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INSIDE

MAY 2002

VOL. 21, NO. 5 (pages 49-60)

New electronic bed board system offers efficiency, dramatic results

On-screen data flow replaces 'little pieces of paper'

(Editor's note: This is the second article in a series of stories on emerging bed management technology. See the cover story of the March 2002 issue of Hospital Access Management *for an article on a real-time bed management system developed by Milwaukee-based Aurora Health System.)*

When **Barbara Wegner**, CHAM, began making calls last spring in search of new technology to help out with her health system's bed control function, she made an interesting discovery: A vendor with whom she already had worked was getting ready to beta-test just such a solution.

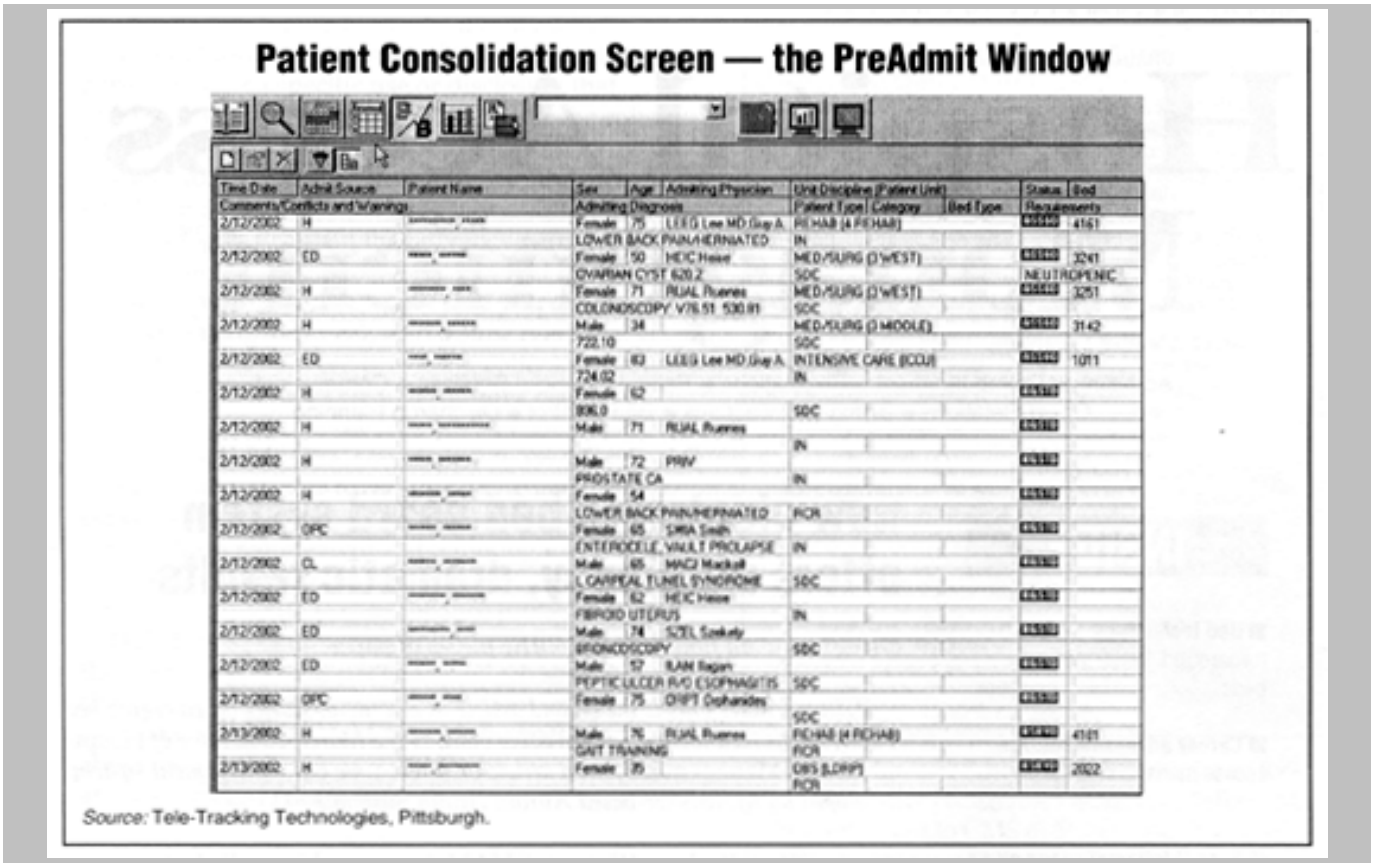
"I found out they were looking for sites to test the new product, so I contacted them and said we'd like to participate," says Wegner, regional director for access management at Providence Health System in Portland, OR.

The Electronic BedBoard, designed by Tele-Tracking Technologies in Pittsburgh, now is in place at Providence St. Vincent, the system's largest

Stay on top of EMTALA with audio conference

Keep abreast of all the latest changes with *EMTALA Update 2002,* an audio conference sponsored by American Health Consultants. The conference, scheduled for Tuesday, June 4, 2002, from 2:30 to 3:30 p.m. Eastern time, will be presented by Charlotte S. Yeh, MD, FACEP, and Nancy J. Brent, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Company. Brent is a Chicago-based attorney, with extensive experience as a speaker on EMTALA and related health care issues.

(See EMTALA audio conference, page 54)



Source: Tele-Tracking Technologies, Pittsburgh.

hospital, and the results have been dramatic, she says.

"We are turning around beds more quickly, and it's impossible to hide a bed now," Wegner says. "There is a 50-inch [flat-panel monitor] that gives the entire picture of the hospital [beds] at a glance."

The beta test — also taking place at three other locations throughout the country — began at Providence in December 2001 and was to be completed by the end of April 2002. Other locations are WakeMed in Raleigh, NC; Doylestown (PA) Hospital, and Winter Haven (FL) Hospital.

Through what the vendor calls PreAdmit Tracking — not to be confused with the process of registering patients in advance of admission — all of the bed requests flowing into the hospital are consolidated onto one computer screen, called the PreAdmit Window.

"Before," Wegner adds, "there were a bunch of little pieces of paper with notes written on them [regarding incoming patients]."

Those pieces of paper might include the surgery schedule, a handwritten direct-admit form, or a fax from the emergency department (ED) about a patient who needs a bed, explains **Gene Nacey**, MHA, founder and workflow consultant for Tele-Tracking Technologies. "There would also be a lot of ADT [admission / discharge / transfer] entries, and notes taken from physicians who've called to say they're sending over a patient."

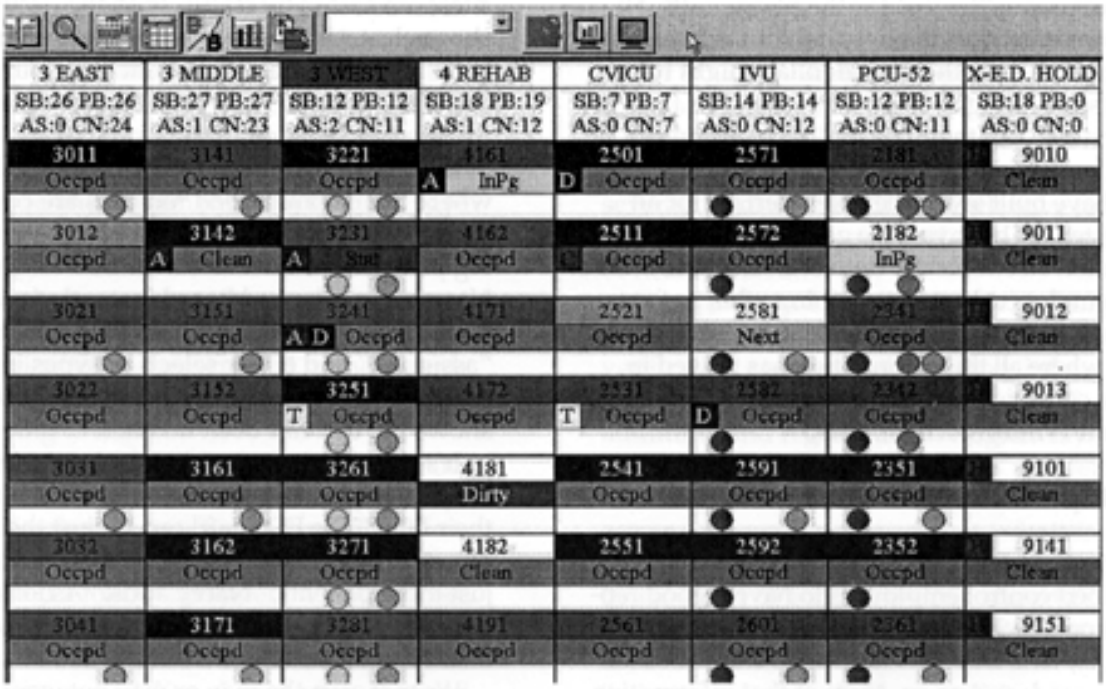
"Typically, there are 10-14 pieces of paper [bed control personnel] are dealing with," he adds.

(Continued on page 52)

COMING IN FUTURE MONTHS

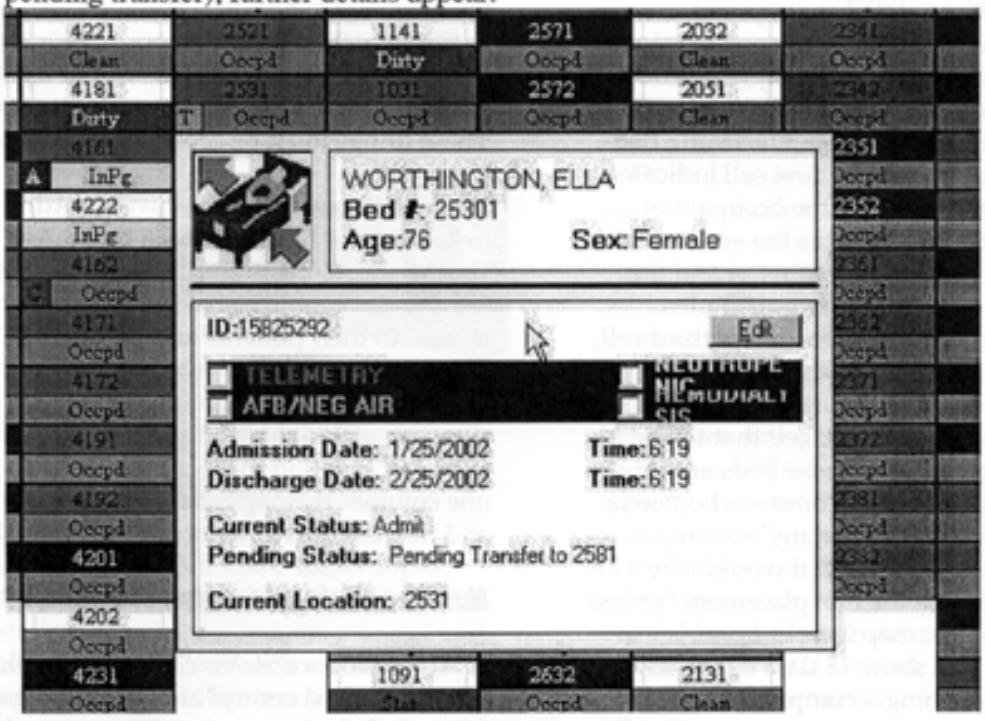
- Call centers' unique staffing challenges
- Your role in denial management
- Lowering turnover, boosting morale
- What a merger means to you
- What's the benchmark for patient identification?

Electronic BedBoard



3 EAST	3 MIDDLE	3 WEST	4 REHAB	CVICU	IVU	PCU-52	X-E.D. HOLD
SB:26 PB:26 AS:0 CN:24	SB:27 PB:27 AS:1 CN:23	SB:12 PB:12 AS:2 CN:11	SB:18 PB:19 AS:1 CN:12	SB:7 PB:7 AS:0 CN:7	SB:14 PB:14 AS:0 CN:12	SB:12 PB:12 AS:0 CN:11	SB:18 PB:0 AS:0 CN:0
3011	3141	3221	4161	2501	2571	2181	9010
Occpd	Occpd	Occpd	A InPg	D Occpd	Occpd	Occpd	Clean
3012	3142	3231	4162	2511	2572	2182	9011
Occpd	A Clean	A Stat	Occpd	C Occpd	Occpd	InPg	Clean
3021	3151	3241	4171	2521	2581	2341	9012
Occpd	Occpd	A D Occpd	Occpd	Occpd	Next	Occpd	Clean
3022	3152	3251	4172	2531	2582	2342	9013
Occpd	Occpd	T Occpd	Occpd	T Occpd	D Occpd	Occpd	Clean
3031	3161	3261	4181	2541	2591	2351	9101
Occpd	Occpd	Occpd	Dirty	Occpd	Occpd	Occpd	Clean
3032	3162	3271	4182	2551	2592	2352	9141
Occpd	Occpd	Occpd	Clean	Occpd	Occpd	Occpd	Clean
3041	3171	3281	4191	2561	2601	2361	9151
Occpd	Occpd	Occpd	Occpd	Occpd	Occpd	Occpd	Clean

If the user right clicks on an occupied bed showing a "T" (which indicates this patient is a pending transfer), further details appear:



Source: Tele-Tracking Technologies, Pittsburgh.

"So this paper is lying around, and they're wondering where to put these patients."

What PreAdmit Tracking does is like data mining, Nacey says. "Except for the phone calls, all the information is in the hospital, but is in different systems. The catheterization lab might have its own scheduling system, admitting has the ADT system, and the ED usually has its own system for tracking patients.

"We have built a very flexible interface for all these systems," he says. "We get the bulk of all this information electronically onto one screen, so when [access employees] are determining what patients they need to place, they can look at one screen [on the PC] where all this information has flowed in. We have consolidated all those sources." **(See the PreAdmit Window screen, p.50.)**

A giant spreadsheet

The next piece of the process, Nacey explains, was for bed control employees to have a good representation of which beds were available, which were dirty, which had patients who were about to be discharged, and so on. Most of that information was available from BedTracking, the telephone-based system Nacey's company began marketing in 1991, he notes, but it wasn't configured to look like a bed board. **(See related story, p. 53.)**

"We created an electronic bed board that looks like a giant spreadsheet," Nacey says. "Each patient unit is a separate column, and each bed is represented by three cells." **(See Electronic Bed-Board illustration, p. 51.)** The first cell indicates the bed number and whether the occupant is male or female, the second gives the status of the bed — clean, dirty, or other options — and the third cell defines up to four other attributes.

One of the most common uses of the third cell, Nacey says, is to indicate a telemetry bed. One of his favorite uses, he adds, is one chosen by Providence, which notes in the third cell that the bed is close to the nurses' station. Those beds are chosen if there is a combative patient or one who needs to be watched more closely for any reason.

Otherwise, Nacey points out, it would take a lot of phone calls to determine that placement "unless you have a geographic map in your brain."

The bed board will show 18 data elements without anyone touching a computer keyboard or mouse, he says. "The monitor shows virtually the whole hospital so you know the status of almost every bed. Some patient units might be very large, so you might have to scroll vertically to see the last 10 or 20 rooms."

Many options are available as to how the information is displayed, Nacey notes. "All the [beta sites] are sorted by status, with the occupied beds shown last, since these are the least interesting." Beds may be sorted alphabetically — in which case the occupied beds conveniently are last — or by number, he adds.

Bed control staff can look from the PC — where the incoming bed requests are consolidated — to the electronic bed board showing the big picture and then make the bed assignment, Nacey says. The bed board instantly is updated when the employee clicks on the patient, then on "assigned" and either selects or types in the bed number, he explains. An "A" in the middle cell shows the bed has been taken.

It's possible, he notes, for employees in various hospital departments to see a mini bed board on their PCs. "The ED [staff] can see just their patients, or one of the units upstairs can see a version with just those patients," Nacey adds. "As long as they're on the general hospital network, a bed board can be installed."

Wegner says she may or may not want to take advantage of this opportunity to share bed management information with other departments. "If we did make a decision to let one of the patient floors have it," she adds, "it would be 'view-only.'"

"Too much information could be a dangerous thing," Nacey agrees. "Folks might try to move patients into available beds without permission. These things must be centrally located or chaos can ensue."

"Each department can have PreAdmit Tracking installed on a workstation in their area," he adds, "but we have the ability to limit the units they see. We can limit them to see only the activities related to their patients and their beds."

In that case, Nacey says, any patients assigned to that unit or waiting for a bed on that unit will show up on that area's PreAdmit Window. The mini bed board in those areas would show only one column, the one containing that unit's beds, and the respective status of those beds, he notes.

New technology creates excitement

At Providence St. Vincent, two people are on duty in the bed control area during the day and for periods in the evening, Wegner explains, with one person handling the job during part of the evening and at night.

"They are isolated in a room by themselves,

where they manage the flow of patients and assign beds to patients being admitted from the ED and by physicians — the urgent call-ins and the electively scheduled admissions," she says. "Everybody is very excited about the technology.

"We're trying to do some measurement [of time and effort saved]," Wegner notes, "but we know that we're turning beds around more quickly."

"It's a wonderful tool," adds **Patricia Weygandt**, manager of access services for Providence St. Vincent. "It has really helped us to more accurately place our patients and do that in a more timely manner. It's great for both the bed control coordinators and the patient placement coordinators to have a clear picture of the house census at a glance."

The patient placement coordinators, she points out, are nurses who function as liaisons between access and nursing. "They help get the patient in the proper place and provide more clinical information when it is needed."

Providence Portland, another of the system's three Portland-area facilities, wants the bed management technology as soon as possible, Wegner says. One of the things she's interested in exploring, she says, is whether the technology could flow between facilities. The idea would be that if beds were tight at St. Vincent, Wegner adds, "we might try to get a patient in at Portland."

The company is working on such a concept, Nacey says. "Our plan is to allow multiple hospitals in one system to have a combined bed board, specifically targeting disaster response issues systemwide."

[For more information on products from Tele-Tracking Technologies, contact Gene Nacey at (724) 339-1424. Barbara Wegner can be reached via e-mail at bwegner@providence.org.] ■

Original bed tracking is basis for new system

It works with facility's phone system

Bed tracking — a term that's often used generically to describe a hospital's bed management activity — actually is the name of a product introduced in 1991 by a Pittsburgh-based vendor now known as Tele-Tracking Technologies.

The technology for BedTracking, which is in place at some 500 hospitals across the nation, was the vendor's jumping-off point for PreAdmit Tracking and The Electronic BedBoard, which are just completing beta-testing at four hospitals, says **Gene Nacey**, MHA, the company's founder and workflow consultant.

The older product "started at the point of discharge or transfer, with a dirty bed," he explains. "We focused on getting that bed clean."

Using an integrated voice response (IVR) system, someone — a volunteer, an escort, or a nurse — enters a number into the telephone that lets the admitting department know the patient is gone, Nacey says. The action also sends a page to the housekeeper assigned to that area. The process — based in the hospital's existing telephone system — also can be used to alert food service not to send a meal to the room and the pharmacy not to send medications.

"The phone transaction sends an update to an admitting computer terminal or to housekeeping," he adds. "It cuts down about 100 phone calls a day for the average admitting department."

If someone doesn't start cleaning the room in the amount of time specified by the hospital, the system will page that housekeeping employee's supervisor, Nacey says. "It's real-time notification. That simple workflow adjustment dramatically changes the way beds get changed and in how timely a manner people know about it, he adds.

The fact that BedTracking works through a facility's telephone system keeps the cost down and makes the process easier to implement than wireless tracking systems, Nacey notes. "It turns telephones into mini terminals."

Experience has shown him, Nacey adds, that nurses who usually do not enter discharges into the admission / discharge / transfer system in a timely manner are more efficient when using the telephone to provide the information.

That's because, he says, "the phone is so much more accessible and it takes 10 seconds or less." ■

Does the access field lack upwardly mobile managers?

Top-level jobs said hard to fill

Is there a shortage of top-level access services professionals who are willing to relocate for a better job? Some industry leaders, who wonder if the preponderance of women in the field may be

EMTALA audio conference

(Continued from page 49)

The conference will outline a new report that puts a national spotlight on inadequate emergency department (ED) on-call coverage. There is a growing trend of specialists refusing to take call for the ED, partly due to increased liability risks for medical malpractice and violations of EMTALA. If you don't take steps to ensure appropriate on-call coverage for your ED, you're at risk for violations and adverse outcomes. This program also will update you on any legislative efforts to compel managed care plans to reimburse hospitals for EMTALA-related services.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the EMTALA Update 2002 audio conference for just $249 for AHC subscribers and $299 for nonsubscribers, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. For more information, or to register, call American Health Consultants' customer service department at (800) 688-2421 or (404) 262-5476, go on-line at www.ahcpub.com, or e-mail customerservice@ahcpub.com. ■

a factor, are posing that question.

Demand is increasing for health care managers — including those in the access field — who can help their organizations increase revenue collection, says **Eric T. Holzer**, CPC, an executive search manager for the health care division of Houston-based Richard, Wayne & Roberts. "[Those managers] play a vital role, and that is only going to increase in the future as economics get tighter and hospitals have to get paid."

But Holzer says his firm has conducted four searches for access directors in the past few months and is having difficulty finding qualified people for those positions. It's taking between one and five months to fill the jobs, he notes, and sometimes the positions have been open a couple of months before his company takes over the search.

A new director-level position he is seeking to fill focuses on admissions and registration consulting, financial consulting, and insurance verification, Holzer adds. "The position is located in the New England area, and my client is looking to pay the right talent between $80,000 and $100,000."

Sometimes the jobs never get filled, he says. "They may promote somebody from within and put the responsibility elsewhere. It depends on the quality of candidates we get."

Jack Duffy, FHFMA, director and founder of Integrated Revenue Management in Carlsbad, CA, says he is aware of more than one senior middle management position in access that has remained open for months at a large California health care system.

"Where are our people?" asks Duffy, who has many years of experience in access management. "One of these positions is system director for access, a job with a salary close to or over six figures. Have we created an immobile population? I think there should be 25 people vying for that job."

There is a limited number of leaders in the access field who have the knowledge base and experience to be successful in a large health care system, suggests **John Woerly**, RHIA, MSA, CHAM, a longtime access director who is now a manager with Cap Gemini Ernst & Young in Indianapolis.

Many of those well-qualified professionals already are in "an ideal situation," based on personal or family needs or work environment, he adds.

Woerly says one of the reasons he has moved into the consulting field is because it allows his family to remain in one location while he travels. When he left his most recent access management position, Woerly notes, he had opportunities for advancement in the field that would have meant relocating his family.

"I wanted my children to finish high school in one place," he says. "If they were younger, I would want to be home; but at 17 and 19, they don't need me as much as they need the stability of surroundings and schoolmates."

Duffy and Holzer say the fact that women hold most of the positions in the access and patient accounting fields may be making it harder to fill top-level jobs. "Typically, it is more difficult to encourage women to relocate because of whatever commitments they've made," Holzer adds. "The majority of the time [those commitments] have to do with family."

An advanced degree, good experience, movement through larger organizations, and a willingness to relocate are factors associated with job advancement, Duffy notes. "Are we incredibly constrained in terms of people willing to meet those conditions?"

"I think we have a bias toward folks who want to be an access manager in one organization until they are ready to retire," he says. "If that's a characteristic, the ability to have an executive track

[in access] is going to be highly constrained."

For those who are interested in moving up the access ladder, Holzer says that the ability to help a health system improve its bottom line is likely to be more prized than a master's or even a bachelor's degree.

"Some who are not degreed are the best in the market," he adds. Many organizations are primarily looking for "somebody who's bright enough to make the upfront process run smoother."

In other cases, Holzer says, the lack of a degree is a deal-breaker. "Every hospital system is different. They handle it in different ways, but this is a skill set that is in demand. It's difficult to find these people, and it usually requires a move."

Specific achievements, rather than generalized job descriptions, will catch the attention of organizations seeking top-level access professionals, he notes. Those might include, he adds, such indicators as, "I've increased upfront collections from this to this in this amount of time," or "I've decreased patient wait time from this amount to this amount by doing this."

There are thousands of business office professionals with the same duties and responsibilities, Holzer says. "When someone reads, 'Responsible for billing, registration, collections,' that's not saying anything about you."

"My suggestion for anyone putting together a resume is to add quantifiable accomplishments," he adds. "Words like 'team player' don't mean anything. What means something is what you have done for your medical facility and what you can do for me if I am a hiring authority."

[For more information, contact:

• Eric Holzer of Richard, Wayne & Roberts. Telephone: (800) 364-7979, ext. 7297, or (713) 358-7297. E-mail: erich@rwr.com.

• Jack Duffy of Integrated Revenue Management. Telephone: (760) 476-0077.

• John Woerly of Cap Gemini Ernst & Young. Telephone: (317) 977-1171.] ■

Writing the appeal letter: First, get the address right

Stick to the point and document

How can we write a more effective appeal letter?

That's the question posed by **Gretchen Smith**, MSPH, contract management systems manager at UNC Hospitals in Chapel Hill, NC, after she read the article in the February issue of *Hospital Access Management* on how hospitals are using contract law to get reimbursement denials reversed.

"We don't seem to be having as much luck [as the hospitals mentioned in the article]," Smith adds. "Are there certain phrases they're using? Would it be possible to get a sample copy of an appeal letter?"

In response to Smith's query, **Linda Fotheringill** and **Malinda Siegel**, partners in the Towson, MD, law firm Siegel & Fotheringill, offered the sample appeal letter reproduced **on p. 56**, and these pointers on crafting a more effective letter:

• **Get the address right.**

It sounds simplistic, but one of the first things is to make sure the appeal is directed to the appropriate address. In a lot of cases, insurance companies say they've never received the appeal, and the excuse can be that it had the wrong address. "Oh, no," they'll say. "Lack-of-authorization letters go to an address in Tennessee, but medical necessity issues are supposed to go to an address in California."

Getting this right requires coordination with your hospital's managed care department in knowing what the provider manual or contract says about the appeal process. If it's unclear, contact provider relations with that payer and get the appropriate information. If the hospital is seeing a pattern of the payer never receiving appeals, consider sending the letters by certified mail.

• **Put a "title" under the address announcing what the letter is.**

Is it an appeal, a request for retroactive authorization, a resubmission of a claim? It's nice to have a title. It can be bold and underlined.

• **Below that, put a caption with the patient's name, the provider, the member number, dates of service, total charges, and maybe the denial date.**

With this, the insurance company can see at a glance what is at issue.

• **Set forth in the first paragraph what you're doing and why.**

After the "Dear Sir or Madam," say, for example, "It is our understanding that charges for the above-captioned patient were denied on the basis of ___." State the problem.

The body of the letter generally will set forth the facts and contract language that dispute the

denial and give the hospital's position on why the claim should be paid.

This is where hospitals get in a little trouble. Sometimes when you tell them to include the pertinent facts, they throw in additional facts that there is no reason to include. Don't volunteer information. Some appeal writers sort of admit to wrongdoing, as in, "He or she was new on the job that day." Stick to the basic facts that will help get the case paid and don't include extraneous detail that muddies the waters.

• After the facts, cite any applicable law that will help you.

Laws vary from state to state, but many have laws related to the provision of emergency services, and laws relating to mothers and babies, among others. In theory, the hospital's corporate counsel could supply this service, although they often have other things on their plate.

• Give the medical claim.

If the payer is denying the claim because you didn't get authorization, you sometimes can turn it around, but you have to give the reason why you didn't get it and why the services were medically necessary. You must show that had the call been made, the services would have been authorized.

• In closing, request that the insurance company — if it intends to uphold the denial —

[Insert Proper Insurer's Address Here]

APPEAL

RE: Patient_____
I.D. # _____
Insurer: _____
Provider: _____
Dates of Service: _____
Total Charges: _____
Our File No.: _____

Dear Sir/Madam:

It is my understanding that *[insurer's name]* denied this claim on the basis that the services were not authorized. We disagree with this determination and request that you consider the following:

Upon admission, the patient presented to *[Hospital]* without any insurance information. It was subsequently determined that the patient was covered by *[insurer]*. The provider contacted *[insurer]* and the patient's admission was authorized by Amy at *[phone number]* with authorization number 1263628.

Under California law, because this patient's services were authorized, *[insurer]* cannot now deny payment to the hospital for these charges. Specifically, Cal. Health & Safety Code §1371.8 (1994) provides that a health care service plan that authorizes or approves medical treatment by a provider shall not rescind or modify that authorization after the provider renders the services. *(Check your state statute for a similar, applicable law.)*

Furthermore, the services provided to this patient were rendered on an emergency basis. Cal. Health & Safety Code §1371.4(b)(1994) requires a health care service plan to reimburse a provider for emergency services rendered to an insured. Additionally, Cal. Health & Safety Code §1371.4(c)(1994) provides that a health care provider is not required to obtain pre-authorization or approval from a health care service plan in order to obtain reimbursement for emergency services. *(Check your state statute for a similar, applicable law.)*

Moreover, the services rendered to this patient were medically necessary. *[Insert specific details supporting the medical necessity of the admission].*

In light of the fact that the services provided to this patient were authorized, emergent in nature, and medically necessary, we request that you reconsider this claim for payment. Should you intend to deny this claim, please advise as to all grounds for your denial. Also, please provide all documentation in support of your denial, as well as a listing of the administrative and appeals procedures that we must exhaust.

To assist you in your review, I have enclosed the UB-92 form and the medical records. Should you have any questions or need additional information, I can be reached at *[phone number].*

I will look forward to a response from you within twenty (20) days of the date of this letter. Thank you for your help in resolving this matter.

Source: Siegel & Fotheringill, Towson, MD.

provide the hospital with all the appeals the hospital must exhaust on the claim.

Even though you ask, the company may not tell you. You should know the answer yourself by checking the provider manual, which may say, for example that you have 15 days to go to the second level. Keep that in mind, or you might miss the deadline for getting in another letter of appeal. You want to keep your options open.

• **Include any documentation that the payer may need.**

This might include a UB-92 form, medical records, or account notes if you need to provide proof that certain things happened. Sometimes the authorization is documented in the records, but send just the parts that document the point you're trying to make.

• **Remember to follow up on your appeals.**

We've found that a lot of hospitals have trouble with this. It takes tenacity. Even though you've written a beautiful appeal and sent it certified mail, you still need a follow-up system where you call and determine if the payer received it. There are usually laws that require them to respond within a certain time period. You should know that and keep track of it, so you haven't done the appeal for nothing.

[Editor's note: Linda Fotheringill can be reached at The Susquehanna Building, 29 W. Susquehanna Ave., Towson, MD 21204. Telephone: (410) 821-5292 or (800) 847-8083. E-mail: sfllc@excite.com.] ■

'Name game' debate draws more response

Readers continue to call and e-mail *Hospital Access Management* regarding the discussion of whether "access services" is a meaningful and appropriate name for the department that, among other things, admits and registers patients. So far, the majority of respondents have said they prefer the traditional "admitting" or "registration" designations.

To a great extent, points of view seem to depend on whether the respondent is affiliated with a relatively small access services (or admitting/registration) department, or a large department that may include areas not strictly related to the admitting function.

For example, **Barbara Wegner**, CHAM, regional director of access services for Providence Health System in Portland, OR, points out that in the case of her organization, access services encompasses several departments, all of which have to do with how patients get in, out, and through the hospital or health system.

"I have responsibility for guest housing, transportation, communication, scheduling, insurance verification and pre-authorization, information desks, and international services, as well as all admitting and registration," Wegner says. "As you can see, the name 'access services' fits perfectly. All these departments fall under the jurisdiction of access services, but they are not 'admitting.'"

The employees in those areas feel good about being a part of access services, she adds, but most do not identify with admitting or registration. In the case of her health system, Wegner suggests, "admitting is called admitting," but it would be ludicrous to have all the areas that fall under access services be part of admitting.

"I do not hear any negative comments about the name 'access services,' she notes. "Sometimes people are not quite sure what it means, and it requires some explanation."

Eliminating the term "access services," Wegner contends, would be a step backward for the field.

Doris Dickey, CPAM, business services manager at Rochelle (IL) Community Hospital, says she gave up on establishing the name "access services" at her facility — a 50-bed hospital with about 30,000 registrations and admissions a year — more than six months ago. "We still call ourselves 'admitting/registration,' as does everyone who interacts with us.

"Yes, the emergency room is now the emergency department," Dickey adds, "and medical records is pretty consistently called hospital information management, but admitting is still admitting."

Other readers, meanwhile, added their votes to the admitting/registration column, including **Denise Leapaldt**, admissions supervisor for Jamestown (ND) Hospital, a 56-bed facility.

"Like other facilities, the bulk of our patient load is Medicare-aged," Leapaldt adds. "The word 'access' is foreign to most of them, and they would have no idea why we were interviewing them."

Leapaldt says she personally has never been

fond of "the access handle" for her department. "It is cold-sounding, confusing, and doesn't explain our purpose to the general public," she says. "After all, [registering the patient] is what we do. Why create more confusion than there already is? We'll leave that to Medicare."

Scott Buckley, CHAM, director of business services at St. Nicholas Hospital in Sheboygan, WI, agrees. "Registration is more recognized and more descriptive than 'access,'" he says. "Change it back."

[Editor's note: Please share your feedback on the issues addressed here, or on any topic related to patient access management, by contacting Lila Moore at (520) 299-8730 or lilamoore@mindspring.com.] ■

New coding credential may interest access staff

It covers 'basic instruction'

A new entry-level coding credential recently announced by the Chicago-based American Health Information Management Association (AHIMA) may be useful to access departments looking to increase their coding expertise.

The certified coding associate (CCA) credential is designed for persons who have had basic coding instruction, or "just enough experience that would be equivalent to taking a basic coding course," according to **Rita Scichilone**, AHIMA's director of coding products and services.

"We have previously offered mastery-level credentials, for those who already have experience in the field, but not anything for the person that went through a basic course, has entry-level coding skills, and wants to get a basic job," she notes.

The CCA credential, she adds, will encompass the basic conventions and principles of the coding system — the ICD-9-CM and CPT/HCPCS codes.

Access personnel who attain this credential, Scichilone says, should be able to assign codes and enhance upfront billing preparation. This expertise also should help in complying with the electronic data interchange provisions of the Health Insurance Portability and Accountability Act, she adds, as the codes addressed are standard code sets.

By offering the credential, she adds, AHIMA is attempting to address what it understands is a nationwide shortage of coding expertise. "What we were hearing is that people were looking for a certification that followed basic training."

Examinations for AHIMA's higher-level certified coding specialist (CCS) and CCS-P (for physician-based coders) credentials are much more complex, Scichilone notes. "We don't require it, but we suggest two to three years' experience for people seeking those credentials."

AHIMA offers the RHIT and RHIA credentials for people with academic degrees and extensive coding experience, she adds. The coding basics course will be offered in four 15-week clusters, beginning in September 2002.

To sit for the exam, candidates must have earned a high school diploma from a U.S. high school, or have an equivalent education background, she adds. It is strongly recommended that candidates also have at least six months' experience in a health care organization applying ICD-9-CM and CPT coding conventions or guidelines, or have completed an AHIMA-approved coding certificate program or other formal coding training.

For more information on the coding credentials offered by AHIMA, go to the organization's web site at www.ahima.org. ■

Changes to privacy rule could lessen access load

Consent requirements lightened

Provisions of the Health Insurance Portability and Accountability Act's privacy rule that have drawn criticism from some health care providers — and could be problematic for access personnel — have been modified in changes proposed by Department of Health and Human Services (HHS) Secretary Tommy Thompson.

The proposed changes, published in the March 27 *Federal Register,* correct unintended consequences that threaten patients' access to quality health care, according to an HHS statement. Comments regarding the revisions were accepted through April 26.

Among other things, the modifications would remove some requirements having to do with the obtaining of patient consent. Proposed revisions that have particular relevance for access personnel include:

• **Strengthening notice provisions and remove consent requirements hindering access to care.**

Under the proposed changes, patients would be asked to acknowledge the privacy notice, but

physicians and other providers could treat them if they did not. Under the rule as now written, patients could be required to visit a pharmacy in person to sign paperwork before a pharmacist could fill their prescriptions. In addition, physicians could refuse to treat patients who refused to sign their privacy consent form.

• Maintaining the "minimum-necessary" rule, while allowing treatment-related conversations.

By covering oral communications and limiting the use of personal health information to the "minimum necessary," the privacy rule raised concerns that routine conversations between physicians and patients, nurses, and others involved in a patient's care could violate the rule.

The proposed changes would continue to cover oral communications and maintain the "minimum-necessary" requirement, but would make clear that physicians could discuss a patient's treatment with other health care professionals involved in their care. As long as reasonable safeguards are taken to protect personal health information, incidental disclosures — such as another patient hearing a snippet of conversation — would not be subject to penalties. Improper disclosures still would violate the rule.

• Assuring appropriate parental access to children's records.

There was concern that the current rule unintentionally limits parents' access to their children's medical records. The proposal clarifies that state law governs disclosures to parents. In cases where state law is silent or unclear, the provisions would permit a health care provider to use discretion to provide or deny a parent access to such records.

• Simplifying authorizations.

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

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

Editorial Questions

Call **Christopher Delporte** at (404) 262-5545.

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Editor: **Lila Margaret Moore**, (520) 299-8730.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Christopher Delporte**, (404) 262-5545, (christopher.delporte@ahcpub.com).
Production Editor: **Nancy McCreary**.

THOMSON
AMERICAN HEALTH CONSULTANTS

The changes would allow the use of a single type of authorization form to obtain a patient's permission for a specific use or disclosure that otherwise would not be permitted under the rule. Patients will still need to grant permission in advance for each use or disclosure, but the proposal would eliminate the need to use different types of forms to obtain that advance permission.

The American Hospital Association (AHA) in Chicago has come out in favor of the proposed changes, saying they "will help restore much-needed balance between protecting patient privacy and giving patients access to responsive health care."

AHA president **Dick Davidson**, who wrote an op-ed column in *USA Today* supporting the revisions, said that removing the "redundant" written consent form requirement and replacing it with a "simple but effective" written acknowledgement "is a common-sense way to enhance privacy."

Davidson's position runs counter to that of the newspaper's editorial board, which says the changes favor health care industry convenience over patient privacy. Additional information about the privacy rule is available on the web at www.hhs.gov/ocr/hipaa. ■

MSP rule change announced by CMS

In the latest chapter in the ongoing saga of Medicare Secondary Payer (MSP) regulations, the frequency with which hospitals must collect MSP information for recurring outpatient services and for hospital reference labs has been reduced, the Centers for Medicare & Medicaid Services (CMS) announced, which was reported by the on-line news service *AHA News Today*. The March 20 decision was made "due to AHA [American Hospital Association] concerns," according to the CMS.

In a letter sent to CMS in March, the Chicago-based AHA expressed concern that the federal agency's previous decision to collect the information every 30 days for recurring outpatient services and every 60 days for reference labs "does not adequately address [Department of Health and Human Services] Secretary [Tommy] Thompson's commitment to paperwork reduction."

AHA officials have stated that the organization will continue to work with CMS to eliminate the requirement altogether for reference labs.

(For a report on reaction to the agency's Sept. 25, 2001, program memorandum on MSP data collection, see *Hospital Access Management*, December 2001, p. 133.) ■