

2009 | 2010

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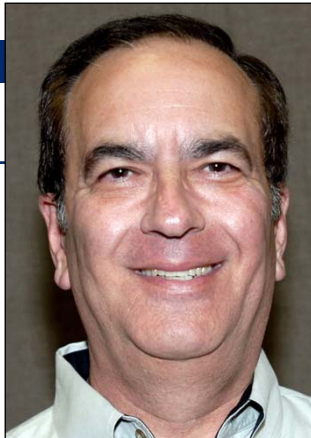
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**MESSAGE FROM THE PRESIDENT**

Dear Fellow HFMA Members



*As I am about to leave the position of President of this wonderful Chapter, I thought about all of the time and effort it took to prepare me for this role. I sometimes forget how much history I have with HFMA, Southern California Chapter. What I never forget, however, are the relationships I have forged, and how valuable those relationships are to me. I can contact these individuals at any time to bounce ideas off of them, ask for advice, validate if my interpretation of legislative rules are the same as theirs, etc. Was it worth it? You be the judge.*

*One of the main objectives of our Chapter is to provide to our membership as much education as possible. We have many talented individuals who give their all to identify and recruit knowledgeable speakers, coordinate the tracks and present the programs so that everyone may take advantage of them. For those of you who work or reside in outlying areas, we have our Educational Outreach Programs; we bring programs to you.*

*The Chapter Vice President is also the Chair of the Program Planning Committee. In addition to locating venues that are as centrally located as possible, this individual coordinates with all Education Committee Chairs to make sure our programs are of the highest caliber possible.*

*We have an Executive Committee comprised of all officers including the Immediate Past President. As President, I took advantage of selecting a Chapter Advisor (a former Chapter President) to offer suggestions and recommendations as seen necessary. These individuals are extremely talented and committed. We have an involved Board of Directors who supported and helped move forward the goals for this HFMA year. Please join me in thanking all of them. When you see them, I hope you say "thank you." I can tell you from personal experience that it really means a lot.*

*Your Committee Chairs and Coordinators are the men and women who develop the educational tracks, keep us current with reporting National, coordinate HFMA Certification efforts, make certain our Newsbrief is published, maintain our website, coordinate Yerger applications, aid in securing Chapter sponsors, represent the Chapter in the Annual Fall Conference, the Region 11 Symposium and one CHA committee, develop Networking and Social Events and prepare the Installation of Officers and Annual Awards Banquet program (to be held on May 20, 2010...we hope to see you there). Please join me in thanking these individuals.*

*The role of President of the Southern California Chapter of HFMA is NOT about one individual; it is about teamwork and commitment. I am incredibly fortunate to work with such an outstanding team. I wish our incoming Chapter President, Chris Kinsey, much success as he and his team guide us through the 2010-2011 HFMA year.*

*As I close this message, I want to thank our membership, Executive Committee, Board of Directors, Committee Chairs and other key individuals for making this challenging year beneficial to all.*

**Rick M. Lash**

President, HFMA, Southern California Chapter

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**COMMITTEES**

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Richard Anzalone

F E B R U A R Y - M A Y 2 0 1 0

**Welcome New HFMA Members**

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Pacific Hospital of Long Beach

**Vincent K. Trac**

St Joseph Health System

**HFMA SO. CALENDAR**

**2010 EVENTS**

**June 4 – Chapter Annual Planning Meeting** 7:30am-12:00pm / Huntington Hospital, Pasadena

**June 20-23 – HFMA's Annual National Institute** Venetian-Palazzo Resort / Las Vegas, Nevada

**June 24 – CHA Hospital Reimbursement Seminar** 9am-4pm / Sheraton Grand Hotel, Sacramento

**June 29 – CHA Hospital Reimbursement Seminar** 9am-4pm / Hyatt Regency, Newport Beach

**June 30 – CHA Hospital Reimbursement Seminar** 9am-4pm / Burbank Marriott

**July 29-30 – AAHAM 3rd Annual Summer Conference** The Dana on Mission Bay, San Diego

**August 26 – Chapter Educational Program I** Embassy Suites, Arcadia / *Save the date!*

**September 19-21 – Fall Conference** Hyatt Regency, Long Beach

**September 23 – Cost Report Education (Beginning)** Center for Healthy Communities, Los Angeles

**SAVE THESE DATES IN 2011**

**January 23-26, 2011 – Region 11 Symposium** *Save the date for next year's Symposium!*

**June 26-29, 2011 – HFMA's Annual National Institute** *Save the date for this Orlando, Florida venue*

*Details on all events can be found on the chapter's website: [www.hfma-socal.org/](http://www.hfma-socal.org/) > click on Events Listings.*

# Strategic Pricing with a Focus on the Market

— Mark Jeziorski —

Generating additional third party payments and improving the overall profile of your hospital's prices relative to the market is possible. By strategically setting prices in the context of the prices in the market, additional third party payments can be generated and a better price profile achieved.

Strategically setting prices means using the charge sensitivity of a charge/service code to influence how its price is changed. Charge sensitivity is a measure of how much third party payments change for a given change in price. Setting prices in the context of the prices in the market means the prices of other hospitals are considered when developing new prices. Finally, the price profile describes the distribution of your prices relative to the prices of the other hospitals in terms of percentiles (e.g. percentage of your prices between the maximum price and the 75th percentile, percentage of your prices between the 75th and 50th percentiles, etc.).

Conducting a strategic pricing project with a focus on the market is a significant undertaking but one that can be worthwhile. A high level of computer model building skills is required and experience working with the Charge Description Master (CDM) and revenue and usage files is extremely helpful. The approach for conducting such a project has many components. However, based on our experience, there are six key components of a successful approach.

## **Key Component 1: Setting the Parameters for the Project**

There are various parameters that influence the development of the prices when prices are established strategically. Some of the critical parameters include, but are not limited to, the following: the targeted change in gross revenues, maximum allowable price increase, minimum prices and whether prices for the same services should be equalized. Some of these parameters affect how the pricing model is constructed. As a result, they need to be established early in the process.

## **Key Component 2: Defining the Market**

The market consists of the hospitals that will be used as benchmarks for price comparisons. This market needs to be defined. The market could be hospitals within a certain geographic area, hospitals of similar size within a certain geographic area or similar hospitals throughout the entire country. The last definition for the market might be most appropriate for specialized hospitals. Once the hospitals have been identified, their prices can be obtained from various vendors.

## **Key Component 3: Working With the Benchmark Data**

Hospital pricing data may not always be robust. There may be minimal or no hospital prices for some of the charge/service codes in your CDM. A decision needs to be made as to how these situations will be addressed. Possibilities include using the prices of other hospitals or multiples of third party reimbursement rates as the benchmarks for price comparisons.

Another aspect of working with benchmark prices that needs to be considered is outliers. A benchmark hospital's price is an outlier if it appears to deviate markedly from the prices of the other hospitals. A decision needs to be made as to whether outliers are going to be identified and excluded from the analysis. If they are going to be identified and excluded, a definition of an outlier needs to be established.

Finally, benchmark prices are not current and could be more than a year old. These prices can be used as is or a trending factor can be applied to them in an effort to estimate current

## **Key Component 4: Having a Comprehensive Scope**

The benefits derived from the project are directly related to the scope. The benefits will increase as the scope of items included in the project increases. In order to generate the maximum amount of benefits, the scope should include items in the CDM with CPT/HCPCS codes, room and board charges, items charged on the basis of time (e.g. operating room charges, recovery room charges, etc.) and cost-based items (e.g. pharmacy, pharmaceuticals, supplies, implants, etc.).

## **Key Component 5: Developing a Pricing Model**

A critical component of the successful approach includes developing a sophisticated model that is able to accurately calculate changes in payments that result from changes in prices. The model should incorporate the benchmark prices, managed care contract terms, historical usage at the charge/service code, patient type, plan code and service/registration area level and claims data to address "lesser of" and "stop loss" contract provisions. The model should be designed to develop initial prices that optimize third party payments given the set of constraints (e.g. maximum increase in gross revenues, prices not exceeding a certain level, prices not going below the minimum prices, equalization of prices for charge codes with the same CPT/HCPCS code, etc.).

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FRONT: Jim Moynihan. BACK, LEFT TO RIGHT: Eric Delgado, Steve Blake, Scott Ujita and Chris Kinsey. NOT PICTURED: Genevieve Nelwan.

## Leadership Training Conference Phoenix, AZ

Scott Ujita

Each LTC is packed from morning to evening with classes. I attended the Program Chair bootcamp that started at 10:00am Sunday morning. Education continued throughout the day. Even lunch was strategically planned as an education event. Sunday ended at 5:30pm with a general session with all of the attendees. Pat Williams, Senior VP of the Orlando Magic, was a great speaker to close out the day. He spoke on the "Seven Keys to Leadership" and provided details on how to be a more effective leader. He was very funny and kept the topic interesting from start to finish.

The remaining two days of LTC were equally rewarding. There was so much to learn about each of the 6 tracks that National had to offer. Our Southern California group also had some time to talk about the upcoming year. We discussed possible education events, membership opportunities, possible social events and other chapter planning aspects. I believe that the 2010-2011 chapter year is going to be a very exciting and rewarding one for each of our members. I encourage each of you to take advantage of our education sessions and also to get involved this year.

If you are interested in getting involved in the chapter this year in any way, you can contact me via telephone at 925-685-9312, or via email at [scott.ujita@toyonassociates.com](mailto:scott.ujita@toyonassociates.com). We will be sure to find a place that can use your help.

The Leadership Training Conference (LTC) is an HFMA National sponsored event. This training prepares future chapter members for various leadership roles in the local chapter. Each LTC has breakout sessions for the President, President-Elect, and Treasurer as well as the Program Planning, Membership and Newsletter Chairs. From April 18th to the 20th, the Southern California Chapter sent six members to training in Phoenix: Chris Kinsey, Steve Blake, Scott Ujita, Jim Moynihan, Genevieve Nelwan and Eric Delgado.

## Strategic Pricing with a Focus on the Market *Continued from page three*

### Key Component 6: Review of Every Price from the Model

Models are wonderful tools that provide tremendous benefit in the realm of strategic pricing. However, models are not perfect. Some imperfections are due to the benchmark data; some are due to the high cost of developing more sophisticated models that require less intervention. As a result of these imperfections, a review of every price generated by the pricing model should be conducted. The review should include checking that items are leveled appropriately (e.g. CT with contrast is priced higher than a CT without contrast).

### Another Consideration

Hospitals receiving Medicare outlier payments may want to determine the impact of the new prices on outlier payments and the cost-to-charge ratios. In fact, these hospitals may want the new prices be developed such that additional third

party payments are generated without impacting the amount of outlier payments. Incorporating the impact of pricing changes on outlier payments and cost-to-charge ratios will add another layer of complexity to the process.

### Conclusion

Strategically setting prices while focusing on the prices in the market can result in additional third party payments and an improved profile of prices. A successful approach to achieving these results involves the six key components. For hospitals receiving Medicare outlier payments, the approach could also include determining the impact of the pricing changes on outlier payments and the cost-to-charge ratios or establishing prices that do not impact the amount of outlier payments.

Mark Jeziorski is President of Sophysical Solutions.  
[markj@sophysicalsolutions.com](mailto:markj@sophysicalsolutions.com).

# Government Programs Update

— Donna Anglin, FHFMA —

The last month has produced a host of Medicare reimbursement changes. Who hasn't heard of the health care reform legislation signed by President Obama on March 23, 2010 (the Patient Protection and Affordable Care Act, "PPACA")? This was followed by the Health Care and Education Reconciliation Act of 2010 on March 30th. The legislation contained many provisions, but only a few were effective right away (or retroactive).

The first provision impacting hospital payments includes cuts to OPSS and IPPS standardized rates of .25% effective on 1/1/10 and 4/1/10 respectively. You can find the IPPS details on the CMS website at CMS Home>Medicare>Acute Inpatient PPS>FY 2010 Final Rule Home Page. The file is called "Wage Index Tables Pre and Post Implementation of PPACA" and contains the updated tables for discharges on or after 4/1/10. The OPSS revised Addendums A and B for effective dates 1/1/10 and 4/10/10 are available at CMS Home>Medicare>Hospital Outpatient PPS>Addendum A and Addendum B Updates. There are also changes to the DSH formula scheduled for 2014 and another FTE Redistribution for 2011. For more information on healthcare reform check out the resources available from HFMA National at [www.hfma.org](http://www.hfma.org).

On April 19th, CMS issued its proposed rule for Inpatient and Long Term Care PPS. The rule was published in the May 4 Federal Register and did not include any of the provisions related to PPACA due to the timing. While the rule provides a market basket increase of 2.4% to the IPPS rates, there is a proposed 2.9% reduction to account for documentation and coding changes, so we are left with a negative "update". This has not happened since the inception of PPS in 1984\*. Although CMS is not proposing any additional changes to wage index for FY 2011, they are retroactively reversing two previous changes; First, the average hourly wage criteria for hospitals that seek reclassification; Second, the State specific budget neutrality adjustment will be changed back to being calculated on a National basis. Both issues will be addressed in a future Federal Register.

A significant change is proposed for SSI data processing for DSH as a result of the Baystate case. The new process would use three databases with the expectation that more records would be matched. This proposal is based on a CMS Ruling (discussed further below).

On April 28th, CMS issued ruling CMS-1498-R. This ruling addresses three key issues involving Medicare disproportionate-share hospital (DSH) payments: the SSI data matching process, Dual-Eligible Days and Labor & Delivery Room Days.

"This administrative ruling will remand certain issues back from the Provider Reimbursement Review Board or other administrative tribunal to the Medicare contractors for a recalculation of the hospital DSH payments," said agency officials at the April Hospital and Hospital Quality Open Door Forum.

"CMS and the Medicare contractors will take the steps necessary to apply a suitably revised data matching process in determining the SSI fraction, and recalculating the DSH payment adjustment, for each properly pending claim on the SSI fraction data matching process issue that is remanded by an administrative appeals tribunal and is found to qualify for relief under this Ruling," states CMS acting Administrator Marilyn Tavenner on Ruling CMS-1498-R. "Such suitably revised data matching process will consist of any new data matching process that is adopted in the FY 2011 IPPS final rule; or, if a new data matching process is not adopted in the FY 2011 IPPS final rule, CMS will use the same revised data matching process as it used to implement the Baystate decision."

For the Dual-Eligible Days issue, CMS has stated that these days should be in the Medicare fraction as beneficiaries and are still entitled to Part A even though their benefits are exhausted. And as for Labor & Delivery Room Days, these will be counted in the Medicaid fraction regardless of whether the patient occupied a routine bed prior to giving birth. This

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## SOLVE THE PROBLEM

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- Third Party Liability Collections

Where Do We Fit In The Revenue Cycle:

- From Bill Drop Date / Early Out
- Late Stage Accounts Receivable
- Bad Debt

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## IME/GME: Are You Taking Full Advantage?

— Vicente Farina —

In addition to the traditional Medicare Prospective Payment System (PPS), teaching hospitals receive two types of additional payments from Medicare through the Part A program: direct graduate medical education (GME) and indirect medical education (IME) payments. GME payments cover the direct fixed costs of training physicians. Medicare makes GME payments to each hospital based on the number and specialties of the residents it trains, its historical costs increased for inflation, and its volume of Medicare patients.

IME payments cover the indirect costs that teaching hospitals incur in caring for patients, given their broader range of services, intensive treatments, patient medical issues and costly physician mix. Medicare's IME payments are adjustments through the prospective payment system (PPS). IME payments are determined by the number of medical residents per hospital bed, a proxy used to measure the intensity of a hospital's teaching activities.

With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These plans are commonly known as Medicare Advantage (MA) plans and include HMO, PPO, private fee-for-service and Medical Savings Account (MSA) plans. When a Medicare beneficiary chooses one of these plans over traditional Medicare, all Medicare-covered health care is provided through the plan. This may include some additional benefits that are not routinely covered under traditional Medicare.

For cost reporting periods starting after October 1, 1997, Medicare makes additional Indirect Medical Education (IME) and direct Graduate Medical Education (GME) payments for Medicare Advantage patients under changes adopted as part of the Balanced Budget Act of 1997. In order to qualify for these additional Medicare payments, Medicare Advantage cases require separate claims processing. The additional IME payment is based on the IME amount by DRG under the Pricer in effect at the time of discharge. The additional GME payment is included in the subsequent cost report settlement based on the number of MA IME days paid. All Medicare Advantage claims are eligible for the IME payments as part of a separate bill to the hospital's Medicare Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC).

Medicare's methodology places the burden upon the provider to identify Medicare Advantage IME claims and code the affected claims correctly before processing. Without an effective data collection process at the time of registration, as well as quality measures in place on the back-end when the MA

claims are paid, there is a potential for providers to overlook some IME billing opportunities. Not capturing 100% of all eligible accounts negatively impacts IME revenue and ultimately affects the facility's ability to reconcile and maximize GME reimbursement through the cost report.

The Revenue Cycle units within teaching facilities throughout the country handle the IME claims volume in a variety of ways. Some facilities have processes in place to bill IME concurrently once the MA claim is submitted. Others elect to submit IME claims quarterly, or all claims once a year, after the MA claims have been paid. Some facilities outsource the function while others use their claims scrubber or contract management system to reconcile IME payments. IME payments are posted to a common general ledger account at some facilities while other providers elect to post the payments directly to each individual MA account.

There is no "one size fits all" approach. Facilities should customize a process that works within the parameters and strengths of their revenue cycle workflow. Ideally, there should be a quality check process in place to identify and capture all eligible accounts upon registration and reconcile payments after a MA payment is received.

The eventual GME settlement amount through the cost report is directly related to the teaching facility's ability to submit all eligible IME MA claims for payment. Days related to IME MA eligible claims not submitted and processed will not be included in the GME Program Managed Care worksheet E-3, Part IV. There is a direct correlation between IME claims processed and ultimate GME reimbursement – underreporting the total MA day figure will negatively impact the GME settlement amount.

The impact that IME and GME reimbursement for MA patients can have upon a given teaching provider is dependent upon a number of factors including the size of the teaching program and the penetration of MA plans in the provider's service area. Penetration varies by State but can also vary significantly within regions of a State. Regardless, all teaching providers can potentially gain financial benefit from increased attention and oversight of their MA IME claim functions.

Optimizing IME and GME reimbursement is contingent upon two key factors - identifying and documenting MA patients at the time of registration and subsequently submitting and collecting on MA claims. Sounds easy enough, but given the complex insurance maze in which providers must operate and the often confusing information obtained from patients at the

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# What's New in Workers' Compensation

Cheryl Canaday

The Division of Workers' Compensation has started the formal rule making process for adoption of standards for electronic billing of industrial claims, known as E-billing.

The idea behind this process is to eliminate much of the paperwork in the Workers' Compensation system, as was the intent behind the implementation of the Electronic Adjudication Management System (EAMS) in 2008.

In EAMS, the parties are able to litigate in a virtually paperless system before the Workers' Compensation Appeals Board (WCAB), eliminating for many the need for a paper file.

Unfortunately, for some, this had a reverse effect, and actually led to the creation of more paperwork within the system by the creation of new forms such as Document Cover Sheets and Separator Sheets, to name a few. Many other forms, such as liens, which were previously only one or two pages, are now multiple pages in length.

It is hoped that the E-billing process, once it makes its way through formal rulemaking, will provide a more streamlined process that EAMS has not quite been able to achieve as of yet. The idea behind electronic claims submission for hospitals is to provide prompt and accurate payment of services (even faster than the timeframe currently allowed by the Labor Code).

Clean claims will be paid faster, and the current proposed regulations even provide the option of electronic remittance (EFT). Of course, paper billing will still be allowed in the system, but providers are enticed to utilize E-billing through the use of optional EFT and guarantee of faster payment.

For many hospitals already participating in some form of electronic billing in other streams outside of industrial claims, there should be a fairly smooth transmission. For others, it is anticipated there will be a learning curve to get up to speed on Workers' Compensation E-billing.

Much of the rulemaking with respect to E-billing focuses on what constitutes a "clean claim." The rules are further specific: once a claim is submitted in one manner, paper or electronic, it may not be cleaned and resubmitted in another manner.

The coding on the UB-04 and HCFA 1500 forms will now have to be scrutinized, more than ever, for proper coding, including modifiers, before initial claim submission. The days of resubmitting a claim simply marked "Tracer" are over. Resubmitted claims will now have to be marked with frequency indicators. All requested supporting documentation would also have to be sent to the payor before resubmission.

Should a dispute arise, either with amount or timeliness of payment, the same rules with respect to lien filing before the WCAB would apply. Important; watch the statute of limitations contained in Labor Code 4903.5. It is the later of 5 years from the date of injury, 1 year from the date of service, or 6 months from when the injured worker settles his or her case.

In the context of E-billing, the industrial carrier would be required to send back acknowledgement of receiving the hospital's claim within one working day. If the claim is being rejected, that acknowledgement is to be sent within 5 days.

If the rejection is missing information, all timeframes are tolled until the requested information is provided. Once the carrier receives this information, the timeframe would start again. The Labor Code still provides that industrial carriers are to make payment within 45 working days upon receipt of all requested supporting documentation, lest it pay penalty and interest.

As part of the proposed E-billing process, supporting documentation would be allowed to be submitted in the following forms: 1) Fax, 2) Electronic submission, 3) e-mail. It will be important to watch what information is ultimately required for clean, claim submission to ensure prompt payment processing.

The proposed regulations will also include what information is to be on the Explanation of Benefits sent from the payor to the provider. It does not appear there will be a required form, per se, only required elements that must be communicated.

All appeals for reconsideration, for instance, have specific appeal codes that must be used for all first, second and third level appeals. It will now be more important than ever to get all required information from the injured worker in the initial engagement. Later obtaining accurate information for clean claim submission will be a time consuming process.

Getting the correct employer name and address, for instance, will now be required. The claim number will also become a required element for all claims which already have a claim number assigned to a particular injured worker's date of injury.

For hospitals, the Medicare provider number and physical address where the services were performed, also become required elements. When possible, the social security number of the patient is also to be listed.

As part of this new process, providers will also be required to make available the name, address and contact information of a contact person at the facility should the payor require further information to process the claim.

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## Got a Claim? TriWest Improves Claims Search Capabilities

Based on user feedback and a usability study, TriWest Healthcare Alliance and its claims processor Wisconsin Physicians Services (WPS), have enhanced the claims search functionality on the secure website at [www.triwest.com/provider](http://www.triwest.com/provider).

Registered users now have several new search options to easily search and find claims associated with their office(s). Examples of the new search criteria are as follows:

- Search by process date
- Search by claim number
- Search by patient account number
- Search by check number
- Search by individual provider

In addition, the following improvements were also made:

- Added expandable help links
- Modified the search screen to make some fields optional
- Redesigned the claim search and result screens to make them more intuitive
- Added claim paid date information to the search results screen

Providers need to be registered to enjoy these new changes and the other many benefits of the secure provider portal.

These include:

- Verify patient eligibility
- Research covered benefits and check referral/authorization and medical review requirements for specific codes
- Submit referrals/authorizations online and check their status regardless of how the request was submitted
- Submit claims online and check claim status regardless of how the claim was submitted
- Download remittance advices
- Claims correspondence/Webmail

Get started. Go to [www.triwest.com/provider](http://www.triwest.com/provider) . . . the secure TriWest website.



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## IME/GME: Taking Advantage?

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time of registration, ensuring that all affected accounts are identified and processed is challenging. Verifying that payment was received on all previously identified accounts can provide a false sense of security for providers. Conducting a retrospective review to detect additional accounts that were not identified through established processes can be a beneficial step that helps to ensure that all IME and GME reimbursement is secured.

In today's tough fiscal environment, it is imperative for facilities to receive payments for all services provided in addition to add-on payments for special situations. Teaching facilities not only risk losing IME revenue but also will be negatively impacted under the GME reimbursement rules if processes and controls are not in place to capture and submit IME claims for all MA patients. Having a thorough process to identify MA patients, reconcile payments and evaluate recovery targets will help facilities maximize IME payments and GME revenue.

*Vicente Farina has worked with BESLER Consulting's Revenue Cycle service line since 2001. Prior to joining BESLER, he worked for an accounts receivable outsourcing company and a regional Health Maintenance Organization. His undergraduate and graduate degrees are from Rutgers University. Vinny can be reached at 732-392-8215 or [vfarina@beslerconsulting.com](mailto:vfarina@beslerconsulting.com).*

## Workers' Compensation

*Continued from page seven*

We will be updating this information in the coming months as we get closer to the implementation and effective date of these new regulations. In the interim, please feel free to contact the undersigned for any further information.

*Cheryl Canaday, President, Recovery Resources Inc.  
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## Government Programs Update

*Continued from page five*

ruling will bring to a close many (dare I say, thousands?) of open appeal issues. Although this ruling may bring these issues to a close, how will the MACs be able to process all these revised NPRs in addition to their regular workload? And how long will it take as CMS has to recalculate all the ratios first? We shall see. It's just another exciting chapter in the world of Medicare reimbursement.

\*Washington Bulletin, April 23, 2010 – Grant Thornton LLP

# Update on California Hospital Association Activity

— Steve Blake, Trustee for California HFMA Chapters —

On May 7, 2010 the CHA Board of Trustees met for an update on California Hospital Association activity. Numerous topics were covered, most significantly:  
**National Health Care Reform | CMS Review of the California Provider Fee Application Section 1115 Medi-Cal Waiver | “Meaningful Use” Criteria for IT**

## National Health Care Reform:

Enactment of the Patient Protection and Affordable Care Act (PPACA) this March sets the stage for a series of changes to health care regulation over the next decade. This defines the landscape for CHA’s federal advocacy for years to come and its leadership role to help hospitals and caregivers adapt to new delivery system approaches and payment structures. CHA will take a proactive role with a series of legislative proposals and active contribution to federal rulemaking. The association will provide member hospitals with the tools needed to improve patient care and plan for the future.

CEO Duane Dauner presented a “Flowchart – Evolution of Health Reform” outlining the major provisions and timeline for PPACA, as well as a white paper “California – A Laboratory for the Future”. CHA is committed to developing options for California that could shape the direction of PPACA in the state and preserve the best aspects of a private health care system within an aligned incentive-based payment system. Key watershed events include:

- Long term policy on Geographic Variation [2011-2012]. This is an issue that, handled irresponsibly, could have penalized California providers billions of revenue annually.
- Creation of Accountable Care Organizations (ACO) [2012]. CHA to take a lead role in formation of the ACO network.
- Cuts to Medicare and Medicaid DSH payments proposed [2014].
- Initiation of state Exchanges [2014] and universal expansion [2017].

With so many changes on the horizon, CHA’s development of a “roadmap” is a critical step to dealing with the challenges and developing new opportunities.

## CMS Review of the California Provider Fee Application

California’s application is in final stages of response to CMS inquiries and approval is projected by the end of May. The mechanics of the funds flow should take from 30-90 days thereafter. It appears likely at this stage that, under AB 1383, funds will be exchanged (provider fee and enhanced reimbursements) for the 7 quarters ended 12/31/10, each quarter pro-

cessed over a monthly interval until current. New legislation [AB 1653] has been introduced to extend this following the expected extension of enhanced federal matching for an additional 6 months through 6/30/11. Most providers have executed CHFT pledge agreements that provide relief for those whose fees exceed revenue and over 95% of the expected pledge commitment. CHA Trustees are committed to closing the gap for 100% participation.

## Section 1115 Medi-Cal Waiver [cit C. D. Dauner 4/28/10]

“The Department of Health Care Services (DHCS) is working on a new Medi-Cal demonstration project waiver to: expand coverage to the uninsured; improve coordination of health care to seniors and persons with disabilities; and obtain new federal financing to strengthen the state’s safety-net hospitals. DHCS issued a concept paper that builds upon the existing delivery system while providing the foundation for implementing health care reform over the next 36 months. CHA supports the waiver concept and is working with DHCS to ensure that all safety-net hospitals received increased funding. The existing waiver expires on August 31, 2010...”

## “Meaningful Use” Criteria for IT

Rules proposed, pursuant to the American Recovery and Reinvestment Act (ARRA), will institute an incentive payment system to reward the development of electronic medical information systems. Recently, Cal eConnect was named as the state-designated entity responsible for development of statewide health information exchange (HIE) and is in the process of forming its board of public and private directors. This statewide exchange will provide a baseline for the evolving definitions and criteria for “meaningful use” definitions and certification of systems for electronic health records (EHR). CHA is working with CMS and the Office of the National Health Coordinator for Health Information (ONC) to encourage workable and flexible regulatory definitions that still meet the stated objectives.

More detail on these and other activities can be found on the CHA Website at: [calhospital.org](http://calhospital.org).

C O R P O R A T E S P O N S O R P R O G R A M



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**2010-2011  
Corporate Sponsorship  
Program**

The Southern California Chapter of HFMA is accepting Corporate Sponsors at the chapter level. Companies that participate in the Corporate Sponsorship Program strengthen the chapter while at the same time increasing their own corporate visibility. As a corporate sponsor, you will be listed on the corporate sponsor page of the chapter website with a link to your corporate website, or a link to the email of a corporate representative, or just an informational page about your company. In addition to the visibility provided on the web site, you will be featured on the Corporate Sponsor page of the chapter's *Newsbrief*.

The Southern California Chapter of HFMA has over one thousand members who receive *Newsbrief* and visit the chapter website on a regular basis. HFMA members from around the country, as well as other interested parties, visit our chapter's website.

Becoming a Corporate Sponsor will increase your company's visibility to healthcare finance professionals and will also ensure that the Southern California Chapter of HFMA is able to continue to provide excellent education programs and networking opportunities.

For more information on sponsorship opportunities contact James Cummings, Sponsorship Chairperson, [cummingsllc@aol.com](mailto:cummingsllc@aol.com).

**WHY BE A CORPORATE SPONSOR?**

Visibility is a powerful advantage, and as a sponsor of the Southern California Chapter of Healthcare Financial Management Association (HFMA-SoCal), you gain exposure to a select audience that is over 1,000 members strong. Our membership consists of CEO's, CFO's, Revenue Cycle, Patient Financial Services Directors, and other healthcare finance professionals. You emerge as a leader by demonstrating your support of professional education and quality programs.

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With your support and technical expertise, HFMA-SoCal will continue to thrive and provide more valuable services to our members and potential members. The Southern California Chapter is proud of its current affiliations with sponsors and looks forward to hearing from you.

All sponsorships are received with great appreciation and in good faith; we are the rewards of your investment.

**I. CATEGORIES AND BENEFITS OF CORPORATE SPONSORSHIP**

BENEFITS	BRONZE \$1,000	SILVER \$2,500	GOLD \$3,500	PRESIDENT'S CLUB \$5,000
Posting at all chapter meetings according to sponsorship category.	X	X	X	X
Listing of sponsor according to level in all Chapter program brochures.	X	X	X	X
Listing of sponsor according to category in each issue of the Chapter newsletter and on Chapter website.	X	X	X	X
Option to sponsor an Information table at all chapter education events.				X
Listing in the membership directory if joined before publication of directory.	X	X	X	X
Free registration certificates at any one chapter education session (as indicated).	(1)	(2)	(3)	(5)
Quarter (1/4) page ad in every newsletter.				X
Option to host a hospitality suite at any Chapter educational program, with President's approval (i.e. sponsoring company will pay fees of suite).				X
Special ribbon and/or name tag designating Chapter Sponsor.	X	X	X	X

C O R P O R A T E   S P O N S O R   P R O G R A M

II. CORPORATE SPONSOR INFORMATION SHEET

**START DATE** This Corporate Sponsorship Program begins on June 1, 2010 and runs through May 31, 2011.

**DETAILS OF THE PROGRAM** Enrollment period will be throughout the chapter year. An email announcement will be sent to all chapter members and vendors listed in the current membership directory. Selected vendors who have expressed an interest in sponsoring past HFMA events will be contacted.

**PAYMENTS** Payments are due with the application/agreement and can be submitted at any time during chapter year. Quoted rates assume a full year's sponsorship at the various levels. Those who desire sponsorship after the beginning of the HFMA year will have prorated fees based on time remaining in the chapter year. A confirmation letter will be mailed after the potential sponsor commits to the agreement. The sponsor will be sent a "Thank You" note once the payment is received. The website will be updated to reflect sponsorship agreement within two weeks of receiving payment.



Corporate Sponsor Application

PLEASE COMPLETE AND RETURN THIS FORM TO:  
James M. Cummings, HFMA-SoCal Chapter Sponsorship Chair  
20638 Merridy Street, Chatsworth, CA 91311

NOTE: Please make checks payable to "Southern California Chapter-HFMA"

SPONSOR'S COMPANY NAME \_\_\_\_\_

CONTACT NAME \_\_\_\_\_

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We would like to participate at the following sponsorship level:

- PRESIDENT'S CLUB (\$5,000)**  **GOLD (\$3,500)**  **SILVER (\$2,500)**  **BRONZE (\$1,000)**
- We would like to make two installment payments.

For more information, contact:  
James M. Cummings, Sponsorship Chair, HFMA Southern California Chapter  
E-mail: [cummingsllc@aol.com](mailto:cummingsllc@aol.com) / Phone: 818-642-2990

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