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IN THIS ISSUE

(Continued on next page)

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To query, or not to query? Each side has its view of the form

Should forms be considered medical record documentation?

In an ideal world, physicians would document their care correctly and completely in the medical record, giving coders all the tools to do their jobs.

But the ideal is seldom real life. In the real world, coders often have questions that must be answered before they can code appropriately. Sometimes they use a query form to ask physicians about incomplete documentation. Physicians can respond by adding documentation to other parts of the medical record or responding on the query form itself, rendering it part of the record.

Now the Health Care Financing Administration (HCFA) says query forms cannot be considered valid documentation in the medical record. This policy has sparked debate on health information management (HIM) listservs and has frustrated the American Health Information Management Association (AHIMA) in Chicago. AHIMA raised this issue with HCFA in a November letter and suggested that it work with HCFA to develop a query process that would comply with Medicare regulations.

HCFA's response — and new policy — was outlined in a Jan. 22 memorandum to its peer review organizations (PROs): "Effective immediately, PROs are not to accept coding summary forms [e.g., Physician Query Forms] as documentation in the medical record when following DRG [diagnosis-related group] validation procedures within their jurisdiction, as necessary to ensure proper documentation within the medical record."

HCFA is concerned that some query forms may lead the physician to make a decision or to write a description that would support the inappropriate upcoding of a DRG, explains **Dan Rode**, MBA, FHFMA, AHIMA's vice

(Continued from cover)

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- Home health wireless solutions
- Is a better patient bill on the way?
- The use of Palm technology in real settings
- More HIPAA standards are released
- The battle over the privacy regulations continues

president of policy and government relations, who says HCFA believes that all query forms are suspect and therefore wanted to eliminate them.

Unfortunately, HCFA used quotes from a book written by an AHIMA staff member to support its argument. The quotes suggest that a complete medical record is ideal, one that has all of the information necessary and is only handled by the physician — without the use of query forms.

"That is certainly what we strive for in our best practices and in the other things that we do with our members, but we have situations that are not the ideal. The query form then becomes necessary," Rode says.

AHIMA addressed the query form issue in a Feb. 12 letter to HCFA. "We are trying to do as much as we can to work with [HCFA] so it understands the issue and comes up with a result that our members, their facilities, and their physicians can work with," Rode says.

Members of AHIMA's Coding Policy and Advocacy and Policy Committees looked over the memo to the PROs and then created a list of their questions and concerns. The list is included in the February letter.

"We have now gone back and raised a number of questions about that memorandum and at the same time have extended a hand to [HCFA] to say, 'You just don't turn this ship around on a dime. It's going to take a little while. What can we do to ensure that our members [comply] with the rules that you are now attempting to establish?'" Rode says. "We recognize that right now, the rules tend to come down on the facility and the coder, and yet the physician is another large element involved."

AHIMA also noted in the letter that members are concerned that PROs do not tend to work alike. "We are concerned about this memorandum being implemented in different ways at different times with different impacts across the country," he says.

Encouraging incomplete documentation?

But do query letters discourage physicians from completing their documentation the first time?

"It's a two-edged sword," Rode says. "We are not in favor of query letters, per se. We would like to see documentation done correctly the first time."

Physicians/coders: Commence talking

Small steps now can reap big dividends later

Central to the query form debate is how coders can ask physicians about incomplete documentation. With recent reimbursement and regulatory changes, however, coders may be surprised to find more physicians asking questions of them, says **LaVonne Wieland**, RHIT, consultant, enVision Group, Naples, FL. **(For more information about the debate over query forms, see p. 49.)**

"It's not just the coders initiating the communication," she says.

Overall communication between physicians and coders has improved over the years, but many coders are so intimidated by physicians that they don't want to talk with them, she says.

Wieland recommends providers take steps to promote communication. "Sometimes it starts by just using a query form," she says. The form tells the physician what is missing and asks him or her to add the information to the documentation. "Once you start building from that type of relationship, the physicians start coming back and communicating to you."

Wieland had that experience when she worked as an inpatient coder in the 1980s. "It got to the point where a couple of the surgeons — if they had a case that was a little bit different from something they have done before — would sit down by my desk and say, 'This is what I did. What order should I dictate it in? What do you need to know to code it appropriately?'

"They were seeking me rather than the other way around," she continues. "They were tired of getting little notes asking them questions. To be proactive, they just started coming to me."

To facilitate communication, Wieland recommends scheduling meetings, monthly or quarterly, between the coders and physicians. The meetings do not always have to have the same format. For example, physicians can attend coding staff meetings to explain a new procedure. Or physicians can speak to coders about what they do in an area in which the coders are having difficulty. "I call it a disease process education seminar," she says.

"The goal is to start communicating with the physicians," she adds. "Coders shouldn't feel that they couldn't ask physicians a question."

The discussion may yield more long-term results than immediate ones, Wieland says. "When you look back, you will realize how much easier it is to communicate with the physicians or that you are now getting the information because you have told physicians what you need to know." ■

Because many organizations have not been able to achieve that ideal as frequently as they would prefer, they must query the physician before they can be paid and comply with the Medicare rules. AHIMA doesn't condone any "leading language" on the forms, Rode says. "On the other hand, there are other ways to write a query in such a way that you are not leading a physician and that you do get that response," he notes. AHIMA, however, will continue the effort to help members get complete records and cut down on the number of query forms, if not eliminate them, Rode adds.

AHIMA is also trying to ensure that HCFA is not asking coders to make decisions they are not qualified to make. "We don't want coders coding with less than full information," he says. "Coders should be coding information in the chart. If the information is not in the chart, we need to get it there." ■

Privacy officers: Are they needed?

HIM professionals might take on these duties

Hospitals have to designate a privacy officer as mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. But hospitals are wondering: With so many privacy functions already falling under the health information realm, do they really need a separate position?

The American Health Information Management Association (AHIMA) in Chicago recently offered its thoughts on the subject by releasing a sample privacy officer job description. AHIMA supports the idea of HIM professionals being used in that capacity. "The privacy function is not

new and has been conscientiously embraced by health information management (HIM) professionals for decades," the association says.

"Credentialed HIM professionals are uniquely qualified to be the designated privacy official as required by HIPAA through their academic preparation, work experiences, commitment to patient advocacy, and professional code of ethics," says AHIMA's president, **Linda L. Kloss**, MA, RHIA.

A person approaching the privacy officer position from ground zero would have to make sure policies are consistent throughout each of the organization's entities, standardize the policies, and promote privacy throughout the institutions and the entities as well as to the consumers, says **Ray Pinder**, MS, RHIA, director of Medical Record Services, Holy Redeemer Health System, Meadowbrook, PA.

"If some organizations are going to recruit [a privacy officer], I think there's going to be quite a bit of overlapping of that person's domain vs. the HIM director's domain." he says. "Medical records and health information management folks have been dealing with information on privacy and confidentiality during their entire careers."

One industry analyst says she is not sure if many hospitals will actually build a privacy officer position. "I think most will either roll it right into the HIM Director's normal responsibility or split the functions somewhere between the HIM director, compliance officer, IT director, and risk manager," says **Darice Grzybowski**, RHIA, manager, HIM Industry Relations with 3M Corporation -Health Information Systems, LaGrange Park, IL.

Issues such as the position of privacy officer are hot topics for Holy Redeemer's HIPAA steering committee. The committee is made up of 24 members from the different entities in the health system, including long-term care facilities, visiting nursing associations, home care, a hospital, and an assisted living entity.

The committee is broken down into five subcommittees to handle the "five key areas of HIPAA": 1) electronic transactions/code sets and electronic signature; 2) assessments and contracts; 3) education; 4) security; and 5) privacy. Pinder is co-chair of the privacy subcommittee. The health system's corporate compliance officer is the other co-chair.

The steering committee has actively discussed the AHIMA job description for privacy officer, Pinder says, and the need for the health system to have a privacy officer and a security officer. But the decision about how to fill those positions has been put on hold. "Because the security aspects of HIPAA have not been finalized yet through Congress, and because there is still a lot of debate about the privacy regulations, the organization doesn't want to name or hire individuals to fill those capacities at this time."

The overlap of duties also gives the health system time to consider its choices. "Some of those duties mentioned in the AHIMA job description, such as the as policies and procedures on confidentiality and privacy, and patient access to information, are already overseen by the HIM director," Pinder says. "That's why we are taking the stand right now that we don't believe it's the right time to hire the individuals until we really know the definite, final regulations on those two hot areas."

From its evaluation of the job description, the committee also knows that the duties of the subcommittees will be interrelated, such as the task of educating the employee population as well as the consumer population on privacy. "[The privacy subcommittee] will hook up with the subcommittee on education, help it to design the programs, and even be part of the programs when we roll them out."

In its job description, AHIMA assumed the privacy officer would report to the chief executive officer or maybe to the chief information officer. Pinder reports to the chief information officer.

"Several members of senior management sit on the steering committees. Therefore, senior-level support is not in question," says Pinder. ■

Here is a sample privacy officer job description

This sample privacy officer job description is offered by the American Health Information Management Association (AHIMA) in Chicago. (The position of privacy officer is mandated by the Health Insurance Portability and Accountability Act [HIPAA] of 1996.) The position description, unveiled at the 2001 Healthcare Information Management Systems Society Conference and Exhibition in New Orleans, is intended to serve as a template for organizations in development of a privacy officer position.

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 organization-wide 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 workforce, extended workforce 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 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 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)

Groups spar over privacy regulations

Glitch may delay effective date until this month

The sparring over the privacy regulations has begun. Many health industry groups are lobbying Congress and the Bush administration to delay their implementation, but they are meeting strong opposition from privacy advocates who wanted the regulations to become policy as scheduled on Feb. 26. The new regulations, which are mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, take effect two years afterward.

According to the American Hospital Association (AHA) in Chicago, the medical groups have won part of the battle by default. The AHA is reporting that a paperwork lapse at the end of the Clinton administration has delayed the privacy regulations' effective date until mid-April. Officials apparently failed to transmit the final regulation to Capitol Hill when it was issued late in December, the AHA says.

This delay gives the medical groups more time to make their case. On Feb. 5, a group of more than 30 health industry organizations signed a letter to Health and Human Services (HHS) Secretary Tommy Thompson asking him to delay implementation of the privacy regulations. The letter lists seven areas of concern that the organizations claim could cause serious disruption of patient care. Thompson has reopened HIPAA privacy regs for a new 30-day comment period.

The AHA and other medical groups also sent representatives to testify before Congress about the privacy regulations. "We believe Congress should closely examine the high costs associated with implementing the privacy regulation and take the necessary steps to ensure that implementation does not put hospitals in financial jeopardy by supplying the necessary funds. While the AHA strongly supports workable federal medical privacy laws, we cannot support yet another unfunded mandate," said **John Houston**, information services director, data security office and assistant counsel for the UPMC Health System in Pittsburgh. Houston testified Feb. 8 before the Senate Health, Education, Labor and Pensions Committee.

Privacy groups, though, have encouraged HHS not to delay the privacy regulations' implementation date. These groups charge that the positions of the medical industry groups are not supported by the text of the regulation. A delay based on these positions, therefore, is "unjustified and unacceptable," says a letter to Thompson from the Institute for Health Care Research and Policy in Washington, DC.

"[HIPAA] clearly anticipates that there might be some difficulties in implementing the administrative simplification provisions [including the privacy regulation] and provides a method for resolving the problems. Delaying the effect date of the entire regulation is not the mechanism provided in HIPAA," the letter states.

Senators seem split over the need for the delay. The AHA has reported, though, that HHS has said it might consider adopting a modification to the final HIPAA Electronic Transactions rule at the urging of the National Committee on Vital and Health Statistics and the Insurance Subcommittee of Accredited Standards Committee X12. Therefore, the AHA remains hopeful that the privacy rule could be revisited. ■

who undertake to adopt or amend privacy legislation, regulations, or standards.

Qualifications:

• Certification as a registered health information administrator (RHIA) or registered health information technician (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.

• Demonstrated organization, facilitation, communication, and presentation skills.

This description is intended to serve as a scalable framework for organizations in development of a position description for the privacy officer. AHIMA advocates the rapid appointment of the privacy officer, to allow early privacy risk assessment, effective planning, and policy development. ■

Here's some help with LMRPs, ABNs

Educate all players, consultant says

Local medical review policies (LMRPs) are among the more challenging aspects of complying with Medicare medical-necessity criteria. They're also another potential reimbursement headache, points out **Jim Smith**, senior health care consultant for Accelerated Receivables Management Ltd. in Park Ridge, IL.

LMRPs, developed by local fiscal intermediaries and carriers under the direction of the Health Care Financing Administration, address tests and procedures that have a higher likelihood — based on claims histories — of not meeting the Medicare criteria for being medically necessary and reasonable, Smith says.

Certain medical indicators, in the form of appropriate diagnosis codes, must be documented and accompany the physician's order for the tests and procedures affected by LMRPs, he notes. "Should the diagnosis code not support the LMRP medical indications for the test or procedure, local fiscal intermediaries and carriers have edits built into their claim systems, which render the claim denied for payment."

38 LMRPs and counting

In Illinois, for example, there are 38 LMRPs in existence and nine more in development, Smith adds. "One of the LMRPs is for an electrocardiogram. Should the patient be sent to a hospital for an EKG with the diagnosis of 'chest pain NEC [not elsewhere classifiable],' the test would be covered according to the existing Illinois LMRP for electrocardiogram."

However, he explains, if the physician also orders lab tests — a complete blood count, electrolytes, and blood glucose, for example — the diagnosis does not justify those tests according to the LMRP and the charges would be denied. Additional signs or symptoms, such as "fatigue and malaise," would be required to justify medical necessity, Smith adds.

Uncovered services

Medicare guidelines will not allow providers to bill patients for uncovered services based on LMRPs unless an advance beneficiary notice (ABN) is signed by the patient before the service is performed, says Smith. He emphasizes that providers may not obtain ABNs on all Medicare patients for all tests ordered to prevent themselves from lost revenue. "ABNs are to be obtained only when the test or procedure ordered is impacted by an LMRP."

Providers must keep proof of signed ABNs on file — hard copy or on-line — to satisfy Medicare auditors, he adds. If the provider bills patients for noncovered services and is not able to demonstrate that an ABN was secured before the service, Medicare can hold the facility liable for violating its contractual agreement and may impose significant financial penalties, Smith cautions. "Dollars associated with tests and procedures provided that do not meet LMRP medical-necessity criteria are lost unless an ABN is signed in advance. The dollars cannot be written off to bad debt or charity."

Failure to manage LMRPs and obtain ABNs appropriately, he points out, can result not only in lost reimbursement, but in charges of fraud being brought against the provider. ■

Make your claim denials work to your advantage

Tracking remittance notices spotlights problems

Since commercial and Medicare payers keep detailed profiles of questionable claims submitted by each provider it deals with, a physician practice can use this information to spot patterns and weaknesses in its own coding and billing operations.

One of the easiest and best ways to start accumulating this information is by tracking the reasons for denial cited on the Remittance Advice Notice received from your Medicare contractor.

Based on data from the Health Care Financing Administration, some of the leading reasons for denying claims are:

• **Poorly documented or outdated diagnostic codes.** To avoid mistakes, make sure your diagnosis codes have been both updated, for physicians and in your computer systems. Stress that they need to be as complete and specific as possible.

The more detail and documentation you have to backup your coding choices, the less likely your claims will be denied.

If you have had problems with frequent denials based on questions of medical necessity, for instance, you may want to check with the carrier and get its latest policies regarding coding for those particular conditions or services. Also get a list of the medical protocols it considers appropriate for how these services should be performed or what it feels are legitimate alternative treatments for these conditions.

• **Medicare is this beneficiary's secondary payer.** One of Medicare's new policing priorities when it comes to processing claims is to ensure it does not get struck paying the bill for patients who should have been covered by private insurance. This makes it important that you have patients update their information, including their most recent employment or retirement status and any alternative coverage each time they come in for a visit.

Tip: To avoid possible denials, consider asking patients to call Medicare and update their files themselves.

• **Duplicative claims.** If you are have a significant number of claims returned because they were duplicates of bills already submitted or currently being processed, check your computer software and billing system for possible bugs. If no problems are found there, you may have simply resubmitted too quickly a bill that needed additional information.

• **Incomplete or inaccurate physician ID and referral numbers.** A simple cross-check of your claims processing software will validate whether the various physician identification and referral numbers required by Medicare have been correctly entered for each physician in your practice.

• **Referrals.** Well-designed forms and office procedures will help eliminate any referral-related payment problems.

Tip: Patient registration forms should have a space to list the physician who referred them to the practice. The same is true for charge slips so the treating physician has enough room to clearly write to whom they referred a patient. This information should be automatically logged into the patient's computer file, with a cross-check to ensure the data are complete and included on the claim. ■

Accurate coding: It's all in the details

Length of wound repair, path report are key

You think you've done everything you can to improve billing and claims filing processes: computerized systems, electronic filing, and even tickler files that tell you when to follow-up with managed care companies regarding payment. The one area that is often overlooked is the documentation needed by the coder to accurately code the claim, say experts interviewed by *Hospital Payment & Information Management.*

If the claim isn't coded correctly, the claim is denied or paid at a lower rate than you might be due, says **Cheryl D'Amato**, RHIT, CCS, director of health information management for HSS, a Hamden, CT-based company that specializes in coding and payment for health care facilities.

Accurate coding depends on documentation from the surgeon, and there are many same-day surgery procedures that often are not fully documented, says D'Amato. "Wound repair, arthroscopy, biopsy, and debridement are commonly the most difficult to code because the documentation is incomplete," she says.

Although physicians capture enough detail for their own billing, operative reports are generally not as specific, says **Rita A. Scichilone**, MHSA, RHIA, CCS, CSCP, CHC, director of the coding program for the American Health Information Management Association in Chicago. This is why it is good to have a strong working relationship with the physician's office staff, she suggests.

"Whenever possible, compare the reimbursement or claim filed for professional fees with the claim filed for facility fees," she recommends. "This will enable the coder to identify details of the procedure not included in the operative report."

Arthroscopy is a good example of a procedure in which documentation for coders is often scant, says Scichilone. "The surgeon will write that he or she 'did a scope' but doesn't define whether it was diagnostic only or if a procedure followed the approach." If there is another procedure such as a meniscectomy, the use of the scope to approach the area is not reimbursed, but the following procedure is, she adds.

Debridement is another area that requires detailed documentation, says D'Amato. "There are different codes for different levels of debridement. Skin and subcutaneous level is coded differently than debridement that involves bone and muscle."

Surgeons also need to document the use of additional techniques to enable the coder to include them on the claim, points out Scichilone. "If a wire locator is used or if a CT or fluoroscope is used for guidance, the surgeon must write those specific techniques in the operative report," she says. "Otherwise, the coder does not even know about them and can't include them in a claim without documentation."

There are several ways a same-day surgery manager can improve documentation that will help coders. "Teach your nurses and physicians about coding," says Scichilone. Show examples of claims that are coded with general, nonspecific documentation compared with claims that are coded with detailed documentation, she suggests. The difference in reimbursement will point out the importance of detailed coding.

Educate your coders as well, adds Scichilone. "Sometimes an incorrect pain management code is simply the coder not understanding epidurals or different types of joint injections," she says.

Recognize that your coders need as much detailed information as possible, says D'Amato. "Some facilities also insist that coding will not occur until the full operative report and the pathology report is in the record," suggests D'Amato. The pathology report is especially helpful when the procedure was for biopsy, she explains.

Make sure you have a process set up for coders to send the records back to the physician for more information, says D'Amato. This will enable them to code the claim correctly, she adds.

This process can involve a designated contact person in the physician's office or simply e-mails to the physician's own address, says Scichilone.

Templates also can be set up for operative reports, says D'Amato. "These forms can remind the surgeon to document the patient's comorbidities such as diabetes or hypertension. Forms also can prompt documentation of details such as length of wound repaired or depth of debridement."

Be careful with forms you use. "Boilerplate" reports may overlook some changes made during a case or not report some of the details, same-day surgery administrators point out.

"Stay away from canned reports that don't vary from procedure to procedure," Scichilone warns. "If all of your operative reports look exactly the same, managed care companies might suspect falsification." ■

AHIMA develops Internet guidelines

The American Health Information Management Association (AHIMA) has developed a set of fundamental principles and list of operational tenets it recommends as a blueprint for protecting the security of patients' health records and ensuring the quality of that information on the Web.

The three fundamental principals are: E-health organizations should provide an easily understandable notice of their health information practices that informs consumers what personal health information is being collected, who is collecting it and how it is being used; these organizations should make it easy to collect authentic, accurate, timely and complete individually identifiable personal health data; and they should maintain individually identifiable personal health information in such a way that ensures it is private, secure, and retained or destroyed only in accordance with the consumer's authorization or applicable law.

AHIMA's list of 39 tenets and how they apply to providers, consumers, and third parties is available in the November / December issue of the *Journal of the AHIMA*, and on-line at www.ahima.org / infocenter / guidelines / tenets.html. ■

Medicare has toll-free lines for billing and claims

The Health Care Financing Administration announced in December that toll-free telephone service is available to physicians, hospitals, and other 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. ■

New claims clearinghouse may begin this summer

But will it really speed payments?

With a lot of hoopla last year, seven large insurers announced they were collaborating to form a new Internet-based electronic claims clearing house to process health care bills.

The San Diego-based MedUnite says its system will permit practices to securely submit about half a dozen health care administrative transactions and receive responses in real time over the Internet. The start-up is funded by Aetna U.S. Healthcare, Anthem Inc., CIGNA HealthCare, Health Net Inc., Oxford Health Plans, PacifiCare Health Systems, and WellPoint Health Networks.

Once the pilot phase is over, MedUnite hopes for a nationwide rollout this summer.

When fully operational, practices will be able to submit paperwork for claims, claim status, eligibility verification, benefits determination, patient referrals, and treatment authorization for a flat monthly fee.

MedUnite's CEO, **David Cox**, says one advantage of the system is that it will be able to immediately tell doctors whether a claim they have submitted is "clean" — contains no errors — rather than have to wait for the traditional review process, which is typically 14 days, before learning if there are any problems with a claim.

However, since MedUnite clients will not be paid electronically, at least at first, they must still wait for snail mail to bring their money.

If you are filing claims electronically, you probably use a so-called claims clearinghouse to process your submission. These clearinghouses "edit" and format the claims according to individual insurers' standards. If a claim contains "technical errors" —- i.e., it can't be read by insurers' information systems or data elements are missing — the claim is rejected and must be resubmitted.

Claims that are clean are forwarded to the insurer in question where they are edited or reviewed for patient-specific criteria, including patient eligibility. If the insurer has a question, or feels the claim has not been properly formatted or documented, it gets kicked back for correction. As a result, it is often several weeks after submission before a practice learns a claim is not going to be paid.

According to MedUnite, only about half of all claims submitted to insurers are considered clean.

Many experts says the real advantage of being able to file claims electronically will come when physicians are able adjudicate claims online in real time with insurers — then be paid electronically. Such a system would mean practices could depend on receiving their money within a few days after a claim is submitted, instead of the average 45 days —or more — it takes now.

Indeed, Empire Blue Cross Blue Shield of New York says it will soon test a program in which it will pay claims electronically within 48 hours. Other insurers are considering using the e-mail systems to handle reimbursement. ■

Seniors' Internet use is productive, growing

Fewer hospitalizations, increased cost savings

One company wondered how chronically ill patients could use the computer to access its Web-enabled disease management programs. It conducted a year-long study on three groups of patients with congestive heart failure (CHF), and demonstrated reduced hospitalizations and shorter hospital stays. Additional findings demonstrated improved compliance, beneficial lifestyle modification, and cost savings.

LifeMasters Supported SelfCare, a provider of interactive health management services in Newport Beach, CA, chose its study population from patients of the Physicians Medical Group in Santa Cruz County, CA. The group of 69 primarily elderly patients with moderate to severe CHF was randomized into two study groups.

The first group, the Web Intervention Group, used a personal computer and the Internet to enter vital signs and symptoms into the LifeMasters database. Web users also had access to disease-specific content, community chat, and e-mail interaction with a LifeMasters nurse.

The second group, the Interactive Voice Response (IVR) Intervention Group, used a touch-tone telephone to enter similar measurements into the same database. IVR users had access to printed disease-specific patient education materials and telephonic interaction with a LifeMasters nurse. A third group, the Non-Intervention Group, did not participate in the intervention but received traditional medical care.

Participation in the study was coordinated by Physicians Medical Group and was funded in part by Intel Corp. of Santa Clara, CA.

The author of the study expected to find some resistance to using the computer from patients of this age — 92% of the participants had not used a computer before. However, she found them surprisingly willing to try it. "We didn't have anyone who said they did not want to use a computer before they tried it. We had two who tried it and said it wasn't something that held their interest," says **Christine Ruggerio**, RN, MSN, manager of Clinical Web Programs for LifeMasters. She presented the results of the study at the 2001 Annual Healthcare Information and Management Systems Society Conference and Exhibition in New Orleans.

The patients adapted to the technology well, she says. "Not only did the technology engage them, but compliance with daily data entry was greater than 80%."

Satisfaction, lower costs

The Web group showed other positive results too. Here are some of the study's findings:

- **Patient satisfaction:** Eighty-three percent of the patients reported high satisfaction with the program, and 73% expressed a belief that the program was making a difference in their care (combined data for Web and IVR groups).
- **Hospitalizations:** The Web group had 20 hospitalizations, while the IVR group had 39 hospitalizations.
- **Length of stay:** The Web group had 149 hospital days; the IVR group had 258 hospital days.
- **Patient compliance:** The Web group had 84% compliance; the IVR group had 76% compliance.
- **Lifestyle change:** Findings indicated positive changes related to diet, exercise, and medication regimens (combined data for Web and IVR groups).

"Overall health care claims costs for the study population remained stable, while overall health care claims costs for the non-enrolled population increased by over $3,600 annually per individual," Ruggerio explains. "This data reflects the impact of a proactive intervention in halting the expected progression of a chronic disease."

In addition, the study population had a decrease in cardiac claims costs of approximately $2,400 annually per individual, while the non-enrolled population had an increase in cardiac claims of greater than $1,200 annually per individual.

The study also found that with training and coaching, patients (average age: 79) were able to use the personal computer and the Internet as a health care tool, as well as to increase socialization. The group eventually used the Internet for other purposes beyond health care, such as e-mailing family and friends, playing games online, researching investments, and exploring other interests.

"This is particularly important for chronically ill patients who are often isolated or homebound," Ruggerio explains. "Resulting depression can often contribute to the progression of their disease. The study showed that the computer can play a contributing role in engaging

patients and actually improving a patient's quality of life."

At the completion of the study in October 2000, 90% of the patients elected to continue using the computer for Web entry of vital signs, health care monitoring, and other Internet uses.

The study challenged two negative beliefs, says **Wells Shoemaker**, MD, medical director for Physicians Medical Group of Santa Cruz, CA: first, bad outcomes are unavoidable for CHF patients; and second, senior citizens cannot master modern electronic communications. "Beyond the reduction in burden of illness and associated financial costs, the project gave participants a new confidence and enthusiasm in their ability to control their own health status."

The results of this study prove that the Internet can be used successfully as a platform for the delivery of quality care, Ruggerio says. "The Web allows us to give our patients more options and the flexibility to tailor programs to meet the varied needs of the individual among large populations."

The next step is to try to find out exactly what these results mean and how they can be generalized, she says. "We haven't completed all of the statistical analysis that we would like on the results," Ruggerio notes. LifeMasters has also provided computers to a group of diabetic patients and is showing good results with them. However, this study was not conducted as a randomized clinical trial.

The researchers also need to look at the number of patients who are getting computers on their own, Ruggerio adds. For example, elderly people constitute one of the fastest-growing populations of computer users. "More patients who have chronic illnesses are going to have access to computers," she says. "We need to find ways to help them." ■

Internet access at no cost to providers

Hospitals also get partial revenue

A hospital in Illinois will soon offer public Internet access without compromising or overloading its telephone lines.

Provena Saint Joseph Medical Center in Joliet is placing two eKiosks, stand-alone Internet workstations, in its main lobby and outpatient admissions area. The eKiosks will feature wireless, high-speed broadband connectivity and will allow users to perform various computer tasks.

"We are excited about what this means to our patients and visitors," says **Lisa Lagger**, Provena spokeswoman. Businesspeople can use the eKiosks to connect to their offices; younger people can use it for research and homework. "It's going to be a terrific asset to our patients and their families and visitors."

Provena signed a three-year agreement with eKiosk of New Lenox, IL, developer of the workstations. Health care is a new arena for eKiosk, which had previously focused on the hospitality and airline industries. "I envision this [venture] to be like the more sophisticated airport lounges that are consumer-focused," Lagger says.

These workstations are the pay phones of the 21st century, says **John Bohrer**, eKiosk's vice president of its health care division. The eKiosks have both phone lines and a variety of ports, such as USB, RJ-11 modem, RJ-45 data, and infrared, which can connect laptops, notebooks, palmtops, and other hand-held devices to the Internet.

The company also recently acquired technology called MyID that provides users with the security of a virtual private network, Bohrer adds. MyID authenticates users through the use of an existing credit card and then allows them to connect to their desktop at a remote location.

First minutes are free

eKiosk users can connect to the Internet for free at Provena for the first 10 minutes. After that, users pay a fee for additional minutes on-line, such as 10 minutes for $2.50. "Users can buy [additional] minutes like a prepaid telephone card," says **Jack Querio**, eKiosk's senior vice president of sales.

The workstations also offer other services for nominal fees. These services include Microsoft Office applications, video e-mail, text e-mail, and text-to-any-fax number. Each unit has an audio headset jack and speaker, a video camera, a microphone, an IBM Microdrive reader, and a floppy disk drive. The workstations also have an attached telephone handset for users to call eKiosk's customer service department at any time.

The workstations, however, do offer free, unlimited access to the information on Provena's Web site. "One of the greatest things from our vantage point is having our own Web site displayed on the

main screen when the eKiosk is not in use. This gives constant, high visibility to the medical center and its Web site," Lagger says.

Hospitals such as Provena determine what information will be available on the workstations, Querio says. Users, for example, can visit the hospital's Web site at any time to find out information about employment and support groups or to receive patient information about topics such as how to care for a new baby, Bohrer says.

Hospitals can also offer "way-finding" software on the workstations, which helps users find their way around health care facilities, Bohrer says. "The hospitals have to provide the software, but the units are set to accommodate it."

eKiosks is talking with health care facilities about placing insurance information on the site, too, Querio says. "Patients could use the site to see if the hospital accepts their insurance and what kind of benefits they have."

It's free for you and generates revenue, too

eKiosks offers the first 10 minutes of Internet use free because it finds various companies that want to advertise to the health care industry, Querio says. Diaper companies Huggies or Pampers, for example, might want to appeal to new parents.

Hospitals can pay for their own advertising on the computer screens, as some airlines have chosen to do on the workstations in their airport lounges, he says. eKiosk, however, provides free advertising for the hospitals on all screens. "Every time a screen pops up [on the unit], it will have information about the hospital," Querio says.

The only cost to hospitals that offer the workstations on-site is that of a telephone line, he adds. "We install and maintain the unit at no cost."

Hospitals receive funds from advertising revenue and usage, too. "We give 15% of whatever revenue is generated from the usage [including ad revenue and actual usage fees] back to the hospital," Querio says. This includes the free 10 minutes, too. "Even the free 10-minute period generates revenue because it is sponsored.

"This is an amenity for the patients themselves who are ambulatory and for their visitors," he says. "It's also a way for the institutions to generate some incremental revenue that they might not generate normally."

Patients and visitors won't be the only users of the eKiosks, Lagger says. "One of the neat things is that they will be available to our employees, as well."

Provena is still awaiting the arrival of its two workstations, Lagger says. The hospital had its choice of different types of eKiosks.

"They can match your furniture," she explains. "Some have chairs hooked to them. Some look like desks. Others have more of a podium style. [The company] offers a lot of options in terms of making them blend with your decor."

eKiosk custom-builds the product, Querio says. "They come in different shapes and sizes, and different finishes."

If the workstations prove to be popular, Provena plans to add more units, Lagger says. Other hospitals in the seven-hospital Provena Health system may follow suit, too. "In our health system, which is the largest Catholic health system in Illinois, we often take successes and try to replicate them at other hospitals. I would imagine that it would not be long before other Provena entities would also be embracing these kinds of units. I would imagine that is a trend that would catch on quickly." ■

New review medical criteria published

19 items can be audited quarterly or annually

Knowing what constitutes medical record completeness this year according to the Joint Commission on the Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, doesn't have to be a guessing game. The organization recently released its "2001 Medical Record Review Summary Sheet," which outlines 19 items that the Joint Commission requires to be included in an ongoing review of medical records. The sheet also includes ways to document any performance improvement initiatives that providers began to address their findings. **(See the "2001 Medical Record Review Summary Sheet" on p. 62.)**

For a provider to be compliant with Joint Commission standards, the medical record review must be ongoing, with audits conducted on a quarterly or annual basis. If conducted on a

(Continued on page 63)

2001 Medical Record Review Summary Sheet

The following items are required (IM.7.10-IM.7.10.1) to be included as part of the organization's ongoing review of medical records. The review must address the **completeness and timeliness of information** of the items listed. While the review is expected to be ongoing in nature, at least quarterly findings for the review process should be available and activities to address improvement evident. The 19 items can be reviewed each quarter or on an annual basis. If they are reviewed each quarter, quarterly findings need to be reported. If the 19 items are reviewed on an annual basis, then the data from the previous two years need to be reported to assure a performance improvement approach to ongoing record review. This form will be used by the surveyors to orient them to the scope of the medical record review activities of your organization for the twelve months prior to survey. The completed form should be attached to the medical record review material supplied for the Document Review Session (the document review session is a survey activity designed to prepare and orient the surveyors for subsequent survey activities). Such material should include reports or minutes for the twelve months prior to survey of the group responsible for the review of medical records.

Were the following items included in the review of medical records during the twelve months prior to survey?	**Findings (Numerator/Denominator)**				**Performance improvement initiative to address findings if appropriate.**
	Q 1/D1	Q 2/D2	Q 3/D3	Q 4/D4	
Identification data					
Medical history, including - chief complaint - details of present illness - relevant past, social & family histories - inventory by body system					
Summary of the patient's psychosocial needs as appropriate to the patients age					
Report of relevant physical examinations					
Were the following items included in the review of medical records during the twelve months prior to survey?	**Findings (Numerator/Denominator)**				**Performance improvement initiative to address findings if appropriate.**
	Q 1/D1	Q 2/D2	Q 3/D3	Q 4/D4	
Statement on the conclusions or impressions drawn from the admission history and physical examination					
Statement on the course of action planned for this episode of care and its periodic review, as appropriate					
Diagnostic and therapeutic orders					
Evidence of appropriate informed consent					
Clinical observations, including the results of therapy					
Progress notes made by the medical staff and other authorized staff					
Were the following items included in the review of medical records during the twelve months prior to survey	**Findings (Numerator/Denominator)**				**Performance improvement initiative to address findings if appropriate.**
	Q 1/D1	Q 2/D2	Q 3/D3	Q 4/D4	
Consultation reports if applicable					
Reports of operative and other invasive procedures, tests, and their results if appropriate					

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

quarterly basis, the quarterly results should be available to the Joint Commission and activities to address improvement should be evident. If the audits were conducted annually, the providers would need to report data from the previous two years to demonstrate process improvement.

Joint Commission surveyors will use the form to orient them to the scope of the medical record review activities of the provider for the 12 months prior to the survey. "We are using [the sheet] as a tool to help us evaluate the organization's activities and compliance with Joint Commission standards," says **Janet McIntyre**, spokeswoman for the Joint Commission. The form also lets providers know what the review process is going to be, she adds.

The completed form should be attached to the medical record review material supplied for the Document Review Session, which is a survey activity designed to prepare and orient the surveyors for subsequent survey activities. The medical record review material should include reports or minutes for the 12 months prior to the survey of the group responsible for the review of medical records. ■

AHIMA offers scholarships

The American Health Information Management Association (AHIMA) in Chicago is offering scholarships and loans to students in the health information management field as part of an ongoing mission to support professional education through its Foundation of Research and Education (FORE). Scholarship awards range from $1,000 to $5,000 and are available to full-time students and part-time students taking at least two courses per quarter or per semester in pursuit of a health information administration (HIA) or health information technology (HIT) undergraduate degree, or a related graduate degree.

This year a new FORE scholarship has been established in memory of AHIMA's past president and executive director, Rita M. Finnegan, MA, RHIA, CCS. The Rita Finnegan Memorial Scholarship was established by a financial gift from MC Strategies, Inc., and a matching contribution from AHIMA. The scholarship will be awarded annually to an outstanding undergraduate or graduate student.

The application deadline for all FORE scholarships and loans is May 31. In addition to a completed application, students also must be accepted for enrollment in an HIA, HIT, or related graduate program and be a member of AHIMA. If applicants are not currently members, they can simultaneously apply for both an AHIMA student

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Editorial Questions

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

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Applications for 2001 FORE scholarships and loans are available on AHIMA's Web site at www.ahima.org/fore/ or by contacting AHIMA via telephone at (312) 233-1100 or e-mail at fore@ahima.org. ▼

AHA confronts transaction code

The final rule on Transactions and Code Sets required by the Health Insurance Portability and Accountability Act of 1996 contains ambiguities concerning use of the National Drug Code (NDC) set for the reporting of drugs and biologic items, according to testimony given by the American Hospital Association (AHA) in Washington, DC. These ambiguities could pose significant hardships on both providers and payers, said **George Arges**, senior director of the AHA's Health Data Management Group and chairman of the National Uniform Billing Committee. During this testimony before the National Committee on Vital and Health Statistics, Argus said that the adoption of the NDC in lieu of the HCPCS (HCFA Common Procedure Coding System) "J" codes now in use would require extensive conversion and replacement of existing information systems, as well as the training costs associated with working with the new code set. Although the cost would vary according to size of facility, hospital estimates put the price at a minimum of $200,000 per facility. ▼

Report: Rigorously protect confidentiality

Health care experts have released ethical guidelines calling on physicians, hospitals, and health plans to rigorously protect the confidentiality of any medical records entrusted to them. The report, "The Domain of Health Care Information Privacy," was created by the Ethical Force Program and initiated by the Institute for Ethics at the American Medical Association in Washington, DC. The report contains more than 30 expectations for protecting privacy that individuals and organizations that deal with identifiable patient information can use to assess their performance. The expectations are organized into eight content areas for protecting individuals' privacy.

Some of the expectations listed in the report include:

- Organizations' privacy policies should be clearly understandable to the public.
- Individuals should be allowed access to view and amend their health records.

For more information about the report, visit www.ama-assn.org/. ■

CALENDAR

- TEPR 2001 — "Your Connection to Electronic Healthcare," sponsored by the Medical Records Institute in Newton, MA, will be held May 8-13 in Boston. This year TEPR sessions are grouped within four main categories: Connectivity, Clinical Documentation, HIPAA, and Empowerment. TEPR also will offer several preconference tutorial sessions.

For more information or to register, call the Medical Records Institute at (617) 964-3923 or visit the Web site: www.medrecinst.com. ■