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INSIDE

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An OIG inspector just walked through your door; what do you do next?

States will be more involved in future audits

The words, "Hello, I'm from the Office of the Inspector General," are enough to keep any HIM professional awake all night. Even when your HIM department is run by the book and documentation is thorough and accurate, there remain the nagging doubts that something could be wrong and the OIG inspector will find it.

Rather than wait for the OIG to show up and raise the anxiety level in the office, there are practical measures the HIM department can take to both prepare for an audit and prevent problems.

"If you're on your toes and are familiar with what's going on in the industry, then you'll know what they're looking for," says **Nadinia Davis**, MBA, CIA, CPA, RHIA, assistant professor of health information management at Kean University in Union, NJ. Davis is a certified internal auditor, whose background in accounting and experience working in the financial services industry has helped her develop a thorough understanding of the auditing process.

It will do no good to become complacent and hope your facility will not be audited by the OIG, because two trends likely will make that audit a reality, Davis notes.

First, the OIG's own compliance suggestion plan recommends routine operational audits; second, the OIG has begun to partner with state governments to conduct audits, and these likely will increase, she says.

So here are some strategies that HIM professionals can employ to prepare for an OIG audit — and to handle an audit once the auditor walks through the door:

1. Channel your energies into responding precisely to the auditor's requests.

An auditor may ask for all of the documentation about every pneumonia case a facility has handled. This may not mean the auditor wants a printout with every upper respiratory code on it. What is likely meant is

that the auditor wants to look for examples of pneumonia upcoding, so an HIM professional should pull the documentation that applies only to pneumonia codes.

Typically, the OIG knows prior to assigning an audit exactly what an organization has billed and coded and has found some pattern that is out of the ordinary. So the OIG auditor will be trying to target specific items and generally is not doing a random audit, Davis says.

For instance, if the auditor asks for pneumonia cases, this means the auditor believes there are cases that were coded for bacterial pneumonia although the physician has not documented evidence of pneumonia.

The OIG might call this upcoding, while the doctor believes the patient had bacterial pneumonia based on the sinus symptoms. Or it could be an instance when the doctor did send out samples for testing, and the results returned after the coder already had recorded the bacterial pneumonia code. This type of problem could be prevented through an internal audit prior to the OIG visit.

Avoid off-hand remarks to auditor

Also, the audit's findings in this example would be limited to the pneumonia coding problems, unless HIM staff volunteer additional information to the auditor.

"Answer the questions they ask and don't say anything more," Davis says. "A lot of times a seasoned auditor can make a lot of assessments from off-hand remarks, which is why disgruntled employees are a nightmare in an audit situation because they blab away about a lot of stuff that has nothing to do with the audit."

This type of problem can lead to a full-blown audit when the OIG auditor merely intended to conduct a cursory check of the facility's records, Davis adds.

2. Document your internal auditing efforts.

"Auditors don't know your job; they don't know your business or what's going on in your department or what your internal auditing plan is," Davis says. For this reason, HIM departments need to document their internal auditing efforts so a professional auditor can see exactly what the department is doing along these lines. Plus, the documentation will offer validity and possibly ameliorate any negative findings that come to light, Davis explains.

For instance, suppose an OIG auditor reviews files from 1996 to 1998 and finds instances of upcoding, which means the facility will owe money to Medicare. This might lead to a broader investigation and more problems. However, if the department has been conducting its own audits and can prove this to the OIG, then perhaps the findings will be limited to those particular incidents, Davis says.

"You tell the auditor that in the past six months you've been reading about what the OIG has been doing and have audited your own staff very carefully, and here are the steps you've taken," Davis says. "Here are the steps you've taken, and you just haven't gone that far back yet."

This type of response will work, she says. "Every person I have spoken to who has said they did work for the OIG has said that when you are demonstrating your compliance, and coming forward with information, and making corrections, it goes a lot easier on you," she says.

"And that's not just the OIG, but true with other payers too," Davis adds.

It's also important for HIM departments to learn how to document well, which is similar to the performance-improvement process a facility might use to achieve accreditation.

"What a department needs to do is say, 'We're going to do coding-quality audits, and we're going to look at our charts and data and see if we can spot any wacky trends, any patterns that look odd, and then we'll do random coding audits of all coders to make sure coding is at an appropriate level,'" Davis advises. "You need to do a good sample of every chart and quarter, and you can go through it and have either your supervisor look at the charts on a routine basis or make the case to management that you need to spend a little money on a consultant now."

3. Be proactive about mistakes.

There may be advice from some quarters that it's better not to do internal audits because if something is found then it can be used against the facility, Davis says.

"The exact opposite is true," Davis says. "If you do these audits and then do something about what you find, then you won't have an audit in the first place."

When a facility receives compliance advice from a lawyer, it's a good idea to make certain the attorney is experienced in the health care field, because some of the advice applied to other areas is not true in this field, Davis cautions.

Facilities that audit their records and fix mistakes also have the opportunity to educate and

train staff to prevent future mistakes, and all of these efforts should be documented, Davis says.

Occasionally, there will be instances in which a HIM professional audits records, finds mistakes, and reports these to the facility's management, who then do nothing about it. This is a difficult situation, but it shouldn't prevent the HIM professional from doing what's right, Davis says.

"If you know stuff is going on, and you can't get your organization to fix it, then document what you said and leave the job," Davis advises. "Find another job, because why should you place yourself at risk for becoming a scapegoat when the organization is audited?"

4. Don't rely on private-payer audits to find your mistakes.

There's a tendency among some organizations to pass on the internal audit and instead wait to see what private payers say in their audits of files. This is a mistake, Davis says.

"They're relying on external auditors to tell them what's wrong, and I don't think that's appropriate, because the only thing Blue Cross is auditing is their own charges. These people are doing audits only of their own stuff, and they're arguing reimbursements on a case-by-case basis, and that's not research," she adds.

Also, OIG audits aren't the only government audits for which an organization should be prepared, Davis warns.

Confidentiality issues will be the subject of future audits as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), she notes.

"You have to look at all areas of exposure, including privacy issues and how the department stands between the outside world and patient records," Davis says. "Understand HIPAA regulations, and don't wait for someone to tell you what to do."

5. Take care of the details and remain calm.

Look at the documentation times that will have an impact on payment, and make certain the charts are in terminal digit order and are filed correctly, Davis says.

"Also make sure you have the support system within your organization to address the findings you might have, and that's where multidisciplinary issues come in," Davis says. "HIM professionals need to be on board by either leading the charge or participating in whatever activities are going on."

OIG auditors — who may be lawyers, former hospital administrators, or accountants — know the language of auditing and are familiar with HIM professionals' work. So dealing with an auditor can be intimidating.

"Everyone I know who's had an OIG audit said it was a total surprise," Davis says. "I've heard stories of people who had agents come to their home, and they make it more nerve-wracking than it needs to be because they don't want you to do anything before they get there."

This is why HIM professionals must remain calm, call their supervisor if they are permitted to do so, and obtain corporate counsel as soon as possible, Davis says.

"They may not let you make these telephone calls, so you should check the auditor's identification and documentation, and then make the calls as soon as you can," she adds.

Also, staff need to be trained on an ongoing basis not to speak with auditors. If an employee greets an auditor, the employee should refer the auditor to the director of the department so all information is filtered through a central person.

"When I was an auditor, I always wanted access to the staff because that's where I got all of my information," Davis says. ■

Contracts help prevent legal, regulatory issues

Consultants should focus on contract specifics

HIM consultants often have informal relationships and agreements with health care facilities. While these usually work out fine, there always is the possibility of a lawsuit or regulatory problem.

To prevent potential problems, the best policy is to have a contract in writing that outlines the consultant's specific duties and performance goals, says **Marie C. Infante**, JD, MS, MBA, RN, senior counsel for Mintz, Levin, Cohn, Ferris, Glovsky & Popeo in Washington, DC.

A report by the Office of Inspector General (OIG) last year discussed consultant liability with regard to upcoding and gaming issues, and this is another reason that a consultant's contract should be detailed in writing.

"Hiring a consultant does not relieve a facility of the ultimate responsibility as far as compliance with regulations, but at the same time, the OIG

may be looking at the consultant," Infante says. "And unless specific performance expectations are written into agreements as far as results, etc., you're at risk of having a dissatisfied customer."

Infante offers these suggestions for how HIM consultants can best manage their contractual relationships with health care organizations:

• **Agree on assigned services.**

What often happens is that a consultant and a health care organization have different ideas about what the consultant will do, and this can lead to misunderstandings and a soured relationship. A contract that outlines both parties' expectations can prevent this problem.

"One thing consultants should be doing in terms of managing relationships with clients is to make sure both parties agree to assigned services," Infante says.

These services will be specific to the individual consultant, but may include record reviewing, monitoring, or making recommendations for documentation improvements.

"An administrator may think you're doing something, and you're not doing it, or you're spending a lot of time on something they don't want you to be doing at all," she says.

• **Set performance expectations.**

Whenever a person is working independently without a supervisor, there are questions about performance that need to be answered on both sides.

For example, the contractor will need to know when he or she will have access to records and whether there will be any obstructions to that access, Infante says.

Likewise, the health care organization may have certain performance expectations that are desired and others that are absolutely necessary, and these should be put into writing.

"Expectations can clearly define what you need to spend as far as time is concerned on the project," Infante says.

For instance, if the health care organization wants the consultant to conduct a 100% chart review of every reimbursement claim received within a certain period of time, then the contract should reflect how many hours per week that task would likely involve.

"Whatever the performance expectation is, you need explicit terms and conditions in the agreement and a clear understanding of what both parties are going to do," she says.

• **Infuse accountability.**

The contract should spell out state and federal standards and regulations, as well as the standards of the particular health care organization. This way, the consultant will know precisely what his or her legal and regulatory requirements are.

Likewise, it should be understood in the contract that the consultant will meet all regulatory standards because the facility will want to hold the consultant responsible.

While it's unlikely that a health care organization will sue a consultant for poor performance, nobody wants a disgruntled client, which is why it's best to have some accountability written into the contract.

"The facility wants to hold the consultant responsible and know what they're paying for, and the contract is a way to infuse accountability," Infante says.

• **Outline payment agreements.**

The contract also should spell out the terms and frequency of payment, as well as what kinds of invoices will be provided and what kinds of deliverables the health care organization will receive, Infante explains.

All of these factors can be written into a contract without the assistance of an attorney, although some consultants and health care organizations may prefer to have legal advice.

"It can be a memorandum of understanding, something put into writing so that everyone says, 'this is what we're going to do and what we agree with,'" Infante says. "This is one simple step to committing things to writing so you have a clear understanding of the expectations on both sides." ■

Using contract law to 'get hospitals paid'

Law firm succeeds with hopeless accounts

What if your hospital could get reimbursement for a procedure even when a required authorization wasn't obtained in advance or when billing wasn't done in a timely manner? How about the premise that if a hospital has provided valuable services in good faith, it's really not fair that it not be paid?

Two Maryland hospitals apparently are on the cutting edge of what some observers say could become a trend among health care organizations

seeking innovative ways to get the reimbursement for care to which they are entitled. Both health care facilities are working with a law firm that specializes in taking denied accounts on which hospitals have thoroughly exhausted all appeals and turning them around, applying the principles of contract law.

After doubling its recovery rate on denied days through a comprehensive internal revenue recovery initiative, Johns Hopkins Hospital in Baltimore realized "there was more hanging fruit," says **Dan Wassilchalk**, MHA, RHIA, director of performance improvement and utilization management. "However, the efforts were very taxing on our staff; because of limited internal resources, we became creative in looking outside." **(See "Hospital gets aggressive in turning around denials," p. 43.)**

A chance conversation between one of the hospital's administrators and a partner in the Towson, MD, law firm of Siegel & Fotheringill, led to the firm working with Johns Hopkins on its denied accounts and ultimately deciding to specialize in the appeal-and-litigation process for third-party reimbursement, he notes.

Less than a year after engaging the firm's services, Wassilchalk adds, the hospital's recovery rate on denied days — which had gone from 10% to 20% as a result of the internal initiative — increased another 10%. Annually, he says, "10% equals a million dollars."

Johns Hopkins has an ongoing arrangement with the firm, Wassilchalk says, and has expanded the effort to include emergency department accounts. "We are soon to move into outpatient ancillaries," he adds.

Firm relies on technical details

"Not every hospital recognizes that something can be done with some of the technical denials," says **Linda Fotheringill**, who, along with Malinda Siegel, is a partner in Siegel & Fotheringill. "There are all kinds of ways to get a hospital paid, using legal principles, if we're able to show the services given."

Fotheringill and Siegel — both of whom were physician assistants "in another life" — consider what they are doing to be "representing the hospital in a contract dispute." Fotheringill explains that what her firm does has nothing to do with the role of a traditional collection agency or outsourcing company. "We don't do form-letter kinds of appeals."

Instead, she adds, "we do an exhaustive review of the medical record. We pull out all the detail on what happened on each denied day, and reconstruct that day. The progress notes might say, for example, 'Vital signs stable, pain improving, drainage decreasing.' With a day like that, we're able to construct a paragraph of data and tell the story of each denied day."

Because as lawyers they are able to do advocacy writing, and as former clinicians they can "read between the lines" to see what happened on a given day of care, Fotheringill says, she and her partner can "take a very aggressive approach" to turning around the denials.

"If we can show that [denied services] were medically necessary, and that if a call had been made, authorization would have been given, using legal principles, we can get the hospital paid," she says. "No damage [to the payer] can be shown. Things happen. Why should the hospital suffer when it gave those services in good faith?"

Recovering 'completely hopeless' claims

St. Mary's Hospital in Leonardtown, MD, which has worked with Siegel & Fotheringill for about two years, has given the law firm the denied claims that it considers "completely hopeless," says **Allen Burton**, the hospital's director of finance. "These are lacking medical necessity, lacking authorization numbers. We have done our best to appeal to the insurance company and had no success."

The reimbursement recovery rate for those "hopeless" accounts, he adds, has been about 19%, amounting to additional revenue of $100,000 per year. Minus the firm's contingency fee, Burton says, the hospital has netted about $80,000 annually.

Like most other hospitals, he notes, St. Mary's also outsources some of its unpaid claims to collection agencies. Those claims, Burton emphasizes, are in a completely different category. "We're giving those accounts to the collection agencies, knowing that some of what we're giving them is truly collectible."

The denied claims appealed by the law firm, he says, represent "money that in the past — because we felt the insurance company was right — we wouldn't have collected any of. I can't stress enough that this is a different niche."

Scott Johnston, technical director for the Chicago-based Healthcare Financial Management Association (HFMA), explains that the approach

is "an up-and-coming practice" that is likely to become more widespread as hospitals with shrinking margins "get more and more into reimbursement and look at getting money any way they can."

Applying the principles of contract law to get hospitals paid is a basic way of looking at the situation, he says. The provider, Johnston adds, is saying, "I gave a service, and I expect to be paid for this service."

"I see it becoming a trend," he predicts. "Once some things are published on this, there will be others that jump on the bandwagon and go forward with it. I think it's a great thing."

Because the law firm works on a contingency basis, Johnston notes, there is no financial risk for the hospital.

'A price to pay for abusive denial practices'

Fotheringill & Siegel recently represented a client in Nevada on a large Medicaid claim that already had been appealed by the hospital. "It was a technical denial, with a very large monetary value," Fotheringill says. After an extensive presentation on the claim's legitimacy, she adds, the Medicaid office continued to deny the claim.

"We asked for a hearing, and they told us no one had ever asked for a hearing before," notes Fotheringill. "They went back and looked at our appeal — the analysis of the law and why the claim should be paid — and [granted the appeal].

"We were prepared to take it all the way," she points out. "That's the part most hospitals don't understand. They don't think about working with a law firm for these kinds of cases."

With managed care claims, Fotheringill explains, "you're bound by the terms of the contract. We look at the terms, interpret, apply the facts, and argue."

One scenario, she says, might involve a case in which the managed care company says it will pay for everything except the last four days of a month-long hospital stay. "If you just take those four days, it doesn't amount to enough money to justify litigation or arbitration."

The firm often is successful in getting cases overturned on a case-by-base basis. "Those we're not successful with, we can track and group by payer, if given permission by the client," adds Fotheringill. "We can bundle those cases and arbitrate or litigate with a group of cases."

A client that allowed the firm to file suit against Blue Cross Blue Shield, she notes, has noticed that there now are fewer denials by that insurance company. "The client believes it's because the payer knows this client is not standing for it, and that there is a price to pay for abusive denial practices."

The reports tracking denials by payer, denial codes, etc., also can be used in managed care contract negotiations, Fotheringill points out. "If you have an attorney looking at the denials you are getting," she adds, "[the attorney] also can be scrutinizing the contracts and can bring to the attention of the billing department the language that is going to cause problems."

A key piece of advice for access managers and all others involved in the billing process, Fotheringill says, is for the various departments to be in communication with each other, rather than "every department being an island." That way, she adds, everyone can understand the impact of the language they're agreeing to." **(See "Pay attention to contract to avoid denied claims," below.)**

Another instance in which a legal principle can be used to reverse a claim denial is when a hospital calls for eligibility verification and is told the patient has coverage, goes forward with treatment, and finds out later that the payer made a mistake and the person wasn't eligible.

"We're able to get paid in many of those cases," Fotheringill says, "because the hospital relied on those representations. There is case law that shows that in that kind of situation, under contract law, you are able to get payment. In a majority of cases, we're able to get payment without resorting to arbitration or litigation." ■

Pay attention to contract to avoid denied claims

Appeal denials, even if a rule is broken

There are several things that access managers can do to help enhance billing efficiency and reduce the risk of claim denials, says **Linda Fotheringill**, a partner in the Towson, MD-based law firm of Siegel & Fotheringill, which specializes in helping hospitals turn around "hopeless" denials.

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DRG CODING ADVISOR.

Motivation and time limit physicians' coding education

Medical decision-making is most important element

In most successful physician practices, the doctor's time is usually fully scheduled, leaving little time for documentation that would meet coding guidelines.

That's why it's a good idea for physicians to seek the advice and expertise of HIM professionals and coders to learn what it is that payers want them to document.

"You need someone who has knowledge about outpatient coding," says **C.B. Daniel**, MD, medical director at Methodist Extended Care Hospital in Memphis, TN.

The typical problem physicians have is they have an established way of approaching a patient visit and of documenting that visit, and it works well for them, Daniel says. "But does it work in a way that the payer signs off on it and says it's sufficient documentation?"

Daniel says the way to make sure your coding meets payer standards is for a physician to solicit an outside independent audit of the charts and documentation. This will show what the strong points and weaknesses are.

This auditor should be someone knowledgeable about outpatient coding, he adds.

"I've been exposed to outpatient and inpatient coders, and they don't like to cross into each other's turf, so you generally don't find anybody who does both jobs at the same time," Daniel says. "It takes a person with a background in outpatient coding guidelines."

Also, physicians will need to know the 1997 documentation guidelines endorsed by Medicare as well as the 2000 guidelines, which soon will be the standard to which they are held.

Other reports to read include the Medicare carrier bulletins and the evaluation and management section of the current CPT book.

Every year, Daniel recommends that physicians read the American Medical Association's (AMA's) coding book's coding principles, which typically has subtle changes from year to year.

The key points that physicians sometimes incorrectly document with regard to coding standards include the following:

- Medical decision-making, which is the most important element for the physician to document, helps to set the proper evaluation and management coding.
- Patient history determines the extent of the exam and justifies the diagnostic work-up.
- Physical exam usually is the least documented of the key elements.

Other elements that should be included in documentation include counseling, coordination of care, nature of the presenting problem, and time of the visit.

Keeping these key points in mind, these are the misconceptions and problems many physicians have with their documentation, Daniel notes:

1. Deciding who takes the patient history.

Physicians sometimes incorrectly assume that they must take each patient's history themselves, but this is not true, Daniel says.

"The guidelines allow you to do a past history and a social history and have it collected by someone else, with the doctor signing off on it," Daniel explains. "Some offices have computerized forms that the patient can fill out at a computer terminal, or an office person can bring the patient back and interview the patient to see why the patient is there and what the history is."

2. Determining how much information is needed on new patients.

There's quite a bit more documentation required when you're seeing a new patient. On each new

patient, a doctor must document the patient's history, the physical exam, and the medical decision-making element.

"To establish payment on existing patients, you need only two of the three key elements to meet guideline criteria, so you call fall off in one area," Daniel says. "But with a new patient, all three areas have to met the level of an evaluation and management visit that you're billing for."

Suppose a new patient comes in and the physician takes an extensive history and an extensive exam. Both are documented and straightforward, but the diagnosis is skin rash or poison ivy. The payer won't pay for the extra work the physician put into the history and physical exam.

"There's a higher standard for documentation for new patients, and the physicians need to understand that," Daniel says.

Instead, what the physician should do is take the new patient's history first and then use that to determine how much of a physical exam is necessary. The more complaints the patient has, then the more extensive the physical exam needs to be, Daniel says.

For instance, a patient who complains of chest pains may have a serious problem that would require a detailed physical exam.

"From a clinical standpoint, you approach a patient one way, but from the documentation standpoint you do it almost the opposite way, which is: 'What was the diagnosis, and what did we do, and how did we get there?'" Daniel explains. "It creates a lot of confusion."

3. Medical decision-making is the art of medicine.

"It's the physician's knowledge of the patient's history and previous medications," Daniel says. "And it's difficult to document the mental steps you went through to make that decision, to meet the criteria."

But under coding documentation guidelines, a physician simply can't say a patient has congestive heart failure or some other diagnosis. The physician has to prove how he or she got to that diagnosis. "It's time-consuming and offensive to physicians," he says.

However, according to Daniel, with computer software and best-practice guidelines, the medical decision-making process can be simplified.

"I have a hand-held computer that I work with now," Daniel says. "If you're an orthopedic surgeon or specialist who sees the same problems over and over, it's easy to buy something that's automated."

For general practitioners, this may be less convenient, so they will have to take the extra time of documenting their medical decision-making process with each diagnosis.

4. Documentation often is lacking basic elements.

Physicians sometimes fail to document their review of systems, which is the history in which a patient is queried about different organ systems to determine whether the patient has any complaints or problems. These include such conditions as blurry vision, double vision, and difficulty in hearing.

Most of the time, the physician will get to know the patient and make informal queries during the consultation, such as, "You don't look good. Have you lost weight, or are you hurting?" Daniel says.

Dictate informal consultation into chart

"Most of the time, that sort of informal consultation doesn't get dictated in a formal manner into the chart, and it needs to be," Daniel adds.

Likewise, the coordination of care needs to be documented. "In a primary care physician's office, that means you're the guy who's responsible for everybody else's action or inaction," Daniel says.

When a patient is referred to a specialist, who then sends a report back to the primary care physician, it will be necessary for the primary care physician to spend time to discuss the report with the patient. The same is true when the primary care physician is the one who gives the patient test results from another site.

"Primary care physicians do this day in and day out, and we don't even consider that this is something we could be reimbursed for," Daniel says. "But we can be reimbursed, and this could contribute to a higher level of visit."

Physicians sometimes also fail to properly document the nature of the presenting problem. This documentation should answer the questions: Why is the patient here today? What is the problem?

"Say it is a routine case of diabetes or hypertension. Then the physician could document that the patient is there for further evaluation and management of diabetes or hypertension," Daniel says.

Stated that way, the payer won't argue with the need for a physician to see such a patient on a routine basis.

5. Document time spent with the patient.

Whenever a physician spends a lot of time counseling a patient or explaining a patient's problem, then there's a cost in time that should be documented.

"Document the time you spend, because it will support your reason for documenting the visit at that level," Daniel advises. "Say the patient has chest pain and needs a cardiac catheterization, and the patient brings in his children who want to know why their dad needs that heart catheterization."

Explaining the procedure and the need for it to the children takes time that should be documented. "You could simply say, 'The patient was seen at a visit today, and the family was counseled about the need to proceed with a heart catheterization, and the total time was 30 minutes,'" Daniel explains.

"If you do a level of visit in less time than is allocated, you're not punished," Daniel adds.

Likewise, physicians should always document when they go over the allocated time, Daniel says. ■

New coding system saves small facility time, money

Rural hospitals gain by technology, too

Odessa (WA) Memorial Healthcare Center is a small 55-bed facility. Despite its size, the facility uses high technology to help it provide the best care in an efficient manner. That even goes for the coders who work in billing, says **Judy Iverson**, medical records associate for the hospital.

"In the past, I needed to spend an average of 20 to 30 minutes looking through two different books to find the right DRG codes," she says. "Now I simply type in the general category of the diagnosis, such as fracture, and the program provides me with the short list of all the possible DRGs."

Iverson picks out the primary diagnosis, uses the same approach for any secondary diagnosis, and even has the option of choosing complications and comorbidities from the program. Finally, the program prints out an attestation ready for signature by the doctor. "The entire process takes only minutes, saving me several hours every day that I can spend on other important tasks."

The hospital long had known the benefits of good computer systems. It had been using Hospital Information Systems software from Sterling Systems in Downey, ID, for billing, accounts receivable, accounts payable, and general ledger. Iverson says the menu-driven software package is easy even for the beginning user, or can be command-driven by more experienced users. All functions are completely integrated. On the other hand, coding until very recently had been a tedious manual process.

"It's not an easy task finding the right code in an ICD-9 reference manual, even for an experienced coder," Iverson explains. "The first problem is deciding the best keyword to go to the index with. Very often, the index directs you to the wrong page or merely to another index entry.

"The less common diagnoses, especially, can really take quite a bit of time to track down. While I have enough experience that I can nearly always find the code, this presents a major problem whenever someone new is assigned to the task. For the first months, this job can be an exercise in frustration, and productivity is inevitably at very low levels."

Management knew there was a problem and had considered purchasing a computerized program in the past but always ran into the same two problems. The first was the cost of the software, which could easily run to several thousand dollars per month. The second was that some of the software packages that the hospital evaluated were so complicated that they almost made using the reference books look easy, according to Iverson.

Among the companies the hospital had looked at in the past were CodeMaster, AMA CodeManager, and Cascade Health Information Software. "They just weren't cost-effective for small hospitals," she says.

When Iverson heard from a friend in another rural hospital about Clinical Coding Expert, a program from IRP Systems in Billerica, MA, she decided to check it out. "The software only costs less than $500 per month, putting it more within our price range," she says. The company sent the facility a demonstration to try out, and Iverson found it very easy to use.

At the same time, the other software company the hospital uses, Sterling Systems, decided to select Clinical Coding Expert to

develop an interface to make it possible to move the codes selected with the system into their billing software.

"It wasn't a very hard sell to management then to purchase the system," Iverson says.

StreamIining the coding process

Iverson says she has saved 50% of her time through the new coding system. She opens the IRP software and types in the basic patient information, such as name, age, sex, discharge status, and admission and discharge dates. The program automatically fills in fields such as the Centers for Medicare and Medicaid Services hospital identification and provider number.

The F2 button opens up the diagnostic area of the program. "I type in the general category of the patient's diagnosis, such as pneumonia," she explains. "As you start typing, the program moves to the first selection that matches the letters you have entered so far. Often you can get to the right category by typing just a few letters."

The program instantly selects all of the codes that have anything to do with the phrase entered and presents them in a list. Almost every time, Iverson says, the proper diagnosis is on the list, and all she has to do is highlight it. She notes that it is rare that she has to enter category a second time, usually due to an obscure term entered the first time.

If the coder needs a fourth or fifth digit, the program provides various options. For instance, if Iverson types in the word "fracture," the program will list all diagnoses that involve fractures. A secondary term usually shoots her to the right spot. But if not, she merely has to choose from a list rather than try to figure out how to spell words such as acetabulam.

"Once I have selected the primary diagnosis, I enter another category for the secondary diagnosis. This process works exactly the same as selecting the primary diagnosis," Iverson explains. The secondary diagnosis for the fracture might be osteoporosis. "I only have to put in three or four letters before the program gets me to the right choice. This is much, much easier than trying to figure out under which term the diagnosis is indexed in the reference manual. Once I'm satisfied that I have all the right codes, I just hit F2 again and the program inserts them all into the form."

The most common complications and comorbidities for a particular primary and secondary diagnosis are provided on the screen — something Iverson says is much simpler than trying to identify them from scratch in a reference manual. The list usually contains around 30 items, arranged in order of frequency. "It's usually just a matter of picking the right ones," she says.

Another stroke of the F2 key, and Iverson is back to the summary screen. The program calculates the estimated reimbursement based on the weight of the DRGs and the patient length of stay. The information is entered into the records, and Iverson can print out an attestation form for the physician. No more typing of forms or making copies for the charts. "It also provides an audit trail of exactly how the codes were determined in case anyone asks."

Iverson can spend more time working on transcription, credentialing, utilization reviews, and billing. She also says coding is more accurate now. "The choices provided by the program — particularly the complications — make it much harder to overlook something," she says. ■

(Continued from page 38)

Here are Fotheringill's suggestions:

• **Know the rules for each payer with regard to billing and appeal requirements.**

If the payer contract indicates that the hospital will abide by all policies and procedures of the payer, find out what these are. If the contract incorporates the "provider manual" by reference, get a copy of the provider manual. It is her experience, Fotheringill notes, that many hospitals don't even know where that manual is, much less are prepared to follow it.

For future contracts, insist on attaching the applicable policies and procedures to the contract. State that the hospital will not accept any changes unless they are agreed upon separately in writing by a designated hospital representative.

"Many hospitals have signed contracts that virtually give the payer carte blanche, and are operating under terms they're not even aware of," she points out.

• **Identify and appeal all nonpayments, denials, and underpayments, even if the hospital has made a technical error, such as not getting preauthorization or failing to bill in a timely manner.**

"If a rule has been broken and you're not getting payment," Fotheringill says, "under contract law, there still could be a remedy whereby the hospital could get paid for valuable services." ■

Hospital gets aggressive in turning around denials

InterQual helped with appeals

Before engaging a law firm to take the appeal of reimbursement denials to the next level, Johns Hopkins Hospital undertook a comprehensive revenue recovery initiative that doubled its recovery rate on denied days, says **Dan Wassilchalk**, MHA, RHIA, director of performance improvement and utilization management.

Wassilchalk was hired in July 1998, and in January 1999, he says, the hospital began what it called "rapid-cycle process improvement."

As part of that initiative, he says, "we learned that we were leaving millions of dollars on the table for care that had already been provided for which we were not being paid. Our department took a much more aggressive stance internally and externally in reducing denials and appealing them, as well as in working old appeals pending response."

During the process, Wassilchalk notes, "we learned that by writing a better [appeal] letter, and concentrating on improved clinical documentation, we doubled our rate of overturning denied days." Between fiscal year 1999 and fiscal year 2000, he adds, the rate went from 10% to 20%, which represents an annual increase of $1 million.

Another way of discounting services

Many hospitals are not aware, Wassilchalk points out, of their denial or recovery rate or of the ratio between clinical and administrative denials. "It's scary not to know what they don't know," he adds. "Some do not have a data collection process on denial management to have their arms around their denial losses."

It's important to realize, Wassilchalk says, that denials, in reality, are another way of discounting services. "So any time your managed care contracts reflect certain negotiated rates, you might as well consider denials an additional discount — and we can't afford it."

The first step hospitals should take in addressing the problem, he suggests, is to "find out how bad you're hemorrhaging from denials. Work closely with the accounting office to establish a tracking mechanism."

"Through typical root-cause analysis process," Wassilchalk adds, "come up with an action plan that would include a strong data collection process, an aggressive approach to appeals, and then a proactive plan to work internally with the care providers to document better and uncover delays in service."

In November 1999, the performance improvement and utilization management department at Johns Hopkins began using InterQual criteria to appeal denials and improve documentation, he says. InterQual, a product of Atlanta-based McKesson HBOC, helps providers measure intensity of service and severity of illness, Wassilchalk adds.

Before turning to a Towson, MD, law firm **(see "Using contract law to 'get hospitals paid,'" p. 36)**, he explains, the hospital first looked internally for help. "We gained some assistance from

other departments that were employing nurses who were looking for part-time work. We also turned to nurses on workers' compensation who were on light duty."

"When we realized we couldn't handle the volume and could use some assistance in interpreting the appeals and grievance process, we turned to Siegel & Fotheringill," Wassilchalk says. "After the word got out a little bit, a couple of other hospitals started turning to them for similar services. Without a doubt, we broke new ground in working with them on this." ■

New health care IT options only the tip of the iceberg

HIMSS conference highlights high-tech solutions.

The "tip-of-the-iceberg" cliché got quite a workout at the recent 2002 annual Healthcare Information and Management Systems Society (HIMSS) Conference and Exhibition held at the Georgia World Congress Center in Atlanta on Jan. 27-31.

In his presentation, "Using Information Systems to Screen for Adverse Events," speaker **R. Scott Evans**, MD, used the iceberg-tip example to detail his experiences implementing computer information systems for the LDS Hospital and Intermountain Health Care organization in Salt Lake City.

"A wealth of information is already there," Evans said, pointing to a slide of the proverbial mostly submerged big block of frozen water. "[With] all events reported, you're going to get the tip — 99% of it is down here, and we just had the little tip up here."

While computer systems monitor a number of patient outcomes, such as clinical events and infectious diseases, adverse event monitoring has experienced a significant boost largely due to an improved process and advanced technology. The need further has been heightened by the Institute of Medicine report pointing to thousands of deaths each year in the U.S. as the result of medication errors. That report continues to be the bellwether document pushing better tracking of such events.

"The only way we found out about adverse drug events was [through] the nurse," Evans said. "The nurses had to fill out the incident report, they had to determine or put down what happened, what the clinical manifestations were, what they did to treat the problem — and fill all of that out on a regular sheet piece of paper. And then you had to have the attending sign it and the nursing supervisor. So after all that time and hassle, we only had nine or 10 adverse drug events [reported]."

Pharmacists quickly experienced the benefits of the new computer tracking system.

"It became very apparent to pharmacists that about 50% of the time, doctors were not [seeing] appropriate clinical manifestations of an ADE or a drug," Evans said. "Quite often they thought it's another underlying problem. So what would they do? They would order another drug."

At another presentation, called "Improved Medication Management," **Dennis Regan**, MD, expounded on the benefits of streamlined interfaces between physicians and pharmacies. As the medical director of information services, Regan has spent the last couple of years establishing such a system at the Deaconess Billings Clinic in Billings, MT, which serves a patient population stretching from Montana into the Dakotas and Wyoming.

His first task was correlating various sources of reference.

"We had hospital information systems you could hook upon, and we had transcription," he said. "We had hospital notes, hospital discharge, clinic notes. So looking back at the repository, you can really see what happened."

The challenge of changing habits

Implementing software to handle the information was not a major difficulty, Regan said, but changing practices and habits was more of a challenge.

"The problem was this was a huge change in the way people do their medication [transcription]," he said.

But the new system drastically reduced the prescription refill process, which Regan said often took in excess of six hours. It didn't take long for doctors and nurses to change their habits.

"Basically, we had 100% adoption by the time six months rolled around, meaning that nursing staff was doing it essentially 100% of the time," he said. "If you recall, it took six hours and 32

minutes [for the manual refill process] — it took the computer refill request down to one minute, 34 seconds. Instead of 3.2 calls per request, we were down to 1.4."

Obvious improvements to immediate patient care notwithstanding, the more accurate computer systems resulted in a number of other benefits. Emergency rooms, for example, often operate without access to patient charts if one is admitted after clinics or offices are closed for the day. Computer network access allows emergency doctors access to a patient's history, ultimately saving them time from the beginning.

Evans also pointed to fewer incidences of unnecessary antibiotic prescriptions. In Regan's examples, overtime for nurses dealing with prescription refill requests was markedly reduced. Improved legibility and computer decision support also point to improvements.

All the data seem to indicate the benefits of streamlining such processes.

"The people we've done this with make it worthwhile," Regan said.

After all, it appears the end result is helping the health care industry get beyond the tip of the iceberg. ■

Countywide 'paper drill' helps keep hospital ready

Registrars staff treatment areas

Personnel at Morton Plant Mease Hospital in Clearwater, FL, regularly take part in a countywide mass casualty drill, which keeps them in "a constant state of readiness," says **Diana Noblet**, CHAM, patient access services manager.

"We feel confident we're ready," Noblet adds. "We have looked at our disaster process and not found any changes desirable."

The countywide exercise is "a paper drill," notes Beth Hardy, a spokesperson for the hospital. "We use paper patients — actual slips of paper — instead of having mock patients with stuff on them. Each piece of paper is a patient."

The disaster drill, most recently involving a mock school bus accident, is set by county emergency management officials, and "different patients are routed to different hospitals," Hardy says. "We know we have seven children coming in, and we walk through the entire process of how it would be [in the event of a real disaster]."

Directly outside the ambulance entrance to the emergency department (ED) there is a disaster cart, explains Noblet. "It contains things to physically protect the [response] team, such things as eye protection, personal protective gear, a mask and gloves. There is also a packet for each patient."

The packet, she adds, contains "paperwork to handle any type of emergency," including a triage sheet and all clinical profiles, as well as a bag for patient valuables. A number assigned to each item matches the number assigned to that patient on the log where the patient is checked in, Noblet says.

"That packet and patient are passed along to a clinician who accompanies the patient to different treatment areas," she says. Registrars are on hand in those areas, as well as at the triage point, Noblet adds.

Patients who are unable to give their names are designated as Jane or John Doe, and assigned an approximate age, she notes. Those patients' date of birth always begins "1/1," she says, to let hospital personnel know the age is approximate.

New ED facilitates process

Morton Plant Mease Hospital's new emergency department (ED), which opened several months ago, is designed so that triage takes place quickly and efficiently, Hardy points out. "Our daily process facilitates the handling [of a disaster]."

Patients are triaged into one of five ED areas, she says. Those include express care, intermediate care, acute care, psychiatric care and obstetric/gynecologic care.

"The triage nurse is adjacent to the lobby, where the public walks in," Hardy explains. "As they walk in, patients are seen by order of severity. It's not the traditional setting where people are sitting in a chair waiting for a long period. The goal is not to have people in that lobby, but to get them into a room as quickly as possible."

When emergency medical services personnel arrive with a patient, they look up at a computer screen that displays the assigned room number for that patient, Noblet notes. "There are no ambulances lined up. They know where to go."

A yellow light above a patient room signals the registrar that a patient is in the room, she says.

Because the ED encompasses 37,000 square feet, she adds, "it's humanly impossible to see all the rooms and watch for someone entering."

There is a computer in every patient treatment room, Hardy points out, which allows bedside registration. "[Access staff] go to every patient, and register right at the bedside. It's been received very, very well by our customers," she says. ■

'HazMat situations' keep access employees on alert

'Phone tree' keeps staff in reach

At Straub Clinic and Hospital in Honolulu, "we've had our fair share of HazMat situations," says **Linda Dullin**, RN, admitting director.

In little more than a week's time, around the middle of October 2001, she says, the hospital was on alert to handle some six incidents involving hazardous materials, although not all resulted in victims being treated at Straub.

DISASTER PLANNING AND BIOTERRORISM

"Right at the time when there were a lot of things going on nationwide," Dullin says, "we had a situation in one of the hotels with a chemical exposure. We got nine people."

With nine patients to handle at once, only two computer terminals in the emergency department (ED), and "physicians calling for their information," she notes, staff recorded initial registration information by hand and entered it into the computer later. "We have clipboards ready and [disaster] logs available."

"Our procedure is that patients go through triage with the medical staff," Dullin explains. "Depending on the time of day, we have one of the access staff there. Otherwise, we do the best we can. We use the medical staff to gather the initial information."

In another incident, she says, a canister exploded in the back of a refuse truck, and the driver and two other people came in contact with a hazardous substance. "We treated one of the three men involved, and the HazMat team [for the city and county of Honolulu] provided us guidance."

Following the release of a potentially hazardous substance at a school, Dullin says, her staff prepared to receive some patients, but the HazMat team was able to handle that situation on the scene.

To respond to exposures to hazardous materials, Straub has a portable decontamination shower set up in the ED parking area, just off the ED entrance, she notes.

"One of the things we've identified on the admitting side," Dullin says, "is that we need to have preprinted stickers with the downtime visit numbers and downtime medical record numbers that we can use if the computer is down or if we need to register by hand." Those stickers, she explains, would be used to identify "lab work, blood tests, anything ordered for the patients. At the moment, we write the number on the requisition itself."

Normally, Dullin notes, staff would use an Addressograph to imprint such items with the patient's name and other basic information, "but [in disaster situations], you don't need a name as much as a visit number."

Even before the Sept. 11 attacks prompted a heightened sense of awareness, Dullin's department had established an emergency preparedness phone tree, she says. "We made sure we had employees' names, their emergency contact, phone numbers, where they lived, and any special considerations, such as whether they had children, only one car, or parents living with them."

On a second list, made after Sept. 11, the employee names were tiered, according to who lived closest to the hospital and how long it would take them to get to the hospital, Dullin adds. "We break [staff] up into three groups. The first group includes myself, the supervisors, and the leads on each shift, and the second and third groups are all front-line access staff." ■

HFMA, AHA project puts focus on patients

'It's about little things'

As hospitals try to make bills more patient-friendly, they should broaden the focus to include a more patient-centered organization.

That's a key theme that has emerged from the Patient Friendly Billing Project of the Healthcare Financial Management Association (HFMA) and the American Hospital Association (AHA), says **Scott Johnston**, HFMA's technical director.

"We went into this looking at, maybe we could blame somebody else for these problems, but we found that we also have to look at ourselves," Johnston adds. "The solution lies not just with the industry as a whole, but also with the individual hospitals."

Initiated more than a year ago, the project's aim has been to address the general sense among consumers that the health care billing system is out of whack, using a multidisciplinary approach to help providers convey bills that are clear, correct and patient-friendly, says HFMA president and CEO **Richard L. Clarke**.

That approach includes, among other things, a process that captures and summarizes bills from all providers and automatically matches them with all payments, a single point of contact for the consumer regarding inquiries, complaints or concerns about coverage and payments, and an appeals process to handle disputes.

"We've completed our first year, and we've released not only a series of reports, but a brochure, and we've also launched a web site," Johnston says. **(For more information on the project, go to www.patientfriendlybilling.org.)**

Not always about clinical outcomes

Feedback from the project's focus groups — and from focus groups conducted by individual hospitals — revealed that the way consumers look at health care isn't always about clinical outcomes, Johnston points out. "You can have good performance results, but if the food is lousy and no one is paying attention, that may negate [in the patient's mind] anything good the clinician has done."

The benefit of the focus groups, he notes, is in "finding out what patients' concerns are and then addressing them, listening more, and getting more in tune with patients." Just taking other hospitals' findings and acting on them doesn't accomplish the same thing, Johnston says , who recommends that all hospitals use focus groups or patient advocacy groups as important resources.

It's about "little things," he says, "like not making popcorn in the employee lounge that cancer patients have to walk by, because the smell upsets those who are going through certain treatments. That was driving some of the patients nuts."

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Editorial Questions

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Another example, Johnston adds, is informing patients that there are two ways to get into the hospital parking lot that they don't know about unless they're told.

"The idea of the consumer in health care is very new," he says. "It's the idea that patients have a choice and they're going to start exercising that choice."

Patients feel 'caught in the middle'

Reaction to the billing project from payers and vendors has been that it's unique for the health care industry to be focusing on patients for once, Johnston notes. "When you think of patient financial services, you think of going back and forth between hospitals and payers. But we have found that patients perceive themselves as being caught in the middle without any help."

"The whole idea behind patient-friendly billing is to address that," he adds. "We feel this is a very important initiative for all hospitals to consider. This is something we can kind of give back." ■

Hospitals get breather on 2001 OPPS rates

'Technical miscalculations' cited

In what is welcome news for access managers, the Centers for Medicare and Medicaid Services (CMS) announced in late December 2001 that the 2002 Medicare hospital outpatient prospective payment system (OPPS) rates will be postponed until the agency conducts a review of the rates and codes announced Nov. 30, 2001 in the final regulation.

Hospitals will be paid at the 2001 OPPS rates until CMS finishes its review, which the agency said would not extend beyond March 31, 2002. CMS also said it will process claims subject to OPPS for dates of service of Jan. 1 or later using the 2001 payment rates, while it continues to review the 2002 rates and codes announced in November.

Claims will be processed in a timely manner rather than being held for three months, the agency said.

The move comes after several health care entities, along with health care leaders in Congress, sent letters to Health and Human Services Secretary Tommy Thompson and CMS administrator Thomas Scully requesting the delay to avoid unnecessary confusion to providers and beneficiaries.

Since issuing the final regulation, CMS discovered a number of technical miscalculations in the assignment of the cost of certain new technology devices to related procedure codes, according to a news release by the CMS public affairs office.

Thorough review to follow corrections

Once the corrections are made, CMS will do a thorough review of all outpatient codes with medical experts and again review the data to make sure there are no additional calculation errors, the release stated. The revised rates and codes then will be published in the *Federal Register*.

There are more than 300 ambulatory payment classification codes (APCs) for outpatient services and 53 APCs that involve new technology devices. ■