

Patient Access ADVISOR

INNOVATIVE SOLUTIONS FOR THE FRONT END

UNCHCS improves financial assistance communications

Editor's note: The following article is the third in a four-part series examining the significant patient financial process changes that the University of North Carolina Health Care System (UNCHCS) in Chapel Hill has undertaken over the past six months. Next month, we'll discuss how UNCHCS has simplified the financial assistance process.

Your organization has done its homework. It has surveyed the patient population, identified areas for improvement, drawn up plans to initiate wholesale change, or huddled to tweak existing processes.

But your work isn't done.

If any of your customers are unaware of the changes you've made or unsure how to take advantage of them, your work will go for naught.

Over the last year, UNCHCS officials have responded to public criticism—questioning its mission as a state

agency—with an overhaul of its PFS operation. The organization's work hasn't gone unnoticed, as UNCHCS has dedicated time and resources into projecting the message of the patient-friendly changes out into the community.

Telephone reminders

Patients who schedule appointments at UNCHCS receive a reminder call with an automated telephone message from the facility. The messages remind patients to bring their insurance cards and copays with them at the time of their appointment.

"They all talked about money, so pretty much, all you'd hear was, 'Bring money, bring money, bring money.' That's not what we wanted to say."

—Karen McCall

However, UNCHCS' revised its messages to inform patients that financial assistance is available and how to inquire about this service.

Revising the phone message recordings was a chore. UNCHCS found that there was a single telephone message for patients at every clinic. UNCHCS has more than 500 individual clinics, which handle about 800,000 visits each year.

"We had to fix about 400 messages," says **Karen McCall**, UNCHCS' vice president of public affairs and marketing.

Further, McCall feared that patients would construe the tone of the original messages as aggressive.

"They all talked about money, so pretty much, all you'd hear was, 'Bring money, bring money, bring money,'" McCall says. "That's not what we wanted to say."

Awareness of assistance policies

In 2005, UNCHCS first introduced an automatic



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discount. Uninsured patients received an automatic 25% discount. UNCHCS handled this discount on the back end; the system didn't require patients to apply.

"We announced this in a press release, but I don't think a lot of people were aware of it, because we didn't need any interaction with the patient to accomplish it," she says.

In January 2006, UNCHCS extended its financial assistance program to those at 250% of the federal poverty guidelines.

Again, UNCHCS was relatively quiet about the lenient eligibility requirements.

"There was concern that if we made too big a deal about it, we'd be overwhelmed," says McCall. "So, we did it low-key, and though there was some pickup in the numbers, we didn't notice it much."

UNCHCS officials became more proactive—first with telephone messages, then with signs in every clinic and a charity care telephone helpline.

The signs now appear in both English and Spanish to accommodate the large bilingual population.

"We also trained our clerks to do a quick look at the [patients' financial information] and the federal poverty guidelines to give them a rough idea of whether they'd qualify for assistance," she says.

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Proactive assistance

Many patients do not understand how financial assistance works, and when and if they should apply.

UNCHCS officials realized how important it is to educate patients about this option early in the process.

To accomplish this, UNCHCS officials trained staff members in each clinic to offer financial counseling to every patient.

"We want to encourage [the patients] to ask questions, so it was important to train clinic staff to interact better with them," says McCall. "Patients should know the different areas they may need to contact, such as our Medicaid counselors."

Awareness of payment plans

Additionally, UNCHCS offers patients the ability to enroll in a no-interest payment plan. Officials want the facility's financial counselors to make sure that all patients who come through their doors know that this is a potential option for them.

But both sides also need to hammer out the details of the payment plan, and preferably before the back end is sending out statement after statement. UNCHCS' policy is for payment plans not to exceed 36 months.

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Case study**Cash collections: Develop a thorough program for your organization's entire patient financial services team***by John Kivimaki*

In 1991, Mary Rutan Hospital in Bellefontaine, OH, initiated a cash up-front program to give providers a process in which to maintain bad debt and collect more revenue on self-pay accounts.

Officials scheduled an inservice for the organization's patient accounts employees to educate them about the importance of cash and credit card collections.

It was the first step in developing a cash up-front program, which the hospital has perfected in recent years.

The initial inservice covered why it was important to increase collections. It discussed how patients viewed their medical bills and the dollars tied up to those bills. The staff learned that 90% of the write-offs were outpatient or emergency room accounts.

Staff members had the background they needed to understand the problems, but didn't possess the tools to fix them.

A successful cash up-front program evolved over several years, and Mary Rutan now boasts a unique approach to collections that relies on the entire revenue cycle to build the bottom line through strategic preparation.

Get administration's buy-in

There are a number of areas to address when getting a cash up-front program off the ground. The first step is gaining your administration's approval.

Be prepared. Break down accounts at registration by payer, showing self-pay volume and dollar amount. Also, show what total dollar amounts are write-offs for the year and what percentage are self-pays.

Explain that a cash up-front program will mean reducing the cost associated with mailing statements

and final letters, and using outside recovery companies and precollection services. Up-front collections will also reduce staff members' time in handling accounts. You'll increase cash flow and reduce bad-debt expense.

After you receive approval for your cash up-front program, begin preparing for your initial inservice for your registration staff members.

Train your employees to ask for money at registration

Once your staff members understand how important it is for the organization to collect more money before you ren-

der services, the next step is to remind them to ask for it. Mary Rutan developed a self-pay checklist for registrars (see training tool insert).

The checklist reminds staff members to acquire a copy of the self-pay patient's driver's license, if possible. It also specifies other important information to identify, such as insurance information and employment status.

There is also room to jot down any comments that the patients make.

Initially, Mary Rutan found that patients were surprised that registrars were suddenly asking for money prior to services. The patients denied the request for payment with some of the following responses:

- ▶ "You never asked for money before."
- ▶ "I didn't bring my wallet (or purse)."
- ▶ "I can't pay today."

There are a number of areas to address when getting a cash up-front program off the ground. The first step is gaining administration's approval.

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Cash collections

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- “I am disabled.”
- “I am unemployed.”
- “I have no money and no job.”
- “I was involved in an auto accident.”
- “This is ridiculous!”

At first, registrars weren't prepared to combat these objections. Officials wanted to walk the fine line between an effective cash up-front program and maintaining a positive public image.

Mary Rutan officials used role-playing to train registrars how to respond to denials. The instructors gave each registrar a handout to review and study. In addition, officials encouraged every registrar to discuss with their supervisor situations in which they had trouble addressing a patient's concern or objection.

The training stressed the following points:

- The hospital is a business, just like any other, that needs money to operate. We need to start educating our patients about this topic.
- We need to get a commitment from the patients about what they will be doing to satisfy their responsibilities for the bill.
- We also need to realize that people do have financial problems, and that we can give them alternatives to help with these problems.
- If the registrar can't work something out, have the patient contact our credit and collections area to discuss their account. Hand out the department's business card to the patient.
- We need to continue to educate our patients about what we expect of them, but we need to accomplish this objective in a caring way. One reason is that many of our patients will be repeat patients in the future.

As Mary Rutan registrars continued to use the self-pay checklist, officials sent out reminders to assist them in overcoming challenges they might encounter.

The following are some of those tips:

- You cannot read copies of drivers' licenses if the copies are too dark, so use a lighter setting on the copier
- If the patient is self-employed, acquire their business address and any other possible information
- With out-of-state patients, stress payment in full or at least some partial payment
- Fill out the self-pay checklist on every self-pay account
- Ask for money up front for every self-pay account, and get at least a partial payment

When you start a cash up-front program at your facility, decide what amounts the hospital will pursue. These may include patient deductibles, copays, balance due after insurance pays, self-pay responsibilities only, ER accounts, inpatient accounts, or outpatient accounts.

Most healthcare providers accept credit cards as payment, but surprisingly, some still don't.

All of these can present problems in determining what the patient owes. When you ask for money up-front, patients will pay only if they think they owe what you are asking.

Patient deductibles on any account are difficult to determine, since other care providers may not have submitted previous bills before the patient came to your facility. Balance after insurance is another headache to figure out.

Unless you can access the insurance company's records online, you will not be able to convince the patient of what he or she owes.

At Mary Rutan, registrars ask self-pay patients for the money. There is no argument on what the insurance will pay. The patient knows he or she owes the bill.

Registrars also collect for noncovered services. For the most part, registrars have very little objection from these patients.

Registrars also ask for insurance copays. These copay amounts are, for the most part, conveniently located on patients' insurance cards.

And the most important aspect is that registrars use a soft-sell approach: "Will that be cash, check, or credit card today?"

Registrars never demand money from the patient.

Set realistic goals

To ensure success in this cash up-front endeavor, be sure to do the following:

- Track payments weekly. Show everyone the results.
- Initiate an incentive program, if possible.
- Listen to your staff members for any problems they may encounter.
- Be enthusiastic and supportive.
- Build a team approach.
- Regularly remind staff members about the importance of the program.

Promote the program

Most healthcare providers accept credit cards as payment, but surprisingly, some still don't. If yours is a facility that doesn't accept credit cards, it's not difficult to set up a payment system with the four major cards: MasterCard, Visa, American Express, and Discover. Contact your local bank to get more information about how to start.

There are a number of steps to take to ensure that the credit card program you set up will be a successful one.

These steps include the following:

- Accept all the major credit cards.
- Display credit card logos in highly-visible areas, such as registration, cashier's office, and the business office.
- Put credit card logos on statements and letters you send to patients.
- Make it easy for patients to use their credit cards by

installing electronic terminals at locations in the hospital. This will speed up payment and balance inquiries.

- Schedule periodic inservices to educate staff members about the progress of the program and to promote ways to increase credit card payments.

Consider incentives

It may be useful to offer incentives to registrars for encouragement and motivation.

The following are steps Mary Rutan officials took to provide incentives for registrars:

- Officials established a monthly cash up-front goal
- From that monthly goal, officials established incentives for reaching it
- Registrars enter into a computer field the amount of cash he or she collected from each registered patient
- Officials distribute a weekly report with the cash figures to motivate and encourage registrars to reach their goal
- Officials pay incentives out monthly

Mary Rutan sees results

The following are some of the results Mary Rutan officials have seen on major accounts/receivables (A/R) indicators:

- Cash collected at registration increased from \$0 in 1991 to \$70,000 in 2005
- Credit card payments have increased from \$26,000 per year to over \$300,000 per year
- Bad debt decreased from 5.06% to 3.59%
- Charity write-offs have increased over 200% since Mary Rutan began handing out financial applications at registration
- A/R over 90 days has decreased from 30.5% to 10.4%
- A/R days has decreased from 63 days to 38 days ■

Editor's note: Kivimaki is director of patient accounts at Mary Rutan Hospital.

Case study

Charity care: Find balance between budget, patient needs

You're a small, rural hospital with no immediate competition, and you'd like to simplify your charity program for your loyal patient population. This may include an easier application process with less paperwork, less uncomfortable—and sometimes embarrassing to the patient and family—financial-profiling, and wider access to those who fall between the cracks.

Think twice, advises **Jeff Shutak**, PFS director at The Memorial Hospital (TMH) in North Conway, NH. Shutak, who has served as the PFS director at TMH for 10 years, has employed several charity programs at the 25-bed facility nestled in the Mount Washington resort area. However, he believes that TMH has finally developed a program that suits both the needs of the patient population and the hospital's charity budget.

TMH's first unique idea has holes in it

Test out a few different programs to see how your community will respond to them before committing to one plan. In July 2005, TMH made the mistake—albeit one with altruistic intentions—of committing to a plan that made charity care available to everyone who said they needed it. This idea came only after TMH realized that it was under budget for three of the previous five years and that not enough of its needy population was applying for assistance. “We decided we'd open the door to whoever needed it. We took our patients at face value,” Shutak says.

TMH asked patients to fill out a simple, one-page form, which asked for basic demographic information and the patient's income.

“We'd print up a card, I'd sign it, and they'd receive full services,” says Shutak. But this no-questions-asked approach came with a steep price.

“We basically had to shut down the program after six months,” Shutak says, because too many people requested assistance. TMH's costs doubled that of its charity care budget.

TMH redirects its efforts

When its simplified charity care program failed in December 2005, TMH went back to its lengthy application process and again required documentation, such as bank statements, car registrations, tax returns, and pay stubs. The patients who enjoyed the previous no-hassles approach didn't understand the change. “We just explained that in order for us to meet the needs of the truly needy, we had to tighten things,” Shutak says.

This, however, was just a temporary bandage for TMH until it could find a better solution for its population. Now the facility is taking another stab at a customer-friendly approach to charity care. This time, TMH is widening the reach of its charity care program with more flexible eligibility requirements.

Beginning on July 1, anyone with \$200,000 or less in assets would qualify for the assistance program. Before July 1, only those with \$100,000 or less in assets qualified. Additionally, those with \$300,000 in net assets qualify for a 30% write-off, and those with \$400,000 qualify for a 15% write-off.

TMH also expanded its net income guidelines. Right now, TMH is offering the assistance program for those at 200% of the federal poverty guidelines (FPG). Starting on July 1, TMH is expanding that to 250% of the FPG. Those at 300% of the FPG qualify for 30% off their bill, and those at 400% get a 15% discount.

TMH decided to rethink its charity requirements after completing statistical analyses on the people it had denied during the previous fiscal year. “We found that more and more people were falling into that percentage cap. We just didn't come up with an arbitrary figure,” Shutak says. “We wanted to help everyone, even the people with insurance who are caught in the middle.”

Shutak is conscious about not overshooting TMH's internal budget. “We'll cut it off once we reach a certain dollar amount,” he says. “We have a very generous [charity] budget, so I hope that never happens.” ■

This Month's

Form

Sample charity care income guidelines

Editor's note: The following is information that The Memorial Hospital (TMH) in North Conway, NH, distributes to patients to inform them of the hospital's Healthcare Assistance Program.

TMH and its hospital-based physicians, including Mount Washington Valley Healthcare, Northern New Hampshire Orthopedic Services, and Northern Women's Health, provide acute care, emergency care, outpatient services, and physicians' services, regardless of an individual's ability to pay. For those situations when an individual demonstrates an inability to pay, services will be given without expectation of compensation. Early recognition of a need for healthcare assistance is strongly encouraged, and as much as possible should be determined before service is rendered. Application after service will also be accepted.

Anyone may apply for healthcare assistance. Healthcare assistance may be used to cover the entire acute, emergency, outpatient service, and physicians' charges. It may also be used to cover amounts due after insurance payments, including deductibles and coinsurances or copayments.

The patient/guarantor's ability to pay will be the sole criteria for receiving financial assistance. Income guidelines will be established and periodically reviewed by TMH based upon the federal poverty guidelines. Income guidelines are as follows:

Household size	Federal poverty level for 2007	Household income @ 200% = 100% discount	Household income @ 300% = 30% discount	Household income @ 400% = 15% discount
1	\$10,210	\$20,420	\$30,630	\$40,840
2	\$13,690	\$27,380	\$41,070	\$54,760
3	\$17,170	\$34,340	\$51,510	\$68,680
4	\$20,650	\$41,300	\$61,950	\$82,600
5	\$24,130	\$48,260	\$72,390	\$96,520
6	\$27,610	\$55,220	\$82,830	\$110,440
7	\$31,090	\$62,180	\$93,270	\$124,360
8	\$34,570	\$69,140	\$103,710	\$138,280

If you think you are eligible for the Healthcare Assistance Program, you may obtain a financial statement at the Healthcare Assistance Office located in the lower level of the hospital. Patients in the hospital may make arrangements to fill out a financial statement by calling Ext. 275. This office will make a determination of whether you will receive financial assistance within 10 working days of receipt of the application and complete documentation. If you have any questions regarding the Healthcare Assistance Program, please call 603/356-5461, Ext. 275.



Download this form in the **Patient Access Advisor** section of www.accessresourcecenter.com.

This Month's

Form

The following is a section of The Memorial Hospital's financial assistance application.

Sample financial assistance application

Date _____

- 1) Patient's name _____

Last	First	Middle
------	-------	--------

 Date of birth _____
- 2) Patient's Social Security number _____
- 3) Patient's mailing address _____
- 4) Patient's residence address _____
- 5) Patient's telephone number _____

Home	Work
------	------
- 6) Name of guarantor _____

Last	First	Middle
------	-------	--------

 (*Guarantor is the person responsible for the payment of the bill*)
- 7) Guarantor's mailing address _____
- 8) Guarantor's residence address _____
- 9) Guarantor's phone number _____

Home	Work
------	------
- 10) Patient's employer _____
 - a) Address _____
 - b) Telephone number _____
 - c) Type of work _____
 - d) Weekly wages _____
 - e) Length of employment _____
 - f) Previous employer _____
 - g) How long at previous employment? _____
- 11) Guarantor's employer _____
 - a) Address _____
 - b) Telephone number _____
 - c) Type of work _____
 - d) Weekly wages _____
 - e) Length of employment _____



Download this entire form in the **Patient Access Advisor** section of www.accessresourcecenter.com.

This Month's
Form

- f) Previous employer _____
- g) How long at previous employment? _____

12) Total monthly income for household

Name _____

\$ _____ Wages _____

\$ _____ Alimony _____

\$ _____ Child support _____

\$ _____ Pension/annuity _____

\$ _____ Disability _____

\$ _____ Public assistance _____

\$ _____ Workers' compensation _____

\$ _____ SSI/Date of first payment _____

SSI eligibility date _____

\$ _____ TOTAL

Source: The Memorial Hospital, North Conway, NH. Reprinted with permission.

UNCHCS

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“We just have a limited ability to track these,” McCall says. “Our collections people are good at collecting money from insurance companies. But it’s hard developing that expertise when our patient payment amount is about 10% of all of our money.”

UNCHCS communicates the different options up front. In some instances, UNCHCS sets patients up with collection agencies that offer longer payment plans.

“Even if the patient has had bad debt before, we’re trying very hard to talk to them about consolidating that debt and finding a payment plan that works for them,” she says.

Financial assistance telephone hotline

UNCHCS officials strongly believed that many of its patients who needed financial assistance the most were unaware of this option.

So early this year, they decided to create a hotline for patients to call with their questions from 7 a.m.–9 p.m.

UNCHCS trained call center staff members to complete the first quick fix, which is to determine whether the patient may qualify for assistance. If they do qualify, the call center staff members transfer the patient to a financial counselor.

UNCHCS officials have placed advertisements in local newspapers, publicizing this feature and plastering the facility’s phone number wherever they can, including on bill statements.

The response so far has been good, says McCall. “We’ve since gotten a number of people in the program.” ■

Questions? Comments? Ideas?

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CMS steps toward severity-adjusted DRG payments

In its proposed rule updating the hospital inpatient prospective payment system (IPPS) for fiscal year 2008, the Centers for Medicare & Medicaid Services (CMS) proposed to adopt a severity-adjusted diagnosis-related group (DRG) system called Medicare-Severity DRGs (MS-DRG).

The April 13 proposed rule amends inpatient hospital reimbursement by:

- Revising the definition and payment hierarchy for secondary diagnoses (i.e., conditions other than the primary reason for admission) and specifying whether these secondary conditions are major
- Requiring hospitals to document all conditions that are present on admission (POA) and proposing financial penalties when certain conditions develop after admission
- Expanding the reporting of hospital quality data from 21 to 27 metrics

Secondary diagnoses

CMS is proposing to create 745 new DRGs to replace the current 538. According to CMS, the reforms are measured steps to improve the accuracy of Medicare's payment for inpatient stays to better account for the severity of patients' conditions.

The proposal will increase payment for some cases while decreasing payment for others. Hospitals treating

more severely ill and costlier patients will receive higher payments, whereas hospitals treating less severely ill patients will see a decline in reimbursement.

The new system would not reduce the overall payment amount to hospitals but may adversely affect some hospitals if they treat patients who are less severely ill, says **Kimberly Hoy, JD, CPC**, director of Medicare and compliance for HCPro, Inc., in Glen Allen, VA. In particular, the rule reduces payment incentives for specialty hospitals that, accord-

“Under this proposed DRG revision, certain ‘major’ comorbidity diagnoses will carry more weight than others.”

—James S. Kennedy, MD, CCS

ing to CMS, may select to treat only the “healthiest and most profitable patients.”

However, some hospitals that see less acutely ill patients due to the more limited nature of their services (i.e., more severely ill patients are transferred) may also be caught in these reductions.

“Under this proposed DRG revision, certain ‘major’ comorbidity diagnoses will carry more weight than others,” says **James S. Kennedy, MD, CCS**, general internist and director with FTI Healthcare in Brentwood, TN.

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CMS offers Medicare NPI deadline flexibility for facilities

The Centers for Medicare & Medicaid Services (CMS) will not enforce the May 23 deadline for national provider identifier (NPI) implementation, as long as covered entities “demonstrate good faith efforts and employ contingency plans,” the agency announced April 2. The NPI will replace the legacy numbers that providers currently use to identify themselves in healthcare transactions.

The enforcement delay allows the industry to continue using legacy numbers on claims as part of contingency plans to ensure payment. Contingency plans may not extend past May 23, 2008. The agency also announced that Medicare will soon release its own contingency plan for use of the new identifier.

“CMS will focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement,” the agency said in its guidance. “CMS will not impose penalties on covered entities that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable and diligent efforts to become compliant . . . ”

CMS will provide written notice to the covered entity of any complaints it receives. The entity will then have the opportunity to do one of the following:

- ▶ Demonstrate compliance with the NPI standards
- ▶ Document its good faith efforts to comply with the NPI standards
- ▶ Submit a corrective action plan

The announcement is a response to several NPI implementation difficulties, says **Chris Apgar, CISSP**, president of Apgar & Associates in Portland, OR, and board member for the Workgroup for Electronic Data Interchange (WEDI). “The industry is not prepared to fully implement the NPI,” Apgar says.

CMS has issued approximately 1.95 million of the new identifiers, but many providers have still not applied for a number. Some reasons include procrastination and lack

of awareness, say industry groups. And despite significant outreach efforts on behalf of CMS and WEDI, some providers remain unaware of the need to obtain an NPI and test it with health plans prior to the compliance date.

The guidance answers these concerns, says **Susan A. Miller, JD**, independent consultant, chief operations officer for Healthtransactions.com in Concord, MA, and coauthor of HCPro, Inc.’s *HIPAA NPI Road Map: How to navigate and implement the National Provider Identifier*. “It is the breathing space that the industry was hoping for,” she says.

More importantly, the enforcement delay allows both providers and payers to participate in contingency plans. “Each health plan can now have its own contingency plan, as each provider may,” Miller explains. “It’s the recognition that there are two players in each transaction. And if your partner is not ready, it gives you, as the other covered entity, the ability to deal with it.”

According to the CMS guidance, good faith efforts to comply might include the following:

- ▶ A health plan making concerted efforts to conduct outreach and make testing opportunities available to providers
- ▶ A healthcare provider obtaining an NPI and being able to use it on Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions

However, covered entities should bear in mind that CMS’ announcement is only permission for contingency plans, Miller warns. The announcement does not force payers or providers to continue using legacy numbers after May 23. For example, a provider can avoid enforcement action by implementing a contingency plan in good faith, but it will run into reimbursement problems with payers that do not adopt such a plan.

“The bad news is that the providers and health plans are now going to have to confront many different contingency plans,” Miller says. ■

DRGs

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Examples will include:

- Acute congestive heart failure
- Systemic Inflammatory Response Syndrome (SIRS) due to noninfectious causes (e.g., burns, trauma, pancreatitis, etc.) with organ dysfunction
- Sepsis (SIRS due to infection) with or without organ dysfunction

Consistent with commitments made in last year's IPPS final rule, CMS contracted with RAND Corporation to evaluate five commercially available DRG products to determine whether Medicare could use them to better recognize severity of illness in its inpatient hospital payments.

CMS is continuing with this evaluation of alternative DRG systems for long-term use by Medicare. In addition, CMS asked RAND to evaluate the proposed MS-DRGs using the same criteria it is applying to the other DRG systems. CMS will not make a decision as to which DRG system to adopt permanently until the RAND evaluation is complete.

POA indicator

Under the proposed rule, CMS will require hospitals to report whether diagnoses are POA. "California and New York have had to do this for years, with Florida, Maryland, and other states starting this year," says Kennedy. "Coders received their marching orders for reporting POA with the 2007 ICD-9-CM rule updates."

If the condition was not coded as POA, the public will believe it occurred after admission, he says. "Physicians must help coders capture POA information if their public data is to accurately reflect their quality of care."

CMS partnered with the Centers for Disease Control and Prevention to identify potential high-volume, hospital-acquired conditions that hospitals could have reasonably prevented and proposed financial penalties for when they occur.

The 13 proposed conditions (and their ICD-9-CM codes) include:

- Catheter-associated urinary tract infection (996.64 &

various urinary tract infection codes)

- Pressure sores (707.00–707.09)
- Object left in surgery (998.4)
- Air embolism (999.1)
- Delivery of ABO-incompatible blood products (999.1)
- Staphylococcus aureus septicemia (038.11)
- Ventilator-associated pneumonia (999.9 + pneumonia code)
- Vascular catheter-associated infection (996.62)
- Clostridium difficile-associated disease (008.45)
- Methicillin-resistant staphylococcus aureus infection (V09.0)
- Surgical site infections (998.59)
- Surgery on wrong body part, patient, or wrong surgery (E876.5)
- Patient falls (no code)

CMS is seeking public comment to determine which of these measures (at least two) to implement for 2008.

Core measure reporting

CMS will require hospitals to report 27 different quality measures, which it will ultimately report to the public on a dedicated Web site. "Hospitals must do this or risk losing a portion of their market basket updates," says Kennedy. Metrics include venous thromboembolism prophylaxis, prophylactic antibiotic selection for surgical patients, and 30-day mortality for heart failure and acute myocardial infarction, as well as a Medicare-approved patient satisfaction survey.

CMS will accept comments on the IPPS proposed rule until June 12. To comment, visit <http://www.cms.hhs.gov/eRulemaking>.

As always, all hospitals should carefully consider how the proposed changes would affect them and make comments individually, or through professional associations to which they belong, says Hoy.

Visit <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-P.pdf> to download a PDF of the proposed rule. ■

Sample self-pay checklist

The registrars at Mary Rutan Hospital in Bellefontaine, OH, use this checklist when registering self-pay patients. It's a critical component of the hospital's cash up-front program.

Patient's name: _____

Patient's phone number: _____

Did you obtain a copy of the driver's license? Yes No

If no, state reason: _____

Did you ask for payment of the balance? Yes No

"Will that be cash, check, or credit card today? We honor MasterCard, Visa, and Discover for your convenience."

A preauthorized credit card can be used for any of the credit cards we accept to satisfy this account.

Does the patient state that he or she has insurance, but no insurance information at this time? Yes No

Obtain as much information as possible below:

Insurance: _____

Policyholder: _____

Name of employer: _____ City: _____

If this service is the result of an auto accident, circle A/A.

Remind the guarantor that he or she will still be billed for this service. To expedite the insurance payment to the healthcare facility, a bill needs to be sent to the responsible party as soon as possible.

If no payment is received today, ask the guarantor when the account will be paid in full.

Write the date of promise here: _____

If partial payment is received today, when will the balance be paid? _____

If unemployed, list source(s) of income here: _____

Has the guarantor applied for assistance through welfare? Yes No

Remember, if you did not receive payment in full, ask for a partial payment today.

Give the patient a registration handout.

Registrar's name: _____ Date: _____

Source: John Kivimaki, Mary Rutan Hospital, Bellefontaine, OH. Reprinted with permission.



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