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(Continued on next page)

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Groups oppose complexity, cost of new coding system

Associations support single coding system

The Health Care Financing Administration (HCFA) heard an earful in mid-May about implementing the new procedure coding system for inpatients, the ICD-10-PCS. During a recent meeting of HCFA's ICD-9-CM Coordination and Maintenance Committee, representatives from several health care organizations expressed reservations about the cost and the complexity of the system.

Under contract to HCFA, 3M Health Information Systems of Salt Lake City developed ICD-10-PCS as a potential replacement for the procedure codes, volume 3, of the International Classification of Diseases (ICD) codes, ninth edition (ICD-9).

The National Center for Health Statistics is also revising a clinical modification (CM) of the World Health Organization's ICD-10 classification. ICD-10-CM is planned to replace the ICD-9-CM, volumes 1 and 2. No implementation date has been set for either system.

In its testimony, the American Health Information Management Association (AHIMA) in Chicago called for the implementation of a single coding system.

"If ICD-10-PCS goes into effect, the push for a single system will escalate because it will be apparent that we will have two highly specific systems with different codes for the same entities," said **Linda L. Kloss**, MA, RHIA, executive vice president and CEO of AHIMA. "The possibility of a single procedural coding system should be evaluated now so an informed national decision can be made about the best long-term solution for all health care settings, services, and payers."

Kloss recommended that federally funded research evaluate the feasibility of moving to a single system.

(Continued from cover)

COMING IN FUTURE ISSUES

- Palm technology guarantees legible prescriptions
- Provider stresses education in coding compliance program
- HCFA speaks out on query form issue
- Physicians file claims to payers directly over the Internet
- HCFA publishes guidance on privacy rule

This research should examine:

- the efficacy of alternative systems across all health care settings, payer types, and health care services;
- the implementation and long-term cost and benefits of a single system compared to the implementation and long-term cost and benefits of operating multiple systems;
- a recommended strategy for implementation that takes into account the need to implement ICD-10-CM for diagnoses.

While AHIMA says ICD-10-PCS is a potential candidate as a single procedural coding system, the organization does not think the system has been adequately tested in all the areas that would be necessary for use beyond hospital inpatient services, Kloss stated.

AHA: Take steps before implementation

The American Hospital Association (AHA) in Chicago also called for extensive testing before the system is implemented.

Before implementation takes place, the AHA wants the new system to be tested for all services in all settings, said **Nelly Leon-Chisen**, director of the central office on ICD-9-CM at the AHA. "Thus far the testing has been limited to primarily the medicine and surgery sections in the inpatient hospital setting."

The testing also should consider the compatibility of the new system with existing payment systems, whether they are DRGs (diagnosis-related groups), APCs (ambulatory payment classifications), or simple fee schedules, she added.

The AHA maintains that the ICD-9-CM is due for an overhaul. "The ability to expand enumeration for a particular procedure category is limited because of the physical numbering constraints contained in the current ICD-9-CM system," said Leon-Chisen. "Consequently, some categories provide vague and imprecise procedure codes."

The AHA has been pleased with field-test results of ICD-10-PCS so far, she explained. "Results indicate that ICD-10-PCS can easily accommodate the expansion of new procedure codes. Coders working with ICD-10-PCS also found the new system to be efficient, logical, and easy to understand and learn."

While coding change is necessary, however, migration to ICD-10 would be costly and complex and should not occur until three years

beyond implementation of Health Insurance Portability and Accountability Act regulations, Leon-Chisen said. She also recommended that HCFA work the cost of implementing significant new regulations into the Medicare prospective payment rate updates.

AMA: We do not support ICD-10-PCS

One organization does not think that ICD-10-PCS should be implemented. "Based on the AMA's support for the elimination of complex regulatory burdens mandated by the Medicare program, the AMA does not support the adoption of ICD-10-PCS," testified **Michael Beebe**, a project director at the American Medical Association (AMA) in Chicago. The ICD-10-PCS system would replace the Current Procedural Terminology coding system, which the AMA developed in 1966.

Beebe made these points against implementation of the coding system:

- Implementation will only add to the regulatory burden faced by physicians and other health care providers.
- The coding system is complex and excessively formal, Beebe said. "PCS is not based on the natural language of physicians and other health care professionals, but rather a highly structured system of character positions with embedded meaning."
- ICD-10-PCS is a substantial departure from ICD-9 and from all existing health care code sets. The system departs from traditional terminology and anatomic organization, Beebe said. This means that an "informed individual cannot begin coding by using an index, intuitive reasoning, or clinical knowledge."
- ICD-10-PCS would require significant resources to implement, both in terms of systems and coder and provider education.

Beebe also expressed concern that the some of the chapters and sections have a limited ability to expand within the system's seven-character alphanumeric structure and that the process for maintaining and updating PCS has not been defined.

Like the AHA, the AMA has concerns about the cost associated with implementing the new coding system. The cost could include significant training of new staff and computer system changes that will likely be needed to accommodate additional characters, Beebe said.

Providers need greater simplicity in the Medicare program, he said. Because of the ICD-10-PCS' complexity and its inherent problems, the AMA says the system may not be worth the implementation cost.

HCFA also announced at the ICD-9-CM Coordination and Maintenance Committee meeting that it would hold a public meeting on the use of physician query forms. A formal announcement including location, date, and details will be placed in the *Federal Register*, according to AHIMA sources. The public meeting is expected to take place at the end of this month. ■

Financial stability? It's in the coding

External audit of medical records is first step

Never before has coding has been so crucial to the financial stability of an organization. As the Office of the Inspector General in Washington, DC, focuses on certain coding practices, health information management professionals are feeling the need to institute coding compliance and education programs.

Ray Pinder, MS, RHIA, has worked with several such programs in his 25 years of being a medical records director. Now, as director of medical records services at Holy Redeemer Hospital and Medical Center in Meadowbrook, PA, he has made it a priority to enhance the coding compliance and education program at his new facility.

"It's important that as a manager, I know the coding quality of my department in case I am questioned by my chief financial officer or chief executive officer on why our case mix index may be going up or down," he says. He needs to know, for example, if any changes in the case mix are significant or just due to a different patient volume that month.

Pinder began setting up the health information management program at Holy Redeemer with the blessing of Don Friel, Holy Redeemer's senior vice president and chief information officer, to whom Pinder reports. First of all, Pinder knew the program needed the assistance of a coding specialist. "I have a strong background in reimbursement methodologies, but coding is not my daily function," he says.

At the end of April, Pinder hired a coding manager to run and enhance the coding compliance and education program and to support the coding staff at Holy Redeemer. The manager, Margaret Giancaterino, RHIT, has more than 20 years of coding experience.

As a new director coming into the facility, Pinder had already discussed with Friel the need to have a baseline study conducted by an external auditing company. "We needed to evaluate the quality of our coding in comparison with external regional and national data," Pinder explains.

Friel had wanted to do such an audit for some time, Pinder says. "Prior to my coming on board, we started talking about the vendors we would [consider]."

To decide among vendors for the baseline review, Pinder pulled from resources that he had used at his previous organization. He then asked for price quotes from the vendors, which he and Friel reviewed. "I made recommendations based on my knowledge of the companies," Pinder says.

The vendor chosen for the audit reviewed three months' data covering all inpatient admissions and outpatient visits. The data were provided by Holy Redeemer's information systems department. When the vendor ran the data through its system, it made a random selection of 100 records on each side. "We used that as our sample size, and it was above 5%. It was a good sample size for the study," Pinder says.

This first review took place within three months of Pinder's employment at Holy Redeemer. The final report, which was submitted to senior management as well as to Pinder, demonstrated that the coding at the facility was well within the national average, Pinder says. "We were informed that the ranges go anywhere from 92% to about 98% for accuracy in coding. We were in a 95% to 96% range."

Reviewing the recommendations

When Holy Redeemer received the results of the audit report, Pinder and Friel sat down with their coders — three full-time and three part-time employees — and reviewed the results with them. "We wanted them to know that they did well in the external review," Pinder says.

The report offered recommendations, because the audit looked at documentation as well as coding. The reviewers broke their comments about documentation into two categories of problems: The coders made errors because they missed documentation that was present, or the documentation was lacking in the first place.

"If the coders missed documentation that was present, we alerted them and put a reminder notice in each of their mailboxes, telling them to look for a certain report [in the record]," Pinder says. "Our coding staff reviewed the audited results and were given the opportunity to dispute cases based on coding guidelines."

If documentation was lacking, Pinder worked with Holy Redeemer's medical director to provide feedback to the medical staff. This feedback was provided either through a newsletter or by the medical director or Pinder going to the medical staff's monthly departmental meetings and giving a documentation update.

Comparing later audit results

Pinder and his coding manager then developed their own coding quality review. On a monthly basis, Giancaterino will review a sample of each coder's work for accuracy and complete the chart review to determine whether all the codes were properly identified. "If any were not, our work tool for both inpatient and outpatient [coding] would document the variances," Pinder says. These tools handle the different types of questions related to diagnosis-related groups and ambulatory classification payments.

Those worksheets are then tabulated, and the coders have an individual monthly review of their coding quality. If problems are found that seem to happen across the board, Pinder and Giancaterino have a general discussion during their monthly coders' meeting about how these patterns can be corrected.

Pinder presents a quarterly summary of this report to the hospital quality performance committee. He will also use the monthly and quarterly reports to supplement the department's annual evaluation for coding accuracy, quality, and productivity. Although the department does have a productivity standard, it is not the most important indicator, he says. "Quality is first and foremost over productivity."

(Editor's note: Next month in Hospital Payment & Information Management, *Pinder addresses the education component of his coding compliance and education program and how his program will affect the entire Holy Redeemer Health System.)* ■

Getting 'self-pays' paid: Hospital seeks solutions

HDX pluses, minuses examined

It's a scenario that can wreak havoc on a hospital's bottom line: A patient comes to the emergency department (ED) and, in the urgency of the moment, has forgotten his insurance card. Or an accompanying family member says, "I think my mom's on Aetna, but I'm not sure." ED registrars create an account listing the patient as "self-pay" and may — as is the case with The Ohio State University (OSU) Medical Center in Columbus — notify the patient of that in a letter a few days later that also asks the person to contact the hospital if he or she has insurance.

In many cases, says **Sue Alden**, RN, MS, director of registration training and quality assurance, the hospital may not get paid for the service. At best, payment is delayed, often for months or more.

As OSU Medical Center looked at ways to optimize its use of the SMS registration system, which was installed in January 1999, Alden notes, a key question was, "How can we enhance our ability to bring money in?" With self-pay accounts responsible for a big part of the institution's missing revenue, she says, one of the answers to that question was to implement the electronic insurance verification system from HDX.

Win-win situation

Although the hospital also had looked at stand-alone systems, notes **Joseph Denney**, CHAM, lead, patient management system implementation, HDX ultimately made sense because of its partnership with Malvern, PA-based SMS. "When you buy the products together, you get a good deal financially. We made a conscious decision [to go with HDX] because of everything else that came along with it."

With HDX in place, the above ED scenario changes dramatically, Denney says. If the insurance company involved is on the system, it will be queried — through entry of the patient's name, Social Security number, and date of birth — and will provide the registrar with a policy number, group number and whether the coverage is effective for that patient account, he adds. "It's a win-win situation."

In addition to those who simply forget their card, Alden says, "we're frequently finding insurance on people who said they were self-pay."

Another advantage to the system, Denney points out, is that a patient who says he has Medicaid may have forgotten that he subscribed to an HMO. "HDX will go in and search the system, and if the patient is in an HMO, that information will come back."

It's too early in OSU Medical Center's implementation of HDX to know exactly the percentage of patients the system will cover, Alden says, "but even if we can check 40%-60% of the cases, we're better off. It's well worthwhile — anything you can do to improve self-pays is worthwhile."

In general, the HDX coverage rate for central Ohio is about 55%, Denney adds, and the company has promised to work with the hospital on special requests. For example, "one of those I would shoot for is our own health plan," he says. "We take care of our own employees, and that's 25,000 people."

Competition should drive improvements

Under the present arrangement, HDX covers about 20 insurers with which OSU Medical Center does business, including Medicare, Medicaid, Medical Mutual of Ohio, and United Healthcare, among others. "Ultimately, we would like to see a company that covers all [insurances]," Denney notes, "and with some of the Internet-based products, that is closer than we might have thought." The competition provided by the companies that provide the service through the Internet, he suggests, will spur other vendors to increase the number of insurers they cover.

With HDX in place, the insurance verification happens as the registration is being done, which saves the time that financial counselors and precert personnel have spent going into another system to check on insurance status, Alden says. In addition, input errors are eliminated. Besides these more obvious benefits, she notes, the system offers these advantages:

- **Information is more specific.** "We're finding that by being able to check eligibility on Medicare, we're getting, for example, exactly how a name is spelled," she points out. "We might have had a rejection before because the name didn't identically match what Medicare had."
- **Plan code confusion is decreased.** Because of confusing insurance cards and patients who

are unclear about the coverage they have, registrars sometimes put in one type of Aetna plan when it should be another Aetna product, Alden says. In one case, she points out, the faint watermark of a "C" is the only difference between the cards for two different insurance cards. Use of the HDX system eliminates that issue for the insurance companies it handles.

• **You can correct problems before the bill drops.** There are real benefits from a quality assurance perspective, she notes. "When you see an account that is missing a number, or doesn't look like the registrar pulled off the right number, you are able to correct that. It allows you to do a lot more upfront fixing."

• **Extra information is sometimes provided.** Staff increasingly have found that when HDX makes a Medicare check, the system not only brings back the information on that account. It may say that, according to Medicare records, the patient also may have another third-party insurance, Alden explains. This is important because it alerts the hospital that it should ask the question of whether Medicare, or another company, is the patient's primary insurer, she adds.

There are drawbacks

Although the HDX system has many pluses, there are some drawbacks that potential buyers should keep in mind, Alden notes:

• **Sometimes HDX has access to an insurance company, but not to all of the company's products.** "You may not be querying all the company's products [when the system goes out to search for a patient's account], but it doesn't tell you this," she says. "You think you've checked all the products, but the HDX contract may be limited to a couple." That means that if HDX handles Cigna's PPO plan, but not its HMO plan, a query on a patient with the latter will come back with the response that the patient isn't covered, Alden notes. "We don't see a lot of this [problem], but it is a limitation."

• **Some interpretation is required.** "We have to find out some things for ourselves," Alden points out. "The response comes back from Medicare and we have to do some interpretation. The biggest concern is the staff's ability to [do this]. It takes more of a thought process." For example, based on the answer that comes back from Medicaid, for example, staff have to determine whether the person has Medicaid or Medicaid disability coverage, she notes. "For us, those are two different plan codes."

With the accounts of inpatients or those having ambulatory surgery, there is a precert area where staff provide "a second-tier verification" to ensure that registrars have identified the right insurance plan.

• **The regions covered are more limited.** The hospital's previous system for checking Medicare coverage extended the search to all regions of the country, she notes. "With HDX, we had to choose whether we wanted the system pointed to one regions vs. another." That means if patients from Kentucky are included, those from Pennsylvania are not, Alden adds. "If the region you need is not included, it's a longer process. We have to do the follow-up by phone."

Alden advises access managers helping make the decision on whether to buy an electronic verification system or which one to buy to choose an option that puts the process into the registration pathway. This way, she says, eligibility is being checked as the registration proceeds.

Denney adds, however, that there are hospitals who batch their accounts at the end of the business day. In such cases, he says, a stand-alone system is the only choice.

Crucial to selecting the right system, Alden points out, is questioning the vendor on how quickly negotiations are conducted with insurance companies it seeks to add to its coverage. "How fast have they added on [in the past] and are they continuing to grow the business?" ■

How good is your eligibility verification?

Company says it can do it better

A Cleveland-based company called the COB Clearinghouse Corp. has issued an invitation — and a bit of a challenge — to the nation's health care providers, and the subject matter is something that access managers struggle with every day. COB Clearinghouse promises to provide "one-stop shopping" for eligibility data on every patient admitted to a hospital through the automation of "coordination of benefits." Coordination of benefits is the process of determining which insurance policy is primary for a particular

(Continued on page 107)

DRG CODING ADVISOR.

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 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."

To bundle or not to bundle?

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

Because outpatient hospital care is often only part of an entire episode of care, the technical and data issues of APCs are more daunting for HCFA.

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

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."

Technology will drive complexity

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, as those procedures have become more common. "That analogy will continue to work throughout the industry." ■

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."

> "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."

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.

Providers' ability to cope with the system will not improve if the outpatient prospective payment 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 information on the increased demand for coders, see p. 104.)**

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 it is inevitable that Medicare will continue to move in that direction, although not as quickly as originally envisioned." ■

New administration OKs HIPAA privacy rules

New major changes added

The Bush administration announced on April 12 that it will not make major changes to the delayed Health Insurance Portability and Accountability Act final privacy rule. Here are the basics:

- **Who's affected:** The regulation covers health plans, health care clearinghouses, and health care providers who conduct financial and administrative transactions like electronic billing and funds transfers.
- **What's protected:** All medical records and other individually identifiable health information held or disclosed by a covered entity in any form.

> Patient consent must now be given for the use of patient information for non-health care purposes.

- **Disclosure:** Providers must give patients a clear written explanation of how they can use, keep, and disclose their health information. Patients must be able to see and get copies of their records and request amendments. You must also give patients a history of disclosures.
- **Consent:** Providers must obtain patient consent before sharing patient information for treatment, payment, or health care operations purposes. Patient consent also must be given for non-health care purposes such as releasing information to financial institutions or their employer or for selling names to mailing lists. Providers cannot condition treatment on a patient's agreeing to disclose health information for non-routine uses. However, this does not apply to the transfer of medical records for treatment purposes because primary care physicians, specialists, and other providers need access to the full record to provide the best quality care.
- **Security.** Providers must adopt written privacy procedures that include who has access to protected information, how it will be used within the entity, and when the information would or would not be disclosed to others. They must also take steps to ensure that their business associates protect the privacy of health information. ■

2001 Medical Record Review Summary Sheet

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

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

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

(Continued from page 102)

patient. The purpose of what is called the National COB Demonstration Project, company officials say, is to bring the national eligibility record together for the first time.

What COB Clearinghouse is offering is "a report card on how we're doing," says **Susan Brock**, regional manager of access services for Providence Health System in Portland, OR, the first health care provider to accept the company's challenge and join the demonstration project. The idea, Brock explains, is "to see what is the quality of the information you're getting, as opposed to what you would get if [insurance eligibility checks] were running through the Clearinghouse.

"Our belief is that we have excellent systems in place," she says. "The plus for us is the opportunity to check the accuracy of what we've done. If it's not what we thought, we know there's an option out there available to us if their system proves to be a tool with greater accuracy."

As part of the project, Providence will share with COB Clearinghouse the insurance eligibility data it received for three days in March, June, and September of 2000 using the systems the health care provider currently has in place, she says. Those data include:

- the insured person's name, Social Security number (SSN), and date of birth (DOB);
- the name, SSN, and DOB of each covered dependent of the insured;
- each person's coverage status;
- each person's effective date;
- each person's termination date;
- the insured's address or residence ZIP code;
- the insurance plan number;
- the identity of the plan sponsor;
- any "other coverage" data known to the Providence system.

Using its proprietary software program, COB Clearinghouse will examine the identities of the individuals in the combined data provided by all the demonstration participants, and will report to Providence:

— "false negatives" in the "other insurance" record provided by Providence, indicating the existence of other insurance for the individual where the Providence record indicates there is no other insurance for that person;

— "false positives" in the "other insurance" record provided by Providence, indicating the absence of other insurance for the individual where the Providence record indicates there is no other insurance for that person;

— the changes in eligibility, double coverage, false-negative and false-positive results over time between March, June, and September.

Also as part of its agreement with Providence — and with other organizations that participate in the project — COB Clearinghouse will distinguish the identity matches that are "unequivocal" from those that are possible, probable, or indefinite.

Benefits of automation

The Washington, DC-based National Association for Healthcare Access Management (NAHAM) has endorsed the project and provides information about COB Clearinghouse on its web site at www.naham.org. "We're hoping to show that an automated system will take out misdirections in coordination of benefits, double payments, [and] all the problems that the hospital network faces in trying to verify eligibility and primacy," says **Jeff Patton**, director of national accounts for COB Clearinghouse. "The key is getting the plan sponsors to recognize the savings there can be with accurate eligibility information and proper coordination of benefits testing," he adds. "It becomes a direct savings to them, therefore saving throughout the system."

In addition to health care systems, project participants include insurance plan sponsors (employer groups), third-party payers, pharmacy benefit managers, and preferred provider organizations, Patton notes.

To be a part of the demonstration project, participants pay $1,000. That fee, company president **Patrick Lawlor** explains in a question-and-answer (Q&A) document on the NAHAM web site, will be used to help cover the cost of merging as many as 10,000 data files to conduct the project. The file will be so large that the programs will have to be run at a Hewlett-Packard Performance Center.

Although the COB Clearinghouse model appears to require the centralization of all the eligibility data in the country, that isn't quite the case, Lawlor explains in the Q&A exchange with NAHAM. "Actually, the model doesn't require a perfectly centralized database," he says. "HIPAA requires health plans to open an eligibility gateway, and the Clearinghouse can use those gateways to complete a search of all possible payers."

It would be much more economical, however, for a payer to put its eligibility data into the

centralized database, Lawlor explains, and making that point is part of the purpose of the demonstration project. The project aims to show payers and their clients, the corporate and governmental health plan sponsors, that it is in their financial interest to maintain eligibility data this way, he adds.

According to information on the NAHAM site, a number of organizations where NAHAM members are employed have postponed buying decisions on electronic eligibility tools pending the results of the demonstration.

[Editor's note: More information on COB Clearinghouse is available at NAHAM's web site and at the company's own site, www.cobclearinghouse.com, or by calling Jeff Patton at (216) 861-2300.] ■

Tired of consultants? Here's a different twist

Company celebrates hospital staff

The problem with the "consultant model" for revamping a hospital's operation, says **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management (IRM), Carlsbad, CA, is that the consultant comes in and solves the immediate problem, but doesn't systematically correct the underlying errors. His company, Duffy adds, "is founded on the principle that the way we can make a significant principle is to train the internal staff to do the sophisticated work that often has been purchased through a consultant."

The training emphasis is on revenue management, he says, and focuses on "the intersection between the bill and the [patient's] chart." That includes registration and coding, charge choosing, contracting, and billing and collections, Duffy notes. The IRM package, he explains, includes a two-week curriculum at the corporate office in Carlsbad for a team of employees. Those employees return to their home hospital — with an advance practice trainer from IRM — for an additional week of training, Duffy says. **(See "Company out to fill gap in chargemaster training," at right.)**

After three weeks, the team is highly motivated and productive, he adds, but it takes two to three years to get it to the optimum level. For that reason, Duffy says, the IRM trainer — who is recruited from the hospital's own community — is assigned to the hospital virtually full time. In the case of smaller facilities, he notes, one person may travel between two clients. "We start with the most sophisticated person we can find," Duffy says, "and that person receives weeks of training with the [IRM] core group."

Since IRM doesn't charge contingency fees, he explains, it negotiates a "master fee" with the hospital and enters into a three-year contract. "We tell them honestly it takes five years to develop skill [at discovering revenue opportunities], and what they're considering buying from us is the ability to accelerate their business to a five-year level," Duffy says.

IRM's first client, he notes, discovered $1 million in additional revenue within 10 days of returning from the Carlsbad training session. That hospital's investment with IRM is around $600,000 a year for three years, Duffy adds, "and their improved performance should be in excess of $36 million."

Consultants with fee-based or contingency services, he says, typically do a project in which they discover the high-dollar, incorrect payments. "They bill [the hospital] $300,000, and save it $1 million," Duffy adds. "For that same $300,000, we train [internal staff] to find the errors, and they find them every day, every year. It's a dramatic difference in mission and approach." This approach, he says, "celebrates the hospital staff instead of them having a persistent feeling of inadequacy, a feeling that the real brains come from the outside." ■

Company out to fill gap in chargemaster training

Job is 'full of bear traps'

Managing a hospital's chargemaster — where every service the hospital gets paid for is listed — is a patient financial services job that is rule-oriented, fraught with compliance challenges, and "full of bear traps," says **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management (IRM), Carlsbad, CA. But despite extensive research, Duffy notes, he found

no training program in the entire country that prepares an individual to be competent in that area. That will change in July, he says, with the introduction of the Chargemaster Institute of America, an enterprise that will be a business partner with IRM.

That situation can be looked at as a microcosm of the state of the art of training in the world of health care revenue management, Duffy suggests. "You can get in so much trouble, so fast, with [inadequate management of] the chargemaster. Every dollar of revenue goes through it," he adds. "In the future, every account will be scrutinized by the Health Care Financing Administration [HCFA], and the intersection between the contract and the chargemaster will determine the success of hospitals."

Many lack time and training

After interviewing a man who worked for a 932-bed hospital that was a potential IRM client, Duffy notes, he discovered that although the individual had responsibility for the chargemaster, he spent only 20% of his job time on that task. Considering that the organization's chargemaster included 72,000 items, Duffy adds, "We said, 'How can you be effective?' He said, 'I really can't.' We asked, 'How were you trained?' He said, 'I wasn't.' He was very bright, but he had no support, and limited time compared to his responsibilities."

To date, Duffy points out, a hospital's option for cleaning up its chargemaster and bringing it up to date and into compliance has been to hire a consulting firm, which in turn recruits a coder. "That coder will come in and test the chargemaster against some kind of standard [and bring it up to speed]. The fee for that will be $100,000, and on the day they finish, the chargemaster becomes obsolete."

The Chargemaster Institute's approach, in contrast, will be to train a person from the hospital — during a three-week intensive course in Carlsbad — on the sophisticated software associated with the chargemaster, he says. As part of the training, that individual will bring the chargemaster up to the industry standard and will learn how to keep it up to standard, Duffy adds.

The new common procedure terminology codes are published annually, he notes, and all graduates of the Chargemaster Institute will come together to install those codes for their organizations. The cost for the entire training cycle will be $19,500, Duffy says.

"These people [who work with chargemasters] are islands of information," he notes. "There is no professional organization that supports that. Some of what they do will be very routine — add a new code, make a procedure change. Some of it will be highly sophisticated, where you get into multi-tiered discussions with HCFA, [as in], 'The physician wants to do this. How do I do it?' You can find a new opportunity at every turn." ■

HCFA proposes increase in rates for hospitals

Hospitals across the United States would see a 2.55% increase in Medicare payment rates in fiscal year 2002, according to a proposed rule issued by the Health Care Financing Administration in Baltimore and published in the May 4 *Federal Register*.

The proposed increase, which would become effective Oct. 1, 2001, will affect about 4,800 acute care hospitals that are paid under the prospective payment system (PPS). The proposed rule also contains provisions to implement a number of mandates in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, which will also become effective Oct. 1, 2001. Among these is a proposed mechanism to facilitate access to high-cost new services and technologies by authorizing special payments to cover increased costs.

The proposed rule also makes a number of revisions to the diagnosis-related group (DRG) classifications. For example, the proposed rule would create two new pancreas transplant DRGs and would create new DRGs for cardiac defibrillator cases and percutaneous transluminal coronary angioplasty cases.

In addition, the proposed rule provides for a three-year hospital geographic wage index reclassification, the use of three-year averages of the average hourly wages in qualifying for geographic

reclassification, and the option to use a statewide index instead of individual wage indexes for the geographic area of a state. HCFA plans to publish a final inpatient PPS rule by Aug. 1, for implementation Oct. 1, 2001. ▼

E-health searches differ from commerce behavior

Patients who use on-line health information say it has a real impact on how they manage their care, according to a recent study. But the study also indicates that typical on-line traffic-building strategies don't seem to work, because usage patterns in e-health bear little resemblance to those in e-commerce.

The study, conducted by the Boston Consulting Group, shows that the more patients use the Web for health, the stronger their response to the call to action issued by health care companies. For example, those who use the Internet frequently are two to three times more likely than infrequent users to take action that affects their diagnosis and treatment.

Reaching patients on-line, however, can be difficult. The research reveals two key dissimilarities between the Internet searching behaviors of patients and consumers:

• Unlike consumers seeking other information on-line, patients don't explore health topics on the web at their leisure or for entertainment. The vast majority — 77% — uses the Internet for health issues only when they have specific questions.

• Internet users don't usually turn to health sites directly when searching for health information. To answer their health queries on the web, 65% of patients usually start with general search engines. Even those who favor specific health-related sites report that they initially found them through general search engines.

The report did find, though, that patients have begun to migrate to more active segments over the past year. This suggests that greater patient access to on-line information is leading to greater patient involvement, the researchers say. In addition, patients who take a more active role in their care are beginning to "stick" to sites. These patients are more likely than patients in other segments to visit health sites and disease-specific sites. ▼

More HIPAA action expected this year

The U.S. Department of Health and Human Services (HHS) will soon release changes to the privacy and transactions and code sets rules of the Health Insurance Portability and Accountability Act, says **William Braithwaite**, senior advisor on health information policy in the department's office of the assistant secretary for planning. Modifications to the rules will be in the form of a notice for proposed rule making publication, says Braithwaite, who spoke at the TEPR 2001 Conference in Boston on May 10. His comments were reported by *Health Data Management*.

HHS expected to release guidance for the privacy rule in May in an attempt to clear up any discrepancies in the final rule, which was released in April. Modifications to the rule, such as more clearly specifying when a patient's prior consent is needed to release his or her medical information, will be included in a notice for proposed rule making and released later this year, Braithwaite says.

HHS also expects to release a notice of changes for the transactions and code sets rule, including doing away with the National Drug Code code sets mandate, he adds. ▼

HHS Task Force will target patient safety

Department of Health and Human Services (HHS) Secretary Tommy Thompson has announced that a new Patient Safety Task Force has been established within HHS that will coordinate a joint effort among several agencies to improve existing systems to collect data on patient safety.

These agencies include The Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Health Care Financing Administration. HHS' fiscal 2002 budget proposal includes up $72 million, an increase of $15 million over fiscal year 2001, for efforts to improve patient safety and reduce the number of adverse events.

In addition, Thompson has charged the task force with studying how to implement a user-friendly Internet-based patient safety reporting format. The group will develop computer networks, user-friendly reporting systems, and standards for coding the content of the reports, reports *AHA News*. The system will feature a uniform data collection method. The Centers for Disease Control and Prevention and the Food and Drug Administration will provide data on medical errors, while the Agency for Healthcare Research and Quality will analyze the causes of medical errors. ▼

Hospital to study effect of electronic medical records

The University of Colorado Hospital in Denver has announced two new grants for controlled studies of how patient care is affected by electronic access to medical records.

The announcement of The Commonwealth Fund gift of more than $282,000 plus a significant grant from CaP CURE was made at a University of Colorado Hospital Authority Board of Directors meeting by Dennis Brimhall, president and CEO.

With support from the Commonwealth Fund grant, researchers Steve Ross, MD, and C.T. Lin, MD, will manage a study of the effect of patient access to electronic medical records (EMRs) on the attitudes, expectations, and experiences of patients and physicians at a specialty clinic for heart failure at the hospital.

Researchers will conduct a controlled study of patients with congestive heart failure who are provided access to their EMRs via the Internet and will evaluate the effect of EMR availability on patients' understanding of their conditions, their ability to provide self-care, and their confidence in the care they are receiving. Physicians' views on medical record access also will be studied.

The grant from CaP CURE will help fund a study of about 30 prostate cancer support group members to determine how their use of the Internet affects their medical care. The grant will help patients communicate directly with their physicians at any time via the Internet. Michael Glode, MD, will direct that study. ▼

HCFA gives direction on cost-to-charge ratios

The Health Care Financing Administration (HCFA) has provided Medicare program intermediaries detailed instructions on how they are to calculate the payments certain hospitals and community health centers are due to make up for some of the losses they suffered in the switch to the outpatient prospective payment system, according to a report in the on-line news service *AHA News Today*.

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HCFA's Program Memorandum Transmittal A-01-51 gives instructions on how to calculate payment-to-cost ratios for determining the transitional corridor payments, or transitional outpatient payments. Rural hospitals with fewer than 100 beds, qualifying cancer hospitals, and children's hospitals are slated to receive the full difference between what they would have gotten under the pre-Balanced Budget Act system and what they would get under the new outpatient prospective payment system. All other hospitals and CMCHs will get a portion of that difference.

The new program memorandum also notes that hospitals using subscripted cost centers and providers that changed the types of services they furnish after the cost reporting period HCFA used to calculate the original ratio may request recalculations of their cost-to-charge ratios. ▼

CBO: McCain-Kennedy bill would drive up care costs

The patient's bill of rights co-sponsored by Sens. John McCain (R-AZ) and Edward Kennedy (D-MA) would increase premiums by an additional 4.2%, according to an analysis by the Congressional Budget Office (CBO).

Critics say this could cause many employers, already facing a 13% increase in health care costs this year, to drop plans. **Dan Danner**, chairman of the Health Benefits Coalition, says it would be "unconscionable" for Congress to enact any legislation that would make health care more expensive and risk the possibility of millions of more Americans losing their health coverage.

Despite language regarding a "cap" on lawsuit damages to employers, the bill still leaves them open to unlimited, class-action suits, the COB study contends. A recent survey shows that 46% of employers carrying health plans would drop them if they were made vulnerable to expanded health care liability. A copy of the CBO analysis, requested by Sen. Don Nickles (R-OK) of the Budget Committee, can be found at www.cbo.gov/showdoc.cfm?index=2796&sequence=0&from=7. ▼

Hospital profit margins show negligible increase

Operating profit margins at U.S. hospitals flattened at an annualized average of 3.69% in 2000, indicating only a slim degree of financial health, according to a report by Solucient, a provider of benchmark information on health care.

Hospital operating margins increased 0.41% over 1999 and remained relatively low, a full 36.6% lower than in 1997. Solucient president Gregg Bennett says margins of from 3%-4% are not sustainable in the long run, especially given the pressure from increasing drug costs and hospital labor shortages. He also says hospitals are still feeling the sting of the 1997 Balanced Budget Act and its clamp on Medicare payments.

Other key findings from the study, "The Health of Our Nation's Hospitals," include: Smaller hospitals finished the year best at 4.84%, their highest operating margin since 1997; larger hospitals produced the slimmest operating margins at 2.83%; regionally, western hospitals posted the weakest operating margins — 3.9%, while northeastern hospitals fared the best, going from break-even in 1999 to almost 5% in 2000. For more information, visit www.solucient.com. ■