AMERICAN HEALTH CONSULTANTS

FOR MORE THAN 18 YEARS

HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

INSIDE

■ **When will it end?** Providers are tired of waiting. They want the final Health Insurance Portability and Accountability Act rules now 147

■ **A new standard for help:** Oregon has some new ways for patients to apply for financial assistance. 148

■ **Don't take that order:** Hospital streamlines appointment process 150

■ ***DRG Coding Advisor*** Consultants' billing advice can attract fraud cops 151

■ **Caught in the middle:** That's where consumers believe they are — stuck between providers and payers 155

■ **E-commerce and HIPAA:** Looking for a return on your HIPAA investment? Think e-commerce 156

OCTOBER 2001

VOL. 19, NO. 10 (pages 145-160)

Query forms: Groups look for a way to avoid hints of fraud and abuse

Organizations now await a CMS directive

The need for timely and complete documentation warrants the acceptance of physician query forms as part of the medical record, two health organizations recently told the Centers for Medicare and Medicaid Services (CMS).

The American Hospital Association (AHA) and the American Health Information Management Association (AHIMA), both in Chicago, testified on July 27 at a meeting convened to discuss the use of coding summary forms. The forms, called physician query forms, are used when the record is reviewed by a Peer Review Organization (PRO) to validate diagnosis-related group (DRG) coding.

CMS and the Office of the Inspector General (OIG) are 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. Therefore, CMS (formerly the Health Care Financing Administration) issued a policy memorandum to PROs in January directing them not to accept coding summary forms as documentation in the medical record following DRG validation procedures specified in section 4130 of the PRO Manual.

The policy memorandum generated a high level of public interest. CMS says it recognizes there are various interpretations of what constitutes proper supplemental usage of coding summary forms. The agency then delayed the new policy until Oct. 1 so it could seek individual input from everyone involved.

Sue Prophet, RHIA, CCS, AHIMA's director of coding policy and compliance, testified that not all query forms should be viewed with suspicion. "We believe the vast majority of query forms are not used with fraudulent intent, and therefore, that using query forms should not immediately be interpreted as an indication of fraud or abuse."

Query forms are needed in health care today, she said. "In our imperfect

world, many times, documentation is not complete, or timely, or accurate. AHIMA members are therefore charged by their facilities, Correct Coding Guidelines, and the AHIMA Code of Ethics, to take action to ensure that missing or questionable documentation, or lack of documentation, is reconciled in order to ensure a complete record and accurate coding. It is this action that led many facilities to establish a query process."

"There is a long-standing tradition of medical records staff querying physicians for additional information when it comes to correct coding," testified **Nelly Leon-Chisen**, RHIA, director of AHA's Central Office on ICD-9-CM. "The 1990 edition of Coding Clinic states, 'The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task.' Coders have been struggling with incomplete documentation for many years and will continue to struggle until the natural language of physicians conforms to coding conventions."

The need for correct clinical coding is also important for benchmarking, quality assessment, research, public health reporting, and strategic planning, in addition to reimbursement, she says. "Without accurate reporting of clinical codes, these critical activities are threatened."

She asked that CMS consider the following implementation issues regarding physician query forms:

- There should be a consistent national standard across federal programs regarding the appropriateness of physician query forms.
- There should be a logical and ethical basis for the query. Query forms should seek clarification only, not steer the physician to a particular code.
- There should be a formal physician query process and written documentation of the communication between the coder and the physician. This physician query form should be a formal part of the medical record, approved through the hospital's internal channels.
- Query forms should allow case-specific customization to allow coders the flexibility to carefully formulate the rationale for the query as well as the diagnosis, symptom, condition, or procedure in question.
- The physician's response on the query form should be accepted as valid documentation to substantiate code assignment.
- When query forms are used appropriately, the peer review organizations should be permitted to use the information obtained for DRG validation.

Prophet proposed that the CMS take a new approach on determining situations where the use of physician query forms might be cause for further investigation. She recommended that PROs be instructed to look for patterns of coding errors in cases of concern. Prophet also recommended that facilities monitor their use of queries and provide education to physicians on the proper documentation of a diagnosis when documentation is repeatedly provided inadequately.

"CMS' discussion on queries has already raised that there are good and bad query processes," she said. "AHIMA's approach to queries is to ensure that the query process should be in place to improve physician documentation and coding professionals' understanding of the unique clinical situation. We further suggest that the facility and its physicians be involved together in developing its query policy and procedure."

Overall, about eight individuals testified at the town meeting, says **Dan Rode**, MBA, FHFMA, AHIMA's vice president of policy and government relations. A few others made comments, and CMS gave an overview presentation.

"Most indicated a desire to see query forms continued," he says. "I believe there were good suggestions on how to do this and what rules the PROs could follow." ■

A flurry of compliance

The HIPAA race is on

Research firms may warn of providers stuck at the starting gate trying to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Many hospital-based participants in a recent survey, however, say they will complete their enterprise HIPAA impact/gap assessments by year-end.

Last month, *Hospital Payment & Information Management* reported on a Gartner survey that found that 85% of health care providers have yet to complete assessments or gap analyses. Gartner is a research and advisory firm based in Stamford, CT.

What do we want? Finality! When? Now!

Final security rule should be similar to NPRM

Providers are tired of waiting — they want the final Health Insurance Portability and Accountability Act (HIPAA) rules now.

Several expressed their frustration in a recent collaborative survey conducted by Phoenix Health Systems in Montgomery Village, MD, and the Health Information Management Systems Society in Chicago. **(For more on the survey results, see p. 146.)**

"The most dangerous barrier is the unknown legislation," one hospital senior manager told the surveyors. "It both delays definitive action on what exists (why waste time if it's going to change) and causes you to do substantial rework as the interpretations are printed."

The Department of Health and Human Services (HHS) has moved toward clarifying at least part of the HIPAA regulations through its first privacy guidance, published in early July. One advisor doesn't anticipate any dramatic changes or delays in the remaining guidances.

"I'm sure that sometime in the next few months, by the end of this year at the latest, [HHS] will probably go through the normal NPRM [Notice of Proposed Rulemaking] process of submitting some suggested changes. I don't think they will be significant or dramatic," says **Joseph L. Pokorney**, vice president of Phoenix Health Systems. "I believe [HHS] will want to get that process completed so that it does not impact the April 2003 date."

Providers also should not expect to see much difference between the proposed and final security rule provisions, according to a report made to Phoenix Health Systems on July 27 by **Bill Braithwaite**, senior HHS advisor on health information policy. "The basic philosophy of the final security rule is unchanged from the NPRM," Braithwaite said, according to Phoenix. The final rule should reduce redundancies and excessive micromanagement. Braithwaite also told the company that the electronic signature standard would not be included in the final security rule, but would be addressed later in another rule.

Pokorney sees the possibility that when the security regulation is published, HHS might make a move via a change in regulation to make all the effective dates the same. "That could also take the form of just relaxed enforcement as opposed to an official changing of the compliance date." ■

But according to a different survey, more than three-quarters of the hospital-based respondents say they expect to be done this year. This survey was a collaborative effort conducted by Phoenix Health Systems in Montgomery Village, MD, and the Health Information Management Systems Society in Chicago. Nearly 15% of respondents say they have already completed assessments.

These results are based on 925 responses to the late July survey. Sixty-three percent of these respondents work in provider organizations; 42% of the provider staff work in hospitals. Respondents were also close to the HIPAA playing field: Just under 80% of all respondents reported that they have official HIPAA roles within their organizations.

Phoenix Health Systems began taking the quarterly surveys in early 2000. This latest installment is the first time the industry has reported that it is focusing more on compliance assessment and implementation than on the preliminary step of creating HIPAA awareness within its organizations, says **D'Arcy Guerin Gue**, executive vice president of Phoenix Health Systems.

The step of creating an overall awareness of HIPAA has been successful for most. About 75% of senior managers and 55% of department heads industrywide were judged as having moderate to high knowledge of HIPAA and its implications. However, respondents stated that 6% of all senior managers and 7% of provider senior managers still have little or no knowledge of HIPAA — representing no change since the April survey and little change from January survey results.

The providers that have moved on to conducting assessments are looking at all parts of the HIPAA regulations. Respondents from hospitals with more than 400 beds reported that 75% are conducting assessments, primarily in compliance with the transactions and privacy requirements of the regulations. One-half are also doing security

and identifiers assessments. Fourteen percent have completed their assessments; 33% expect to be done within three months; and another 33% expect to finish within six months.

In hospitals with 400 or fewer beds, two-thirds are conducting transactions, privacy and identifiers assessments, with one-third doing security assessments. Eleven percent of 400-bed hospitals have completed assessments, 32% expect to be done within three months, and another 37% at the end of the year.

In addition to impact and gap assessments, respondents say HIPAA project planning and implementations are under way across the industry, as well. Two-thirds of hospitals, payers, and clearinghouses and more than half of vendors are doing project planning.

Among hospitals with more than 400 beds, participants reported that two-thirds are preparing transactions, privacy, and security project plans; one-third are already working on implementation. Half of respondents from hospitals with 400 or fewer beds are doing transactions and privacy project plans, with less emphasis on security. Twenty-five percent are working on implementations, again primarily in transactions and privacy.

About one-third of hospitals and half of payers, clearinghouses, and vendors have already begun implementing the HIPAA regulations. Even physician practices and other providers, which usually lag behind in HIPAA awareness, are moving forward: Of nearly 200 responding, about half have begun doing assessments, and more than one-third are working on project planning and implementation.

Many providers aren't making their compliance efforts totally by themselves, the survey finds. Among hospitals, 45% of respondents said they are using outside consultants to support HIPAA compliance — 83% of these to conduct or support assessments, 47% for project planning, and 27% for implementation.

Overall, the great majority — about three-quarters of all respondents — hope to tie their compliance efforts to organizational strategic plans (including exceeding HIPAA requirements, in many cases) and reap the potential benefits associated with HIPAA, Gue says. "Given this proactive approach, it is not surprising that about two-thirds of all providers agreed that their organizations will have to be HIPAA-compliant in order to execute their e-health strategies," Gue notes.

The complete results of this quarterly survey have been forwarded to several administration and congressional offices at their request, Gue says. Recipients include leaders of the Department of Health and Human Services, members of the House Ways and Means Committee, and other Capitol Hill leaders who want to better understand factors in the health industry's compliance progress. ■

Oregon has new standard to apply for financial help

Access managers say it's unprecedented

In what appears to be an unprecedented effort, hospitals throughout Oregon have agreed to use a standard form for patients to apply for financial assistance.

As part of the collaborative effort, the hospitals have said they will post prominent signs and offer pamphlets and bilingual business cards telling patients how to apply for the monetary help, explains **Barbara Wegner**, CHAM, regional director of access services for Providence Health System in Portland.

Prompted by a consumer group, the initiative began with four hospitals in the Salem area and then moved to Portland, Wegner says. "It's nationally unprecedented," she adds, "that competing hospitals would get together and do something this substantive for patients who don't have coverage."

Although Providence and other nonprofit health care organizations already had procedures for applying for financial help, the agreement makes the process simpler for patients and for access personnel, Wegner points out. "If a patient had been seen recently at another facility and had filled out a form, that person could present the form to a registrar and help facilitate the whole process."

In line with the guidelines, she says, Providence makes business cards available in waiting areas to inform patients of the financial assistance program in four different languages - English, Vietnamese, Spanish, and Russian. Applications also can be translated into other languages as needed, Wegner notes.

The project had its impetus about two years

ago, when an advocacy group called the Oregon Health Action Campaign (OHAC) did a study to identify barriers to health care, says **Tim Miller**, MA, program manager and organizer for the Salem-based group. "One of the problems we discovered was that people accessing health care didn't know anything about charity care or free care," Miller notes.

Although nonprofit hospitals are not explicitly required to give charity care per se in exchange for their exemption from income and property taxes, he explains, they must by law provide "community benefits." Those benefits can take various forms, such as supporting a women's clinic, for example, or providing free care to those unable to pay, Miller adds.

'Nothing was uniform'

In the course of the study, he says, OHAC documented several cases of patients who would have been eligible for charity care according to the guidelines of the hospitals who treated them, but never learned about that option. Instead, they accumulated huge debts, were threatened by collections agencies and, in one case, declared bankruptcy, Miller says.

"The law is there, but the hospitals had different ways of [fulfilling] it and different standards," he adds. "Nothing was uniform. The community didn't know about it, and wouldn't know unless they found out by accident."

After hearing about the study findings, Miller says, the Salem hospitals, and later the Portland hospitals, agreed to work on a uniform charity policy. Eventually, the Oregon Association of Hospitals and Health Systems (OAHHS) adopted a voluntary agreement that set the standard for all Oregon hospitals in regard to free care, he says. **(See "Here's how the Oregon program is set to work," p. 150.)** The OAHHS board approved a booklet developed by the Portland hospitals, "Financial Assistance Guidelines: A Suggested Policy for Oregon Hospitals," for distribution statewide.

When the issue came before the OAHHS board about a year ago, the hospital association saw it as an opportunity to suggest common language that could be used in hospitals across the state, says **Karen Normandin**, communication director for the Lake Oswego-based association. "It took several months to hash over definitions and come up with a set of guidelines and to make the information available in several languages."

There's also an element that has to do with employee education, Normandin notes. Employees in admitting, emergency department, and clinic areas are to be prepared to provide information on the program, she adds. "When eligible consumers are in the organization, they can ask questions about financial help, and [these employees] can direct them."

Plans are, Normandin says, for participating hospitals to get back together in a year and see how the program is doing. "One of the purposes is to network and collaborate so that everyone benefits."

From Miller's point of view, "the bad part [of the program] is that it's only voluntary. The good part is, it's the first agreement on a statewide basis in the nation." His organization's next step, he says, is to determine what can be done to make sure all hospitals participate.

However, Normandin says the financial assistance guidelines "would be pretty complicated to mandate. We have about 65 member hospitals, and about 40 of those are small, not as stable [as the larger participants]. It's a different situation in a lot of communities. We're participating in it as a voluntary program."

Oregon residents who make less than 150% of the federal poverty level — about $27,000 for a family of four — are eligible for the Oregon Health Plan, the state's health insurance plan for the poor. But they may be excluded for other reasons — for example, if they have more than $2,000 in cash or bank accounts.

The voluntary guidelines adopted by the Oregon hospitals state that financial assistance generally is secondary to all other financial resources available to the patient, including insurance, government programs, third-party liability, and assets. They also state, however, that full financial assistance usually will be provided to a responsible party with gross family income at or below 150% of the Federal Poverty Guidelines.

Under the newly adopted policy, uninsured patients with incomes between 150% and 200% of the poverty level are eligible for aid on a sliding scale to help pay hospital bills. The details of that scale are left up to each hospital, says Normandin.

The financial assistance given is specific to each admission, and the patient will be screened for changes in eligibility when there is a readmission or new episode of care, Miller says.

However, Normandin indicates, that screening

process is greatly streamlined by the standardized application form. "My understanding is that the patient would have a copy of what was filled out [for earlier hospital visits], and that the information would be transferrable. "There is a shared responsibility on the part of the patient and the person helping the patient fill it out," Normandin adds. "There is a requirement in the guidelines that the form be filled out completely."

The effort has generated "lots of positive comments," she says. "Folks are enthusiastic about using common language and not having to reinvent the wheel." And, she points out, "[providing assistance] is part and parcel of their mission." ■

Here's how the Oregon program is set to work

The Oregon Association of Hospitals and Health Systems put together this mission statement regarding the collaborative effort by the state's hospitals to make it easier to apply for health care financial assistance:

1. The objective of hospital financial assistance and services is to help the hospital meet its community obligations to provide financial assistance in a fair, consistent, and objective manner. The guidelines will provide structure to a discussion about a patient's financial need.

2. Hospitals will determine the best way to educate employees about the facility's protocols regarding assistance so that employees will know how to refer a patient or family to the appropriate location for information.

3. Request for financial assistance may be made at any point before, during, or after the provision of care. A responsible party choosing not to apply for financial assistance will not automatically be considered for assistance.

4. The guidelines include:

- Suggested policy statement regarding financial assistance.
- Sample screening practice for financial assistance.
- Sample operating policy.
- Sample account follow-up and collection practice.
- Sample wall sign and business cards.
- Suggested payment option explanation for reverse side of hospital statement. ■

Patients don't get orders as process is smoothed

Illegible, lost prescriptions not an issue

Southern Ohio Medical Center in Portsmouth has streamlined the process where a physician's order becomes a scheduled appointment for the patient, and improved its customer satisfaction in the bargain. Rather than giving the order for an outpatient test or procedure to each patient as he or she leaves the office, the physicians' staff are asked to hold those orders until the end of the day, explains **Pamela Partlow**, RN, manager of registration and central scheduling.

Clarify information

The physician's staff make sure all the patient's demographic information is there and that there is medical necessity. It then batches all of the day's orders to the hospital by fax or courier, Partlow adds. "We ask them not to give the order to the patient because the patient [often] loses it or can't read what the test is," Partlow says.

When that happens, her staff have to call the physician to clarify the information. By that time, the physician might not remember who the patient is, she adds. Patients who show up without the order, meanwhile, must wait until registration employees contact the physician's office and have another order faxed over, Partlow points out.

With the new process (which the 350-bed hospital began piloting in January 2001), patients are given a bright-green card with the telephone number for central scheduling, she says. The card instructs the patient to call the number within two to three days, Partlow adds. If the patient doesn't call to arrange an appointment within a week, registration staff make three attempts to contact the patient, she says. "If [the patient] refuses to have the test or doesn't return the calls, we document all that on the order," Partlow explains, "and send it back to the physician's office for their files."

To facilitate the process, the hospital hired seven employees and now offers central scheduling services between 7 a.m. and 11 p.m., she says. The impetus for that substantial investment was

(Continued on page 155)

DRG CODING ADVISOR.

Consultants' billing advice can attract fraud cops

Be skeptical about aggressive coding

A recent report from the General Accounting Office (GAO) waves a caution flag at providers about following the advice of reimbursement and coding consultants that seems to manipulate claims just to increase payment, without regard to medical necessity or standard billing procedures.

"This aggressive and unethical approach puts the [physician] client . . . at substantial risk," **Lewis Morris**, assistant inspector general for legal affairs with the Department of Health and Human Services, testified before Congress.

"Ultimately, providers need to recognize that hiring a consultant does not relieve them of the responsibility to ensure the integrity of all their dealings with Medicare and Medicaid," he warned.

GAO used undercover agents

As part of its investigation, the GAO sent a doctor and a criminal investigator undercover to two workshops and a seminar conducted over the past year by reimbursement consultants.

In its report, "Consultants' Billing Advice May Lead to Improperly Paid Insurance Claims," the GAO concluded the workshops offered advice that could open physicians to fraud investigations if they followed the billing suggestions.

According to the GAO, among the questionable advice given at the conferences was that physicians:

- not report or refund overpayments from insurance carriers;
- provide tests and procedures that were not medically necessary so they could bill at a higher level, while creating documentation to support the higher charge;
- give patients with low-paying insurance, such as Medicaid, appointments at inconvenient times during the day that are usually hard to fill.

In a related action, the Office of Inspector General (OIG) has issued a special advisory for physicians on the best way to spot consultants selling questionable advice.

It suggests you should be wary of any consultants who:

- claim they have a special relationship with or "inside" connection at Medicare or the OIG;
- claim their services or products are approved or recommended by Medicare, the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, or the OIG;
- guarantee specific results that are unreasonable or improbable through legal billing;
- encourage aggressive billing schemes or other unreasonable practices that are fraudulent and abusive;
- recommend you not cooperate when told some of your claims are going to be audited.

Bottom line: If what a consultant is promising you sounds too good to be true, it probably is. ■

Liaisons enhance the ties between docs and hospital

Goals: Increase revenue, bill correctly

Four physician liaisons at Straub Clinics and Hospital in Honolulu streamline the relationship between business services and caregivers, providing education on coding and feedback on billing errors, among other duties.

"If there is information about coding, changes in Medicare regulations, or any process at Straub that has an impact on physicians and their practice, these four people are the link," adds **Linda Dullin**, RN, director of admitting, whose department reports to business services. The physician liaisons also work under the administrator of business services and report directly to **Sheri Richard**, billing and operations manager.

"Their main goal, their whole function is to enhance revenue in the physician office and to ensure that [physicians] are coding and billing appropriately, to be the link with business services," Richard says. "They're able to give [physicians] feedback on what charges are being submitted and to make sure that a charge tag has been submitted on all patients."

Following trends

The physician liaisons work hand in hand with Straub's coding department, she says, learning about trends found from audits or from reviewing or spot-checking charges and then passing that feedback along to physicians. If Straub's 150 or so physicians — in the hospital or in satellite clinics on Oahu and on the other Hawaiian islands — have questions about billing, "they have someone to go to," Richard adds.

The physician liaison positions were created, she explains, when Straub converted in July 1998 to the IDX computer system for both billing and admitting for hospital and clinics. At that time, the registration personnel in the physician offices began reporting to business services rather than to clinical operations, Richard says.

"The whole idea was that registration [errors] could be so detrimental to billing," she adds, that it made sense to have business services provide that oversight. To facilitate the relationship with these employees who were physically separate, the physician liaison positions were established.

Since that time, the physician receptionists have moved back under clinical operations, Richard notes, which makes the role of the physician liaisons more crucial than ever. The decision to return the employees to clinical oversight, she says, was the realization that they played a number of roles unrelated to registration. "The clinical operation [administration] truly believed they needed more control over the front desk [staff]."

Initially, the physician liaisons reported directly to her boss, the administrator of business services, Richard says, but since October 2000, she has been their supervisor. Because she supervises both claims processing and a department called Charge Corrections, where denials are handled, Richard can provide the data and information the liaisons need to do their job, she notes.

The liaison positions are "really a good thing," Richard says. "[Otherwise], it's hard for the business office to get information to the physicians. They see a lot of errors, but there's no one to do the training and education." A problem with the billing for immunizations, she notes, led to the institution of brown-bag lunches to address billing concerns with physicians and their staffs.

"All the [immunization bills] needed an administration code and there were various types of codes and different bills for different payers," Richard explains. "[The physician offices] weren't picking the right code, and we were getting a lot of denials." A lunch session was scheduled to present the errors and discuss how to code the bills correctly, she adds.

The brown-bag sessions — at 11 a.m., noon, and 1 p.m. — now are held monthly and last about one-half hour, Richard says. "We usually take our top rejection or denial problem and pinpoint that issue." The sessions, which are open to the entire organization, begin with a brief presentation and the distribution of cheat sheets on the topic at hand, she adds. "We're pretty focused." Afterward, the physician liaisons — who divide their duties by medical specialty, such as pediatrics or orthopedics — may meet separately with a group they cover, Richard says.

"We have data to show this is how much [the billing system] is kicking out for internal medicine or pediatrics and so forth and to show specific errors," she adds.

Sessions count as compliance education

Richard, who chairs the brown-bag sessions, says she works closely with Straub's compliance department in planning the meetings. In most cases, the presentations can count toward the two hours of compliance education required annually for all Straub employees, including physicians, she notes.

"Physicians usually look at, 'What's in it for me?'" Dullin points out. "We look at whether [the topic] is something we can give them credit for. We have sign-in sheets that are turned over to human resources. That's something you can use as a hook."

An upcoming topic that she will address at the

session, Dullin notes, is the handling of outpatient observation patients. "I will meet with the physician liaisons beforehand to go over the presentation and also to make sure that they provide feedback to me when questions arise from their physicians."

The presentation will probably be a group effort, she says, with involvement from other utilization/case management, medical records, and business services personnel. An earlier presentation on advance beneficiary notices was made by Straub's former training coordinator and business services compliance advisor, Dullin adds.

The physician liaisons, Richard points out, work individually with all the players in the physician practice. "There is the physician, the nurse, the clinical director, and the front desk supervisor, and we treat them each separately," she says. "Just because [the physician liaison] has talked with the physician, doesn't mean [he or she] has communicated with the whole department.

"Any employee of the organization can go to the physician liaison to ask about coding or reimbursement, and the liaison gets the answer and responds back," Richard adds. One of the liaison's main goals, she notes, is to present to the physician various reports done by Straub. "There are financial reports and an accounts-receivable analysis. These tell the physician how well he's done, how many procedures he's done within that month."

The liaisons are responsible for providing education — on coding and other issues — to any new physician that joins the organization, she says.

'Minipreadmits' done by physician staff

Because physicians' offices and the hospital are on the same computer system, the physicians' staffs are able to do "minipreadmits" or "minipreregs" that facilitate the registration process, Dullin points out. "If a patient goes to the physician and needs to get an arthroscopy, for example, someone in the physician's office goes into our computer system and does a mini prereg," she says. "Once they've done that, they also schedule the physician's time. They send a notice to us to anticipate that patient on this day for this procedure." This eliminates the need for paper being faxed back and forth to arrange the procedure, Dullin adds.

Having a physician champion is another important way that patient access and business services can enhance physician cooperation and avoid having physicians feel "they're being dictated to," she says. "If the physicians are moaning about a certain thing, or just don't get it, you need somebody who will support what's being done and will be a link in communicating corrective action."

The medical director of a group that deals with a large number of patients from Pacific Ocean islands, for example, is a good person to champion issues that have to do with length of stay and utilization management, she says. Because those patients often require extensive care and follow-up, Dullin notes, that physician is particularly well-equipped to explain accompanying concerns to his colleagues. ■

Coding and payment part of CMS proposal

Rule would create new payment group

A new proposal from the Centers for Medicare and Medicaid Services (CMS) contains some changes for coders.

The proposed rule changes the structure of certain payment classification groups to reflect the recommendations of an advisory panel composed of independent experts in issues relating to hospital outpatient coding and payment.

The rule proposes to create a new payment group for observation services furnished for beneficiaries who come to the hospital with heart problems and asthma.

Saving millions for beneficiaries

Hospitals would also receive a 2.3% increase in Medicare payments for outpatient services beginning Jan. 1, 2002. The proposed rule is designed to save Medicare beneficiaries millions of dollars by continuing to reduce coinsurance payments for outpatient services.

As required by the Balanced Budget Act of 1997 (BBA), Medicare pays more than 6,000 hospital outpatient departments for the services they provide based on the Outpatient Prospective Payment System (OPPS), which went into effect

Aug. 1, 2000. The system is designed to encourage efficient delivery of care and to ensure more appropriate payment for services.

The proposed rule outlines possible approaches CMS may use to estimate the extra payments Medicare makes to hospitals when they use certain devices, drugs, and biological products as part of an outpatient procedure.

"In light of the ongoing shift of health care services from the inpatient to the outpatient setting, it is critical for Medicare to ensure that we are paying appropriately for outpatient services and that beneficiaries have access to quality care," said CMS administrator **Tom Scully**. "We believe this proposed rule achieves those goals."

The OPPS establishes base payment rates based on groups of services, known as ambulatory payment classifications, that are clinically similar and require comparable resources. Prior to implementation of the OPPS, hospitals were paid for outpatient services based on costs and beneficiaries' coinsurance was based on 20% of the charges billed by hospitals, rather than 20% of Medicare allowed charges, and beneficiaries often had to pay more than half the cost of those services. The proposed rule continues to lower beneficiaries' maximum coinsurance for these services, as required by the BBA.

The proposed rule outlines possible approaches CMS may use to estimate the extra payments Medicare makes to hospitals when they use certain devices, drugs, and biological products as part of an outpatient procedure. Congress required Medicare to make these extra pass-through payments temporarily, but also capped the estimated total amount of such payments at 2.5% of the estimated overall amount paid under the OPPS.

If the department's estimate shows the cap would be exceeded, the law would require an across-the-board reduction in extra pass-through payments. The proposed rule does not make an estimate. CMS is also working with Congress to consider appropriate changes to the law.

The proposed rule can be viewed on the CMS web site, www.hcfa.gov. CMS will accept public comments on the rule until Oct. 3, and will publish a final rule later in the fall. ■

(Continued from page 150)

customer service, Partlow adds. "Patients [had been] very dissatisfied with coming in and having to wait an hour to get registered for an outpatient procedure. Then they would have to go to the department [where the procedure was to be performed] and wait about another hour. That's been cut down greatly, too."

To make the handling of orders more efficient, she notes, the hospital provides free outpatient order forms to physicians. "That way, when they batch [the orders], they are all the same. Many physicians just use [prescription pads] to write the orders, but our forms include all the tests; they can just make a check mark by the appropriate one."

The reason all this has been worthwhile, Partlow says, is that patient satisfaction has dramatically increased. "Now the patient just walks up and is already preregistered. They don't have to wait, and we don't have to make numerous calls because someone forgot the order."

In addition, she says, the outpatient departments know that at a particular time, a certain number of patients are scheduled to have a certain procedure, so departments can staff accordingly. Before, patients could just walk in without an appointment and present an order for a basic lab test or X-ray. The departments didn't know how many patients to expect, Partlow notes. Even procedures such as CAT scans and cardiac tests were done on a walk-in basis, she adds.

Since the pilot program began in January, the hospital's policy is that all outpatient tests — including complete blood counts — are scheduled by the patient through central scheduling, Partlow says. The results have been gratifying, she adds, with most waits reduced to two or three minutes.

In addition to increasing patient satisfaction and reducing the number of lost orders and phone calls to the physician offices, the new process offers physician staffs a check-and-balance system, she points out. "When we schedule an appointment, we fax [the physician office] a confirmation form so they can see if they ordered the right test," Partlow says. "Also, that confirmation has the date and the time of the test so they know when they should be getting the results." This fax-back confirmation feature is an optional part of the process, she notes. Of the 100-plus physician practices in the area, Partlow says, about 30 participate in the new process.

To promote cooperation and compliance from the physician practices, Southern Ohio Medical Center hosts a quarterly "registration and central scheduling informational breakfast meeting," she notes. Although the breakfast meeting was established before she joined the department four years ago, Partlow says, attendance has increased dramatically since she began promoting it. The breakfast now draws between 90 and 100 attendees, she notes. Her theory, Partlow says with a laugh, is, "If you feed them, they will come."

The staffs of all physician offices and nursing homes in the area are invited, she says, and the audience may include nurses, office assistants, unit clerks, and nursing home administrators. Also attending in addition to herself are the supervisors for registration and central scheduling.

"We may have other department directors or supervisors," Partlow adds. "For example, the director of the cardiac lab [did a presentation on] how to prep patients before a cardiac test, and the correct way to explain things to the patient."

As part of another program, she says, a physician discussed mammograms and breast cancer, and the supervisor of the breast center explained the difference between a screening mammogram and a diagnostic mammogram. That distinction, Partlow notes, is a medical necessity issue and should be addressed during the registration process.

"Medical necessity has been a big [topic] lately," she adds. "We've gone over with [physician staff] the need to have a diagnosis on the test ordered. If they have a question, they ask at the meeting, or they call later. It's a share of information back and forth." ■

Billing 'out of whack,' focus groups believe

Consumers believe there is gaming going on between the provider and the payer when it comes to billing, and that they are caught in the middle. Those are among the concerns expressed by participants in focus groups conducted as part of the Patient Friendly Billing Project of the Westchester, IL-based Healthcare Financial Management Association (HFMA) and the American Hospital Association (AHA).

The project aims to help health care providers convey bills — or, more precisely, "a series of financial and other communications" — to patients and their families that are clear, correct, concise, and patient-friendly, says **Richard L. Clarke**, HFMA president and CEO. The first phase of the project, he adds, will focus on hospitals and health systems but eventually, the focus will broaden to medical practices and payer financial communications.

Problem is in 'the system'

There is the general sense among consumers, Clarke notes, that the "system" is fundamentally out of whack. "Multiple bills from multiple providers, interacting with one or more payers — all using different forms, terminology, and approaches — creates a system that is almost impossible to track and understand."

While short-term fixes can be made to improve patient financial communications, the main question, he says, is how the system can be changed to get the consumer out of the middle. "To change the system," Clarke points out, "will require the interaction, cooperation, and agreement of providers, payers, government, and employers — a daunting task."

The Patient-Friendly Billing Project, he adds, recommends a multidisciplined approach that will include these elements:

- a process that captures and summarizes bills from all providers, and automatically matches them with all payments;
- a consolidated communication that clearly identifies all the services that were provided for an episode or episodes of care, the coverage of that care by health or other insurance companies, expected health insurance payments, and what is due from the consumer;
- a single point of contact for the consumer, by telephone or web site, designed to respond to inquiries, complaints, or concerns about benefits, coverage, and payments;
- an appeals process to handle disputes that consumers may have about eligibility, coverage, charges, and payments.

Also under this ideal system, Clarke says, payments by consumers would be made to a single source, and automatically distributed to providers and suppliers involved in the episode of care.

[Editor's note: For more information about the Patient-Friendly Billing Project, call (800) 252-HFMA, ext. 3.] ■

E-commerce efforts are best HIPAA payback

Start with enterprisewide team

Health care organizations that have not yet developed a strategy for complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 should start by establishing a HIPAA task force with an enterprisewide focus, suggests **Julie J. Welch**, MBA, RHIA, a Chicago-based consultant with Cap Gemini Ernst & Young. Keeping in mind the areas of e-commerce, technology, processes, and policy, Welch says, consider taking these steps:

- **Perform an assessment of readiness.**

This means reviewing existing policies and procedures and technology and comparing them to the HIPAA requirements to see where the gaps are and what you need to do to bridge them. Some organizations are engaging consulting firms or hiring a HIPAA expert to help in this process.

- **Develop and deliver a HIPAA awareness program.**

Bring staff up to speed. Raise their level of understanding by educating them on what HIPAA is and what areas it touches within the organization. Distribute a HIPAA overview, facts on its history, and provide an educational session.

- **Establish budgeted resources and dollars.**

The Wall Street Journal has estimated that HIPAA compliance could cost the nation's hospitals two or three times the $8 billion that Y2K preparations set them back, Welch points out. The Aug. 17, 2000, *Federal Register* (65:160) estimates that the average cost per hospital just for upgrading software to translate and communicate standardized claims forms will be $250,000 for 2002, she adds. That doesn't include costs associated with privacy and security.

Health care providers pondering their huge investment, Welch suggests, might want to look at the e-commerce aspects of HIPAA implementation as a way to get a tangible return on that investment. With the privacy regulations, for example, there's no benefit for going beyond basic compliance, she notes.

But the electronic data interchange part of HIPAA, Welch says, offers opportunities for progressing to electronic medical records, and for

implementing billing methods heretofore used only by the banking and credit card industries. Consider having patients pay their bills through a web site, for instance, or step into a paperless environment for patient accounting.

• **Develop a plan for action including infrastructure changes and resource needs.**

This includes, among other things, the technology involved in sending claims information out into the world while meeting HIPAA requirements — items such as firewalls for computer systems. It also covers physical changes that might be needed to ensure privacy while registrations are conducted, and ensuring that information systems and data are safeguarded from unauthorized access. It might be necessary, for example, to not only institute electronic signatures for computer access, she notes, but to run an audit to see who's accessing what.

Look it up

For individuals interested in educating themselves about HIPAA, Welch recommends these resources:

• A web site where you can obtain copies of the final rules from the *Federal Register*: aspe.os.dhhs.gov/admnsimp. It contains the posting of laws, processes, regulations, and comments.

• A listserv from which you can receive e-mail notification when new regulations are released. To subscribe, send an e-mail to listserv@ list.nih.gov. Include your name and the phrase "subscribe HIPAA regs" in the body of the message. ■

Medicare to increase inpatient payment rates

Medicare will increase its payment rates for inpatient hospital care by 2.75% starting Oct. 1, the Centers for Medicare and Medicaid Services (CMS) announced July 31.

The increase for fiscal year 2002 will affect about 4,800 acute care hospitals that are paid under Medicare's inpatient prospective payment system. The new rate, which reflects the law's requirements for updating Medicare payment rates, was published in a final rule in the Aug. 1 *Federal Register*.

Medicare law pegs the annual updates for acute care hospitals for fiscal year 2002 to the estimated increase in the hospital market basket — the inflation rate for goods and services used by acute care hospitals — minus 0.55 percentage points. For fiscal year 2002, the hospital market basket is projected to increase by 3.3%. The update is 2.75%.

The final rule does not address provisions in the proposed rule dealing with expediting the incorporation of new medical services and technologies in the inpatient prospective payment system coding and payment methodology. CMS will address this issue in a separate final rule to be published later this summer. ▼

Medicare outpatient payments to increase

Hospitals will get a 2.3% payment hike effective Jan. 1 under the Centers for Medicare and Medicaid Services (CMS) proposed rule for 2002 outpatient prospective payment system (PPS) rates, published in August. CMS administrator **Tom Scully** said the rule would achieve the goal of making appropriate reimbursement payments given the ongoing shift of services from the inpatient to outpatient setting, according to *AHA News.*

While the rule outlines possible approaches for CMS in estimating payments for hospitals' use of pass-through devices, drugs, and biological products in outpatient services, it makes no actual estimate. Congress required Medicare to make such payments temporarily, and capped them at 2.5% of the estimated overall amount paid under the outpatient PPS. Currently, should the estimate exceed the cap, an across-the-board cut on all pass-through payments would be required. The proposed rule can be viewed at www.hcfa.gov/regs/propcy2002.htm. ▼

Web site accreditation standards available

Standards for the nation's first independent accreditation program for health web sites were released in July by URAC, the Washington, DC-based health accreditation organization. The URAC board of directors has formally endorsed the standards.

The URAC standards are based on the 14 Hi-Ethics Principles and draw upon the work of various organizations — such as the Internet Healthcare Coalition — to develop ethical frameworks for health web sites.

The 15-page standards manual, which is available to both web site owners and the general public, includes 53 specific standards and detailed descriptions of what Web sites must do to achieve accreditation. The Health Web Site Standards can be found on URAC's Web site at www.urac.org/websiteaccreditation.htm. ▼

Physicians express dislike for HIPAA

A mailed survey of 344 physicians conducted by the Association of American Physicians and Surgeons (AAPS) in Tucson, AZ, shows almost unanimous opposition to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy rules, scheduled for full implementation in 2003. Ninety-six percent thought the rules would further compromise patient privacy.

Physicians already believe that third parties ask for information that physicians believe violates confidentiality, with 51% of respondents reporting such requests from government agencies and 70% from health plans.

Nearly 87% reported that a patient had asked that information be kept out of the record, and nearly 78% of physicians said that they had indeed withheld information from a patient's record due to privacy concerns. While only 19% admit to lying to protect a patient's privacy, 74% state that they have withheld information for that reason.

'Physician ethics will be further challenged'

"Patients are withholding information and doctors are lying because of privacy concerns," says **Kathryn Serkes**, AAPS public affairs counsel. "The obvious conclusion is that these rules will only exacerbate the situation to the point of distorted, incomplete, and potentially dangerous medical records becoming the norm. Physician ethics will be further challenged, the choice between government compliance and lying for a patient."

The poll results were disclosed at a news conference in conjunction with the announcement of a lawsuit to be filed by AAPS against the Department of Health and Human Services challenging the regulations. ▼

CMS proposes changes for physician fee payment

Proposed changes to the Medicare physician fee schedule for calendar year 2002, as well as proposals for other policies affecting Medicare Part B payment for physicians and other providers, have been announced by the Centers for Medicare and Medicaid Services (CMS).

The fee schedule specifies payments to physicians for more than 7,000 services and procedures ranging from routine office visits to cardiac bypass surgery. In 2002, Medicare will spend approximately $45 billion on physician services.

COMING IN FUTURE MONTHS

- ASP stores digital medication images
- Web site offers way to get transcription quotes
- CMS announces more agency reforms
- A look at the payment system for rehab hospitals
- Senate leader laments the AMA's 'statutory monopoly' on CPT codes

Included in this year's rule are proposals for reimbursing expanded Medicare preventive services mandated by the Medicare, Medicaid and state Children's Health Insurance Program Benefits Improvement Act of 2000. This includes payment for annual glaucoma screenings for persons at high risk for glaucoma, effective Jan. 1, 2002. Medical nutrition therapy provided by a registered dietitian or qualified nutrition professional for individuals with diabetes or renal disease will also be reimbursed for the first time.

Improving beneficiary access

In addition, this rule includes proposals to increase payment for screening mammography services and to provide payment for certain new technology mammography services. These changes would improve beneficiary access and address concerns of the medical community that the current payment for these services is too low.

The proposed rule will be published in the Aug. 2 *Federal Register*. CMS will accept comments on the proposed rule until Oct. 1. A final rule will be published in the fall. ▼

AHIMA now provides computerized testing

The American Health Information Management Association (AHIMA) announced in August that it has begun providing computerized testing for the Association's Registered Health Information Administrator (RHIA) and Registered Health Information Technician (RHIT) exams.

Computerized testing offers a number of advantages over the pencil-and-paper method, the association says, including:

- **Flexibility.** Candidates can schedule the test throughout the year, instead of being locked into one testing date per year.
- **Accessibility.** AHIMA's testing agency, Applied Measurement Professionals, has more than 100 assessment centers for computerized testing nationwide, compared to the 52 test sites available for pencil-and-paper test administration.
- **Immediate feedback.** Candidates will receive their exam scores at the test center immediately after completing the test
- **Easier re-testing.** Candidates who fail the exam will not need to wait a full year before they can re-test. Re-examination is available once per quarter.

For additional information about the computerized testing process or for an application, visit AHIMA's certification web site at www.ahima.org/certification. ▼

Hospital Payment & Information Management™ (ISSN# 1074-8334), including **DRG Coding Advisor**®, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Payment & Information Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30-6:00 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), $599. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $359 per year; 10 to 20 additional copies, $240 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $100 each. (GST registration number R128870672.)

Editorial Questions

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

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

Editor: **Sue Powell Coons**, (614) 848-5254, (suby33@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Production Editor: **Brent Winter**.

AMERICAN HEALTH CONSULTANTS
THOMSON HEALTHCARE

Hospital closures are said higher this year

During the first half of this year 24 hospitals with 4,088 staffed beds have either closed their doors — partially or entirely — or announced plans to do so, compared with 20 for the same six months last year, according to Dynamis Healthcare Advisors.

The Cleveland-based health care consulting firm said in a report that this year's closure trends are similar to those seen in 2000. Of closures in 2001, five have been in rural communities, and 19 were urban hospitals. Seven closures were for-profit facilities, and 17 were not-for profit facilities.

Midwestern closures

Geographically, most of this year's closures were in the Midwest, followed by the East Coast. Ohio led the list of closures with four closures or announcements. At the same time last year, Ohio also led the list, with five. Closures to date in 2001, according to the report, have affected 4,203 staffed beds and approximately 13,000 employees.

For more information from the Dynamis report, go to www.dynamis-hc.com. ▼

Medicare has new system for rehab

The Centers for Medicare and Medicaid Services (CMS) announced in July a new Medicare payment system for certain special hospitals that care for Medicare beneficiaries recovering from strokes, joint replacements, or other conditions requiring inpatient rehabilitation.

The prospective payment system (PPS), required by the Balanced Budget Act of 1997, is scheduled to go into effect on Jan. 1, 2002. CMS published the final rule on the PPS in the *Federal Register* on Aug. 7. The PPS replaces the existing cost-based payment system.

Under the new payment system, rehabilitation facilities will be paid based on the characteristics of each patient they admit. Medicare will pay hospitals more to care for patients with greater needs, as determined by a comprehensive assessment of their condition. ■

• The American Health Information Management Association (AHIMA) in Chicago is hosting its **73rd National Convention and Exhibit** Oct. 13-18 in Miami Beach. "Return on Information" will provide the latest information on topics ranging from the Health Insurance Portability and Accountability Act of 1996 and data quality management to compliance and security. For more information, visit AHIMA's web site at www.ahima.org/convention/ or contact the association at (312) 233-1100.

• **The Third National HIPAA Summit: From Theory to Practice — From Planning to Implementation** will be held Oct. 25-26 in Washington, DC. Pre-conference symposia will be held on Oct. 24. On Oct. 25, the summit features a full-day plenary session town meeting on regulating health care privacy and data security. Leading federal and state regulators will be available for interaction. For more information, visit the web site www.hipaasummit.com/ or call (800) 684-4549. ■