HEALTHcents

Eastern Michigan Chapter

November 2002

Volume 1,Issue 9

President's Message

If you're waiting at your mailbox for your Eastern Michigan Chapter HFMA directory, we have great news. You can go back to your desk and relax (when was the last time someone told you that?). Surf on over to www.hfma-emc.org and it'll be right there, always at your fingertips. Well, except for those occasions when that nasty server goes down. You can access it at work AND at home. No need to carry that book around with you.

This is really momentous for EMC. It's been in the works for the past three years, and National has finally acquiesced to allowing Chapters to use their websites for this purpose. It's akin to coming out of the dark ages. Susan Stokes is still working out some of the kinks, such as listing members by employer (not a National requirement), but I think you'll like using it. For those of you who have no internet access and receive this newsletter via "snail mail", we will be sending you a plain paper copy.

I want to express my thanks to Linda Height who took on the responsibility for getting accurate information and to Susan Stokes who is responsible for putting Linda's information on the website. Great job, ladies!

Happy Thanksgiving to all!

UPCOMING MEMBER MEETING

The next Member Meeting will be on November 19, 2002 on the 8th floor of the Medical Building at Providence Hospital.

The HFMA Managed Care Committee Presents: "Looking Ahead to 2003: The Lansing Agenda" Speaker David Finkbeiner, Michigan Hospital Association, Senior Director of Legislative Issues and Bill Burke, Knight Consulting, who is a lobbyist for the (Michigan Association of Health Plans) will also be sharing his thoughts with us.

With this month's historical election behind us, it is now time to look forward to what benefits or damage the lame duck session holds and what next year's administration and legislative agendas may be. With the defeat of Proposal 4, a new Democratic Governor and a Republican House and Senate, it will be interesting to see what will happen over the next year or two. Please come and hear how these two experts agree (or differ) upon the various issues facing today's healthcare

Sign up today through the internet for our next member meeting http://www.hfma-emc.org and get the lower registration price!

7:30 to 8:30 am Board Meeting
8:00 to 8:30 am Registration/Continental Breakfast
8:30 to 9:00 am Member Meeting
9:00 to 10:30 am Managed Care Presentation
10:30 am Adjournment

Cost will be
Early Registration $30 Member $40 Nonmember
At Door $40 Member $50 Nonmember

WELCOME NEW MEMBERS

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ACCESS THE MEMBERSHIP DIRECTORY ON-LINE
www.hfma-emc.org

HFMA FALL CONFERENCE HIGHLIGHTS

Over 300 HFMA members, guests, and speakers attended the 49th Annual Fall Conference held over the course of two days, October 17th, and 18th, at the Ypsilanti Marriott.

Following the National Theme to "create the future", attendees heard the first hand account experience of Ken Raske, President of the Greater New York City Hospital Association, surrounding the events of September 11, 2001 and the days following. With the destruction of the disaster control center in the World Trade Center complex, the Hospital Association's offices were transformed into the disaster relief command center with Ken directly involved in coordinating the health care response to aid the victims and rescuers.

Thursday evening attendees were entertained by the insights and humor of WDIV TV 4 Health Reporter and News Anchor, Lila Lazarus. Also Thursday, Ted Anderson, from Mid Michigan Medical Center – Clare and the Great Lakes Chapter, was announced as the 2002 recipient of the Ernie Laetz Education Award.

Throughout the two days, attendees had the opportunity to choose from over 20 different breakout sessions covering patient accounting, finance, reimbursement, compliance, regulatory, and industry updates. National Chair-Elect, Dave Canfield attended and presented the results and recommendations from the National Patient Financial Services Task Force. The session, "ABC's of Embezzlement" provided a standing room only crowd with real life examples/document samples of actual cases. All sessions were well attended, which is a tribute to the efforts and quality of the speakers who volunteer their time to prepare and present. The Committee is in debt to all of their efforts.

Returning to kick off the schedule on Friday, Jeanne Scott presented "Surviving the Hangover from the Economic Binge: Healthcare Reform in the Slowing Economy". Although Jeanne is retiring this year from NDC Health, she promises to keep her free newsletter coming to those who request it and will stay on the speaker trail in the near term.

With Conference attendance up over the prior year, increased participation from vendors and additional sponsors, the conference committee is already looking forward to planning the 50th Annual Conference, which is scheduled for October 16, and 17, 2003. If you have any ideas how to mark this special anniversary event, or would like to join the Committee (3 meetings during the period of January through May 2003) in planning this event, please contact Kelli Oliver at 313-937-3764 (Olier@AOL.com) or Bob Dery at 248-223-3223 (Bob.Dery@plantemoran.com).

COMPLIANCE CORNER

Kenneth R. Marcus, Esq.
Compliance Committee Chairperson

The Department of Health and Human Services Office of Inspector General ("IG") issued the following Advisory Opinions since the last issue of *Health¢ents* went to press:

Advisory Opinion No. 02-15 (October 7, 2002): The OIG approved the proposal of a municipal corporation that owned and operated an ambulance service to deem revenue payments of local real estate taxes from residents of the municipality as payment of co-payments and deductibles by the residents for emergency ambulance services. For the full text of this opinion, see: http://oig.hhs.gov/fraud/docs/advisoryopinions/2002/ao0215.pdf

Advisory Opinion No. 02-14 (October 7, 2002): The OIG opined that a proposal to provide free safety equipment to hemophilia patients and free electronic pagers to the parents of pediatric hemophilia patients violated the prohibition against inducements to beneficiaries. For the full text of this opinion, see: http://oig.hhs.gov/fraud/docs/advisoryopinions/2002/ao0214.pdf

Advisory Opinion No. 02-13 (October 4, 2002): The OIG opined that a proposed arrangement involving financial assistance by a non-profit foundation that a pharmaceutical company proposes to establish and fund in order to subsidize cost-sharing amounts incurred by financially needy patients using its drug potentially exposed the requesting party to administrative sanctions, but a determination regarding the parties' intent was beyond the scope of the opinion, and thus a definitive conclusion could not be reached. For the full text of this opinion, see: http://oig.hhs.gov/fraud/docs/advisoryopinions/2002/ao0213.pdf

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COMPLIANCE CORNER

Kenneth R. Marcus, Esq., Compliance Committee Chairperson

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Whistleblowers Allege IG Reduces Enforcement Efforts

In another development, Congress is now investigating the effectiveness of the OIG. Sen. Chuck Grassley, ranking member of the Committee on Finance, recently initiated an external review of whether changes at the IG's Office will result in weaker policing of health care fraud. Sen Grassley said he initiated the audit because he received numerous allegations from several whistleblowers about significant personnel changes in the IG's Office since IG Janet Rehnquist took office in August 2001. The whistleblowers have told Grassley there have been 19 senior level staff changes -- an exceptionally high figure for that office. The whistleblowers allege that IG Rehnquist has mandated involuntary retirements and re-assignments for career employees with stellar reputations for fighting fraud, waste, and abuse in federal health care programs, including several recipients of presidential awards. The whistleblowers say that all of the six deputy inspectors general when Rehnquist took office have been reassigned or otherwise no longer are in their positions.

Opportunity to Benefit from *Monmouth* May Expire February 27, 2003 Kenneth R. Marcus, Esq.

During 2002, numerous hospitals in Michigan and nationwide have filed suit in federal court seeking an order that their cost reports be reopened to count all Medicaid eligible days for purposes of the disproportionate share adjustment ("DSH Adjustment"). The principal legal authority is the case of *Monmouth Medical Center v. Thompson*, 257 F.3d 807 (D.C. Cir. 2001). In ruling in favor of the providers, the Court in *Monmouth Medical Center* granted "mandamus" relief, and ordered the intermediary to reopen the DSH Adjustment payment determinations for hospitals consistent with HCFA Ruling 97-2. A petition for rehearing en banc was denied, and the deadline to petition the Supreme Court for cert. has expired. Accordingly, *Monmouth* is a final decision. Moreover, *Monmouth* was followed in the decision of *Bartlett Memorial Medical Center v. Thompson*, 171 F. Supp. 2d 1215 (W.D. Okla. 2001). *Bartlett* currently is on appeal before the United States Court of Appeals for the 10th Circuit.

If a Hospital qualifies for but did not receive DSH payment under HCFAR 97-2, or if a Hospital qualifies for additional DSH payment under HCFAR 97-2, serious consideration should be given to filing an action in the United States District Court for the District of Columbia, which enjoys jurisdiction for all hospitals seeking mandamus relief to enforce HCFAR 97-2, and which must follow the *Monmouth* decision.

Depending upon the specific facts, the Centers for Medicare and Medicaid Services ("CMS") is now settling certain cases seeking reopening orders in light of *Monmouth*. Thus, CMS is agreeing to order the Intermediary to conduct a reopening to include all Medicaid eligibles. Other cases with different fact patterns likely will be decided on a cost effective, consolidated basis.

The "mandamus" relief on which these cases is based has a 6 year statute of limitations. Thus, the opportunity to benefit from this litigation could expire as of February 27, 2003, which is the sixth year anniversary of HCFA Ruling 97-2.

A hospital would be well advised to review whether any cost reporting periods were subject to reopening but not pending on appeal before the PRRB regarding the DSH Adjustment issue as of February 27, 1997. ***That is, if the NPR was issued on or after February 27, 1994.*** Under *Monmouth*, it might be possible to obtain relief for such cost reporting periods. Of course, the hospital must be able to support its claim for the DSH Adjustment.

Numerous consulting firms are available to assist hospitals in making this determination. The author is admitted to practice before the United States District Court for the District of Columbia and actively represents numerous hospitals that have filed suit.

Financial Analysis/Decision Support Committee

Outpatient Service Line Reporting

The September meeting of the Financial Analysis/ Decision Support Committee featured a presentation and discussion on Outpatient Service Lines. Mark Leonard, Director of Cost Accounting and Reimbursement, presented Service Line definitions and reports currently utilized at William Beaumont Hospital, Troy. Following the presentation there were discussions related to different methodologies Hospitals use to define Service Lines and report the information. For inpatients many hospitals use DRG's as the basis. However, that same methodology cannot be used on the outpatient side of the business. Hospitals that create both Inpatient and Outpatient Service Line reports have the challenge of using consistent Service Line definitions. Some of the hospitals utilize the Attending Physician assigned to the given case. That case is then assigned to Service Lines based on the Physician's Specialty. Other hospitals use more complex iterations to assign cases to a Service Line. A couple of Hospitals look at combinations such as, the facility at which the patient was serviced (such as a women's center or cancer center), the Physician assigned to the case, and the Principal Diagnosis on the case. It is very important to assign Service Lines in a manner that is meaningful to the organization. If the Medical Administration structure is based on Physician Specialties, it makes sense to set up Service Lines based on the Physicians that fall under the responsibility of the respective Medical Chiefs.

Most Hospitals report the same type of data on their Service Line reports. The reports generally include data elements such as: Cases(Visits), Charges, Total Cost, Direct Cost. Some Decision Support systems also allow Hospitals to report an Expected or Actual Reimbursement figure and an estimate of Net Income or Loss. For the inpatient reports, Hospitals also include Average Length of Stay and compare that to some type of benchmark.

Within the Service Line reports, other outpatient data can also be grouped and reported by: APC, ICD9 Principal Procedure or Diagnosis, CPT4 codes, etc.. Reporting this Service Line information for both inpatients and outpatients is very important to managing a Hospital, controlling costs, and helping with disease management practices. These Service Line reports that are generated must be handled very carefully within the Hospital and in conjunction with the Medical staff.

The change in focus of the Financial Analysis/Decision Support Committee has been very successful. Participation in the Committee has more than tripled since the reformation. With the Committee growing in participation like it is, there is a lot of good input and ideas that are discussed at the meetings. The next meeting of the Committee will be on Friday November 22nd at 8:30 AM. The topics will be as follows:

Financial Analysis: Methodologies for Economic Justifications, Project Selection, and Pricing Studies
Decision Support: Presentation on Cost Savings and Opportunities Related to Reductions in Length of Stay.

Location:
BCN-Riverside Building
25925 Telegraph Road
Suite 210
Southfield, MI 48034
This Conference Room is located on the 2nd floor of the BCN Building on Telegraph Road between 10 and 11 mile.

If you have questions or suggestions regarding the Committee please Email Mark Leonard at mleonard@beaumonthospitals.com or Tina Wood at twood@dmc.org. Thank you and we hope to see you at the meetings.

NEWSLETTER SUBMISSION DEADLINES

December 2, 2002	**January 6, 2003**	**February 3, 2003**
March 7, 2003	**April 7, 2003**	**May 2, 2003**

Please note that the Newsletter will be published monthly with your cooperation. Any information for inclusion should be sent to Maryanne VanHaitsma
E-mail to: mvanhait@dmc.org phone#(248) 549-2703

OUTSOURCING PHYSICIAN RECEIVABLES

Nancy Allcroft, BSN, MBA, CPA
James Yarsinsky, CPAM

As healthcare providers consider opportunities to improve their own patient financial services, the notion of outsourcing portions of receivables where the they may not have internal expertise, is being addressed more and more. In many business offices, there exists billing for small balance claims, including professional fee (inpatient and outpatient) and outpatient facility claims. Thresholds for "small balance" write-offs indicate this is an area that is ripe for review by senior management for billing/ collection effectiveness and outsourced where appropriate.

There are several key factors to consider when outsourcing **physician account receivables**. The following factors differentiate outsourcing for physician fees from hospital inpatient or outpatient facility fees:

The first factor is specific to physician credentialing with payers. If a physician is credentialed with a managed care payer, then he/she should be paid by the payer. If not credentialed at the time service is rendered, the physician amount billed may be disallowed by the payer. Many outsourcing firms are willing to assume the A/R without first performing due diligence for credentialing. This is a lose-lose situation, since the vendor will not be paid and will have little incentive to collect on claims; therefore, the hospital or practice will not see the expected improvement in cash.

Accordingly, in order to develop a time frame for the outsourcing, a comparison of physician credentialing with contracts that comprise more than 5% of each physician's revenue should be performed. The lack of credentialing could have a major impact on cash collections. If all physician practice receivables are outsourced, all hospitals where the physician providers have privileges should be reviewed. Some hospital contracts require the physicians be credentialed under the hospital in order to be paid for identified hospital services (professional component, such as EKG interpretations). Ultimately, this requirement of several credentials under each managed care payer complicates matters and demands detailed tracking of each provider's credential status with payers.

Second, and perhaps more obviously, there is a high potential for poor quality of registration information in a multi-site physician group practice. In healthcare account receivables, many denials by insurers result from poor information entered at the time of registration. Therefore, it behooves the consultant CPA to review the current quality of information and set up a plan for long-term denial management (and therefore, denial reduction and improvement in A/R turnover).

Other than the foregoing, the following should be considered for outsourcing of both physician and facility A/R:

- Which accounts should be outsourced; i.e., is it a partial or total outsource? A review of the institution's ability to attract highly skilled billers should be performed. As many senior officers and directors are aware, professional and facility billers are no longer the entry-level hire of ten years past. It takes a good two years for a biller to be skilled at billing more than one payer, an attribute that is important with secondary billing requirements.

- A kick-off meeting for project planning purposes should include individuals associated with all aspects of the revenue cycle. The vendor should review and document current internal procedures and identify where procedures might change with outsourcing. Current workflows, systems and communication between departments are important to review; then, appropriate controls may be added or modified for the new workflow and procedures.

Controls should address (i) appropriate balancing and reporting functions for outsourced cash applications (ii) the completion of charge entry; for example, for outpatient claims, a comparison of the number of daily encounters with number of registered patients, (iii) number of claims sent to the outsourcing firm compared with the number of received (log), (iv) the disposition of accounts, i.e. denial write-offs, or other, (v) ongoing review of the vendor's performance, vis-à-vis aging summary, denials, bad debt and other metrics.

- Reporting capabilities are not comparable amongst vendors. Ask what it will take to create a report that is not a standard one. For physician outsourcing, it is best to outsource to a vendor with more open architecture (or database capabilities) and a good report writer so that it is simple to pull special request reports.

- Review changed internal staffing needs as a result of the outsourcing arrangement. If the staffing resource requirements have not changed, the expected improvement in cash should exceed the incremental cost for the outsourcing. If there are to be layoffs, the vendor may be interested in interviewing all prospective layoffs. It is likely one or two staff members may be absorbed by the vendor for an ongoing project.

- In fulfillment of HIPAA requirements, security and confidentiality should be addressed by both parties:

    - If it is an "outsourcing" that includes access to the hospital's system, be sure there is adequate security, preferably, a firewall and encryption capabilities.

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- All agreements should include a Business Associate Agreement, in compliance with HIPAA, b y April of 2003.
- The vendor and each vendor staff member working with the client account should sign a confidentiality agreement.
- Ensure that the vendor administers an ongoing training program, and that security, privacy rules and electronic transaction requirements are reviewed regularly.

Summary

Detailed planning and involvement of all stakeholders will ensure a smoother transition in outsourcing and clearer expectations among the parties. The CFO and/or the Director of Patient Financial Services should perform a vendor site visit to gain confidence in vendor quality and performance. The visit, coupled with identified workflow, procedures and output should ensure a smooth

TO REBILL OR NOT TO REBILL" LET US ASK THE QUESTION!

David Cavell, CHFP, Director Business Office
Chelsea Community Hospital

CEO, CFO, Patient Accounting Directors, Compliance Officers or consultants, before you initiate a rebilling project please ask yourself these questions:

- First did we correct our current processes, fix the errors so that future services are properly coded and billed? Is the root cause of the problem identified also occurring in other areas of the hospital?
- What is the true cost of this rebilling project? Consider labor and time involved in returning the payment, billing and posting the account again? Also include the opportunity cost lost, because the personnel working on the project who are not working on current bills but reworking paid claims. Consider establishing your own "yardstick" by accurately identifying actual reimbursements against costs both actual and opportunity costs.
- Are we sending a clear message to the payor? Are we saying we are not sure what we are doing? After all, we identified that we incorrectly billed, maybe we have opened the door for an audit.
- On the positive side have we fixed a problem that could have given us an administrative heart break during a future audit? Are our efforts to rebill and recode claims fulfilling our values of accuracy and proper claims processing?
- What about secondary balances? Consider the patient's perspective, they receive and pay a balance bill. When we rebill the claim does it impact them? They could owe more or may be due a refund?
- Are we sure we are going to improve our payments by the dollars projected? Consultants can over-estimate how much a hospital will receive on a rebilling project.
- Once paid on a claim, rebilling does not ensure it will be paid again.

Most of these opportunities come from consultants who identify that we could have done it differently, coded it differently, missed a key procedure. It could also come from recognition of a clinical areas breakdown in charge processing.

Maybe the best way to approach the issue is to simplify and ask two questions: Is it the right thing to do and will the real return exceed our true costs?

I have asked two respected consultants for their perspective of this issue. Nancy and Jim have a variety of experience in different roles in the healthcare environment.

Jim De Francisco (574) 255-4675 or
mailto:james.j.defrancisco@gte.net

There are several issues to consider that are all vitally important.

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The first is obviously compliance and this has at least two aspects. First, if the original billing violated a compliance standard then corrective action must be taken and this could necessitate rebilling. Second, be very careful in doing anything that could take you out of compliance by delegating a rebilling project to a team (internal or external) that pushes the envelope or takes you out of compliance.

The next issue is from the standpoint of productivity and return on investment. It is essential to determine thresholds based on charge dollar value at net reimbursement levels. This would indicate a methodology that prioritizes high dollar items. Billing time is often more valuable than actual its actual cost so if you are spending valuable time chasing small dollars that do not produce a ROE worth at least 3x the investment you are probably making a poor business decision.

Be careful that you don't take staff time away from more important functions to support the rebilling project. Robbing Peter to pay Paul is never a good practice.

Next is the importance of long term correction of the root problem(s). It would be much better to sharpen the pencil than to increase the length of the eraser. Fixing the problem for current and future claims processing is much more critical than rebilling the lost revenue of the past. Look for patterns relative to incorrect or delayed data inputs, charge inputs, codes, etc. and fix them asap.

Finally, the message that you are sending to payers (primary and secondary) as well as patients is a critical factor. You risk losing much credibility if you do extensive rebilling. The cost is in delayed claims processing (insurance companies decide to hold your claims until they receive your "final" bill) and increased audits. My approach to the question of to rebill or not to rebill would be based on all the above factors.

Nancy Allcroft
(248) 324-3710; allcroft@allcroftgroup.com

If there is access to additional human resources, we would confine rebilling to large dollar amounts where legitimate improvements in reimbursement reside. The incremental benefit should outweigh the cost of the project, and the cost should include all expenses for rebilling the primary, secondary and patient. The cost of rebilling primary and secondary should include the risk of federal compliance or other audits. The cost of rebilling patients should include the risk of poor impact on community relations.

In an either/ or decision and with static human resources, it is a far better investment for a hospital to correct the problem on a going-forward basis and improve cash flow long-term. This approach yields a net present value of annuity returns, outweighing a short term improvement in cash flow.

Above all, review current procedures and improve future results:

- Review causes for inaccurate coding or late charges impacting reimbursement. Implement internal controls to decrease these risks in the future. This might include regular (unannounced) audits and daily department checks of procedures performed against charge entry detail.
- If the order entry system is separate from the billing system, where the orders are electronically linked to the billing system, review the programming and ensure that all orders entered "point" to the correct charges in the billing system.
- Conduct ongoing training in reimbursement related matters where department activities impact reimbursement results. Get everyone involved in revenue management.

CEO, CFO, Patient Accounting Director, Compliance Officer and consultants before you go forward with a new reprocessing project please consider all the of above issues and opportunities.

HAVE A SAFE AND HAPPY THANKSGIVING

Calendar of Events– HFMA

NOVEMBER 2002

11-19 Member Meeting (Providence Medical Bldg. 8th floor; 8:30AM)

11-21 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

11-22 Financial Analysis/Decision Support (BCN Building; 8:30AM)

11-26 Physician Practice Committee Meeting (CSB, Warren Rm S-101; 9AM)

DECEMBER 2002

12-2 Healthcents Submission deadline

12-6 Revenue Cycle Committee Meeting (Beaumont Business Center; 2:30PM)

JANUARY 2003

1-6 Healthcents Submission deadline

1-16 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

1-22 Member Meeting (Providence Medical Bldg. 8th floor; 8:30AM)

1-23 Financial Analysis/Decision Support (BCN Building; 8:30AM)

1-28 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

FEBRUARY 2003

TBD Annual Bowling Night

1-3 Healthcents Submission deadline

2-20 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

2-25 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

2-27 Financial Analysis/Decision Support (BCN Building; 8:30AM)

MARCH 2003

3-7 Healthcents Submission Deadline

3-20 Member Meeting - Annual Ins. & Reimb. Update (DoubleTree, Novi; 8:30AM)

3-20 Membership Committee Meeting (following I & R Update- Double Tree)

3-25 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

3-26 Managed Care Committee Meeting (CSB, Warren Rm S-101; 8:30AM)

3-27 Financial Analysis/Decision Support (BCN Building; 8:30AM)

APRIL 2003

4-7 Healthcents Newsletter Submission

4-17 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

4-22 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

4-24 Financial Analysis/Decision Support (BCN Building; 8:30AM)

MAY 2003

5-2 Healthcents Newsletter Submission

5-15 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

5-15 Managed Care Committee Meeting (CSB, Warren Rm S-101; 8:30AM)

5-22 Financial Analysis/Decision Support (BCN Building; 8:30AM)

5-22 Membership Committee Meeting (prior to Member Meeting at Fairlane Club)

5-22 Member Meeting - (The Fairlane Club, Dearborn; 5PM)

5-27 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

JUNE 2003

6-12 Annual Golf Outing – Shenandoah Country Club

6-19 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

6-24 Physician Practice Committee Meeting (CSB, Warren Rm S-101; 9AM)

6-26 Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

Dates subject to change if necessary.

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FY 2002-2003

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