


The Chili Pepper Express Newsletter

October 31, 2010

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 Dean & Terry Newton

President's Corner



Brenda Cox
 Chapter President
 2010-2011

When scanning healthcare headlines, ideas often repeated are "change", "improvement" and "value." I am becoming more familiar with how these words are affecting me as a participant in the healthcare community through work and personal exchanges.

These words are also important for our South Texas HFMA Chapter. At the end of October and the beginning of November, the national HFMA office will randomly survey chapter members via email to determine how our chapter is serving your needs and what we can do to "improve" and bring higher "value" to your membership. Survey results are available to all chapter members and are used by each board committee to help design and develop future programs and activities for our chapter.

Survey responses from FY '10 and program evaluations were used to plan this year's meetings and activities:

- In the 2010 survey over 70% of chapter members identified healthcare payment reform and changes in Medicare/Medicaid reimbursement as the top two topics of interest. In response we featured speakers on these topics at the following chapter meetings:
 - May 2010 – annual SPI meeting addressed both topics
 - August 2010 – joint meeting with ACHE and Chapter Road shows addressed healthcare payment reform
 - September 2010 – regulatory updates on changes in the state Medicaid program and Medicare Advantage plans
- The 2010 survey showed that members were concerned about the overall cost and length of the programs.
 - Event length**
 - We have introduced our Road Show concept (thank you Tammie Jackson) to help bring more educational opportunities to local areas. These 4 hour programs are built around daily operations and kept at a low cost.
 - We reduced our Fall Meeting format from 1½ day to 1 full day, thus eliminating the necessity for overnight travel.
 - Event cost**
 - Our sponsorship committee, under the direction of Glen Boles and Cipri-



ana Zamora, has worked hard to grow and maintain our chapter sponsorship contacts.

- These sponsorships help offset the program costs and allow us to keep our meeting registration fees low. Our chapter offers educational hours for around \$15/hour, which is much less than other forms of education.
 - Our chapter also maintains our license through the Texas State Board of Public Accountancy in qualifies our educational credit hours for licensed CPAs.
- Our members' survey responses indicated an interest in **broadening our topics** and looking beyond traditional finance areas.
 - We have developed collaborative relationships with ACHE to address common areas of professional interest across the healthcare industry.
 - We continue to participate in our statewide meeting to foster collaboration between the 3 TX chapters as well as participating in our Region 9 meeting for collaboration with 6 other HFMA chapters.
 - We have broadened our educational offerings to include physician and clinical collaboration issues.

If you receive a survey email from National HFMA, please participate so that we know how we are best serving you. If you are not, please complete an evaluation form the next time you attend one of our meetings. In addition, chapter board members and officers can be contacted directly; contact information is listed on our chapter website at www.stxhfma.org/leaders.

We are here to make your South Texas chapter an essential part of your successful career. It is an honor to serve you,
 Brenda Cox, FHFMA
 South Texas President

Meeting Calendar

Mark your calendars **NOW** so you won't forget to attend STX HFMA's meetings during the upcoming year. Our scheduled meetings are:

Date	Meeting	Location
November 14-16, 2010	HFMA Region 9 Annual Conference	New Orleans, LA
December 1-2, 2010	Virtual Healthcare Conference	Online
January 28, 2011	Healthcare Landscapes 2011	San Antonio, TX
February 2011	Education Roadshows	Final Dates and Locations TBD
May 26-27, 2011	South Texas Chapter Annual Institute	South Padre Island, TX
June 26-29, 2011	2011 Annual National Institute	Orlando, FL

ANI: The Healthcare Finance Conference

Save the Date:

The 2011 ANI: The Healthcare Finance Conference will be held at the Gaylord Palms Resort and Convention Center, Orlando Florida from June 26-29, 2011.



Chapter Involvement Opportunities: The South Texas Chapter Needs YOU!!

Attention members. Your Chapter desperately needs committed members to serve on key committees:

- **Sponsorship Committee**
recruits sponsors and coordinates sponsorship activities
- **Certification Committee**
teaches certification courses and proctors exams
- **Program Committee**
develops agendas and recruits speakers for the Chapter's meetings
- **Newsletter Committee**
drafts articles for the quarterly "Chili Pepper Express" newsletter
- **Membership Committee**
recruits new members and manages social events for the membership

This is a great way to get involved, learn about the inner workings of the South Texas Chapter, make new friends, and position yourself to move up to a senior leadership position. Please contact any of the Chapter's Officers or Committee Chairs for more information. PLEASE VOLUNTEER TODAY!!!

Healthcare Landscapes 2011

January 28, 2011 San Antonio, Texas

Healthcare Landscape 2011

The South Texas chapter of HFMA is proud to be a sponsor of this extremely popular annual conference. The event is again being held at the beautiful Oak Hills Country Club and features a packed lineup including a presentation by Debra Kuchka-Craig, the National President of HFMA. The Keynote speaker is Leah F. Binder, the CEO of the Leapfrog Group. Please register early as this conference sells out annually and space is limited!



HFMA National Chair Debra Kuchka-Craig will elaborate on her theme of **Step Up!** Debra Kuchka-Craig serves as the Corporate Vice-President for Managed Care with Medstar Health in Maryland. She has been a member of the **HFMA Board of Directors** since 2005 and formerly served on the **Managed Care Advisory Council**, the **Board of Examiners**, the **National Advisory Council**, the **Strategic Planning Committee**, and the **Audit and Finance Committee**. She has received the **Follmer Bronze**, **Reeves Silver**, **Muncie Gold**, and **Medal of Honor** merit awards for service.



Keynote Speaker Leah F. Binder, will present: **A new formula for success: How hospitals and employers must work together to achieve results in an era of health reform.** Leah Binder is currently the CEO of the Leapfrog Group and has formerly served as a Vice-President with the Franklin Community Health Network in Maine and as the Senior Policy Advisor on Healthcare with the Office of Mayor Rudolph Giuliani in New York. She is currently a member of the **Critical Care Roundtable**, the **Institute for Interactive Patient Care**, and the **NQF Steering Committee on Serious Reportable Events** and is widely published in the areas of health-care quality and efficiency.

Sponsored by:

Healthcare Financial Management Association

American College of Healthcare Executives

Greater San Antonio Healthcare Foundation

Topics Include:

Step Up

Deborah Kuchka-Craig - National Chair, HFMA

Keynote: Quality and Cost Efficiency

Leah F. Binder - The Leapfrog Group

Hospital/Physician Relations

Jerry Bell - Fulbright & Jaworski

Breakout Sessions for Students - ACHE Category II Panel

Career Positioning: Proactively Managing Your Professional Development

Karen A. Stiefel - Baptist School of Health Professions

Mary L. Maher - UT Health Science Center San Antonio

Debbie Cox - Central Texas Medical Center

AHA/THA Update

Megan Cundari - American Hospital Association

Dan Stultz - Texas Hospital Association

Medicare Update

James M. Georgoulakis - Webster University

Hospital Management

Stanley F. Hupfield - INTEGRIS Family of Foundations

Physician Integration Approaches

Door Prize Drawings

Reception on the Patio

Sponsored by Fulbright & Jaworski

Continuing Education Credit

Program attendees will be eligible to receive 6.0 ACHE Category II hours, 1.5 Category I hours, and 8.5 CPE credits approved by TSBPA through South Texas Chapter HFMA, sponsor #009106. All sessions are Group Live, and there are no prerequisites.



Welcome New Members!

The South Texas Chapter HFMA welcomes the following new members since 7/1/10

Robert Trussell
Foundation Surgical Hospital

Lori Anderson
Select-Plus Network

Misty Burns
Director of Patient Accounting
Christus Spohn Health System

Donny Anderson
Select-Plus Network

David Abramson
UT Health Science Center

Amber Roberson
GE Healthcare

Neil B Alexander
The Innova Group

Patricia G Benbow
Yoakum Community Hospital

David Perez
St. David's North Austin Medical Center

Kristye Langford
South Austin Hospital

David M Waterson, III
Intermedix

Leslie Simmons
Memorial Medical Center

Elizabeth Warriner
Seton Shoal Creek Hospital

Sunil Reddy
Care Regional Medical Center

Christopher Davis
PricewaterhouseCoopers LLP

Mac Franklin, Jr.
Valley Baptist Medical Center

Dale Hershfield

Juan C. Bautista
Kaplan

Sherri Williams
San Marcos Treatment Center

Stefan Werdegarr
Siemens Healthcare

Jonathan K Leer



Welcome Transfers!

I wasn't born in (South) Texas, but I got here as fast as I could!

Christopher Taylor
NextCare Urgent Care
Transferred from Chapter 69-Texas
Gulf Coast

Matthew D. Cannon
Cornerstone Healthcare Group
Transferred from Chapter 53-Lone
Star

Jason W. Anglin
Memorial Medical Center
Transferred from Chapter 53-Lone
Star

What's Hiding in Your Vendor Inventories?

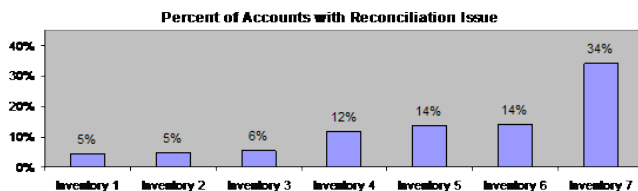
By Steven Levin

Today, most hospital business offices rely on third party vendors, such as collection agencies, extended business office partners and eligibility firms, to augment their internal collection efforts. Every day, accounts and financial updates flow back and forth between a hospital and its vendors. Despite everyone's best intentions, the current operating routines and processes often result in inconsistencies between the inventory records of a hospital and its vendors.

Always thought to be a relatively minor issue, recent research suggests the inventory reconciliation problem is significant, pervasive and critical. Reconciliation issues between providers and their vendors can lead simply to lost cash and high operating costs or go so far as to create regulatory issues and major public relations problems.

The Magnitude of Inventory Reconciliation Issues Can Be Significant

Based on findings from inventory reconciliation initiatives at multiple providers around the United States, between 5% and 34% of inventory held at vendors had reconciliation issues with the providers' records.

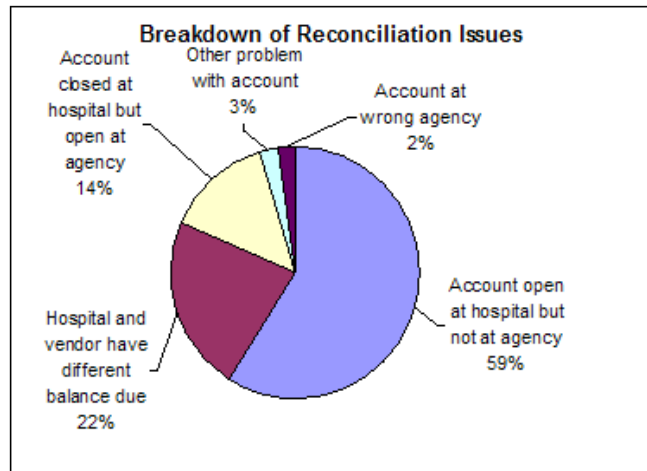


Source: Connance Benchmark Research

The average reconciliation error rate across this sample of providers was 13%. However, even in situations

where the provider had only a single vendor, the reconciliation error rate was high.

Reconciliation issues broke down into five categories:



Source: Connance Benchmark Research

Vendors also appear to demonstrate different performance on account and inventory reconciliation activities. As the research indicated, some vendors seemed to systematically operate at lower than 90% accuracy while others were close to 98% accurate.

How do Inventory Reconciliation Problems Happen?

For each account, countless financial events such as payments, adjustments, reversals, etc. occur every day both in the hospital business office and in vendor operations. All these events need to be dutifully credited, debited and noted in both provider and vendor inventory records in exactly the same way.

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Vendor Inventories

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For instance, an event as simple as a patient going to the hospital to pay a past-due bill previously sent to a collection agency creates a string of follow-on events in the hospital's patient accounting system that need to be connected to and mirrored in the collection agency's inventory records. That same check, subsequently failing to clear at the patient's bank, will lead to another series of reversal transactions that need to be mirrored yet again. If the reversal occurs in the next month, it means that all the unwinding activity will be part of a different monthly close effort. As these examples demonstrate, there are multiple opportunities for reconciliation issues to percolate in even the simplest, most common events.

By having the ability to access and benchmark thousands of account placements and recalls every day between providers and vendors around the United States, some trends have emerged. These include:

1. Accounts are closed in the patient accounting system, but not recalled from the vendor;
2. Accounts are closed by the vendor, but not updated as such in the patient accounting system;
3. Accounts on payment plan appear at the vendor, but are not documented as such in the provider's records;
4. Vendor is continuing collection efforts on accounts on hold for review at the provider; and,
5. 'Missing transactions' or transactions that are recorded in the patient accounting system, but are not sent to the vendor, and vice versa.

Over time, the small numbers of account problems compound and mature into the 5% to 34% inventory recon-

ciliation issues noted earlier.

Possible Negative Outcomes from Reconciliation Issues

Not only are the number of accounts involved significant, but these reconciliation problems lead directly to problematic outcomes. Some of the more concerning problems include:

Reconciliation Issue	Possible Ramification
Account open at hospital, but not at agency	<ul style="list-style-type: none"> ▪ No work is being done on the account so no money is being collected. ▪ Patient may incorrectly be told that their financial obligations are complete.
Hospital and vendor have different balance due	<ul style="list-style-type: none"> ▪ Vendor is either pursuing too much or too little money, both of which are problematic. Too much exposes the hospital to legal and public relations issues. Too little leaks cash. ▪ Unexplained changes to the balance due undermine patient confidence in the accuracy of the bill now and in the future. This breakdown delays patient payment as the patient is expecting the billed amount to change. ▪ Creates unproductive administrative costs at both the vendor and provider when the gap is identified and needs to be explained.
Account closed at hospital, but open at vendor	<ul style="list-style-type: none"> ▪ Vendor is requesting payment on an account that has been resolved or otherwise closed. ▪ In the event that the account has been written off to charity or taken as bad debt on a cost report, significant legal and compliance issues are created. ▪ Patient goodwill and community relations put at risk. ▪ Vendor is incurring costs to collect.
Account at wrong vendor	<ul style="list-style-type: none"> ▪ Collection efforts may be inappropriate for the type of account. Different agencies are often contracted to operate under different policies, processes, and commission rates. ▪ Patient satisfaction risked by exposure to more aggressive collection tactics than warranted.
Account at two vendors	<ul style="list-style-type: none"> ▪ Patient is pursued by more than one vendor, creating

In almost every situation, reconciliation issues are elevating operating costs, distracting management attention and reducing cash recovery. It also creates the opportunity to undermine patient satisfaction, generate negative PR in the local community, and put the provider at risk with regulators, CMS and other oversight organizations.

What Can a Provider Do to Address Inventory Reconciliation Issues?

Many hospital business offices only perform spot checks

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Vendor Inventories

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or “rough reconciliations” due to the volume of activity, inaccessible account data and limitations with patient accounting system. Many hospitals also use time consuming, manually intensive account matching, thinking they can solve their reconciliation problems with human intervention. While better than doing nothing, they are insufficient.

The scale and scope of the previously mentioned research plus the trend to use more outsourcers in business office processes suggest providers and their vendors need to enhance key routines:

Check placement files for misplaced accounts and identify root causes of problems.

Despite their best efforts, hospitals do occasionally send a handful of accounts to a vendor that either should not have been sent to a vendor or were already sent to a vendor. When this happens, it is critical that the accounts are identified, inventory records are corrected, and the underlying reasons for the account being incorrectly placed are identified and corrected.

Reconcile balances for all accounts in placement and recall files. It is not sufficient to simply confirm receipt of the placement file and total number of accounts. Individual account balances need to be verified as well, preferably by cross checking account-level financial transactions.

Reconcile full inventory at each vendor, at least monthly. Given the compounding effect of problems over time, full reconciliation at least monthly is necessary. In many situations, weekly reconciliation of the entire inventory may be appropriate.

Update policies and procedures and monitor adherence. A number of inventory issues are created as a result of inadvertent customer service activity, such as incorrectly moving or closing an account or applying an incorrect transaction code. A good practice is to review policies and procedures at least once per year to check that they are up to date, cover all reasonable situations and are understood by employees in the business office and at vendors. The provider also needs to monitor adherence to these policies and procedures.

Ensure comprehensive and common reporting. Numerous hospitals unknowingly rely on incomplete information or reports generated using different variable definitions. Having accurate reports that are common across vendors to track inventory reconciliation is central to having clean, accurate account inventories.

Long term, cost effective approaches generally are technology enabled, automating the exception identification process.

Ultimately, whenever a provider corrects existing inventory reconciliation issues and prevents new ones from occurring, they are improving the patient experience, reducing operating costs and compliance risks, and enabling their vendors to be more effective. It is a true win-win-win experience.

About the Author

Steven Levin is CEO and co-founder of Connance, a leading provider of back-office, self-pay collection and scoring solutions. Contact him at slevin@connance.com or visit www.connance.com

In almost every situation, reconciliation issues are elevating operating costs, distracting management attention and reducing cash recovery.

Preparing for the Certification Exams: Study Guides

By Lenora Johnson

The South Texas Chapter is committed to helping our members achieve the Certified Healthcare Financial Professional (CHFP) status. Achieving this designation helps prepare you – the healthcare finance professional - for increasingly responsible positions in the healthcare industry. Additionally, the designation of CHFP demonstrates your dedication to professional development.

You can study and prepare for the exams through a variety of methods. One way is using the HFMA study guides as part of independent or group study. The South Texas Chapter has a complete study guide set available for Chapter mem-

bers to borrow which includes the Core as well as Specialty exam study guides of your choice, applicable for exam dates through 12/31/2010. The Chapter will loan you any of the study guides for a two (2) week period, depending upon availability. Please contact LeNora Johnson, Certification Chair, at durango500@sbcglobal.net for details.

Exam Information

Every candidate must pass the Core Exam which is general in nature and covers a broad array of financial topics pertinent to healthcare. These topics include accounting, finance, patient financial services, physician practice management and managed care. Every candidate must also pass one of the following specialty exams.

Accounting and Finance: Content consists of accounting and finance theory and application as it applies to the healthcare industry. Having a CPA designation is not directly related to passing this specialty exam. A candidate can expect to spend about 15 hours of study in preparation.

Patient Financial Services: Content consists of claims administration, patient access issues, collections processes, and other issues pertinent to the entire revenue cycle. The content focuses primarily on issues applicable to hospitals and health systems and requires about 12 hours of study in preparation for the exam.

Physician Practice Management: Content consists of issues pertinent to the physician practice, including ICD-9 and CPT -4 Coding, physician compensation methods, Relative Value Units, and credentialing. This exam requires about 12 hours of study for preparation.

Managed Care: Content consists of issues pertinent to managed care companies as well as to providers of care participating in managed care contracts. A candidate can expect to spend approximately 14 hours of study in preparation for this exam.

2010 Exam Dates & Proctor Information

Friday, November 12, 2010 at Noon
Monday, December 20, 2010 at Noon
LeNora Johnson - 210.394.1521
durango500@sbcglobal.net

Baptist Health System—School of Health Professions
8400 Data Point, San Antonio, TX 78229

Sample exam questions: www.hfma.org/certification/chfp/examcontent/SampleExamQuestions.htm

Purchase printed Study Guides at: <http://www.hfma.org/certification/chfp/selfstudy/>

Additional information is available at <http://www.stxhfma.org/pages/certification> and <http://www.hfma.org/certification/chfp/>

Additional exam dates are planned.
Check the website for updates!



South Texas HFMA was officially chartered on October, 27, 1970 with Henry Naizer serving as the very first chapter President.

Please join us at our annual meeting in South Padre Island on May 26-27th to celebrate forty years of serving our members!

Certification Changes

Effective January 2011

New for January 2011, the HFMA Board of Examiners has revised the certification program. A summary of the changes and a brief FAQ is shown below. For complete details see www.hfma.org/certification or email certification@hfma.org

Existing Certification Program	New Certification Program (effective January 2011)
Successful completion of two (2) certification examinations required: the Core and a Specialty (Accounting & Finance, Patient Financial Services, Managed Care, Physician Practice Management)	Successful completion of one (1) comprehensive certification examination is required
Candidates must be regular members of HFMA for a minimum of two (2) years.	Candidates must hold HFMA membership. No time duration prior to becoming certified is required.
Preparation materials are available as printed hard copy	Preparation materials will be available online

F

Q: At what career level is the certification program designed?

A: The intended audience for certification is mid-level healthcare finance professionals who aspire to the executive level and/or who desire confirmation of financial management expertise.

A

Q: Why are changes being made to the certification program?

A: HFMA desires to provide deep technical financial management education and career development opportunities. Certification is an integral service to achieving these goals.

HFMA conducted a comprehensive field study to review certification program features. The findings specified members desires for:

- Financial management education that is comprehensive, crossfunctional, integrated;
- Increased access and availability of preparation materials and examinations;
- Ease of use

Q

HFMA's Board of Examiners employed these findings as guiding principles in restructuring HFMA certification.

HFMA Region 9 Annual Conference

November 14-16, 2010 New Orleans, Louisiana



General Sessions

- Healthcare Reform Update
- Financial/Clinical Collaboration
- Executive Panel Discussion
- RAC: An Executive Overview
- Physician Integration: Aligning Interests, Coordinating Quality, and Lowering Costs
- Executive Perspective on EHR Challenges
- CIO Panel Discussion
- Fraud and Embezzlement: Lessons From the Trenches

Revenue Cycle Track

- Living With RAC: Audit Results / Best Practices
- Splitting the Reimbursement Pie: ACE Case Study and Incentive
- A For-Profit vs Non-Profit Conversation on Healthcare: How to Go From \$17 million to \$438 million in Three Years

Accounting/Finance Track

- Accounting Update

- Medicare Cost Reporting
- Reducing Clinical Costs
- Managing the Supply Chain to Cut Costs

Leadership Track

- Leadership in a Time of Change and Uncertainty
- Developing Your Staff to Achieve
- Leadership Persuasion Skills: Getting the Results You Want!
- Effective Written Business Communications
- Moving Up to CEO

Certification Training Track

- HFMA Core Certification Coaching Course
- HFMA Specialty Managed Care Course
- HFMA Specialty Accounting/Finance Course

PLUS Sunday Early-Bird Sessions

- Louisiana Medicaid Update
- Compliance Update

Ten ICD-10 Items to Review and Budget for in 2011 and Beyond!

By Veronica Hoy

It is budget season! Between the conversations of infrastructure builds, quality initiatives, civic responsibilities, ACO's, healthcare reform, and payment reductions, you may hear "5010" or "ICD-10" in the executive suites. While many know the compliance date is coming, most do not realize the percentage of their revenue that is needed to fund a comprehensive plan.

If you haven't already done so, now is the time for all covered entities to review their budget plans to ensure they have incorporated the essential elements for a successful International Classification of Diseases, Tenth Revision (ICD-10) plan. This HIPAA mandated code set update date is established and there is no indication that the date will change. On October 1, 2013 the U.S. healthcare system will transition from ICD-9 to ICD-10 for diagnosis (ICD-10-CM) and inpatient procedure coding (ICD-10-PCS) for all HIPAA transactions. Meeting this compliance date requires an enterprise transformation of systems, operations and financial processes. In this article, we present ten things for you to review or include in your 2011 budget review.

In building a budget for ICD-10 there are cross departmental issues and overlapping needs such as dual system processing and enterprise-wide testing requirements. An approach including a governing body with responsibility and ownership over such areas as technology, operations and finance is suggested. A comprehensive enterprise-wide plan is an essential efficiency item and ensures all necessary touch points are covered. When considering budgets, if you have not already done so, an enterprise-wide assessment, evaluation and plan development for ICD-10 is a must for 2011.

Technology

In an electronic environment, the beginning of the ICD-10 solution is a separate piece of health insurance reform legislation referred to as Version 5010 (5010), which defines the technical electronic transaction

standards mandated for HIPAA transactions. (5010 is oversimplified here but details can be found at <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>) 5010 compliance includes, among other things, incorporating changes required for transmission of claims and payment data in an ICD-10 format, and 5010 will have been a requirement for over 20 months, when ICD-10 is effective October 1, 2013.

One of the areas in your 2010 budget for the 5010 initiative should have been to achieve Level 1 testing which consisted of internal testing to verify a covered entity can send and receive compliant transactions. Level 2 testing is legislated to be completed in 2011. Level 2 testing consists of external testing with trading partners and operating in a dual processing mode.

This requires knowing the programming and testing schedule of all your external vendors, including payers, healthplans, and providers with whom you transmit HIPAA transactions, and integrating their plans with your own internal systems design, development and test plans. The Level 2 compliance date for all covered entities is by January 1, 2012 and is a definite 2011 budget item.

When considering budgets, if you have not already done so, an enterprise-wide assessment, evaluation, and plan development for ICD-10 is a must for 2011.

If your 5010 budget already includes the software modifications and upgrades such as writing interfaces and reports to conform to the new ICD-10 code set formats, then you do not need to cover it again with ICD-10. If you have not already included these items in the budget, now is the time to begin thinking of 5010 and ICD-10 in a combined fashion and develop a comprehensive multi-year plan. Assign someone to plan and estimate resources needed for all external and internal systems analysis, design, development and testing. The technical components of the plan should include an inventory and review of every application, report, form and interface which will need to be reprogrammed to ICD-10 and/or 5010 standards. In this scope, you can expect to see over a hundred reports, forms, and other documents to be revised and up to 40 different systems or interfaces which will need some level of programming change, and testing.

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ICD-10

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Preparation and planning for testing needs are to be budgeted because the scope, schedule, testing and validation of changes are a covered entities responsibility. If something is not programmed or interfaced correctly, internally or externally, it could mean untenable revenue reductions for covered entities. A recent risk analysis indicated that for every dollar not spent in preparation, there was \$100 in net revenue that was at risk.

Another area for technical review and evaluation is the hardware or systems engineering environment. Hardware and processing capacity must be evaluated to ensure adequate resources are available for ICD-10. Dual processing will be a requirement for ICD-10 for some time with testing taking place parallel with operations. All vendors will not migrate on the same day therefore dedicated testing servers are expected to be required, which is an expense to factor into the budget. It is important to inventory equipment and evaluate the transmission capability and physical storage of hardware. Besides the dual processing demand, ICD-10 will increase the number of claims, records, and overall data storage requirements. Enterprises should budget to ensure they have adequate processing and storage capacity for live operations and testing.

Operations

Similar to the software and hardware inventories, operationally, a full evaluation of processes, policies and departmental touch points impacted by the ICD-10 code set is something to budget for in 2011. Once identified, a focused risk assessment, training plan and a compliance approach for ICD-10 can be constructed for each department including front-end, middle and back-end revenue processes such as preadmissions, coding, billing, collections, and many others that will be impacted by a change to ICD-10.

Operationally, it is too early to begin coding in an ICD-10

format, but it is not too early to train personnel in the new code sets. Providers, data users and coders will all need code set training. Training should begin with the basics of ICD-10, the benefits of the code set, the changed structure, as well as the expanded and revised meaning of each of the digits in the new code sets (remember, in the transition the number of codes moves from approximately 14,025 to 68,000 diagnosis codes and from approximately 3,824 to 87,000 procedure codes).

Trending data will be an important executive decision point. Training data users in 2011 is a good strategy to employ so they also have input into the solutions process. For the data users in your enterprise, once there is a

core understanding of the code set changes, a facility can begin to craft a plan for crosswalking ICD-9 data for use with ICD-10 trending and analysis. Familiarizing staff with the GEMS crosswalk available now so they have knowledge and understanding of how the new codes will change future reporting is beneficial.

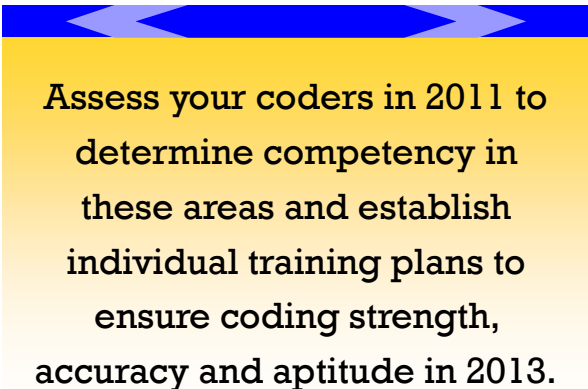
Coders know that ICD-10 requires strong comprehension of anatomy, physiology, and pathophysiology.

Assess your coders in 2011 to determine competency in these areas and establish individual training plans to ensure coding strength, accuracy and aptitude in 2013. Starting with anatomy training is a good strategy because of the specificity required in ICD-10 coding. Since coders code what is documented in the chart, also schedule a baseline documentation optimization/integrity review in 2011. The purpose of the review is to evaluate that the care documented is representative of the care rendered and can be coded with the expected specificity in the ICD-10 code sets.

Finance

As already mentioned, putting together a multi-year budget is something to consider. Doing this begins to validate the financial needs in 2011 and beyond. Post go-live, trending and productivity are key areas to include in your plan. Enterprises will want to have trending information to help them evaluate the impact of go-live and

(Continued on page 13)



Assess your coders in 2011 to determine competency in these areas and establish individual training plans to ensure coding strength, accuracy and aptitude in 2013.

ICD-10

(Continued from page 12)

to identify problem areas for correction. At go-live some financial targets to track are days not billed, claims delayed, claims denied, and similar financial targets. Define and begin capturing these data points in 2011.

Performing reimbursement modeling and identifying what key performance measurements to use to evaluate ICD-10 success are two other areas that can be incorporated into a 2011 budget to get a jump on the ICD-10 go-live process. Plan for a database modeling system which can use ICD-9 data and perform ICD-10 trend analysis to

In coding it is estimated that there will be as much as a 50% productivity drop for months following the ICD-10 activation.

ensure the proper training is conducted and that when it comes to contracting, appropriate terms and coverage points are included in any contracts coming up for renewal which will extend beyond the ICD-10 effective date of October 1, 2013. Whether it is constructing an ICD-10 database for trending, modeling contracts, or establishing important areas for focused review, a modeling database is a helpful planning tool for financial analysis of the impact of ICD-10 on your enterprise.

After go-live, productivity will drop. In coding, it is estimated that there will be as much as a 50% productivity drop for months following ICD-10 activation. Similar to MS-DRG's the increased complexity of the coding model will keep productivity lower than it is today, by an estimated 20%. A manpower plan or a reserve fund to curb the financial impact of productivity drops in 2013 is an important budget element to consider. The coding resources available continue to be in high demand with manpower market shortages. If necessary, work with external vendors to develop a plan of action and commitment for resources in 2013.

In summary, ten things you can do while building your 2011 budget to ensure ICD-10 success in 2013:

- 1. Commit to a multi-year enterprise plan and budget**
- 2. Conduct an assessment and develop an ICD-10 plan**
- 3. Manage to plan by having a governing body and assign accountability and ownership**
- 4. Commit to providing resources for success (hardware and software assessment, Level 2 compliance, training, and testing resources)**
- 5. Engage vendors, payers and trading partners in the process and know their plan for 5010/ICD-10**
- 6. Test the skills of staff and develop training plans, for coders, physicians and data users**
- 7. Provide auditing of records for Provider Documentation Integrity reviews**
- 8. Customize your results with your own data trending and mapping plan**
- 9. Establish a database for modeling financial reimbursement, monitoring key performance indicators, and negotiating contract terms**
- 10. Have a manpower plan with expertise and knowledge in ICD-10, whether it is project management or coding support, if necessary, use external partners to provide resources.**

Adding thought to these things in 2011 will help you build a multi-year plan and give you confidence of success with ICD-10 activation.

*About the author: Veronica Hoy has an MBA and is Vice President of **SOURCECORP HealthSERVE Consulting, Inc.** Visit <http://www.sourcecorp.com/icd10/> for a description of SOURCECORP HealthSERVE's ICD-10 services. **SOURCECORP**, Incorporated provides business process outsourcing solutions and specialized high value consulting services to clients throughout the U.S. Headquartered in Dallas, the Company has locations in the U.S., Mexico, Philippines and India. For more information, visit our corporate website, www.sourcecorp.com, our divisional site, <http://www.sourcecorp.com/Lines-of-business/HealthSERVE/> or contact Charlotte Piontek at charlottepiontek@srcp.com or 1-877-369-0344.*



The South Texas Chapter is now a LinkedIn Group! Under the direction of Christopher Snyder, the South Texas Chapter has begun a LinkedIn site to enhance member communication and serve as a resource for industry trends and issues. The guidelines for membership are shown below. Join now!

GUIDELINES

Mission Statement: provide HFMA South Texas Chapter members with an exclusive, professional site to exchange quality information without solicitation to gain knowledge of current industry trends and issues.

Eligibility to join site

South Texas Chapter member (provider and vendor)

Vendors must be sponsor of chapter or Texas state-wide

Non-member

Anyone employed by a provider that is in our geographic area

Vendors that sponsor chapter or Texas state-wide

Industry experts that will provide quality information

Keynote speaker candidates for conferences

No vendor solicitation of any kind

Only sharing of quality ideas and articles pertaining to the latest healthcare industry trends and issues

No self-serving objectives

Reoccurrence will result in being removed from site

Vendor campaigns to promote services will be held on a monthly basis

Must be a chapter member and sponsor to be eligible

Editor's Alley

It is our goal to ensure that The Chili Pepper Express Newsletter continues to meet the needs of chapter membership by providing timely and relevant information to enhance your membership experience with the South Texas chapter of HFMA. If you have any comments or suggestions relating to any aspect of the newsletter (i.e. frequency, content, method of delivery, etc.) please let us know. Thanks.

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Top 10 Ways to Maximize Collections Through Efficient Billing Processes

by Lee Matricaria

Efficient billing and collections processes are critical components to a successful and profitable medical practice. Any efforts you make to improve efficiencies can help better capture the money you earn. Most practices leave anywhere from 5 to 30% of their reimbursement on the table because they either lack the proper processes, staffing, training or technologies. By following this Top 10 list, you can regain control of your billing operations and be on the road to increased revenues.

Verification of Benefits and Patient Registration. A step frequently overlooked in establishing best practices in billing is verification of benefits. It is increasingly important to take the time to verify the patient's benefits prior to the date of service. Determining if the patient has coverage for the upcoming procedure can decrease the cost of collections, as well as minimize the risk of having to write-off a balance. This is also when a practice should address outstanding patient balances and co-pays. An efficient registration process can significantly improve your cash flow.

Medical Coding. Insist that AAPC Certified Professional Coders perform your coding. This step is critical in ensuring that all codes are billed correctly the first time. Missed or improper codes could equate to thousands of unbilled dollars, as well as expose you to potential liability and compliance issues. Consider hiring an auditing consultant or firm annually to ensure that claims are being coded correctly and completely. This can either confirm that your coding processes are correct or serve to help rectify any problems.

Charge Validation. Prior to submission, claims should be scrubbed via an industry specific tool which utilizes both standard and custom edits. This system should automatically detect coding combinations related to

unbundling, modifier appropriateness, and mutually exclusive procedures. Medical necessity concerns can be discovered, and proper channels are exercised to improve or amend documentation.

Remittance Management & Payment Posting.

The retrieval and processing of claims should be done with electronic remittances from government and large commercial payers whenever possible. Automating this process reduces human error and highlights claims that need additional follow-up. The ERA/EFT combination puts money into your account quicker, and allows for timely billing of secondary claims.

Denials Management. Understanding the issues surrounding a denial is critical to know what course of action to take to rectify the situation and obtain payment. Denials management is often a neglected area of the billing cycle due the labor involved and intrinsic knowledge needed to work outstanding claims. A dedicated team should be assigned to the posting and follow-up of denials. Trends in payer reimbursement can be identified and addressed. Appeals and reviews to combat payer tactics should be submitted and followed through to conclusion. Try and target problem areas that affect the bottom line in order to obtain the maximum reim-

(Continued on page 16)

Maximize Collections

(Continued from page 15)

bursement for all the services you provide. Managing the process can be time consuming and sometimes difficult, but it is essential in optimizing cash collections. Having a team of individuals who understand this process is the number one factor in maximizing cash collections.

Insurance Follow Up. An essential element to help you maximize collections is to have a timely, effective follow-up process in place. You should initiate follow-up efforts with insurance payers on unresolved claims at the right time based on their payment patterns. Your follow-up specialists can use a variety of tools including claim status websites and phone calls to achieve results in the shortest amount of time. Diligence in this area keeps patients out of the loop until the patient responsibility amount is fully determined.

Reporting Capabilities. Your end of month reports should be customized to provide you with the specific metrics that are most valuable to your practice. They should provide a comprehensive view of your practice's financial performance and give you the insight to make smart business decisions. If you can't measure it, you can't manage it. Understanding these details and how they affect your business are the foundation of effective practice financial management.

Hold the Collection Agency Accountable. Your collection agency handles many accounts, so it can be easy for mistakes to occur. While the occasional error may not significantly harm the practice, if it happens repeatedly and is not detected in a timely manner, the impact could be significant.

Technology. To do medical billing right, your technology platform needs to be state-of-the-art. You should invest in the right billing platform, claim scrubber software, have the ability to submit claims electronically, have a robust document imaging system and use electronic remittance for posting. The use of outdated technology may prevent the practice from running its billing operations to maximum effi-

ciency. The long-term benefits and savings of investing in the right technology can often easily surpass the costs.

Choosing a Billing Company. It is important to understand that not all billing companies are the same. Some items to consider are experience in your specialty, technology platform, service offerings and the willingness to customize their services to your requirements. Be aware of the benchmarks and ranges for what billing companies charge for your specialty, and understand that not all operations are equal. Sometimes, a low price option can undercut the competition because the services offered may neglect some of the labor intensive practices that are required to capture every dollar. Make sure there are no hidden costs for items like billing secondary payers, patient statements, and postage fees that you will need to factor in. Saving a little money on the rate charged by the billing company is shortsighted if they skimp on the steps addressed above.

To collect all of the money you have worked for requires fully optimizing each of these billing functions to realize efficiencies. Each area might only be responsible for a small percentage of collections, but taken together you can quickly find your practice leaving a large amount of revenue on the table. The first 80% of your payments are relatively easy to collect, it's the next 20% that is harder to obtain and more expensive for an office or a billing company to properly staff the functions that are required to collect your money. You need to efficiently manage each of these billing functions so as to not leave any money on the table. This is money you have earned, so it's important that you have a team or a partner that is willing to go out and fight for every dollar.

Lee Matricaria is president of Data Management, Inc. (www.dmimd.com), a leading provider of hospital based physician billing services since 1976. Data Management delivers revenue cycle management solutions designed to meet the strategic business objectives of your practice. Should you have questions or comments about this article, please e-mail Lee@dmimd.com or call (309) 693-2636.

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Other Happenings:

“Other Happenings” is where we will list educational and networking opportunities in collaboration with other HFMA Chapters, primarily the Gulf Coast and Lone Star Chapters here in Texas. We will work in conjunction with the Newsletter Chairs from these Chapters to provide you with as many educational opportunities as possible.

Gulf Coast Chapter HFMA Events:

A full schedule of GCC events can be found at <http://www.hfmatxgc.org/hfmacalendar.php>.

November Monthly Meeting

Methodist Hospital
Fri, Nov 19th 2010, 11:15

HFMA Monthly Luncheon Meeting
November 19, 2010
11:15 am - 1:30 pm

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