Audit cath labs effectively

There’s a lot riding on the accuracy of cardiac catheterization laboratory (cath lab) billing and coding.

“Cardiovascular procedures are some of the highest paid under Medicare, and that automatically makes it an area of focus for compliance,” says Leatrice Ford, RN, BSN, CCS, CEO of ConsultCare Partners, LLC, in Louisville, KY. “Compound that with the press related to device recall and the liability associated with patient safety, and you’ve got more risk than just fraud and abuse.”

Too many organizations fail to provide the level of auditing and staff member educational support cardiac cath programs require, Ford says. “Cardiac coding and billing is some of the most complex of all service lines, and many facilities do not devote enough resources to make sure it’s done correctly,” she adds.

A comprehensive cath lab audit can uncover problems, capture lost revenue, begin improving processes and procedures, and help the organization avoid compliance problems.

Set objectives

The first step involves creating an audit plan for exactly what will be studied. Ford offers the following list of areas to consider:

➤ **Charge capture:** Ensure that all possible charges are recorded and no overbilling takes place.

➤ **Coding procedures:** Determine whether the appropriate codes are used on a consistent basis.

➤ **Devices:** Verify they are being used with FDA approval and according to Medicare criteria.

➤ **Documentation:** Ensure the information provided about medical necessity is clear, and the procedure is documented as billed.

➤ **Quality of care:** Make sure to track complication rates and find out whether any procedures fall below accepted complication benchmarks. Establish tracking processes to improve outcomes.

➤ **Physician credentialing:** Clarify physicians’ credentials to find out whether they are correctly credentialed to perform the procedure and are not closely tied financially to the device manufacturer.

“One [topic] is not more important than the others, but I feel many facilities are not staying on top of the appropriateness of procedures and whether devices are being used appropriately,” Ford says. “They also can be sloppy in their billing.”

“Ultimately, the hospital is responsible for the care delivered to the patient. You can’t close your eyes to it and believe it’s the physician’s issue. You can’t let profit deter you from doing the right thing.”

—Leatrice Ford, RN, BSN, CCS
Cath labs

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Select a sample

Take a look at 3%–5% of claims, says Denise Hall, RN, BSN, a partner with Pershing Yoakley & Associates, PC, a public accounting firm in Knoxville, TN. That’s a reliable sample or pool of claims to study because it will identify trends but not overwhelm the auditor with volume.

“I like to base the sample population on a year’s worth of claims because you get a good representative sample,” she says. “You can get away with doing six months, but anything less than that is too narrow a window.”

Avoid selection bias in the claims by picking them with the help of a random number generator, such as anything less than that is too narrow a window.

If your focus is on compliance, only include those claims involving government payers, Hall says. These claims are most likely to cause the organization major problems, such as large recoupments, a corporate integrity agreement, and possibly, treble damages if fraud is identified.

Create a team

A variety of individuals and departments should be involved in a cath lab audit, even if they are initially resistant to it.

Departments such as health information management (HIM), finance, or the cath lab may not admit they need special help in documentation, coding, and billing for cath lab services, Hall says.

They may not want to admit there’s a need to dedicate a coder to oversee proper coding and billing. But it can be important to help all parties involved understand that correct data help the organization ensure compliance, measure profitability, and provide quality care based on evidenced-based medicine.

Physicians sometimes are reluctant to help with documentation issues, and many hospitals are hesitant to confront physicians about issues related to medical necessity or appropriate use of devices, Hall says. Still, it’s crucial to get buy-in from a variety of areas for the audit to be effective.

“It’s a team effort, and no one department can do it alone,” Ford says.

Collect documentation

Gather together all the information you’ll want to review as part of the audit. This should include:

➤ Clinical documentation from the procedure under review
➤ Physician dictation and/or procedural documentation
➤ The procedure report, which outlines all the equipment and medications used
➤ An itemized bill, so you can see the charges generated
➤ The UB-04 claim form
➤ The remittance advice

You will need to compare the documentation to the charges that were generated and billed to determine whether there are discrepancies, Hall says.

“You should expect to identify some errors,” she says. An error rate of less than 5% is good, but anything more than that demonstrates a need for staff training and a follow-up audit approximately three months after the education.

Look for missed charges

It’s particularly important to have someone familiar with cardiac cath CPT codes involved in the audit, Hall says. “They often need a clinical background because cardiac cath coding can be technical in nature,” she says.

Cath labs are unique because they use so many high-priced implants, says Rosanna Coppola-Borges, CPA, internal audit director at Mercy Hospital in Miami.

“If you are missing an implant, that’s a large chunk of change there,” she says.

Mercy Hospital uses a revenue capture specialist to examine cath lab cases involving medical devices to ensure that the procedures related to the implantation of those devices were captured along with the devices themselves.

Mercy Hospital found that, in some cases, the wrong procedure had been charged. In other instances, procedures had been missed.

In another audit related to the cath lab, Mercy Hospital used a computer tool from ACL software (www.acl.com) to validate accounts. This audit analyzed whether all aspects of a procedure had been charged (e.g., it looked for missing fluoroscopy charges in pacemaker procedures or inpatient accounts that failed to capture

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Did you miss it?

Plagued with compliance risks, increased federal regulatory attention, and inappropriate billing, the catheterization laboratory (cath lab) requires a systematic auditing strategy—the foundation of financial success. With HCPro, Inc.’s audioconference “2007 Cath Lab Audits: Strategies to streamline compliance,” learn strategies to streamline compliance in your cath lab and accurately code for its services. Hospitals across the country continue to struggle with reporting requirements and reimbursement for outpatient cath lab services. That’s why HCPro developed this intensive two-hour audioconference designed to help you and your staff audit for compliance in the following high-risk areas:

➤ Correctly determining the difference between billing for the professional and technical portion of procedures
➤ Properly billing for drug-eluting, drug-coated, and bare-metal stents
➤ Accurately determining which patients are inpatients and which are outpatients
➤ Correctly billing for diagnostic, therapeutic, and combined heart caths

To purchase a CD-ROM of this informative audioconference, visit www.hcmarketplace.com/prod-5642.html or call our customer service department at 877/727-1728.

Pick the right team members for your cath lab audit

Involve the following healthcare professionals in your catheterization laboratory (cath lab) audit:

➤ Cath lab management, to conduct reviews
➤ Health information management, to provide coding advice
➤ Quality assurance staff members, to provide advice regarding procedure appropriateness
➤ Medical staff office members, to maintain credentialing criteria for physicians
➤ Physician directors, to counsel physicians to improve outcomes and prevent inappropriate use of technology
➤ Compliance department members, to advise the organization about improvement efforts and to determine issues where self-reporting may be necessary
Cath labs < continued from p. 3

charges for OR time). The hospital identified $400,000 in missed charges through this process for the period reviewed, September 1, 2006, to March 31, 2007.

Identify errors

In addition to spotting overlooked charges, an audit should identify mistakes in coding or billing. “There’s a great deal of complexity” in cath lab coding and documentation, especially as more involved procedures are performed, Hall says. And that can lead to costly coding errors.

Some facilities use the chargemaster to automatically populate the bill with both charges and CPT codes, she says. This works well for the majority of procedures that are routine. However, that automation can cause problems in charging for more complex procedures such as stent placements and other invasive procedures that also tend to be more variable. “There’s a real opportunity for charge and coding errors,” Hall says.

Other facilities have HIM code all cath lab procedures, and still others use a hybrid model, with only the routine processes being included in the chargemaster. In either case, errors can take place when charges are coded through the chargemaster and manually.

At Mercy Hospital, an audit found that devices were not always properly charged and that one model sometimes was substituted for a similar but not identical one. “These implants are constantly being changed with other models,” Coppola-Borges says. Not being exact, though, might mean the difference between the hospital being reimbursed for a $10,000 implant rather than a $20,000 device.

Also, errors of this type can become a compliance problem. Medicare expects documentation to support charges.

Follow through

When problems are identified in an audit, it’s important to work with the staff members involved in coding, charging, and billing to address the shortfalls, Hall says. These individuals need specific information about what they should do differently.

At Mercy, the hospital provided in-service training to its billing specialists based on audit findings. Physicians, too, need to receive feedback and training about audit findings, Ford says.

“If you don’t have a program where physicians are being educated and counseled on their data, you are probably missing some compliance issues,” she says. “Ultimately, the hospital is responsible for the care delivered to the patient. You can’t close your eyes to it and believe it’s the physician’s issue. You can’t let profit deter you from doing the right thing.”

IPPS changes affect hospital compliance, reimbursement

CMS implemented new hospital inpatient prospective payment system (IPPS) rules in October 2007 in an effort to improve the accuracy of Medicare payments and enhance quality-improvement efforts.

The new system represents a major change in the capturing of complications and comorbidities (CC) via coding.

“Hospital finance and reimbursement specialists need to understand the impact that the IPPS changes will have on the entire system,” says Gloryanne Bryant, RHIA, RHIT, CCS, corporate senior director of Coding HIM Compliance for Catholic Healthcare West in San Francisco.

The IPPS change created 745 new severity-adjusted DRGs (Medicare Severity DRGs, also known as MS-DRGs) to replace the previous 538 DRGs. It revises the CC list of ICD-9-CM codes.

There also has been a reclassification, creating up to three tiers of payments for many of the 745 DRGs.
CMS based these tiers on whether the patient has a reportable:

- Major CC (MCC)
- A CC
- No CC documented

**Phase-in period**

Aspects of the inpatient change took effect October 1, 2007. CMS plans to phase in other parts during the next two years. In federal fiscal year (FY) 2008, hospitals will be paid a blend of one-third charge-based weights and two-thirds hospital cost-based weights for the DRGs, according to CMS. In FY 2009, the payments will be completely determined by cost-based DRG weights.

CMS published the change in the August 22, 2007, Federal Register, but the changes were first proposed by the Medicare Payment Advisory Commission (Med-PAC) in 2005. Hospitals need to examine how the changes will affect their facility, says Leatrice Ford, RN, BSN, CCS, CEO of ConsultCare Partners, LLC, in Louisville, KY.

Facilities need to ask:

- What diagnoses are they capturing now that will influence future payments?
- Which captured diagnoses won’t have any influence in the future?

**Complications and comorbidities**

CCs represent one of the biggest changes. For example, far fewer diagnosis codes reflect severity for an individual patient, and far fewer count as a complication or a concurrent condition.

Under the new system, just 40.34% of patients will have one or more CCs, compared to 77.66% under the old system, according to the CMS statement in the Federal Register.

“Over the past 24 years, we’ve basically had the same list of CCs . . . so it will take some training and education to get use to identifying other CCs,” Bryant says.

**Quality reporting measures**

In addition to these changes, CMS is now asking hospitals to provide 27 quality reporting measurements under the Reporting Hospital Quality Data for Annual Payment Update program.

And the agency provides a substantial incentive for submitting the information. Hospitals that submit data about all 27 quality measures receive a 3.3% market-basket increase, whereas hospitals that do not submit data receive a 1.3% update.

Many hospitals expressed frustration that several different groups require different kinds of quality data, Ford says. Even so, hospitals need to make sure they gather and submit the information.

“Find out where data is being gathered and what type of data is being gathered to see if there’s some efficiencies in having one set of data capture,” she says.

**Specialty hospital disclosure**

The IPPS changes also create new disclosure requirements for specialty hospitals. The facilities must disclose physician ownership and give patients the name of those owners if they request it.

Also, members of the medical staff with an ownership interest in the hospital must disclose that ownership position to any patient referred to the hospital. If there are times when the hospital does not have a physician scheduled, the facility must notify patients in writing of that fact and describe how it would deal with emergencies.

And hospitals must notify patients in writing if a physician is not present in the hospital 24 hours per day, seven days per week, as well as how the facility would deal with emergencies when no doctor is present.

“If the patient is being electively admitted to a facility by an owner physician, the disclosure should happen at the time the admission is discussed and planned,” Ford says. “The patient shouldn’t find out the day [he or she registers]. Make it a part of the scheduling process.”

Meanwhile, specialty hospitals with ERs need to implement routine procedures for telling patients who arrive what services are available, because there’s often no time to waste in such situations, she says.

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“Nondisclosure can make it look like they are covering it up,” Ford says, referring to the owner-physician relationship.

**Present on admission**

Another major part of the IPPS rules change requires hospitals to document conditions the patient already has when he or she is admitted to the hospital. If a patient has certain conditions, but staff members do not note them as present on admission (POA) in the record, CMS will assume they developed at the hospital.

CMS plans to stop paying for the treatment of those conditions in October.

Navigating this change requires close monitoring by hospitals, Bryant says. Coding and HIM professionals must follow the POA guidelines published by the American Hospital Association.

“The guidelines are well written, and every hospital HIM department should have reviewed them with their coding staff,” Bryant says.

Hospitals need to focus on the POA guidelines. Failure to ensure adequate documentation affects both financial reimbursements and quality measures, says Deborah Mange, RN, BSN, documentation specialist at EMH Regional Medical Center in Elyria, OH.

“Education of staff to increase the quality of documentation will be essential,” Mange says. “Is the admission nurse doing good skin care assessment? Does the admission tool aid in the capture of the conditions, or does it need revision?”

For each of the conditions under focus, Mange says, ask the following questions:

- What safeguards can be implemented?
- What education needs to be done?
- Do new forms need to be developed to assist with accurate capture of all relevant diagnoses?

**Documentation is vital**

Better clinical documentation will be important for addressing many of the IPPS changes. This documentation must capture the severity of a patient’s condition more clearly than in the past.

Better clinical documentation—and changes in documentation specificity to capture patient severity should be emphasized—will be important for addressing many of the IPPS changes, not just those related to conditions that are POA.

For example, Ford says, hospitals should provide more specific documentation about heart failure because generic diagnoses are not considered CCs, even though many of those patients are very sick.

Facilities should focus more on helping doctors provide specific documentation for conditions such as:

- Congestive heart failure
- Chronic kidney disease
- Decubitus ulcers
- Malnutrition

Meanwhile, other aspects of care previously important for physicians to record are not always so vital under the revised system.

“We have spent years lecturing physicians about documenting certain conditions, and many of those are falling off the important CC list,” Ford says.

Under the new payment system, proper coding and documentation takes on new, substantial financial implications for hospitals. Even small oversights can have consequences.

Relearning what diagnoses now drive the DRG changes one step or even two steps higher can significantly affect severity profiles and reimbursement, Mange says. There needs to be refocused efforts on how to capture CCs and MCCs.

**Start training and educating**

Use a two-step process to train and educate staff members, Ford says. Educate coders first, and then target the training to physicians.
Although physicians do care about the fiscal effect of the payment changes on their hospitals, they want to properly portray the severity of their patients’ illnesses, she says.

“The new changes mean relearning a whole new DRG system [and] how it is numbered and grouped to define severity,” Mange says.

Initially, provide staff members with a broad picture of the changes, she says.

Include an explanation of the specific changes—additions and deletions—in the CC list. Conduct open discussions about how the change will, at first, affect coder productivity.

Get specific, Mange says. Talk about where and what to look for in the chart to capture a code for a more specific diagnosis.

Discuss whether a physician should be questioned to obtain more details.

“The initiation of present on admission and the MS-DRGs concurrently will be quite time-consuming for coders,” Mange says. “Estimates of productivity will need to take those changes into consideration to allow for both the increased time it will take to code charts, as well as allowing time for coders to learn the new requirements and systems.”

**Auditing and monitoring changes**

Staff member training may also come following increased MS-DRG auditing focused on the non-CC and MCC cases, Bryant says.

“Monitoring should be ongoing and more intense at first, doing some feedback chart reviews, possibly together if time allows,” Mange says.

However, understanding the full picture through auditing won’t be easy.

The complete renumbering of DRGs makes it difficult for compliance and audit professionals to trend data over time, Ford says.

“Many facilities are trying to figure out how they will monitor data because the crosswalk is patient-specific,” she says.

Also, because many upcoding targets changed, hospitals need to determine which MS-DRGs to audit when looking for over- and undercoding, she says. She expects undercoding to be an even bigger issue in the future.

**Teamwork needed**

The best way to ensure compliance with the new payment system is a team approach, Ford says. Coders need to help clinicians understand coding guidelines, and clinicians must help coders understand the medical picture.

And, she says, auditors must investigate complication codes to ensure quality issues are addressed.

Teamwork among all hospital disciplines helps to:

- Identify process breakdowns
- Recognize areas in need of improvement
- Create ideas to improve documentation

“Looking at it as a challenge to achieve the best possible hospital practices and patient care will hopefully be part of the outcome of this CMS initiative,” Mange says. “Hopefully, in the long run, the outcome will be better healthcare delivery. It will most certainly take concentrated energy and focus to get there.”
Compliance partners: Tips to win over the board

You may have noticed increased attention from the board of directors and compliance board recently. Spurred to action by federal rules related to corporate responsibility and heightened attention regarding healthcare nonprofit organizations, board involvement in compliance concerns is no longer simply “good business”; it is the law.

The Sarbanes-Oxley Act of 2002 set more-stringent rules for corporate executives and directors of all businesses. Many serving on private sector boards take that heightened awareness with them when they serve on nonprofit boards at hospitals.

Also, the Internal Revenue Service (IRS) has shown an increased interest in 990 forms filed annually by nonprofits.

These forms outline an organizations’ expenses and income. Government officials blamed some board members for failing to detect tax-code violations or fraud committed by the organizations they assist.

“We are certainly seeing a lot more enforcement activity . . . The government is looking at whether boards are exercising their fiduciary responsibility,” says Paula Sanders, an attorney at Post & Schell in Harrisburg, PA. Heightened enforcement, in turn, has some members of the board of directors asking more questions about compliance.

Stronger partnerships

However, the increased attention can work in favor of compliance officers. The increased attention from board members can help build a stronger partnership between the board of directors and those responsible for maintaining compliance on a daily basis. “It’s that heightened sensitivity that makes for a good working relationship,” Sanders says.

Board of directors members cannot and should not try to manage the day-to-day affairs of compliance, but board members are responsible for asking management questions about the organization’s compliance processes, says Shawn Y. DeGroot, CHC, CCEP, vice president of corporate responsibility for Regional Health in Rapid City, SD. These questions include those related to both structural and operational practices within the compliance program, she says.

“The board assumes ultimate responsibility for organizational performance, the conduct of the hospital as an institution, assurance for medical staff accountability for quality of care, and maintenance of professional standards,” DeGroot says.

There are a variety of ways that this oversight can be facilitated to benefit the entire organization.

Foster interest

Compliance officers should describe what compliance staff members do and why they do it, says Gerry Hinkley, an attorney with Davis Wright Tremaine, LLP, in San Francisco. Compliance goes to the core of the board of directors’ fiduciary responsibilities.

Don’t be afraid to speak about the moral underpinnings of compliance efforts, along with the real threat posed by criminal or civil enforcement actions.

“Any time you can ennoble [the idea of doing the right thing], it’s a good thing,” he says.

Helping the board of directors understand the regulatory environment in which the organization operates may be the single biggest element to building a healthy board-compliance relationship, Sanders says.

“The biggest element [of an effective relationship] is a common knowledge base about the regulatory, operational, and general legal regulations in which their kind of organization operates,” she says.

(See “Steps for effective compliance-board communications” on p. 9.)

Enlist audit committee assistance

Often, the best vehicle for communicating with directors is through the board’s audit subcommittee, Hinkley says. The full board then hears a report about compliance issues from its audit committee.
Hinkley suggests that the audit committee establish a year-long agenda to review compliance.

Each month, the committee should look at a compliance-related topic, so the whole agenda gets covered annually.

Spending an hour a month on compliance is not too much for the audit committee, he says, because compliance issues are a crucial aspect of the committee’s work. Directors need to hear what risks exist and how compliance staff members address those potential problems.

All boards—whether through a subcommittee or directly—have certain obligations, Sanders says.

They need to ask questions. These questions include whether the compliance committee meets regularly, whether the hotline works, and whether regulatory issues are identified.

Obtain direct access to the board

If the compliance officer does not have the opportunity to meet with the board of directors face to face, it’s a sure sign that the board-compliance relationship doesn’t work well, DeGroot says. If another member of the management team presents the compliance officer’s report to the compliance board, then the process isn’t as transparent as it should be, DeGroot says. Under such circumstances, the message may be diluted or colored by a perspective not related to compliance.

Steps for effective compliance-board communications

Take the following steps to communicate effectively with the board:

1. Orient new members. Start the education process as soon as someone joins the board. Two documents on the OIG Web site (http://oig.hhs.gov/fraud.htm)—Corporate Responsibility and Corporate Compliance and Corporate Responsibility and Health Care Quality—are excellent resource tools for that orientation, says Shawn Y. DeGroot, CHC, CCEP, vice president of corporate responsibility for Regional Health in Rapid City, SD. The documents provide the fundamental responsibilities from the perspective of the OIG and the American Health Lawyers Association, she says.

2. Continue to inform. Make sure that information sharing continues after orientation, so veteran board members remain current about the always-changing regulatory environment. Paula Sanders, an attorney at Post & Schell in Harrisburg, PA, says some of her clients have a robust understanding of board and facility obligations. However, organizations with more parochial, less vigorous compliance boards tend to be the organizations with problems. It’s important for managers and compliance officers to work on educating board members, even if it is an uncomfortable process at first, Sanders says. “Sometimes, compliance officers and senior managers can be sensitive to not seeming to be condescending to the board,” she says, but there are ways to address that concern. Sanders likes to share OIG guidance in board packets, she says. Directors then can educate themselves without anybody seeming presumptuous, she says.

3. Tailor the message. Members of the board of directors can’t be expected to know every detail of running a healthcare facility or its compliance program, Sanders says. “The board doesn’t have to know the nitty-gritty of what is going on,” she says. Too much information can overwhelm board members and cause them to miss important points. “Some boards do have compliance fatigue,” she says. Healthcare regulation is complex, so DeGroot offers a strategy for handling letters from government agencies. If a letter runs more than a single page, DeGroot attaches a summary sheet to the letter and distributes it in informative packets for the compliance board. The summary gives:
   - A brief background of the issue
   - The date the issue was identified or when the organization was notified of it
   - When the issue was previously reported to the board
   - A few sentences summarizing the letter from the federal agency and actions taken
   - Information about whether the item is for directors’ information only or whether action is required from the board in the form of a board motion.

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Compliance partners < continued from p. 9

Executives sometimes express some hesitancy regarding frank discussions with the compliance board or board of directors, Sanders says.

“In an ideal world, I think it’s great for the board or audit committee to meet alone—even for a half hour annually—for candid discussions,” she says.

This helps the compliance department feel it has the resources and support it needs from the board and the executive suite.

Such meetings also help identify cultural problems within an organization that may stand in the way of effective compliance efforts, DeGroot says.

“Fear of reprisal versus open communication can foster whistleblowers,” she says. “A fundamental understanding of the [organization’s] culture is crucial.”

Board members need to understand that compliance has to operate without interference, in order to be effective.

“It needs to operate independently of senior management,” Hinkley says. “Senior management and the audit committee need to bless the course [of the compliance team] and let it do its thing.”

There can’t be any kind of retribution when a compliance problem is identified, he says.

A compliance officer or team member should not be “punished for finding a problem, but celebrated with thanks for doing [his or her] job.”

Provide regular reports

The board should be getting regular updates about all aspects of compliance, Sanders says.

“Even the minor things you wouldn’t report on a daily basis should get reported, in summary, on a quarterly basis,” she says.

For example, hotline statistics may not require in-depth reporting, but the board should hear about them nonetheless. On the other hand, certain issues need to come to the board’s attention right away, Sanders says. These include:

- Voluntary disclosures to government agencies
- Search warrants executed
- Subpoenas issued

The board should hear about such events even if the court order seeks information in an investigation of a third party rather than the organization itself, she says.

“Boards need to know what is going on if there is criminal or civil exposure, or a risk to the reputation of a facility,” she says.

The compliance officer should communicate:

- The topic of concern
- The date the issue was identified
- Whether an audit or investigation will be conducted

Compliance also needs to identify any potential outcomes that could result in additional agency scrutiny, harm to the organization’s reputation, or penalties, DeGroot says.

In addition, compliance officers should inform the board of any cultural problems—including fear of reprisal, management tone, or communication failures. Any trends from hotline calls that might indicate a systemic problem also should come before the board.

When issues are resolved, be sure to tell the board what happened in simple and direct language, says DeGroot.

The statement might be something like: “An investigation was conducted and the issue was unsubstantiated” or “A self-disclosure was made to the government and a corrective action plan that includes staff education has been implemented.”

Questions? Comments? Ideas?

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Take a step-by-step approach to analyze bad debt

Editor’s note: This is the first article in a two-part series about auditing and managing bad debt. This month, we explain CMS guidelines and offer you audit tips to use at your facility. In an upcoming month, we will explore bad-debt policies and documentation techniques.

Proper Medicare bad-debt management can produce significant funds for an organization, but lack of attention in this area can create major compliance headaches.

“Bad debt is the only dollar-for-dollar reimbursement in the Medicare cost report,” says Jon P. Neustadter, partner at Hooper, Lundy & Bookman, Inc., in Los Angeles. “It is important for providers to review their collection efforts to make sure they are compliant and will pass muster during an audit.”

Nobody wants to find out too late about poor documentation or allegations of inconsistent collection efforts.

Medicare is becoming “much more stringent on ensuring that the requirements are met,” says Laura McDonnell, corporate business manager at Merrimack Health Group and principal of CDL Billing and Consulting in Haverhill, MA.

CMS directions

Luckily, CMS drew a good road map to help you ensure your bad-debt collection efforts work well.

CMS sets the following criteria for reimbursement of Medicare bad debt:

➤ The debt must be related to covered services and derived from deductible and coinsurance amounts
➤ The provider must be able to establish that reasonable collection efforts were made

➤ The debt was actually uncollectible when claimed as worthless
➤ Sound business judgment established there was no likelihood of recovery at any time in the future

Beyond these four broad rules, Medicare rules and manual provisions also offer the following guidances:

➤ Your collection efforts must be identical for Medicare and non-Medicare patients
➤ You must issue a bill on, or shortly after, the date of the patient’s discharge or death

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Bad-debt audit tips

Anthony Almeda, CPA, CFE, internal audit director at Community Health Systems in Franklin, TN, offers the following six tips to making the most of a bad-debt audit:

1. Select a sample of patients of all financial classes, except indigent financial classes. Base the size of the sample on the size of the organization and the risk the organization associates with this process.
2. Gather adequate and accurate documentation of insurance coverage to determine the financial class.
3. Evaluate the collection efforts of each patient to determine the adequacy of the collection effort and the time period of collection effort.
4. Ensure the Medicare collection efforts are at least as rigorous as collection efforts of other financial classes.
5. If you use a collection agency for other financial classes, make sure you use an agency for Medicare accounts, too.
6. Classify all financial classes as bad debt prior to referral. If you only classify Medicare accounts as bad debt, they cannot be reimbursed due to differential treatment. When a patient has multiple accounts with balances, determine how the payments will be posted. The provider cannot automatically choose the older account to post the payment. Unless the patient designates which account to post the payment to, the payment must be posted in proportion to the amount of Part A, Part B, and uncovered services the patient has outstanding.
Bad debt < continued from p. 11

➤ Your collection efforts have to be substantial, involving activities such as:
  – Subsequent bills
  – Collection letters
  – Telephone calls
  – Collection agencies
➤ Document your efforts
➤ Follow written policies and procedures

Here’s a step-by-step look at how you can accomplish this work in an orderly fashion:

1. Identification. As a first step, make sure you have the policies and procedures in place to identify Medicare-eligible patients. “Poorly implemented procedures to identify Medicare patients can lead to not reporting the patient as Medicare bad debt–eligible for reimbursement,” says Anthony Almeda, CPA, CFE, internal audit director at Community Health Systems in Franklin, TN.

Make sure there is a procedure in place for obtaining a signed advanced beneficiary notice (ABN) in order to notify the patient of uncovered services, Almeda says.

2. Auditing and monitoring. Ongoing monitoring must take place to ensure patient financial services employees pursue the credit and bad-debt policies, says Day Egusquiza, president of AR Systems, Inc., in Twin Falls, ID. “We have a procedure in place and check each month to ensure that the procedure is followed for all bad debt,” McDonnell says. Also review this at the end of the year. Audits help ensure that policies and procedures are in place and are being followed. Write-off policy audits should be taking place at least annually, with repeat audits in the interim if problems are identified, Egusquiza says. One key area is to compare Medicare bad debt to non-Medicare bad debt to ensure consistency of implementation.

3. Special care. Each organization’s individual risk must be considered as it determines whether audits should take place annually or several times during the year. No matter how frequent, Almeda says, audits should answer the following questions:
  – Are personal and telephone contacts documented?
  – Are non-Medicare accounts being sent to collection agencies, but not Medicare accounts?
  – Have you billed the patient for services that the provider should have known are not covered?
  – Are you classifying Medicare patients as bad debt before at least 120 days of the collection effort or are you writing Medicare patients off to bad debt before non-Medicare patients?
  – Have you obtained an ABN from the patient when one is required?

Choose a sample of all financial classes to audit because the provider must make the same collection efforts on Medicare accounts as non-Medicare accounts.
Dear Healthcare Auditing Strategies subscriber,

As you look through this month’s issue, you will quickly notice that Healthcare Auditing Strategies has changed its look. We hope you’ll agree that it’s a switch for the better.

Not only does our new design allow for easier reading, it also lets us include more content in the same 12-page format while also being able to offer additional graphic and photo options.

Additionally, the new design allows us to better connect the newsletter with our online resource, the Healthcare Audit Resource Center (www.auditresourcecenter.com). We hope you’ve had a chance to check out this comprehensive Web site.

Don’t worry—we’re not changing any of the reporting or features that you’ve come to expect each month. Healthcare Auditing Strategies will continue to be your top source for information regarding auditing and compliance concerns, tools, tips, and best practices to help you handle changes and challenges in 2008!

As always, we’d love to hear your comments about the redesign or story ideas that you’d like to see covered. We’re committed to making sure that Healthcare Auditing Strategies and the Healthcare Audit Resource Center bring you the news and advice you need to help you in your day-to-day activities.

Please drop me a line or call at any time. In the meantime, enjoy Healthcare Auditing Strategies’ brand-new look.

Sincerely,

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