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INSIDE

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Hands across the hospital: A guide for handling international patients

Language, cultural concerns, scheduling pose challenge

In an era of managed care and federal cutbacks in health care reimbursement, international patients — who typically pay full charges for medical services — are understandably a prized part of a hospital's or health system's business.

Along with this retail rate, as it is often called, come issues and requirements that go beyond providing medical care. They present a unique set of challenges for any health system and particularly for access personnel.

"There is a need for a variety of ancillary services that are critical to providing access," notes **Lesley Macherelli**, embassy liaison for the Boston-based Partners Healthcare System's international program.

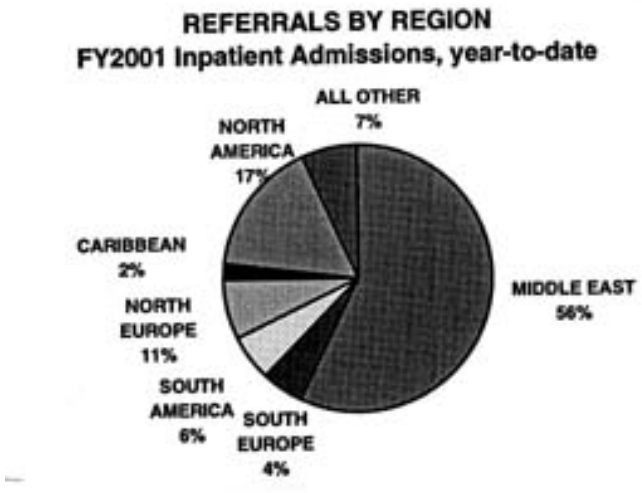
Some issues are remarkably the same — patients complain about wait time or question the amount of their bills — and some are decidedly different.

Guiding people through the system means not only accompanying patients to appointments, but assisting them at the airport and with housing arrangements in a city that is foreign to them, she adds.

"You're assuming a lot if you [believe] someone who doesn't speak English and has lived most of his or her life in a small town in another country can figure out which Sheraton is which," Macherelli points out.

At Brigham and Women's Hospital, one of five Harvard Medical School-affiliated hospitals for which Macherelli helps coordinate international business, the volume has grown in recent years, says **Kerin Howard**, manager of the hospital's international program. Residents of the Middle East make up the majority of Brigham and Women's international patients, she notes, but the business is increasing both in numbers and in countries represented. **(See graph, p. 110.)**

Before Brigham and Women's established a separate office for international patients two years ago, Howard says, she worked with those patients as part of her job in the access services department, which is a



Source: Partners Healthcare System, Boston.

24-hour, seven-day-a-week operation. The international office, she notes, is open from 7 a.m. to 8 p.m. and has someone on call around the clock.

International patients, she says, typically make a deposit in advance of their stay of between 75% and 100% of the estimated amount of their bill.

"We do a lot with embassies, so [in those cases] we get a letter of guarantee," says Howard, who reports to Brigham's director of admitting and oversees a staff of eight. "Every patient at Brigham and Women's Hospital gets the same quality of care, but we do try to take into consideration the special needs of the international patient."

Patients can elect to pay for concierge services, she says, which the hospital outsources to a local company. "They assist with hotels, transportation, banking, grocery shopping, changing flights, and any other services that a concierge typically provides."

The Pavilion, a newly refurbished patient floor with private rooms only, was scheduled to open Sept. 4 and will be available to patients — international and domestic — willing to pay a premium for special services and amenities, Howard adds.

When it comes to scheduling the U.S. patient, "we look at length of stay in the hospital, but with the international patient, it's important to consider length of stay in the country," notes Macherelli. "Every day they're out of their country, it's costing them much more than just hospital charges. They're paying for hotels to bring family members with them, and there's the out-of-work component."

In addition to closely scheduled appointments for international patients, she explains, close attention must be paid to things that otherwise might be taken for granted.

Ensuring that the patient is there on time and follows preoperative instructions, such as not eating after midnight, is not necessarily a given, Macherelli says. Patients have been known to show up for surgery saying they really hadn't eaten, had "just had a croissant and a coffee," she adds.

Many of Partners' international patients, the majority of whom come from Arabic countries, "are not early-morning people," notes Howard. "Cultural ideas about time are not the same as here."

Such eventualities, she says, underscore the importance of "doing some education on our end." Her department uses a variety of handbooks and educational literature for international patients, Howard adds.

"One international patient is like having 10 domestic patients," she says. "It's not just language. It's cultural issues, and it's the need to have everything done in an efficient and often expedited manner. When they're leaving, they need a final bill, all their records, and their medications."

Helping Howard keep the fast pace that's required are three administrative employees who work in the office and five Arabic-speaking patient coordinators who accompany patients to their appointments and serve as interpreters, she says. Spanish is the next most frequently spoken language among international patients, Howard notes, but that language need is met by the hospital's interpreter services department or by bilingual admitting staff.

A Partners nurse stationed in the United Arab Emirates helps get patients and their records ready for the trip to Boston, she notes.

COMING IN FUTURE MONTHS

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- What's the benchmark for patient identification?
- The gap between policy and procedure

Having a good customer service program is a big advantage for any access department dealing with international patients, Howard says. Like their domestic counterparts, these patients can present a variety of scenarios that must be handled with patience and tact.

"Sometimes patients come for [a medical procedure] they think will cost a certain amount and it turns out to be more complicated," she says. "There are some common things, but you never know what to expect. They're all unusual; there's nothing straightforward."

In effect, Macherelli points out, working with the international patient sets back the clock to a time when health care providers had more time to dedicate to patients.

"Medicine is so highly specialized, we often don't have time to look at the totality of a patient's experience," she adds. "[With international patients], you have to look at the whole experience — the foods they eat, [and] the cultural and familial ramifications."

Providing access services to these patients encompasses two kinds of concerns — infrastructure and cultural — and the two categories overlap, Macherelli notes. "Critical [to the process] are triage and the scheduling of appointments, and to do that, you have to have people who can interpret and translate medical records."

With Muslim patients, there are myriad cultural issues, Macherelli explains. "To have a man come into the room and move a bedridden female patient onto another bed can be horrifying to someone," she says. "It has to happen, but there needs to be some sensitivity as to how it happens. [Providers] must be sensitive to patients' cultural mores or patients can get so distraught that the delivery of care is compromised."

Traditionally, female Muslims will only see female providers, Howard says, particularly for gynecological problems. When it makes sense clinically, the hospital will accommodate those patients, she adds. If a male physician is the best clinician in a particular field, or the only appropriate person on call during the weekend when an in-vitro fertilization needs to take place, Howard says, "usually, the patient will agree" to the care.

Devil's in the details

Simply entering the international patient's demographic data into the system can present an interesting challenge, Macherelli points out. Names are typically hard to spell and hard to pronounce, and "virtually every Arabic name begins with 'Al-,'" she notes. "If a [registrar] types in 'Al-,' hundreds of names come up. You have to take these fields all the way down to the date of birth and home address [to identify the patient]."

The date of birth also can be problematic, Macherelli adds. "I have seen the same person give a different date of birth on each of three visits."

In some cases, she says, the day and month are reversed. "It seems like a small thing, but it can cause constant confusion if the dates of birth don't match up from one year to the next on blood work. You need a thorough intake questionnaire."

Assorted challenges notwithstanding, working with international patients can be a particularly rewarding and positive experience, Howard says. "It's about making a difference in people's lives. We have a patient here from the Middle East who is pregnant with conjoined twins. She wouldn't have the same outcome if she had stayed in her own country."

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Access is no longer alone in revenue capture effort

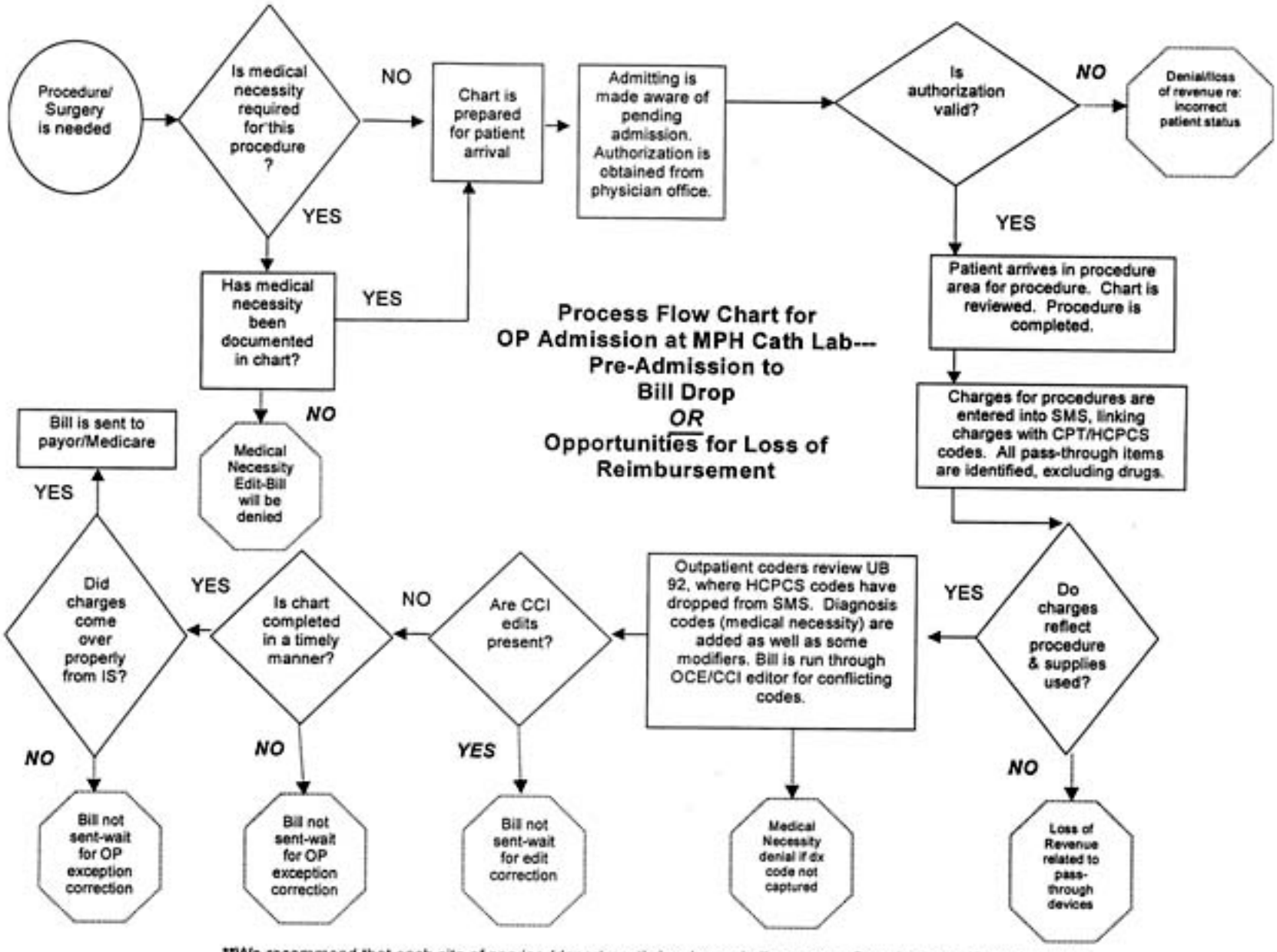
Cardiology, oncology take responsibility

Here's a concept that could make an access manager's day: Each department in the hospital is responsible for being educated on reimbursement within that discipline — be it cardiology or oncology or radiology — and taking an active role in understanding its impact.

"Who knows more about cardiology than the director of cardiology?" notes **Robert Lynch**, director of cardiovascular and pulmonary services for Morton Plant and North Bay hospitals in Clearwater, FL. "You can't have access services people in every department to assist with documentation every time a person goes from cardiology to surgery. It's the people there who are accountable."

While in years past the personnel in oncology or cardiology or radiology concentrated only on

(Continued on page 113)



Source: Morton Plant Hospital, Clearwater, FL.

the clinical, he says, they now must understand that running a hospital requires a three-legged stool management approach and the legs are service, outcomes, and cost.

An initiative known as the revenue capture program, which drives home this point to personnel at the Morton Plant Mease Healthcare, a community health alliance that is part of the Baycare health network, has been responsible for adding millions to the bottom line at his hospital alone, Lynch adds.

"The key is to move reimbursement out of the basement," he explains. "It needs to be moved up to the department level. The people there are taking care of patients, but they're also running a business, and they have to understand business management and make sure they get paid for the hard work they do."

With that in mind, Morton Plant Mease offers a course — for the directors and managers of all revenue departments — called "Capturing Reimbursement and Documentation." Another course is called "Capturing and Auditing the Revenue." A process flowchart used in the course illustrates where the hospital is at risk for not getting paid. **(See illustration, p. 112.)**

What happens in his organization that does not occur at most other hospitals, Lynch points out, is that personnel from the various departments go to the physicians' offices and help them with reimbursement and documentation issues. "What we've been able to show physicians is that by improving their processes for documentation in the hospital, they can substantially increase revenues in their own practices."

Key to the success of his own department, he notes, was the reallocation of a registered nurse who had a strong interest in reimbursement, coding, and documentation. That person interacts on a daily basis with all the departments related to cardiology and facilitates the revenue capture process, Lynch says. "I know it is difficult to take staff away from your area, but reassigning based on a priority is sometimes best for all."

Foundation must be there

The foundation of a successful revenue initiative, he emphasizes, is a good hospital-physician relationship. "The physicians and the hospital administration and the team members have to believe that there is a symbiotic relationship. If that's not there, you're in trouble."

It's one thing for the hospital to have an internal auditing process and to look at ways of saving money through its own internal processes, Lynch says. "When you get into the revenue capture arena, you really get serious about it. You're looking at all your providers, and you cross the boundaries from internal to external."

Questions to be asked, he adds, are, "Do you have the right information? Is that information brought down to the level of site of service?"

If everyone involved doesn't really understand what the program is about and know all the building blocks, Lynch points out, they won't be able to interact appropriately. "I'm a strong believer that people have to understand why they're doing something, not just be told to do it."

One example, he says, is all the talk about the importance of physician compliance in documentation to Medicare and in the HMO approval process.

"They talk about all these rules [physicians] are supposed to know, but there are actually two sets of rule books — InterQual and Milliman & Robertson," Lynch adds. "Medicare uses InterQual, and Medicare HMOs and PPOs sometimes use Milliman & Robertson."

Adding to the potential for discrepancy, he says, is the fact that medical schools often have a different lingo than that contained in the Correct Coding Initiatives, and that the language the physician is familiar with varies according to when he or she attended medical school.

"It's real important to know that if you go into a department and try to teach documentation, it's a little like teaching medicine," Lynch notes. "You have to know the root cause and origin."

If a patient comes into the emergency department (ED) and says, "Doctor, my chest hurts," he continues, that could indicate a pulmonary, cardiac or skeletal-muscular problem. If the physician admits the patient for chest pain, there are problems right off the bat, Lynch adds, because some payers say some individuals with chest pain should be classified as outpatients and others as inpatients.

If tests are done and it turns out the person has gastritis or a hernia and so is discharged, then because the classification was "inpatient," there is a denied admission, he says. On the other hand, if the person is admitted as an outpatient, and then serious cardiac problems are discovered and no one changes the admission criteria, the hospital may end up receiving an outpatient payment for a coronary artery stent placement, Lynch adds.

That's why, he says, "you can't lay down a set of

arbitrary rules and expect anybody to follow them."

Instead, Lynch explains, his organization uses an algorithm or decision tree in key areas such as the ED, cardiology, and radiology. "You compile a revenue and reimbursement profile, building each episode of care onto the next episode, so it's concurrent."

Specially trained nurse case managers work in the ED and make daily rounds on the floors to assess the documentation for patient status and for the revenue and reimbursement profile, he adds. "This process has proved to be extremely successful in reducing rework on claims denials and improving our reimbursement status."

That means, Lynch says, that after the initial admission to the ED, someone will say, "What should it be?" and after the heart catheterization, "What should it be?"

"After each event," he adds, "you should reassess the patient's reimbursement status as well as the clinical status. But what happens in most institutions is that it's all done retrospectively, after discharge. Then they realize the proper documentation didn't occur somewhere during the stay, and so we didn't get paid for the work we did."

Another part of the revenue capture program, he notes, is that every day all patient services departments get an audit from patient accounts of everything that was charged the previous day and how that compares with what was actually done.

"As good as we are, we still find discrepancies," Lynch says. "Putting in charges is not [a clinician's] priority, so it's not unusual for them to forget some item during a critical time, or for the documentation from the physician to be more symptomatology than diagnosis."

There's a big difference between the two, he adds. "A lot of physicians write more symptoms than diagnosis, but you code off diagnosis. We audit every day just to make sure everything was documented appropriately the day before. We have no idea yet if we got paid, we're just checking for appropriate documentation."

It's key that the audit be done daily, Lynch notes. It's not unusual for hospitals to do a monthly audit, he adds, but that just wouldn't be meaningful for his department, which does 25 or 30 heart catheterizations a day.

Every other day, he says, each department gets a list of cases, including "name, type, everything," that coding or patient accounts personnel have had a problem with. "Then we can retrospectively go down and assist admitting and coding employees." People in most departments are trained to perform that function, he says. "It's the responsibility of the department [personnel] to know their service."

"We're able," Lynch adds, "through a very positive interactive relationship with coding and patient accounts, to either help them get paid for what we do or identify the documentation errors and fix them for next time."

"Site of service" is the operative phrase, he emphasizes. "What's important is, wherever the service is provided, taking action along the way to make sure the proper steps are taken. We've come a long way, and we have a long way to go, but we're realizing just how valuable this is."

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Starting a new job? Make lists, volunteer

Devise short- and long-term plans, AM suggests

Whether you're creating an access department from the ground up, starting an access job at a larger health care system, or simply moving from supervisor to manager at the same hospital, settling into a new position can be daunting.

Anthony M. Bruno, MPA, MEd, recently became director of patient access and business operations at Presbyterian Medical Center of the University of Pennsylvania Health System in Philadelphia, where he is charged with establishing a new department that will participate in a systemwide revenue management initiative. **(See related story, p. 115.)** During his years in access management, Bruno says, he has developed a checklist of actions to take when assuming a new position.

• **Develop a "names-to-know" list.**

"As I meet people, I put them on a list of 'names to know' or 'people to get back to,' he says. "This may be someone in maintenance or security, not necessarily someone I would have to talk to on a regular basis." If the power goes out on his computer, Bruno adds, it's nice to be able to call and say, "Hey, Bob, remember me? I'm that new guy you just met."

• **Always start a personal phone book with the name, title, and telephone number of people**

you'll be working with.

Writing the names in your own book, as opposed to simply using the directory supplied by the new institution, helps you to recall who the individuals are, Bruno says. "It's more personal, and helps jog the memory."

• **Volunteer to be on committees.**

"This is a great way to meet people and to start networking in the hospital," he points out. For example, Bruno volunteered to represent Presbyterian Medical Center on the University of Pennsylvania Health System's HIPAA (Health Insurance Portability and Accountability Act of 1996) steering committee.

• **Put together a plan with short-term and long-term goals.**

"This plan gives me a guide, a working tool," Bruno says, "which, of course, I adjust as I go along." In his current situation, he explains, he was preceded by a consultant who identified a number of areas that needed to be addressed. "I'm using that as a guide, but I'm also developing my own plan."

His three-year plan, Bruno notes, includes the goal of promoting and implementing a comprehensive, impressive customer service program. A short-term goal, one he hopes to accomplish in the next couple of months, is to promote organization management, team building, and communication and service skills by instituting a mentoring program. Another short-term goal is to meet one-on-one with each staff member.

• **Think and work outside your comfort zone.**

If you're more comfortable with, say, admissions, than with other areas you oversee, Bruno says, it's easy to get caught up in focusing your attention there. Try to get out of that comfort zone, he suggests, by making a conscious effort to spend more time in outpatient services or the emergency department. ■

New job has a tall order: Create access department

It's part of revenue management initiative

In July, when **Anthony M. Bruno**, MPA, MEd, assumed the position of director of patient access and business operations at Presbyterian Medical Center in Philadelphia, he was facing more than the usual transition to a new job.

Bruno has been charged with creating a brand-new department at the hospital, which is part of the University of Pennsylvania Health System, and making it an integral part of a major systemwide revenue management initiative.

His mission, Bruno explains, involves "taking departments that have been decentralized and putting together a centralized operation of the business activities." The new arrangement, he adds, will allow not only a focused, consistent training of staff, but also the opportunity for cross-training in different areas.

Previously central registration, financial counseling and cashier services reported to the patient accounts department, emergency department (ED) registration reported to ED administration, and admissions reported to the chief medical officer, Bruno says. Now all those areas are consolidated under patient access and business operations.

As he handles the nuts and bolts of creating a department where one did not exist before — including allocating office space, setting up files and revising policies and procedures — Bruno is also involved in evaluating the scope and responsibility of the different areas he oversees.

Then, he says, "we will make the determination of what is needed to carry out the health system's Code Green Workplan." That project — begun in 1999 — is designed to "improve our management of the entity revenue cycle and increase the health system's profitability," Bruno adds. In the past couple of years, he explains, the system has undergone a positive turnaround after experiencing a serious budget shortfall in 1999.

"We are now writing the fiscal year 2002 work plan," Bruno says, with an eye on continuing to reduce registration errors, billing rejections, and denials in an effort to decrease days in accounts receivable and ultimately improve the bottom line.

"On the front end, we're talking about expanding collaborative work efforts between registration, medical records, utilization management, and patient accounts," he notes. "All of these departments directly impact our ability to manage rejections, denials and the revenue cycle."

Meanwhile, Bruno says, he has been interviewing people for several positions that are being created for the new department, including manager for quality assurance and training, manager of the admissions center, and a manager to oversee central registration and registration services in ancillary departments.

"Right now, I am building a management team for the new department," he explains. "We really need a strong teamwork approach to aggressively manage our responsibilities in the revenue cycle. In today's health care environment, every patient registration and account is important. You have to be extremely accurate and thorough and take all opportunities to appropriately bill a patient's insurance and, if there is none, determine if the patient is eligible for assistance."

The new department also will work very closely with clinical resource management and social work, Bruno says, to ensure that admissions meet the appropriate clinical admission criteria. "We are just beginning to re-engineer our preadmission and transfer processes."

[Editor's note: Hospital Access Management *will give periodic updates in future issues on the establishment of the patient access and business operations department at Presbyterian Medical Center of the University of Pennsylvania Health System. Anthony Bruno may be reached at (215) 662-9297 or by e-mail at anthony.bruno@uphs.upenn.edu.]* ■

Late-night ED scenario sparks EMTALA debate

In this case, registrar can't take no for answer

(Editor's note: Access managers with responsibility for overseeing emergency department [ED] registration often find themselves in the middle of decisions being made about how best to comply with provisions of the Emergency Medical Treatment and Active Labor Act [EMTALA]. In the Q&A exchange below, an EMTALA expert explains how ED personnel should handle what for many hospitals is a frequent late-night scenario.)

Question: During the night, police officers frequently bring individuals to the hospital for screening of blood alcohol levels. Our lab is staffed with only one person and is locked, which makes it difficult to access. If the officer brings the person to the ED for the blood draw, are we required to do a medical screening examination (MSE)?

Answer: "The primary issue is whether or not the individual's presence at the ED constitutes a request for examination or treatment that triggers the hospital's duty under EMTALA to provide an MSE," contends **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC.

The law holds that the request for the MSE can come from anyone, not just the patient, he stresses. "Thus, the police officer's request for blood alcohol testing may itself be sufficient to constitute a request," he says.

Also, he notes that the Center for Medicare and Medicaid Services (CMS) views alcohol intoxication to be a "sufficiently severe medical symptom to warrant the label 'emergency medical condition'" (59 *Fed Reg* 32,107 [1994]).

Thus, an intoxicated individual has an emergency medical condition until the hospital proves otherwise, concludes Bitterman. "Furthermore, while the issue is legally debatable, the [CMS] believes that anyone coming to the ED for tests must be provided an MSE unless the patient voluntarily withdraws the request for the examination."

Police bring people to the ED to obtain a blood alcohol level because they believe the individuals to be intoxicated, but they don't know for sure, says Bitterman. "Many emergency conditions mimic alcohol intoxication, including hypoglycemia, cerebral hypoxia, head injury, metabolic abnormalities, or other toxins," he warns.

Neither the hospital nor the police should automatically presume alcohol intoxication to be the cause of the patient's condition, Bitterman emphasizes. "The emergency physician should perform an MSE in these cases," he says.

However, the patient can refuse the MSE offered by the ED physician and request only that blood be drawn and provided to the police officer, says Bitterman. "But only competent individuals can refuse the MSE, so the ED physician [not a registrar or a nurse] must first ascertain that the patient is competent to refuse," he underscores.

If the individual is clinically too intoxicated to make an informed decision, then the physician must keep that person in the ED until he or she is competent enough to make rational decisions, Bitterman adds.

He warns that these are clearly high-risk individuals. "To not offer them an examination or determine if they are competent to refuse an exam is a major risk management mistake," he says. "If you offer them an exam and they refuse, and are competent to do so, then EMTALA no longer applies and you can proceed to draw the blood."

Finally, Bitterman rejects the notion that EMTALA does not apply if the individual does not have an emergency medical condition. "The law requires the hospital to provide an MSE to

anyone presenting requesting examination or treatment for a 'medical condition.' It does not say for an 'emergency medical condition,'" he explains. "Only after the hospital performs the MSE and the MSE determines the patient does not have an emergency medical condition, then and only then does EMTALA not apply further."

Bitterman acknowledges that if the patient denies requesting or refuses the MSE, then you do not have to supply one. However, you should offer one and document the patient's refusal and competence to refuse, he cautions.

"Alcohol-related incidents are an extremely common source of litigation against hospitals," he adds. "Common sense should prevail." ■

Here comes a flurry of compliance assessments

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's end.

A recent 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.

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 already have 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 also were 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 also are 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 that 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 a third of hospitals and half of payers, clearinghouses, and vendors have even begun implementing the HIPAA regulations. Even physician practices and other providers, historically behind in HIPAA awareness, are moving forward: Of nearly 200 respondents, 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 found. 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."

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. ■

What do we want? Finality! When? Now!

Providers are tired of waiting — they want the final Health Insurance Portability and Accountability Act (HIPAA) of 1996 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. 117.)**

"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 that **Bill Braithwaite**, senior HHS advisor on health information policy, made to Phoenix Health Systems on July 27. "The basic philosophy of the final security rule is unchanged from the NPRM," he said, according to Phoenix. The final rule should reduce redundancies and excessive micromanagement. He 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." ■

Medicare hikes pay for outpatient services

Hospitals will get a 2.3% payment hike for outpatient services effective Jan. 1, 2002, under a proposed rule for the outpatient prospective payment system (OPPS) released in late August by the Centers for Medicare and Medicaid Services (CMS).

The rule would achieve the goal of making appropriate reimbursement payments given the ongoing shift of services from inpatient to outpatient setting, according to Tom Scully, CMS administrator.

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 temporarily make such payments and capped them at 2.5% of the estimated overall amount paid under OPPS.

The OPPS establishes base payment rates based on groups of services, known as ambulatory payment classifications, that are clinically similar and require comparable resources. Before the implementation of OPPS, hospitals were paid for outpatient services based on costs.

Currently, should the estimate exceed the cap, an across-the-board cut on all pass-through payments would be required. The proposed rule, published in the Aug. 24 *Federal Register,* can be viewed at the CMS web site, www.hcfa.gov. CMS will accept public comments on the rule and publish a final rule later in the fall. ▼

HIPAA privacy rule called incomplete

Additional requirements are needed under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy rule's minimum-necessary standard, according to **Dan Rode**, MBA, FHFMA, vice president of policy and government relations for the Chicago-based American Health Information Management Association (AHIMA).

In testimony before the Privacy and Confidentiality Subcommittee of the National Committee of Vital and Health Statistics, Rode recommended the following requirements be added to the standard:

- The covered entity should be permitted to use its professional judgment and request additional justification for the amount of protected health information requested by another covered entity.
- Responsibility for disclosure of health information should be centralized under the direction of the provider's health information management professional to ensure compliance with legal requirements and adherence to policies for disclosure.
- The requester of personal health information should present or sign a statement stipulating that the requested information is limited to the minimum necessary for the stated purpose.
- A statement prohibiting use of the information for other than the stated purpose and requiring destruction of the information after the need has been fulfilled should accompany any disclosure of health information to external requesters.

Rode also expressed concern with the rule's "right of the individual to request restrictions of uses and disclosure." AHIMA recommends that the "right" to restriction either be deleted from the rule or that it be optional for the covered entity to extend this right.

"From a clinical perspective, suggesting that individuals should restrict how protected health information is used or disclosed to carry out treatment, payment, or health care operations may affect future case decisions in ways not intended by the patient," Rode said. "This is contrary to the medical, ethical, and legal obligations that require

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Editorial Questions

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providers to maintain accurate and complete medical records." For a copy of Rode's testimony, visit AHIMA's web site at www.ahima.org. ▼

AHIMA privacy seminar, annual convention set

The Chicago-based American Health Information Management Association (AHIMA), is sponsoring a 14-city two-day program designed to educate the health care community on the practical measures needed to be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy rule.

The program, "Getting Practical with Privacy," will look at the individual mandates and provide practical solutions on how to implement the HIPAA directives into daily organizational operations.

Seminar dates and locations include: Oct. 18-19, 2001, Miami Beach Convention Center, Miami Beach, FL; Oct. 25-26, 2001 Holiday Inn O'Hare, Chicago; Nov. 5-6, 2001, Hilton Seattle Airport and Conference Center, Seattle; Nov. 12-13, 2001, Hilton Philadelphia, Cherry Hill, NJ; Nov. 15-16, 2001, Inverness Hotel and Golf Club, Denver; Jan. 17-18, 2002, Sheraton Gateway Hotel, San Francisco International Airport; Jan. 31-Feb. 1, 2002, Holiday Inn Select, New Orleans; Feb. 14-15, 2002, Marriott Las Colinas, Dallas; Feb. 21-22, 2002, Loews Vanderbilt Plaza Hotel, Nashville, TN.

March 7-8, 2002, Stardust Resort, Las Vegas; March 21-22, 2002, Millennium Hotel, St. Louis; April 11-12, 2002, Tremont Hotel, Boston; April 30-May 1, 2002, Hilton Scottsdale (AZ) Resort & Villas; May 13-14, 2002, Holiday Inn Fairlane, Detroit.

HIPAA expert Jill Callahan Dennis, JD, RHIA, will lead each session, and alternating with her will be Michelle Dougherty, RHIA, AHIMA professional practice manager; Gwen Hughes, RHIA, AHIMA professional practice manager; and Harry Rhodes, MBA, RHIA, director of HIM products and services at AHIMA.

The cost for the two-day seminar is $185 for AHIMA members and $225 for nonmembers. For additional information, visit www.ahima.org/privacy or contact AHIMA at (312) 233-1100.

In other news, AHIMA will host its 73rd Annual Convention and Exhibit Oct. 13-18 at the Miami Beach Convention Center. "Return on Information" will provide information on topics ranging from HIPAA and data quality management to compliance and security.

Information about convention activities, registration forms, and discounted hotel and travel rates is available on AHIMA's web site at www.ahima.org/convention. ▼

Prompt-pay law not helping in NJ

Managed care companies operating in New Jersey are continuing to lag in some areas of paying hospitals on time — and in some cases, are even slower — more than a year after the state adopted a prompt-pay law for HMOs, according to survey of members of the New Jersey Hospital Association (NJHA). NJHA surveyed its members during the first quarter this year and found that while some HMOs have improved in some areas compared to October 2000, overall performance was down in payment of electronic claims in 30 days (as required by the new state law) and payment of interest on overdue claims.

The survey also showed that accounts receivable due hospitals by HMOs also increased during the past year. The study showed that manual claims payments were the only area showing "marked improvement." ■