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THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

BDO KNOWS HEALTHCARE

CONTENTS

MAKE YOUR EMERGENCY DEPARTMENT A REIMBURSEMENT WINNER

By Herbert Bruss, RT(R), RCC, MA, Manager Data Quality and Compliance – The Rybar Group, Inc.

HEALTHCARE HAS ALWAYS BEEN IN A STATE OF FLUX. NOW, AS WE PREPARE FOR CHANGES UNDER NEW RULES FOR REIMBURSEMENT FOR MEDICAL CARE, ONE THING IS CERTAIN: THERE WILL BE CHALLENGES.

One of the ways a hospital Emergency Department can maintain financial viability and minimize losses is to provide to each patient and payor a bill that is understandable and reflects a true picture of what service was rendered and why. It should also be a product, that when scrutinized by an auditor or third-party reviewer, contains the proper documentation for the billed services provided. To engineer such a product isn't easy because there are so many different components to an emergency room visit.

Imagine that you have cut yourself in your kitchen. The cut is minor but you can't stop the bleeding. You don't stop to wonder,

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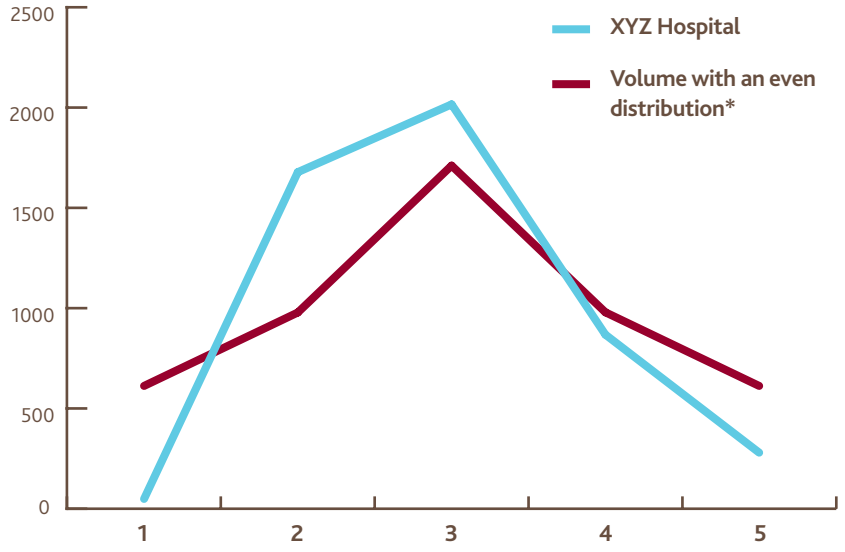
"Will Medicare pay for this?" or "Do I need to contact my insurance company?" All you know is that you probably need stitches to stop the flow of blood, so you go to the nearest emergency room.

The patient is not the only one hemorrhaging. The emergency room is having a hard time getting control over lost revenues. Hospitals are working very diligently to increase the accuracy of their revenue cycle and claim processes. Under-billing results in lost charges that are due to the hospital for the services rendered – charges that help guarantee the financial viability of the organization. Over-billing leads to compliance issues that won't stand up under an audit. So what can your department do to maintain your revenue and reduce liability? There are three parts to the answer: Anticipate, Act and Audit.



* refers to an even distribution or the bell-shaped curved advocated by groups like AHIMA who say that the Emergency Room's(ER's) level of service should be evenly distributed. The x = the five level of services provided in a typical ER and the y = the volume in this Emergency Room department. The curve is leaning to the left so there are perhaps some underpayments in this ER.

ANTICIPATE

First, anticipate the services you'll be rendering. Decide which services and supplies you will offer your patients when you create your ChargeMaster. One of the most overlooked components of this master list is the level of service line. Every Emergency Department is mandated to designate at least five levels of care. The lower levels are for minor issues. Level 1 might be for treating a cold. A Level 5, on the other hand, might be reserved for a patient with a possible heart attack. Whatever the issue, the department must take into consideration the time and resources needed to treat that patient, documenting so that the level of care matches the resources used. Therefore, it is important to anticipate what is required for each patient, then act.

ACT

Consistency is the number one action point. The staff must act consistently in reporting appropriate levels of service based on Health Information Management documentation. Unfortunately, the rushed nature of the Emergency Department makes documentation a challenge. Sometimes it must take a back seat to an urgent situation. In that case, develop a plan whereby supplies and services will not be overlooked. Despite the challenges, action must be taken to be consistent in documentation so that the final bill will be a true reflection of the level of service and resources used in treating that patient. Action on its processes must be followed by periodic audits. Automated coding and documentation systems continue to improve and provide for enhanced accuracy.

AUDIT

After the dust has cleared and the services have been rendered, it is very important and helpful to audit a sample of bills from all levels to verify that your total billing process is accurate for both the payors and the patient. Your internal audit must confirm that you did what you said on your claim form. An external audit is an excellent way for unbiased eyes to look at the process and see that you have anticipated the services, acted on the processes and double-checked the results with an audit. An audit can uncover many disturbing trends and inconsistencies in resource use and charges. An example of this is where a lower-level of emergency services was charged in a month when a higher level should have been charged because of the greater demand for supplies. Perhaps seasonal changes that brought more illness, weren't reflected in the level of services. Whatever the situation, consistent auditing can help to insure that hospitals charge and are reimbursed accurately for the services they provide.

Comparing the volume of services to a bell distribution curve is one way to make sure that charging and billing accuracy is increased. Consider the Emergency Department of XYZ Hospital which offered a high-end service to its patients but only charged for a lower level of service (the distribution of charges for the month as shown above).

When you compare XYZ Hospital's visits to an Emergency Department that has an even distribution of services and a bell-shaped curve, this particular hospital left $114,060 of revenue on the table in this year alone.

The bottom line is this: there are huge opportunities to stay afloat during the days of healthcare reform. What can you do to make your Emergency Department a winner? Start by following the AAA method of getting your department in order: Anticipate, Act and Audit your services so you can improve on your charge capture process and continue to provide the fine services at your facility and maintain financial viability.

The Rybar Group, Inc., established in 1989 in Fenton, Mich., is an independently owned and operated member of the BDO Seidman Alliance. The firm provides specialist reimbursement consulting and other services to the healthcare industry.

For more information, contact Claudine Hildreth, Director of Client Relations and Business Development – The Rybar Group, Inc., at childreth@therybargroup.com.

COMMUNITY HEALTH NEEDS ASSESSMENTS FOR 501(c)(3) HOSPITALS – ACTION REQUIRED NOW

By Laura Kalick JD, LLM in Tax

The Patient Protection and Affordable Care Act added sections 501(r) and 4959 to the Internal Revenue Code (IRC). Section 501(r) contained four requirements that 501(c)(3) hospitals must meet in order to maintain their exemptions. Three of the requirements are already in effect. The fourth requirement, the Community Health Needs Assessment (CHNA) has an effective date of taxable years beginning after March 23, 2012. This means that most hospitals will have from now until their tax year ends in 2013 to conduct a CHNA and adopt an implementation strategy. If there is noncompliance, not only will a hospital lose its 501(c)(3) status, but it will also incur a $50,000 penalty for any taxable year in which it is not in compliance with the CHNA requirement. If the hospital incurs such a penalty, it must report that fact on its Form 990.

▶CHNA EFFECTIVE DATE EXAMPLES:

- Hospital's year end is June 30. Hospital has until June 30, 2013, to complete the Community Health Needs Assessment.
- Hospital's year end is Dec. 31. Hospital has until Dec. 31, 2013, to complete the Community Health Needs Assessment.
- Hospital's year end is Jan. 31. Hospital has until Jan. 31, 2014, to complete the Community Health Needs Assessment.

The IRS has not yet issued regulations to implement the new law. However, last July, the IRS issued Notice 2011-52 (Notice) to provide hospitals that wanted to begin the CHNA process with some guidance upon which they could rely. The Notice also requested input from the public in the form of comments on some issues.

Currently the CHNA rules only apply to 501(c)(3) hospitals that are licensed as such. It is important to note that if a government hospital has obtained IRC 501(c)(3) status that these rules apply to them even if they have been excused from filing Form 990.

In short, a hospital will meet the CHNA requirements if at least every three years it has conducted a community health needs assessment and has adopted an implementation strategy to meet the needs identified. The CHNA must take into account input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of or expertise in public health, and the CHNA must be made widely available to the public.

▶DOCUMENTATION

What follows are the specific documentation requirements for the CHNA:

(1) A description of the community served by the hospital and how it was determined. In general the community will be defined geographically, but there could be another basis for the definition such as for a specialty hospital.

(2) The process and methods used to conduct the assessment, including sources, dates and analytical methods used to identify community health needs.

(3) How the CHNA takes into account input from those who represent the broad interests of the community, and individuals with special knowledge or expertise in public health who have current relevant data. Meetings held, focus groups, interviews, surveys, written correspondence, etc. should be documented.

(4) A prioritized list of all of the community health needs identified through the assessment and the process and criteria used for setting the priorities; and

(5) A description of the existing healthcare facilities and resources available to meet the health needs identified.

▶CURRENT DATA

The CHNA must be based on current data relevant to the health needs of the community. This information would be available from public health departments and other resources including databases that could be available from nonprofit and other organizations.

▶WIDELY AVAILABLE

The CHNA must be made widely available to the public. This can be done by posting the report on the hospital's website or providing a link with clear instructions as to how to access the report.

▶IMPLEMENTATION STRATEGY

The hospital must adopt an "implementation strategy" regarding each of the community health needs identified, and describe either how the hospital will meet the need or that the hospital does not intend to meet the need and why. The implementation strategy must be approved by an authorized governing body of the hospital by the end of the same taxable year in which the hospital conducts the CHNA.

▶CONCLUSION

Hospitals should begin the CHNA process as soon as possible in order to be able to be in compliance with the new requirement. Preliminary steps include putting together an inside team and identifying outside advisors who might be able to assist in gathering data, identifying programs, analyzing strategies and writing reports.

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REVENUE CYCLE... CASH FLOW ISSUES SINCE THE IMPLEMENTATION OF 5010

By Claudia Birkenshaw Garabelli, MSA, Revenue Cycle Services Manager – The Rybar Group, Inc.

REVENUE CYCLE MANAGEMENT IS UNDER CONSTANT PRESSURE WITH COMPETING PRIORITIES AND CHALLENGES TO BRING IN THE CASH. HOWEVER, IMPLEMENTATION OF THE NEW ELECTRONIC DATA STANDARD FORMAT OF 5010, WHICH WAS EFFECTIVE JAN. 1, 2012, HAS DRASTICALLY CURTAILED DAILY ACTIVITIES AND CASH FLOW.

The EDI standards are core processes that impact every aspect of the revenue cycle, from billing to payment to verification.

The new EDI platform, commonly referred to as 5010, was mandatory Jan. 1, 2012. Some payors throughout the country have been struggling to get their claims to the payors or to receive payments from certain payors. Nuances vary from state to state and it may depend on which clearinghouse you use, if you're sending a 4010 and your clearinghouse is rolling that to a 5010, if you're sending the 5010 but your clearinghouse converts it to a 5010, if your payor accepts the 5010, and more. Some payors are accepting the 5010 but are struggling making payments. Mistakes have been made due to little or no understanding of the standards nor of what actually changed. Due to lack of time, I have seen providers put implicit trust in their clearinghouse or other vendors and many of them have not invested the necessary time or resources.

▶MISTAKES BEING MADE DUE TO NO/LITTLE UNDERSTANDING OF STANDARDS

A core issue is a basic lack of understanding of electronic standards. Even if you believe you have resolved 5010 issues, this trend is continuing to grow and it's important that you understand the basics. Let's review the background.

Congress addressed the need for a consistent framework for electronic healthcare transactions and other administrative simplification issues through the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI of the Act, requiring the adoption of standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

In August 2000, the final rule was published in the Federal Register entitled "Health Insurance Reform: Standards for Electronic Transactions." This is commonly referred to as the Transactions and Code Sets final rule. That rule implemented some of the HIPAA Administrative Simplification requirements by adopting standards for electronic healthcare transactions developed by standard setting organizations (SSOs) and medical code sets to be used in those transactions.

▶WHAT EXACTLY WAS ADOPTED?

Standard Transactions were adopted so that when certain data was sent from a provider to a payor, it met "standards." When data is sent electronically, it's called Electronic Data Interchange (EDI) and it may also be referred

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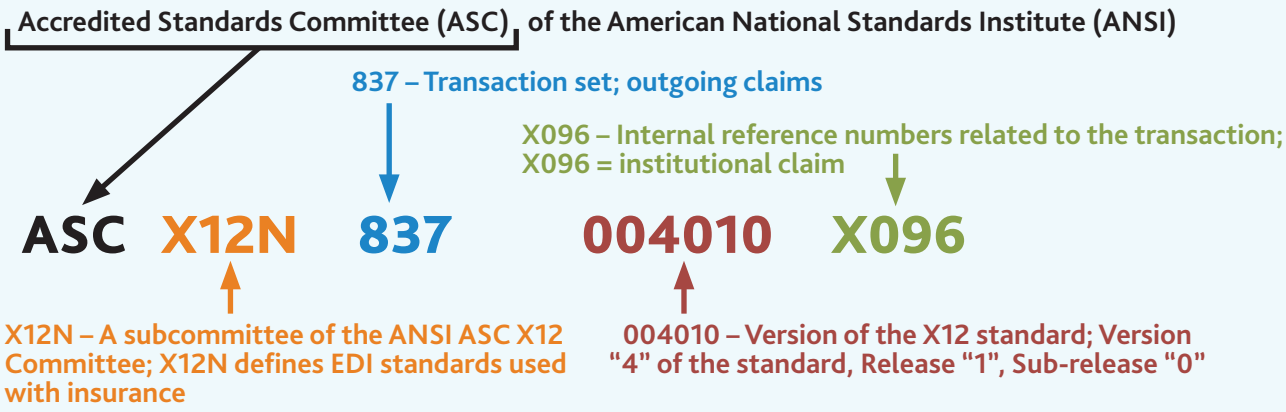
Table 1



to as Electronic Transaction Standards (ETS). The format used prior to Jan. 1, 2012, was the 004010A1.

HIPAA mandated that standard codes be used for diagnosis (ICD-9 and ICD-10 as of 10/1/2013), procedures (HCPCS, CPT, and ICD-9 procedure codes for inpatient claims), CDT (dental), and National Drug Codes (NDC) and codes to identify providers (National Provider Identifier, NPI).

The standards also affect how data is transmitted electronically, specifically:
- Claims and encounter information
- Payment and remittance advice
- Claims status
- Eligibility
- Enrollment and disenrollment
- Referrals and authorizations

When claims are sent electronically, it is referred to as the 837 standard. When payments are sent, it's referred to as the 835. See the EDI standards listed below and their various nuances:

EDI Standards – moved from the 004010 format to the 5010:

- 837 – Claims
  - 837 I – Institutional & 837 P - Professional
- 835 – Payment - Remittance Advice (RA)
- 270 & 271 – Eligibility Inquiry & Response
- 276 & 277 – Claim Status Inquiry & Response
- 278 – Prior authorization/referral

▶READING ABOUT THE TRANSACTIONS DOES NOT HAVE TO BE CONFUSING

When you read that a format is ASC X12N 837 004010 X096, what does that mean? This terminology is less confusing if you break it into its five segments, as defined in Table 1:

ASC – Source of a standard; this standard comes from the American National Standards Institute (ANSI) Accredited Standards Committee (ASC). You may also see this referred to as "ANSI ASC" or just "ASC." Both indicate the same source of a standard.

X12N – A subcommittee of the ANSI ASC X12 committee. The X12N subcommittee defines EDI standards used in the insurance industry which is what impacts healthcare providers, payors and clearinghouses.

837 – A transaction set. When the 837 transaction is listed, it may refer to specific standards for various types of claims: institutional, professional, and dental. The 837I refers to institutional claims used by hospitals, nursing homes, and others (the UB-04 claim form). The 837P refers to professional claims used by physicians and others (the 1500 claim form).

004010 – The version of the X12 standard. This is commonly referred to as "version 4010." It identifies version 4 of the standard, Release 1, sub release 0.

X096 – An internal reference number related to the transaction. In the case of the 837 transaction, three versions exist: institutional, dental and professional. The reference numbers X096, X097 and X098 identify these, respectively.

Institutional-X096 | Dental-X097
Professional-X098

If you are having problems or if things are running smoothly, I encourage you to work closely with your vendors and payors, and contact your state association as well as the National Uniform Billing Committee (NUBC) if you use the UB-04 claim form (facility claims) and the National Uniform Claim Committee (NUCC) if you use the 1500 claim form (professional claims). The standard code sets can be purchased from the Washington Publishing Company, and it is an investment that must be made.

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- Hospitals
- Integrated Delivery Systems
- International Health Research Organizations
- Long Term Care
- Physician Practices
- Preferred Provider Organizations (PPOs)
- Senior Housing, including CCRCs

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