

Louisiana LEDGER

THE OFFICIAL NEWSLETTER OF THE LOUISIANA CHAPTER OF THE HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

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Yes, Those CMS Enrollment Forms Really Do Matter

The Affordable Care Act includes provisions to help reduce fraud and abuse. One segment of the federal government's efforts is the heightened focus on the Medicare enrollment process for both Medicare and Medicaid providers. The final rule on these changes can be found at 42 Code of Federal Regulations (CFR) §§424.500-424.570. These governmental efforts to reduce fraud and abuse necessitate that providers maintain current provider enrollment information. Providers are under greater scrutiny and their enrollment information must be updated as changes occur in order to avoid unpleasant disruptions in revenue.

Providers who fail to keep their provider enrollment information current risk deactivation of their Medicare and Medicaid billing privileges. The information which must be maintained includes information not just specific to the physician but also information regarding the physicians' practices. Changes to this information must be submitted within ninety (90) days of the effective date of the change.

Information which must be kept current includes but is not limited to changes in the physical address of practice, changes in the correspondence/ mailing address of practice, changes in billing companies, initiation of use of a billing company, changes in managing employees, additions or deletions of managing employees, changes in business structure such as moving from a professional corporation to an LLC, withdrawal of a member of an LLC who has a five-percent (5%) or greater ownership interest, the addition or deletion of a practice location, and changes in location of medical record storage if the records are stored off-site.

Failure to maintain current information with the Medicare/Medicaid contractor may result in additional work and expense, in addition to a disruption in revenue. When a provider's Medicare and/or Medicaid billing privileges have been deactivated, the provider must complete and submit a new enrollment packet. During the interim period for processing of this enrollment packet, payments for Medicare and/or Medicaid will be suspended. The new enrollment packet must be approved and processed before billing privileges can be restored; this process may take several months to complete. Meanwhile, the provider is

forced to function on reduced revenue. The deactivation of Medicare/Medicaid billing privileges does not affect the Medicare Participating Provider of Supplier Agreement but certainly can place a financial burden upon a practice.

A deactivation from Medicare/Medicaid is different from a revocation of billing privileges. When a provider's billing privileges are deactivated, the billing privileges are stopped but can be restored upon submission and processing of an updated 855 form. In contrast, a revocation means that the provider's billing privileges are terminated; this termination usually lasts for a minimum of a year but may last for a number of years depending upon the circumstances.

To help minimize the risk of deactivation of Medicare and/or Medicaid billing privileges, providers should take the following steps:

- 1) Maintain accurate records including executed copies of office leases, employment records, changes of mailing address, banking records, etc;
- 2) Designate one individual, who has been properly trained to handle 855s or hire a professional who is familiar with the 855 process to handle this for you;
- 3) Maintain copies of all documents submitted for any changes so that in the event of a discrepancy with the contractor, the documents are available as proof of the information which was actually submitted; and,
- 4) **All** 855 forms should be submitted via Federal Express or certified mail return receipt, as it is not unusual for documents to be misplaced in the contractor's file and proof of the date of submission can be crucial.

Accuracy of information and timeliness of submissions are critical. Adopting the approach to insure that any and all changes are submitted to the Medicare contractor timely will greatly reduce the likelihood of Medicare deactivation and reimbursement problems related to changes within the practice.

Elizabeth Maier is an attorney with Gachassin Law Firm, which is dedicated to the representation and counseling of healthcare providers.





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Check Your Founders Points

Did you know that you can check your founders points 24/7 through the HFMA web site www.hfma.org?

It is easy. Just follow these few, easy steps.

1. Go to www.hfma.org
2. Click on membership
3. Go to manage my account
4. Log in with your user name and password
5. Click on the box that says view founders points

If you find a discrepancy, contact LAHFMA's Founder contact, Chris Kohlenberg.

President's Message

As we begin the New Year we are preparing for the impact of the Affordable Care Act. I hope part of everyone's New Year's resolution is to remember to keep the patient at the center of all decisions that are made in preparing for this impact. The year 2013 will be challenging for those of us in healthcare finance. Please use your membership in HFMA to help you in dealing with these upcoming challenges.

The Region 9 meeting was held in New Orleans this past November. Over 430 participants attended the meeting. As always the Louisiana Chapter was well represented. I would like to thank Theresa Avery and Bob Ramsey for representing our chapter in planning and organizing this successful meeting.

I hope to see everyone at our Winter Institute which will be held at the Baton Rouge Marriott on January 27th- 29th. I would like to thank our Program Chair, Alicia Jones, for her hard work with organizing this meeting. Alicia has also worked with our Social Chair, Laurie Borne, to help create a new social event for the Winter Institute. *The Issue* will be performing on Monday, January 28th at Sullivan's Ringside. Please join us for an evening of networking and fun. Hope to see you there.

Please remember to mark your calendar for our Annual Institute to be held at the Lafayette Hilton on May 5th thru May 7th. The Annual Institute is our biggest meeting of the year and features many activities, including the always popular Crawfish Boil.

I would like to thank everyone who took part in our member survey. We should be receiving the results very soon. As always, the Board will review the survey to help guide the chapter's future strategic plan and programs.

The incoming Board of Directors is beginning to plan the next year's activities and select committee chairpersons. Please consider how you could best contribute to our chapter. If you are interested in getting more involved next year or have any questions, please contact our incoming President, Alicia Jones.

On behalf of the Board of Directors, I would like to wish everyone a happy and prosperous 2013.

Sincerely,
Scott D. Richard
President, LAHFMA 2012-2013

Committees and Chairpersons

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Advanced Programming	Charmaine Vidrine	
Compliance	Sharon McGee	Rob Hawkins
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Membership	Mary Leah Walke	
Membership Directory	Mary Leah Walke	
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Strategic Planning	Scott Richard	Lucius Butts, Alicia Jones
Bylaws	Doug Jerome	
Nominations	Scott Richard	Lucius Butts, Chris McGivaren
Medicare/Medicaid	Rob Hawkins	
Sponsorship	Lucius Butts	Chris McGivaren, Mike Mousset
Vendor Exhibit	Olivia Wilbert	
Social Networking	Bud Parnell	
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WELCOME NEW MEMBERS

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Asst. CFO
Teche Regional Medical Center

Kim Delatte
Comptroller
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Ochsner Clinic

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CFO
Slidell Memorial Hospital

Thomas J. Stranova, ScD
MHA Program Director
Tulane



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MEMBERSHIP NEWS

MEMBERSHIP NEWS provided by
Membership Committee.

MEMBER-GET-A-MEMBER PROGRAM

How the program works:

Recruit One or Two Members (new* or former **) and receive your choice of:

- An HFMA apparel item (approximate retail value of \$25)
- \$25 Fuel Visa Prepaid Card.***
- Recruit Three or Four Members (new* or former **) and receive:
 - A \$100 Visa prepaid card good anywhere Visa debit cards are accepted worldwide.
 - An entry into a drawing (among those recruiting three or four members) to receive a \$1,000 cash prize.
- Recruit Five or More Members (new* or former **) and receive:
 - A \$150 Visa prepaid card.
 - An entry into a drawing (among those recruiting five or more members) to receive a \$2,500 cash prize

New!

Member iPad Drawing

For every new or former member you recruit, you will receive one entry into a drawing for a brand new iPad! There are three chances to win! Drawings will be held in October, January and March.**** You will be contacted if you win, and your name will be announced in the following month's Membership Marketing Brief!

Member Make a Difference Grand Prize

For every new or former member you recruit, you will receive one entry into the drawing for the Member-Get-A-Member Make a Difference Grand Prize worth \$5,000. You will receive \$3,000 in cash for yourself and a \$2,000 donation in your name to the charity of your choice.

The more members you sponsor, the greater your chance to win!

CHECK OUT THE LAHFMA WEB-SITE

We have added our policies for easy online access by our members. Click on "policies" on the tool bar at the top of the home page to find the LAHFMA Bylaws, Strategic Plan, Conflict of Interest Statement, Record Retention policy, Whistle Blower policy, and our Expense and Reimbursement policy.

Upcoming LAHFMA Events

2013 Winter Institute
location TBD

**Sunday January 27th thru
Tuesday January 29th 2013**
(dates tentative at this time).

2013 Annual Institute
Lafayette Hilton

**Sunday May 5th thru
Tuesday May 7th 2013.**

Do I Qualify for a BP Claim?

See Chart on page 4

On April 20, 2010, an explosion occurred on British Petroleum's Deepwater Horizon rig in the Gulf of Mexico.

The disaster killed 11 workers and set off a spill which continued for 87 days, fouling large areas of the southern coast of the United States.

On top of the environmental damage, many industries along the Gulf Coast were indirectly affected.

In September 2011, federal regulators concluded that BP bears ultimate responsibility. As a result, BP booked \$38.1 billion to cover its liabilities from the incident.

While no final agreement has been reached as to the actual settlement and payout, some important issues have been clarified and are noteworthy to the healthcare industry.

Many healthcare providers are under the false assumption that the settlement funds are restricted to industries directly related to the Gulf such as tourism and commercial fishing. This is NOT true.

In July 2012, parties involved clarified that the settlement INCLUDES healthcare providers, since many were inadvertently affected by the spill.

The settlement merely requires that a provider be in a specific geographic areas and meet certain causation tests that are PURELY mathematical.

As a result, many healthcare providers in the affected region may be entitled to file a claim.

Unfortunately, most providers are unaware of this option and even fewer have the expertise to navigate the draconian claim process. The settlement is over thousand pages long and few have read the entire document.

While we've simplified the process as much as possible in the attached flowchart, the financial causation tests require complex calculations under hundreds of scenarios.

Most attorneys and/or CPAs have limited experience with this process and are subcontracting with specialists to assist in preparing their claim.

Receivable Recovery Service is uniquely qualified in this area and is available for the next 30 days to assist any LAHFMA member with a free consultation regarding their claim.

Dedicated Observation Units: The Clinical and Financial Implications

By: Cyndy Kowalski, RN, MPA, C-CDIS

Current healthcare reform efforts have identified inefficiencies in access, cost, and quality of care within acute care hospitals. The Affordable Care Act is strengthening the case for dedicated observation units. Medicare's payment penalties for excess 30 day readmissions will place more pressure on hospitals to decrease inpatient readmissions. In this environment of increased scrutiny, few opportunities exist with the potential to reduce cost, enhance patient satisfaction, and improve the quality of care. Although hospitals have explored the concept of observation, many have not developed such units for reasons that include limited space, resources, or an understanding of the clinical and financial implications.

Visits to Emergency Departments (ED) exceed 120 million each year¹, inpatient beds are scarce and expected to become more so, Medicare payments are becoming less, and audits and denials are becoming greater. The decision to develop any type of observation service begins with a solid commitment from Senior Leadership and strong Physician and Nurse Leadership.

The Center's for Medicare and Medicaid Services (CMS) define observation care as "ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." Observation care is intended to be a time-limited outpatient service. According to CMS, "the decision whether to discharge a patient from the hospital or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours."

It is our experience that patients placed in dedicated observation units are more accurately diagnosed, discharged to home faster, payers avoid costly admission charges, and scarce inpatient bed capacity is more appropriately utilized. More frequent use of observation can reduce unnecessary admissions and improve fiscal performance for the hospital while increasing patient satisfaction.

Patients who are managed in dedicated (versus virtual) observation units are more likely to receive necessary testing, have shorter lengths of stay and lower overall care costs, in addition to enhanced patient satisfaction. Providing an alternative to avoidable admissions, observation units allow the hospital to reserve inpatient beds for those patients that need it and relieve ED overcrowding.

The virtual model is certainly inexpensive, presents as easy to implement, using beds located throughout the hospital, and existing staff however, it does contain potentially significant drawbacks, including inconsistent care and delays. It can be a "culture shock" for inpatient clinical staff to care for observation patients whose care requires timely and more frequent assessments and testing. It is unfortunate to lose sight of managing these patients within the 12-24 hour window.

Understanding the profitability of a dedicated observation unit starts with the basic hospital profit equation in which profit equals revenue minus costs. Observation units can convert previously unprofitable inpatient admissions into profitable observation stays. Hospitals must be careful about shifting too many cases into observation units.

To finish the profit equation and assist in determining the profit potential of an observation unit, costs must be considered. There are fixed costs; which will include start up and maintenance of the unit and staffing costs. The number of observation patients that one nurse must manage is often higher than inpatient ratios. Variable costs, such as linen and paper charting supplies are relatively insignificant.

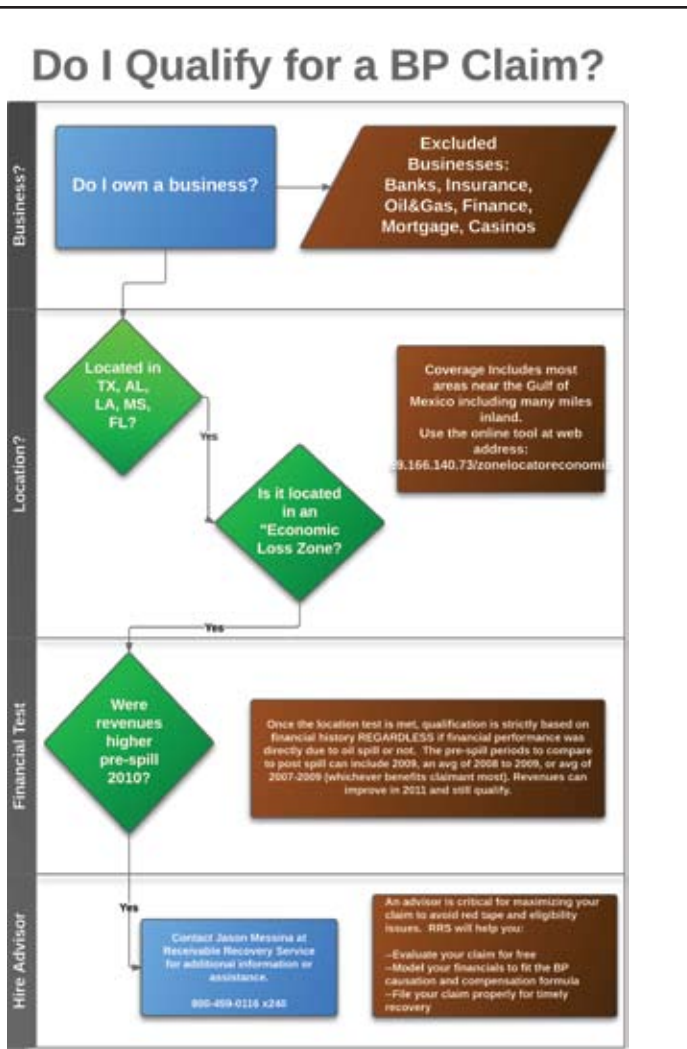
For every patient treated in an observation unit and discharged who would have otherwise been admitted, an inpatient bed could be occupied by a patient with the intensity of service which necessitates the acute level of care. Chest pain is one of the more common observation diagnoses. A patient admitted vs. placed in observation may result in a denial due to lack of medical necessity and recoupment of the MS-DRG. If the patient is most appropriate for observation, the facility has the opportunity to bill outpatient charges such as observation hours and infusion services. An efficient observation unit provides opportunity to manage patients as outpatients and determine the most appropriate plan of care.

Observation units can convert previously unprofitable hospital admissions into profitable observation stays while still providing appropriate evaluation, treatment, and risk stratification.

BESLER Consulting provides a variety of observation and case management services. For more information, please contact Cyndy Kowalski, RN, MPA, C-CDIS at 609-514-1400 or ckowalski@besler.com.

REFERENCES

•Centers for Disease Control and Prevention, National Center for Health Statistics. (2010) Selected patient and provider characteristics for ambulatory care visits to physician offices and hospital outpatient and emergency departments. United States, 2008.



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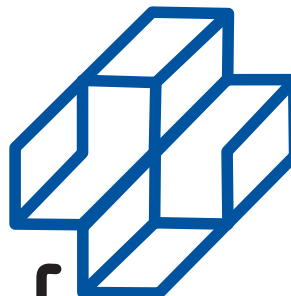
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What's "New" in the OIG Work Plan

By: Kathy Ruggieri, Senior Director, Revenue Cycle Services

The U.S. Department of Health and Human Services, Office of Inspector General (OIG) has recently issued the Fiscal Year (FY) 2013 OIG Work Plan. This is an annual Work Plan that addresses the current focus areas of the OIG, including projects still in process from prior FYs in addition to new focus areas for the upcoming year.

Although the Work Plan addresses initiatives for all types of providers, this article will focus on some of the new hospital audits. Some of these audits may or may not be indicative of future Medicare payment reductions. It is recommended that Hospitals stay abreast on these focus areas throughout the year to best anticipate future revenue reduction initiatives.

Diagnosis Related Group (DRG) Window

The DRG Payment Window Policy has been a component of the Inpatient Prospective Payment System (PPS) regulations since 1983. There have been changes to this policy over the years, and in 2012, the DRG Payment Window was expanded to include wholly owned physician practices. The OIG focus for 2013 will be to analyze claims data to determine how much CMS could save if it bundled outpatient services delivered up to fourteen (14) days prior to an inpatient hospital admission into the DRG payment. The current DRG payment Window Policy bundles all outpatient services delivered three (3) days prior to an inpatient admission. The OIG anticipates that significant savings could be realized if the DRG window was expanded from three (3) to fourteen (14) days. Hospitals should pay close attention to these audits as an expansion to this program will have significant financial implications to hospital outpatient service revenue.

Compliance with Medicare's Transfer Policy

The Medicare Post Acute Transfer Rule was implemented in FY 1998 and has been

expanded in FYs 2005, 2006, 2007, 2008 and 2012. Pursuant to federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. In contrast, a hospital that transfers a beneficiary to another facility is paid a graduated per diem rate for shorter lengths of stay. The OIG has performed significant audits of claims that were reimbursed the full DRG rate and has provided guidance to CMS on claims processing edits that would concurrently identify claims that were actually transferred to another facility and would result in the lesser per diem rate. Based on these recommendations, the Medicare Administrative Contractors (MACs) have implemented claim edits to identify these situations to prevent overpayment situations. Historical OIG audits identified the effectiveness of these edits. OIG audit results have revealed an 85% effective rate with the claims processing edits. The MACs were charged with making additional changes to these edits to further improve the effectiveness. In 2013, additional audits will occur to evaluate the effectiveness of these claim edits to determine if the edits have improved.

Payments for Discharges to Swing Beds in Other Hospitals

The OIG will review Medicare payments made to hospitals for discharges that were coded as discharges to a swing bed in another hospital. Swing beds are inpatient beds that can be used interchangeably for acute care or skilled nursing care. Currently, federal regulations allow for a full DRG payment for discharges coded as "Swing Bed" (patient discharge status code of "61"). However, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another PPS hospital. This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged "early", and then admitted to another post acute provider post discharge. Since Medicare does not pay a reduced

payment for discharges to a "Swing Bed", the OIG will evaluate these situations and if appropriate, recommend that CMS evaluate their policy related to payment for hospital discharges to swing beds in other hospitals. In the event this change is implemented, hospitals who discharge patients to "Swing Beds" and utilize patient discharge status code of "61" will experience further claim reductions as additional claims will be impacted by the Medicare Post Acute Transfer Rule.

Non-Hospital Owned Physician Practices Using Provider Based Status

The OIG will assess the impact of non-hospital owned physician practices billing Medicare as provider based physician practices. A determination will also be made with regard to whether provider based status meets CMS billing requirements. Since provider based status can result in additional Medicare payments, it also increases a Medicare beneficiaries' coinsurance liabilities. Hospitals that bill with a provider based status should evaluate whether the Medicare criteria specific to provider based physician status is met.

It is clear that the OIG is looking for opportunities to further reduce Medicare reimbursement. It is important for Hospitals to keep current on these potential revenue reductions. It is recommended that Hospitals continue to take full advantage of comment periods to communicate concerns with regard to payment reduction initiatives.

BESLER Consulting can help your organization recover otherwise lost revenue, maximize reimbursement, increase compliance, improve efficiencies and reduce costs. For more information, please contact Kathy Ruggieri at (732) 392-8227 or kruggieri@besler.com.

Employing Excluded Parties

Have you noticed the recent rash of Office of Inspector General's (OIG) civil monetary penalties levied on providers for employing excluded parties? Here's a few of the penalties in November and October when providers self disclosed the excluded party's employment to the OIG.

Community General Hospital (CGH), NY, agreed to pay \$248,362 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that CGH employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

Baptist Hospital, Inc. and Langhorne Cardiology Consultants, Inc. (Baptist and Langhorne), Florida, agreed to pay \$172,604 for allegedly violating the Civil Monetary Penalties Law. The OIG

alleged that Baptist and Langhorne employed an individual that they knew or should have known was excluded from participation in Federal health care programs.

Dr. Akram Abraham d/b/a Abraham Medical Clinic (Dr. Abraham), Massachusetts, agreed to pay \$43,014.80 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Dr. Abraham employed an individual that he knew or should have known was excluded from participation in Federal health care programs.

Home Healthcare Connection, Inc. (HHCI), Kansas, agreed to pay \$81,102 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that HHCI employed an individual that it

continued...

knew or should have known was excluded from participation in Federal health care programs.

Auburn Community Hospital (ACH), New York, agreed to pay \$150,000 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that ACH employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

Valley Healthcare, Inc., East Orange General Hospital, and Essex Valley Medical Transportation Services, Inc. New Jersey, agreed to pay \$61,570 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that the respondents employed two individuals that it knew or should have known were excluded from participation in Federal health care programs.

Duke University Health System, Inc., d/b/a Duke University Hospital (Duke), North Carolina, agreed to pay \$6,395 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Duke employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

Salida Hospital District d/b/a Heart of the Rockies Regional Medical Center (HRRMC), Colorado, agreed to pay \$120,580 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that HRRMC employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

From this list above providers can see the OIG's position on employing excluded parties, so regular clearances can protect hospitals or minimize the risk of civil monetary parties. The penalties above do not include the internal costs of dealing with a reportable occurrence.

As a condition of participation in the Louisiana Medicaid Program, providers are responsible for ensuring that current as well as potential employees and/or contractors have not been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid and/or the Office of Inspector General (OIG). Providers who employ or contract with excluded individuals or entities may be subject to penalties of \$10,000 for each item or service the excluded individual or entity furnished.

Providers must check the following two websites prior to hiring or contracting with an individual or entity and on a monthly basis

to determine the exclusion status of current employees and contractors. All current and previous names used such as first, middle, maiden, married or hyphenated names and aliases for all owners, employees and contractors should be checked.

<http://exclusions.oig.hhs.gov/search.aspx>

<http://www.epls.gov/eplsearch.do>

If an individual's or entity's name appears on either website, this person or entity is considered excluded and is barred from working with Medicare and/or the Louisiana Medicaid Program in any capacity. The provider must notify the Department of Health and Hospitals with the following information:

Name of the excluded individual or entity, and...

Status of the individual or entity (applicant or employee/contractor).

If the individual or entity is an employee or contractor, the provider should also include the following information:

Beginning and ending dates of the individual's or entity's employment or contract with the agency,

Documentation of termination of employment or contract, and...

Type of service(s) provided by the excluded individual or entity.

These findings should be reported to

**Department of Health and Hospitals Program Integrity
Special Investigations Unit
P. O. Box 91030
Baton Rouge, LA 70821-9030**

Providers should note that the EPLS site has switched to System for Award Management (SAM). I wonder if the penalties above have anything to do with the name. SAM can be found at <https://www.sam.gov/portal/public/SAM/>.

Additionally, providers should check the US Treasury's Specially Designated Nationals (SDN) list to ensure they are not employing or contracting with prohibited persons or entities. The SDN website is <http://sdnsearch.ofac.treas.gov/>.

Regular excluded party clearances can minimize the cost and time of dealing with issues surrounding excluded parties. —Rob Hawkins

Another Band-Aid for Medicare Reimbursement The Fiscal Cliff "Doc Fix"

On January 1, 2013, Congress agreed to the 2013 American Tax Relief Act, designed to avert the "fiscal cliff," that included taxing and spending provisions of varying levels. For healthcare sector, the key issue was Medicare physician reimbursement, and preventing a 26.5% drop in physician fees initially stemming from the 1997 Balanced Budget Act (BBA), which included a provision called the Sustainable Growth Rate (SGR). The SGR is a complex formula used to set annual expenditure targets for Medicare and to adjust physician payment in order to keep Medicare spending from exceeding the rate of growth in the gross domestic product (GDP). In the beginning years of the BBA, the cumulative amount spent by physicians on Medicare was below the targeted amounts specified by the SGR. However, in 2001 the payment rates decreased by 4.8%,

generating momentum for the adjustment to physician reimbursement be delayed. Since then, Congress has stepped in annually to delay the expected decreases in reimbursement, a process called the "doc fix." This annual tradition creates a problem as 26.5% of cumulative reimbursement cuts are now needed to break even after ten years of deferring the cuts. Congress and the President have signaled that they favor repeal of the the SGR as a whole, but because that repeal would cost approximately \$300 billion over ten years as a result of the accumulated costs, they keep approving temporary "fixes."

2013 American Tax Relief Act

The result of the SGR's impact is delayed for another year and will cost \$25.2 billion over the next decade. And even this number, however slight

compared to the \$300 billion cost of applying the SGR, has come at significant cost. The largest cut includes \$10.5 billion from hospitals by a downward adjustment in annual base Medicare payment rate increases. Other cuts include payment adjustments for End Stage Renal Disease (ESRD) (\$4.9B), re-basing payments for Disproportionate Share Hospitals (DSH) (\$4.2B), modifying the coding intensity between Medicare Advantage and Medicare fee-for-service (\$2.5B), reduced payments for certain therapies provided on the same day (\$1.8B), and eliminating the Medicare Improvement Fund (\$1.7B).

Issues with SGR

With the implementation of the Patient Protection and Affordable Care Act (PPACA), as well as a post-recession

continued...

commitment to more responsible spending decisions, momentum is building for attempts at a more permanent solution. The Alliance for Health Reform has pointed out that the SGR has various problems, including its spending rates being based on a one year period between 1996-1997, its failure to account for the influx of baby boomers who began joining Medicare in 2011, and the lack of incentive for individual physicians to decrease their Medicare expenditures without a commitment from the profession as a whole.

Proposed Solutions

If Congress is to repeal the SGR, there are various ideas for solutions. For example, the Medicare Payment Advisory Commission (MedPac), a non-partisan body that advises Congress on Medicare policy, recommends that if Congress repeals the SGR, it should continue to

hold primary care doctor payments steady because of their already low rate, their inability to increase volume or intensity of their practice, and the focus on primary care in PPACA. Growth rates for specialty physicians would receive the full cut and would then be frozen after three years.

The Medicare Physician Payment Innovation Act of 2012, a proposal sponsored by Pennsylvania representative Allyson Schwartz, proposes to fund the repeal with money saved from the withdrawal of troops in Afghanistan and Iraq. But this money has been earmarked by multiple interest groups for funding and is ostensibly part of a general effort to decrease federal government spending in the first place.

Another potential solution has been advanced by Kentucky Senator Rand Paul, who proposed a new reimbursement

formula with the SGR repeal paid for by eliminating the expansion of Medicaid and the inclusion of subsidy payments in PPACA.

As we've seen in the implementation of PPACA, the interplay of stakeholders is complex and can be unexpected. As a result, the planning for the solution to the "doc fix" must be a dialogue that takes place concurrently with healthcare reform. As payment systems shift to a more integrated model, the "doc fix" must be considered. The Medicare reimbursement rate does not have to be solved in a year, but a long term plan must be agreed upon before the SGR deficit becomes too large to reverse.

Stephen M. Angelette is an associate attorney specializing in healthcare at Breazeale, Sachse & Wilson LLP in Baton Rouge, Louisiana.

Fiscal Year 2014 Wage Index Development Timetable

By: David Verbaro

On October 3, 2012, The Center for Medicare and Medicaid Services (CMS) released the FY 2014 Hospital Wage Index Development Timetable. This timetable provides hospitals with a set of important dates and deadlines that must be followed during the review of their submitted wage index and occupational mix data. Along with this timeline, two preliminary wage index files were released. The first of the two files contains the unaudited FY 2010 Worksheet S-3 wage data. This file includes wage data from any cost reports submitted through June 30, 2012. The second file is the 2010 occupational mix survey data that was included in the FY 2013 IPPS final rule, excluding hospitals that were designated as Critical Access Hospitals as of September 2012.

From the time these files were released until December 3, 2012, providers have an open window to review their wage data one last time and request any necessary revisions. Any adjustments to this data must be submitted to FI/MAC with supporting documentation by the December 3rd deadline in order to be considered. This data will be reviewed by

the FI/MACs over the next 10 weeks and revised wage index and occupational mix Public Use Files (PUF) will be released on February 21, 2013. Hospitals that submitted initial revisions will have until March 3, 2012 to submit any requests for error corrections or desk review adjustments that are included in these PUFs. This data will be published sometime in April or May in the form of the proposed rule. It is vital that all providers review this data during this open window so that their wage index data will be as accurate as possible when published in the 2014 IPPS Final Rule effective October 1, 2013.

It is also important for providers to review their occupational mix data that was derived from the 2010 occupational mix survey, as this data is used for a three (3) year period. Providers who missed out on this open window for FY 2013 should be sure to take advantage of this opportunity as the data will be used for both FY 2014 and 2015. With the national average hourly wage (AHW) steadily increasing year after year, it is important for providers to continually improve their Core Based

Statistical Area's (CBSA) wage index. A failure to shadow the national growth will result in a decrease in Medicare reimbursement from year to year for all providers in that CBSA.

Whether it is done internally or contracted with a vendor, many hospitals feel that it is senseless to dedicate time, money, and resources to an area which may be altering in coming years under the healthcare reform. However, with the details and timeframe of the wage index changes unclear, hospitals should continue to take advantage of existing wage index opportunities by assuring their data is compliant and that they are receiving the maximum amount of reimbursement possible under the current system.

BESLER Consulting provides a variety of wage index services including reviews and audits of both wage index and occupational mix. For more information, please contact David Verbaro at 732.392.8242 or dverbaro@besler.com.

