

# the right mix

news from the Carbis Walker LLP Health Care Team  
Spring 2007

## NPI Extension Gives Providers More Time

As you are all aware, the Centers for Medicare and Medicaid Services (CMS) has extended the deadline for providers to obtain their National Provider Identifier (NPI) numbers. Under the most recent plan, all transactions would have become "NPI only" as of May 23, 2007. The new date for NPI-only transactions will be May 23, 2008.

One of the major sticking points was apparently that CMS did not have a policy in place to facilitate the communication of NPIs amongst providers. Because there was no policy in place, providers did not know how to obtain the NPIs of physicians who referred patients to them. CMS has promised that it will make data available to assist providers in developing crosswalks between old provider numbers and NPIs.

Please keep in mind that CMS has not actually suspended the May 2007 compliance date. They have just stated that there will be relaxed enforcement of the date until May 2008. CMS will enforce the NPI requirement in response to complaints; therefore, it still behooves providers to ensure that they have their NPIs and are using them as of the May 23, 2007, date. If CMS receives a complaint regarding non-implementation of NPIs, it will notify you in writing. You will then have a chance to show that you are making good-faith efforts to be in compliance with NPI rules, or you may have to submit a written corrective action plan.

It may also be in the provider's best interests to ensure that all referring physicians have obtained their NPIs and have processes in place to begin using them. If a physician that refers patients to you is not NPI compliant, you may wish to stress to that physician the importance of still obtaining

their NPI by May 23, 2007, and, if you have the means to do so, assist them through the process.

If you have any questions regarding the delay in mandatory NPI usage, please contact James Hunt at 724-658-1565 or [jhunt@carbis.com](mailto:jhunt@carbis.com), or Rod Bogle at 412-635-6270 or [rbogle@carbis.com](mailto:rbogle@carbis.com).



## Medicare Reimbursement Issues

Two very common questions that we continually receive involving Medicare reimbursement relate to billing Medicaid for dual eligible beneficiaries and the "no-pay" billing of Medicare eligible residents in skilled nursing facilities. We would like to highlight the issues and give brief explanations of them.

As for bad debts, as you all know, to be eligible for reimbursement through the Medicare program, claims on dual eligible patients must be billed to Medicaid even though the end result will be a Medicaid denial. When the Medicare intermediary audits dual eligible bad debts, the first thing that they will look for is an official denial from the Medicaid program. It is important to bill Medicaid and receive this denial as soon as possible after providing services to a dual eligible patient. In the event that you miss the billing window to the Medicaid program, we have seen instances where the provider may contact their local County Assistance office and obtain a letter stating that the patients for which they are claiming Medicare bad debt were eligible for Medicaid but payments would have been denied because the amount of reimbursement received from Medicare would

have exceeded the amount that Medicaid would pay. This should be a last ditch effort, however, and the focus should be on obtaining denials up-front. It would be beneficial for providers to take a quick review of their billing processes to ensure that bills are sent to Medicaid for all dual eligible patients.

As you all know, the Medicare program clarified that no-pay bills were necessary for all Medicare beneficiaries in skilled nursing facilities as of October 1, 2006. This was just a clarification of an already existing policy that was not being enforced consistently by intermediaries throughout the country. If no-pay bills are not submitted to Medicare, the program will begin to shut off Medicare payments until the situation is remedied. In order to ensure an uninterrupted Medicare cash flow, providers should take a quick review of their processes to ensure that no-pay bills are consistently being submitted to the Medicare program.

If you have any questions regarding these Medicare reimbursement issues, please contact James Hunt at 724-658-1565 or [jhunt@carbis.com](mailto:jhunt@carbis.com), or Rod Bogle at 412-635-6270 or [rbogle@carbis.com](mailto:rbogle@carbis.com).

## IRS Releases Suggested Governance Guidelines for Tax- Exempt Organizations

On February 2 the Internal Revenue Service ("IRS") released proposed, suggested governance guidelines [http://www.irs.gov/pub/irs-tege/good\\_governance\\_practices.pdf](http://www.irs.gov/pub/irs-tege/good_governance_practices.pdf) for tax-exempt organizations. Since the guidelines are proposed, following the guidelines is not a requirement for tax exemption, but they are intended to emphasize what the IRS believes to be important for organizations obtaining and maintaining tax exempt status.

The guidelines address the following general topics: (1) adoption of a mission statement, (2) adoption of a code of ethics and whistleblower policies, (3) satisfaction of the duty of care/director diligence, (4) satisfaction of the duty of loyalty/effective conflicts of interest oversight, (5) constituent transparency, (6) oversight of fund-raising activity, (7) stewardship of financial affairs, (8) payment of reasonable compensation, and (9) adoption of a document retention policy.

We recommend that exempt organizations consider a review of their current governance policies and practices relative to these new suggested governance guidelines. If you would like to get a complete copy of the guidelines, they can be found at [www.irs.gov](http://www.irs.gov) or by calling Jeff Petrell at 412-635-6270.

### CMS Releases Proposed Rule for SNF PPS

On April 30, 2007, the Centers for Medicare and Medicaid Services (CMS) released the proposed rule for the Federal Fiscal Year 2008 Skilled Nursing Facility Prospective Payment System (PPS).

The main piece of information in the proposed rule is the \$690 million, or 3.3 percent, payment increase that CMS is proposing for participating skilled nursing facilities in fiscal 2008. However, it is not certain that this 3.3 percent increase will actually take effect. Both the

President's budget and the recommendations of the Medicare Payment Advisory Commission (MedPAC) include a proposal for a zero percent increase in payments to skilled nursing facilities for fiscal 2008.

The full proposed rule can be read and downloaded at [www.cms.hhs.gov/SNPPS/downloads/cms-1545-p-display.pdf](http://www.cms.hhs.gov/SNPPS/downloads/cms-1545-p-display.pdf). If you have any questions regarding the proposed rule, please contact James Hunt at 724-658-1565 or [jhunt@carbis.com](mailto:jhunt@carbis.com), or Rod Bogle at 412-635-6270 or [rbogle@carbis.com](mailto:rbogle@carbis.com).

### Charity Care Guidelines

Due to a wide diversity in reporting practices and confusion in the proper classification between bad debt and charity care, the Healthcare Financial Management Association's (HFMA) Principles and Practices Board has recently revised Statement 15, Valuation and Financial Statement Presentation of Charity Care and Bad Debt by Institutional Healthcare Providers. Bad debts result when a patient who has been determined to have the financial capacity to pay for health care services is unwilling to settle the claim, whereas charity care is provided to a patient with demonstrated inability to pay. The revised statement outlines the importance of properly reporting charity care and bad debt, examples of eligibility criteria for charity care, timing of charity care eligibility determinations, recordkeeping for charity care and bad debts, and valuation and disclosure of charity care and bad debts. The objective of this guidance is to significantly improve the accuracy and consistency relative to

bad debt disclosure, reflecting only those amounts initially expected to be collected with an offsetting reduction in revenue. Although the impact to the bottom line will be negligible, the ability to distinguish true bad debt and revenues will be improved.

These guidelines are applicable to all taxable and tax-exempt institutional health care providers, including hospitals, skilled nursing facilities, sub-acute care facilities, multi-specialty clinics, freestanding ambulatory centers, and continuing care retirement communities. The revised Statement 15 will significantly affect the way health care providers record bad debt and charity care. In order to be prepared for the changes, hospital management will need to have a complete understanding of the new requirements. If you would like further information on these changes or would like assistance with adopting the revised statement, please feel free to call James Hunt at 724-658-1565 or [jhunt@carbis.com](mailto:jhunt@carbis.com), or Michael Garczynski at 724-658-1565 or [mgarczynski@carbis.com](mailto:mgarczynski@carbis.com).

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