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# HFMA Today

Official Newsletter of the North Dakota Chapter of the  
Healthcare Financial Management Association

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healthcare financial management association

Volume 6, Issue 3 April 2003

## Presidents Message

by Steve Ilse



President's Message

Thank you for the support each member has given to our Board and the efforts they put forth to make this an exciting and beneficial year for all members of our organization.

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As I think about it I guess I feel very lucky to have been a part of our growth in membership, highly successful programs and implementation of new ideas that resulted in financial growth for the chapter.

We have had many fine programs. We started out the year with the Eide Bailly LLP Symposium in Fargo; Then the Medora joint meeting with ND, SD, WY, and MT; and then The Accounts Receivable Program in Grand Forks; Also The Reimbursement session in Bismarck; and the Concordia Institute in Fargo. As President, these innovative sessions are exactly what I wanted to see happen.

Let's not forget also the fine efforts and accomplishments in two specific areas. Membership was a principal concern as the 2002/2003 year began to take shape. We had lost 16 members and all Board members shared this concern in regards to the continued growth of our chapter. Mike Schumacher answered the challenge and we are now in line to win the "Awards of Excellent for Membership Growth and Retention. Can you imagine losing 16 members and gaining 20 new members? Great job Mike and let me not forget your committee. This is the stuff a year is made of.

How about our upcoming President? He revamped the design of our Sponsorship Program with the aid of his committee, a process, which allows for sponsors to be well recognized while supporting our chapter. Thank you to those sponsors, Eide Bailly LLP, Blue Cross Blue Shield of ND; JC Christensen and Associates; our Platinum Members. AR Audit Services; Brady, Martz & Associates, PC; Collection Center, Inc., our Gold Members. Allied Interstate, Inc and Vaaler Insurance, our Silver Sponsors.

So what can a retiring President of HFMA say? Wow, it was my pleasure to learn from the best and work for the best. Good Luck Doug and may you be able to savor the memories that I will have when I leave this office. Truly, a year to cherish and remember throughout my career.

Steve "ELWAY" Ilse

## Welcome New Members!

### David B. Manning

Clinic Manager Prairie Oral Surgery  
1815 S University Dr Fargo, ND 58103-4941  
Work Phone: (701) 478-4404  
Fax: (701) 478-4407  
Email: davidm@prairieoralsurgery.com  
Join Date: 2/20/03

### Karin Dulski

Director PFS Innovis Health  
3000 32nd Ave, South Fargo, ND 58103  
Join Date: 3/13/03

### Tina M. Steckler

Account Executive  
1518 5th Avenue W. Williston, ND 58801  
Work Phone: (701) 774-2078  
Email: steckler@dia.net  
Join Date: 6/1/03  
Sponsor Name: Kerry S. Monson

### Mark Leier

Chief Financial Officer  
4920 15th Ave SW #204 Fargo, ND 58103  
Work Phone: (701) 793-1705  
Join Date: 3/27/03

### Karen Sanders

Director, Pts. Accounts  
627 Sims Dickinson, ND 58601 Work Phone:  
(701) 456-4512  
Fax: (701) 456-4800  
Email: sanderskd@prodigy.net  
Join Date: 4/2/03



## IMPROPER FEE-FOR-SERVICE PAYMENTS TOTAL \$13 BILLION IN FY02

An OIG investigation revealed that improper Medicare payments made during FY02 totaled \$13.3 billion, or about 6.3 percent of the \$212.7 billion in processed fee-for-service payments reported by CMS. Although this dollar amount is higher than the \$12.1 billion estimated for FY01, the error rate remains at the all-time lowest level achieved last year. The OIG asserts that while CMS has vigilantly monitored the error rate and developed appropriate corrective action plans, medically unnecessary services and undocumented services continue to be pervasive problems. The FY02 Medicare fee-for-service error rate will be the last one published by the OIG.

To read the report, "Improper Fiscal Year 2002 Medicare Fee-For-Service Payments", go to <http://www.oig.hhs.gov/oas/reports/cms/170202202.pdf>

## HEALTH SERVICES FIELD CONTINUED TO ADD JOBS IN JANUARY

Health services employment rose by 18,000 in January 2003, close to the average monthly growth for the healthcare industry in 2002, according to the monthly employment numbers released by the Bureau of Labor Statistics on February 7.

On a seasonally adjusted basis, hospital employment grew by 8,000 jobs in January, or .20 percent, to a total of 4.3 million jobs. Physician offices lost 3,000 jobs, or .10 percent, for a total of 2.1 million jobs. Nursing and personal care facilities added 2,000 jobs in January, an increase of .10 percent, for a total of 1.9 million jobs. Home health agencies added 4,000 jobs, an increase of .60 percent, for a total of 660,000 jobs.

For more employment statistics from the BLS, go to <http://www.bls.gov/bls/employment.htm>

## HFMA partners with CCH to help hospitals increase Medicare reimbursement

Hospitals across the country are in financial straits and struggling to stay solvent in the face of declining Medicare and Medicaid reimbursement. Because more than 70 percent of hospital income is derived from Medicare and Medicaid payments on average, hospitals depend on these programs for their very survival. But Medicare and Medicaid regulations are complex, and it's easy for hospitals to make mistakes in reporting—mistakes that can exclude them from program participation. *Medicare and Medicaid AnswersNow™*, a new Internet service from information solutions provider CCH Inc. and HFMA, can help hospitals minimize their risk of misreporting charges and realize the full reimbursement for services they provide.

*Medicare and Medicaid AnswersNow™* provides concise and accurate answers to more than 1,300 hospital reimbursement questions, with more questions and answers added every week. Reimbursement managers and their staffs, hospital administrators, CFOs, coding and billing managers, and Medicare specialists can all benefit from this online questions-and-answers-based product developed by the Medicare and Medicaid law analysts at CCH.

In addition to the continually updated, plain-English questions and an-

swers, Medicare and Medicaid AnswersNow™ also offers the following valuable tools and resources:

- APC calculator to help predict reimbursement for outpatient services;
- DRG calculator to help predict reimbursement for inpatient services;
- Sample forms;
- Extensive glossary for easy reference;
- Broad search functionality; and
- Links to select full text of federal regulations, CMS manuals, and more.

"Medicare and Medicaid AnswersNow™ will be a very useful service for hospital financial personnel, and HFMA is pleased to support it and make it available to our mem-

bers," said HFMA President and CEO Richard L. Clarke, FHFMA. "Hospitals are under a lot of financial pressure right now and we believe this product will help them attain more of the reimbursement dollars to which they are entitled."

For more information or to order Medicare and Medicaid AnswersNow™, call (800) 449-9525 or visit the CCH online store at [health.cch.com/onlinestore](http://health.cch.com/onlinestore). A singleuser one-year subscription to Medicare and Medicaid AnswersNow™ is \$899; additional site licenses are \$175 per site. Special pricing is also available for Medicare and Medicaid AnswersNow™ when it is purchased together with the CCH Medicare and Medicaid Guide and other hospital reimbursement-related products.

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**Cal Ripken, Jr. - ANI keynote in Baltimore**

On June 22-26, in Baltimore, Maryland, three exciting and empowering keynote speakers will grace the stage at HFMA's 2003 Annual National Institute (ANI). Each speaker will lend his hard-earned knowledge during one of three general sessions Monday through Wednesday. On Monday, future Hall of Fame shortstop and retired Baltimore Orioles third baseman Cal Ripken, Jr., will describe the lessons he learned from his father about the importance of patience, perseverance, commitment, practice, respect for others, and teamwork —lessons that helped him spend 21 successful years in the major leagues and set standards for achievement that will never be surpassed. These essential principles helped Cal create an unbreakable foundation for his career and will provide attendees with the ability to create their own unstoppable future. Tuesday's keynote address will be presented by Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission. As a key player on this 17-member panel that advises Congress on Medicare policy issues, Glenn will give audience members an inside perspective into Medicare by discussing the present-day healthcare economic environment, healthcare policy issues of the current administration and Congress, and how these policy changes could affect the ever-changing world of Medicare. Quint Studer, a National HFMA Board member and founder of the Studer Group, will deliver the final keynote

address on Wednesday. Drawing upon his 19 years in health care, including periods serving as president of Baptist Hospital, Inc. and COO of Holy Cross Hospital, Quint has created tools and techniques to help organizations achieve superior operating results. Quint also has been instrumental in demonstrating that patient, employee, and physician satisfaction create bottom-line results. Participants will learn how this level of excellence can reduce employee turnover, rejected claims, and agency costs, as well as increase clinical outcomes, volume, and the bottom line. For the latest updates, full program information, and to register, visit [www.hfma.org/ani](http://www.hfma.org/ani) or call (800) 252-HFMA (4362), ext. 2.

### North Dakota Workers Compensation Clarification

Below is the administrative rule on ER services. There seems to have been some confusion in the area of CT scans and MRIs done in the ER.

92-01-02-33. Utilization review and quality assurance.

The bureau has instituted a program of utilization review and quality assurance to monitor and control the use of health care services. Prior authorization for services must be obtained from the bureau or its managed care vendor at least twenty-four hours or the next business day in advance of providing certain medical treatment, equipment, or supplies. Medical services requiring prior authorization or preservice review are outlined in section 92-01-02-34. Emergency medical services may be provided without prior authorization, but notification is required within twenty-four hours of, or by the end of the next business day following, initiation of emergency treatment. Reimbursement may be withheld, or recovery of prior payments made, if utilization review does not confirm the medical necessity of emergency medical services.

Documentation of the need for and efficacy of continued medical care by the medical service provider is required at the direction or request of the bureau or the managed care vendor while a claim is open.

The bureau may require second opinion consultations prior to the authorization of reimbursement for surgery and for conservative care which extends past sixty days following the initial visit.

Questions to this or other Workers Compensation rules - please contact Peg Haug at [phaug@wcb.state.nd.uw](mailto:phaug@wcb.state.nd.uw)

### HFMA BRINGS PROVIDERS AND PAYERSTOGETHER TO IMPROVE CLAIMS PROCESSES

HFMA and the American Association of Health Plans (AAHP) will host another innovative opportunity for providers and health plans to gain a mutual understanding of claims processes and administrative systems through open dialogue and communication. "Managed Care and Claims Processing: Improving Communications Between Health Plans and Providers," to be held in Philadelphia on May 5, 2003, provides a candid look at the health plans' processes related to claims payment. Health plan faculty will share with providers their benefit determination, medical policy, and claims administration processes to help groups organize a system to maximize the prompt payment of claims. In turn, provider faculty will share their claims processes and office procedures with health plans, allowing them to gain a better understanding of the provider's perspective.

For more information and to register, go to [www.hfma.org/education/seminar\\_spring/mcare\\_aahp.htm](http://www.hfma.org/education/seminar_spring/mcare_aahp.htm)

### CORRECTION NOTICE ISSUED FORTCS MODIFICATIONS

A notice containing some significant corrections to the final rule on modifications to transactions and code sets was published in the March 10, 2003, Federal Register. As noted in the February 28 HFMA Express News, the rule published in the Federal Register on February 20 was not the final version but an earlier draft. A single corrected version of the rule will not be published; instead, when the next Code of Federal Regulations is published, targeted for the end of 2003, it will contain the corrected version. The notice can be read at [http://www.access.gpo.gov/su\\_docs/fedreg/a030310c.html](http://www.access.gpo.gov/su_docs/fedreg/a030310c.html) scroll to Health and Human Services Department

The correct version of the rule is available at the CMS web site at <http://www.cms.hhs.gov/regulations/hipaa/cms0003-5/0003ofr2-10.pdf>

### CMS CLARIFIES BILLING ED SURGERIES, BLOOD PRODUCTS

A recent PM (A-03-014) published by CMS warned hospitals against billing a single emergency department (ED) visit charge, if the visit includes charges for surgical procedures that were performed in the ED at the time of the ED visit. Hospitals should bill for the ED visit and a separate charge should be billed for any surgical procedure performed. The PM also provides a summary of Inpatient Part B services paid under OPPS and under other payment methods.

continued from page 4

For a hospital that runs its own blood bank, or purchases blood products, it is inappropriate to bill for the blood and blood products and an additional charge for storage and processing, CMS clarified in the PM. However, when the hospital incurs administrative costs from a community blood bank for the bank's processing and storage fees, the hospital can bill these costs in Revenue Code 390 and report the HCPCS code assigned to the blood products and the number of units transfused. A related issue is Medicare's payment for transfusing blood. Medicare will pay the hospital a transfusion ambulatory payment classification for transfusing blood once per day, regardless of the number of units transfused.

To read the PM, go to [http://www.cms.hhs.gov/manuals/pm\\_trans/A03014.pdf](http://www.cms.hhs.gov/manuals/pm_trans/A03014.pdf)

**PHYSICIAN OFFICE QUALITY OF CARE MEASURED BY CMS**

CMS recently began pilot-testing its quality measures for health care provided in physician offices. The Doctor's Office Quality project will focus primarily on chronic-

disease management and preventive services related to the treatment of diabetes, heart failure, coronary artery disease, hypertension, osteoarthritis, and major depressive disorders.

The three-year demonstration is overseen by quality improvement organizations (QIOs) and will involve 300 physicians in California, Iowa, and New York. The physicians will work with the QIOs to gauge their performance on a list of about 20 measures identified by CMS. In addition, participating practices could get CME credits, lower liability premiums, or public recognition. To read about the project, go to <http://cms.hhs.gov/facappac/amastmt.pdf>

**BCBSA REPORTS HOW PREMIUM DOLLARS ARE SPENT**

The growth in health plan administrative costs contributed only modestly to the increase in premium costs from 1998 to 2002, according to a report by Milliman USA that was commissioned by the Blue Cross and Blue Shield Association (BCBSA). Milliman found that while premiums for commercial business increased by an average of 7.4 percent annually, administrative costs grew at only an average rate of 4.6 percent annually. The report shows that in 2001, an average of 85.7 percent of commercial premiums for all health plans went to pay medical claims with 11.6 percent going to administrative costs and 2.7 percent going to profits. Performance of Blue Cross and Blue Shield plans was close to those averages, with an average of 86.5 percent of commercial premiums going to medical claims, 11 percent going to administrative costs, and 2.5 percent going to profits. To read the report, go to <http://news.bcbs.com/relatives/20445.pdf>

**MEDICARE INSOLVENCY TO COME EARLIER THAN REPORTED LAST YEAR**

The Medicare Hospital Insurance Trust Fund (Part A) will dry up four years earlier than predicted last year, according to the March 17 report of the Medicare trustees. The report predicts insolvency by 2026 due to higher-than-expected spending, lower-than-expected revenue, and the aging population.

The outlook for the Supplementary Medical Insurance Trust Fund covering Part B of Medicare is better, and is "adequately financed into the future" the trustees say. However, spending is rising rapidly, which means beneficiaries' Part B premiums will get adjusted automatically as costs go up. The Part B premium is expected to nearly double over the next 20 years.

The reports are available at <http://www.cms.hhs.gov/publications/trusteesreport/>

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## FDA PROPOSES BAR CODE TECHNOLOGY ON DRUG LABELS

Certain human drug product labels and biological product labels will be required to have bar codes, according to a new rule proposed by the Food and Drug Administration (FDA). According to the FDA, this technology would reduce medication errors in health facilities. The proposed rule, published in the March 14, 2003, Federal Register, applies to all prescription drug products, including biological products, vaccines (except for physician samples), and other over-the-counter drugs (OTC) that are frequently used in hospitals. Standardized bar codes would also be required on prescription drug products used in other settings such as retail pharmacies. The bar code would contain the National Drug Code number, which serves as unique identifying information about the drug.

In a related story, the FDA announced a proposed second rule aimed at improving the reporting of safety problems involving medicines. Under the rule, pharmaceutical companies would be required to submit to the FDA, within 15 calendar days, all reports they receive of actual and potential medication errors occurring in the country. To read the proposed rules, go to [http://www.access.gpo.gov/su\\_docs/fedreg/a030314c.html](http://www.access.gpo.gov/su_docs/fedreg/a030314c.html)

## CMS PREDICTS MEDICARE PHYSICIAN PAYMENT RATES WILL DROP IN 2004

Medicare payment rates to physicians will decline by an estimated 4.2 percent in 2004, CMS predicts in a March 20, 2003, letter to MedPAC. According to CMS, from 2004 to 2007 physician fee schedule rates will decrease as the current payment formula compensates going forward for increased spending in 2002 for physician services and lower gross domestic product per capita for both 2002 and 2003.

The Consolidated Appropriations Resolution (CAR) of 2003 allowed CMS to revise the FY98 and FY99 sustainable growth rates (SGR), which resulted in a 1.6 percent update to the physician fee schedule rates starting March 1, 2003. According to CMS, the revision will also result in higher updates for years beginning 2004 than would have occurred had the CAR not been enacted. CMS did caution, however, that the estimates are preliminary and will likely change by November 2003, when the update for 2004 is promulgated.

For more information on the physician payment formula and the change estimates go to <http://www.cms.hhs.gov/physicians/mpfsapp/step0.asp>

## MEDICARE PAYMENT CHANGES IMPLEMENTED

In late March, CMS told fiscal intermediaries to implement payment changes for rural health clinics (RHCs), federally qualified health centers (FQHCs), rural hospitals, and hospitals in "other than large" urban areas. According to Program Memorandum (PM) A-03-021, the Medicare upper payment limits for services rendered January 1, 2003, through February 28, 2003, are:

\* \$66.46 for RHCs \* \$103.18 for urban FQHCs \* \$88.71 for rural FQHCs

For services rendered March 1, 2003 through December 31, 2003, the upper payment limit per-visit increases to:

\* \$66.72 for RHCs \* \$103.58 for urban FQHCs \* \$89.06 for rural FQHCs

The PM also clarified that separate payments are made under Part B to RHCs and FQHCs for diabetes-self management training services and medical nutrition therapy services. However, RHCs and FQHCs can become certified providers of these services and bundle those costs into their facility payment rates.

## MEDICARE REVISED STANDARDIZED AMOUNTS, CAPITAL RATES ANNOUNCED

New FY03 operating standardized amounts for inpatient prospective payment system hospitals (PPS) in other than large urban areas were published in program memorandum (PM) A-03-023, effective April 1, 2003. The changes raise the amounts to the level of large urban areas, as required by the FY03 budget resolution passed in February. The standardized amounts for large urban areas are revised slightly because of the recalculation of the budget neutrality factors.

Along with the new standardized amounts, the PM also announces the new PPS capital rates. The new rates, which are effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, are:

\* National urban/rural areas labor-related amount: \$3,022.31 \* National urban/rural areas nonlabor-related amount: \$1,228.48 \* National capital rate: \$406.93

To read these PMs, issued March 28, go to [http://cms.hhs.gov/manuals/pm\\_trans/A03021.pdf](http://cms.hhs.gov/manuals/pm_trans/A03021.pdf) and [http://cms.hhs.gov/manuals/pm\\_trans/A03023.pdf](http://cms.hhs.gov/manuals/pm_trans/A03023.pdf)



# Concordia Institute Memories

*The Hunter Group's Larry Scanlan presents about key success factors at Concordia Institute.*



*Natinal HFMA President Dick Clark presents at the Concordia Institute*



*Steve Ilse passes the gavel to Doug Okland at the last board meeting for FY2003*

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# **2003 HFMA Meetings**

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The North Dakota Chapter would like to thank the following sponsors for their donations. These donations are used to assist us in providing high quality educational programs for our members at a reasonable cost. During the year, each sponsor is recognized in a variety of ways, including program announcements, sponsorship boards at meeting activities, chapter newsletters, social events and in the membership directory.

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