payment system

RHC – rural health clinic

RHL – rehab high RUG category

RML – rehab medium RUG category

RUG – resource utilization group

SCH – sole community hospital

SNF – skilled nursing facility

SNU – skilled nursing unit

RUG 53: adjust or lose revenue

by Darryl Bueker, dbueker@bkd.com

The August 2005 release of CMS's final rule implemented changes in the RUG case-mix classifications and per-diem rates for Medicare services provided by SNFs and SNUs.

The major change for services provided on or after January 1, 2006, is the addition of nine new payment categories to the existing 44 for a total of 53 (RUG 53).

Until December 31, 2005, there were 26 "automatic qualifier categories" in the RUG payment system. The payment rates for these upper 26 categories have significant rate decreases effective January 1, 2006.

Because the nine newly created categories will have relatively high payment rates, it's crucial for LTC facilities to understand this new system and adjust their procedures to receive proper Part A revenues under Medicare PPS.

How to succeed under RUG 53

The key to success under the RUG 53 payment methodology is for your facility to accurately identify ADL activities. To establish an ADL activity, the patient must require ADL assistance at least three or more times over a seven-day period.

Here's how it works:

- Capture the ADL activity using data from all three shifts. ADL scoring should reflect the patient's lowest functioning level.
- To qualify for the nine new RUG categories, the patient must score at seven or above, which is the lowest qualifying ADL score in the nine new RUGs categories.

- The nine new categories are a combination of rehabilitation services and extensive services.

CMS intends for the impact of implementing the new system to be neutral, meaning the increased payment resulting from the nine new RUG 53 categories is offset by reductions in the payment levels for the existing 44 categories. **The impact of this change can be substantial.**

Consider the example of a St. Louis, Missouri, facility. As the numbers in the box below show, the percentage decreases in the selected payment levels vary by amount and are substantial.

An LTC facility that doesn't adjust to the new payment system will be negatively affected because the cost of rendering a service under the new system will not change.

Therefore, the decreased Part A revenues will result in decreased profitability. To demonstrate the payment levels for the nine new categories, we've listed the payment amounts, again for the St. Louis, Missouri, 2006 transition wage index, for four selected categories:

RUG Category	1-1-06 Rate
RUX	\$520.14
RUL	456.79
RHL	327.96
RMX	382.69

Accurate completion of the MDS is crucial for the most appropriate RUG classification. Each RUG is assigned a case mix index (CMI) value: the higher the CMI, the higher the reimbursement.

Depending on the specific MDS data, patients can be classified into more than one RUG group. The group with the highest CMI will be assigned, which is important because problems in rehab contract pricing can result and add to the complexity of this issue.

Your facility will have many issues to consider in the event changes are made to your existing rehab provider contract. Generally, "per-minute pricing" is still preferable to "case-mix per-diem rate pricing."

Working together works best

Implementing the RUG 53 system makes it more important than ever for your facility's nursing staff and rehabilitation provider to work closely together to obtain sufficient, accurate medical data for comprehensive assessments.

This will help Part A Medicare beneficiaries to be placed in the most appropriate category, resulting in improved quality of care for

Because the nine newly created categories will have relatively high payment rates, it's crucial for LTC facilities to understand this new system and adjust their procedures to receive proper Part A revenues under Medicare PPS.

the patient, as well as increased Part A payments for the facility.

Other key issues:

- Under RUG 53, the upper 35 categories are now considered to be Medicare Part A automatic qualifiers.
- Through a unique aspect of the new system, the payment rates for two of the *medium* categories of rehab and extensive services are actually higher than the corresponding *high* categories. For example, an RML in St. Louis, Missouri, pays \$351.01 PPD, while an RHL in the same city pays \$327.96 PPD.
- Facilities will have to work closely with their rehab provider, and both must provide input into the patient care rendered.
- Before the RUG 53 system, ADL scoring didn't have an impact on a patient that qualified as a rehab patient, but it now has substantial impact, as detailed above.

Educating your staff on the issues mentioned in this article will help you succeed under RUG 53. ■

RUG Category	12/31/05 Rate	1/1/06 Rate	Per-day Decrease	% Decrease
RUC	\$473.88	\$441.59	\$32.29	6.8%
RUA	403.57	385.84	17.73	4.4%
RVB	353.18	337.34	15.84	4.5%
RMC	329.93	283.86	46.07	14.0%
SE3	351.16	312.90	38.26	10.9%
SSB	252.32	220.41	31.91	12.6%

Is your billing cycle ready for high-deductible

by John Britt, jbritt@bkd.com

Motivated by the high cost of health insurance premiums, patients, insurance companies, employers and even the Internal Revenue Service (IRS) want to change the payment landscape so more responsibility is given to patients.

One result—high-deductible health plans (HDHPs)—comes in the form of health reimbursement arrangements (HRAs) and health savings accounts (HSAs). Though plan mechanics vary, the objective of both is to:

- Increase the deductible amounts
- Lower insurance premiums
- Give patients control over a portion of their health care dollars

How HRAs & HSAs affect your billing cycle

How do HRAs and HSAs affect the billing cycle of your hospital or clinic? As the “patient responsibility” portion of your claims increases, nonpayment or delayed payment will likely increase dramatically.

Historically, the self-pay portion of patient accounts has been the most difficult amount for providers to collect. It is likely HRA and HSA products will magnify the normal confusion associated with insurance copays and

deductibles. Without an effective plan for managing these higher self-pay amounts, bad debt write-offs could increase.

Your billing staff should expect more questions from patients and may see increased reluctance to pay until reimbursement from their HDHP is assured. Moreover, insurance companies and employers are still developing processes for handling HDHPs and assessing their implications for insurance costs.

It’s a good time to re-evaluate your billing policies and processes to reduce the risk of uncollectible accounts. Develop a strategy for working with HDHPs and test your policies and resources to determine their ability to effectively implement such a plan.

Establish payment plans and protocols for collecting patient accounts. Working with patients to obtain payment for their portion of a medical claim becomes even more critical with HDHPs. Clearly define your policies. Consistently apply and regularly monitor them.

Your collection success rate will be significantly higher if your registration staff discusses your policies with patients during preadmission/previsit consultations. Many providers have improved collections by requiring a deposit or setting up a payment plan before providing the service when circumstances warrant.

If you decide to allow payment plans, be careful about allowing too long of a time period for payment. Encourage patients to make credit or debit card payments.

Proficient registration staff a must

Once management establishes the protocols, address the proficiency of your registration staff. It should have a pleasant attitude, as well as a firm understanding of:

- Compliance issues, such as HIPAA
- Acceptable insurance plans
- Organizational policies for claims’ payment

Your registration staff also should know how to:

- Determine when pre-authorization is necessary
- Recognize HDHPs
- Explain to patients the impact such plans will have on them
- Collect accurate demographic data, such as patient addresses and insurance information
- Communicate skillfully with patients and their families
- Explain hospital policies to patients

Keep the lines of communication open between registration staff and the billing office. Are billing experts available and willing to answer questions during registration? Do they provide feedback and updates about new insurance plans to the registration staff?

Processing claims efficiently

It’s critical for your account collection staff to take care of patient balances in a prompt and consistent manner. By the time the appropriate insurance company processes a claim and determines the patient’s balance, it may be two to four months past the original date of service.

Therefore, as soon as the balance transfers to the “patient bucket,” it’s imperative to inform the patient of his/her responsibility.

Sample Dashboard Indicators

	Dec. – 20xx	Dec. – 20xy	Dec. – 20xz
Total Accounts Receivable			
Balance Outstanding	\$ x,xxx,xxx	\$ x,xxx,xxx	\$ x,xxx,xxx
Accounts Receivable Days	65	61	57
Percent A/R > 90 Days	40%	38%	33%
Net Collection Rate	70%	75%	77%
Patient Balance (Self-pay)			
Balance Outstanding	\$ x,xxx,xxx	\$ x,xxx,xxx	\$ x,xxx,xxx
Accounts Receivable Days	90	88	87
Percent A/R > 90 Days	60%	61%	65%
# of Claims on Edit List	x,xxx	x,xxx	x,xxx
Average Dollars per Claim	\$ x,xxx	\$ x,xxx	\$ x,xxx

health plans?

Design your progressive correspondence with patients so the account is collected within a reasonable time after the patient's balance is identified or sent to a collection agency.

Finally, administrators and managers must ensure systems are in place to monitor the process and the staff. Periodically review staff follow-up on payment arrangements and make sure proper authority is obtained on accounts written off.

If a collection agency is used, seek its feedback about the timeliness and accuracy of information received from your staff. Complete a monthly review of your accounts receivable information, including:

- Aging reports
- Number of accounts
- Average account balance
- Collection rate

To help identify trends, select a small number of key measures, like those listed in the table.

These processes are beneficial when working with HDHP claims, but they also can be used to process all claims. However, HDHPs

should renew your awareness of the patient responsibility portion of your accounts receivable balances.

When patients sign up for an HDHP, they may be told the new plan will give them "more control" over their health care dollars, but they may not yet realize that their increased control also increases their responsibility for payment.

Because HDHP is a new concept for many patients, some will be apprehensive and resistant to prepaying their medical bills in the same way some patients resist paying copays up front.

You will likely hear the following comments: "Send it through my insurance first" and "I have already met my deductible." This may have been acceptable in the past, when deductibles were in the \$200 to \$500 range. Now, a patient could be responsible for \$2,000 to \$5,000.

Lay strong foundation

As HDHPs become commonplace, using the following steps as the foundation for your

It's a good time to re-evaluate your billing policies and processes to reduce the risk of uncollectible accounts. Develop a strategy for working with HDHPs and test your policies.

accounts receivable processes will help put you ahead of the game:

- Establish protocols for the collection process
- Educate registration staff
- Communicate early and clearly with patients
- Apply collection procedures in a consistent and timely manner
- Monitor your processes and your staff (by managers & administrators)
- Use key indicators ■

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Applying trending techniques. . .

continued from page 8

offices identified by the plan is the incorrect reporting of modifier -26 when billing for the physician interpretation of cardiography and echocardiography procedures.

For this diagnostic service, a cardiology practice could run an internal report on 50 submitted claims as an effective compliance plan and reimbursement strategy.

Trending can enhance your practice management processes by helping you identify baseline statistics and track reimbursement outcomes.

The report might show a significant number of claims were submitted without the appropriate modifier, resulting in noncompliance with coding and billing requirements, incorrect reimbursement or a complete denial of payment.

If the report identifies any trends, practice management should request an external audit to:

- Identify process errors
- Provide education for pertinent physician and coding staff

- Correct errors in claims and resubmit for appropriate reimbursement

Trending methods can help you identify specific education needs in your practice. For example, a department productivity report can demonstrate that one of four general internal medicine physicians consistently reports E/M level 99215 for established patient visits. This information might provide support for a focused department audit and education on E/M assignment.

When education programs are based on audit findings, they can be tailored to the needs of your physician group, which not only facilitates communication among physicians but encourages improved service documentation and coding.

This example shows how accurate reporting of the level of service can:

- Result in appropriate reimbursement
- Decrease the chances of carrier compliance audits

Other ways trending methods help

Trending methods are critical to practice offices as they attempt to:

- Target areas of risk
- Conduct focused compliance and reimbursement audits

- Provide necessary education to physician and billing staff
- Receive appropriate reimbursement for services performed

Trending can enhance your practice management processes by helping you identify baseline statistics and track reimbursement outcomes. ■

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