President’s Message
Jayne Kroner
Chapter President 2011-2012

The fall season is quickly approaching. On October 25th, the HFMA National office will be delivering the annual membership survey directly to your email inbox. It is your opportunity to let us know your thoughts and feelings on the education and social events provided throughout June 2010 - July 2011. In the year forthcoming, we hope to again meet your needs of today and surpass them tomorrow.

Did you miss the Napa Wine Train social event? The chapter worked diligently to provide a significant discount to our members and over 100 guests joined this event. We hope to do a similar social event next year in the Napa Valley. If you would like to help with next year’s event please let me know.

Call for Volunteers
We are looking for volunteers to help us with the following responsibilities:
1. Volunteer Coordinator
2. Fall Conference ‘Thunder Valley’ Room Monitors
3. Assist in organizing webinars for financial healthcare topics
4. Learn and teach the HFMA ‘Evidence-Based Revenue Cycle Improvement’ program
5. Founders Awards Co-chairperson
6. Participate as a committee member in the Revenue Cycle Forum Chat, PFS, Finance or Compliance Committees
7. Volunteer a few hours at an upcoming education event

If you are interested or just want more information, please send an email to volunteer@hfma-nca.org.

In the near future you should receive in your snail mail box a print version of the chapter membership directory, a quarterly education calendar and a brochure for the Fall Conference.

In conclusion, I am honored and humbled that you have allowed me this opportunity to lead this incredible chapter and extremely capable leadership team. I will do everything possible to make this the best year ever for YOU and the entire HFMA Northern California chapter membership.

Please feel free to contact me at any time, no matter is too small. We are looking for volunteers NOW. Call me at (925) 685-9300 or email jaynek@ciriusgroup.com. The entire leadership team and their contact information is listed on the chapter website at www.hfma-nca.org.
Are You Ready for HIPAA 5010?

TRICARE Management Activity, TriWest Healthcare Alliance (TriWest) and Wisconsin Physicians Service Insurance Corp. (WPS) are taking action to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) version 5010 transaction standards. HIPAA requires all covered entities in the healthcare industry to implement and use mandated standards in the electronic transmission of healthcare transactions, including claims, remittance, eligibility, claims status requests, their related responses, and privacy and security standards.

As you prepare for the implementation of HIPAA 5010, an important step to take will be to contact your vendor, clearinghouse, billing service or payer if they supply your software. They will provide detailed information on what steps your office or facility needs to take toward a smooth transition.

Here are some readiness questions that you should ask:

- Will HIPAA 5010 and ICD-10 software upgrades or changes be provided in one or multiple releases?
- What will be the cost of upgrades or changes to my practice?
- When will upgrades or changes be available for testing?
- When can I begin testing each transaction (ex. 837 Claims, 835 Remittance Advice)?
- Will I be required to test with each trading partner or payer?
- What are the steps and timeframe for completing a testing cycle?
- Can 4010 and 5010 transactions be processed concurrently?
- How will I know my implementation has been successfully completed?
- What is your contingency plan if your systems are not compliant on January 1, 2012?


Gloryanne’s Corner: CMS Transmittal 190 and 3rd Quarter RAC Report

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CMS Transmittal 190, Posts New Interest Rates

On July 12, 2011, the Centers for Medicare and Medicaid Services (CMS) posted transmittal 190, change request 1752 regarding interest rates. This Change Request provides a quarterly update of the Medicare interest rate for overpayments and underpayments. This transmittal was re-issued to correct the X-ref date showing as July 11th to the effective date of July 18th for the 11.50% interest rate. This includes changing the closing date of the 11.0% interest rate from July 10th to July 17th. The transmittal number, date issued, and all other information will remain the same.

The Medicare Administrative Contractor (MAC) is advised that this constitutes technical direction as defined in their contracts.

You can view this transmittal online at: [http://www.medicarefind.com/searchdetails/Transmittals/Attachments/R190FM.pdf](http://www.medicarefind.com/searchdetails/Transmittals/Attachments/R190FM.pdf)

CMS Releases Third Quarter RAC Report

On July 14, 2011 the Centers for Medicare and Medicaid Services (CMS) released the third quarter Medicare Fee for Services report for the National Recovery Audit Program. Region D, which includes California, had the highest overpayments collected through the work of Health Data Insights (HDI).
The Recovery Audit Contractors corrected $592.5 million in payments from the Medicare Fee-for-Service program through June 30, or up until the end of the third quarter of the 2011 fiscal year.

The report also provided information regarding the areas which had the most errors and for Region D it was around medical necessity. The following is from the report:

Minor Surgery and other treatment billed as inpatient: (Medical Necessity). When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.

Share this information with your RAC and Compliance Committee. In addition, be sure to attend the Northern California HFMA Fall Conference in September, as we will have a representative from HDI providing an update on the RAC program.

To access the above mentioned report go to: http://www.cms.gov/Recovery-Audit-Program/Downloads/FFSUpdate.pdf

Gloryanne's Corner ... continued from page 2

Early Out/Extended Business Office Self Pay Collections Payment Plans Mail Returns Workers Compensation Charity Care

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The Impact of Howell v. Hamilton on the Reasonable Value of Non-Contracted Emergency Services
Frank P. Fedor
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When the California Supreme Court outlawed balance billing for claims under the Knox-Keene Act in Prospect Medical Group v. Northridge, 45 Cal. 4th 497 (2009) it avoided the “difficult problems” in determining the reasonable value of non-contracted emergency services furnished by hospitals and emergency physicians.

On August 18, in Howell v. Hamilton, 2011 WL 3611940 (2011) the California Supreme Court, by a 5 to 1 majority, supplied much grist for the mill of how to value non-contracted emergency services.

Howell v. Hamilton Howell addressed only the collateral source rule in personal injury litigation. That rule prohibits the person causing the personal injury (the “tortfeasor”) from obtaining the benefit of the injured person’s prudence in purchasing medical or other insurance. Everyone agreed that the injured plaintiff could obtain as damages the amount that her plan paid the hospital. The issue before the Supreme Court was whether the plaintiff could also recover as damages the difference between the billed charges and the discounted amount paid by the contracted plan. The Supreme Court held that an injured plaintiff whose medical expenses are paid through private insurance may recover as medical expenses no more than the amounts she or her insurer paid for the medical services received.

Because Howell v. Hamilton did not address the reasonable value of non-contracted emergency services, nothing it said about hospital pricing has any binding effect on a future case about the value of non-contracted emergency services. Nevertheless, five Supreme Court Justices had a lot to say about hospital pricing. It is only prudent to consider how the views expressed in Howell v. Hamilton might affect a hospital’s strategy in preparing to prove the reasonable value of non-contracted emergency services.

The Supreme Court plunged into several studies on how hospitals set chargemaster prices and how they negotiate contract prices. The Court found negotiated contract prices to be a better measure of the value of medical damages in a personal injury case than billed charges:

[Looking to the negotiated prices providers accept from insurers makes at least as much sense, and arguably more, than relying on chargemaster prices that are not the result of direct negotiation between buyer and seller. For this reason as well, it is not possible to say generally that providers’ full bills present the real value of their services . . . . In effect, there appears to be not one market for medical services but several, with the price of services depending on the category of payer and sometimes the particular government or business entity paying for the services. Given this state of medical economics, how a market value other than that produced by negotiation between the insurer and the provider could be identified is unclear.]

Of course the Court ignored that the decision not to contract is a sign that billed charges do reflect market value. The same market that allows hospitals and plans to contract also leaves them free not to contract as they each best perceive their own interests. The same reasoning applies to individuals who can afford to purchase insurance, but see their best self interest to remain uninsured and use their “saved” premiums for their self-perceived higher and better uses.

The Drumbeat Continues to Grow for Additional Scrutiny of Nursing Home Hiring Practices
Kathryn Doi
Partner, Healthcare Law Practice Team
Murphy Austin Adams Schoenfeld LLP

In March, the federal Department of Health and Human Services (“HHS”) Office of Inspector General (“OIG”) reported that 92 percent of the 260 nursing facilities it sampled in 2009 employed at least one person with at least one criminal conviction. (OIG, Nursing Facilities’ Employment of Individuals with Criminal Convictions, OEI-07-09-0010, March 2011.)

The OIG reported that almost 44 percent of employees had been convicted of property crimes such as burglary, shoplifting or writing bad checks. The workers most likely to have convictions were housekeeping/laundry/maintenance/security (all included in one category), nursing assistants and dietary workers.

The OIG report followed on the heels of a report of the California Senate Office of Oversight and Outcomes, issued March 18, 2010, that was based on 20 cases in which the State Department of Social Services cleared caregivers to work in residential care facilities for the elderly, unaware that the California Department of Public Health (“CDPH”) had revoked the person’s nurse assistant certification for negligence, abuse, theft or other serious misconduct. (California Senate Office of Oversight and Outcomes, Dangerous Caregivers: State Failed to Cross-Check Backgrounds, Exposing Elderly to Abusive Workers, March 18, 2010.)

Currently, federal regulations require nursing facilities that participate in the Medicare and Medicaid program to develop and implement written policies and procedures designed to prevent the facility from employing “individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law” or “have had a finding entered into the State nurse aid registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.” (42 C.F.R. § 483.13(c)(1)(ii)(A) & (B).) Interpretive guidelines from the Centers for Medicare and Medicaid Services (“CMS”) for this regulation state that “[nursing] facilities must be thorough in their investigations of the past histories of individuals they are considering hiring.” (CMS, State Operations Manual, Appendix PP, F225.)

But if the State of California cannot keep track of problem nurse assistants and clears them to work in other capacities, it is that much harder for the nursing facilities. The California Medical Board and Board of Registered Nursing list disciplinary actions on their public websites, California law requires criminal record clearances processed by the state Department of Justice for nurse assistants (Health & Safety Code § 1338.5), and the CDPH maintains a nurse aide certification verification website as required by federal law (42 C.F.R. § 483.75(e)(6)). But there are currently no comparable databases for unlicensed employees who may apply to work at nursing homes.

The OIG report acknowledges a provision of the Patient Protection and Affordable Care Act (P.L. 111-148) (“PPACA”) that requires the HHS Secretary to carry out a nationwide program for States to conduct national and statewide criminal background checks for “direct patient access employees” of nursing facilities and other providers. This program is currently underway, administered by CMS, and
The Edge - Northern California Chapter's Newsletter

Howell v. Hamilton ... continued from page 4

Having concluded that the negotiated contract price was the most accurate “market price” of medical services, the Court was set to conclude that this was the only medical damages the injured plaintiff could recover. The difference between the discounted contract rate paid by the plan and the hospital’s billed charges was characterized as the “negotiated rate differential”. The Court held that the negotiated rate differential was for the benefit of the parties who negotiated the contract, and not the patient who purchased insurance. The “negotiated rate differential” was not negotiated on behalf of any particular person or with respect to any particular charges or services, but reflected the overall benefit to the provider and the plan of their deal.

In expanding upon this portion of the analysis of the negotiated rate differential, the Court clearly showed that it understood that discounted rates were the result of a negotiated contract, and that plans without contracts would pay more than these negotiated discounted rates. "Plaintiff’s insurance premiums contractually guaranteed payment of her medical expenses at rates negotiated with the providers. Indeed, had her insurer not negotiated discounts from medical providers, plaintiff’s premiums presumably would have been higher, not lower." Id. at 13. “A tortfeasor who injures a member of a managed care organization may pay less in compensation for medical expenses than one who inflicts the same injury on an uninsured person treated at a hospital (assuming the hospital does not offer the person a discount from its chargemaster prices).” Consistent with these examples, a tortfeasor who injures a member of an HMO that has a contract with the hospital where the member was provided emergency services will pay less than the member of an HMO that did not have a contract with that hospital.

Howell v. Hamilton is the new law for the collateral source rule. It is non-controlling obiter dicta for the issue of the reasonable value of non-contracted emergency services. Nevertheless, the attitudes of the five majority justices show how they may approach a future case about the valuation of non-contracted emergency services.

The OIG report recommends that CMS develop background check procedures in conjunction with the National Background Check Program. Specifically, the OIG recommends CMS should (1) clearly define the employee classifications that are “direct patient access employees,” and (2) work with participating States to develop a list of convictions that disqualify an individual from nursing facility employment under the federal regulation and timeframes in which each conviction bars the individual from employment.

In its written comments on the OIG report, CMS agreed with the recommendations. CMS stated that in its solicitation to States for the National Background Check Program, the definition of “direct patient access employee” is “anyone who routinely comes into contact or has the potential to come into contact with residents/clients.” CMS stated that this definition is deliberately “broad, and outcome based, … which in nursing homes should include all staff.” CMS also stated it will work with the States through the National Background Check Program to assist them in developing lists of convictions that disqualify individuals from employment, as well as defining whether any of these conviction types can be assumed to be mitigated because of the passage of time and which convictions should never be considered mitigated or rehabilitated.

The National Background Check Program may eventually provide a helpful hiring tool for nursing homes. In the meantime, nursing homes would be well served to ensure that they engage in a careful and thorough screening of all potential employees. A solid employment screening program should include (1) written policies and procedures, (2) a comprehensive methodology that includes criminal background checks, license verifications, and credit checks, as appropriate for the risk presented by the applicant’s position, (3) criteria for evaluating and making decisions on the background check results that are consistently applied, (4) compliance with federal and state regulatory requirements, and (5) other measures to uphold fair hiring and anti-discriminatory practices. In addition, while not required by federal or state law, nursing facilities have access to FBI criminal history records to conduct background checks on applicants for positions involved in direct patient care. (P.L. 105-277, § 124 (Oct. 21, 1998))

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2. Learn and teach HFMA National’s “Evidence-Based Revenue Cycle Improvement” program
3. Founders Awards Co-chairperson
4. Join a committee: Finance or Compliance
5. Help out during larger education events with registration and as a room monitor

If you are interested or just want more information, please send an email to volunteer@hfma-nca.org

The Drumbeat Continues to Grow .... continued from page 4

California was awarded $3 million in February 2011 to design a comprehensive applicant background check program for jobs involving direct patient care.

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Waste Not, Want Not
Turning up the Revenue Cycle for Healthcare Reform
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Are the people, processes and technology that make up your revenue cycle functions ready to take on healthcare reform? As we are all aware, the Patient Protection and Affordable Care Act includes a mandate that will require 30 to 40 million, currently uninsured individuals, to obtain health insurance coverage. With approximately 95% of the U.S. population covered by private or government-administered health insurance in 2015, the revenue cycle will be strained with the anticipated growth and expansion of healthcare demand. At the same time, healthcare delivery systems will be adapting to health insurance exchanges, payment reform initiatives, increased regulation and the transition to ICD-10-CM. It is now more critical than ever to examine and identify less than optimal revenue cycle workflows. Efficient infrastructure and processes, to ensure timely submission of a clean claim, which is paid in full on the first transmission, will be crucial for cash flow.

Lean Manufacturing (Lean) is the perfect tool to actively engage team members to seek out and eliminate waste in the revenue cycle workflow. Lean is often mischaracterized as being a cost reduction strategy when, in actuality, it is a continuous process improvement system, that quite often reduces cost. I was exposed early in my career to the ideas of Dr. W. Edwards Deming, an American statistician and quality guru, whose principles became the foundation of the Toyota Production System (TPS) or Lean.

Having attended graduate school in western Michigan, the headquarters for worldwide furniture manufacturers, Steelcase and Haworth, I had the opportunity to gain first hand insight into process improvement methodologies. As a Practice Administrator working in the healthcare sector, I had no idea how much value stream mapping and measurement of outcomes, in the manufacturing sector, would influence my approach to providing financial leadership to healthcare entities.

The main objective of TPS /Lean is to provide the best possible service to the customer through the elimination of all forms of waste. Let’s start out by defining waste as anything that adds cost or time without adding value. Defining value is a little more difficult, so for the sake of simplicity, we will use the TPS definition of value, which is defined as something the customer is willing to pay for. The first step in eliminating waste from the revenue cycle is to develop a process map of how the current process really flows, starting with patient access through account resolution. Once you have a true depiction of the current process, each activity in the current process is identified as a value adding task or non-value adding task. There will be some non-value adding tasks that are necessary to meet business or regulatory requirements but do not add value. For example, submitting claims electronically through a clearinghouse is a necessary part of the revenue cycle but does not add value to the customer. Sending paper claims directly to the payor, when electronic submission is an option, does not add value to the customer or to the practice and would be considered waste.

So what exactly constitutes waste? Waste is identified as a non-value added task, not necessary for business or regulatory reasons. Lean philosophy breaks waste down into 8 categories. Once team members understand the 8 categories of waste, they can begin to identify and eliminate waste from the revenue cycle workflow.

The 8 categories of waste are:

- **Overproduction** refers to producing work or providing a service before it is required or requested. Examples of overproduction include redundant work, such as entering repetitive information on forms, printing extra copies of documents, and multiple team members performing the same task due to lack of clear ownership of the function.

- **Waiting** includes anything that interrupts the workflow and causes a delay in the next processing step. Examples include patients waiting to see the provider, insufficient number of software licenses and waiting for charges to be entered in the EPM/EMR. Backlogs and bottlenecks in the process are usually associated with waiting.

- **Excess Motion** is any movement that does not add value or reverses the process flow.
Keys to Effective Denial Management

Ashley Sonn
Product Marketing Manager, Institutional Services
Emdeon

Estimates show denied claims represent over 13% of gross revenue for providers nationwide. Some studies suggest that over 90% of those denials were preventable and nearly 70% could be overturned. An additional 6% of gross revenue was lost to underpayments. These numbers are staggering when you combine lost revenue as a result with the high cost associated with resolving these denials.

To face this challenge, providers must have an effective strategy in place to identify denials, manage their resolution and analyze root cause to facilitate prevention of future denials. Some keys to an effective denial management strategy include:

1) Capturing all remittance information necessary for denial management

A primary source of denial information is the payer remittance advice (RA). Many providers focus on payment posting from the RA and neglect to capture all of the information critical for effective denial management. For denial follow-up, it is important to capture and categorize all payer reason and remark codes.

2) Paying attention to payers who provide hard copy remittance reports

To maximize collections, providers must manage denials for 100% of their payer mix. Payers who cannot provide electronic remittance advice (ERAs) typically represent around 15% of total revenue, and many providers feel that the cost of capturing denial information from a hard copy remittance report is just too high to chase such a low percentage of revenue. A simple cost/benefit analysis will likely reveal that the cost of capturing denial information from a hard copy remittance report is easily outweighed by the denial recovery opportunity, and the opportunity to identify and prevent future denials.

3) Identifying and managing underpayments

If your denial management process does not identify and manage underpayments, you may be losing up to 6% of your annual gross revenue. Managing underpayments is frequently overlooked as part of a denials management strategy. First, you can qualify partial payment denials from remittances by looking for specific reason codes to identify charge-level denials. Second, it is critical to identify payment variances by comparing remittance paid amount to the expected payment amount. This can be challenging if HIS systems, contract management systems and denial management systems don’t work well together, however, this problem is easily and clearly worth re-engineering.

4) Considering how denied accounts are assigned to follow-up staff

Too often the focus on resolving EVERY denial results in chasing hundreds of low balance denials while sacrificing valuable resources who could be working on resolving collectible denials. Make sure follow-up assignments are reasonable. If a follow-up work queue has 2,000 denied accounts in it, the likelihood of staff always working on the most important account will be pretty staggering when you combine lost revenue as a result with the high cost associated with resolving these denials.

5) Automating or streamlining follow-up activity

Efficiency is the key to maximizing recoveries. Follow-up staff should have tools to save them time, allowing them to work and resolve more accounts. Some examples:

- Payer-specific appeal letter templates that can be auto-filled with account-level information like Patient Name, PCN, MRN, DOS, Denial Reason Codes, etc
- Write-off authorization tools to streamline the request and approval process
- Canned follow-up actions and notes to prevent staff from wasting valuable time typing the same thing over and over again
- Quick access to view and/or print the EOB and the denied claim
- Automated alerts that notify users when a prior follow-up action has not resolved the denial within the designated period of time

Continued on page 8
Waste Not, Want Not ... continued from page 6

Examples include patient registrars walking to the copy machine to make copies of patient information, looking for misplaced documents and inconsistent changing between computer screens when inputting data in EPM/EMR.

Transport waste in the revenue cycle involves less than optimal flow of data and people. Examples include re-entering data between incompatible systems (EPM and clearinghouse); work being passed back and forth for clarification and outdated procedures/lack of clarity.

Over processing waste occurs when more steps than necessary, to add value to the customer, are included in the process. Examples include excessive paperwork, gathering irrelevant information and submitting duplicate claims to the payor.

Unnecessary Inventory includes the usual inventory items, as well as inefficient use of time. Examples include outdated forms/manuals, unnecessary e-mail/paperwork, and work in progress (outstanding encounters and discharged but not final billed claims).

Defects/Errors /Re-works are mistakes that were not corrected at the source and require additional attention. Examples include not obtaining the correct patient demographic information, not setting up payers in the clearinghouse and submitting claims to the incorrect payor.

Under-utilized People are defined as not using team member skills to their potential. Lean work teams are seen as a resource to be developed and well trained in their functions (1). Examples of under-utilization include the supervisor correcting patient insurance information in EPM, management not including the team members responsible for a task when evaluating process improvements opportunities and supervisor not training team members to use the functionality of EPM.

Teammwork and a common focus are essential elements to streamlining your revenue cycle workflow. Lean helps you look at your revenue cycle workflow from a holistic point of view, as opposed to individual steps. By mapping out your current process, you are able to see the interaction between all activities and identify where insufficient processes result in delays, duplication of efforts and errors or “waste.” Applying Lean to your revenue cycle workflow will eliminate waste, which will accelerate cash conversion and liquidation of accounts receivable.


Keys to Effective Denial Management ... continued from page 7

6) Tracking and analyzing the outcome of denial follow-up

Make sure the outcome of each resolved denial is clearly identified. Analyze outcomes and educate staff to evaluate processes that historically have not been successful overturning denials. If sending the same appeal letter to the same payer for the same denial reason on 100 different claims has not overturned any denials, consider creating a new follow-up plan for that denial reason.

7) Identifying root cause and focusing on prevention

Increasing denial recovery rate is good. Decreasing initial denial rate is better! The key to prevention is in identifying the root cause. When providers understand root cause, they can make business decisions to facilitate prevention. Studies suggest that almost 80% of denials are Patient Access errors, but if the cause is unknown, staff may not be solving the right problem. It is worth the effort to evaluate and assign root cause to denials which includes identifying trends and taking steps to prevent future denials.

8) Setting and tracking financial and operational performance goals

Dashboard-style reporting tools are very helpful to communicate performance metrics throughout the organization and to manage performance. Important denial performance metrics include: initial denial rate, recoveries on denials and underpayments, rate of appeals overturned, monthly denial trends by payer and error type, denial outcomes by payer and error type.

These tips are some of the keys to a comprehensive and effective denials management strategy. Combining these eight tactics with a strong denial management solution will simplify execution of this strategy.

Source for all statistics in article: The Healthcare Advisory Board
**Becoming a (Financially Stable) System**

*Reprinted from Lancaster Pollard “The Capital Issue Newsletter”*

Before Watauga Medical Center merged with two other hospitals to form the Appalachian Regional Healthcare System (ARHS), the 117-bed rural North Carolina facility had maintained a strong 5% operating margin and a comfortable amount of cash on hand. But soon after, the system ended a year $10 million in the red with a bank’s noose tight around its neck and the collapsing credit markets pulling it tighter.

To thrive in its newly systemic configuration, ARHS would have to improve internal operations and convince an increasingly skeptical market of its rediscovered stability. The efforts resulted in an investment-grade rating for the rural system and a more affordable debt structure designed to be easily adaptable to future system needs.

**Relearning to Thrive**

As part of its strategic plan, Watauga joined with Cannon Memorial Hospital and Blowing Rock Hospital, two nearby critical-access hospitals, to become a system. Neither critical-access hospital was profitable on its own, so ARHS slid quickly into an operational downturn.

“When you change the whole complexion of operations, you can’t keep doing the same thing and expect different results,” said ARHS CFO Kevin May.

With no competitors the hospitals did not have the ability to increase revenue by taking market share. Instead they had to create efficiencies, cut expenses and improve revenue-cycle operations. Additionally, considerable attention was given to IT, with integrated software deployed to improve communication among departments.

Watauga also applied for, and received, sole community-provider status in 2009. “That brought the appropriate amount of Medicare reimbursement to Watauga and it was significant,” May said.

The new system went from losing $10 million in operations one year, to losing $500,000 from operations the next, to earning about $7 million— an $18 million turnaround in two years on a $140 million system-wide budget.

With their financials turned around, ARHS had the perfect opportunity to present its new face to the capital markets and revamp its entire debt structure.

**Approaching the Markets**

Before its about-turn, ARHS had a 12-month letter of credit enhancing $31.4 million of variable-rate bonds. The same bank that issued it also was the counterparty on an interest-rate swap, so the system had to renew its credit facility every year with a bank that held all the leverage. Almost at the same time came the credit collapse of 2008 and the LOC structure’s terms and conditions became more onerous.

Besides being tied to a constantly-expiring letter of credit, Watauga Medical Center was the sole obligor on the existing debt. It was also providing financial support to Cannon Memorial and Blowing Rock hospitals, necessitating a debt structure that would allow for undisturbed flow of funds throughout the system.

Lancaster Pollard walked the newly established ARHS through creating an obligated group of all three hospitals. It then assisted the system in obtaining a credit rating, using the credit write-up to describe the hospitals’ impressive turnaround. The obligated group structure, combined with the system’s continued operational improvements, provided Standard & Poor’s rating agency the assurance it needed to offer an investment-grade BBB+ credit rating.

The $35.5 million refinance was structured with fixed-rate, tax-exempt bonds. With no renewal risk, ARHS now has a stable debt structure providing flexibility to issue additional debt in the future.

**A Common Future, an Uncommon Task**

“Bringing new hospitals into a system, an affiliate agreement or creating a system as ARHS did, isn’t like becoming brothers,” May said. “It’s more like becoming conjoined twins.” Certainly, it’s not something hospital leaders do every day, every year, or even every decade.

ARHS is still adjusting to its new form, but May offers several suggestions for hospitals that are considering becoming part of a system:

- Have a solid business plan.
- Be conservative in borrowing and realistic about how much the system can afford to pay back.
- Make sure the hospitals involved get to know one another’s cultures, including medical staff, and operations.
- Engage outside experts to help integrate systems and services.
- Use debt rather than liquidity to finance projects, at least until the hospital has built a comfortable financial cushion.

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**Share Your Perspectives and Opinions on Current Healthcare Provider Industry Developments**

*Participate in the 2011 Finance Survey*

The HFMA Northern California Chapter Finance Committee is excited to announce the 2011 Finance Survey.

We believe it is essential to maintain up-to-date on the dynamic trends affecting our members. As such, we are requesting your perspectives and opinions on current healthcare provider industry developments in California, as well as National trends.

To participate, please visit: [http://www.zoomerang.com/Survey/WEB22OXKC768ET](http://www.zoomerang.com/Survey/WEB22OXKC768ET)

The survey will be open until September 16. Findings will be shared in The Edge and serve as the basis for the Finance Road Show meetings over the next six months. We look forward to hearing your perspectives and sharing the findings.
Welcome New Members!

- Marshall R. Abramson - Controller, Castro Valley Health Inc.
- Nicole Ball - Patient Financial Services, Kaiser Permanente
- Ryan Cabral - Manager, NCO Financial Services, Inc.
- Sergio Casas, RHIA, CCS - Consultant
- John Rohitishwar Chandar, Jr. - Executive Director, Golden Living Center Portside
- Anna O. Cheong - Senior Reimbursement Analyst, St. Rose Hospital
- Dusty Colvard - IT Director, Tehachapi Valley Healthcare District
- Cindy Crosslin - Chief Finance Officer, Plumas District Hospital
- Eric P. Duran - Management Consultant/Senior Project Manager, California Information Systems
- Janine Edwards - QA/Training Coordinator, Patient Access Services, ValleyCare Health System
- Jim D. Eldridge - Area Finance Officer, Kaiser Permanente
- Karen Farr - Senior Business Analyst, Emdeon
- Jennifer Foley Clark - Marketing Director, Genentech Incorporated
- John Fowler - Chief Executive Officer, HealthCPA
- Stefni Girnus - Patient Financial Services Manager, Kaweah Delta Health Care District
- Anthony Gutila - Consultant, Toyon Associates, Inc.
- Joann Hamilton - Manager, Business Services, St. Rose Hospital
- Staci Hardesty - Account Executive, Gardner Group, Inc.
- Rhonda D. Harkins - Patient Financial Services, Mammoth Hospital
- Peter Hohl - Chief Operating Officer, OakCare Medical Group
- Priscilla Knolle - Systems Director Clinical Documentation
- Jacqueline C. Korajkic - Audit Manager, Armanino McKenna LLP
- Guarav Kumar - Revenue Cycle Manager, Accretive Health
- Anita Kratka - VP, Business Development, M Squared Consulting
- Jeff T. Jones - Business Intelligence Manager, Catholic Healthcare West
- Matthew J. Lardie - HIM Director, J&L Teamworks
- Damon Lewis - Principal, Triage Consulting Group
- Heidi K. Lourey - Project Manager, California Reimbursement Enterprises, Inc.
- Fulvio Bing M. Mappayo - Vice President, Intelenet Global Services LLC
- Bill Merrell - James + Gable Insurance Brokers, Inc.
- Andrew Miller - Chief Finance Officer, Cepheid
- Gregory Montemayor
- Maura Noel - Recoveries Administrator, Central CA Alliance for Health
- Maria Novelero - Hospital Administrative Director, University of California at San Francisco
- Robert Palinsky - Director, NCO Financial Services, Inc.
- Stephen Michael Paul - Senior Consultant, CareFusion
- Linda L. Peasley - Revenue Integrity Manager, Fremont Rideout Health Group
- Ken Perez - VP of Marketing, MedeAnalytics
- Naomi Pestanas - Associate Marketing Manager, MedeAnalytics
- James Phillips - Kaiser Permanente
- Aaron Poole
- Geoff Pridham - Manager, Nursing Administrative Services, Stanford Hospital & Clinics
- Gale Richards - Partner, Bioquest
- Alicia Rodriguez - Patient Financial Services Manager, Kaweah Delta Health Care District
- Darren F. Smith - Vice President, J.P. Morgan Asset Management
- James Suver - Adjunct Faculty, Chico State University
- Felicia Y. Sze - Associate, Hooper, Lundy & Bookman, Inc.
- Rand K. Takeuchi - Moss Adams LLP
- Phyllis Towles - President/CEO, VIP Concierge, LLC
- Jennifer Van Matre - Accounting Director, Trinity Hospital
- Allison L. Viramontes - Administrative Fellow, Sutter Health
- Diana Weddigien - Senior Accountant, Moss Adams LLP
- Cynthia L. Weinthalier - Treasury Solutions Officer, Bank of America
- Bill D. Wing - Senior Vice President, Adventist Health
- Carl Zimmerman - Associate, Health Evolutions Partners

Welcome Members Who Transferred In!

- Douglas Oblak - Healthcare Consultant, Marketing Concepts
- Cynthia L. Johnson, FHFMIA - Chief Marketing Manager, GE Healthcare
- Beverly B. Moffat, CPA - Reimbursement Analyst, Sutter Health
- Regan Richards - Assistant Director, CDM & Revenue Capture, Stanford Hospital & Clinics
- Michael Miesen - Analyst, Huron Consulting Group
HFMA NORTHERN CALIFORNIA - SPOTLIGHT ON A MEMBER

ALISANNE FREW
Director of Business Development - North America, GCS Healthcare International Collections

Years in Healthcare: 2.5
Years in HFMA: 2.5

What are your personal and professional benefits realized from HFMA?
Making Providers laugh at conferences

How did you end up in Healthcare? Did you choose it or did it choose you?
My Swiss International Collection firm relocated me from Paris to the United States to head up the North America Business Development. Oui, je parle francais ... if you ever want to take a trip to Paris - call me.

Tell us about yourself:
I love history and comparative religions. I have a vacation home in Luxor, Egypt where I love to study ancient civilizations.

There’s no right or wrong answer, but if you could be anywhere in the world right now, where would you be?
On Richard Branson’s shuttle to the first five-star hotel in outer space.

What do you like to do for fun in your spare time?
Eat oysters and drink champagne on the beach or fresh mango juice and dates on the desert.

What’s the last book you read?

What would you do if you won the lottery?
Give a lifetime grant to a botanical garden preserving endangered ayurvedic plants.

What is your greatest achievement outside of work?
Not eating fast food. I like slow food.

What is your greatest achievement outside of work?
Not eating fast food. I like slow food.

Who are your heroes?
Anyone chosen to speak at the annual TED Conference
The best advice I ever had was “Focus” - an advice from my father
The best part of my job is Connecting with smart people

My favorite food is Apples from my garden
My first car was a Fiat 500 1973 at the University of Paris, France (double clutch!)

My favorite car is Mohave Jeep
Favorite Quote
“No pain, no pain” - George Carlin

One of the most important HFMA-sponsored education programs for the chapter year – HFMA’s MAP Event – takes place in Miami on October 26-28, 2011.

MAP Event is a peer-to-peer program where you’ll take away tools to make real-life performance improvements, instill proven practices, extend accountability, and achieve revenue cycle excellence.

During hands-on sessions, HFMA’s MAP Award winners – hospitals demonstrating outstanding results – will share proven practices to preserve net revenue, improve Cash Collections, reduce DNF, Aged A/R, and FBNS, and much more. MAP Award winner – Baptist Hospital of Miami – will also conduct a tour of its facility and lead a session hosted by Baptist’s VP, Revenue Management.

You will also discover 6 new national key performance indicators (KPIs) – called MAP Keys – part of the industry’s 25 most compelling revenue cycle metrics established by healthcare leaders through HFMA’s MAP initiative.

What is HFMA’s MAP?
HFMA’s MAP gives you the revenue cycle tools you need to Measure performance, Apply evidence-based strategies for improvement, Perform to the highest standards across the board, and receive recognition for your success.

Why? You can earn up to 20 CPE Credits
How much? Members: $895 / Non-Members: $1,019
Where? Doral Golf Resort and Spa in Miami, Florida

How do I learn more and register? Visit www.hfma.org/mapevent

Please forward this to interested colleagues and/or staff in your organization today! If you have questions, HFMA’s Member Services Center will be happy to assist you at (800) 252-4362, ext. 2.
Get to Know Greg Moga, HFMA Regional Executive for Region 11

I have the privilege of serving as HFMA’s Regional Executive for Region 11, which is made up of seven Chapters on the West Coast - San Diego, Hawaii, Nevada, Northern California, Southern California, Oregon, and Washington / Alaska. Our Region just returned from our Fall President’s Meeting, where the Chapter Presidents and President-elects gave me the assignment of writing this article to tell you what being a Regional Executive, and what I, Greg Moga, am all about.

A Regional Executive (RE) serves as the primary link between chapters and National HFMA. The RE oversees and maintains regional programs, policy, operations, and finances that involve policy making and compliance authority as it relates to the Davis Chapter Management System (DCMS) and the Chapter Balanced Scorecard (CBSC). REs are to monitor chapter performance and to convene and organize regional leadership meetings, such as the Fall Presidents’ Meeting. There are a total of 13 REs in the Regional Executive Council and we meet in person three times a year: in June at HFMA’s Annual National Institute; in November in Chicago; and in April at the Leadership Training Conference. We also take part in five or six conference calls each year.

I was privileged to be elected to serve as Regional Executive after two terms as President of the Washington/Alaska Chapter. My predecessor as RE was David Epstein, of the San Diego Chapter; my successor as RE is Keith Ridley of the Hawaii Chapter, and his successor in turn (REE) is Diana Gernhart of the Oregon Chapter. The RE role rotates among the seven chapters in our region. To be eligible to serve as RE you must have served at least two years as a chapter officer, and one year as a chapter president.

I began my membership with HFMA in 1985, as a young attorney working for a healthcare reimbursement law firm in Chicago, Illinois. It was not until my family moved to Seattle in 1996 and I attended a Washington/Alaska Chapter conference - where I remember feeling so warmly welcomed by the chapter members - that I realized that I wanted to be a part of the leadership of HFMA.

HFMA has helped me to live a bigger life. Getting out of the office to network, and create working relationships and friendships has led me to know terrific people working in healthcare finance all across the United States. I now have friends and business colleagues in every major city in the United States. I urge all of you to follow my path - give your time and effort to your colleagues and peers through HFMA and it will be returned to you tenfold.

As I get older I repeat often (to my children and to anyone else who will listen) the central themes of my life. Live the biggest life that you can. Love the people that love you. Everyone has a story. You don’t know what you don’t know. And we are all, as John Guare wrote, connected within Six Degrees of Separation, to everyone else on this increasingly inter-connected planet.

I value my connection to each of you and to your Chapters. I hope to attend a conference at each of the seven Region 11 Chapters this Fall. Just let me know how I can be of assistance to you, and to your career both in HFMA and outside of HFMA. That is my role, in my year as your RE. I consider serving as Regional Executive to be the culmination of my ‘HFMA career’ and hope that all of you will have as rewarding and fulfilling an HFMA career as I have had.

Is One of Your Professional Goals to be a Certified Healthcare Financial Professional (CHFP)?

As of January 1, 2011 the Requirements Changed

As this year’s Professional Excellence Certification Chair, I encourage all members to make it a goal to become a Certified Healthcare Financial Professional (CHFP). This certification is intended for mid-level healthcare professionals with a minimum of three to five years healthcare experience.

This certification will demonstrate your healthcare knowledge and expertise to senior management, your co-workers, and the industry.

As of January 1, 2011 the requirements are:
1. A minimum of three to five years Healthcare Management experience
2. Current and active regular or advanced HFMA membership
3. The successful completion of one comprehensive certification
4. Successfully completing the on-line certification examination

The exam will consist of 150 multiple choice questions covering six content areas:
1. Revenue Cycle
2. Internal controls
3. Budgeting and Forecasting
4. Disbursement
5. Financial reporting
6. Contracting

The cost is:
1. $195 for on-line study materials, this is recommended but not required
2. $395, this includes all applications, testing, and processing
3. $200 for Retesting

If you need help with payment, the chapter has available scholarships. In order to qualify for the scholarship, you will be asked to sign a contract and commit to taking the exam.

The chapter is also offering Certification Practicum sessions in collaboration with the Oregon Chapter. These sessions are designed to help HFMA members prepare for the examination. It consists of four 1 ½ hour webinar sessions that cover some of the more challenging topics tested on the CHFP exam.

In September, the chapter is offering live study group sessions at the Fall Conference to be held at Thunder Valley Casino in Sacramento and then again at the 2012 Region 11 Symposium in Las Vegas. Reach your goal this year.

Please contact Daisy Noguera, Professional Excellence Certification Chair with any questions at daisy.nogueara@chomp.com.
In Appreciation  Thank you to our Corporate Sponsors for their continuing support of the Northern California chapter!

Job Opportunities

Visit the chapter website (http://www.hfma-nca.org) for details and a complete listing of job openings

Assistant Controller - Alameda County Medical Center, San Leandro (posted 8/23)
Accounting Manager - Alameda County Medical Center, San Leandro (posted 8/23)
Manager - Budget - John Muir Health, Walnut Creek (posted 8/22)
Chief Financial Officer - Methodist Hospital of Southern California, Arcadia (posted 8/15)
Senior Director of Financial Operations - Recruiting Solutions, Inc., Sacramento (posted 8/15)
Financial Analyst II - NorthBay Healthcare (posted 7/1)

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TrovatT@sutterhealth.org

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