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Do your patients a favor: ID payments up front

'It's a benefit,' says collections expert

The best piece of advice for those starting an upfront collections program is not to call it that, says **Lori Zindl**, president of Outsource Inc. in Pewaukee, WI.

It can be a patient service program, a patient information program, or a patient financial services program, she adds. "I really haven't come up with a catchy name." The point, Zindl says, is that by implementing such an effort, you are actually trying to inform patients of their financial responsibility for a service they're receiving.

"Collections," she adds, "is a by-product."

At a recent meeting where Zindl spoke on the subject, she notes, "a good 25% of the 100 or so attendees" indicated their hospitals were making some effort toward upfront collections.

Emphasize service

The tack that access managers wanting to follow suit should take when selling such a program to administrators, nurses, and physicians, she advises, is to emphasize the customer service aspect. "It should be something that sounds like a benefit for patients because that's what it is. It's a communication of what their insurance payments are."

While popular wisdom holds that registrars will alienate patients by informing them of what they owe and asking them to pay it up front, she points out, her experience has been that the alienation is already happening on the back end of the revenue cycle when patients are surprised by a bill weeks after their hospital visit.

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COMING IN FUTURE ISSUES

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"They think [upfront collections] will chase patients away, but in fact, we are chasing them away, and it's happening from the billing side," Zindl says. "I constantly hear complaints of, 'Nobody told me my insurance wouldn't cover this.' Patient accounting becomes the bad guy, the bill becomes bad debt, and the patient doesn't come back for service."

The answer to objections or questions about starting the upfront program, she adds, should be that it is "due to popular demand. The patients asked us to do this."

At hospitals where Zindl has helped establish upfront collections programs, the response "is amazing," she says. "Once you start collecting, they are willing to pay. They've been paying in the physician's office for years, and it's mostly our fear that's stopping it [from happening at hospitals]."

She suggests that registrars say to the patient something along the lines of, "We've contacted your insurance company and they've stated that you have a $50 copay. We can accept that payment in several ways."

Troublesome companies

Another strategy Zindl suggests is, in the case of insurance companies that are problem payers, to hand patients a letter stating that "we have trouble with your insurance company; they don't pay on time, and if we don't have payment within 45 days, we'll have to bill you."

This underscores the fact that the upfront program is not just about collecting money, but is a customer service effort, she adds.

Zindl emphasizes that if patients "ever get the idea that money is more important than care," a facility is in trouble. How the situation is best handled depends on the timing, she notes. If the subject is broached during a preadmission telephone call, the registrar might suggest paying with a credit card or mailing the hospital a check. If the first encounter is at the point of service, Zindl adds, it's a good idea to hand the patient a preaddressed envelope in addition to mentioning the credit card option.

Her hospital clients "have a lot of luck with those envelopes," she says. The ones distributed at registration should bear a special code, Zindl stresses, so they can be identified when the payment is posted to the patient accounting system. "You should track those payments because [upfront collections] should get credit," she notes. "Any time you get payment before the

insurance [processes the claim], you're doing your hospital a favor."

If the patient says he or she doesn't trust your estimate of the copay or deductible and wants to wait to pay until the insurance payment has been settled, Zindl says this strategy is effective: "Have them sign something that says, 'I give you permission, when the insurance is processed, to charge this to my Visa [or MasterCard], as long as the balance doesn't exceed [the estimate you've provided].'"

When money is collected up front on the basis of an estimate, a good refund policy is a must, Zindl says. "You will burn bridges if you make a guess and collect payment and then don't refund promptly. Don't make them wait 90 days for their refund."

Although infrequent, refunds are necessary occasionally, Zindl notes. One client, a four-hospital system in the Milwaukee area that began an upfront collections program in April 2000, had to issue about 20 refunds between then and January 2001, she says. That health care system collected $250,000 in upfront payments during the same period, compared to zero the previous year, Zindl adds.

That's a significant impact on the bottom line, she notes, particularly since some estimates are that every dollar collected up front is worth 12 times the value it has if collected after the typical billing cycle.

Personnel at the health care system mentioned above, Zindl says, attribute their program's success to a "baby-steps" approach. It makes sense, for example, to start with obstetrics patients, she points out. "You can work it out with the physicians to notify the patients, and in most cases can send out a letter seven months ahead."

Another good place to start is with clinics where the copays are straightforward and easily calculated, Zindl says. "Even if you collect $100 a month up front," she emphasizes, you're ahead of the game. "If your expectation is that you will collect all [that is due], that's not going to happen."

"You have to be prepared that they won't pay," Zindl says, "especially if they didn't get advance notice." With that in mind, she adds, the more conversations that take place about the program before it begins, the better. Zindl compares the effort needed to the notice that was given when hospitals went to a "no smoking" policy.

"As a starting process, put up signs in the emergency department or the hospital six months in advance that, effective this date, copays or deductibles will be expected at the time of service," Zindl suggests. "You can also put the information on the patient statements for the same period, any communication you can do so that first telephone call in the preadmission process is no shock." ■

Ongoing team effort makes APCs work

Monitoring, customer service important

Key to the successful implementation of ambulatory payment classifications (APCs) is oversight by an ongoing multidisciplinary team that continues to function even after you go live with the process.

That's the No. 1 suggestion offered by **Karen Geisler**, HFMA, CHFP, patient financial systems consultant for Trinity Health, a multistate health care organization based in Novi, MI, that recently implemented a program for handling APCs.

"Having the team is just essential," Geisler explains. "This is not a process that can be solved in patient accounting. It is a reimbursement change that affects operations; if they're not involved, you can't be successful."

After hiring an outside consulting firm to help with its APC readiness assessment, Trinity shared the results throughout the system and put in place APC teams of between eight and 15 people at its various hospitals, Geisler says. The teams include operations, clinical, and reimbursement personnel, she adds, and although the health system distributed a recommended structure, each facility designed a team that fit its own organization.

The readiness assessment, meanwhile, helped Trinity identify areas on which to focus its attention, Geisler notes, including:

- **The chargemaster.**

The teams looked at the chargemaster to determine how it could better reflect the way APCs would pay. The Health Care Financing Administration (HCFA) has acknowledged, for example, that CPT codes are for physicians and don't exactly mirror hospital operations, Geisler points out. For that reason, HCFA stated that each facility could develop its own way of assigning evaluation and management (E&M) codes, but that it must have a policy and procedure for doing so.

"You need to have a plan," she says. "Will you assign [the code] via the chargemaster, or will

medical records assign that code? There is no right or wrong, but a policy decision."

Another decision that must be made, Geisler says, is how the modifiers — indicators added to the CPT code that more fully describe the procedure — for APCs will be entered. "Are you going to drive [the modifiers] from the chargemaster or is the department responsible for entering them?"

If the department is given that task, the chargemaster is smaller, she notes, "but the clinical staff have to have a total grasp of APCs and when a modifier is appropriate." Some modifiers are entered by medical records staff, Geisler adds, while others are generated by the ancillary department, including those for radiology and those that are attached to E&M codes when there are additional services.

Creating a link

• **The computer system.**

After making the above decisions, she notes, the hospital must then do the prep work from the perspective of the computer system. Trinity, for the most part, uses Atlanta-based McKesson-HBOC's Star patient accounting applications, Geisler says, and works with 3M HIS in Salt Lake City because it offers products that link with those applications.

The 3M APC Finder is a coding tool that each facility, depending on its health information management (HIM) department, will "tell you they need or they don't need," she adds. At Trinity, HIM directors made the decision as to whether the product was needed, based on the coding expertise of the personnel and the complexity of the patient mix, Geisler notes.

On the billing side, McKesson-HBOC developed an interface to the Star patient accounting applications with the 3M APC Grouper Plus, Geisler says. Grouper Plus groups the APCs, and checks for conflicts with the Correct Coding Initiative (CCI), a set of rules that looks at the relationships between groups of CPT codes, she explains. Basically, the CCI provides that if you do one procedure that you subsequently will group into an APC, you may not bill other procedures with it, Geisler says.

Grouper Plus also gives the reimbursement for the claim, both for charges bundled under the APCs, and for those paid according to a fee schedule, such as lab charges, she adds.

APC implementation was challenging from a technical perspective, Geisler notes, because Trinity personnel "had to learn to work the interface and how to work the claims. For the most part, it was the hospitals' first exposure to the CCI, so they not only had to learn a new reimbursement methodology, they had to learn the CCI edits."

• **HCFA's ongoing changes.**

"It's hard to keep our heads above water," she points out. "Our biggest ongoing challenge is keeping up with changes to the regulations. HCFA continues to make frequent changes, and the vendor has to add those, then test and install."

Initially, there was a problem with the payments for coinsurance and deductibles from the fiscal intermediary, Geisler says. Although computed correctly, the electronic remittance advice was posted wrong, she notes. The claims "were paid correctly, but some erroneous hospital bills were sent to patients. We had to look at all the payments manually." That problem has since been solved, Geisler adds.

HCFA originally had an addendum to the APC regulations listing procedures that would be covered only if done in an inpatient setting, she notes. After realizing many of those are often done on an outpatient basis, the agency changed the list, "but implementation lagged behind the arrival of APCs," Geisler adds. "That was resolved by the first of January, but there were several months where we were told to hold the claims for those procedures."

One of the big APC issues has been the "pass-throughs" that have been allowed for medical equipment and some drugs, she says. These items — designated by "C" (equipment) and "J" (drug) codes — include some high-dollar equipment, such as pacemakers, and expensive drugs, Geisler says, and are paid in addition to the APC.

The identification of those items has been a challenge because HCFA has changed the list many times since APCs became effective in August 2000, she notes. Part of the difficulty is that the codes for those items are now "vendor-specific and device-specific," Geisler says. "Somebody needs to monitor the chargemaster so these [changes] are reflected."

The need is not only to keep the chargemaster updated, she points out, but for users to understand that they need to charge for them. "If they're not detailing them on the bill, the provider could be missing reimbursement for which it is eligible."

This kind of monitoring is one important reason why the APC teams must remain in place, Geisler notes. The hospitals also need to maintain a log of rejections from the payer, she adds. "They can take these back to the team and work through the issues. Until we get a real handle on

reimbursement and rejection, [the teams] need to meet at least monthly, maybe more if there are specific issues to be addressed."

In some cases, Geisler says, it is effective to form subgroups to discuss issues involving, for example, a particular ancillary service. The group can address that concern and then report back to the team, she adds.

Get automated, monitor updates

Whether it's the Grouper Plus or similar software offered by other vendors, Geisler says, she believes "an automated solution" to APCs is needed so that providers can get a handle on whether they're being reimbursed as expected. It's actually a three-way comparison that's necessary, she adds. "Compare the charges against the expected reimbursement and against the reimbursement you receive so you can look back at how you charge. That will help you as you go forward."

The software is "a huge benefit," Geisler says, because "it allows us to edit our claims and prepare an accurate bill for the fiscal intermediary." The team is able to take the feedback on rejections back into the departments and change the procedures as needed, she notes.

"It's a painful process," Geisler adds. "You might find, for example, that in radiology they always charge for these two X-rays, but the CCI edits say that when you charge for one, the second is included. That has not been hospital policy, which has treated them as two distinct [procedures]. Now you have to decide if they truly are two distinct procedures and [the code] needs a modifier, or if you change the procedure so that it's one charge. [The grouper] gives you a tool to question that."

Geisler also offers the following advice for providers struggling with APC implementation:

• **If you haven't had your chargemaster reviewed by an outside firm, do it now.**

"You need to do this to make sure the right charges are set up, the right CPT codes are attached, and that they are assigned to the correct revenue codes for Medicare."

• **Make sure someone is monitoring HCFA updates and implementing them into the process.**

Trinity has an employee that looks at the HCFA Web site (www.hcfa.gov), at least weekly, and distributes changes throughout the system, Geisler says.

• **Keep groupers updated to the latest version of the software.**

The 3M grouper typically receives quarterly updates, she notes, but there have been patches in between because of HCFA updates.

• **Keep customer service in mind.**

Along with the new outpatient prospective payment system has come a drastic change in the coinsurance process for beneficiaries, Geisler points out. Personnel should be trained to explain the changes and answer patients' questions, she suggests. In Trinity's case, she adds, each hospital developed its own training in this area, depending on computer system needs. ■

Here's a frontline report on JCAHO

Patient privacy, quality efforts highlighted

Access managers tend to seek out any bits of information they can from their peers who have recently undergone a visit from the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

That goes double when the surveyed organization receives high marks, as was the case last summer with Aurora HealthCare in Milwaukee, whose five metro-area hospitals got JCAHO scores ranging from 97% to 99%, according to **Charlene Freimark**, supervisor of patient access services.

Freimark was on hand at two of the hospitals — Sinai Samaritan Medical Center and St. Luke's South Shore, which is part of St. Luke's Medical Center — to field questions from JCAHO surveyors, she says.

In her first encounter, Freimark says, she was asked how the department handled patient confidentiality, and whether it had implemented any recent quality improvements, particularly those that involved collaboration with other areas of the hospital.

"The way we have it set up here is that patients go into a room [to be registered] and can close a glass door if they need to," she explains. "There are three rooms in a row, and each has a desk and two chairs and a sliding glass door. [The surveyor] said that was the ideal way to have it [arranged] because of confidentiality concerns."

As for quality initiatives, Freimark explained that the access department had worked with nursing to improve the giving of advance directives to patients, she says. The concern was that because 50% of Aurora's patients were admitted through the emergency department (ED), having access personnel handle the advance directives was not the most efficient way to do it, Freimark adds.

"We had the responsibility transferred to the nursing desk on the floor," she says. When the nurse goes into the room to do the initial assessment, he or she also goes through the advance directives with the patient, Freimark says. "We made sure every patient got them and got an explanation."

The JCAHO surveyor asked whether things were done differently at the various metro hospitals, she says, and her response was that the procedures were the same at all five facilities, with different codes used to indicate the different hospitals.

The surveyor also questioned Freimark about the admitting department hours, and expressed concern that at the end of the day there is just one person on duty, she notes. "She asked how that person was kept safe. That's the first time I've heard that kind of question." The JCAHO representative was satisfied, Freimark adds, with the explanation that the employee has access to a distress button that can sound an alarm at the switchboard.

Another question had to do with how patient satisfaction is measured, "how we know we're doing a good job," she says. Freimark explained that in addition to formal surveys that are sent out to patients after their hospital experience, Aurora also has "complaint and compliment" forms available throughout its facilities.

The surveyor Freimark spoke with at Sinai Samaritan, she says, asked her what she looked for when interviewing a new employee. "I told him the normal things, like experience with customer service and a background in insurance, but that's not what he was looking for."

Instead, she adds, the surveyor made the point that "the up-and-coming thing was that admitting people should be trained in medical terminology, probably because in order to get the bill paid, you now need to be more specific as to why the patient is having a test done."

That surveyor also questioned Freimark about the orientation that new employees receive, "whether we go through the rules and regulations, describe how the time clock works, and [introduce] the employee to the workplace and co-workers," she says. "We had told him that no employee ever starts without a formal orientation and a department orientation. He didn't seem to believe it, but it's the truth."

Some JCAHO changes

Her understanding had been that, in line with a new JCAHO policy, the surveyors would make visits during the evening and night shifts, Freimark notes, and that did happen, although not in the admitting areas. "We knew it would probably happen, but we didn't know when. They usually came in, and went to a specific area." The targeted areas varied at each hospital, she says, but did not include admitting.

These off-shift visits are a new focus for JCAHO, confirms **Charlene Hill**, an agency spokeswoman. They will be part of the process for 24-hour facilities when the survey lasts two days or more. Most hospital surveys, she notes, last three days.

"We did a pilot test, and the organizations [that participated] were supportive," Hill says. "They felt it added value and should be part of the regular survey process." The weekend visits, she adds, happen only when the survey time includes a weekend.

(Editor's note: Look for information on the JCAHO's 2001 survey process — and hear from hospitals who've experienced it — in the next issue of Hospital Access Management. *News about JCAHO is available on the agency's Web site at www.jcaho.org.)* ■

Readers look for clarity on MSP requirements

'Recurring visits' policy examined

Some good news about the Health Care Financing Administration (HCFA) revising its policy on Medicare Secondary Payer (MSP) requirements has been circulating. The problem has been that, so far, access managers haven't been able to find the information in any official missives from the agency.

When the on-line news service *AHA News Today* reported HCFA was relaxing MSP rules,

by cutting back on the number of times questionnaires must be completed and how long they have to be kept, *Hospital Access Management* shared the information with its readers in a brief announcement.

Unfortunately, access managers eager to take advantage of the changes reported to *HAM* that they couldn't find confirmation on the HCFA Web site or from communications from their Medicare fiscal intermediaries.

That doesn't surprise **Kathy Chadoir**, owner of CMBS Consulting in Milwaukee and previously a longtime employee of United Government Services (UGS), the Medicare intermediary for Region 5, which includes Wisconsin.

It's not unusual, she notes, for HCFA to issue informal communiqués to its Medicare intermediaries that don't reach providers. Sometimes the communications are verbal and never even make it into print, Chadoir says.

In making its news announcement on the MSP changes, she speculates, *AHA News* — which could not be reached for comment — may have been made aware of an informal communication to intermediaries.

Complicating the situation further is the fact that the intermediaries for the various regions operate somewhat independently, interpreting the HCFA regulations in various ways.

"It's all up to your region and how [that intermediary] enforces the guidelines," she adds. "From an auditing standpoint, some are more relaxed than others. UGS went by the book. There was no gray area."

In October 2000, Chadoir notes, HCFA issued a communiqué to intermediaries stating they cannot hold a provider noncompliant for being unable to produce specific MSP questionnaires during an on-site audit.

"If the auditors were to request 15 specific questionnaires, and they could produce only 10, the provider can't be held noncompliant," she adds. Before that HCFA communication, Chadoir says, UGS had required providers to produce all requested questionnaires.

As to whether providers must get MSP questionnaires completed at every encounter when there is a series of patient visits — an ongoing question for many access managers — she says she has been aware since at least 1997 that this is not necessary.

At that time, while she was still working for UGS, Chadoir says, she checked with HCFA on the issue and was told that providers "don't have to do it every time as long as they update periodically." However, she notes, HCFA "won't say what 'periodically' is, and has never clarified the requirement in print.

"[HCFA] will never say, 'Don't do them,'" Chadoir adds. "They just won't be that definitive."

In the case of recurring patient visits — as with chemotherapy treatments, for example — most providers update the MSP information at 30-day intervals, she says. "They say, 'We saw you 30 days ago. Has anything changed since then?'"

When auditing those accounts, Chadoir explains, UGS checks to make sure that the UB92 bill type matches what the questionnaire states. "The first bill in the series should be '132,' every bill after that should be '133,' and the final discharge bill should be '134,'" she says. "If you just bill at the beginning and end of the series, then it's '132' and '134.'

"That was never put out in a bulletin to providers, only to intermediaries," Chadoir adds, "and even to them, it wasn't in black and white."

The last piece of information she heard regarding the recurring visit policy, she notes, was that HCFA was revisiting the requirement, possibly in the wake of a threatened lawsuit by an advocacy group or a beneficiary that considers the repeated questioning an invasion of patients' rights.

Chadoir says she expects an official transmittal from HCFA regarding the MSP requirements by the middle of the year. She speculates the agency may be changing "the whole section of the manual" that deals with the subject.

[Editor's note: Kathy Chadoir may be reached at 7916 W. Mill Road, Milwaukee, WI 53218. Phone: (414) 649-7070.] ■

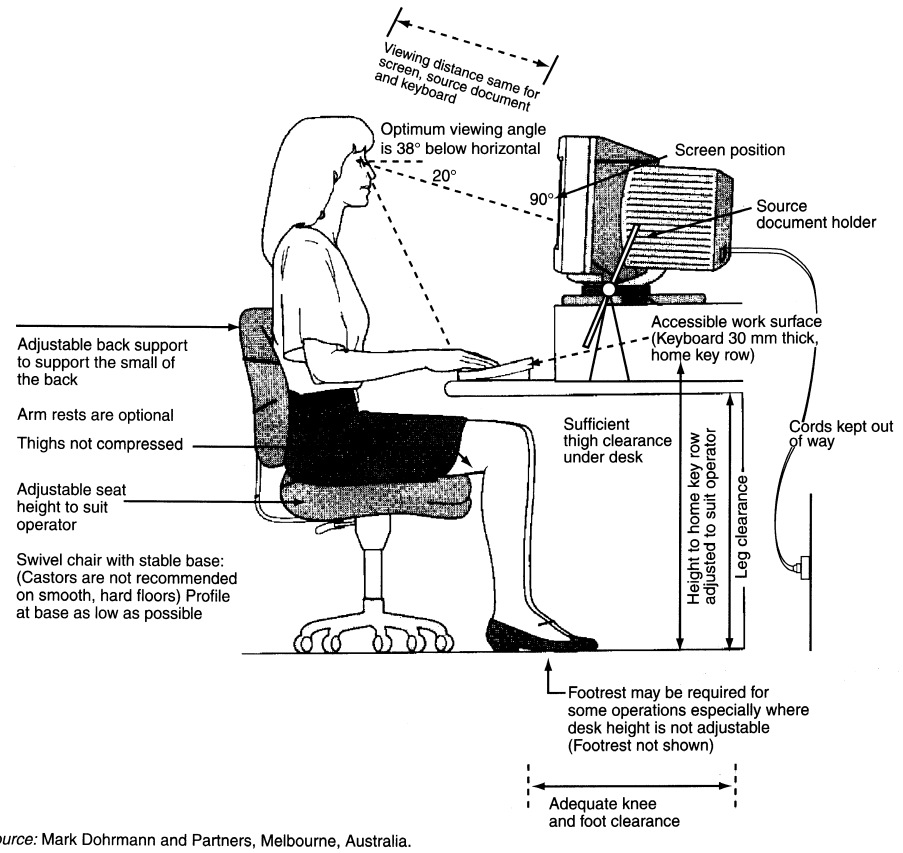
Is your department ergonomically correct?

AM addresses workplace injury

When one of her access services associates filed a worker's compensation claim that was due to carpal tunnel syndrome, **Liz Kehrer,** CHAM, patient access manager at Centegra Health System in McHenry, IL, collaborated with the system's health nurse to make some workplace accommodations for that individual.

Among other things, that associate was given a

Proper Posture: It's the Law



Source: Mark Dohrmann and Partners, Melbourne, Australia.

were satisfactory, those changes included adjustable keyboard trays to accommodate registrars of varying heights and foot rests to take the pressure off the upper leg, she explains. "When [the registrar] is sitting in a chair, the end of the chair tends to cut off the circulation to the back of the thigh." The foot rest elevates the leg, she adds, so that the pressure is relieved.

To make the furniture that is already in place for a new preregistration center more ergonomically correct, Kehrer says she ordered additional equipment, including arm and wrist rests and telephone headsets.

(Editor's note: For more information on the OSHA ergonomics standard, visit the agency's Web site at www.osha.gov.) ■

chair with arm rests, and a cushion for the keyboard tray to help support her wrists, Kehrer says. Discussions with the nurse alerted her to the federal Occupational Health and Safety Administration's (OSHA) ergonomic standard, which became effective in January, she notes.

Rule will be effective October 2001

OSHA is scheduled to begin enforcing the standard, which requires hospitals and health care providers to take specific actions to address job-related musculoskeletal disorders and implement a broad-based ergonomics program, in October 2001.

With that in mind, Kehrer says, she took some additional steps toward making the workplace ergonomically correct for all the access staff. Using a template for the design of a video display terminal station that the nurse provided as a guideline ***(see illustration, above)***, Kehrer made some changes.

In addition to ensuring the proper specifications for chair height and distance from the monitor

Patients' rights part of privacy regs debate

Report highlights uncertainty many feel

Preparing to implement the federal privacy regulation, issued late last year by the Department of Health and Human Services (HHS), is an ongoing concern for access managers and their organizations.

Various affected parties continue to weigh in with their perspectives on the final rule for what was dubbed the "Standards for Privacy of Individually Identifiable Health Information." **(See privacy officer description, pp. 45-46.)**

Taking some of those perspectives into account is a report by the General Accounting Office (GAO), requested by the Senate Health, Education, Labor, and Pensions (HELP) Committee. It

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Sample Position Description: Privacy Officer

Hospitals and health care systems across the country are scrambling to put into effect the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, including one that directs them to designate an official to establish and monitor privacy practices and training.

Access managers and directors and their departments — as the first point of contact with patients and the caretakers of their health information — will work closely with this individual. Regional access directors are likely to participate in his or her hiring.

Here's a sample description for that position offered by the Chicago-based American Health Information Management Association:

Position Title: (Chief) Privacy Officer

Immediate Supervisor: Chief executive officer, senior executive, or health information management (HIM) department head.

General Purpose: The privacy officer oversees all ongoing activities related to the development, implementation, maintenance of, and adherence to the organization's policies and procedures covering the privacy of, and access to, patient health information in compliance with federal and state laws and the health care organization's information privacy practices.

Responsibilities

• Provides development guidance and assists in the identification, implementation, and maintenance of organization information privacy policies and procedures in coordination with organization management and administration, the privacy oversight committee, and legal counsel.

• Works with organization senior management and corporate compliance officer to establish an organizationwide privacy oversight committee.

• Serves in a leadership role for the privacy oversight committee's activities.

• Performs initial and periodic information privacy risk assessments and conducts related ongoing compliance monitoring activities in coordination with the entity's other compliance and operational assessment functions.

• Works with legal counsel and management, key departments, and committees to ensure the organization has and maintains appropriate privacy and confidentiality consent, authorization forms, and information notices and materials reflecting current organization and legal practices and requirements.

• Oversees, directs, delivers, or ensures delivery of initial and privacy training and orientation to all employees, volunteers, medical and professional staff, contractors, alliances, business associates, and other appropriate third parties.

• Participates in the development, implementation, and ongoing compliance monitoring of all trading partner and business associate agreements, to ensure all privacy concerns, requirements, and responsibilities are addressed.

• Establishes with management and operations a mechanism to track access to protected health information, within the purview of the organization and as required by law and to allow qualified individuals to review or receive a report on such activity.

• Works cooperatively with the HIM director and other applicable organization units in overseeing patient rights to inspect, amend, and restrict access to protected health information when appropriate.

• Establishes and administers a process for receiving, documenting, tracking, investigating, and taking action on all complaints concerning the organization's privacy policies and procedures in coordination and collaboration with other similar functions and, when necessary, legal counsel.

• Ensures compliance with privacy practices and consistent application of sanctions for failure to comply with privacy policies for all individuals in the organization's work force, extended work force, and for all business associates, in cooperation with human resources, the information security officer, administration, and legal counsel as applicable.

• Initiates, facilitates, and promotes activities to foster information privacy awareness within the organization and related entities.

• Serves as a member of, or liaison to, the organization's institutional review board or privacy committee, should one exist. Also serves as the information privacy liaison for users of clinical and administrative systems.

• Reviews all system-related information security plans throughout the organization's network to ensure alignment between security and privacy practices, and acts as a liaison to the information systems department.

• Works with all organization personnel involved

(Continued)

with any aspect of release of protected health information, to ensure full coordination and cooperation under the organization's policies and procedures and legal requirements.

• Maintains current knowledge of applicable federal and state privacy laws and accreditation standards, and monitors advancements in information privacy technologies to ensure organizational adaptation and compliance.

• Serves as information privacy consultant to the organization for all departments and appropriate entities.

• Cooperates with the Department of Health and Human Services' Office of Civil Rights, other legal entities, and organization officers in any compliance reviews or investigations.

• Works with organization administration, legal counsel, and other related parties to represent the organization's information privacy interests with external parties (state or local government bodies) who undertake to adopt or amend privacy legislation, regulation, or standard.

Qualifications

• Certification as an RHIA or RHIT with education and experience relative to the size and scope of the organization.

• Knowledge and experience in information privacy laws, access, release of information, and release control technologies.

• Knowledge in and the ability to apply the principles of HIM, project management, and change management.

• Demonstrates organization, facilitation, communication, and presentation skills. ■

focused on these two issues:

• **The rights of patients and the responsibilities of the entities that use personal health information, as set forth in the federal privacy regulation.**

• **The concerns of key stakeholders regarding the regulation's major provisions.**

According to the report, there is a great deal of concern with the breadth and complexity of the regulation coupled with uncertainty about how organizations must comply. For example, HHS noted "the regulation establishes the privacy safeguard standards that covered entities must meet, but it leaves detailed policies and procedures for meeting these standards to the discretion of each covered entity."

Following are highlights of some key areas of concern identified in the GAO report, *Making Patient Privacy a Reality: Does the Final HHS Regulation Get the Job Done?* as summarized on the Web site of the National Association of Healthcare Access Management.

Several patient advocacy groups are concerned that the regulation permits physicians, hospitals, and other covered entities to market commercial products and services to patients without their authorization. While patients have the right to request restrictions on certain disclosures, providers are not required to accept such requests.

The American Medical Association (AMA) questioned why providers are required to obtain patient consent to disclose personal health information for all routine uses, but this standard is not applied to health plans. While the AMA supports this requirement on providers, it believes it should be extended to health plans, who often use identifiable information for quality assurances, quality improvement projects, and utilization management, to name a few.

Several groups raised questions about the implementation of the consent requirement. For example, pharmacists are worried about the difficulties in obtaining written consent prior to treatment (filling a prescription for the first time), if it is called in by a physician and picked up by a family member or friend.

Research organizations have concerns with several privacy-specific criteria added by the regulation, which they believe are too subjective. For example, an institutional review board must determine whether the privacy risks to individuals whose protected health information is to be used or disclosed are reasonable in relation to the value of the research involved.

The regulation acts as a federal floor, which is superceded by state laws that are more stringent. Therefore, the regulation may pre-empt some, but not all, state laws. This could prove cumbersome for covered entities, particularly those that operate in more than one state. While patient groups are pleased that states have the option to enact stronger privacy laws — and many feel states will begin to take such action — provider organizations would prefer uniform standards that eliminate the state-by-state variations,

according to the GAO report.

Complicating the issue further, HHS does not intend to provide technical assistance regarding state pre-emption issues, thus requiring covered entities to perform their own analysis.

Many of the groups interviewed for the report questioned whether the HHS Office of Civil Rights is equipped to assist entities in implementing the regulation. The office is currently understaffed for the task at hand and has yet to release its strategic plan for moving forward. Further, the majority of covered entities, with the exception of small health plans, are required to be compliant with the regulation by Feb. 26, 2003. *(Editor's note: Due to a bureaucratic foul-up, officials apparently failed to transmit the final regulation to Capitol Hill in late December, which has necessitated extending that deadline to April 14, 2003.)* Many feel this is an unrealistic time frame that may need to be extended.

In general, members of the Senate HELP Committee agreed this is a critically important issue that must be addressed. Republicans questioned the cost and complexity of the regulations and whether two years is adequate for covered entities to put the necessary systems in place to be compliant. Democrats, on the other hand, felt the regulation was a good first step, but that more must be done to provide patients with additional protections. This issue will likely remain on the Congressional radar screen over the next several months as more information becomes available on implementation from HHS and more organizations have time to digest the more than 1,500 pages in the regulation.

The American Hospital Association (AHA), meanwhile, has issued model consent and notice forms to help hospitals comply with the privacy regulations mandated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The forms were attached to a regulatory advisory on HIPAA-mandated privacy practices by the AHA, which has requested a delay in implementation of the regulation.

The AHA's model notice requires eight pages to inform hospital patients of their privacy rights. To see the advisory and model forms, go to www.aha.org. ■

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Editorial Questions

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

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NEWS BRIEFS

Upper-level hiring looks strong

People looking for executive and professional positions in the health care field should have little trouble finding a job, according to a recent hiring survey conducted by search and recruitment firm Management Recruiters International Inc. of Cleveland.

The survey reported that 54.3% of the health care executives with responsibility for hiring said

they plan to increase their staffs in the first half of this year, up 8.5 percentage points from the 45.8% level of the second half of 2000.

Another 42.5% of those surveyed said they plan to maintain current staff size, up 10.3 points from second-half 2000, while only 3.2% plan staff decreases, a decline of 18.8 points from last year's second half. Across all industries, 58.8% of hiring executives projected new hires during the current half, 35.2% plan to maintain current levels and 5.9% plan decreases.

For more information, see MRI's Web site at www.BrilliantPeople.com. ▼

Blues report results of anti-fraud effort

Based on 1999 and preliminary data from 2000, the Blue Cross Blue Shield Association (BCBSA) has reported aggregate recoveries and savings of more than $133 million.

BCBSA CEO **Scott Serota** says the collective Blue plans nationally opened 12,000 fraud cases, 544 of which resulted in referrals to law enforcement agencies. The result was 183 criminal convictions. The vast majority of the cases came through calls made to hotlines, internal tips or claims examiners, he says.

Last May, BCBSA established a special unit to coordinate anti-fraud efforts throughout Blue Cross Blue Shield investigative and auditing departments. While the unit has been working with the FBI in combating fraud, a BCBSA spokesperson stated that it doesn't pursue a case as fraud if it's obvious that a provider made an honest mistake, for example, in attempting to comply with burdensome Health Insurance Portability and Accountability Act of 1996 regulations. ▼

AHIMA plans October meeting

The Chicago-based American Health Information Management Association (AHIMA) will hold its 2001 National Convention and Exhibit Oct. 13-18 at the Miami Beach Convention Center.

The convention's theme is "Return on Information." For more information, contact AHIMA at (312) 233-1100 or visit its Web site at www.ahima.org.

The 2000 AHIMA conference was held jointly with the National Association of Healthcare Access Management (NAHAM) in Washington, DC.

NAHAM's 2001 conference and exposition, "Strategies for Service Excellence," will be June 7-9 at the Hilton Resort Walt Disney World in Orlando.

The conference will focus on strategies for being on the cutting-edge of service delivery. Speakers will include Michael T. Myers of Pricewaterhouse-Coopers, whose subject will be service delivery within the health care continuum, Jeanne Scott, director of government relations at National Data Corp., who will speak on the politics of health care, and Robert P. Murphy, vice president of operations at Pensacola, FL-Baptist Hospital Inc., will talk about operational excellence.

Workshops by NAHAM members will cover such topics as "First Impressions" and "Zero Defects Tolerance." Also scheduled are the popular University Hospital session, roundtable discussions, and storyboard presentations.

For more information, call the NAHAM office at (202) 367-1125 or visit its Web site at www.naham.org. ■