



HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

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What's needed for best practices? Clean data collection, benchmarking

Experts offer advice on how to make it work

Initiating a benchmarking process could be the HIM department equivalent of having one's teeth drilled. It's not likely to be something coders and HIM managers eagerly anticipate.

However, given an organized and methodical approach to the process, it can be done well, and it can result in process improvements that are lasting and cost-effective.

"We have developed what we believe are the best ways to run an HIM department, given a set of circumstances, and we did that based on our cumulative

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years of experience," says **Cindy Doyon**, RHIA, product manager for data management solutions at QuadraMed Corp. in Covina, CA. QuadraMed is a software technology and HIM consulting company.

Doyon, along with **Debi Primeau**, RHIT, western region vice president of HIM Services Division of QuadraMed Corp. in Lomita, CA, spoke about developing benchmarking and best practices at the 73rd National Convention and Exhibit of the Chicago-based American Health Information Management Association (AHIMA), held Oct. 13-18, 2001, in Miami Beach, FL.

Doyon and Primeau suggest these guidelines for HIM departments to conduct benchmarking and develop best practices:

1. Define benchmarking and best practices.

People often confuse the two terms, but the simplest definition is that a best practice is an optimal or ideal way to perform a business process or procedure, and benchmarking is the search for industry best practices that lead to superior performance, Doyon says.

Developing best practices requires similar strategies to continuous quality improvement activities, Doyon says. (See chart, "Standard Types of Benchmarking," p. 178)

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Standard Types of Benchmarking

METHOD	DATA TYPE	VALUE-ADDED	KEY QUESTION
Program Classification	Objective	Prioritization	Where are most of the costs?
Nationwide Cost Improvement Survey	Subjective	Perceptions of Interested Parties	What do interested parties think?
Paired Cost Comparison	Objective	Performance Disparities	Is there a DOE/non-DOE disparity?
Component Benchmarking	Objective/Subjective	Process Differences	What best practices can be adopted or adapted?

Source: U.S. Department of Energy, Office of Environmental Management.

“You analyze your data and decide on changes,” she adds. “But it’s never done and goes on continuously.”

2. Collect information about benchmarking.

HIM department managers can learn more about benchmarking guidelines from organizations that have successfully incorporated these strategies into their business. One

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such web site is www.benchmarking.org. Also, the U.S. Department of Energy has a web site that includes information on benchmarking: www.em.doe.gov.

AHIMA is another source for information, as the organization has published a variety of benchmarking information and conducts a best-practices award program.

3. Learn the difference between qualitative and quantitative processes.

Qualitative information is the descriptive part of a process, Doyon says.

“Discover why numbers are different and analyze the steps that go into what you’re evaluating,” Doyon says. “You have to do a qualitative analysis in order to do a best practice because that’s the only way to identify items, numbers, and steps you have to change in order to achieve your benchmark.”

On the other side, quantitative or metric analysis is where someone uses specific numbers or targets in the analysis.

“Once you’ve done the number part, then you can identify where you’ll have something different

or some goal to strive for,” Doyon explains.

“Quantitative is the numbers with a comparative analysis.”

Here’s an example of a situation that requires both quantitative and qualitative analyses: Department A has fewer complaints than departments B and C, Department B does more procedures than A and C, and Department C has fewer full-time-equivalents (FTEs) than either A or B. The quantitative analysis has determined which department is best at each of these three practices, while the qualitative analysis will need to answer these sorts of questions:

- Which department is best?
- Which results are the most important to what the organization wishes to achieve?

4. Determine what will be benchmarked.

First, managers should define the process that will be benchmarked, first selecting something that is simple to study, Doyon suggests. (See chart, “Benchmarking Components,” p. 179.)

“And it should probably have some high-level exposure within your organization so that you can get buy-off from the administration,” she adds. “Then after doing that, plan and clearly define what you want to benchmark.”

Primeau advises that these questions be asked when benchmarking:

- What are functions or processes being benchmarked?
- To whom or what will we compare?
- How will the data be collected?

5. Collect data.

There are several ways to collect data, and each has its pros and cons, Primeau says.

Benchmarking Components

First, a manager may collect data through on-site observation, Primeau says.

When observing a department, it's best to have a standardized tool that is uniform across all organizations and sites that are reviewed. In other words, the site observer will ask the same questions of the same staff at the same time and then observe the processes without making judgment, Primeau says.

"The observer needs to be trained, and we would suggest that there be some advance warning as a courtesy to the department and director," Primeau adds.

The second type of collection strategy is to use a survey tool and survey the department by telephone, Primeau says.

"On-site observation is the best way to go, but as far as feasibility and the time-process, the telephone interview is most popular," Primeau notes.

A third strategy is to use a survey tool with a mail survey, which is slower and typically has a lower rate of return than telephone surveys.

Whether the survey is conducted by telephone or mail, there are generic tools available for such use. However, it's best that a benchmarking program take the generic tool and specifically design it to be used for the specific reviews required by the organization, Primeau cautions.

"I would use some of the predefined tools as a guide — some of the ones out there on web sites and in AHIMA journals on benchmarking would work — but they should be customized to the individual survey," Primeau says.

6. Start analysis.

Once the data are collected, the hard work begins: analysis. **(See chart, "Benchmarking Steps and Processes," p. 180.)**

First, list the elements that were included in the data and identify the ones that an organization wishes to strive to improve, Doyon says.

"Do a quantitative data analysis first," she says.

Source: U.S. Department of Energy, Office of Environmental Management.

"You may have data from 10 to 15 places, and these can be laid out on a grid with numbers."

After seeing the results on a chart, it's time to select the best three or four items for conducting a detailed analysis, using qualitative analysis, Doyon says. Rank them from the top on down in order of importance.

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"You will start to identify which steps or processes are similar or different and which you may want to incorporate into your own organization," Doyon says.

Another strategy for selecting processes to change is to pay attention to the complaints a department has received from other departments or from within its own staff, Primeau suggests. "Also look at where you might have some backlog or process improvement opportunities."

When selecting the most important two to four processes to change, managers should choose processes that are amenable to change and that will have an impact on the organization.

Benchmarking Steps and Processes

Benchmarking Step	Specific Benchmarking Process
1. Select component	Selected tank monitoring
2. Define key performance variables	Focused on cost
3. Identify benchmarking partners	DOE Sites A and B, Non-DOE Federal Commercial
4. Determine data collection method	Survey and field visits
5. Collect data	Benchmarking project team visited partners
6. Determine and understand current performance gaps	Benchmarking project team conducted analysis
7. Predict future performance levels	Not applicable
8. Communicate findings	Report to interested parties
9. Establish goals	Not applicable - demonstration project
10. Implement actions and monitor progress	Not applicable
11. Measure results	Not applicable
12. Recalibrate benchmarks	Not applicable

Source: U.S. Department of Energy, Office of Environmental Management.

“Maybe you can’t make one change because of X condition, but maybe you can do Y or Z and result in the same impact on the organization,” Doyon says.

For example, suppose a department chooses to work on reducing accounts receivable days, which are the days outstanding for Medicare records not yet coded. “Then the data-gathering of what you’re going to measure is the average processing time for Medicare inpatient records, and we define the average processing time as the time elapsed from the patient discharge until the bill is dropped,” Doyon says. “And so in the HIM department we would look at collecting the record, assembling the record, analyzing the record, coding the record, and the impact of the record if it’s incomplete and needs physicians to complete its deficiencies.”

Some of the data that will be collected in this scenario would be the number of beds in the hospital, the percentage of Medicare discharges, the average charges per day per FTE, and which FTEs are defined as those most directly affecting the processing time of the record, Doyon says.

7. Implement best practice changes.

After analyzing the information, the department might decide that the departments that had

the best outcomes in this benchmarking comparison of the above example had a variety of best practice processes, including:

- adjusting work schedules in the record assembly area;
- providing a noise-free environment for coders;
- hiring dedicated clerical staff for transcription;
- using a universal chart order or assembly;
- cross-training staff;
- good communication among staff and sharing of the department’s status in accounts receivable.

What organizations need to do to improve their own best practices is to select one or more of

these processes to be incorporated into their own practice and then see if this change

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leads to an improved outcome in accounts receivable collections, Doyon says.

“You should set a goal, so that if you’re currently at 15 days in accounts receivable, your goal would be to reduce it to eight days,” Doyon says. “And then phase in your goal, because you don’t have to achieve it all at once or implement it all at once.”

Also, keep in mind that best practices require an ongoing commitment from an organization, Doyon adds.

8 Avoid common mistakes.

One of the biggest mistakes a manager makes is to have preconceived ideas about what will happen, Primeau says.

“Often what happens is the people collecting the data knows what they want to get out of it before they begin the process,” Primeau says. “So they’re not doing it with a completely objective eye, and this could lead to a bad analysis.”

To avoid this problem, a manager should make sure those involved in the benchmarking project are familiar with the processes and are trained to be aware of this potential problem during the process of surveying and collecting data, Primeau suggests.

Another big mistake that’s often made is that the manager and department fail to clearly define

the data that will be collected, Doyon says.

“If you don’t define clearly enough, you will get misinformation from other people and it will skew your results and drive you to an incorrect conclusion,” Doyon explains. “If you take more time in the beginning of the process to specifically define the data that’s to be collected, then you will reap huge rewards.”

Along with that issue, it sometimes happens that a department provides the surveyor with inaccurate information, Primeau says. This may be by accident or intentional.

“The institutions being surveyed want to appear better than they are, so they could be skewing their results,” Doyon says.

An on-site survey has a better chance of preventing this type of problem because it’s more difficult to skew data when someone is observing what is being done, she adds. ■

These steps can make benchmarking work well

The DOE makes these suggestions

The U.S. Department of Energy (DOE) in Washington, DC, offers these suggestions for how best to implement and use a benchmarking process. While the DOE has developed these guidelines specifically for the DOE and government contractors, the process described also may be applicable to the health care industry, including HIM departments.

The DOE’s suggestions are summarized below:

Benchmarking Initiative Process Suggestions

Here are suggested improvements to the benchmarking initiative methodology that should be applied to future benchmarking efforts, as well as aspects of the initiative that were valuable and worth repeating. The individual suggestions are grouped under broad initiative process categories.

1. Overall project

- Allow more time in each phase of the initiative. The logistics involved in planning for and executing such a wide-ranging initiative are enormously complex. More time should be allotted for consulting with interested parties, identifying partners, conducting the site visits, and performing the analysis. If additional time is unavailable,

the objectives of each element of the initiative should be carefully matched to the initiative schedule. This would improve the degree to which the overall project objectives are targeted and would permit more time for data analysis.

- Conduct the elements in sequence, not in parallel. Conducting the elements of such an initiative in sequential phases would allow for a more targeted approach to identifying potential areas for cost improvements and provide factual support for ideas about what drives costs in those areas. For example, a mail survey could provide a high-level indication of the areas about which people are most concerned. A paired cost comparison could then follow, comparing projects in order to provide detailed cost information about those areas. Finally, a component benchmarking exercise could focus on management practices, policies, or procedures that contribute to cost increases.

- Develop highly specific project selection criteria. Due to schedule constraints, it was necessary to provide general project selection criteria in order to allow participating organizations to gather the most easily accessible data that would meet the selection requirements. However, the generic selection criteria yielded a choice of projects that were only partially comparable. The benchmarking project team selected the best available projects, but could only compare portions thereof. For future studies, it would be beneficial to develop a more detailed set of project specifications. This would provide a better initial

project selection pool and allow more complete project comparisons.

2. Involving interested parties.

- Foster awareness of DOE's relationship to tribal governments. All organizations working on DOE initiatives must be made aware of DOE's government-to-government relationship with tribal governments. The organizations and the project overall should interact with tribes as sovereign governments which have unique interests and concerns, and not as members of the public or citizen interest groups. In particular, they must be aware of the need for full tribal participation in the federal decision-making process, in accordance with the federal trust responsibility and consistent with the DOE American Indian Policy.

- Streamline the delegation and performance of tasks to involve interested parties early. Streamline the delegation and performance of tasks, such as approving invitation lists and making initial phone calls to interested parties. This would permit more advance notice about meeting dates and might allow the representatives of some groups that would otherwise be under-represented to adjust their plans in order to participate or to suggest substitutes.

- Interested party input into the benchmarking process contributes materially to its success. Interested parties at the kickoff meeting strongly expressed their views that the original scope of work for the paired cost comparison could not be achieved within the schedule. Working with interested parties, the benchmarking project team was able to develop an achievable scope of work that still met the overall intent of the benchmarking initiative, as well as the expectations of interested parties.

3. Visiting sites.

For component benchmarking, use a structured methodology supported by appropriate management tools, including checklists and survey.

- Provide as much information as possible prior to the visit. This practice assures that appropriate facilities and people are being contacted and informs partners about the kind of data required.

- Prepare an overview briefing. Assume that partners know nothing about the initiative and (depending on the audience) prepare a short, informal discussion, or a more formal presentation.

- Conduct site visits with the people most knowledgeable about the project. This practice is necessary to gain a clear understanding of the

project and all contributing costs. Face-to-face interviewing and data-gathering techniques can be used to obtain real-time information about costs.

- Develop performance indicators to help explain reasons for cost differences. For example, DOE pays for state health and safety inspectors to reside at some DOE facilities. Thus inspections are more frequent and more costly than those in private industry. Developing performance indicators for these types of activities would help DOE explain the reasons for cost differences and to ask for comments and suggestions.

4. Gathering data.

- The cost of operations data is often considered sensitive. Industry and DOE contractors are concerned about contract competition so sources and data must be protected. A greater number of participants would help in this area. The objectives and likely benefits of the initiative must be stated clearly to provide comparisons only with comparable data.

- Required information may be nested within sensitive documents. Companies may be reluctant to release entire documents so the project team must be specific about actual data needed. ■

Charge description master is everyone's responsibility

Expert offers guidance to staff training

The hospital charge description master is not a wild bull behind someone else's fence. It's the responsibility of each HIM individual, department manager, and finance person, and the only way to tame the beast is to make certain everyone knows what it is and what their part is in handling it.

"It's absolutely important that anyone who generates any kind of information in a hospital understands what

their part is on their charge description master," says **Lora**

A. DeWald, MEd,

RHIA, CCS, CCS-P, vice president of health information management for Avera Health in Sioux

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(Continued on page 187)

DRG CODING ADVISOR.

Understanding modifiers a key to better coding

How does modifier -25 differ from -26?

Normally, Medicare only pays physicians once for a specific service provided to a specific patient per day. However, there are exceptions that are usually noted by placing a modifier on a code.

Here's a primer on how to use these modifiers correctly:

- **Modifier -25 (new patient visit).**

Modifier -25 is primarily designed for use with a new patient visit or a consultation, which is usually for a new patient. The usual justification for using this modifier is when a physician does the entire work-up of the patient, and a procedure is performed as a result of the work-up.

Tip: Most practices get into coding trouble for using modifier -25 with an established patient.

- **Modifier -26 (professional component).**

If not correctly used, modifier-26, professional component, can produce both undercoding and overcoding. For instance, the global package for certain radiological procedures includes the technical and professional component. If a physician performs a fluoroscopy, and you include modifier -26, this indicates the physician both owns the equipment and interpreted the fluoroscopy data.

Because Medicare pays more for the owning or leasing of equipment than for interpretation, you would be overcoding if you used modifier -26 and your facility did not really own the equipment. However, if you own the equipment and use modifier -26, you would be undercoding.

- **Modifier -50 (bilateral procedure).**

Superbills make this one of the most misused modifiers in anesthesia, say experts. Many physicians, for example, think each time they perform a separate injection it is counted as an additional procedure. But superbills are designed to have a

first level and then subsequent levels of service.

For example, say a physician does a bilateral injection at two levels, meaning she gives four injections. The doctor then writes on the superbill the primary procedure times one and additional levels times three. However, this really should have been coded as the primary procedure times one plus modifier -50, and a subsequent level times one plus modifier -50.

- **Modifier -59 (services not usually performed together).**

This modifier is used to identify services not usually performed together except in certain circumstances. Reasons why two procedures or services that are not normally reported together might be included on the same UB-92 form include:

- separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician;
- different session or patient encounter;
- different procedure or surgery;
- different site or organ system;
- separate incision.

After an extensive surgery, for instance, you can use modifier -59 to inform the Medicare fiscal intermediary that the additional procedure codes are not being inadvertently duplicated on the UB-92.

The two biggest misuses of modifier -59 are using it to report a CPT/HCPCS code that is mutually exclusive when reported with another code and using it to report a CPT/HCPCS code that is a component of another code.

Here are some questions you should ask yourself to determine if the -59 modifier should be used in specific situations:

1. Do any of the codes violate the correct coding initiative edits?

2. If yes, is modifier -59 appropriate to explain the violation?

3. Are any of the codes being repeated for this case?

4. If yes, would modifier -59 be appropriate to explain the duplication?

5. Do any of the codes have “separate procedure” in their narrative description?

6. If yes, would modifier -59 be appropriate to explain that in this case, the “separate procedure” is not an integral component of some larger procedure? ■

Coding intrapartum care: A case study

How would you code the following case?

The following case study from the American Academy of Family Physicians *American Family Physician* magazine illustrates how various coding strategies can work with regard to intrapartum care:

Mary, a 22-year-old white female, goes to her family physician’s office for maternity care at six weeks gestation by dates and size. Prenatal care is routine, and the family physician provides one “new OB H&P” and 10 routine prenatal visits. Mary goes into spontaneous labor at 40 weeks and has mid-labor severe fetal distress requiring one hour of face-to-face and 30 minutes of non-face-to-face prolonged physician attendance by the family physician before a consultant performs a cesarean section. The family physician assists at surgery and then provides uncomplicated postpartum care for the mother and baby for three days.

Based upon these facts, coding options include:

- 59426 Antepartum care; 7 or more visits (plus Pap and lab)
- 99223 Initial hospital care, level 3
- 99354 Prolonged (face-to-face) services; first hour
- 99358 Prolonged (non-face-to-face) services; first hour
- 59514-80 Assist at cesarean section
- 59430 Postpartum care (plus Pap and lab)
- 99433 Subsequent hospital care, normal newborn
- 99238 Hospital discharge day management
- 99431 Normal newborn H&P

To show you how different carriers might interpret this scenario, here are some of the instructions from insurance companies instructing family physicians on how to bill for the evaluation and management of a maternity care patient who ultimately undergoes a cesarean, as described above.

• **Blue Cross/Blue Shield of Oregon:** According to this carrier, the scenario indicates that the family physician should bill for only antepartum care using the appropriate evaluation and management codes and, if performed, the assist at the cesarean section (59515-80). If the family physician will be following the patient for postpartum care, the physician should also code 59430.

• **Lincoln National Life Insurance Company of Indiana:** This company also suggests that the family physician bill for antepartum care using the appropriate evaluation and management codes for initial hospital care such as 99221 or 99222. Of course, if the family physician assists in the cesarean section, the family physician could also bill 59515-80.

• **Oregon Office of Medical Assistance Programs:** The family physician should code 59899 for unlisted procedure, maternity care, and delivery, as well as 59515-80 if the family physician assists in the cesarean section.

Note: If you compare the instructions of the insurance companies with the coding options discussed earlier, you would be undercoding the actual work performed. That’s another reason why it is vital that additional documentation such as a copy of the hospital admission note, intrapartum progress notes, or a written summary outlining the nature of services delivered be included with the claim.

A sample letter

Many practices find it effective to attach a face letter to the claim, acknowledging that the claim is unusual and asking claim processors to pay special attention to the claim. Here’s a sample letter prepared by *American Family Physician* magazine that you could use when corresponding with your insurer in situations such as this.

XYZ Insurance Company
Anywhere, USA
12345-6789
Patient Name:
Patient Number:

To Whom It May Concern:

I am submitting a hard copy claim with this cover letter to inform you of the unusual circumstances associated with this patient.

I was the primary physician for [patient's name], who had a normal pregnancy until she was admitted to the hospital. Up until that time, I followed and took care of all of her antepartum needs. Because of fetal distress, I was obligated to spend a prolonged time with the patient. A decision was made to perform a cesarean section, and a specialist was consulted. I assisted at the cesarean and performed all of the newborn and postpartum care.

This claim contains those codes that describe all of my antepartum, intrapartum, newborn care, and postpartum work-up. Appropriate documentation is also enclosed.

I would appreciate careful review of this claim. Should you have any questions, please do not hesitate to contact this office.

Sincerely,

Signature

Note: Any claim submitted for unusual circumstances or services should always be submitted on hard copy and not electronically. ■

How one practice conducts its own coding audits

Process is built into the office routine

Rather than thinking of coding audits as just another administrative hassle, Inlet Medical Associates of Murrells Inlet, SC, considers coding audits to be part of its total quality management approach to running the medical practice.

Courtesy of the American Academy of Family Physicians' Family Practice Management bulletin, the practice's principals, **William Jackson Epperson, MD**, **Karl S. Hubach, MD**, **Karen E. Menn, DO**, and **Sharon Oates, FNP**, explain their philosophy and approach to coding audits:

"We believe that the way we do business affects the way we take care of patients, and that

all issues that affect patients merit our attention. Our patients deserve the best care and the best service we can offer.

"With this objective in mind, we've developed a coding audit process based on the principles of total quality management that has significantly reduced patient billing problems, saved personnel time, improved our collections and, best of all, improved our documentation and quality of care.

'Delegating coding can lead to bad business'

"One of the fundamentals of this process is that the clinician is primarily responsible for all coding. We believe that delegating coding can lead to bad business and bad service. We train each member of our office staff to review our coding with the mindset of an outside auditor. They catch errors, ask questions, and make suggestions regarding accuracy. Diagnosis and procedure coding manuals are readily available in the patient care, checkout, and insurance billing areas of our office.

"Here's how our system works: When patients check out of the office, they are given a copy of their superbill. Another copy is printed and returned to the providers' dictation area. We review these at lunch or at the end of the day, while the patient visit is still fresh in our minds. We check for accuracy and to make sure no charges were omitted. This review also helps to guard against embezzlement.

"We then hold a weekly 30-minute meeting over lunch, involving our physicians, nurse practitioners, physician assistants, front-office staff, and office manager. We choose two or three charts at random from each provider's patient contacts for the previous week. We review each chart as a group, paying attention to the quality of the documentation and the quality of the care that was documented; then each provider proposes a code for the visit. Finally, the provider whose chart we're discussing reveals the code that was submitted and defends it.

"It's important to try to make these discussions positive rather than an exercise in finger-pointing. A negative environment will discourage participation. We frequently refer to the CPT manual and coding tools during these meetings.

"Before instituting a system like this and at regular intervals thereafter, it's important to review each provider's coding distribution and collection per encounter. A software program like

Excel that allows you to graph the data facilitates this process. In fact, with such programs, these simple graphs are a snap. You should expect your individual physicians' coding patterns and collections per encounter to differ; individual practice styles, patient mix, and payer mix will affect these measurements.

Coding may change over time

"The purpose of this comparison is to examine how individual physicians' information may change over time as a result of the regular audits. If the popular conception that family physicians tend to downcode is true of your practice, you'll probably see a shift in your bell curve.

"Relatively simple graphs of each provider's code distribution can provide helpful feedback for any practice seeking to improve its coding. Physicians' patterns may not be identical because

of individual practice styles and patient and payer mixes, but you can track each individual's coding patterns over time. This will help you judge whether coding practices are improving.

"For a physician with typical monthly collections of \$30,000, a 3% improvement brought about by the audit process would amount to \$900 a month. That increase, divided by the four hours of time it took one physician to produce it, comes to \$225 per hour. We believe this to be a conservative estimate of the value of regular audits for most fee-for-service practices.

"Physicians who are already overburdened by paperwork and meetings may resist, but we believe the economic outcomes make the time investment worthwhile. We also know that because we've been proactive, we would probably perform well in an outside audit and avoid the fines and other penalties that might otherwise result." ■

How well do you know rules for E/M coding?

Here's a quick quiz

Just how well do you know the basics of evaluation and management (E/M) coding? Take this quick quiz developed by the justcoding.com web site to test your knowledge. The answers are at the end of the test.

1. When assigning E/M codes, which of the seven components are considered to be key components?

A. Counseling, Medical Decision Making, and History

B. History, Examination, and Coordination of Care

C. History, Examination, and Medical Decision Making

D. History, Medical Decision Making, and Coordination of Care

2. A new patient is defined as:

A. A patient who has received professional services from a physician within the past three years

B. A patient who has not been treated by a physician within the past three years

C. A patient who has never sought medical care
D. A patient who has not been seen by the physician within the past three months

3. Time is not considered a descriptive component in which of the following settings?

A. Hospital observation services

B. Office consultations

C. Critical care services

D. Emergency department services

4. Which area of service does not rely on the distinction of new vs. established patient?

A. Inpatient consultation services

B. Office or outpatient services

C. Emergency department services

D. Initial hospital care services

5. The time component is significant in assigning E/M codes because:

A. It can substitute for one of the key elements in any situation

B. It can substitute for the key components when it accounts for 50% of the encounter

C. It can be inferred from the text of the encounter

D. It is only a substitute for the history component

Answers: 1-C, 2-B, 3-D, 4-C, 5-B ■

Falls, SD. DeWald spoke about the chargemaster at the 73rd National Convention and Exhibit of the Chicago-based American Health Information Management Association (AHIMA), held Oct. 13-18, 2001, in Miami Beach, FL.

"The charge description master is not just something that happens in the finance department," DeWald adds.

DeWald offers this advice on how to educate staff about the chargemaster and their responsibility toward keeping it accurate:

- **Define the charge description master.**

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AHIMA Conference**

"A chargemaster is nothing more than lines of services provided in a facility," DeWald says. "It usually has six components per line, with the first component being the charge number."

The charge number is defined with many different terms, including the general ledger number, the hospital number, and others, DeWald says.

"It is necessary for every individual who provides charges to a bill to know what the definition for this bill is in their respective facility," DeWald says.

The charge number usually performs two functions:

- The first three or four digits identify the department in which the costs, charges, and revenue are posted.

- The next series of the number identifies the service, supply, or pharmaceutical.

The charge number is the number that is keyed into the billing system to generate a line-item bill (also called an "itemized" bill) for the services, supplies, and pharmaceuticals provided to the patient during an episode of care, DeWald explains.

"These itemized charges are eventually compiled and passed to the UB-92, where they are organized according to revenue codes," she says. "These revenue codes were developed by the National Uniform Billing Committee [NUBC] and are revised and updated annually."

DeWald points out that the revenue code is to the UB-92 what the charge number is to a claim. "These revenue codes summarize multiple items charged in a single department to one line item on the UB-92," she says.

For example, an outpatient bill for a surgical

procedure may have many lines identifying items such as surgery time, equipment, and supplies. When the claim is passed to the UB-92 and submitted for payment, all of the charges for that cost center will be added up and appear as one line on the UB-92 with a revenue code of 490, DeWald says.

"This number is followed by a description of the service line, the Common Procedural Terminology [CPT] or Health Care Financing Administration Common Procedure Coding System [HCPCS], followed by the number of units described by the service line and the charges per unit," DeWald says.

DeWald suggests educating staff on how a charge description master works. "Take pieces of the chargemaster and tell how it starts out as an internally assigned department number, which determines cost centers, and how those cost centers relate to revenue centers and how important it is for the description of the CPT/HCPCS code to match what's described in your chargemaster," she says.

It's important that staff grasp the difference between the internally developed charge code and the NUBC revenue codes, DeWald adds.

"The other thing they need to know is that it often takes more than one CPT or HCPCS code to completely describe and bill a service," DeWald says.

- **Describe ways of assigning codes to the chargemaster.**

DeWald uses an example of a needle localization of a lesion in the breast to show how different codes might be used on the chargemaster. "In order to localize that lesion, occasionally they have to take the patient into the radiology department, where X-ray will be used to locate the precise location of the lesion, followed by placement of a localization wire, and then you have two charge lines," DeWald says. "There will be one for the radiology portion of that procedure, which many times is hard-coded or comes to the claim directly from the charge description master."

However, the needle localization part may be assigned by a coder in HIM or someone in radiology.

"One of the things we try really hard to do is assign as many codes as possible through the chargemaster, hard-coded, so we have as little human intervention as possible," DeWald says. "That's our goal, and as HIM professionals and coders, the emphasis we have to make is that these code numbers must be correct, whether the

codes are assigned through the charge description master or by a person.”

- **Check for coding accuracy.**

Coders shouldn't fear hard-coding, because it creates a new opportunity in the HIM field, DeWald adds.

“You need to monitor the code numbers driven onto the claim by the chargemaster to make sure they are still the accurate codes, because every year in January there are a lot of new codes,” she says. “Last year there were more

HPIM at the 2001 AHIMA Conference

than 300 new codes — either new codes or description changes.”

With the advent of the hospital outpatient prospective payment system (PPS), the Centers for Medicare and Medicaid Services is adding and/or deleting HCPCS codes on a quarterly basis, DeWald notes.

Therefore, someone needs to make certain that these codes become part of or are removed from the charge description master, and this probably will be the coder's role, she adds. **(See story on keeping the chargemaster up to date, below.)**

It should be the coding professional's responsibility to make certain that code numbers are accurate, updated, and then charged through the chargemaster, DeWald says.

“Now because most payment is based on CPT or HCPCS codes, it's extremely important that the number be correct, because if you assign an incorrect number, your payment will be incorrect,” DeWald explains. “Or you will be making a claim for a service that you didn't provide, simply because you assigned the wrong number.”

- **Show staff how to take responsibility for the chargemaster.**

Coding professionals often fail to understand what a chargemaster is and cannot recognize that maintaining or developing the chargemaster is part of their responsibility, DeWald says.

“There is a big reluctance on the part of many coders to accept what they see as an added responsibility,” DeWald says. “They see it as something they do in finance, and ‘We don't do that,’” DeWald says. “But coding accuracy is more than assigning codes; it's also checking those codes that someone else has assigned to make sure they are correct.”

- **Look for these future developments.**

The chargemaster becomes more automated each year, and someday it might be entirely

automated, DeWald says.

“Some people say that it's already automated and we don't need a coder, but I have an idea that this is quite a long ways in the future,” DeWald says. “What will happen is that the coder will become the auditor, who will monitor to make certain these code numbers are hard-coded into the chargemaster correctly and to make auditing claims to make sure they're coming out correctly.”

DeWald predicts that as the chargemaster becomes more automated, it will provide even more work in the HIM department.

For example, coders need to be aware that a single incorrect digit on a chargemaster could result in a facility losing thousands of dollars, because all procedural codes now are the basis for Medicare payments under PPS.

The best coders are those who are methodical and have an almost obsessive personality when set to the task of determining or verifying codes, DeWald says.

“They have to have tremendous patience for details,” she says. “On occasion, you might take 20 minutes to decide which part of the finger — one tendon vs. another tendon — was affected and why that's important,” DeWald says.

DeWald says that in her opinion, the best coders are those individuals who have a passion for the study of disease and trauma, but can't stand the sight of blood. ■

Take these steps to keep your chargemaster updated

And how to keep it that way

Coding professionals will need to pay even closer attention to the chargemaster than they have in the past, and this is not an easy task.

However, with the right guidelines, it can be done competently and consistently. **Lora A. DeWald**, MEd, RHIA, CCS, CCS-P, vice president of health information management at Avera Health in Sioux Falls, SD, offers these 14 steps to keeping the chargemaster updated:

1. Organize a management team consisting of:
 - accounting — persons responsible for the cost report;
 - business office — biller;

- information systems — programmer;
- HIM — coder.

2. Depending on the size of your facility, you may have to establish charge description manager (CDM) teams at the department and even interdepartmental level. For example, the Radiology Department CDM team may consist of four management team members, plus the radiology department manager and support personnel for overall department oversight, as well as interdepartmental CDM teams for services such as interventional radiology.

3. Identify charge lines that are currently active by having Information Systems generate a report listing all the charge lines that were active during the past year.

4. Match these charge lines against the chargemaster.

5. Delete from your chargemaster all charge lines that are not currently active. Make certain you retain an intact copy of what you currently consider your chargemaster for cost reports, audits, and other look-backs.

6. Finance/Accounting should review charge lines on your revised chargemaster for appropriate cost center placement. For example, rental for a colonoscope should be in the procedure room/OR cost center, rather than in the cost center for medical supplies.

7. Distribute departmental chargemasters to department CDM teams. If you are a very small facility, you may be able to work as a “committee of the whole.”

8. Do a line-by-line review to match the revenue code, descriptor, and HCFA Common Procedure Coding System (HCPCS) code to each charge number.

9. Identify and code all supplies, drugs, and other pass-through items that require HCPCS codes and special revenue codes, such as chemotherapy drugs that require J9XXX series HCPCS codes and a 636 revenue code.

10. Decide:

- what HCPCS codes will be assigned through the chargemaster;
- who assigns which HCPCS codes;
- who assigns modifiers;
- who makes changes to the chargemaster;
- how charge lines are added and deleted;
- how pricing is determined.

11. Monitor, monitor, monitor!

12. Look for:

- duplicate HCPCS codes for same service;
- unbundling — two HCPCS codes billed

when one is more appropriate;

- Correct Coding Initiative edits;
- correct charge lines on the itemized bill;
- accuracy of the UB-92;
- appropriate payments.

13. Design a procedure to maintain your chargemaster.

14. Identify an individual who:

- serves as a liaison between the billers, coders, and clinical areas;
- is responsible for reading and overseeing implementation of program memoranda, newsletters, and bulletins;
- annually distributes new CPT, HCPCS, and ICD-9 CM coding manuals;
- works with departments to implement updates as necessary;
- monitors, monitors, monitors! ■

CRM called ‘ultimate’ in call center progression

Makes access ‘customer-centric’

By **John Woerly**, RHIA, MSA, CHAM Manager, Cap Gemini Ernst & Young Indianapolis

Customer relationship management (CRM) is the access process of the future. It can be defined as “the alignment of people, process and technology to drive the acquisition of new customers and strengthen existing relationships by improving their duration and profitability.” It is the glue that holds various systems and processes in place to enhance the customer experience.

CRM is the ultimate phase in a sequence that for many hospital systems might start with multiple call centers. With the traditional arrangement of work functions by care site, one group of employees at Hospital A might handle pre-arrival functions (preregistration, benefit verification, and precertification/ authorization), while another group does scheduling. At Hospital B in that system, yet another group would handle those functions. This arrangement does not fully allow consolidation of services, process standardization or deployment of resources.

The second phase would be to have a “cluster

contact center,” where a health system with five hospitals might have just two places where pre-arrival functions are done. The third phase is a consolidated contact center, where a greater variety of functions are pulled together into a work unit.

In the fourth phase, the health system has multiple channel access centers, with technologies added for decision support, CRM and Intranet services.

With CRM, the ultimate phase, two high-value, consumer-driven solution offerings — applications that support and enhance the customer access process and the web-enabled extension of care delivery — would be realized. The differentiating factor is the customer-centric approach, founded in the principles of CRM. This approach is particularly well suited to manage the complexity of business processes used by health care organizations.

Consumer-centric health delivery models must be able to accommodate all customer/patient interaction modes, including telephone, fax, web, or e-mail. However, there are currently no health care vendor applications that effectively combine automation of customer access process (scheduling, registration, and insurance verification, for example) with an integrated set of solutions to drive down transaction costs while improving customer satisfaction and quality of care.

Customer access solutions

At the core of the customer access solution is a robust set of CRM technologies that will allow health systems to strengthen existing customer relationships and to acquire new customers. These CRM applications will enhance customer access to business processes by facilitating the exchange of information, regardless of the medium (or channel) used to distribute the information.

Once the information is received from the disparate sources, workflow rules built into the CRM application will provide a structured mechanism for routing information or queries to the appropriate person and/or information system. CRM applications that support the

front-end customer access process carry the potential to significantly improve efficiency, thereby reducing costs. For example, by tying the insurance verification activities to an enterprisewide scheduling function, a health care system will be able to identify and resolve insurance issues earlier in the access process. Additional efficiencies can be realized by the centralized nature of the scheduling process, which streamlines workflow through standardized processes. Customer satisfaction is similarly improved due to the personalized “one and done” approach to interactions with the organization.

Components of the customer-centric customer access solution include a multichannel contact center serving as the hub for all customer interactions. Contact center processing can be centralized or distributed, based on provider preference. Through the use of telephony and unified messaging applications, effective consolidation and distribution of information becomes possible, regardless of whether the mode of contact is fax, telephone, e-mail, or something else.

The contact center will serve as the single contact source for all customer inquiries (account status or locators, for example) and service requests, such as appointment scheduling, referral requests or issue resolution. This functionality will be enabled by the integration of contact center applications to health system legacy systems.

Seamless integration of CRM application rules and routing with health system legacy systems will allow all customer interactions to be queued, logged, and resolved in an efficient manner. Processes supported by the customer access solution include:

- scheduling;
- preregistration (demographic and financial data collection);
- preadmission preparation (preadmission testing coordination, education);
- verification of insurance eligibility;
- financial counseling/medical assistance application;
- patient tracking;
- discharge planning;
- claims status checking;

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— customer service inquiries and complaints. Some of the terms being used in association with this operational level include:

- **Branding.**

This has to do with defining yourself through your customers, ensuring that they are aware of your name, your services, and your reputation for service. You want the customer to think of you, when they think of the products or services you offer. For example, in thinking of fast food and hamburgers, McDonald's comes immediately to mind.

- **Profiling.**

This is the process of continuously learning about customer needs and anticipating those needs, of giving them value. It is recognizing the customer as an individual and then tailoring your offerings to best meet his or her needs. An example of this is realizing that a couple in their 30s raising a family would seek and require pediatric care, and providing a pediatrics health care guidebook. A couple in their 70s, on the other hand, would not be interested in pediatric care but might benefit from geriatric care information.

- **Customer empowerment.**

A key part of patient access in the future will be empowering customers to serve themselves, when and how they wish to do so. A simple example is a person who wants to schedule an appointment and has the choice between making a telephone call and being put on hold for a period of time or scheduling the appointment on-line.

Among the things that CRM can provide for patient access are:

- **Multiple service combinations.**

You can have access to customers, and they to you, through e-mail, fax, regular mail, intranet, and inbound/outbound voice transactions (predictive dialing).

- **Integration of voice and electronic transactions into a single workflow.**

This will enable access managers to blend their work and balance their workloads. An employee working at a computer, for example, also has a headset on and is talking to a customer, instead of reaching over for the telephone. The work is blended on the computer for voice or electronic functionality.

- **Computer telephony integration (CTI).**

CTI allows users to pass data from one computer to the next, which facilitates such efficiencies as predictive dialing, automated call distribution, integrated voice response, and work queuing.

With skill-based work routing in place, an

employee who speaks several languages, for example, can recognize what geographic area calls are coming from and what language a caller may need. Another use of skill-based work routing is to better utilize staff resources. An employee may be primarily assigned to pre-registration functions, but can also be utilized in appointment scheduling.

Maybe 80% of the person's job is to do pre-registration, but if the schedulers are busy, he or she can help there. The system will know to divert the calls to that employee automatically without the employee having to move work locations.

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• **Integration of all transactions into a comprehensive customer contact history.**

You house all calls coming in to scheduling, so if down the road, someone says, "I called to make this appointment," we could go back and see that transaction, as well as listen to that call. This also would be beneficial to customer service areas. If there is a billing dispute, hospital employees could go back to the initial contact (fax, e-mail, telephone call, etc.) and see the activities that took place.

The patient database and history that is established through this technology also can be used for marketing purposes. When a person has moved into town and called the hospital to ask for information, you could track down whether the person actually used any of the hospital's physicians after you made that referral. If you put a million dollars into marketing, you can find out if it paid off, as well as what areas of service are being utilized.

Other uses of the technology include physician referral, "Ask-a-Nurse" programs, disease management, and medical records inquiries, as well as employee self-service regarding benefits and payroll information.

The same technology also facilitates productivity reports for each employee, for example, including the gathering of information on length of talk time and who is being served during a call.

(Editor's note: Before joining the consulting firm of Cap Gemini Ernst & Young, John Woerly spent many years in hospital access management. He recently spoke on the subject of CRM at the annual National Association of Healthcare Access Management conference in Orlando, FL, and was to make a presentation on CRM in October at the American Association of Healthcare Administrative Management in Reno, NV.) ■

Medicare to cover home blood tests

The Centers for Medicare and Medicaid Services (CMS) will now cover home testing that enables patients with mechanical heart valves to measure how well their blood is thinned.

Previously, there had been no national coverage

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policy for self-testing prothrombin levels (also called INR testing) in the home for patients with mechanical heart valves, and the insurance companies that process and pay Medicare claims had been denying claims for home prothrombin self-testing.

"This simple home test can help Medicare beneficiaries reduce their risks of strokes and bleeding," Health and Human Services Secretary **Tommy G. Thompson** said in a release. "The decision reflects our commitment to expanding Medicare coverage to include effective preventive care and services."

Noted CMS administrator **Thomas A. Scully**, "This decision will give a new option to Medicare beneficiaries who need to get frequent prothrombin tests. The scientific data we reviewed showed that when patients with mechanical heart valves used these devices at home, they may suffer fewer strokes and bleedings."

Under existing local carrier coverage policies, patients receiving home health care could have their prothrombin level measured by home health personnel, and phlebotomists could come to patients' homes to draw samples to be processed in laboratories. The new national coverage policy allows beneficiaries to perform the test themselves and could permit more frequent monitoring of a patient's response to blood-thinning medication. ■

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