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Success for hospitals lives at the crossroads

Too often, each spins in its own world

The crossroads of the administrative record and the medical record is where the key to financial health lies for health care providers, suggests **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management in Carlsbad, CA.

The access department is the basis of patient demographics — putting the patients' charts together and making the initial code selection — and the physician lays the foundation of clinical messaging, Duffy says.

"Billing and contracts intersected with clinical messaging — that's the source of all wealth coming into a hospital — and if there's any lack of clarity, hospitals never reach the full value of the work they do."

Too often, he adds, "each [process] spins in its own world, and they don't intersect. It's the most troublesome part of our business, and a big piece of overhead. Access holds half the deck; the other half is in the documentation/coding hand. Unless you play both hands together, you can't move your organization to optimum reimbursement."

Strength and weakness

Ironically, Duffy points out, some of the moves that have strengthened the profile of access management also have contributed to this lack of communication. "Historically, there was the omnipresent business manager who knows both the front and the back end," he says, "but we've modified a lot of our reporting relationships to move access into clinical areas. There may be an emergency department [ED]

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COMING IN FUTURE ISSUES

- Designing access from the ground up
- What you should know about ergonomics
- Looking for enterprise solutions
- What merging and unmerging mean to you
- An update on HCFA's rules for MSP

manager, for example, while the business office has its own manager."

"The good news is it has elevated the [access] profession," Duffy adds. "The bad news is it disconnected some of the knowledge pieces."

Access professionals, he advises, "have to go back and reunite the knowledge base." As key members of the team that work toward this intersection of the clinical and the administrative records, "they must share with the team their payer-specific knowledge about what the drivers are that cause reimbursement to go up and down," Duffy says. "If they're so isolated that they don't know, then the first level of collaboration is to reacquaint with the [reimbursement] success and failure rate of their registered patients."

That means looking not only at how many accounts get paid, but at how many get paid at the rate the hospital contracted for, he points out.

Along that line, **Beth Ingram**, CHAM, director of patient business services at Touro Infirmary in New Orleans, emphasizes the role of the hospital's contracting arm and of physicians' offices in ensuring the facility's financial viability.

"It is essential that the data collection [in the access department] meet the payer requirements established by contracts and by regulatory agencies," Ingram says. "In addition, the clinical departments must develop their documentation/charging mechanisms to support the individual requirements of the payers. All of this is predicated on clear, accurate data from the physician office into the system, and continued documentation throughout the stay to support the care that is delivered and charged for."

Access managers can facilitate this marriage, she adds, by making sure that contracts and regulatory requirements are understood by their customer base, which includes all ancillary and clinical departments. They can help determine, Ingram notes, where a breakdown in the process limits reimbursement.

One simple example of the role access should play, she says, is in the handling of an order for a procedure that is received from a physician's office. Before completing the registration, Ingram adds, the access department can verify that all the data needed for the ultimate coding and payment is present, including the diagnosis.

"Many access departments enter the diagnosis code on the front end, and in those cases this issue might not apply," she says, "but I have been in more than one organization recently where all coding is still performed by medical records. In

those cases, medical records are dependent on the data collected at the point of entry.

"While this sounds very elementary," Ingram points out, "it is not as easy as it sounds unless the facility has a made a commitment to bridge the gap between administrative issues and clinical issues and has the cooperation of the medical staff."

How technology can help

Another way access managers can help their organizations optimize reimbursement is to look at ways that technology can be deployed to enhance the intersection of the two records.

A number of companies, Duffy notes, are looking at extending the technologies of application service providers (ASP) into the health care arena.

One product that focusCore, an ASP and managed desktop company in Irvine, CA, is helping to develop is a software program for physicians, says **Dawson Davenport**, the company's vice president and director of sales and marketing. One application of that software is that the physician can make choices regarding a patient's diagnosis and treatment, marking them on a piece of paper that can be scanned into the computer system, he notes. In the future, the physician might use a personal digital assistant to do the same thing.

The software can fill in the codes and language associated with those choices, Duffy points out. Instead of the physician having to expand on and make sense of those notes later and manually enter them into the record, the software archives them, he says.

"Rather than being handled two or three times," Davenport notes, the information is entered into a computer file. "When integrated into the billing system, it allows acceleration of the billing process."

No long memory needed

The physician doesn't have to go back at the end of the shift and remember 40 or 50 patients, possibly forgetting some things, Duffy says. "Some of those [forgotten pieces] might be billable procedures." With new regulations such as ambulatory payment classifications in place, he adds, "There is a huge premium paid on how well records are documented."

Another product focusCore is helping develop is a machine — preconfigured to go to a hospital-specific portal — that allows patients or their families to order the items they need before leaving the ED, says **David Upton**, president and CEO.

If the patient needs crutches, for example, his or her family can go to this machine, place the order, and arrange the location at which it can be picked up, during the period when they'd otherwise be killing time in the ED waiting area, Upton explains.

Although the machine currently is designed to be accessed at a kiosk, he adds, "eventually, we will shrink the kiosk to a handheld device."

Perhaps more significantly, says Duffy, that device also can be used by patients or their family members to review their demographic or insurance information and make any necessary corrections before they leave.

As a customer service feature, he notes, the device could have a function that allows the people spending hours in the waiting room to shop or play games or otherwise entertain themselves. The hospital, as sponsor, would get a percentage of whatever revenue is generated, Duffy notes.

The kiosk option was expected to be available to hospitals by the second quarter of 2001, Davenport says, while the handheld device is one of numerous items being reviewed in the company's laboratory. "We're testing to make sure the [smaller devices] are durable enough and stable enough to be effective."

Finding unpaid bills

focusCore is partnering with a company called Bid Industries.com, Upton says, to offer health care providers assistance in integrating record keeping and billing. As with the other products being developed, the service happens through something called "subscription-based computing."

"[Bid Industries] provides a software package that can magically find a big portion of unpaid [accounts], and focusCore is tying our Internet widget around it," Upton adds. **(See related story, p. 28.)**

Health care organizations make purchasing decisions all the time, Duffy says, and access managers are often involved in those decisions. "What I'm suggesting is that before you make the next purchase decision, ask these questions":

- Is the product compiled to work on a handheld device?
- Instead of introducing more paper, can you introduce more functionality without paper?
- How does the coder interact with the record?
- Can you reduce the time it takes to code? ■

Subscription computing: Upgrade without outlay?

Here's a cheaper way to improve integration

Are outdated hardware and the lack of integration between computer programs preventing your facility from making much needed improvements in its operations? Instead of trying to convince your boss that it's time for a major capital outlay for new computers, you might want to check out subscription-based computing.

One of the companies offering this option to assist health care providers in integrating their record-keeping and billing capabilities is focusCore, an application service provider (ASP) and managed desktop company in Irvine, CA.

Subscription computing, says **Dawson Davenport**, focusCore vice president and director of sales and marketing, allows businesses to upgrade and expand their information technology (IT) infrastructure without making a large capital expenditure.

In addition to creating instant wide-area networks and intranets, Davenport notes, the company also does hosting and integration of legacy applications — like an existing patient registration system, for example — that allow hospitals and other organizations to migrate to a modern platform.

"The problem most hospitals have is they look so much inward in technical capability and as a result, by not having an up-to-date platform, end up having a tremendous conflict in systems," he says. "The costs associated with managing those becomes burdensome, but they've created such a high-dollar IT infrastructure, it's hard to justify changing."

With subscription computing, Davenport explains, there is a monthly fee for each "seat" that is occupied — one location may be used by people on different shifts — and new seats can be added or taken away "virtually overnight," if necessary.

Access departments can make use of subscription computing to, among other things, more easily ensure the accuracy of their billing processes, notes **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management, Carlsbad, CA.

"With a subscription service, like an ASP, software can be packaged in a way that the tools for testing the integrity of the revenue cycle and the payment posting process can be integrated at the provider level," he says. Companies like focusCore, Duffy adds, can create a link so that this testing — of things like whether the provider was paid correctly — can be a normal piece of the transaction, rather than a separate program that has to be written.

"Instead of owning their own software and it never being the right version," he notes, providers can outsource their computer needs to a company using a high-speed data line. It takes away the hassle of "always being two versions behind" and having to retrain staff with each change in technology, Duffy says. ■

Registrars certified in push for quality

Competency fair will streamline the process

Clarian Health in Indianapolis has launched a major patient access training initiative that includes the annual certification of all registrars, an aggressive data quality program, and a corrective action policy for weeding out poor performers.

The new training and data quality team also is responsible for training new registration hires and providing continuing education for about 400 registration employees throughout the health system, says **Sue Underbrink**, who manages that team in addition to serving as manager of patient access services for Indiana University Hospital, one of Clarian's three acute-care facilities.

Since April 2000, when Underbrink added the first full-time equivalent (FTE) to her team, the training and data quality staff have grown to include two trainers and a system and data analyst, she notes, and have an ambitious agenda under way for 2001. Programs that are ongoing or in the works include:

- **The annual certification of registrars.**

The team attempted to certify all Clarian registrars last year, Underbrink says, evaluating the employees on whether they were following approved processes, utilizing available tools, such as on-line insurance verification and entering accurate data.

"As is true everywhere you go, there are cost restraints, so this year we're looking to be a little more creative, to make the best use of our

resource," she adds. "To facilitate the large number of registrars requiring certification, we're planning to host a competency fair in 2001. All Clarian registrars will be required to attend the fair, where competency for the registration process will be validated."

The fair probably would be held several times, Underbrink says, including on the weekend and evening to accommodate the people on those shifts.

• **Continuing education for registrars.**

The training and data quality team will provide quarterly educational offerings, including soft-skills training. Service excellence, Underbrink notes, is a major focus at Clarian Health Partners. Other topics will be drawn from the results of manual audits and system reports. The training and data quality team is providing feedback to registration management on duplication of medical record numbers, account duplication, returned mail, and missing registration data, she adds.

• **Back to basics.**

Because the patient access staff are made up of long-time employees who've never been through the formal registration training and newer employees who have, Underbrink says, there are plans to conduct back-to-basics training for the entire staff. "Those newer employees sometimes pick up bad habits from those who never had the formal training," she points out. "We want to hit the [problems] we see through the reports and audits, and then continue with the quarterly education meetings.

"Some of the areas we know we're having problems with are missing authorizations on managed care Medicaid and insurance errors, such as the wrong plan code, or missing information that can cause the [bill] to be denied."

• **Implementation of a registration data quality policy.**

The goal is for the team to look at 20 registrations per month for each registrar, assigning a point value to various components and averaging the scores of the registrations to come with a monthly score for each registrar, Underbrink explains. There also will be an overall score for the unit to which the registrar belongs.

"We've been doing this within our own [patient access] departments," she notes, "but not every registrar reports to patient access services." Various clinics owned or operated by Clarian handle their own registrations, Underbrink says. The registration data quality will be a companywide policy to ensure consistency throughout the organization, she adds.

The goal is for registrars to score 95% or better on the audit and, if they do, they will be recognized through mention in the system's patient access newsletter and with individual and/or departmental awards, she explains. Those who score 85% or below will be placed on corrective action, a four-step process that can include oral counseling, written counseling with documentation in the employee's record, suspension, and finally termination.

In addition to rating employees through the face sheet audits, the team "will take it very seriously if [a registrar] creates a duplicate medical record, or looks someone up and registers the wrong patient," Underbrink says. Employees who make those mistakes will go directly to the written-counseling step, and will remain in corrective action for six months, as opposed to the three months required for scoring below 85%. If there are no further errors, the employee drops out of corrective action, but if the problems continue, the process will be followed to its conclusion.

Accurate completion of the Medicare Secondary Payer questionnaire is one of a number of registration components her team will monitor, Underbrink notes.

• **Registration and the bottom line.**

At the beginning of this year, the denial management group within patient access became aware of significant write-offs that were due to eligibility and certification issues, Underbrink says. "Based on that information, we have undertaken an aggressive initiative. Two data quality teams have been deployed to observe registration throughout the organization. The teams are observing processes, checking for accuracy, and providing immediate feedback, allowing registrars to make corrections on the spot."

The results of this effort will be shared with registration management, she notes, and continuing education will be provided based upon the results. A second observation period will follow in approximately three weeks to determine if improvements have been made, Underbrink adds.

• **A training and data quality Web page.**

"We're developing a Web page for the training and data quality group that will have hot topics, frequently asked questions and answers, and a training schedule," she notes. It will give information on upcoming events, and provide an online registration form for classes.

• **Initial training of new registrars.**

Her staff currently conduct three days of intensive training on registration pathways for new employees, but have plans to extend that to 10 days, Underbrink says. "We want to incorporate more of the soft-skills and customer service training, and have more time for registrars to practice." New registrars do receive on-the-job training when they report for duty, and future plans are to include a train-the-trainer class to the data quality group's repertoire, she notes. "We want to provide on-the-job coaches some education in an effort to provide consistent training."

The training efforts under Underbrink's direction are making a substantial difference in registrar performance, notes **Marne Bonomo**, PhD, RN, Clarian's director of patient access. "Managers in all areas of the organization have user-specific error reporting for the first time ever. All areas are eager to improve and teamwork is at an all-time high.

"We all want to be successful," Bonomo adds, "and the efforts of our training and data quality group are helping us to make that difference." ■

Frontline distraction: It's time to RAVe on

Even the ED will benefit

As part of its ongoing reinvention of access services, ScrippsHealth in San Diego has created RAVe Center, which consolidates registration, authorization, and verification functions and removes them from the distractions of the front line.

The small "e" in the acronym indicates the work will be done via e-commerce, explains **Norma Pearce O'Toole**, manager of the center, and plans are to extend the RAVe Center's role even into the emergency department (ED).

The RAVe Center staff, she says, will be responsible for preregistering all patients, identifying any authorization or precertification needs, verifying eligibility, and determining how much the patient will owe out of pocket for the service being provided. **(See flowchart, p. 31.)**

"The problem, we have found, has been that registration personnel, due to the demands of the facility, are pulled away from their primary role of registering patients to do other duties," Pearce-O'Toole says, such as providing customer service or supporting clinical staff.

Under the new arrangement, the RAVe Center staff will be located in Scripps' patient financial services building, away from the daily pressures of the admitting/registration office, she explains.

Its staff will make payment arrangements — or at least give an estimate of the cost, depending on the patient's benefit plan — before he or she even arrives at the hospital, Pearce-O'Toole says. "The focus is [for the patient] to pay at that point," she says, whether by credit card, an electronic check from the patient's bank account, or through a payment plan with the hospital.

Impact: Claim denial

The RAVe Center pilot program was in the radiology department of one of Scripps' facilities, and that focus will continue as the center gets up and running this month, she notes.

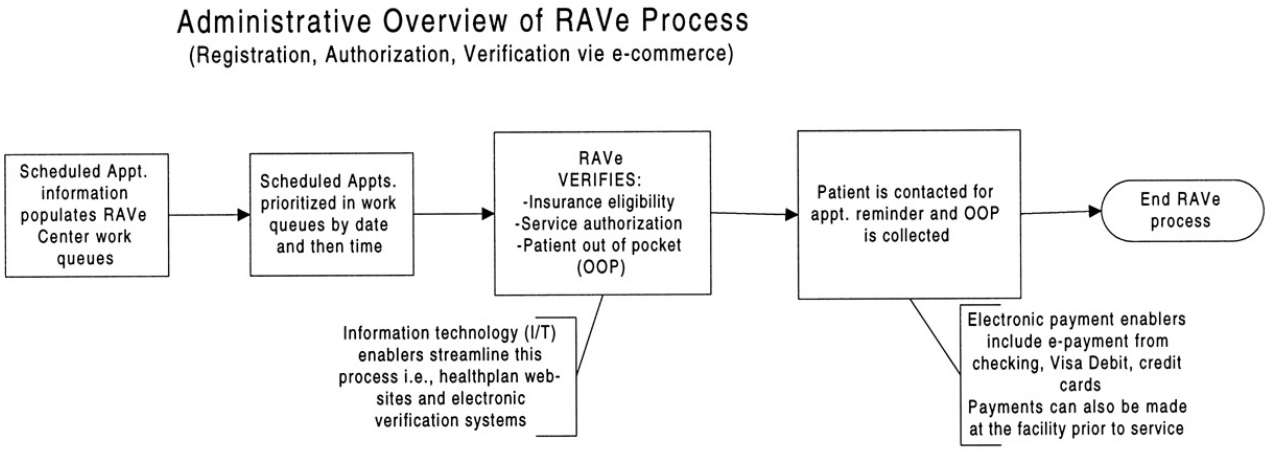
"Green Hospital radiology department performs about 300 services per day, and with that volume, we don't have the staff to perform this [preregistration] function in its entirety," Pearce-O'Toole says. "That's why we chose it [for the RAVe Center debut], to have the greatest impact."

The largest impact, she adds, is expected to be on the rate of claim denial. Because prior to the center's creation, there was no one in that radiology department to verify insurance eligibility, make sure the proper authorization was in place, or determine benefits and patient out-of-pocket costs, the gains in those areas will be significant, Pearce-O'Toole suggests.

Although it's starting out small, the RAVe Center ultimately will support all the departments in Scripps' five hospitals, including the ED, and will operate 24 hours a day, seven days a week, she says. The full rollout of the program is expected to take about a year.

"We have determined that the more electronic enablers we have, the more successful the process will become," Pearce-O'Toole notes. "We want to build an electronic database to hold all the benefit plan information so that we may access these easily to determine the patient's out-of-pocket responsibility. Everybody has a benefit plan code. Some have a $200 deductible, some have a $500 deductible, some have 20% coinsurance. We will obtain all that information from the carriers and load it into the database."

With that information at its disposal, the RAVe



Source: Scripps Health, San Diego.

staff can run queries on each service, and inform patients of their copay or uncovered cost, she adds. "We currently don't have that level of detail available electronically for all of our health plans, so we have to make some phone calls."

The e-commerce feature of the RAVe Center will facilitate extending the process to the ED, Pearce-O'Toole says, but patients' rights under Emergency Medical Treatment and Labor Act regulations will continue to be protected.

"We hope that when the patients are triaged, they will give the nurse their name, date of birth, and Social Security number," she explains. "That information, in electronic format, will be sent to the RAVe department. It will do an inquiry as to what insurance they may or may not have and, if there is a match, will determine what copayment that patient will owe."

Before that patient leaves, Pearce-O'Toole says, the RAVe staff will have informed the ED that the patient, for example, owes $50.

Scripps has a team working to ensure that the confidentiality of patients' medical information, as provided for in the Health Insurance Portability and Accountability Act of 1996 privacy standard, also is safeguarded, she says. They will be feeding information back to the RAVe team regarding the standard, which becomes effective in a little under two years.

Enhanced customer service is another RAVe Center goal, Pearce-O'Toole notes. "Historically, when the patient comes in, [he or she] is not even aware of what the out-of-pocket costs will be," she points out, and hearing that information at the point of service may be disconcerting. "The RAVe Center will address those expectations before the patient is even seen."

Additionally, she says, the RAVe Center staff will answer any questions regarding the logistics of the visit, providing such information as directions to the facility, where the patient should park, and how much it costs.

The calls made to patients also serve as reminders of the appointment, Pearce-O'Toole adds. "We currently have a large no-show rate."

Getting consensus

The largest obstacle to putting the RAVe Center in operation has been obtaining the consensus of physicians and department administrators on the necessity of getting authorization before services are rendered, Pearce-O'Toole says. She cites a typical scenario:

Currently, the physicians send over a patient, a walk-in, to have an MRI (magnetic resonance imaging) with no authorization, she says. "[The physician] has requested the authorization from the insurance or the [management services organization], but hasn't received it. The physician still wants the patient to have the MRI, so as a courtesy we perform it, but if we don't get the authorization, we don't get paid."

To make the new system work effectively, Pearce-O'Toole notes, "we have to gain the administrators' and physicians' [cooperation] to

say we are not going to perform services without authorization." It's a customer service issue as well, she says, in that staff at times may inform patients that the service they are about to have may not be covered and ask them if they are willing to take responsibility for the cost.

Those patients, Pearce-O'Toole adds, may be asked to sign a noncoverage waiver.

[For more information, contact Norma Pearce-O'Toole at (858) 657-4091 or by e-mail at pearce-o'toole.norma@scrippshealth.org.] ■

'7 on, 7 off' takes a bow

ED staffing no longer a problem

Tired of struggling to find registration coverage for those late-night and weekend shifts? Valley View Hospital in Glenwood Springs, CO, has a solution that might work for you.

Registration is one of several departments — coding and the laboratory are two others — that make use of a hospital policy that allows employees to work "seven on, seven off" shifts, explains **Cindy Vorhees**, director of patient financial services.

For the past few months, four of her 13 employees have worked seven 10-hour days, and then had seven days off, Vorhees says, and the results are "so far, so good." Two of the employees work the 2 p.m. to midnight shift in the emergency department (ED), and the other two work midnight to 10 a.m., she adds. A full-time employee who splits her time between the ED and the main registration area works in the ED when neither of the other employees is there, so that coverage is continuous, Vorhees notes.

Staffing gets easier

Having the "seven on, seven off" employees has eliminated an ongoing problem finding weekend staffing, she points out. The schedule leaves a staffing hole between 10 a.m. and 2 p.m. on weekends, Vorhees says. But since there has traditionally been an extra ED registrar on weekends to help with the increased volume, she notes, the new arrangement just means that instead of double coverage during the midday hours, there is one registrar on duty. From about 2 p.m. to 9 p.m. on weekends, there are two ED registrars, Vorhees adds.

"You don't have to worry about vacation and holidays [for those on the new shift]," she notes. "If Christmas is in your week, you work it." The people on this shift, O'Toole adds, tend to "either work another job or have seven days to play."

"This shift [typically] is not for people who are set on weekends off or who have a family," she says, although one woman uses the shift to avoid putting her children in day care. "She works 2 p.m. to midnight, and her husband is there in the afternoon."

Because they have no vacation or holiday benefits, she says, employees on this shift work 70 hours a pay period, but are paid for 78. They do accrue sick leave, but very slowly, O'Toole adds.

[Editor's note: Cindy Vorhees, director of patient financial services, can be reached at Valley View Hospital, P.O. Box 1970, Glenwood Springs, CO 81602. Telephone: (970) 945-3456.] ■

ACCESS FEEDBACK

MedCambio elaborates on its payment network

Reader questions how it can work

Several readers have contacted *Hospital Access Management* asking for more information on the health care payment network described in the January 2001 issue. The company featured in the article, Del Mar, CA-based MedCambio, promises its hospital and physician clients a switch from 72 days in accounts receivable to 72 hours.

MedCambio aims to makes good on that claim by implementing a system that will calculate reimbursement at the point of service. It pays the provider immediately, based on a percentage of the calculation.

In response to the article, **Peter A. Kraus**, CHAM, business analyst for patient accounts services at Atlanta's Emory University Hospital, points out that insurance contracts don't always pay according to calculations. "Managed care

contracts can be ambiguous, and there's always the issue of whether the patient should be having the particular treatment in the first place." Kraus also observes that the examples in the article were for specific outpatient services, and wonders if the concept is adaptable to extended inpatient care.

The article's subhead, "Wave bye-bye to the billing department," prompted Kraus to ask if MedCambio would assume responsibility for getting the account billed in addition to replacing collections. (It's actually *manual* billing that's likely to become obsolete if the electronic commerce that MedCambio promotes becomes widespread.)

Cleaning your claims

Kraus notes that insurance carriers demand enormous amounts of documentation from medical facilities, which they often use as a delay tactic to avoid paying the claim. "The article doesn't explain," he adds, "what MedCambio proposes to do to make even relatively routine billing and collection problems disappear for them."

Carol Miller, vice president of the MedCambio Alliance Partnership with Superior Consultants, a part owner in the enterprise, addresses Kraus's concerns as follows.

"We agree that insurers are difficult to do business with, that they can deny claims, delay payments, ask for additional information, etc. However, MedCambio and its alliance partners are working with major insurers to develop direct routes of claims submission with totally clean claims."

It is MedCambio's intention, Miller says, to understand the benefit and data requirements of the major insurers, to direct the provider's or hospital's claims through its system to ensure that they are "clean," and then to have the hospital or provider submit the claims directly via the Internet portal.

"Besides this piece," she adds, "MedCambio is planning on developing direct and close working relationships with major managed care organizations and insurers to provide cost savings to provider, hospital, and insurer by reducing unnecessary man-hour costs in obtaining payment on claims." This will enable the insurers to reduce their own internal cost to process a claim, Miller notes, and will reduce the burdensome back-and-forth telephone calls involved in trying to get the claim resolved.

Although MedCambio will not personally "get the account billed," she says, it will offer one of its partners to expedite the Internet eligibility and billing process if the hospital does not have an appropriate Internet vehicle in place.

"MedCambio and its partners," Miller says, "are interested in reducing, not eliminating, the back office collection process by improving the Internet portals for eligibility, authorization, and billing on the front end and electronic auto adjudication and posting on the back end." This will prevent human cracks in the process, she says, that can keep missed charges and late charges from being billed in a timely manner.

While MedCambio's demonstration sites initially have focused on outpatient operations, a company spokesman says, plans are in place to implement the payment network for inpatient services, as well.

[Look for more information on this reimbursement technology in future issues of HAM. *If you would like to offer feedback on this issue, or any other of interest to access managers, please contact editor Lila Moore at (520) 299-8730, or through e-mail at lilamoore@mindspring.com.]* ■

Swatting payment errors on inpatients

A government program gets to work

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 began 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.

Finding an error sample

The Wisconsin PEPP program has two parts, explains **Bill French**, MBA, RHIA, vice president, PEPP for MetaStar. First, the PEPP staff review 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).

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 an on-site 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 remeasure 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 back to the hospitals. "We ask that their internal coding management, evaluation, or internal review programs review our recommendations," French says.

The PEPP staff have an entrance interview with the facility and an exit interview. "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.

Underpaid vs. overpaid

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 of 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 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 communicate information about the program back to the advisory group organizations.

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 has been done to preclude the admission?

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Editorial Questions

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• 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 classification payments]. I think it has heightened the need for and appreciation of timely, accurate documentation." MetaStar is providing recommended minimum documentation requirements to assist providers in including essential elements of information in the medical record.

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 the HCFA. The information presented does not necessarily reflect HCFA policy.) ■

days' stay can result in 10-15 pages of detailed charges. The process of accumulating these charges is a nightmare of automatic and manual input, and electronic and paper hand-offs." ▼

NEWS BRIEFS

Patient-friendly billing aim of HFMA initiative

The Healthcare Financial Management Association (HFMA) and the American Hospital Association are working together on an initiative to improve hospital billing.

"Patient-Friendly Billing," an initiative by the two Chicago-based organizations, aims to identify the reasons for the complexity of the current billing systems, the barriers to billing simplification, and best practices in patient billing communication, according to **Richard L. Clarke**, FHFMA, president and CEO of HFMA. "Patients often do not understand what is being charged, what their insurance should pay, what they owe, and why they owe it," Clarke says. "Research suggests it is the main complaint by the public about hospitals. A few

OIG recommends EMTALA efforts

A report issued by the Office of Inspector General (OIG) of the Department of Health and Human Services says most emergency department staff and on-call physicians that it polled are familiar with the Emergency Medical Treatment and Labor Act (EMTALA), but many are unaware of recent policy changes and believe current regulations exceed the intent of the law.

The OIG posted two final reports in late January EMTALA. The first, "Survey of Hospital Emergency Departments," concludes that additional efforts should be made to communicate policy decisions, and legislation should be supported that compels managed care plans to reimburse hospitals for EMTALA-related services.

The second report, "The Enforcement Process," states EMTALA enforcement is compromised by long delays, inadequate feedback, and regional inconsistencies. ■