



(Continued from cover)

work from home and receive their records over the Internet. When Inova Fairfax advertised the jobs accordingly, it was fully staffed within three weeks. . . . . 4

**Johns Hopkins pulls back \$3.6 million from the abyss**

Johns Hopkins Hospital in Baltimore began a five-part program, the Revenue Recovery Initiative, to recoup a potential \$20 million left on the table. In fiscal year 2000, Johns Hopkins' effort recovered \$9 million — \$3.6 million from a reduction in payment denials. . . . . 5

**DRG Coding Advisor . . . . . 7**

**Associations lobby legislators for relief**

The Congressional session may have been lame duck, but it carried primary urgency for health care organizations pushing for relief from Balanced Budget Act of 1997 cuts. If relief is not passed this year, hospitals could lose more than \$5 billion in government support, says American Hospital Association President Dick Davidson. . . . . 11

**Plane crash highlights a gap in medical data**

Officials in Suffolk County thought they had their bases covered after forming a mass disaster committee. But when TWA flight 800 crashed into the Atlantic Ocean off the coast of Long Island the officials weren't sure how to set up and organize the medical records that would be used to identify the victims. . . . . 13

**Less controversy for rehab's PPS proposal**

Early November revealed another prospective payment system, this one much less controversial than the one for outpatient services. . . . . 14

**News Briefs**

Health industry to establish stronger patient privacy protections, survey says . . . . . 14  
New law opens road for electronic transactions . . . . . 14  
OIG posts FAQ on its corporate integrity agreement billing reviews . . . . . 15

**COMING IN FUTURE ISSUES**

- More final HIPAA regulations are unveiled
- Self-destructing e-mail: Does it have a place in health care?
- Is Balanced Budget Act relief on the way?
- The role of HIM in CPR projects
- The IOM revisits the medical mistakes issue

definitions of what clinical decision support (CDS) is.

“Some people refer to outcomes measurement. Some say disease management. Other people just talk about good access to clinical data,” Portela says.

The award-winning article “A Practical Framework for Understanding Clinical Decision Support,” which Metzger co-wrote, classifies CDS systems in four general categories. These categories are:

- **Access to information:** This is the most basic aspect of decision support and provides easy access to general or patient-specific clinical data and information. “CDS capabilities in this category are aimed at delivering the right information at the right time and place to enable information clinical decision making,” the authors say.

“It is essential that hospitals start automating their clinical documentation, at least at this first level,” Portela says.

- **Guided choice:** Provides a second level of support for clinical decision making. CDS capabilities in this category are designed to make it easy for care providers to make the right choices among available options.

“First you have to have the clinical documentation,” Portela explains. “Then you start throwing in all the software modules that help you with the guided choices.”

- **Knowledge-based prompting:** This level of CDS is designed to assist clinicians in making the right care decisions. “These CDS tools help to determine the correct clinical diagnosis in planning therapy or by alerting the clinician to relevant important information,” the authors say.

- **Understanding clinical practice:** CDS capabilities in this category are aimed at achieving overall improvement in care delivery. These systems are population-focused and are used retrospectively to identify patterns and trends, which in turn can be used to guide future decisions, identify current best practices, and evaluate and refine clinical guidelines, the authors say.

Most hospitals were too busy last year dealing with Y2K issues to focus on CDS, Portela says. “They only implemented core functionality — ancillary systems, financial systems, and order entry systems. Now they are all trying to get to the decision support level right away. Without doing the first clinical documentation

phases, they are not going to be able to analyze the data at the level they want.”

### ***Almost everyone will play catch-up***

Only about 10% of the hospitals and physician groups have their clinical data automated, Portela says. By the time others catch up, it may be too late.

“It will take CIOs an average of 12 to 18 months to find the [clinical decision support] products and install them,” he says. “That will be too late. They will not be able to compete.”

Application service providers (ASPs) offer one option that allows health care facilities to outsource the automation.

“ASP models offer an opportunity to have someone else other than the hospital take care of its information technology,” explains **Bruce Fried**, JD, partner at the Washington, DC-based law firm Shaw Pittman and chair of its health law group. “For many community hospitals, an outsourcing ASP strategy makes sense, both in terms of economics and the challenge to keep technicians and up-to-date systems.”

ASP allows people to implement systems quickly without going through those long selection processes, Portela says. “It also allows the CIO to throw the risk of failure to the vendor.”

An outside company, for example, can offer a clinical data repository (CDR) via remote connectivity.

“In essence, all your data will be [in the CDR], and the vendor will start applying third-party products on top of the database to do the analysis — the clinical decision support, outcomes measurement, disease management,” Portela explains. “Not only is the vendor going to look retrospectively at the data that you have within your institution, but with the hospital’s permission, the vendor will be able to provide comparative data of how you are performing compared to other institutions.”

The ASP model, however, just addresses some of the upfront technology cost, Metzger says. It doesn’t solve the whole problem.

“You still have to make a lot of change in the practice. You still have to train physicians and you still have to give them time to adjust.”

Since many providers are challenged with the first phase of clinical decision support, Portela recommends they first begin automating the clinical areas that are high in data collection, such as the intensive care units, the emergency departments,

and the labor and delivery departments. Then they or an outside vendor should collect the data from those units and from areas such as labs and radiology. Once those data are in one central, clinical repository, they can start adding to the data repository to start providing the type of reports that they need. “After you do those basic steps, the rest is not that hard.” ■

## **Fasten your seatbelt for the revolution, please**

*Technology drives the big changes in health care*

New information technology is driving a revolution in the health care industry — and providers need to adjust, says a health care expert.

“This is not the latest groovy idea. These changes will be fundamental, profound, and long-lasting,” says **Bruce Fried**, JD, partner at the Washington, DC-based law firm Shaw Pittman and chair of its health law group. “They will change the relationships between hospitals, their patients, physicians and the community generally. That being said, how does the hospital community recognize that and take advantage of it?”

Fried spoke of the revolution at the September conference of the American Health Information Management Association. System efficiencies are desperately needed in health care, he says. The Internet and other technologies are now providing an easier way for consumers and providers to

### **AHIMA conference spotlight**

In this, the second of two parts, *Hospital Payment & Information Management* spotlights presentations made at the 72nd National Convention and Exhibit of the American Health Information Management Association. The convention took place in late September in Chicago.

This month: taking technology from a groovy idea to practical application, a glimpse at the efforts of a major health care facility to reduce its denial rate, and the data collection needs of a community in the wake of a mass disaster. ■

gain access to data.

New technology is also reinventing the clinical side of health care. "We are seeing the ability to capture clinical data, to aggregate that data, and to analyze it in a way that will allow us to truly understand what in medicine works [and] what doesn't. Who in medicine works and who doesn't? Why is it that different clinicians have different outcomes with the same sorts of patients, even adjusting for different kinds of risk?" he wonders. "The technologies offer the ability to move medicine from being primarily art to something approaching science."

Providers will see economic efficiency opportunities and opportunities for clinical improvement and advancement. They are also going to see opportunities for improvements in customer satisfaction, Fried says. "Unlike other service organizations, health care has been largely unconcerned with the patient experience, from a customer perspective."

Health care will become a consumer-driven business, he adds. "Consumers are empowered. Consumers have expectations. They are no longer simply going to rely on providers to tell what is best for them. Part of that is going to turn on not only the clinical side but the consumer experience, as well."

### *The big question: What should you do?*

So how should providers prepare for this revolution? Fried offers these recommendations:

- Understand that the opportunities regarding information technology cannot be pursued simply by assigning the responsibility to the chief information officer.

"An institution that is going to take full advantage of information technology and the Internet needs to understand that we are talking about a systemwide change. There needs to be a work group or task force or coordinating committee," Fried says. "All the factors that are integrated into the hospital system need to be involved in thinking about how their relationships with their external audience — patients, vendors, managed care organizations — can be improved."

- Ask fundamental questions.

"Ask, 'How can we improve? What do we want to get out of new technology? Can we improve clinical care? Can we improve the customer experience?'" Fried says. "When you have a team in place and have addressed the questions that get to what is the business objective, then you can begin

to build strategies around taking advantages of these new ways of communicating."

Government mandates, such as those stipulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), should not distract providers, he says. "Y2K was distracting and expensive. HIPAA will be too. But there is always likely to be an ongoing series of challenges. If you only focus on the challenges, you don't pursue the promises, as well."

Fried says he expects the Health Care Financing Administration to release regulations that require hospitals to implement systems that reduce medical errors. "The regulations will drive new information technology investments that will not only reduce the incidence of medical errors but will improve the quality of health care that is being delivered."

The overall changes in the industry will be dramatic over the next five years, Fried says. "We will look back and say, 'Wow, why did we ever do it the other way?'" ■

## Coders needed! Work from home!

*They stayed home in droves, fully employed*

For three years, Inova Fairfax Hospital in Falls Church, VA, struggled with a 25% vacancy rate in coding positions. Then the facility began using application service provider (ASP) technology that allowed coders to work from home and receive their records over the Internet.

An advertisement boasted of these conveniences and a miracle occurred: Inova Fairfax was fully staffed within three weeks.

"You get inundated with coders by adding that one little line — 'work from home,'" says **Jennifer Shearer**, RHIA, director of Inova Fairfax's medical record department.

Inova Fairfax is using eWebCoding, an ASP based in Atlanta and a division of Intertech Information Management. "They provide the scanning hardware and the software and the storage of the chart. All the hospital and the coder need is an Internet connection," Shearer says.

Preliminary results show that with the new system, Inova Fairfax has gained one hour of productivity per coder, per day for outpatient charts.

One of the inpatient coders who had met productivity requirements of 20 charts coded and abstracted per day has now exceeded 27 charts per day for six months. The quality of the coding has not decreased. Shearer attributes the increase to the coders having better concentration and fewer disruptions while working at home.

### **Setting up the system**

The installation process of the ASP model was minimal and took only a few weeks, Shearer explains. The main computer system is located and maintained at a remote site, and only workstation hardware was installed at the hospital and coders' homes. The users downloaded software from the Internet.

Inova Fairfax, which pays a per-chart fee, began its program by scanning and coding emergency room records first. The hospital has a scanner who is responsible for submitting records to each coder in a queue. The coders are then able to download the information from the Internet. Once they complete the record, they submit it back to the server.

For security reasons, the records undergo three levels of encryption. They are encrypted as soon as they are scanned and go across the Internet to the server. They are encrypted again when they go from the server to the coder's house, and once more when the coder opens the files.

Once the technology was implemented, all but one of Inova Fairfax's 18 coders wanted to work out of their homes, Shearer says. Inova Fairfax is located in a congested area, and the commute for clinical coder **Cheryl Shackleford**, CCS, can take 30 minutes to 2½ hours.

The hospital decided to only allow coders to work from home who were experienced and had been employed a minimum of six months. The coders remained hospital employees and were initially required to come into the office every other day to ensure that there were no glitches in the remote abstracting and bill dropping process. New coders remain on-site for three months until they establish their productivity and quality baselines.

The coders like the control they now have over their hours, Shearer says. "They regain so much time in the lives by not having to commute."

Each coder still comes into the office, usually two days a week, to code large bills or multi-volume admissions. The hospital decided not to scan large volume (more than three-volume) records because of the fatigue factor. The coders

don't complain, though, because a rotating schedule allows them flexibility in these days, too.

"We rotate so everyone has the opportunity to be home certain days," Shackleford says. She began working from home last July. The rotation also means that one coder is not responsible for coding the complicated bills all the time.

The work arrangement takes off the edge of having to work overtime, too, especially during the holidays. "We don't mind doing extra to help the backlog since we are working from home," she says.

Morale among the coders is great, Shackleford adds. "It is absolutely wonderful to be able to work from home."

### **Other services offered**

eWebCoding offers services for individual coders too. Coders, for example, can fill out a mini-resume, and that information is shared with the company's customers, says **Beth Friedman**, RHIT, director of marketing. "We have a coding pool."

The company is also introducing a free site with about 30 sample records for coders to use. "This site is for students in university programs or coding programs who are learning to code," she explains. "They can practice coding on an electronic image versus a paper chart."

*(Editor's note: A white-paper discussion of Inova Fairfax's switch to an ASP model for coding is available on the Web at [www.ewebcoding.com/02\\_01\\_tech.asp](http://www.ewebcoding.com/02_01_tech.asp).) ■*

## **Attacking denials recoups \$3.6 million for hospital**

### *Internal processes, problem payers in spotlight*

**P**rovider organizations know that declining government reimbursement is only one factor that sends them into the red.

Johns Hopkins Hospital in Baltimore, saw that it might be leaving millions on the table every year due to denials, a lackadaisical approach to appeals, ineffective relationships with payers, inaccuracies at registration, loopholes in contracts, missing medical records, late charges, bills

processing, coding and case mix intensity, and poor clinical documentation. The hospital system then began a multi-phase program that it called the Revenue Recovery Initiative to try to recoup those dollars. In fiscal year (FY) 2000, the effort recovered more than \$8 million — \$2.6 million of which resulted from a reduction in payment denials and overturned old denials.

The hospital had been experiencing a climbing denial rate, says **Dan Wassilchalk**, MHA, RHIA, director of performance improvement (PI) and utilization management (UM) for Johns Hopkins. In the first half of FY98, the hospital denial rate had reached a high of 2.8% on the clinical side and 1.4% on the administrative side, a total of 4.2%. By the end of FY98, the clinical denial rate dropped to about 2.6% on the clinical side, but the administrative rate increased the same amount.

“A 4% to 4 ½% denial rate is like discounting your service,” Wassilchalk says. “Who can afford to do that when you have hospitals with profit margins of 2% and less? When you are hovering on the edge, it can make the difference between whether you end up in the black and or in the red.”

At Johns Hopkins, every tenth of one percent in the denial rate was equivalent to about \$340,000, he explains. “We realized that to drop it three-tenths of one percent was worth \$1 million.”

### ***Looking inside first***

The PI/UM department decided to make a strong attack on denials. “We began by asking, ‘How can we be more productive on the internal side before we could extend resources to focus on the payers?’” Wassilchalk says. “Following a recent 20% downsizing in our department, we knew our budget wasn’t going to increase so we had to examine our use of existing resources to become more efficient.” **(For more information on the effort by providers’ associations to push legislative relief from Balanced Budget Act of 1997 cuts, see p. 11.)**

The first step was to generate a culture for change, with the understanding that the hospital could not afford to operate while losing these amounts of denied revenue. The department would integrate PI and UM to where the two functions would no longer be managed separately, and would capture data and focus on problematic cases in terms of both clinical and financial outcomes.

Wassilchalk also realized that through staffing restructuring, combined with reorganization and retraining in the department, PI could be trained to do UM duties and vice versa. Therefore, the department rewrote job descriptions, established performance standards and adjusted salaries to account for the added skills and knowledge required for the positions. Following the rewriting of the job descriptions, all staff members had to reapply for their positions. Staff turnover reached 35%.

### ***Beside laptops eliminate transcribing***

Then the department addressed the work processes themselves to see what it could do more efficiently. Some of the changes it made included:

- Capturing patient data on the nursing units through dedicated ports made available for the staff’s laptops.

The old process involved writing down the information, bringing it to the office and keying it into a computer. “That forced us to do a ‘check out and check in’ process,” Wassilchalk says. “In the morning, we checked out with our census, which took about a half hour. In the afternoon, we checked back into our census. That took about a half hour, too.”

By capturing all of the data on a laptop plugged into a network on the nursing units, the department eliminated the need for check out/check in. That saved an hour a day for each staff person — a total of 16 hours a day. The department plans to reinvest some of these savings to provide the staff with hand-held devices to ease recording and documentation while on the floor.

- Becoming functional unit- or department-based, rather than nursing unit-based.

In a declining length of stay in the old process, patients were handed off from one PI/UM specialist to another, up to three times depending on the level of care and the transfer of care. Instead, the PI/UM department wanted one specialist to follow the patient from admission to discharge wherever that patient went. “That would provide continuity among the case management program,” Wassilchalk says. The “triad case management team,” which consisted of social work, case management and PI/UM members, would be able to follow the patient based on the patient’s assigned service or functional unit. “This created

*(Continued on page 11)*

# DRG CODING ADVISOR.

## Mine the patient history for vital chart data

*Better documentation means better coding*

Properly documenting a patient's history is fundamental to correct evaluation and management coding. Here are some tips from **Brett Baker**, a coding and reimbursement expert for the American College of Physicians-American Society of Internal Medicine, on what to do and not do when documenting a patient's medical history.

First, it's important to remember that besides the data gathered from the medical exam and the physician's decision-making skills, the level of service selected is primarily influenced by the information gathered when taking the patient's health history, says Baker.

The CPT 2000 recognizes four types of history for E/M service codes. A history can be:

- problem-focused;
- expanded problem-focused;
- detailed;
- comprehensive.

Each type of history includes some or all of the following elements:

- chief complaint (CC);
- history of present illness (HPI);
- review of systems (ROS);
- past family and/or social history (PFSH).

"You should use your clinical judgment and the nature of the presenting problem to determine the extent of the history of present illness, review of systems, and past family and/or social history," advises Baker.

In documenting the history of a present illness physicians can use either the 1995 or 1997 E/M guidelines until HCFA releases a new set of instructions. Both the 1997 and 1995 E/M guidelines state that history of present illness is a chronological description of the development of the patient's present illness from the first sign or symptom, or from

the previous encounter to the present encounter. It includes the following elements:

- location;
- quality;
- severity;
- duration;
- timing;
- context;
- modifying factors;
- associated signs and symptoms.

"According to the 1995 guidelines, a brief history of present illness consists of one to three elements, while an extended history of present illness consists of four or more elements," says Baker. "You should describe these elements in the medical record."

According to the 1997 guidelines, a brief history of present illness consists of one to three elements (identical to the 1995 guidelines), while an extended history of present illness consists of at least four elements, or the status of at least three chronic or inactive conditions. Baker also advises describing these elements in the medical record.

The following questions are good for determining the extent of the history of present illness:

- Where does it hurt? (location)
- How is the pain incapacitating? (severity)
- Does it increase in the evening? (timing)

The history of present illness elements listed in the E/M guidelines (location, severity, timing, etc.) generally pertain to patients with acute problems. For documenting the history of present illness of a patient with a chronic or inactive condition, the 1997 E/M guidelines specifically refer to chronic conditions when discussing an extended history of present illness.

"Although you will not necessarily touch on the

same elements in the guidelines that fit more closely with an acute problem [location, quality, severity, etc.], you should ask other questions to determine whether your history of present illness for a patient with a chronic condition is brief or extended," he says. Sample questions could include:

- Are your symptoms recurring?
- Are you sticking to your medication regimen?
- Has your blood sugar been normal?

Since the current two sets of guidelines don't spell out specific elements or questions relating to chronic or inactive conditions, Baker says you should just ask what you feel is most appropriate under the clinical circumstances.

Many practitioners are not sure if the time that they spend counseling a patient's family member or other care decision makers can be considered when deciding on a level of E/M service.

"Before answering that question, it helps to first review the criteria determining when a physician can choose a level of service based on time spent counseling," recommends Baker. CPT 2000, for instance, states that time spent with a patient can be the key factor in selecting a level of E/M service when counseling or coordination of care accounts for more than 50% of the encounter.

Baker's advice is to select a level of service by determining the "typical time" assigned to most of the E/M service codes that corresponds to the amount of time you spent with the patient.

CPT 2000 defines counseling as a discussion with a patient or family concerning one or more of the following:

- diagnostic results, impressions, or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction;
- patient and family education.

Here's an example. If you spent 20 minutes of a 30-minute face-to-face encounter counseling an established patient during an office visit you would qualify to bill CPT code 99214 because the 30 minutes of face-to-face time exceeds the "typical time" of 25 minutes, says Baker. "You could bill CPT code 99214 regardless of the extent of history, examination, and medical decision making."

Then there is the issue of time spent counseling

a patient's family member or decision maker.

"Medicare recognizes time a physician spends counseling a family member and/or other care decision maker only if the patient is present," he notes. Time spent counseling without the patient present cannot be used as the key factor in determining which level of E/M service to bill.

Here's something to remember: Medicare's policy of requiring the patient to be present is more restrictive than the CPT 2000 definition of counseling. As such, Baker recommends excluding the time you spend counseling family and/or other care decision makers when the patient is not present if you are using counseling to determine the level of service billed.

"Of course, Medicare also recognizes the time a physician spends counseling a patient directly," he adds.

### ***An exception***

Medicare makes one exception to the requirement that a patient must be present for time spent counseling a family member or other caregiver when the physician is providing critical care. The exception states that time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options may be counted toward critical care time only when:

1. The patient is unable or incompetent to participate in giving a history and/or making treatment decisions.

2. The discussion is absolutely necessary for treatment decisions under consideration that day.

3. All of the following four elements are documented in the physician's progress note for that day:

- the patient was unable or incompetent to participate in giving history or making treatment decisions, as appropriate;

- the necessity of the discussion (e.g., "no other source was available to obtain a history" or "the patient was deteriorating so rapidly I needed to discuss treatment options with family immediately");

- the treatment decisions for which the discussion was needed;

- the substance of the discussion as related to the treatment decision.

HCFA memorandum B-99-43 to its Medicare carriers provides them with these instructions. For a copy of the memo, go to [www.hcfa.gov/forms/transmit/pmemos.htm](http://www.hcfa.gov/forms/transmit/pmemos.htm). ■

# Pick an E/M guideline and stick with it

## *Self-audits can find holes in your operation*

Selecting the correct evaluation and management (E/M) code can be more art than science. This is especially true given the current state of flux over issuing a final set of revised E/M guidelines. Until finalized — which may take two more years — the Health Care Financing Administration (HCFA) says that practices can use either the 1995 or 1997 E/M guidance when making coding decisions.

**Barb Pierce**, a coding consultant with Professional Management Midwest, in Des Moines, IA, advises that you “pick whichever guideline works best for you, then stick with it.”

She prefers the 1997 guidelines because the 1995 guidance is more vague in specialty-specific issues. For instance, the 1995 E/M guidelines provide no related definitions, but still require a comprehensive multi-organ system exam.

No matter which E/M version you choose, unless there’s proper documentation to go along with your codes you risk triggering bells and whistles in the HCFA audit office.

One sure way to set yourself up for an audit is to code E&M consultation consistently at a level 4 or 5. Always claiming a high consultation level will put your claims outside the curve compared to what other physicians are submitting for similar situations, which is just the kind of thing auditors look for.

## *Prospective reviews help spot errors*

Conducting so-called prospective reviews of claims before they are filed is a powerful way to cut down on costly errors and prevent hassles with HCFA and its intermediaries.

Here are recommendations from Pierce to help improve your prospective review of E/M codes:

- **Don’t take the physician’s word that the documentation is adequate.** Do regular sample reviews to spot any patterns of improper coding.
- **Make sure medical records are complete and legible.** “It’s not whether you can read them, but whether a consultant or outside auditor can read them,” Pierce stresses.
- **Document patient encounters.** This needs to include the reason for the encounter and relevant

history, physical examination findings and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and legible identity of the observer. If there is no documentation, the rationale for ordering diagnostic and other ancillary services should be easily inferred. “Medical necessity must be proved. You must link diagnosis with procedure code,” she emphases.

- **Other past and present diagnoses need to be available to the current treating and/or consulting physician; appropriate health risk factors should be identified.** The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented.

- **The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.** “If the physician did a 99214, there must be documentation for a 99214,” she says.

- **Encounter forms and the medical record should relay the same information.** “Oftentimes, the physician doesn’t do documentation for days or weeks or longer,” which creates the possibility of a conflict, she notes.

*Tip:* One way to avoid this situation is to create a “progress notes” system for physicians who don’t immediately dictate their notes. This is a system in which they simply check appropriate boxes on a form when they see a patient. It is somewhat crude, but it also “prompts the physician to document certain procedures,” notes Pierce. ■

# How coding reviews could save you \$30 million

## *Good reviews are worth bundles*

Is precise coding really that important? If you’re still asking that question, even just occasionally to yourself, consider this: “The University of Pennsylvania is now in the process of paying \$30 million to settle an action that grew out of a government review of just 100 of its medical records,” notes **Lynne Northcutt-Greager**, a coding expert with the Medical Group Management Association (MGMA) in Englewood, CO.

Add to that the fact that quality coding helps minimize delayed or incorrect reimbursement and

reduces denials based on lack of documented medical necessity, which improves fast flow.

“The best mechanism for improving your coding performance is a coding review,” stresses Northcutt-Greager. Regular coding reviews need to be a basic part of your compliance program. Whether or not you’re already doing scheduled reviews, here are some suggestions from Northcutt-Greager and MGMA on how to structure a coding review for maximum effectiveness:

- **Goal setting.** What are the goals of the review? Should it be prospective or retrospective? What types of services should be looked at? Which payers will you focus on? Are there multiple locations that need to be reviewed?

- **Choosing a reviewer.** The criteria for selecting a coding reviewer depends on the areas on which your organization needs to focus. Different reviewers will approach the review from different perspectives, depending on whether their backgrounds are in accounting or insurance, for example. Consider the reviewer’s qualifications, expertise, education, and training. Make sure the reviewer knows your specialty and the issues on which you want to focus.

- **Scope.** Once the reviewer has been chosen, you need to decide on the scope of the review. The reviewer and administrator should work together to decide whether the reviewer will: examine physician production; review forms used in the organization; compare medical record documentation to actual services provided; compare payer billing requirements to specific patient records; and review operational areas like billing processes and information flow.

“There’s no standard reviewing format that covers all the bases for every practice,” notes Northcutt-Greager. Reviews will vary depending on the organization’s size, specialty, and payer contract requirements. That’s why it is important that the reviewer gears the review to the issues affecting your organization.

- **Post-review.** After the review, you’ll have to start thinking about how to implement the reviewer’s recommendations. Be prepared; this could involve further evaluation, training sessions, software upgrades, corrected billings or refunds, or even consultation with legal counsel, she advises.

Basically, “you’ll need to respond to anything that’s a potential compliance problem.”

Here are some other recommendations from the MGMA for immediately upgrading your coding:

- Make sure current copies of coding books and reference materials are available to everyone

involved in the coding process.

- Send staff to seminars on coding.
- Hold periodic staff meetings to discuss coding issues.
- Communicate updates and make Medicare and other payer bulletins available.
- Make sure everyone responsible for accurate coding understands the material. ■



## Coding assessment offered

The American Health Information Management Association (AHIMA) in Chicago has developed a web-based program with the educational coding needs of health care organizations in mind.

“Coding Assessment and Training Solutions” provides an opportunity for organizations and coders to assess coding skills and knowledge, and to keep abreast of the latest coding practices and policies. The program allows organizations to validate the coding skills of staff members, and to discover where improvement is needed.

The initial phase of the interactive program addresses the area of assessment. This portion provides resources to assess and validate individual coding skills and identify areas requiring improvement. The results of the testing allow organizations to assess their need for ongoing and future coding training.

After assessing knowledge in such areas as coding principles, coding guidelines, document analysis, problem solving, and data management skills, training needs may be outlined. The online training materials include instructional information, exercises and actual case applications.

Training includes coursework in up to 19 different specialty areas. Online access and self-administration will allow users to learn at their own pace, dependent on initiatives and time available. All training allows users to accrue continuing education hours.

For more information about “Coding Assessment and Training Solutions,” contact AHIMA at (312) 233-1158. ■

(Continued from page 6)

better communication among all the involved members.”

### ***Improving communication with payers***

Then the department looked for ways to improve communication between the hospital and its payers. The steps it took included:

- Adding cell phones for the staff and projecting length of stay.

Staff hated returning voice mail messages, Wassilchalk says. To counter this, the department distributed a matrix to all payers, which included phone numbers, beeper numbers and cell phone numbers of all of the triad members, sorted by functional unit or by medical staff department. At any time, payers could look at the matrix and know what treatment the patient was receiving, and be able to determine who would be the best person at Johns Hopkins to contact. “We were looking to provide the right information at the right place at the right time so

we could avoid voice mails,” he explains. The department also purchased InterQual criteria to allow the PI/UM staff to “speak the same language” with payers.

As might be guessed, the number of telephone calls regarding insurance questions increased quickly, up 24% from FY99 to FY00. On the positive side, the number of certified days increased 31%. “That meant we were approving more days on the front end,” Wassilchalk says.

Staff, however, had difficulty meeting the demands of the telephone calls. The PI/UM department, therefore, instituted two new policies. One, staff would only make phone calls twice a week. Second, the department would press payers to approve days upfront based on either Hopkins’ critical paths or some published length-of-stay norm.

“We hope these practices will reduce the number of phone calls to an exception basis (to those inquiring only about patients who have exceeded the projected length of stay or patients who didn’t have a projected length of stay assigned,” Wassilchalk says.

## **Associations lobby for some BBA relief**

*Hospitals could lose \$5 billion this year*

**T**he Congressional session may have been a lame duck, but it carried primary urgency for health care organizations pushing for relief from Balanced Budget Act (BBA) of 1997 cuts.

The American Hospital Association (AHA) in Chicago estimates that America’s hospitals and health systems need \$25 billion over five years to help offset the cuts. The AHA was gathering forces with other health care organizations as members of Congress returned to duty on Dec. 5 to discuss five budget bills and a tax package that includes a “revised” BBA relief bill, the Medicare, Medicaid & SCHIP Beneficiary Improvement & Protection Act of 2000 (HR 5543). The bill costs about \$33 billion over five years. If relief is not passed this year, hospitals could stand to lose more than \$5 billion in government support, according to AHA President **Dick Davidson**.

Although Congressional leaders have been optimistic that BBA relief legislation would pass, the AHA and other health care organizations

were not taking any chances. First, they drew health care member delegations and grassroots activists together on Capitol Hill for Advocacy Days, held Nov. 14-17. Organizations cosponsoring these events include the AHA and its related organizations, the Association of American Medical Colleges, the Catholic Health Association of the United States, the Federation of American Hospitals, the National Association of Public Hospitals and Health Systems, Premier, and VHA. After being briefed on the BBA relief situation, the advocates spoke to their elected representatives to try to persuade them to support the relief legislation.

The organizations also began a fax-back campaign. A form that resembles a petition was sent to hospital CEOs and other leaders. The form asked the executives to gather signatures and addresses from employees, volunteers, and patients and then to fax the information to the legislators. In addition, a new ad campaign from the Coalition to Protect America’s Health Care in Washington, DC, hit the airwaves, asking for support of the relief effort.

*Hospital Payment & Information Management* will follow the progress of the BBA relief legislation and will report on it in future issues. ■

- Increasing the number of on-site reviewers.

The department decided to increase its number of on-site reviewers, too. At the beginning of FY99, the system had four payers on site. The number has now increased to 10. “We communicate on a routine basis throughout the week with the payers, and we work together to delegate reviews,” Wassilchalk says. “We can reduce phone calls by having the payers on-site, and they find it is a good investment by being there. Physicians — the medical directors of the health plans as well as our attendings — appreciate them being on site, too, because information can be gathered and decisions can be understood in a timely manner.”

### ***Developing team payer management***

With the savings and efficiencies it had gained, the PI/UM department created Team Payer Management. The team has two major functions:

- Manage on-site reviewers and assign one or two nurses in the department to the high-volume, problem-prone payers.

“This allowed the hospital to assure right-time, first-time information to the payers,” Wassilchalk says. The double-digit denial rates for the top three problem-prone payers decreased by half in six months.

- Track, record, manage and follow-up on denials and appeals, and report this information routinely throughout the organization.

The department generates a lot of data on denials, Wassilchalk explains. Denial activity is tracked monthly by payer, department, reason, DRG (diagnosis-related group), physician and other variables.

Overall, Johns Hopkins saw its clinical denial rate decrease from 2.6% to 2.3% in FY99 and 1.8% this past fiscal year. On the administrative side, the rate decreased from 1.6% to 1.0%. “We are now looking at a combined denial rate of about 3%,” he says. “The latest statistics show that the average denial rate for Maryland is 4.5%. Our staff is thrilled and proud.”

The department not only had to work on claims currently being processed, but it needed to address denials and appeals that remained in limbo in the system. For example, when the department started this initiative in calendar year 1999, it identified \$1.9 million in appeals dating back to January 1997 that had never generated a response from the payers.

The hospital decided to hire someone to focus

on those old appeals. “It’s a matter of keeping the pressure on the payers,” Wassilchalk says. Collections in FY00 for that effort total more than \$900,000. Continuing into FY01, the hospital has already collected more than \$1 million in old appeals.

The hospital next plans to address emergency department visits, where it hopes to capture another \$250,000 in overturned denials. After that, the focus will turn to outpatient services.

In addition to the reduced denial rate and the collection of old appeals, Johns Hopkins also increased its appeal rates and recovery rates. The facility was only appealing about 40% of all of its denials. “You can’t win if you don’t play; we had to increase our appeal rate,” Wassilchalk says.

In addition, the PI/UM department realized that staff needed to learn how to write a better appeal letter. “Our appeal letters were terrible in structure and content,” Wassilchalk says. To help with the letters, Johns Hopkins consulted legal counsel and nurses from payer organizations to give their perspective on the way the provider’s appeals were interpreted. “We taught our staff to write a better letter and we saw our overturn rate double.”

### ***Recovered: \$2.6 million***

Wassilchalk did not want to burden his staff with the letter writing, however, because they were spending more time talking with payers. The department, therefore, began to outsource the appeal writing. “We went to the employee health office and found nurses who were injured and couldn’t work on the patient care units, but who could read a chart and write a letter.”

The appeal rate rose to almost 70%, and the hospital’s overturned denial rate doubled from 10% to more than 20%. When the savings of all of the department’s efforts are totaled, more than \$2.6 million has been recovered. Wassilchalk highlighted the success on a storyboard at the September conference of the American Health Information Management Association in Chicago.

Some of the money saved has been reinvested in software and other technology. Other funds were used to reward and recognize — through luncheons, picnics, and seminars, for example — everyone involved in the success of the project, Wassilchalk says. “That serves as the momentum for fueling continuous improvement.” ■

# Plane crash highlights gaps in data gathering

*Database set up after TWA 800 tragedy*

Officials in Suffolk County, Long Island, NY, thought they had their bases covered after forming a mass disaster committee. But when TWA flight 800 crashed into the Atlantic Ocean off the coast of Long Island on July 17, 1996, the officials weren't sure how to set up and organize the medical records that would be used to identify the victims.

"That was the one component of the mass disaster planning they hadn't considered," says **Beth Friedman**, RHIT, director of marketing for eWebCoding in Atlanta. Friedman and her husband were visiting her in-laws when the accident occurred. Her father-in-law was the forensic dentist for Suffolk County and was the coordinator of the mass disaster committee. "When the plane crashed, he gathered the committee and was primarily the lead dentist in the [victim identification] process."

As soon as the accident occurred, officials gathered family members of the victims and asked them to contact physicians and hospitals to request that the victims' medical records be sent to Long Island. The county, however, was not prepared to handle these records and had to create a database and filing system "on the fly," Friedman explains. Realizing the county could use her medical records expertise; Friedman and her husband decided to stay in town for about five days and volunteer to help. She recounted her experience on a storyboard at the September conference of the American Health Information Management Association in Chicago.

The Federal Express packages started arriving in two or three days from around the country and other parts of the world. The incoming information was in disparate media, Friedman says. "The dentists sent dental X-rays. Hospitals sent paper records." The families also provided photographs as well as victim identification sheets that detailed victims' identifying marks. "We had all types of information that we had to pull together."

This proved to be a challenge. At first, clerks receiving the information were filing each piece in a different filing cabinet. Photographs, therefore, were filed in one place, dental records in another.

Friedman knew from her experience in database management that this filing method would not help officials identify victims quickly. "I said, 'We need to have all the patient information in one place so the dentists can open the folders and have all the information in front of them.'" The office made that switch the first day, revamping the filing system so that everything was filed by passenger name.

The medical records workers then collaborated with the dental team to figure out the logical way to set up the data. "We created a checklist," Friedman says. "We said, 'Here are the pieces of information that we are trying to capture.'" As the information came in, clerks checked off what they received for each passenger. The second step was deciding how to file this information to make it most useful for the dentists to do the confirmation identification.

Then the medical records workers created an electronic database in Access to start logging in what information they had and what they still needed. "At that point, we had huge manila file folders with each of the passengers' names and had those filed alphabetically in the 'war room,' the place where we dealt with the records," Friedman says.

## *'What if?' scenarios now possible*

Since these initial stages of information gathering, the Suffolk County Medical Examiner's Office has created extensive databases from the accident. The databases include all of the post-mortem information for each victim, including the person's injuries. Special software links this information to the actual seat the person was using on the plane. "That enables them to do a lot of 'what if?' scenarios," Friedman says.

County officials have since included data collection in its disaster plan. One part of the plan involves using a scanner in the "family area" to scan the paper documents, making the media of the records more uniform.

County forensic professionals have spoken nationally about the lessons they learned from the disaster, Friedman says. They have also worked with medical professionals from other disaster sites to encourage communities to form a disaster committee and have a plan in place.

"If communities could think about some of these issues ahead of time and be prepared," she says, "the [victim identification] process would be much more efficient." ■

# New PPS more fulfilling, less controversial

*Proposal contains few surprises*

Early November revealed another prospective payment system (PPS), this one much less controversial than the one for outpatient services.

On Nov. 2, the Health Care Financing Administration published on its Web site its proposed PPS for rehabilitation facilities. These facilities can be either freestanding or units of acute care hospitals. HCFA posted the proposal on the *Federal Register* Web site on Nov. 3.<sup>1</sup>

Health care officials have found few surprises in the proposal, reports the *American Hospital Association News*. Here are some of the features of the system, which will be phased in over two years, as reviewed by the AHA.

- Rehab facilities will be paid on a per-discharge basis (for operational and capital costs).
- There will be comorbidity adjustments for

varying degrees of patient needs.

- A transfer provision will determine payments for patients who are transferred to other facilities before treatment completion.

- Payments will be adjusted for geographic differences in wages and for disproportionate shares of low-income patients; rural facilities will receive special adjustments.

- Additional payment adjustments (derived from a set-aside fund made up of 3% of the overall rehab PPS budget) will be made for outlier cases.

- Facilities will use the Minimum Dataset Post-Acute Coding assessment tool to determine each patient's needs and appropriate payment categories.

The proposed rehab PPS is designed to pay 2% less than those under the existing cost-based system, but this percentage may change if Congress passes Balanced Budget Act relief legislation.

## Reference

1. 65 *Fed Reg* 66,303 (Nov. 3, 2000). ■



## Survey: Create stronger patient privacy rules

American hospitals and health care payer organizations are preparing to meet growing consumer and governmental concerns about patient information security and privacy, according to a survey conducted by Phoenix Health Systems in Montgomery Village, MD.

Phoenix's October on-line survey of 468 health care industry representatives indicated that the majority of hospitals, payers, and other health care organizations acknowledge that new regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require their immediate response. Under HIPAA, health care organizations must comply with new security and privacy standards to protect individually identifiable health information.

Most organizations' HIPAA-related efforts are focused first on building internal awareness of the

public's privacy concerns, the relevance of HIPAA, and the implications for health care organizations' operations. More than half have begun the process of assessing their organizations' systems, procedures, and practices to identify privacy and security vulnerabilities. Their next steps will include actual compliance planning, internal implementation and staff training.

Complete fall 2000 HIPAA survey results, including graphics, are available at [www.hipaadvisory.com/action/survey/fall2000.htm](http://www.hipaadvisory.com/action/survey/fall2000.htm). ▼

## Road opens up for electronic transactions

The Electronic Signatures in Global and National Commerce Act (E-SIGN), which took effect Oct. 1, "paves the way to a paperless health record," says **Gwen Hughes**, RHIA, a health information management practice manager at the American Health Information Management Association (AHIMA) in Chicago. Hughes published her thoughts in the November/December issue of the *Journal of AHIMA*. "Transactions that previously had to be documented and retained on

paper or accurate reproductions thereof, can now be obtained and retained electronically.”

E-SIGN primarily states that a signature, contract, or other record of a transaction may not be denied legal effect, validity, or enforceability solely because it is in electronic form, Hughes says. The law opens additional possibilities for HIM professionals, including:

- Consumers who wish to do so prior to admission, might register; be provided the notice of information practices required by the 1996 Health Insurance Portability and Accountability Act and some state laws; peruse and sign the necessary financial documents; and complete consent forms while still at home.

- Consumers could electronically request or authorize disclosure of their health records. They might be able to pay any related fees via e-commerce.

For a further discussion of the law and its repercussions, visit the Web site [www.ahima.org/inconf/inconf.0011.1.html](http://www.ahima.org/inconf/inconf.0011.1.html). ▼

## Feds offer answers to your questions

The Office of Inspector General (OIG) has posted on its Web site 23 new answers to frequently asked questions (FAQ) on corporate integrity agreement (CIA) billing reviews.

Most corporate integrity agreements or settlement agreements with integrity provisions (agreements) require that a billing review be conducted, either by an independent review organization (IRO) or in some cases by the provider, with a verification review performed by the IRO.

Over the past several years, the language used in these CIAs and agreements to describe the billing reviews has evolved from being general in nature to fairly specific.

For this reason, the OIG has updated its original list and has added a specific index of topics covered by these FAQs, as follows:

- reporting of overpayments;
- independence of an IRO;
- selecting an IRO;
- material violations;
- CIA billing reviews.

To access the FAQs, go to [www.dhhs.gov/progorg/oig/cia/ciafaq1.htm](http://www.dhhs.gov/progorg/oig/cia/ciafaq1.htm). ▼

## Four major health care studies released

In conjunction with leading businesses, the Health Insurance Association of America (HIAA) in Washington, DC, released four major studies in October that look at prospects for a defined contribution system for employment-sponsored health insurance, the burgeoning seniors marketplace, insurers' communication with consumers, and insurers' use of technology. These studies include:

- PricewaterhouseCoopers' "Defined

Hospital Payment & Information Management™ (ISSN# 1074-8334), including DRG Coding Advisor®, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to Hospital Payment & Information Management™, P.O. Box 740059, Atlanta, GA 30374.

### Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, ([customerservice@ahcpub.com](mailto:customerservice@ahcpub.com)). Hours of operation: 8:30-6:00 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), \$547. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Two to nine additional copies, \$328 per year; 10 to 20 additional copies, \$219 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are \$91 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact American Health Consultants®. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcpub.com>.

### Editorial Questions

For questions or comments, call Lee Landenberger at (404) 262-5483.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: Sue Powell Coons, (614) 848-5254, ([suby33@aol.com](mailto:suby33@aol.com)).  
Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, ([brenda.mooney@ahcpub.com](mailto:brenda.mooney@ahcpub.com)).  
Editorial Group Head: Coles McKagen, (404) 262-5420, ([coles.mckagen@ahcpub.com](mailto:coles.mckagen@ahcpub.com)).  
Managing Editor: Lee Landenberger, (404) 262-5483, ([lee.landenberger@ahcpub.com](mailto:lee.landenberger@ahcpub.com)).  
Production Editor: Nancy Saltmarsh.

Copyright © 2001 by American Health Consultants®. Hospital Payment & Information Management™ is a trademark of American Health Consultants®. DRG Coding Advisor® is a registered trademark of American Health Consultants®. The trademarks Hospital Payment & Information Management™ and DRG Coding Advisor® are used herein under license. All rights reserved.



Contribution: Is It In Your Future?" This study defines "defined contribution health benefits" (DCHB), looks at factors and trends affecting the development of DCHB, and examines market barriers to the establishment of DCHB as an accepted health benefit.

- Tillinghast-Towers Perrin's "Convergence of Products in the Senior Marketplace." This study examines how insurers are planning to deal with the fastest growing segment of the U.S. population.

- Xerox Corp.'s "Strengthening Consumer Relationships Through Strategic Communications." This study examines how health insurers can improve communications with consumers.

- IBM's "Leveraging Information Technology to Solve the Privacy Puzzle." This study examines privacy issues as health insurance companies increase their use of the Internet.

Brief abstracts of each study are available at [www.hiaa.org/news/news-state/001031abstracts.htm](http://www.hiaa.org/news/news-state/001031abstracts.htm). The complete studies are available at [www.hiaa.org/forum21.htm](http://www.hiaa.org/forum21.htm). ▼

## E-health groups have a quorum

Three Internet health organizations announced in October that they were forming a coordinating committee to collaborate on ethical conduct codes. The committee has a goal of ensuring a system of e-health codes that is understandable to the public and that uses a common terminology. The organizations involved in this committee are:

- Hi-Ethics (Health Internet Ethics), a collation of 20 of the most widely used U.S.-based consumer health Internet sites and information providers.

- Health on the Net Foundation, a not-for-profit portal for medical and health-related information group based in Geneva, Switzerland.

- Internet Healthcare Coalition's e-Health Ethics Initiative. The Internet Healthcare Coalition is a Washington, DC-based nonprofit organization. Its initiative aims to provide a forum for the development of a universal set of ethical principles for health-related Web sites.

The first step of the collaboration will be the

### EDITORIAL ADVISORY BOARD

**Phoebe Bennett, RHIA**  
Director  
Medical Records  
Bay Area Hospital  
Coos Bay, OR

**Martin J. Gaynes, Esq.**  
Schmeltzer, Aptaker &  
Shepard  
Attorneys at Law  
Washington, DC

**James H. Braden, MBA**  
Executive Director  
Health Information  
Management  
The Detroit Medical Center

**Patricia C. Goebel, MS,**  
RHIA  
Director  
Clinical Information  
Jennie Edmundson Hospital  
Council Bluffs, IA

**Margaret M. Foley, MA,**  
RHIA  
Department of Health  
Information Management  
Temple University  
Philadelphia

**Darice Grzybowski, MA,**  
RHIA  
National Manager  
HIM Industry Relations  
3M HIS  
Salt Lake City

**Bill French, MBA, RHIA**  
Vice President  
Payment Error  
Prevention Program  
MetaStar  
Madison, WI

**Lela McFerrin, RHIA**  
Director  
Health Information  
Management  
Baptist Memorial Hospital  
Memphis, TN

development of a common glossary of definitions and terms for verification and compliance efforts. E-health consumers should be able to easily compare security and privacy statements using universal descriptions. The common terminology will be used by the three organizations when communicating future developments. The groups hope their efforts may set domestic standards and may eventually lead to cooperation on an international level. ■



- The CPT Coding Changes for 2001 (Hospitals and ASC Facilities) audio seminar is being offered Jan. 25. For more information, call the American Health Information Management Association in Chicago at (312) 233-1100.

- The 2001 Annual HIMSS Conference and Exhibition will be held Feb. 4-8 in New Orleans. The conference is sponsored by the Healthcare Information and Management Systems Society in Chicago. For more information, visit the Web address at <http://216.122.166.44>. ■