



# HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

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With disaster possibilities growing, it's time for preparedness, training

*The key strategy: Keep your disaster program flexible*

**S**ept. 11th and anthrax bring home one important message to all health care professionals, including HIM specialists: There is no possible way a department can prepare for every contingency.

It's not like the old days of preparing for natural disasters such as fires, hurricanes, tornadoes, earthquakes, and floods. These days, a coding department could be shut down for hours or even a day or longer just by the appearance of an envelope coated in a powdery white substance. Likewise, after a hospital has been hit with a large influx of casualties after a terrorist attack, HIM professionals could find themselves taxed by people trying to locate missing loved ones and insurers trying to identify covered patients.

**SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS**

The good news is that HIM departments do not have to prepare for every possible disaster in order to effectively handle what comes along. "The value of disaster planning isn't necessarily that you anticipate the right disaster, but that you talk about it with your staff so that you know what resources are available so these can be applied to a disaster you didn't think of," says **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with the Chicago-based American Health Information Management Association (AHIMA).

Some disasters have internal and often unforeseen causes, adds Hughes, who has written articles and spoken to health care groups about disaster planning.

"Say a sprinkler system goes off and sprays everything," Hughes offers as an example. "Then the paper can get wet and be ruined, so you might have tarps in the department to throw over them."

Or if a hospital is flooded from the ground up, as happened last year in Houston, then an HIM department could save its paper documentation

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by putting boxes of files on stretchers that are borrowed from the emergency department, Hughes adds.

HIM disasters sometimes are caused by employee sabotage, says **Jill Burrington-Brown**, MS, RHIA, a Snohomish, WA-based professional practice manager with AHIMA. Burrington-Brown also has written about disaster planning and has studied the problems faced by Oklahoma City hospitals after the bombing of the Murrah federal building in 1995.

"I had a mini-disaster at one facility where over a six-month period a clerk whose night job was to file records had been putting files above the ceiling tiles in the department," Burrington-Brown says. "Within four months we knew we were missing a lot of records, but we couldn't figure out where they were."

This caused a great deal of documentation problems when records were being requested and none of the hard copies could be found. Then when the department finally found the files during a heating system check, there was a second mini-disaster because now the staff had to cope with filing an additional 10,000 records and making them accessible as soon as possible, Burrington-Brown says.

"We made a plan of how to keep up the regular workload while having the records filed as fast as possible," Burrington-Brown adds.

That type of scenario proves that it's impossible to anticipate every type of potential disaster, Hughes says.

"But the value is in going through the process and discussing things with the staff anyway," she explains. "Sure, if we anticipate employee sabotage, like someone who is angry getting into the payroll system, then as soon as we plan for it, the disaster will be something different."

Nonetheless, all HIM departments can take some basic disaster-planning precautions and follow strategies that will assist them in remaining flexible should an unforeseen disaster event occur. Here are some suggestions from Hughes and Burrington-Brown and from AHIMA:

- **Know your liabilities and limits.**

Under the Health Insurance Portability and Accountability Act (HIPAA), health care providers are required to maintain patient privacy. Breaches in an HIM department's electronic records and the unintended release of confidential information could result in major regulatory and legal problems, so it's highly important to ensure that records remain private and protected

during a disaster.

For example, if an HIM professional discovers white powder on a paper document and suspects anthrax contamination, then the document must immediately be placed in a plastic bag and delivered to a laboratory for testing, Hughes says.

"You should do a chain-of-custody on the paper, including making a loan record to the person who will make certain it's not anthrax," she says.

Then, if the paper turns out to be uncontaminated, it can be returned immediately to the department. If it is contaminated, it can be sterilized and returned when it's deemed safe.

After Oklahoma City, health care providers often mentioned that it would be a good idea for the area to create a centralized computer database that all providers could share. This would have the benefit of giving families one place to go for information, Burrington-Brown says.

"HIPAA does allow for disasters and it does allow for the release of information to agencies who are legally or by charter dealing with disasters for the purpose of location of families in the case of a patient's death," Burrington-Brown says.

### *Get in touch with restoration companies*

To prepare for the documentation damage that a disaster could cause, HIM departments should contact fire or water damage restoration companies to determine what kinds of services they can provide in restoring electronic and paper documentation. **(Read about contracting with restoration companies on p. 3.)**

These companies also might have information that could help a department better prepare for a disaster. Also, HIM departments need to assess the facility's insurance coverage to see what costs are covered during a recovery period and what strategies can be taken to limit liability and loss, according to a practice brief Hughes wrote.

When records cannot be reconstructed, an HIM department might look into various strategies, including reprinting documents from undamaged databases in admission, transcription, etc.; transcribing documents from the dictation system; and obtaining copies that were distributed to physician offices and others.

- **Draft a disaster plan.**

First, use what is already available.

"Most plans could work for all sorts of other disasters, but it would be appropriate for people

# Ensure patients' privacy before the disaster

*Before a disaster strikes*

Every disaster plan should include a strategy for coping with damaged records. It's a crucial first step in the HIM department's recovery.

If the facility contracts with a fire, flood, or storm damage restoration company, it's a good idea to have a contract ready that would address various provisions for ensuring the privacy of the documentation.

According to a disaster planning practice brief written by **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with the American Health Information Management Association (AHIMA) in Chicago, the damage restoration contract should stipulate that the restoration business will:

- Specify the method of recovery.
- Not use or further disclose the information

**SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS**

to revisit those annually and tweak them in some way," Hughes says.

For instance, nearly all HIM departments probably created extensive electronic disaster plans as they prepared for Y2K. Those plans could be dusted off and used to prepare for an electronic attack, such as an Internet virus that destroys files.

"What you do is list your core and electronic processes, starting with a master patient index, for example, so that you can locate patient records," Hughes says.

Then take the function that's electronic and list the various assumptions of what has caused the electronic failure or disaster and describe what might happen, what resulting problems will occur, what is available to the department in the event of the problem, and how to design ways to work around the problem, Hughes adds.

Examples of disasters that should have a similar flowchart or contingency checklist include fire, flood, bioterrorism event, hurricane, explosion, extended power outage, and earthquake.

**(Read about how to generate a contingency plan, p. 4)**

other than as the contract permits or requires.

- Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the contract.
- Include the items required in business associate contracts in accordance with the Health Insurance Portability and Accountability Act privacy rule.
- Report to the contracting organization any inappropriate use or disclosure of the information of which it becomes aware.
- Ensure that any subcontractors or agents with access to the information agree to the same restrictions and conditions.
- Indemnify the health care facility from loss due to unauthorized disclosure.
- Upon termination of the contract, return or destroy all health information received from the contracting organization and retain no copies.
- Specify the time that will elapse between acquisition and return of information and equipment.
- Authorize the contracting entity to terminate the contract if the business partner violates any material term of the contract. ■

If there is a terrorist attack or a major natural disaster, it's possible that hospitals will be inundated with more patients than they believe they can handle, and these patients may arrive in unexpected ways, Burrington-Brown says.

"One thing I've seen in the experiences of people who worked through the Oklahoma City bombing or the New York City bombing is that the numbers of people they receive at hospitals is far more than they ever planned for," Burrington-Brown says. "Departments are saying, 'Let's plan for 50 casualties, because that's what our hospital can reasonably handle.' But they need to plan for more than they can handle comfortably."

In the event of a major disaster, the people who are injured may not be organized by rescue workers and sent to hospitals in an orderly fashion. It's likely that area hospitals will receive patients through a variety of means, including ambulances, private cars, and walk-ins, and it's likely they'll enter at any door of the hospital, as well as emergency department doors, says Burrington-Brown.

These types of scenarios affect HIM departments because patients may not always have

identification and insurance coverage information on their person. They may be unconscious or disoriented and unable to answer questions by intake workers. Often their family members do not know where they are.

“You may have large numbers of people for whom you have no name, insurance, or other demographic information. So how do you track these people during their stay?” Hughes asks.

HIM staff may need to work with intake staff in identifying patients and gathering information, Burrington-Brown says.

One strategy under these circumstances is to develop a simple system of identification and clean up the documentation later, she says.

For example, after the terrorism attacks in Oklahoma City and New York City, hospital workers identified patients through tags with check boxes that listed physical characteristics, Burrington-Brown says.

“On the back of the tag were stickers with the same numbers as the tags, so that as samples were sent to the lab, the stickers and lab samples had the same numbers,” Burrington-Brown says.

Even this system posed some unexpected consequences. Some patients were so traumatized by the disaster experience that they could not tolerate having anything tied to them, so the tags had to be put on clips, she adds.

• **Learn from trials, tribulations, and mistakes.**

HIM departments can learn from the problems other facilities have had during disasters, as well as from their own disaster drills and actual events.

This is why it’s important to practice disaster drills twice a year when possible, Burrington-Brown says.

And it’s a good idea for an HIM department to hold its own mini-disaster drill, independent of the hospitalwide drill, Hughes suggests.

“It’s not just having a plan written down, but having regular discussions with the staff to talk about what might happen and how any of them might need to be the boss and do what needs to be done when it happens,” Hughes says.

An example of learning from others’ experiences might include stocking an HIM department with identification tags and clips that could be used in the event of an emergency in which victims cannot easily be identified, Burrington-Brown says.

“Stock three to five times more than you think you’ll need because you don’t know what your numbers will be,” Burrington-Brown says. “And

make sure the people involved know what to do with them, and that includes admitting people and HIM people.”

Finally, keep in mind that after a disaster there may be heightened emotions and staff may be personally affected by deaths and injuries, so it’s important to let employees vent, grieve, and heal emotionally.

Once this process is under way, HIM professionals may begin to evaluate how the department handled the disaster and what can be done to improve the process in the event of future disasters. ■

## Here are the essentials of a contingency plan

*AHIMA offers strategies and samples*

**A**mong the strategies published by the Chicago-based American Health Information Management Association (AHIMA) is the following advice about how to create a contingency plan, which is

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part of a paper written by **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with AHIMA.

Here are some of AHIMA’s and Hughes’ suggestions for information that should be included in a contingency plan created for each plausible disaster:

1. The facility name.
2. The department name.
3. The contingency plan originator.
4. The date.
5. The major function being addressed, i.e., chart tracking/location, and provision.
6. The disaster being considered, i.e., hurricane or earthquake.
7. Some assumptions about the disaster, i.e., how will the disaster affect: utilities, staffing, and/or the ability of staff to report to work; security of health information; the facility itself; hardware and software; equipment and supplies; other departments; and patients presenting to the facility for treatment.
8. A description of the existing process used for the particular major function being addressed.

9. An if/then scenario, i.e., if this function is not performed, what will be the result?
10. Interdependencies, i.e., what other processes depend upon the provision of this information or service? On what information or services is this process dependent?
11. Solutions/alternatives, including steps that can be taken to minimize damage or disruption before the disaster, ensure stability, or provide for orderly recovery.
12. The limitations and benefits of each solution or alternative.
13. Activities that will need to be performed before the disaster in order to make this alternative possible, i.e., acquisition of equipment, implementation of back-up systems, development of disaster-related forms and materials, procedures, and staff training.
14. The names of the individuals responsible for performing these activities.
15. A list of individuals or departments with phone numbers who should be contacted or notified relative to the disaster and the implementation of this particular contingency plan. ■

## Documentation/coding can create problems

### *Florida PEPP focuses on dehydration, pneumonia*

The Florida Payment Error Prevention Program (PEPP) determined that two of the major coding issues experienced by hospitals involved coding problems with pneumonia patients and unnecessary cases of dehydration.

These two diagnoses could result in an excessive payment by Medicare of more than \$2,000 per case. On the other hand, a hospital could lose thousands of dollars through inaccurate coding and incomplete documentation, according to **Mark Michelman**, MD, MBA, physician coding advisor for Morton Plant Mease Healthcare of Clearwater, FL. Michelman also is the medical director of quality utilization management for Morton Plant Mease and clinical coordinator with the Florida peer review organization Florida Medical Quality Assurance Inc. of Tampa, FL.

The Florida PEPP focused on those two diagnoses because they were areas in which some of the more common coding and documentation

mistakes were made, Michelman says.

In the case of pneumonia, hospitals were sometimes billing Medicare for complex pneumonia (DRG 79) cases, such as gram-negative pneumonia or aspiration pneumonia, when those cases proved through chart reviews to have a more accurate diagnosis of simple pneumonia, such as community-acquired pneumonia (DRG 89). The community-acquired pneumonia cases were typically those involving patients who were generally healthy before coming into the hospital with fever, cough, and congestion. The X-ray would indicate a pneumonia diagnosis, but the patient could be treated with a short hospital stay, he explains.

In the more complex pneumonia cases, the patients are frequently immunocompromised or are frail elderly people living in nursing homes, and the treatment usually is more intense, using different antibiotics.

“We had a predictive formula that predicted the billings of DRG 79 for complicated pneumonia cases based on prior billings,” Michelman says. “For example, if a hospital had billed 20% of pneumonias with that DRG last year, we could predict based on hospital demographics what the billing should be for the coming year, and we found that some hospitals had billed more than was predicted by the model.”

PEPP reviewers then substantiated the data by reviewing medical records from each of the hospitals that had more DRG 79 diagnoses than predicted. Some of the DRG 79 cases would have been more accurately coded as DRG 89 cases, which is the coding for simple pneumonia, a less costly diagnosis.

Based on the chart review information, reviewers identified 20 hospitals in Florida that had the greatest discrepancy between predicted DRG 79 cases and actual billed DRG 79 cases, Michelman adds.

“We asked these hospitals to submit to our organization a quality improvement plan and, invariably, in many of these cases a major issue was inadequate or illegible physician documentation to support the higher-paying DRG,” Michelman explains. “In some cases, hospitals would upcode to generate more income for their hospital.”

Since Florida PEPP drew attention to the pneumonia coding problem, the 20 hospitals have decreased their billings for DRG 79, Michelman says.

Likewise, Florida PEPP found that hospitals were incorrectly coding dehydration cases, many of which were situations in which a patient

either did not meet the criteria for a diagnosis of dehydration or cases in which a patient with dehydration was inappropriately admitted into the hospital or stayed in the hospital for longer than necessary, Michelman says.

“Many times the admission might have been appropriate, but the physician documentation wasn’t there to support the admission,” Michelman adds.

Here is how the hospitals improved their physician documentation and coding accuracy during the Florida PEPP projects:

- **Hospitals identified root causes.**

In the case of the pneumonia project, hospitals mainly identified these root causes: lack of information, lack of knowledge, and the need for more coding education and improved documentation by physicians.

With the dehydration project, hospitals decided the root cause was primarily an issue of physician documentation.

Patients with dehydration typically have excessive fluid losses due to vomiting, diarrhea, and sweating, and their clinical signs include rapid heart rate, low blood pressure, dry mucus membranes, poor skin turgor, and abnormal lab values, Michelman says.

Treatment typically is intravenous fluid replacement. But the problem was that physicians often were diagnosing patients with dehydration (DRG 296/297) when there was no documentation that the patient had any of the clinical signs or manifestations of dehydration, he says.

For instance, a physician might say a patient is 85 years old, weak, and came into the hospital after passing out. While that patient could have dehydration, the description cited does not by itself justify that diagnosis, Michelman explains.

“Many times they have no history, no physical findings, and no lab abnormalities consistent with dehydration,” Michelman says.

Also, there often was a problem with the treatment given to these patients. The IV fluid sometimes was administered at an inadequate rate to treat dehydration if the patient actually had the problem. In other cases, there were patients treated for dehydration for three or more days in the hospital when their condition could have as easily been treated on an outpatient basis or observation status.

“We found that two-thirds of the patients did not meet the criteria for the diagnosis or to be in the hospital, and that’s a very high number,” Michelman says.

“A coder can code a diagnosis if the doctor says the patient has that diagnosis,” Michelman adds. “But the doctor has to document why he’s saying that, based on history, physical findings, and therapy, and the coder needs to make sure it’s documented.”

- **Hospitals determined the process for improvement.**

There were five basic areas identified for improvement in making the correct pneumonia diagnosis. These were as follows:

- improving physician education;
- improving education and re-education for coders;
- starting an internal and external audit process for making certain documentation in coding is appropriate;
- assigning a physician coding advisor who would interface with coders and physicians to answer coders’ questions about whether clinical documentation is adequate to support a diagnosis;
- using physician query forms as a communication tool, to be sent to doctors via fax, e-mail, or hard copy, in which the coder would ask the physician to clarify a diagnosis. The physician would have to respond to the query in the body of the medical record, whether it was in the history and physical, progress notes, discharge summary, or an addendum.

“Some hospitals also wanted doctors to be reviewed by their peers in an educational format,” he adds.

### *Letting physicians counsel physicians*

In this process improvement, physicians would receive general education about properly diagnosing dehydration or pneumonia. Then, in situations in which a physician is found to have made an improper diagnosis and the improper diagnosis was coded and billed before it was discovered that the patient didn’t meet criteria for the diagnosis, other physicians would counsel the doctor who made the diagnosis to prevent future errors and improve physician documentation, Michelman says.

- **Demonstrate improvement.**

The Florida PEPP re-sampled the 20 hospitals’ charts six months after they had submitted their process improvement suggestions for more accurate pneumonia diagnoses, and reviewers found a decrease in the number of DRG 79 codings that

*(Continued on page 11)*

# DRG CODING ADVISOR.

## National emergency leads to more depression coding

### *Start with patient's medical record*

**T**he combination of the holiday season and emotional reactions to the events on and after Sept. 11 mean practices are seeing a major jump in the number of patients with some form of depression.

When treating such patients, your code selection starts with the patient's medical record. For ICD-9-CM subcategories 296.0-296.6, make sure to use the correct fifth-digit subclassification code to identify the extent of the patient's condition. These are:

- 0 — unspecified;
- 1 — mild;
- 2 — moderate;
- 3 — severe, without mention of psychotic behavior;
- 4 — severe, specified as with psychotic behavior;
- 5 — in partial or unspecified remission;
- in full remission.

Reactive depression is the result of such stressful events as the death of a loved one, the loss of a job, or the end of a relationship. The patient experiences mild to moderate depression, but is able to continue his or her life, usually within a few months.

If the medical record says the patient's condition is "situational" or "adjustment reaction with depressed features, in a patient with no previous existing mental disorders," it is usually coded 309.0 (brief depressive reaction) or 309.1 (prolonged depressive reaction). **Caution:** Codes from the 309 category should not be assigned with any other code in the "Mental Disorders" chapter of the ICD-9-CM code book.

Use CPT code 90862 (pharmacological management) if:

- the physician is managing medication for

a patient receiving psychotherapy from a limited-licensed colleague;

- the patient's condition is being effectively treated by medications only;
- the physician is managing medications for a patient with an organic disorder such as senile dementia;
- the patient is receiving no other services during the encounter;
- an evaluation and management psychotherapy service is provided during the same encounter.

Remember that only the appropriate evaluation and management or psychotherapy code should be assigned.

If a Medicare patient receives an uncomplicated drug monitoring, such as an adjustment in the dosage, assign HCPCS Level II code M0064. For comprehensive drug management services, assign CPT code 90862. ■

## At times you can bill for E/M and prevention

**W**hile the Centers for Medicare and Medicaid Services (CMS) is expanding the range of medical services Medicare will pay for, many other types of routine related services remain uncovered. In cases such as a routine physical examination for a senior citizen, for instance, you will need to get Medicare patients to sign an Advance Beneficiary Notice that permits you to bill them, because Medicare does not cover this service.

However, in situations where a physician finds

a patient has significant medical problems that require further investigation during an otherwise routine health exam, most practices either use a preventive code or an evaluation and management (E/M) code when billing the claim.

However, in such circumstances it is often appropriate to bill both a preventive code and an E/M code, which can have a major impact on the ultimate reimbursement.

Specifically, American Medical Association guidelines say it is acceptable to use codes from both categories when “the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service.”

#### *Problem must be linked to E/M code*

In this situation, use modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to append the code for the problem-oriented E/M service. In turn, Medicare should reimburse the problem-oriented code (99213).

**Case study:** A 72-year-old Medicare patient comes in for his routine annual physical. He has no complaints, and there is nothing on his chart since his last physical. During the examination, the doctor notes pallor and decides to perform a complete blood count, which reveals anemia. Additional clinical work is done to help find the cause of the anemia. Responding to questions from the doctor, the patient notes that he has been feeling a little off lately, but “has not really thought about it.”

The documentation that has been gathered shows there are enough key components for physical exam and medical decision-making to justify a level 3 problem-oriented, established patient, E/M service.

In this case, the practice should bill for both a code 99397 (preventive medicine service, established patient, 65 years and older) and 99213-25 (level 3 office or other outpatient established patient visit, significant separately identifiable E/M service).

**Tip:** It is vital that the problem or condition be linked to the problem-oriented E/M under this coding combination. As such, two diagnoses should be placed on the claim. Code 99213 will not be considered significant or separately identifiable enough without a condition warranting use of the code. ■

## CMS clarifies billing for teaching physicians

**T**he Centers for Medicare and Medicaid Services (CMS) has modified the Medicare Carriers Manual to clarify billing for certain teaching physician services that are exempted from the requirement that the physician be physically present during the key portions of the service (Transmittal Letter 1723).

To qualify for the exemption under the new standard, claims for services must contain the “GE” modifier in Item 24d of form HCFA-1500. Claims for services that require the presence of a teaching physician during the key portions of the service must contain the “GC” in Item 24d of the HCFA-1500 form.

Since 1996, the rule has been used for certain low-level evaluation and management services. Residents who met certain requirements could provide key portions of the service in the absence of the supervising teaching physician. ■

## CMS issues memo on use of physician query forms

**T**he director of the Centers for Medicare and Medicaid Services (CMS) Quality Improvement Group has issued a Policy Clarification Memorandum stating that “the use of the physician query form is permissible to the extent it provides clarification and is consistent with other medical record documentation.”

This clarification reverses a similar memo issued in January 2001 instructing peer review organizations (PROs) not to accept physician query forms as a substitute for documentation in the medical record.

According to the new procedures for PRO reviewers in the Oct. 11 Policy Clarification: “In conducting medical review for validating the DRG, the PRO reviewer shall use his or her professional judgment and discretion in considering the information contained on a physician query form along with the rest of the medical record for purposes of DRG validation. If the physician query form is leading in nature or if it introduces new information, the reviewer shall refer the case

to the physician for review. The PRO must perform physician review as described in the PRO Manual at 4130(D) and provide the opportunity for discussion if necessary.”

When the Paperwork Reduction Act eliminated the need for physician attestation for Medicare inpatient cases in 1992, the physician query form lost popularity. However, its use has increased once again with the renewed emphasis on fraud and abuse issues.

Professional coding standards say coders should ask physicians for clarification and additional documentation before they code a case file containing conflicting or ambiguous data. The Office of Inspector General’s Compliance Guidance for Third-Party Billing Companies also notes that coders should communicate with physicians when their documentation is unclear or conflicting. ■

## Time must be devoted for critical care codes

CPT codes 99291 and 99292 are used to report critical care services. But what is sometimes overlooked is that physicians billing for critical care must have devoted their full attention to the patient. Consequently, they cannot bill for evaluating or managing any other patient during the same time period.

The physician must report the time period she or he spent working on the critical care patient’s case. This time can be spent at the patient’s bedside or on the hospital floor, as long as the doctor is immediately available to the patient. However, any time spent outside the patient’s unit or floor, such as when taking telephone calls, cannot be billed as critical care.

To report services for a patient who is not critically ill but happens to be in critical care, intensive care, or another specialized care unit, use subsequent hospital codes (99231) or hospital consultation codes (99251-99263). Use code 99291 for the first hour of critical care provided on a given date.

Report the code only once per date, even if the physician has to break up the visit into separate parts. Critical care totaling less than 30 minutes on a given date should be reported using the appropriate evaluation and management code.

Use code 99292 to report each additional 30 minutes of care beyond the first hour, as well as the final 15-30 minutes of critical care on a given date.

Critical care services lasting less than 15 minutes over the first hour or less than 15 minutes beyond the final 30 minutes should not be reported separately.

**Warning:** Claim examiners see a red flag when two physicians divide the time and one bills using code 99291 while the other uses 99292 for the same patient on the same date. ■

## Use modifier -60 for complicated surgeries

The CPT manual introduced modifier -60 in 2001 to allow providers to indicate when a procedure was more complex than normal due to an altered surgical field. Previously, coders had to use the usual services modifier (modifier -22) for a variety of conditions. The -60 modifier, however, is more specific.

Modifier -60 should be used when a procedure is significantly more surgical or requires more time as a result of:

- previous surgeries;
- significant scarring, adhesions, or inflammation;
- distortion of the anatomy;
- irradiation;
- infection;
- trauma;
- very low birth weight ( i.e., neonates and small infants weighing less than 10 kg). ■

## What the OIG wants on all proper bills

While it is the provider’s responsibility to document each case, coders need to screen each claim carefully to ensure it is thoroughly and properly documented to speed the payment process and prevent queries from investigators. Here’s a checklist of items that the Office of Inspector General says every properly documented claim

should be able to reference:

- reason for the patient encounter;
- appropriate history and evaluation;
- documentation of all services;
- documentation of the reason for all services;
- ongoing assessment of the patient's condition;
- information on the patient's progress and treatment outcome;
- documented treatment plan;
- plan of care, including treatment, medication (including dosage and frequency), referrals and consultations, patient and family education, and follow-up care;
- changes in the treatment plan;
- documentation of the medical rationale for the services;
- documentation that supports the standards of medical necessity, such as certificates of medical necessity for durable medical equipment, prosthetics, orthotics, supplies, and home health services;
- abnormal test results addressed in documentation;
- identification of relevant health risk factors;
- documentation that supports the evaluation and management codes that are billed;
- medical records that are dated and authenticated;
- prescriptions. ■

## Outpatient Medicare pay to jump 2.3% next year

Hospitals will receive a 2.3% increase in Medicare payments for outpatient services effective Jan. 1, 2002, under a final rule announced today by the Centers for Medicare and Medicaid Services (CMS).

The new hospital Outpatient Prospective Payment System administers more than \$17.5 billion in reimbursement for more than 6,000 hospital departments.

The rule includes a one-time policy change for next year to reimbursements for new high-cost and high-technology drugs and devices mandated by Congress in the Balanced Budget Refinement Act of 1999. The rule updates payments annually to hospitals for Medicare outpatient services in the prospective payment system that began Aug. 1, 2000.

"Given the restraints of the law, this rule adopts the best possible balance between protecting beneficiary services in outpatient settings and ensuring that those beneficiaries have access to all the new drug and device technologies that are critical to their improved health," said **Tom Scully**, CMS administrator.

The regulation "folds in" 75% of the costs of high-technology drugs and devices to the base payments for outpatient services, resulting in a significant enhancement of payments for these new technologies. Under the law, all of the costs are required to be included in the base payments for 2003, and the payment system for 2002 begins the transition of those new payments. ■

## Medicare digs up ban on services to relatives

Adding to the fine print that goes with deciding when it is OK to waive copayments or provide physician courtesy services for free, Medicare has restated a relatively obscure ban on reimbursing doctors for any services they provide to immediate relatives of their partners and colleagues.

The rationale: Practices should not bill for such services because they would probably have been provided for free if Medicare was not there to pay for them.

Medicare's ban on billing for immediate family members was first introduced in the 1994 carrier manual. Now a 2001 Illinois-Michigan carrier bulletin declares: "Medicare will not cover charges by providers who are immediate relatives of the beneficiary or by providers who are members of a beneficiary's household. Medicare excludes payment for these providers because items and services furnished by them would ordinarily be furnished free of charge based on their relationship to the beneficiary. This exclusion applies to physician services, including services of a physician who belongs to a professional corporation and services incident to those services."

Not only does the ban include physician services provided in-office but also any physician extender services provided incident to the physicians' services in the office, ancillary tests provided in the office, and hospital consults physicians provide to relatives of colleagues, say experts. ■

(Continued from page 6)

were billed compared to the baseline chart review. In the hospitals that were not targeted for process improvement, there was no change in the DRG 79 codings, Michelman says.

PEPP reviewers found that with the dehydration diagnosis, there were two peaks for length of stay (LOS). The first was at three days and the second was at seven days, he says.

Either of these LOS figures would often be inappropriate, because a patient treated for dehydration typically should be treated and discharged before three days have passed, Michelman says.

“Three days is the length of stay that a patient needs to be in the hospital before being eligible to go into a nursing home, so we felt that the patient was kept in the hospital to justify going into a nursing home,” Michelman says.

Those patients who were treated for dehydration for seven days were frequently patients who should have received another diagnosis that would have been more appropriate, Michelman says. They might have had malignancies, renal failure, or some other cause of dehydration; if they had been properly diagnosed and coded, then the hospital would have received a higher reimbursement than it would for dehydration, Michelman adds.

*[Editor's note: For more information about Florida PEPP and its coding and documentation projects, contact Mark Michelman, MD, MBA, at Morton Plant Mease Healthcare, 232 Jeffords St., Clearwater, FL 33756-0210. Telephone: (727) 461-8016. E-mail: mark.michelman@baycare.org.] ■*

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

*Many providers 'not aware,' consultant says*

**W**ith 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.”

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.”

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.”

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 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](http://www.healthlinkinc.com).] ■*

## Closer look at denials shows payers at fault

*Admissions effort recovers more than \$1 million*

**W**hen 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.”

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

## *Report on eligibility*

**C**OB 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.

## *Payers must go electronic by October 2002*

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 of 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.

## *Return on investment is 8.9 to 1*

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 — the

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agency recovers about \$750 million a year, he notes. "That wouldn't happen if there were not double coverage."

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.

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](http://www.cobclearinghouse.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.

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

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

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 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 (HIPAA) 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;

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— 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.

*[Editor's note: For more information about the emergency care benefits, go to [www.va.gov/health/elig](http://www.va.gov/health/elig) on the Internet, contact the nearest VA health care facility or call (877) 222-8387.] ■*