SPRING 2013
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THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

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HOW HEALTHY IS YOUR HOSPITAL'S TAX EXEMPT STATUS?

By Laura Kalick, JD, LLM in Tax, BDO USA, LLP

How are you going to answer the questions on schedule H of Form 990? The IRS has issued two sets of proposed regulations to implement Internal Revenue Code (IRC) section 501(r), which sets forth certain requirements for a hospital to maintain its 501(c)(3) status.[1] The policies enumerated in IRC 501(r) must be adopted by an authorized body of the hospital and implemented, i.e., consistently carried out by the hospital in order to have the policies "established." In general, the proposed regulations apply to hospitals licensed by one of the 50 states and the District of Columbia, including government hospitals that have 501(c)(3) status. Also, a hospital that is operated through a disregarded entity such as a limited liability company is subject to the rules.

▶LESS THAN 100 PERCENT STRICT COMPLIANCE

The proposed regulations just issued on April 3, 2013,[2] provide guidance regarding the community health needs assessments (CHNA's)[3] and also the consequences of failing to satisfy the requirements of section 501(r). The April regulations are very welcome because before their issuance it was possible that inadvertent and minor noncompliance could have resulted in loss of 501(c)(3) status, with all the attendant consequences. Highlights of the April regulations as they relate to failures to satisfy the requirements of section 501(r) are as follows:

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Material discussed is meant to provide general information and should not be acted upon without first obtaining professional advice appropriately tailored to your individual circumstances.

To ensure compliance with Treasury Department regulations, we wish to inform you that any tax advice that may be contained in this communication (including any attachments) is not intended or written to be used, and cannot be used, for the purpose of (i) avoiding tax-related penalties under the Internal Revenue Code or applicable state or local tax or (ii) promoting, marketing or recommending to another party any tax-related matters addressed herein.

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HOSPITAL TAX EXEMPT STATUS

Omissions and errors

A hospital's omission of required information described in the 501(r) regulations will not be considered a failure to meet a requirement of section 501(r) if the omission or error was minor, inadvertent and due to reasonable cause and the hospital facility corrects such omission or error as promptly after discovery as is reasonable given the nature of the omission or error. Omissions or errors that rise above the level of minor and inadvertent, but are not willful or egregious, can be excused if corrected and disclosed in accordance with future IRS guidance.

Facts and circumstances

The IRS should consider all the facts and circumstances in determining whether to revoke 501(c)(3) status including: the relative size, scope, nature and significance of any failures to meet the section 501(r) requirements, as well as the reasons for such failures and whether the same type of failures have previously occurred, and whether there has been prompt correction and safeguards implemented to prevent future failures. However it is expected that if the organization's failures to meet the requirements of section 501(r) are willful or egregious, such factors will ordinarily result in revocation of the 501(c)(3) status of a hospital organization.

Taxation of noncompliant hospital facilities

A noncompliant hospital will be subject to tax. In applying the tax, the income derived from a noncompliant hospital facility during a taxable year will be the gross income derived from that hospital facility during the taxable year, less the deductions allowed by chapter 1 of the code that are directly connected to the operation of that hospital facility during the taxable year. The computation will exclude any gross income and deductions already taken into account in computing any UBTI . The facility-level tax will be reported on the Form 990-T.

Tax exempt bonds

If a hospital organization operating a noncompliant hospital facility continues to be recognized as described in section 501(c)(3) and otherwise exempt from tax under section 501(a), the fact that a hospital facility-level tax is imposed as a result of the facility's failure to comply with section 501(r) will not itself cause the interest on such bonds to be taxable.

▶THE JUNE 2012 PROPOSED REGULATIONS PROVIDE A ROADMAP FOR COMPLIANCE [4]

Since noncompliance with the rules can result in the loss of 501(c)(3) status for the hospital facility, management should review the guidance in the proposed regulations in order to come into compliance with the rules. A summary of that guidance is as follows:

▶THE FINANCIAL ASSISTANCE POLICY (FAP)

IRC 501(c)(3) hospitals must have a financial assistance policy (FAP) that includes criteria for who is eligible for assistance, an application and how to apply for assistance, how those eligible will be charged and the billing and collection policies for those eligible for assistance.

Widely Publicizing the FAP

The proposed regulations make it very clear that the FAP must be *widely publicized* in a way that allows it to reach those who might need it the most. The steps that must be taken include:

- Making paper copies of the FAP, its application and a plain language summary available conspicuously in public locations in the hospital and by mail in English and in the primary language of any populations with limited proficiency in English that constitute more than 10 percent of the community residents

- The FAP must include measures the hospital will take to inform and notify the community about the FAP so that the communication reaches those who are most likely to require financial assistance, for example informing public agencies and nonprofit organizations that address the health needs of the community's low-income populations.

- The FAP must include the steps the hospital will take to make the FAP, its application and a plain language summary (in English and required languages) widely available on a website.

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▶AMOUNTS CHARGED TO PATIENTS WHO ARE FAP-ELIGIBLE (THE CHARGES POLICY)

Persons who are eligible for the FAP cannot be charged gross charges or the hospital's charge master charges. The proposed regulations provide that a hospital meets the charges policy if the hospital limits the amount charged for any emergency or other medically necessary care it provides to a FAP-eligible individual to not more than the *amounts generally billed* (AGB) to individuals with insurance covering that care. The proposed regulations provide two methods for hospitals to use to determine AGB.

(1) Look-Back Method

Under the look-back method, a hospital must determine AGB for any emergency or other medically necessary care provided to a FAP-eligible individual by multiplying the hospital's gross charges for that care by one or more percentages of gross charges, called AGB percentages. The hospital must calculate its AGB percentage(s) no less frequently than annually by dividing the sum of certain claims paid to the hospital by the sum of the associated gross charges for those claims. These AGB percentages must be based on all claims that have been paid in full to the hospital for emergency and other medically necessary care by either Medicare fee-for-service alone or by Medicare fee-for-service and all private health insurers together as the primary payer(s) of these claims during a prior 12-month period.

(2) Prospective Medicare Method

The second method is the prospective Medicare method. Under this method a hospital may determine AGB by using the same billing and coding process the hospital would use if the individual were a Medicare fee-for-service beneficiary and setting the AGB for the care at the amount the hospital determines would be the amount Medicare and the Medicare beneficiary together would be expected to pay for care.

Under the proposed regulations, these two methods of determining AGB are mutually exclusive, and a hospital facility may use only one method to determine AGB. After choosing a particular method, a hospital facility must continue to use that method.

▶THE BILLING AND COLLECTIONS POLICY

A hospital will meet this requirement only if the organization does not engage in "*extraordinary collection actions*" (ECAs) before the organization has made "*reasonable efforts*" to determine whether an individual is eligible for assistance under the FAP.

Extraordinary Collection Actions (ECAs)

ECAs include any actions taken by a hospital against an individual related to obtaining payment of a bill for care covered under the hospital's FAP that require a legal or judicial process. ECAs that require a legal or judicial process include, but are not limited to, actions to—

- Place a lien on an individual's property;
- Foreclose on an individual's real property;
- Attach or seize an individual's bank account or any other personal property;
- Commence a civil action against an individual;
- Cause an individual's arrest;
- Cause an individual to be subject to a writ of body attachment; and
- Garnish an individual's wages.

The proposed regulations provide that ECAs also include reporting to credit agencies and selling the individual's debt to a third party. The proposed regulations provide that if a hospital refers or sells an individual's debt to another party during the application period, the hospital will have made reasonable efforts to determine whether the individual is FAP-eligible only if it first obtains (and, to the extent applicable, enforces) a legally binding written agreement from the other party to abide by certain requirements.

Reasonable Efforts

In general, to have made reasonable efforts under the proposed regulations, a hospital must determine whether an individual is FAP-eligible or provide required notices during a notification period ending 120 days after the date of the first billing statement. Although a hospital may undertake ECAs after this 120-day notification period, a hospital that has not determined whether an individual is FAP-eligible must still accept and process a FAP application from the individual for an additional 120 days. Accordingly, the total period during which a hospital must accept and process FAP applications is 240 days from the date of the first billing statement.

Notification about the FAP to Patients

The hospital must make "reasonable efforts" to notify individuals about the FAP by distributing a plain language summary of the FAP, and offer a FAP application form, to the individual before discharge from the hospital facility. A hospital facility must also include a plain language summary of the FAP with all (and at least three) billing statements for the care and all other written communications regarding the bill provided to the individual during the notification period. In addition, the hospital must inform the individual about the FAP in all oral communications regarding the amount due for the care that occur during the notification period. Finally, the hospital must provide the individual with at least one written notice that informs the individual about the ECAs the hospital (or other authorized party) may take if the individual does not submit a FAP application or pay the amount due by a date (specified in the notice) that is no earlier than the last day of the notification period. The hospital must provide this written notice at least 30 days before the deadline specified in the notice.

▶THE EMERGENCY MEDICAL CONDITIONS POLICY

The proposed regulations provide that a hospital must establish a written policy that requires the hospital to provide, without discrimination, care for emergency medical conditions (within the meaning of EMTALA) to individuals, regardless of whether they are FAP-eligible.[5]

▶SUMMARY

Form 990, Schedule H has questions regarding the implementation of IRC 501(r) and now the proposed regulations provide a road map as to what is needed for compliance. The proposed regulations apply for taxable years

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HOSPITAL TAX EXEMPT STATUS

beginning on or after the date the rules are published in the *Federal Register* as final or temporary regulations. Hospitals may rely on the proposed regulations until final or temporary regulations are issued. Considering that tax-exempt hospitals are being reviewed by the IRS every three years for compliance with these rules, it becomes mandatory for management to look into whether your hospital is compliant or else risk the possibility of losing tax exempt status. So the steps that must be taken are to first look at the policies and see if they stack up against the proposed regulations. Fill in any gaps. The authorized body should approve any changes. And, here is the most important part: implementing the policies and communicating with all responsible hospital personnel that these are the policies and that they cannot be changed. This may require education sessions with personnel. IRS will be checking websites to make sure that the FAPs are widely publicized; this is easy for them to do. Please read the proposed regulations for further details and contact us for assistance in implementing the policies that will allow your hospital to keep its 501(c)(3) status.

1 The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, Pub. L. No. 111-148 (the "Act"), provides additional requirements for hospitals to qualify as charitable organizations under section 501(c)(3). 1. The community health needs assessment (CHNA) requirement; 2. The financial assistance policy requirements; 3. The charges requirement; and 4. The billing and collection requirement.

2 (REG-106499-12. Community Health Needs Assessments for Charitable Hospitals http://www.ofr.gov/(X(1)S(u2sebd2zmdoac3boqsl2u55q))/OFRUpload/OFRData/2013-07959_PI.pdf

3 Please read Proposed Reg-106499-12 for the rules on CHNAs. The proposed regulations provide the rules for the date upon which the implementation strategy must be adopted in order to be in compliance. A notice outlining details for compliance with the CHNA requirements was previously issued. Hospitals could rely on the provisions described in Notice 2011-52 with respect to any CHNA made widely available to the public, and any implementation strategy adopted, until six months after the date further guidance regarding the CHNA requirements was issued. The proposed regulations provide such guidance. See BDO Knows Healthcare https://bdoworld-dept.bdo.com/sites/BDSPortal/BDS%20Document%20Library/BDO%20Knows%20Healthcare-Winter%202012_FINAL%20Rev.pdf for additional information on the CHNA.

4 The Internal Revenue Service issued proposed regulations http://www.irs.gov/irb/2012-32_IRB/ar06.html (REG-130266-11), regarding "Additional Requirements for Charitable Hospitals" in June of 2012 and they were published in the Internal Revenue Bulletin in August.

5 The proposed regulations provide that an emergency medical care policy will generally satisfy this standard if it requires the hospital to provide the care for any emergency medical condition that the hospital facility is required to provide under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations, the chapter regarding the Centers for Medicare and Medicaid Services' standards and certification and including the regulations under EMTALA.

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PErspective in Healthcare

The healthcare industry has experienced a paradigm shift. New reimbursement models, spikes in the rate of uninsured, an aging population and changes mandated under healthcare reform have all combined to reshape the industry. This change also brings significant opportunities for new industry players to emerge and old ones to redefine their models within the new healthcare environment.

This dynamic has piqued the interest of many private equity sponsors looking to capitalize on these emerging opportunities. In fact, according to the ***BDO PErspective Private Equity Study***, nearly 20 percent of fund managers expect the healthcare and biotech industry to provide the greatest opportunities for new investments in 2013.

So, where will these opportunities come from? Two segments of the market that are providing particularly compelling investment opportunities include:

Walk-in and urgent care facilities: More and more walk-in clinics and urgent care facilities are popping up throughout the U.S. and many of these facilities are backed by private equity capital. In fact, private equity firms invested $4 billion in 2012 in health and medical services, including urgent care, up from $3.5 billion in 2011, according to Thomson Reuters data. For funds, these facilities are attractive because profits are expected to grow as more Americans are insured under healthcare reform. Management, on the other hand, benefits from funds' ability to help clinics standardize procedures, consolidate overhead costs and facilitate future expansion and growth.

Healthcare information technology: As providers work to deliver higher quality of care at lower costs, high-tech solutions that streamline processes, lower the risk of readmissions, enhance electronic medical record systems and create solutions to administer state healthcare insurance exchanges will be critical. As such, many private equity and venture capital funds are finding opportunities to invest in companies with innovative technologies that will help elevate the quality of care, while reducing costs. In fact, Mercom Capital data indicates that $1.2 billion was invested in 163 healthcare information technology deals in 2012, up significantly from $483 million in 49 deals in 2011.

PErspective in Healthcare is a feature examining the role of private equity in the Healthcare industry.

BRIDGING THE GAP IN THE REVENUE CYCLE ~

How Hospitals Can Sustain Strong Revenue Streams in a Time of Change

By: Lynn Marie Pepper, CPAM, Revenue Cycle Services Consultant, The Rybar Group

Absent action by the United States Congress, hospitals and other providers will be subject to a 2 percent across-the-board Medicare payment cut beginning April 1, 2013. Healthcare reform will bring about quality of care initiatives and improvements, but reduced and shared payments across the continuum of care will have a significant impact on reimbursement and daily processes.

On the future horizon, through the bundled payments for care improvement initiatives, payments may be linked for multiple services received during an episode of care up to 90 days after discharge. These and other changes will influence the future of financial and revenue cycle performance for all healthcare providers.

Revenue cycle streams must sustain strong, steady cash flows. Providers can accomplish that by being current and efficient in billing, as well as collecting in a timely and effective manner. With so much focus and so many resources given to mandated EHR and meaningful use deadlines, costly system upgrades and ICD-10 trainings and transitions by Oct. 1, 2014, there are numerous ordeals to face.

Revenue cycle leaders need to monitor their business closely. It is vitally important to stay abreast of all the regulatory changes with the Centers for Medicare and Medicaid Services, Medicare Fiscal Intermediary or Medicare Administrative Contractor (MAC) depending on your state, and monitor issues with your top payors. Work closely with them, reviewing current contracts to mitigate risk associated with ICD-10 and develop contingency plans to prepare for a potential interruption in cash flow.

Determine the 20 most commonly used diagnoses and ICD-10-PCS procedure codes and talk with your three top payors. Are their systems designed to accept these codes? How will they process claims? Will they take your ICD-10 codes and "bridge" them to their own internal ICD-9 codes? If the contract includes ICD-9 diagnosis codes when processing claims, is it being updated and who is checking the revised language? Are their systems upgraded and able to read all the diagnoses sent on a claim before rejecting for lack of medical necessity? How prepared are they for upcoming changes, and can you create your plan around them in order to mitigate hardship?

Accelerate Cash Flow *(Is your ATB over 90 days old, greater than 20% of your gross AR?)*	**Reduce Write Offs** *(Are you monitoring contractuals and zero paid claims?)*
Increase Point of Service Collection *(Are you conducting financial clearance for 100% of "all" scheduled patients?)*	**Cut the Number of Denials** *(Are you reviewing your top writeoffs and payor contracts?)*
Shrink Amounts Going to Bad Debt *(Are you providing stellar customer service by providing financial counseling, financial clearance, and screen checks for Medicaid and/or disability?)*	**Reduce AR Days** *(Are you proactive and involved with your payors?)*
Obtain Access to ICD-10 Specialist *(Have you started? Have you conducted a Gap analysis?)*	**Decrease DNFB** *(Are your hold days greater than five? Do you understand why?)*

In today's healthcare environment, revenue cycle leaders and functions need to go beyond traditional AR management operations with both a metric-driven and a patient-centric focus. Educate, communicate and talk with your patients about finances at every point in the revenue cycle. Over 55 percent of employers across the country offer high dollar deductible health plans today. With Healthcare Reform, that is projected to increase to 85 percent with a $5,000 deductible. It is important to incorporate strong patient financial policies at the time of registration, communicating expectations, listing contact information and available payment options. This is just as important to do as obtaining consent-to-treat forms, past medical history and preparing and presenting discharge instructions.

Revenue cycle leaders today have the responsibility of changing the culture of their organizations from revenue cycle management to revenue integrity across the enterprise. Bridge the denial gap by doing a root cause analysis of payment delays, measure and identify high dollar issues, and hold the team/departments responsible. Accountability is key to unlocking the hidden treasures of lost revenue. Ask yourself the question, "What are the top three things that keep me up at night?" The table above depicts some of the common key performance measures that revenue cycle leaders should consider.

It is important for revenue cycle leaders to "Bridge the Gap" of information by obtaining, processing and implementing all the regulatory changes. Communicate pertinent information to your patients, communities, staff members and colleagues at key critical points in time to ensure the best possible outcomes and ensure that information and processes are flowing as expected, leading to a strong revenue cycle stream.

Lynn Marie Pepper is a revenue cycle consultant with The Rybar Group, a healthcare financial consulting firm and independent member of the BDO Seidman Alliance. Lynn can be reached at lpepper@therybargroup.com.

ICD-10 BEYOND CODING: HOW ICD-10 IMPACTS YOUR BOTTOM LINE

By Cortnie Simmons, MHA, RHIA, CCS, CDIP, Kforce and Lynn Marie Pepper, CPAM, Revenue Cycle Services Consultant, The Rybar Group

On Oct. 1, 2014, healthcare organizations will be required to transition from ICD-9 to ICD-10 for diagnosis and inpatient procedure coding. The mandate is expected to deliver better precision in reporting for episodes of care and morbidity, as well as more accurate reimbursement payments and reduced denial claims. The move to ICD-10 is more than just a coding change, however. With the new version's addition of more than 65,000 codes, ICD-10 brings its own unique set of across-the-board challenges.

From physician clinics to acute care hospitals, ICD-10 will affect all the people, processes and technologies that currently touch ICD-9 within a healthcare organization. This translates into far-reaching impacts across operations, finance and technology – from clinicians to billing, accounting, registration and information services. Providers will need to prepare for the resource and time-intensive needs behind their ICD-10 transition, and anticipate that readiness will likely take more than 18 months.

To achieve success, an ICD-10 compliance road map should include comprehensive assessments to identify documentation deficiencies, streamline workflows and minimize risk, including education and training programs to ease the transition for physicians, coders and ancillary staff. Without this understanding, providers transitioning to ICD-10 may suffer significant risk to their reimbursement and revenue cycle and, ultimately, the delivery of quality patient care.

Evolution of the Classification System

In 1853, at the first International Statistical Congress in Paris, it was agreed that there should be a uniform classification of diseases for the world to use. The first standards for classification were introduced in 1855, providing an outline for how the coding process should work. Following that time, multiple revisions and changes were made to the code, but it wasn't until 1948, after the creation of the World Health Organization (WHO), that a universal agreement on the standards was developed. The new standards were developed with the idea of putting together not only a classification of causes of death, but also classifications of illnesses and injuries.

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the current version being used by the U.S. today, came about in 1977. It was designed for the classification of morbidity and mortality information for statistical purposes and for indexing information by disease and operations. It exceeds its predecessors in the number of codes provided and it provides for greater specificity. The use of the present day system was mandated in 1989 by the Catastrophic Coverage Act of 1988. Though this Act was later repealed, the payment process was already set, as insurance companies had adopted the standards.

While most of the world has switched to ICD-10, the U.S. has remained on the current system due to billing and payment concerns. The pending ICD-10 system offers an expanded list of codes for conditions and procedures, providing a much more specific picture of the physician-patient encounter than can currently be captured with ICD-9.

How ICD-10 Changes the Front-End, including Admissions, Patient Access/Registration, Scheduling and Insurance Verification

ICD-10 will have a significant impact on hospital's front-end staff and processes. Even though they are not coders, the front-end team will need to thoroughly understand ICD-10's changes and new information requirements in order to gather enough specificity for preauthorization. Discussions with payers will need to transpire to create training materials and determine exactly what is needed to meet medical necessity as well as obtain authorizations. For example, ICD-10 obstetrics and asthmatic diagnosis codes identifying additional specificity as to what trimester, or type and severity of asthma will be required, respectively.

Healthcare providers should assess entry points of diagnosis capture from the time a physician orders an elective admission, schedules an outpatient surgical procedure, diagnostic and other tests to un-scheduled visits in the emergency room. Providers

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will need to collect information from each department, identify the current ICD-9 codes used, determine what ICD-10 codes they would translate to, and assess whether the current documentation/information provides enough specificity to assign an ICD-10 code. If documentation deficiencies exist, staff will need education and training to support ICD-10 specificity requirements, including scenarios in which patients are scheduled for tests or when a patient walks into a hospital for a lab test or an X-ray. Narrative symptoms and diagnoses given today will not meet the requirements of ICD-10. Depending on the patient flow for the type of patient, providers may want to invest in process improvements that minimize productivity loss under ICD-10. Of course, providers must understand what systems are currently used and determine all the structures where these codes live and the logic of how they move through those systems.

Clinical Documentation Improvement and Education/Training

Under ICD-10, documentation assessments will be just as essential as coder assessments in mitigating reimbursement risk to transitioning healthcare organizations. Documentation assessments can give providers thorough insight into how ICD-9-CM codes will map to ICD-10-CM/PCS, and illustrate any deficiencies that may exist in clinical documentation practices. Providers can initiate retrospective and concurrent assessments, as appropriate, of inpatient health records for conflicting, incomplete, or non-specific provider documentation under ICD-10. These reviews can be conducted in the patient care units or remotely using the Electronic Health Record (EHR).

For example, a healthcare provider may choose to start its clinical documentation review with a sample of billed and closed Medicare inpatient claims, and review those claims for clinical coding accuracy, documentation deficiencies leading to missed opportunities for more accurate MS-DRG assignment and clinically appropriate reimbursement, and the quantification of potential lost revenue from missed clinical coding opportunities.

Based on the assessment outcomes, healthcare organizations can then take the necessary steps to integrate ICD-10 education and training courses based on specialties for impacted physicians, nurses and ancillary departments. Post go-live, ongoing assessments will allow for the timely identification of knowledge gaps and modifications to education and training strategies. Identified training needs, as well as the method of delivery, can be tailored to each stakeholder group. For example, some groups may be best served through online education or webinars, whereas “lunch and learns” are the typical training methods most appreciated by physicians.

ICD-10’s Impact on the Back End, from Billing and Payer Contracts to Claims Adjudication and Denials

The business impact and risk on the back end is very high, with an increase in accounts receivable days due to ICD-10, multiple system upgrades, flaws with new interfaces and an expected high rejection rate as payers adjudicate claims. The struggle will be caused by interface issues with vendors submitting claims to payers, claim scrubbers, inefficient training of staff, decreased productivity, escalating backlogs and billing delays.

Healthcare organizations need to examine current payer contracts; do they specify ICD-9 diagnosis or procedure codes? If so, special consideration should be made to truly understand the ramifications, especially in light of the vast increase in codes. Do the contracts need to be modified? Who is responsible for accomplishing this? How is that progress communicated to the revenue cycle management within the organization?

Providers should also examine what is causing claim denials today. It is critical to segregate and analyze denials in order to mitigate rejections after ICD-10 as well as to work closely with payers (what is their state of readiness, what edits will they use?), to assess current UB-04 coding accuracies, poor mappings and payment models. It is expected that the most frequent denial will be due to ICD-10 code errors but that could occur due to an internal interface problem as codes/claims move from systems within the hospital, to the claim scrubber, and are transmitted to a third party before moving to the payer for adjudication.

In order to fully prepare for ICD-10, providers should develop contingency plans and prepare for a potential interruption in cash flow and increase the cash reserve days on hand.

Information Technology Impacts

A major impact area of the ICD-10 transition is information technology. On the road to ICD-10 compliance, healthcare providers need to weigh the extent of vendor system upgrades -- including practice management system vendors, electronic health record vendors, clearinghouses billing services – on their resources and budget. Planning, testing, deployment and stabilization of software systems are all critical quality assurance measures that should be accounted for as part of the ICD-10 implementation budget.

In preparation for internal readiness, interviews should be conducted with information technology staff and vendors. Based on interview responses, ICD-10 impacted systems can be identified, as well as supporting information technology process/system changes and costs (hardware, software, incremental vendor costs) need for implementation, including staffing, education and budgeting. A structured project management approach can ensure the proper internal/external coordination and communication steps are taken.

Quality Measures/Pay-for-Performance

With its increased granularity, the expanded code set supports quality reporting and pay-for-performance programs. According to AHIMA, the increased level of detail and severity reporting can help clarify connections between the provider's performance and the patient’s condition, including accounting for medical complications and safety issues. In addition to accounting for more accurate diagnoses, ICD-10 stands to improve data and reimbursement policies regarding the use and effect of new technologies for procedures.

Financial Impact Analysis and Avoidable Risk

Estimating the financial impact of ICD-10 and the potential for DRG shift is difficult, if not impossible, without coding claims in ICD-10. Providers can't afford to wait until the groupers, encoders and HIS systems are upgraded and actually ready to perform

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these functions. With this in mind, it's critical that providers conduct an ICD-10 financial impact analysis to measure how ICD-10 will affect their reimbursement and cash flow. The analysis should account for overall DRG shift totals, DRG shifting based on documentation deficiencies (the avoidable) and DRG shifting based on ICD-10 coding system (the unavoidable).

As part of their ICD-10 preparation, healthcare organizations should develop a detailed road map to capture all significant financial activities throughout implementation, such as the impact analysis. They should develop a finance budget of associated costs and determine the adequacy of contingency planning to address possible disruptions to cash flow. Organizations should also plan for potential pay and benefit changes for certain personnel necessitated by short supply and/or high demand.

Conclusion

From registration to billing and human resources, nearly every role and department within a healthcare organization will be impacted by ICD-10. The complexities behind the delivery of quality patient care, combined with the challenges of achieving readiness for the impacted people, processes and technologies means that ICD-10 requires a holistic project management approach. In working toward the transition, providers need to ensure they take into account the amount of time, effort and resources required in order to achieve ICD-10 success.

Despite all the worry and change, healthcare providers can turn their ICD-10 transition into a positive opportunity to implement documentation and coding efficiencies that, in the long term, will actually result in improved claims accuracy with fewer denials, as well as greater efficiencies in the billing and reimbursement process. Due to the specificity of the ICD-10 code set, once payers streamline their processes, fewer attachments will be required and less documentation should be requested, which will increase adjudication time and result in quicker payments.

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BDO HEALTHCARE INDUSTRY PRACTICE

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