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Final privacy regs touch 'every facet of hospital operation'

Rule extends coverage to paper, oral communications

The Department of Health and Human Services (HHS) has gone beyond its proposed rule and given the privacy of health information even more protection in its final regulations, which were released Dec. 20. Some industry analysts charge that the rule could seriously impede the flow of critically important information.

The most significant change in the final regulations: They now apply to paper records and oral communications in the hands of covered entities in addition to electronic records. The regulations also limit the routine and non-routine release and use of private health information. **(For highlights of the final rule, see p. 36.)**

The privacy regulations are part of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996; they were designed to limit the non-consensual use and release of private health information and to give patients the right to access their medical records and to know who has access to them. The regulations will go into effect in two years.

HIPAA imposes a massive and complex burden on providers, health plans, and clearinghouses, as well as their business associates, say attorneys from the law firm Davis Wright Tremaine. "It's going to touch on almost every facet of hospital operation and the patient care process," says **Reece Hirsch**, JD, a partner in the firm's San Francisco office.

Some analysts are openly critical of the final privacy rule. "We are very concerned about the new requirement that providers must now obtain prior written consent for even the most routine health care treatment and payment," says **Mary Grealy**, president of the Healthcare

(Continued from cover)

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Leadership Council in Washington, DC.

The regulations will impede the flow of essential data to health providers and medical researchers, and patients will pay the price, she says. "Within these hundreds of pages of rules and regulations there are numerous hurdles, barriers, and obstructions that will curtail the flow of information through the health care system. Who pays the price when a doctor, a pharmacist, or a lab technician can't get the information they need in a timely manner? The patient will, and that's something about which we should all be concerned."

The American Hospital Association in Chicago is concerned that hospitals could be held responsible for the mistakes of its business partners, such as insurers, clearinghouses, and accrediting agencies that misuse patient information. "While hospitals will take every step possible to ensure that contractors comply with these important rules, with anywhere between 50 to 750 business partners, it's unrealistic to expect them to monitor the internal business practices of each," says **Dick Davidson**, AHA president.

His organization is also troubled that the rule gives law enforcement officials easy access to patient records without sufficient restrictions on how that sensitive information can be used, Davidson says. For example, law enforcement officials can request protected information for the purposes of locating a missing person.

"We have visions of *America's Most Wanted* calling an institution and asking for information," says **Dan Rode**, MBA, FHFMA, vice president of policy and government relations for the American Health Information Management Association (AHIMA) in Chicago. "There needs to be some clarification [of this provision] — I'm not sure that's what [HHS] meant."

Although the AHA is concerned that the costs for complying with the privacy rule could be staggering for hospitals, AHIMA hasn't seen anything in its review that calls for a panic, Rode says. "There are a couple of things that need to be corrected and there are some things that need more explanation. But we haven't found anything that would cause us to want to rescind [the rule] at this point."

AHIMA does have questions about whether all providers are considered to be covered entities under the final rule. "A covered entity on the provider side is defined as an organization

that uses electronic transactions. It's possible that some physicians [who do not use information this way] may not be considered a covered entity."

With this in mind, would a provider need an authorization before contacting one of these physicians regarding a patient's treatment, Rode asks. "It appears that when [HHS] wrote this, they presumed that all providers were covered entities. That may not be the case."

The Secretary of HHS could correct a lot of these problems within the first year these rules are out, according to HIPAA, Rode says.

Legislation is also needed to fill in several gaps in the legislation, he adds. For example, information exchanged in regard to workers' compensation claims has no restriction.

What does this mean for you?

The challenges providers face from these privacy regulations will depend on the size of the organization, Rode says. "We also don't have the security regulation in front of us, which is the other foot on this giant. It may have some obstacles, as well."

Providers' privacy teams need to analyze the regulations themselves to see where their practices fit the requirements of the rule, Rode says. "Look at consents and authorizations. See whether some of what is being handled now on a non-consent basis has an authorization, and look at fundraising and marketing materials to see if they comply with the rule."

Institutions that have a wide-open practice for medical records within their own staff are now going to be required to classify personnel and determine who has access to what and when, Rode explains. "For larger institutions, that is going to take some time."

Institutions are also going to have to look at their business associate situations and determine what contractual language will need to be changed. "They may have to bring in legal counsel to determine whether they are or are not a covered entity under certain circumstances and whether their business associates are," he says.

Some providers already have software in place to track the release of information. Most institutions, however, have yet to conduct training on the issues of privacy, nor have they written policies and procedures to address them, Rode says.

Rode says he expects that state hospital associations and respective parties within the state governments will be comparing the federal regulations against state law. "If there are concerns, they can address them through the state [representatives] to determine which would take precedent or decide if the state should ask for an exception."

Providers and health plans may also benefit from discussing the extent to which they should share information, Rode says. "The rule says the health plan gets to decide that issue, but at the same time the onus is on the health plan to provide a rationale as to why they need information above and beyond what is included in the transaction."

Hospitals and physician offices have an advantage over health plans in implementing the final regulations, Rode says. "Hospitals have addressed many of these issues in their release-of-information practices and their health information management practices. Their medical records departments in many cases already have a privacy officer who overlooks this kind of activity. For most physician offices, this is a containable, sizable kind of activity and probably can be handled quickly once the offices understand the rules."

Health plans, however, will need more analysis and planning, mainly because they haven't had a medical records function, he explains. "They are going to have to take a look at their protected health information and determine what controls they are going to need. For many of these groups that is going to be a fairly large challenge because they haven't had the expertise."

Health care institutions should also prepare for public reaction once the regulations take effect and become publicized, Rode says. He anticipates an increase in the number of patients who request access to their records and who have questions about the rule for their providers and insurers.

"Since many states have not had a law allowing access to medical records, providers may have an initial volume [of people requesting access,]" he says. "That certainly is going to affect institutions." That volume should diminish, he predicts, ultimately becoming no more of an issue than it is currently.

Then there is the question of how the rule will be policed. "The federal government has no funding for the Office of Civil Rights to do much with this," Rode says. The enforcement issue will have to be examined in the coming year, with the Office of the Inspector General's office having some involvement too.

Until enforcement becomes more of a reality, Rode expects that most action on the rule will be taken on a complaint-by-complaint basis. "We will still be talking about the exception rather than the rule. Providers will have to look at it from that perspective, as well." ■

Highlights of the final regulations

Lawyers at the offices of Davis Wright Tremaine recently took the time to analyze the massive final privacy regulation issued by the Department of Health and Human Services (HHS) on Dec. 20, 2000. Here are the parts of the regulations that Clark Stanton, JD, Paul Smith, LLB, and Reece Hirsch, JD, partners in the San Francisco office; Kathy Fritz, RN, APN, JD, an associate attorney in the Portland office; and Richard Marks, JD, a partner in the Washington, DC, office, found particularly interesting.

• **The extension of the regulation to include all individually identifiable health information.**

The most significant change is that the regulations now extend to all individually identifiable health information in the hands of covered entities, regardless of whether the information is or has been in electronic form, the lawyers say. This includes purely paper records and oral communications. In contrast, the proposed rule only covered information that had at some point existed in electronic form. The difficulty of tracking electronic and non-electronic information had convinced many observers that the distinction made in the proposed rule was unworkable, but there are concerns that HIPAA (the Health Insurance Portability and Accountability Act of 1996) may not authorize this expansion of the regulations' coverage.

• **The change in business partner agreements.**

Business partner agreements (now called business associate contracts) need no longer give patients direct rights over health care information in the hands of a covered entity's business associate. In addition, the final regulations also withdrew from the proposed rule a hotly debated requirement that business associate contracts declare patients to be third-party beneficiaries of the contract.

• **The clarification of business association monitoring.**

The final regulations clarify that covered entities are not required to actively monitor business associates for compliance with their contracts, although they must take action if they know of practices that violate the agreement. The regulations also clarify that physicians on hospital medical staffs are not, by virtue of their staff membership, business associates of the hospital. "When a hospital shares protected health information with a third party that it contracts with to carry out some facet of its operations, the provider will have to enter into an agreement with that business associate to ensure that the business associate is observing the same safeguards that the covered entity is required to adhere to," Hirsch says. "Building that language into all of the hospital's vendor contracts will be burdensome."

• **The introduction of the organized health care arrangement.**

The final regulations introduce the concept of an organized health care arrangement, which is a clinically integrated setting in which patients receive care from more providers than one, or an organized system of health care, or a combination of group health plans or group health plans and insurers. Participants in an organized health care arrangement are permitted to use and disclose information for the health care operations of the arrangement, just as they are for their own health care operations. Participation in an organized health care arrangement does not, by itself, make the participants business associates of one another.

• **The additional requirement for patient consent.**

Subject to limited exceptions, providers and other covered entities will need to obtain a patient's consent to the entity's disclosure of the patient's health information for treatment, payment and the entity's own operations. This is a significant shift from the proposed rule, which would have permitted such use of information without the patient's authorization. The consent requirement is an important provision that wasn't in the proposed regulation, Hirsch says. "It means that a hospital must obtain this new consent to privacy practices as part of every admission."

• **The limited use of patient information for fundraising.**

Providers will be pleased to know that the

regulations permit them to use limited patient information, without patient authorization, in connection with their fundraising activities, including fundraising by related foundations.

• **The retention of the "minimum necessary" standard.**

The final regulations retain the minimum necessary standard first set forth in the proposed rule, under which a disclosure of protected health information, even where authorized by the regulations, must be limited to the minimum necessary to accomplish the purpose for which it is made. Under the final regulations, however, this determination does not have to be made when responding to a request from another covered entity. Instead, the final rule states that a covered entity requesting protected health information from other covered entities must limit its request to what is reasonably necessary to accomplish the purpose for which the request is made.

The good news is the exception to the standard, Hirsch explains. "For example, if you are a physician who is sharing a medical record with another physician for the purpose of consultation, the physician doesn't have to worry about restricting access to portions of the medical record that may not be directly relevant to the consultation."

If a provider is sharing health information with a billing company or even among departments in its own facility, however, the hospital will have to decide how much information is sufficient. "That is a muddy issue," he says. "The regulations do not provide specific guidance so ultimately the provider must make its own good-faith judgment. And the judgment will have to be made on a case-by-case basis. This can be viewed as a fairly burdensome requirement."

• **The new requirements for group health plans.**

The final regulations include new requirements relating to disclosures of protected health information by group health plans. Group health plans include insured and self-insured plans sponsored by employers, and other employee welfare benefit plans subject to ERISA (the Employee Retirement Income Security Act of 1974). However, self-administered plans having fewer than 50 participants are not covered. For a group health plan to share protected health information with a plan sponsor — typically, the employer, there must be specific restrictions on the sponsor's use and disclosure of the information. For example, the sponsor must restrict access to protected health information to employees who perform health plan administrative functions on behalf of the sponsor.

• **The continuation of special requirements for research purposes.**

The final regulations continue the special requirements for use of protected health information for research purposes, such as approval by an institutional review board or a privacy board. However, the requirements in the final regulations are more comprehensive and restrictive than in the proposed rule.

• **The delegation of the privacy regulations enforcement.**

Enforcement of the privacy regulations has been delegated to the HHS Office of Civil Rights. The regulations do not provide for a private right of action that would permit patients to sue for violations, but there are both civil and criminal penalties for violation, including a fine of up to $250,000 and imprisonment for up to 10 years for knowingly disclosing or obtaining protected health information if done for commercial or personal gain or for malicious harm.

Marketing provision adds new hurdles

The final HIPAA privacy rule will also impose new requirements on the activities of hospitals marketing products or services to their patients, Hirsch says.

Some people have thought this provision liberalizes the ability of the health care provider to use patient information to engage in marketing solicitation, he says. "I don't think it creates that much flexibility. In fact, it creates some new hurdles for providers to jump through before they can engage in certain marketing activities."

The provision says that the covered entity doesn't have to get the authorization of a patient to do marketing communication if the entity is communicating face-to-face with the individual or if the communication relates to products or services of nominal value. (This provision applies to the marketing of hospitals' services, as well.)

But if it is another form of communication and if it involves the services of the hospital or a third party, then the entity must meet a series of requirements. "You have to make sure the patient understands who the communication is coming from. You have to disclose any financial relationship if you are getting paid to make the communication, and you have to let the patient know how to opt out of receiving future communications," he says.

The entity also has to make reasonable efforts to ensure that patients who opt out are no longer receiving communications.

If the entity is targeting patients based on a particular medical condition, it has to explain to the individuals why they were targeted and how the product that is being marketed relates to their health.

"I don't believe most health care providers are currently following that rigorous a standard when they are engaging in marketing to patients," Hirsch says.

[*Editor's note:* For more information about the privacy rule, Reece Hirsch can be contacted at (415) 276-6514 or reecehirsch@dwt.com.] ■

Peer review addresses inpatient payment errors

Spirit of cooperation emphasized

While most hospitals struggle to implement the prospective payment system for outpatient services, a government program is working to reduce payment errors on the inpatient side. The Wisconsin Medicare peer review organizations (PRO) is viewing this program as an opportunity to educate hospitals on coding, utilization management, and documentation activities to reduce billing errors.

The Health Care Financing Administration's (HCFA) Sixth Scope of Work (Aug. 1, 1999, to Jan 31, 2003) for Medicare PROs directs them to initiate a payment error prevention program (PEPP). The PEPP is patterned after HCFA's Health Care Quality Improvement Program, which involves analyzing and changing the patterns of care to improve quality in the health care system. The PEPP is designed to assist hospitals in reducing payment errors for Medicare inpatient stays in acute care hospitals reimbursed under the diagnosis-related groups (DRG) reimbursement system.

The first phase of state implementation began in August 1999, the second in November 1999. Wisconsin began implementing the program in the final, Feb. 1, 2000, phase. Madison-based MetaStar, Wisconsin's PRO, has a three-year contract with HCFA, during which the overall payment error (over- or underpayment) is to be reduced and a program is to be put in place to prevent future payment errors.

The Wisconsin PEPP program has two parts, explains **Bill French**, MBA, RHIA, vice president of PEPP for MetaStar. First, the PEPP staff reviews randomly selected records to establish a baseline error rate for Wisconsin. "Basically, it is a scorecard for the PRO," he says. Any process improvement activity requires a baseline against which to determine if improvement has been made.

The records are selected from Medicare claims data from October 1997 through September 1998 by a clinical data abstracting center (CDAC) under contract to HCFA. Each state has the same number of records selected. "They are reviewed as part of a national payment error sample," French says.

The CDAC reviews the records using the InterQual criteria for the admission necessity and the Coding Clinic (ICD-9-CM system) for DRG assignment. "They do not apply any review above the initial screening," he explains. The CDAC then forwards any records with potential coding or utilization problems to MetaStar for review.

"These records may not say anything about any particular hospital because such a low number of charts from any one facility are reviewed," French says. MetaStar applies the "full case review" process to any records referred by the CDAC. Cases with potential problems are sent to physician reviewers. Letters are sent to the hospital for comment prior to a final determination. The hospital has the same appeal rights as in any DRG or admission validation accomplished by the PRO. Corrections for underpayment or overpayment will be forwarded to the fiscal intermediary (FI).

Taking an educational approach

Although the PEPP is a mandatory program, MetaStar is taking a collaborative and educational approach, French says. In the past, programs such as this included chart review but not a lot of feedback. In addition to the CDAC chart reviews, MetaStar, through analysis of claims data, identifies hospitals and specific records where there may be potential payment error problems. Hospitals receive their lists and a site

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Medicare will pay some costs of preventive exam

Be sure to use the right E/M code

A ticklish question many providers and coders come across is whether Medicare will pay for a medically necessary service provided during the course of a comprehensive preventive examination.

"Medicare will pay for the evaluation and treatment of an acute illness or the ongoing treatment of a chronic condition provided during the course of a comprehensive preventive examination," says **Brett Baker**, a reimbursement expert with the American College of Physicians-American Society of Internal Medicine.

Medicare requires that you bill the appropriate outpatient evaluation and management (E/M) service code and the preventive medicine service code that corresponds with the beneficiary's age (in most instances, CPT 99387 or 99397).

Meanwhile, "the extent of the history, examination, and medical decision making involved in treating the symptoms and/or diagnosing conditions associated with the acute or chronic problem determines which office or outpatient E/M service code you select," notes Baker. For instance, the office or outpatient E/M service codes describe the portion of the visit that is covered and reimbursable by Medicare.

However, he also advises you to check with your Medicare carrier to see if it has any restrictions on which office or outpatient E/M service code you can bill in conjunction with a preventive medicine service code.

"Your carrier, for example, may prohibit you from using the highest office or outpatient E/M service code, CPT 99205 and 99215," he points out.

It's important to note that Medicare will deny payment for the preventive medicine service code because the law prohibits the program from paying for a comprehensive preventive examination.

Medicare requires you to use a formula to determine how much to bill the beneficiary for the non-covered preventive portion of the visit. Baker says you should bill the beneficiary your established charge for the comprehensive preventive examination — less the Medicare allowable for the Medicare-covered, medically necessary portion of the visit.

Here's a case study: You evaluate and treat a 70-year-old beneficiary's hypertension that you detect during a comprehensive preventive examination. You have been the beneficiary's physician for the past several years. The service you furnish relating to the patient's hypertension involves an expanded problem-focused history, an expanded problem-focused examination, and medical decision making of low complexity.

"This medically necessary service permits you to bill a mid-level established patient office visit, CPT 99213," says Baker.

In this case, you should report this code, along with the established patient preventive medicine service code for a patient 65 years and older, CPT 99397.

Medicare's average allowable for CPT 99213 is $47.23 (your payment may vary, depending on your geographic location). Assuming you submit an assigned claim and the beneficiary has met the deductible, your carrier will probably pay you $37.78 — or 80% of the allowable. Your established charge for a comprehensive preventive examination is $150, so you would bill the beneficiary $102.77, or $150 minus $47.23.

You would report the ICD-9 code for benign hypertension, 401.1, to justify the 99213. You would likely report ICD-9 code V70, general

medical examination, as the reason for the 99397, even though Medicare will never pay for the preventive medicine service code regardless of the diagnosis.

Tip: Ask your carrier about its policy on how to bill when you provide a Medicare covered, medically necessary service during the course of a comprehensive preventive examination. The formula your carrier uses to determine how much to bill the patient may differ slightly from what is described above, Baker suggests.

You should also explain to your patients that they will be billed for the preventive examination, the portion not covered by Medicare. "This will be especially helpful if you have not billed a medically necessary service in conjunction with a preventive service in the past," he notes. ■

Attitude, perseverance keys to the appeals route

Place the burden on the MCO

(*Editor's note:* The following guest article was prepared by Appeal Solutions, a Texas consulting firm specializing in medical reimbursement and appeals management issues.)

"Attitude is more important than facts." This quote is from noted psychiatrist Karl Menninger, who understood the vast importance about attacking a difficult situation with a strong mindset.

In appealing denied insurance claims, you need to have the mindset that it is the insurance carrier's burden to prove that the claim was not processed correctly and that any ambiguities in the coverage terms were construed in the insured's favor. A strong mindset will also give you the perseverance necessary to continue to appeal a claim the insurer strongly defends.

Attitude is more important than facts, because the right attitude will help you persuade the insurance carrier to look at the facts differently.

Many claims are overturned after a single appeal letter. If that's not the case, you want to persist with filing appeals until you get a satisfactory answer. When you do not receive an adequate response to your appeal from the appeals committee, it is imperative that you continue to appeal.

Persistence is often the key to overturning a denied claim. Many carriers overturn as many denials on the second and third appeals as on the first appeal. It is crucial to keep the appeal active, even after the initial denial.

In fact, statistics released from major insurance carriers indicate that about 25% of appeals are overturned on the first appeal and another 25% are overturned on the second appeal.

If you believe payment is indicated by the policy terms, continue to appeal the claim. See below for information on keeping your appeal alive.

Don't settle for 'denial upheld'

It's not unusual to find that your carefully researched and strongly worded appeal is not being reviewed adequately by the claims department. In such instances, you can redirect your appeal to someone in a better position to review and respond to the information you have cited. Consider sending your appeal to one of the following:

- **Carrier's legal counsel.** If you have cited regulatory information, you can request a review and written response from the legal department.
- **Carrier's president. I**f your appeal involves a possible breach of claim processing procedures, ask the president or other senior management official to respond.
- **Department of Labor.** If the insurance is self-funded, file a complaint with the U.S. Department of Labor. Send a copy of the complaint to the insurer.
- **Employer.** The employer will have an appeals committee if the group is self-insured.
- **State department of insurance.** File a formal complaint with your state's department of insurance if you are unable to get a satisfactory response. Send a copy of the complaint to the insurer.
- **State medical association.** Many medical associations now have a complaint review process and will assist you with resolving denied insurance claims.

As you work your way up the appeals food chain you must make sure your request for intervention is clear and convincing. Letters to an insurance company president or legal counsel, for instance, should be specific as to where the appeal reviewer failed in the review of your claim.

Some common complaints providers have

about the claims review process include:

• The appeal reviewer did not fully review a certain portion of the medical records. State which portions you wish to have reviewed and addressed.

• The appeal reviewer was not trained in your medical specialty.

• The appeal reviewer did not gather sufficient proof to justify the denial. Even though the carrier may have an official position on the treatment course, the reviewer must still assess the appropriateness of this particular treatment for this particular patient.

• Case or statutory law was cited in your initial appeal letter, but the reviewer failed to cite any case or statutory law in the carrier's favor, or offer a different interpretation of the law you quoted.

*Tip: I*f the reviewer essentially ignored the law your letter cited, an additional review is justified.

When you follow up on the status of these letters, your call will likely be screened by the management party's assistant. Clearly state that the information you want to discuss is highly technical and you need to speak directly with Mr. President or Mr. Legal Counsel. If the company president fails to respond within a reasonable time, direct the letter to the legal counsel and vice versa.

If you are seeking reconsideration on a number of claims dealing with the same issue, seek a face-to-face meeting with top management officials. Ask that the meeting take place in your office.

Some facts on denials

Having a claim denied is different from having it downcoded — it means you get no money as opposed to some payment. Here are the facts on denials:

• The Health Care Financing Administration rejects 26% of all claims processed, according to **Sara M. Larch**, chief operating officer of University Physicians Inc., the University of Maryland School of Medicine faculty practice in Baltimore. Of those claims, 40% are never resubmitted.

• In 1999, the Medical Group Management Association found the median denial rate among its medical practice members was nearly 14%. So-called "top performing practices," however, only had a 7% denial rate. ■

You can then assemble the many parties affected by the denials including professional staff, billers, and even patients.

Follow up any phone and face-to-face conversations with a letter detailing what issues were resolved and your understanding of how future similar claims will be processed. If there are still unresolved details, you will need to restate your position on these issues and indicate that you would like a written response regarding the unresolved issues.

Bottom line: Tenacity may be your biggest asset when appealing claim denials. Do not give up until you are satisfied with the answer you receive.

You can contact Appeals Solutions at 1565 W. Main Street #208, Lewisville, TX 75067. Telephone: (888) 399-4925. Fax: (972) 420-7880. E-mail: sales@appealsolutions.com. ■

Here are ways you can fight downcoding

Move up the complaint ladder quickly

The first best way to stop payers from downcoding your claims is to make doubly sure they are correctly coded and documented when submitted, say experts. But if you believe you are being treated unfairly, don't be afraid to fight back. Here are some steps you can take:

1. If you believe your claims are correct and your bills are still getting downcoded and denied by claim reviewers, most experts advise that you not waste any more time with accounting clerks and instead take your complaint up the corporate ladder directly to the plan's medical director.

2. If you don't get any satisfaction from the medical director, then quickly file an internal appeal. To help navigate the appeals process, make sure you keep detailed notes of what you've done to resolve the disputed claim — and who you talked to at the plan.

3. It's also wise to report any suspected instances of downcoding to your local medical society or hospital association, which may track complaints to determine if it is an isolated incident or part of an emerging pattern.

Tip: If unhappy with how you're being treated by plan payers, you may want to add some

political clout by asking your local or state medical society or hospital group to intervene on your behalf.

4. The next stop on the complaint chain is your state insurance department. State regulators are often reluctant to get involved in individual payment and contract disputes, but the fact that you're filing a complaint will give you added leverage by raising your case's visibility another notch. Plus, if enough providers file complaints, this puts more pressure on public officials to do something about the situation.

5. If all else fails, **James Wieland**, a Baltimore health care attorney, advises you to take the plan to court. "I have had good luck taking, or threatening to take, a carrier to arbitration or small claims court," he notes.

Warning: Only go down this road if you are sure your claim was properly coded and if you have the documentation to prove it.

Here are some other key factors to keep in mind:

- **Keep accurate and complete records.** Without this, you don't have a legal leg to stand on.
- **Have a good contract.** Review any contract before you sign it. Most contracts spell out reasons for downcoding and what the physician can expect during an appeal.
- **Follow procedures.** Make sure you've filled out the claim correctly. If a claim comes back, call the claims administration and check to see if more documentation is necessary. ■

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 CIAs 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.

The access the FAQs, go to www.dhhs.gov/progorg/oig/cia/ciafaq1.htm. ■

Coding assessment offered by AHIMA

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 specialty areas. On-line 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. ■

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visit by the PEPP staff is scheduled.

When the PEPP staff visit hospitals, they work with them to identify root causes, develop a process improvement plan, and re-measure to determine if improvement is realized. "When we visit the hospitals we try to accomplish more than just a coding and utilization review where we look over the charts," French says. "We look at the coding programs and the utilization programs they have in place. We try to share what we consider to be the basic components of a program."

MetaStar looks at identified records during the visit, but the records do not receive full case review; therefore no payment adjustments are initiated. Instead, the PEPP staff make recommendations to the hospitals. "We ask that their internal coding management, evaluation or internal review programs review our recommendations," French says.

The PEPP staff conduct entrance and exit interviews with the facility. "We provide them with written follow-up," he says. "We ask them to respond to the written report."

MetaStar also tries to determine common needs of the hospitals. "That's the whole purpose of the program — to provide something back to the state that might be helpful in preventing future payment errors," he says.

For example, one of the resources MetaStar provides is a seminar on coding septicemia. "Septicemia, a generalized infection vs. localized infection, has been a problem for coders because of unclear documentation," he explains. Another tool is a model compliance plan. The plan, developed by the Texas PRO, is made available to hospitals to assist in developing and updating compliance plans.

Errors include under- as well as overpayment

MetaStar's DRG validation of charts referred by the CDAC has found that slightly more hospitals were underpaid than overpaid. French explains, "If it's a lower payment, the hospital can appeal."

On the utilization side for the CDAC chart, payment is taken back if the admission is denied. "Again, that is a small number," he says. Payment adjustments are made only on the charts referred by the CDAC for establishment of the national payment error rate.

MetaStar has yet to find a pattern of errors that it considers fraudulent. If it did, it would discuss the findings with the HCFA regional office, and a decision would be made about whether the review would be escalated.

"Our approach is to address the issues and work with the hospitals to solve the problems resulting in payment errors," French says. "Sometimes guidance from one federal contractor may appear to conflict with another federal contractor. We work with all the federal contractors involved in Medicare payment to achieve consistency."

To help on this front, MetaStar has formed an advisory group. Membership of the Advisory Group includes United Government Services (FI), Wisconsin Physician Services (Part B carrier), Wisconsin Rural Health Cooperative, State Medical Society, Wisconsin Health and Hospital Association, Wisconsin Health Information Management Association, and the Healthcare Financial Management Association. In addition to achieving consistent understanding of the Medicare program, this group is designed to provide feedback about the PEPP to MetaStar and to communicate information about the program back to the advisory group organizations.

Many problems point to documentation

The problems that MetaStar is finding in its records review are not surprising to the PRO. No. 1 on the list is documentation, particularly on the charts referred by the CDAC. "A lot of it is basic. It's the same kind of issues we have had forever," French says.

The CDAC only sends MetaStar the records regarding individual hospitalizations. "We don't get clinic notes or previous or subsequent admissions," he says. Most of the problems involve not having the documentation in the individual patient record to indicate:

- What was done prior to the admission?
- What was done to preclude the admission?
- Why was the admission appropriate?

"One challenge is that physicians understand terminology differently than it is used in the coding system," French says.

"Documentation is just so key," he adds. "Hospitals have been busy this last spring and summer with implementation of APCs [ambulatory payment classifications]. It has heightened the need for — and appreciation for — timely, accurate documentation." MetaStar is providing recommended minimum documentation

requirements to assist providers in including essential elements of information in the medical record.

Improvement through lessons learned

MetaStar has been fairly well-received at the hospitals it has visited — about 35 so far — because of its educational approach, French says. "We try to give them more feedback and provide some basic tools on which to build coding and utilization programs in a compliance environment." Development of tools is based on the need for improvement identified in hospital visits. In most cases, lessons learned can be shared with other hospitals with similar problems.

(*Editor's note:* This material was prepared by MetaStar, the Wisconsin peer review organization, under a contract with HCFA. The information presented does not necessarily reflect HCFA policy.) ■

Pointing fingers won't help in safety search

Joint Commission standards address med errors

Hospitals should no longer operate within a culture of blame, says the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. With the addition of standards that address patient safety and medical error reduction in hospitals, the organization seeks to shift the culture to one of patient safety.

These standards are another step by the Joint Commission to focus on the issue and to have an impact on patient safety, explains spokeswoman **Janet McIntyre**. Previous efforts range from the sentinel event policy, in which hospitals report adverse events that seriously harm patients, to the revision of the Joint Commission's mission statement to include patient safety.

A look at the standards

Requirements for establishing ongoing patient safety programs in organizations accredited under the *Comprehensive Accreditation Manual for Hospitals* will be added in the following standards areas:

• **Leadership.**

Hospital leaders are to create an environment that encourages error identification and remedial steps to reduce the likelihood of future, recurring errors. Such an environment includes minimization of individual blame or retribution for those involved in an error or in reporting an error. The focus is to be on establishing an actual or virtual organizationwide patient safety program that uses internal and external knowledge and experience to prevent the occurrence of errors.

"There is a need for leaders at hospitals to create an environment that encourages the reporting and the analysis of errors," McIntyre says.

• **Improving organization performance.**

Hospitals are to implement a program for proactive assessment of high-risk activities related to patient safety and to undertake appropriate improvements. These activities are to be selected by the hospital based on available knowledge and information, including information that is provided by the Joint Commission through its study of sentinel events.

• **Management of information.**

Hospitals are to aggregate patient safety data to identify risk to patients; apply knowledge-based information to reduce these risks; and effectively communicate among all caregivers and others involved in patient safety issues to guide and improve professional and organizational performance.

"Our root-cause analysis requirements say the most immediate cause of an error may be an individual, but it's typically the result of a series of breakdowns. You have to get down to the root cause before you can try to reduce the risk that the same thing will happen again," McIntyre explains.

• **Other functions.**

Hospitals are to place emphasis on patient safety in areas such as patient rights, education of patients and their families, continuity of care, and management of human resources. The standards state that the patient or the patient's family be informed about the results of care — including unanticipated outcomes.

Implementation should begin in July

The Joint Commission actively sought input from the health care industry on the development of the final standards. For example, the organization consulted an expert panel that included patient safety and medical error reduction leaders,

as well as representatives from government, hospitals, insurance companies, universities and advocacy groups. It also posted the standards on its Web site for public comment last summer.

In addition, a broad field evaluation was conducted among a random sample of accredited hospitals and selected professional associations, consumer groups, and government agencies. The standards also were reviewed by the Joint Commission's Hospital Professional and Technical Advisory Committee and by the Standards and Survey Procedures Committee of the board of commissioners.

"We certainly sought comments from providers and worked closely with them on the standards," McIntyre says. These new standards enhance the nearly half of current Joint Commission standards that already relate to patient safety.

These standards aren't about creating new structures or offices within a hospital, McIntyre adds. "They are about saving lives and an integrated and coordinated approach to the process." The Joint Commission expects the standards to be implemented in July 2001.

(*Editor's note:* The standards can be viewed online at www.jcaho.org.) ■

Q&A

Computer-based records are more than paperless

By **Margret Amatayakul**, MBA, RHIA, FHIMSS
President
Margret\A Consulting
Schaumburg, IL

Last September, I presented a tutorial at the 72nd National Convention and Exhibit of the American Health Information Management Association on the role of the health information manager in computer-based patient record (CPR) projects. The following Q&A covers what health information management (HIM) professionals should consider before undertaking CPR projects.

Q: What was the purpose of your tutorial?

A: The objectives of the presentation were to provide health information management professionals tools to help them do CPR projects.

The three-hour tutorial covered subjects including:

- How do you get involved in the CPR steering committee and who should the members be?
- What is a CPR?
- How do you develop a migration path?
- How do you select your vendors?

I also talked about process redesign, the information technology infrastructure, and a framework for conducting an in-depth analysis.

Q: Does everyone agree on the definition of a computer-based patient record?

A: No. Some people just think a computer-based patient record means going paperless. Others think it means trying to get physicians to do order entry, but that hasn't been satisfactory. The ambulatory environment is different.

Q: Are one-size-fits-all CPRs available?

A: I don't believe that a computer-based patient record is something you buy off the shelf. I believe it is a theory of information systems, policies, and procedures that you put together to form a whole package.

Q: Where do HIM professionals begin in this process?

A: To achieve the state of having a computer-based patient record, you need to start by defining current clinical applications and any financial and administrative applications that relate. Describe current networking capabilities. Then plot out what you want to achieve with a computer-based patient record. You need to define what that means in your own organization.

Q: What strategies do HIM professionals need to address?

A: There are a lot of issues that need to be addressed:

- What is the vision for your CPR?
- What is your functional strategy? Are you going to look at functions that are strictly for communication or is it going to be decision support, knowledge management?
- What is your technical strategy? Are you going to go with the latest and greatest technology? Are you going to keep your mainframe

and add to it? Are you going to throw out everything and buy new?

• What about your acquisition strategy? How are you going to buy [the technology]? Are you going to buy, lease, or use an ASP? How are you going to implement it — all at one time or phase it in?

• What is your operations and maintenance strategy?

Q: How should HIM professionals build a migration path?

A: You have to know what the environment is and where you want it to go. Then you can chunk it off into phases, such as:

• What applications do you have today? Therefore, over the course of the next several years or phases or however you define them, what applications do you have to add?

• What do you have to do your database? Do you have to buy a repository? Are you going to buy data mining tools?

• What do you need to do with your network?

I recommend looking at both actual system interfaces as well as user interfaces. What kind of technology is the physician going to use to provide prescriptions — hand-held wireless devices? Also look at the nursing staff. Are you going to have bedside terminals? Are you going to get them wireless devices?

Then look at your operations. What are the steps you have to take [in this area]? Obviously, you want to set up a CPR steering committee. You might have to do a MPI [master patient index] cleanup project. You may have to adopt new policy. You may begin to look at how you automate your clinical pathways.

Q: Have providers made much progress in the CPR process?

A: A majority of providers have identified that CPR is an ultimate goal. Many of them have started on migration path, whether they have formalized it. I don't think they are very far [in the process].

There are some key hurdles that organizations have not been able to get over. There may be a vendor who wants to sell an integrated system and will tell a [provider] to buy everything from ABC company. But the provider might say, "ABC doesn't do this and this, which I really want." Unfortunately, no one company has the answer to everything. No one company has the ambulatory product, the hospital-based product, etc. The organization needs to determine, too, if it is going to choose [one component] or some sort of combination.

Some providers have a lot in place. They are in a good position to start focusing on the clinical information. It has to do with readiness on the part of users.

Q: What specifically is the role of the HIM professional in CPR projects?

A: We are the only health professionals that are explicitly trained in the flow of health information throughout our organizations. While we may not have all of the technical background, we make excellent liaisons between the clinical folks and the technical folks, the IS/IT people. Involvement of the HIM professional should be encouraged.

(*Editor's note:* Amatayakul also addresses this topic in her book, *Supporting the Computer-based Patient Record: A Practical Guide for Health Information Management Professionals*, available from the American Health Information Management Association in Chicago.) ■

Medicare installs toll-free lines for billing and claims

The Health Care Financing Administration announced in December that toll-free telephone service was available to physicians, hospitals, and home health providers who care for Medicare beneficiaries, to answer their questions about billing, claims processing, and other Medicare-related issues.

Previously, providers paid long-distance phone charges to call the private insurance companies that process and pay Medicare claims.

Providers will also get information at no cost from the 68 Medicare call centers, bringing the toll-free service to providers in every state, the District of Columbia and U.S. territories. The toll-free lines serve all Medicare physicians, home

health agencies, and durable medical equipment suppliers.

Each center has its own toll-free phone number, which contractors are publicizing through bulletins and Web sites. Messages informing providers about the availability of the new toll-free service have been placed on all existing toll lines. ▼

HCFA postpones UB-92's 6.0 implementation date

The Health Care Financing Administration has delayed the implementation date for version 6.0 of the UB-92 until April 1, 2001, due to problems that delayed providers' ability to test, according to Transmittal A-00-100, dated Dec. 22. In April 2000, HCFA had announced that versions other than 6.0 would not be supported after Dec. 31, 2000.

The instructions applied to all providers in addition to all coordination-of-benefits trading partners. In the meantime, fiscal intermediaries will need to support both versions (6.0 and 5.0) of the UB-92.

Providers should not wait until March 31, 2001, to manage the conversion. To monitor progress made by the facility, reports must be submitted weekly on Tuesdays.

The entire transmittal is available at www.hcfa.gov/pubforms/transmit/A00100.pdf. ▼

HCFA accepts new code for cryosurgery

The Health Care Financing Administration now accepts a new current procedural terminology (CPT) code for cryosurgery of the prostate gland, according to transmittal 1689, dated Dec. 22, 2000. The new code is 55873, which is new to CPT 2001.

Because the new code includes not only the cryosurgical ablation procedure but also the ultrasonic guidance for interstitial cryosurgical probe placement, it replaced the previous two HCPCS codes, G0160 and G0161, on Jan. 1, 2001. Providers may continue to use G0160 and G0161 codes for claims with dates of service through March 31, 2001. This change requires an update in Sections 4174.3 and 4174.4 of the *Hospital Medicare Manual*.

To view the entire transmittal, go to www.hcfa.gov/pubforms/transmit/R1689B3.pdf. ▼

OIG requests new safe harbor provisions

The Inspector General has requested submission of proposals and recommendations for developing new and modifying existing safe harbor provisions and new OIG (Office of the Inspector General) Special Fraud Alerts. This request was published in the *Federal Register* on

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Editorial Questions

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Dec. 14, 2000 (65 FR 78124).

Due to the broad nature of the anti-kickback statute of the Social Security Act, "safe harbor" provisions were designed to specify various payment and business practices that would not be treated as criminal offenses under the statute, even though they may be potentially capable of inducing fraud.

In addition, the OIG has also periodically issued Special Fraud Alerts to give continuing guidance to health care providers with respect to practices the OIG regards as unlawful. These Special Fraud Alerts serve to notify the health care industry that the OIG has become aware of certain abusive practices that the OIG plans to pursue and prosecute, or to bring civil and administrative action, as appropriate. ▼

Coding group chooses a new chair-elect

Cheryl D'Amato, RHIT, CCS, has been named chair-elect for the Society for Clinical Coding (SCC) in Chicago and will assume responsibilities as the chair of the SCC in January 2002. D'Amato is the former president and a member of the Connecticut Health Information Management Association, and has more than 20 years of professional experience. She is director of health information management at HSS Inc. in Hamden, CT. ▼

Bush moratorium won't affect privacy

In a memorandum dated Jan. 20, President Bush issued a moratorium on the publication and implementation of new federal regulations. The moratorium is designed to give the new administration an opportunity to review pending federal regulations.

What effect will this moratorium have on the rules required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996? The final rule establishing electronic transaction standards and code sets should not be affected by the moratorium at all because it went into effect on Oct. 16, 2000, says the Phoenix Health Systems in Montgomery Village, MD.

The moratorium temporarily postpones, for 60 days, the effective date of regulations that have been published in the Federal Register but have not yet taken effect.

Phoenix Health Systems, publisher of the online newsletter *HIPAAlert*, also took an informal poll of health care attorneys and several health care organizations, including the American Hospital Association in Chicago, about the status of the privacy regulations. The poll reveals a consensus view that the privacy regulations are entirely exempt from the moratorium. "This position is based on a careful analysis of the memorandum, which states that regulations promulgated pursuant to statutory or judicial deadlines are exempt from the president's directive," the organization says in a statement. ■

The **5th Annual Distributed Medical Intelligence**, "HighTech for High Touch in Next-Generation Healthcare," will be held March 11-13 in Breckenridge, CO. The focus will be technologies and health care delivery that can be applied in natural and man-made disasters as well as traditional healthcare settings. ■