Health Care NEWS

Beyond Your Numbers • March 2007 • Vol. 25, No. 1

Health care industry a top fraud target

by Angela Morelock, amorelock@bkd.com

According to a recently published report of the Association of Certified Fraud Examiners (ACFE), health care ranks fourth among all industries for the number of internal fraud cases.

The **2006 ACFE Report to the Nation on Occupational Fraud and Abuse** also indicates the health care organizations that fall victim to fraud have median losses of $160,000 per incident. In other words, half the losses exceed $160,000, a frightening total.

Of the 89 health care cases profiled, the fraud schemes used were split fairly evenly among the following:

Theft of cash - either before or after it's recorded

Accounts payable check tampering - issuing fictitious checks or altering legitimate checks to vendors

Expense reimbursements - fictitious or inflated business expenses submitted by employees for reimbursement

Payroll - payment of false or overstated compensation payments

Theft of noncash assets - including equipment, inventory, securities, etc.

Billing schemes - submitting false health care claims

In recent years, an alarming variety of schemes have been used to perpetrate fraud on health care organizations, which is consistent with the findings of BKD's Forensics & Dispute Consulting (FDC) division. Its certified fraud examiners (CFEs) regularly investigate fraud and embezzlement in health care organizations and determine losses. Considering how much money flows through this industry, it's not surprising it's a major target.

While many health care organizations devote substantial resources to prevent false or noncompliant claims, some theft risk areas are still passed over and often receive relatively little attention. The following precautions may help your organization be alert to and help limit fraud risks.

Know your contractual adjustment accounts

Over the last 10 years, BKD's FDC division has investigated many embezzlement cases

continued on page 2

Inside

- Will perfect storm hit home health? 4
- Conferences, Webcasts & Writers 5
- In brief 6
- Numerous TRHCA provisions affect health care industry 6
- Last year's top five Medicare SNF questions 7
- NPI review & update: it's almost here! 8

2007 Work Plan: OIG's message to providers

by Joe Watt, jwatt@bkd.com

The Office of Inspector General (OIG) **2007 Work Plan** (**Work Plan**) for health care organizations contains numerous project areas for all types of providers and presents OIG's perception of potential risks to Department of Health & Human Services (DHHS) programs and activities.

In other words, the **Work Plan** is like a message to providers from OIG, alerting them to review the contents to learn and address what applies to their health care organizations. Providers who do not address these issues may receive an unwanted OIG visit.

Review each area the **Work Plan** lists and determine what issues apply to your organization. If a potential risk is present, gauge its magnitude, take the necessary investigative steps and develop documentation supporting your review and conclusions.

This year's items

This year's **Work Plan** focuses on hospitals, including 25 items ranging from hospital capital payments to oversight of specialty hospitals. Following is a recap of just a few of the areas targeted and OIG's approach to their review:

Medicare-dependent hospital program - Review the use of FY 2002 base-year costs for payment to Medicare-dependent hospitals (MDHs) for discharges starting October 1, 2006. The MDH payments would be based on 75% of the FY 2002 adjusted hospital-specific costs.

Inpatient rehab facility classification criteria - Review the extent to which admissions to inpatient rehabilitation facilities (IRFs) met specific regulatory requirements and whether the facilities billed for services in compliance with Medicare regulations.

IPPS wage indices - Determine whether hospital and Medicare controls are adequate to ensure the accuracy of hospital wage data used to calculate wage indices for the inpatient prospective payment system (IPPS).

continued on page 3

Health care industry a top fraud target . . .

continued from page 1

where fraud losses were hidden in third-party contractual adjustment accounts, an easy "dumping ground" for fraud losses.

Contractual and other write-off accounts pose a unique risk to the health care industry for the following reasons:

- Almost every patient account creates some sort of contractual adjustment, resulting in a tremendous volume running through these accounts.
- Most health care providers aren't certain what their contractual accounts contain.
- Because fairly open access is needed to allow posting of payments in the patient accounting system, it's generally easy for a large number of employees to post an adjustment to contractual accounts.
- In most cases, it's impossible to reconcile the contractual and write-off accounts on a daily basis or ensure each entry has valid support.
- Compared to total revenue, the balance and percentage of these accounts can vary dramatically as reimbursement rates change, making period-to-period comparisons difficult to use in spotting fraudulent entries.

If sliding fee scales are offered, the risk increases dramatically because the fee percentage collected from the patient can be easily manipulated by employees.

While you may not be able to reconcile these accounts to supporting documentation on a daily basis, there are steps you can take to protect the integrity of contractual accounts and limit your risk.

First, make sure employees handling cash or checks cannot post contractual adjustments, bad debts or other write-offs. Personnel who post these adjustments should absolutely not have access to cash or checks.

Second, regularly perform an analytic review of contractual adjustment accounts by payer type and investigate dramatic changes. Remember, if you have a large volume, it will take a large number to affect those percentages.

Third, test contractual and write-off accounts at least quarterly. Select healthy samples from the contractual accounts to trace to supporting documentation. Also, select a healthy sample of explanation of benefits (EOBs) and trace contractual amounts on the EOB to what was actually posted. It's important to test them going both directions.

Fourth, establish proper approval procedures of write-offs not supported by EOBs or other readily available supporting documentation. While it may be fine to have an established de minimus amount patient accounting personnel can write off without further approval, items greater than that amount should be subject to a review and approval process. Document approvals in writing.

Listen to patient complaints

Patient complaints can be an early warning sign that's often missed. Investigate patient complaints about improperly posted payments but assign this task to someone other than the person who handles the payments.

Our FDC team is aware of several cases where the red flag of a patient's complaint was missed because the only person available to resolve the matter with the patient was the one stealing the payments. To help spot problems and enable trend analyses, log or record patient complaints that deal with payments.

Know your vendors

Vendor acceptance should be a rigorous process. Some of the largest health care fraud losses involve kickbacks (where an employee buys a product and splits an overbilling with a vendor's employee) and conflicts of interest (where the organization, knowingly or unknowingly, buys from a vendor an employee has an ownership interest in).

If you lack a standard approval process for new vendors, consider implementing one. Another important yet frequently overlooked step is to maintain a vendor master file, which you should routinely review to remove inactive vendors and to thwart manipulation and use by unscrupulous employees.

Also, ask for a monthly report of changes made to the master file and investigate any unusual data or information. Most accounting systems can produce a report documenting any changes to the file over a given period. Make the report a standard policy and let appropriate personnel know you'll regularly publish and review it.

Limit access

Generally, it's best not to allow accounts payable personnel to change the vendor master file. If you do, be sure to review their work closely. Supervision is a must for avoiding fake vendors, collusion in a kickback scheme or other tactics.

Further, do not give accounts payable clerks access to checks or check stock before or after they've been signed, especially if your system automatically prints a signature when checks are processed. Use a system where checks are printed outside the control of your accounts payable group.

Also, review and approve checks (and attached supporting documentation) before they are mailed, even though many organizations now have systems that don't require a manual signature.

Control corporate plastic

Many organizations use credit cards, and employees regularly abuse them because card activity often receives insufficient oversight. Though many organizations think they need corporate plastic, facilities of all sizes get along fine without it, and some use a simple reimbursement system where employees turn in expense reports and receipts for reimbursement, which are processed weekly or through the payroll system.

Your organization can issue expense advances to employees for larger purchases or extended business trips, but if you can't part with your credit cards, be sure to take these steps:

- Limit the number of cards you issue. The more you have, the less likely you are to take time to verify purchases on your monthly statement.
- Have a written policy that clearly describes your organization's terms for its credit card use and have employees agree to it in writing before they receive a card. Enforce the policy.
- Review charges each month. This is often done by upper management, but it may be delegated to a trusted employee who isn't afraid to question or report abusive charges.
- Require itemized receipts describing what was purchased.
- Set lower credit limits for each card.

Implement review

It's often difficult for accounts payable clerks to distinguish between legitimate and illegitimate requests. Therefore, before accounts

payable (or payroll) can grant an employee's or management's request for reimbursement, the request must be reviewed and bear documented approval.

To avoid improper reimbursements, it's essential to review and approve detailed supporting receipts for expenses. Management-level employees can make appropriate judgments about expense report items. Appoint a senior manager to trade with the reviewer and have each sign off on the other's expense reports.

Apply the rules to everyone

Many organizations hesitate to investigate warning signs, especially if the suspect occupies a position of influence and control. Typical "fraudsters" are older, well educated, don't have a criminal background and are often trusted employees, the very qualities that allow them to ascend to a position of relative power.

Therefore, others in the organization are reluctant to question the fraudster's directions or actions, allowing the individual to operate without significant oversight. The key to prevention is this: **The rules should apply to all.**

Support for reviews and audits must start with management. Without it, internal auditors and other personnel may think it inappropriate to question the actions of senior staff, who are the most likely to commit fraud.

The anti-fraud environment can only exist with support from those at the top. Your management must "walk the talk" in a way your employees can see. ■

2007 Work Plan: OIG's message to providers . . .

continued from page 1

Inpatient hospital payments for new technologies - Review payments made to hospitals for new services and technologies.

Critical access hospitals - Review critical access hospital (CAH) cost reports to examine administrative and other costs incurred for inpatient and outpatient services before and after a conversion to CAH status.

Rebates paid to hospitals - Determine if hospitals properly report purchase credit rebates in their Medicare cost reports.

These are just six of OIG's targeted **Work Plan** areas for hospitals, and there are many more that may affect your health care organization. Do not delay your review of the **Work Plan** and follow the steps outlined above to perform a self review.

Organizations OIG will target

What other health care organizations does OIG plan to look at? Its list includes home health agencies (HHAs), nursing facilities, hospice organizations, physician practices (covered in the November 2006 **Health Care News**) and medical equipment suppliers. Following are some of the specific areas OIG will target:

Home health

- Home health outlier payments (This review determines if outlier payments to HHAs comply with Medicare laws and regulations.)
- Enhanced payments for home health therapy (This review determines if an HHA's therapy services meet the Medicare regulations threshold for higher payments.)
- Accurate coding of claims for Medicare home health resource groups (HHRGs) (This review determines the extent to which Medicare HHAs accurately code the HHRG in the outcome and assessment information set.)

Nursing facilities

- Skilled facility rehabilitation and infusion therapy services (Through medical review, OIG will analyze whether rehabilitation and infusion therapy services provided to Medicare beneficiaries in skilled nursing facilities (SNFs) were medically necessary, adequately supported and actually provided as ordered.)
- SNF involvement in consecutive inpatient stays (This review determines whether SNF care provided to Medicare beneficiaries with consecutive inpatient stays was medically reasonable and necessary.)
- SNF day-of-discharge payments (This review determines whether Medicare inappropriately pays SNFs for day-of-discharge services.)
- SNF consolidated billing (This review determines if controls are in place to preclude duplicate billings under Medicare Part B for services covered under the SNF prospective payment system (PPS). It also assesses the effectiveness of common working file (CWF) edits established in 2002 to prevent and detect improper payments.)

Hospice

- Hospice payments to nursing facilities (This review determines the accuracy of hospice payments for services provided to dually eligible patients/residents of a nursing facility).
- Hospice plans of care and appropriate payments (This review determines if assessments were completed and if the plans of care correctly reflect the assessments for beneficiaries receiving hospice care.)

Medical equipment & supplies

- Durable medical equipment payments for beneficiaries receiving home health services (This is a review of the medical records of beneficiaries receiving HHA services for durable medical equipment (DME) items and supplies to determines if they were reasonable and necessary for the beneficiaries' conditions.)
- Medicare payments for therapeutic footwear (This review determines whether therapeutic footwear furnished by individual suppliers are reasonable and necessary for beneficiaries.)
- Medical necessity of DME (This review determines the appropriateness of Medicare payments for certain DME items, such as power wheelchairs, wound care equipment and supplies or orthotics.)

Document internal reviews

These are just some of the **2007 Work Plan's** targeted focus areas. We encourage you to review OIG's entire plan at **http://www.oig.hhs.gov/publications/workplan.html**. As you review each applicable area, document your findings and how your organization manages the risk.

It's much easier and less costly if you perform a self review to identify areas for improvement than to have OIG conduct an investigation. Put the **2007 Work Plan** to work for your organization and review the targeted areas before the OIG does it for you. ■

Will perfect storm hit home health?

Mark Sharp, msharp@bkd.com

Could a perfect storm be brewing in home health? Though questions about the solvency of the Medicare program continue, a solution has yet to come to the fore.

Current environment

The Medicare Payment Advisory Commission (MedPAC) projects Medicare's hospital insurance (Part A) fund will be insolvent by 2018. In the last two federal fiscal years, more than 45% of Medicare expenditures have been funded by general tax revenues. Congress is required to study Medicare expenditures if general revenues are used at such a level for two consecutive fiscal years.

At the same time, MedPAC continues to report average profit margins of 16% in Medicare home health. Approximately 80% of the freestanding home health agencies (HHAs) are reportedly making a profit in their Medicare business. Some observers contend the 20% not making profits in Medicare are simply mismanaged.

However, factors such as penetration of Medicare managed care, servicing rural areas and market dynamics could influence those agencies with deficit margins in Medicare. Regardless, the microscope is focused on home health.

There has been a massive infiltration of new-start agencies across the country. Also adding strength to the storm is merger and acquisition activity in home health that, over the last two years, has been at its highest level in a decade. It's likely this combination will cause those who oversee the Medicare program to wonder why the home health business is such an attractive market.

MedPAC has recommended freezing Medicare home health rates since 2003; Congress did freeze them in 2006, but the lame-duck Congress last fall is credited with allowing the industry to avoid the freeze or cuts in 2007. At the time of this writing, President Bush's 2008 budget recommends Medicare home health rates be frozen for the next five years.

The above factors create the right conditions for a perfect storm in home health.

Table 1: BKD Home Health Dashboard Indicators

Dashboard Indicator	All United States Lower Quartile	Median	Upper Quartile
All Agencies			
Medicare payer mix (based on patients)	54.8%	77.3%	96.4%
Visits per Medicare episode	14.1	17.0	21.0
Number of episodes per Medicare patient	1.2	1.4	1.9
Estimated number of hours per visit			
Administrative staff	0.7	1.2	1.9
Total staff	2.6	3.5	5.1
Estimated average case-mix weight	1.0804	1.2114	1.3472
Average payment ratio	0.9411	1.0842	1.2378
Average payment per Medicare episode	$1,995	$2,326	$2,718
Freestanding Agencies			
Total cost per Medicare episode	$1,643	$2,022	$2,595
Profit per Medicare episode	$ 47	$ 384	$ 714
Profit margin per Medicare episode	2.5%	16.2%	28.8%
Overall agency profit (loss) margin	(2.2)%	3.7%	12.8%
Hospital-based Agencies			
Total agency cost per Medicare episode	$1,151	$1,471	$1,834
Profit per Medicare episode based on total agency costs	$ 68	$ 471	$ 733
Profit margin per Medicare episode based on total agency costs	9.8%	26.2%	36.5%
Total cost per Medicare episode (with hospital overhead)	$1,623	$2,035	$2,525
Profit (loss) per Medicare episode	$ (489)	$ (52)	$ 238
Profit (loss) margin per Medicare episode	(25.5)%	(3.2)%	13.6%

Note: Quantities and medians are not correlative; each line item stands alone. Contact your BKD Health Care Group advisor for more information.

Not so fast

Early in 2007, CMS is expected to issue a proposed rule on refinements to the Medicare home health PPS, which may include the most significant changes since its implementation in October 2000. This PPS refinement may just be home health's saving grace for avoiding any immediate cuts in payment rates. The earliest anticipated implementation date for these refinements is January 1, 2008, after the required comment period and the crafting of the final rule.

While the design of PPS refinements will be budget neutral in overall impact to home health outlays, their true effect will surface only after implementation, and many believe this is what will deter drastic cuts to payment rates until further information is available.

PPS refinements

We won't know the actual proposed refinements to the home health PPS until the proposed rule is issued, but they are expected to include these changes:

- The most notable and publicized change relates to the 10-visit therapy threshold. The proposed rule is expected to implement three separate therapy thresholds for in-

creased payment at 6, 14 and 20 visits. These thresholds are expected to combine with a "smoothing" method through which a small increased payment is applied with each additional visit between 6 and 14 and between 14 and 20. Payment specifics at each threshold level or the smoothing amounts aren't yet known.

- CMS studies have shown subsequent episodes of care, on average, are more costly than start-of-care episodes. As a result, the PPS may be refined to pay base amounts for first and second episodes and higher amounts for third-plus episodes.
- Additional refinements are expected to include the use of limited diagnosis variables with consideration of diagnoses, such as neurological, orthopedic and cardiac.
- There has also been discussion that supplies may be pulled from the episodic payment bundle and covered separately.
- Other changes could involve the four-visit low-utilization payment adjustment (LUPA) threshold and the application or continued existence of partial episode payments (PEPs) and significant change in condition (SCIC).

Where does your HHA stand?

Could your agency withstand any downward adjustments to the Medicare payment rates? Do you know how your agency's performance compares to its peers? **Table 1** provides national benchmarks for some key dashboard indicators in Medicare home health operations.

These benchmarks are excerpts from the **2006 National Home Health Operations Dashboard Report** developed by Eli Research in cooperation with BKD Health Care Group.

The dashboard indicators were compiled using data from all Medicare cost reports for both freestanding and provider-based agencies filed with CMS for fiscal years ended primarily in 2005. To learn more about this report and to compare your agency's data to a specific peer group, visit **http://www.bkd.com/hh.**

Winds of change

It's unclear what will happen with home health PPS payment rates or whether the storm will materialize. Contact your BKD Health Care Group advisor for help weathering any changes ahead by helping improve operations and assessing how looming payment reductions could affect your agency. ■

Conferences, Webcasts & Writers

Speakers

Conference: **HFMA National Joint Revenue Cycle and Managed Care Conference, Baltimore, MD, March 9**

Topic: Bridging the Gap—Strategies for Working Together to Deliver Efficient, Quality Care and Get Paid for It

Speakers: Sally Hardgrove & Cindy MacQuarrie

Date: March 9

Conference: **American Health Lawyers Association Institute on Medicare and Medicaid Payment Issues, Baltimore, March 21-23**

Topic: Special Medicare Reimbursement Policies for Rural Providers

Speakers: John Cooper, **BKD, LLP** & Chris Rossman, Foley & Lardner LLP

Date: March 21, 2007

Conference: **National Rural Health Association Annual Conference, Anchorage, AK, May 15-18**

Topic: Optimizing Resources for Rural Community Health Centers

Speaker: Jeff Allen

Date: May 16, 2007

Conference: **Healthcare Financial Management Association Annual National Institute, San Diego,** June 24-27

Topic: Rural Medicare PPS Regulatory and Legislative Update

Speaker: Tim Wolters & Brad Brotherton

Date: June 26, 2007

Topic: Protecting Your Organization from Fraud and Embezzlement

Speaker: Angela Morelock

Date: June 27, 2007

Audio Conference

Conference: **Eli Home Care Audioconference**

Topic: P4P: Prepare Your Agency for Success

Speaker: Karen Vance

Date & Time: March 29, 2007; 12:00-1:00 CT

Preregister At: **http://www.audioeducator.com/**

Webcasts

Webcast: **HFMA Webcast**

Topic: Rural Medicare PPS Regulatory & Legislative Update

Presenters: Brad Brotherton & Tim Wolters

Date & Time: May 2, 2007; 2:00–3:45 p.m. CT

For More Information: Contact Jenny Comstock, 417 865-8701 or jcomstock@bkd.com

Writers

Publication: **Compliance Today**

Article: Compliance - Getting Everyone on Board

Author: Larry Fogel

Issue: February 2007

In Brief

Administration budget includes significant Medicare cuts - President Bush's proposed fiscal 2008 budget includes cuts for most providers. Under the budget proposal, the market-basket payment updates for hospital inpatient and outpatient services will be reduced by 0.65% annually. SNF and inpatient rehab facilities would receive no update in 2008, with market-basket minus 0.65% thereafter. Home health agencies (HHAs) would receive no update for 2008 through 2012, with market-basket minus 0.65% thereafter.

The administration once again proposes to eliminate reimbursement for Medicare bad debts over a four-year period. While the Democratic Congress is unlikely to ratify the budget cuts in their entirety, providers should monitor budget developments and communicate their concerns to their legislators.

Proposed medical education changes buried in LTCH rule - The February 1, 2007, **Federal Register** includes proposed updates to the long-term care hospital (LTCH) PPS rates effective July 1, 2007. CMS believes recent case-mix changes are due to improved coding by LTCHs rather than actual changes in patient acuity. CMS proposes outlier policy changes as well as a reduced payment update, which will result in an estimated decrease of 0.7% in the average LTCH payment rate. The actual DRG classifications will still be updated October 1, consistent with the update to the acute-care DRG system.

The proposed rule also includes a proposal to revise the requirement that hospitals incur "all or substantially all" of the costs of a resident's training in nonhospital settings.

Effective for cost reporting periods beginning on or after July 1, 2007, CMS proposes that hospitals must document they incurred at least 90% of the total cost of the residents' salaries and fringe benefits and the portion of the cost of teaching physicians' salaries attributable to the medical education.

Providers may base teaching physicians' costs on actual data or on the assumption three hours a week is spent on teaching activities, with compensation based on national averages for physician compensation by specialty area.

Comments on the proposed rule are due by March 26, 2007.

Revised occupational mix survey proposed - CMS is required to complete the the occupational mix survey process every three years. Though it accomplished this in 2006, CMS proposes the next survey will take place by September 1, 2008, and use 12 months of data from pay periods ending between July 1, 2007, and June 30, 2008.

CMS has revised the departments hospitals can include in the nursing categories and has clarified other aspects of the collection process. Critical access hospitals (CAHs) continue to be exempt from the survey. Comments on the survey are due by April 3, 2007. ■

Numerous TRHCA provisions affect health care industry

by Tim Wolters, twolters@bkd.com

On December 20, 2006, President Bush signed the *Tax Relief and Health Care Act of 2006* (TRHCA), preventing a scheduled cut in the Medicare physician fee schedule and implementing other changes in provider and physician payments.

Provision specifics

TRHCA froze payments to physicians, preventing a 5% cut to the physician fee schedule that was to become effective January 1, 2007; however, in setting the 2008 fee schedule, the law specifies the freeze is not to be taken into consideration. Thus, without further action, speculation is the fee schedule could decrease as much as 10% in 2008.

While freezing physician fees, TRHCA also provides for a 1.5% bonus payment during the last half of 2007 for physicians, therapists and other professionals reporting certain quality measures. For more information, visit: **http://www.cms.hhs.gov/PQRI**.

Following are other provisions that will affect the health care industry:

- TRHCA extends for a third year the outpatient laboratory cost reimbursement provision for certain hospitals located in qualified rural areas and with fewer than 50 beds.
- With an effective date set for January 1, 2007, CMS planned to prohibit reference labs from direct billing the technical component of their services, but TRHCA delays this one year.
- Wage index reclassifications under Section 508 of the *Medicare Modernization Act of 2003* (MMA) are extended six months, through September 30, 2007. In revising the hospital wage index, TRHCA requires CMS publish one or more proposals in the fiscal year (FY) 2009 PPS proposed rule, which has an April 2008 publication date. Such proposals may take into account MedPAC recommendations that are to be submitted to Congress in a report due June 30, 2007.
- Starting in 2009, TRHCA provides a 2% reduction in the outpatient PPS payment update for hospitals failing to report quality data. The reduction may also be applied to ambulatory surgery centers (ASCs).
- The Part B therapy cap exception process implemented under the *Deficit Reduction Act of 2005* is extended a second year, through December 31, 2007. The therapy caps do not apply to hospital Part B therapy services.
- Among the various Medicaid provisions, the TRHCA lowers the limit on Medicaid provider taxes from 6% to 5.5% from January 1, 2008, through September 30, 2011.

TRHCA's impact on the operations of individual providers will vary. Contact your BKD Health Care Group advisor for more information concerning its impact on yours. ■

Last year's top five Medicare SNF questions

by Eric Doerhoff, edoerhoff@bkd.com

SNF providers have had questions about the prospective payment system (PPS) since its 1998 inception. As PPS evolved, so have the questions and challenges, with the implementation of RUG 53 a prime example of the types of changes providers have encountered in recent years.

In assisting clients, BKD's long-term care (LTC) consultants have identified five SNF PPS issues as the top areas of provider confusion and concern. Following is information designed to help your SNF make sense of these questions.

What do I need from the hospital, and how can I use it? - Acquiring the necessary documentation from referral hospitals can be challenging and knowing how to use it is imperative for profitable operations. Your SNF can "look-back" into a patient's hospital stay for certain services rendered during a specific time, but, to include those services on the MDS, you must acquire copies of the appropriate documentation that shows the service was provided.

Intravenous (IV) medication must be documented on a medication administration record (MAR) that shows the specific medication, the date it was given and by whom. This documentation should be part of your permanent medical record to support the MDS coding, and, after obtaining it, you must understand how to use the information.

For instance, IV medications have a 14-day look-back time frame that frequently allows the SNF to include the service on the 5-day assessment (and quite likely on the 14-day assessment as well if the assessment reference date (ARD) is chosen wisely).

Acquiring hospital documentation and properly using the information often means the difference between accessing the upper 9 RUG groups and *not* accessing them, which may significantly reduce payments.

When does a patient break their "spell of illness" and renew their benefit days? - Medicare beneficiaries are entitled to 100 days of Medicare coverage in a SNF, usually referred to as their benefit period. To renew the 100-day benefit period, they must break the spell of illness, which occurs when a beneficiary does not receive a skilled service in a SNF and has no hospital admissions for a period of 60 consecutive days.

Skilled services in a SNF are daily intervention orders by the physician that require the skills of qualified technical or professional health personnel, *e.g.*, RNs, LPNs, licensed therapists (PT, OT and SLP) or audiologists. The services must be provided by or under the supervision of these skilled nursing or skilled rehabilitation personnel to ensure patient safety and achieve the medically desired result.

If a patient is discharged home or to a lower level of care for 60 days, or resides in the SNF for 60 days without receiving a skilled service, his/her 100-day benefit period is reset. A key issue for SNFs is knowing what is defined as a skilled service. For example, one Stage III or IV pressure ulcer with at least two skin treatments over seven days qualifies as a skilled service, but routine medication administration is not.

For what items or services are SNFs financially responsible? - Under PPS, SNFs are paid a per diem rate with the understanding that a package of items and services are covered by that rate. Covered services include pharmaceuticals, therapy, certain diagnostic services and room and board. Certain other "excluded services" are not included in the packaged services and are not the financial responsibility of the SNF. These include common services such as CT scans, MRIs, dialysis supplies and chemotherapy.

Keep in mind, the location where some of these services are performed has an impact on whether they are excluded. Medicare annually updates a comprehensive list of HCPCS codes that delineate excluded services, available at: **http://www.cms.hhs.gov/SNFConsolidatedBilling/**.

As a SNF provider, verify who is financially responsible for a service before providing it, including services provided outside the SNF setting, such as a physician's office or hospital outpatient department. You may find it beneficial to enter an agreement with outside providers who routinely provide services to Medicare inpatients.

A patient was in the hospital for three midnights, yet our claims were denied. Why didn't we meet the three-day qualifying hospital stay requirement? - Most SNF providers understand that, to qualify for the SNF Medicare benefit, a Medicare beneficiary's hospital stay must include three midnights; however, the proper coding of that stay on the UB-92 is occasionally a source of confusion.

The day of discharge from the hospital must be listed on the claim to include the preceding midnight; this becomes an issue if the patient was in the hospital for only three midnights. A claim will be denied for not having a qualifying stay if, for example, the stay is documented from January 15, 2007, to January 17, 2007, when the patient was actually transferred to the SNF January 18, 2007, the date the claim should have listed as the day of discharge.

If the claim is denied, the dates of service are posted to a common working file, and the SNF must complete a claim adjustment to correct the problem before it can resubmit the claim.

Why do so few patients access the nine new RUG categories? - The BKD Health Care Group has analyzed national data and reviewed client utilization to establish benchmarks. Our benchmark for utilization of the upper nine combined RUG categories is approximately 60% of total Medicare days.

In other words, your SNF should expect six of 10 Medicare patient days to classify in the combined RUGs, assuming the patient receives therapy services, has had an extensive service **and** an ADL score of 7 or greater. The proper capture of ADLs is a challenge for many facilities and can be a barrier for accessing the upper 9 RUG categories.

By not capturing all ADLs on the MDS, your SNF could miss revenue as a result of undercoding. Routinely provide ADL documentation training to all clinical staff. Further, we recommend you implement an ADL documentation policy that includes tools to assist clinicians with proper documentation.

* * *

Your SNF regularly faces these five key issues and many others unique to your skilled nursing care. Contact your BKD Health Care advisor for more information or for help finding answers to questions like these. ■

NPI review & update: it's almost here!

Rodney Walsh, BKD Technologies, rwalsh@bkd.com

CMS adopted an NPI motto: "Getting an NPI is free – not having one can be costly." It states very clearly the importance of obtaining your NPI numbers, sharing them with applicable providers and payers and engaging with your software vendors, clearinghouses and payers in NPI testing. If these steps don't sound familiar, make it a high priority to accomplish these activities as soon as possible.

Who needs an NPI?

As a reminder, **all** health care providers must obtain an NPI—whether they are individuals (physicians, nurses, dentists, chiropractors, physical therapists or pharmacists) or organizations (hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of DME, pharmacies, etc.).

Any separate business entity with a separate tax identification number that submits standard HIPAA transactions must obtain an NPI. Likewise, it is recommended each Medicare provider number have a corresponding NPI.

How do I obtain my NPI?

Each individual provider must apply for the NPI. A free online application is available at **http://www.NPPES.cms.hhs.gov** or call the NPI enumerator to request a paper application: **800 465-3203**.

Using legacy numbers during the transition

Through May 22, 2007, Medicare will accept the NPI as the primary number, but claims may not be paid if there is any problem with it.

Medicare strongly recommends providers, clearinghouses and billing services continue to submit the Medicare legacy identifier as a secondary identifier. Legacy identifiers may include the provider identification number (PIN), national supplier clearinghouse number (NSC), online survey certification and reporting number (OSCAR) or the universal provider identification number (UPIN).

Beginning May 23, 2007, CMS Systems will only accept NPI numbers.

Identifier crosswalks

Each health plan may create its own crosswalk to crosscheck NPI and legacy identifiers. **CMS continues to stress to providers the importance of entering every current identification number on their NPI application, which will help build Medicare's identifier crosswalk (for Medigap and secondary payer purposes).**

CMS also asks providers already assigned NPIs to update their national plan and provider enumeration system (NPPES) information with their legacy identifiers. ■

Summary of key resources & links to information

CMS NPI Web Site http://www.cms.hhs.gov/NationalProvIdentStand/

Medicare Educational Resources
http://www.cms.hhs.gov/NationalProvIdentStand/ 04_education.asp#TopOfPage

National Plan and Provider Enumeration System (NPPES) https://nppes.cms.hhs.gov

National Plan and Provider Enumeration System (NPPES) 800 465-3203

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