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Does your agency know how to serve notice in cases of noncoverage?

New rules from HCFA on notifying Medicare patients

With Transmittal A-99-52, the Health Care Financing Administration (HCFA) took another step toward modifying the standards for providing Medicare beneficiaries with written notice when home health agency administrators suspect the beneficiary's services would not be covered under Medicare.

This move comes on the heels of a failed attempt by HCFA last September to institute a mandatory form for the beneficiary notices. Because HCFA was not in compliance with the 1995 Paperwork Reduction Act, the proposal never became law. The new standards set out in Transmittal A-99-52 took effect Feb. 14 and include a combination of mandatory standards to accompany the submission of claims upon beneficiary demand and a model notice, the use of which is voluntary. Although HCFA is only recommending that the model notice be used, it is pursuing authorization to institute these notices as a mandatory form.

Q&A from NAHC addresses the issues

The National Association for Home Care (NAHC) in Washington, DC, has devised series of questions and answers that explores the issues surrounding the confusion caused by Transmittal A-99-52. **(Those questions and answers are listed below and continue through p. 39.)** Since the issuance of the transmittal in mid-December, NAHC has received numerous inquiries from agencies across the nation attempting to decipher these instructions and comply with responsibilities.

However, the content of the instructions and the nature of the process used by HCFA to institute modifications in the notice standards make it tough to fully comprehend HCFA's intentions. HCFA has been either incapable or unwilling to work with the home care community in this matter, according to the NAHC.

Q. Were home health agencies obligated to utilize the model home health advance beneficiary notice beginning Feb. 14, 2000?

A. No. The use of the model notice is voluntary. However, it is recommended that the model notice be utilized because HCFA indicates that proper use of the model notice will create a "safe harbor" for home health agencies demonstrating compliance with notice responsibilities.

Q. If we choose to develop our own notice for patients, what must we include in that notice?

A. The first requirement for the production of a notice is to ensure the design and readability conform to HCFA standards. The transmittal requires that no body text or heading should use a font size less than 12 points. Italics or any typeface that is difficult to read should not be used. The beneficiary's options, including the option to continue to receive care and to request that the agency submit a demand bill, should be clearly apparent. It must also be clear and obvious to the beneficiary that the agency, not the Medicare program, is issuing the notice. The notice must state the reason the agency considers the care to not be covered and the effective date of that decision. The notice should also state the consequences of the option exercised by the beneficiary and include some form of signed acknowledgment of receipt.

Q. Our agency has started to use HCFA's model notice, and we have received complaints from patients that it is confusing. What should we do?

A. You may wish to consider providing patients an additional notice indicating that the HCFA model notice has not been created by your agency but rather the federal agency. That notice could include a reference to the intermediary, HCFA regional office, or HCFA central office as a place where patients could communicate their concerns.

Q. Do we have to provide the notice to patients every time care is to be terminated or reduced or when admission to care is denied?

A. No. The notice responsibilities set out in Transmittal A-99-52 only apply where the agency thinks that care ordered by the patient's physician would not be covered under the Medicare home health benefit conditions for payment. There must be a physician's order for care in spite of the agency's opinion that the care would not meet Medicare coverage standards. In the absence of a physician's order for care, the notice requirement would not apply.

There will be other circumstances where care is terminated or reduced or where an admission is rejected that do not relate to the patient's eligibility for Medicare coverage. In such circumstances, the notice requirement does not apply and the model notices should not be provided in order to avoid patient confusion.

Q. Why does a home health agency have any responsibility for providing written notice to a patient regarding the individual's eligibility for Medicare health care coverage of home health services?

A. There are two provisions of the law which form the basis for the notice responsibility. First, the patient's bill of rights, which is part of the conditions for agency participation in Medicare, requires that agencies notify patients, orally and in writing, before care is initiated, of the extent to which Medicare payment may be expected and the charges for services that will not be covered by Medicare. Second, the limitation on liability provision, which is designed to protect patients and providers from retroactive Medicare coverage denials, shifts liability to the provider of services where the provider knew or should have reason to know that services would not be covered under Medicare. Home health agencies avoid the shift of liability for noncovered care only by providing patients with written notice, prior to the delivery of services, informing the patient that it is the agency's opinion that care would not be covered. These responsibilities have existed for a number of years.

Q. Our agency regularly notified patients when we determined that care was not covered under Medicare. Why is HCFA making these adjustments at this time?

A. HCFA's actions are primarily in response to a lawsuit pending in federal court. While the court has yet to decide the merits of the respective parties' positions, it appears that HCFA has determined that the notice process can be improved and has taken the steps discussed here to accomplish such. At this point, the beneficiary plaintiffs in that lawsuit do not appear to be satisfied with the changes and are continuing litigation.

Q. What actions should we take if the patient is not capable of comprehending the notice?

A. It is acceptable to deliver a notice to an authorized representative of the beneficiary. However, if the ability to understand the notice relates to the ability of the person to read and comprehend the English language, or to a visual or hearing impairment, the agency should take steps to accommodate those individuals so that actual notice of the information is communicated to the individual.

Q. What kind of notice should we give to a patient when the patient is shifting from Medicare coverage of home health services to a Medicaid home care program?

A. In those circumstances, the Medicare denial notice should be delivered to the patient even though care is continuing and the only change is in the source of payment. Since the model notice fails to take account of situations where care continues and the third-party payment source changes, patients should be informed that there would not be a personal liability for the cost of the care.

Q. The transmittal states that a home health agency must submit a claim to Medicare where a beneficiary demands such submission after receiving the notice. Is this a change?

A. No. Medicare beneficiaries always have had the right to request or demand that an agency submit a claim to Medicare where that agency has notified the patient that it did not believe the services were covered by Medicare. The claim should be submitted as a condition code 20, and the intermediary must undertake a full review and adjudication of the claim. The changes set out in the transmittal relate more to the detail that is offered regarding this responsibility. In addition, the agency must "promptly" submit a demand bill, defined as in accordance with normal billing cycles.

If the intermediary decides the services are covered, the agency will be required to refund any payments which were collected from the beneficiary or other third-party payers. All demand bills will be subject to a full medical review by the intermediary. In the transmittal, it is Medicare's position that an agency will be prohibited from charging the beneficiary or other third-party payer if the demand bill is not submitted promptly within the normal billing cycle.

Q. How does the home health advance beneficiary notice fit within the patient's bill of rights, which requires that the patient be informed, in advance, about any changes in a care plan?

A. There is a separate provision within the bill of rights, which provides that a patient has the right to participate in planning care and treatment and has the right to be informed, in advance, about the care to be furnished, and of any changes in the care to be furnished. The home health advance beneficiary notice does not squarely fit within this requirement. Instead, this bill of rights requirement applies regardless of whether the care delivered to the patient is within Medicare coverage standards. Any change in a care plan triggers the home health agency's responsibility to provide advance information to the patient. Home health agencies need to recognize this distinct and separate responsibility.

Q. Can we expect to see any more changes in the beneficiary notice requirements?

A. Yes. HCFA is currently attempting to secure authorization to make the model notices mandatory. Within that process, it is possible that the content and format of the notice will change. In addition, the class action lawsuit on behalf of Medicare beneficiaries may result in a court order to modify the notice. NAHC will keep the home health community informed of these changes as they develop. ■

Hospital home health is hardest hit by BBA

A recent study commissioned by the American Hospital Association (AHA) in Chicago and conducted by Lewin and Associates, a private consulting firm in Falls Church, VA, has shown that hospital-based home health agencies have far and above been hit hardest by the Balanced Budget Act of 1997 (BBA) when compared to its effects on inpatient care and other Medicare services provided by hospitals.

In its study, Lewin extrapolated Medicare expenditures following the enactment of the BBA and the Balanced Budget Refinement Act of 1999 (BBRA) for inpatient and outpatient services, home health care, and those services that are exempt from the hospital prospective payment system (PPS). According to the results, over the next four years overall Medicare revenues are predicted to be 13% lower under BBA and BBRA than had they never been enacted. Hospital home health by comparison can expect reduction in reimbursement of about 34.4% and, even with BBRA reductions, will continue to grow to 37.5% in 2004. BBRA will increase payments to hospital home health agencies by only 2.8% from 2000 to 2004.

A National Association for Home Care release noted that even with the adjustments allowed under BBRA, "margins for outpatient services, hospital-based home health, and PPS-exempt services would all be negative through the year 2004." (A margin analysis compares projected costs to projected reimbursement.) For hospital-based home care, the study says, margins range from -7.8% in 2000 (accounting for the start of PPS) rising to -16% in 2001 (when the 15% reduction takes effect) then leveling off at -14.8% by 2004. In comparison, overall hospital margins range from -3.2% in 2000 up to -6.6% in 2004.

(Lewin and Associates' hospital-based home health projections are derived from data sources developed by Lewin for the National Association for Home Care analysis of BBA published in August 1998. Those data, based on cost reports from agencies nationwide, were updated using more recent data on home health spending and AHA data, and incorporating assumptions about the impact of the proposed PPS for home health. The report adds to the growing body of evidence that home health remains in a fiscal crisis due to inadequate Medicare reimbursement.) ■

What is billing errors and omissions insurance?

Can you afford not to have it?

Your agency provides a service and a valuable one at that. You deserve to get paid. You try to stay abreast of changes in reimbursement policies, and you try to submit your charges in as timely a fashion as possible.

Even so, you don't always get paid. Why? There are literally thousands of reasons, most of which can be traced to billing errors made possible thanks to Health Care Financing Administration guidelines, 50 state-specific sets of Medicare rules, a host of carrier-specific Medicare rules, individual guidelines for commercial insurance carriers, and 50 sets of state-specific workers' compensation guidelines.[1]

When it comes to billing submissions, one error can mean that you won't be paid but it can also weigh in with much more severe consequences. "Unfortunately, the government doesn't distinguish between a human error and someone who knowingly bills Medicare for a patient they never saw," says **Sheila Callison**, CPCU, ARM, RPLU, CPDM, vice president of Keenan HealthCare in Pasadena, CA. "It seems to treat a clerical error pretty much the same as fraud."

She says this is one of the reasons companies such as Keenan HealthCare, a full-service brokerage and consulting company, have developed a billing errors and omissions insurance policy for hospitals, health systems, provider networks, and individual physicians.

"These policies were really developed by the insurance industry as a response to the government-increased scrutiny as related to legislation and the feeling that there was a lot of billing fraud in the health care system," she says. "As the number of audits continued to grow, people began to look at the policies they had and saw that there were exclusions from standard policies that would keep them from having coverage for fines or penalties and in some cases defense costs."

As Callison points out, when an individual or agency starts looking at fines of $5,000 to $10,000 per billing error, "you start to see some serious potential liability."

The ABCs of E&O

Billing errors and omissions policies will cover, among other things, civil fines that result from a government audit as well as the cost of the audit process itself. Additionally, the policies will cover legal and other costs involved with investigating possible errors in Medicare and Medicaid billing.

What the policies won't cover, however, are intentional fraudulent claims. Unintentional

errors are the object of the coverage, notes Callison.

In order to qualify for such coverage, the home care agency must have a corporate compliance policy in place. "It doesn't need to be the best one going, but you have to have addressed it and have a formal process in place," she says. "These policies are underwritten and, without that, an insurance carrier won't even consider you."

Some insurance companies, if you buy their coverage, will provide a corporate compliance software product, she adds. "Underwriters like to know that you are using the appropriate type of software to catch billing errors, too." **(See related story, p. 42.)**

It's possible that a hospital home health agency is already covered by one of the hospital's policies. Callison suggests checking under the hospital's general liability policy or even its officers' policies. In general, if the agency is a subsidiary of the hospital and the hospital has an errors and omissions policy, both entities will be covered. "This is definitely the most cost-effective way to go," she points out, adding that an extra benefit to being tied to a hospital is that it is all the more likely to have a strong corporate compliance program in place.

"Where does the agency get the money when they're already providing care for less than cost?"

If your agency is covered through the hospital's policy, the next step is to make sure adequate protection is provided. "A policy might be written to cover $1 million, but the hospital or home health agency might be liable for up to $50 million or more," she explains. Even if you are covered, in most instances the policy will have exclusions so that the agency won't be covered for billing error claims, Callison says.

"People assume that if they have real liability or malpractice insurance, they should be pretty well covered, but they need to look at what the policy really covers and what the exclusions are," she says.

From a practical standpoint, the government is increasingly going after what it sees as a high percentage of fraudulent Medicare billing within the home health industry, Callison says. As such, agencies are under increased scrutiny and the chance of being audited has become substantially greater than in the past.

The results are that some agencies and hospitals have had fines in the millions of dollars, she adds. By the time an audit rolls around, "you're negotiating a settlement amount. Having a strong corporate compliance program in place and an insurance program are things the government is looking for and they can help mitigate the final assessment."

Even with a obvious need within the industry to have billing errors and omissions insurance, Callison says she hasn't seen a rush to sign up. "From a practical standpoint, it's been interesting. When we first heard about it, we really thought people would say, 'I've got to have this,' but the reality is that very few organizations have purchased."

Price is a significant part of the problem, she admits. Individual physicians will pay somewhere in the vicinity of $1,000 annually — a cost-effective policy when one considers the potential financial risks of not being covered. But hospitals are looking at minimum premiums of $50,000 and up. Premiums depend in large part on the number of billings a hospital or home health care agencies does, explains Callison. "Not only the number of billings but the costs involved are a factor, with the idea that the more billings you do, the greater the chance for error."

"When people look at the limits and then the premiums, they tend to think to themselves, 'We've had risk before and have a good corporate compliance record so we're willing to take the risk of being self-insured.' It really boils down to the price and your confidence in your billing operations," she says.

Linda Rashba, MS, RN, BSN, administrator of St. Francis Home Care Services in Poughkeepsie, NY, doesn't see an immediate need to acquire a billings errors and omissions policy for her agency. "For our part, we don't have a high percentage of Medicare problems," she says. "We do validation upfront so we're not having a lot of denials. If it were otherwise, however, I might want to protect myself and my agency." **(See related story, p. 43.)**

Paying for it

Greg Solecki, vice president for Henry Ford Home Health Care in Detroit, doesn't have a billing errors and omissions policy for his agency. "The home health industry is so severely undercapitalized and can hardly afford the surety bonds that I'm wondering how anyone can afford

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this, even if it is a good plan and makes sense," he says. "Where does the agency get the money when they're already providing care for less than cost?"

Solecki says, the need for such insurance "speaks to the behemoth that has become the billing process.

"It's a telling comment about what we're required to go through to get reimbursed for trying to make a difference in the lives of patients and their families," he adds. "It's really sad that we've come this far so that we need this type of insurance. It says more about the Medicare program and regulations and billing than it does about covering your exposure from errors."

Even so, Solecki describes himself as a realist and says he can see the reason that went into creating just such an insurance policy.

"The billing process is so filled with minutia and has become so cumbersome that I'm not sure that the people who most need this insurance are even close to understanding that they need it," he notes.

"I have empathy for the new product line because much like other products that have been felt to be of benefit to the home health care community, they are things the industry just can't afford. Take laptop computers and palm pilots, for example. These are things that make sense from an industry perspective. Even so, we can't afford what we need most," he adds. "This seems like a wonderful product that meets our needs, but we can't afford it because no one is meeting ours."

Reference

1. Klasa M. Automated billing — new generation of systems provides tools to improve compliance. *Health Care Innovations* 1999; 9:18-21. ■

Codified billing: Software makes it simple

When it comes to Medicare billing, there is a seemingly infinite number of items that can go wrong. Resourceful companies looking to break into the health care market saw a way to not only provide a service but turn a profit at the same time, and so came the birth of billing and coding software.

Companies such as Burr Ridge, IL-based ADP Context set out to find automated solutions to medical coding, claims editing, and reimbursement issues confronting the health care industry. To date, the firm has more than 60 Knowledge Products — its software line — covering such areas as coding, fee management, and regulatory compliance.

Some software "actually looks at claims to see if you have the information required by your carrier in order for it to be accepted. It will check to see whether you have a primary diagnosis and the appropriate code," says **Marge Klasa**, DC, RN, manager of clinical content for ADP Context, of her company's software.

"In the coding software, we have edits that indicate exactly what is allowed as a code. It doesn't suggest which modifier to use, for example, but will alert the user to the fact that one is needed." she says.

Programs can be interfaced

To cut down on duplication, software can "interface with other programs so that it's pulling a patient's name and information, which will be reflected on an actual claim that is electronically sent to the carrier."

Even with a software program that seems to do the work for you, Klasa warns that there "should always be one person in charge so that someone can go back and review things and make changes if necessary. The only way for this software to really work for you is to have a certified staff member, whether it's a registered health information technology person or a registered coder. They need to have the education and knowledge base in this area. I can't emphasize that enough."

If your agency employs an experienced coder, you might be asking yourself what good software programs will do. "They can help reduce

SOURCE

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the number of errors, and anything that does that has to be helpful to a business," says Klasa. "Any time you don't get reimbursed quickly you're losing money, and sometimes you're not even able to re-submit. You want all your bases covered when it comes to compliance so you know what you're dealing with and you don't waste time."

To that end, all software providers offer training classes, basic workshops, and more to help employees master the program, Klasa says. Additionally, they have seminars for correct coding.

In an article Klasa wrote for *Health Care Innovations*,[1] she gives a brief rundown of just how coding software works in an agency context: Once a service has been rendered, the medical coder receives a summary of the services on an encounter form that is provided by the physician. This information is then entered into the system. The system will prompt the coder for the diagnosis and procedure codes and, as it does so, the software allows the user to identify the most appropriate code for that particular episode of care.

The coder will also be notified if there is an acceptable link between the diagnosis and the procedure codes. Once the proper codes have been entered, the entire claim and the patient history can be reviewed and compared to a particular payer's rules. Should any errors appear as flagged, the coder can correct them on a real-time basis before the claim is submitted.

Check the facts first

But before you run out and buy the first program you see, there are a few facts you should know. First, prices should be comparable to what a practice management company would charge, says Klasa. Second, piecemeal plans are available if an agency only wants the software and a few other components. Then, too, there are a few shopping tips she offers. Any system you purchase should be able to:

❒ identify the appropriate procedure and diagnosis mismatches;

❒ identify whether the procedures are linked to the diagnosis code;

❒ identify unbundling occurrences;

❒ identify service violations and overutilization;

❒ flag users for overlooked charges (e.g. injections, surgical trays, etc.);

❒ have the ability to be integrated with a current practice management system;

❒ be easy to learn and use, particularly in light of high rates of staff turnover;

❒ have sources for payer rules disclosed by the vendor and updated frequently for users;

❒ offer a high-quality "help line" or other resource to provide assistance.

Reference

1. Klasa M. Automated billing — new generation of systems provides tools to improve compliance. *Health Care Innovations* 1999; 9:18-21. ■

Try these home care best billing practices

Everyone has his own way of working. Some ways are better than others, but they are usually subjective. Not so when it comes to financial-related matters, especially those to do with billing.

One mistake can be extremely costly; two can be fatal to an agency's profit structure. **Betsy Drennan**, reimbursement manager for VIP Home Care in Amarillo, TX, has several tips to help ensure your agency doesn't fall victim to "death by erroneous billing."

1. As soon as the patient is admitted, always verify Medicare benefits and beneficiary information using the HIQA system through Advantis, Passport, INET, or any other on-line claims system that other fiscal intermediaries use.

2. Always have the patient sign a service agreement stating that the patient will be responsible for any charges that Medicare will not pay and for which the patient has been notified.

3. Develop a regular billing cycle and try to

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bill as soon as possible after the billing period has closed.

4. Get a software program that allows you to run many reports during the patient's stay on services to ensure that all documentation that is needed for billing is in place. Examples of such reports include missed visit reports, orders outstanding reports, and a log/scheduled/ordered difference report that shows whether a visit had been logged in and is inconsistent with either scheduling or any orders that were logged into the system.

5. Always run absent data reports, orders outstanding reports, and missed visit reports on the day of billing. Any patient who appears in these reports should be "held" until the items are cleared.

6. Make sure your billing department is running regular aging reports and posting payments daily. This procedure will ensure that any denials or corrections, etc. are caught daily and will be more effective than doing a lot of research at the end of each month to determine where the mistake was made.

7. When your billing department runs an aging report (running one every week is suggested), write in the reason that any balance is outstanding 30 or more days. This will help to remind you of the reason as well as help keep your management staff informed of the case's status.

8. Perform semiannual audits. Audit all billing files to ensure that each piece of required documentation is in them. Then list the patients who were on services and the dates of services, and make certain their claims are on-line. Rerun bills on all patients and make sure that they match those originally sent out so you can be certain that no adjustments need to be made. Check to see if your billing software will let you run a short report, which will tell you when visits have been added to the system after billing was completed.

9. All reimbursement managers and billers should view the claim count summary of Advantis/INET, etc. on a daily basis to get a quick overview of all their claims and their particular status.

10. Remember that in Texas, private-pay patients must be billed the same amount that you bill Medicare for services. (What you collect is optional, but the patient's bill must match that of Medicare.)

11. Hold frequent inservices with clerical staff to keep them updated on new regulations, etc., and to review any problems that you have noticed. Keep a log of corrections and review them with the office manager on a monthly basis. During this time, you can offer suggestions on how to prevent these same corrections from being made in the future. ■

It's back, due to popular demand

Hospital home care conference returns

Due to the popularity of the "Hospital Home Care State of the Industry" conference held last December, the Center for Hospital Homecare Management Inc. in Hamden, CT, and its co-sponsors, *Hospital Home Health* and the Tennessee Hospital Association, presented a repeat performance in Nashville, TN, on March 6. Additional seminars will be scheduled in coming months.

The seminars are geared specifically to helping hospital home care agencies survive in the new prospective payment system (PPS)-driven home health market. Keep in mind that home care was the most-eliminated service by hospitals in the last year, according to a recent American Hospital Association study.

Many hospitals are debating whether to close their home care facilities or whether they should try and make them viable sources of profit. If the latter is the case, then many of these home care agencies will need to be restructured. Should you attend a future seminar? Consider these questions:

✔ Does your hospital have a short- or long-term mindset about home care opportunities

and positioning strategies?

✔ Has the cost shift and overhead allocation benefit under the old Medicare home health cost-based reimbursement system clouded executive management's view of home care's potential benefit to your hospital?

✔ Do you know why a hospital's policies and procedures can make it very hard for its home care department to be bottom-line successful?

✔ Do you know the real reason why so many hospital-based home health agencies are not thriving today?

✔ Do you know what your hospital must do for your home care operation to be more successful?

Some of the topics covered during the recent seminar series were:

• **Strategic Management: The National Home Care Marketplace** — Competitive industry dynamics, financial pressures, key business trends and Wall Street perspectives.

• **Financial and Operation Efficiency Under the New Medicare Home Health PPS System** — An explanation of the proposed Medicare home health PPS regulations, financial and operational coping strategies for PPS and initial budget planning approach for PPS.

• **Restructuring Your Hospital Home Care Business(es)** — How the home health PPS regulations will influence your choice of structure, the reasons the current structure of most hospital-based home care operations makes it very hard for them to compete and be profitable, the emerging models (and their advantages and disadvantages) for restructured hospital-based home care, and key elements in private-duty organization structure decision making.

• **Private Duty Market Strategy, Services and Profit Secrets** — How a major hospital system has been profitable in the private-duty market, what services it offers, how it is organized and structured, and what opportunities this may imply for your marketplace.

• **DME/Infusion/Retail Center Business Strategies and Operations** — A look at market dynamics, Medicare cutbacks, and key management responses, and the HCFA DME competitive bidding project.

For those who have been unable to attend but would like to learn more about the topics addressed, a seminar handbook is available for $225. Send a check made payable to the Center for Hospital Homecare Management Inc. (CHHM), 230 Treadwell St., Suite 603, Hamden, CT 06517. ■

New codes proposed for home health, hospice

At the National Uniform Billing Committee (NUBC) February meeting in Baltimore, representatives from the Health Care Financing Administration (HCFA) provided an update on the status of EMC V.6 revisions and presented requests for new billing codes for home health and hospice claims. Here is a summary of pertinent NUBC actions:

• The NUBC agreed on Jan. 6, 1999, to use "6" as a new electronic claims version in order to allow for expansion of the number of lines available on claims to 450. Information related to implementation of EMC V.6 is available on the HCFA Web site in the Program Memorandum section. HCFA announced that the effective date for implementation of V.6 is July 1, 2000.

HCFA received approval for addition of third-digit frequency codes to the NUBC manual. The third-digit frequency codes have longstanding use by HCFA but were never officially approved by the NUBC.

• The committee also approved HCFA's request for a new Source of Admission Code effective Oct. 1, 2000, with implementation of the home health prospective payment. Code "C" will be used on the home health Notice of Admission in those cases where a patient has been discharged from a home health agency and is readmitted within the same 60-day period. A second request for a code to be used on the original 60-day final claim to indicate "discharged with treatment goals met, and readmitted within existing payment period" was deferred until further information can be gathered about its usefulness.

• The NUBC developed and approved a definition for "clean claim." This definition resulted from numerous requests from providers to establish a nationally acceptable definition that can serve as a standard to ensure prompt claims processing.

A clean claim has been defined as: "Absent a written definition that is agreed upon through contract, participation agreement, law, or regulation, the NUBC recommends that a clean institutional claim is a properly completed billing instrument [paper and electronic] that consists of the UB-92 data set, or its successor, submitted on the designated paper or electronic formats as adopted by the NUBC with entries stated as

mandatory by the NUBC, along with any state-designated data requirements determined and approved by the state uniform billing committee and included in the UB-92 manual effective at the time of service. It does not involve coordination of benefits (COB) for third-party liability or subrogation as evidenced by the information provided on the claim related to COB." ■

These organizations are paying for fraud

The University of Chicago Hospitals and its faculty physician group will be paying $10.9 million to settle Medicare and Medicaid fraud charges that have resulted from an ongoing federal probe into how teaching hospitals and their faculty practice physicians go about billing government insurance programs. Meanwhile, the 392-bed Medical Center at Princeton, NJ, recently agreed to a $2 million fine resulting from Medicare fraud charges related to its outpatient billing from 1992 to 1997. The hospital has stood by its defense that it mistakenly billed some outpatient services as inpatient services as the result of a misunderstanding of billing regulations.

A $4 million fine has been assessed on the American Health Foundation, which was also ordered to pay back the federal government $4.2 million in overdrawn grants, stemming from charges of research grant fraud. Allegedly, the foundation, a not-for-profit organization, which carries out research on cancer and other chronic diseases, spent overdrawn Health and Human Services research grants to pay for private projects and ventures. ▼

DeKalb Regional seeks OK to move headquarters

The DeKalb Regional Healthcare System (DRHS), a Georgia home health care agency originally set up to serve patients in Fulton, Gwinnett, and DeKalb counties, has applied for state approval to move its headquarters from Fulton to DeKalb. The agency, which was purchased two years ago by Decatur Hospital, now receives the majority of its patient referrals from DeKalb County. Accordingly, the agency has petitioned the state to move its headquarters to 6425 Powers Ferry Road in DeKalb County. The move would cost the DRHS nothing and all three counties will continue to be served. ▼

What's the latest in mergers, changes?

Methodist Healthcare in Memphis, TN, plans to give 80-bed Methodist Healthcare Middle (Lexington) Mississippi Hospital, to the University of Mississippi Medical Center (UMMC) in a deal expected to be completed in April. The transfer of the hospital's assets and property, valued at about $5 million, will subsidize operations for the next three years. UMMC intends to merge the hospital with a nursing home and a 29-bed hospital in Durant, MS, to form a countywide health care system.

Province Healthcare Co. in Brentwood, TN, has acquired 45-bed City of Ennis (TX) Hospital through a $3 million, 30-year lease agreement. The hospital's previous owner, Baylor Health Care System in Dallas, eliminated inpatient services at the facility in January. Province plans to restore full services by April 1.

On Feb. 29, Primary Health Systems (PHS) in Wayne, PA, closed 344-bed Mount Sinai Medical Center-University Circle, one of its four acute-care

COMING IN FUTURE MONTHS

- How PPS harms beneficiaries
- Taking another look at hospice care
- Making private duty work
- BBA's impact on hospitals, patients
- Fall prevention protocols

hospitals in the Cleveland-area market. The daily census at the facility had dropped to 70 patients, leading to the decision to close, said Primary Health, which just last year filed for Chapter 11 bankruptcy protection. PHS has not decided what to do with the facility, but will continue to operate the 98-bed Mount Sinai Medical Center East in Richmond Heights, OH. ▼

Organization celebrates 15 years by closing shop

Just as it celebrates its 15th year of operations, the Arizona Healthcare Federation has announced that it is closing its doors. Plans call for closing the organization on May 31.

When it opened, the company provided an alliance for 10 independent Arizona hospital systems, but with the rise in mergers and consolidations only five systems remain as members. They are:

- Phoenix Memorial Hospital;
- University Medical Center;
- Yuma Regional Medical Center;
- Casa Grande Regional Medical Center;
- Catholic Healthcare West's (CHW) St. Joseph's Hospital and Medical Center in Phoenix, and Chandler Regional Hospital.

Baptist Hospitals and Health Systems Inc. had been part of the federation for years but dropped out after of selling its hospitals and nursing homes.

A few of the federation's services — joint contracting and purchasing programs — will be taken over by CHW's Shared Business Services. Among the programs the federation implemented was a $235 million pooled capital trust tax-exempt financing vehicle, which gave members access to funds for capital equipment and building projects. Most recently, the federation was awarded a grant from the Flinn Foundation to conduct a program in Yuma County for uninsured children. ▼

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New name for National Hospice Organization

Effective February, the National Hospice Organization in Alexandria, VA, has a new name — the National Hospice and Palliative Care Organization.

The new name is intended to reflect the group's evolution in end-of-life care and is designed to foster recognition of the role hospices provide in extending such care. The new name, according to the organization, "reflects the success that hospice programs have already achieved in caring for individuals who have advanced illness."

Palliative care, as defined in 1990 by the World Health Organization, addresses not only physical pain, but emotional, social, and spiritual pain to achieve "the best quality of life for patients and their families." Hospice care is provided to more than 500,000 Americans annually, either in the patients' homes or in a home-like setting.

The organization, founded in 1978, represents nearly 2,500 hospice care programs and thousands of hospice professional in the United States, making it the largest nonprofit membership organization for hospices and palliative care.

For more information on the organization and the services and educational programs it offers, visit the group's Web site at www.nhpco.org. ▼

AHA comments on Clinton budget

The American Hospital Association (AHA) in Chicago has released a statement on its concerns about the Clinton administration's budget plan, which calls for even further Medicare funding cuts for hospitals that care for seniors and their families.

In the proposed budget, Medicare cuts would be used to entirely fund a program designed to give seniors access to affordable prescription medication. While the AHA is in favor of the program, it believes that surplus funds, not Medicare cuts, should be used to fund the program.

Additionally, the AHA says that:

• It agrees with the president's plan to devote a substantial portion of the surplus to shore up Medicare.

• It supports the president's commitment to expanding access and coverage to uninsured Americans.

• It commends the administration's commitment to reducing medical errors and the careful study of this issue. ■

CE objectives

After reading this issue of *Hospital Home Health*, you should be able to:

1. Demonstrate a basic understanding of Transmittal A-99-52 and how it affects home health agencies.
2. Distinguish what is covered under a billing E&O insurance policy.
3. List the criteria of a good billing software program.
4. Specify a list of good billing practices. ■