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**REGISTER NOW!**

OHFMA’s Spring Program for this year will be at the Renaissance Hotel Oklahoma City, Oklahoma

April 2 and 3, 2003

Registration forms and agenda are available. Contact Lloyd Haggard if you need a copy  
 Room reservations may be made by calling (405) 228-8000

*You will not want to miss it!*



**INVOLVEMENT**

**YOUR PRESIDENT WANTS YOU!**

By Ann Paul, President



In the last newsletter, I told you about the key initiatives that are underway for the Oklahoma Chapter of HFMA, and I told you that my personal goal as chapter president this year is to engage your involvement in HFMA. Our first Oklahoma Chapter Leadership Training Conference (OK LTC) was a great success with more member participation than expected. The attendees of this meeting rated their satisfaction with this program as very high. Our next OK LTC will be held March 7<sup>th</sup> – *look for more information in this newsletter.*

- ☐ Your idea of how we can improve the Oklahoma chapter
- ☐ A topic idea you would like to see included in a chapter educational program
- ☐ A topic for which you would be willing to draft an article for our next newsletter
- ☐ Your interest in participating in our next OK LTC

I am looking to *every* Oklahoma Chapter HFMA member to respond! In this way, you can take credit for “Creating the future...” of our chapter – helping us to successfully reach and meet your needs and the needs of your fellow associates in the health care finance industry.

*For 2003, I wish you the most outstanding year you have ever experienced!*

Satisfaction with our October 2002 and January 2003 educational programs was high as well, with very focused topics included in the agenda. Our January program in Tulsa was designed to have something for everyone and the keynote speaker, David Goldsmith, was a real asset to our agenda.

I have one more action I would like to request of you to get your involvement in our chapter. E-mail me (or drop me a note) with one or more of the following:

**Please contact National HFMA with address, employer, or other membership changes at:  
 1-800-252-HFMA, ext. 350**



## OHFMA Leadership 2002-2003

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### HFMA & THE INFORMATION AGE

Are you currently receiving "HFMA Wants You to Know," a weekly email for HFMA members? If not, and you would like to receive a free subscription, send an email to [memberservices@hfma.org](mailto:memberservices@hfma.org).

The Oklahoma Chapter has implemented email distribution of the chapter newsletter and other updates. We will continue to mail newsletters to those members for which we have no email address. If you do not receive the email version and would like us to have your email address on file, please email Lloyd Haggard at [lhaggard@bkd.com](mailto:lhaggard@bkd.com).

If you need to change your member demographic information, including your email address, contact [memberservices@hfma.org](mailto:memberservices@hfma.org).

### WE WANT YOUR FEEDBACK!

Do you have ideas on topics for upcoming educational programs? Are there ways we can serve you better either through networking opportunities or educational initiatives? Other comments or suggestions?

Call or e-mail:

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### EDITORIAL POLICY

The statements and opinions appearing in articles are those of the author and do not necessarily reflect the view of the Oklahoma Chapter, the Healthcare Financial Management Association, or the editor. The editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondences are assumed to be released for publication unless otherwise indicated.

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# The Twelve Missing Links in Revenue Cycle Management

No new Band-Aid is likely to fix your receivables problem. More than likely it will be a contribution of strategies – all orchestrated by the receivables manager to overcome the “sins of omission” that contribute to high days and bad debt.

Here are the sins of omissions and how to correct them.

## **Sin #1 – Loose control prior to service**

**What to do:** Develop a well-organized system and train personnel to obtain information prior to medical service given in order to negotiate potential problems, make good decisions and obtain all necessary information needed for billing and collection follow-up. Have admission program under accounts receivable manager. *“Do it right, up front.”*

## **Sin #2 – Sloppy controls of patient discharge**

**What to do:** Set up a tight discharge control system to gather and control necessary data, improve collections, and firm up all arrangements. Train cashiers to collect more at discharge. Maintain cashier productivity reports.

## **Sin #3 – Letting small balance accounts eat you alive**

**What to do:** Neutralize outpatient and emergency room accounts by developing a specific collection system and strategy that isolates their type of high volume, low dollar accounts, allowing you to concentrate on the larger balance accounts. Design collection notices and billing cycles that will work on smaller balances.

## **Sin #4 – Lousy one-on-one collection skills**

**What to do:** Improve one-on-one collections with debtor and third-party insurance accounts. Train and motivate employees.

## **Sin #5 – Little time and effort spent on collecting insurance**

**What to do:** Concentrate your forces on collection from insurance – the factor that will make the most contribution to lowering days revenue outstanding and improve cash flow. Build up your knowledge of insurance companies as it relates to payment of your bills. Maintain various billing reports. Tolerate integral billing backlogs or extended delay from third-party payers.

## **Sin #6 – Carry self-pay accounts on installment**

**What to do:** Try to avoid carrying your self-pay accounts on an installment basis. Use credit cards, bank notes, and payment in full policy. The more you have to follow-up on installment accounts, the less time you have to spend on other more profitable accounts.

## **Sin #7 – Using collection letters that don't work**

**What to do:** Gain a good understanding of how to design collection letters that will pay off. Keep them to a minimum. Use them in special spots.

## **Sin #8 – A computer system that doesn't collect**

**What to do:** Get the most mileage from your computer in terms of accurate reporting, creative exception reporting for good decision-making and in productive collection notices. Pay close attention to cycles and color coding of your notices as well as use of automated collection system.

## **Sin #9 – Don't take time to analyze**

**What to do:** Perform the kind of analysis of your collection system receivables that will tell you what has to be done for cash flow improvement.

## **Sin #10 – Forget good public relations**

**What to do:** Maintain favorable public relations through employee awareness, training and constant procedure/policy review.

## **Sin #11 – Forget good public relations**

**What to do:** Use individual and team goal-setting to provide direction, thrust and motivation. Set up brainstorming meetings, encourage employee involvement and provide report feedback to staff. Restructure jobs so they are more self-motivating.

## **Sin #12 – Don't make your collection agencies pay-off dividends**

**What to do:** Get the most from your collection agency by proper choice, evaluation, monitoring and auditing. Consider the most effective use of agencies in conjunction with your collection system.

This article is reprinted from the February 2003 *Revenue Cycle Manager* newsletter published by Zimmerman & Associates, a leader in health care revenue cycle management. If you would like further information, call 800-525-0133 or [newsletters@zimm-assoc.com](mailto:newsletters@zimm-assoc.com).

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## Checking in With Past Presidents

Rebecca Speight, CHFP, CPA



Before the annual chapter meeting in Oklahoma City last April, the chapter undertook the task of finding and inviting all of our past presidents to attend a special honorary luncheon at that meeting. It was a great experience, meeting and visiting with many of the past leaders of our organization and to see and hear about the impact that HFMA has had on their careers.

In the March 2002 newsletter, we visited with Tom Giaudrone, Rick Wagner, Fred Mills, and Kevin Gore about their HFMA experience. This month we will be highlighting our conversations with two additional past presidents – John Meharg and Jerry Gardner. John (JM) is currently the Director of Information Technology Services at Norman Regional Hospital and served as chapter president in 1990-1991. He is also certified as a Fellow in HFMA. Jerry Gardner (JG) is the Vice President for Audit Services for INTEGRIS Health and has served as a chapter president twice – in 1985 in Texas and for 2001-2002 in Oklahoma

### How long have you been an HFMA member?

*JM:* Longer than I would like to admit but over 25 years. *JG:* 25+years.

### Were there people that mentored you in HFMA/in your career?

*JM:* I first began my career in health care at Valley View Hospital. Jim Powers, a very longtime member and past president of HFMA was my boss and talked to me about joining HFMA and challenged me to become certified. I was also fortunate to have very good leadership ahead of me within the HFMA officer structure. Errol Mitchell, Steve Dorsett, and others helped me when I first became an officer, and gave me great insight as to what I should do – and of course what I should not do. *JG:* From the NY Metro chapter, Joe Levy with Catholic Medical Center.

### Any favorite memories from years past?

*JM:* There are many fond memories of HFMA, many of which cannot be related here, but all revolve around great friendships made and great times shared. When all of the “old, old” presidents got together last April in Oklahoma City, it

was a great time, sharing those old stories. *Some seem to have gotten wilder with age!* *JG:* Mentoring new members about HFMA and networking opportunities.

### What value does OHFMA bring to your current position?

*JM:* I am still involved in health care financing, as I am over HIM and Cash Management, so HFMA is still of great value to me. I do not attend as many meetings as I would like, but I still read the monthly journal and subscribe to some of the e-mail notices. *JG:* Networking and keeping current with regulations and rules.

### What can OHFMA do to enhance that value?

*JG:* Better programs for CFOs, CAEs, etc. More support for local programs and live videoconferences.

### Where do you see health care in ten years?

*JM:* CHANGING, CHANGING, CHANGING!! *JG:* Highly regulated, automated, and provider-limited choices because of need, want, and cost. ■

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## Certification Update

Rebecca Speight, CHFP, CPA

Who or what is a CHFP? Why would anyone want to become a FHFMA? These are questions that the certified members of the Oklahoma chapter would be happy to answer for you.

Certified Healthcare Financial Professional (CHFP) is the first level of certification within our organization. To become a CHFP, you must have been a member for at least two years and passed both a core examination and one specialty exam in accounting and finance, managed care, patient financial services or financial management of physician practices. A Fellow of the Healthcare Financial Management Association (FHFMA) requires an individual to be a CHFP, have at least five years of membership and the accumulation of career development and Founders Award points.

The chapter is pleased to recognize the following individuals for completing the testing necessary to become certified members of HFMA.

Karen Hendren, CFO  
*Stillwater Medical Center*

Bryan Bodnar, Supervisor  
*BKD, LLP*

In addition, Kevin Gore, a partner with *BKD, LLP*, completed the application and testing to become a FHFMA in August 2002.

The certification exams will be updated and new study materials will be in use beginning January 2003. Because of the Board's continued commitment to certification, the chapter has purchased a complete set of the study materials that can be loaned to members. If anyone is interested in reviewing the materials or taking the exam, please contact Art Mires, Certification Committee Chair, or Rebecca Speight, Treasurer, to make arrangements to receive the books. ■

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## Welcome to our Newest Members!

The Oklahoma chapter has had 42 new members join since the beginning of our fiscal year. Be sure to stop and say hello at the April meeting to those folks.

- Michelle Burkett  
*BKD, LLP*
- Gene Heinrich  
*Woodland Outsourcing*
- Stephen Melone  
*INTEGRIS Marshall Memorial Hospital*
- Tina Green  
*Saint Francis Health System*
- Scott Pilgram  
*Pushmataha County Hospital*
- Thom Biby  
*Okmulgee Memorial Hospital*
- Steven Holder  
*DHHS Indian Health Services/W.W. Hastings*
- Shirley Reynolds  
*Renaissance Women's Center Edmond*
- Matt Mooney  
*MEDITECH*
- Greg Butler  
*Scholarship Recipient – Student Member*
- Malinda Kingfield  
*Scholarship Recipient – Student Member*
- Cheryl Patterson  
*Cushing Regional Hospital*
- Sandra Davis  
*Bristow Memorial Hospital*
- Linda Hocker  
*Oklahoma University Medical Center*
- Cathy Sheffert  
*Stillwater Medical Center*
- Deborah Miller  
*Works & Lentz, Inc.*
- Shelly Dunham  
*Okeene Municipal Hospital*
- Christine Mullen  
*Tulsa Regional Medical Center*
- Mark Funck  
*Madole Wagner, PLLC*
- Michael Carter  
*Mercy Health Center*
- Eric Cantrell  
*AIM Healthcare Services, Inc.*
- Trish Emig  
*Stillwater Medical Center*
- Richard Dericks  
*Dericks Leasing & Financial Co.*
- Jayne Charles  
*Tulsa Regional Medical Center*
- Bob Golden  
*CAC Financial Group*
- Djogan Djogan  
*Oklahoma University Health Sciences Center*
- David Blair  
*First Consulting Group*
- Sara Brown  
*BKD, LLP*
- Susan Horst
- Joyce Davis
- Cheryl Pierce  
*Carolinas HealthCare System*
- Nicholas Crafts
- Milena Davis  
*Perry Memorial Hospital*
- Joby Brown  
*Transworld Systems, Inc.*
- Angela Morningstar  
*Saint Francis Health System*
- Carey Deal  
*BKD, LLP*
- Gina Simmons  
*Hillcrest Healthcare System*
- Regina Lodes  
*Saint Francis Health System*
- Jason Bray  
*INTEGRIS Health Care*
- Jami Allington  
*INTEGRIS Grove General Hospital*
- Strawn Steele  
*INTEGRIS Bass Baptist*
- Alan Shane Wells  
*Medical Center of Southeastern Oklahoma*

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## Financial Limitation on Outpatient Rehabilitation Services

*By Stoney Oxford*

On February 7, 2003, CMS issued Program Memorandum (PM) AB-03-018. The subject of the PM is the implementation of the financial limitation for outpatient rehabilitation services.

### History

The Balanced Budget Act of 1997 (BBA) required payment under a prospective payment system for outpatient rehabilitation services which include:

- Physical therapy (PT)
- Outpatient speech-language pathology (SLP)
- Occupational therapy (OT)

BBA required the application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital) of an annual per beneficiary limit of \$1,500 for all outpatient PR services, including SLP services, and a separate \$1,500 limit on all OT services. The \$1,500 limit is based on incurred expenses and includes applicable deductible (\$100) and coinsurance (20 percent). The annual limitation does not apply to services furnished directly or under arrangement by a hospital to an outpatient, or an inpatient who is covered by Part B only.

The limitation is based on the services the Medicare beneficiary receives, not the type of practitioner who provides the services. Therefore, physical therapists, speech-language pathologists, occupational therapists as well as physicians and nonphysician practitioners could render a therapy service.

### Moratorium

The Balanced Budget Refinement Act of 1999 and SCHIP Benefits Improvement and Protection Act of 2000 placed what amounted to a three-year moratorium on the application of the financial limitation for claims for therapy services with dates of service January 1, 2000 through December 31, 2002. This moratorium has been revoked for claims with dates of service on and after July 1, 2003.

### Application of Financial Limitation

For claims submitted with dates of service on and after July 1, 2003, the financial limitation will be applied by both the fiscal intermediary and carrier for OT, PT, and SLP services December 31, 2003. For subsequent calendar years, the financial limitations will be effective for the entire calendar year. For calendar year 2003, the financial limitation will be \$1,590 (the original \$1,500 indexed by the Medicare Economic Index [MEI]).

There are two separate \$1,590 limitations: one for PT (including SLP) services and the other for OT services. This financial limitation is an annual per beneficiary limitation. The \$1,590 limitation is on the allowed incurred expenses, which are defined as the Medicare Physician Fee Schedule (MPFS) amount prior to any application of deductible and co-insurance. If the beneficiary has already satisfied the Medicare Part B deductible, the maximum amount payable by the Medicare program is \$1,272 for PT including SLP; that is 80 percent of the \$1,590 for PT, including SLP, and \$1,272 for OT services.

For skilled nursing facilities (SNFs), this limitation will apply to outpatient rehabilitation services furnished to SNF residents not in a covered Part A stay. The limitation also applies to SNF nonresidents (outpatients) receiving these services at the SNF regardless of whether the services are furnished by the SNF itself or by an outside therapist.

Once the limitation is reached, the beneficiary should be informed that any additional outpatient rehabilitation services would result in the beneficiary exceeding the financial limitation. This is necessary because the beneficiary is responsible for payment of all outpatient rehabilitation services that exceeded the financial limitation on an annual basis. ■

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## HFMA Express News



One of the many benefits of HFMA membership is the ongoing update of regulations and information that is available, both on the web site and in e-mail updates. *HFMA Express News* is a weekly update of critical financial regulatory issues that includes links to the applicable web sites, including regulations. To sign up for the update or review archives of previously issued updates, go to [www.hfma.org/publications/expressnews](http://www.hfma.org/publications/expressnews).

A few of the items included in the February 7, 2003, issue of *HFMA Express News* include the following:

### **Scully Says Outlier Rule Coming Soon**

A rule changing Medicare's outlier policy is nearing release, CMS administrator Tom Scully announced during the CMS Hospital Open Door Forum February 4<sup>th</sup>. The interim final rule, which could be out within the week, is expected to take effect immediately. Asked about a transition period for hospitals affected, Scully said there would be none. The outlier threshold, he stated, will drop from \$33,000 to around \$22,000, which should allow outlier payments to many hospitals that haven't received those payments previously.

Scully also noted that statewide averages will no longer be used to calculate outlier payments. Hospitals with cost-to-charge ratios (CCR) lower than the statewide average have

been permitted to use that statewide CCR ratio to achieve greater reimbursement than if they used their actual CCR.

For more information on the CMS Open Door Forums, go to <http://www.cms.gov.opendoor/>.

### **Rehab Facilities to Face Strict Criteria in FY04**

Starting October 1, 2003, rehabilitation hospitals will have to meet the "75/25 requirement" or get paid under the acute care hospitals' DRG prospective payment system, CMS administrator Tom Scully announced February 4<sup>th</sup>. The 75/25 requirement says that at least 75 percent of a rehabilitation hospital's inpatient population must require intensive rehabilitation services for one or more of ten conditions specified in regulations over the course of the most recent 12-month cost reporting period.

CMS suspended enforcement of the policy due to inconsistencies in how the intermediaries were handling enforcement, Scully indicated. The inconsistency is being addressed, and there will be aggressive enforcement of the 75/25 criteria with the start of the 2004 federal fiscal year.

For HFMA's list of inpatient rehabilitation PPS links, go to [http://www.hfma.org/resource/focus\\_areas/medicare/authoritative\\_sources/inrehabpps.htm](http://www.hfma.org/resource/focus_areas/medicare/authoritative_sources/inrehabpps.htm). ■

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### **Intermediaries Now Required to Code LMRP Denials**

Fiscal intermediaries are being required by the Centers for Medicare and Medicaid Services (CMS) to give the same notice to hospitals as they do to Medicare beneficiaries when they deny a claim based on a local medical review policy (LMRP).

In a program memorandum (AB-02-184, issued January 3), CMS instructed FIs to begin giving such notice to hospitals starting April 1. "Providers must know why their claims are denied so they can decide whether to appeal those claims denials, and so they will know how to avoid such denials in the future," CMS says.

To that end, CMS created a new remittance advice remark code to be used in conjunction with existing messages. Remark code N115 reads: "This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at [www.lmrp.net](http://www.lmrp.net) or if you do not have web access, you may contact the contractor to request a copy of the LMRP."

Beginning April 1, all new established LMRP edits must contain the new remark code in addition to current applicable messages. By October 1, every LMRP edit must contain the remark code. ■

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### **CMS Revises Payment Suspensions Policy for Unfiled Cost Reports**

The Centers for Medicare and Medicaid Services (CMS) has revised its regulations concerning payment suspensions for unfiled cost reports. CMS issued a program memorandum describing the changes, which are effective for cost reports due on or after January 1.

The revision allows payment suspension to be made in whole or in part rather than only in whole, as has been policy until now. CMS says that because a smaller fraction of payments are made based on the cost report, the change will allow flexibility in determining the amount of the payment suspended.

The PM identifies the following percentages to be used when suspending a provider's payments for failure to file a timely cost report:

- |                           |      |
|---------------------------|------|
| • Up to 60 days late:     | 20%  |
| • 61 – 120 days late      | 50%  |
| • More than 120 days late | 100% |

The memorandum, A-02-128, is available at [www.cms.hhs.gov/manuals/memos/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/memos/comm_date_dsc.asp).

