AMERICAN HEALTH CONSULTANTS

FOR 20 YEARS

Hospital Access Management™

Admitting ● Reimbursement ● Regulations ● Patient Financial Services ● Communications
Guest Relations ● Billing & Collections ● Bad Debt Control ● Discharge Planning

INSIDE

DECEMBER 2001

VOL. 20, NO. 12 (pages 133-144)

New memo either could relax rules on collection, or make them tougher

Task still daunting and 'almost comical'

Editor's note: In this issue, Hospital Access Management *takes a look at access managers' reaction to a recent change in the rules associated with the gathering of Medicare Secondary Payer information.*

Depending on the access manager you ask, the Sept. 25 program memorandum purporting to relax the Medicare Secondary Payer (MSP) data collection rules either does just that . . . or it crystallizes the need for some oppressive, labor-intensive procedures that some hadn't realized were required.

Part of the confusion appears to stem from the different interpretations of the MSP rules by the various fiscal intermediaries that act as the go-betweens for the Centers for Medicare & Medicaid Services (CMS) and providers.

"For many, this is relaxing the rules; and for others, it's more restrictive," says **Beverly Varshovi**, associate director for admissions at Shands Hospital at the University of Florida in Gainesville. "It depends on what they were doing before and what their fiscal intermediary (FI) was telling them."

Great, unrealistic expectations

Even access managers who believe the memo from the CMS does lighten the burden on access staff maintain that the whole business of gathering MSP information is still fraught with unrealistic, if not absurd, expectations.

"It isn't relaxed enough as far as I am concerned," says **Beth Ingram**, CHAM, director of patient business services at Touro Infirmary in New Orleans. "The audit trail to prove who you checked the information with on a monthly basis is still very cumbersome, and getting that information on reference lab work is still extremely cumbersome.

"We really thought that would be relaxed or eliminated, but clearly it wasn't, so I am frankly disappointed," Ingram says.

Policy changes

Basically, the program memorandum outlines these three policy changes.

1. The instructions ease requirements for collecting MSP information for laboratory services when the physician or other provider sends a specimen to the hospital for evaluation, but there is no face-to-face encounter with the patient.

Several access managers told *Hospital Access Management* off the record that their facilities have never collected MSP data on lab specimens. For those hospitals, this provision is not a benefit — it's a rude awakening.

The task is less daunting if the hospital lab receives specimens mostly from people who have been patients at the facility, they say, but poses a huge logistical challenge for labs that handle testing for individuals from all over the country who have never been to that hospital.

The revised policy states that hospitals must collect MSP information from a beneficiary or his or her representative for these services, but says that it may use information already collected if it is no older than 60 days.

The dilemma of how best to contact a person whose specimen is being tested at a hospital's lab remains, notes **Peter Kraus**, business analyst for Emory University Hospital in Atlanta, although now it has to be dealt with less frequently. Gathering the MSP information for specimens that come in from all over the country poses "an almost comical challenge" for access personnel, he adds.

Calling Medicare recipients whose specimens have been sent to the hospital's lab and asking them, for example, whether they receive black lung benefits or have had a kidney transplant "is going to generate a lot of confusion from the patient on the other end of the phone," says **Barbara Wegner**, CHAM, regional director of access services for Providence Health System in Portland, OR.

Those patients, she adds, are likely to react with, "Why is St. Vincent Hospital calling me? I haven't been to that hospital." And, Wegner points out, all the effort is for what may be a $25 account.

At Shands, access staff do call Medicare patients who haven't been seen at the hospital, but whose lab work was sent there, and ask the MSP questions, says Varshovi, and it is "very confusing" for those patients.

In another unfair twist, the freestanding laboratories — those not associated with a hospital — don't appear to be under the same regulations, adds **Jeanne Hughes**, regional quality assurance and training manager for the Providence system. If dealing with the hospital lab and its MSP questions becomes too much trouble, Wegner notes, Providence customers may decide it's easier just to send their blood samples to one of those other labs.

Providence's specimen business is very large — more than 500 samples in a recent one-week period — and only 28% of those were associated with patients who had made a recent visit to the hospital, Hughes says. Wegner estimates she may have to add two full-time equivalents to keep up with the MSP workload.

The Sept. 25 memorandum also states that hospitals should keep an audit trail to show they collected MSP information that was no more than 60 days old when the bills for their Medicare patients were submitted, and should document who supplied the MSP data. What is particularly disturbing to many access managers is that the memo goes on to say that if the hospital's use of outdated or inaccurate information leads to Medicare making an incorrect primary payment, the hospital will be liable to repay the overpayment. The hospital also can be fined for giving inaccurate information.

"We can receive this information from someone else, but we are still considered at fault if

(Continued on page 136)

COMING IN FUTURE MONTHS

- Building bridges with staff training
- Lowering turnover, boosting morale
- What's the benchmark for patient identification?
- More on preparing for HIPAA
- Gaining physicians' cooperation

The MSP Questions

Here are the questions access employees are required to ask Medicare recipients to determine if Medicare should, in fact, be the "primary payer" for the account.

Please Complete the Following:

Yes No Are you retired? If yes, the date that you retired_____

Yes No Are you on disability? If yes, date of disability _____

Yes No Are you employed? If yes, who is your employer? _____

Does your employer have 20 or more employees? Yes No

Does your employer have 100 or more employees? Yes No

Yes No Do you have insurance through your current employer? Insurance Company: _____
Policy Number: _____

Yes No Is your spouse retired? If yes, the date she/he retired_____
Yes No Is your spouse employed? If yes, who is the employer? _____
Yes No Does your spouse's employer have 20 or more employees?
Yes No Does your spouse's employer have 100 or more employees?
Yes No Do you have insurance through your spouse's current employer? Insurance Company: _____
Policy Number:_____

Yes No Are you being seen today because of an accident? If yes, date of accident: _____

What happened? Auto Accident Work Accident Other Accident
Please describe what happened and where _____
_____

Yes No Are you on dialysis? If yes, what date did you begin?_____
Yes No Are you or have you been on self-dialysis? If yes, start date? _____
Yes No Have you had a kidney transplant? If yes, date? _____
Yes No Are you receiving black lung benefits?
Yes No Are today's services being paid by a government/research grant? If yes, name of grant
_____

Yes No Has the Department of Veterans Affairs authorized to pay for today's care at this facility?

Is your Medicare entitlement based on: Age Disability ESRD (Kidney Disease)

Medicare Number:_____Patient Account Number:_____
Patient Name: _____
Signature:_____ Date:_____

Source: Providence Health System, Portland, OR.

what is given is incorrect," says Hughes. "Now we need a new field in the computer system to document who provided this information to us."

Liz Kehrer, CHAM, system administrator for patient access at Centegra Health System, in McHenry, IL, says she has these immediate concerns with the provision:

- "The lab would need a process to track when MSP data was last collected, with a flag to alert [staff] to the expiration date of the data."
- "What proof does the lab have that a subsequent specimen[s] was ordered for the same reason as when the MSP data was collected?" In other words, Medicare could be the primary payer in one case and secondary in another, she points out.
- "The lab / hospital is still liable for submitting a 'fraudulent' claim and is exposed to the problems related — that is, penalties and the risk of jeopardizing Medicare certification — because the provider 'chose' not to verify the information."

Kraus notes that he always enjoys his access director's "disdainful perspective" on the whole MSP concept. "She deeply resents [CMS] making hospitals do what she regards as their work. No other carrier requires the providers of service to determine liability, much less holds the providers accountable if they get it wrong."

It is particularly irritating, he adds, that the MSP requirement isn't enforced with physician visits.

Collecting MSP data

2. They drop the requirement for collecting MSP information when the beneficiary is enrolled in a managed care plan.

Some access managers — who for obvious reasons did not want to go on record with the apparent oversight — told *HAM* they were not aware that it had ever been necessary to collect MSP data from Medicare managed care patients.

Others, like Varshovi at Shands Hospital, said they already had discontinued the practice. "We had stopped it last May because we had gotten information that we didn't have to do it."

It's one of the items in the memo that is probably most significant, says **Anthony M. Bruno**, MPA, MEd, director, patient accounts and business operations, at Philadelphia's Presbyterian Medical Center, because of the volume of patients it affects. But he says his hospital had discontinued the practice in 2000, and the facility where he worked previously — like Varshovi's — had stopped collecting MSP data from Medicare managed care patients this past spring.

"We worked with our fiscal intermediary, and finally nailed it down," Bruno adds. "They said, 'I guess you don't have to do that.'"

A hospital's experience with MSP and other requirements "depends on the kind of relationship you have [with the FI]," he notes, and whether the FI is forthcoming and communicative or more remote.

The on-line news service *AHA News* reported in its Oct. 30 issue that Medicare+Choice [managed care] beneficiaries are exempt from the MSP questionnaire. The article stated that the announcement came out of a meeting between what was then known as the Health Care Financing Administration (HCFA) and U.S. Rep Saxby Chambliss (R-GA), who had been pressuring HCFA to change its MSP policy. According to the same article, MSP requirements for hospitals acting as reference labs were to be addressed later.

Access managers who tried to confirm these announcements or get further details, however, told *HAM* they had difficulty finding the documentation for them, possibly a further reflection of the lack of consistency in FI interpretations and communications.

3. For beneficiaries receiving recurring outpatient services, they require that MSP information be verified only once a month.

Bruno says this information does represent a lessening of the MSP burden for Presbyterian Medical Center. "We're now doing it on every visit." He adds, however, that his facility does not have a large number of Medicare patients on recurring accounts.

Although Shands Hospital had been somewhat "lax" with collecting MSP data on recurring patients, that changed with the hiring of the hospital system's director for core billing, Varshovi says. Since that time, she adds, "we have gone by the letter."

The newly hired director, she explains, had been told by a fiscal intermediary in Ohio that getting MSP information on each visit by recurring patients was not necessary, and that hospitals "could be flexible" on the reference lab issue. He had a rude awakening, however, after being called to testify before the Office of the Inspector General (OIG), Varshovi explains.

After arriving at Shands, she notes, "he said, 'I'm never going before the OIG again. . . . What are you doing about MSP?'"

Similar to its Ohio counterpart, Varshovi says,

the Florida FI had also said "common sense" would suggest it was enough to confirm the MSP data with recurring patients before the bill dropped.

After the heads-up from Shands new core billing director, she adds, her department has taken a proactive approach to the MSP regulations.

"At least every six months, we pull a day's worth or two days' worth of Medicare patient accounts in all arenas to make sure [the MSP data] is there," Varshovi says. "The second thing we check for is whether the questions were asked appropriately and documented appropriately."

During these checks — which may involve a week's worth of data for smaller Shands hospitals — each account is audited and scored for MSP compliance, she says.

Outpatient services

An emphasis at Shands on the creation of financial specialists whose primary function is to create a billable account and do whatever it takes has helped facilitate this process, Varshovi notes. "I have counterparts in community hospitals that struggle with this. While they may have 17 people for 24-hour coverage, there are 50 specialists at my hospital."

Her challenge, she says, is the variety of locations where outpatient services are being rendered. "We are retrospectively trying to gather data, by getting into physicians' systems and looking at historical data.

"At our facility, all diagnostic testing is hospital-based, but there is a clinic that is wholly owned by the University of Florida," Varshovi adds. "There is no hospital charge — it's just like the patient saw a physician in the community — but if that physician sends for lab or X-ray, there's now a [hospital] bill."

Because that patient never came through hospital registration, there is no hospital account, she points out, which means there is no MSP questionnaire, advance directive information, or anything else associated with that patient. Her department is working on a project to reduce those occurrences, Varshovi adds.

Rule stretches computer skills, logic

The need to verify MSP data every 30 days for recurring patients, notes Hughes, means modifications to Providence's computer systems will be necessary. "Our current system has a 'verified date,' but that is for one date per account number. Now I need to show I verified it in March, April, May, and June. The other piece is to document who provided us the information. This will be a significant cost to our system."

At Emory University Hospital, Kraus notes, "from a billing perspective we'd love to re-register every 30 days, but the ancillary department and customer service priorities limit us to 90-day accounts. So the MSP challenge remains in diminished form."

Centegra Health System is in good shape as far as this requirement is concerned, Kehrer says. "We have our recurring/cycle patients set up on monthly accounts. The MSP information is verified on the patient's first visit of the new month."

There is a discrepancy in logic, Hughes points out, in that MSP information for reference lab specimens has to be verified only every 60 days, while the data for recurring patients must be confirmed every 30 days.

As for her general reaction to the memorandum from CMS, she adds, "I really don't think they have any idea what reality is in a health care system these days." ■

Here's a wake-up call on EDI part of HIPAA

Many providers 'not aware,' consultant says

With all the attention being given to the federal privacy rule — set for implementation in April 2003 — another key part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 apparently is failing to get the attention it deserves.

HIPAA's electronic data interchange (EDI) provisions — with a much closer implementation deadline of Oct. 16, 2002 — have, in many cases, "fallen between the cracks," suggests **Liz Johnson**, RN, MSN, CHE, executive vice president and national HIPAA practice leader for Houston-based Healthlink, a health care consulting firm.

By that date, hospital access personnel — and their counterparts in physician offices — must have new transactions in place for billing, says Johnson, and collect new data in a different way.

When the proposed rules for EDI were put forth, she says, providers were so busy with concerns

about the year 2000 (Y2K) computer issues "that they kind of missed it." When the privacy rules came around, providers "were all back awake again."

"A lot of people are not aware of this," she adds. "EDI is the first part [of HIPAA] that actually has to be in place. I speak almost daily on the subject and people are still like, 'You're kidding,' or 'Will you just send me a form?'"

What's called for, Johnson emphasizes, is not a form but a new way of collecting information in an electronic manner.

Most health care billing today is done with the UB92 form (for hospitals) or the HCFA 1500 form (for physicians), she notes. Every payer can ask hospitals to fill out the UB92 a different way "so there are 400 different ways" to do it, Johnson adds. "Going forward, they will all accept [bills] in the same way, which is a big plus once we get there."

New EDI standard

Under the new EDI standard for billing, providers will complete an 837I (institutional) or an 837P (professional) bill, she says. "The things [hospitals] collect today on the UB92 will not be the same data they collect when they complete the 837I. The world becomes complex."

Two components are required, Johnson explains. There must be a process in place to collect the new data, and technology will have to support the new data. One question to be asked, she says, is, "Do I have a field to put them in?" Another priority, Johnson adds, "is to work with vendors and say, 'When are you going to have this technology ready for me to put this new information in? I have to test it and I have to train my people on how to use it.'"

It's important to point out, she says, that while large vendors are very cognizant of the new requirements, smaller vendors are not so aware. Hospitals with proprietary systems may have even more cause for concern, Johnson suggests.

"There are all kinds of vendor response issues to deal with," she says. "What if the guy down the street [who set up your system] is not going to do any more with that application? There are a number of vendors that are saying, 'We got ready for Y2K, but we aren't doing this HIPAA thing. We have seven applications that do this, but we're going to keep the top three and the other four are going away.'"

Such an approach is understandable, Johnson says, but it may put providers in a bind. "In a small hospital — or even in a big one — you don't always get to have the latest and the greatest. There are decisions on what you can actually spend. Sometimes you buy the financial system and sometimes you buy the MRI."

Here's how to start

Her recommendation to access managers, she says, is to take these steps:

- **Increase education and awareness.** That involves not only enhancing your own personal knowledge, but educating your staff.
- **Determine the baseline.** "Where are we today? What do we already collect? How can we tweak the process so it's right for the future?"
- **Do remediation planning.** Decide what you're going to do. Set up a time line, including what actions vendors will take, and then implement that plan. There should also be a post-implementation plan, Johnson says, "because nothing ever goes as smoothly as you think it will."

Healthlink's approach is to educate hospital personnel, and to make sure their physician offices are aware of the EDI requirements, she notes. "If [hospitals] own physician practices or do billing for them, they are impacted as well. Those covered by this law are providers, payers and clearinghouses."

One example of the new data that are called for, Johnson says, has to do with "getting more information and more specific information around the events that lead up to hospitalization. There is also more information [required] about accident sites and causality sites."

For as long as she's been in the health care industry, Johnson points out, the letter "S" has meant "single." Going forward, she says, "the letter 'S' means 'separated,' and the letter 'I' means 'individuals.' For people out there who have been doing this for years, and for whom it's gotten pretty routine, this is a big change."

Implementing EDI

There are a number of companies building "bridging" or "transition" strategies to assist health care providers with EDI implementation, Johnson notes, but she cautions against relying too much on that kind of help.

"They say, 'I'll go out and get the data and put it in the right format,'" she adds, "but if you're not collecting the data now, how will

An opportunity to get answers about HIPAA

Access managers with specific questions regarding their hospitals' implementation of provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 are asked to send them to *Hospital Access Management.*

As the deadline for HIPAA compliance approaches, *HAM* will publish those questions, with answers provided by experts in the field.

Please send your queries about HIPAA to editor Lila Moore at lilamoore@mindspring.com or call (520) 299-8730. ■

this electronic thing go out and get it, if it's not there? It doesn't matter how fancy or elaborate the bridging strategies, you can't capture what has not been collected."

Healthlink has an assessment and project management tool called HIPAA TRAAC, Johnson says, that is aimed at helping hospitals determine if they're ready for billing, and if not, what's missing.

"It also allows you to find out [if your computer system] meets security requirements," she adds. "There is a questionnaire that says, 'It has to do this, it has to do this . . .' [The tool] also lists all the security policies and procedures required by law. You can enter yours in the same table and see what you have. It's a way of getting your baseline information in and then monitoring it to make sure you're making progress toward getting compliant."

HIPAA TRAAC includes a "public library" of software applications and hardware interfaces, with information on what is happening with them, Johnson notes. "You can find out what McKesson is doing with STAR — what version is going to be compatible."

Information specific to an institution goes into its own "private library" in HIPAA TRAAC, she says.

[For more information about Healthlink or HIPAA TRAAC, call Louisa Dow at (800) 223-8956 or visit the company's web site at www.healthlinkinc.com.] ■

Closer look at denials shows payers at fault

Admissions effort recovers more than $1 million

When the high rate of reimbursement denials at Shands Hospital at the University of Florida in Gainesville was attributed to errors by the admissions department, associate director **Beverly Varshovi** decided a closer investigation was in order.

"My style is, I can fix anything, but you need to show me," says Varshovi. "I want evidence, not anecdotes. I said, 'Let me see the accounts.'"

The results of that effort led to the discovery that a huge number of the "lack of pre-cert" designations by the insurance companies were incorrect, and to the recovery of more than $1 million rightfully owed to the hospital, she explains.

Pre-cert stories

In the past fiscal year, from July 2000 to June 2001, the patient financial services (PFS) department wrote off $2.3 million in pre-cert denials, Varshovi says, and the admissions department was able to reduce the figure to $935,000. In the six months before that, she adds, from January 2000 through June 2000, her department reversed $830,000 in denials.

At first, the PFS at the Gainesville-based hospital provided admissions with a list of accounts that were being written off, Varshovi notes. As the two departments began to work together as partners, she says, PFS staff gave admissions a heads-up on accounts they were about to write off because the payer had stated there was a "lack of pre-cert."

Rotating the task among different assistant managers, admissions personnel began looking up each account on the list to see who had created it, and in what setting, Varshovi says. "Seeing the employee's initials on the account, we would go back to that individual and say, 'The payer is saying there was no pre-cert. What can you tell me?'"

Because her staff routinely scans pre-certs and keeps them on file, the investigation revealed that in a "tremendous" number of cases, the pre-cert was on file, authorization had been obtained, and the payer was "somehow mistaken," she adds.

What Shands calls an "insurance verification

pre-certification documentation form," she says, includes eligibility and benefits data, who was spoken to at the insurance company to obtain that information, and who was spoken to — usually in a separate call — to get the pre-cert.

"We research each and every one," Varshovi notes. "With about 20% [of those sent back for "lack of pre-cert"], there actually is an error."

> "We're 'not for profit,' but they're businesses in the business of making money for stockholders. If the account gets written off, what does the payer care? The client got quality services, and we got nothing."

In a large number of cases, there are "clinician issues," she adds, whereby the access employee gets authorization for one service, and the clinician expands or adds on a procedure without notifying admissions.

For example, Varshovi says, "a mammogram leads to an ultrasound and no one gets back to us." Sometimes, an insurance company takes the opportunity to deny payment for both services, even the one for which a pre-cert had been obtained.

Wrongful denials

In some instances, a change in a patient's status leads to a wrongful denial. "Payers have a different way of storing data," she explains. "If we called on a short-stay observation patient, they would give us one pre-cert number, but then when the patient met the criteria for an inpatient stay, we would get another number. We can only store one number, so we would send the latest one [on the claim], but they stored the file under the original [number].

In other cases, she says, the insurance company actually reverses itself, after giving the hospital the OK for a procedure. "We're 'not for profit,' but they're businesses," Varshovi points out, "in the business of making money for stockholders. If the account gets written off, what does the payer care? The client got quality services, and we got nothing."

An ace-in-the-hole for Shands is often the fact that admissions staff digitally record all the calls during which inpatient pre-certs are obtained, she notes. "We only let them know that we can replay the conversation. We've never had to actually play it for them."

The latest initiative in this reimbursement arena, Varshovi says, is the building of an intranet insurance verification form. This will allow the admissions department's partners — physicians and PFS — to easily access patient account information. That should be ready next year, she adds.

Because the positive return on investment is clear, Shands likely will eventually dedicate a full-time equivalent to the investigation of pre-cert denials, Varshovi says. "It's pretty unfair to the assistant managers [to perform the task] because the time commitment is significant," she notes. "We rerun the patient accounts, sort by payer, and share the results with the managed care department for contractual purposes."

Meanwhile, Varshovi continues to raise the bar for pre-cert denial turnarounds. "We still want to reduce pre-cert write-offs by 20%," she says. "My goal is that PFS should have to do nothing. We're not there yet." ■

Company issues a demo project report

The goal is one-stop shopping

COB Clearinghouse — a company that promises to eventually provide one-stop shopping for eligibility data on every patient admitted to a hospital — has released a preliminary report on its National COB Demonstration Project.

The Cleveland-based company aims to achieve its goal through the automation of "coordination of benefits," the process of determining which insurance policy is primary for a particular patient. The purpose of the national project, company officials say, is to bring the national eligibility record together for the first time.

The preliminary report is on 4 million eligibility records contributed by health care providers, payers, and insurance plan sponsors, says company president **Patrick Lawlor**, who adds that project participants are being added on virtually a daily basis**.** By the end of October, the ongoing project had 30 million records, he says.

Participants provided the company with insurance eligibility data they received for three days in March, June, and September of 2000, using the systems the participants currently have in place.

Under requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, payers must make data available electronically by October 2002, so at that point their records will become part of the project whether they agree or not, Lawlor notes. "My expectation is most will be [involved in the process] well before that."

Using its proprietary software program, COB Clearinghouse examined the identities of the individuals in the combined data provided by all the demonstration participants.

Lawlor points out that the preliminary results arise from a sampling only 4 million insured lives, and constitute testing against less than 5% of the total record possible. Findings were as follows:

- 4.47% of the insured population submitted for the National Demonstration Project was primary elsewhere in March 2000;
- 4.68% of the insured population submitted for the project was primary elsewhere in June;
- 4.29% of the insured population submitted was primary elsewhere in September.

The preliminary results, Lawlor says, indicate an avoidable expense of $111 per insured person per year, or roughly $230 per insured employee per year, based on national average claims. The return on investment in automating coordination of benefits, he says, is about 8.9 to 1, meaning that the avoidable expense is 8.9 times the cost of automation to a large plan sponsor. The 4.47% extrapolates to 16% in a complete data collection, Lawlor adds.

That's because, he explains, the preliminary run was on only 4 million records, mostly from Ohio and Pennsylvania, while each state has between 12 million and 15 million covered lives. "If we found 4% of [the amount tested], then the statisticians tell me we should come out at around 16% when we're finished."

"Nobody really knows" the number of eligibility records in the United States, Lawlor says. "I think it's 300 million."

Since the country has a population of approximately 270 million, and 40 million of those people don't have insurance coverage, there is obviously a large incidence of "double coverage," he adds.

"What happens," Lawlor says, "is that a patient comes in to admitting and says he's covered by Aetna. He doesn't say that he's also covered by Cigna and that it's primary."

Through the government's Medicare Secondary Payer (MSP) effort — by which it determines instances when a payer other than Medicare should be responsible for a patient's bill — it recovers about $750 million a year, he notes. "That wouldn't happen if there were not double coverage."

MSP relief discussed

COB Clearinghouse has met with officials of the Centers for Medicare and Medicaid Services (CMS) to discuss the potential for a more efficient way of determining the primary payer, Lawlor says. "We've told them that if a hospital put its claims through our filter, it would find all the accounts that are primary to Medicare."

If that were done, he adds, access personnel wouldn't need to ask Medicare patients the MSP questions, thus eliminating a tedious and time-consuming task. **(See cover story.)**

The question COB Clearinghouse posed to CMS officials, Lawlor says, is, "How about if we certify that providers have adequate interfaces [to determine the primary payer] and then give them exemption from audits and penalties [associated with the MSP process]? It's not complicated."

With the electronic requirements associated with HIPAA, he points out, time lags between when a person changes coverage and when that information is available to a provider will be virtually eliminated.

[For more information on COB Clearinghouse, call (216) 861-2300 or visit the company's web site at www.cobclearinghouse.com.] ■

What are you doing to get ready for HIPAA?

Workgroups, fact-collecting part of Shands' effort

Is your access department scrambling to get ready for implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996? You're obviously not alone. *Hospital Access Management* would like to hear about HIPAA solutions you've developed, or even interesting dilemmas you're facing. Maybe another *HAM* reader can help.

Meanwhile, **Beverly Varshovi**, associate director for admissions at Shands Hospital at the University of Florida in Gainesville, reports that she has her managers and assistant managers busy coming up with "HIPAA facts" to add to the department's resource base.

"In July, I just started asking the 10 of them to bring me a fact a week," Varshovi says. "We started a box. Now we have 180 facts."

Access staff have been instructed to keep a record of individuals or organizations to whom they send data, whether by fax, e-mail, telephone, or automated reporting, she notes. "We've had everybody start keeping logs. We're building a list of who we give data to and why."

Key web sites

In addition, Shands staff have been developing a departmental list of key HIPAA web sites, Varshovi says. "Some are better than others." **(See list, p. 143.)**

Most of the seven hospitals that comprise Shands HealthCare are hiring a person to oversee privacy and security issues, says **Elizabeth White**, JD, who was hired in August 2001 as the privacy officer for the health care system. Depending on its size, she notes, a hospital may allocate the responsibility to someone already on staff. A security officer for the Shands system was brought on board more than a year ago, White adds.

Key individuals throughout the Shands system are participating in a HIPAA task force, she says, and the task force has broken into subgroups to address individual aspects of the law. One group, for example, is dealing with the issue of obtaining consent for the release of patient records.

"We're going through the drafting process and finding the most effective way of documenting and recording, White says. "We're considering incorporating [the process] into the computer system."

There is a HIPAA provision, she points out, that allows the provider to refuse treatment if the patient won't give consent, and some instances where consent is not required.

Some hospital departments, like Varshovi's, are "good about keeping logs" of where they send patient information, White notes, and others are not as good. "Those that don't keep control will have to make big changes."

Although the privacy rule becomes effective in April 2003, "most places are actively taking steps now to limit disclosures," she says.

One of the biggest tasks her organization faces in becoming HIPAA-compliant, White notes, has to do with the staff education and cultural change that must take place. "Changing perceptions may be the most challenging [aspect]," she adds.

[Please send your HIPAA questions and/or solutions to Lila Moore at lilamoore@mindspring.com or call (520) 299-8730. Beverly Varshovi may be reached at (352) 265-0322.] ■

Shands staff make HIPAA web site list

Here is a list of web sites, compiled by the admissions staff at Shands Hospital at the University of Florida, that may help your

department prepare for HIPAA implementation:

1. www.hipaacode.com
2. www.wedi.org
3. www.orhima.org
4. www.aha.com
5. www.hipaa.com
6. www.mgma.com
7. www.sharpworkgroup.com
8. www.benefitsnext.com
9. www.hippo@altavista.net
10. www.smed.com/hipaa/index.php
11. www.hcfa.gov/medicaid/hipaa
12. www.hipaadvisory.com
13. www.aha.org/hipaa/hipaa_home.asp
14. www.hipaa-IQ.com
15. www.insure.com
16. www.tumbleweed.com
17. www.wedi.org
18. www.orhima.org
19. www.aha.com
20. www.hipaa.com
21. www.mgma.com
22. www.sharpworkgroup.com
23. www.benefitsnext.com
24. www.hcfa.gov
25. www.wpc-edi.com/hipaa/
26. www.wpc-edi.com/taxonomy
27. www.phoenixhealth.com ■

Report looks at need for collecting race data

A new report from The Commonwealth Fund may help access personnel understand and better explain the importance of collecting racial and ethnic data during patient registration.

The report finds wide gaps between the goals of federal initiatives to eliminate racial and ethnic disparities in health care and how federal health agencies are collecting the data needed to achieve those goals.

Taking the lead

The report, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices,* calls for the U.S. Department of Health and Human Services (HHS) to take a leadership role in meeting the challenges of collecting and reporting health data that include information on race, ethnicity, and primary language.

In interviews conducted with administrators at federal health agencies, the authors of the study, Ruth T. Perot of Summit Health Institute for Research and Education Inc. and Mara Youdelman of the National Health Law Program Inc., heard reports of widespread confusion in the health care sector about the legality of collecting information on the race and ethnicity of people served by their programs.

Health administrators also reported concerns over misuse or misinterpretation of data, lack of

Hospital Access Management™ (ISSN 1079-0365) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Access Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. -6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $435. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $348 per year; 10 to 20 additional copies, $261 per year; for more than 20 copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $73 each. (GST registration number R128870672.)

Editorial Questions

Call **Lee Landenberger** at (404) 262-5483.

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

Editor: **Lila Margaret Moore,** (520) 299-8730.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Production Editor: **Nancy McCreary**.

AMERICAN HEALTH CONSULTANTS
THOMSON HEALTHCARE

standards or enforcement, and technical difficulties in collecting or using the data.

Recommendations to HHS

The report recommends, among other things, that HHS take these steps:

- Ensure that federally supported programs such as Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) collect and report data for their enrollees by race, ethnicity, and primary language. Independent analysts estimate that the Social Security Administration's Medicare beneficiary eligibility file is less than 60% accurate for all racial/ethnic classifications other than black or white.
- Require that the Health Plan Employer Data and Information Set and standards for implementing the Health Insurance Portability and Accountability Act include collection of data by race, ethnicity, and primary language. Racial and ethnic categories used under HIPAA must be compliant with Office of Management and Budget standards.
- Ensure access to quality health care for people with limited English proficiency by collecting data and monitoring adherence.
- Inform insurers, health plans, providers, agencies, and the general public that data collection and reporting by race, ethnicity, and primary language are legal and often required by law.
- Assure that states and providers have greater access to federally acquired data.
- Support research on existing best practices for collection and reporting of data by race, ethnicity, and primary language. ■

Hospitals get help with veterans' bills

The Department of Veterans Affairs (VA) has announced that it will begin reimbursing non-VA hospitals for emergency care when it's obvious that a delay in care would be hazardous to the veteran's health and when no other VA or federal facility is available.

This is true for veterans who are:

- enrolled in VA health care;
- have been seen by a VA health care professional within 24 months;
- carry no other form of health insurance, including Medicare or Medicaid.

The VA pays 70% of the applicable Medicare rate, the veteran pays nothing, and VA payment is considered payment in full. The VA will pay for private-sector emergency care only until the veteran can be safely transported to a VA facility.

Under the new rules, civilian hospitals should report to the VA within 48 hours of treating a veteran who has no other means of payment. If any third party pays all or part of the bill, the VA will not provide reimbursement.

The proper form

To obtain payment or reimbursement for emergency treatment, within 90 days of discharge, a claimant must submit to the VA medical facility of jurisdiction a completed standard billing form, such as a UB92 or a HCFA 1500. A signed, written statement certifying that the claim meets all the conditions for payment must accompany the completed form.

For more information about the emergency care benefits, go to www.va.gov/health/elig on the Internet, contact the nearest VA health care facility or call (877) 222-8387. ■

FOR 20 YEARS

Hospital Access Management™

Admitting ■ Reimbursement ■ Regulations ■ Patient Financial Services ■ Communications
Guest Relations ■ Billing & Collections ■ Bad Control ■ Discharge Planning

2001 Index

When looking for information on a specific topic, back issues of Hospital Access Management *newsletter, published by American Health Consultants, may be useful. To obtain back issues, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcpub.com.*