HFMA Today

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

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Presidents Message

by Doug Okland

I would like to start the year by thanking Steve for leaving the chapter in great shape! The North Dakota Chapter again brought home more than its share of chapter awards for the last year. We won the C. Henry Hottum gold award for educational performance improvement, the gold award of excellence for education, the silver award of excellence for certification, the silver award of excellence for membership growth, the Yerger award for membership recruitment and the Yerger award for improvement for our tiered sponsorship program. Great work Steve and everyone else involved in the chapter!

HFMA: IT'S PERSONAL! This is the theme for the upcoming year, and I can't think of a better theme for HFMA. We have an excellent chapter that provides high quality education to our members along with numerous other benefits, but what I think of when I think of our chapter is the friendships that I have developed along the way. This has been the most rewarding aspect of active involvement in the chapter. Healthcare finance is a challenging and stressful profession, and having friends to contact for assistance or advice is invaluable. I have called others in the chapter for advice on many occasions, and I have been on the receiving end of those calls, also.

GET INVOLVED! I encourage all members of our chapter that are not currently active to get involved. The rewards of active participation far outweigh the time investment you will make. If you are not sure how to become more involved or what contribution you could make, call me. The chapter, while strong, always needs more involvement from its members. We have many committees and activities going on at all times, and together we can find the right level of involvement for you.

MAKE US BETTER! If there are ways we can improve the chapter to increase your involvement, let me know. We do an annual membership survey to look for feedback on how we can improve, but formal surveys are not always the best method to find ways to improve. I welcome personal feedback from any members if they have suggestions that the chapter could implement that would result in increased involvement. I may even ask you to assist in making the changes!

THANK YOU! While much of my message has been about trying to increase individual participation in the chapter, I also want to thank those of you that are already actively involved. Our chapter continues to have a strong memberhip base that is actively involved. The geographic dispersion of our members makes this even more impressive. I want to thank all the members of the board, the chapter officers and the committee members that will work to keep our chapter moving forward this year. Thank you for your work and your friendship!

LET'S HAVE A GREAT YEAR AND ENJOY WHAT HFMA AND OUR CHAPTER HAVE TO OFFER!

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Staff Accountant
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CMS ISSUES AMBULATORY SURGERY PAYMENT RATES FOR 2004

The ambulatory surgical center (ASC) payment rates and wage index will increase effective October 1, 2003, according to CMS Program Memorandum AB-03-0116, released August 8.

The new rates for facility services furnished on or after October 1, 2003, increased by the change in the consumer price index for all urban consumers (CPI-U) required by law, are:

Group 1 - $340

Group 2 - $455

Group 3 - $520

Group 4 - $643

Group 5 - $731

Group 6 - $840 ($690 + $150 for intraocular lenses [IOLs])

Group 7 - $1,015

Group 8 - $989 ($839 + $150 for IOLs)

Group 9 - $1,366

The PM also includes FY04 wage index values for calculating individual ASC payment amounts on or after October 1, 2003.

To make the changeover to the new rates for ASC services on and after October 1, 2003, contractors may hold claims until the rates and wage indices have been updated in their systems, or they may process claims using FY03 rates and wage indexes, and adjust them later.

CMS CORRECTS 2003 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

CMS has corrected inconsistencies in the 2003 Medicare Physician Fee Schedule Database (MPFSDB), which will both increase and decrease payments. Corrected data was provided to carriers and intermediaries on August 5, 2003, according to Program Memorandum AB-03-119. Providers paid under the MPFS should note that this instruction also tells contractors that they need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they should adjust claims brought to their attention.

Providers should receive 30 days notice before the revised payment amounts are implemented and should note that the effective dates for the various corrections go back as far as January 1, 2002. Intermediaries or carriers are to inform affected provider communities by posting the relevant portions of the instruction on their web sites by August 22. In addition, this information is to be published in their next regularly scheduled bulletin.

The implementation date for the PM is October 1, 2003.

PROPOSED MEDICARE PHYSICIAN FEES DROP 4.2 PERCENT IN 2004

Medicare physician fees would be cut by 4.2 percent under a proposed rule released August 8. The negative change is attributed to slow growth in the economy and to significant growth in physician outlays in 2002. Even with the reduction, CMS estimates that for calendar year 2004, Medicare will pay about $48.7 billion to 900,000 physicians and other suppliers for services paid under the fee schedule, up from a projected $47.9 billion in 2003.

“Physicians should note that while CMS is required to publish a proposed physician fee schedule rule at this time, both the House and Senate versions of Medicare legislation contain provisions that address the proposed fee schedule cuts,” said CMS administrator Tom Scully. The House Medicare prescription drug benefit bill Scully was referring to would make the update at least 1.5 percent in 2004 and 2005, while the Senate bill includes provisions to prevent anticipated cuts in 2004 and 2005. If the legislation becomes law after CMS issues the final physician fee schedule rule, the law will supersede the final rule.

CMS also announced plans to issue a separate proposed rule addressing practice expenses for the administration of drugs, along with changes in the payment methodology for the drugs.

The fee schedule proposed rule was published in the August 15 Federal Register. Comments on the proposals will be accepted until October 7.

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CMS EXPANDS AND IMPROVES MEDICARE WEB SITE TO ASSIST HEALTH CARE PRACTITIONERS AND PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) unveiled an expanded and improved CMS’ Web site, http://www.cms.hhs.gov/, to make it quicker and simpler for providers and health care practitioners to access valuable information that will help them better serve Medicare beneficiaries.

This information is aimed at allowing more effective use of the CMS Web site by focusing on the informational needs and interests of Medicare providers, including physicians and other practitioners. Most of the new Web pages are accessible from the Professionals tab at the top of http://www.cms.hhs.gov.

“We want doctors, hospitals and other health care providers to know that valuable, updated Medicare information is available to them at a single, easy-to-find Web site,” CMS Administrator Tom Scully said. “These Web pages also remain open to any beneficiary, family member or others who want to be more knowledgeable about specific areas of the Medicare program.”

Individual Web pages eventually will be prepared for all Medicare providers. Thus far, CMS has created pages for physicians, various types of hospitals including acute inpatient, outpatient, critical access, long-term care and inpatient rehabilitation facilities, home health agencies and ambulance service companies.

Following are the Web addresses for the new pages now available:

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·Ambulance services: http://www.cms.hhs.gov/suppliers/ambulance/

·Drugs: http://www.cms.hhs.gov/providers/drugs/

·Physicians: http://www.cms.hhs.gov/physicians/

·Hospitals: http://www.cms.hhs.gov/providers/hospital.asp.

·Acute inpatient: http://www.cms.hhs.gov/providers/hipps/

·Outpatient Prospective Payment System:

http://www.cms.hhs.gov/providers/hopps/

·Critical access hospitals:

http://www.cms.hhs.gov/medicaid/survey-cert/cah.asp.

·Long-term care hospitals:

http://www.cms.hhs.gov/providers/longterm/

·Inpatient rehabilitation facilities:

http://www.cms.hhs.gov/providers/irfpps/

·Home health agencies: http://www.cms.hhs.gov/providers/hha/.

Each of these pages contains links to information related to

specialized areas, such as federal regulations and notices, program memoranda, training

and educational activities, and frequently asked questions. They also have general information links that can be found on all new provider audience sites that relate to open door forums, Medicare conditions of participation, program integrity and other subjects that would be of interest to all audiences.

To keep informed of changes, providers can bookmark pages or sign up for the appropriate Listserv (http://www.cms.hhs.gov/medlearn/listserv.asp.) Other pages are currently under development for ambulatory surgical centers, durable medical equipment, federally qualified health centers, hospice, rural health and skilled nursing facilities.

CMS PROPOSES OUTPATIENT PAYMENT CHANGES

Medicare payments for outpatient services would increase by 3.8 percent in CY04 under the proposed outpatient PPS rule released by CMS on August 6. The proposed rule includes:

The conversion factor for 2004 of $54.289 is an increase from $52.151 in the November 2002 final rule. Increasing the conversion factor are the full market basket adjustment of 3.5 percent (required by current law), a wage index budget neutrality factor of 1.003, and 0.3 percent for the reduction in pass-through payments.

A proposed ambulatory payment classification (APC) structure would take into consideration the organ(s) being examined or treated, as well as the type and complexity of the procedure (including a comprehensive restructuring of new-technology APCs).

Criteria would change for packaging payment for drugs, biologicals, and radiopharmaceuticals.

Revisions and clarifications would be made to the methodology for calculating unadjusted copayment amounts.

As with the inpatient PPS rule published last week, a provision included in the Medicare prescription drug benefit legislation would bring a reduction from the market basket of 0.4 percent along with other changes, should the legislation become law.

CMS will consider comments if received by October 6, 2003. CMS posted the proposed rule on its web site and will publish the document in the August 12 Federal Register.

Yet to come are the physician fee schedule update for CY04 and the long-awaited proposal for a psychiatric services PPS. The proposed psychiatric PPS is still going through the clearance process and could be weeks away from appearing in the Federal Register. As a new payment system, it can be expected to take five months to implement after it is in final form.

FITCH: LIQUIDITY RATIOS DECLINED, CAPITAL NEEDS INCREASED IN 2002

Hospitals and health systems saw stable operating performance in 2002, but liquidity and debt-service-coverage ratios declined and capital needs increased, according to a Fitch Ratings report released this week.

The 2002 operating margin of 1.5 percent was the same as 2001, despite the excess margin ratio dropping by one-third, from 3 percent in 2001 to 2 percent in 2002. The operating margins held up, in large part, because of favorable results from revenue cycle initiatives, according to the report. The outlook is for a decline in operating profitability.

The report also found that the median debt-service-coverage ratio, 2.7, dropped to its lowest point since 1994, down from 3.0 in 2001. Also, the days-cash-on-hand ratio dropped to 133.2 days from 2001's 145.0 days, also at its lowest level since 1994.

HOSPITAL MORTGAGE INSURANCE PASSES SENATE COMMITTEE

On July 31, the Senate Committee on Banking, Housing, and Urban Affairs approved the Hospital Mortgage Insurance Act of 2003. The bill (HR 659) amends the National Housing Act to revise hospitals' need and feasibility standards for obtaining mortgage insurance. The Committee amended the bill approved by the House in March to allow critical-access hospitals to be eligible for the mortgage insurance program for three years.

HFMA is offering an audioteleconference (ATC) on this topic on August 27, 2003. To read additional information on the ATC goto http://www.hfma.org/education/atc/august27_2003.htm.

FUNDS AVAILABLE FOR RURAL HEALTH NETWORK GRANTS

The Health Resources and Services Administration (HRSA) has announced the availability of $1 million to fund the Rural Health Network Development Planning Grant Program during FY04. These grants will be awarded for a one-year period. Applications are due September 10, 2003.

For more information goto http://www.access.gpo.gov/su_docs/fedreg/a030731c.html.

OUTPATIENT PPS CAN UNDERMINE EFFECTIVE REVENUE CYCLE MANAGEMENT

The level of revenue losses due to unsuccessful outpatient prospective payment system (OPPS) revenue cycle management can be staggering. A new report by 3M Health Information Systems and HFMA outlines the challenges facing providers who wish to successfully integrate outpatient PPS into their revenue cycle.

Most hospital managers underestimate the magnitude of OPPS claims problems. A 2002 analysis by 3M Health Information Systems Consulting Services of 1 million pre-scrubbed OPPS claims from 80 hospitals had error rates ranging from 8 percent to 30 percent. Eighty percent of the hospitals reviewed had significant incidence of compliance or cash-flow problems. Major problems identified were:

Coding errors 56 percent

HCPCS errors: 86 percent of coding errors

The charge description master was the source of 79 percent of HCPCS errors

The health information management department was the source of 21 percent of HCPCS errors

ICD-9 errors: 14 percent of coding errors

Billing errors 27 percent

Charging errors 17 percent

The fact that losses can be spread out across so many bills and claims often makes it difficult for hospital executives to acknowledge the problem and commit the necessary resources to solve it. A hospital might readily write off a loss of less than $50, but such a loss could be occurring a thousand times a month. An accounts receivable manager could be working diligently to reduce the volume of suspended claims, often resolving the same issue day after day, without addressing the root cause of the claims' suspension. Many hospitals do not have the information processes in place to track these losses.

System Integration is Key

Financial managers may have difficulty identifying and resolving process problems when these problems originate outside the financial area. The amount the average hospital spends on

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reworking claims and managing denials averages $75-$125 per claim, not including the potential lost reimbursement for a denied claim.

Hospitals are working hard to integrate the systems they currently have, linking the electronic medical record, if they have deployed it, with claims and billing systems, admitting/discharge systems, medical eligibility and authorization systems, and finance/reporting/analysis systems. In many hospitals, however, some of these systems, especially eligibility and authorization, are still paper-based and fragmented.

Additional challenges include obtaining capital for information systems development and upgrades, determining return on investment for systems development, and finding satisfactory financial analysis software in the current information systems market.

Tips for OPPS Success

A number of hospitals have moved with some success toward managing the outpatient revenue cycle. Although there is no single, overarching solution in this key area, some practices that yield success are now emerging. For example: (1)

1. Appoint an APC or revenue cycle management coordinator to be responsible for the organization staying up to date on the frequent OPPS changes.

2. Appoint a manager to take charge of maintaining the CDM to reflect all OPPS changes.

3. Carefully review your organization's billing processes and take any necessary steps to ensure that errors are caught and fixed before claims are submitted.

4. Bill for late charges, using an adjusted claim submitted to the payer in a timely fashion.

5. Invest in information systems that perform editing, grouping, and payment-estimating functions specific to OPPS. The systems should include decision support tools that can analyze performance under OPPS.

6. Review remittance advices religiously to ascertain why items are rejected. Don't be afraid to call the fiscal intermediaries for clarification of denials.

Conclusion

Hospital finance leaders nationwide are working to address the myriad issues associated with outpatient revenue cycle manage-

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J.C. CHRISTENSEN
& ASSOCIATES

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ment. Successful managers will need to invest in developing people, resources, and process and system improvements. As more services move toward the outpatient sector and more revenues fall under the OPPS reimbursement system, the need to capture reimbursement and mitigate compliance exposure will become ever more pressing.

Footnote

(1) Fee, David N., "Success with APCs," Healthcare Financial Management, September 2002, pp. 68-72.

SOURCE : Issues in Outpatient PPS: Keys to Successful Revenue Cycle Management , a special educational supplement published with the July hfm. Developed collaboratively by HFMA and 3M Health Information Systems.

We Say Goodbye to a fellow FriendCal Paulson, 52, Died June 2nd, 2003

Cal Pualson was a past president of NDHFMA, a friend, and a wonderful man. He was instrumental in advancing the financing of health care services in North Dakota. He was fair and honest and his presence from the health care scene in ND will be greatly missed.

North Dakota Chapter Wins Big!

Steve Ilse receives 2003 Awards at HFMA's ANI Presidents Banquet

2003-2004 HFMA Meetings

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North Dakota Chapter
HFMA
Phil Schmid, Communication Chair
Eide Bailly, LLP
1050 East Interstate Ave.
P.O. Box 1914
Bismarck, ND 58502-1914
Phone: (701) 255-8472
Fax: (701) 255-8489
Email: pschmid@eidebailly.com

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