



# The Gem Statement



## President's Message



I am often asked, "What do you enjoy most about your involvement with HFMA?" My answer is always the same: *"Interacting with and learning from exceptional healthcare professionals within the state of Idaho!"* Our most recent meeting in Boise provided wonderful opportunities for this, and I want to say thank you!

Thank you to all who attended and presented at the Winter 2012 meeting! I observed that the meeting was well organized, with excellent attendance and speakers. While I gain insight and

perspective from the wide array of speakers at HFMA meetings, I felt especially fortunate at this meeting to hear from **three** Idaho Healthcare Facilities, including:

- Elmore Medical Center
- Saint Alphonsus Regional Medical Center
- Weiser Memorial Hospital

I know we all gained valuable insight and knowledge from the best-practices at each of these organizations and I appreciate them taking the time to share with all of us.

If you believe that your organization currently performs a best practice which others would benefit from, please contact our President Elect, Tom Murphy. Tom diligently works to provide members with quality speakers, and would love to hear from you!

I would also like to thank our members who took the time to participate in the member satisfaction survey! I am thrilled to tell you that the results of the survey conclude that member satisfaction has increased over prior year. As I discussed in the July 2011 Newsletter, our Board has made it a priority to respond to the feedback included in the surveys. Without honest and timely feedback, it is difficult to respond to the needs of our Chapter – so again, thank you for participating!

I will close my message by quoting the famous author, Victor Hugo: *"Winter is on my head, but eternal spring is in my heart!"* I look forward to seeing each of you at our Spring 2012 meeting to be held in Coeur d'Alene.

*Jennie Pipoly*

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## Grabbing the Reins of Your Self-Pay Population

By: Tyler Eppley with CSI Financial Services

**W**hile Patients and Hospitals Struggle with Debt, There is a Win-Win Solution

The term "Perfect Storm" has been used many times during the current economic downturn. It is especially true when referring to the increasing challenges patients are facing while trying to afford healthcare.

*Consider this: Employers are offering fewer benefits, which results in employees paying higher deductibles and more out-of-pocket medical expenses. Despite reduced insurance coverage, healthcare costs continue to increase, exacerbating the burden of medical expenses on the patient. The Milliman Medical Index reports that healthcare costs for a typical family of four increased 7.2 percent in 2009 to an all-time high of \$18,074.*

With unemployment at a 27-year high, fewer patients have any form of health insurance, forcing more patients to use their rapidly dwindling savings to pay for the majority, if not all, of their healthcare expenses. Patients are doing their best to pay their obligations and avoid being sent to collections, however, there are fewer lenders in the market and the [Credit CARD Act of 2009](#) has made it more difficult for most consumers to obtain credit.

Patients who are not able to meet the provider's minimum payment guidelines are being referred to collections, which in turn contributes to a deteriorating hospital-patient relationship.

The Perfect Storm shows no signs of letting up. As Health Care Reform becomes reality, insurance companies will be required to insure more people, resulting in even higher

deductibles and additional strain on patients and the hospitals that will have difficulty collecting payment from the patients. A survey by [AMN Healthcare](#) revealed that approximately 70 percent of healthcare executives believe reform will hurt their facility's financial stability.

Statistics show that the volume of loans being processed has risen dramatically over the past few years while the average loan amount has dropped from approximately \$1,500 to \$850 per patient. This statistic demonstrates that the rising cost of healthcare combined with challenging economic conditions makes it difficult for patients to pay a lump sum payment of nearly any size.

While the Perfect Storm continues, the sun is beginning to shine on self-pay patients and hospitals. Healthcare providers are embracing with greater enthusiasm patient financing programs that give patients the ability to pay out-of-pocket expenses over time, which also can help reduce their bad debt and, importantly, also reduce their A/R days.

The relationship between a healthcare provider and patient is critical to the provider, the patient, and the community at large. Giving patients a financing option with greater flexibility to pay their self-pay balance will not only help preserve that relationship and improve the revenue cycle, but also increase census as patients continue to look for affordable healthcare.

For more information about ClearBalance, visit [www.ClearBalance.org](http://www.ClearBalance.org) or contact Tyler Eppley via [teppley@clearbalance.org](mailto:teppley@clearbalance.org) / (858) 200-9226.

## EMC Lean Accomplishments

By: Doreen Krabbenhoft

**L**ean is a management concept designed to eliminate waste, lower costs, improve safety, increase quality and improve morale. Elmore Medical Center (EMC) is committed to implementing Lean principles throughout the facility and has begun the journey to incorporate Lean concepts in all departments.

The first major Lean implementation project started in the Central Services (CS) department. "When we started Lean in May, one of our goals was to empty out a large CS Storage room. The storage room was filled from top to bottom with boxes of supplies. Some of the supplies had not been used for 10 years, but we kept them with a "just in case" mindset. By implementing Lean concepts the CS department was able to completely clear out the room by removing unneeded items and reducing the amount of supplies kept on hand, significantly lowering the cost of inventory kept in stock." stated Debra Jourdan, CS manager. "I didn't think we could get out of the storage room without running out of supplies. But we did it!"

Key Lean accomplishments include:

Implementing Lean principles has saved nearly \$150,000 since May, 2011

Cost of carried inventory in the facility has been decreased by \$111,572.

A Top 5 board has been installed in the CS department which highlights progress made in Safety, Quality, Costs and Productivity.

Using Lean 5 S strategies the hospital has reclaimed 339 square feet of storage space. (See photos to the right) and cleaned out and organized the majority of closets and storage areas throughout the facility.

Organizing storage areas has increased staff efficiency. Staff can, at a glance, locate needed supplies and equipment. Visual management tools have been implemented to ensure the areas remain organized.

Kanban (reorder) cards are being used in Long Term Care, Acute Care, Lab, and the Emergency Department. Par levels for all supplies are established and when new stock is needed the Kanban cards are used to initiate the restocking process.

Starting in October 2011, Lean implementation was expanded to include 10 additional departments. A dynamic group of 26 EMC employees participated in training to serve as the Lean implementation Core Team for the facility-wide Lean implementation. Working with the departments the Lean Core Team members help to educate and facilitate implementing Lean techniques in the other departments.

"Departments that have implemented Kanban (reorder) cards are spending less time searching for supplies, calling CS and tracking orders." commented Jourdan. "The CS staff is spending significantly less time filling inventory orders and restocking"

Elmore Ambulance Service staff used Standardized Work to analyze the procedures used for their required daily Rig Check and have been able to decrease the time it takes from 1 hour to only 30 minutes!

Critical to making Lean successful was that staff had to be given the tools and training they needed to be successful. They are asked to see things through the eyes of the patient and find a better way of doing things. The Lean process looks at the entire picture/process while respecting the ideas and work of everyone in the process. Lean requires input and time from all the staff to be successfully implemented.



# Rx for Accounts Receivable

By: Kate Homan, site Director Saint Alphonsus Ontario and Baker City

In 2011 the West Region Shared Service Center (WRSSC) who is responsible for the billing and follow-up for Saint Alphonsus Regional Medical Center (SARMC) implemented a new prescription (Rx) to reduce accounts receivable (AR) days. The Rx for AR process was developed by another Trinity hospital and shared with all shared service centers within the organization. The billing and follow-up team in Boise created an Rx for AR to meet the needs of the department as well as the organization. The goal was to increase productivity and work accounts that have the greatest impact on AR days. This article will provide information about how the program was created, provide some examples of the feedback that was received from the work team, and will provide the reader with examples that can be used to improve AR days in their facility.

To start the project, the manager provided education on the types of accounts that needed to be worked to help reduce AR days. The team discussed the importance of working high dollar claims first, regardless of age and adhering to follow-up protocol. They discussed how working denials timely helped to determine if the patient was responsible or if the insurance company required further information to process the claims and how to identify trends to prevent denials from reoccurring. The team was educated on the payer contract terms for days to pay as well as the average days it was taking each payer to issue payment from the date of claim submission.

Once the education was completed meetings were held with the teams to discuss their current schedules and to develop the new prescription for reducing days. Using the knowledge gained from the training, the team determined what accounts should be worked at what time of the month. The teams also discussed the following benchmarks that were used to assist with the amount of time each category should take based on the volume of claims in that category (Clark, 2008).

1. 95% of claims should be error-free
2. Less than 5% should fail the claims scrubber
3. Net AR days should be between 45 to 55
4. Suspense or bill holds should be two to four days
5. Denials should be less than 5% of net revenue or a 5% error rate
6. Billers should be able to work over 145 non electronic claims per day
7. Follow-up team should be working 45 to 55 accounts per day

The teams provided a breakdown of the work they did each day, how long it took them to complete the work, identified the types of accounts that needed to be worked first, and determined the amount of time they should be spending on each category of accounts. They also identified processes improvements. Some of the categories used were:

1. Billing of claims
2. Very High, High, Medium, Low and Very Low dollar claims
3. Denials
4. Appeals
5. Partial paid claims

The billing teams determined the amount of time needed to submit the claims each day. They identified when the claims needed to be received by the clearinghouse so they would reach the payer same day. This was accomplished by working with the clearinghouse to develop a schedule of what time of day each payer needed the claims to achieve the goal of same day receipt.

Once the tasks were identified and the amount of time needed to accomplish each task was determined, a schedule was created for each day. The schedule was based on 450 minutes (eight hour day with 1/2 hour lunch). The team members were able to share when they liked to take breaks and lunch. Below is an example of the Rx for AR for the team doing the billing and follow-up for Blue Cross and Blue Shield. The time in the examples is the minutes per day in each week.

Assignment:	Week 1	Week 2	Week 3	Week 4
Billing Claims / Payer Rejects	45	45	45	45
Denials - everything over \$5,000 Paid/Reject (cat- 511 and 513 and 410 and 411)	180	180		
Denials - everything over \$15,000 and \$4,999 to \$5.00 ((cat- 511 and 513 and 410 and 411)			180	180
Vhigh, High, Dollar Outstanding Claims - Cat BVA, BHA, RVA, RHA, BSA	90	90	90	90
Med Dollars Outstanding Claims - Cat BMA, RMA	30	30	30	30
Low Dollars Outstanding Claims - CAT BLA, RLA	15	15	15	15
Appeals	60	60	60	60
Phone and E-mails Communication Categories (246-I) and (746-P)	30	30	30	30
Total	450	450	450	450

On the above example you will notice that high dollar denials were worked week three and four. This was done so that the accounts that often were patient responsibility could be worked at the begging of the month so statements went out for possible payment by end of month. For many of the payer's denials don't have to be resubmitted they just need additional information to process, thus we still have an opportunity to get those accounts paid by end of month. Depending on the payer or the types of denials, it might be better to work the higher dollars week one and two. Rx for AR is not a one prescription fits all program, it allows the facility to customize the program to fit their needs.

Below is an example of the work schedule. This helped the team know when to change tasks and gave them "permission" to move onto the next task even if their work queues were not completed. This was important because in the past the teams were not spending adequate time on the accounts that could help reduce the days. They were often completing their queues before they moved to the next task even if that queue was not one that would reduce AR days by end of month.

	M-F Biller 1		M-F Biller 2
CA	7:00 to 7:45	CA	7:00 to 7:45
e-mail and phones Appeals 223-Insurance (246-I) and (746-P)	7:45 to 8:00	e-mail and phones Appeals	7:45 to 8:00
Denials	8:00 to 9:30	Denials	8:00 to 9:30
Break	9:30 to 9:45	Break	9:30 to 9:45
Denials	9:45 to 11:45	Denials	9:45 to 11:45
Phone calls e-mails Appeals	11:45 to 12:00	Lunch	11:45 to 12:15
Lunch	12:00 to 12:30	Phone calls e-mails Appeals	12:15 to 12:30
Follow UP RWS Vhigh and high	12:30 to 2:00	Follow UP RWVS Vhigh and high	12:30 to 2:00
Break	2:00 to 2:15	Break	2:00 to 2:15
Follow UP RWS Med Low	2:15 to 3:00	Follow UP RWVS Med Low	2:15 to 3:00
Phone calls e-mails Appeals	3:00 to 3:30	Phone calls e-mails Appeals	3:00 to 3:30

The team was very supportive of the new process. The manager used Survey Monkey to obtain anonymous feedback on how the new process was working and what needed to be changed. This information was shared with the team and modifications were made to the process based on the feedback provided.

## Rx for Accounts Receivable, Continued

Rx for AR has provided the team with the knowledge and importance of working the accounts in such a way that the majority of the dollars, not claims, are paid in the same month or as quickly as possible. If you decide to try your own prescription for AR, be sure to remember what most doctors would tell you if you are starting a new medicine, "It is important to follow-up and make sure the prescription is working and if it is not a new prescription should be prescribed."

This information was presented at the Winter HFMA meeting in Boise. I would like to thank all those that participated in the discussion and shared the great work they are doing to

reduce AR days. The presentation materials for this session will be posted at [http://www.idahohfma.org/site/epage/99922\\_318.htm](http://www.idahohfma.org/site/epage/99922_318.htm). If you would like further information or have questions about the information in the article, please contact Kate Homan at [kathoma@sarmc.org](mailto:kathoma@sarmc.org) or 514-881-7373.

### References

Clark, J. J. (2008). Strengthening the Revenue Cycle. *hfm Healthcare Financial Management*, 62 (10), 48-54. Retrieved from EBSCOhost.

## HFMA Membership—Idaho Chapter

### New Member Spotlight

Please join us in welcoming our newest Chapter Members!

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

Katherine Fisher—Kootenai Hospital District

Brian Barclay—Abbott

Danielle Lynas - Gritman Medical Center

Kathy Batyr—Barganier & Associates

Amy Johnson—St. Luke's Health System

Lindsey Pierece—Bonner General Hospital

Chad Evans—Mountain View Hospital

Kim Stanger—Hawley Troxell

Celinda Snyder—Whitecloud Analytics

Steve Schubert III—Unified Health Services

## 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.

## Transition of Idaho Hospitals to the FY 2012 Changes in Industrial Insurance Reimbursement

By: Kathy Ball, Sr. Reimbursement Analyst, St. Luke's Regional Medical Center

Effective January 1, 2012, the State of Idaho Industrial Commission made changes to the rules covering physician, clinic, and hospital reimbursement. These changes can be found in IDAPA 17 Title 17 Chapter 9 (17.02.09 Medical Fees).

The changes to physician and clinic reimbursement were not significant, however changes to some hospital types were.

The Medical fee schedule conversion factors were increased slightly for the Anesthesia and Radiology components. The annual adjustment of these conversion factors for the schedule is covered in more detail by Section 72-803 of the Idaho Code.

Critical Access and Rehabilitation hospital reimbursement was changed as well. The reimbursement for outpatient and inpatient acceptable charges increased from 80% to 90%. Implantable hardware continues to be reimbursed at 150% of acceptable charges for these hospitals.

Significant changes were made concerning the reimbursement for PPS hospitals for services rendered after January 1, 2012. A summary of those reimbursement changes are below.

The Industrial Insurance hospital outpatient reimbursement changed from 80% of acceptable charge, to a Medicare "OPPS-like" system. The reimbursement change incorporates the Medicare status indicators, RVU factors, HCPCS codes, and some specific billing modifiers (50, 51, 80, and 81). The system adopted by the Industrial Commission incorporates many of the factors (for reimbursement) from the Medicare OPPS reimbursement program, but not all. Instead, a "base rate" (\$138 for 2012) of \$138 is multiplied by the respective HCPC RVU, to create a reimbursement rate. Status indicators also play a role in whether an item is reimbursed separately for the outpatient procedure, or simply considered to be a part of another HCPC within the procedure, and included in the reimbursement of that HCPC.

PPS hospital inpatient reimbursement changed from 85% of acceptable inpatient charge, to a "DRG-like" system. The relative weight and DRG are consistent with the Medicare DRG table; however, the Industrial Commission varies from Medicare by the usage of a "base rate." The base rate for 2012 is \$10,000. This base rate is multiplied by the respective DRG RVU to determine the inpatient reimbursement. Additional payments are allowed for outliers. The amount allowed for an inpatient outlier is equal to: (the hospital customary charges that exceed \$30,000 + the calculated DRG payment) x 75%. Implant charges are not included in this calculation.

Additionally, implantable hardware reimbursement for PPS hospitals decreased from 150% to 110% of aggregated invoice costs for both outpatient and inpatient encounters. Aggregate invoices must now exceed \$10,000 for additional inpatient implant reimbursement. For example, if implantable invoiced hardware costs equal \$40,000, the hospital reimbursement would be \$43,000. The formula would be equal to: \$40,000 x 1.1 (subject to a \$3000 reimbursement cap above the invoice cost). For outpatient procedures, the aggregate invoice cost must exceed \$500 (limited to a cap of \$1000 above invoice).

Given the complexity of the new reimbursement rules, I developed a spreadsheet to assist PFS personnel. This reimbursement calculator has the necessary parts of the CMS DRG, OPPS, and Lab tables integrated so that we can simply enter the DRG or HCPC for an account, and can receive an amount reflective of the appropriate expected reimbursement. The amount received from this spreadsheet can then be used to validate the payment received from the respective industrial insurance sureties.

## Career Opportunities!

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### Recruitment for Senior Accountant/Audit In-Charge

Dingus, Zarecor & Associates PLLC is a growing CPA firm and is currently seeking a senior accountant/audit in-charge, preferably with three to six years of experience. We are large enough to provide the challenge of diverse, high quality clients, yet small enough to give you the personal attention that will help you achieve your potential. Our clients are healthcare and not-for-profit organizations. Healthcare, not-for-profit, and A-133 experience is preferred, but not required. We have a relaxed work environment, excellent compensation and hour requirements, and some travel. If you are a positive, motivated person with the desire to be a part of a growing team, please e-mail your resume and cover letter to Zoraida Etter at [zetter@dzacpa.com](mailto:zetter@dzacpa.com).

Please visit our website to learn about other exciting career opportunities

[http://www.idahohfma.org/site/epage/6235\\_318.htm](http://www.idahohfma.org/site/epage/6235_318.htm)

## HFMA Idaho Chapter—Educational Events Calendar

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### **April 12 - 13, 2012 Spring Meeting**

- *Coeur d'Alene, Idaho*

### **July 19 – 20, 2012 Spring Meeting**

- *McCall, Idaho*

# Chapter and Vendor Information

## HFMA Idaho Chapter

2011-2012

### President

**Jennie Pipoly**, Kootenai Medical Center  
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### President-Elect

**Tom Murphy**, Weiser Memorial Hospital  
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#### Job Referrals

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