

THE NEW AND EXPANDED HFS SERVICES!

HFS Consultants Continues to Expand

In addition to a new location, **HFS** keeps adding new product lines and services, helping our clients work more efficiently by saving them time and money. In this economy, every little bit helps!

New Office for Southern California

HFS recently opened our fifth location. The new Santa Ana office is in the Hutton Centre campus, which is being renamed MacArthur Place, and is in one of the more prominent buildings at the city's southwestern edge next

to Costa Mesa. The building location is in an up-and-coming, burgeoning area with many new high-rise condominium developments and retail projects, just off the 405 Costa Mesa Freeway. The 4 Hutton Centre office building is on 2.7 acres, including a lake. The building contains 18 tenants, including Stearns Cos., Carter & Burgess Inc., Borland Software Corp. and LandAmerica Financial Group Inc. Just two blocks away is The John Wayne Orange County Airport.

If you are near or visiting the Santa Ana area, please feel free to take a tour of the new **HFS** office.

HFS Acquires One of the Best Medicare/Medicaid Consulting Groups

We are very pleased to announce that **HFS** has hired **Trahan H. Whitten**, the former National Managing Partner of the nation's largest Medicare/Medicaid reimbursement consulting group. Trahan brings with him a hand-picked team of reimbursement experts that include the former Western Region's Regulatory Geographic Practice Leader, **Matthew Beymer**, four of the nation's leading regulatory and wage index specialists, **Scott Yasuda**, **Fred Fisher**, **Geoff Ho** and **Erin Miller**, as well as DSH, IME/GME and third party revenue recognition and payment experts. The group is located in the new **HFS** office in Santa Ana, California.

This team has helped many health systems and hospitals across the country build the finest practice methodologies for cost report preparation, pre and post-file cost report reviews, standardized work papers sets and policies & procedures to improve the accuracy and compliance of their third party reporting practices.

In this acquisition, **HFS** also got the best wage index review team and one of the finest DSH groups anywhere. Along with the existing Oakland-based reimbursement group under **John Pfeiffer**, the combined team's career experiences now include the entire spectrum of regulatory services from full outsourcing engagements to specialized projects. **HFS** is now able to offer the full spectrum of services for all providers up to and including large regional and national provider organizations.

We are very excited about the addition of this group, its technical capabilities and national experience, and how it complements our current service offerings. To contact **Trahan**, call 949-500-9185.

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PUT HFS CONSULTANTS ON YOUR TEAM

Since 1991, California healthcare organizations have made **HFS Consultants** an integral part of their operations. When they needed a CFO or business office manager, started up a rural health clinic or had reimbursement problems, we were there.

We are over 100 Consultants strong, and growing.

Count on our team's skills and knowledge, gained through years working with every kind of facility, from hospitals to rural health clinics to assisted living facilities. Make HFS part of your team for success and growth!

HFS SERVICES INCLUDE:

- **Hospital Turnarounds:** Comprehensive economic recovery programs, staffing and workflow redesign, cost control systems
- **Facility Management:** Interim and long-term, permanent executive staffing
- **Clinical Operations:** Clinical department organizational review, new services development, Title 22, OBRA and JCAHO assessment and education, case management, staffing improvement and RAC Assessments
- **Revenue Cycle Management:** Billing and patient accounting, workflow analysis, CDM review and updates, receivables management, billing systems review and planning
- **Health Information Management:** Coding compliance, web-based and interim coding, operational assessments, coding education, and clinical coded data analysis and documentation improvement services
- **Compliance:** Initial assessment according to OIG guidelines for compliance with participation in the Medicare and Medicaid programs
- **Accounting:** Financial statement preparation, budgeting, business planning and litigation support
- **Mergers & Acquisitions and Financing:** M&A analysis, market/feasibility studies, financial structuring for bonds, appraisals and business valuations
- **Licensing and Program Development:** Licensing, change of ownership, HPSA/MUA, Critical Access Hospital, RHC, FOHC, primary care clinic and swing beds development and licensing, OSHPD reporting and physician practice evaluation
- **Reimbursement:** Medicare, Medi-Cal and OSHPD cost report preparation and appeals, SNF and RHC rate setting, reimbursement maximization, disproportionate share, reimbursement impact analysis
- **Recruitment and Interim Staffing:** Interim staffing (CEO, CFO, Controller, Business Office Manager, HIM Director, Coder, Biller, Director of Nursing, etc.), executive recruitment
- **Support Services Consulting:** Supply Chain (Non Labor Expense Management/Reduction, Logistics Improvement, Interim Management), Pharmacy Management, Central/Sterile Processing, Food & Nutrition Services Improvement, Laboratory Management, Environmental Services Management

WE NOW HAVE FIVE OFFICES TO BETTER SERVE YOU

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HFS BUSINESS PARTNERS



HFS CHARGE MASTER MANAGEMENT SOLUTIONS

Do you know what is in your charge master? With our new enhanced Charge Master Management Solutions we will help you find out. The HFS experts combine the latest software tools with years of experience in many healthcare CDM's to improve your reimbursement. We offer the following services.

I. Charge Master Review and Assessment

The first step involves an initial off-site review and assessment of the charge master. This assessment is a 100% review of all line items involving procedures, supplies, equipment, pharmacy and pass-throughs. The elements we focus on are:

- Review all CPT/HCPCS codes for accuracy, validity and relationship to charge description numbers
- Review all procedure and service descriptions for accuracy and clinical appropriateness
- Review all revenue codes for accuracy and linkage to charge description numbers
- Ensure that the usage of all CPT/HCPCS and revenue codes are in compliance with current Medicare/Medicaid guidelines and other existing payer contracts
- Review the appropriate usage of modifiers
- Review covered and non-covered services
- Review all charge dollar amounts for consistency throughout departments
- Review all procedure and service descriptions to ensure consistency throughout the facility
- Review charge description numbers for uniqueness and validity
- Review all department code numbers for uniqueness and validity
- Review pricing against peer facilities and benchmark reimbursement

After the initial review, HFS will use the results to plan our onsite visit to perform the following in-depth

services:

- Work with department managers to define the procedures being performed, review compliance issues and identify needed changes in coding and billing practices
- Review the UB-04s, final detail bills, medical records and last remittance advice to identify problems and recommend corrective action
- Review outpatient procedural charges for laboratory and rehab departments, identify problems and recommend corrective actions in compliance with relevant laws and regulations
- Review interventional coding for radiology and cardiology services
- Determine with your clinical department directors, the clinical approach taken for procedures and make appropriate adjustments to CPT code assignments
- Provide training on CPT and APC coding issues, regulatory compliance and pricing methodology
- Coordinate and direct meetings to address and resolve any final charge master, charging or billing issues
- Work with the management team to ensure that all aspects of your policies are reflected in the charge master

Conclusion of the Review Process

HFS will conduct a verbal exit conference with your management team and provide an edited hard copy of the charge master with a detailed written report identifying specific changes and recommendations in coding, pricing and billing issues. The report will also include suggested process improvements for each department and input on APC-related issues.

Implementation of Changes to the Charge Master

Due to a variety of reasons facilities have difficulty implementing corrected charge master recommendations. This generally involves situations such as staff shortage/

turnover or department managers' lack of knowledge about coding. HFS offers assistance on all levels to coordinate and guarantee successful implementation.

- We offer focused education in areas such as interventional component coding to insure that all staff members understand their department's methodology of billing for services. This type of education will elevate and empower staff with new knowledge and necessary skills.
- HFS will input the approved new charge master into your system and will also provide complete implementation support to ensure that the charge master updates are implemented in a timely manner.

II. Charge Master Ongoing Maintenance

The changes that impact your charge master come faster than most hospitals can address. HFS offers Quarterly or Annual Charge Master Reviews to help you keep current with changes made to CPT codes, government regulations and CMS outpatient coding and billing requirements. The service includes the submission of your charge master on a selected schedule, with access to charge master experts who provide recommendations with supporting documentation. We also offer an extended maintenance plan that provides services for entering new line items and charges into the charge master as well as additional education to the appropriate department heads.

III. Other Charge Master Services

Education

HFS provides ongoing charge master education customized to your specific needs. HFS can provide your staff or department managers with on-site education that will address the internal process for reviewing and maintaining the charge master.

Strategic Pricing

Significant attention is being di-

HFS - NEW AND EXPANDED

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Fred Fisher, Trahan Whitten, Erin Miller, Matthew Beymer and Scott Yasuda. Geoff Ho not pictured.

Insurance and Risk Management

HFS Consultants now offers a new service in the Insurance and Risk Management area. **Elizabeth Kubota** heads up our Risk Management Services products.

The service includes the following functions:

- Assessment of current premiums and policy coverages for least cost opportunities
- Evaluation of loss history, deductibles, and other factors affecting risk expenses
- Assistance with broker, underwriter, and other relationship selection
- Evaluation of risk reduction programs (training, etc.) and assistance with augmentation and improvement where appropriate

For one of our clients, Mission Community Hospital, HFS evaluated spending for insurance coverage in several areas including hospital professional liability, Directors and Officers, Workers' Compensation, property, and general liability. An appraisal of the hospital's loss history revealed little support for the premium levels in place at the time. Active negotiation with incumbent and competitor brokers and underwriters produced a premium reduction of over 52%. Similar results have been provided for other clients.

Elizabeth has an extensive background in the medical risk management field, including claims for CNA Insurance, service as the Corporate Risk Manager for both the Southern California Physician Insurance Exchange and The Doctors' Company and Director of Risk Management for Children's Hospital Los Angeles. She works from our Glendale office and is available at 818-957-2649.

In addition, HFS has been engaged by several organizations to provide interim management services in the Supply Chain area.

For the County of Santa Clara, **Joe Grimes** provides medical contracting expertise in the County Procurement Services department. Joe has been in this role for over a year and is currently engaged through June of 2009. His experience is uniquely suited for this engagement, as he was Director of the Pharmacy program for a large national Group Purchasing Organization for over 19 years. Joe has been with HFS via Contract Support Services, which merged with HFS, over six years ago, and is located in the Glendale office.

HFS has also provided an interim Corporate Materials Manager for Vista Healthcare, a chain of medium sized acute care and long term acute care facilities in Southern California for 14 months. Initially engaged to provide interim services on a short term basis, Vista has elected to continue using HFS because of access to a wide range of expertise from an organization already familiar with their needs and business environment. This role is filled by Miguel Sandoval from the Glendale office who has served a variety of healthcare organizations in the Supply Chain arena, including Catholic Healthcare West, Kaiser Permanente, and Children's Hospital Los Angeles.

High Value Non-Labor Expense Reduction Programs

For Mission Community Hospital, a mid size acute and psychiatric facility in the San Fernando Valley, HFS recently completed a focused program for medical supplies, purchased services, and selected non medical supplies that netted over \$1 million in annual savings. The primary contacts are John Holder, Chief Financial Officer, and Heidi Lennartz, Chief Executive Officer, for the hospital.

For Northridge Hospital Medical Center, a large acute care trauma center facility owned by Catholic Healthcare West, HFS recently completed a project that netted over \$1.5 million (annually) in savings in orthopedic implants and produced a price reduction exceeding 60% for most procedures. Primary contacts are Paul Brydon, Chief Financial Officer, and Mike Wall, Chief Executive Officer, for the medical center.

For both projects HFS provided analytical resources, assisted with medical staff and management orientation and coordination, directed contract negotiations, and facilitated implementation to assure achievement of financial goals by the institutions. Both projects were supported by our Glendale office.

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HFS EMPLOYEE ADDITIONS AND CHANGES

HFS has been adding team members to accommodate the increase in client engagements in a variety of business services. Among the team members we have added are:

Patricia Bishop joins the Clinical Operations practice as a Senior Consultant. She has over 25 years experience in healthcare, working initially as a staff nurse in critical care, emergency and surgical services, progressing to health care facility leadership, administration within the California Department of Public Health and consulting in healthcare management.

Diana Surber rejoins HFS as a Manager, providing over 20 years of expertise in financial feasibility studies, financial analysis and accounting, business and strategic planning, interim CFO and controller work.

The Medical Billing department in the Fresno office has added **Bridgett Montano, Linda Darnell, Patricia Lucero, Monica Robledo, Elizabeth Ramirez, Loretia Atkinson** and **Jacqueline Martinez**.

The Administrative Team adds **Linda Ly** to assist in A/R management, Accounts Payable and collections efforts.

HFS welcomes all our new employees!

Corky Rockwell, a long time Senior Consultant with HFS has accepted a position as Director of Nursing at The Heritage of San Francisco. She will be greatly missed within the HFS family and we wish her all the success in the world. Stay in touch, Corky!!

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Grant Writing Services

HFS Consultants would like to announce the hiring of **Cecilia Murillo**, Senior Consultant. Ms. Murillo has over six years of experience in the nonprofit sector, most recently in the area of fund development. Her expertise in fundraising has:

- Raised over \$1M in foundation and corporate revenues for a community clinic
- Produced major fundraising events with revenues in excess of \$150K
- Increased direct mail campaign returns by more than 10%

Ms. Murillo has built solid relationships with Bay Area foundations and can assist in directing your organization's grant-seeking process through research, evaluation and execution of proposals for:

- General Operating grants
- Equipment and technical grants
- Program specific grants
- Service Area Competition grants
- New Federally Qualified Health Clinic (FQHC) Applications
- Health Professional Shortage Area (HPSA) Applications

If you would like to learn more about how **HFS** can increase your funding revenues, please contact **Cecilia Murillo** at ext. 288.

SB541 -PATIENT CONFIDENTIALITY

The State Legislature passed SB541 in 2008, authorizing strict penalties for breach of hospital patient confidentiality. Hospitals will be fined for substantial breaches of patient information and must report any breach to CDPH.

At **HFS**, we understand the complexity of the interpretation of SB 541. As indicated by CHA legal consultant Lois Richardson during a phone conference on January 29, 2009, she stated that many questions were unaddressed in the legislature of this bill. She also stated that CDPH is reluctant to interpret the statute or provide details on how they will enforce it. There were many scenario questions from facilities regarding what should and shouldn't be reported. Hospitals must be proactive in planning and implementing their policy in order to comply with this bill. It was also recommended that each hospital develop a team consisting of at least four staff members with expertise in clinical, legal, IT, and medical records to provide prompt action on any allegations and investigations of breaches in order to comply with the current 5 day reporting mandate.

At **HFS**, we have consultants with varied areas of expertise, including a senior consultant who has been a District Administrator for CDPH and who can assist you in preparation for compliance with this bill. Please contact **Becky Carroll**, ext 285 for valuable insight and assistance.

HAC'S & POA'S - MEDICARE TIES REIMBURSEMENT TO QUALITY

The Inpatient Prospective Payment System (IPPS), implemented in 1983, was intended to reward hospitals for being efficient by making a single payment to the hospital based on the average costs of treating a patient with a particular diagnosis, rather than paying for the actual costs of each case. However, in 2005, the Deficit Reduction Act granted Medicare legal authority to use its payment system to encourage hospitals to also improve the quality and reliability of care they provide. October 2007 opened the new era in Medicare reimbursement with the implementation of MS DRGs (Medicare Severity Diagnosis Related Groups). Not only did the payment groupings increase by 207 groups and add a new category, Major Complication/Co-morbidity (MCC) was added but there was a requirement that by October 2008, claims which included hospital acquired conditions (HAC) would affect reimbursement.

Hospital Acquired Condition

This requirement was based on the Deficit Reduction Act of 2005. The Act required the Secretary to identify conditions that:

- (a) are high cost or high volume or both,
- (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and
- (c) could reasonably have been prevented through the application of evidence-based guidelines.

On July 31, 2008, CMS included 10 categories of conditions that were selected for the HAC payment provision.

The 10 categories of HACs include:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
6. Manifestations of Poor Glycemic Control
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following:
 - Coronary Artery Bypass Graft (CABG) - Mediastinitis
 - Bariatric Surgery
 - Orthopedic Procedures
10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
 - Total Knee and Hip Replacement

In order to establish the fact that a condition was acquired in the hospital, an indicator for each diagnosis was necessary to determine the origin of the condition. Thus prior to implementing the reimbursement

changes, the indicator for Present On Admission (POA) was necessary to apply.

Present On Admission

On May 11, 2007 the Code of Regulations (CR 5499) was published to require reporting Present On Admission (POA) indicators to be included for all diagnoses and the corresponding ICD-9-CM codes reported on the claim forms for discharges on or after 10/1/07. Allowances were made for transition until 4/1/08 when claims were returned if POA information was missing.

The following are the POA indicators:

- **Y** - Yes - present at the time of inpatient admission.
- **N** - No - not present at the time of inpatient admission.
- **U** - Unknown - documentation is insufficient to determine if condition is present at time of inpatient admission.
- **W** - Clinically Undetermined - provider is unable to clinically determine whether condition was present at time of inpatient admission or not.
- **1** or **BLANK** - Exempt from POA Reporting List - Code categories are exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission.

There is no required timeframe as to when a provider must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. Determination of whether the condition was present on admission or not will be based on the applicable Medicare POA guideline, or on the provider's best clinical judgment. If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

Application of ICD-9-CM codes are a joint effort between the healthcare provider and the coder to achieve complete and accurate documentation, code assignment and reporting of diagnoses and procedures. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not.

HAC'S & POA'S - MEDICARE TIES REIMBURSEMENT TO QUALITY

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Payment Implications

If a claim includes a code from the listed HACs, the determining factor related to payment is the POA which will indicate if the condition arose during the hospitalization. The payment will be based on the MS-DRG assignment. If a diagnosis from the HAC list is included but does NOT have a POA flag the MS-DRG will be calculated without that diagnosis and payment will most likely be a lower level.

full market basket update for FY 2008.

The new measures are:

A. Surgical Care Improvement Project (SCIP) Measure:
SCIP Cardiovascular 2, surgery patients on a beta blocker prior to arrival who received a beta blocker during the peri-operative period

B. Re-admission Measure:

Heart failure (HF) 30-day risk standardized re-admission measure (Medicare patients)

C. Nursing Sensitive Measure:

Failure to rescue (Medicare patients)

D. AHRQ Patient Safety and Inpatient Quality Indicator Measures:

Patient Safety Indicators (PSIs) – Nine total

E. Cardiac Surgery Measure:

Participation in a systematic database for cardiac surgery

PREVIOUSLY ADOPTED MEASURES FOR REPORTING FOR FY 2010 UPDATE

- Heart Attack (Acute Myocardial Infarction)
- Heart Failure (HF)
- Pneumonia (PNE)
- Surgical Care Improvement Project (SCIP) - (Previously SIP)
- Mortality Measures
- Patients' Experience of Care (survey tool)

PAYMENT TABLE

POA Code	POA Definition	Payment Implication
Y	Diagnosis present at time of inpatient admission	CMS will pay the MS-DRG CC/MCC for those HACs that have a "Y" POA indicator.
N	Diagnosis NOT present at time of inpatient admission	CMS will NOT pay the MS-DRG CC/MCC for those HACs that have a "N" POA indicator.
U	Documentation not sufficient to determine if the condition was present at the time of inpatient admission.	CMS will NOT pay the MS-DRG CC/MCC for those HACs that have a "U" POA indicator.
W	Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	CMS will pay the MS-DRG CC/MCC for those HACs that have a "W" POA indicator.
1/Blank	Exempt from POA Reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data electronically on a 4010A.	CMS will NOT pay the MS-DRG CC/MCC for those HACs that have a "1" POA indicator.

Reporting Hospital Quality Data for Annual Payment Update Program

The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program was originally mandated by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. The Deficit Reduction Act of 2005 increased that reduction to 2.0 % from the original 0.4% in the annual market basket update for hospitals.

Additional expansion of the quality measures became effective with the final IPPS rule. This adds 13 to the current 30 measures with one reduction to a total of 42 measures to report in 2010. CMS will reduce payments to hospitals that do not successfully report quality measures adopted under the program by two (2%) percent from the percentage increase that would otherwise apply to their payment rates. These measures are publicly reported on the CMS Hospital Compare website.

Nearly 95 percent of hospitals in 2007 participated successfully in the reporting program and received the

Never Events

Medical errors defined as events that should **NEVER** happen in a hospital. The National Quality Forum has defined these as Serious Reportable Adverse Events or "Never Events". These include:

- Surgery on a wrong body part
- Surgery on a wrong patient
- Wrong surgery on a patient

Specific consequences for these occurrences are in the public comment period with a final decision to be published in April 2009.

Medicare is committed to improve the quality of care received during a hospital stay and to make sure that Medicare only pays for items and services that are reasonable and necessary. The IPPS rule for 2008 begins the quality and reimbursement connection and creates a need in the hospitals to closely monitor services to eliminate errors.

For further information on these categories and their implications, please contact **Kathy McCaffrey** at ext. 304.

POST ACUTE CORNER

PERMANENT RAC PROGRAM ANNOUNCEMENT

As stated on the CMS website, "the RAC demonstration program has proven to be successful in returning dollars to the Medicare Trust Funds and identifying monies that need to be returned to providers. It has provided CMS with a new mechanism for detecting improper payments made in the past, and has also given CMS a valuable new tool for preventing future payments." On October 6, 2008, CMS announced the names of the new national RACs. Region D which includes California will be overseen by HealthDataInsights, Inc. of Las Vegas, Nevada. RAC reviews will begin once again in March of 2009.

Changes with the permanent review process will include the use of certified coders, physicians, internal oversight by outside reviewers, and the return of contingency fees with an overturn in the RAC decision.

CMS just recently announced it has delayed the Medicare Recovery Audit Contractor (RAC) permanent program and put a moratorium on all RAC-related informational sessions across the country. CMS has yet to release further details but told the American Hospital Association the action was necessary due to "a RAC protest and a stay of performance."

PALMETTO GBA DOCUMENTATION FOR MEDICAL REVIEW

At the recent joint CHA Hospital Services for Continuing Care and Center for Medical Rehabilitation Services Annual Conference, a keynote address was given by Dr. Harry Feliciano, Director, J1 Medical Affairs for Palmetto GBA. He spoke of Palmetto's responsibility with the Comprehensive Error Rate Testing (CERT) program to continuously monitor the accuracy of Medicare fee-for service (FFS) payments and their process for accomplishing this task. Palmetto has adopted a documentation review procedure developed from the World Health Organization's International Classification of Functioning, Disability, and Health (ICF) taxonomy.

Palmetto has trade marked this process as Going Beyond Diagnosis®, which facilitates identification & communication of available healthcare resources and promotes decision-support. ICF defines and describes domains using categories that are relevant to healthcare providers, but not found in ICD-9-CM. It standardizes the characterization of structural and functional impairments, helps relate them to activity limitations and participation restrictions, includes environmental factors, and complements ICD-10. ICF has two parts, each with two components:

Part 1. Functioning and Disability

- Body Functions and Structures
- Activities and Participation

Part 2. Contextual Factors

- Environmental Factors
- Personal Factors

Part 1 describes health domains and Part 2 describes health-related domains.

Functioning and disability impairments of Part 1 are problems in body function or structure such as signifi-

cant deviation or loss. These domains include mental functions, sensory functions and pain, structures related to movement, and neuromuscular and movement related functions.

Other impairments include activity limitations which are difficulties an individual may have in executing activities, and participation restrictions which are problems an individual may experience in involvement in life situations. Domains here include mobility, self-care, interpersonal interactions and relationships, and community, social and civic life.

Part 2 environmental factors, make up the physical, social, and attitudinal environment in which people live and conduct their lives. These domains include products and technology, support and relationships, attitudes, services, systems, and policies.

When performing a medical review, Palmetto GBA will utilize the ICF taxonomy while reviewing the documentation in the patient's medical record. An ICF Guidelines Worksheet, developed by Palmetto GBA, is available on the following URL:

www.palmettogba.com/rhhi/GoingBeyondDiagnosis

PHYSICIAN CERTIFICATION/RECERTIFICATION

At a recent Open Door Forum, CMS stated that SNF's can meet the requirement of the initial certification for the need of skilled services by having the physician in the hospital sign the certification. They also stated that delayed recertifications do not necessarily have a timeline associated for obtaining the physician signature. Three sections of the Code of Federal Register were cited as reference to their deci-

sions. They are:

- 42CFR424.20 (e)(1)
- 42CFR424.20 (b)(1)
- 42CFR424.11 (d)(3)

They did state that the state's MAC may have a different interpretation of the regulations and that the SNF's should talk with the MAC if they are experiencing decisions in opposition to CMS' interpretation.

CREENTIALING/BILLING ISSUES

An important component to receiving the proper reimbursement for services rendered lies in enrollment of your provider locations and practitioners in Medicare and Medi-Cal programs.

Many facilities find it difficult to maintain required information for adequate enrollment in state programs, managed care plans and commercial payer programs. Each has different filing and information requirements. It often falls to Patient Accounting to retroactively enroll physicians after billing problems occur.

With the Medicare Fiscal Intermediary transition on September 2nd for all California based healthcare facilities from NGS (Part A) and National Heritage (Part B) to Palmetto in Georgia, there is much confusion surrounding provider enrollment and rate setting.

HFS can develop a contact file for each of your phy-

sicians, detailing all required information for enrollment in multiple plans including:

- Practitioner NPI confirmation
- Drivers license
- Medical license
- Proof of insurance coverage
- Existing Medicare or Medi-Cal provider identification numbers
- Designated contact person at the facility

HFS then utilizes this information for program and plan enrollment, tailored to the needs of the provider or facility. Proper enrollment ensures proper plan reimbursement and reduces claim rejection rates.

For further information on Credentialing updates and packages for your needs, please contact **Gwynn Smith** at ext. 315.

PALMETTO IS YOUR NEW FISCAL INTERMEDIARY

Effective September 2nd, CMS formally transferred Medicare Fiscal Intermediary responsibilities for California based healthcare facilities and the J1 MAC region from NGS (Part A) and National Heritage Insurance Company (Part B) to Palmetto GBA in South Carolina and Georgia.

Palmetto was awarded the Jurisdiction One (J1) region consisting of California, Hawaii, Nevada, Guam, American Samoa and Mariana Islands for all Part A and Part B issues, including provider enrollment, provider audit and reimbursement and facility rate setting.

There have been transition issues in the following months, including inadequate access to customer service phone lines and a shortage in analysts to handle the large volume increase in providers and practitioners in the J1 region.

Although all correspondence is directed to Palmetto, they have been subcontracting both enrollment applications and audits to several other intermediaries, including First Coast Service Options in Florida. Palmetto accepts all inbound applications and correspondence, scans the forms and emails them to appropriate subcontractors.

This added link leads to additional time for the review process. CMS is monitoring Palmetto's progress in length of time responding to customer calls and volume of enrollment applications processed.

HOSPITALS TO RECEIVE HUD 242 APPROVALS

HFS is pleased to announce that we have completed financial feasibility studies for three acute care hospitals on the West Coast that have successfully received mortgage insurance through the HUD Section 242 program for the purpose of insured financing for construction projects, capital improvements and refinancing of existing debt.

The hospitals are:

- Ridgecrest Regional Medical Center – Ridgecrest, CA
- Highline Medical Center – Burien, WA
- Methodist Hospital of Southern California – Arcadia, CA

HFS is the first consulting firm to assist in obtaining HUD insurance for any acute care hospitals located in various western states. Our team understands the regulations and requirements set forth by HUD and can walk your management staff through all aspects of the program.

For further information on the loan application process, please contact **Tammy Staeden**, Director of Financial Feasibility at (262) 293-3643.

SOCIAL RESPONSIBILITY AT HFS



Right before Thanksgiving, 15 volunteers consisting of HFS employees and their friends and family served supper at Glide Memorial Methodist Church in San Francisco. Glide operates the largest soup kitchen in the County and serves more than 50,000 meals per month.

HFS has a Social Responsibility Committee that offers employees opportunities to become involved in their communities. If you are interested in participating in one of the group functions throughout the year, please e-mail dbertasi@hfsconsultants.com.

A CASE STUDY: WHOLE HOSPITAL ASSESSMENT

This summer **HFS Consultants** was engaged by Tulare District Hospital ("TDH") to conduct a 15-week comprehensive operational and financial assessment.

This program was instituted at the request of the Management Team and Tulare County Board of Directors. The hospital is preparing to build a new \$120 million four-story tower, including a state-of-the-art imaging center, that will significantly improve patient care. Hospital CEO **Shawn Bolouki** wanted to make sure he was running a first class operation when they moved into the new facility.

HFS was asked to prepare findings and recommendations in the key operating and financial management departments. Specifically, **HFS** provided a thorough examination in each of the following departments and their components:

Patient Care Services, Clinical Services, Financial Services, Strategic Planning and Administrative Services and Revenue Cycle.

HFS Consultants provided a team of organized professionals with the experience we required to assist us in analyzing our Hospital operations and the healthcare needs of our community. Their review, blueprint and recommended action plans identified a first year savings in excess of \$12 million to the District. We would highly recommend HFS to any healthcare organization.

**-Shawn Bolouki
Chief Executive Officer
Tulare District Hospital**

To accomplish this study, **HFS** organized a team of 35 staff specialists to provide specific deliverables. During the assessment, no fewer than 14 **HFS** personnel worked on site to conduct interviews, perform observations, collect data, and investigate specific study objectives. All worked collaboratively with the management and line staff at the hospital and support for our program was excellent.

We conducted face-to-face interviews with senior staff and Board Trustees to gain further insights needed for this engagement. An additional key part of this process was to conduct weekly conference calls with the TDH Management Team to discuss findings and to report on

the progress in meeting the study objectives. **HFS** also prepared an executive summary which was presented to the Board of Directors, management, and line staff at a series of meetings in October.

In our detailed assessment we found the following opportunities:

1. Improved efficiency with management of bad debt reserves and contractual allowances
2. Coding accuracy improvements to reach a benchmark level of 95%
3. Operational and policy improvements in the revenue cycle process
4. Recommendations to improve labor utilization control
5. Reduction of expenses due to management of supplies in pharmacy, implants, consumables, and laundry/linen

HFS provided recommendations designed to raise performance to levels comparable to similar California district hospitals, and bring departments in line with best practices and current standards. We also outlined the need for a cost and quality management reporting system that is accurate, relevant, timely and meaningful.

The opinion surveys were particularly enlightening. Physicians were 83.3% satisfied with the overall quality of care. In the area of job satisfaction, employees rated themselves 82.9% satisfied. And regarding quality of care, patients said they were 91.5% satisfied!

If certain recommendations are fully implemented in the areas of reimbursement, cost reporting and revenue cycle, **HFS** found that TDH would experience a one time annual savings of approximately **\$5,700,000**.

HFS also found opportunities to generate additional annual income for TDH in the amount of **\$7,200,000** in the areas of staffing and supplies, revenue cycle and medical record coding.

Among our consulting staff, the universal impression of Tulare District Hospital was of a hospital populated with caring and professional people who are extraordinarily motivated to do the right thing. Moreover, we noted that the hospital administrative team is goal oriented with a strong commitment to quality care. They recognize that improving quality while implementing changes is a significant challenge, but one they fully embrace. We were grateful for the opportunity to serve such a fine institution.

HFS RECENT ENGAGEMENTS

- **A different type of engagement:** The HIM Division worked on a project to mentor new coders in the last half of 2008. The sponsoring organization provided a basic coding training program for individuals interested in a coding career. HIM auditors reviewed records and provided feedback to the individual students as they learned how to apply codes to actual medical records as well as the ICD-9-CM coding guidelines.
- **HPSA designations:** Red Bluff service area, combining service areas in the city of Merced, combining service areas in Lake County, combining service areas in northern Mendocino County, Lake Arrowhead service area and Exeter service area. Each designation impacts multiple communities.
- Medi-Cal licensing and certification for two nursing homes in southern California.
- RHC certification as free standing for three separate physician groups in the northern Sacramento Valley.
- Risk Management expenses evaluation and cost reductions for Mission Community Hospital in the San Fernando Valley in southern California.
- Medical contracting review and interim Procurement Services Officer for the County of Santa Clara.
- Financial feasibility study for Del Puerto Healthcare District associated with the purchase of a building for expansion of clinic operations.
- Sierra Kings Healthcare District - analysis of debt covenant compliance and recommendations for improved operating performance.
- Trinity Health Care - Novi, MI - assist in the development of an implementation plan for system wide consolidated reimbursement reporting and compliance functions.
- Adventist Health - Roseville, CA - review of filed Federal and State cost reports for accuracy and compliance.
- Develop, staff and train Business Office personnel and billing procedures for multi-specialty clinics owned by Tahoe Forest Hospital in Truckee, California.
- Interim services as Director of Decision Support at Enloe Medical Center in Chico, CA.
- Provide outsourced dental billing for Trinity Hospital in Weaverville, California.

EXECUTIVE SEARCH PROJECTS

One of the lesser known practice areas for HFS is Executive Search and Recruitment. **Don Whiteside** is the practice leader and is involved in every search. **Jerry Anderson** and other members of our staff are important team members. The contact and recruiting work is performed by these high level senior executives and not assigned to junior staff. This will benefit your organization by increasing the responsiveness of potential candidates.

Our search approach and philosophy emphasizes professionalism and respect for both our clients and candidates. Our experience has demonstrated that candidates are more likely to consider opportunities when they are treated with respect, honesty, confidentiality, and warmth.

- Completed November 2008- **Charlie Harrison**, Chief Executive Officer, Mountains Community Hospital in Lake Arrowhead, CA
- Completed November 2008- **Chad Chadwick**, Chief Executive Officer, Hi-Desert Medical Center, in Joshua Tree, CA
- Completed September 2008- **Tom Hayes**, Interim President and CAO, John Muir Medical Center, in Concord, CA
- Ongoing- Controller, Confidential Healthcare Organization, Central California
- Ongoing- Patient Financial Services Manager, Northern California

If you would like information on how HFS can assist your organization in locating and placing a highly skilled professional, please contact **Don** at ext. 311 or **Jerry** at ext. 307.

HFS CHARGE MASTER MANAGEMENT SOLUTIONS

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rected toward the costs of healthcare and the pricing methodologies employed by providers. The basic principles a rational pricing system should include:

- Be simple to administer and communicate
- Be developed using a framework that is both rational and defensible to the public, the government and the third party payer community
- Create accountability by providing the public with comparative data for price comparisons
- Satisfy the financial requirements of the providers
- Provide stability in healthcare administrative processes

esses

Most hospitals have simply implemented an "across the board" percentage increase in their charge masters annually with little thought to relationships between costs and charges. Our experts will work with you to develop meaningful pricing methodologies based on accepted conventions such as RBRVS, CPUs, Medicare weights, and competitive considerations. Additionally we will assist management in defining pricing objectives that will ensure competitive pricing and further promote price transparency.

If you are interested in finding out more about any of our Charge Master Management Solutions please call **Gwynn Smith** at ext. 315.



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In October 2008, **Steve Rousso** led a panel discussion at the annual ACHD conference in San Diego. The featured guest speakers were **Steve Peace**, Former State Senator and **Willie Brown**, CEO, Willie L. Brown Institute, former Speaker, California State Assembly and former San Francisco Mayor.

