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INSIDE

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2002 Reader Survey

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Don't delay, HIPAA expert cautions; Use extension to work with vendors

Extra time isn't automatic — you have to file request

Despite a bill extending the deadline for implementation of the Health Insurance Portability and Accountability Act's (HIPAA) electronic data interchange (EDI) provisions from Oct. 16, 2002, to Oct. 16, 2003, don't just assume you have the extension.

Hospitals still have to file for it, cautions **Liz Johnson**, RN, MSN, CHE, executive vice president and national HIPAA practice leader for Houston-based Healthlink, a health care consulting firm. U.S. House bill 3323 also requires that the extension request be accompanied by a proposed budget for HIPAA, she adds.

Actually providing specific dollar amounts would be difficult, Johnson notes, since the extension has to be filed by Oct. 16, 2002. Providers may not know how much they'll need to spend, she says. "If the vendors can't tell us how much it will cost, how can we tell the government?"

"I think the point [of that requirement] is that you are recognizing there is a potential need to spend money," Johnson says. "Are you prepared, if appropriate, to spend budgetary resources?"

Because the bill does not provide for the review of budgets, she adds, Johnson suspects that what will be required is "some kind of attestation or affidavit that you're going to do these things."

The Centers for Medicare & Medicaid Services (CMS) is expected to provide a template for EDI transactions by March 31, 2002, Johnson says. "CMS is pushing hard to have entities file electronically."

Computer software vendors, meanwhile, are doing better in terms of HIPAA preparation, she adds, noting that Healthlink is monitoring the status of 910 vendors. "I feel better about the action we're seeing from major vendors. They're realizing they're going to have to do it. We're getting more substantial answers and are seeing things I think are reliable."

Still, Johnson says, the situation comes down to two primary questions: How much will it cost providers to make the necessary system modifications, and exactly when will it happen?

"Some [vendors] say, 'We'll be ready,' but it's like, 'You'll be ready for *what?* Are you going to do strictly claims submission for institutional claims, or are you ready to do whatever we can do?'" Johnson says she suspects most major vendors will be ready to submit claims (forms 837I, 837P, and 837D) and receive electronic remittance advice (form 835).

Providers need to pay particular attention, she points out, to the fact that the new process calls not only for a new format, but for additional information to be gathered.

"What's interesting is that the 837I (the form hospitals will complete under the new EDI billing standard) has 160 elements we've never collected before," Johnson says. "That's more than just reformatting. Providers need to collect those."

That means vendors will need to provide a place to record the new data, and a process for doing so, she points out. "[Providers] need to list the new data elements and then have the vendor tell them where they will go in the system. What's being perceived out there is a simplification of what really has to be done."

"Some [providers] think the vendors will do it all," Johnson adds. "But many vendors don't realize how many new elements there are." Another issue, she says, is *where* the data will be collected. "Most of it will happen at registration, but some information is clinical in nature."

The prevalent perception of hospital personnel with whom she works is, 'It's not an issue — my vendor will get me what I need,'" Johnson says. "But the question is whether the vendor even knows."

Providers should inform their vendors that they will begin testing for HIPAA compliance by April 2003, determining their ability to send a bill to a payer electronically, she suggests.

Johnson advises access managers and other hospital professionals not to think of the EDI deadline extension as a delay. "It really only buys you six extra months [because of the need to do testing], and you need the time because the vendors are not really ready," she explains. "Take the opportunity to get your organization ready and be cognizant of [the vendor issue]."

"We're still getting sunset notices [from some vendors]," Johnson adds, "telling [providers] they're not going to support changes. You need to verify that your vendor will be ready."

Providers should work out a schedule with payers, ensuring that they will cooperate in the testing process, she notes. "You can't just test a system without being able to send to somebody."

Privacy rule won't be delayed

Despite widespread speculation that the effective date of the HIPAA privacy rule would be delayed along with the EDI standard, Johnson says that will not happen. "The bill specifically states that it will not be delayed." Implementation of the privacy standard is set for April 13, 2003, she notes.

Since the Sept. 11 attack, Johnson says, the government's focus, understandably, has been on national security, and the work on HIPAA slowed down for a time. But the need for individuals to protect their personal information "is even clearer today," she points out.

As far as implementation of the HIPAA privacy provisions is concerned, Johnson says it's time to swing into action. "We know the first deadline is for privacy now, and [providers] need to move into that mode, recognizing the need for policy and procedure changes and new authorization and consent procedures."

"When you get those figured out," she adds, "you need to train people. So don't stop anything you're doing for EDI, but also get ready for this part. It all goes hand in hand now, so you really have to work on both concurrently."

[Editor's note: Access managers with specific questions regarding their hospitals' implementation of HIPAA provisions are encouraged to send them to Hospital Access Management. *As the deadline for HIPAA compliance approaches, we will publish the questions with answers provided by experts in the field. Please send queries to Lila Moore at lilamoore @mindspring.com, or call (520) 299-8730.]* ■

COMING IN FUTURE MONTHS

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Exhaustive record review fuels law firm's approach

Willingness to take appeals to 'next level' is key

Hospitals only can go so far in reversing payment denials until they're willing to arbitrate, contends **Linda Fotheringill**, partner in a Towson, MD, law firm whose specialty is using the principles of contract law to get hospitals paid.

The cover story in the February 2002 issue of *Hospital Access Management* described the successful experiences of two Maryland hospitals that engaged the law firm of Siegel & Fotheringill to go after denied accounts on which all appeals had been exhausted.

Below, Fotheringill responds to the questions of several *HAM* readers who asked for more information on the process used by her firm.

Question: Is the process used in your firm only for commercial insurance denials, or has it also been applied with success to Medicare and Medicaid cases?

Answer: It has been applied with great success to Medicare and Medicaid cases. We do the appeals, handle them as with any other case. For the most part, the cases we get are denials of medical necessity or inappropriate level-of-care denials, although we do get some technical denials. We do an exhaustive review of the records. It's a very detailed, very specific appeal, and we're very successful at getting them overturned at the appeal level, assuming the appeal is filed in a timely manner.

In Maryland, the [time limit for appeals] is 30 days from the date of the denial for Medicaid, and 60 days for Medicare. When the case is not resolved to our satisfaction at the appeal level, sometimes we negotiate. Say four days have been denied, sometimes they say, "We're willing to pay for two; but with the last two, we think [the cases] truly did not justify an acute level of care." We might be willing to settle for something in between. Sometimes we agree to take a certain number of days at the acute level and some at the administrative rate. Sometimes we feel strongly that we should proceed.

At any rate, when we are not happy with the result, we go to the next level and request a hearing. We think that is relatively unusual. I certainly don't know of any firms doing this on the East Coast. We have had tremendous success with Medicare. In Maryland, the Medicaid Office of Administrative Hearing has been rather adamant about not giving in before the hearing. We're starting to see them recognize that we are very serious about our cases, that we are willing to go to the mat, and they're becoming a little more willing to evaluate our appeals.

Question: How many of the cases you handle are related to admissions through the emergency department (ED)?

Answer: We've handled hundreds, if not thousands, of ED cases, and have had tremendous success with [turning around] ED denials. There are two kinds — those where the services are flat-out denied and then, more often, those where the cases are denied based on the final diagnosis code. What we are seeing is, for example, a patient who comes in with abdominal pain, is evaluated, has blood work and an ultrasound, and the final diagnosis is dysmenorrhea, constipation, or some other benign diagnosis. As matter of course, we've found many payers are denying cases based on the final diagnosis code.

The most dramatic example of this we've handled is a case in which the diagnosis code was something that meant "cuts and bruises." The case involved a 9-year-old girl who was hit by a car and thrown 30 feet through the air. The physicians were trying to rule out internal injuries so they did a huge work-up. Fortunately, the child was fine, but obviously the work-up was warranted. The payer covered the EMTALA (Emergency Medical Treatment and Active Labor Act) screening fee, which was $30 or $50, and that's all. They denied the rest of the charges. We're very successful in overturning those cases.

ED cases are not a big part of our practice because not all of our clients refer us those cases. Those that do, refer all of them. It depends on how the hospital system is set up. They're usually divided into inpatient and outpatient, and usually focus on the inpatient cases first. Generally speaking, [the dollar amounts of] ED denials are less, but still can be a huge loss. Because each case has a lower dollar amount, the focus isn't there. I'm not sure a lot of hospitals understand there can be a lot of success in overturning ED denials. Because we're able to group cases, and because we have a system where we're able to deal with them in an efficient manner, we're able to work with them even if the amount is low.

Ideally, hospitals have their own system for tracking denials, but not all do. We have a system

for tracking all the cases referred to us, so what we can do for our clients is let them know how many cases were ED denials from a particular insurance company and what the reason was. They can use that in contract negotiations, to go back at negotiation time to seek some better language. If it were me, and I saw a pattern, I would be working out an agreement ensuring that payer does not have a system set up to automatically deny all cases with a benign diagnosis code.

If [hospitals] know up front that a pattern exists, it may be that as a last resort they should have the billing department send records [documenting the case]. The UB92 is not set up to come to a diagnosis based on a "rule-out" — like an ectopic pregnancy, which could be life-threatening. And sometimes rule-outs aren't expressed in the ED records, which are not geared toward getting reimbursement. Some things are so obvious they're not writing them down — like a pregnancy test being given to a young girl with abdominal pain to rule out ectopic pregnancy.

Question: Could you explain more about the fee arrangement you use?

Answer: Everything we do is on a contingency-fee basis, which means it's risk-free to our hospital clients. If we work a case and there is no recovery, there's no cost to the client. There is a range of percentages, depending on the kind of cases we're getting. Some of our clients are sending us a mix of aged accounts receivable (AR) and denials. In that mix, there obviously are easier cases and administrative denials that don't require as intensive a review. Obviously, an aged AR is easier than a case that's been appealed unsuccessfully, where the hospital already has done everything in its power to overturn a denial, including having the medical director of the hospital write the appeal or having the CFO talk directly to the payer. Some clients send only medical necessity and clinical denials, which are all incredibly difficult. So our fee is based on where in the spectrum the case falls, and whether we're incurring all of the risk for out-of-pocket expenses. We have one client we work with for a lower percentage. That client gives us an extremely large volume and advances the arbitration and out-of-pocket litigation costs. [Fee arrangements vary] with community hospitals compared to tertiary centers. Very often a $4,000 case is just as difficult as a $50,000 case.

Question: On what basis do you revoke untimely filing denials when those deadlines are contractually spelled out and the facility doesn't meet them? Is it on the basis of medical necessity? But if that's it, then what good is the clause in the contract?

Answer: It is done on the basis of fairness. When we get an untimely filing denial, we look at what went on. Very often there's a reason. Maybe the patient came in as an emergency, and didn't have an insurance card, and days and months went by before the hospital got the information. Or maybe the patient gave information that was incorrect, the wrong insurance company was billed, and the deadline came and went. We look very carefully at the reason for untimely billing.

We argue for equitable remedies that are available in contract law. These contracts, more often than not, are written so that most of the burden is on the hospital. The hospital must do this, must do that, or it doesn't get paid. On the other hand, what is in that contract that is going to happen to the payer when they make a mistake? It's all one-way, and that's not fair.

Rarely do you see in a contract where there is a penalty to the payer when it doesn't pay in a timely manner. There are prompt-pay laws, but those are rarely utilized. Certainly, we see that payers are making mistakes all the time. Whatever happens to them? Nothing. If it's a large-enough case, even if the hospital did make a mistake, it's worth arbitrating on the basis of contract law.

There is a principle of contract law called *quantum meruit* that is based on fairness. In that case, the hospital would be seeking judgment or payment for the value of the services given before the breach of not sending the bill on time. There's another legal principle based on "unjust enrichment." The bottom line is that it's unjust to have a situation where the hospital provides services, and some minor technical problem occurs. Usually there's a reason, and it's not a common occurrence, so why should the payer benefit from that? It's not a major breach of the contract. It's a pretty minor mistake, and you did save somebody's life.

Most of contract law is based on common sense and fairness. We use those principles to get around [contract breaches]. We wouldn't take just any case based on not getting a bill filed in time, but we usually find a good reason. Even with a pretty large dollar amount, we're willing to argue

common sense. Why should the hospital always be the one to suffer? Some contracts are slanted in the payer's favor, but they can't subtract your legal rights. We're willing to give it a go.

Question: To what extent is your approach dependent on state law? Are Maryland hospitals taking advantage of favorable statutes in their state, or is this a viable alternative everywhere?

Answer: We're always using state law. There are some favorable statutes and case law in our state, but there also are federal laws that are helpful. Most states have statutes that can be helpful to hospitals. We represent hospitals all over the country, not just in Maryland. As issues arise, we research the laws of that state that would apply on a case-by-case basis. There are certain kinds of statutes that we typically see. Some relate to ED services and say no authorization is needed. Some say that if the payer provides authorization, the payer can't go back and retract payment on some basis. There are federal laws regarding payment for mother-and-baby services, as well as prompt-pay laws. Plus, the contract-law principles apply in every state, although they may be interpreted differently. The general principles are there in every state and would apply to every state.

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On-line discharge system is effective tool for access

Payer communication enhanced

A new on-line reservations and booking system is streamlining the discharge process at New York Hospital of Queens in Flushing, where case managers are using the software tool to determine the availability of post-acute services, then request and schedule those services over the Internet.

The system has broad implications for access managers, who can use it to identify a patient who is at risk and automatically trigger a referral to the case manager.

Since implementing eDischarge, a product of Needham, MA-based Curaspan Inc., in mid-January 2002, staff dramatically has reduced time spent on the telephone, enhanced the quality of report writing, and are able to make more precise matches of patients with care facilities, says **Caroline Keane**, RN, MSN, ANP, CCM, director of case management and social work.

Access managers can use the system both to get information on past admissions — which can be particularly helpful with patients who are "frequent admitters" — and for on-line authorizations from third-party payers, notes **Jackie Birmingham**, RN, MS, CMAC, managing director for professional services at Curaspan.

"When admitting the patient, it's good to have a history of where the person is admitted from," Birmingham says. "It's a closing of the loop between access and case management."

The system has a portal, she notes, which can be used to send patient information to payers and receive on-line authorization for services. "The [request for authorization] can go over this secure site and can electronically 'beep' the payer." **(See eDischarge illustration on p. 42.)**

Communication with payers is enhanced, Keane says, in that her staff can take a list of all the facilities within a certain plan and electronically transfer the patient review instrument (PRI) and other information in real time. "We don't have to find a fax machine and fax to five different facilities."

Then, she adds, "we can make one phone call to a managed care company and say, 'This patient has been medically approved by one of your preferred providers. Can I get an authorization number?'"

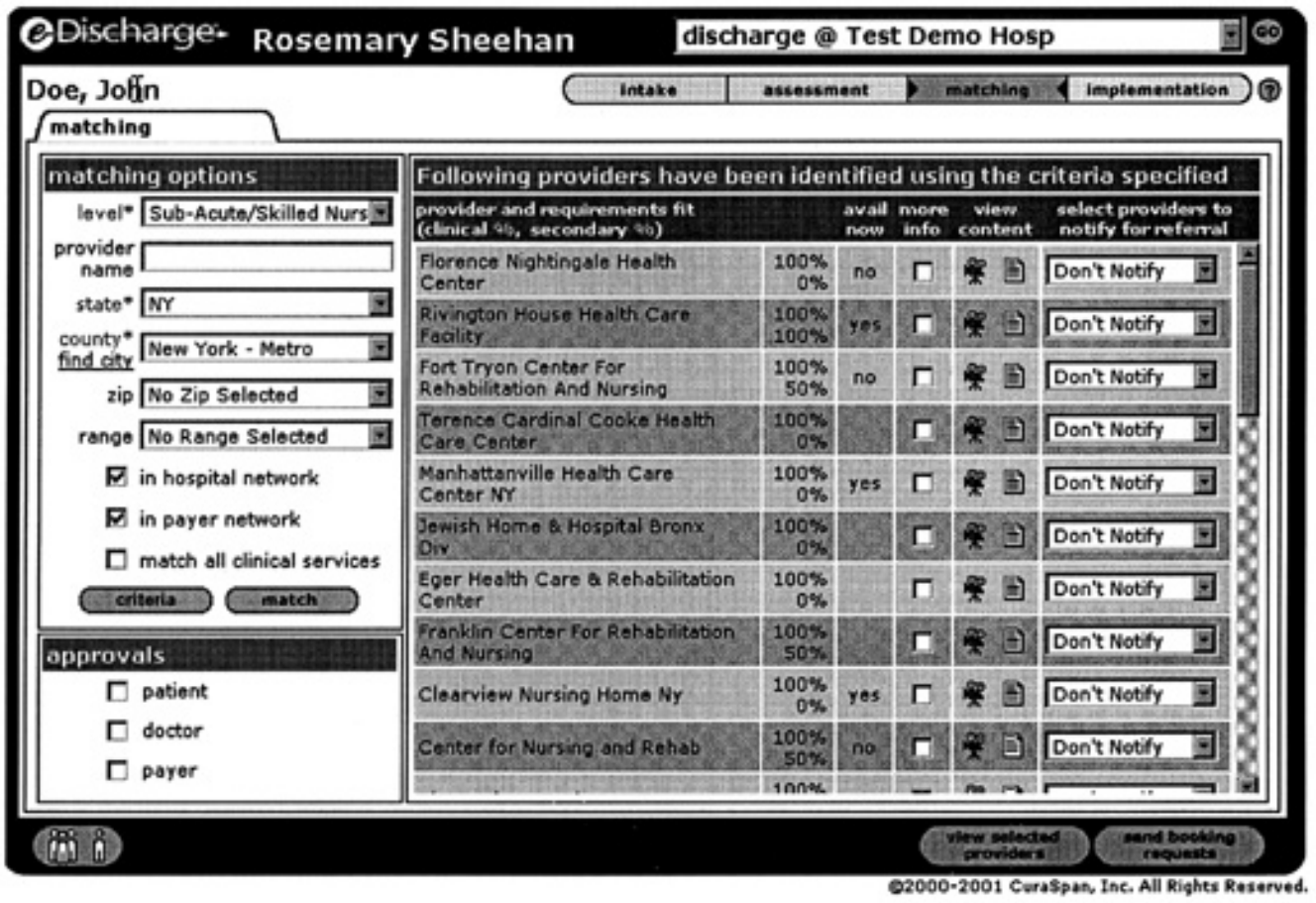
"It's real-time," explains Keane. "We used to send out PRIs — maybe a 20-page package — to five facilities via fax. Even though it was programmed into the fax machine, it took a lot of effort, and then maybe it didn't go out right. Now we put in one [PRI] and send it out to all five at once. The PRIs are much more legible."

The high-quality reports alone are a huge plus to her operation, Keane says. But Columbia Presbyterian, the network to which her hospital belongs, chose to implement eDischarge in large part because of the patient privacy protection it provides, she notes.

With the privacy regulations of the Health Insurance Portability and Accountability Act becoming effective in April 2003, Keane adds, "we're looking toward the future. This is an encrypted system, a secure system. We decide how much information the person on the other side receives, and at what time we give it."

As part of the eDischarge process, post-acute

On-Line Discharge System Enhances Communication



Source: Curaspan Inc. Needham, MA.

providers that take referrals from the hospital, including skilled nursing facilities, home health services, and rehabilitation facilities, complete a profile outlining the services they offer. Each day, the provider updates the bed or service availability.

At her hospital, Keane explains, there is a merged case management/social work department, with 19 registered nurse case managers, seven social workers, and one placement coordinator, who acts as a liaison between the post-acute facilities and the social workers. The hospital has about 460 patients at any one time, she says, and her department arranges between 200 and 220 nursing home placements patients per month.

The case manager drives the discharge plan, Keane says, determining whether the patient should be placed in a facility or cared for at home, doing the initial intervention with the patient's family, and performing the ongoing chart review.

Once the discharge plan is firmed up, and there is a solid placement need, the case manager makes a referral to the social worker, Keane says. "The case manager continues to review the case, and as the patient becomes closer to 'discharge-ready,' issues the PRI, entering it electronically into the computer."

Meanwhile, she adds, the social worker has developed a relationship with the family, helping them understand the process and negotiating where the patient will receive post-hospital care.

When the patient is ready for discharge and the PRI is completed, the case manager transfers it to the social worker, who completes the departmental screen of the patient and transfers the case to the placement coordinator with a list of appropriate

Need More Information?

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facilities, Keane says. "The placement coordinator electronically sends out queries to facilities the patient and family have chosen, and awaits the follow-up. When she gets that, she transfers the information appropriately. If there is a medical need or question, it goes to the case manager, but if there is a financial or psychosocial need, it goes to the social worker."

Once the patient is accepted by the facility, she notes, the PRI is updated, if necessary, and the social worker proceeds with the transfer. If the patient came from a nursing home and is returning there, the process is driven by the case manager from start to finish, and there might not be a social worker involved, Keane adds.

To protect patient confidentiality, identifying information on the patient is sent to the provider only after the final match is made, she notes. "We can give [the provider] just a look at the PRI and whatever clinical information is necessary. We're not giving them next of kin until we're ready to give them next of kin, and we're not using fax lines that may not be secure."

The eDischarge system "eliminates the back-and-forth," Keane points out. "Otherwise, people are going back and forth, faxing within the building, going up and down [floors] all day. We've decreased the unnecessary steps."

A clerical employee, for example, used to spend five hours collecting data and typing and distributing a monthly report showing where patients have been placed, she says. "The system does it in a minute, and we run a great report at the end of the business day."

Her staff can look at data showing where a patient was placed, how many facilities were sent applications, and what facilities have taken what types of patients in the past, Keane adds.

Using the criteria match that is part of eDischarge, case managers sometimes are able to find an appropriate placement for patients they didn't think a facility could accommodate, she points out. "We'd look at the criteria match and say, 'Oh, we didn't know they did dialysis,' so it was a heads-up that a facility we didn't think about would take a patient."

Placement of people with extreme needs, such as a recent 540-pound patient, also is facilitated by the on-line system, Keane says. "We can query [regarding] specific patients who have specific needs to see if a facility we don't use very often can provide that service.

"You know the facilities in your area that you use all the time," she adds, "but occasionally a facility is changing its scope of practice or opening a new unit. It's right there on the computer."

Don't touch that phone

An important point to remember, Keane points out, is that the on-line discharge system by necessity must "change the way you do business. You have to set a limit [on telephone calls], squelch that knee-jerk impulse to use the phone."

Although cases already are being turned around and decisions being made more quickly, she says, Keane expects further improvements as her staff gets more comfortable with the system. "We've created our own security measures, but as time goes by we'll drop some of the unnecessary [backup] steps and will get faster."

"Any time there's a change," she adds, "there's always a little holding on to the past, but the future is where you need to be." ■

ACCESS FEEDBACK

What's in a name? Losing 'Access'

Most say 'access' is not precise enough

The question posed in the March issue of *Hospital Access Management* regarding the viability of "patient access services" as the name for those departments that, among other things, handle admitting and patient registration, drew more

Getting parents' consent can be access challenge

Jean Steinbrecker, admissions manager at Children's Mercy Hospital in Kansas City, MO, is looking for suggestions on how best to obtain consents from the parents of her facility's young patients.

"It's mainly an inpatient concern," Steinbrecker explains. "We do a lot of direct admits, where the physicians call and make arrangements, and the patients bypass admissions and go to the nursing floor. The [nurses] notify admitting."

Sometimes parents accompany the patient, but if the patient comes by transport, they may not, she notes. "We struggle with getting the consent signed. The nurses don't think it's their responsibility. If they do try to get the parents to come to the admitting department, sometimes they don't make it."

When admitting employees go up to the patient's room, they may find the parents are there only in the evenings, Steinbrecker says. In some cases, admitters try to get telephone consents, she notes. "We have had a few cases in which no consent form was signed."

"It's not a huge problem," she adds, "but it's enough of one that I'd like it not to be there."

In response to the area's large Hispanic population, Spanish-speaking staff are on site on weekends to pull reports on overnight admissions and try to obtain consents, Steinbrecker says. "Our weekend admissions are done by bed control staff, but they don't go to the floor."

[Please send feedback on access issues to Lila Moore at lilamoore@mindspring.com *or call (520) 299-8730.]* ■

response from readers than any previous issue addressed in this column.

Jack Duffy, FHFMA, director and founder of Integrated Revenue Management in Carlsbad, CA, and a veteran administrator in the access field, suggested in that issue that there might be a trend toward going back to names such as "admitting" and "registration" for those departments.

Most of the *HAM* readers who had called or e-mailed by press time said they would welcome a return to the traditional nomenclature.

Kathy Pope, regional director for admitting at Christus Schumpert Health System in Shreveport, LA, says, "'Hospital access' is too vague a term. Call it what it is." Pope said her facility's administrators chose not to change her department's name despite the industry push to do so. "Our concern was that patients would not understand where to find admissions/registration if the name was changed to 'Hospital Access Department.'"

"That is probably one of the reasons that the name change has not been as acceptable as medical records changing to health information services," she notes.

In the latter case, Pope adds, the department name and signage were changed accordingly at her facility.

Beth Ingram, CHAM, director of patient financial services at Touro Infirmary in New Orleans, says she believes there is a push in some areas of the country to return to the more traditional titles.

"For our facility, and several I was in while doing consulting, the focus is on having departments named something that patients can relate to," she adds. The idea, Ingram says, is for patients to "easily identify from signage where to go to have their needs met."

Julie Harris, CHAM, director of admissions and health care information management at Mt. Graham Community Hospital in Safford, AZ, says her hospital did not change the admitting department's name to "access" because of possible confusion with a government program. "Arizona's Medicaid program has the same name — AHCCCS," she adds.

While hospital administrators are fine with calling the department "admitting" or "admissions," Harris says she would prefer something else. "I don't have any other names in mind. Hopefully, someone will come up with a great name that our administration would prefer to 'admitting.'"

Connie Haynes, admitting supervisor at Estes Park (CO) Medical Center, also asked to go on record as being in favor of "going back to 'registration' or 'admitting.' We never have really called it that," she adds. "No one cared for it."

Linda Southard, regional manager for patient registration for Asante Health Care in Medford, OR, says there was a lot of discussion in 2000 among the upper-level executives of her health care group regarding changing the name of the registration department.

"One of our executives wanted to use 'patient access' and the other did not," Southard adds. "I, as the regional manager, wanted to keep the name

Audio conferences target disasters, medical disclosure

Have you missed one of American Health Consultants' (AHC) recent audio conferences? If so, two upcoming conference replays offer another opportunity to take advantage of excellent continuing education opportunities for your entire facility.

• **Disaster Response at Ground Zero: How NYU Downtown Hospital Handled Mass Casualties With All Systems Down**, originally held on Jan. 10, takes participants to the heart of the World Trade Center disaster on Sept. 11. Just a few blocks away from the crash site, NYU Downtown was cut off from crucial lifesaving supplies and power, even as hundreds of injured came through the ED doors. HazMat teams on the roof of the hospital had to vacuum all of the debris out of air ducts to maintain air quality and keep generators running. Physicians and nurses had to balance urgent care with proper documentation. Learn how to prepare your facility for the unthinkable. The replay will be available from 8:30 a.m. on Tuesday, April 16, to 5:30 p.m. on Wednesday, April 17. Current AHC subscribers pay $249, which includes free CME and CE credit. The cost is $299 for nonsubscribers.

On April 23 and 24, **What to Say When Something Goes Wrong: Do the Right Thing When Trouble Strikes** also will be available for replay. This successful audio conference covers the major fear factors clinicians experience when confronting issues of medical disclosure. Learn benefits for patient and provider, as well as the risks of litigation and how to avoid costly legal battles. Free CE for your entire facility is included in the $249 fee for AHC subscribers.

To register for either one of these replays, contact American Health Consultants' customer service department at (800) 688-2421 or customerservice@ahcpub.com. ■

'patient registration.' Finally, after much discussion, we did not change the name because we felt our patients would not know what 'patient access' meant."

However, **Peter A. Kraus**, CHAM, business analyst for patient accounts services at Emory University Hospital in Atlanta, says he does not have the sense that the access name is becoming passé. "My take is that it remains the best overall description of the front end of health care," he says.

"I've always felt that 'access' complements, not displaces, traditional names such as 'admissions' and 'patient registration,'" Kraus adds. "The NAHAM [National Association of Healthcare Access Management] Continuum illustrates how admissions and registration are subsets of access. In my opinion, the more specific term 'admissions' is entirely appropriate when applied to admitting functions within the broad perspective of access.

"Bear in mind," he continues, "that 'access' applies not only to the wide scope of front-end functions, but also to the diverse responsibilities of many front-end managers and directors. It can serve to define and enhance the stature of the job, thereby helping to promote career advancement." ■

Correction

The technology used to create the bed management database featured in the cover story of the March 2002 issue of *Hospital Access Management* was IBM Websphere and DB2 — not Oracle, says **Marne Bonomo**, PhD, regional director for Aurora Health Care in Milwaukee. Aurora's information systems staff informed Bonomo of the technology clarification after the *HAM* deadline, she says. ■

Insurance industry trend may push POS collection

Unprepared hospitals 'will be vulnerable'

Two recent studies may be harbingers of changes in health care coverage that could affect how access departments do business. Those changes, suggest a veteran health care professional, could mean higher deductibles and a pressing need for more aggressive point-of-service collection.

The number of employers offering health insurance is likely to decrease if the recession continues and unemployment rises, according to a RAND study released in late February.

Using data from two national surveys of employers conducted during the 1990s, RAND economists sought to demonstrate the link between local markets and employer-sponsored

health coverage in the most recent issue of the "International Journal of Health Care Finance and Economics." RAND, based in Santa Monica, CA, is a nonprofit institution that aims to improve policy and decision making in number of fields.

The report said employers are more likely to offer coverage and contribute a larger share of its cost in communities where labor markets are tight. **M. Susan Marquis**, the co-author of the report, said she wouldn't go so far as to say the recession will unravel the employment-based health insurance system, but that report findings raised the issue as a matter of concern.

Meanwhile, the nation's employees want more control and choice in health care, are interested in consumer choice models, and rank health care as their most important benefit, according to a recent study by Hewitt & Associates, an outsourcing and consulting firm based in Lincolnshire, IL.

Overall, respondents to the Hewitt survey of 528 U.S. employees expressed confidence in their ability to make sound coverage decisions, with 87% saying they understood "fairly or very well" how to choose the best health plans for their needs.

These reports come at a time when insurance companies find themselves at the end of a "premium development cycle," says **Jack Duffy**, FHFMA, founder and director of Integrated Revenue Management in Carlsbad, CA, and *Hospital Access Management* consulting editor. "[Insurers] have gone to employers each year with double-digit increases on the premium side, and can't go back to them again."

Just as employers have increasingly gone to "defined contribution plans" for employee pensions, Duffy predicts, they will do the same with health care benefits if faced with more premium increases.

That means, he explains, that employers will be increasingly likely to make a contribution toward an employee's health care coverage, rather than buy comprehensive coverage from an insurer such as BlueCross BlueShield or Aetna.

Employees faced with arranging their own coverage, in turn, are likely to have health care plans with large deductibles, Duffy says. "What kind of access environment do we enter into when our patients owe $5,000?"

Access managers, he suggests, will get a call from hospital administrators asking, "Will you collect that $5,000 as you're admitting the patient?"

"More and more patients will be presenting with multithousand-dollar deductibles, and if your department is not prepared with credit cards and financial counseling, you're toast," Duffy adds.

Other access innovations, such as call centers, aimed at reducing revenue cycle time, he says, "may have to be quickly replaced with the ability to have a much more in-depth financial relationship with patients related to copays."

Access departments who haven't properly trained staff and who aren't prepared to swipe credit cards or use an automated clearinghouse to enable them to take counter checks over the telephone, Duffy says, "will be very vulnerable." ■

'Improper payments' declined, OIG says

What the Office of the Inspector General (OIG) characterizes as improper payments under the Medicare program declined for the sixth straight year in 2001, according to a report from the Department of Health Human Services.

The improper payments declined to 6.3%, or $12.1 billion of the $191.8 billion of Medicare payments last year. That's down from a 6.8% rate, or $11.9 billion, in 2000, and less than half the 13.8% rate estimated in 1996, according to the report.

The OIG began estimating in 1996 the percentage of fee-for-service Medicare payments involving medically unnecessary services, documentation deficiencies, or miscoding. For 2001, the OIG randomly examined the medical records for 6,594 claims filed for 600 beneficiaries, out of 931 million claims filed for 34 million fee-for-service enrollees. For more information, go to http://oig.hhs.gov/oas/reports/cms/a0102002.htm. ▼

Report outlines planning by hospitals for bioterror

Financial and capacity shortfalls have hospitals concerned about being overwhelmed by a major bioterrorism attack, even though they are devoting significant resources to prepare for possible attacks.

That's the conclusion of a white paper from the La Jolla, CA-based Governance Institute, an organization of health care executives and trustees. The report describes how hospitals are reconfiguring their triage areas, ambulance bays, ventilation systems, and even surgical masks to prepare for incidents that could produce many more casualties than the Sept. 11 and anthrax attacks.

A supplement to the paper contains a checklist for action related to bioterrorism. The report is available for $7 by calling (858) 551-0144. ▼

AHA pushes for change in EMTALA regulations

Emergency Medical Treatment and Active Labor Act (EMTALA) screening regulations should be changed to differentiate between critical and noncritical patients, according to a hospital administrator testifying on behalf of the American Hospital Association (AHA).

The change would allow caregivers to provide other options to noncritical patients during times of severe emergency (ED) department overcrowding, **Jody Lehman**, corporate vice president for Baptist Health South Florida, said in testimony before the Department of Health and Human Services' Task Force on Regulatory Reform.

In the first of five hearings held by the task force, Lehman suggested additional reforms, including the formation of an EMTALA Advisory Committee, providing an administrator-level

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review in the complaint process, and excluding ED services from local medical review policies. ▼

Patient satisfaction rates dropped in Sept. 11 week

Patient satisfaction with health care services fell sharply during the week of the Sept. 11 attacks, according to a recent study by Press, Ganey Associates.

However, patient evaluations returned to normal levels the following week. Overnight patients were significantly less satisfied with the care they received immediately following the attacks, compared with patients who were discharged in the proceeding weeks.

Press, Ganey said the drop in patient satisfaction was likely due to stress among staff that manifested itself in a drop in productivity and attention to detail. The stress caused patients to be more demanding about their medical care and more sensitive to service breakdowns in the hospital, the study found. For more information, go to www.pressganey.com. ▼

'Reach for the Stars' at NAHAM conference

The National Association of Healthcare Access Management's (NAHAM) annual conference and exposition will take place May 19-21 at the Pointe Hilton Squaw Peak Resort in Phoenix.

"Reach for the Stars: Achieving Excellence in Patient Access Management" will cover topics ranging from HIPAA compliance to staff development and revenue cycle improvement. A popular pre-conference seminar, the University Hospital Session, will address topics of particular relevance to the university hospital-based access manager.

Returning as speakers for the plenary sessions will be Michael T. Myers Jr., director of the health care regulatory group practice for PricewaterhouseCoopers, and Jeanne Scott, director of government relations for NDC Health in McLean, VA.

For more information on the NAHAM conference, call (202) 367-1125 or visit the organization's web site at www.naham.org. ■