



EVERGREEN CHAPTER

American Association of Healthcare
Administrative Management
formerly American Guild of Patient Account Management

BOARD MEMBERS:

PRESIDENT: Greg Moga

gmoga@pacificmedicaid.com

FIRST VICE PRESIDENT: Lee Johnson

LJohnson@CWHS.com

SECOND VICE PRESIDENT: Darlene Wood, CPAM

woodd@u.washington.edu

SECRETARY: Lee Spingelt, CPAM

lees@pacmed.org

TREASURER: Ed Jose, CPAM

edjose@u.washington.edu

CO-DIRECTOR I Government/Payer Relations

Deborah Williams / dawilliams@providence.org

Monica Lelevich / mlelevich@peacehealth.org

DIRECTOR II Membership Dev: Kim Walthew

kwalthew@hchnet.org

DIRECTOR III Ways & Means/Corp Partners

Joyce Gibb / jgibb@merchantscredit.com

DIRECTOR IV Publication: David Cartier

dcartier@pacificmedicaid.com

DIRECTOR V Certification: Jerry Brooks

jerryb@u.washington.edu

CO-DIRECTOR VI Education

Vonda Lange / Vonda_Lange@Valleymed.org

Kim Back / Kim_Back@valleymed.org

CHAIRMAN OF THE BOARD: Judy Veazie, CPAM

veazie@Kalama.com

EDITOR:

David Cartier

1120 Cherry Street #300

Seattle, WA. 98104

(800) 544-9923

(206) 215-2333

(206) 215-2344 fax

dcartier@pacificmedicaid.com

THE EVERGREEN CONNECTION

Volume 17, Number 2

Fall 2002

President's Message



Yesterday I woke up to a feel of fall in the air. A brief morning shower and brisk wind from the south made me think of my many friends in AAHAM and our upcoming programs. September has seemed like along way off but now our Fall Quarterly, scheduled for Thursday September 12 at the Sea-Tac Embassy Suites, is only a month away with one of our best programs ever. Our main speaker will be Sheryl Vacca, Director of Health Care Services with Deloitte and Touche LLP, Los Angeles. Sheryl will be presenting Best Practices: Compliance Plans for Business Offices. This is a timely presentation with current compliance issues, auditing and training tips, policy & procedure requirements, and many other critical elements for effective compliance programs specific to Patient Financial Services. Our Fall Quarterly will also include a presentation on electronic billing to DSHS, an update from the Washington State Hospital Association, and the latest information on litigation over DSHS's recent spenddown audits.

Now it really is along way off until our Winter Quarterly, scheduled for Friday December 6, 2002, but I am thrilled to tell you that we have Rose Dunphy, CPAM, AAHAM's National Certification Chair, coming to provide training for Technical and Professional Certification. Rose is one of the most engaging and dynamic speakers I have ever heard. This will be

your opportunity to provide your staff with the knowledge they need to become certified! Watch for a special flyer announcing the details of this terrific program.

Finally, if you're not involved with one of the Evergreen Chapter's committees, this fall is time to think about giving some of your time and effort to greater involvement with the Evergreen Chapter. I have been a member of AAHAM (and its predecessor AGPAM) for almost fifteen years. I can tell you, without hesitation, that for every amount of time and effort I have given to AAHAM, I have been re-paid ten-fold in knowledge, contacts, and most importantly, friendships among my peers at hospitals across the country. So when the fall winds blow and the rains return- think AAHAM. You'll be glad you did!

Greg Moga

INSIDE THIS ISSUE:

- President's Message
- Medicaid Waiver
- Billing of Mammography Services
- August Payer Provider Relations Committee Meeting
- MI EMER Spenddown Meeting
- APC Update
- Letter from the Editor
- DSHS News Release
- Calendar

MEDICAID WAIVER

by Bev Peterson, Pacific Medicaid Services

On 7/22/02 DSHS released the draft of the section 1115 Waiver entitled the Medicaid and State Children's Health Insurance program (SCHIP) Reform Waiver (MSRW) to be submitted to CMS. The stated goal of the waiver is to increase the number of individuals with health insurance coverage by sustaining the state's current Medicaid coverage

commitments and expanding Basic Health enrollment by 20,000 adults. DSHS submitted a section 1115 Waiver in 11/01, however, the initial waiver was sent back to DSHS for further information and clarification of the proposed changes. The current waiver includes several aspects that have the potential to prevent clients from receiving necessary medical care and will increase the cost providers incur treating these clients.

Some important features of the waiver are:

- The implementation date is 1/1/03.
- Proposes a co-pay for all coverage groups (except American Indians and Alaska Natives) for name brand prescriptions and emergency room services (prescription co-pay will be waived if the drug is deemed medically necessary by the client's medical provider).
- Proposes monthly premiums for certain optional CN and Medically

Needy clients in households with income above 100% of the FPL. The amount of the premium varies depending on the optional coverage group a client is on. Both co-pays and premiums would apply to SCHIP clients.

- Elimination of non-emergent dental care, optical care and hearing care for certain adults. The state would retain flexibility to change optional services for mandatory and optional populations.
- The waiver proposes to expand coverage to parents of Medicaid and BHP children with income at or below 200% of the FPL through the BH plan. The expansion population would be subject to the BHP pre-existing conditions criteria.
- Proposes freezing enrollment if caseloads and expenditures were forecast to exceed appropriations (during which time applications would be accepted but no coverage would be available) of optional coverage groups, which are:

- CN optional children
- CN optional HWD (healthcare for workers with disabilities)
- MN aged
- MN blind & disabled
- MN other (pregnant women and children with income above the CN limits)
- SCHIP

The enrollment freeze would apply to new persons seeking coverage in an optional population. It would not apply to clients with existing mandatory coverage who are transferred to one of the optional groups

due to a change in their circumstances. (For example a client who has been receiving CN coverage due to a disability and becomes eligible to receive SSDI payments

would no longer be eligible for CN due to income but would not be affected if an enrollment freeze were in place for MN populations). The freeze would be in effect no longer than 6 months before the Legislature was scheduled to convene. The Legislature would have the options of lifting the freeze by enacting a supplemental budget to provide the needed funding, maintaining the freeze for the remainder of the fiscal year, providing supplemental funding to lift the freeze from selected but not all groups or financing increases in mandatory and optional CN populations and not providing any supplemental funding for the optional groups. ❖



See You There!

**Fall
Quarterly
Thursday,
September 12th
Sea Tac
Embassy Suites**



Billing of Mammography Services

From CMS

Important Information Regarding the Proper Billing of Mammography Services:

CMS instructed Medicare Intermediaries in transmittal 1842 issued in September 2001 to return to the provider (RTP) claims containing HCPCS code 76085 without code 76092. However, based on CMS findings, claims containing only code 76085 are being submitted and separate claims are also being submitted with code 76092 for the same date of service. Because services are being billed on two separate claims, the beneficiary is disadvantaged by not receiving payment for both of these covered services. CMS has asked us to advise our providers that code 76085 must be billed on the same claim with 76092 and to return any claims to the provider that are not billed appropriately with an explanation that payment for code 76085 cannot be made when billed alone.

In addition, claims are being submitted with both HCPCS codes 76092 (screening mammography-film) and G0202 or G0203 (screening mammography-digital) when only one type of screening mammography should be billed. Again, CMS has asked us to advise our hospitals not to submit claims reflecting both a film screening mammography (76092) and a digital screening mammography (G0202 or G0203) since payment will not be made for both. CMS will be instructing us at a later date in a manual instruction to return to the provider claims containing both a film screening mammography (76092) and a digital screening mammography (G0202 or G0203). ❖❖❖

August Payer Provider Relations Committee Meeting

by Lee Johnson, Central Washington Hospital


How many times per week (or is it per hour, per minute?) do you hear your billing staff complain about problem payers? "Our AR Days would be so much better if they would just pay our claims and stop playing all those games to delay or deny payments" they tell you month after month. Have your staff surprised you as they mutter utterances that would blush an old salty seaman about a particular payer's problems? These are the times you wish you could pick up the telephone and call a person at that payer but you just didn't know who to call.

The next time you hear one of these complaints ask yourself if you or your staff attended the last Washington State Payers Relations Committee held on May 15th at Steven's Hospital in Edmonds? Oh, your staff was too busy that day, well then how many of these meetings this past year have they attended? Ah, I see, too busy again. So are they too busy fixing the same problem over and over again instead of resolving it and moving on to new challenges? They could be so much more effective at reducing AR issues by meeting face to face with the payers and partner with them on permanent resolutions! Maintaining a high AR and restricting your facilities cash flow is not a long term career strategy!

So if you want to be informed, pro-active and involved in addressing and fixing problems you need to attend the next Washington State Payer Relations Committee.

Representatives from many of the major payers are in attendance at these meetings as are many progressive providers. These meetings are held quarterly and are chaired by Chery Mustard of Uniform Medical Plan (CMus107@HCA.WA.GOV). The next meeting of the Washington Payer Provider Relations Committee is scheduled for August 21, 2002 from 9:00 a.m. to 12:00 p.m. at Valley Medical Center in Renton. Next time remember that when you point the finger of blame for your problems that you've got three fingers pointing right back at you. Hold up your hand and try it, you'll see! That's three good reasons for you to attend the next meeting! See you there! ❖❖❖


Are Your Receivables Managing You?



Aging receivables have a way of assuming a life of their own. Before you know it, they can consume an inordinate amount of your staff's time—and restrict your cash flow.

ARS can help you get back on a winning string, just as we've helped hundreds of hospitals around the country clean up their receivables, reduce A/R days and improve cash flow. We'll provide whatever assistance you need. Like no one else, we can even bring an entire team of professionals to your site.

Call Theresa Mathew at 360-730-2202 or 206-669-6506. And put yourself back in control of your receivables.



Advanced Receivables Strategy, Inc.
 360-730-2202 or 206-669-6506
www.advancedreceivables.com
We are proud to be an Evergreen Chapter
 AAHAM Corporate Gold Sponsor



MI EMER SPENDDOWN MEETING

by Corey Shank, Pacific Medicaid Services

There are two ways organizations can work with one another successfully. One is an understanding by those involved, where organizations coordinate their efforts, seeking common success. In this scenario, the goal is jointly sought, which makes a more structured process unnecessary. There is an understated accountability appreciated by all.

Another type of working relationship among organizations is rigid and regulated. The process of the relationship is mandated with assigned responsibilities, leaving little room for diversion. To succeed in this manner, the process must be accessible to everyone, and efficiencies must be embedded within.

The problem with EMER and spenddown is neither one of the ideals is followed. And we are faced with a combination of the worst from both.

Hospitals are accountable for millions of dollars in overpayments made by the state, as well as interest on these dollars at an inflated rate (12% flat penalty). Economically speaking, even if these payments weren't due the hospital, the state is still making money because of the high interest penalty. Nevertheless, hospitals know enough in their dealings that our government works by statute and regulation. Why should we assume that being accountable for EMER and Spenddown should be any different? We shouldn't. Sure, there is a regulation on where to put EMER and Spenddown information on a claim...Where is the rule for getting that information in the first place? From the patient, from the

eligibility office?

In the best case, DSHS would be One, rather than a compartmentalized collection of mute entities. The state's systems would communicate with each other (ACES & MMIS). As it is, Medicaid in Washington is an entirely different creature than any other payer for medical services.

DSHS, WSHA, PMSI and representatives from hospitals convened to address the

“Compliance with billing guideline varied by hospital with no clear correlation between size and compliance.”

issue of EMER and Spenddown. Interested organization should thank WSHA for facilitating this meeting. In the discussions, it became clear that the issue is split in two parts; 1) current audit cycle which involves historical accounts, and 2) how to formulate a process to affect correct accounting for EMER and Spenddown in the future.

The current audit cycle, the discussion was short but informative. DSHS has identified \$13 million in overpayments. \$6.5 million already completed, and the remainder pending request from another 12 or 13 hospitals. A good quote from the minutes of this meeting reads: *“Compliance with billing guideline varied by hospital with no clear correlation between size and compliance.”* Meaning, no matter the size of the hospital; compliance (according to DSHS) was poor. If all these hospitals had compliance issues, the problem is not the hospitals, but the process itself. An audit process should be to identify the anomalous

occurrence, not to penalize every hospital for having to work within a faulty system.

The best of the meeting focused on creating a process in which DSHS and hospitals can work in a mutually understood and acceptable process. In terms of ideas, the meeting went very well. However, this meeting did not have an air of negotiation. The result was a collection of proposed methods to resolve the issue. Plausible solutions included: 1) Account for the \$2000 EMER by adjusting the reimbursement rate down; 2) allowing hospital access to the EMER/ Spenddown information either online or through a dedicated phone number; 3) DSHS adjudicate claims, and shift the accountability to themselves; 4) develop a Point of Service system where a patient's EMER and Spenddown were automatically known...a 'smart card' coupon.

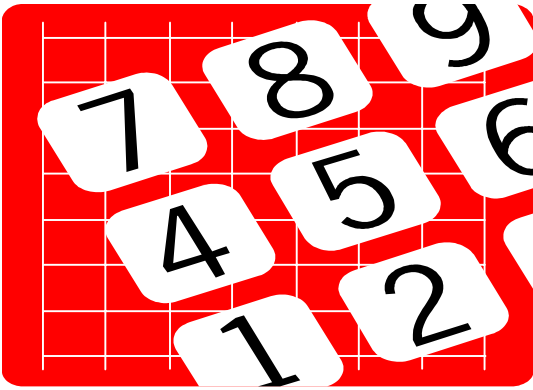
The problem is the institution of any of these solutions. Of course time is always an issue, as is timing...the timing could not be worse: HIPAA. In the original thread of HIPAA is Administrative Simplification. Hospitals deserve quick and resolute action to be taken. But of course, HIPAA brings in so many other issues relating to Security that it will scare most anyone away from taking action on an Information System. DSHS/MAA is not any different.

Right now, each facility needs to focus on identifying its own process and effectiveness. This is not an issue affecting only a few, it is epidemic. To get more information, get in touch with WSHA, or with David Cartier of Pacific Medicaid Services. These are resources available, whether it relates to the current audit cycle or a prospective look at a process for accounting for EMER and Spenddown on claims sent to DSHS. ❖❖❖



APC Update

by Day Egusquiza, AR SYSTEMS, Inc



TRANSMITTAL A-02-050:

Good news first! Effective 7-1-02, 3 new pass through codes: C1783-Ocular implant, aqueous drainage assist device; C1888-Catheter, ablation, non-cardiac, endovascular (implantable); C-1900-Lead, left ventricular coronary venous system. This brings the total pass through devices to 100.

Bad news: Of the 100, 95 are eliminated for separate payment consideration on 12-31-02. As of 4-1-02, you will remember that 75% of the pass through payment is rolled in to the APC that it impacted. The remaining 25% has a 63.6% pro-ratio reduction - this is the amount left to be eliminated.

Good news: The transmittal has excellent narrative on how the pass throughs should be used. Extensive narratives.

Good news: Clarity on "fractured" devices and a 2nd one has to be used. Declare both C codes = 2 payments. However, if the device is 'faulty' -this is an issue for the vendor. These can not be billed. Also, clarity on using items within a kit and multiple pass through devices used.

ADDENDUM B Web site: Medicare has issued a web site for the electronic version of Addendum B with the 3-1-02 version:

(Most current-effective date 4-1-02) <http://www.hcfa.gov/regs/hopps/ChangeF4CY2002.htm>.

This contains the detail, per CPT-4 code, of each gross payment and copayment. An ABSOLUTE must tool for Business Offices and reimbursement staff.

DRUG BENEFIT: As you are probably aware, this week saw the passage of a Drug Prescription benefit in the House, HF 4954 with an effective date of 2005. It has

many components which will benefit the patient, the outpatient pharmacy benefit and hospitals.

REMEMBER: Self administered medications given in an outpatient environment (ER, Observation, Day Surgery, Cancer Centers) are considered NON-Covered for Medicare patients and must be collected from the patient. This is because there is no outpatient prescription benefit. (259 revenue code) Same applies to take home meds/253. Watch this legislation closely as there will be a direct impact to hospitals... (Expected that the Senate will reject at least this time around. Price tag: \$30 billion.)

More later... Stay tuned for more fun. ❖❖❖

LETTER FROM THE EDITOR

by David Cartier, Pacific Medicaid Services

The Board voted to award Darlene Wood, CPAM a free registration to AAHAM 2002 Annual National Institute. It was awarded in recognition of Darlene's many years of service and profound dedication to the Evergreen Chapter of AAHAM. The 2002 ANI will be held from October 8th through the 11th at JW Marriott Galleria in Huston, Texas. Each chapter is given one scholarship each year for the ANI.

Mark you calendars and plan on going to Texas with Darlene. I attended last year and had a wonderful time in Reno (came out ahead too). It is a unique opportunity to network with your fellow professionals from around the country and, more importantly, get up to speed on the latest developments in our fast-moving field. I learned a lot last year and plan on being there again this year. It looks like a wonderful program. Come to Texas and take the proactive approach to building your professional success. Invest in yourself.

Please go to www.aaham.org to download a event brochure and find more information. If you can't find the time to come this year, start planning ahead for Ft. Lauderdale in 2003, St. Louis, MO in 2004 or New Orleans in 2005.





News *Release*

www.wa.gov/dshs

OLYMPIA – The Washington Medicaid program plans to circulate a new draft Medicaid Reform waiver early next month to give the public, health-care providers, Medicaid clients and stakeholders another opportunity to review and comment on a series of cost-containment measures that will be proposed to the federal government.

Medicaid representatives said the waiver package will include premiums for the highest-income Medicaid clients, co-pays for all clients to discourage inappropriate use of emergency rooms and brand-name prescription drugs, and an enrollment freeze for some optional groups the state could resort to in the event actual enrollment begins to exceed the state's forecast.

"These changes will be an important statement to legislators and taxpayers that the program is better managed and its clients are doing what they can to share in the cost of their care and consume services more prudently," said Doug Porter, the Assistant Secretary who heads the Medical Assistance Administration (MAA) in the Department of Social and Health Services.

Some draft decisions are still being weighed in light of the public testimony solicited at 10 Town Hall meetings held around the state in May and June. After the additional comment period in July, the proposals will be finalized and sent to the federal Centers for Medicare and Medicaid Services (CMS) by early August, Porter said.

"If we receive federal approval by the end of the year, we will be able to take these proposals to the Legislature in 2003 so they can take effect with the beginning of

the new biennium in July 2003," Porter said.

Porter noted that the state faces unprecedented funding challenges next year, and Medicaid – with costs growing faster than 10 percent a year – could become a tempting target for legislators trying to trim state expenditures in the face of revenues that are growing at only 2 percent or less.

"Our hope is that these cost-containment tools will help us slow the growth of expenses and give legislators more leverage," Porter said. "But as we've warned people throughout our Town Hall hearings, the waiver is not a magic bullet. We are talking about saving tens of millions of dollars with this waiver; the current projection for revenue shortfall is \$1.2 billion, and Medicaid reductions to address this would likely be measured in the hundreds of millions of dollars."

The waiver also asks the federal government to let the state keep approximately \$150 million in unused federal State Children's Health Insurance Program (SCHIP) funds over the next five years. Washington is restricted by law now from using those funds for other health-care needs.

Because Washington was an early state in the effort to find and cover uninsured children, the SCHIP program virtually guarantees that the state will have about \$30 million a year in leftover funds. Currently, that money must be returned to the federal government, which then distributes it to other states with higher uninsured rates.

Porter noted that the Medicaid and SCHIP

Reform Waiver will detail the specific "waiver populations" that determine which clients would have to pay premiums or get benefit changes, and who would be subject to an enrollment freeze. The waiver's limited co-payments are proposed to apply to all Medicaid clients, he said.

Discussion at the Town Meetings generally dealt with these areas:

- **Enrollment freeze:** When appropriated funding will no longer support the current level of expenditures, an enrollment freeze on some optional programs could protect all current enrollees. (Mandatory Medicaid programs would continue to accept eligible applicants.) The enrollment freeze could last until legislators convened to appropriate additional funds, or enrollment returned to forecast levels. This is how the state's Basic Health program operates.
- **Premiums:** Optional program enrollees with higher incomes would have to pay the small premiums (on the order of \$10 to \$15, with a cap for larger families). This is also similar to the Basic Health plan.
- **Co-Payments:** Any Medicaid client could be charged a \$5 co-pay if they insisted on expensive brand-name drugs unnecessarily or \$10 if they sought non-emergency care at a hospital Emergency Room.
- **Benefit redesign:** Some optional adult benefit packages would be streamlined, retaining major medical, hospitalization and preventive coverage, but dropping dental, vision and hearing. The coverage would still be broader than the Basic Health program, and all Medicaid children would continue to receive full-scope Medicaid coverage.

EDITORS: Waiver-related documents and other information are available on a special MAA Web site at <http://maa.dshs.wa.gov/medwaiver>. To receive a free fact sheet on the waiver, interested parties also can e-mail stevej2@dshs.wa.gov





2002



American Association of Healthcare Administrative Management

Schedule of Events

- April** WSHA Administrative Simplification Educational Workshop
Apr. 3rd: Valley Medical Center
Apr. 9th: Mt. Vernon
Apr. 16th: Kelso Red Lion Inn
- May 16** Quarterly, SeaTac Marriott
- June** Membership Directory Distributed
- July** Newsletter
- August** "Spotlight on National Membership"
- September 12** Quarterly, SeaTac Embassy Suites
- October 9-11** Annual National Institute Houston, TX
- November 1** Fall Target Workshop
- November** Newsletter
- December 6** Quarterly, SeaTac Embassy Suites

January

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

March

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

April

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

July

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

www.aaham.org





Merchants Credit Association



Joyce Gibb, Director of Marketing

Lyle Maichel • Robert Valasco

Phone (425) 643-2613 or (800) 755-1107

Fax: (425) 643-8546

Email: mcacollect@aol.com

PO Box 7416 • Bellevue, WA 98008

- Or in Bellingham -

Marian Rawls, Regional Manager

Phone: (360) 738-4817

Fax: (360) 738-1476

4120 Meridian #290-A • Bellingham, WA 98226

- Hospitals
- Healthcare
- Commercial
- Professional
- Credit Unions
- Courts/City Services

Over 64 Years of Service!

Locally owned & operated

www.merchantscredit.com

A Diamond Corporate Sponsor for the Evergreen Chapter

THE EVERGREEN CONNECTION

David Cartier, Editor

1120 Cherry Street #300

Seattle, WA. 98104

(800) 544-9923

(206) 215-2333

(206) 215-2344 fax

e-mail: dcartier@pacificmedicaid.com

TIME DATED MATERIAL