Healthcare Financial
Management Association
2200 Jefferson Ave.
Toledo, Ohio 43624

THE EXAMINER is published four times per year.

Our objective is to provide members with information regarding chapter activities as well as ideas to help individuals in the performance of their job duties.

Your chapter leadership strongly encourages the submission of material for publication. Articles should be typewritten. Letters should be legible and must be signed. The editor reserves the right to edit material and accept or reject contributions whether solicited or not.

Send all correspondence or materials for publication to:

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Opinions expressed in articles or features are those of the author and do not necessarily reflect the views of the Healthcare Financial Management Association, Northwest Ohio Chapter, or the editor.

Newsletter Committee

HFMA is just like any organization: the more hands, the easier the tasks. And involvement does make your membership more meaningful and a more valuable resource. You also get to know other members in a way that you might not by just attending meetings. We are looking for a few more members - we meet only once a year and handle everything else through e-mail. Go beyond the numbers...contact us!

Our Newsletter Committee is as follows:

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Chris Rizzo
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Examiner

hfma™ northwest ohio chapter
healthcare financial management association

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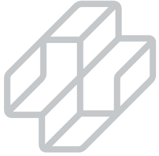

Chapter Improvements Highlighted with Awards

Newsletter Committee: Jody Forney, Chris Rizzo, Dawn Balduf (not pictured Barb Allgire)

At our August 26 meeting held at the Toledo Botanical Gardens, our past President, Dave Wilson, as a last official act, had the pleasure of presenting two awards that the chapter received at ANI in June.

The Henry Hottum Award for Education Performance Improvement is awarded to chapters that exceed a growth in educational hours by more than 6.8% over the previous year. Last year, our chapter increased hours by 18.47%!! We averaged 8.47 educational hours per member. In our strategic plan, it is an objective of the chapter to provide high quality, timely, and affordable educational opportunities. We have been able to secure expert presenters, and the results speak for themselves. This is the fourth time in seven years that we have earned this award, largely due to the strong program committees that have been committed to programming excellence.

Program Committee: Samantha Platzke, Hayley Studer, Diane Walther, Amy Gill (not pictured John Jones and Robin Walters)

Additionally, for the first time ever, our chapter earned the Helen M. Yerger Award for improvement of the chapter's member communications. *THE EXAMINER* has gone from a single sheet to a true newsletter format over the past several years. The workshops by Mary Pretzler at the Leader Training Conferences have certainly paid off for our chapter.

Congratulations to these teams of dedicated volunteers!

President's Letter

Dear Members,

When was the last time you had "one of those days"? You know what I am talking about; you are stressed out, attempting to meet deadlines with two different issues at the same time. You are running around, frantically searching for solutions to those issues that you have just heard about within the last week…and you heard about them from your boss! As you turn to run to the security of your office, one of your staff asks for help with a problem. With carotid arteries and eyes bulging, teeth clenched, and a face that would go well on Halloween night, you respond with your best Clint Eastwood imitation, "Go ahead, make my day." Welcome to the real world of Healthcare Financial Management.

Of course, you are not alone! I find the frequency of "one of those days" increasing, as the changes in healthcare increase. So you may be wondering if I have a sadistic tendency to bring up such unpleasant reminders. Every one of us has responsibilities on the job, and we must find our own way to cope with difficult days. It really is not different in other industries. Frequent changes require business leaders to think outside the box, regardless of the type of business. I cope by volunteering my time. Given my previous revelation, you must be thinking that I have lost my mind. Well, stop laughing hysterically and consider my reasoning.

By volunteering with the Northwest Ohio Chapter of HFMA, I get a break from the daily environment in which I work. I interact with other professionals who experience the same difficulties that I encounter. I learn their solutions to their issues, which generally are very similar to my own issues. I learn new approaches. I enjoy the discussions with other members in an atmosphere without stress. I enhance my own professionalism through the networking opportunities. You may assume that is it is just "misery loves company," but I feel that I get much more out of volunteering with our HFMA chapter than I put into it.

I look forward to our chapter board meetings, not only for the reasons stated above, but because I get a sense of pride that I have contributed to the preservation of our chapter. That allows other members to enjoy the opportunities that I have enjoyed with HFMA since 1985. Please consider volunteering with our chapter in the near future. We need a Certification Chair and a Membership Chair, and the Newsletter Committee needs new members. The chapter can really use your time and talents, and I am sure that you, too, will discover your own rewards of volunteering.

Sincerely,
Darrell Topmiller

beyond the numbers

New Look for the New Year

We will begin emailing the newsletter in 2005. Additionally, issues will be accessible through our website, www.nwohiohfma.org

While this will result in a cost savings for the chapter, our primary reason for making this change is to promote member satisfaction since the majority of members requested an electronic format.

If you do not want to receive the newsletter through email, please contact one of the newsletter committee.

2004–05 Corporate Sponsorships

The Northwest Ohio Chapter of HFMA is grateful to its sponsors. This is the second year for our Sponsorship Program, in its current form. These companies have helped our chapter earn national awards by enabling us to afford high-quality speakers and educational sessions, which in turn results in increased attendance at our meetings.

Please express your thanks to representatives from our sponsor companies when you see them at chapter events.

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United Collection Bureau, Inc.

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Contact: Doug Headman, 419-866-6227, ext 6309, daheadman@ucbinc.com

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Innovative revenue cycle consulting and education services: Operational assessments; process/ organizational design; focused operational improvement assistance; interim management; outsource feasibility evaluation; employee skill assessment and onsite training; technical and leadership mentoring/coaching; compliance and HIPAA assistance and education; outsource vendor operational assessments, proposal evaluations/ site visit preparation.

Contact: Bobette Gustafson, 906-343-6687, b_gustafson@gustassoc.com

Masters Associates

Masters Associates Receivables Management provides results-driven revenue cycle services from assessments to benchmarking to compliance issues. We help you achieve both your immediate and long-term goals.

Real Experience. Real Solutions. Real Value.

Contact: Charlotte Masters, 419-534-2852, www.mastersassoc.com

Bronze Sponsors

Mutual Hospital Services

Mutual Hospital Services is a not-for-profit, shared service that works only with healthcare providers to resolve live A/R and bad-debt accounts. We provide a full range of programs that follows accounts from "cradle to grave" at the lowest net cost for service value.

Contact: www.mutualhospital.org or call 1-800-968-4042

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Once the strategy is developed, management can develop a balanced scorecard. A balanced scorecard is more than just financial results. Over the last number of years there has been more of a market value on intangible assets, such as leadership, culture, employee satisfaction, than on tangible assets.

In order for an organization to be successful with balanced scorecards, there has to be consistency from department to department. The meeting ended by going over a case study that happened to be a local hospital in their first year of using balanced scorecards.

To obtain references on balanced scorecards e-mail Ken Moore at kenmoore@quantuminnovations.net. Mention you are a member of Northwest Ohio HFMA and he will e-mail a list of references.

submitted by Amy Gill, Program Chairperson

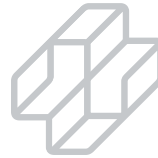
Board To Buy Certification Study Guides

As announced in the last issue of *THE EXAMINER*, your Board has voted to purchase a set of study guides for the certification exams. These study guides will cover the exams for 2005 and 2006.

Requirements for Certified Healthcare Financial Professional (CHFP) are:

- Two years total as an HFMA member
- Two years of professional experience in either the healthcare or finance industry
- 60 semester hours of college coursework or 60 professional development contact hours
- References from a current elected chapter officer or director and your CEO or supervisor
- Successful completion of the HFMA Core c ertification exam
- Successful completion of one HFMA specialty certification exam
- Submit application with one-time fee

If you are interested in utilizing the study guides, please contact one of your officers or directors.



HFMA Chapter Leadership

Officers

- **Past President:** Dave Wilson, Fisher-Titus Medical Center, Norwalk, 419-668-8101 ext 6272, dwilson@ftmc.com
- **President:** Darrell Topmiller, Fulton County Health Center, Wauseon, 419-335-2015 ext 2106, dtopmiller@fulhealth.org
- **President elect:** Kim McClure, Toledo Hospital, Toledo, 419-471-5530, kim.mcclure@promedica.org
- **Secretary:** Samantha Platzke, Mercy Health Partners, Toledo, 419-251-2046, samantha.platzke@mhsnr.org
- **Treasurer:** Todd Howell, Seneca Medical Inc, Tiffin, 419-447-0222, thowell@senecamedical.com

Board Members

- Carol Callan, Ernest & Young, Toledo, 419-321-6306, carol.callan.@ey.com
- Robert Goshia, Paulding County Hospital, 419-399-1106, rgoshia@saa.net
- Dawn Balduf, Mercy Health Partners, Toledo, 419-251-4594, dawn.balduf@mhsnr.org

Chairpersons

- Amy Gill, Program, Fisher-Titus Medical Center, Norwalk, 419-668-8101 ext 6280, agill@ftmc.com
- Dawn Balduf, Newsletter/Public Relations, Mercy Health Partners, Toledo, 419-251-4594, dawn.balduf@mhsnr.org
- Char Masters, Sponsorship, Masters Associates, Toledo, Ohio, 419-534-2852, mastersassoc@aol.com
- Rob Goshia, Website, Paulding County Hospital , 419-399-1106, rgoshia@saa.net

beyond the numbers

"Unbilled" is Not a Bad Word

The most common area overlooked in the revenue cycle is patient claims that have never been billed. Hundreds, and sometimes even thousands of cases, sit idle for 45 days up to two years. By that time, the claim filing deadline is long past due. On the average, a facility with both inpatient and outpatient services has an average case worth approximately $1,500. If the average facility had over 2000 cases sitting "unbilled" in their over 45 day aged bucket, the hospital has the probability of losing close to $3,000,000. Most hospitals and clinics can't afford to give up that kind of revenue. What they do not realize is that the time and cost of unbilled case recovery is far less than what can potentially be lost.

Part of a facility's accounts receivable total and certainly an influence on the days in AR are those dollars hanging out there in cases ready to be billed with services rendered; cases that are not ready to bill with services rendered; and those cases that are actively being occupied by services being rendered (in-house patients). In most medical facilities, these pre-bill arenas are lacking the detailed tracking needed in the revenue cycle.

A medical facility's unbilled report listing may carry different identification names, such as DNFB (Discharge, not final billed), "unbilled", pre-bill list, Missing Elements (MER), Missing Criteria for Billing (MCB), and others. Most hospitals do not monitor or review their unbilled reports, and those that do, do not analyze them to their fullest potential. I have witnessed many aatient accounting and HIM managers, financial advisors and consulting groups analyze "unbilled" data. It appears they all seem to come up with the same cause for billing delay: that the unbilled cases on these reports "just need coded". However, from a HIM department coder's perspective, it is easier said than done.

Typically, an HIM staff member would be required to recover the unbilled listing (given to them by the accounts receivable or finance department). First, they would pick some of the higher dollar cases or possibly the oldest cases, which would make the most impact. One by one, they would go into the file room, pull the patient's chart, go to the date of service that was lacking diagnosis or procedure codes, and code the case. But, what if the documentation isn't in the chart, where do they go from there? In most instances, that case on the report is skipped, and the coder goes on to next one in the same manner. What happens to those cases not found the first time around? Are they looked for day after day, week after week? Is there a case by case follow-up process in place? Do the lower balance cases ever get a chance to be recovered? If not, do the lower balance cases begin to accumulate and gradually increase the unbilled grand total?

Many questions can arise when analyzing these "lost" and "unbilled" cases. Was the documentation ever sent to the HIM department? Does the case truly exist? Was documentation of the service rendered, created? If so, where is it? Does the service area maintain copies of this information? Is the patient care note misfiled in the HIM file room? Is the whole patient chart missing from the file room? Did the patient have services in another department recently and was the chart mistakenly not signed out to that service area?

Let's say, the patient never had services on that date. Were the patient care services performed on a different date and the wrong case was used to post the charges? Were the charges posted to this patient's case appropriate or do they truly belong to another patient (i.e. Mis-posted charges)? There are unlimited reasons for billing delays, and they vary from case to case. To have a determination that an unbilled case "only needs coded" is an "un-researched", inaccurate, and vague excuse.

How are the unbilled cases researched or recovered? Is the HIM staff member qualified or have enough knowledge of the patient path to determine the cause for a case not to be billed? Do they understand what types of errors could occur as early as when the physician office schedules the appointment? Do they know the process taken by the registration staff to pre-register that case, with the proper or accurate service codes, patient types, and system information? Did the patient have multiple services from multiple service areas, creating various charges and various documentation pieces? Could

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the patient have two cases for the same date of service, only to find that the documentation is on one case and the charges are on the other? Do the staff members have the knowledge of the documentation process and forms utilized by all departments providing patient services? For example, is the HIM staff familiar with radiology dictation, nursing documentation, and physician documentation and dictation, as well as other notation avenues utilized by various patient care areas? How is that documentation delivered to the HIM department for processing, filing, analysis, or coding? Are only a few outside departments or nursing units conscientious enough to send their completed documentation to HIM in an orderly and timely manner? Are there bottlenecks and inaccuracies stemming from outside department's delivery processes? Are there chart and documentation tracking programs or processes in place?

Capturing the flow of information of an individual case can be a monumental task, and there are hundreds or thousands of cases produced during a common hospital or clinic day. Standardizing the flow and timeliness of that chart/documentation flow can many times be out of reach for the HIM director and their managers and staff. All departments providing patient care should have a good working relationship with the HIM department. With that, they should also have a check point system set up to assure that the documentation is completed and timely sent to the HIM department for processing. Without this, the service areas could take the chance of the case not being coded, which would have a negative long-term impact on that service area. If the case is not coded, there will be no payment or revenue returned to the department who provided the service for the patient. The service would virtually be provided to the patient free-of-charge.

Organization of data and intra-department processes are necessary to timely and accurately track all patient information from pre-registration to the time the claim is paid. Proactively having the knowledge of the patient path and tracking the documentation that travels along the path, is a must for the HIM department. Without this knowledge and process, the HIM department falls vulnerable to become a bottleneck or brick wall in the revenue cycle.

Cleaning up and/or maintaining a facilities unbilled cases is not an impossible task. With the proper knowledge, computer systems support and process changes between the HIM department and the patient care areas, the "Unbilled Report" would not be a bad word.

Written By: Barbara Allgire, Co-owner/Analyst
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Know Your Score

The group intently listens to Ken Moore

The educational meeting on October 21, 2004 was "Using a Balanced Scorecard to Execute Strategy" presented by Ken Moore, President of Quantum Innovations. The meeting started on a happy note for Ken since he was a Boston Redsocks fan and the Redsocks had just become the American League Champions the night before.

Ken wanted to make clear that what you are measuring has to be understood. Your organization cannot execute a strategy if you cannot comprehend its measurements. Once you have accumulated your measurements, you can then develop your strategy. A strategy is a set of hypotheses about cause and effect, in other words an "if-then" statement. Based on the strategy, your organization can tell if it's measuring the right target. He emphasized that a strategy can only be successful if executed properly and there is accountability.

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HFMA Forums: What's in it for You?

HFMA offers four professional communities for members who are looking for an HFMA experience tailored to their interests: the Patient Financial Services (PFS) Forum, the Chief Financial Officers (CFO) Forum, the Managed Care Forum, and the Healthcare Compliance Forum. HFMA established the forums to meet the specialized information, leadership, and networking needs of members in these niche markets. In exchange for annual dues, every forum member receives services and benefits tailored to their area of the healthcare industry.

Shared Experiences and Expanded Contacts

Webster's Dictionary defines'"forum" as "a public meeting place for open discussion." The most exciting feature of forum membership is the immediate access it grants you to peers who are facing similar workplace and career challenges. Networking opportunities offer people the opportunity to meet face-to-face or on-line with two primary goals: building relationships and accessing others' knowledge. Because there'are four different forums, each representing a different section of the HFMA population, networking opportunities are more likely to be concentrated on people who do what you do and struggle with similar problems.

HFMA's forum members are invited to collaborate on projects to help their respective communities. Forum members demonstrate a willingness to share resources—whether the resource is a shared sample job description for a front-line staff member or a joint effort to demonstrate the value that a hospital provides a community. This sharing of information is a substantial value to all community members. Through forum member-only networking activities at major HFMA conferences, members gather and learn side-by-side at members-only events or roundtables. By subscribing to members-only electronic networking programs, such as e-mail list serves or online communities, forum members can access the expertise of their colleagues to answer questions, exchange ideas, or share strategies. Forum members also have access to a directory of their peers so they can find their forum colleagues all over the country.

Stay Informed

Custom-tailored communications is another key benefit of forum membership. Technological advances have ushered in a new environment where information is abundant and immediately accessible. Forum members are provided the advantage of practical, real world solutions through members-only Forum Quarterly Insights publications. The publication is designed primarily in a question-and-answer format, tapping industry experts and healthcare providers alike, asking them to share their thought leadership and actual experiences with the rest of the forum community. Recent publications have tackled issues such as electronic health records, threats to hospital tax exemption, career development planning, the Medicare drug discount program, and the benefits and regulatory risks of joint venture arrangements.

Additionally, every forum has its own website, with archives of all forum publications, access to libraries of information, presentations, checklists, job descriptions, and countless articles and resources targeted to specific forum member needs.

Forum members who join or renew their Forum membership by September 1 of each year are entitled to two coupons for discounted HFMA education, including audio webcasts and live educational events. In addition, all Forum members have free access to special members-only audio webcasts, with no coupon required. This benefit alone more than pays for the cost of joining any given forum, and the education gleaned is invaluable.

Experienced Leadership

Each of HFMA's professional communities is led by a cadre of leaders who represent the interests and values of HFMA forum members at the National level. In addition, the forums are managed by the National Advisory Council on Forums, headed up by a member of HFMA's National Board of Directors, Frances H. Crunk, FHFMA as its Chairman. Members of the National Advisory Council on Forums, representing each forum are; Nancy C. Bell, FHFMA, Chairman of the CFO Forum Advisory Council; Jane F. Jackson-Clayton, Chairman of the PFS Forum Advisory Council, Bonnie D. Lovell, MBA, FHFMA, Chairman of the Managed Care Forum Advisory council and Patricia A. Underwood, FHFMA, CPA, Chairman of the Healthcare Forum Advisory Council.

To join any one of HFMA's four specialty forums, go to: www.hfma.org/join. If you have any questions about HFMA's specialty forums contact Anne Paul, Specialty Forums Manager at apaul@hfma.org.

Peer Reviewed by HFMA

HFMA's Peer Review process is designed to provide healthcare financial managers with an objective third party evaluation of a product or service used in the healthcare finance workplace.

The product or service is rigorously reviewed by a peer review panel consisting of current product customers, prospects who have not purchased the product, HFMA members and HFMA technical directors. The panel either validates or revokes the product or service and its performance claims based on the following criteria:

- The product or service has demonstrated that it provides a return on investment; can improve productivity or process effectiveness; meets its promoted benefits; and is accurate, effective and easy-to-use.
- The vendor has demonstrated superior customer service and technical support of the product or service.
- The vendor delivers excellent customer relations to effectively and efficiently resolve customer issues.
- The product is based on practical industry knowledge and proven experience.
- The vendor and the product or service maintains a strong reputation of integrity in the healthcare field.
- The vendor and its product or service are compatible with HFMA's brand and value statements.

After successfully completing the process, vendors may use a "Peer Reviewed by HFMA" mark to communicate their involvement to potential customers. If you're looking for a new product or service and don't know where to start, look for the new "Peer Reviewed by HFMA" mark.

- Approved HFMA Peer Reviewed Vendors
  (Craneware, Inc.)
  (Chargemasters.com)
  (MedAssets)

For more information on the Peer Review Program, read the FAQs or e-mail peerreview@hfma.org.

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recently as yesterday, the stated CMS policy shifted yet again. We also discussed Financial Assistance Policies, including eligibility and notice. Mr. Barry discussed payment plans, collection (external agencies), and important factors for providers to consider. For example, will interest be charged on payment plans? How are outside collection agencies supervised? Is hospital approval required for an external collection agency to bring suit?

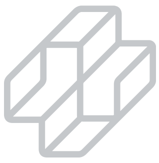
Mr. Barry concluded his presentation with a brief discussion of possible long-term solutions – none of which are easily achieved.

(Summary provided by Chris Rizzo)

Mystery Member

Unfortunately, Jerry Lear, the August Mystery Member, did not claim his prize. Will this issue's Mystery Member do better???

Look over this issue carefully and look for your name as the Mystery Member! Then contact either Dawn Balduf, Jody Forney, Chris Rizzo, or Barb Allgire for your prize.



As the Hospital Turns: The Dr. Green Saga

Law student Dr. Grace Green

If you missed the August 26 False Claims Mock Trial, you certainly missed an opportunity to see your fellow HFMA members in a different light! Picture this cast:

- Alan Ganzi as the grandfatherly neuro-proctologist Dr. Charles Sage
- Samantha Platzke as the brilliant Dr. Grace Green
- Todd Howell as the oily Chris Fink (who even his mother couldn't love)
- Beth Hickman as stick-to-the-facts Jean Complicity
- Kim McClure as Arnie I'm just the HR guy Appeaser
- Dawn Balduf as the overwrought Ophelia Frazzled
- Amy Gill as The Judge

The aptly-named whistleblower, Chris Fink

The rest of the HFMA members in the audience were the jury. Now, if that wasn't the world's most sympathetic jury! Yet after listening to the facts presented by attorneys Keith Barber and David Honig, the verdict was in favor of the villain Chris Fink and the U.S. Government.

The presentation was an entertaining, yet eye opening, way to point out the vagaries of the False Claims Act. As the saying goes, the road to hell is paved with good intentions, and that pretty much sums up the situation pointed out in the trial. And although the trial was fictional, it was extremely realistic and could easily happen.

The HR Facts according to Arnie Appeaser

Be sure to read David Honig's article elsewhere in this issue for more on the False Claims Act.

Here's what your fellow members had to say about the Mock Trial:

"One of the best presentations we've had"

"Just very good and fun!"

"Excellent presentation…very important and informative"

New Members

Robyn Mcghee
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HIPAA: Is There a False Claims Allegation Lurking?

By: David B. Honig, Esq.
Juli K. Shields, Esq.
Hall, Render, Killian, Heath & Lyman, P.S.C.
Indianapolis, Indiana

The Administrative Simplification standards of the Health Insurance Portability and Accountability Act of 1996[1] ("HIPAA") is the largest piece of legislation to hit health care providers in the last decade. From the date the first round of final regulations were issued in 2000 (the Transaction and Code Set Regulations), to the last major compliance date of April 2005 (the Security Regulations), it will have taken almost five years for providers to interpret, decipher, ponder and implement new privacy, confidentiality, security and transactions policies and procedures.

Even now, fifteen months after the compliance date for the Privacy Rule, and nine months after the extended date to comply with the Transaction and Code Sets Regulations, the health care industry is not fully compliant with HIPAA. A recent survey conducted by the Healthcare Information and Management Systems Society and Phoenix Health Systems reveals that less than half of health care organizations are ready to conduct all HIPAA standard transactions, and a full twenty percent of health care providers are still non-compliant with the Privacy Rule.[2] As of February 29, 2004, the Office for Civil Rights (the enforcing agency of the Privacy Rule) had received 4,755 complaints of privacy violations, and had referred forty of those complaints to the Department of Justice because they involved a criminal matter. Full compliance with HIPAA is clearly in the future for providers, if it comes at all.

The undeniable fact that HIPAA compliance is elusive, and will continue to be, raises issues regarding the False Claims Act. The false certification theory of falsity and the emerging *per se* knowledge standard under the FCA magnify the possible effects of noncompliance of HIPAA and give more teeth to the FCA.

False Certification. The False Claims Act[3] permits the government or a private whistleblower to bring a lawsuit alleging false or fraudulent claims to a government program. Claims can either be actually false on their face or under the "false certification" theory. Under the false certification theory, a provider can submit a legitimate and complete claim for payment, yet if it has not fully complied with federal laws and regulations, the claim can be alleged to be false.[4] HIPAA is one of those federal laws, compliance with which is critical under this theory.

For example, assume that a hospital runs short of copies of its Notice of Privacy Practices for a day and half, and fails to provide new patients with it. The Notice of Privacy Practices is the cornerstone of the Privacy Rule; it is the one document that the public receives that provides information about the patients' rights and the provider's responsibilities. Failure to distribute copies of the Notice is a clear HIPAA violation.[5] The admitting clerk, who is responsible for giving the Notice to new patients, is disgruntled with hospital management, and is good friends with the billing clerk, who is knowledgeable about false claims. The two clerks come together and file a *qui tam* action with the local federal prosecutor, claiming that all of the claims filed during the day and a half that no Notices were distributed were false under the false certification theory.

The above example is not as far fetched as it may initially seem. Application of the false certification allegations coupled with a high profile HIPAA violation, such as described above, is a plausible scenario, particularly in those circuits that have adopted the false certification or implied false certification theory. Indeed, because *qui tam* allegations are filed under seal, there could currently be one or fifty such claims in existence.

Per Se Knowledge. The *per se* theory of knowledge of a regulatory violation that is the next wave of false claims allegations is another minefield for HIPAA violations. Because this theory asserts that any regulatory violation

proves recklessness or deliberate ignorance, many HIPAA violations are ripe for federal prosecutors or *qui tam* relators to hold up as a *per se* false claims.

Consider this scenario: Currently, few providers are 100% compliant with the Transaction and Code Sets Regulations, primarily because the government provided a grace period for allowing covered entities under HIPAA to continue to file legacy (traditional) claims without the fear of penalty. These entities, however, are technically in violation of the Transaction and Code Sets Regulations, and while they do not presently face the penalties imposed under HIPAA for noncompliance, an astute employee might assert that the noncompliance is reckless disregard for the truth or falsity of its claims that are all filed contrary to applicable law. In some jurisdictions, this allegation may be well received.

Now What? So what is an unsuspecting provider to do? Given the current and future state of the false claims landscape, any obvious and not-so-obvious violations of a federal statute or regulation should be carefully reviewed and remedied to the extent possible. Legal counsel should be consulted to evaluate the violations, as well as provide advice on any areas of regulatory concern. Seeking and taking legal advice on these matters is a sound defense to false claims allegations, and sometimes the only viable defense if the false certification or *per se* knowledge standard is the basis of the claim. Educating employees on the provider's compliance initiatives, as well as having and promoting a clear process for reporting compliance concerns, can go a long way in avoiding *qui tam* actions for a FCA violation. Finally, dusting off the organization's compliance plan and taking a fresh look at it can reveal current deficiencies that should be addressed, all while keeping in mind the evolving state of the False Claims Act.

For more information on the False Claims Act and HIPAA, contact David B. Honig, Esq. at dhonig@hallrender.com or Juli K. Shields, Esq. at jshields@hallrender.com or either at 317-633-4884.

Billing for the Uninsured

The September 30 Northwest Ohio HFMA program on "Billing for the Uninsured" was held at the Holiday Inn Express in Perrysburg. This timely program was very well attended, indicative of the unwanted national and legal attention hospital self pay billing practices have received in recent months – not to mention the unfavorable press. The program was presented by Dennis Barry, Partner, Vinson & Elkins, LLP. Mr. Barry's principal area of practice is the health care industry, with an emphasis on advising providers with respect to Medicare laws and regulations.

Mr. Barry provided background information on the uninsured – who they are. The fact that self pay is billed at full charges (which are irrelevant to cost) is more of a problem for the non-indigent, particularly those who are also not wealthy and have difficulty paying for their healthcare. Those who are between 200% - 400% of Federal Poverty Guidelines are most at risk – and represent approximately 20% of the uninsured patient population. Those patients below 200% of Federal Poverty Guidelines will likely qualify for free care under most provider charity policies.

Mr. Barry brought us up to date on the status of the current lawsuits recently in the news, as well as other legal actions and threats related to charitable obligations, tax-exempt status, collection actions, and others. We also discussed the cost-to-charge ratio and outlier payments, and the negative impact on reimbursement of reducing charges (to bring charges more into line with cost). These are timely issues for all of us, including Karol Bortel, CFO from Wood County Hospital, this issue's Mystery Member.

In addition, Mr. Barry reviewed the CMS policy on discounts for the indigent, Medicare Bad Debts and the required collection effort, and waiver of co-payments. He pointed out that some of the guidance CMS has given in recent months on discounts for the indigent has not been in writing, and has been ambiguous. As

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