

Value ~ Added

A Publication of the Feeley & Driscoll, P.C. Health Care Services Group

Corporate Governance Independent Board Leadership

Board Reform is essential, it also makes strategic recruitment more important. The responsibilities of board members of healthcare organizations have changed dramatically over the last several years. What might have once been a ceremonial role now holds responsibilities and risks. Due to the heightened awareness of board misconduct which led to bankruptcies of several large companies, Congress was motivated to pass the Sarbanes-Oxley Act (the "Act") which became law on July 30, 2002.

While the Act only applies to publicly traded companies, the duties the Act imposes on directors and officers may be extended by the courts to other organizations and may change the duty of care owed by directors and officers and increase their exposure to personal liability.

Unbinding the Ties

In light of heighten scrutiny of board activities, healthcare organizations can benefit from adopting a board policy that embraces the independence requirements of the Act. To accomplish this, boards will need to adopt policies that may change the character of relationships they have with their board members. Under the Act, an independent director can have no material relationship with the organization other than his or her role as a director. The requirement means no commercial relationships; no family ties to management; no professional-services contracts to perform banking, consulting, accounting or legal work for the organization.

Furthermore, independence is required of all directors on the committees overseeing auditing, compensation, and board nominations. Implementation of these recommendations will require healthcare organizations to consider a review of their current independent status. Boards should consider the following:

- Does the organization conduct an annual independence review of its officers and directors

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- Has the organization loaned funds to officers or directors or guaranteed debt
- Does the audit committee have the primary responsibility of overseeing the activities of the audit firm
- Does the board receive adequate data to effectively conduct their duties
- Has the organization adopted a Code of Ethics for the board and officers
- Has the organization updated its conflict of interest and disclosure policies recently
- Has the organization reviewed the sufficiency of its internal controls and their effectiveness?

In Search of Number Crunchers

With the complexity of transactions, new financial instruments, and off-balance-sheet items, audit committees need more knowledgeable people. In the past, audit committees have often leaned on one person with deeper knowledge of financial statements to shoulder much of the oversight role. In a recent poll conducted by CFO Magazine, respondents said that the level of financial expertise on their audit committees is “good” or “excellent”, however almost half reported that their committees need more expertise.

Some organizations have taken the initiative to provide additional education for their directors by conducting training sessions on accounting and finance topics in addition to industry related information. The result of this additional training is that directors are putting in more hours. Recent surveys indicate that directors now expect to spend between 175 to 200 hours per year on board business, verses 100 to 125 hours in the recent past.

Meeting the Challenge

We can assist your organization in fulfilling this obligation by helping develop independence policies, provide education on healthcare financial trends, conduct internal audits of complex transactions or help your organization develop an executive dashboard report for directors and officers to monitor strategic initiatives and key operating indicators more easily.

The FBI used its FY 2001 funding of \$88 million to support 776 positions (445 agents) funded in prior years and an additional 48 positions (30 agents) in 2001. There are 14 dedicated health care fraud squads across the country and the number of pending investigations is up over 400 percent from 591 in 1992 to 2,870 in 2001. Funding to the FBI is projected to reach \$114 million by FY 2003 supporting the fact that Healthcare fraud detection is among the highest priorities within the FBI.

The results being achieved by the federal government prove that there is certainly nothing to become complacent about. With recoveries and convictions such as these, the healthcare industry should be prepared for intense scrutiny for some time to come.

5 Things You Need to Know About the Proposed Nursing Facility User Fee Reg's

As first reported in the last issue of *Feeley & Driscoll's Value-Added*, the FY 2003 State Budget included a plan for a new nursing facility “user fee” that would allow the Commonwealth to allocate additional Medicaid dollars to nursing facilities without any additional state spending. Similar types of user fee structures are currently used in eighteen states.

Regulations to implement the nursing facility user fee have now been proposed and the key “talking points” are:

1. Nursing facilities will be assessed a user fee on all non-Medicare patient days amounting to approximately \$145 million per year. The user fee for FY 2003 is **\$9.60**. (This amount will be calculated each year by the DHCFP.)
2. The user fee will be assessed on each non-Medicare patient day at the facility. A Medicare patient day is a traditional fee-for-service patient day under Medicare Part A or any day paid for by a Medicare HMO, including Evercare, Tufts, Secure Horizons, *et cetera*.
3. Each home will be required to pay a quarterly assessment to the Division. Each assessment must be submitted on a quarterly assessment form, which is prepared by the Division. The due date for the form and the assessment itself is forty-five days after the end of the fiscal period or the date of approval by the Centers for Medicare and Medicaid Services (the first assessment only). ***The first assessment's due February 15, 2002.***
4. If a facility fails to remit an assessment by the due date, the Division will assess interest at 1½ % per month on the outstanding balance. The Division may also impose a late fee of up to 5% per month of the outstanding balance. The Division may also impose a per diem penalty of \$100 per day if a facility fails to submit required reports or furnish other documentation requested under this regulation.
5. Thanks to Federal financial participation (“FFP” or “the Federal match”), the \$145 million in collected user fees will result in a \$261 million increase to Medicaid nursing facility rates. The funds are allocated as follows:
 - \$129 million for increased payment rates to nursing facilities, including funds to reimburse the Medicaid portion of the user fee;
 - \$70 million to fund the costs of changing the base year used to calculate nursing home rates from 1998 to 2000;
 - \$50 million to support a flexible rate add-on for wages, hours, and other costs of direct care staff;
 - \$12 million to fund rate adjustments for capital expenditures with priority to nursing homes located in under-bedded areas of the state.

Hospital Conditions of Participation: Clarification of the Regulatory Flexibility Analysis for Patients' Rights

Federal Register: October 2, 2002 (Volume 67, Number 191, page 61805-61808)

Agency: Centers for Medicare & Medicaid Services (CMS), HHS.

Action: Interim final rule; clarification of regulatory flexibility analysis.

On July 2, 1999, CMS published an interim final rule with comment period introducing a new Patients' Rights Condition of Participation (COP) that hospitals must meet to be approved for, or to continue participation in, the Medicare and Medicaid programs. Several aspects of that interim final rule with comment period were challenged, including its regulatory flexibility analysis (RFA). As a result of this action, a Federal court, without enjoining continued enforcement of the rule, ordered the Secretary of the Department Health and Human Services (DHHS) to complete a compliant RFA to accompany the interim final rule with comment period. This document addresses the court's order.

Conditions of Participation: Immunization Standards for Hospitals, Long-Term Care Facilities, and Home Health Agencies

Federal Register: October 2, 2002 (Volume 67, Number 191, pages 61808-61814)

Agency: Centers for Medicare & Medicaid Services (CMS), HHS.

Action: Final rule with comment period.

Changes in Medicare Appeals Procedures Based on Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

Federal Register: October 7, 2002 (Volume 67, Number 194, pages 62478-62482)

Agency: Centers for Medicare & Medicaid Services (CMS), HHS.

Action: Notice of CMS ruling.

Program Exclusions: September 2002

Federal Register: October 11, 2002 (Volume 67, Number 198, pages 63435-63440)

Agency: Office of Inspector General, HHS.

Action: Notice of program exclusions.

Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2003

Federal Register: October 21, 2002 (Volume 67, Number 203, page 64641-64643)

Agency: Centers for Medicare & Medicaid Services (CMS), HHS.

Action: Notice.

This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance

amounts for services furnished in calendar year 2003 under Medicare's Hospital Insurance program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. The inpatient hospital deductible will be \$840. The daily coinsurance amounts will be: (a) \$210 for the 61st through 90th day of hospitalization in a benefit period; (b) \$420 for lifetime reserve days; and (c) \$105.00 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

Effective Date: This notice is effective on January 1, 2003.

Monthly Actuarial Rates and Monthly Supplemental Medical Insurance Premium Rate Beginning January 1, 2003

Federal Register: October 21, 2002 (Volume 67, Number 203, pages 64643-64649)

Agency: Centers for Medicare & Medicaid Services (CMS), HHS.

Action: Notice.

Effective Date: January 1, 2003.

Part A Premium for 2003 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

Federal Register: October 21, 2002 (Volume 67, Number 203, pages 64649-64651)

Agency: Centers for Medicare & Medicaid Services (CMS), HHS.

Action: Notice.

Effective Date: This notice is effective January 1, 2003.

Current List of Laboratories Which Meet Minimum Standards To Engage in Urine Drug Testing for Federal Agencies

Federal Register: October 3, 2002 (Volume 67, Number 192, pages 62072-62073)

Agency: Substance Abuse and Mental Health Services Administration, HHS.

Action: Notice.

Contact Feeley & Driscoll

Please visit www.fdcpa.com/healthcare.htm to receive the latest health care news and the dates and agendas of our upcoming Reimbursement Roundtables for Hospitals and Long Term Care Providers

If you have any questions or would like to discuss further any of the issues discussed in Value Added with one of our health care specialists, please contact us at (617) 742-7788 or

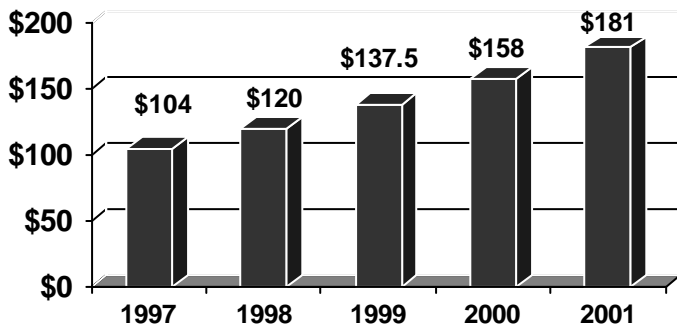
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The Dangers of Compliance Complacency

In the wake of September 11th, it can be tempting to think that federal investigators are too preoccupied with the fight against terrorism to worry about compliance in the healthcare industry. Such thinking represents a false sense of security for healthcare providers. Let's review some statistics that show why "Compliance Complacency" is so dangerous.

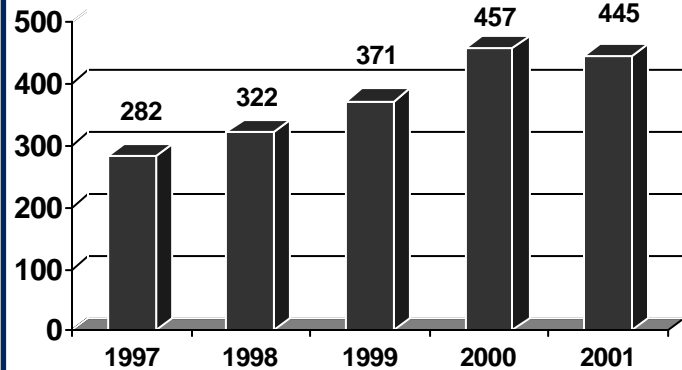
The Health Insurance Portability and Accountability Act (also known as HIPAA or the Kennedy Kassenbaum Act) was signed into law on August 21, 1996. HIPAA not only requires that recoveries from healthcare investigations be deposited in the Medicare Trust Fund but also appropriates monies from the Trust Fund to an expenditure account called the Health Care Fraud and Abuse Control Account. Each year, the HHS Secretary and the U.S. Attorney General jointly certify to the Control Account amounts necessary to finance anti-fraud activities. The amounts certified to the Account have increased 74% since 1997, as shown in Figure 1.

Figure 1 - Amounts Certified to the Health Care Fraud and Abuse Control Account (in millions)



In the Annual Report for FY 2001 issued by the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) in April 2002, the largest return to the government was reported since the inception of the program. The Federal Government won or negotiated more than \$1.7 billion in judgments last year. Over \$1.3 billion was collected of which \$83 million was paid to whistleblowers. The amount collected by the Health Care Fraud and Abuse Control program has increased 438% since FY 1998. Federal Prosecutors have been busy filing criminal indictments (see Figure 2):

Figure 2 - Indictments Filed

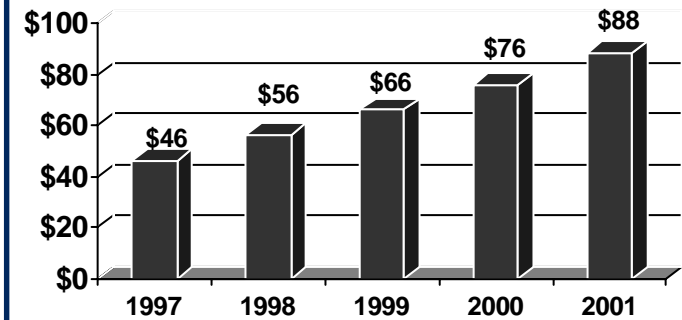


A total of 465 defendants were convicted for health care fraud-related crimes in 2001 and HHS excluded 3,756 individuals and entities from participating in Medicare and Medicaid.

Fiscal year 2001 marked the fifth year of the Fraud and Abuse Control Program. During those five years, the Trustees of the Medicare Trust Fund extended the estimated financial life of the Medicare Trust Fund by 30 years citing "the continuing efforts to combat fraud and abuse." Also in the last five years, over \$2.9 billion has been returned to the Medicare Trust Fund, more than 2,000 defendants have been convicted for healthcare fraud-related offenses, and over 15,000 entities or individuals have been excluded from the Medicare/Medicaid Programs.

HIPAA also separately requires FBI Mandatory Funding for healthcare fraud enforcement. FBI funding under HIPAA has almost doubled since 1997 (see Figure 3).

**Figure 3 - FBI Funding Under HIPAA
(in millions)**



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CMS Program Memorandums - October 2002

Reasonable charge update for 2003 for splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes and certain intraocular lenses

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 10-11-02, Transmittal No. AB-02-136, Change Request 2371

Installation of Version 27.4 of the Provider Statistical and Reimbursement (PS&R) Report

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 10-11-02, Transmittal No. AB-02-100, Change Request 2401

Changes in Transitional Outpatient Payment (TOP) for 2003

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 10-11-02, Transmittal No. AB-02-098, Change Request 2356

This PM outlines changes in the Outpatient Perspective Payment System (OPPS) for services furnished during calendar year 2003. As of January 1, 2003, TOPs are reduced for all providers except those hospitals that receive hold harmless TOPs (cancer hospitals, children's hospitals

and rural hospitals having 100 or fewer beds). You must revise the monthly interim TOP calculations to reflect the new calculation effective January 6, 2003.

Provider Education Article: Home Health Agencies' (HHAs) responsibilities regarding patient notification

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 10-25-02, Transmittal No. A-02-104, Change Request 2320

Annual update of HCPCS codes used for Home Health consolidated billing enforcement

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 10-11-02, Transmittal No. AB-02-137, Change Request 2402

Annual desk review program for Hospital Wage Data: Cost Reporting periods beginning on or after October 1, 1999, through September 30, 2000 (For FY 2004 wage index)

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 10-4-02, Transmittal No. A-02-94, Change Request 2394

2003 OIG Work Plan

The Office of Inspector General (OIG) recently published their Work Plan for Fiscal Year 2003. Released annually, the Work Plan previews OIG projects that are scheduled in the upcoming year for each of the major entities within the Department of Health and Human Services —

- Centers for Medicare and Medicaid Services
- Public Health Service Agencies
- Administrations for Children, Family, and Aging

Information is also provided on projects related to issues that cut across departmental programs, including state and local government use of federal funds, as well as the functional areas of the Office of the Secretary. Some of the projects described in the Work Plan are statutorily required, such as the audit of the department's financial statements, which is mandated by the Government Management Reform Act.

The Work Plan can serve as an invaluable guide for healthcare professionals and organizations to identify the targets of OIG scrutiny and enforcement activity. The 2003 Work Plan covers the full spectrum of healthcare, from medical necessity and coding issues to clinical trials and care provided in nursing homes. Some of the issues highlighted this year include:

- **Outpatient PPS** – The OIG will evaluate the effectiveness of internal controls on adequately documented, properly coded, and medically necessary services. Studies will include a review of outlier payments.
- **Hospital privileging** – The OIG will review hospital privileging activities within the context of the Medicare Conditions of Participation (CoPs). The Work Plan highlights the privileging process as one of the “most fundamental internal safeguards in hospitals.”
- **Nursing Homes** – The OIG intends to focus more than ever on the quality of care that nursing homes provide residents. In addition, the OIG plans to study the appropriateness of certain Medicaid payments to skilled nursing facilities (SNFs), including payments for ancillary services, as well as whether facilities that receive Medicaid payments are claiming unallowable administrative expenses.
- **Home Health** – The OIG will assess how the implementation of the home health prospective payment system (PPS) has impacted quality of care, and whether PPS has had any effect on the accuracy of coding and billing.

- **Clinical Trials** – The OIG plans to review Medicare payments to clinical trials to determine whether payments were made in accordance with program specifications. The OIG will also examine whether current Medicare billing systems can accurately monitor the appropriateness of payments.
- **Physicians** – The OIG will conduct studies to validate the appropriateness of consultation services and the accuracy of coding for evaluation and management (E/M) services.

The Work Plan also indicates that the OIG will no longer be allocating resources to investigate facilities or practices that make errors or mistakes on claims. This revelation came as a surprise to many in the healthcare industry, and providers may now feel that they are off the hook regarding this issue. However, we strongly encourage our clients to remain attentive and vigilant in their compliance efforts.

Feeley & Driscoll, P.C.

Reimbursement Roundtable Series

As you know, Feeley & Driscoll, P.C. is hosting a series of complimentary roundtables designed to help you and your staff stay abreast of breaking issues impacting your institution's financial position.

Each roundtable will include discussions lead by a combination of experts from Feeley & Driscoll's Healthcare Services Group and outside agencies, payors and regulators.

We encourage you to send a member (or members) of your team to participate in these valuable, timely and informative sessions. All meetings will be held at F&D's Training Center, 200 Portland Street, Boston, MA 02114. Please call Scott Cavallo at 617/742-7788 x369 or email ScottC@fdcpa.com to reserve your space now. We look forward to seeing you.

Watch this space for the 2003 schedule of Reimbursement Roundtables!

Compliance Corner

An update on recent activity by the Department of Health and Human Services Office of Inspector General (HHS-OIG)

A common theme among OIG audits the last several months has been Disproportionate Share costs. Five (5) audits have been performed this year alone on the subject.

Medicaid provides that States make additional payments called Disproportionate Share Hospital (DSH) payments to hospitals for the uncompensated costs of serving disproportionate numbers of low-income or indigent patients. This is a way to provide supplemental payments to safety net hospitals that serve the large numbers of low-income Medicaid or uninsured patients

The start of these audits occurred when legislation proposed to increase Medicaid DSH reimbursement from 100% to 175% of costs. However, the OIG believed that Medicaid DSH payments were not always being retained and used by public hospitals and the DSH funds received were not always calculated correctly. The OIG determined a need to conduct additional audits of DSH payments among different States to determine if unallowable costs were being claimed on a nationwide basis.

Of the five (5) audits on two (2) states, California and Missouri, four audits revealed overstated DSH payments and one incorrectly calculated DSH payment, which resulted in an underpayment. The OIG has cited many explanations for variances in DSH payments, including:

- Lack of procedures / controls over cost reporting measures
- Calculation errors while compiling DSH costs
- Use of projected amounts instead of actual expenses and payments; and
- Not limiting total operating expenses to amounts that would be allowable under Medicare cost principles.

Until the OIG has finished their round of audits, they have asked legislators to hold off or appeal the decision to increase DSH payments to 175%

The OIG 2003 Work Plan addresses hospital specific disproportionate share payment limits. At the request of CMS, the OIG is reviewing states' DSH payments to selected hospitals to verify that the states calculated the payments in accordance with their approved state plans and that the payments to individual hospitals do not exceed the limits imposed by the Omnibus Budget Reconciliation Act of 1993.

2003 Charge Description Master: Observe these Observation Changes

As you sharpen your pencil and clear off your desk in preparation for your annual review of the hospital's charge description master (CDM), a few points of interest lie in the category called "Observation". Here's a summary of some important changes.

Intravenous Infusion Codes

Many hospitals are unaware of the opportunity to use code G0258 (observation infusion APC 0340, \$43.27). Effective April 1, 2002, the Center for Medicare/Medicaid Services (CMS) designated code G0258 to be used for intravenous infusion during a billable observation stay. This code must be billed with code G0244 to be payable, and it includes placement of the IV access. CPT code 36000 should not be reported in addition to G0258.

Use this opportunity while time still permits. Per the November 1, 2002 Federal Register, Healthcare Common Procedure Coding System (HCPCS) code G0258 will be deleted after December 31, 2002. There will be a 90-day grace period for the code. Continue to bill Q0081 for Medicare patients who receive an IV infusion and do not meet the guidelines for billing G0244. CMS has determined that the OCE logic can be modified to allow payment for G0244 even though Q0081 (Infusion Therapy) is assigned to an APC with status indicator "T".

Direct Admit Codes

Payment for APC 0339 jumps 7% to \$376.47. CMS announces the new direct admit codes. G0263 (direct admission of patient with diagnosis of congestive heart failure, chest pain, or asthma for observation) would receive no separate payment (it would be considered bundled into APC 0339). G0264 (initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma) would link to APC 0600 (\$43.96).

It is important to provide education to physicians concerning the packaging of the observation service under APCs. The appropriate use of the service should be the focus. Examples of appropriate and inappropriate use should be given, such as inappropriate standing orders for 23-hour observation following surgery. The hospital should convey to the physicians that appropriate usage of the observation service is the goal.

Keep those pencils sharpened and erasers ready. Now is the time to address the upcoming changes related to observation services.



Coding Corner

Criteria to Bill Using Time as Factor

We have all heard the complaint from a patient, “I was only with the doctor ten minutes and he charged me \$65.00”. However, the truth is that there are limiting circumstances when a physician is actually allowed to base his service on time. Here are the criteria required to bill using time as a factor.

To bill an E&M service based on time, more than 50% of the amount of time for the visit must have been devoted to counseling and/or coordination of care. The documentation must describe the counseling or the coordination of care, and the visit must be a face-to-face office visit. This does not replace the need to perform other key elements of an E&M visit. Time-based billing is used when extensive time is taken to counsel a patient.

Documentation is key to compliance when billing with time. Three things must be present in the medical record to validate the service.

1. Description of counseling/ coordination of care
2. The total length of the visit
3. The total time spend just counseling the patient

One of the most common errors physicians make is leaving out one of the above elements. To avoid such a mistake, consider the following sentence as a model to document legitimate physician work that supports time-based billing. “I spent 20 minutes of a 30 minute visit discuss-

ing her/his diagnosis and treatment options”. This one simple sentence contains all three required elements to bill a time-based visit. Examples of counseling / coordination of care are such things as:

- Discussion of new diagnosis /education needed
- Scheduling and /or helping patients make treatment and care decisions
- Determining course of treatment best for patient

To determine the appropriate E&M service to code refer to the CPT description. If the required elements of a visit have already been met or exceeded and time is still a determining factor, the code may be bumped up a level. If however, the required elements of the visit have not been met, but the counseling and / or coordination of care took up 50% of the visit, you would bill the associated E&M code. For example, you would use a 99213 for a 15-minute established-patient visit, a 99214 for a 25- minute visit, and a 99215 for a 40-minute visit.

When providing test results, time can be particularly advantageous. In such cases, as a prostate cancer screen, there is a great deal of time spent talking about surgical options but not much work is involved in taking a history or performing an exam. Therefore, billing with time as a factor would probably result in a higher level of code. All three time-based requirements must be present in the medical record.