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In new era of e-health, feds take a step to cutting costs through new sets for codes

Not much change from the proposed rule

The first standard regarding electronic health information has finally arrived — and health information management (HIM) professionals should be pleased with the code sets.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) mandated that the Department of Health and Human Services (HHS) in Washington, DC, adopt standards that would help reduce the costs of administrative and financial transactions in the health care industry. The first standard, Transactions and Code Sets, was published in the *Federal Register* on Aug. 17.[1] The effective date of this rule is Oct. 16.

"The final rule is pretty close to the proposed rule and didn't contain any big surprises," says **Sue Prophet**, RHIA, CCS, director for coding policy and compliance at the Chicago-based American Health Information Management Association (AHIMA). "On the whole, I would say we were pleased with it."

Specifically, Prophet says she was pleased to see that the official coding guidelines for ICD (International Classification of Diseases)-9-CM were included as part of a standard code set. "One of the biggest complaints we hear from our members is how payers aren't following the official coding rules and how they want members to code things incorrectly. This causes all kinds of problems with inconsistency and noncomparability of data."

Here is how the final rule clarifies the use of the standard code sets:

• ICD-9-CM, Volumes 1 and 2 (including the Official ICD-9-CM Guidelines for Coding and Reporting), is

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DRG Coding Advisor

News Briefs

COMING IN FUTURE ISSUES

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the required code set for diseases, injuries, impairments, other health problems and their manifestations, and causes of injury, disease, impairment, or other health problems.

• ICD-9-CM Volume 3 Procedures (including the Official ICD-9-CM Guidelines for Coding and Reporting) is the required code set for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals: prevention, diagnosis, treatment, and management.

• National Drug Council is the required code set for drugs and biologics.

• Code on Dental Procedures and Nomenclature is the code set for dental services.

• The combination of HCPCS (HCFA common procedure coding system) and CPT-4 (common procedure terminology) is the required code set for physician services and other health care services.

• HCPCS is the required code set for other substances, equipment, supplies, and other items used in health care services.

Prophet says she was also glad to see the rule specify the versions of the codes. "Another big complaint from our members is that some payers don't necessarily update the code sets in their computer systems; they want providers to either continue to use the [older code] sets for months after they were supposed to have been effective with the new codes or, in some cases, use whatever code set was in effect two or three years ago rather than the version that is in existence today.

"This causes all types of problems when you are dealing with different payers that want different versions and that are taking different codes," she continues.

Prophet recommends that HIM professionals read and understand the final rule. Then, they should consider the interactions and issues they have with their payers. "One issue to consider is that CPT will be the standard procedural coding system for noninpatient hospitals services. There are some payers that have been requiring ICD-9-CM procedure codes for facility-based outpatient services. That will obviously be a change."

What else about the rule?

Chris Wierz, vice president and HIPAA practice leader of Phoenix Health Systems in Montgomery Village, MD, examined the final

HIPAA standard and detailed some of the differences between the proposed and final rules. Here is what she found:

• **Elimination of the on-line interactive transaction exception.** In the proposed rule, interactions between server and browser, direct data entry, and fax back were exempt from the standards. In the final rule, those transmissions must now comply with the data content, but not with the data format. For example, with dumb terminals, where the provider directly keys data into a health plan's computer, the format need not comply with the standard, but the data elements or content must comply. "The final rule makes it clear that a health plan may not offer an incentive for a health care provider to conduct a transaction under the direct data entry exception," she says.

• **Elimination of the exception for standard transactions within a corporate entity.** An exception in the proposed rule allowed nonstandard transactions to be used within a corporate entity, to minimize the burden of change. Under the final rule, covered entities must use a standard transaction when transmitting to another covered entity, whether the transmission is inside or outside the entity.

To help determine when entities must use standard transactions, descriptions of each transaction are now clarified in the final rule. In addition, the preamble in the final rule provides examples of when a standard transaction must be used. However, confusion remains on this issue and further clarification is being sought.

• **Clarification of applicability to health plans.** The proposed rule was unclear on whether a health plan must comply with a standard if it doesn't currently support that standard electronically. The final rule requires a health plan to accept and/or send a standard transaction that it conducts but does not currently support electronically. Therefore, a health plan must be able to electronically transmit a standard that it currently only transmits on paper. Health plans may still choose to use a clearinghouse in order to comply.

• **Clarification of applicability to paper transactions and noncovered entities.** Many comments suggested that the final rule also cover paper transactions. The decision was made not to include them at this point since many paper forms do not support the data content required. Also, HHS indicates that applying the standards to both paper and electronic transmission would not support HIPAA's overall objective to encourage standard electronic transmission.

Several commenters recommended that the standards should apply to employers/sponsors who use electronic data interchange because of their major role in health care administration. HHS has responded that since HIPAA doesn't specifically require employers/sponsors to use the transaction standards, HHS will not apply the regulation to them. However, health plans may negotiate trading partner agreements with employers and sponsors that require the use of standard transactions.

• **Clarification of small health plan definition.** The proposed rule defined a small health plan as a health plan with fewer than 50 participants. The final rule uses the Small Business Administration's size standards, specifying a small health plan as one with annual receipts totaling less than $5 million.

• **Addition of case management to regulation.** In the proposed rule, case management was considered an atypical service and therefore not subject to the standards. The final rule reverses this exception. Case management is now considered a health care service since it is directly related to the health of an individual and furnished by health care providers.

• **Addition of several definitions.** Several new definitions are included to clarify applicability and scope of the rule. These include trading partner agreement, covered entity, work force, business associate, and designated standard maintenance organization.

• **Addition of suggested implementation time lines.** Time line suggestions for implementation are included in the preamble. Given the complex implementation sequencing issues that are anticipated, health plans are encouraged not to require providers to use the standards during the first year after the final rule's effective date. Health plans are also encouraged to give providers at least six months' notice before requiring a standard transaction.

What remains unresolved?

Wierz also says that a number of issues remain unresolved in the final rule. These include:

• **Pre-emption by states.** The proposed rules did not offer pre-emption requirements. The final rule indicates that the pre-emption issue will be resolved in the context of the HIPAA Privacy final rule. Amendments to the Transactions and Code Sets rule will also be made at that time.

• **Compliance assessment and enforcement.**

The issues of compliance, timing, appeals, self-assessment or certification demonstrating compliance will be addressed in an enforcement Notice of Proposed Rulemaking, to be published next year.

• **Interaction with privacy.** A statement concerning the importance of developing standards to protect the privacy of individually identifiable health information is included. HHS states that if the privacy standards are substantially delayed, or if Congress fails to adopt comprehensive privacy legislation, it would seriously consider suspending application of the transaction standards or withdrawing the rule.

"It appears that HHS is concerned that the public may view this rule as a new example of the lack of privacy of their health information," she says. "HHS may have re-emphasized the importance of privacy legislation to encourage public support and successful implementation of this first of the long-awaited final HIPAA rules."

Reference

1. 65 *Fed Reg* 50,311 (Aug. 17, 2000). ■

New Web site offers access to database

Claims status, eligibility available in real time

Submitting claims and checking eligibility status through a dial-up connection to payers is nothing new. Now, one major payer is offering providers this service through a secure Web site — and giving its members access too.

In essence, Blue Cross and Blue Shield of South Carolina in Columbia has Web-enabled its mainframe transactions, explains **Terry Povey**, chairman of the Internet steering committee for the company. Blue Cross wanted to allow its members and providers the opportunity to conduct their business transactions with the company at any time, and in real time.

"We were trying to accomplish another means of superior customer service," he says.

Users of the system are able to access account updates immediately.

To access the database, users must visit Blue Cross' Web site, www.SouthCarolinaBlues.com, and then select "My Insurance Manager." A demo is available on the site for guests to view the technology.

Through "My Insurance Manager," members can check:

- personal claim status;
- amount paid toward deductible;
- out-of-pocket amounts;
- hospital inpatient and outpatient authorization status;
- eligibility status;
- explanation of benefits (EOB) statements;
- other health insurance such as coverage through a spouse.

Depending upon their health plan and product, members can also:

- change primary care physicians;
- order ID cards;
- view benefit booklets;
- check bill status.

By signing on to "My Insurance Manager," providers can:

- check a patient's claim and / or eligibility;
- view benefit booklets;
- check hospital inpatient and outpatient authorizations;
- see how much a patient has paid toward the deductible;
- check a patient's out-of-pocket amounts;
- confirm whether a patient has any other health insurance.

Providers can also go on-line to check one function for numerous patients or check all functions for one patient. Multiple staff members within a provider's organization can be authorized to perform these tasks on-line.

Setting up the site

SouthCarolinaBlues.com was developed as collaboration between its insurance services division, corporate information systems, and corporate communications departments, the company says. Beginning in early 1999, a steering committee comprising representatives from each of those areas worked on the project for nearly a year. The company also hired Open Network Technologies, of Clearwater, FL, to develop "My Insurance Manager," which interfaces with Blue Cross' internal mainframe computers.

Blue Cross maintains the security of the site through socket layer encryption. This means that all personal information is encrypted. Users must create a profile and receive a password before

accessing the system.

The information in the profile, such as member ID number and birthdate, also enables Blue Cross to know how to route an e-mail message in case the information the user needs cannot be located on the Web site. "[Users] can select 'Ask Customer Service,' and the system will route the question to the appropriate customer service area," Povey says. "In that profile, we wanted to establish enough information that would allow us to respond promptly."

Fewer questions to customer service

After research and design, the site was unveiled to the company's 10,000 employees in November 1999. Blue Cross tested the system for a month, and then publicly announced the site in December.

The company decided to take a low-key marketing approach to the system. "The market for 'My Insurance Manager' was so focused on our own membership base and our providers that were part of our network," Povey explains. "All [of] the communication, training, promotion and marketing, therefore, has been directed to those audiences. We have had growing utilization as individuals find out about it."

Blue Cross inserted information about "My Insurance Manager" in EOB statements to policyholders and in remittances to providers beginning last February. Company representatives also demonstrated the site to providers, and placed a message about the technology on the company's voice response unit (VRU), which providers and patients often call to receive more information about accounts. In addition, all of the payer's advertising and brochures referenced the Web site.

The system is still too new for Blue Cross to see if the Web access has reduced the number of calls into the VRU. By monitoring the utilization of the site or its hits to various functionalities, though, the company does have indications that "My Insurance Manager" is doing its job.

"We are finding on a weekly basis that when providers or members sign onto 'My Insurance Manager,' they submit an additional question only 3% of the time," Povey says. That indicates that 97% of the time users can find the information they seek on the site.

Blue Cross sees a much higher opt-out rate with its VRU, she adds. "Sometimes, [users] get on the VRU and then have to opt out [of the system] and talk to a customer service representative almost 50% of the time."

Povey says Blue Cross has received a great deal of attention from "My Insurance Manager." If providers would like more information about the site, they can call Elizabeth Hammond at (803) 788-0222, ext. 44626. ■

Internet, new insurance rules are the hot topics

More providers respond to this year's survey

The 11th Annual HIMSS (Healthcare Information and Management Systems Society)/IBM Leadership Survey got a little help from e-mail this year, increasing response rates 11% over 1999.

The survey was posted on both the HIMSS and the College of Healthcare Information Management Executives Web sites. In addition, this year's survey was also e-mailed to HIMSS members and other health care professional organizations prior to the HIMSS annual conference in Dallas in April. "This new approach gave survey participants the time and opportunity to research necessary data and ensure quality responses to each survey question," says **Gary Kurtz**, FHIMSS, HIMSS chairman.

The plan seemed to pay off. This year, 1,111 senior executives and managers from health care provider and vendor organizations around the world responded to the survey, an increase of 11% over 1999. Of those participants, the number of health care providers (860) represented an increase of 12% (eighty-seven percent of respondents were members of the Chicago-based HIMSS). The survey was completed over a one-month period, from March 9 to April 7.

Internet technology a concern

The survey covered several topics, including information technology (IT) priorities, overall IT utilization, IT budgets, computer-based patient records (CPRs), data security, Web applications, and emerging IT technologies.

Respondents said the most widespread single business issue facing health care providers over the next two years is compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (70%). Providers also showed their concern for containing costs by naming

"improving operational efficiency" (60%), cost pressures (55%), and Medicare cutbacks (38%) as top business issues in their organizations.

e-health emerged as one of the leading business issues among providers in the survey. About 44% of the participating providers felt that e-health was a top business issue for their organization.

When asked for their top IT priorities for this year, nearly two-thirds of the participating providers said "deploy Internet technologies" (63%). Almost as many said that "upgrading systems for HIPAA" was a top priority (55%). Many providers still expressed concerns about recruiting and retaining quality IT staff (37%).

Considering their priorities for the next two years, respondents named clinical information systems (71%), Web-based applications (70%), and clinical data repositories (65%) as the most important health care application areas for IT investment. Respondents also indicated that they placed higher importance of implementing CPR and EDI (electronic data interchange) in the next two years than in this year.

Other important findings

The survey also reported these findings in reference to the following topics:

• **IT barriers.** Lack of financial support and proving return on investment (ROI) for IT investments are the two most significant barriers to IT implementation, and they have grown in significance since 1999, the survey reports. About one-fifth of the participating providers felt that the top barrier at their organizations to implementing IT was "difficulty in providing quantifiable benefits / returns on investment," while another one-fifth felt that "lack of adequate financial support for IT" was the most significant barrier. Both have grown in importance since 1999, especially the ROI barrier (15% in 1999, 22% today).

• **Security concerns.** By far, respondents named HIPAA compliance as their top security concern (72%). Internal breaches of security (51%) was the second most cited security concern among participating providers. This compares to 38% who were concerned about "unauthorized use of data by third parties," and 31% who were concerned about "external breaches of security."

• **HIPAA compliance preparation.** Ninety percent of survey respondents claimed to have some knowledge about HIPAA requirements. More than one-third of them have installed security technologies, documented security policies and procedures, and assessed organizational compliance during the past year to move toward HIPAA compliance. About one-quarter of the providers have hired a security officer or implemented security policies and procedures. These were substantially lower in the 1999 survey.

• **IT budgets.** Sixty-six percent of respondents expected an increase in IT budgets in 2000, compared to 71% in 1999. Only 33% of this year's respondents reported that their organizations' IT budgets will definitely increase, down from 44% in 1999. Another 33% said their budgets will probably increase, and 17% of respondents anticipated no change in their budgets.

• **IT staff.** Most health care providers expected an increase in their IT staff during the next 12 months in the range of 5% to 10%.

• **Technology adoption.** The most widespread technologies among health care providers are Web sites and high-speed networks, followed by intranets, client-server systems and data security systems. Nearly all participating providers (96%) currently have a Web site. The providers said they primarily use the sites for promotion or marketing purposes. Employee recruitment, consumer health information and on-line physician / provider directory were the other widespread functions of current Web Sites. During the next two years, respondents expected e-business (46%) and voice recognition (35%) to be the most widely adopted new technologies.

• **Outsourcing practices.** The importance of the Web and e-business is shown in the ways providers are choosing to outsource their services. For example, Web site (33%) and applications development (25%) were the most widespread IT outsource services used now among the participating providers, followed by network operation support, e-business, PC support, and technical support (all in 18% to 19% range).

Respondents also showed an interest in a new topic on this year's survey — on-line application service providers (ASPs). More than two-thirds (68%) of health care providers surveyed expressed interest in the concept of renting applications over the Internet on an "as-needed" basis. One-fifth were extremely or very interested in ASP services, while almost one-half were somewhat interested. Nearly one-third (31%) of the providers were not interested.

The survey also showed that providers relied most heavily on industry peers (60%) and customer references (52%) when making their

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DRG CODING ADVISOR.

HCFA policies on codes, pacemakers draw questions

Changes would be contained in 2001 fee schedule

The Health Care Financing Administration's (HCFA) proposal to create two new codes for physician supervision of patients' home health care is being called a potentially confusing situation by some provider organizations. HCFA is considering using the codes, which would only be used by Medicare, instead of using codes created by the American Medical Association's Current Procedure Terminology Editorial Panel.

"Every year or every other year, it seems like HCFA comes up with new codes as opposed to what CPT does," notes **John DuMoulin**, director of managed care and regulatory affairs for the American College of Physicians — American Society of Internal Medicine in Philadelphia.

"It's very frustrating because it's a real hindrance to people who are providing legitimate services that should be covered by Medicare."

HCFA to cut pacemaker payment by 60%

HCFA also wants to cut by Medicare payments to doctors who implant pacemakers and defibrillators by 60%. This drop in payment is the result of the agency's plan to split implantation surgery and postoperative reimbursement, which are currently bundled together, which would mean separate Medicare claims for the surgery and follow-up care.

HCFA says physicians will be able to compensate for any pay losses in the surgery component when they file claims for the follow-up care.

The problem is that HCFA assumes the physicians who implant those devices also provide the follow-up care, notes **Robert Cannom**, MD, president of the North American Society of Pacing and Electrophysiology.

"The majority of the time the physician who puts the pacemaker in never sees the patient again, particularly in a managed care environment," says Cannom. In turn, the proposal, "penalizes the implanting physician dramatically while benefiting the follow-up physician unrealistically." ■

Dissecting the 2001 physician fee schedule

Many changes, but few real fireworks

While the new physician fee schedule Medicare recently proposed has some medical specialties unhappy, it does not contain the kind of controversial policy initiatives that have caused so much hoopla over the past several years.

According to the schedule, Medicare expects to pay physicians $39 billion in 2001, up from $37 billion this year. Payments will be based on a blend of 75% resource-based relative value units (RVUs), and 25% from the old charge-based system reflecting historical costs. According to present legislation, the physician fee schedule should be entirely RVU-based by 2002.

The schedule also includes updated RVU weights for CPT/HCPCS codes and changes in geographic practice cost indices (GPCI) that help determine how much physicians will be paid for specific Medicare services, but "no major policy announcements," notes **Pat Smith** of the Medical Group Management Association's (MGMA)

Washington, DC, office.

Here are the details of Medicare's proposed 2001 physician fee schedule, according an analysis of the document done by MGMA.

• **Inpatient stay/observation.** Current HCFA policy varies when it comes to physician payments for inpatient observation when a patient is admitted on one day and discharged the next because HCFA policy draws an "arbitrary line at midnight," contends the MGMA analysis.

To correct the problem, HCFA proposes to pay for both inpatient hospital admission services (CPT codes 99221 and 99223), and hospital discharge services (CPT codes 99238 and 99239) for inpatient services when a patient stays for 24 hours or longer — and when the length of stay is documented as such.

"If a patient is admitted for observation for eight hours or less, HCFA will pay only for admission services on that day, and the discharge service will not be separately billable," says the MGMA. However, if admitted as an inpatient at a hospital or as an observation patient for a period between eight and 24 hours, HCFA will pay for both the admission and discharge services — with some modifications. For instance, the physician work RVU values for the various discharge CPT codes will be lowered to recognize the difference in the work involved.

• **Changes in the global fee for selected codes.** HCFA wants to change the reimbursement for several codes connected to pacemaker and cardioverter defibrillator procedures. As many of those patients require substantial postoperative care, some of which is not directly tied to the implanted device, these services are often covered by a global fee. In turn, a physician may end up providing services unrelated to the implantation of the device and for which they are not reimbursed.

In turn, HCFA proposes that the global period for the following codes be changed from 90 to 0 days: 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33218, 33220, 33233, 33234, 33235, 33240, 33241, 33244, 33249, 33282, and 33284.

HCFA would also reduce the work RVUs for those codes to reflect the fact that the service no longer covers such an extensive period of time.

• **Antigen supply.** HCFA intends to increase current limits on the supply of antigen Medicare will cover at one time from 12 weeks to 12 months to reflect current treatment standards.

• **Resource-based practice expense phase-in.** The Health Care Financing Administration (HCFA) will continue the phase-in of resource-based practice expense relative value units (PERVU), switching over from the older system of charge-based PERVUs. For 2001, PERVUs will be 25% charge-based and 75% resource-based. This phase-in will be completed in 2002 when PERVUs will be solely resource-based.

• **Collecting data to modify practice expense RVUs.** HCFA is not accepting practice expense data from specialty organizations for the moment since the American Medical Association has not finished pilot testing and vetting a new survey instrument for collecting the kind of statistical data Medicare is asking for to determine practice expense RVUs. Look for more debate on that issue since this data could have a significant impact on the distribution of RVU-related payments among different specialties.

• **Payment for casting materials.** "Because HCFA policy allows separate payment for splints, casts, and other devices used for the reduction of all fractures and dislocations, the agency proposes removing those expenses from practice expense calculations for applicable codes," notes the MGMA.

Mental health added

• **Facility and nonfacility payments.** HCFA added community mental health centers (CMHCs) to the list of locations considered to be facilities. The list also includes hospitals, skilled nursing facilities, and ambulatory surgery centers. That means physician services supplied in a CMHC will be reimbursed at the lower facility rate, says MGMA.

Practices also should note that HCFA has clarified that the nonfacility practice expense is to be used when calculating payment for such outpatient therapy services as physical, occupational therapy, and speech language pathology regardless of the actual setting.

• **Mid-level practitioner reimbursement.** HCFA only wants to use physician practice expense data when determining the practice expense RVU for mid-level practitioners.

"Removal of the services performed by mid-level practitioners from the practice expense calculations would simplify the methodology and be consistent with the statutory requirement that HCFA reimburse mid-level providers based on a percentage of the physician fee schedule amount," says the MGMA analysis. Under the Balanced Budget Act, mid-level practitioners are now paid

at 85% of the physician fee schedule.

• **Geographic practice cost indices (GPCI) update.** As required by law, HCFA proposes to update the GPCIs across the country and phase that update in over 2001 and 2002. Changes to the GPCI values will be based on the same data used to calculate the previous update. The GPCI is comprised of three different values: physician work, practice expense (which is a combination of employee wages, rent, and miscellaneous), and malpractice costs. The figure for each of those three costs represents HCFA's estimation of its percentage in the overall cost of providing services. When multiplied by RVU values, GPCIs are used to modify payments to reflect local variations in the three values.

Bottom line: Those changes to GPCI values will be budget-neutral and are not expected to have a significant impact on payment rates, says the MGMA.

• **Anesthesia services.** Currently, anesthesiologists can be paid for up to four concurrent procedures, provided they comply with certain guidelines. However, HCFA policy does not instruct carriers how to pay for services when an anesthesiologist fails to meet all of those guidelines.

Options HCFA is considering to correct that oversight include:

— specifying that the physician furnishing medical supervision must perform, at a minimum, the preoperative evaluation, participate in induction, remain available for consultation, and provide a minimum level of monitoring;

— establishing payment for medical supervision at 40% of the payment amount for the service performed by the physician alone;

— applying the proposed medical supervision payment amounts to incompletely medically directed cases;

— limiting the number of concurrent cases the physician can supervise to five.

• **Physical therapy supervision and benefit caps.** Before now, questions existed about whether an owner-physical therapist had to be present to supervise other licensed physical therapists in the group. HCFA takes the position that a physical therapist who owns a practice may be "off the premises" when other legally authorized therapists are providing patient services — and those licensed therapists may furnish supervision for therapy assistants.

• **Outpatient therapy caps.** HCFA says it is gathering information on alternatives to the present annual cap on therapy services. If you have comments or suggestions, don't be shy. Ideas HCFA's considering include:

— establishing a cap per diagnosis rather than per year;

— establishing payment based on patient groupings by primary diagnosis and average number of treatments, with options for variants;

— basing payment on an episode of occurrences of illness or injury with a cap amount adjusted to address geographic differences in cost;

— developing a sustainable growth rate for outpatient therapy services.

If you want to comment on any part of the proposal, send one original and three copies of your statement to: HCFA, Department of Health and Human Services, Attention: HCFA – 1120 – P, P.O. Box 8013, Baltimore, MD 21244-8013. To be considered, comments must be received by Sept. 15. ■

HCFA data now available for benchmarking E&M

FOI request no longer needed

Recent policy changes mean the Health Care Financing Administration (HCFA) no longer require you file a Freedom of Information Act request to obtain the raw data files of practice evaluation and management (E&M) coding patterns. And since the information is also free, this makes the data readily accessible to any physician practice.

Because this raw E&M data is grouped by specialty, it's fairly easy to convert to percentages that can be used to compare your billing patterns to national practice patterns, notes **Todd Welter** of Denver's R.T. Welter & Associates, a consultant for the Medical Group Management Association.

An example

For instance, consider this hypothetical example of the E&M billing patterns of an internal medicine practice which bills 725 out of 924 established patient visits with code 99213. After converting HCFA's data file to a useable benchmark, you find the national average for code 99213 for the same number of patient visits is only 213.

The implication: the practice is probably

playing it safe when it comes to its E&M coding — and almost surely underbilling — in an effort to avoid getting caught up in regulatory questions, says Welter.

"You want to use this kind of data to get a doc's attention about the importance of proper coding — and its impact on reimbursement," says Welter.

Converting data files

Here's reimbursement consultant Welter's tips on how to create your own in-house E&M benchmarking database.

1. Access HCFA's main Web site: www.hcfa.gov.
2. Click "Stats & Data."
3. Click "1999 Resource-Based Practice Expense Data Files."
4. Click "1998 Procedure Code Utilization-By-Specialty," then download the data.
5. Find your specialty.
6. Look for the specific series of E&M you want to examine more closely.
7. Convert this national info to a percentage benchmark. For instance, if there were a 1,000 total for the series, and there were 240 "1s," then the percentage of "1s" is 24%. If there were 360 "2s," then the percentage of "2s" is 36%.
8. Create your own in-house base comparison by converting codes used by individual physicians — or the entire practice — to a percentage for each series.
9. Compare the national percentages for each "1" through "5" E&M entry to the numbers your practice actually coded for that series. For example, if the national average for a "2" in the series you are examining was 14%, and you coded 10,000 of those codes, your figure converted to the national average would be 140.
10. Compare your number for that code to the national converted figure.
11. Take your fee schedule and determine how much you billed per code per year.
12. Compare this to the national average. ■

CPT codes adjusted to reflect AMA updates

The Health Care Financing Administration (HCFA) has added several new replacement codes to the ambulatory surgery centers' (ASC) list of services furnished on or after Jan. 1, 2000. The American Medical Association's (AMA) Jan. 1, 2000, update to the current physicians terminology (CPT) book had caused some ASC codes to be deleted, resulting in several carriers and intermediaries denying payment for the deleted codes.

HCFA's Transmittal No. AB-00-28 also added CPT code 36833 to the list, since the AMA's definition for ASC code 36832 was split. CPT codes 15580 and 15625 were deleted and will not be replaced due to the revised CPT code descriptions. Finally, the transmittal says that type of service (TOS) "F" (ASC facility usage for surgical services) should be used when modifier SG appears on an ASC claim. Otherwise, TOS "2" (surgery) for professional services rendered in an ASC should be used.

For carriers, the implementation date for those changes was May 29, 2000; for intermediaries, the implementation deadline is Oct. 1, 2000. To read HCFA's announcement, which includes the full list of replacement codes, go to http://www.hcfa.gov/pubforms/transmit/AB002860.pdf. ■

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decisions on where to outsource their IT services. About one-third of the providers pointed to consulting firms (36%), trade shows/conferences (33%), and publications (28%) as other key influences.

(For a look at the complete 11th Annual HIMSS/IBM Leadership Survey, visit HIMSS' Web site at www.himss.org.) ■

HCFA's E/M Documentation Guidelines: 1995-2000

By **Michelle A. Green**, MPS, RHIA, CMA, CTR
Professor
Alfred (NY) State College

When the Resource-Based Relative Value Scale system (RBRVS) was implemented in 1992, the Health Care Financing Administration (HCFA) requested that the American Medical Association in Chicago revise the common procedure terminology (CPT) visit codes for office and hospital services. The American Medical Association revised the codes and created evaluation and managment (E/M) services. HCFA then released E/M Documentation Guidelines so that Medicare could be certain it was paying for correct levels of service. The guidelines implemented in 1994 are referred to as the 1995 Documentation Guidelines (DG), but they were criticized because requirements for a complete single system examination were unclear. Because medical reviewers rarely gave credit for complete single system exams, specialists were not able to meet the documentation requirements for higher level E/M services. In addition, it was difficult to ensure work equivalency between multi- and single-system exams.

In response, an alternative set of DGs was developed to include 10 single-system examinations and clarification of definitions for multisystem examinations. Those guidelines are referred to as the 1997 DGs. The original intent was to replace the 1995 with the 1997 DGs. However, many physicians objected because they perceived the 1997 DGs as too complicated and having the potential to detract from patient care. Therefore, in April 1998, HCFA instructed Medicare carriers to use both the 1995 and 1997 DGs when reviewing records, and physicians could use whichever set of guidelines was most advantageous.

Draft 2000 E/M documentation guidelines

In June 2000, revised draft guidelines were released that represented a simplification of the 1997 DGs, which contained an extensive list of physical examination elements and documentation requirements based on performance and documentation of the number of elements from the list. The draft 2000 DG physical examination requirement is reduced to three levels based on the number of organ systems examined. The review of systems is also based on the number of organ systems. For example, a detailed examination includes findings from three to eight organ systems, rather than the total number of elements examined. Thus, the counting of examination elements is basically eliminated. Medical decision making is also simplified to three levels, with clear requirements that can be cross-referenced to clinical vignettes currently under development. **(For a look at those levels, see p. 156.)**

HCFA will pilot-test the draft 2000 DGs, and continuing education will be provided for their implementation. The final guidelines likely will be adopted in 2002. Until then, providers should continue to use either the 1995 or 1997 DGs, whichever are deemed more advantageous. Regard-less of the DG version used, a properly documented patient record is an essential component of good clinical care and necessary to support the level of E/M service code submitted on a claim. When care is not properly documented (for example, inadequate or nonexistent documentation), improper payments result. In addition, according to the Office of the Inspector General, audits reveal that it is not unusual for well-intentioned physicians to code as much as two levels apart for identical services because of varying interpretations of definitions of CPT histories, physical examinations, and medical decision making.

To see the draft 2000 DGs, or to download all three versions of the DGs, go to http://www.hcfa.gov/medicare/mcarpti.htm and scroll down to the heading *Documentation Guidelines for Evaluation and Management Services*. Click on the

Town Hall Presentation (MS PowerPoint).

(Editor's note: Michelle A. Green is co-author with JoAnn Rowell of Understanding Health Insurance: A Guide to Claims Processing. *She can be contacted at greenma@alfredstate.edu.)* ■

Medical decision making simplified in guidelines

The draft 2000 Evaluation and Management (E/M) Documentation Guidelines have simplified medical decision making to three levels, with clear requirements that can be cross-referenced to clinical vignettes (currently under development), explains **Michelle Green**, MPS, RHIA, CMA, CTR, professor in the department of physical & life sciences at Alfred (NY) State College. **(For more explanation about the draft 2000 E/M Documentation Guidelines, see p. 155.)**

To determine the level of decision making for an encounter, the medical record should include documentation of an assessment and plan for each problem evaluated during the encounter, the draft documentation guidelines say. "The assessment and plan for each problem should include documentation of 1) the status/severity/urgency of the problem(s) and the risk of complications and deterioration; 2) the amount and complexity of data reviewed and differential diagnosis(es); and 3) the diagnostic and therapeutic tests, procedures, and interventions ordered and the treatment plan." Here are the three levels, as explained in the draft documentation guidelines:

A. Low Complexity Medical Decision Making

Typically, the problem(s) addressed will 1) be of low severity, low urgency, and low risk of clinical deterioration and complications; 2) have a limited differential diagnosis and limited review of additional data; and 3) have straightforward diagnostic and/or therapeutic interventions and a straightforward treatment plan. For the purpose of documentation, two of those three elements must either meet or exceed the requirement for low complexity.

B. Moderate Complexity Medical Decision Making

Typically, the problem(s) addressed will 1) be of moderate severity with a low to moderate risk of clinical deterioration; 2) require review of a detailed amount of additional information with an extended differential diagnosis; and 3) require complicated diagnostic and/or therapeutic intervention, with a complicated treatment plan. For the purpose of documentation, two of those three elements must either meet or exceed the requirement for moderate complexity.

C. Highly Complex Medical Decision Making

Typically, the problem(s) addressed will 1) be of high severity with a high risk of complications and clinical deterioration; 2) require review of an extensive amount of additional information with an extensive differential diagnosis; and 3) require highly complex multiple diagnostic and/or therapeutic interventions, with a highly complex treatment plan. For the purpose of documentation, two of those three elements must either meet or exceed the requirement for highly complex medical decision making. ■

Outpatient PPS' design, use concern government

Commission navigates complex situation

A government commission may support the goals and broad outlines of the outpatient prospective payment system (PPS), but it raises concerns about elements of the system's design and implementation.

The analysis of the outpatient PPS was presented in the Medicare Payment Advisory Commission (MedPAC)'s "Report to Congress: Selected Medicare Issues." MedPAC is an independent federal body that advises Congress on issues that affect Medicare. The commission has 17 members who have a variety of experience in the financing and delivery of health care services. The commission is supported by a full-time executive director and a staff of about 30 analysts.

Here are some of MedPAC's recommendations to Congress based on its analysis:

• The Secretary [of the Department of Health and Human Services] should monitor changes in practice patterns across ambulatory care settings to ensure that differences in payment do not lead to inappropriate shifts in site of care.

"Changes in technology, practice patterns, and the organization of medical services have led providers to offer the same services in multiple ambulatory settings," the report says. "Ensuring consistency of payment across sites of ambulatory

care, therefore, becomes an important issue."

The financial incentives inherent in payment differences could lead to inappropriate decisions about where care is delivered.

• The Secretary should study the accuracy of and changes in coding practices with the implementation of the outpatient PPS.

"Previous research conducted on the inpatient setting indicates that changes in coding practices do significantly contribute to changes in measured case mix," the report says. "Because coding behavior is anticipated to change with the implementation of the outpatient PPS, similar analyses are needed for outpatient services to separate which changes in measured service mix are attributable to true changes in resource use versus change in coding practices."

• Congress should enact legislation to accelerate the rate of beneficiary coinsurance buy down under the outpatient PPS and establish a date certain for achieving a coinsurance rate of 20%. This date should result in a time frame for implementation consistent with other Medicare payment policy changes.

"The [currently mandated] process for achieving a 20% coinsurance rate — referred to as the beneficiary buy down — is gradual and could take decades to achieve," the report says.

• The Secretary should carefully monitor implementation of the outpatient PPS system to ensure that:

— it does not have unintended, adverse consequences on beneficiaries' access to care;

— it does not compromise the quality of care delivered;

— the annual reductions in beneficiary coinsurance as a share of total payment are realized.

"The commission's concerns about access arise from structural aspects of the payment system, the financial and administrative impacts of the PPS on individual hospitals, and the relatively complex process for reducing beneficiary financial liability for outpatient services," the report says.

In regards to quality, MedPAC says that expanding the list of services that can be provided in an outpatient setting entails an obligation to ensure adequate quality of care for beneficiaries receiving those services in this setting.

Finally, the commission expressed concern that the process for buying down beneficiaries' disproportionate share of payments for outpatient services is relatively complex. Give the complexities, it will be important to "monitor where beneficiaries realize the reduction in financial liability over time," the report says.

(Editors note: For a look at the complete report, visit MedPAC's Web site at www.medpac.gov.) ■

White House says it will tighten records privacy

Expect new regulations from the Clinton administration giving patients greater control over their medical records, *The New York Times* reported on Aug. 20.

The paper said that the new regulations — to be issued before the Nov. 7 presidential election — will set federal standards requiring doctors, hospitals, and insurance companies to limit the disclosure of personal medical information, according to the paper. Under the new rules, doctors must inform patients about their rights and how their information might be used.

Many payers aren't happy about the new rules. The Health Insurance Association of America and the Blue Cross and Blue Shield told the *Times* that the regulations are unworkable and would impose new costs on patients and employers.

Public opinion polls show the American public increasingly wary about the privacy of their medical records. The timing of the new rules, which don't require congressional action, could help Vice President Al Gore's presidential campaign, the *Times* said. ▼

AHIMA introduces four new Web sites

The American Health Information Management Association in Chicago launched four new Web sites designed to help users understand critical issues in health information.

Each site is initially targeted to four specific

practice settings: hospitals and integrated networks, ambulatory care and surgical centers, physician group practices, and managed care organizations. Additional health care settings will be added in the future. All four Web sites can be accessed at www.ahima.org/roi/.

The Web sites are specifically targeted to chief executive officers, chief information officers, chief compliance officers, chief financial officers, and human resource managers. At each site, users will find resources to help them understand key issues in health information, including articles and practice briefs on a variety of health information topics. Topics include coding, compliance, information security, computerized patient records, data usage and quality, reimbursement, and health information management (HIM) best practices. In addition, visitors will learn about the HIM profession, the benefits of hiring certified HIM professionals, and the value of their contributions to health care organizations.

The new Web sites also provide tools to assist in recruiting qualified HIM professionals. A qualifications checklist is available as a quick reference guide on the skills, training, and certifications required of professionals in the HIM field. Users can also find ready-to-use position descriptions and classified ad templates. ▼

Reports assess new Medicare outpatient PPS

HCIA-Sachs, a Evanston, IL-based provider of strategic health care information, is offering reports designed to help hospitals assess the financial impact of ambulatory payment classifications (APCs) — Medicare's new outpatient prospective payment system. Drawing on a database covering virtually all U.S. hospitals and freestanding centers, the reports will also assist facilities in determining market share of services grouped by APCs and in examining potential growth. HCIA-Sachs officials stressed that the company's existing products will incorporate outpatient data at the APC level.

The reports were developed in response to client queries about the impact of the APCs, which replace the current cost-based reimbursement for Medicare outpatient services. Under the new APC system, which was implemented Aug. 1, certain procedures will gain or lose reimbursement, while other services, such as physical therapy, will remain unchanged.

The data represents approximately one hundred million Medicare encounters and more than 35,000 facilities nationwide. Further, the information is actionable because it furnishes hospitals with actual, rather than projected, statistics. ▼

Some Internet health care users are cyberchondriacs

A national survey of more than 1,800 users of the Internet for health care information found that users are more proactive health care consumers than nonusers. Some consumers who visit health care Web sites often, however, are less satisfied with their health care in general and more likely to seek alternative treatments.

The study, The Internet Healthcare Project, was conducted by Princeton, NJ's Consumer Health Sciences (CHS), a provider of consumer health care information for the pharmaceutical industry. The data premiered at the Drug Information Association Conference, "e-Business and e-Process: Transforming the Pharmaceutical Industry," in Boston, and were presented by CHS president, Jane A. Donohue, PhD.

Internet health care users are not only more proactive, they are more likely to ask a doctor for a prescription medication, and are more apt to question physicians about their advice. Those attitudes and behaviors hold true for both frequent and occasional Internet health care information seekers, but are even more extreme for the frequent information seekers.

According to Donohue, many frequent Internet users can also be classified as cyberchondriacs. Many of those people surf the Web for health care information on a daily basis. When compared with the general population, those people are less satisfied with the health care they receive, are generally in poorer health, visit physicians and alternative health providers more often, miss more days of work due to poor health, and are the most likely to seek health care information from a variety of sources.

However, all of the 50 million Americans turning to the Internet for health care information insist that Web sites be reliable, informative, and updated frequently. Those qualities are considered to be very important by more than 80% of respondents.

The study also found that women are more likely than are men to be frequent users of the Internet for health care information. Demographically, Internet health care information seekers are typically better educated, with higher incomes than non-Internet users.

Full results of the CHS Internet Healthcare Project are available for purchase. For more information, contact Consumer Health Sciences at (609) 924-4455 or visit the Web site www.consumerhealthsciences.com. ▼

HIPAA compliance course offered on-line

The American Health Information Management Association (AHIMA) in Chicago is offering a Web-based continuing education course for achieving compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. "How to Achieve HIPAA Compliance" introduces participants to HIPAA administrative simplification requirements, explains how to monitor government actions regarding the requirements, and provides guidance for implementing the required HIPAA standards.

This course covers compliance with HIPAA requirements in seven modules:

- **Module I: HIPAA Overview.** Reviews the legislative and regulatory process leading to the passage of HIPAA and provides an overview of the requirements.
- **Module II: Privacy and Security.** Distinguishes the issue of privacy from security and explains how each is treated under HIPAA.
- **Module III: Technical Standards.** Explores the necessary technical security standards.
- **Module IV: Policies and Procedures.** Focuses on the security policies and procedures that HIPAA requires.
- **Module V: Identifier Requirements.** Reviews the HIPAA identifier requirements.
- **Module VI: Code Set Standards.** Introduces the required claims and related transaction standards and code sets.
- **Module VII: Developing a HIPAA Compliance Program.** Provides a 10-step plan to achieve compliance.

Professionals in HIM, health information systems, and health care informatics can access the course through the association's Web-based Interactive Learning Campus by visiting www.ahimacampus.org. The on-line education tool offers users the ability to update their skills and learn new ones in the convenience of their own homes or offices. Campus programs are updated regularly and available 24 hours a day.

The cost of the program, which includes all seven modules, is $600 for members and $750 for nonmembers. AHIMA members receive one continuing education credit per module for a total of seven credit hours for the course. To register for this course, or to find out about other AHIMA online courses, visit www.ahimacampus.org. Once registered, participants can log on as often as necessary to complete each module. ■

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Editorial Questions

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CALENDAR

• **e-Business Strategies for Healthcare CIOs** will be Oct. 17-20 in LaJolla, CA. The forum is sponsored by the College of Healthcare Information Management Executives in Ann Arbor, MI. For more information, contact Gail Arnett at (734) 665-0000 or e-mail: garnett @cio-chime.org.

• **Systems Approach to Reducing Medical Errors Conference** will be Oct. 20 at Loyola University in Chicago. The conference is cosponsored by the Greater Chicago Chapter of the Healthcare Information and Management Systems Society (HIMSS), the Midwest Alliance for Nursing Informatics, the Northern Ohio HIMSS, and the Wisconsin Dairyland Chapter of HIMSS. For more information, contact HIMSS at (312) 664-4467 of visit the Web page www.himss.org/education/proedu/rme/rme.home.html.

• **Telehealth 2000** is Oct. 31-Nov. 3 in Los Angeles. The conference is sponsored by HIMSS and the University of California-Davis Health System Continuing Medical Education in conjunction with several other health care providers and payers. For more information, visit HMISS' Web site at www.himss.org. ■