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Special Report:
Privacy Standards, Records Access

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Unlimited access creates a brave new world

Why wait? Appointments can be the next day

A patient thinks of his or her health care providers and says, "They give me exactly the help I want and need exactly when I want and need it."

Sound revolutionary? It's one of the tenets of an initiative called Idealized Design of Clinical Office Practices (IDCOP) that is being promulgated by the Institute for Healthcare Improvement (IHI) in Boston.

The initiative, led by IHI president and CEO Donald M. Berwick, began in 1998 and involves about 23 health care organizations in the United States and Sweden, explains **Karen McKinley**, RN, CHAM, senior director of system access services, for Geisinger Health Services in Danville, PA.

"It is our belief that the health care system is broken," adds McKinley, who is past president of the National Association for Healthcare Access Management. "You can't attack the whole system at once — it's too complex — so the initiative was focused in a specific area, the office practice, to begin to improve health care delivery."

Geisinger Health System got involved with IHI in January 1999, when it was invited to be a prototype site for the clinical office practice initiative. The project is ongoing, she notes, and has no scheduled date of completion.

The IDCOP model focuses on the following four themes, all of which are interrelated, says **Pat Rutherford**, MS, RN, vice president of IHI.

• **Access.** Patients have unlimited access to the care and information they need, when they need it. Access to care should be available 24 hours a day, seven days a week, 365 days a year.

COMING IN FUTURE ISSUES

- Designing access from the ground up
- Looking for enterprise solutions
- What merging and unmerging mean to you
- Tips on 'customer relationship management'
- How the new ergonomics regs affect access

• **Interaction.** Interaction between the patient and care team is deep and personal. The care team has memory of the patient. Every patient is the only patient.

• **Reliability.** The system exhibits high reliability in that it provides all and only the care known to be effective.

• **Vitality.** The practice has vitality: a happy staff, a spirit of innovation, and financial viability.

The theme of "access" — which has a different meaning here than the one access managers typically associate with it — is getting a lot of publicity, Rutherford calls it "a delighter." Described initially as "open access" and now referred to more accurately as "advanced access," she notes, the idea is that patients have unlimited access to the care and information they need when they need it.

"This is our overarching, guiding principle," Rutherford explains. "When patients or consumers want to have interaction with providers of health care, they have access. It may be a visit, a telephone consultation, an e-mail, or a group visit. The relationship with the clinician could happen in a variety of ways."

The phrase "open access" scared off some clinicians, she says, because they thought it meant patients could walk in whenever they wished. Actually, "they call and are fit in, but within a schedule."

Under the ICDOP initiative at Geisinger, for example, the health care organization is taking actions with scheduling that are aimed at advancing access for patients in the clinic setting, McKinley explains.

The concept of advanced access is woven into the training module on scheduling, adds **Lynn Schankweiler**, CHAA, training specialist at Geisinger. "It is about meeting today's needs today. It basically means the provider tries to keep a part of the schedule open to accommodate the person that needs or wants to be seen today."

It doesn't matter, Schankweiler notes, why the person wants to be seen today — it could be because he needs a physical or because she thinks she has the flu.

Advanced access also means, she says, that wherever in the health system the patient makes contact, that employee will facilitate the meeting of that patient's needs. When the patient is checking out, for instance, and needs a follow-up appointment, Schankweiler says, it's not enough to say, "Here's the number to call for radiology."

"Our employees are expected to facilitate or coordinate the request," she explains. For example,

Schankweiler adds, the employee should actually make the call or schedule the appointment directly on-line for the patient.

Advanced access is best explained, Rutherford says, by consultants Mark Murray, MD, MPA, and Catherine Tantau, MPA, who developed the concept in the early '90s, when they managed a large primary care department for Kaiser Permanente in north Sacramento Valley, CA.

Their implementation of what is alternately called "advanced access," "open access," or "same-day scheduling," included two crucial features:

- continuity, meaning the system's ability to match patients with their own personal physician;
- capacity, meaning room on the daily schedule.

The system, described at length in the September 2000 issue of *Family Practice Management*, has one underlying rule: "Do today's work today." (The article "Same-Day Appointments: Exploding the Access Paradigm" can be found on the World Wide Web at www.aafp.org/fpm/20000900/45same.html.)

Although not directly related to what is commonly thought of as the access department, many of the concepts used in the clinical office practice initiative "could apply to many areas," Rutherford notes, including admitting and the emergency department (ED).

"It's about really understanding what your workload is and scheduling [with those in mind]," she says. "In the ED, for example, it's usually quiet in the morning, so you want to staff accordingly to meet that demand. You probably have peaks of activity within the admitting office, so how do you deploy personnel so there are not long waits, but a continuous flow?"

One of the neat applications for the access department, McKinley points out, "is that we have enhanced our staff development. We can achieve levels of staff functionality and satisfaction that we haven't seen in a long time."

Also under IDCOP, she says, health care is interactive and providers work to ensure that care is individualized. "Communication is based on patient preference," McKinley adds, noting that a patient might be asked, "Do you need a return appointment or could your needs be met through e-mail or over the telephone?"

The theme of reliability, she says, suggests a match between new science and best practice. The idea, McKinley explains, is that "all and only" effective and helpful care is given.

"Our systems should provide all past information about a patient to eliminate repetition and duplication," she says. "In addition, any new knowledge about the patient's condition or treatment options should be right at our fingertips to be used during the patient visit."

IDCOP "talks about a clinical office that is financially viable, innovative, and a great place to work," McKinley notes. "We try to teach that clinical practice should be a 'living laboratory' within a 'learning organization.' Remember that you always have something new to learn."

There are measures of success that correspond to each of the four IDCOP themes. Under "vitality," for example, providers look at:

- proportion of work that is innovative;
- new patient visits;
- staff morale;
- operating margin.

For the theme of "interaction," the measures are:

- patient ratings of quality interactions (visit and nonvisit);
- use of shared decision-making models;
- patient/provider match.

IHI offers these questions for providers seeking to understand and improve their own practices:

- Who is your patient population?
- How many patients do you have?
- What are their needs?
- How do you currently meet patient and family needs?
- Who in your practice does what?
- What are your current patient and family outcomes?
- Who should your practice collaborate with in the health system/community?

[For more information on the Idealized Design of Clinical Office Practice and other IHI initiatives, visit the organization's Web site at www.IHI.org. Karen McKinley may be reached at (717) 909-3382 or by e-mail at kmckinley@geisinger.edu.] ■

The new privacy: Rules, fines, prison

'The burden is always on the front line'

The first federal standards for protecting the privacy of Americans' medical records — issued in December by the Department of Health and Human Services — are more far reaching than first proposed and promise to significantly impact the

operation of hospital access departments.

The rules cover not only electronic medical records — as was proposed by the administration a year ago — but paper records and oral communications. They require patients' written consent for even routine disclosure of information, which was not covered in the earlier plan.

The new standards, which take full effect in two years, guarantee patients access to their health files, restrict the release of their personal information without their approval, and give them greater say about how the files are used. **(See related story, p. 17.)**

"There are definitely going to be a lot of things [access professionals] will have to react to," says **Nancy Farrington**, MBA, CHAM, vice president of the National Association of Healthcare Access Management (NAHAM). "One of the most significant pieces in terms of access is that individual organizations make decisions about who is going to share information on the rules with patients," adds Farrington, who is MPI/CDR administrator for Main Line Health Data Center in Berwyn, PA. "Based on our experience with Advance Directives, it seems likely that will be done in access. To try to do it in other departments doesn't make much sense."

According to the fact sheet issued with the rules, providers and health care plans are required to given patients a clear, written explanation of how those entities can keep and disclose patient information, she points out.

"That means that every hospital and outpatient clinic will have to have a handout available for patients saying, 'Here's how we use your information, here's how we store it, and here's our process for disclosing it.' That's something that's never been done before — proactively providing information to patients on how their health information is handled."

The requirement that providers must have patients' consent before information is released will impact health care organizations differently depending on what they're already doing in that regard, Farrington says. And, she adds, "how in-depth that [requirement] goes we won't know until more rules are issued."

"In many environments at this time, health care providers have a blanket consent form signed that enables them to release information for payment purposes," Farrington says. "Patients sign it the first time they see the doctor and never see it again. The way this portion [of the new standard] is written there is the anticipation that [the obtaining of this consent] will be more specific and more frequent."

At present, she notes, many providers don't ask patients coming in for routine outpatient services to sign any release because those patients come with a form from their HMO authorizing the visit. That may change, Farrington suggests, meaning the addition of significantly more paperwork for access personnel, as well as time spent explaining the provisions to patient. "The burden is always on the front line."

The patient's choice

It also will be interesting to see what develops from the idea that a patient may be quite specific about restrictions on the use and disclosure of information, she says. Even now, Farrington adds, some patients at her organization refuse to provide their Social Security number, which Main Line uses as a primary identifier.

With the new privacy rules, she says, in theory, patients would have the ability to specify any piece of information and say that providers can't share it with physicians or other providers. "[Hospitals] would have to develop all sorts of computer systems to determine what is shareable and what is not."

Another potential change in hospital computer systems, Farrington says, will involve the ability to monitor those who have access to patient demographic information. "Right now at our organization, we have the ability to identify which employees look at clinical data, but not those who look at demographic data."

There is a big learning curve, she notes, any time there are computer changes. Additionally, "someone will have to review who looked at the data and whether they had a reason to do so. That's a burden on management."

The full implications of the regulations won't be apparent, Farrington suggests, until experience and case law come into play. She cautions, however, that access managers "don't have the luxury to wait and see" before taking action. Those who wait two years before making changes will be so far behind they're likely to find themselves in gross violation of the law, Farrington predicts.

"We need to start immediately to prepare," she says, "so as the nuances of the regulations become reality, we're most of the way there."

Penalties in connection with breaches of patient privacy "have been long anticipated," Farrington notes. "I've been warning registration staff for a

long time about the mistakes they make that can violate patient confidentiality. If, for example, they put the wrong doctor's name and the wrong doctor gets the patient's results, they are potentially subject to fines. It will require a lot more accuracy not to have penalties."

Initially, the fines levied in connection with the privacy standard will be related specifically to intentional wrongdoing, she predicts. "But once all that happens, the feds will start looking for breaches that are just the result of error."

As to whether individual employees, or just their institutions, will be liable, Farrington notes, "We'll need to see how it plays out, but it says here [in the regulations] that the penalty could be a year in prison. Obviously, a hospital can't be put in prison, so at some point an access representative who deliberately disclosed patient information could be subject to time in a penitentiary."

One of the provisions of the new privacy standard that has garnered the largest public reaction, she points out, is that the umbrella has been expanded to cover not only electronic records, but written and oral information.

"That is absolutely logical and had been anticipated by many people," Farrington says, "and it [highlights] the need for continuous improvement in the culture of our health care organizations. If you walk through the corridors or the hospital parking lot, you routinely hear doctors talking about patients. In the past, that was not appropriate. Now it is illegal.

"This shouldn't be shocking in that these are behaviors we should all have been mindful of in the past," she adds. "Now the potential is there for fines and imprisonment. ■

Protection is privacy's goal

Penalties for violations are steep

The new federal privacy regulation, issued in December by the Department of Health and Human Services (HHS) will protect medical records and other personal health information maintained by health care providers, hospitals, health plans and health insurers, and health care clearinghouses.

The regulation, mandated by Congress when it failed to pass comprehensive privacy legislation, includes these standards, according to a fact sheet released by HHS:

- limit the nonconsensual use and release of private health information;
- give patients new rights to access their medical records and to know who else has accessed them;
- restrict most disclosure of health information to the minimum needed for the intended purpose;
- establish new criminal and civil sanctions for improper use or disclosure; and establish new requirements for access to records by researchers and others.

The standards extend coverage to personal medical records in all forms, including paper records and oral communications. The earlier proposal had applied to electronic records and to any paper records that had at some point existed in electronic form. The final regulation provides protection for paper, oral, and electronic information, creating a privacy system that covers all personal health information created or held by covered entities.

The final rule also requires that most providers get their patients' consent for routine use and disclosure of health records, in addition to requiring their authorization for nonroutine disclosures. The earlier version had proposed allowing routine disclosures — disclosures for purposes of treatment, payment and health care operations (such as internal data gathering by a provider or health care plan) — without advance consent.

Advance written consent for routine purposes will be similar to the practice most patients are accustomed to when they visit a doctor or hospital today. However, the regulation will provide additional protection by requiring that patients must also be given detailed written information on their privacy rights and how their information will be used.

Other changes from the proposed rule include:

- **Allowing disclosure of the full medical record to providers for purposes of treatment.**

For most disclosures, such as health information submitted with bills, providers may send only the minimum information needed for the purpose of the disclosure. The final rule gives providers full discretion in determining what personal health information to include when sending patients' medical records to other providers for treatment purposes.

- **Protecting against unauthorized use of medical records for employment purposes.**

Companies that sponsor health plans will not be able to access personal health information from the sponsored plan for employment-related

Price tag for new rules: $22.5 billion

The cost to the health care industry of complying with just some of the proposed privacy rules stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) could reach $22.5 billion over five years, according to a report sponsored by the American Hospital Association (AHA). Earlier estimates by the Department of Health and Human Services put the cost at $3.8 billion, but the fact sheet issued with the standard put the figure at $17.6 billion.

The report, prepared by First Consulting Group of Long Beach, CA, found that compliance with the minimum necessary use of information rules would cost hospitals at least $1.3 billion over five years. If hospitals must invest in new information systems or upgrade current systems, the cost could rise to $19.8 billion, the report found.

Rules requiring that hospitals identify and monitor all business partners who use or access patient-identifiable information would cost $2.3 billion over five years, according to the report, which will be available soon on AHA's Web site (www.aha.org). ■

purposes, without authorization from the patient.

The bipartisan Health Insurance Portability and Accountability Act of 1996 (HIPAA) called on Congress to enact comprehensive national medical record privacy standards by Aug. 21, 1999. When Congress was unable to enact standards by this deadline, HIPAA required that HHS issue regulations. Proposed regulations were published Nov. 3, 1999. The issuance in December 2000 of final regulations completes the regulatory process of HHS on health information privacy under the HIPAA provision. The regulation will be enforced by the HHS Office for Civil Rights.

The new regulation reflects these five basic principles:

1. Consumer control

The regulation provides consumers with critical new rights to control the release of their medical information, including: advance consent for most disclosures of health information; the right to see a copy of their health records; the right to request a correction to their health records; the right to obtain documentation of disclosures of their health information; and the right to an explanation of their privacy rights and how their information may be used or disclosed.

2. Boundaries

With few exceptions, an individual's health care information should be used for health purposes only, including treatment and payment. For example, a hospital may use personal health information to provide care, teach, train, conduct research, and ensure quality. However, employers who also sponsor health plans may not obtain information for nonhealth purposes like hiring, firing, or determining promotions, without permission from the individual. Similarly, insurers may not use such information to underwrite other products, such as life insurance. Disclosure is to be kept to the minimum information needed for the purpose of the disclosure.

3. Accountability

Under HIPAA, for the first time, there will be specific federal penalties if a patient's right to privacy is violated. For noncriminal violations of the privacy standards by the persons subject to the standards, including disclosures made in error, there are civil monetary penalties of $100 per violation up to $25,000 per year, per standard.

In addition, criminal penalties are provided in HIPAA for certain types of violations of the statute that are done knowingly: up to $50,000 and one year in prison for obtaining or disclosing protected health information; up to $100,000 and up to five years in prison for obtaining or disclosing protected health information under "false pretenses"; and up to $250,000 and up to 10 years in prison for obtaining protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain, or malicious harm.

4. Public responsibility

The new standards reflect the need to balance privacy protections with the public responsibility to support such national priorities as protecting public health, conducting medical research, improving the quality of care, and fighting health care fraud and abuse. For example, when there is an infectious disease outbreak, public health agencies need to obtain important information to better protect the public. The new regulation provides standards for how such information should be released to balance privacy and public health needs.

5. Security

It is the responsibility of organizations that are entrusted with health information to protect it

against deliberate or inadvertent misuse or disclosure. The final regulation requires covered organizations to establish clear procedures to protect patients' privacy, including designating an official to establish and monitor the entity's privacy practices and training. ■

Consultant shares some tricks of the access trade

'Concentrate on the BIG'

With the demands placed on today's access managers — from overseeing staff to keeping abreast of the latest dictates from Medicare — there may be little or no time to put into practice sophisticated patient access processes.

"So many times, we return from an educational conference with full intentions of implementing those wonderful programs presented by respected colleagues and consultants," says **John Woerly**, RHIA, CHAM, an Indianapolis-based manager with Cap Gemini Ernst & Young who worked for many years as a director of access services.

"What I see within the patient access profession is a desire to make positive changes, but an access manager tied up in day-to-day operations may fall behind in new products and/or processes," Woerly adds. "They may not have the time or background to analyze, plan, and implement changes that could have a major impact on their institution."

For access managers disillusioned because they haven't had the opportunity to put that presenter's recommendations to the test — and for those who are attempting to come up with their own innovations — Woerly offers some guidelines on how to be your own consultant:

• **Concentrate on the BIG.**

Investigate processes with the biggest dollar savings for the institution, or the process that, if corrected, would generate the largest improvement in customer satisfaction.

Keep in mind, Woerly advises, that you won't have time to do it all, so start with the activities that produce the biggest results. "You don't want to preregister a lab test when you can better utilize the available time on an MRI [magnetic resonance imaging] account, which has a higher dollar impact upon the institution if not preregistered and precertified," he says. "As you further refine your process, you can build upon your success and add."

After selecting the process to improve, Woerly suggests, break the process into steps. "In developing a prearrival process, for example, it is important to establish work priorities — to decide what time frame you have to complete the work, how to communicate scheduling updates to the staff, and a hundred other steps.

"Within the simple step of preregistering," he adds, "you have to look at the time of the patient's arrival, testing to be performed, whether the patient has a current file within the computer system, etc."

Common problems identified

As he works with clients at health care organizations across the country, Woerly says he often comes across these barriers to an optimally functioning access department.

• **Lack of system and process integration.**

When necessary databases either don't exist or aren't being used to automate the process, he points out, that shows a lack of integration. Ask yourself, Woerly suggests, "What tools do staff have to do their job?" Addressing this problem might mean, for example, creating an access database of third-party payers with their contact information and benefit requirements, he says.

"Simple, manual processes also may not be integrated. . . . Examples are process gaps, multiple hand-offs, and duplication of effort."

• **Absence of process, or fragmented alignment of the process.**

"This is a barrier to realizing excellent customer service, as well as to ensuring financial and data integrity," Woerly says. "An example of fragmented alignment may be registration functions at multiple locations that are inconsistently performed. They also may have multiple reporting channels, which only adds to the inconsistency in performance."

Having multiple locations and multiple reporting channels may be completely justified and fine, if there is consistency in approach, he adds, "but many times there's not."

There also may be processes that no one wants to own, that have the wrong owners — they're disinterested or unknowledgeable, for example — or for which ownership is unclear, Woerly points out, citing as an example the processing of outpatient/observation patients.

"I was in a meeting with clients where we

talked about third-party payer denials," he says. "One outstanding area of denials was patients classified as 'Outpatient Observation.' Someone said, 'We've talked about this for five years and no one wants to own it.'"

The issue was large and encompassed multiple departments and participants, he notes, but someone needed to take ownership and sponsor the process redesign.

• **Inconsistent and inadequate training and feedback.**

"There may be a lot of word-of-mouth training, on-the-job training," Woerly notes. "New employees may learn under the worst or best registrar." If training is not organized and the new associate gets a negative first impression, he or she may become disheartened with the new position, he adds. These conditions may contribute to high turnover, as well as poor work habits and job performance, Woerly says.

• **Technology does not fully support people and processes.**

This may be because there are multiple, nonintegrated or noninterfaced systems, he says. "An employee may enter data, and then hand [the information] to another person, who enters them into another system." This kind of inefficiency may occur, Woerly points out, because "value-added enablers are not in place." Those enablers, he adds, might include an access database, or an on-line Medicare Secondary Payer or Advance Beneficiary Notice process.

Processes may become so complex — multiple steps, large volumes, etc. — that automation is required to effectively and efficiently perform the task, Woerly suggests. "In a multihospital system, prearrival activities — resource scheduling, preregistration, benefit verification, precertification, authorization, and patient financial education — may require automated work queues vs. 'shuffling paper' from one associate to the next," he adds.

An automated work queue, Woerly explains, balances workloads based on pre-established priorities. "You get to the point where you have to go paperless," he says. "You can't do large-volume scheduling and preregistration successfully by shuffling paper."

At one organization where Woerly served as director of access services, he points out, studies showed that time spent shuffling paper accounted for an entire full-time equivalent (FTE) of the 25 FTEs within preregistration.

That paper shuffling, Woerly explains, involved getting copies of new schedules, getting the add-ons to the schedule, and "putting this piece of paper over here and waiting for someone to call back." If the patient or payer didn't call back within the same workday, which is common, the workload continued to accumulate, he says. "The next day, the employee may forget yesterday's paper is there, because other demands are coming in.

"When the employee is off for a day, the workload has to be redistributed and 'yesterday's work' passed out to others," Woerly adds. "With more than 800 patients a day being preregistered, think of the opportunities to lose a sheet in the paper shuffle."

It's easy to view your own department's operations day in and day out and not see the improvements that could be made, Woerly notes. When acting as your own consultant, he suggests, it may be helpful to do what he did when embarking upon a new job as access director, a position he has held at several different health care organizations.

"Make a list of what is working and what is not working and what you need to do," Woerly says. "Think, 'What can I do to help the place?' Try to see things through the eyes of a new employee, or even a new patient.

"Think out of the box. Ask your associates, 'What one thing would you do to improve processes that would enhance customer satisfaction?' You may be very surprised by the answers. The solution may truly be staring you in the face." ■

ACCESS FEEDBACK

System looks at using Omega software in ED

'We can't give ABNs'

Baycare Health in Clearwater, FL, has made dramatic strides in screening physician orders for medical necessity, thanks to some new software from Tampa, FL-based Omega Systems and a lot of hard work and customizing by **Mary Roberts**, CCS, coding manager for ambulatory care service,

Here's a way to reduce Medicare misunderstandings

Having trouble explaining to your Medicare patients what the new ambulatory payment classifications mean to them? Here's a sample letter recently circulated among members of the National Association of Healthcare Access Management that you may want to use as a blueprint for your own communication with patients:

Dear Medicare Recipient:

The federal government began a new system for reimbursing hospitals for providing care to Medicare patients effective Aug. 1, 2000. This change applies only to payment for outpatient services and is called the "outpatient prospective payment system." It involves a predetermined rate for reimbursement called "ambulatory payment classifications." It is important that you be aware of this change as it may affect your hospital bill.

You may be aware that you are responsible for paying a portion of the total charges for your care that Medicare does not cover. This is called "coinsurance." One of Medicare's goals, over time, is to reduce the amount of coinsurance that is due. The senior group American Association of Retired Persons (AARP) has supported this change for this reason. However, these reductions will not occur immediately in all circumstances for all beneficiaries. The coinsurance amounts for outpatient services are based on a national average. But fees for these services, based on the cost of providing them, are not the same across the country. Therefore, at least in the short run, some Medicare beneficiaries may actually experience an increase in coinsurance due for certain services provided. Please be aware that Medicare has established these fees, not the hospitals.

Hospitals will continue to provide the highest quality of care while meeting the challenges of these changes. Questions may be directed to the Medicare Help Line at (800) 633-4227. You may also contact your local AARP office. If you have specific questions regarding your current hospital bill, please call _____. ■

and other staff. **(See *Hospital Access Management*, January 2001, p. 3.)**

Now, Roberts says, Baycare is looking for other ways to make use of its medical necessity software and has focused its attention on the emergency department (ED). The health system would welcome feedback from access managers at other facilities, she adds, as it attempts to develop a way to reduce ED reimbursement denials while keeping a safe distance from any potential violation of federal COBRA / EMTALA requirements.

"We can't give Advance Beneficiary Notices (ABNs) to patients, and we don't want to get into access of care issues," Roberts emphasizes. "We want to make sure everyone in the ED gets the care they need, whether or not they meet medical necessity. If they don't meet it, we won't withhold treatment."

Baycare is primarily interested in convincing ED physicians to document more thoroughly the reasons behind the orders they write for patients, she notes. "Most of the time there is a good reason for the tests they order — it's just not documented." That lack of documentation results in the health system not being paid for tests that in fact do meet medical necessity, Roberts adds.

"In the past, a patient would come in with head trauma, and the physician would put that down and order a CAT scan of the head," she explains. "Now [in order to meet medical necessity], the physician must document his or her thought processes. Maybe the person is dizzy and that's why the physician thinks the test is needed. Before, they didn't have to put that."

As a first step, Baycare has put an article in the medical staff newsletter, asking that physicians document the reasons behind their orders for radiology procedures, Roberts says. "We ask them to put ['dizziness' or whatever the reason for the test might be] in the requisition sheet that goes to radiology."

A proposal under consideration, she notes, is that the radiology technician who receives an order will check to see if it meets medical necessity, using the Omega software. If it does not, Roberts adds, the clerk will go back to the physician and ask, "Why do you think the patient needs a CAT scan?"

This will happen, she explains, in the same way that technicians currently call to clarify whether,

for example, the physician wants a complete series of X-rays. "We're not going to be telling them what should be on [the order]," Roberts says. "We won't get into a situation where we're leading the physicians.

"We're not sure how this will work," she emphasizes. "We don't know how the physicians will feel about talking to the technician about additional documentation." The plan likely will be tried first on nonurgent patients, Roberts notes.

"These are our preliminary thoughts," she adds, "on how to use this product that we already have on our computers. How can we move it into an emergency setting without compromising our care?"

[If you have feedback on the idea of using medical necessity software in the ED, please contact Lila Moore at (520) 299-8730 or lilamoore@mindspring.com.] ■

Coding skills, credentials increasingly key for access

'Modifiers' make the difference

As access managers work to get their departments up to speed on their role — however small or large it may be at present — in fulfilling the new outpatient coding requirements, it appears that the devil is in the details.

What may appear to be insignificant omissions in the coding of an account can result in a hospital either being denied reimbursement for a service, or receiving less than it is due, cautions **Eileen DeFeo**, CPC, president of the Southern Jersey Chapter of the American Association of Professional Coders (AAPC), which is based in Somers Point, NJ.

Access departments that are not monitoring their accounts as they make their way to the billing system may be unaware of errors that are costing their hospitals money, she suggests.

"Modifiers" — indicators added to the CPT (procedure) code — provide the complete description that is now required for payment by the hospital's Medicare fiscal intermediary, DeFeo explains. Without the full description — indicating that the procedure is on the left side, for example — reimbursement may be denied, or be incomplete, she notes.

The account for a patient who has an electrocardiogram and whose condition then warrants a second one must have a modifier appended to the CPT code on the second charge for the same day, DeFeo says. "If you don't put '76,' which indicates a repeat procedure, you have a good chance of getting a line-item rejection for duplication."

If the bill for an X-ray of the hand doesn't indicate whether it's the left or the right hand, she points out, it's in danger of being rejected. "That seems like a very simple example, but if you're not monitoring these things and how they get to your billing system, there may be a problem."

That route to billing might begin, DeFeo notes, with the registrar looking at the physician's order and keying in that information, which then goes through an interface to the clinical system. It is accessed by a technician in radiology, for example, who performs the procedure, completes the order, and then sends it to the billing system, she adds.

DeFeo recommends that access managers do a daily auditing log of the charges being sent to billing, in order to catch those that are not fully coded.

With the increased emphasis on upfront accuracy prompted by the new outpatient prospective payment system, hospitals are becoming more aware of the need to have access employees with a knowledge of coding, she notes.

"Right now, coding for outpatient procedures is becoming crucial," says DeFeo, who recently was hired to provide coding expertise for a hospital access department. "I am seeing more access personnel who are going to seminars on coding, and some who are taking courses on CPT and ICD-9 coding to enhance their skill level."

The AAPC offers national certifications, DeFeo points out, including certified professional coder (CPC), which emphasizes coding used in physicians' offices, and CPC-H, which is geared to coders who work in hospital outpatient services and thus focuses on diagnosis (ICD-9) codes.

Both certifications cover diagnosis coding and CPT coding and so are useful for access personnel, she notes.

The organization has an independent study program, and sites throughout the country where people may sit for the exams, DeFeo says. Those sites include the local AAPC chapters, she adds, which can be reached through the national office. Attending local chapter meetings, she adds, is also a good way to keep up with changes in coding and reimbursement requirements.

Laureen Jandroep, OTR, CPC, CCS-P, owner and consultant of A+ Medical Management and

Education in Egg Harbor City, NJ, says her Web site, www.codingandreimbursement.net, is receiving increasing numbers of inquiries from access personnel regarding certification.

"More people are interested in becoming certified to show they have the level of knowledge to survive in this industry," adds Jandroep, who is an approved instructor for AAPC's professional medical coding curriculum. "Many times, people get certified as a coder but work as a biller or an accounts manager."

"Coder," she points out, is a relatively new job title, even in medical records departments, where until recently that job was blended with other health information management duties. Now, she notes, coding expertise is a highly desirable addition to the resumes of applicants for access services and other hospital departments.

"I just visited a hospital that is interested in having me conduct a coding seminar for its employees, including some in the access department," Jandroep says. "Facilities like that are getting well prepared for the future."

Even for staff who are not going to be certified coders, she suggests, "training in coding helps develop skills in problem solving and critical thinking and how to do the research when they have a question."

[Editor's note: The American Association of Professional Coders, W. 700 South, Salt Lake City, UT 84101, may be reached at (800) 626-2633, and has a Web site at www.aapcnatl.org.

Jandroep may be reached at A+ Medical Manage-

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Editorial Questions

Call **Lee Landenberger** at (404) 262-5483.

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Editor: **Lila Margaret Moore,** (520) 299-8730.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Production Editor: **Nancy McCreary**.

ment and Education, 330 N. Genoa Ave., Egg Harbor City, NJ 08215; (609) 965-9585. Web site: www.codingandreimbursement.net.] ■

NEWS BRIEFS

Here's a look at funds restored under BIPA

Hospitals and health care systems get $11.5 billion over five years in the Medicare, Medicaid, SCHIP Benefits Improvement, and Protection Act of 2000 (BIPA), passed by Congress late last year.

Among other benefits, BIPA restores Medicare funds cut in the 1997 Balanced Budget Act (BBA). The funds are broken down as follows.

• $3.7 billion: Medicare payments will rise 3.4% in 2001, up from 2.3% from BBA. Estimates show prices rising by 3.05% in FY 2002, up from an estimated 2.5% under BBA.

• $900 million: Medicare outpatient payments will rise 4.4% in 2001, up from 2.5% under BBA.

• $700 million: Payment reductions for indirect medical education have been frozen at 6.5% for FY 2001 and FY 2002.

• $100 million: An additional 1% reduction in Medicare Disproportionate Share Hospital (DSH) has been eliminated in FY 2001 and FY 2002.

• $700 million: 55% to 70% increase in Medicare payments for bad debt.

• $300 million: Increase in floor payments for direct graduate medical education payments to 85% of the national average.

• $1.25 billion: Elimination of Medicaid DSH cut under BBA for FY 2001 and FY 2002 along with an increase in allotments in low-DSH states.

• $200 million: Removal of the 2% payment reduction for rehabilitation hospitals in FY 2002; they can move immediately to the prospective payment system (PPS).

• $1.35 billion: Medicare DSH payment eligibility equalized between rural and urban hospitals.

• $350 million: 3.2% rise in skilled nursing facility (SNF) payments in FY 2001, with additional payments for nursing costs.

• $200 million: Change in rules for provider-based status by grandfathering existing provider-based entities for two years and adding geographic market area option.

• $625 million: Rural hospital improvements, including making the Medicare-dependent hospital program more equitable, updating the target amounts for sole community hospitals, increasing critical access hospital payments, and improving rural ambulance payments.

• $300 million: Long-term care hospital payments increase.

• $125 million: 5% increase in hospice payments for FY 2001.

• $525 million: One-year delay of 15% reduction in home health payments, full market basket for FY 2001.

• $150 million: 10% increase in rural home health agency payments.

• $25 million: Increased incentives for psychiatric hospitals.

• $50 million: Increased renal dialysis composite rate. ■