



Payers Corner and News Roundup

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President's Message

Ken Jensen
Chapter
President
2009-2010



Well here I am, starting my first month as President of the HFMA Northern California Chapter. Coincidentally, I came across a 1961 financial statement for my hospital and Eugene Green was the Chapter's President that year. The hospital's per-day cost then was \$49 with an annual budget of less than \$700,000. The hospital opened that year with construction funded through the Hill-Burton Act. There was no Medicare or Medi-Cal and most non-paying patients were seen at county facilities. It was a whole lot different then.

When I came into the healthcare business in the early 70's, Marlin Clark was our Chapter President. The per-day costs then were around \$80 and Medicare was beginning their first audits. Medi-Cal "reform" was in full swing under Governor Ronald Reagan. Back then, the yellow #2 pencil with a removable eraser was the accountant's main tool. Victor ten-key adding machines were over \$2,000. In time we evolved from the pencils and

columnar pads to NCR posting machines to punch cards. Health insurance and government programs became more complicated and computer programs became more sophisticated.

Early in my career the focus of healthcare finance was on debits, credits and balancing. However, the business became complicated. In order to survive in the evolving financial environment, a successful person would have to keep tabs on the ongoing changes. One way of doing that was to be involved with HFMA. Personally, I had been in and out of HFMA for various reasons that I really cannot justify now. When I was "in" I found the educational programs and associations invaluable in addressing critical issues and enhancing my career advancement. Key people such as Doc Barto, who gave me great insights into receivables management, and Carl Hitchner who gave direction in the early phases of MediCal and insurance contracting allowed me to grow faster and understand issues in a better way.

In the 70's I met Walt Luke, my first Medicare auditor. We were both fairly new to the game and helped each other through the process. We have consulted with each other over the years on a number of issues, but more importantly we have developed a good friendship.

My membership and participation in HFMA activities, both regionally and nationally, have helped me get where I am now, a CFO comfortable with my profession and relationships with others in the business.

I encourage you to take full advantage of your membership. Build your education hours, they will pay off. Involve yourself and develop your networks.

In closing, I want to thank Chuck Aquisto for his tenure as last year's president, and I look forward to working with the Board and Committees in this new year.

Oh yeah, our hospital's per-day cost is reaching \$3,500 and government programs are becoming even more complicated.

CHAPTER EDUCATION AND EVENTS CALENDAR

For details visit
www.hfma-nca.org

August 1, 2009

HFMA Day at the Ballpark
San Francisco Giants vs.
Philadelphia Phillies
AT&T Park, San Francisco, CA

September 13-15, 2009

California Fall Conference
Hyatt Regency, Monterey, CA
<http://www.hfma-cafallconf.org>

October 9, 2009

2009 HFMA Northern California
Golf Tournament
Hiddenbrooke Golf Course,
Vallejo, CA

PAYERS CORNER



A Possible "Silver Lining" of the Permanent RAC Program

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Providers in California who were subjected to take-backs via PRG-Schultz during the RAC Demonstration Project will agree that it was a painful and costly experience. The American Hospital Association (AHA) has estimated that it cost providers an average of \$2,000 to \$7,000 per patient account to file a RAC appeal. Hospitals that chose to appeal the take-backs are still fighting the cause **up to and including lawsuits with the Federal Court** stating, "CMS unlawfully reopened claims without showing good cause as required by Medicare regulations." We will share the outcome of the federal lawsuits once they are published.

The good news is the RAC Demonstration Project is over and it appears that CMS did observe opportunities for improvement for the permanent RAC. The most obvious improvement is that CMS held educational sessions to explain the permanent RAC program to the providers *before* we received confusing letters in the mail and we were able to meet representatives from our assigned contractor – HealthDataInsights (HDI).

If you missed the CMS RAC 101 session from the Northern California HFMA Spring Conference on April 30, 2009 or the San Francisco presentation sponsored by CHA on May 4, 2009 you can obtain the Power Point Presentations from the chapter website by following this link: www.hfma-nca.org/Chapter/Resources.asp. The files can be found under the Spring Conference Revenue Cycle folder with these titles: CMS RAC Presentation and HDI RAC Presentation.

The possible silver lining of the permanent RAC program in California may lie with our assigned contractor – HDI. They were the contractor for Florida who found the most underpayments of any of the contractors during the Demonstration Project. Lane Edburn is the Executive VP for HDI who made the presentation at the HFMA Spring Conference on April 30, 2009 and he explained that HDI would like to encourage providers in California to research possible "UNDERPAYMENTS" to bring to HDI's attention because HDI will receive the same commission and **no one appeals their decision**.

Consequently, it would be a good idea for hospitals to request assistance from their Medicare Reimbursement expert(s) to see if he/she could identify possible trends of underpayments. HDI plans to launch a website once they receive approval from CMS where providers can alert them to possible underpayment trends. Following is HDI's contact information (once the website is operational):

HealthDataInsights (HDI) Contact Information:
Phone: (866) 590-5598
Fax: (702) 24-5595
Email: racinfo@emailhdi.com

Medi-Cal's June Checkwrite Date Altered

The California Department of Health Care Services website (http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_10628.asp) posted this notice on June 18, 2009.

The June 25, 2009 checkwrite payment will be deferred to July 1, 2009 (state's next fiscal year) for providers who render services for the following programs/services. Deferral of the last June checkwrite will be carried into future years.

- Abortion services
- Child Health and Disability Prevention (Medi-Cal funded)
- Expanded Access to Primary Care
- Genetically Handicapped Persons Program
- Healthy Families
- Medi-Cal
- State-only California Children's Services

The following programs are excluded:

- Cancer Detection Programs: Every Woman Counts
- Children's Treatment Program

New Patient Discharge Status Code 21 Coming on October 1, 2009

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Get ready for a new patient status code which represents discharges or transfer to court or law enforcement. Status code 21 will be used starting October 2009. Hospitals who submit claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries will be impacted.

The National Uniform Billing Committee (NUBC) created this new Patient Discharge Status Code 21 to define discharges or transfers to court/law enforcement, which includes transfers to incarceration facilities such as jail, prison, or other detention facilities. Medicare systems will accept this code for claims with discharge dates on or after October 1, 2009.

Note for Inpatient Prospective Payment System (IPPS) hospitals: the post-acute transfer payment policy will not apply to claims that contain Patient Discharge Status Code 21.

Hospital finance and HIM will need to communicate with their IT leadership on this change and also check with their HIM vendors so that the systems are programmed, tested, and ready by October 1, 2009. This has been an area where there have been errors in the past for hospitals, so be sure you test the programming change.

The official instruction, CR 6385, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1718CP.pdf> on the CMS website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> also on the CMS website.

Privacy Penalties and Balance Billing

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You Snoop, You Pay (Part Two): CDPH Imposes \$250,000 in Privacy Penalties

The California Department of Public Health (CDPH) imposed its first administrative penalty under California's new privacy law, SB 541, for Kaiser Permanente Bellflower's failure to prevent unauthorized access to one of its patient's medical record.

In early February, 2009 the hospital discovered that at least 2 employees had snooped into the electronic medical record of a patient. In response, the hospital placed an electronic privacy banner on the patient's electronic file which automatically popped up anytime the record was accessed. The banner alerted hospital employees not to view the record unless they had a legitimate/medical need to do so. Then, a couple of days later, on February 5, 2009, in accordance with the new breach-notification requirements of SB 541, the hospital self reported, notifying the CDPH and the patient of the unauthorized access. The hospital cooperated with the CDPH in an immediate investigation which revealed that, in actuality, more than two dozen individuals breached the same medical record, 6 doing so after the posting of the privacy banner. The snooping was widespread and extended beyond the Bellflower campus.

Under SB 541, the CDPH is authorized to levy penalties of \$25,000 for the first unauthorized access and \$17,500 for each subsequent breach, up to a cap of \$250,000. In this case, the CDPH imposed the maximum penalty of \$250,000. As a result of this incident, one employee was terminated, 14 resigned and eight were reprimanded. The hospital received survey findings and prepared a plan of correction. The CDPH has referred this matter to the California Office of Information Integrity (CAL OHII), which has the power to levy additional penalties against the individuals involved and seek disciplinary action against any licensed practitioner under the companion law, AB 211.

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ERISA Does Not Preempt Claims That Providers Assert Under Health & Safety Code 1371.4

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Introduction

On May 11, 2009, the Second District Court of Appeal held that claims against commercial insurers arising under California's Health & Safety Code § 1371.4 are not preempted by the Employee Retirement Income Security Act ("ERISA") and may proceed under state law. *Coast Plaza Doctors Hospital v. Blue Cross of California*, 2009 WL 1272631 ("Coast"). Thus, according to Coast, providers may pursue insurers and health plans for reimbursement of charges for emergency services rendered to group health plan members. Whether federal courts will agree with Coast remains to be seen.

About the Case

In Coast, the plaintiff, Coast Plaza, admitted a Blue Cross member for surgery. Coast Plaza was an "out of network provider," i.e., it did not contract with Blue Cross to provide services to plan members. The patient made an advance payment to Coast Plaza and the surgery proceeded without complications. A few days after the surgery, the patient developed life-threatening respiratory distress and was transferred to Coast Plaza's intensive care unit ("ICU") for treatment. Following stabilization, Coast Plaza contacted the patient's medical group to have the patient transferred to an in-network provider. The medical group would not authorize the transfer and refused to be involved in the patient's care. The patient remained in Coast Plaza's ICU for approximately two months, after which Coast Plaza billed Blue Cross for the services provided. After failing to obtain reimbursement, Coast Plaza filed suit alleging six causes of action, each of which were premised on §1371.4. Section 1371.4 requires health plans to reimburse providers for emergency services provided to plan enrollees. Blue Cross demurred to the action, arguing that Coast Plaza's claims were preempted by ERISA.

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More HIPAA Changes Coming: 5150 and DO Transaction Code Sets!

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Did you know there are new Medicare regulations on HIPAA 5150 and DO Transactions and Code Sets? What are the HIPAA 5150 and DO regulations? Why the change? Who is affected? When are you required to have the system changes implemented? What must be changed? How do I start? Here is a quick summary from the First National Provider Education Call held in June.

HIPAA versions 5150 and DO regulations deal with the EDI (Electronic Data Interchange) format requirements for all the standard transactions (837 Claims, 276/277 Claim Status, 270/271 Eligibility, 835 Remittance, TA1 Transaction Acknowledgement, and 997 Functional Acknowledgement). CMS is making these changes because the current 4010 version is outdated. Many of the rules did not fit the business practices of the industry and many of the standards were not implemented because of their limited utility and value. The new version 5010 incorporates more than 500 changes that remove ambiguities, inconsistencies, and shortcomings of the current format standards in order to increase the value of the transactions and to accommodate changing business needs such as referrals and authorizations. The new version also incorporates the requirements of the Medicare Prescription Drug Improvement and Modernization Act (MMA), as well as set the prerequisites for the coming ICD-10. CMS emphasized that this new version does not add the processing or crosswalk to use the ICD-10 codes but just sets up the infrastructure preparation for ICD-10. So, expect more changes to come!

All HIPAA Covered Entities (Providers, Health Plans and Clearinghouses) and Business Associates such as Billing/Service Agents will be affected. January 1, 2012 (except small health plans) is the cut off date for the old transactions. Medicare will be ready to begin transitioning on January 1, 2011.

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Privacy Penalties and Balance Billing ... continued from page 2

Health facilities are already asking questions and seeking guidance about the limits of the new laws, and without any clarification from the CDPH, they are treading cautiously. It is not uncommon for a health facility to accidentally send a fax to a wrong fax number, or inadvertently access a patient's medical file, both events arguably triggering a self report to the CDPH. New regulations may take some time to be issued.

Equally significant, Congress passed the American Recovery and Reinvestment Act of 2009's HITECH Act, which contains a number of measures expanding the current federal privacy and security protections for health information. HITECH establishes a federal breach notification requirement for health information and extends the reach of the Federal privacy rules to business associates doing work on behalf of providers and insurers. Even more, the HITECH Act provides heightened oversight and enforcement of the privacy and security laws by infusing resources into the system and increased penalties.

Stay tuned as we will keep you apprised of future developments.

California Supreme Court Prohibits Balance Billing of Patients by Emergency Providers

Earlier this year, the California Supreme Court ruled that emergency room physicians may not balance bill patients for amounts that health plans or capitated payors are obligated to pay. *Prospect Medical Group, Inc., et al. v. Northridge Emergency Medical Group, et al.* (S142209). In other words, under *Prospect*, when a health plan or capitated payor submits a payment to a provider for lower than the amount billed, the provider cannot directly bill the patient for the difference. Generally speaking, *Prospect* involved a billing dispute between emergency medical services physicians, on the one hand, and the health plans that had capitated their services on the other. *Prospect* brought two related suits against the emergency physicians seeking a determination by the court that the practice of balance billing was unlawful under the Knox-Keene Act. The trial court and appeals court both had found that balance billing was not prohibited by the statute. The California Supreme Court reversed.

The Supreme Court observed that putting patients in the

middle of billing disputes between physicians and health plans places unjustifiable pressure on them. It forces patients to complain to their HMOs, pressuring HMOs to make unreasonable payments. The California Supreme Court held that the only recourse for emergency room physicians is to pursue the payors directly. Balance billing is not the answer since emergency room physicians have the right to resolve their disputes directly with health plans by applying the factors for reasonable and customary value set forth the regulations of the Department of Managed Health Care (DMHC). Although the *Prospect* decision dealt with physician providers of emergency services, health plans and others will likely contend that the decision also applies to hospitals.

The Court limited the decision to the circumstances presented by the case (*i.e.*, billing the patient for emergency services when the physicians have recourse against the patient's health plan). As a result, it leaves open a number of important questions:

- What are a provider's options when the entire bill is not paid but the payor fails to give a reason for the underpayment or indicates that the

underpayment was not for coverage reasons?

- What is a reasonable payment for emergency services rendered to an HMO patient?
- What are the meaning and validity of the October 15, 2008 regulations adopted by the DMHC defining balance billing as an unfair billing pattern?
- Since *Prospect* applies only to the Knox-Keene Act, what happens in the Department of Insurance or ERISA context?

Before the Supreme Court's ruling in *Prospect*, at least one class action lawsuit was filed against providers alleging that balance billing of a patient for non-contracted emergency services while also trying to collect from a patient's health plan was an unfair business practice. Another class action lawsuit has now been filed on behalf of a class of emergency medical services patients against providers alleging balance billing was an unfair business practice after the *Prospect* decision. Both class action lawsuits are still currently pending. *Prospect* and the issues it presents will undoubtedly be the source of a great deal of legal wrangling.

ERISA ... continued from page 2

On appeal from an order in favor of Blue Cross, the Second District reversed the order, holding that §1371.4 is a law regulating insurance that is exempted from preemption under ERISA's "saving clause." In reaching its conclusion, the Court found that §1371.4 "regulates insurance because it imposes conditions on the right of insurers, like Blue Cross, to conduct their business in California." *Id.* at 8. The Court also found that §1371.4 regulates insurance because 1) it requires insurers to pay for emergency services; 2) it expands the insured's access to hospitals because it prohibits an insurer from requiring authorization for emergency care; and 3) it does not permit the insurer to bargain to pay only for in-network services. *Id.* at 9.

Although not binding on federal courts, the Coast decision is instructive and likely to influence decisions regarding claims arising under §1371.4 in both state and federal courts.

Conclusion

Claims against health plans that rely on Health & Safety Code §1371.4 and similar provisions of the Knox-Keene Act are likely not subject to ERISA preemption.

COME OUT TO THE BALLGAME! HFMA Day at the Ballpark San Francisco Giants vs. Philadelphia Phillies August 1, 2009, 6:05 PM at AT&T Park

Ticket Price: \$35 each (Lower Box seats)

Includes tailgate party featuring South of the Border Faire with beer, wine and beverages.

RESERVE YOUR TICKETS TODAY!

Call (925) 828-4532 or visit our website (www.hfma-nca.org) to download the event flyer and reservation form.

Newsletter Comments

Is there a topic that you'd like to read about or get featured in the chapter's newsletter? Please send your suggestions to Terry Paff, Newsletter Committee Chair, at terry@rashcurtis.com. You tell us the topic, we'll go find the article.

OIG Oversight and the ARRA

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The American Recovery and Reinvestment Act of 2009 was passed to “jump-start” the economy “in the face of an economic crisis, the magnitude of which we have not seen since the Great Depression.” In addition to creating jobs, investing in new infrastructure, and expanding renewable energy development, it will have a significant impact on healthcare. Not only is the U.S. Department of Health and Human Services (HHS) responsible for approximately \$137 billion to improve and preserve health care along with increasing health information technology, but the Recovery Act added \$17 million to the Office of Inspector General (OIG) for increased oversight and protections of the HHS funds.

The OIG is mandated “to protect HHS program integrity and beneficiary well-being by detecting and preventing waste, fraud, and abuse” and identifying ways to improve the effectiveness and efficiency of HHS programs. With the injection of ARRA funds, HHS will have the opportunity to increase services and programs

among a variety of agencies. Oversight and monitoring by the OIG will be enhanced to protect these funds.

The OIG Office of Audit Services (OAS) will increase its oversight and reviews of agencies and providers. At the State and local level, OAS will conduct audits and review grant award procedures for Head Start and Early Head Start programs, and the Agency for Children and Families grant awards. In addition, it will focus on States’ Medicaid eligibility requirements, the use of the increased Federal Medical Assistance Percentage (FMAP) funding, and the county contributions to the non-federal share.

The OIG Office of Evaluation and Inspections (OEI) is developing work plans to evaluate the implementation of the health information technology (HIT) initiative. The Recovery Act commits approximately \$19 billion to implement a coordinated application of electronic health records (EHR) and provide incentives to healthcare providers to adopt certified EHR technology. OEI will assess the effectiveness of the implementation efforts. It will provide oversight of the coordination effort between the State and Federal governments to avoid duplication and help ensure the implementation of systems that promote care coordination and exchange of information as mandated in the HIT initiative.

One of the more significant administrative parts of the Act is the “Whistleblower Pro-

tections.” Complaints by employees regarding such issues as mismanagement, waste, fraud, and abuse are to be filed with the Office of Inspector General. The Act prohibits any non-federal employer receiving funds under the Act from discriminating against any employee that discloses information that the employee believes is evidence of waste, fraud, or abuse of covered funds. The Act defines employers as contractors, sub-contractors, grantees, or recipients of funds. Funds may include supplemental Medicaid funding, disproportionate share funding, HIT grants and Medicare adjustments. The reprisal protections are extended to employees who completely bypass the organization’s internal compliance policies. The Act further requires employers that receive ARRA funds to post a notice of rights and remedies so that all employees are aware of their rights and obligations under the Act.

The ARRA is intended to stimulate the economy and create jobs. In addition, Congress is calling for greater accountability and transparency in how the funds are spent. Employers should be proactive in ensuring that procedures are in place to prevent waste, fraud and abuse.

More HIPAA Changes Coming ... continued from page 2

All systems that submit claims, receive remittances, exchange claim status or eligibility inquiry and responses must be analyzed in order to identify software and business process changes. The new versions will have different format requirements so software must be modified to produce and exchange the new formats. Business processes may need to be changed to capture the additional data elements that will be required. All of these changes will need to be coordinated and tested just like you did when HIPAA’s standard transactions and code sets were first implemented five years ago!

Some of the action steps you could take now include sharing this information with your IT Department and system vendors. Inquire about when they are planning to review the new requirements and planning the required system upgrades. Start to evaluate the impact of these new changes to your routine operations and begin planning for testing, training, and transitioning to new systems and new processes.


CMS will continue to develop and disseminate educational materials and progress updates to provide answers and directions for providers and vendors, so keep up with all the upcoming communications. There will be a dedicated web page for HIPAA 5010 and DO to help you: http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp.

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For Looking at Retro MS-DRG Audits and Identifying Opportunities

Gloryanne Bryant, RHIA, RHIT, CCS
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and

Patti Ashley, LVN, CCS
President Coding & Audit Services
Health Information Partners (H.I.P)

As all those in healthcare are aware, the implementation of MS-DRGs (Medicare-Severity Diagnostic Related Groups) in the hospital setting has significantly increased its attention and scrutiny of the ICD-9-CM (International Classification of Diseases, Ninth Edition, Clinical Modification) coding and clinical documentation areas. MS-DRGs were implemented in October 2007 within the Inpatient Prospective Payment System (IPPS) for acute care hospitals.

Understanding documentation and coding patterns and trends is one way to identify opportunities for improvement and ultimately increase overall coding accuracy, Case Mix, and IPPS revenue. One way to study or identify patterns and trends in coding is to conduct retrospective (after discharge AND after the initial billing/payment has been received) focused-based MS-DRGs audits on those cases that group to MS-DRGs without a CC/MCC (Comorbid complication and Major Comorbid and Complication). Over the past 18 months, the CHW Corporate Coding HIM Compliance Department has been and continues to provide the oversight for MS-DRG audits for our multiple acute care facilities to identify opportunities and where education might be warranted based on the audit findings. Using an external HIM (Health Information Management) vendor, the CHW Coding HIM Compliance Department implemented a special project with goals of identifying both documentation improvement opportunities and actual coding improvement opportunities. This had the overall purpose of capturing a better reflection of our patient severity while at the same time improving our MCC/CC (Major comorbidity/complication) capture rate and IPPS reimbursement. The audit also validated the assignments of POA (Present on Admission) and Patient Discharge Status (disposition) codes.

Key Stakeholders Included:

- Corporate Coding HIM Compliance
- Hospital HIM Director

- Inpatient Coding Staff
- HIM Coding Vendor

Another stakeholder included during the *report of findings* phase, was the Case Management Director and/or the Clinical Documentation Improvement Specialist (CDIS).

The audits were designed to be conducted onsite and on a monthly basis. In order to select the MS-DRG charts for the monthly or regular audits, we utilized a coding compliance software called SMART (Systematic Monitoring and Review Technique) from PWC (Price Waterhouse Coopers). In addition, we utilized other DRG reporting software which allowed us to narrow the report type and selection of the MS-DRG to include only those cases without the CC/MCC MS-DRG based upon title. Initially the audits were performed on a monthly basis at each acute care hospital within the CHW system and once the audits supported improvement in the coding accuracy percentage for at least a three month period and documentation opportunities lessened, the facility removed them from the monthly hospital audit cycle.

The HIM Vendor Role Included:

HIP (Health Information Partners) was asked to participate in ongoing MS-DRG audits back in October 2007 when we moved into this new IPPS (Inpatient Prospective Payment System) environment, which is driven by capturing patient severity. Scheduling the monthly onsite reviews began in November 2007 with the facilities, as well as holding exit conferences to ensure all involved departments will be available to participate. Included in the exit conference are the HIM Director, Coding, Case Management and Administration staff.

The Auditors utilized in this review process have multiple credentials and have been in the HIM coding consulting field for an overall average of ten years (it's important that staff have the coding credentials along with the hands-on experience as auditors).

Once the onsite review has been completed, a follow-up call was placed with the hospital-assigned contact to verify that all audit findings and recommendations have been agreed upon prior to preparing the final report.

The final report includes a spreadsheet with a tab for cases with no changes identified, as well as educational findings (no reimbursement impact), individual worksheets on cases where a variance had been

identified, a summary of cases for claim resubmission, and a final summary of statistics. An executive summary report included the project scope, hospital audit statistics, observations, coding trends, documentation opportunities, and recommendations. In conclusion, the final audit report is sent to the Corporate Coding HIM Compliance Department, facility HIM Director, facility CFO, and other designated department heads depending on the findings identified. It was the responsibility of the HIM Director to share the findings with their Case Management Director and the CDIS staff.

The following is an example of the *Variance Types* we identify in the review process. It is not uncommon for a case to have more than one Variance issue identified. However, it is only those cases affecting reimbursement that affect the accuracy rate.

Variance Type	
PrDx Chg	
ReSeq PrDx	X
Add 2nd Dx	
Chg 2nd Dx	
Delete 2nd Dx	
PrProc Chg	
Chg 2nd Proc	
Add Proc	
Delete Proc	
Disposition	X
Documentation	
Charging	
CDM	
UB	
UR	
Pt Type	
POA	
Other	

Again, the primary goal for this project was to examine the accuracy of the MS-DRG assignment through identification of documentation improvement opportunities and improving coding accuracy. This means a validation of the principal diagnosis selection, how the codes are sequenced, and whether or not any secondary diagnoses codes or CCs or MCCs

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Contract Coding Services: Getting What You Pay For

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Catholic Healthcare West



When hiring contract coding staff services for your facility or organization, there are some vital elements you must consider before selecting your vendor of choice. The facility HIM (Health Information Management) department houses the coding professionals who have the responsibility and accountability for assigning all ICD.9.CM diagnosis and procedure codes for a given patient encounter as well as the reimbursement received based on that code assignment. Code assignment determines the severity of illness and risk of mortality of your patient population, especially for the Inpatient Prospective Payment System (IPPS). Coding staff should be skilled enough to capture it to the highest level of specificity based on the documentation in the body of the medical record and the first time around. Utilize the following key elements when considering a coding vendor:

- Credentials
- Continuing Education Certification
- Type of Experience
- Coding Test/Assessment
- Vendor Quality Checks
- Coding Accuracy

Credentials

Although having staff that are RHIA (Registered Health Information Administrator), RHIT (Registered Health Information Technician), CCS (Certified Coding Specialist), and or CPC-H (Certified Procedural Coder – Hospital) credentialed is certainly a best practice, it may not always be possible, but is strongly recommended. Evidence of a Coder's credential should be provided to you before a vendor places coding support staff at your facility. It is recommended you not finalize the contract until you are provided copies of these documents for all staff the vendor anticipates placing at your facility.

Continuing Education

The vendor of choice needs to and should provide you with the previous 12 months of continuing education certification to validate ongoing education and credentialing via CEUs (Continuing Education Units) has occurred. You need to know what type of education the outside staff has participated in and most of all, if they receive sufficient education updating them on the coding changes each year. It is surprising how many vendors do not use this as a best practice standard. Most coding professionals working for coding consulting firms look to their employer to provide them CEU opportunities. Coding professionals concur, in discussing this with their colleagues, that the employer should share some responsibility for the cost. It is a win-win situation for both the employer and the coding professional because the employer uses it for marketing their services and the coding professional

requires it for credential maintenance.

With the major changes to the IPPS and implementation of MS-DRGs and Present on Admission (POA) indicator reporting, making sure your contract coding staff is updated on the changes is without a doubt a very important and mandatory requirement. Coding vendors should provide evidence that their staff are participating in ongoing education whether within their organization or from outside venues. When they cannot provide copies of the continuing education certification, find another vendor.

Experience

Another important component is the number of years experience the contract staff have under their belt. As complex as the coding process is and continues to be, an inpatient coder should have a minimum of 3-5 years experience. Experience is the key factor and is critical because

it provides the coding professional the needed knowledge to know when to query the clinician for documentation clarification. Knowledge of clinical scenarios does not come overnight, but over time. Now more than ever, both experience and knowledge are important factors aiding in accurate code assignment. Another reason experience is a crucial element relates to the capturing and reporting of the "POA" indicators. Coding professionals with superficial experience can be a detriment to your institution and its reimbursement as they may not be reflecting the true picture of your patient population. Remember, experience is knowledge and knowledge is experience. Do not hire without it and request proof of the experience.

Coding Test/Assessment

Do not hire a contract coding service that does not test the skills of their coding professionals regardless of how well they know the coding quality of that staff member. Testing is the only way to determine the abilities of coding staff. Any contract service you hire should provide you with a copy of coding test/assessment results for the particular individual. In addition, it is definitely recommended that you provide anyone coding your records with the same test you would administer to someone you would consider hiring yourself. No one else knows the case complexity and types of records your facility has or the patients you treat as well as you do. Testing is one way of knowing the abilities of contract staff and if they have the knowledge to handle your types of medical records. If you are comfortable with sending your internal test to the vendor, without the answers of course, have them administer the test to the potential candidate and send the completed test back to you for grading. Of course you

would want to give them a timeframe for getting it back to you. Seriously consider this; you might be thankful you did.

Quality Checks

All vendors should be conducting quality checks (QCs) of their coding staff at least once a year and provide you with a report of their coding quality. However, more frequent quality checks may be necessary based on the initial QC findings. This should be a requirement outlined in the contract language along with the numbers/percentage of cases to be audited, the frequency, and the timeframe to be audited or chances are it may not be done. Some coding consulting firms do not conduct adequate or timely quality reviews of their staff unless a problem is brought to their attention by the facility. While attending the 2008 AHIMA (American Health Information Management Association) convention in Seattle I had a conversation with a coding vendor firm and I asked the company how often they conducted coding quality checks on their staff and they replied, "We do not conduct them unless it is a client contract requirement." The reason for this may be the affect on their profit margin as it is a costly and time-consuming process for the vendor. However, you are entitled to it. When QCs are not conducted, it places your facility at potential significant risk for both overpayment and underpayment. These QCs will assist you in determining whether or not you want to continue utilizing the services of that vendor.

"Quality, Accuracy and Compliance should be ingrained into the coding vendor's staff and operations and reflected in your contract with the vendor of choice."

Coding Accuracy

When you make a vendor selection, the coding staff they provide you should have at least a coding accuracy rate of 95%, nothing less. Currently, the Centers for Medicare and Medicaid Services (CMS) requires an accuracy rate of 96%. Why should you settle for less than their expectations? In addition, the more accurate your coding is, the more accurate your entitled reimbursement.

In summary, it is your responsibility to validate any and all ICD-9-CM codes assigned to your claims to ensure you are reimbursed what you are entitled, nothing more, and nothing less. All of the above comments would also apply to the outpatient coding arena and use of CPT/HCPCS codes. HIM Directors, Managers and Coding Supervisors are in a position to expect and ensure that a vendor provide you with the

quality product for which they are being paid for by requiring the vendor test their contract coders before placing them with you, provide the test results to the facility, perform quality checks at a minimum of once a year, provide proof that their coders are receiving the necessary continuing education to do the job they are hired for, and last but not least, by DEMANDING an accuracy rate not less than 95%. Quality, Accuracy and Compliance should be ingrained into the coding vendor's staff and operations and reflected in your contract with the vendor of choice. The vendor of choice needs to be held accountable too as well as provide proof of these elements.

For looking at Retro MS-DRG Audits and Identifying Opportunities continued from page 6

were missed or incorrectly coded was conducted. POA (Present on Admission) indicators were also included as an element to validate because of their impact on MS-DRG payment effective with discharges on or after October 1, 2008. The reviews consisted of validating the documentation and coding of any and all procedures, the discharge disposition, physician query opportunities, and any coding patterns or trends.

The Written Summary Worksheet of Audit findings include:

- Total number of records reviewed compared to identified variances
- Any difference from prior review
- Indicate any patterns or trends (ICD-9-CM, Discharge Disposition, Documentation, Physician, etc.)
- Identify operational issues effecting coding
- Recommendations and Action Plan for correction and improvement

Due to space constraints, only the first part of the article is published. The complete article with sample review findings , audit observations and results is posted on the chapter website: <http://www.hfma-nca.org/Newsletter/>.

HFMA 2009 ANI - Making it Count

Jayne Kroner, FHFMA
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The Seattle weather was perfect, but as our leaders reminded us were are definitely in the midst of "A Perfect Storm." Each of the general speakers brought a unique perspective to their presentation material that was personal but yet fully drew us out into the larger ocean landscape of the difficulties we face in these turbulent political and economic times.

Cathy Jacobson, HFMA Incoming President, was extremely eloquent in her presentation about her role at Rush University Health System and the economic difficulties, and the teamwork needed to overcome all the odds and shrinking margins.

Dick Clark, CEO of HFMA, made quite an impact on the audience with his presentation titled "Leading Turmoil." An interesting shared fact that the negative total margin for all hospitals is 54% (view the presentation at <http://www.hfma.org/ClarkeANI09.htm>).

Patrick Lencioni was considered a favorite speaker by all who heard him. He was energetic, knowledgeable and hit the mark with his very practical suggestions on how to optimize your success in leadership.

As one of the final core speakers, former Vice President **Al Gore** continued to engage his audience with political, legislative and global updates.

The break out education sessions were quite varied and numerous. Those attended by myself and other colleagues were well done with take aways from each session. Our understanding was that the total attendance at ANI was approximately 4000 attendees. National felt that the attendance was down by only 15% than last year.

On June 15, Chapter Officers were invited to dinner and a presentation of each chapter's yearly earned awards. The Northern California Chapter received six of these awards. Kudos!

On June 17, National HFMA hosted the Annual Chairman's Reception and Banquet installing the newly appointed National Directors and Officers. The Northern California chapter was well represented by **Christine Sarrico**, HFMA Northern California Past President and CFO of Enloe Medical Center, when she was honored with the appointment of an HFMA National Director. Kudos!



HFMA Northern California Past President Christine Sarrico (3rd from left) was inducted as HFMA National Director at the ANI Awards Banquet. With her in photo are (L-R): Kathleen Cain, Chapter President-Elect; Jayne Kroner, Chapter Treasurer; and Cindy Rudow, Chapter Board Member.

The Results Are In and Northern California Chapter Takes Home the Prize!

Stephen R. Thompson MBA, FHFMA
Director, Patient Financial Services
Marin General Hospital
thompssr@sutterhealth.org

In our last newsletter I talked about the history of the Helen M Yerger award and the reasons why our Chapter has chosen to put the time and effort into submission. The Northern California Chapter submitted a total of eight applications for consideration. The submissions and final status are as follows:

SINGLE CHAPTER ENTRIES

- PFS Road Shows – Submitted by **Aimee Arata** and **Lynn Kelly** – *Awarded for the 4th year in a row*
- Newsletter – Submitted by **Terry Paff** and **Walton Luke** – *Awarded*
- Website Revisions - Submitted by **Chuck Acquisto** (Immediate Past President) – *Awarded*
- Membership – Submitted by **Ramona Hernandez** – *Awarded for the 2nd year in a row*

MULTI – CHAPTER ENTRIES

- Fall Conference – Submitted by **James Moynihan** (Southern California) and **Steve Thompson** (Northern California) – *Awarded for more years than memory provides*
- Region 11 – Submitted by all of the Region 11 chapters – *Awarded for more years than memory provides*

• Fall Conference CFO Golf Event – Submitted by the Northern and Southern California chapters – *Not Awarded*

• PFS Road Show to Hawaii – Submitted by the Hawaii and Northern California Chapters – *Not awarded*

Your chapter walked away with a total of SIX Yerger Awards plus a Bronze Certificate for member retention and a Silver certificate for Certification.

CONGRATULATIONS to the staff that submitted these awards and to all of our members, since you are the reason

we are here and providing education in a number of forums. I would be less than truthful if I did not admit that we are disappointed that we did not win all eight submissions, but we will use this as an opportunity to determine how we can improve our programs and our submissions.



These awards are not just for bragging rights, although there is that element, but are a reflection of the content and quality of how the Chapter works to meet the needs of each of you. If it was not for our loyal members, we would not be one of the largest chapters in the United States.

We are often reminded that service to HFMA is voluntary and it is not our lives or our careers, but if you watch the Board and Committee members at work, you will see a passion that is infectious in so many ways.

In looking to the next year, we are in Year two of the Chapter Yerger Committee under the very special leadership of **Cindy Rudow** from ValleyCare in Livermore and Pleasanton. Cindy brings a strong sense of guidance and practical experience.

Thanks again for making the Northern California Chapter so unique.

How to Enjoy a Marathon

Dan Dreblow

Regional Sales and Consulting Director

J&L Teamworks



I do not enjoy running...it is my least favorite event of all of the Triathlon sporting activities. I have completed eighteen sprint triathlons and the bicycle leg is my favorite section. The swimming in the ocean is always exciting and then, last and least, comes running. Sounds like a lot of work to me.

One characteristic of all experienced runners is that they love to give advice. Their required workouts are filled with hours of distance running...who has the time for all of this? And who would want to spend their recreational time with hours of running on city streets? Boring...plus all of the injuries outdoor runners endure is quite discouraging.

Recently, I completed the Orange County Marathon in about 5.5 hours. A slow time but then again, I am a slow runner. Of the 8,000 participants, about 1,350 ran the

full marathon and I overheard a police officer's reporting that there were about 150 runners behind me. I usually beat about 10% of the participants so this was within my zone.

Why run in a marathon in the first place? The obvious point would be that completing a marathon would seem like an impossible task for a 57 year old male with limited running experience. I have completed a half-marathon several years ago, but the last two miles there were quite a struggle.

My training philosophy is simple: "Train for the hills" because no one quits on the flat lands. In the gym, I spend my 45-60 minutes, (2-3 times per week), climbing hills on whatever equipment is available. Slow speed with high resistance. My legs are conditioned to climb: walking, running or biking - climbing is everything. During the event, it almost seems like my legs will question me, "So where are the hills and when do we get started?!"

During the event, I would text family and friends every 6-7 miles on my progress. Some people were surprised that I would have time to text a message. Being on the course for 5.5 hours does provide for some free time plus the text messages resulted in some very encouraging responses.

Once I finished, I was surprised to see the response from friends and family. My wife's ex-husband invited me to lunch (this is California you see). He wanted to see if I could still "walk and talk" and "Yes," I could do both.

As a professional salesman, who has an extensive travel schedule, I have limited opportunities to train but when my schedule allows, my focus is on "climbing hills" and "losing weight." A very simple but effective approach to all of the events I participate in. If you believe that you do not have the time to prepare for an event, you are simply wrong! Everyone has three hours per week.

For healthcare financial managers who are postponing their retirement plans due to the deteriorating economy, maintaining your health becomes even more critical. Competing in events is a great motivator to get you in the gym since the better shape you are in, the more fun the event is.

For new runners, start at 5K and work your way up...you will soon become curious because there is a ½ marathon or full marathon scheduled for a beautiful area of the state that just seems like it would be fun. I have found a new home with marathons and a new challenge to explore.

There is no time like the present, to walk to the starting line. As us "Old Goats" like to say, "Let's start the race...we are not getting any younger!"

Going to Hawaii!

I was actually visiting family in Southern California when I saw the e-mail from a colleague telling me I had won a drawing at the HFMA conference he was attending in Sacramento. When he wrote that it was a trip to Hawaii, I thought he was kidding! In fact, I spent the whole weekend convinced he was kidding! It wasn't until Ramona from CSB called and congratulated me that I realized he had been serious—I did win a trip to Hawaii! I am absolutely floored and really, really happy! I am so looking forward to enjoying the sun, sand and sights of Hawaii! Thank you very much, HFMA and Aloha!

Vicki Lee

Executive Director, Revenue Management
John Muir Health



Congratulations to the Hawaii Raffle Winner!

John Muir's own **Vickie Lee** won this year's Hawaii giveaway. We look forward to hear about her trip and photos when she returns. Aloha!

New Members Get A Certificate for One Free Registration to a Chapter Education Event

All *New Members since January 1, 2009* will receive a certificate for one free registration to a Chapter education event. New Members can choose to apply their free registration to any of these chapter events:

- PFS Road Shows
- Managed Care Road Shows
- Back to Basics at the 2010 Spring Conference

Please look out for your certificate and yearly roster. For questions, please contact:

Ramona Hernandez - Membership Chair

Phone: (415) 475-4595

Email: rhernandez@californiaservicebureau.com

Ana Hernandez - Membership Co-Chair

Phone: (714) 476-7160

Email: ana@diversifiedhealthcare.org

MEMBERS ON THE MOVE

Gloryanne Bryant, RHIA, RHIT, CCS

HIM Managing Director

Kaiser Permanente Northern California - Oakland

Email: gloryanne.h.bryant@kp.org

Carl Hill

Senior Account Executive

California Service Bureau/True North AR

Paula Murphy

Manager, Patient Financial Services/Admitting
Doctors Medical Center

WELCOME NEW MEMBERS!

- **Lillie Allen** - KFH/P **Robert Barrett** - Regional Manager, Healthcare Resource Group
- **Monica N. Bernkrant** - Accounts Receivable Consultant, Horizon West Health Care
- **Adrienne Burgoyne** - Director Financial Decision, Adventist Health
- **Micki L. Campbell** - Manager, CHW Sacramento Region
- **Nellie Carrillo** - Follow-up Coordinator, Community Hospital of the Monterey Peninsula
- **Margaret Casarez** - Chief Financial Officer, San Joaquin Valley Rehab Hospital
- **Judy Chandler** - Sales, SOURCECORP Deliverex
- **Jaymes Cheney** - Budget & Reimbursement Analyst II, Adventist Health
- **Robert A. Chrisoulis** - Partner, Revenue Recovery Services, Inc.
- **Neil R. Cohn** - Client Service Coordinator, Diversified Healthcare Resources
- **Michael Corey** - Partner, Pricewaterhousecoopers
- **Lupe Correa** - Billing Coordinator, Community Hospital of the Monterey Peninsula
- **Somshankar Das** - President and CEO, E4e, Inc.
- **Terese Davis** - Director, Patient Access & Communication
- **Holly Delaney** - Director Revenue Cycle Reporting, Kaiser
- **Monica Dellosa** - KFH/P
- **Jennifer W. Draa** - Senior Manager, Kaiser Permanente
- **John Fach** - Financial Consultant
- **Mathew Fischer, MBA** - Group Marketing Manager, Intuitive Surgical
- **Antonio J. Fonseca** - Non Government Follow-up Supervisor, Caritas Business Services
- **Brian Ford** - Budget Analyst, Community Hospital of the Monterey Peninsula
- **Edward A. Gardner** - Executive Director, Kaiser Permanente
- **Darlane M. Johnsen**
- **Lauryn Jones** - VP Business Development Healthcare, E43, Inc.
- **Dhyan D. Lal** - Sr. Revenue Cycle Services Director, Conife Health Solutions
- **Felix Lee** - Business Analyst
- **Garfield Liggett** - Sr. Manager/Director, Kaiser Permanente
- **Jorge Martinez** - Student, Diversified Healthcare Resources, Inc.
- **Maureen Muzinich** - Director of Admissions Services, Sutter Roseville Medical Center
- **Jacqueline Nelson** - Supervisor, NorthBay Healthcare System
- **Marni L. Richards** - Director of Revenue Management, Sonoma Valley Hospital
- **Keenan Rooney** - Managing Director, Resources Global Professionals
- **Crystal Ruditsky** - Lead Analyst, Adventist Health
- **Christopher Salemme** - Sr. Manager, Kaiser
- **Diane Smart** - Asst. Director PBS, Community Hospital of the Monterey Peninsula
- **Geoff Smyth** - President Healthcare, E4e, Inc.
- **Louis C. Starr, III** - Asst. Director, Watsonville Community Hospital
- **Karin Stryker** - Accountant III, Contra Costa County
- **Janet Walsh** - Regional Finance Manager, Olympus America, Inc.
- **Irene Wong** - Medenalytics

In Appreciation

Thank you to our Corporate Sponsors for their continuing support of the Northern California chapter

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Job Opportunities

Visit the chapter website (<http://www.hfma-nca.org>) for details and a complete listing of job openings



- 📍 **Chief Financial Officer** - San Mateo County Health System (posted 6/23/09)
- 📍 **Financial Analyst III** - Caritas Business Services (posted 6/18/09)
- 📍 **Director, Revenue Analysis and Operational Reimbursement** - Caritas Business Services (posted 6/18/09)
- 📍 **Supervisor Business Office** - St. Joseph Health System - Sonoma County (posted 6/15/09)
- 📍 **Chargemaster Coordinator** - Washington Hospital (posted 6/15/09)
- 📍 **Deputy Finance Officer** - SF Department of Public Health/Laguna Honda Hospital (posted 6/10/09)
- 📍 **Chief Financial Officer** - Mt. View Hospital, OR (posted 6/1/09)

Northern California Chapter Board of Directors

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Kathleen Cain - President-Elect
Steve Thompson - Secretary
Jayne Kroner - Treasurer

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