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(Continued on next page)

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Get used to it: HIPAA privacy regulations are here to stay

Decision catches many in the industry off guard

The American Hospital Association (AHA) and other health care groups had every reason to be optimistic. On April 8, the *New York Times* reported that the Bush administration was planning to revise the privacy rule mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

"The Bush administration has concluded that federal standards to protect the privacy of medical records, adopted with much fanfare by President Bill Clinton in his last month in office, are unworkable and must be revised," said the article, which quotes unnamed administration officials. The Chicago-based AHA and other groups have actively lobbied for this type of outcome.

It didn't happen. On April 12, Health and Human Services Secretary **Tommy Thompson** announced that President Bush has decided against delaying or substantially changing HIPAA privacy regulations. The regulations went into effect as scheduled on April 14, giving the health care industry two years to comply with the rules.

Industry concerns about the rule will be addressed through guidelines or recommended modifications, Thompson says. Some of these include:

- Doctors and hospitals will have access to necessary medical information about a patient they are treating, and they will be able to consult with other physicians and specialists regarding a patient's care.
- Patient care will not be hampered by the confusing requirements surrounding consent forms. For example, pharmacists will be able to fill subscriptions over the phone.

(Continued from cover)

COMING IN FUTURE ISSUES

- Is a better patient bill on the way?
- Palm technology sends written prescriptions directly to the pharmacy
- Coding management during change of ownership
- Create a coding compliance and educational program for medical records
- Physicians file claims to payers directly over the Internet

• Parents will have access to information about their children, including information about mental health, substance abuse, or abortion.

A swift reaction

The nation's hospitals were "profoundly disappointed" in the Bush administration's decision, says AHA President **Dick Davidson**.

AHA's overriding goal has always been to ensure confidentiality of patients' medical information without hampering care and treatment, he says. But, without critical changes, he does not think the current rule passes that test.

The American Medical Association in Chicago urged Thompson to modify the rule quickly. "At a minimum, physicians need the full two-year compliance period to modify their practices in order to comply with the rule. It is imperative that any changes to the rule or implementation guidelines are provided as expeditiously as possible," says **Donald J. Palmisano**, MD, an AMA trustee.

The president of the Healthcare Leadership Council in Washington, DC, agreed. "With the two-year implementation clock ticking, hospitals, health systems, and pharmacies nationwide are going to be developing expensive, complex new systems to comply with these regulations. To ensure that they do not encounter excessive delays and billions of misspent health care dollars on the path to progress, it is essential that the administration act swiftly in spelling out how it will fix the flaws in these regulations," says **Mary R. Grealy**.

The organizations that supported going forward with the rule were pleasantly surprised. "A federal law — particularly a law that standardizes health information privacy practices nationwide — is still needed," says **Linda L. Kloss**, MA, RHIA, executive vice president and CEO of the American Health Information Management Association in Chicago. "These regulations represent a significant step toward that goal. This decision confirms our confidence that will happen."

"[This] development constitutes another milestone toward achieving the goals [of weaving privacy into the fabric of our health care system]," says **Janlori Goldman**, director of Georgetown University's Health Privacy

(Continued on page 84)

Health professionals wanted rule to stay as is

Most say compliance price tag too low

Many health care groups, such as the Chicago-based American Hospital Association and American Medical Association, have rallied for changes in the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, saying it is flawed and burdensome.

But one survey shows that many individual health care professionals and managers wanted the rule to remain as written.

The survey was conducted in March by Phoenix Health Systems, a Washington, DC-based health care information systems consulting firm, for its newsletter *HIPAAlert*. The survey received responses from 517 senior managers, chief information officers, department managers, compliance and security managers, physicians, and other professionals from hospitals, insurance companies, health maintenance organizations, claims clearinghouses, medical practices, and vendors.

The survey addressed the contentious issues in the HIPAA privacy rule. Participants were asked to say whether they felt specific provisions should be removed, loosened, remain (stay the same), or be stricter.

Across the board, the overwhelming pattern of response to the survey was in support of the privacy rule as written, the survey says. No pattern emerged to suggest that people from one part of the health care environment consistently had a different bias from those in other industry segments. **(For reaction to the Bush administration's decision to implement the privacy rule, see p. 81.)**

Here are some of the respondents' opinions about the rule's provisions:

• **"Consent and Authorization" rule: Patient health information may not be used unless authorized.**

Sixty-four percent of respondents agreed with this rule. In one of the few exceptions to the survey's trend of agreement with the privacy rule, 75% of payers wanted this provision removed completely.

• **Use and disclosure of patient data is allowed without authorization for medical research, law enforcement, and other public needs.**

More than half of respondents agreed with this provision. However, 56% of respondents said the provision allowing limited use of patient data for fundraising should be stricter; only 34% agreed with it as written.

• **Consent is required for use of patient data for reasons such as treatment and health care operations.**

Sixty-three percent of respondents agreed; 17% wanted this rule loosened.

• **Only the "minimum necessary" disclosure of health information is allowed, even when authorized.**

Sixty-three percent of hospital staff and 59% overall agreed this provision should remain as is.

• **Patients have the right to inspect health data used to make decisions about them.**

Sixty-nine percent of all respondents agreed this rule should remain the same; 82% of providers agreed.

• **State laws that are stricter should pre-empt HIPAA.**

Fifty-three percent of participants agreed with this rule; 40% said HIPAA should always pre-empt the state laws.

• **The privacy rule applies to all individual patient data, whether electronic, paper, oral, or other.**

Seventy percent of all respondents believed this provision should remain as written.

• **Business associate agreements are required.**

Sixty-four percent of all respondents supported the general provision requiring such agreements. However, just under half (48%) agreed that they should be held responsible for addressing business associates' violations if aware of them, with 22% suggesting that the latter requirement be loosened.

• **Patients have no right to sue under HIPAA.**

The majority (66%) agreed with this provision; the remainder felt the opposite.

The survey also found that 57% of respondents said the Department of Health and Human Services' estimate of a $3.8 billion price tag for privacy compliance is too low. Ten percent said it's about right. Six percent said it's too high, and 27% said they didn't know. ■

Project. **(For a look at what individual health care professionals said about the rule, see p. 83.)**

The fight is not over, however, and could end up being settled by an act of Congress. One such measure, House Joint Resolution 38, would allow Congress to repeal a federal agency's regulation on an expedited basis. Another, the Medical Information Protection and Research Enhancement Act of 2001, would make substantial changes in the rule.

Meanwhile, organizations are continuing their lobbying efforts. The AHA's chief Washington counsel, **Melinda Hatton**, says the association will go to Congress as well as to the Bush administration to seek federal funding to help hospitals comply with the HIPAA privacy rule, reports the *AHA News*.

Meanwhile, the association is working to persuade the White House and the Department of Health and Human Services to make changes in the new HIPAA regulations, says Hatton. The AHA's immediate goals are to fix the rules, make changes quickly, and not allow the rules to become an unfunded federal mandate, she explains. The AHA is concentrating on changing rules affecting consent requirements, minimum necessary use and disclosure of medical information, and oral communications. ■

MDs desire 'essential' Internet services

Lack of industry standards their primary concern

Physicians are eager to embrace the Internet's transformation of health care but are cautious about the lack of uniform standards, a recent survey says.

The survey, which polled physician leaders (medical directors and presidents) and office-based practicing physicians in medium and large practice organizations, found agreement that computers already have had a positive impact on the practice of medicine and quality of care. The survey was conducted by Rochester, NY-based Harris Interactive on behalf of the Health Technology Center (HealthTech) in San Francisco, in cooperation with PricewaterhouseCoopers in Los Angeles and the Institute for the Future in Menlo Park, CA.

The researchers surveyed physicians because they are on the front line but still carry most of the risk, says **Lee Akay**, senior partner for the PricewaterhouseCoopers MCS Healthcare Practice in Los Angeles and co-sponsor of the survey. "We wanted to understand their current situation about the Internet and what enabled it." The researchers also wanted to know how they could encourage use of Internet services among physicians.

On-line services will improve medicine

More than a third of the physicians and practice leaders responding to the survey considered a wide range of Internet-enabled core business and clinical services to be essential to health care, with 96% of those surveyed agreeing that these technologies will make the practice of medicine easier and will improve quality of care before 2003.

The physicians identified six Internet-enabled services as "essential" for organizational success and found value in them because they reduce administrative costs, speed payments for care, and improve quality of care. The essential clinical applications were diagnostic reporting and electronic medical records (EMR). The essential administrative services include claims processing, eligibility authorizations, referral authorizations, and information technology systems support.

Some of the respondents were already using these technologies in their jobs. These applications include:

- claims processing services (35%);
- diagnostic reporting (34%);
- pharmaceutical information (34%);
- purchase of medical office products (29%);
- e-mail communication with patients (29%);
- electronic medical records (EMR). (Nineteen percent indicated they are testing or have fully implemented EMR.)

"Physicians are actively seeking to integrate computers and the Internet into their practices and do not appear to need further convincing that technology will play an increasingly significant role," says **Molly Joel Coye**, MD, MPH, HealthTech CEO.

Although physicians see the potential in Internet-enabled services, they are cautious about implementing them. For example, only 7% of the survey respondents have adopted automated prescription systems, despite the Institute of Medicine's 1999 patient safety report recommendation.

What is holding them back? The physician leaders in the survey overwhelmingly agreed (93%) that "lack of system compatibility across health care organizations" is a critical barrier to realization of the full potential of Internet-enabled systems in medicine. This concern about standards ranked much higher than concern about confidentiality and privacy, which ranked only sixth among the concerns. About half of the respondents rated privacy as a minor concern.

Most respondents (93%) said industrywide agreement on standards would be an effective way to drive change in the health care industry. Eighty-four percent said this was the preferred way to bring about universal use of the Internet.

When asked who might step in to fulfill the needed integration and standard-setting, more than two-thirds of the respondents said the most effective action would be steps taken by the Health Care Financing Administration (HCFA) in Baltimore or steps taken by major health plans to require participating physicians to use the Internet for claims processing. The physicians saw little value in creating a nonprofit government-sponsored program to handle these issues.

"These results suggest that HCFA could improve the coordination of patient care and reduce health care costs by supporting providers in their movement onto the Internet and by making Internet filing a requirement," Coye says.

"Health plans can learn [from this survey] that physicians are willing to work with them to develop standards, help design some of the benefits, and at the same time get their portion of the health care dollars," Akay adds.

Only 59% of the responding physicians said increased payment for claims filed over the Internet would be sufficient to cause rapid, widespread change, she says. Akay finds this result to be one of the most surprising in the survey. "You would think that if you increased the capitation rate or if you added some type of fee to Internet usage, Web-enabled services or Internet usage would increase," Akay says. "The physicians, however, were more interested in standards throughout the organization, led by either HCFA on the government side or large plans."

Standards set by the Health Insurance Portability and Accountability Act of 1996 could be a conduit for accelerated adoption of industry-wide standards, Akay says. "The fundamental key to success is how quickly and how well those standards are implemented."

He also sees a challenge not only in establishing standards throughout the industry but also in figuring out how to share the efficiencies that are created by Web-enabled technology. "One group shouldn't get all of the benefit. Finding a way to share those efficiencies [among hospitals, physicians, and health plans] will be key."

The survey was conducted from Nov. 29, 2000, through Jan. 10, 2001, with a total of 215 practicing physicians and physician leaders of medical practice organizations with at least 25 physicians. The surveys were completed on-line using random samples of physician practices drawn from the American Medical Association Group Practice File and the Physicians List.

The survey data was weighted to reflect the composition of the Practice File and the Physicians List with regard to the following variables: group practice size, region, and medical specialty (for practicing physicians only). ■

Medicare+Choice tests private fee-for-service

Program will be offered in 17 states

Anticipating a trend toward increasing use of fee-for-service payments, the Health Care Financing Administration last year approved a request by the Sterling Life Insurance Company of Chicago to offer the first private fee-for-service health plan option for Medicare patients. The plan is now available in 17 states.

Medicare participants enrolling in the new private fee-for-service plan will not be restricted to a network and may get health care services from any Medicare-eligible provider in the country.

Sterling's fee-for-service option provides coverage for all Medicare Part A and B services, plus worldwide emergency care and coverage of increased inpatient hospital days.

Providers who choose to provide care to beneficiaries enrolled in a private fee-for-service plan will be paid on a fee-for-service basis by the plan and are not subject to utilization review.

This is the first private fee-for-service plan to apply under the Medicare+Choice program. The Sterling plan will be offered primarily in rural areas where Medicare+Choice options have not been widely available. It is expected to be popular with beneficiaries in these areas.

States where the plan will be available are:

Alaska, Idaho, Kentucky, Minnesota, Nebraska, Nevada, New Mexico, Oregon, South Dakota, Tennessee, and Utah. It will also be offered in selected counties in Arkansas, Louisiana, Mississippi, Ohio, Texas, and West Virginia. Contact your local Medicare carrier for more information. ■

Many practices paid twice for same service: OIG

Changes in pay practices recommended

The same Medicare claims are often paid twice because carriers' processing procedures are not set up to catch duplicative payments, according to a study by the Office of Inspector General (OIG). What's more, these double payments frequently go unnoticed by auditors.

Based on its research, the OIG concludes that up to 25% of the providers studied had a "significant number of" (meaning at least 20) potential duplicate billing overpayments.

The OIG says confusion among carriers and providers about whom to submit bills to for specific services is the main cause of most double payments. Other reasons for duplicate billing include confusion resulting from carrier transitions, having offices or performing services across state lines, and inadvertent errors by billing services.

Some providers, for instance, told the OIG they submitted duplicate bills to Medicare because they just did not know which carrier to bill for a certain claim. One New York City physician told investigators that he learned that services he provided in Queens should be processed by a different carrier from the one that processed claims for services he provided in other locations.

He resubmitted his claim for the services delivered in Queens to the appropriate carrier, assuming he would not receive reimbursement from the incorrect carrier. However, he was reimbursed by both carriers for the same services rendered in Queens.

To prevent such multiple reimbursements, the OIG is recommending that the Health Care Financing Administration (HCFA) revise its Common Working Files edits to detect and deny duplicate billings to more than one carrier. These files were established in 1991 to improve the accuracy of Medicare claims processing.

However, if HCFA determines this change is too costly, the OIG wants it to increase its post-payment reviews, especially in regions where providers commonly perform services in multiple carrier jurisdictions.

To access the report, "Medicare Payments for the Same Service by More Than One Carrier" (OEI-03-00-00090), check the OIG web site at www.hhs.gov/oig/oei/whatsnew.html. ■

Worried about fee waivers? No need to, says OIG

Still, caution is the keyword

Concerns on the part of the Office of Inspector General (OIG) that unusual charitable practices of some providers and ambulance services could be considered illegal has had many practices worried they would be rousted by the fraud police for occasionally waiving the copayments of poorer patients.

"Not to worry," says OIG spokeswoman **Alwyn Cassil**. The OIG does not plan any kind of organized investigation into co-pay waiver practices, she promises.

Providers are permitted under Medicare Part B to waive copayments once they have made a good-faith effort to determine the financial condition of the beneficiary. The OIG, however, was concerned that the routine waiver of copayments could be associated with serious violations of reimbursement rules.

When it comes to creating a workable definition of financial hardship to justify waiving a co-pay, "I recommend my clients use an objective standard, preferably one set by another entity," says **Mike Carlson**, a health care lawyer in Birmingham, AL.

"For example, I have clients who have used their state's Medicaid eligibility standard. Others have used the food stamp program's standards and the federal poverty guidelines," he notes. The financial hardship line starts to blur, however, when it comes to what could be considered a temporary situation resulting from an unusual personal circumstance such as divorce, loss of a job, or catastrophic illness.

"Before we will waive Medicare co-pays and

(Continued on page 91)

DRG CODING ADVISOR.

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

Should forms be considered part of medical record?

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 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 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.

Working in a less-than-perfect world

"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?'"

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. 87.)**

"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 different from something they'd 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." ■

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."

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." ■

Navigating the abyss of medical necessity

Break the rules and you'll pay the price

Knowing whether the patient, the provider, or the government is liable for payment of a service that Medicare or one of its local carriers says is not medically necessary is becoming increasingly important to a practice's financial health.

As part of its crackdown on fraud and abuse in the Medicare program, the Health Care Financing Administration (HCFA) and local carriers are devoting more energy to determine if providers are following established guidelines regarding the medical necessity of the services they bill for — plus required documentation.

Medicare's policy says it only pays for those services and procedures it has determined to be medically "reasonable and necessary" for diagnostic, treatment, and therapeutic purposes.

Does the beneficiary know?

According to the Medicare manual, if a provider knows or should have known that a specific service was not covered by Medicare, then the provider is financially liable for the service. But if it is determined the beneficiary knew or should have known the service he or she received was not covered by Medicare, then the beneficiary is ultimately liable.

However, if neither the patient or the provider knew or "could have reasonably been expected to know" that the service was not considered medically reasonable and necessary and would not be covered by Medicare, then HCFA is ultimately responsible for paying the claim.

Bottom line: Providers are responsible — and will be increasingly held accountable — for knowing which services are covered and considered medically necessary and which are not.

To keep from being stuck with unpaid claims, providers and their staff must stay current with Medicare payment policies. Practices also need to know when to avoid any possible confusion by asking patients to sign a liability waiver stating that the patient knows Medicare will probably not pay for a certain service and the patient — not Medicare — is responsible for paying that bill.

Currently, there are three basic ways Medicare can deny payment:

1. Medicare will deny claims for non-covered services that have never been paid by Medicare under any conditions. These include such things as routine check-ups and certain immunizations or drugs. Because it is clear the beneficiary is responsible for payment in these circumstances, no provider liability waiver is necessary.

Get waiver for unnecessary services

2. Medicare will not reimburse for services deemed not medically necessary by HCFA or local carriers. In this situation, the beneficiary should sign a waiver of liability in advance, expressly accepting responsibility for payment.

Tip: The modifier -GA added to the end of the CPT code indicates to the carrier that the patient has signed a waiver of liability.

3. Unbundled services cannot be billed to a Medicare beneficiary. For instance, if a provider gives a patient an injection and performs an evaluation and management (E/M) service on the same day, the physician cannot separately bill Medicare for the E/M service and the patient for the shot. HCFA considers the injection to be included in the E/M service payment. Billing the beneficiary separately for the shot would be classified as unbundling, and patients are not responsible for paying for unbundled services under Medicare. ■

HCFA expands cancer coverage

A national campaign to screen Medicare beneficiaries for colorectal cancer — the No. 2 cancer killer — was launched in March by the Health Care Financing Administration (HCFA). The Centers for Disease Control and Prevention, the National Cancer Institute, and HCFA are targeting people 50 and older in an early detection and prevention effort called Screen for Life.

As part of this program, beginning in July, Medicare will begin to cover screening colonoscopy every 10 years for people not at high risk for colorectal cancer.

Medicare currently covers a:

• yearly take-home fecal-occult blood test with no co-pay or deductible;

• flexible sigmoidoscopy every four years (beneficiaries pay 20% of the Medicare-approved amount after the annual Part B deductible);

• colonoscopy for high-risk individuals every two years (beneficiaries pay about 20% of the Medicare-approved amount after the annual Part B deductible);

• barium enema as an alternative to either the sigmoidoscopy or the colonoscopy.

"We want our beneficiaries to know that Medicare covers four types of colorectal cancer screening tests," said **Tommy G. Thompson**, Secretary of the Department of Health and Human Services. "Medicare is encouraging every one of our beneficiaries to ask his or her doctor or health care professional for a colorectal screening test." ■

New review medical criteria published

19 items can be audited quarterly or annually

Knowing what constitutes medical record completeness in the eyes of the Joint Commission on 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 launch to address their findings.

Improvement must be demonstrated

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 audits are conducted on a quarterly basis, the quarterly results should be made available to the Joint Commission, and activities to address improvement should be evident. If the audits are 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 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. ■

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 in Washington, DC by the American Hospital Association (AHA). These ambiguities could pose significant hardships for both providers and payers, says **George Arges**, senior director of the AHA's Health Data Management Group and chairman of the National Uniform Billing Committee.

During his testimony before the National Committee on Vital and Health Statistics, Arges said the adoption of the NDC in lieu of the Health Care Financing Administration's "J" codes now in use would require extensive conversion and replacement of existing information systems, as well as the associated training costs in working with the new code set. Although the cost would vary according to the size of the facility, hospital estimates put the price at a minimum of $200,000 per facility. ■

(Continued from page 86)

deductibles, the patient must apply and qualify for charity services, regardless of the third-party payer or their lack of insurance," says **Stephanie David** of the Mountain States Health Alliance, a managed healthcare system based in Johnson City, TN.

Waiving medical fees for services provided to other physicians, family, and friends used to be common among most practices. However, the emphasis on fraud — or the appearance of it — has discouraged such professional courtesies.

Be wary of referral relationships

But the practice is not automatically considered illegal as long as the decision is not based directly or indirectly on that person's ability to refer federal health care business to you, and as long as it is not a consistent practice of waiving the entire fee for services to a group of people, including employees, physicians, or their family members.

Whether waiving fees as a simple professional courtesy is legal generally depends on how you select recipients and how you extend the courtesies.

According to attorney **Alice Gosfield** of Gosfield & Associates, Philadelphia, the following are potential traps to avoid:

— selecting recipients in a way that directly or indirectly takes into account their ability to affect past or future referrals;

— providing professional or other health care services for free or at a discounted rate in a way that creates a financial relationship that violates self-referral restrictions.

"Just providing or accepting professional courtesies can place you in the potentially awkward position of trying to prove that they were not intended to induce referrals," notes **Andrew H. Joseph**, JD, assistant vice president with Strategic Management Systems, a management consulting business in Alexandria, VA, that specializes in compliance and ethics programs in health care.

Also, waiving copayments for federal health care program patients who are not financially needy can put you in potential violation of the False Claims Act, because the government views the routine waiver of deductibles or copayments as a misrepresentation of the actual charge — in other words, a false claim. ■

Thinking outside the box reaps benefits for clinic

Patient access, collections have increased

East Albany (GA) Medical Center does things a little different from the typical medical practice: The support staff escorts patients and takes vital signs; a nurse reminds the patients of unpaid balances; and the entire 56-member staff, from the front desk to providers, can be in constant communication with each other via walkie-talkies.

And it works.

The clinic, in rural south Georgia, employs 19 physicians and 10 physician assistants who see more than 39,000 patients a year. Patients can get an appointment within 24 hours after calling, and all patients, including walk-ins, are in and out in 45 minutes or less.

After an extensive re-engineering project geared to increase efficiency and improve patient access, patient satisfaction is at an all-time high and collections are up. And the project costs very little because it uses common, off-the-shelf technology such as cordless telephones and electronic databooks.

The redesign project took place over a six-month period as four members of the clinic staff attended a six-month course in re-engineering and applied the techniques they learned to improve patient flow.

"The seminars taught us about redesign and thinking outside the box. We took those concepts and started applying them in our clinic," says **Ron Malcolm**, PA-C, a physician assistant and leader of Team Delta Force, the redesign team. Other members of the team were Bernard Scoggins, MD, medical director; Diane Carter, business manager; and Belinda Morrison, RN, nurse manager.

After a 90-day implementation period and trial, the redesign team is in the process of expanding the redesign to include the other six clinics operated by Albany Area Primary Health Care.

Their efforts have received an Innovations in Health Care Award from the American Academy of Physician Assistants / Physician Assistant Foundation / Pfizer recognition program.

The goal of the project was to increase efficiency at the clinic and cut down on lengthy waiting times for patients. The team started by taking detailed measurements of patient flow. Each team member followed patients one at a time from the

time they walked in the clinic door until they left. This helped identify the problems and bottlenecks.

Their solution was to change the way the clinic operated and boost communications by using inexpensive, off-the shelf technology including walkie-talkies for all staff, electronic databooks and cordless telephones for the nurses, and computer terminals in all the treatment rooms. **(For more information on how the clinic uses walkie-talkies, see story at right.)**

"We used everyday equipment that doesn't cost much. If you really take the time, you can see that there is a better way to do things at very little cost," Malcolm says. The biggest cost was $12,100 to buy and install computers in each treatment room.

The staff of 56 is divided into teams, which include a front desk clerk and a records clerk as well as the provider and the nurse. Some of the clerks work with more than one team.

"A critical part of the redesign was training everyone on the staff to be a part of the team," Malcolm says. For instance, the front desk people and records people are trained to escort the patient to the treatment room and take basic vital signs.

Initially, the nurse director provided the training. The clinic has worked with a local technical school on a cross-training curriculum. When the clerks have finished their training and meet the proficiency standards set by the practice, they will get a step raise in hourly wages.

"They are really excited and love being part of the team. It makes them feel involved with the patients," Malcolm says.

Cordless phones enable contact with pharmacy

The clinic couldn't afford to put telephones in each treatment room but was able to buy six 900 Mhz cordless phones for each team's nurse to use. The nurses also have electronic databooks that include pharmacy names and telephone numbers.

Thus, if a patient in the treatment room isn't sure whether her medicine needs refilling, the nurse can call the pharmacy. The process has greatly reduced the number of phone calls the practice receives for prescription refills, Malcolm says.

"We had been inundated with elderly patients calling us after their visit to say their prescription needed refilling. It added a whole level of additional work, pulling the chart, getting the approval of the provider, calling the pharmacy. This way, the proper number of refills can be made because the nurse knows when the follow-up appointment is." ■

Walkie-talkies solve communications problem

Team members can be in touch instantaneously

Like most medical offices, East Albany (GA) Medical Center had problems with communication between the providers and nurses before their re-engineering project. In fact, improving communication was the first task the practice's re-engineering team tackled.

The team decided to try solving the problem by using walkie-talkie headsets to provide two-way communication between nurses and providers.

Ron Malcolm, PA-C, team leader for the redesign project, gives this example of time savings: Imagine that the provider leaves the exam room to go look for the nurse. Meanwhile, the nurse is around the corner making a telephone call. There is an inevitable wait for the provider and the patient.

Time savings accumulate rapidly

With the walkie-talkies, the provider merely asks the nurse for whatever he or she needs, without leaving the patient's side. "Multiply that day in and day out, and the time savings are enormous. The frustration level just melted away," Malcolm says.

The process worked so well that the clinic added the front desk person and the records person to the same walkie-talkie frequency.

Now, if a patient is coming in late or has any other issues, the front desk can communicate instantaneously with the provider or the nurse. The records person also hears the conversation and can be looking for the chart by the time the conversation is over.

Adjusting to the walkie-talkies was frustrating initially, Malcolm says. "At first, the chatter was truly awful. We learned to minimize the chatter so we were communicating only about the patients," Malcolm says.

The walkie-talkies are not secured lines, so staff are cautioned not to mention specific names or diagnoses. Also, when a provider doesn't want to be interrupted, he or she can push a button that sends a code that his or her headset is off. Later, the provider can flip the switch to go back on-line. ■

Manage costs, contracts to survive reimbursement

Stay on top of HCFA's updates

Reimbursement levels will continue to decrease and present challenges to same-day surgery managers because Medicare and other payers are focusing on outpatient procedures, says **MaryAnn Edwards**, RN, MSA, supervisor of ambulatory surgery at Henry Ford Health System in West Bloomfield, MI. This focus makes controlling costs more important than ever, she points out. "Our hospital has set up purchase and acquisition teams that group similar departments together to look at supplies and equipment to see if we can standardize supplies," she says.

Standardizing or reducing the number of different supplies and vendors enable the facility to take advantage of greater discounts for volume purchasing and avoid special orders, she explains. "The savings give us more money to spend on new technology," she adds.

Purchasing technology will be an even greater challenge for same-day surgery managers who are watching budgets shrink, says **Beth Derby**, RN, MBA, executive vice president at Health Resources International, a West Hartford, CT-based management and consulting firm for ambulatory surgery centers. Managers of surgery centers owned by physicians will feel the greatest challenge; their physicians are accustomed to purchasing what they want because they own the center, she says.

"Doctors at hospital-owned same-day surgery programs are experienced with rejection," she adds. "These surgeons don't expect to get every piece of equipment they request, but physician owners will have to make tough decisions."

The manager will have to be prepared with data to show which specialties' new technology will offer the best return for the program, she adds.

Reimbursement has resulted in and will continue to generate a lot of changes for same-day surgery programs, says **Penny Dykstra**, RN, CNOR, director of outpatient services at Saint Joseph's Hospital of Atlanta. "The changes in reimbursement initiated by [the Health Care Financing Administration] in August 2000 for hospital-based outpatient programs were the biggest changes since the inception of Medicare," she says.

The challenge for hospital-based programs has been the switch from reporting based on diagnosis-related groups to the use of common procedural terminology (CPT) codes, with payment differences based on how the procedure is coded, she says. "Outpatient programs have typically relied on manual data collection that is not efficient with the new prospective payment system," says Dykstra. Every same-day surgery program should have or get automated systems that make data collection simpler and more accurate, she suggests.

Change is the one constant in the HCFA system that Dykstra can safely predict, "HCFA will continue to monitor the hospital outpatient system and make changes, so managers need to stay on top of updates," she says. Annual reviews and updates are required by Congress, adds Dykstra. The best way to find out about updates is to visit the HCFA web site (www.hcfa.gov), suggests Dykstra. "Visit this site regularly," she adds.

Freestanding ambulatory surgery centers also can check the HCFA web site for information and keep an eye on what is happening for hospital-based programs, suggests Dykstra. "While the rules for freestanding programs will differ, a manager will get an idea of the trends in reimbursement," she says.

Make sure coding is accurate

The earliest HCFA can implement ambulatory payment classifications (APCs) for outpatient centers, based on the old data used for hospital-based programs, is January 2002, but an implementation date no earlier than January 2003 will give HCFA an opportunity to use new data to develop rates, says **Kathy Bryant**, JD, executive director of the Federated Ambulatory Surgery Association in Alexandria, VA. In the meantime, managers of freestanding ambulatory surgery centers or office-based programs should focus on knowing their costs and making sure their coding is accurate, says Bryant. More importantly, she cautions managers not to purchase materials, software or services that promise to help outpatient program managers prepare for APCs.

"The information upon which these materials are based is the two-year-old proposed rules that received over 6,000 comments when originally published," she points out. There is no way anyone can accurately predict what the final rules for outpatient centers will be since HCFA is constantly changing the rules for hospital-based programs and gathering new data, she adds.

Proposed rates can be used in the decision-making process for a new piece of equipment or a new service if the manager remembers the rate may change, says Bryant. "Look at the proposed rate, but plan on a 20% margin of error to determine if this is a good addition to your program," she adds. Remember that HCFA will be changing reimbursement rates regularly when you negotiate managed care contracts, says Bryant. "If the contract refers to Medicare rates, be specific about which rates," she suggests. Make sure the contract allows for updated rates, the addition of CPT codes, and new procedures approved by Medicare for same-day surgery programs, she adds. ■

Is your department ergonomically correct?

Foot rests, keyboard trays can help

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

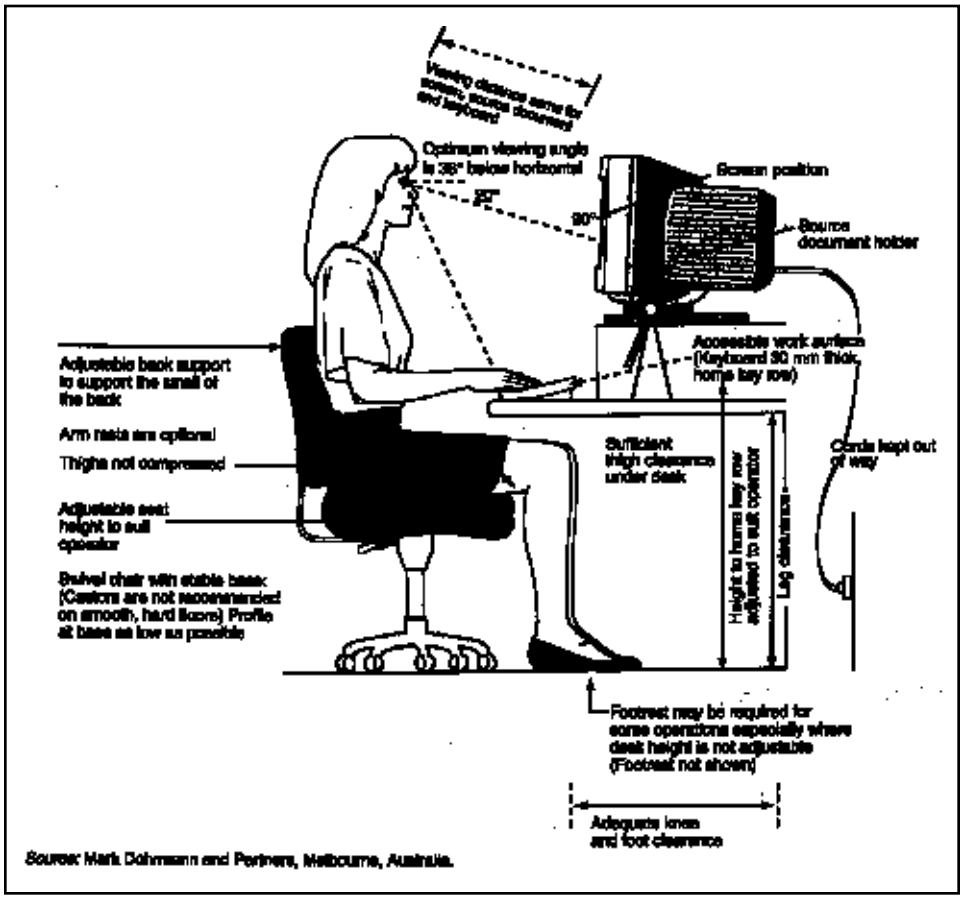
Among other things, that associate was given a chair with arm rests, and a cushion for the keyboard tray to help support her wrists, Kehrer says. Discussions with the nurse alerted her to the federal Occupational Safety and Health Administration's (OSHA) ergonomic standard, which became effective in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

OSHA is scheduled to begin enforcing the standard, which requires hospitals and health care providers to take specific actions to address job-related musculoskeletal disorders and implement a broad-based ergonomics program, in October 2001. With that in mind, Kehrer says, she took some additional steps toward making the workplace ergonomically correct for all the access staff. Using a template for the design of a video display terminal station that the nurse provided as a guideline, Kehrer made some changes. **(See illustration, below.)**

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

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

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



Medicare begins coverage of intestinal transplants

Medicare coverage of intestinal transplants for beneficiaries with irreversible intestinal failure began April 1, with the implementation of a National Coverage Decision by the Health Care Financing Administration in Baltimore. These procedures will be available at three transplant centers recently approved by Medicare: the University of Pittsburgh Medical Center, the Jackson Memorial Hospital Transplant Center in Miami, and The Mt. Sinai Hospital in New York. The procedure will benefit the relatively few Medicare beneficiaries whose intestines are unable to absorb nutrients.

Intestinal transplantation is a relatively new technology that has been pioneered in this country primarily at the University of Pittsburgh School of Medicine. Fewer than 1,000 transplants have been performed in the United States, with approximately two-thirds of the patients being children. ▼

AHIMA, 3M to provide Web-based APC courses

The American Health Information Management Association (AHIMA) in Chicago has joined with 3M Health Information Systems in Salt Lake City to offer web-based continuing education (CE) training for understanding and successfully navigating the outpatient prospective payment system (OPPS) environment and ambulatory payment classifications (APCs).

The curriculum includes:

• **APC Basics (8 CE credits).**

This course provides the information needed to understand the impact of the OPPS on health care organizations. It includes an overview of APCs and addresses the topics of data required for APC assignment, chargemaster maintenance and billing, and charging accuracy.

• **APC Coding and Documentation Issues (12 CE credits).**

This course reviews how the accuracy of outpatient coding affects APC reimbursement and discusses ways to improve critical outpatient coding. It also includes lessons on HIM operations related to APC implementation, HCPCS coding, evaluation and management coding, and the use of modifiers.

• **Outpatient Code Editor (OCE) Essentials (5 CE credits).**

This course outlines information on billing and reimbursement issues related to the APCs so

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Editorial Questions

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health care organizations can maintain cash flow and minimize claims rejections and denials. Topics covered include OCE edit categories including National Correct Coding Initiative (NCCI) edits, denial management, and operational issues.

Health information management professionals can access APC courses through AHIMA's Continuing Education Interactive Learning Campus. Courses can be bought separately for $250 each or all three for $650. To register for APC courses or to find out about other AHIMA on-line courses, visit www.ahimacampus.org. For a free demonstration of the program, visit www.ahimacampus.org/demos. ▼

Lack of education, private billing blamed for errors

Witnesses at a House of Representatives hearing in April said a lack of regulatory education and the private companies who process Health Care Financing Administration (HCFA) Medicare billing and payments are to blame for errors in compliance and billing, reports the American Hospital Association (AHA) News.

At Medicare's inception in 1965, providers were given authority to name payment intermediaries. **Michael Mangano**, acting inspector general for the Department of Health and Human Services, said that authority should belong to HCFA so the organization could better monitor the private contractors who file payments and billing to providers of Medicare services, the AHA says.

Committee members echoed remarks by Health and Human Services Secretary **Tommy Thompson** to the effect that HCFA reform should include modifications in private contractor selection. Other errors were attributed to the vast and complex Medicare regulatory policies, which cause many doctors to drop out of the program for fear of penalties for honest mistakes. However, HCFA representative **Mark Miller** said payment errors have been cut in half since 1996 and the administration is involved in a comprehensive outreach program to educate providers. For more information on the hearing, visit the House Energy and Commerce Committee web site at www.house.gov/commerce/. ▼

Johns Hopkins launches hand-held antibiotics guide

Johns Hopkins Medicine in Baltimore has launched a peer-reviewed database and point of care decision-support system designed to give hospital- and office-based physicians free updated information on antibiotics and their proper use.

The Antibiotic Guide (ABX Guide) is the first in a planned series of regularly updated digital medical handbooks from Hopkins specialists. The guide works on the web (http://hopkins-abxguide.org) and personal digital assistants (PDAs), such as the Microsoft PocketPC.

The guide offers information on more than 160 drugs and more than 140 diseases treated by both specialists and primary care physicians. Emergency alerts, such as Food and Drug Administration recalls, can be "pushed" to all users in an instant, assuming physicians access the updated database regularly.

Development of the ABX Guide was funded by unrestricted educational grants to Hopkins POC-IT from various sponsors. Sponsors are acknowledged in a special section on the web site, but no banner or commercial advertising exists in any of the applications. ■