

Medicare provider enrollment updated

by Jennifer Fielding, jfielding@bkd.com

In April 2006, CMS issued updates to the Medicare provider enrollment process affecting all health care providers. Changes include:

- Providers must use newly issued Medicare enrollment forms dated April 2006; new CMS Form 855s are available online: cms.hhs.gov/cmsforms/cmsforms/list.asp
- New CMS Form 855s **require** providers to list their national provider identifier (NPI) on the application; those submitted without an NPI will be rejected and will not be processed. If they haven't already, providers should take steps to obtain the necessary NPIs.
- Providers must maintain all information submitted to Medicare, which requires they submit a Form 855 that notifies Medicare

of changes to the information on file. Examples include a change in ownership, changes in managing employees, such as executive directors, changes in members of the board of directors and a change of address or telephone number.

- Regulations published by CMS require providers to report any changes in enrollment information within 90 days after they are made. The regulations also allow penalties to be imposed on health care providers that do not comply with this requirement.
- To receive and maintain Medicare billing privileges, providers will be asked to periodically update and certify the accuracy of their enrollment information. CMS has indicated it plans to implement this process in 2007.

commercial insurance provider numbers for all electronic billing transactions.

In general, providers should obtain an NPI for each service location that has a separately identifiable Medicare or Medicaid provider number. Individual practitioners billing Medi-

Providers may apply for an NPI online or download an NPI application from CMS at cms.hhs.gov/apps/npi/01_overview.asp.

care (physicians, nurse practitioners, etc.) also must obtain an NPI number and provide it to billing personnel for the hospital or other main provider.

During the transition to NPI, Medicare claims will be processed with current Medicare provider numbers *and* the NPI until May 23, 2007. From that date forward, only the NPI will be accepted.

Providers may apply for an NPI online or download an NPI application from CMS at cms.hhs.gov/apps/npi/01_overview.asp.

Provider enrollment processes can be difficult to navigate successfully. For more information about provider enrollment, contact your BKD Health Care Group advisor. ■

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NPI recap

NPIs are 10-digit numbers issued for all health care providers and institutions as part of HIPAA. They will eventually replace existing provider UPIN numbers, Medicare provider numbers, Medicaid provider numbers and

IRS issues compliance check questionnaire

by Gary Garwitz, ggarwitz@bkd.com

On May 15, 2006, the IRS mailed 600 hospitals across the country a new form titled "Compliance Check Questionnaire Tax-Exempt Hospitals."

The questionnaire, designated as a Form 13790, requested a voluntary June 15, 2006, response, though failure to respond could still result in an IRS examination.

The questionnaire includes many ques-

tions not previously asked by the IRS, so it emphasizes certain items and includes the following general categories:

Patients - How do they pay? How much charity care is provided? How many patients are Medicare and Medicaid patients?

Emergency room (ER) - How accessible is the ER? Is access restricted for patients

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Tax exempts must follow IRS campaign fundraising rules

by Gary Garwitz, ggarwitz@bkd.com

As the 2006 election year heats up, intense campaigning and political fundraising is just around the corner. Charitable organizations need to be careful as this process unfolds.

IRS set to enforce penalties

Charitable organizations are absolutely prohibited from directly or indirectly participating or intervening in any political campaign on behalf of (or in opposition to) any candidate for elective public office.

The prohibition applies to all campaigns, including those at the federal, state and local levels. If your organization violates this prohibition, it risks the revocation of its tax-exempt status and the imposition of certain excise taxes.

The IRS has stepped-up enforcement activity in this area, issuing additional guidance this year to further define activities it considers to be a charitable organization's intervention in a political campaign.

IRS Fact Sheet 2006-17, *Election Year Activities and the Prohibition on Political Campaign Intervention for Section 501(c)(3) Organizations*, is available at the IRS web site (www.irs.gov) and offers detailed information.

Limit your lobbying efforts

Charitable organizations are allowed to participate in limited lobbying activities. In today's political world, many large charities are engaged in some lobbying efforts; however, this cannot include the support or opposition of a particular candidate.

Even if they don't lobby directly, many organizations do so indirectly through other organizations, such as a local chamber of commerce or regional, state and national trade associations like the American Hospital Association.

The actions of some charities have drawn attention from Congress and the IRS. When considering potential political or lobbying activities, keep in mind:

- Political campaign intervention is strictly prohibited
- Lobbying on behalf of certain issues is allowed but only on a limited basis

As politicians become more aggressive in asking for financial and other support, the rules governing a charity's political involvement are becoming increasingly complex with penalties for violations more severe.

Your charitable organization can't afford to lose its tax-exempt status. Understand IRS rules and comply with them. Before the election year rallies, contact your BKD advisor for more information. ■

E-filing Form 990 mandatory for some exempt organizations

by Joyce Dulworth, jdulworth@bkd.com

Certain exempt organizations are required to file their returns electronically for tax years ending on or after December 31, 2005. Mandatory electronic filing applies only to organizations filing a total of 250 or more returns in one year. The most common IRS forms considered are the W-2, 1099, 990, 990-PF and 990-T.

For example, an organization that files a Form 990 and a W-2 for each of its 249 employees would have to file electronically if it meets certain asset thresholds. If their total assets are \$100 million or more, exempt organizations are required to file Form 990 electronically beginning with tax years ending on or after December 31, 2005.

For tax years ending on or after December 31, 2006, exempt organizations filing Form 990 are required to file electronically if

their total assets are \$10 million or more.

Organizations filing Form 990-PF must file electronically for taxable years ending on or after December 31, 2006, regardless of asset size. Entities may opt into the program early if they wish to file electronically before they are required.

By requiring electronic filing, the IRS hopes to decrease its processing costs and increase its abilities to mine information from Forms 990 for compliance purposes. Because the IRS believes the electronic filing requirement is not onerous, it will only grant waivers in certain exceptional cases.

* * *

If these requirements apply to your tax-exempt health care organization, contact your BKD Health Care Group advisor for more information about how we can help your organization file these forms electronically. ■

IRS issues

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who cannot afford to pay?

Medical staff privileges - How are privileges restricted?

Uncompensated care - How much uncompensated care is provided? How are reported amounts determined (costs or charges)? Are amounts limited? This section includes additional detailed questions.

Billing practices - Several detailed questions seek information about how patients are billed and how charges are determined.

Community programs - What kind of programs are provided? How are the health care needs of the community considered?

Compensation practices - Hospitals are asked to list officers, directors, trustees and key employees along with their compensation and how it is determined.

Carefully consider your answers

The nine-page questionnaire includes several very detailed questions and several that require substantial explanations. Your hospital should not answer any questions



Select CDM software updates carefully

by Deb McDaniel, dmcdaniel@bkd.com

A hospital's CDM plays a critical role in a hospital's billing process. Even with the onset of automated resources for analyzing the CDM with software, the end-all solution for updating and maintaining it has yet to be found.

Meeting the requirements for compliance and obtaining appropriate reimbursement from all payers demands vigilance from soft-

ware vendors and CDM coordinators, as well as frequent communication throughout the hospital's revenue cycle (RC) information flow.

Select CDM software that works for you

Your hospital's RC committee, including health information management (HIM), patient financial services (PFS), finance, nursing and ancillary and administration, should evaluate and select CDM software.

The best-case scenario includes incorporating their evaluation into the request-for-proposal (RFP) process. By using key principles of project management, *e.g.*, time constraint, cost, scope, quality, human resources, change and risks, the RC committee can define deliverable objectives from CDM software implementation.

To help determine the software solution that will work best for your hospital, complete and document an evaluation checklist:

- What is the interoperability of the proposed software with your current PFS software?
- Does the proposed CDM software have a successful interface history with the hospital's current billing and claim-scrubbing software?
- Will the CDM conversion be an automated or manual process, and what quality-control measures does the vendor provide to ensure it converts accurately and comprehensively? Will a testing schedule be provided and completed by the vendor?
- Are standard reports available to download the CDM into Microsoft Excel or other user-friendly applications?
- What training and ongoing education are available to help personnel use the software to its fullest functionality?
- How is vendor-provided data measured and reported? Is it reliable and high quality?
- How timely are updates (developed from federal revisions) to hospital claims-processing and reimbursement manuals?
- Is a medical necessity module available?

- Is peer data available for prices, procedure descriptions and clinical department modeling? What criteria are applied to screen data for compliance requirements mandated by the OIG and federal programs?
- What reporting functions—audit trails for all CDM changes or financial modeling—are included with the software? Are they user-friendly or do they require IT expertise to compile the data and report? Can the software run when the audit functions are turned off?

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compliance check. . .

without a thorough understanding of the implications of its answers.

Warning: This is not a questionnaire clerical staff should complete and file, but one that requires the attention of the highest levels of management along with the help of experienced professionals. Do not underestimate the potential repercussions your answers to survey questions could have.

Many hospitals have wonderful stories about how they meet the health care demands of their communities, and it's important to include that information. Therefore, to tell your hospital's complete story, don't limit your answers to the survey's questions.

For hospitals that have yet to receive a questionnaire, BKD recommends a self-assessment. Obtain a copy of the questionnaire and use it as a drill to determine how your organization measures up.

Your hospital may not have received one of the first 600 questionnaires, but it's still likely you'll be held accountable in the future. Contact your BKD Health Care Group advisor for more information about how to respond appropriately to the questionnaire. ■

Speakers' Bureau

Seminar: National Association of Community Health Centers Annual Convention, Community Health Institute & EXPO, Chicago, August 25 - 28

Topic: Using MOM to Improve Your Revenue Cycle: Measure, Organize and Move

Speaker: Jennifer Fielding

Topic: Exploring the Facts and Fiction of Financial Statement Audits—A View from the Auditor's Perspective

Speaker: Mike Schnake

Date: August 28, 2006

Seminar: National Rural Health Association Rural Health Clinic & Critical Access Hospital Conference, St. Louis, October 3 - 6

Topic: Critical Access Hospital Reimbursement Issues

Speaker: John Sheehan

Date: October 4, 2006

Seminar: HFMA Healthcare Accounting & Reporting Conference, Atlanta, October 8 - 10

Topic: Protect Your Organization From Fraud and Embezzlement: Stories From the Trenches

Speaker: Angela Morelock

Date: October 9, 2006

RUG 53 update: accurate documentation

by Eric Doerhoff & Cindy Macquarrie,
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Over the past several months, as providers struggled to adapt to RUG 53 changes, a group of BKD Health Care Group advisors made observations, analyzed data and researched resulting trends.

Following are highlights from their study, which may offer guidance to SNFs as they continue to adjust.

Benchmarks - The Health Care Group's study included 32 SNFs located across

Writers' Bureau

Article: Navigating Medicare Provider Enrollment

Author: Michael Schnake & Jennifer Fielding

Publication: Access for All

Date: May/June 2006

Article: Identify and Monitor Compliance Risks: Strategies for Heeding Warning Signs and Avoiding Violating the Law

Author: Larry Fogel & Joe Watt

Publication: New Perspectives

Date: Spring 2006

Article: Additional Medicare Reimbursement Available to Sole Community Hospitals/Medicare-Dependent Hospitals Experiencing Volume Decreases

Author: Tim Wolters

Publication: RAP Sheet

Date: Spring 2006

Article: Corporate Ethics Starts at the Top

Author: Larry Fogel & Joe Watt

Publication: Compliance Today

Date: May 2006

Missouri, Kansas, Oklahoma and Texas. With several months of data available, results varied significantly among providers in their utilization of the nine new RUG categories.

To maintain previous-year revenue levels (assuming no change in volume), results indicated most providers will need approximately 30% of their patients classified in the new categories. A more realistic goal for many may be closer to 50%. (Obviously, only patients that truly fit into these categories should be coded as such.)

Surprisingly, 25% of the SNFs that were studied did not bill Medicare for a single day in the nine new categories. Many others had approximately 50% new-code utilization, while one SNF exceeded 60%. SNFs with minimal utilization of the new RUG categories must review the way they manage their Medicare program:

- Did we receive and install the minimum data set (MDS) software updates that coincided with RUG 53?
- Are we using the look-back period properly?
- Are we capturing hospital services provided during the look-back period?

For you to utilize the new categories sufficiently to maintain or exceed previous-year revenue levels, review your programs and make adjustments accordingly.

ADL scoring - The ADL score has played an integral role in determining a patient's RUG level in the past, but, with the advent of RUG 53, the ADL score carries more weight than ever.

To access the new categories, patients must have an ADL score of at least 7 for the "L" categories (RUL, RVL, etc.), and they must have a minimum score of 13 for RHX, 15 for RMX and 16 for RVX and RUX. Without these scores, patients won't be able to qualify for the nine new categories, regardless of their rehab or clinical needs, which tie significant payment differences to the ADL score.

For example, using the Medicare rates for a Kansas City, Missouri, SNF, the difference between an ADL score of 6 and a score of 7 could mean the difference between RML and RMA, which respectively pay \$366.21 and \$281.60 per day.

In this example, a difference of one point in ADL scoring accounts for an \$84.61 per-day difference in Medicare reimbursement, illustrating the importance of tracking and documenting required assistance with ADLs.

Does your current system truly capture the patient's ADL information? Does the department or individual responsible for documenting this information have a firm grasp on what is and isn't staff "assistance"?

Proper capture and documentation of ADL assistance is critical for appropriate reimbursement and compliance. Review your current system to ensure it meets your needs and leads to appropriate ADL scoring. At \$84.61 a day, you can't afford not to.

Extensive services - A fundamental change in the nine new categories is that they combine both a nursing and a rehab component. The nursing component consists of an extensive service, which may include either intravenous (IV) medications administered during the 14-day period preceding the assessment reference date (ARD) or IV fluids administered during the seven-day period preceding the ARD. It's not uncommon for patients to receive one of these services during their qualifying hospital stay, which SNFs can capture on the MDS using the look-back period.

Another way to potentially access the new categories is by capturing your extensive services. Providers that offer IV therapy and other ongoing, extensive services have more opportunities to benefit from the new categories. Review your current IV therapy program or consider implementing one:

- Does our IV therapy program, or lack thereof, delay or deter admissions?
- Do we lose revenue as a result?
- What barriers prevent us from implementing an IV therapy program?

There are hurdles to implementing and offering SNF-based IV programs, such as increased cost, staff requirements and liability exposure. Carefully evaluate the cost vs. the benefit. Offering IV therapy may not be feasible for all providers, but it might be worth a closer look due to RUG 53's increased focus on extensive services.

MDS - The MDS was initially used to develop

essential as SNFs adapt

care plans and as a blueprint for providing quality resident care. Over the years, this assessment tool has expanded to monitor survey inspections and implement SNF PPS as a basis for payment.

The key to appropriate payment is the accurate completion of the MDS and the areas critical to receiving appropriate reimbursement under RUG 53, including the ARD, ADL and special treatments.

Special treatments - To code all special treatments, obtain specific data about patient services provided during the hospital stay. Don't assume treatments were provided—even those based on a diagnosis or typical treatment plan—but acquire supporting documentation.

Because this information may not arrive until after the MDS completion due date, perform pre-admission screening to collect information, including—at a minimum—any IV fluids or medication received and parenteral nutrition provided. It's also imperative to know the last date such services were provided.

Coding ADLs - As mentioned, ADL scores are a component of all RUG categories and make a difference in the amount of reimbursement received. This means a resident's ADL score must reflect the need for limited assistance in three of the four areas assessed, including bed mobility, eating, transfer and toileting.

During the day, the resident may need little, if any, assistance. However, at night, the resident may require additional assistance. Staff must document the level of assistance required throughout a 24-hour period, so the MDS can accurately reflect the care provided, and the facility can receive the appropriate reimbursement.

ARDs, last but not least - The final component, but by far the one with the greatest impact on reimbursement, is the ARD, which sets the time for collecting information about the resident's status. For Medicare, specific time frames must be followed. Grace days can be used if they accurately reflect the services provided.

One way to get an appropriate payment is to set the ARD that favorably captures services provided during the assessment period. Without careful ARD selection, you could potentially lose thousands of dollars annually; however,

setting the most appropriate ARD may not be as easy as it sounds. It takes flexibility and a thorough understanding of the MDS and how it affects payment levels under Medicare.

Although the ARD for required Medicare assessments has been important in the past, it's even more so under RUG 53. Many SNFs have simply used day five and day 14 as the ARD for the 5-day and 14-day assessments, respectively. Occasionally, grace days (day six to day eight) were used for the first assessment and, infrequently, an earlier date was used to capture services from the hospital stay.

Under RUG 53, using day five and day 14 may not yield a payment rate commensurate with the care provided. For example, IV medication discontinued the day before discharge to the SNF can be captured on the 5-day assessment and most likely will result in higher reimbursement. But waiting until day 14 for the second assessment would preclude SNFs from capturing the IV again, thus potentially lowering their reimbursement.

Therefore, ARD adjustment is now critical for all Medicare assessments. As the saying goes, "timing is everything," and the difference in payment for not using the appropriate ARD can exceed \$1,000 over a 16-day period. Your MDS coordinator must be aware of the total care and services provided both in the SNF and during the prior hospital stay.

* * *

Accurate documentation is essential. The RUG 53 system introduced certain challenges, but the key to success is accurate documentation in the medical record, which makes a substantial difference in MDS accuracy and SNF reimbursement. Training your staff to efficiently document the care provided and how to code the MDS can have a positive impact on your bottom line.

Contact your BKD Health Care Group advisor for more information about the nine new categories and how to improve your reimbursement under RUG 53. ■

RUG 53 Help Available

To help skilled nursing facilities evaluate their use of the new RUG 53 payment system and to identify areas for improvement, BKD Health Care Group will provide a complimentary analysis of your facility's current Part A RUG distribution.

To learn more and to download a simple data collection form, visit our web site: www.bkd.com/industry/health_care/Long-term_Care/. E-mail your completed form to your BKD advisor or healthcare@bkd.com. A consultant will analyze your data and call you to discuss opportunities for potential improvement with the new RUG 53 system. ■

Helping SNFs cope with no-pay & benefits-exhaust claims

by Jo Anne Thompson, jthompson@bkd.com

Though it may not be what SNFs hoped for, CMS has finally issued guidance on "benefits-exhaust" and "no-payment" claims billing.

Issued April 28, 2006, Transmittal 930 confirms SNFs must submit benefits-exhaust and no-payment claims for all residents who remain in a Medicare-certified bed after their Part A stay ends.

Submitting benefits-exhaust claims

SNFs must continue to submit monthly benefits-exhaust claims for residents who continue to receive skilled care after exhausting the 100 days their benefits allow.

By definition, beneficiaries can only qualify for a new skilled benefit period if they go 60 consecutive days without receiving skilled or
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Helping SNFs cope with no-pay. . .

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acute care. Therefore, if a SNF resident continues to receive skilled care and no monthly claims are submitted to indicate there has been no break in skilled services, then the resident's benefit period resets in error.

To be considered at a skilled level of care, residents must meet Part A criteria. Therefore,

Transmittal 930's effective date is October 1, 2006: Submit claims for all newly admitted residents or for those whose Part A stay begins on or after that date.

clinicians and therapists must help billers determine which beneficiaries still receive skilled care and when their level of care drops below the skilled criteria.

Submitting benefits-exhaust claims is a necessary process to ensure appropriate tracking of eligible benefits.

Meeting other Transmittal 930 requirements

A more onerous requirement of Transmittal 930 instructs SNFs to also submit no-payment bills for beneficiaries who received previous care covered by Medicare Part A, then subsequently dropped below a skilled level of care but still reside in a Medicare-certified bed.

Submitting no-payment claims has been an area of controversy for some time. It was hoped CMS would relax its no-payment

billing requirements, especially because many SNFs have certified all their beds for Medicare and no longer have distinct skilled and non-skilled areas.

CMS did clarify submitting monthly no-payment claims isn't necessary and, contrary to what some FIs had contended, are only required upon discharge. This eases the burden somewhat but still puts greater responsibility on facilities to track and bill claims for which they will not receive payment.

If their software supports it, many facilities may choose to submit monthly no-payment claims because it could be easier than tracking who was discharged each month and determining whether a no-payment claim should be submitted for that resident.

What SNFs need to know

Transmittal 930's effective date is October 1, 2006: Submit claims for all newly admitted residents or for those whose Part A stay begins on or after that date.

The no-payment claim requirement

means SNFs must track and submit significantly more claims for the facility's residents than in the past, even though these claims do not impact the benefit period and will result in no payments to the facility.

SNFs should also be aware of the differences between coding claims for exhausted benefits and coding no-payment claims:

- Benefits-exhaust claims are submitted as covered charges and are coded exactly like a Part A claim being billed for payment. Therefore, do not submit them until the common working file shows zero remaining benefit days.

If a beneficiary previously stayed in another facility that has not yet billed, it may be necessary to contact the former SNF provider to request it submit its claim(s) so the common working file will be updated appropriately.

- Conversely, no-payment claims are billed as noncovered charges with condition code 21 and 210 as the bill type.

For more information about Medicare billing requirements for benefits-exhaust or no-payment claims, contact your BKD Health Care Group advisor. ■

Glossary

ACFE – Association of Certified Fraud Examiners

ADL – activities of daily living

ARD – assessment reference date

CCI – Correct Coding Initiative

CDM – charge description master or “charge-master”

CMS – Centers for Medicare & Medicaid Services

DRG – diagnostic-related group

ER – emergency room

FI – fiscal intermediary

HIM – health information management

HIPAA – Health Insurance Portability and Accountability Act of 1996

IRS – Internal Revenue Service

IT – information technology

IV – intravenous

MDS – minimum data set

MGCRB – Medicare Geographic Classification Review Board

OCE – outpatient code editor

OIG – Office of Inspector General

PFS – patient financial services

PPS – prospective payment system

RC – revenue cycle

RFP – request for proposal

SNF – skilled nursing facility

UPIN – unique physician identification number

In Brief

Awaiting inpatient PPS final rule -

As we go to press, we are awaiting issuance of the inpatient PPS final rule effective October 1, 2006. CMS will respond to comments on its proposed restructuring of DRG weights, which will base relative weights on hospital costs rather than charges. CMS will announce whether it will implement this restructuring this year, implement the proposed severity-adjusted DRG system it tentatively planned for fiscal 2008 or delay all such changes for at least another year.

The final rule will likely announce plans to implement a 100% occupational mix adjustment to the hospital wage index. Because CMS does not expect to have final wage data available at the time it issues the final rule, it has tentatively announced hospitals should plan to file MGCRB requests by September 1, 2006, without the benefit of having final wage data. Hospitals would finalize the requests 30 days after CMS posts the data on its web site.

Finally, the rule will also announce the general market basket update for DRG payments, proposed to be 3.4%. Hospitals should pay close attention to this final rule and the impact it may have on their operations. Once it's published, more detailed

information will be available at www.bkd.com.

Second occupational mix survey due -

As a reminder, PPS hospitals should file their second-quarter 2006 occupational mix survey no later than August 31, 2006. The survey will generally include data from April through June 2006. Hospitals may want to wait and submit the survey after CMS publishes the inpatient PPS final rule, as CMS may provide additional insight into the completion and use of the survey.

Increased scrutiny of Medicare bad debts -

A number of intermediaries are increasing their scrutiny of Medicare bad debts claimed for reimbursement by providers. Specifically, the standard being applied is that bad debts should not be claimed for reimbursement through the Medicare cost report if any collection efforts are still underway, including use of a collection agency.

Recent court decisions have confirmed intermediary adjustments on this issue, as well as on the Medicaid "must-bill" policy. This policy says providers must bill crossover Medicare deductible and coinsurance claims to state Medicaid plans even where the plans state no payment will be made on such claims.

In light of this new guidance, providers

should review their policies for writing off bad debts for cost report purposes.

Blood glucose coverage in SNFs -

Billing for blood glucose testing and monitoring is still a controversial area though related regulations have not changed since December 2000. FIs have continued issuing bulletins and newsletters to educate providers about when to bill the service under Medicare Part B; however, during a recent teleconference, an FI stated blood glucose billing accounted for a large part of its comprehensive error rate testing (CERT) for SNFs.

For this service to be covered as a diagnostic test, it must be ordered by a physician, with results reported promptly, so the physician can use them to manage the patient's specific medical condition. By itself, a standing order (including a sliding scale) for a repetitive diagnostic laboratory service rarely substantiates medical necessity and is usually considered routine monitoring.

SNFs that continue to bill for routine monitoring should be aware of the potential for claims review by their FI and the likely denial of payment or recoupment of claims previously paid. ■

Select CDM software updates carefully. . .

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- Does the vendor supply standardized audit processes for "what-if" modeling to test the CDM data?
- What policies and procedures are available for implementing the proposed software and converting to automated CDM updates and maintenance?
- What edits (OCE, CCI, etc.) are built into the CDM software? Are they customized to the hospital's payer mix, patient mix, etc., as part of the software's functionality? Is this a "user group" process or can indi-



vidual end users define and implement customized edits?

- Does the vendor certify the accuracy of data provided with the software and its future updates?

Evaluate staff's qualifications

To successfully implement and use CDM software, evaluate your staff's skill set and gap assessment. For example, does your hospital's staff have the necessary credentials and experience with (1) health care information database design concepts, (2) aggregate data analysis and (3) data verification and integrity requirements?

If not, does the vendor provide this expertise or must the hospital bring in CDM consult-

ants for support in addition to periodic external review?

Again, this evaluation must be conducted by the revenue cycle committee that represents every hospital department, including HIM, PFS, nursing, ancillary, finance and administration.

It's important to communicate results from the CDM software evaluations to all staff levels in the RC flow, which may take the form of internal reports to specific departments or groups.

The more carefully you plan, execute and report your assessments and implementation, the more likely the results will be accepted and required actions taken. ■

Preventing medical practice fraud: stay alert to red flags

by **Rand Gambrell**, rgambrell@bkd.com

If you own a \$5 million medical practice, did you know fraud could potentially lighten your wallet \$250,000 annually?

That's the loss U.S. businesses are expected to suffer according to the Association of Certified Fraud Examiners' (ACFE) **2006 Report to the Nation on Occupational Fraud & Abuse (2006 Report)**. ACFE's study estimates U.S. businesses lose approximately \$650 billion a year, *i.e.*, 5% of their annual revenue, to fraud.

Though widespread, fraud is not always easy to detect, especially while it's taking place. Stay alert to the following warning signs that indicate fraudulent activity may be lurking.

Little or no segregation of duties -

Especially when collecting/recording cash is involved, this situation creates opportunities for fraud but offers a way to prevent it. Assign different people to receive cash payments, record cash collections, deposit the cash collected and reconcile the accounts. Not segregating these tasks may make it all too easy for an employee to walk out the door, cash in hand.

Unusual bank statement items - It's essential to review monthly bank statements for unfamiliar transactions or transactions without supporting documents, such as approved invoices, approved check copies, etc.

Unexplained adjustments - Regularly review the reconciliations for your cash accounts (accounts receivable, accounts payable, etc.) for large adjusting entries to make them balance. Do you recognize the adjustments, or can your employees explain them?

Complaints - Do you receive complaints from vendors about outstanding account balances when your records show the payment has been made? What about complaints from patients who claim to have paid their balances but continue to receive statements?

Write-offs - Does your practice experience large write-offs of accounts receivable, or has the percentage of write-offs increased?

Employee tips - Do employee comments or concerns indicate fraud is occurring at your practice? According to the **2006 Report**, employee tips uncovered fraud at more than a third of the businesses surveyed.

Listen to your intuition - Do you generally sense things are as they should be at your practice? The **2006 Report** points out accidental discovery accounts for more than 25% of all exposures, making it the second most common way fraud is detected. Investigate if things don't feel right. Even if you don't uncover fraud, you may discover areas open to risk, making protection possible.

With an estimated 5% of your practice's annual revenue potentially lost to fraud, you must continually monitor your office for the red flags described above.

Be proactive: Learning to prevent fraud with anti-fraud measures—fraud awareness, ethics training, reviewing your practice's internal controls—can help reduce your chances of becoming a target and can also result in smaller losses should fraud strike.

* * *

BKD's Forensics & Dispute Consulting

(FDC) division has expertise in the areas of fraud prevention and detection and can help you review transactions, interview employees, gather documents and, if necessary, prepare reports suitable for prosecution and litigation.

FDC team members include industry and service professionals, consulting attorneys, forensic accountants, certified fraud examiners, certified information systems security professionals and other litigation services consultants familiar with courtroom testimony and the forensic needs of attorneys. Contact your BKD advisor for an introduction. ■

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