



The GemStatement



President's



This is my final President's Message, my year as president has passed quickly. It has been a challenging year for our members. The downturn in the economy has created many challenges for healthcare professionals. We are all dealing with declining reimbursements, staffing cutbacks and budget constraints. I hope your involvement with HFMA has provided each of you with tools to deal with the economic challenges we face.

I want to thank the Officers and Board of Directors for their support this past year. It has been a pleasure working with

this group. We started the year a little shaky with Board and Officer changes, everyone pitched in and we quickly made the transition. This was the year of the "newborn", we surely broke a record for the number of babies in one term. Congratulations to Jennie Pipoly, Jennifer Schmidt and Chris Brazil on their new babies!!!

I want to also thank the Sponsors for their generous support. Our Sponsors support and involvement is key to our Chapter's success.

It has been a privilege to serve the Idaho Chapter, I hope that the board and I have met the chapter's expectations—thank you for the opportunity.

Susan

P.S. Hope to see all of

you in Lewiston for our Spring meeting. Chris and the crew have been working hard to put together an outstanding program. The meeting will start with a Jet Boat dinner cruise into Hell's Canyon—it should be a lot of fun!!



Inside this issue:

Red Flags Rule Compliance	2
Case Study: Gooding County Memorial Hospital	5
ANI 2009	6
Chapter News and Events	7
Worries About Affordability of Care Rise	8
RAC and ROLL - How are you doing?	11
Chapter Officers and Directors	13

Special points of interest:

- Red Flag Rules
- New Hospital for Gooding
- ANI 2009—Join Us!
- Chapter News and Events
- RAC Preparedness

Red Flags Rule Compliance Now Standard Part of Revenue Cycle Operations

By Bruce Nelson, Vice President, Sales and Marketing, SearchAmerica, a part of Experian

Hospitals are working diligently on their programs to comply with the new Identity Theft Red Flags and Notices of Address Discrepancy from the Federal Trade Commission (FTC) to combat identify theft at their facilities. However, as the details of their programs are being evaluated many questions arise:

- Will our proposed program create too many false positives or 'red flags' that we cannot manage appropriately?
- How should the collection of patient demographic information alter our program?
- Should a red flag account be identified at patient registration or during the billing and collections processes following services?

Providers Have Assumed More Responsibility

The Red Flag Rules require healthcare organizations to properly identify patients in order to protect their identity. The FTC assures the healthcare community that the Red Flag Rules should not prevent any organization from providing medical services to a patient. Instead, they have placed another layer of responsibility onto providers.

Some in our industry have referred to this new regulation as an "unfunded mandate" which obligates hospitals and clinics to proactively identify ID theft triggers based on FTC criteria. This new criteria may cause unnecessary triggers due to routine patient interaction. For example: a patient calls and states "I have never been to your facility." This fairly routine event according to the FTC is a Red Flag rule trigger. In this situation, after researching, the patient had a specimen taken at their doctor's office which was later ran at the hospital's lab thus creating a false positive Red Flag trigger.

Most Medical ID Theft Risk is Internal

Medical ID theft most often results from internal misuse of patient or guarantor information. This shouldn't be surprising. Retailers have known for decades that most of their shoplifting incidences occur not from its shoppers, but its employees. Hospitals are not immune to this phenomenon.

The Red Flag Rules do require internal controls over staff and preventive steps to reduce the number of Red Flag alerts and identity theft cases for a hospital *before they occur*.

Storing photocopies of government IDs such as driver's licenses and Social Security cards within patient files is currently commonplace. These files can be accessible by all individuals participating in the care of the patient, including lab technicians, nursing staff, physicians, physical therapists, pharmacists and pharmacy technicians, among others. However these can be the information sources needed by identity thieves to perpetuate their crimes. This process requires review to ensure appropriate controls are in place to eliminate the temptation by internal staff.

A recommended solution to prevent internal misuse of patient information would be to automate the demographic validation process. This involves utilizing state of the art identity verification workflow and storage solutions. Access would be controlled by user security and passwords

Red Flags Will Be Numerous Under Current Processes

Creating too many false positives is a justifiable concern by all healthcare providers. Many every day billing questions and occurrences could be used alone to identify a Red Flag account, but would create dozens or hundreds of red flag accounts each day – the vast majority of these would not be true instances of identity theft.

For example, if a patient arrives at the Emergency Department (ED) without documentation, should this be considered a red flag account?

The answer is not a simple yes or no, but an assessment of the demographics and what is considered normal for each facility. For example, if a facility serves a large immigrant population it will not be uncommon to encounter patients in the admissions process without documentation. In this case, this alone shouldn't constitute a Red Flag as it would create too many false positives and become burdensome for the hospitals and its patients. Instead, Ms. Lefkovitz recommends adding other criteria that would identify a Red Flag, such as billings returned to the provider by the post office as undeliverable.

Red Flags Rule Compliance Now Standard Part of Revenue Cycle Operations (Continued)

The FTC is advising each provider to assess its patient populations and identify potential red flag criteria that are too commonplace to be considered an anomaly. Instead the FTC is advising providers to develop multiple criteria that must be encountered before identifying it as a red flag.

A few examples of common billing questions that may prove to be a false positive red flag are:

- Billing Inquiries:
 - Patient claims to never have been at the hospital
 - Patient claims to have never received the medical service on the bill
 - Dispute of a bill based on claim of identity theft
 - Mail sent to patient repeatedly returned as undeliverable despite ongoing transactions on active account
- Clinical Identifiers:
 - Medical services are inconsistent with a diagnosis
 - Allergies listed on chart are disputed by patient
- Admissions Alerts:
 - Patient provides insurance number but provides no insurance cards
 - Lack of correlation between Social Security number range and date of birth
 - Repetitive address or phone number supplied by multiple patients on financial assistance applications
 - Personal information inconsistent with information already on file

Steps to Improve Compliance

Until the Identity Theft Red Flags and Notices of Address Discrepancy, most hospitals discovered identity theft cases after medical services were rendered and the patient released. This unfortunate discovery resulted in unrecoverable expenses. Now not only will there be a loss in

revenue, but potential government fines if processes are not in place and used consistently. The following are recommended steps that hospitals can use to mitigate their risk and improve their compliance with recent regulations:

Step One: Be Proactive

The FTC has mandated providers to become both proactive and reactive in their approaches. Historically this has not been the case, and hospitals have followed-up on accounts only when their traditional billing and collection efforts failed.

Emphasis needs to be on the prevention of Red Flag instances.

To do so, providers need to establish new controls. First, they need to dramatically limit access to SSN and other patient identification information to internal and third party (e.g., collection agencies) to prevent internally generated cases. Minimizing the internal theft of medical IDs will have the most significant impact on reducing both red flag instances and losses from identity theft.

Secondly, patient folders need to be stripped of all mentions and photocopies of government IDs. This includes folders for new patients, recurring patients, and former patients.

Step Two: Involve Other Departments

Securing patient information cannot be achieved by finance and administration alone, executives are required to monitor the Red Flag Program periodically. However, other departments need to become actively involved in the process. The following are just a few examples:

Human Resources. For hiring, payroll, credential validations, and other activities performed by this group, human resources staff have access to the identification (SSN, driver's license number, etc.) needed by identity thieves. Hospitals need to be sure this information is secure and accessed only by those that need it.

Likewise, as they hire, they should pay attention to any background checks that include identity theft citations or convictions. These individuals need to have very strict controls on their access to patient information,

or no access at all, and have their activities monitored frequently.

Human Resources is usually vital in setting up permissions and access to a providers facility and systems. Administration should team with this department to create access controls that are consistently and appropriately

Red Flags Rule Compliance Now Standard Part of Revenue Cycle Operations (Continued)

maintained, at hiring and throughout a staff member's employment.

Lastly, as hospital personnel are oriented to the provider's policies in training sessions, they need to become aware of the Red Flag Rules and, if appropriate, their role in compliance. This will specifically impact registration and billing staff, but all hospital staff should be aware of the need for strict controls over patient identification information.

Healthcare Information Management (HIM)/Medical Records. This department is critical for proactive reduction in identity theft and compliance with the Red Flag Rules. Its staff must work with finance and administration to identify new user permissions and controls to protect the electronic storage of government IDs in patient folders (until removed) and the secure database where they will reside. They should also review their current procedures used to detect misuse of passwords that have access to identification information.

In addition, patient folders contain identification information that will need to be removed. Medical Records is critical to performing this task as they are knowledgeable in where this information resides within the folders for current patients and in historical records that may be accessible to staff. This department is instrumental in developing the plan that will govern the information in new patient folders as well as how to 'clean' existing and former patient documentation.

Step Three: Develop Industry Best Practice

Virtually all hospitals must comply with the Identity Theft Red Flags and Notices of Address Discrepancy. Providers should team together to share their programs and aid one another in developing best practices for those serving similar patient demographics.

Your Red Flag Policy should reflect a strong due diligence process with a goal to decrease premature filings. The following are some examples of industry best practices that hospitals are considering and/or including in their Red Flag Rules programs:

Red Flag Policy Triggers:

- Differing Information. Management will be immediately notified when personal information provided by the patient is inconsistent with current patient information residing in its systems.
- Altered Documents. Management will be immediately notified if a patient's identification documents appear to have been altered.

- Unauthorized Charges. Management will be immediately notified when the hospital is advised of unauthorized charges applied to bank or credit/debit card accounts from their organization.
- Fraud Alert. If a fraud alert is associated with a patient account, the information must be verified with the guarantor or disregarded if unable to validate.

Proactive Protection of Patient Accounts:

- Website. All patient websites or portals containing patient information must be password protected.
- Phone Inquiries. Date of birth or a SSN of the account guarantor will be verified on all inbound phone calls requesting account information.
- Statements. Requests for medical documents and/or patient statements will only be sent to the address on record for the guarantor.
- Physician/Health Provider Requests. These offices will be provided an identification code that will be required when requesting account information.
- Name and Address Changes. A photo ID (for in-person requests) or the patient's date of birth and/or SSN (for phone requests) is required to change the name and/or address on a patient's account.

Payment/Refund Controls:

- Credit Card Payments. All payments given via phone will require the 3-4 digit identification number located on the backside of the credit card.
- Refunds. All patient refunds will be mailed to the address of the guarantor or refunded to the original credit/debit card used for payment.

Policy Changes:

- Updates to the Red Flag Program. Management will periodically update its Red Flag Rules program based on its experience with identity theft, new methods of identity theft are discovered, and the availability of new solutions to detect, prevent, and mitigate identity theft.

For information from the FTC on the Red Flag Rules, visit www.ftc.gov, call (202) 326-3058, or email your questions to redflags@ftc.gov.



Case Study: Gooding County Memorial Hospital

Reprinted with permission from Lancaster-Pollard

Waiting for improvement in the credit market has paid off for an Idaho hospital that has closed on affordable financing for a replacement facility. Gooding County Memorial Hospital is replacing its 40-year-old hospital using a \$27.6 million mortgage insured by the Federal Housing Administration's Section 242 program.

Background and Challenges

Gooding County Memorial Hospital had an outdated layout, a flat roof and limited space for necessary service lines. Renovating the landlocked 1969 facility would have been more expensive than replacing it. Gooding also faced complex borrowing limitations because of an Idaho Supreme Court ruling (*City of Boise v. Frazier*). In requiring a voter supermajority and imposing dollar limits on municipal bonds, the ruling stifled Idaho municipal financing. The hospital engaged Lancaster Pollard to find a creative financing solution to make the replacement hospital project happen.

Financial Solution

Lancaster Pollard determined that the interest rate environment at the time would have made using unenhanced bonds prohibitively expensive, so the firm evaluated multiple credit enhancement strategies at once, including bank letters of credit, USDA loans and other options.

Gooding and Lancaster Pollard selected FHA Section 242 hospital mortgage insurance to enhance \$27.6 million in taxable notes. Using taxable notes reduced the hospital's up-front cash requirements, and the notes also priced more favorably than tax-exempt bonds at the time. In an innovative move, Gooding created a new nonprofit organization in order to issue the debt in compliance with the Supreme Court ruling. The new operations and building are under the 501 (c)(3), and the hospital was able to retain its community's financial support via a conduit for the existing county tax levy.

During early 2009, Lancaster Pollard and Gooding waited for the capital markets to stabilize before locking in an affordable interest rate.

Outcome

The new hospital will be called North Canyon Medical Center. The loan carries the equivalent of an "AAA" debt rating, which is expected to save the hospital \$9 million in interest over the 25 year amortization. The debt also has very favorable covenants that will position North Canyon

Medical Center for future growth and long-term success.

Any questions about the financing and market-related aspects of North Canyon Medical Center can be directed to Alan Spidel of Lancaster Pollard at (303) 773-7151 or aspidel@lancasterpollard.com.

Tricare Provider Seminars

TriWest Healthcare Alliance Corp. is offering our latest **TRICARE provider education seminars** throughout the 21-state TRICARE West Region. The seminars, which **begin April 1, 2009 and run through mid-June**, will furnish you and your staff with the latest information on TRICARE programs, policies and procedures.

For those new to TRICARE, these seminars are a great opportunity to learn about the TRICARE program. They can also serve as a good refresher for those who have previously attended a TRICARE seminar. If you have recently attended a seminar and feel comfortable with the TRICARE program, you may wish to send another team member from your office or bring a less experienced person with you.

Each attendee will receive the 2008 Provider Handbook and Quick Reference Guides. Updates on the latest **enhanced functionality** of the secured provider portal will also be covered, including some **exciting new tools** available this spring.

Seminars are scheduled for both medical/surgical and behavioral health providers. There is no charge to attend a seminar.

Registering online at www.triwest.com/provider is the most convenient way for you to **pre-register** for a seminar. You will benefit from the following:

- Immediate E-mail confirmation of your registration
- Reminder e-mail notice prior to your scheduled seminar
- Eligibility to participate in a drawing for a small prize at the seminar

If you have questions regarding the content of provider seminars, you may contact your local representative, e-mail providerservices@triwest.com or call 1-888-TRIWEST (888-874-9378).

**The seminar will run approximately 2½ hours; however, the end time may vary based on the level of audience participation.*

HFMA 2009 ANI - Washington State Convention & Trade Center

At HFMA's 2009 Annual National Institute (ANI)—to be held this year at the Washington State Convention and Trade Center from June 14-17—you'll get the ideas and tools you need to achieve outstanding results in your career and organization.

ANI is the premiere education and networking event for healthcare financial professionals! ANI offers you:

ANI Inspiring Keynotes

Monday, June 15: The Five Temptations of a Leader, presented by Patrick Lencioni

Tuesday, June 16: Thinking Green: Economic Strategy for the 21st Century, presented by the Honorable Al Gore

Wednesday, June 17: Moving Toward a High Performance Health System, presented by Karen Davis, joined by Leading Hospital Executives

Breakout Sessions

There are 84 Breakout Sessions offered at ANI that address topics in the areas of financial management, patient financial services/revenue cycle, payment/reimbursement/managed care, compliance/legislative and the new Peer Review® Showcase track. You'll walk away from these Breakout Sessions with ideas and tools you can use throughout your organization. Attendees also receive access to every handout and tool from all four topic areas – that's complete information from all 84 sessions!

Preconference Programs

Gain access to more ideas and tools when you sign up for Preconference Workshops or a Preconference Seminar. All Preconference Programs will be held Sunday, June 14.

- Preconference Workshops are half-day programs led by facilitators that are designed to give you hands-on experience with tools and solutions that relate to a topic. Choose to attend one workshop in either the morning or afternoon or maximize your opportunity by attending both morning and afternoon workshops.
- Preconference Seminars are full-day programs led by speakers that include lunch and are held from 8:00 a.m. to 5:00 p.m. Seminars are taught in a classroom setting with techniques and approaches incorporated into the lecture.

Sunday Opening Reception

Kick off ANI by greeting old friends and making new ones at this year's Opening Reception.

Idea Exchange Exhibit

Get up to speed with the latest ideas and newest solutions during the ANI Idea Exchange Exhibit! During Monday's and Tuesday's lunch and evening receptions, you'll get a chance to meet and mingle with more than 400 healthcare financial management suppliers, as well as your fellow attendees.

Annual Chairman's Reception and Banquet

The Annual Chairman's Reception and Banquet is always one of the most memorable times at ANI. Enjoy dining and dancing and be a part of the installation of HFMA's new Board of Directors and the presentation of the Frederick C. Morgan Individual Achievement Award, the Association's highest honor for career-long contributions to healthcare financial management and HFMA.

And this is just a sample of what's going on at ANI! There's also a Forums Networking Breakfast, the Saturday Golf Outing and the Sunday post-welcome reception at Tap House Grill...the list goes on and on. For complete information on ANI and to register, visit www.hfma.org/ani or call (800) 252-4362, extension 2.



Chapter News and Events

2009 Spring Meeting and Awards/Officer Recognition Dinner

Please make plans now to attend our Annual Spring Meeting and Awards/Officer Recognition Dinner to be held Thursday, April 30 and Friday, May 1, 2009, at the Red Lion in Lewiston, Idaho. Please see the enclosed agenda for our outstanding line-up of education for this meeting! In addition, please plan and leave a little early on Wednesday the 29th and join us for a **Jet boat** ride deep in to the bowels' of Hells Canyon—with dinner!

IDAHO CHAPTER SPRING MEETING

Red Lion, Lewiston, Idaho

Wednesday, April 30

12:00pm Board Meeting

3:00pm **Jet Boat Trip and Dinner!**

Thursday, May 1

7:30am Continental Breakfast

8:00am Welcome and Announcements

8:15am **The High Cost of Poor Communication:
Building Positive Relationships, Yielding
Positive Results**

10:15am Break

10:30am **Utilizing Scorecards and Benchmarks
Effectively**

Noon Lunch (on your own)

1:15pm **Is Your Provider Contract Friend or Foe**

2:45pm Break

3:00-4:30 **Using an Electronic Financial Record in the
Revenue Cycle**

4:30-5:15 **HFMA Certification & Fellowship Programs**

6:00pm Social and Dinner

Friday, May 2

7:30am Continental Breakfast

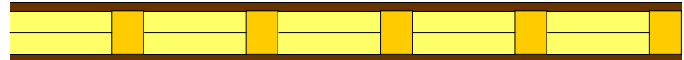
8:00am Welcome and Announcements

8:15am **Linking the pieces to save cash in your
Supply Chain Management (SCM)**

10:15am Break

10:30-
11:30 am **Idaho Legislative Update**

11:30-
12:30 pm **Estimating Idaho Medicaid Settlements—
When a Wild Guess Just Won't Do**



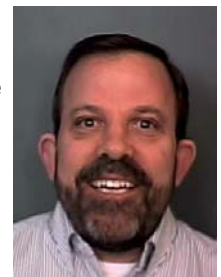
New Member Spotlight

Please join us in welcoming our newest Chapter Members!



Welcome! We look forward to seeing you at our next meeting!

Tom Safley, FHFMA, has 30 years of experience in accounting and finance, and has been a member of HFMA since 1986. Tom first joined the Northern California HFMA chapter, and served on the regulatory reporting task force for two years. Tom relocated to central Oregon in 1995, and became an active member of the Oregon HFMA chapter. In Oregon, he served on several board committees, and became a board member and officer of the chapter. Tom served as the President of the Oregon chapter in 2005-06, and has received the Bronze, Silver, and Gold awards from national HFMA.



Worries About Affordability and Availability of Care Rise

This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible information, research and analysis on health issues.

As economic conditions continue to worsen, the public is increasingly worried about the affordability and availability of care, with many postponing or skipping treatments due to cost in the past year and a notable minority forced into serious financial straits due to medical bills, according to the Kaiser Family Foundation's first health care tracking poll of 2009.

In the face of the country's current economic challenges, the public's support for health reform remains strong and their trust in President Obama to do the right thing in health care reform is high.

Slightly more than half (53%) of Americans say their household cut back on health care due to cost concerns in the past 12 months. The most common actions reported are relying on home remedies and over-the-counter drugs rather than visiting a doctor (35%) or skipping dental care (34%). Roughly one in four report putting off health care they needed (27%), one in five say they have not filled a prescription (21%), and one in six (15%) say they cut pills in half or skipped doses to make their prescription last longer (see chart).

Consequences of Health Care Costs

In the past 12 months, have you or another family member living in your household done each of the following because of the cost, or not?



Did any of the above 53%

Source: Kaiser Health Tracking Poll (conducted Feb. 3-12, 2009)

"Experts and policymakers have multiple agendas in health reform, but when half the public reports skimping on care because they can't afford it, it's very clear that what the public wants most from health reform is relief from health care costs,"

said Kaiser President and CEO Drew Altman.

The 27 percent of the public that reported they had "put off or postponed getting health care [they] needed" were asked about the specific types of care they had foregone. The most common responses were delaying going to the doctor for a temporary illness (19%) or for preventive care (19%). But nearly as many—16 percent—report putting off care for a more serious problem, either postponing a doctor's visit related to a chronic illness such as diabetes or delaying major or minor surgery.

Not all medical care can be postponed, however, and the survey indicates that roughly one in five (19%) people experienced serious financial problems recently due to family medical bills. Specifically, 13 percent say they have used up all or most of their savings trying to pay off high medical bills in the past 12 months, and just as many say their medical debt means they have difficulty paying other bills. A similar proportion (12%) say they have been contacted by a collection agency, while a smaller share (7%) report being unable to pay for basic necessities like food, heat or housing.

Beyond actual financial hardship due to medical care, the survey also indicates a rise in worries associated with health care costs. Nearly half of Americans (45%) report they are "very" worried about having to pay more for their health care or health insurance, the highest proportion measured in Kaiser polls since late 2006. Roughly four in 10 (38%) are very worried about affording health care they need—a number that rises to 56 percent among those who believe someone in their household will lose a job this year.

Fully one-third (34%) of those with health coverage are worried they will lose it. While these concerns are prevalent among low-income Americans, one-third of households earning between \$30,000 and \$75,000 per year are also "very worried" about losing their health care benefits.

Support for Action on Health Care Reform Strong, But High Expectations Pose Challenge

The share of Americans who say that their country's economic problems make it more important than ever to take on health care reform has remained remarkably stable over the past five months at roughly six in 10 (62%). However, the partisan divide also remains large with Democrats overwhelmingly (79%) saying reform is more important than ever and most Republicans (58%) saying the nation cannot afford to tackle health care reform at this point. Independents tilt the balance by being in favor of reform now (57%).

Health care continues to rank as one of the top issues on the nation's policy agenda. The economy dominates (71%) the

Worries About Affordability and Availability of Care Rise (Continued)

public's priorities for the president and Congress, followed by making Medicare and Social Security more financially sound (49%)-a new issue added to the list this month. Terrorism (42%) and health care (39%) rank third and fourth.

Interestingly, while the majority of Americans view action on health reform as more important than ever and believe reform would be good for the country as a whole (59%), fewer think it would personally benefit them or their family (39%). A plurality (43%) of Americans do not expect to be personally impacted by reform and a small minority (11%) think they would be worse off.

"Far more people see themselves directly benefiting from health reform and far fewer see themselves being negatively affected than we saw in the Clinton health reform debate. Today's economic anxieties have created a better starting point for health reform than we saw last time around", said Dr. Altman.

While health reform remains popular, the public has high expectations for how easily reform might be achieved. A majority (58%) of Americans say that if policymakers made the right changes, they could reform health care "without spending more money to do it." This majority view is shared across political party identification, age group and income level. A majority (56%) of the public also believes that the health system can be reformed "without changing the existing health care arrangements of people like yourself."

Seven in 10 Americans (72%) have a "great deal" or "fair amount" or trust in President Obama "to do or recommend the right thing for health care reform," giving him a 12 percentage point lead over the next most trusted actor in health care reform. Following Obama on the list of trusted players are doctors' organizations (60%), Democratic leaders in Congress (57%) and AARP (57%).

When Americans hear policymakers talk about health care reform, they predominantly are thinking about cost and coverage. When asked what "health care reform" means to them, 40 percent of the public respond with a cost concern-people paying less for care, care being more affordable, or lowering the prices or medical goods such as prescription drugs. Just as many (39%) describe reform as providing insurance to more people or helping the uninsured. Quality or delivery system reform did not leap to the minds of Americans with only nine percent mentioning it in their responses.

See you at ANI 2009!!!
June 14-17, 2009



Please visit
<http://www.hfma.org/ani> for
details on this wonderful event!

We look forward to seeing you
all there!





HFMA Membership

HFMA National's On-line Membership Directory

Have you visited HFMA National's On-line Membership Directory lately? Here's the link: <http://www.hfma.org/login/index.cfm>. When you select "HFMA Directory", not only can you search for members of our chapter, you can also search for all of your HFMA colleagues by name, company, and location - regardless of chapter! Using an on-line directory instead of a printed directory ensures that you always have the most up-to-date contact information.

While accessing HFMA National's On-line Membership Directory, you may view your current contact information and make edits to your profile. You can also view any products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It is vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you will ensure that HFMA continues to provide you with valuable information and insights that further your success.

RAC and ROLL—How Are You Doing on Your Preparedness

By Day Egusquiza, President, AR Systems, Inc.

As we all wait for the lifting of the postponement –which should occur in Feb – there is considerable of defense work that should be occurring. Some facilities have ‘bad habits’ that should be rooted out, resolved with aggressive corrective action to prevent future problems. Let’s look back and see the focus of RAC –and don’t forget the Medicaid Integrity Program (MIP) that is with us due to the Deficient Reduction Act of 2005.

The CMS Recovery Audit Contractor (RAC) program was developed to bring accuracy and fairness to the Medicare Fee for Service program, not Part C or D. Based on the results of the 3-year RAC demonstration project, CMS has made updates to the program policies and procedures to minimize the provider compliance burden while ensuring greater accuracy and maximum transparency. Changes include:

- Reduction of the claim look back period to a maximum of 3 years, beginning with PAID claims of 10-1-07.
- Establishing RAC medical record request limits based on provider type (PIN) for each 45 day period.
- If more than 45 days are required to reply to a request, an extension may be requested in writing to the RAC.
- Requirement for RAC to have appropriate licensed professions, including a medical director, certified coders, and other specialist.
- Provision of password-protected Web sites for providers to more easily track claim status by Jan 2010.
- Requirement for RAC to seek approval from CMS to review new claim areas.
- Evaluation of the accuracy and performance of each RAC by an outside contractor with an accuracy score released annually.

To discourage erroneously denials just to boost the RAC’s revenue –as they are only paid a contingency percentage of recouped funds – a loss at any level of appeal will result in the RACs forfeiting their contingency fees.

True success – Proactive Improvement to Reduce Vulnerabilities

While the changes outlined above will ease the provider’s burden, true success will come when providers create systems and processes that find and eliminate improper payment before the arrival of an audit letter. One CFO told me after I had conducted a training: “So what we know was not working that we should have fixed and didn’t fix, better get fixed?” Short version – yes!

One way to proactively prevent improper payments is to determine the cause of those that are occurring and make rapid, changes with ongoing, internal auditing to ensure compliance.

Based on the demonstration state findings, below are some pro-active defense auditing that should occur – both inpt and outpt.

- 1 day stay. Separate the audit into ‘severity of illness’ and ‘intensity of illness’.
- Observation. Separate into 3 categories: ER to OBS, OR/surgery to Recovery to OBS, Direct admit to OBS.
- 3 day qualifying stay. Separately address severity of illness to get into a bed/day 1 and then look at each additional days for the clinical reason to be in a bed. Documentation tends to focus on the need to have 3 days prior to transfer to a SNF rather than the clinical reasons the pt is still in the facility. The SNF will be adversely impacted if the 3 day is denied/recouped.
- ER bell curve. Closely audit for intensity of service to support the leveling system.
- Hospital based clinic use of E&M leveling –with or without a procedure.
- 59 modifier. Who is applying ?
- J code units. Audit to ensure the multiplier is working correctly.
- DRG high vulnerability + volume of higher MS-DRGs
- Drug administration. Audit for start and stop times in all outpt treatment areas.

Hospital owned physician directed clinics. Audit to ensure physician documentation supports levels being billed. Hospital is at risk for all this activity.

RISK: Ensure there is always a validation review done PRIOR to submission of records. Fragmented medical records exist in many facilities due to the hybrid record – partial electronic, partial online documentation, partial paper. Major risk for incomplete records to be submitted. This also provides an opportunity to identify potential at risk activity.

Finally, don’t audit for the sake of auditing. Ensure there is an aggressive action plan attached to all findings that includes training on reimbursement rules, documentation enhancements, accountability of all clinical areas in standards of documentation with ongoing auditing and feedback. The adventure continues.

Career Opportunities!



We do not have any local jobs to post in this issue, however you may visit the National HFMA job bank by pressing ctrl and clicking on the following link:

<http://jobbank.hfma.org>

If your organization has any finance positions available and would like to have them posted to our website and/or published in our July newsletter, please contact:

Rosa Bowling

Weiser Memorial Hospital

(208) 549-4493 or

rbowling@weiserhospital.org



Chapter and Vendor Information

HFMA Idaho Chapter

2008 – 2009

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