Audit Update: Claims that are related

CMS will deny a physician’s Part B claim when it’s “related” to a denied hospital Part A claim

By Erin Brearley

AUDITS EXPAND TO PHYSICIANS

For years, hospitals have been subject to large volumes of audits and denials for inpatient hospitalizations that are not considered “medically necessary” in the inpatient setting. One pain point for hospitals is that while the Part A hospital denial is usually due to lack of physician documentation supporting inpatient status, the corresponding physician’s Part B claim for the same hospitalization gets paid. This makes it difficult to incentivize non-employed physicians to improve their documentation.

All of this changed on September 8, 2014, with the implementation of Transmittal 534, which was later rescinded and replaced with Transmittal 541: Claims that are Related. This transmittal gives the Medicare Administrative Contractors (MACs), Recovery Auditors, and Zone Program Integrity Contractors (ZPICs) authorization to deny claims “related” to the denied hospitalization. CMS has made a number of revisions to the transmittal since then, but the intent to deny related claims has remained.

THE DEFINITION OF “RELATED”

Only “related” claims can be denied. “Related” is defined in the transmittal as any claim that can be validated using documentation from the denied claim. For example, if the contractor reviews an inpatient surgical hospitalization, and denies the hospital’s claim because “services could have been provided as outpatient,” Medicare contractors have the authority to deny the surgeon’s Part B claim as well. The transmittal states that, “for services where the patient’s history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, post-payment recoupment will occur for the performing physician’s Part B service.”
Words From Your President

Our industry is in the midst of great change on many levels, and it touches each one of us in a myriad of ways. In this context, I find myself increasingly more appreciative of the incredible value HFMA brings to both my professional life and our industry as an indispensable resource.

This was validated at the HFMA Fall President’s meeting I attended last month, where the HFMA Chapter Presidents, Chapter President-Elects, Regional Executives, and National Executives and staff came together in Chicago to network, share best practices, and discuss the Healthcare Financial Management Association’s strategic direction.

During his opening address, Joe Fifer, President and CEO of HFMA, reaffirmed HFMA’s mission to lead the financial management of health care. He discussed how the organization is working to fulfill this mission by developing individuals so they are well-equipped to improve organizational performance. These high-performing organizations are then positioned to shape the entire healthcare system.

HFMA Changes Health Care

It is obvious that the very core of our health care system is changing. The challenges we face must be solved by partnering with other key stakeholders and erasing traditional healthcare boundaries between hospitals, physicians, and payers. As Joe Fifer reiterated at the Fall President’s Meeting, HFMA has always been the leading organization for healthcare finance professionals, and finance professionals continue to be the core membership group at the heart of this organization. HFMA’s vision is to bring value to the industry as the leading organization for healthcare finance, and this involves reaching out beyond finance professionals to become the ultimate resource for financial expertise and knowledge across all settings in the healthcare system. That is the vision that your National HFMA leaders are focused on achieving, and one supported by your NH/VT Chapter leaders through timely, local, and regional educational offerings; CHFP and CRCR certification training and support; relationship-building and networking opportunities; and many other activities. Without the dedication of our member volunteers, none of this would be possible, and I continue to be incredibly grateful for your commitment!

I invite you to visit www.hfma.org to take advantage of all that HFMA has to offer. Be sure to check out the Forum Tools & Articles, as well as familiarize yourself with the exciting HFMA Industry Initiatives and Affiliation Groups being used to actively shape the national health care landscape. It is an exciting time to be a healthcare financial professional, and HFMA is committed to Leading the Change!

Sincerely,
Amy Vaughan

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(617)549-9498 b.lynch@gragil.com
CERTIFICATION CORNER  By Diane Blaha

This article lists the Certification resources for our Chapter. These are the latest activities for the NH/VT Chapter:

The last days of summer have slowly faded away and fall is now upon us. With the changing of the leaves comes the transformation of one season to another and the transition to a more relaxed time of year. We hope that this new season sparks your interest and affords you the time to study the material, to take the exam, and become certified as a Certified Healthcare Financial Professional (CHFP), Certified Revenue Cycle Representative (CRCR), or a Certified Technical Specialist (CTS).

To help you in the process, the Certification Committee encourages you to take advantage of the resources found on the Chapter’s website www.nhvthfma.org. These items can be found under “NH/VT HFMA, Certification” (on the left hand side). They include:

► Hints on How to Study (suggestions made by successful members);
► CRCR Recorded Webinars (From August 2014 and two Pre-recorded Webinars);
► Test Your Knowledge and Mix N Match Articles (sample exam questions); and
► Coaching Courses (ask us or National about other chapters).

In addition, for iPhone and iPad users, there is an application called Quizlet that allows you to search for CHFP and CRCR interactive flashcards.

Finally, the CRCR program helps set standards of performance for revenue cycle staff. Its designation proves a high level of revenue cycle knowledge and expertise.

Just a little feedback from one of our most recent successful CHFP members:

Kelly Foy, CHFP from Central Vermont Medical Center reports:

“Thank you all for the congratulations, the practicum session opportunity and the dollar incentive! I hope I inspired my colleagues and we will have two or three more CHFPs from my organization in the near future.”

“The practicum lead by Christoph Stauder really helped me prepare and study for the exam. I spent 2-3 hours per day since the day-long practicum on 9/10/14 and crammed for about 12 hours this last weekend. All the study time was definitely needed for me. I spent most of the time on the financial ratios and probably should have paid closer attention to contract management. The Quizlet app definitely helped prepare me for many questions on the test as well. The Online Proctoring and registration with Castle Worldwide was pretty seamless and effective; however, I would definitely recommend a wired internet connection vs. wireless.”

Congratulations to our two newest certified members:

Sandra Berube, CRCR
Northeast Rehabilitation Hospital
Decision Support Analyst, General Accounting

Kelly Foy, CHFP
Central Vermont Medical Center
Decision Support Analyst

THE DENIAL PROCESS

Medicare contractors must obtain CMS approval before they can begin reviewing related claims. Once they have approval, the MACs and Recovery Auditors must post the intent to review on their website. The contractors are not required to request additional documentation prior to denying a “related” claim. Denials can be automated or denied after manual review. The auditors have a look-back period of 36 months from the payment date.

THE APPEAL PROCESS

Part A and Part B claim denials must be appealed separately, meaning the hospital and physician must appeal separately. This also means the hospital could win, and the physician could lose, or vice versa.

HOW TO PREPARE

► Monitor your MAC and Recovery Auditor websites for notification that they intend to review “related” claims
► Hospitals and physicians can work together to reduce denials. Hospitals can help physicians understand utilization requirements and improve their documentation so everyone gets paid
► Hospitals can share their appeal expertise with physicians who may be new to the Medicare appeals process

Source

CMS Manual System: Pub 100-08 Medicare Program Integrity: Transmittal 541
Top 10 Considerations in Evaluating an Affiliation

By Jonathan Spees, CPA

Although the number of healthcare transactions declined in 2013 from the record levels seen in 2012 (see below), affiliation in some form remains high on the list of possible strategies being discussed among healthcare leaders. The following are ten things that should play an important part in these discussions.

► Why affiliation? In order to achieve a successful result from an affiliation transaction, it will first be necessary to have a clear understanding of the objectives to be accomplished. Affiliation objectives should result from a gap analysis identifying areas of need for a particular organization. This gap analysis can then be used to define what success might look like, because organizational needs can be matched against the competencies and values of potential affiliation partners (and transaction structures). This creates the result most likely to succeed.

► What are the risks of exploring an affiliation transaction? A corollary to defining the goals and objectives of a potential affiliation is understanding the risks involved with engaging in the process. These risks include creating organizational stress due to uncertainty, redirection of leadership efforts, expenses (including opportunity costs), sharp drops in information, potential regulatory hurdles, and many others. With increased scrutiny of affiliation transactions from the Federal Trade Commission (“FTC”) and state attorneys general, anti-trust considerations should be addressed early in the process. Evaluation of these risks should not be overlooked, and the potential benefit to be achieved from a transaction must be measured against these real costs before the decision to move forward to explore an affiliation is made.

► Is now the right time? In this time of change in the healthcare delivery and financing system, there remains substantial uncertainty regarding what will ultimately prove to be the successful organizational models, how systems of coordinated care will evolve, and even the long-term sustainability of organizations, some of which may appear financially sound today. Absent a burning platform (like deteriorating financial or market position or an immediate capital need which cannot be financed internally), it may be more prudent to defer an affiliation decision until visibility regarding the winners and losers in a particular market becomes clearer, particularly if the affiliation decision requires giving up control. On the other hand, an objective assessment of opportunities to be a “game changer” in the market should also be considered: is there an opportunity to show leadership in a market that is still in a game of “musical chairs?”

► Who is the right partner? The choice of affiliation partner can be more complicated than it might seem and depends on many factors, including culture, financial strength, clinical program development, quality, risk diversification, and many others. Perhaps the most important of these is culture – which trumps strategy every time. Cultural fit should not be ignored in due diligence regarding an affiliation transaction, since it may ultimately prove to be the most important factor in determining a successful outcome. Leadership should assure that appropriate resources are allocated to evaluating culture fit as they make the case for affiliation.

► What is the best structure for an affiliation? There are many alternatives available to organizations seeking affiliation transactions, ranging across the spectrum from loose clinical or administrative agreements to full asset combinations through mergers or acquisitions. Determining the optimum affiliation structure will depend largely on the gap analysis described above, evaluated in the context of the importance to an organization of retaining independence. In general, the level of control retained by an affiliating organization varies indirectly with the amount of capital required as part of the affiliation, and organizations must understand that with capital usually comes control. Some innovative joint venture models do allow organizations receiving a capital infusion to retain a significant measure of control in governance, and the joint venture structure may represent an appropriate balance between the need to attract capital and retain control.
How will the organization approach valuation? Valuation can be a complicated issue for organizations seeking an affiliation, particularly in the for-profit world where the primary objective in an affiliation transaction may not be obtaining the highest price. In all cases, however, organizations must determine that they are receiving fair value in return for what they are contributing to the combined organizational structure. In loose clinical affiliations or administrative agreements, there may not be substantial financial commitments. In other, more closely aligned transactions, value can be attributed to such things as implementation of electronic medical records (“EMR”) or other IT systems, future capital commitments, commitments with respect to maintenance of clinical services or physician recruitment, along with a variety of other factors. These value metrics should be considered against the alternative of a cash-for-assets sale with the proceeds accruing to an independent foundation to determine the optimum strategy which allows an organization to fulfill its mission over the long term.

What is the best way to find a partner? There are two basic approaches to finding a partner with whom to affiliate: 1) a widely distributed Request for Proposal (“RFP”) and 2) targeted negotiations. Each has its advantages and disadvantages. Choosing the right option may depend on the level of affiliation desired. For affiliations that do not involve capital or a change in control, it may be more appropriate to negotiate with a single or small group of potential partners. In major affiliation transactions, however, the best way to assure success is often to cast a wide net and create a competitive situation by issuing a formal RFP.

Does the organization have the right communications plan? An affiliation transaction is often one of the most significant corporate events in an organization’s history, involving discussions at many levels throughout the organization. In today’s highly connected environment, the velocity of information exchange makes it essential to develop a comprehensive communications plan early in the affiliation process since rumors and inaccuracies can be widely and quickly distributed. A carefully thought out communications plan can help mitigate this risk and best position an organization to control its messaging.

Who should be on the internal transaction team? Depending on the size and complexity of a potential affiliation, it is likely that an internal team will need to be assembled in order to manage the process. Leaders must understand that the affiliation process can create uncertainty in the market, on which competitors may seek to capitalize. In addition, the passage of time creates transaction risk by expanding the window for deal-breakers to occur. It is therefore essential to allocate sufficient resources, develop a project management plan to complete the transaction as quickly as is reasonable, and hold people accountable to such plan. Since a common vision is one of the key determinants of a successful affiliation, the internal team can also be an important means to promote “buy in” from the organization for the affiliation.

Does the organization have the right external transaction team? Again, depending on the size and complexity of a potential affiliation, most organizations will want to engage a team of experienced transaction consultants, including financial advisors, valuation professionals, transaction attorneys, and anti-trust experts. There are myriad of issues which must be properly addressed in crafting, negotiating and closing an affiliation transaction that is optimally positioned for success. Because affiliations are not every day occurrences in most organizations, the advice of experienced professionals familiar with issues and resolutions can optimize results, mitigate risk, and avoid potentially costly landmines.

The current economic climate for healthcare providers will force continuing consolidation – either as a survival strategy or as the result of forward-thinking collaboration efforts. For more information regarding affiliation transactions or to inquire about how best to navigate through the nuanced process of affiliation, please contact Jon Spees, Senior Vice President, The Camden Group at 310.320.3990 or jspees@thecamdengroup.com. The Camden Group is a national healthcare business advisory firm with offices across the country, including in Boston and Rochester.

HFMA Board Member Profile

Kristina Griffin is the Director of Contracting and Network Development at NH Healthy Families (NHHF) and is currently working towards her MBA at Plymouth State University. She has been with this organization since March of 2014. Prior to NHHF, Kristina worked at Well Sense Health Plan as a Contract Manager for the NH Medicaid Care Management Program, and did network development related to the network build and go-live of the program. This was a great experience for her because she got to see a program start from infancy and get to the point of taking on membership. In the past she also held a Budget and Reimbursement Analyst position at Catholic Medical Center which exposed her to many different facets of healthcare and how a provider organization works.

In 2007 Kristina became a student member of HFMA. The decision to become a member was influenced by Les Macleod, one of her professors in the Healthcare Management and Policy major at UNH, who strongly encouraged students to become involved in professional organizations. When she graduated from in 2009 she then became a regular member. Since her career became focused in this direction of the healthcare industry, HFMA has proven to be a huge resource for her.

As the Newsletter Chair a few times in the past, Kristina was able to meet many of the contributing writers and develop a network of professional contacts. Her involvement in HFMA has positively impacted her career and she enjoys that it is a great group of people to work with in the industry outside of the direct 9-5 working relationship. Kristina believes the benefits of certification are something everyone should consider working towards, and joining a committee gives one a great appreciation for the work, time, and coordination of people and topics that goes into getting a program off the ground. Outside of work Kristina is tap dancer, teacher, and choreographer. She also enjoys gardening, home renovation projects, hiking, and spending time with family and friends. Other volunteer work she is involved in is Board of Directors for Southern NH Youth Ballet.
CROSS BALANCED.resp.240.jpg

CORPORATE COMPLIANCE UPDATE – 2014

Janet Hodgdon, CPA, CPC • Baker Newman Noyes

Compliance remains a major focus of the Department of Health and Human Services. Through CMS, the OIG, and others, oversight of Medicare and Medicaid reimbursement continues to expand. This article summarizes and provides an overview of some of the recent efforts of these departments.

I. A REVIEW OF THE 2014 OFFICE OF INSPECTOR GENERAL WORK PLAN

The 2014 OIG work plan relative to possible healthcare fraud and abuse was published in January 2014. The document is filled with a plethora of new topics and proposed audit activities as well as continuation of audit activities on subjects from years past.

This fiscal year’s list is quite similar to prior years but holds a few surprise categories in which the OIG is not providing much clarification or specifics related to the subject to be reviewed. So that healthcare providers may be better prepared in scheduling their own internal monitoring and reviews, we have prepared an overview of some of the more significant 2014 OIG audit topics highlighting the issue and providing insight into the subject matter.

HOSPITAL CONCERNS AND GUIDANCE

Medicare

NEW INPATIENT ADMISSION CRITERIA – NEW

Informally known as the “Two Midnight Rule”, this is a hot topic. Although enforcement of this criteria is delayed until March 2015, hospitals should focus on compliance with the rule, as in many cases it represents a substantial change in admission criteria. Self-audits, case management, and utilization review should be part of the compliance plan.

MEDICARE COSTS ASSOCIATED WITH DEFECTIVE MEDICAL DEVICES – NEW

The OIG is taking the lead on a CMS concern regarding the cost of replacement devices. They will study the cost of this through review of medical claims to determine the effect on the Medicare trust fund. Hospitals should remember that modifiers should be reported on claims associated with warranty and recalled implantable devices used during operative procedures.

ANALYSIS OF SALARIES INCLUDED IN HOSPITAL COST REPORTS – NEW

The OIG plans to review hospital cost report data to determine if limits (through the cost report) should be placed on salary amounts paid to certain highly compensated employees. It wants to ensure the reasonableness of compensation paid. In the home care industry, these limits have long been in place and it appears this may be expanded to other provider types eventually.

IMPACT OF PROVIDER-BASED STATUS ON MEDICARE BILLING

Provider-based status can result in additional Medicare payment for services in a provider-based facility as well as increase a beneficiary’s coinsurance. The Plan will be looking at these facilities to ensure they are meeting all criteria required to be provider-based and also determine the impact on Medicare payment, believing there may be financial incentive to this status. The review objective is to ensure Medicare pays similar amounts for similar services, regardless of the provider status. Hospitals should be aware that the OPPS rule for CY 2015 is proposing to require hospitals to report modifiers when reporting charges for off-campus location services.

COMPARISON OF PROVIDER-BASED AND FREESTANDING CLINICS – NEW

A review will be conducted to compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made for similar procedures and evaluate the reasonableness and rationale.

REVIEW OF INPATIENT AND OUTPATIENT PAYMENTS (PPS)

The OIG proposes to use their sophisticated data mining tools as well as computer system matching programs to select claims failing to conform to specific CMS billing requirements. They will focus on those failures to comply with billing instructions that result in hospital overpayments.

This type of review is broad and, without more specific criteria, hospitals will be open to an aggregate of potential review issues. Hospitals are advised to monitor and review billing requirements as published in the Internet Only Manuals.

OUTPATIENT HOSPITAL DENTAL CLAIMS

Medicare considers dental services to be excluded from Medicare coverage. The plan is to investigate hospital outpatient claims adjudicated to payment for dental related services and possible provider overpayments.

Hospitals should assure procedures are in place in the billing office to prevent claim submissions to Medicare for non-covered statutory excluded services. This process should include screening for non-covered services but also related and incidental services associated with these non-covered services.

OUTPATIENT EVALUATION AND MANAGEMENT SERVICES BILLED AT THE NEW PATIENT RATE – NEW

A review of the new clinic rate for evaluation and management services will be undertaken to ensure that overpayment issues do not exist based on the alignment of the new evaluation and management service codes and whether a patient is a new or established patient.

INDIRECT MEDICAL EDUCATION PAYMENTS – NEW

Provider data will be reviewed to ensure IME payments were made in accordance with Federal regulations and guidelines and calculated properly. Prior OIG reviews have found overpayment situations so this is back on the table this year.

OVERSIGHT OF HOSPITAL PRIVILEGING – NEW

Hospitals participating in Medicare must have an organized medical staff that periodically appraises its members. The OIG believes this oversight contributes to patient safety and quality of care. Their review will encompass how privileges are granted to medical staff, including verification of credentials and review of the National Practitioner Databank.
CRITICAL ACCESS HOSPITALS – SWING BEDS

There is also concern with the payment methodology for CAH swing beds. It is reviewing this methodology to ensure payment to CAHs for this level of service is reasonable and appropriate.

LONG-TERM CARE HOSPITALS

There is a plan to review and determine the extent to which Medicare made improper payments for interrupted stays in long-term care hospitals (LTCH) in 2011. It also plans to identify readmission patterns and determine the extent to which LTCHs readmit patients directly following the interrupted stay periods. An interrupted stay occurs when a patient is discharged from an LTCH for treatment and services that are not available at the LTCH and is readmitted after a specific number of days. In the past, the OIG has identified vulnerabilities in CMS’s ability to detect readmissions and appropriately pay for interrupted stays.

Medicaid

The Work Plan adds topics of interest and continues to support the OIG’s concern and continuation of reviews associated with State Medicaid program involvement with drug rebate programs, State coverage under the Home Community and Personal Care services, State provider and supplier reimbursement policies, provider termination, and the Medicaid integrity program audits.

Summary of the OIG Work Plan

The OIG reported expected recoveries of approximately $5.8 billion for FY 2013 related to investigative recoverables. Another $19.4 billion in savings was identified related to legislative, regulatory, or administrative actions that were supported by OIG recommendations. It further accomplished 3,214 individual/entity exclusions from participation, 960 criminal actions and 472 civil actions. It is increasing its use of its extensive database to data mine for more efficiency and effectiveness in pinpointing its oversight efforts.

It is clear, based on the successes described in its semi-annual report to Congress and on its website, that the OIG will remain extremely active in its audit and review activities of all provider types.

II. CONCLUSION

The Department of Health and Human Services, through its agencies, continues its oversight of Medicare and Medicaid payments to healthcare providers across the continuum of care. The future appears no different and, in fact, appears to include even more oversight than currently exists. Providers should carefully review and analyze each of the many work plans and rules that have been published in the past few months and incorporate review and analysis into their compliance plans.

Author: Janet Hodgdon is a Director in the Healthcare Division of Baker Newman Noyes and works in its Boston, MA office. For further information, she can be reached at jhodgdon@bnncpa.com.
Unfortunately from time to time, auditors encounter situations where a client's ability to continue as a going concern for the near future is in question. These scenarios are due to an inability to secure needed financing, declining patient/resident occupancy, or any number of matters placing financial stress on an organization. At these times, the audit process can slow down if there has not been significant collaboration between the auditor and client, as the auditors assess a need for an alternate audit opinion and additional reporting disclosures. The Financial Accounting Standards Board (FASB) seeks to clarify that these reporting matters are the responsibility of management.


The ASU provides new guidance, as GAAP presently provides no guidance on the responsibility of management to evaluate whether there is substantial doubt about an entity’s ability to continue as a going concern or provide disclosures in the footnotes. Generally Accepted Auditing Standards (GAAS) require that an auditor evaluate whether there is substantial doubt about an entity’s ability to continue as a going concern for a reasonable period of time, which is not to exceed one year from the date of the financial statements being audited. GAAS also requires an auditor to consider the possible effects on the financial statement, including disclosures in the footnotes regarding uncertainties about an entity’s ability to continue as a going concern.

FASB issued this ASU to address the lack of guidance in GAAP, the differing views about when there is substantial doubt about an entity’s ability to continue as a going concern, and the diversity in methods used in disclosing the relevant conditions and events in an entity's footnotes.

**Management’s Evaluation**

Under this ASU, as part of preparing financial statements for each annual and interim reporting period, management is responsible for evaluating whether there are conditions or events, considered in the aggregate, that raise substantial doubt about an entity’s ability to continue as a going concern within one year after the date that the financial statements are issued (or available to be issued when applicable). This aspect requires management’s involvement in the assessment, as well as the responsibilities which remain for auditors under GAAS. Management’s evaluations should be based on relevant conditions and events that are known and reasonably knowable at the date the financial statements are issued (or available to be issued when applicable). It is important to note that the timeframe imposed on management is extended over the responsibility of auditors, as the issuance date is used rather than the date of the financial statements being audited.

Substantial doubt about an entity’s ability to continue as a going concern exists when relevant conditions and events, considered in the aggregate, indicate that it is probable that the entity will be unable to meet its obligations as they become due within one year after the date that the financial statements are issued (or available to be issued). The term probable is used consistently with its use in the Contingencies Topic of the FASB Accounting Standards Codification (450).

Upon management’s identification of conditions or events that raise substantial doubt about an entity’s ability to continue as a going concern, management should consider whether its plans to mitigate those relevant conditions or events will be able to alleviate the substantial doubt. The mitigating effect of management’s plans should be considered only to the extent that (1) it is probable that the plans will be implemented effectively and, if so, (2) it is probable that the plans will mitigate the conditions or events that raise substantial doubt about an entity’s ability to continue as a going concern.

**Disclosures**

If conditions or events raise substantial doubt about an entity’s ability to continue as a going concern, but the substantial doubt is alleviated as a result of consideration of management’s plans, the entity should disclose information that permits users of the financial statements to understand all of the following (or refer to similar information that is disclosed elsewhere in the footnotes):

- Management’s evaluation of the significance of those conditions or events, in relation to the entity’s ability to meet its obligations.
- Management’s plans that alleviated the substantial doubt about the entity’s ability to continue as a going concern.

If substantial doubt remains after consideration of management’s plans, an entity should include a statement in the footnotes indicating that there is substantial doubt about the entity’s ability to continue as a going concern within one year after the financial statements are issued (or available to be issued when applicable). The entity should also disclose information that enables users of the financial statements to understand all of the following:

- Primary conditions or events that raised substantial doubt about the entity’s ability to continue as a going concern (prior to consideration of management’s plans).
- Management’s evaluation of the significance of those conditions or events, in relation to the entity’s ability to meet its obligations.
- Management’s plans that are intended to mitigate the conditions or events that raise substantial doubt about the entity’s ability to continue as a going concern.

**Application and Effective Date**

The amendments presented in this ASU apply to all entities and are effective for annual periods ending after December 15, 2016, and for annual periods and interim periods thereafter. Early application is permitted.

This new ASU does not materially impact “going concern” disclosures, but instead clarifies who is responsible for identifying the matter and deciding what disclosures are in play. If you find yourself in this situation, it is always best to start discussions with your auditors early in the process to ensure a smooth reporting process.

Contact us with questions about these or any other accounting matters you may have.

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Certified Revenue Cycle Representative (CRCR)

by Jane Piotrowski, CHFP

Back in 2011, HFMA added to their list of certification programs, the Certified Revenue Cycle Revenue Cycle Representative (CRCR). This program is designed to set standards for performance for Revenue Cycle staff. By becoming certified in the CRCR program, you prove that a high level of knowledge has been reached.

This year, for the first time, the NH/VT chapter, along with the Arizona, Connecticut and Wisconsin Chapters, worked together to coordinate four coaching sessions (webinars) to assist those interested in the CRCR Certification designation. These sessions were held on the four Wednesdays in August and focused on the key areas of the exam, i.e. Compliance; Patient Access; Claims Processing and Financial Management.

The response to this program was outstanding! A total of 92 participants (from all four chapters) signed up and participated in the webinars. The NH/VT Chapter was represented with 18 of those participants.

Were you interested in the CRCR designation but didn't have the time to commit during the scheduled webinars? You can still do it!!! The recorded webinars are listed on our website under “Certification Coaching Sessions.” Each session is 90 minutes long and, along with the study guide, is summarized as a resource and available for listening at your leisure.

For more information about this program or any other HFMA Certification program, please contact one of the Certification Committee members.
SAVE THE DATE!!

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Reserve your overnight accommodations now by calling (866) 592-9611. A limited number of rooms are being offered at a contracted rate of $165 per night for 2 people, so call now!
“Rebuilding the revenue cycle process substantially increases cash liquidation for a rural community hospital”

By: Cheri S. Kane, FHFMA, AMCPE, Managing Director, PwC Health Insurance Advisory

Small hospitals are in every rural community in the United States. Many of these hospitals were started by family farmers and their local communities dreaming of having their own healthcare facilities.

The hospital discussed here has a story that mirrors those of thousands small, rural hospitals throughout the country struggling to survive in an ever-changing healthcare maze. Today’s hospitals are pressured by reductions in private-pay cash collections, reduced volume, and declining payer reimbursements. Although all hospitals are facing these challenges, they are often amplified at community hospitals unaffiliated with larger networks.

BACKGROUND

This is a story about one small community hospital that improved its bottom line by rebuilding its revenue cycle. So, what was wrong? Like many hospitals, this hospital’s number-one mission is to provide quality services to patients. But, typically, it did not ask patients for payment at the time of service, did not consistently verify insurance, and did not make documentation for reimbursement through the state’s financial assistance program a priority.

After five years of declining cash flow and a negative operating margin (5.3%), the hospital was in dire straits. Fortunately, its new CFO had a plan to pull the hospital out of the red. The first step was to make a business case to the board. After seeing the hospital could potentially trip one of its financial ratio covenants in its letter of credit if it didn’t act soon, the board gave the CFO’s plan the green light.

The CFO’s plan was centered on the need to rebuild the hospital’s revenue cycle. The current director of patient financial services didn’t have the knowledge, nor did the team have the expertise to manage the payer issues. After a biller’s extended illness resulted in a substantial decline in cash flow, the CFO decided that drastic changes were needed and that the hospital should consider outsourcing to improve the hospital’s revenue cycle process.

To help document the revenue cycle issues, the hospital hired an external consultant to perform a complete assessment of the current revenue cycle process. The consultant identified the following issues:

- Human capital
- Lack of leadership and knowledgeable staff
- No staff accountability
- Lack of staff training/cross-training
- Process
- Lack of policies/procedures
- Inconsistent billing
- Irregular cash posting
- Technology
- Lack of registration quality
- Inconsistent insurance verification
- No point-of-service estimator
- Outdated billing editor

THE OUTSOURCING DECISION

Because the CFO was doubtful the rural hospital could attract the talent required to turn around the revenue cycle, the consultant and the CFO recommended outsourcing the business office as a way to reduce costs and increase cash flow while delivering industry benchmark results.

The key responsibilities for the outsource vendor would be to:

- Demonstrate positive results in business outsourcing
- Hire an onsite director and team
- Perform all business office functions
- Succeed under a fixed monthly fee with incentives
- Possess extensive experience in the services to be contracted
- Negotiate a multi-year agreement
- Co-manage patient financial services with hospital leadership

In addition, the outsource company would have to accept an annual base rate below the hospital’s current costs with incentive compensation once the hospital achieved its financial goals.

The vendors were told that the goals of the business office outsource were to:

- Maintain a high level of customer satisfaction
- Reduce the hospital’s costs
- Reduce accounts receivable (A/R) days
- Increase cash liquidation
- Reduce gross bad-debt placements
- Increase financial assistance

CONTRACT NEGOTIATION

A key component of the vendor contract negotiation was to align the outsource company’s incentives with the hospital’s financial objectives. Thus, the hospital offered a monthly fee based on its historical costs along with cash incentives to achieve specific goals. The key components of the agreement were as follows:

- Base contract fee
- Incentives
- A/R days
- Gross bad-debt reductions
- Vendor responsibilities:
  - Financial assistance
  - Cash posting
  - Refunds
  - Billing
  - Insurance follow-up

IMPLEMENTATION

After selecting the vendor, the hospital and vendor evaluated displaced staff members for potential positions with the vendor and the hospital. This step was instrumental in providing staff consistency during the transition. Fortunately, reallocating staff to new positions, after some additional training, was easily accomplished.
Throughout the outsourcing engagement, customer service was a top priority — patient complaints would need to be resolved timely and effectively. Hospital leadership understood that it would need to closely manage the outsourcing company in order to achieve a positive outcome. Initially, the CFO met with the outsourcing company weekly to help resolve issues with service and quality.

Key performance indicators (KPIs) tracked included:
- Days in A/R
- Dollars billed by payer
- Cash collected by payer
- Clean claims rate
- Point-of-service collections by service and staff member

KEY OPERATIONAL CHANGES

DRIVING SUCCESS:

Discharged not final billed (DNFB) and post-DNFB

The team quickly identified that DNFB was an issue. Some staff members didn’t know how to bill for specialized services, such as skilled nursing. Thus, the outsourcing company had to develop policies and procedures to correctly code and/or bill specialty claims to resolve substantial billing backlogs.

Bill editor implementation

After the first two months, the clean-claims rate was less than 15%. Clearly, the billing system was causing substantial issues. The billing staff was unable to correct and bill the daily claims in a timely manner. After some research with the billing vendor, the director of patient financial services determined that the billing system required substantial updates as well as bridge routines to substantially improve the clean-claims rate. In lieu of upgrading the old system, the hospital opted to purchase a state-of-the-art billing system to speed the billing process.

The outsourcing company offered to assist the hospital with the acquisition of the new billing system, given that the change would also improve the outsourcing company’s ability to achieve its financial goals. The hospital and the outsourcing vendor acquired a new billing system. Subsequently, the outsourcing vendor contracted the bill editor, with costs in excess of the hospital’s previous baseline billed as a pass-through to the hospital’s agreement.

Hire a financial counselor

The hospital hired a full-time financial counselor to discuss payment arrangements for each patient’s financial responsibility and to screen patients for state and locally funded programs. This employee met with each admitted patient and some outpatients to develop payment plans and to find other means to subsidize their care. In addition, a loan program was developed for patients unable to obtain local or state funding.

Implement a point-of-service estimator

A point-of-service estimator was implemented to calculate a patient’s financial responsibility based on insurance coverage. Consultants provided self-pay collection training to the staff to drive point-of-service collections. If the patients were unable to make suitable financial arrangements, loans and extended payment plans were also offered.

FINANCIAL RESULTS

In the first year, the hospital reduced gross A/R days from approximately 70 to 40. Net A/R days improved from 56.6 in Year One to 33.4 in Year Two, with A/R days estimated to reach 30.6 in Year Three.

In addition, the hospital’s point-of-service collections substantially improved through staff training and a new point-of-service estimator. The results of the point-of-service collections are as follows:
- Year One = $27,000
- Year Two = $185,000
- Year Three = $233,000
- Year Four = $465,000

Operating margin increased from a negative (5.3%) to a positive 2.8% between 2008 and 2010. Gross bad-debt placements decreased from 8.2% at its highest level to 4.4% as of December 31, 2011.

LESSONS LEARNED

The hospital learned the following key lessons during the outsourcing process:
- Overcommunicate with employees – Employees need to feel comfortable that their positions are stable in order to achieve a smooth transition.
- Perform a complete assessment – A complete assessment should be documented, by the new outsourcing company or by a consultant, to review the hospital’s policies, procedures, and processes. Had the outsourcing company reviewed the KPIs for the clean-claims rate, it would have known how imperative it was to perform a billing conversion immediately to improve the hospital’s cash flow.

- Identify and hire key business office staff – The outsourcing company should identify key personnel before the outsourcing announcement. These staff members should be retained through the transition and throughout the agreement, if possible.
- KPIs – Obtain a complete historical listing of the KPIs and identify areas requiring immediate action to increase the hospital’s cash flow.

SUMMARY

For this rural hospital, net accounts receivable improved from $5.6 million in Year One to $3 million, and is estimated to reach an additional $2.9 million reduction in Year Two. The impact to cash from this initiative was approximately $2.5 million over the two-year period.

Outsourcing may not be a viable option for all hospitals; however, if your organization is unable to hire and retain qualified revenue cycle staff, or requires an infusion of technology and other resources to boost revenue cycle operations, outsourcing may be a viable option worth considering.
# New Hampshire/Vermont Chapter Education Calendar

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<td>Executive Courtyard Banquet Facility, Manchester, NH</td>
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<td>Medicare Cost Reporting — Introduction</td>
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HFMA CHFP Certification Candidate Practicum

Christoph Stauder, CPA, FHFMA by Peter Smith, FHFMA

Recently Conducted Live On-Site Practicums: September 9 in Worcester, MA, September 10 in Lebanon, NH, and September 11th in Portland, ME.


The Region 1 HFMA Chapters sponsored a FREE series of one-day CHFP certification coaching sessions that was supplemented by an extensive participant package that addressed certification overview, case studies, and related exam topics. In addition, the NH/VT Chapter offers a $100 incentive to any member who passes the CHFP exam.

Comments from NH/VT Participants:

"Christoph was amazing presenter! Very informative...motivating session”

"A lot of materials covered in one class...great way to start the studying process”

“Thank you for making it relevant to today/real world and allowing questions/discussion”

You may have missed these awesome coaching sessions, but please check out our NH/VT website for other valuable resources. GET CERTIFIED!
Experience HFMA’s Virtual Conference created for healthcare finance leaders. This interactive, live 4-day event includes influential speakers, dynamic education sessions, online networking opportunities, industry solutions, and CPE credits.* Attend these online events available from the comfort of your home or office. Available online and in real-time. hfma.org/virtualconference

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Visit hfma.org/cts for more details.
Healthcare Reimbursement 2015

On September 24, 2014, the Planning Committee of the NH VT HFMA chapter was pleased to offer the first live program of the year entitled Healthcare Reimbursement in 2015. This seminar was held at the Fireside Inn in West Lebanon, NH, with over 60 healthcare professionals from across New Hampshire and Vermont in attendance.

The program included a wide-range of reimbursement related sessions including an update from NGS, the regional Medicare Administrative Contractor on Meaningful Use Audits, Cost Report Settlements, Provider Taxes, Wage Index Timelines, Audit & Reimbursement initiatives and more. There was also informative discussions on the 2015 Final IPPS Rule for PPS and Critical Care Hospitals; the 340B Drug Program from an Operations Perspective; Provider Based Physicians, Provider Based Clinics, Employed and Primary Care Physician Reimbursement Update; and implications of CMS’s new Regulations on the Medicare Cost Report. In addition, there was a moderated Healthcare Reimbursement Reform Panel with the NH & VT organizations that are leading the way into ACOs, Bundled Payments and Decision Analytics.

The next live program will be the NH Health Protection Program focusing on Medicaid Expansion held in conjunction with the New Hampshire Medical Group Management Association. This event will be held on November 12th at the Executive Courtyard in Manchester, NH and will include presentations from the Governor’s Legal Counsel, NH DHHS and Medicaid Managed Care Contractors. For more information on this and other live educational events, please visit our web site.

Estimates show hospitals underpaid $330M each year Medicare transfer revenue.

This headline is missing 30% of its words. Losing 30% of your Medicare post-acute transfer revenue on the table doesn’t make much sense either.

On average BESLER Consulting can identify 30% more post-acute transfer revenue than a hospital’s internal process or primary review vendor. This could mean making hundreds or thousands of dollars in additional revenue simply by asking us to take a second look.

Watch a short video now at www.drgtransfer.com to see how you can get on the road to a bigger underpayment recovery.

©2014 BESLER Consulting | HFMA staff and volunteers determined that Transfer DRG Revenue Recovery Service has met certain criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this service.
2014 Fall Institute

Lake Morey Resort in Fairlee VT was the picturesque site of the 2014 Fall Institute on October 15th. While earning education hours, attendees learned about new trends in Patient Access, Patient Financial Services and Revenue Cycle Management. Industry experts included representatives from NGS, VAHHS and NHHA, NH and VT Hospital HFMA members as well as Professional Organizations. It was a wonderful networking opportunity for our members and provided great exposure for participating vendors.

Planning for the 2015 Spring Institute, to be held at Holiday Inn-Concord NH on April 8, 2015, is well underway with more than half the presenters secured. Mark your calendars now!

your TURN

Whether you work at a hospital, health system, physician practice, or payer, HFMA keeps you informed on fast-moving developments in healthcare finance. Member events, publications, seminars, and online tools identify best practices, and help you manage change.

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The New Hampshire/Vermont Chapter of the Healthcare Financial Management Association (HFMA) is a professional membership organization for individuals in financial management of healthcare institutions and related patient organizations.