

## Presidents Message

by Don Schott



It's "A Whole New World." The tragedy of September 11 has impacted all Americans. We certainly grieve for the families that lost loved ones in the terrorist attacks and our prayers and thoughts especially go out to them during this holiday season.

This impact on America was witnessed directly by our program chairs of the North Dakota Chapter's Fall Conference in Grand Forks in early November. A national speaker was scheduled to kickoff a full day's educational conference on account receivables. However, a day prior to the event, the program chairs, Jim Novak, Jerry Peeler and Nancy Schultz, were notified that the national speaker would not be making the trip from out East. Earlier in the week, Governor Tom Ridge, Homeland Security Director, issued a terrorist alert that stated "...based on credible information, another

terrorist attack is possible for the latter part of the week and Americans should be on high alert." This threat of potential terrorism thwarted any ambitions that our national speaker had for flying from Boston to Grand Forks and resulted in the cancellation of her program. The Chapter certainly recognizes the predicament the speaker was in and favors no animosity toward her. However, the cancellation left the program chairs in quite a dilemma. With less than 24 hours before the conference was slated to start, they put together a full day's program. With the help from Eide Bailly, LLP and several other Chapter members, they put on a program that, I feel, was second to none. I would like to thank them and all the "last minute" speakers for their excellent, informative presentations and their willingness to help out the Chapter.

The fall meeting is also the time of the year that we recognize four chapter members for the HFMA accomplishments they have earned during the year. Under the guidance of Phil Schmid, the North Dakota Chapter earned three national awards which were presented to Phil at ANI in San Antonio, Texas, last June. The chapter applauded Phil at an awards breakfast on his accomplishments and recognized him for his leadership in the award winning multi-chapter conference held in Rapid City, South Dakota, in the summer of 2000, and also for retaining a high percentage of certified members. Steve Isle was also recognized for his leadership as program chair last year and for earning the Charles F. Mehler Gold Award for Excellence in Education. On a local level, 23 members received length of service awards recognizing them on one of their "5" year increment anniversaries. In all, 235 years of membership service were recognized. Last, but certainly not least, Bonnie Kuehnemund was presented with the Outstanding Member Award. A well deserved appreciation for her many years of service on the board, leadership on the history committee, and her much appreciated photography talent. In addition to those specifically honored, a heartfelt thanks to all of our members who are giving of their time and talents to help make this Chapter a success.

In that realm, I am pleased to announce that the North Dakota chapter has been selected as one of five Chapters nationally to participate in a pilot program to implement a Chapter website. This site is intended to provide our membership a seamless system of service to both national and local Chapter activities and information. The goal is to have these Chapter websites operational by January 31, 2002. If all bodes well, the next newsletter may be available on-line.

I hope to see all of you in Bismarck in February at our educational conference and installation banquet. I wish all of you a Happy New Year!

Don Schott, FHFMA  
2001-2002 President

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**Welcome New Members**

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**Attention Members**

*Bring a prospective member to our February Meeting and you will be entered for a chance to win a*

***Palm Pilot***

*sponsored by  
 Specialized Management.*

*Prospective Members will attend this Meeting for free and the Chapter will pick up their lunch.*

**News From National**

HFMA wants you to know - November 21, 2001 A service of the Healthcare Financial Management Association

Use site visits to ensure billing compliance for outside vendors

Patient Financial Services (PFS) professionals today are outsourcing more and more revenue-cycle processes to improve efficiency and outcomes, and reduce operational expenses. When billing and related processes are outsourced, however, particularly for Medicare and Medicare claims, providers could expose themselves to billing compliance violations.

Providers are obligated to ensure that all claims they submit for services provided to beneficiaries of Federal healthcare programs are in compliance with Federal regulations, whether they submit the claims themselves or have an outside vendor submit the claims for them. Providers that outsource billing and related functions may be at greater risk of violations of laws and regulations because they cannot entirely control the compliance process of the vendor. When seeking to outsource billing and other revenue-cycle functions, therefore, PFS professionals should carefully evaluate each potential outsource partner to determine its level of commitment to compliance and identify mechanisms it has implemented to prevent violations from occurring.

The vendor's degree of compliance with the OIG's guidelines largely can be determined through a site visit that includes structured interviews with the organization's leadership and discussions with employees. During the site visit, the provider's PFS representative should seek to determine whether the vendor has, a minimum:

- A designated compliance officer who is appropriately qualified authority, and active;
- A designated compliance committee, composed of individuals who are appropriately qualified, empowered, and active;
- A documented compliance plan and a statement of business ethics that have been approved by the organization's board of directors, owner, or other authority;
- Documented general and technical compliance education plans for all new and existing employees;
- Appropriate performance assessment instruments that are used routinely to evaluate employee competence relative to general and technical compliance issues;
- Documented protocols that are used for routine auditing, monitoring, and sampling of all compliance processes;
- An appropriate process for investigating and resolving potential compliance issues or violations; and
- A documented self-disclosure plan.

The PFS professional also should seek to determine whether employees have free access to the organization's compliance officer and essential information, including regulations, fraud alerts, and other compliance-related publications. The vendor's employees also should have access to a hot line for reporting potential compliance violations. Moreover, there should be evidence that the vendor publishes the hot line and encourages employees to use it. Finally, the PFS professional should review the vendor's employee performance and disciplinary plan to see whether compliance is an essential element in the plan.

*Source: Handling the Compliance Challenges of Outsourced PFS Functions, by Bobete M. Gustafson, published in Healthcare Financial Management, October 2000.*

**Effective Supply Chain Management is a Three-Dimensional Challenge**

To date, the healthcare industry has made little progress in capturing the estimated \$11 billion in process cost-savings opportunities identified in 1996 by a bellwether report "Efficient Healthcare Consumer Response" (EHCR). According to staff responsible for major independent delivery networks, the primary issue is that healthcare institutions have done a reasonable job in implementing systems that address individual segments of the supply chain, but they are lacking the technology and perspective to implement solutions that target the entire supply chain.

Further automating individual processes that are already automated is not going to significantly improve the supply chain. The gains will come from providing solutions that link disparate segments of the supply chain allowing for a global view. All partners in the supply chain must be able to see activity throughout the chain to improve their own decision making. This end-to-end view of how each activity, process, and decision affects all other activities, processes, and decisions is essential to drawing costs out of the supply chain and improving performance.

## The three Dimensions of the Supply Chain

A three-dimensional view of the supply chain shows how the supply chain operates, and can help identify cost-reduction opportunities through implementing well-reasoned Internet commerce strategies. These dimension are:

### 1. Organizations that Comprise the Supply Chain

When the EHCR was published in 1996, the document proposed three elements to the healthcare supply chain - production, distribution, and consumption. While this is the classic view of how a supply chain operates, it aggregates some important organizations and decision makers in the supply chain. These elements should be disaggregated to understand each organization's listing information requirements. These organizations are patient/clinical provider; integrated delivery networks (IDN) or provider administration, distributor; manufacturer; group purchasing organization (GPO), and E-commerce provider.

### 2. Process Tasks that Drive Supply Chain Activities

Twelve fundamental tasks exist in the cycle of the supply chain. Each of these tasks has its own information needs and requirements to optimize the supply chain. In addition, each must provide information to others in the supply chain. The tasks are selection, requisition, order; manufacture, transport, receive, inventory, distribute, consume, pay (product provider), charge (consumer), and report (finance/analysis).

### 3. Information flows

Almost all key process challenges relate to the collection, processing and flow of information from one process to another; from one system to another; and from one organization to another. Optimizing these information flows provides the fuel that is required to make good decisions about supplies and the supply chain.

There are multiple participants at almost every stage of the supply chain process. At a minimum, 18 primary information flows are the minimum required to place, receive, pay for, and use a product in today's healthcare supply chain. Twenty-eight supplementary information flows are additional flows required to provide each organization with the information to optimize decision making and reduce costs.

Source: *Resource Management Update: Healthcare Supply Chain. For the complete white paper, go to [http://test.hfma.org/resource/focus\\_areas/supplychain.pdf](http://test.hfma.org/resource/focus_areas/supplychain.pdf)*

## HFMA partnership examines supply chain management

Cost management is a top issue for financial executives in the current environment of decreased reimbursement and increased costs. HFMA has joined forces with McKesson Information Solutions to focus on supply chain management as an opportunity for healthcare organizations to control costs. As a first step in this process, HFMA and McKesson have developed a white paper detailing the supply chain and identifying key opportunities for improvements.


Join HFMA! Go to <http://test.hfma.org/membership.joinhfma.cfm>

To subscribe, unsubscribe, or change your e-mail address, send an e-mail to mail to: [lnoble@hfma.org](mailto:lnoble@hfma.org)

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## Employee Evaluation Form

### Grade your employees on the following"

- 
- Punctuality:** Does h/she show up to work
    - On time
    - Early
    - Late
    - Occasionally
  - Appearance:** Does he/she show up wearing
    - Appropriate Professional Clothes
    - Bathrobe
      - Cotton-ankle length
      - Something out of Victoria's Secret
        - If Employee is Male - mark x in box
        - Employee is Female - Polonoid will be requested
      - Curlyers in hair or needing a shave (Applies to both sexes)
      - Wearing clothes they wore to the nightclub last evening
  - Customer Care:** Does he/she
    - Address patients by Sir or Ma'm
    - Call the patients by the first name
    - Call the patients by last name
    - Call the patients by the illness, malady or STD they have
  - Respect:** does he/she address the physician(s) by
    - Referring to them as "Doctor"
    - Refer to them by Dr. (last name)
    - Refer to them by Dr. (first name)
    - Refer to them as "Bones, Hotlips or Sweetcheeks"
  - Telephone Habit:** Does he/she answer the phone by
    - Practice name, their named and May I help you?"
    - Practice name, their name and "Hold"
    - "Doctors Office"
    - "Please state your illness, annual income and method of payment"
  - Employee Relations:** How does employee get along with colleagues?
    - Friendly but professional
    - Rude and sarcastic (should be transferred to gov't job)
    - Quiet and withdrawn
    - Has had 13 sexual discrimination/harassment suits brought against them (should apply as candidate for President of the US)
  - Job Performance**
    - Excellent performer
    - Adequate but lack initiative
    - Trys but fails to achieve adequacy
    - Should have Lip Balm as company benefit due to level of butt kissing.
  - Coding Knowledge**
    - Is certified by AAPC, AHIMA or PAMCOM
    - Know how to recognize JD-9 book from ten feet away.
    - Believes CPT means Cannot Potty Train
    - Believes E&M means enemas, handcuffs and leather sexual practices.
  - Insurance Claim Knowledge**
    - Proficient on Insurance Claims format and appeals process
    - Proficient on typing HCFA 1500 claim forms on paper only
    - Can recognize a HCFA 1500 claim form only if printing is red
    - Hands police officer Managed Care card when pulled over to receive ticket

Don't forget to visit Don's clean jokes on the web at: <http://www.donself.com/jokes.html>  
Don Self & Associates, Inc.

## Ongoing Legal Wrangling

It is all about the Health Insurance Portability and Accountability Act of 1996 (HIPA) ... and the battle is on.

The Department of Health and Human services (DHHS) filed a motion to dismiss a suit filed in Houston by the Association of American Physicians and Surgeons, Inc. and Congressman Ron Paul (R-Surfside) which attempts to overturn the privacy regulations included in HIPAA. This suit alleged that the privacy regulations are unconstitutional because they would interfere with doctor-patient relations, potentially allow the government access to patient medical records without a warrant, and intrude on states' rights regarding personal medical records.

The DHHS has parried the suit with a 56 page motion to dismiss that includes the argument that since the regulations have not begun and will not begin to take effect for over a year, the plaintiff's suit should not be legally reviewed. This time, between now and the effective date, still allows DHHS to issue additional guidance.

HIPAA regulations include a "privacy" regulation side which was designed to protect patients' privacy and ensure that medical records are not misused. Patients would be able to inspect, copy and amend their records, and healthcare providers would have to have the patients consent prior to disclosing certain medical information. Congressman Paul, a physician, contends that the regulations will, in fact, allow the government and certain private interests a federal right to access medical records without consent.

*This suit follows a similar lawsuit filed by the South Carolina Medical Association. [resource: Austin American-Statement; AP]*

## Compliance officers forum news a benefit of compliance officers forum membership

*To read this newsletter in its entirety, go to [http://www.hfma.org/members/compforum/2001\\_12.html](http://www.hfma.org/members/compforum/2001_12.html)*

### Final Rule Changes Ambulance Restocking Safe Harbor

The HHS Office of Inspector General (OIG) has published the final rule on safe harbor protections for ambulance restocking. Under specific conditions, the safe harbor enables receiving facilities to replenish ambulances for drugs or medical supplies, including linens, used in the transport of a patient. Comments on the May 22, 2000, proposed rule yielded significant changes. The IG outlines specific requirements for participating in the safe harbor, including billing and documenting appropriately, no links to referrals, and compliance with all other applicable laws.

### CMS Delays Definition of "Set-In-Advance" Compensation under Stark II

CMS has changed the effective date for a key definition of the final Stark II regulations - "set-in-advance" compensation - from January 4, 2002, to January 6, 2003. CM determined that the one-year delay was necessary to allow further consideration of the current definition as it relates to compensation arrangements that are based on a percentage of a fluctuating measure, such as collections or billed amounts. Such arrangements would not be permissible under the current definition.

*To read the entire Compliance Officers Forum article, go to [http://www.hfma.org/members/compforum/2001\\_12.html#stark](http://www.hfma.org/members/compforum/2001_12.html#stark)*

### Medicare paid \$91 Million for claims with incorrect UPIN information

A recent OIG inspection reveals that in 1999, Medicare paid \$91 million for medical equipment and supply claims with invalid or inactive unique physician identification numbers (UPINs). Of that total, \$32 million was paid for medical equipment and supply claims involving 14,000 different invalid UPINs, 106 of which had more than \$50,000 in allowed charges associated with them. The \$59 million paid for medical claims with inactive UPINs involved 28,000 inactive numbers.

*To read the entire compliance Officers Forum article, go to [http://www.hfma.org/members/compforum//2001\\_12.html#UPIN](http://www.hfma.org/members/compforum//2001_12.html#UPIN)*

### OIG Releases Advisory Opinions 19-21

The OIG has issued three new advisory opinions, including a rare disapproval. In Advisory Opinion 01-19, the OIG green-lighted an arrangement in which a hospital donates office space to a charitable organization that provides nonfinancial support to terminally ill patients. In Advisory Opinion 01-20, the OIG determined that an arrangement in which a hospice-through which Medicaid funds flow-furnishes extra payments to nursing facilities could trigger sanctions because such payments would qualify as prohibited remuneration under the antikickback statute. In Advisory Opinion 01-21, the OIG issued a favorable opinion on a hospital's investment in a physician-owned ASC.

*To read the entire Compliance Officers Forum article, go to [http://www.hfma.org/members/compforum/2001\\_12.html#OIG](http://www.hfma.org/members/compforum/2001_12.html#OIG)*

### Medicare Exclusion Database Replaces Publication 69

CMS published a program memorandums (PM) alerting intermediaries and carriers that the Medicare Exclusion Database (MED) will replace Publication 69, the monthly Medicare and Medicaid report that contains information on all provider exclusions and reinstatement actions in Medicare, Medicaid, and other federal healthcare programs. The

*continued on page 5*

MED contains a standard format cumulative exclusion database and is designed to communicate with other CMS databases like NSC, OSCAR, and the UPIN file.

To read the entire compliance Offices Forum Article, go to [http://www.hfma.org/members/compforum/2001\\_12.html#MED](http://www.hfma.org/members/compforum/2001_12.html#MED)

## OIG Semiannual Report Takes Stock of FY01

The OIG released its first semiannual report under the leadership of new Inspector General Janet Rehnquest. The OIG boasts FY01 "taxpayer savings" of more than \$18 billion. This includes \$16.1 billion in implemented recommendations and other reactions "to put funds to better use." The bulk of the remaining savings came from settlements with HCA and Quorum. During FY01, there were also a record 3,756 individuals and entities excluded from participating in the federal healthcare programs.

To read the entire Compliance Offices forum article, go to [http://www.hfma.org/members/compforum.2001\\_12.html#semi](http://www.hfma.org/members/compforum.2001_12.html#semi)

## HFMA News

2002 HFMA CFO Exchange to Focus on Leadership: CFO Exchange participants will discuss practical leadership and strategic planning skills that will inspire success in their organizations. The conference will feature a special pre-conference workshop spotlighting a strategic approach to employee retention. Thomas Scully, Esq., Administrator for the Centers for Medicare and Medicaid Services, has been invited to present the keynote address. Other annual session topics include a Washington update, Compliance and HIPAA Driving Results through Service Excellence, and Boosting the Bottom Line: Unconventional Approaches, Proven Results. Go to <http://www.hfma.org/cfo> for more information.

HFMA and MCKesson Address Cost -Savings: HFMA has joined forces with MCKesson Information solutions to explore ways that healthcare organizations can realize cost savings through increased productivity and efficiency of supply processes, and labor, facility and equipment utilization. By focusing on resource management through this joint effort, the two organizations can help the industry more readily identify inefficiencies and suggest practical ways to papers beginning with a white paper detailing the supply chain and identifying the key areas that allow for substantial cost savings, process and quality improvements. This white paper will be published in the January 2002 issue of HFMA's magazine, HFM. After distributing the white paper, HFMA will conduct a supply chain management survey. HFMA will then release a follow-up report based upon the findings at HFMA's CFO Exchange, held March 3-5, 2002, in Palm Harbor, FL.

## Upcoming Audio teleconferences

January 9: Current Legal and Regulatory Issues for Financial Executives , <http://www.hfma.org/visitors/audiotel.atc10902.htm>

January 16: The Impossible Dream: Managing Nursing Salary Costs, <http://www.hfma.org/visitors/audiotel.atc11602.htm>

January 23: Reducing Costs While Improving Results in the Revenue Cycle, <http://www.hfma.org/visitors/audiotel.atc12302.htm>

January 30: The Ongoing Integrity of the Care Master: Getting It Right and Keeping it Right, <http://www.hfma.org/visitors.audiotel.atc13002.htm>

Registering for HFMA audioteleconferences is fast and easy. Call the HFMA Member Service Center at (800) 252-4362 or go to <http://www.hfma.org/visitors/audiotel/index.htm>



## Fight Demands for old Claims

Judith Wittmier, Vice President - Practice Management Consultant  
Specialized Management

One of the more recent issues in recent months has been insurance companies demanding refunds for claims that are years old. If you simply pay these without question you are perhaps reducing your bottom line unnecessarily. Watch those revenues and fight back on these demands.

Several practices have reported receiving recoupment requests on claims that are 2-4 years old. The letters ask for refunds because audits show the claim should have been denied or that the claim had been overpaid. Quite often they are from insurers with whom you do not have contracts.

The first thought of most practices is that they have done something in error and in this day and age that can be frightening. Frightening enough to simply pay without question.

The first thing you must do is search those old files and retrieve the original payment information. Often you will find the letters themselves are in error. Most importantly before you proceed be sure you haven't done anything wrong. Once you have done that then tackle the issues one at a time. (1) Your charges were above "standard claims payment policies." If you don't have a contract with that particular insurer the answer is: We believe no refunds are due. Dr. XXX is a non contracted with that particular insurer the answer is: We believe no refunds are due. Dr. XXX is a non contracted provider for your insured and as such we are not contractually bound to abide by your payment policies. If your physician is a contracted provider, check your contract to be sure they are requesting appropriate refunds. (2) the second issue is often that the claim was not coded correctly, if you believe you have indeed correctly coded the claim the answer is: "In reviewing the information sent to us we find that we billed procedure codes that were included and defined in the applicable year's AMA CPT4 manual. The codes billed described the treatment and services that were provided to your insured.

Many of the insurers don't bother to reply to the refusal to pay letters and very often just doing them prevents more from being sent to you.

Be sure however to maintain (as I am sure you all do) appropriate records so that you can legally refute these requests. You should have documentation to prove your statements. It is also suggested that if you are receiving many such requests you contact your legal department or lawyer for sound legal advice in dealing with such situations.

# **2001-2002 HFMA MEETINGS**

**February 7-8, 2002**

Reimbursement and Critical Access  
Bismarck

**April 4-5, 2002**

Concordia/HFMA Institute  
Fargo

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