HFS consultants

Solutions digest

Spring 2011 Newsletter

Complete Solutions for Healthcare Management

$87,000,000 to Southern California Hospitals

Hospital Association of Southern California (HASC) & HFS Consultants Team Up to Deliver $87,000,000 in Reimbursement to Southern California Hospitals

HASC and HFS teamed up again this year on the 2010 Wage Index Improvement Project (WIIP). Voluntary participation in the WIIP was requested from hospitals in Los Angeles, Orange County, Riverside, San Bernardino, Ventura, and Santa Barbara.

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EHR and What It Means for Clinics

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$87,000,000 in Reimbursement Goes to Southern California Hospitals

Trahan Whitten

Hospital Association of Southern California (HASC) & HFS Consultants Team Up to Deliver $87,000,000 in Reimbursement to Southern California Hospitals

HASC and HFS teamed up again this year on the 2010 Wage Index Improvement Project (WIIP). Voluntary participation in the WIIP was requested from hospitals in Los Angeles, Orange County, Riverside, San Bernardino, Ventura, and Santa Barbara. HFS conducted a review of the filed wage index information and assisted participating hospitals to improve the accuracy of their reported average hourly wage information (AHW).

Results

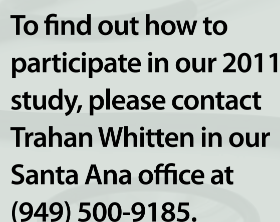
It is estimated the improved accuracy of the reported AHW data will increase Medicare inpatient reimbursement by $87.9 million in Federal Fiscal Year 2012.
This estimate is based upon data published in the February preliminary Public Use File (PUF), adjusted for known corrections to Intermediary review errors related to certain hospitals.

The estimated $87.9 million in benefit to Southern California hospitals is a huge success and far exceeds the initial expectations of the 2010 WIIP ($45.9 million above our initial goal of $42 million).

WIIP will generate an estimated $87.9 million in Federal Fiscal Year 2012

Estimated Benefit - February Preliminary PUF with Known Anticipated Revisions

Key	A	B	C	D = A+C	E	F
Hospital Group	Est. Filed FFY 2012 AHW (Oct. Initial PUF)	Total HFS Findings per Feb. PUF with Anticipated Revisions	Net AHW Change Accounting for Known Anticipated Revisions	Revised FFY 2012 AHW	Est. AHW Compared to the Est. Rural CA AHW	Est. Benefit from HFS Findings (above the Est. Rural AHW)
Los Angeles Core Hospitals	$42.50	$2.28	$1.90	$44.40	$1.41	$70,111,000
Los Angeles Reclassified Hospitals (Orange and San Bernardino Counties)	$42.50	$1.54	$1.09	$43.59	$0.60	$10,839,000
Orange County Reclassified Hospitals (Riverside County)	$42.28	$1.18	$0.71	$42.99	$0.00	$0
Santa Barbara	$43.37	$1.15	$1.15	$44.52	$1.53	$2,220,000
Ventura	$45.23	$1.45	$1.44	$46.67	$3.68	$4,726,000
TOTAL						**$ 87,896,000**



To find out how to participate in our 2011 study, please contact Trahan Whitten in our Santa Ana office at (949) 500-9185.

HFS and HASC would like to express our sincere appreciation to the hospitals that participated and helped fund this successful engagement. The success of the 2010 WIIP is in large part due to the collaborative efforts of the Southern California hospital community.

HFS is also excited to work with HASC on the WIIP again in 2011. With greater participation and support from HASC membership, HFS believes we can deliver another successful project again this year. ⊞

Safety Net Provider Statistics

HRSA and CMS have always placed emphasis on the ability of Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to act as the safety net providers across the nation. These clinics provide access to primary care services for the working poor, low income families and the indigent populations.

The Federal agencies place different regulations on each type of clinic. For example, FQHCs are required to offer a sliding fee scale to all patients based on their ability to pay, whereas RHCs are not required to do so. In return for handling all patients regardless of ability to pay and other requirements, the Federal agencies provide access to greater amounts of grants and funding to FQHCs versus RHCs. In reality, the majority of RHCs treat the same patient demographics in rural communities and offer the same services.

Recently published statistics from CMS for 2008 summarized Medicare eligible patient care in RHCs and "rural" defined FQHCs nationally. The results were startling: RHCs handled over 1.6 million Medicare patients compared to 265,000 patients for rural FQHCs. In addition, RHC saw in excess of 2 million Medicare beneficiaries versus 919,000 beneficiaries seen at rural FQHCs.

Two thoughts arise from these statistics; (1), most FQHCs are located within a service area defined as "urban" located in more densely populated areas, and (2), RHCs are attending to the needs of the vast majority of the Medicare patients in their service areas, and attending to those needs without access to the Federal funding available to their rural cousins. ⊞

Long Term Care Corner

Skilled Nursing: MDS 3.0

CMS announced in December that the amendment requiring the development of the HRIII RUG has been repealed. Therefore, as of October 1, 2010 the RUG IV will remain in effect through out the 2010-2011 fiscal year. Facilities will not need to monitor for possible payback or the reconciliation of revenue received since October 1, 2010 under RUG IV.

Post Acute Planning

With the advent of bundled reimbursement and readmissions penalties within 30 days of discharge, hospitals are looking to establish professional relationships with post acute providers in their communities, especially if they no longer have their own hospital based SNF or IRF.

Community long term care facilities and providers can assure the hospitals and patient's physicians that they have the proper qualified staff to provide care, monitor changes in condition, and handle these changes so that they do not intensify to an emergent level of care, requiring acute intervention and possible readmission. Hospitals in turn can assist with training of the community staff, mentoring the staff with system assessment skills, and expanding contractual relations with physicians to include the community affiliates. This will assist in developing trust between the providers and assures a continuum of care for the local residents that is satisfactory to all parties.

EHR and What It Means for Clinics

The Health Information for Economic and Clinical Health Act (HITECH) portion of the American Recovery & Reinvestment Act of 2009 (ARRA) provides incentives and regulations for the use of electronic health records (EHR) by all Medicare enrolled practitioners, whether a single physician or a multiple site clinic group.

The HITECH act has three objectives: a) use of certified EHR in a "meaning manner", b) use of certified EHR technology for electronic exchange of health information to improve quality of healthcare, and c) use of certified EHR technology to submit clinical quality measures (CQM) and other such measures selected by the Secretary (of Health and Human Services).

CMS stated the criteria for meaningful use is based on a series of specific objectives, each of which is tied to a measure that allows Eligible Professionals (EPs) and hospitals to demonstrate that they are meaningful users of certified EHR technology.

The use of EHR will be rolled out in stages over the next five years. For Stage 1, which began January 1, 2011, there are 25 objectives/measures for EPs. The objectives/measures have been divided into a core set and menu set. EPs and eligible hospitals must meet all objectives/measures in the core set (15 for EPs and 14 for eligible hospitals). Where it is impossible for an EP or eligible hospital to meet a specific measure, an exclusion was defined in the final rule. If an exclusion applies to an EP or eligible hospital, then such professional or hospital does not have to meet that objective/measure in order to be determined a meaningful EHR user. For example, if an EP has two exceptions (one for a core objective/measure and one for a menu objective/measure), the EP would need to meet the remaining 14 objectives/measures in the core set and four of the remaining nine objectives/measures in the menu set.

What are the 25 objectives/measures? Here's a partial list:

- CPOE (Computerized Physician Order Entry) – 30% of patients seen with meds have at least one med ordered by CPOE
- eRx – >40% permissible scripts are sent electronically
- Capability to report ambulatory clinical quality measures (CQM) to CMS & State – 3 required measures, 3 elective measures
- Implement 1 clinical decision support rule
- Provide patients with an electronic copy of their health information upon request
- Provide clinical summaries for patients for each office visit
- Drug/Drug and Drug/Allergy interaction checks capability
- Record patient demographics – at least 5 specific items
- Maintain up-to-date problem list of current diagnoses per patient
- Maintain active medication list
- Maintain active medication allergy list
- Record and chart changes in vital signs
- Record smoking status for patients age 13 and up
- Demonstrate ability to exchange key clinical information among providers electronically – at least one test during 2011
- Protect electronic health information – system security capabilities

Clinical Quality Measures to Report

What are the CQM's mentioned that must be reported to CMS and State agencies? The three required measures are: Hypertension/Blood Pressure Measurement, Preventive Care & Screening for Tobacco Use Assessment and Cessation Intervention and Adult Weight Screening and Followup. The three alternative measures are: Weight Assessment & Counseling for Children/Adolescents, Influenza Immunization for patients age 50 and up and Childhood Immunization status. This provides clinics with an understanding of what CMS wishes to target in the national population over the next 20 years.

Implementation Schedule

The implementation of EHR will be spread over a five year period beginning January 1, 2011. Both the Medicare and State Medicaid (Medi-Cal) programs will provide incentives to practitioners to become compliant with EHR requirements. Under the Medicare program eligible professionals include doctors, dentists, podiatrists and chiropractors.

The Medicaid programs add nurse practitioners, certified nurse-midwives and physician assistants (if working in an FQHC or RHC) to the eligibility list.

Incentives

What are the incentives? The Medicaid programs offer slightly more money and are less restrictive in their requirements. Medicare offers $44,000 maximum over a 5 year period, with an additional 10% available if the eligible professional

works in a HPSA (Health Professional Shortage Area) designated service area. Medi-Cal offers $ 63,750 maximum over 6 years. These payouts will be made on a "per practitioner" basis, tied to the personal NPI identifier for each provider.

Clinic and physician groups can utilize these funds to upgrade or change the

> *"CMS objective is to obtain widespread adoption of electronic information exchange... to facilitate the exchange of patient information among multiple sites and practitioners."*

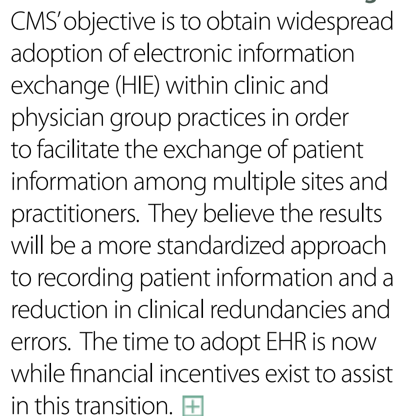
site's practice management system (hardware & software) to include all required components of an EHR.

An interesting situation

If a physician practices strictly in a clinic setting and is compensated for patient care by that clinic, how does the clinic get reimbursed for the physician's incentive payment?

Consideration should be given by clinic management to negotiating a handover of the funds from the physician, especially if the physician utilizes the resources and practice management system of the clinic.

Obtaining widespread adoption of electronic information exchange



CMS' objective is to obtain widespread adoption of electronic information exchange (HIE) within clinic and physician group practices in order to facilitate the exchange of patient information among multiple sites and practitioners. They believe the results will be a more standardized approach to recording patient information and a reduction in clinical redundancies and errors. The time to adopt EHR is now while financial incentives exist to assist in this transition.

ICD-10-CM/PCS – How Important is this Anyway?

With all the changes to electronic records the question posed is "How important is ICD-10-CM anyway?"

The short answer to the question is… VERY IMPORTANT. The change to ICD-10-CM will influence processes throughout the health care system including payers, providers, vendors, clearinghouses, third party administrators, independent laboratories, employers, and researchers. The result of this change will probably have an effect on cash flow during the transition period but more so if facilities have not fully updated internal processes.

The goal of this article is to provide a more detailed answer to the question and provide a time table for implementation. The change to ICD-10-CM/PCS is required under the Health Insurance Portability Accountability Act – HIPAA.

Profile of ICD-9-CM

ICD-9-CM is over 30 years old and stands for International Classification of Disease, 9th revision, Clinical Modification. The clinical modification was an adaptation of the World Health Organization's ICD-9. The fundamental reason for ICD-9 was to gather basic health statistics. The clinical modification used in the US allows for more precise codes to describe the clinical picture of the patient than the statistical groupings or trend analysis in ICD-9. Further, the technology used to transmit the clinically coded data has changed significantly from 1979.

Over the years ICD-9-CM has limited the medical community in defining their diagnoses as medicine continues to identify new diagnoses and differentiate current diagnoses. Additional diagnoses are not able to be added to categories in ICD-9-CM due to the numeric structural limitation.

Profile of ICD-10-CM/PCS

The ICD-10 classification system is the latest version with its historical origins in the 1850s. ICD-10 was endorsed by the 43rd World Health Assembly in May 1990 and came into use in WHO Member States as early as 1994. It had been assumed that since the USA uses the ICD-9-CM for reimbursement and case mix this was the reason for delays in implementation of ICD-10-CM. However, other countries also use ICD-10 for reimbursement and case mix. For example, the UK has been using it since 1995, most of the rest of Europe by 2000 and Canada by 2001.

story continues on page 5

ICD-10-CM/PCS - continued from page 4

Differences between ICD-9-CM and ICD-10-CM/PCS

There are structural differences between ICD-9-CM and ICD-10-CM diagnostic codes which are outlined in the table below:

ICD-9-CM Diagnosis Code Structure	ICD-10-CM Diagnosis Code Structure
Approximately 14,000 codes	Approximately 68,000 codes
3~5 characters in length	3~7 characters in length
First digit may be alpha (E & V) only	First digit is always alpha
Second ~ 5th digits are numeric	Second and third digits are numeric 4th ~ 7th digits alpha or numeric
Lacks detail like laterality	Very specific includes laterality
Limited space for adding new diagnostic codes	Flexibility for adding new codes due to the alpha numeric structure
Data analysis difficult due to non-specific codes for administrative and medical research	Specificity improves coding accuracy and richness of data for administrative analysis and medical research

The ICD-10-CM classifies the diagnoses identified in the health care system. ICD-10-PCS identifies the Procedural Classification System.

ICD-10-CM substantially increases the level of clinical detail that can be captured and reported. This table demonstrates there is an increase of 4.5 times the number of codes. The other factor is the actual structure of the characters in the length and definition by position in the code. The structural changes in the codes demonstrate the impact on computer recognition and transmission in the system side of the healthcare environment.

The structural differences for the procedural codes are even more extensive as indicated in the table below:

ICD-9-CM Procedure Code Structure	ICD-10-CM Procedure Code Structure
Approximately 3,500 codes	Approximately 72,000 codes
3~4 numeric characters in length	7 alpha-numeric characters in length
Based on outdated terminology and technology	Reflects current usage of medical terminology and devices
Limited space for adding new codes	Flexibility for adding new codes
Lacks detail like laterality	Very specific and allows laterality
Lacks description of methodology and approach for procedures	Provides detailed descriptions of methodology and approach for procedures
Generic terms for body parts	Detailed descriptions for body parts
Limits DRG assignment	Allows expansion of DRG definitions to recognize new technologies and devices

This table demonstrates an increase of more than 20 times the volume of procedures with more highly structured characters where each digit indicates a specific meaning.

Example of the effect of conversion

In ICD-9-CM only one code exists for angioplasty (procedure for widening a narrowed or obstructed blood vessel). ICD-10 will provide 1170 code descriptions with granularity that pinpoints the location of the blockage and device used for each patient.

Transmission of Data

Before efforts can truly focus on the implementation of ICD-10-CM/PCS, organizations must first upgrade to the Accredited National Standards Institute Committee X12 Version 5010. This is the updated electronic health care transactions and drug program definitions. The 5010 X12 standards version updates the standards for claims, remittance advice, eligibility inquiries, referral authorization and administrative transactions.

Timeframe

On October 1, 2012, ANSI X12 Version 4010A1 will be replaced by version 5010 of electronic transmission of health care transactions. External testing of the 5010 transmissions begins **on January 1, 2011** and Medicare will begin to accept those transactions. Version 4010A1 will not be accepted for transmission after the October 1, 2012 deadline.

On October 1, 2013, ICD-9-CM will be replaced by the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) to report diagnosis data across all sites of service. The International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) will replace ICD-9-CM procedure coding for all inpatient procedures.

All providers in every health care setting will be required to use ICD-10-CM diagnoses coding. Only hospitals will be required to use ICD-10-PCS which will be placed on inpatient claims. These codes will be used to calculate the MS-DRG using ICD-10-CM/PCS. Physician claims will not use ICD-10-PCS even those for inpatient visits.

There will be no impact on the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes.

AHA developed a four phase approach for ICD-10 and Version 5010 transaction implementation. Phase 1 and 2

are essentially past with suggestions for establishing an internal structure for identifying leadership and conducting internal assessments and gap analyses of vendors, staff and budgets for implementation.

Phase 3 is defined as beginning January 1, 2011 through the end of 2012 and includes specific task assignment, developing metrics and monitors for progress assessment and training for staff and physicians. In addition to testing and validation of system changes, a clear process for reporting progress toward completion is critical. This is the time to begin training of the staff at various levels in the organization including physician training and identification of documentation gaps.

On October 1, 2013, ICD-9-CM will be replaced by ICD-10-CM to report diagnosis data across all sites of service.

Phase 4 starts in January 2013 where the focus is staff training, evaluation of software and upgrades, reinforcement of physician documentation training and impact analysis of case mix. The training will be focused on coders, quality staff, billers and staff involved and compliance reporting.

Financial Impact

In 2010 a payment impact analysis was conducted at CMS using the Medicare Provider Analysis and Review (MED-PAR) data to identify the possible impact on MS-DRG reimbursement related to the conversion to ICD-10.

The results of the payment impact analysis show that the conversion to ICD-10 version of MS-DRGs will have a minimal impact on aggregate payments to hospitals and the distribution of payments across hospitals. Specifically the transition from the ICD-9-CM version of the MS-DRGs to the ICD-10 version of the MS-DRGs showed aggregate payments to hospitals was +0.05 % and on the distribution of payments across hospital types was -0.01 to +0.19%. It can be anticipated that CMS will begin to optimize MS-DRGs for ICD-10 once ICD-10 coded data becomes available allowing the MS-DRG payment weights to be simultaneously recalibrated. The database used to create the simulated ICD-10 data was from the FY 2009 MedPAR data with a total of 11 million claims.

The analysis used the General Equivalence Mappings (GEMs). The GEMs are a comprehensive, translation dictionary between ICD-9-CM and ICD-10. As a translation dictionary, the GEMs provide a starting point for the conversion of ICD-9-CM based applications to a native ICD-10 version of the application. This is how the GEMs were used to create the ICD-10 MS-DRGs. Any attempt to use the GEMs to map ICD-9-CM data to ICD-10 data as opposed to convert an application to a native ICD-10 version of the application is extremely problematic.

Conclusion

In order to send and receive payment for services provided in the health care industry, all systems need to be updated to version 5010 for all electronic transmissions beginning January 1, 2012. The ICD-10-CM/PCS will be implemented on October 1, 2013 and transmitted through the Version 5010. No payment will be made if either the transmission or coding system is not up to date after October 1, 2013.

Begin the implementation planning and education now for ICD-10. Conduct the gap analysis; assess the needs for the transition to assure your payments will not be interrupted due to ICD-10 conversion. ⊞

To find out how HFS can assist you in preparing or training for ICD-10 - CM/PCS, contact Leslie Hunt @ ext. 290.

Kathy McCaffrey

A beloved member of the Oakland staff died tragically in an accident on April 2nd. Kathy will be deeply missed. A scholarship fund has been established in her memory. Contributions may be made to AHIMA Foundation, Kathy McCaffrey Merit Student Scholarship Fund, 233 N. Michigan Avenue, 21st Floor, Chicago, IL 60601.

Please contact LaVonne LaMoureaux at LaVonne@CaliforniaHIA.org ⊞

HFS Employee Additions:

Nick Addleman has rejoined HFS as Manager with over 20 years experience in Long Term Care financial reporting and management. Nick has worked as a Medicare auditor for Blue Cross, been CFO for a chain of California nursing facilities and been a Manager with Ernst & Young. Nick was formerly a Principal with HFS and has returned. Nick gets his freak on skateboarding in pikes & drops with the younger generation….

William T. (Tim) Vanderford joins the HFS Reimbursement group after working as the Director of Reimbursement for Ochsner Clinic Foundation in New Orleans. Tim has an extensive background in Medicare, DSH and Medicaid reimbursement, hospital accounting, cost report filings, audits and settlements. Tim joins our Santa Ana office. ⊞

HFS Glendale Office Activities

The Glendale office was very busy this past year in Supply Chain engagements, one of our specialties. One of the largest engagements was with the County of San Diego Health and Human Services Agency (HHSA), analyzing the operations and efficiency of their Psychiatric Hospital Pharmacy.

The HHSA Pharmacy is a full service pharmacy operation serving the County HHSA's, Mental Health Services, Public Health Services, Inpatient County Psychiatric Hospital, and other various County clinics. The San Diego County Psychiatric Hospital is an in-patient 45-bed facility with roughly 140-150 admissions per month and an average length of stay of roughly 7 days. The HHSA Pharmacy operation fills an average of roughly 55,000 prescriptions annually, covering four County service locations (San Diego County Psychiatric Hospital, the North Central, East and Southeast Walk-in Clinics). Of note, patients are all County patients, and all patients are indigent.

The Pharmacy assessment was a comprehensive review of operations, drug and expense management, use of informatics, and market demographics and planning. Included in these major review areas were areas such as Productivity Analysis, Medication Utilization Evaluation, and Formulary Review.

Recommendations

Following the assessment, recommendations were made in the following areas

- Productivity Analysis
- Labor Reduction Options
- Pharmaceutical Procurement
- Medication Utilization Review
- Formulary Review
- PAP Program
- Informatics Review
- Other Options (such as consolidation and outsourcing)

Another key Supply Chain Engagement is the ongoing supply cost management services provided to Santa Clara Valley Health & Hospital System, the second largest public health system in the state and a major trauma center. The 574 bed medical center was led through a rigorous competitive bidding process for a house-wide patient monitoring system, which resulted in a 38% savings totaling $2.4 million.

Among the other competitive solicitations completed were cardiac rhythm management devices (at a nearly $250,000 savings). Additional physician preference items for orthopedics and cardiology are currently in process, with significant benefits expected from the competitive solicitations for trauma products, spinal implants, and hip & knee implants.

Corcoran Pharmacy

Glendale also began an engagement with Corcoran District Hospital for consultant Pharmacist services. Corcoran Hospital, with a licensed bed count of less than 100 beds, is not required to have a full-fledged Pharmacy, but instead operates with what is known as a "Medication Room". However, even Hospitals without a Pharmacy must retain a consultant Pharmacist to provide guidance on medication usage policies, evaluate medication usage, help minimize medication errors, participate in the Pharmacy and Therapeutics Committee, maintain emergency stocks of medications, and help the Hospital comply on Health Department, Title 22, and CMS regulations. In addition to these services we are providing assistance on efficient pharmaceutical procurement. ⊞

If you would like more information on these services, please contact David Lash in our Glendale office at (818) 957-2649.

Spotlight on Med/Surg

Rich Parsons, Vice President / Principal
Director of Management and Operations Consulting

While it can be argued, we believe that the Medical Surgical (Med/Surg) units are the most important department in an acute care hospital. They house the majority of patients, are the most operationally intensive, and generally provide the most revenue. It is on the Med/Surg units that inpatients generally form their patient satisfaction opinions, which gives a hospital its reputation for quality care.

From our productivity studies, it also appears as if the Med/Surg units are the most difficult to manage. Considering that nurses must meet the needs of dozens of patients in terms of clinical and customer care, it's easy to understand the challenges. In California, managers must work within the nurse-to-patient ratios, and other mandated break, lunch and Title 22 rules.

One means of helping Med/Surg nurse managers and their CNOs to improve is benchmarking their operational performance against their counterparts in similar facilities. Measuring a unit's productivity, cost and quality against top performers provides guidance on where and how to direct improvement efforts. Until recently, rigorous and fair benchmarking has proved to be expensive and time consuming for most community hospitals that don't have a large planning staff.

Recently, however, HFS created a tool that allows us to quickly evaluate operating performance in any hospital department. Using the Office of Statewide Health Planning and Development (OSHPD) Annual Financial Disclosure Reports, we developed a method of determining productivity and cost performance per unit of service quite economically. We are able to array this data against quality metrics as well. Med/Surg has traditionally been evaluated by dividing the number of productive hours by patient days during an equivalent period. Observation patients are included when placed in Med/Surg units, and the data are adjusted accordingly, using the OSHPD statistical method.

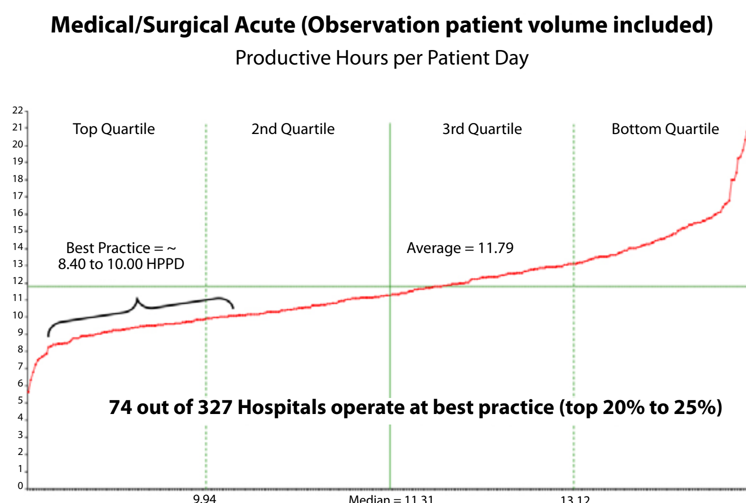
HFS recently analyzed Med/Surg productivity in over three hundred acute care hospitals. Figure 1 below displays the result of this analysis:

From our studies, it is clear that the best practice is 10.00 productive hours per patient day ("HPPD") or less. The average / mean occurs at 11.50 HPPD, and the most expensive units operate at 13.00 HPPD or more. Because of the limits inherent in a 1:5 nurse to patient ratio, we believe that it is unlikely that Med/Surg nursing units can operate effectively below 8.20 hours per patient day, unless the department gets along without a charge nurse, certified nurse assistants, or unit secretary. The issue of patient acuity usually arises when discussing nurse productivity. Many believe that higher acuity patients require more direct care staffing and it is self-evident that staffing needs are higher in the Intensive Care Unit and the Step-Down Unit, than in Med/Surg.

The data from OSHPD suggests that there need be no conflict between a high Case Mix Index, a surrogate measure for acuity, and best practice staffing. The correlation is pretty clear, but we will simplify the matter by using as examples two hospitals, which according to HealthGrades, Inc., are the best in California.

For 2011, only two hospitals from California appeared in the

Figure 1



Range of Productivity Performance for Med/Surg Departments
25th percentile = 9.94 Hours per Patient Day (HPPD)
50th percentile = 11.31 Hours per Patient Day (HPPD)
75th percentile = 13.12 Hours per Patient Day (HPPD)

SPOTLIGHT ON MED/SURG - continued from page 8

HealthGrades, Inc. top 50 Best Hospitals in the United States. They were Glendale Memorial Hospital and Health Center and St. John's Health Center in Santa Monica.

Both had Case Mix Indexes in the highest acuity quartile, meaning that 75% (or more) of all hospitals were identified as having a lower CMI. Glendale Memorial ran Med/Surg at 9.22 HPPD, which is in the most efficient 10%. With a Case Mix Index of 1.45, St. John's HPPD for Med/Surg was 10.59, which is strong performance that places this facility in the second best quartile.

The financial impact of controlling labor expense in this area is extraordinary. For a typical hospital with an average daily Med/Surg census of 100, a one hour per patient day improvement will net the hospital around $2 million per year. By benchmarking all departments to California top performance, our clients have seen labor savings opportunities between 7.6% and 20.6%.

For a comprehensive profile of department productivity, please contact Rich Parsons at ext. 249.

Figure 2

Staff Updates

Manager of Post Acute Consulting **Larry Blitz** was recently appointed to the Mental Health Board of Santa Clara County by the Santa Clara County Board of Supervisors. Larry was also appointed to the Chair of the Fiscal and Planning Committee. Mr. Blitz has provided operation turn-around management for psychiatric hospitals as well as creating Alzheimers-Dementia units in Gero-Psychiatric facilities.

In addition in January, Larry Blitz was appointed by the Superior Court of California to be the Quality Monitor & Auditor for the Settlement and Stipulation of Lavender vs. Skilled Healthcare Group, Inc., one of the largest healthcare judgments in U.S. history. As a former owner and manager of several post acute hospitals and settings, Larry was recognized by being nominated to the position by the consumer group that filed the case against Skilled Healthcare. Both parties approved Larry's nomination for this two year monitoring engagement.

Enrolling in Medicare? Here's What to Watch

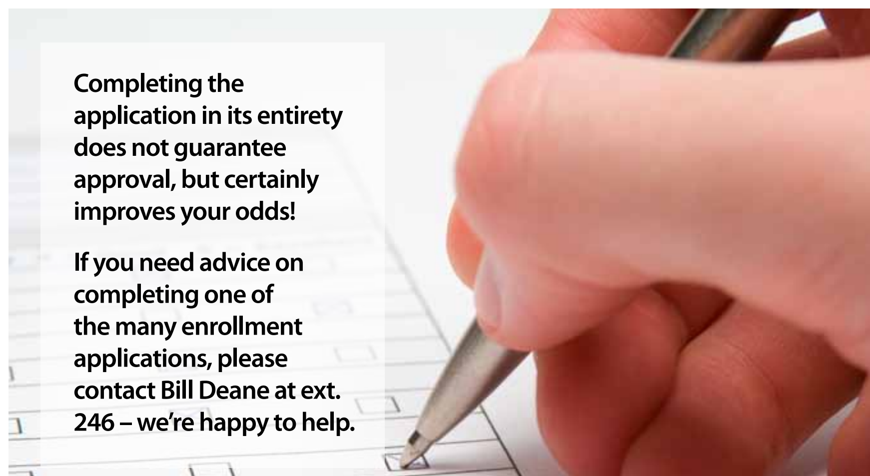
As consultants we assist providers in enrolling or changing required information to the Medicare Fiscal Intermediaries (F.I.).

For most California providers, the F.I. is Palmetto GBA and they are not located in California. To report a change or enroll in the program, Medicare requires the completion of an enrollment application known as a CMS-855A. When submitting applications, there are many items to consider in order for your application to be accepted and approved.

Applicants should know the following;

- If you are opening a new practice location, always obtain a new NPI number for that location. The F.I. will always require site specific identifier. Go to the NPPES website to enroll and obtain a new number.
- Always call the Palmetto Customer Service Center to track your application or register a complaint. Otherwise they will not assign a tracking number and cannot determine how long it takes to resolve a problem. They call it a "CCN".
- The Palmetto J1 Part A Provider Contact Center (PCC) telephone number is (866) 931-3906 or fax (803) 763-0604. Complex issues related to claims, billing eligibility, provider education and other provider issues can be addressed at the above phone number from 7 a.m. to 5 p.m. PST.
- Palmetto has different customer service centers depending on the complexity of the problem – you may be transferred or told to call a different number to handle your issue.
- When you call the PCC, have your provider name, NPI number & PTAN available – otherwise, Palmetto cannot recognize who you are.

- What's a PTAN? "Provider Transaction Access Number". CMS still assigns a new Medicare provider number when you enroll to link with your NPI number – Palmetto Provider Enrollment calls them "PTAN".
- Just to throw you off, Palmetto Audits Department (the audit people) call the same number an "OSCAR".
- Always complete the "Section 13 – Contact Person" in the 855A application. Include a phone number, FAX number and email address. Palmetto usually contacts by FAX. Otherwise, correspondence mailed to your facility may get lost!
- Once you submit an enrollment application, you'll receive a one-page letter (via FAX) acknowledging receipt of your application and assigning a "CCN" for tracking purposes.
- What's Palmetto doing with my application? They have 30 days to respond from receipt of application. Upon review they can request additional information (another letter called "Request For Information") and reset the 30 day window to respond again. You can look up your application progress on-line: J1 Provider Enrollment Application Look Up at PalmettoGBA.com.
- If you do not respond to a Request for Information from Palmetto within 30 days, your application will be terminated. Once terminated you cannot resubmit for 60 days from the date of the termination letter.
- If you are submitting an application for a physician/mid-level that is foreign born, include a copy of their passport with the application. Palmetto will want proof of citizenship, although it's not stated anywhere. ⊞



About HFS Consultants

HFS Consultants focus on the needs of hospitals and other healthcare organizations for financial, strategic management, operations, organizational and competitive change and growth.

Social Responsibility at HFS:

Last December HFS sponsored, volunteered and coordinated a charity fundraiser poker tournament for the Lafayette School Mentoring Project, an Oakland non-profit that offers tutoring and mentoring to grade school age children in West Oakland schools. The event was held at the First Unitarian Church downtown and all available poker seats were sold out. The event raised $2,000 for LSMP to help offset operating costs. HFS staff assisted in soliciting poker and raffle prizes, prepared food & drinks, served attendees and hosted the evening.

HFS employees participate in a variety of volunteer activities throughout the course of the year. If you would like to learn more about upcoming volunteer activities, please contact **Debora Bertasi** at **dbertasi@hfsconsultants.com.**

HFS consultants

505 Fourteenth Street, Fifth Floor
Oakland, California 94612

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New Engagements

- Operations improvement program at Marin General Hospital, Clinical Laboratory automation and cost reduction program at Fremont Rideout Health Group, Joint Commission clinical laboratory mock survey program at San Mateo Medical Center.
- Supply Chain engagement for Resurrection Health Care in Chicago: cost management and price reduction for spinal implants and cardiovascular products (pacemakers, internal defibrillators, and stents).
- Supply Chain assessment for John Muir Health System in Concord.
- Interim Pharmacy Management for Bear Valley Medical Center; evaluation for conversion to closed door pharmacy.
- Outsource Materials Management for Bear Valley Medical Center.
- Complete research and white paper for California Healthcare Foundation regarding Accountable Care Organizations and how they will impact rural hospitals.
- CFO Search for St. Joseph's Eureka Hospital.
- CEO Search for Plumas District Hospital.
- Interim CFO for Biggs Gridley Memorial Hospital.
- Interim Decision Support Analyst for Alameda County Medical Center.
- Review of financial projections and business valuation for San Francisco Jewish Homes associated with the acquisition of a skilled nursing facility.
- Occupational Mix and Wage Index engagement for St. Joseph's Health System.
- Revenue Cycle Director and Director of Case Manager Search for Emanuel Medical Center.
- Interim Materials Manager at St. Vincent Medical Center and Tri-City Regional Medical Center.
- Coding validation for Palo Alto Medical Foundation.
- Revenue Cycle compliance and revenue cycle review for San Diego Public Health.
- Business office assessment, out-sourced A/R backlog, on-site A/R management for Marin Community Clinics.
- Revenue Cycle compliance review for San Diego County Psychiatric Hospital.
- Interim Business Office Manager for Marin Community Clinics.
- Wage Index for St. Helena Hospital.
- Assistance with TAR appeals Vibra Hospital of San Diego.
- Occupational Mix filing for Lompoc Valley Medical Center.
- Revenue Cycle and Compliance review for Vista Community Clinics.