HEALTHcents

Eastern Michigan Chapter

hfma: it's personal

January 2004

Volume 1,Issue 16

MEMBER MEETING ANNOUNCEMENT

The Revenue Cycle Committee Presents:

Effective Benchmarking Techniques and Strategies presented by
Phil Gaughan, Vice President, Solucient, LLC

Thursday, January 22, 2004

Providence Professional Building

7:30—8:30	Board Meeting
8:00—8:30	Registration/Continental Breakfast
8:30—9:00	Member Meeting
9:00—10:30	Presentation by Phil Gaughan

Member-Get-A-Member

Keep recruiting those new members. The Member-Get-A-Member recruiting incentives continue through April 30, 2004, and include HFMA apparel items, gift certificates, and a chance to receive $2,500 cash.

Recruit... and Win...
~ 1 or 2 new members - Your choice of an HFMA apparel item (worth approximately $25)

~ 3 or 4 new members - $100 gift certificate redeemable at hundreds of brand-name merchants plus an entry for each member you recruit into a $1,000 cash prize drawing

~ 5 or more new members - $150 gift certificate redeemable at hundreds of brand-name merchants plus an entry for each member you recruit into a $2,500 cash prize drawing

NEW!! For every member recruited from June 1, 2003 through April 30, 2004, receive one entry into the drawing for our new ULTIMATE REWARD -- a $5,000 travel gift certificate from Tower Travel!

Visit www.hfma.org/members/strength for full details.

The Eastern Michigan Chapter is also offering a free golf outing registration to the member who recruits the most new members for our chapter this year. Visit the website www.hfma.org/join or call 800-252-hfma, ext. 2 for more information.

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Teaching Hospital Alert: Major Amendment To Medicare Medical Education Payments For Interns and Residents Rotating To Nonprovider Settings

Kenneth R. Marcus

With the widespread publicity surrounding enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, many hospitals may have overlooked the significant amendment to the Medicare Graduate Medical Education ("GME") payment and Indirect Medical Education ("IME") adjustment. ***At risk is a substantial number of full time equivalent ("FTE") interns and residents, equating to forfeiture of substantial Medicare payment, regarding rotations to "nonprovider" settings. In the event and to the extent that Medicaid and third party payors follow the Medicare program, even further reductions in payment could occur. Compliance implications also may arise.***

In the August 1, 2003 *Federal Register*, the Centers for Medicare and Medicaid Services ("CMS") amended the GME and IME regulations and engaged in protracted discussion regarding the appropriate interpretation and application of these regulations. The specific concern of CMS is that providers are inappropriately receiving Medicare payment relating to rotation of interns and residents to nonprovider settings, such as physician offices. ***CMS also has expressed particular concerns relating to arrangements between hospitals and dental schools regarding dental residents.***

Specifically, and in short, the following issues are arising as cost reports for the 1999 fiscal year and later are audited:

1. Single Hospital Arrangement Per Teaching Program. CMS has stated that a single hospital must bear all or substantially all of the costs of a nonprovider teaching program. CMS has stated as follows:

   "A hospital cannot count any FTE residents if it incurs all or substantially all of the costs for only a portion of the FTE residents in that program setting." ***A representative of the Intermediary has stated that the understanding of the Intermediary is that if two or more hospitals rotate interns and residents to the same nonprovider teaching program, none of the hospitals may count the FTE's.***

2. Written Agreement. A hospital is required to have in place a "written agreement" with the nonprovider evidencing that the hospital bears all or substantially all of the costs relating to the training program. This requirement has been in effect for cost reporting periods and discharges occurring on or after January 1, 1999. ***Many hospitals have ignored or given short shrift to this requirement.*** To further complicate matters, the Intermediary and to some extent CMS has been inconsistent as to whether a written agreement may be signed retroactively. Where the written agreement is in place, the Intermediary has found fault with the format. While there may be little remedial action that may be taken, a hospital can avoid further disallowances by assuring that the proper format is adopted, executed and maintained on file for audit. Moreover, steps can be taken to identify, preserve and pursue legitimate appeal opportunities in the event FTE's are disallowed due to defects in or absence of a written agreement.

3. Supervising Physician Costs. In what a number of observers see as a reversal in prior guidance, CMS is now stating that in most instances the supervising physician incurs a cost. Accordingly, CMS takes the position that the hospital must reimburse the supervising physician for such costs, and that the arrangement should be stated in the written agreement.

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Healthcents Newsletter :

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Please send all comments/questions/articles to me at the above e-mail address. See calendar for submission deadlines. Thank you for your continued support!

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

WELCOME NEW MEMBERS

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James Parr	KPMG
James Riffle	Prism Healthcare Resources LLC

WHEN MAY A PHYSICIAN BILL FOR OVERSEEING CARE?

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As a general rule, Medicare will pay a professional fee only if the billing physician examines the patient in person or visualizes some aspect of the patient's condition without the intervention of a third party's judgment. Care Plan Oversight (CPO) is one of the few exceptions to the requirement for direct contact between the physician and patient. CPO consists of physician supervision of patients who are under the care of a home health agency or hospice and who require complex or multi-disciplinary care including regular physician involvement in the care plan, review of patient developments, and/or review of diagnostic test results.

A physician must satisfy a significant number of requirements in order to qualify for Medicare payment for CPO. These requirements are often misunderstood, as evidenced by the fact that when the Office of Inspector General (OIG) recently audited a sample of CPO claims, the OIG determined that 100% should not have been paid – mostly due to lack of required documentation.

The OIG's study found widespread compliance with the following requirements for coverage of CPO:

- CPO was provided while the beneficiary was receiving covered home health or hospice services.
- The physician who furnished CPO also signed the home health or hospice plan of care.
- The physician provided a covered face-to-face service to the beneficiary within the six months before the first CPO service.
- The physician did not have a prohibited financial relationship with the home health agency or hospice.
- The physician did not bill Medicare for an end stage renal disease capitation payment for the same beneficiary for the same month in which CPO was furnished.

The OIG found physicians frequently **failed** to comply, however, with the following Medicare coverage requirements:

- The physician failed to document in the patient's record the CPO services furnished, including the date and **length of time** associated with each service.
- Many physicians incorrectly believed that they were entitled to bill CPO simply for signing the home health or hospice plan of care.

In addition to the coverage requirements discussed in the recent OIG audit, Medicare also requires the following:

- CPO must be performed **personally** by the billing physician; services "incident to" a physician's service do not qualify as CPO.
- Only one unit of CPO may be billed each calendar month and a total of at least 30 minutes of CPO per month is required in order to bill a unit.
- The following **do not** count toward the 30 minute minimum: consultation with the physician's own office personnel; discussion with a patient or patient's representative regarding adjustment of treatment or medication; low intensity services included in another E & M service; work covered by the E & M codes for discharge of the patient from the hospital or from observation; routine post-op care performed during a global surgical period; travel time; and most conversations with pharmacists.

The OIG's recent activity can be expected to focus carrier attention on physician compliance with the requirements for billing CPO, especially for those physicians who bill the codes more frequently than the norm.

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4. Community Support/Redistribution of Costs. CMS has now stated that even if the "written agreement" and related requirements are satisfied, the Intermediary must disallow the FTE's if the Intermediary determines that there has been "community support" or a "redistribution of costs." While these concepts are somewhat complex, the bottom line is that the Intermediary is required to determine whether, as of January 1, 1999, any provider has incurred all or substantially all of the costs relating to the nonprovider teaching setting. If the Intermediary determines that no provider has incurred all or substantially all of the costs relating to the nonprovider teaching setting, the Intermediary will conclude that there has been community support and/or a redistribution of costs. In that event the Intermediary will disallow the FTE's. While there is a "grandfather" provision protecting for up to three years interns and residents who commenced
their training prior to October 1, 2003, hospitals nonetheless should review their arrangements to assure compliance upon expiration of the grandfather period.

Experience over the past four years demonstrates that, in general, hospitals may not have been as attentive to these requirements as was necessary. ***Some hospitals that believed they had satisfied the "written agreement" requirement have had a "rude awakening" following the audit.*** To compound the problem, and as summarized above CMS has amended the regulations, thus further exposing hospitals to the dual risk of reductions in payment for medical education activities and/or compliance issues. The good news is that there is still an opportunity

- To take remedial action;
- To identify, protect and pursue appeal rights; and
- To take preventive actions to avoid future disallowances.

When it is considered that for GME one FTE could equate to as much as $100,000, clearly significant payment may be at risk. Hospitals and their representatives would be well advised to devote proper attention to this issue.

CHAPTER CHAMPIONS
SPONSORSHIP PROGRAM
2003 – 2004

Eastern Michigan Chapter

Last year, the corporate sponsorship committee developed a variety of levels that allows advertising your firm or product though our website, newsletter or educational programs. Building upon the Chapter Champion sponsorship program, we again offer this opportunity. You could be a SUPERSTAR, a WINNER, a PLAYER or a SPONSOR for the Website, an Educational Program or Newsletter.

Contact Shelley Lake (248) 544-2300 at slake@voyager.net or Deborah Sieradzki at (586) 292-6446 at sieradeb@yahoo.com for more information.

January Special - Two ¼ page Newsletter Advertisements (with a link to your website) for only $400.

Call or e-mail as space is limited.

PHYSICIAN CORNER
Dave and Marianne

Physicians (whether employed in institutional based groups or in private practice) are struggling with the idea that they must manage their practices like a business, requiring skills they have not aggressively developed. Most of the angst we have observed from both clients and attendees at our education seminars center on the areas addressed below -- all of which can contribute to decreased cash flow. Over the next several articles, we will address how to develop improved financial management techniques -- but in order to measure improvement, it is necessary to establish performance measures.

The Patient Revenue Cycle.

In analyzing problems associated with cash flow, it is important to look at all aspects of the patient process -- that is from the moment the patient schedules an appointment until the resolution of the claim for that service. Each step in the process involves controls, performance measures or management actions that need to be implemented as appropriate. Our primary focus in this series will be directed to issues associated with Charge Capture, Claim Processing, Payment Posting and A/R Management that may negatively impact Cash Flow and increase risk exposure. The following table highlights several critical performance measures. How do you compare?

Description	Target
A/R Greater than 90 Days	20 – 25 %
Medicare Greater than 90 days	< 5 %
Bad Debt	1 – 3 %
Clean Claim Rate	95 %
Fatal Edits	< 1 %
Post Submission Rejections	< 8 %
All Charges entered within 48 hours	> 90 %
Return Mail	< 1/2 %
Over the Counter Collections	>80 %
Payment Posting Accuracy	100 %

Charge Capture

Lack of effective management controls over the charge capture process can lead to as much as a 5 to 10 percent lost charge rate. There are rather straight forward steps that can be instituted to ensure that charges for all services provided are correctly rendered to a third party insurer or patient. This generally does not require extremely sophisticated or complex processes to be put in place.

Claims Development and Processing

The goal of every practice should be to achieve at a minimum a 95% "clean claims" rate. Many practice management systems have little or insufficient front-end/ pre-submission edits. For those that do, it is very difficult to monitor and trend the type of error without improvising by downloading information and utilizing external databases and/or spreadsheets to monitor performance and identify and quantify problem areas

Payment Posting

Payment messages are often misleading. General statements that the practice has agreed to accept the insurers usual and customary reimbursement with little regard as to whether the practice participates with that insurer has created the "intimidation" factor typically conveyed by third party insurers in the "tone" of their remittance advice. As a result, valid balances may be uncollected. We find as much as a 6% payment posting error.

Accounts Receivable Management

Depending on the specialty, the amount of daily charges unpaid at any time should not exceed 60 days and the percentage of unpaid accounts with balances from the service date over 90 days should not exceed 15 - 20 %. Increased intensity of claim adjudication can translate to approximately two days of a provider's effort each month may be denied by third party payers.

Compliance and Management Controls

The risk associated with transactions required to process services should also be addressed. Most large groups and institutional providers expend considerable effort on compliance as it relates to coding and documentation, but there is little emphasis on what risk may occur as a result of processing a claim, posting a payment or following up on an outstanding balance. If accomplished, this effort can lead to cash flow improvement.

There are several suggestions noted above as to standards for measuring performance in the claims process. This speaks to the critical need to establish a more comprehensive approach to management of the claims process and managerial reporting.

Please forward comments, ideas or questions to Maryanne VanHaitsma at HealthCents or directly to Marianne or Dave Speicher at 810:231-7771 or e-mail to saihcc@htdconnect.com. We look forward to your involvement.

Eastern Michigan Chapter 2003-2004 Calendar

JANUARY

1-14-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
1-19-04	Healthcents material submission deadline
1-22-04	Member Meeting (Providence Hospital; 8AM)
1-22-04	Membership Committee Meeting (following member meeting)
1-27-04	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)
1-28-04	FADS Committee Meeting (St. John, 28000 Dequindre; 8:30AM)

FEBRUARY

2-04-04	Managed Care Committee Meeting (St. John, 28000 Dequindre; 8:30AM)
2-11-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
2-19-04	I & R Committee Meeting (Robbins Executive Park West, Troy; 8:30AM)
2-23-04	Healthcents material submission deadline
2-25-04	FADS Committee Meeting (St. John, 28000 Dequindre; 8:30AM)

MARCH

3-10-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
3-18-04	Member Meeting - Insurance and Reimbursement Annual Update (Holiday Inn Livonia West; 8AM)
3-18-03	Membership Committee Meeting (following member meeting)
3-22-04	Healthcents material submission deadline
3-23-04	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)
3-24-04	FADS Committee Meeting (St. John, 28000 Dequindre; 8:30AM)

APRIL

4-07-04	Managed Care Committee Meeting (St. John, 28000 Dequindre; 8:30AM)
4-07-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
4-15-04	I & R Committee Meeting (Robbins Executive Park West, Troy; 8:30AM)
4-19-04	Healthcents material submission deadline
4-21-04	FADS Committee Meeting (St. John, 28000 Dequindre; 8:30AM)

MAY

5-12-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
5-20-04	I & R Committee Meeting (Robbins Executive Park West, Troy; 8:30AM)
5-20-04	Member Meeting (Detroit Athletic Club - Evening Meeting) Membership Committee Meeting (Prior to member meeting)
5-24-04	Healthcents material submission deadline
5-25-04	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)

JUNE

6-9-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
6-10-04	Annual Golf Outing – Tanglewood Golf Course – South Lyon

MARK YOUR CALENDARS!

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2003-2004

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