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IN THIS ISSUE

A Look Forward

This month, *Hospital Payment & Information Management* looks several years into the future of health information management. Industry experts offer their insights on what to expect five to 10 years down the road.

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IOM report paints dark picture of current health care system

Information technology key to redesign

The future of the present health care system is bleak, according to a new government study. If the industry is to succeed, the system needs to be completely redesigned — with information technology playing a major role.

The report, "Crossing the Quality Chasm: A New Health System for the 21st Century," is a follow-up to the Institute of Medicine (IOM) of the National Academies' controversial 1999 report that addressed medical errors, "To Err Is Human: Building a Safer Health System."

Medical errors are just a symptom of a dysfunctional health care system, says the committee that wrote the report. America's health system is a tangled, highly fragmented web that often wastes resources by providing unnecessary services and duplicating efforts, leaving unaccountable gaps in care and failing to build on the strengths of all health professionals, the new report declares.

The report lists six aims for improving the health care system and calls for immediate action to improve care over the next decade. It also provides what it calls 10 "simple" rules to guide the 21st-century health care system as well as 13 recommendations to make health care "safe, effective, patient-centered, timely, efficient and equitable." **(For a look at those aims and rules, see pp. 67-68.)**

"The system is failing because it is poorly designed," says **William C. Richardson**, committee chairman and president of the W.K. Kellogg Foundation of Battle Creek, MI. "For even the most common conditions, such as breast cancer and diabetes, there are very few programs

(Continued from cover)

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that use multidisciplinary teams to provide comprehensive services to patients. For too many patients, the health care system is a maze, and many do not receive the services from which they would likely benefit."

Taking an organic approach

The committee was charged with coming up with a design for the 21st-century health care system, explains **Paul Plsek**, president of Paul E. Plsek & Associates of Roswell, GA. Plsek, who gives consultations on innovation and improvement for complex organizations, advised the committee.

After a couple of meetings and some attempts to make clarifications, the committee found itself reconstructing the Clinton health care plan with boxes and arrows, Plsek says. "They decided that that kind of mechanistic design wasn't going to work."

He met with committee members more than a year ago to discuss the science of complex adaptive systems (CAS). CASs are composed of agents that are constantly organizing and reorganizing into ever-increasing complexity on the basis of a few simple rules. As complexity increases, new structures and behaviors emerge.

"A system as complex as health care needs to evolve," Plsek says. "It can't be designed in a mechanistic sense."

Attempts to design systems that are organic in nature have been failures in the past, he explains. "There are some classic stories from ecology and botany of people trying to recreate prairie land by trying to landscape it with wild plants. It's a dismal failure. Botanists realized they have to let some things grow and see what happens. They can water, fertilize, cut some things back, but in the end a prairie has to grow itself. They couldn't design it."

The same is true for the health care system, he adds. "It's going to have to grow itself. It's gotten to the state of complexity that it is in by evolution, not by anyone's design." Plsek has written an appendix to the report that describes an approach to large-system redesign using simple rules and other concepts from the science of CAS.

The time to consider a different approach to the health care system may be now, he says. "There is a growing sense of awareness and frustration that we have tried several structural

Six ways to improve the health care system

In its report "Crossing the Quality Chasm: A New Health System for the 21st Century," a committee of the Institute of Medicine of the National Academies proposes six aims for improvement to address key dimensions in which today's health care system functions at far lower levels than it can and should.

The report says health care should be:

- **Safe** — avoiding injuries to the patient from the care that is intended to help him or her.
- **Effective** — providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered** — providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely** — reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient** — avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable** — providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. ■

fixes to health care." At times, the industry thought managed care, capitation, and integrated delivery systems would provide fixes. "We've had enough rounds of people trying what they think were obvious, quick solutions. I think the frustration has grown that there are more people who are willing to say, 'We should approach this in a completely different way.'"

Technology is redesign key

The report encourages teamwork among health care workers and makes much greater use of information technology. Advances in technology are sorely needed, the report says. "Patient information typically is dispersed in a collection of paper records, which often are poorly organized, illegible, and not easy to retrieve, making it nearly impossible to manage various chronic illnesses that require frequent monitoring and ongoing patient support."

It is amazing how much information is still on paper and is not easily accessible, Plsek says. "There needs to be a major revolution in information systems in health care organizations."

The IOM committee agrees. A nationwide effort is needed to build a technology-based information infrastructure that would lead to the elimination of most handwritten clinical data within the next 10 years, the committee says.

The committee recognizes that many payment, policy, and legal issues stand in the way of technological innovation. Still, the use of automated medication order entry systems can reduce errors in prescribing and dosing drugs, and computerized reminders can help both patients and clinicians identify needed services, the report says. **(For more information about vendors working together to reduce medical errors, see p. 68.)**

Innovations have already begun

Some innovations are already taking place, Plsek says, including electronic medical records and the use of Palm Pilots for order entry. "Those innovations will accelerate over the next five years," he predicts.

Organizations have begun receiving incentives to innovate with information technology, Plsek says. One example is a $20.9 million initiative, "Pursuing Perfection: Raising the Bar for Health Care Performance," that the Robert Wood Johnson Foundation in Princeton, NJ, is offering hospitals and physician organizations for pursuing ways to dramatically improve patient outcomes.

The IOM report also recommends that a $1 billion innovation fund be established. "If that comes into play, it will certainly spur some new approaches," Plsek says.

Some organizations are taking the report to heart, he adds. "There are already a number of organizations that tend to be on the leading edge that are beginning to access the report," he says. "I get calls from people wanting to talk more about it. I think there will be some early adopters and innovators who have already been thinking in some of these new directions and [about these] new rules."

The big question is how people will embrace the changes suggested in the report, Plsek says.

Rules to guide the 21st-century health care system

As the second part of the five-part strategy for change to the current health care system, a committee of the Institute of Medicine (IOM) of the National Academies proposed the following 10 rules to guide patient-clinician relationships in the 21st-century health system. In formulating these rules, the committee has been guided by the belief that care must be delivered by a carefully and consciously designed system, and this system must be designed to serve the needs of the patient first and foremost. **(For more about the IOM's report, see cover story.)**

1. Care based on continuous healing relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

2. Customization based on patient needs and values. The system of care should be designed to meet the most common types of needs but should have the capability to respond to individual patient choices and preferences.

3. The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision-making.

4. Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. Evidence-based decision-making. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

6. Safety as a system property. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. The need for transparency. The health care system should make available to patients and their families information that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

8. Anticipation of needs. The health system should anticipate patient needs, rather than simply reacting to events.

9. Continuous decrease in waste. The health system should not waste resources or patient time.

10. Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care. ■

"Certainly there are things that pull in the opposite direction. The strong legislation around patient privacy and confidentiality would tend to pull in the direction that's opposite of what the report says."

For example, the "simple" rules offered in the report call for transparency of information as opposed to secrecy. "I think there are some dynamic tensions in the system," Plsek says. "How do we make sure that information about care is available when needed and where needed without compromising the confidentiality of the patient? That is a paradox that remains to be resolved." ■

Clients will be part of information tech team

Vendors also will form more collaborations

Expect more of a team environment in information technology solutions in the future, says an organization serving that industry.

"Clients are going to become more involved as a partner in the solution, rather than looking to the vendor or to the consultant to take on all the risks of the decision," says **Carla Smith**, chief

executive officer of the Center for Healthcare Information Management (CHIM) in Ann Arbor, MI. "The client is going to start to share the risk."

When she looks into the future, Smith also expects more collaboration between vendors. CHIM recently announced a collaborative Patient Safety Initiative focused on identifying the power of information technology in mitigating medical errors.

The initiative seeks to provide the health care industry with impartial data that demonstrate how and to what degree information technology can help reduce medical errors in both ambulatory and inpatient settings. Health care information technology vendors and institutions, both CHIM members and non-CHIM members, have been invited to submit their systems' performance data in case study format to CHIM for review.

This review will consist of verification by an independent advisory board of industry experts selected by CHIM and through independent corroboration, such as with the chief medical officer of the health care setting where data were collected or through publication in a peer-reviewed journal. Advisory board members will be announced before summer arrives.

This effort is the first time software and information technology companies have collaborated on the issue of patient safety, CHIM says in a statement. Patient safety gained importance with the Institute of Medicine (IOM) of the National Academies' 1999 report that addressed medical errors, "To Err Is Human: Building a Safer Health System." **(To find out more about the Institute of Medicine's report, see cover story.)**

"Our members got together and said patient safety was an important issue," Smith explains. "We think we have a tool that can help reduce medical errors. We want the industry to know about that."

Corporate partners 3M Health Information Systems of Salt Lake City, Eclipsys Corp. of Delray Beach, FL, ePhysician of Mountain View, CA, and Per-Se Technologies of Atlanta sponsored the initiative. Smith says CHIM has started trying to collect the data and will probably have something ready to publish toward the end of the third quarter.

"We look forward to sharing positive results with key legislative decision makers once we have gathered sufficient information. To that end, we invite any organization with relevant data to contact us," Smith says. ■

Analysts begin making the case for APCs

How will they compare to DRGs?

Now that ambulatory payment classifications (APCs) have been in place for the outpatient prospective payment system, some analysts are comparing them favorably to the Diagnosis-Related Groups (DRG) system for inpatient services. Others, however, aren't so sure about the way to go.

The real question is whether payers will follow the lead of the Health Care Financing Administration (HCFA) and use a system similar to APCs, says **Dean Farley**, PhD, vice president of health care policy and analysis for HSS, Hamden, CT. "Certainly we are seeing some of that now. A number of payers are looking at APCs and similar types of payment vehicles," Farley notes.

Payers who are accustomed to the benefits of the DRG system may be disappointed if they put into place an outpatient prospective payment system similar to HCFA's. "The DRG system was pretty sophisticated, probably more than APCs at this point," he says. "I am interested in how private payers will respond once several of them get the payment system in place and realize that many of the benefits of inpatient payment systems don't carry over. I don't know whether they will continue to adopt that system or look at other strategies."

The cases for and against bundling

The DRG system created incentives for the hospitals by bundling services together in packages, but HCFA has not made an effort to revisit this issue with APCs, Farley says.

"DRGs gave a single payment for an entire hospital stay. They gave hospitals a great deal of latitude in terms of how they chose to treat that patient. That's where you get incentives to improve efficiencies," he says. "With APCs, the hospital is basically paid for each individual service — not bundled together in treatment categories."

Because outpatient hospital care is often only part of an entire episode of care, the technical issues and data issues are more daunting for HCFA, Farley says. "I think HCFA will want to

Coders will be in increasing demand

But can technology take over coding functions?

Coders will be more in demand than ever in the future, says one industry analyst. New technology, however, threatens to turn that demand in the opposite direction.

"There are a couple of forces that are at work right now that have long-term implications on the role of coders," says **Lamar Blount**, CPA, FHFMA, president of Healthcare Management Advisors in Alpharetta, GA. First, with the conversion to ambulatory payment classification methodologies for outpatient hospital reimbursement and prospective conversions that Medicare has made for other providers, the demand for coders is higher than ever and still increasing.

"Hospitals that once felt that the majority of what they do could be controlled through coding, driven through the Chargemaster, are realizing that they still need a professional coder to be sure about many more of the types of services that previously were not affected at all by the accuracy of the codes," he says.

On a negative note, advancements in voice recognition technology and the increasing accessibility of computerized records and transcription may allow codes to be automatically determined by the system, as opposed to a human reading a record and developing a code, Blount says. He expects this kind of technology to be adopted first in larger institutions and medical schools and universities. As that technology becomes more affordable, then smaller, medium-sized providers might be next. "Over the long term, I expect in more than five years that the demand for coders will decline."

Blount expects coding to also become more complex. "The continuing advances in medical technology means there are more tests and procedures than we have had available in the past. All of those require codes."

For example, coders who once knew every possible X-ray code have had to learn CT and MRI procedure codes, too. "That analogy will continue to work throughout the industry." ■

move in the direction [of bundling] even though MedPAC [the Medicare Payment Advisory Commission] has argued that HCFA shouldn't go with the straight fee-schedule type of arrangement for hospital outpatient services."

One analyst, however, says bundling services would not properly and adequately reimburse a hospital. "When you go to a bundled, single APC per encounter, then the reimbursement level has to reflect the average for all those types of cases that could be included in that bundle," says **Lamar Blount**, CPA, FHFMA, president of Healthcare Management Advisors in Alpharetta, GA.

The risk would be that providers would try to gain by doing fewer of the things that could have been included in that single encounter, he continues. The provider, for example, could have the patient return at some other time for care that could have taken place in the first visit.

The current system is also beneficial and convenient for patients, Blount says. "They can take less time from work to be able to come in and have more than one thing done in an outpatient encounter."

In addition, there is too much diversity between hospitals and from patient to patient to make a single APC system for the entire outpatient encounter work well, Blount says. "[The current system] results in a more appropriate reimbursement that recognizes the differences between patients and between facilities in terms of the extent of services that could occur within a single patient encounter."

For example, some patients may see three or four different clinics within an organization, he says. "If that was not generating a single, distinct APC for each of those types of services, then that type of organization would likely be severely financially hurt by going to an all-inclusive bundle situation in which each patient encounter has one APC."

The worst and the best

The frustration with APCs is that many providers were not prepared to cope with the system. HCFA acknowledged that it wasn't prepared to cope at that point either, Farley says.

The ability to cope with the system will not improve if the outpatient prospective payment

(Continued on page 75)

DRG CODING ADVISOR.

Fear of federal fraud police may be costing you a lot

Uncertainty leads to underpayments

More physicians are being extra-cautious when billing Medicare, afraid of drawing the attention of the federal fraud police. Add to this the services that are often unknowingly undercharged by many practices, and you can end up missing out on a sizable amount of legitimate payments.

Being cautious in today's regulatory environment is prudent. However, there's no reason you should not be paid full freight for legitimate services. Next time you review your back-office practices, check to see if you are making any of the following common billing and coding mistakes that can leech the lifeblood out of your practice's cash flow:

• **Underbilling for office visits.**

Intimated by the idea of being red-flagged by government bean-counters, more physicians are taking the cautious approach and down-coding office visits for fear that claiming levels four and five visits will prompt an audit.

Is billing inconsistent with normal patterns?

Sadly, there is some truth to that thinking. But the real smoking gun auditors look for is a constant billing of higher evaluation and management services across a wide array of patients in a manner that seems inconsistent with normal practice patterns.

In turn, if you do a properly documented (documentation is very important) multisystem exam of a moderately ill patient that requires multiple diagnoses and you only bill for a level three service instead of level four, you are just denying yourself appropriate payment, which in a busy practice can quickly run into the thousands of dollars.

On the flip side, billing a level four service for a hypertensive patient who comes in every month could get you into trouble.

• **Mismatching ICD-9 codes and procedure codes.**

Too many physicians simply mark ICD-9 and CPT codes on a superbill, assuming the billing office will take care of the rest.

The problem is that this can mean CPT and ICD-9 codes get mismatched or left off the bill altogether — a sure-fire way to get a claim denied or questioned.

Private codes can prevent mismatching

One way to avoid this problem is to have the physician place his or her own private code (a number or letter) matching each diagnosis with the corresponding CPT codes on the superbill to eliminate confusion about which ICD-9 goes with which CPT.

While many experts say it is easier for physicians to use a superbill or fee slip that already lists the practice's most frequently used CPT and ICD-9 diagnostic codes, others argue that offices should just do away with the superbills and have physicians write out their diagnoses while more experienced billers fill in the most appropriate diagnosis-related codes.

• **Not using the most specific and recent ICD-9 codes.**

Despite the fact many four-digit ICD-9 codes have been replaced with more specific five-digit codes, many physicians still use the older four-digit format without thinking.

Unfortunately, Medicare is now more likely to challenge these four-digit claims. Some examiners, for instance, will question why a simple code for abdominal pain was used instead of a code

Some key rules that must be followed

The best way to avoid payment and audit questions about your billing procedures is to make your claims are fully documented. Make sure, for instance, that:

- The medical record is complete and legible.
- Documentation of each patient encounter includes or references: the chief complaint and / or reason for the encounter and, as appropriate, relevant history, examination findings, and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and legible identity of the health care professional.
- If not specifically documented, the reason for the encounter and / or chief complaint and the reason for ordering diagnostic and other ancillary services can be easily inferred.
- Past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, are accessible to the treating and / or consulting physician.
- Appropriate health risk factors have been identified.
- The patient's progress, response to and changes in treatment, planned follow-up care, and instructions and diagnosis are properly documented.
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement are supported by the documentation. ■

specifying the exact location of the pain.

• **Not using modifiers.**

At first glance, coding rules prohibit billing a patient for an office visit and a minor procedure on the same day. But it is allowed to bill for both an office visit and a minor procedure provided the physician does enough to justify both charges, the services are properly documented, and a modifier -25 is used to let the payer know more was done than just giving the patient an injection.

The catch: If the patient was only scheduled to receive a joint injection, for example, and that's the only service you provided, you cannot charge for both the procedure and the office visit.

Physicians often forget that they can bill for administration of an injection as well as for the drug or vaccine itself.

• **Not billing for injections.**

According to the ProStat Resource Group in Shawnee Mission, KS, physicians often forget that they can bill for administration of an injection as well as for the drug or vaccine itself.

Remember that charging for both an injection (a minor procedure) and an office visit on the same day without using a modifier is generally prohibited. But there are exceptions. For instance, when giving a vaccination for pneumonia, influenza, or hepatitis B, physicians can bill for the office visit, the injection, and the vaccine.

• **Confusing new patient visits with consultations.**

A patient consultation pays more than a new patient visit. To justify billing for a consult over a new patient visit, the patient must have been sent to you for a consult by another physician, and you must provide the referring physician with an opinion or advice — preferably in writing, which should then be included in the file.

• **Not billing for counseling.**

When a physician spends more than half of his or her face-to-face time counseling a patient or coordinating care — calling other physicians, making arrangements for diagnostic tests, etc. — he or she can bill for a higher level of service, even if the physician doesn't perform an exam or make a new diagnosis, says Orlando, FL-based practice consultant **Leslie Witkin**.

For instance, if during a visit a physician sees a patient recently diagnosed with cancer and does nothing but counsel the patient, talk to family members, and make arrangements for further treatment, the doctor is still entitled to code the visit as a level five, provided that more than half of the visit — 20 minutes minimum, because level-five visits must be least 40 minutes long — was spent counseling the patient and coordinating care.

• **Not billing for the nurse's time.**

A level one code can be used for office visits if nursing staff provide routine services when a physician is not present. However, it is best to bill only for when the nurse does those small extra things like showing a patient how to use insulin or giving the patient some other kind of detailed instructions. ■

Four steps to speed the reimbursement process

Fight back against slow payment

It's happening more and more: Payers are denying routine services and finding invisible clerical errors in claims, bills are being "lost," and it's taking longer and longer for bills to be paid in full.

Pressed by financial problems, many HMOs and other insurers are simply using any excuse possible to find ways not to pay legitimate claims, say reimbursement experts.

Here are some tips to help your practice reduce claim denials, speed turnaround time, and boost cash flow:

1. File frequently.

Most experts recommend you have the bill prepared and out the door within three to four days after service has been rendered. Anything less, and you are just making the payer what amounts to an interest-free loan.

Some offices prefer to file claims even more frequently. Frederick (MD) Internal Medicine makes a habit of filing claims daily. Besides speeding cash flow, daily filing reduces paperwork by processing claims on a same-day schedule rather than waiting to do a week's worth of claims at once.

2. Know what you are due.

"It's been my experience that a great many carriers are failing to reimburse practices based on their negotiated fee schedule," says **Brian Kane**, CPA, president of HealthCare Advisors in Annandale, VA.

To help track what you are being paid vs. what you should receive, Kane suggests creating a simple grid with the insurance companies across the top and the main 10 to 15 CPT codes on the left side. Next, fill in what insurers are contractually required to pay for these procedures, then check these amounts against explanations of benefits (EOBs) received from payers.

The EOB differences may seem small, maybe as little as five or ten dollars per patient. But this small change can add up to big bucks over the course of a year. Plus, the more aggressive you are in auditing and demanding full payment, the less likely it is payers will continue pulling the same tricks.

3. Track denied claims by payer and code.

The more information you have at your fingertips, the easier and faster it is for you to spot and correct underpayment patterns of particular carriers.

4. Collect copayments and deductibles quickly.

Rather than billing patients, most reimbursement experts suggest you collect any copayment due before the patient leaves the office. When this is not possible, some practices have found that giving the patient a pre-addressed envelope to use to mail in the payment improves collection rates. The same attitude should apply when the patient is responsible for a deductible in his or her coverage.

One way to easily track this is to create a chart of your top CPT codes and most frequently encountered insurers, listing their deductibles and co-pay policies for each code. Your front office staff can then easily refer to this chart to improve collection rates. ■

Savings mount up in 'real time' processing

Small slices from the cutting edge

Despite the introduction of various electronic and automated claims processing systems and techniques, the administrative burden and cost of processing medical claims continues to rise for many practices, according to an Indiana group practice.

"We're doing everything we can to automate everything we can," says **Mary Valdez**, manager of patient accounts for the Indianapolis Women's Health Partnership (WHP).

Yet, despite the fact that 80% of WHP's claims are processed electronically — compared to the 50-60% national average — it still costs this group practice an average of $7.42 to process each claim.

On the up side, the introduction of electronic data interchange (EDI) has cut two weeks off WHP's claim payment cycle. It now takes two months for the average claim to be paid instead of two and a half months.

Even with EDI, 30%-35% of claims are denied because of alleged errors or missing information, she says. "This claim rejection rate is compounded by the problems our various payers are having

with their EDI systems." For example, she says, "our EDI system may show a claim has been accepted by the payer when, in fact, it has been lost or just disappeared."

As an alternative, WHP has moved to a "real-time" claim resolution system distributed by RealMed Corporation of Indianapolis.

"With a real-time system, before the patient leaves our office, they are given an automated accounting of how much their insurance covers for that visit, and how much, if anything, the patient owes, without filing any paperwork," says Valdez. "By taking care of the transaction in one setting, with the patient present, and not having to re-open the claim file three or four times, we are starting to move our savings from processing claims into more quality care for the patient."

On a larger scale, Health First, a Melbourne, FL-based health network with specialties in cardiology and women's and children's services, has expanded its electronic medical records and claims management to make its use easier for the ambulatory physicians in its 29 clinics.

"This is an active managed care market with many patients who need both primary and specialty care," said Health First spokesman **Rich Rogers**. For instance, Health First wants any authorized caregiver in the system to have a patient's records available when the person arrives for a visit. "This assures them they're being cared for in a close-knit and efficient health care community, and they avoid the hassle of having each provider they see do a new chart work-up," says Rogers. ■

HMOs to use new funds to boost physician pay

Opposition may come from Congress

Health plans in the Medicare+Choice program are expected to use much of this year's $1 billion allocation of increased federal funding to boost payments to physicians and hospitals, say industry experts. However, this provider pay hike could be threatened by rumblings from legislators, according to Capitol Hill watchers.

Congress passed a Medicare "give-back" bill late last year that earmarked $11 billion over five years to strengthen Medicare+Choice, primarily by persuading health plans to remain in the four-year-old program. Of that amount, $6.2 billion was provided in direct payments to managed care plans, and just under $1 billion of that goes to plans in this calendar year.

"We are looking at shoring up our provider networks in certain markets," says **Dick Brown**, director of media relations at Humana Inc. in Louisville, KY. "We want to make certain we can keep providers in our Medicare+Choice networks and give our members the access that they want to the providers they need."

But there also is concern emerging from Congress about the give-backs. Rep. **Fortney "Pete" Stark** (D-CA), for instance, argues that not enough physicians were dropping out of Medicare+Choice to justify directing these extra dollars to them. Also, Rep. **William Thomas** (R-CA) likes the idea of using any extra funds to provide benefits directly to seniors. ■

Coding assessment offered by AHIMA

Program is Web-based

The American Health Information Management Association (AHIMA) in Chicago has developed a Web-based program to educate coders. "Coding Assessment and Training Solutions" provides an opportunity to assess coders' skills and knowledge and to keep abreast of the latest coding practices and policies. The program allows organizations to validate the coding skills of staff members and to discover where improvement is needed.

The initial phase of the interactive program addresses the area of assessment. This portion provides resources to assess and validate individual coding skills and identify areas requiring improvement. The results of the testing allow organizations to assess their need for ongoing and future coding training.

After assessing knowledge in such areas as coding principles, coding guidelines, document analysis, problem solving, and data management skills, training needs may be outlined.

For more information about "Coding Assessment and Training Solutions," contact AHIMA at (312) 233-1158. ■

(Continued from page 70)

system continues to churn at the rate it is churning now, he adds. "By law, we are seeing weights and categories changing every three months. That's a very fast pace for the providers to have to keep up with, just from a management perspective."

Providers are also seeing changes in reimbursement policy that are being made on the fly, Farley says. "These changes are being made through program memoranda, not through regulations. In some cases, they are not being made explicit."

In addition, providers often find surprises in HCFA's Outpatient Code Editor. "The changes are not being well-articulated. The providers are trying to hit a moving target, and they don't necessarily even know what that target is," he says. **(For specific information about coding, see p. 70.)**

In a worst-case scenario, the outpatient prospective payment system will lose support if the pace of the changes and the lack of communication about them continue. "It will also be difficult for HCFA to figure out how to rationalize the system," Farley predicts. "They won't have a stable system that they can analyze and understand."

If the situation does change, however, providers might find a system they could embrace. "The providers could recognize the importance of the payment that they are creating and invest in their outpatient coding as they haven't in the past."

A whole new system

Based on the history of DRGs, Blount says there is a reasonably good chance that the government will only tinker with APCs for at least 10 years. However, he does see the chance that the federal government could go to an all-capitated system. "Just as it pays HMOs on a capitated basis, it could do the same with the rest of the providers," Blount notes. He says such a change in reimbursement could reasonably occur sometime in the future, but he doesn't see that happening any time soon.

Farley says he expects a continued movement toward code-based reimbursement. The Balanced Budget Act (BBA) of 1997 put Medicare on the path to prospective payment — fee-schedule, code-based reimbursement, he says. This reimbursement is driven by diagnostic procedure codes on the bill for virtually all Medicare services. "Once the BBA is fully phased in, those payment systems will cover 99% of the Medicare dollar. I think is inevitable that Medicare will continue to move in that direction, although not as quickly as originally envisioned." ■

Technology will increase value of transcriptionists

Electronic record focuses attention on data capture

Transcriptionists may have worried about their jobs with the advent of speech recognition technology. But in the coming years, they may find their roles stronger than ever — increased by the same technology that once threatened to replace them.

The transcription profession is definitely going to change, says **Claudia Tessier**, CAE, chief executive officer of the American Association for Medical Transcription in Modesto, CA. "We anticipate the increased merging of new technologies with the talent and knowledge of medical transcriptionists. The change has already started, but it is going to accelerate and be more dramatic."

The need for the human touch

Speech recognition technology is no longer viewed as the ultimate solution to replace transcription, she says. "Vendors now are increasingly aware that if they take the technology of speech recognition and combine it with the knowledge of the medical transcriptionist, they can be much more effective and can be bigger players in the market," Tessier says.

When working with medical transcriptionists, the speech recognition system would do the first pass for the record, but that record is recognized as a draft, she explains. The transcriptionist preferably would immediately edit the record, recognizing and clarifying any inconsistencies or redundancies.

The transcriptionist would be able to make the document clearer, more complete, and more consistent than direct speech recognition, because medical transcription is not a verbatim process,

Tessier says. "It's an editorial process. Verbatim transcription can be a barrier to communication because people do not speak the way they communicate in writing."

Unfortunately, physicians who are happy about using speech recognition don't always review their work before they sign it, she adds. "Since they thought they said what they intended to say, they assume that the document is accurate as dictated." Tessier says she has seen multiple demonstrations of how it takes almost no effort to quickly identify errors, some of which are minor. "Some, however, are medical errors. The wrong term was used, or the procedure started on the left side and ended up on the right side. It takes that attention to reviewing the document for completeness, accuracy, clarity, and consistency to assure that the information is what you want documented."

Tessier says she doesn't think the person who dictated the record should also act as its editor. "Few people want to do that and can do that well for themselves."

Transcriptionists also can make contributions when data entry is structured, as with touch screens. "You often need the opportunity for free text," she says. "[The clinicians] may need to dictate information to the history or to add the reasoning behind a diagnosis, particularly with a differential diagnosis, and the transcriptionist would add this free text to the structured text."

Overall, Tessier says she sees an evolution of the transcription profession in which the editing skills, medical language, and content knowledge of the transcriptionist become more important. "The transcriptionists with the more sophisticated knowledge of medical care will have wonderful [career] opportunities."

Technology may aid clarification of content

The evolution of the transcriptionist role may not depend on direct relationships with physicians, though. Tessier expects that relationships between transcriptionists and physicians will continue to be as variable as they are now. "There will continue to be some direct relationships. There will also perhaps be an increase in the instances where transcriptionists and physicians will never see each other, because they might be on opposites sides of the country or the world."

Tessier says she hopes that new technology will improve transcriptionists' opportunities to get clarification of confusing dictation or inconsistent content. For example, a physician may use a new term that is not familiar to the transcriptionist. The transcriptionist tries to research the term but cannot find it. He or she then leaves a blank in the document and asks the physician to fill it in as well as to provide feedback so the transcriptionist will know the term in the future.

"Unfortunately, the feedback too often never comes," Tessier says. "We hope there will be ways to reinforce the attention given to providing feedback about new technology and new techniques so the knowledge base of transcriptionists can increase faster than they could find the information on their own."

Everybody does it

Transcriptionists may find that they are working on records dictated by staff other than physicians, too.

Physicians are doing more documentation with dictation and transcription, but so are health care professionals of other disciplines, Tessier says. "It's as though the development of the electronic patient record has stimulated a greater awareness and greater utilization of [dictation and transcription]."

The massive attention given to the electronic patient record has brought attention to dictation and transcription for data entry, especially because no alternative technologies have worked out to be the ultimate solution, Tessier says. "It has brought interest in it that all of our marketing efforts were not able to do." ■

HIPAA: It's always on my mind

Regulations are a priority for survey respondents

An increasing focus on Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and approaching compliance deadlines appears to have caused a shift in the information technology (IT) priorities anticipated by health care organizations, according to the 12th annual Healthcare Information Management Systems Society (HIMSS) Leadership Survey.

Analysis of preliminary survey results finds that the No. 1 IT priority for providers — both for the next 12 months (61%, compared to 55% in 2000) and for the next two years (54%, vs. 51% last year) — is upgrading security on IT systems to meet HIPAA requirements. In addition, Internet technology, which was last year's No. 1 IT priority, posted a decrease of 17%, cited by 46% of this year's participants vs. 63% in 2000.

Questions in the 2001 survey covered topics such as IT priorities, overall IT utilization, IT budgets, computer-based patient records, data security, web applications, and emerging IT technologies. The preliminary results reflect initial analysis from providers only. The final results and full report, including vendor responses, should now be available on the HIMSS Web site. No significant statistical changes between the preliminary and final reports are anticipated for this year's survey.

HIPAA named 'top business issue'

In terms of the "top business issues facing health care in the next two years," HIPAA compliance was cited by 79% of participating providers, compared to 70% last year. Cost pressures were the next-highest-ranked business issue this year, cited by 53% of respondents, vs. 55% in 2000. Improving operational efficiency, which was ranked No. 2 last year at 60%, dropped dramatically, down to 44% this year. Other top business issues for respondents included availability / retention of staff (44%) and reducing medical errors (41%).

HIPAA also topped the list of providers' security concerns. Complying with HIPAA security regulations regarding computerized medical information was cited by 74% of respondents, up slightly from 72% last year. The impact of HIPAA is also clearly demonstrated by this year's preliminary results, which indicate an overall increase in both respondents' knowledge of the requirements and the steps that have been taken toward compliance.

In other areas surveyed, respondents also indicated major percentage changes in the types of emerging technologies to watch. Wireless information appliances, web-enabled business transactions, hand-held personal digital assistants for workgroups, voice recognition, and extranet were cited by providers as the top technologies being considered for implementation over the next two years.

The survey represents the opinions of senior executives and managers from health care provider and vendor organizations from across the United States and around the world regarding the use of information technology. Fifty-three percent of provider organizations represented are multi-entity health care networks with hospitals. Another 22% are stand-alone hospitals. The remainder includes a wide variety of health care organizations, including long-term care, home health care, group medical practices, HMOs, and the military.

Seventy-six percent of provider respondents work for a hospital or an integrated health system. In terms of job responsibility, 76% of provider respondents are department management or staff within a single facility. Sixty-six percent of provider respondents hold the title of chief information officer, vice president of IT, or senior IT manager. The primary role of 66% of provider respondents encompasses IT management.

The survey was sponsored by Superior Consultant Co. in Southfield, MI, and Dell Computer Corp. in Austin, TX. ■

Trauma codes misused by home health agencies

Relevant medical diagnosis should be reported

A number of home health agencies are incorrectly using the diagnosis codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) when reporting the primary diagnosis for post-surgical admissions on the Outcome and Assessment Information Set (OASIS) and Uniform Billing Form-92 (UB-92), reports the Health Care Financing Administration (HCFA) in Baltimore. The agencies are using diagnosis codes for trauma instead of reporting the relevant medical diagnosis.

These trauma codes, which come from the ICD-9-CM chapter "Injury and Poisoning," are reserved for injuries from accidents and intentional violence. They include categories for fracture (800-829), dislocation, sprains and strains (830-849), internal injuries (860-869), open wounds (870-897), and

other injuries and burns (900-999). This means surgeries and amputations performed for treating disease are not coded from the "Injury and Poisoning" section.

The only common condition in home health in which a trauma code is used is fracture due to a fall, other accident, or intentional injury, HCFA says. Therefore, in most cases, hip fracture and other fractures treated surgically or otherwise are correctly coded with a trauma code (using one of the codes for fracture, 860-869).

V-codes are not allowed on OASIS, even though they are the most appropriate code to use in many post-surgical wound cases, according to ICD-9-CM coding guidelines. Rather than using V-codes, the OASIS instructions indicate the agency should code the primary diagnosis from the condition responsible for the surgery. HCFA says this requirement raises a problem for diagnosis coding in many post-surgical wound care cases.

How to code wound care diagnosis?

If the agency selects a code for the condition that led to the surgical wound, the result may be a diagnosis that the patient no longer has. Nevertheless, when a patient is admitted to home care mainly for surgical wound assessment and treatment, the condition responsible for the surgery must be used as the primary diagnosis. For example, on OASIS, it is correct to report spinal stenosis (724.0x) as the primary diagnosis in the case of a successful laminectomy performed to treat it, even if the patient is considered cured after surgery.

Agencies that have erroneously coded disease-related post-surgical cases with a trauma diagnosis should submit a corrected claim to ensure accurate payment.

Also, HCFA says to note the following guidance issued in Program Memorandum (PM) A-00-71 (www.hcfa.gov/pubforms/transmit/a0071.pdf). This PM stipulates that "the principal diagnosis must match on the physician-certified plan of care, the OASIS and the UB-92. In addition, V codes are not acceptable as principal or first secondary diagnoses but could be recorded in item 21 entitled Orders for Discipline and Treatments. The ICD-9-CM coding guidelines should be followed in assigning an appropriate V code." Possible appropriate V-codes when the patient requires post-surgical wound care include V54.x, V58.4x, and V58.3. ■

Controversial ergonomics rule struck down

The ergonomics rule didn't make it very far into the Bush administration.

The rule, which aimed to reduce the incidence of repetitive motion injuries in workers, was one of the last-minute legislative efforts by the Clinton administration. Health care and business groups opposed the rule, however, saying it was too costly and burdensome.

The House vote on the rule was 223-206. Sixteen Democrats joined majority Republicans in opposing the rule, while 13 Republicans voted to leave it in place. After a day-long debate, the Senate voted 56-44 to kill the rule, as six Democrats sided with all 50 Republicans. This was the first time such a safety rule had been repealed.

"Putting aside all the rhetoric and demagoguery, this debate was about whether OSHA's [Occupational Safety and Health Administration's] ergonomics regulation was the best way to ensure safety and health in the workplace," says Ed Gilroy, co-chairman of the National Coalition on Ergonomics in Washington, DC. "We are gratified that both chambers of Congress have agreed that the answer to this critical question is a resounding 'no.'" ▼

Fight over privacy regs continues

Some Democratic members of Congress are up in arms over Health and Human Services Secretary Tommy Thompson's decision to reopen the HIPAA privacy regulations for an additional 30 days.

The Democrats, which include Sens. **Ted Kennedy**, D-MA; **Patrick Leahy**, D-VT; and

Tom Harkin, D-IA, along with Reps. **John Dingell**, D-MI; **Ed Markey**, D-MI; and **Henry Waxman**, D-CA, held a press conference in March to denounce the decision, the *AHA News* reports. The Congressmen said any delay in the HIPAA privacy regulations' April 14, 2001, effective date, or in their full implementation date of April 14, 2003, would be a violation of campaign pledges made by President Bush. Also, the members said no hospital, health care organization, or corporation should be allowed to sell medical information for profit.

The Chicago-based American Hospital Association (AHA) holds a different opinion. "While we appreciate the members of Congress' involvement on this important issue, we don't agree with them," says AHA Vice President and Chief Washington Counsel **Melinda Hatton**. "Nationwide, hospitals are telling us that the privacy regulations in their current form are not workable. We have firmly concluded that they need to be fixed before they go into effect, not after." ▼

HCFA announces payment rates for 2002

Federal payment rates for Medicare+Choice managed care plans will increase by about 5.3% in most counties across the country, according to the Health Care Financing Administration (HCFA) in Baltimore. Payment rates in other counties will rise by the guaranteed minimum increase of 2%.

The expected payment rates reflect the law's requirements, including recent changes included in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), enacted last December. The new payment rates for 2001 and 2002 can be viewed on the HCFA Web site at www.hcfa.gov/stats/hmorates/aapccpg.htm

For 2002, the floor amounts will be $553.04 for urban areas with populations of 250,000 or more. In other counties, the floor amount will be $500.37. For the months of March through December 2001, the rates are $525 and $475 respectively. All of these rates reflect increases mandated by BIPA. ▼

Improper Medicare payments have dropped

The Department of Health and Human Services (HHS) reported in March that improper Medicare payments to doctors, hospitals, and other health care providers in fiscal year 2000 continued to show sustained decreases since the department's Inspector General began tracking Medicare's payment error rate five years ago. The error rate measures payments made by Medicare that are not "properly supported by

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health care providers' documentation or which otherwise do not meet Medicare reimbursement requirements."

For the second straight year, HHS and the Health Care Financing Administration received "clean" audit opinions of their financial statements from the Office of Inspector General (OIG). The OIG serves as independent auditor as required under the Government Management Reform Act.

Medicare's estimated error rate was 6.8% in fiscal year 2000, compared with nearly 8% the previous year, according to the OIG's latest report. The error rate has fallen to roughly half of the 14% rate estimated in fiscal year 1996, the first year that the Inspector General conducted an audit to estimate Medicare's overall error rate.

The fiscal year 2000 error rate represents an estimated $11.9 billion in improper payments out of the total $173.6 billion in fee-for-service Medicare payments, compared with $13.5 billion in fiscal year 1999 and $23.2 billion in fiscal year 1996. HCFA met its target for reducing the error rate to 7% in fiscal year 2000 and continues to take steps to meet its fiscal year 2002 goal of 5%.

The OIG calculated the improper payment rate by examining a valid statistical sample of 5,234 Medicare claims across the United States valued at $5.3 million. OIG auditors reviewed the medical records supporting the claims with the assistance of medical experts and then projected the sample findings over the universe of Medicare fee-for-service benefit payments, which totaled $173.6 billion during fiscal year 2000. ▼

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CIA information sheet posted on OIG web site

The Office of Inspector General (OIG) has posted a general information sheet for Corporate Integrity Agreements (CIAs) and Settlement Agreements with Integrity Provisions on its web site. The site offers the following links:

• Current Listing of Corporate Integrity Agreements and Settlement Agreements with Integrity Provisions;

• Frequently Asked Questions Related to OIG Corporate Integrity Agreements;

• Corporate Integrity Agreement Annual Report Content Checklist.

To see the CIA information, visit www.dhhs.gov/progorg/oig/cia/index.htm. ■

• The 2001 HIPAA Conference, sponsored by members of the Joint Healthcare Information Technology Alliance in Washington, DC, will be held May 23-25 in La Jolla, CA. The Department of Health and Human Services' Bill Braithwaite, PhD, MD, will open the meeting with an update on the Health Insurance Portability and Accountability Act of 1996 administrative simplification regulations. Other industry experts also will address the participants.

For more information, call the American Health Information Management Association in Chicago at (312) 233-1100 or visit its web site at www.ahima.org. ■