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HIM professionals are crucial in efforts to prevent fraud and abuse allegations

Biggest problem is lack of proper documentation

It's an old story that just grows more complicated with each passing year of new Medicare coding changes and health regulations: Coding mistakes, whether intentional or not, can lead to a government investigation about fraud and abuse.

"Usually the biggest problem is the lack of proper documentation on the part of physicians or other providers," says **Charles E. Colitre**, BBA, president of Med-Management Group Inc. of Akron, OH. Before heading a health care compliance consulting company, Colitre worked for the FBI, supervising investigations in health care and other fields in the Northeastern Ohio region.

"Particularly in the evaluation and management codes, the documentation needs to cover enough of the required areas to justify the coding level," Colitre says. "Clinicians need to be very specific about what their impressions are and what the diagnosis is."

Strategies to prevent federal investigations into alleged fraud and abuse include having a compliance program in place that includes HIM staff.

Whenever a health system has a compliance program that is designed to prevent errors and that corrects problems as they arise, federal officials will see this as a mitigating factor in any investigation, Colitre says.

Health care facilities also should have ongoing staff training about coding changes and to reinforce policies and procedures, says **Karen Scott**, MEd, RHIA, CPC, CCS-P, owner of Karen Scott Seminars and Consulting Services of Bartlett, TN. Scott also is an associate professor in Health Information Management at the University of Tennessee in Memphis.

"Make sure people are up-to-date. That's the main thing," Scott says. According to federal regulations, if a coder or health care professional could have or should have known about a policy, coding change, or

regulation, then that person is held responsible for fraud or abuse that results from ignorance, Scott says.

This means HIM staff must keep up with the ICD-9 and CPT books, as well as the official coding guidelines developed by cooperating parties which include the American Hospital Association (AHA), the American Health Information Management Association, the Centers for Medicare and Medicaid Services, and the National Centers for Health Statistics. The guidelines cover both inpatient and outpatient coding.

"There are official coding guidelines available on the CMS web site and in several other places," Scott says.

Also, HIM staff are responsible for knowing information, including local carriers and fiscal intermediary rules, sent out by Medicare on memorandums, quarterly publications, and bulletins, Scott says.

The carriers and fiscal intermediaries typically have web sites that publish the rules, and they'll send printed information to health care facilities. "But that often doesn't make it down the trail and get to coders, so coders need to make sure they're up-to-date on all that," Scott says. **(See story on educating staff to prevent coding problems, p. 86.)**

Another prevention strategy is for all departments within a health care system, including the HIM department, to have their own policies and procedures, Colitre says.

"Policies and procedures will ensure that the procedures that they perform and the supplies and services they render are properly captured and billed," Colitre says.

"Overall, within a health care system, those departmental policies and procedures should mesh together under one compliance officer who makes sure it's all running as one system," Colitre says.

Hospital systems make good targets

HIM professionals should keep in mind that hospital systems traditionally are attractive targets for the government because they have the money to pay fines, Colitre adds.

Another fraud and abuse strategy is to know how peers are coding various procedures. The government often will target facilities where physician coding is outside the norm, Colitre says.

For example, if a particular facility has a greater-than-average number of codes for the more complex pneumonia cases, then the government might investigate to see if the facility is upcoding pneumonia cases.

Coders are responsible for making certain that a physician's documentation adequately supports the diagnosis. If additional documentation is needed, the coder should send the physician a query form requesting more information.

However, coders need to be careful that they do not lead physicians to a coding answer, because doctors might just write down whatever the coder suggests, Scott adds.

For example, there's often a problem deciding whether a code should be for septicemia or urinary tract infection. Clinically, the two are similar, although septicemia is more severe, and this code results in higher reimbursement from Medicare.

"The Office of Inspector General has found that some hospitals were overcoding septicemia when there wasn't enough documentation to show it was that," Scott says. "So hospital coders are looking at these charts and thinking it could be septicemia, but it might not be. They need clear documentation from the physician that it is septicemia."

Coders need to be certain the physician's documentation, blood culture findings, and clinical findings clearly indicate a septicemia diagnosis before it can be coded that way, Scott adds.

HIM departments that conduct regular audits of charts and coding will catch coding mistakes or physician trends that result in higher-than-typical charges.

"If an HIM auditor sees that one physician is always using a particular drug while peers are not, this should be called to someone's attention," Colitre says. "HIM people can work with their compliance officers to [engage in] ongoing monitoring and to put systems into place that will assist individual departments to monitor properly."

Currently, an area that is receiving a lot of fraud and abuse attention is coding of patient services in connection with clinical research trials, Colitre says.

Typically, patients who are also research subjects receive free medications during a clinical drug trial, and the drugs usually are provided by the sponsor of the trial. But there are cases when the patients have side effects that require additional medication such as an anti-nausea agent, Colitre explains.

"You have to be very careful that if these drugs are being provided by the sponsors that you are not turning around and billing for them," he says. "It's very critical that those charges are pulled out."

HIM professionals need to watch for those types of charges and should be aware of cases involved in clinical research so they can be sure there is no improper billing, Colitre adds. "Those people should be identified in information systems, and their trial research items should be clearly identified, accounted for, and not charged to the payer." ■

Here are the rules for using new APC observation code

Closed ED observation units will reopen

A 45-year-old woman with a history of high cholesterol comes to your ED with nausea and shortness of breath. Her cardiac markers and electrocardiogram (ECG) are normal. Do you discharge or admit?

In this case, the woman was sent to an ED observation unit. Three hours later, she began having chest pain and a second set of enzymes and an ECG revealed a myocardial infarction, recalls **Sandra Sieck**, RN, director of cardiovascular development at Providence Hospital in Mobile, AL.

In the past, the patient would have been discharged with a possible return admission within 72 hours, or admitted without a confirmed diagnosis, says Sieck. New reimbursement for ED observation gives you a "third door" option for patients, reports Sieck.

As of April 1, you're reimbursed by the Centers for Medicare and Medicaid Services (CMS) for observing patients with chest pain, asthma, and congestive heart failure in the ED, due to a new ambulatory payment classification code (APC 0339). **(See resource box for information on how to obtain a copy of the complete CMS ruling, p. 84.)**

The new APC code has a payment rate of $351, and it will be a major financial boost if you provide observation services for Medicare patients, according to **Michael A. Ross**, MD, FACEP, director of the emergency observation unit and chest pain center at William Beaumont Hospital in Royal Oak, MI.

"The amount that is paid for this observation APC is greater than what is paid for any of the emergency visit APCs, and it is in addition to those," he explains.

This is appropriate, because more time and nursing care are required for observation patients, adds Ross. **(See related story on what to tell your administrator about the new APC code, p. 85.)**

Some ED observation units closed after APCs were implemented in April 2000 because there was no separate reimbursement. But that likely will change, according to Ross. "Since the new APC code was announced, the number of calls I have received about ED observation has quadrupled," he reports. "I have also seen several EDs open new units in the last six months."

Some patients still left out

Some ED managers argue that CMS didn't go far enough, because many patients still are not covered.

"CMS first offered no separate reimbursement and are now giving it back only for 20% of patients," argues **Louis Graff**, MD, FACEP, FACP, associate chief of emergency medicine at New Britain (CT) General Hospital.

He points to the following conditions that are not covered under the new APC code: dehydration, abdominal pain, syncope, gastrointestinal bleeding, atrial fibrillation, and seizures.

"If you are observing a patient with a condition other than chest pain, asthma, or congestive heart failure, you won't be reimbursed," he says.

To be reimbursed for any patient observed in the ED, you must follow specific criteria required by CMS, as follows:

- **An ED visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601, or 0602) must be billed in conjunction with each bill for observation services.**

If you don't have a billing code for an ED visit or clinic visit, you will fail the billing audit by CMS and won't be reimbursed for observation, says Graff.

"There are specific CPT billing codes for the three conditions, and you need to be familiar with them," he adds.

- **Observation care must be billed hourly for a minimum of eight hours up to a maximum of 48 hours.**

Ross notes that most patients do not spend

more than 12-15 hours in an observation unit. "If a patient's length of stay is beyond that, you may be losing money, or at least not maximizing payment," he says. "So it's in your best interest to do everything possible to meet that benchmark."

He notes that the patient's stay in ED observation isn't counted from when the physician writes the orders, because that is a physician service and not a hospital service. "The clock starts when the nurse *acts* on the physician orders," he explains. Therefore, it's important that the ED nurse documents that action in a clearly identifiable way, says Ross.

"CMS does not specify the setting observation must take place in," he notes. "If the physician wrote the orders in the ED, the nurse could start the orders there, before the patient actually is brought to the observation bed."

It's also important for physicians to document the time they discharged the patient from observation, because that is when the "clock" ends, adds Ross.

• The patient must be under the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

CMS requires in-person physician involvement for ordering observation, assessing, and writing orders and admission/discharge notes, says Ross. He gives the following examples of "bad observation" in CMS' view:

— prolonged ED visits billed as observation;

— patients discharged but awaiting a ride home, to meet the eight-hour rule;

— a patient in a holding pattern who is not being actively managed.

"These are examples of the type of service they are trying to steer away from," says Ross. "They want clear documentation of very aggressive physician involvement. For that kind of service, they are willing to unbundle observation."

• The medical record must include documentation that the physician used risk stratification criteria.

You must use specific criteria to support the use of ED observation, advises Ross. "You need a written policy for how the service will operate in general and also written policies for each of the specific conditions you will be managing," he says.

• The physician must write admission and discharge notes in the medical record.

Here's where to get more information about APC rules

The Centers for Medicare and Medicaid Services final rule, which contains information about the new ambulatory payment classification code created for ED observation, is titled *Medicare Program; Correction of Certain Calendar Year 2002 Payment Rates Under the Hospital Outpatient Prospective Payment System and the Pro Rata Reduction on Transitional Pass-Through Payments; Correction of Technical and Typographical Errors.* The final rule was published in the *Federal Register* on Nov. 30, 2001, and an amendment was published March 1, 2002.

To order a copy, contact New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or your Visa or MasterCard number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $10. The *Federal Register* is available at many public and academic libraries. It is also available via GPO Access, a service of the U.S. Government Printing Office. The web site address is: www.access.gpo.gov/nara/index.html.

Ross notes that the following documentation is required for ED observation patients:

— the initial history, physical, and medical decision-making done in the ED;

— progress notes;

— a final discharge summary including the clinical course in the unit, final examination, medical decision-making, and discharge instructions.

"This allows the ED physicians to bill the 'observation' professional CPT codes instead of the 'emergency' codes," says Ross. "The advantage is that the observation CPT codes also pay for the work of discharging the patient, whereas the emergency codes do not."

• With regard to direct admissions from physician offices, separate payment for observation will not be made unless a physician is

present to order the initiation of observation services and to monitor the patient as clinically appropriate.

When a patient is admitted directly from a physician's office, there is no separate payment for observation, says Ross.

"CMS is making it crystal-clear that payment for that type of observation occurs, but it's a bundled payment," says Ross. Instead, the patient could be sent from the physician's office to the ED where initial evaluation and management occurs, Ross suggests. "In many cases, that patients may actually meet inpatient criteria," he says. "If not, they still can be observed." ■

Share this good news with your administrator

New code gives incentive for ED observation

The new ambulatory patient classification (APC) code for ED observation presents an exciting opportunity for better outcomes, both clinical and financial, according to **Sandra Sieck**, RN, director of cardiovascular development at Providence Hospital in Mobile, AL.

"Show your hospital CEO that this is a win-win situation for patients, hospitals, ED physicians, and cardiologists," she urges. "Finally, hospitals have a financial incentive for ED observation."

Here are some key points to share with your administrator:

• **There will be a boost in revenue.**

The new APC code will have a significant impact at William Beaumont Hospital in Royal Oak, MI, according to **Michael A. Ross**, MD, FACEP, director of the emergency observation unit and chest pain center.

"With the introduction of APCs, we were not paid in any identifiable manner for a third of the patients we observed," he says. "Now we are paid for those cases, in a way that I think is fair and equitable."

The ED observes approximately 7% of its total census, reports Ross. "We have a very high acuity and avoid admitting 80% of the patients we observe," he says.

He reports that of patients older than 65 observed in the ED over the past five years, 34% had chest pain, asthma, or congestive heart failure, the three covered conditions under the new APC.[1]

Ross says the ED observation service was "hanging by a thread" after the implementation of APCs in April 2000. "If the additional payment had not been given, we might have had no choice but to close the unit and admit everybody," he says.

Ross points to another financial benefit of ED observation. "At our facility, we found that one observation bed effectively opened between 2.35 and 3.15 inpatient beds by providing accelerated care," he says.[2,3]

The hospital desperately needed the additional capacity because of overcrowding, he explains. "That factored into our decision to continue ED observation," says Ross.

Sieck recommends handing your administrator a single-page flow chart that shows how to optimize clinical and financial outcomes. "The chart demonstrates patient flow from triage through discharge from the ED, admission or observation, and shows you how to receive the additional reimbursement from the new APC code," she says.

• **There are better clinical outcomes.**

The new APC code gives you a chance to provide better care without being hindered by lack of reimbursement, says Sieck.

"We are now able to provide the quality of care that the community deserves," she says. "We can find out whether the patient had a heart attack, is going to have a heart attack, and educate them about risk factors for a heart attack, all in the ED."

She points to research showing that patients with sporadic chest pain take over two days to consider coming to the ED.[4] "By the time they have compounding symptoms, there is a mean time of 2.5 hours before they enter the hospital," says Sieck.

She points to an ED observation unit as "an environment of easy access" that can reduce delays for patients seeking care.

• **Cardiologists will benefit from ED observation.**

According to CMS, cardiologists had a 12% reduction in reimbursement last year and therefore have an incentive to pick up more patient volume, says Sieck.

"They can do this through the ED observation unit," she urges. "More than half of ED patients with chest pain are unassigned to a physician."

The ED physician can call for a consultation from a number of physicians, Sieck explains. "If

you would like the referral, play ball with the ED," she says.

• **You can improve patient throughput in your ED.**

Sieck gives examples of two typical ED patients that can occupy a bed for hours: a patient with acute myocardial infarction who may be treated with thrombolytics, and a patient with non-ST segment elevation and unstable angina waiting for lab results.

"Meanwhile, a woman in your waiting room is complaining that her child was up all night with a 104-degree fever, and they have been waiting for six hours," she says.

If you create a designated area to observe the chest pain patients, you can dramatically reduce delays in your ED, according to Sieck. "You can then place the other patients in beds which were previously used by chest pain patients," she says.

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Use education to prevent fraud and abuse problems

Good training can be simple and cheap

There are many different ways HIM professionals can educate their staff about how to prevent coding mistakes that could lead to a Medicare fraud and abuse investigation.

"Figure out your staff's educational levels," advises **Karen Scott**, MEd, RHIA, CPC, CCS-P, owner of Karen Scott Seminars and Consulting Services of Bartlett, TN. Scott also is an associate professor at the University of Tennessee in Memphis.

"You can bring someone in to do seminars, but if they teach coding basics and your staff have been working for 20 years in the field, their needs may not be met," Scott says.

HIM departments might use any of these education/training strategies:

• **Lunch and learn sessions:** This is where a department might have one day a month for staff to meet and be educated over lunch, Scott suggests.

Lunch could be bags from home or pizza provided by the facility. The education could be any topic of current interest, such as a change to local medical review policy.

Make staff part of training process

The luncheon session could be led by one person who is in charge of educational updates, or it could be a shared responsibility where everyone on staff has the opportunity to educate themselves and then teach others about a particular topic, Scott says.

"You could divide up new information and give everyone a page or new policy to study and then report back," Scott says. "This approach puts more emphasis on the staff, and it makes them a part of the training process."

Lunch and learn sessions often succeed because the informal setting encourages group discussion, which helps to reinforce the lecture, Scott adds.

Sessions might include information from the Medicare rules and regulations and the *Coding Clinic* publication that is published quarterly by the American Hospital Association.

"*Coding Clinic* is something else that every facility should be aware of because it has the official guidance, approved by the cooperating parties, including the Centers for Medicare and Medicaid Services (CMS). If *Coding Clinic* gives a certain way to code a scenario, then that's the gospel and you have to follow it," Scott says. "Do the lunch-and-learn session as the new *Coding Clinic* publication comes out, and this is another cheap and easy way to train and update staff."

• **State coding roundtables:** Each state's health information management association, which are affiliates of AHIMA, has a coding roundtable that is offered in free one- or two-hour sessions, Scott says.

In Memphis, TN, for example, the coding roundtables are held every other month and include a physician speaker who discusses a

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DRG CODING ADVISOR.

Expert offers guidance for using category 3 CPT codes

Medicare clamps down on use of 'unlisted codes'

With 10% or more changes to the more than 8,000 Current Procedural Terminology (CPT) codes each year, health care coders may find themselves intimidated by the prospect of learning what's new and what has changed.

"This year 950 changes were made to the CPT text itself in all different areas," says **Celeste Kirschner**, manager at PricewaterhouseCoopers of Chicago. Kirschner is a health care consultant who provides business advisory services for health care organizations. Kirschner is an expert on CPT codes and spent 16 years as the director of CPT with the American Medical Association in Chicago.

Also, there were 269 codes that were deleted in 2002, and coders may find that the code they have been using no longer is valid, Kirschner says.

"But it's not always the code change itself that necessarily is important," Kirschner says.

Even the guidelines and introduction to CPT changes can affect the way coders select a particular CPT code. "There were a couple of sentences added to the CPT text that were very important because they changed the philosophy of coding for some procedures," Kirschner says.

For example, the introduction to the CPT text refers to coders not selecting a code that merely approximates a code provided if the code they're trying to describe doesn't exist, Kirschner explains.

"If the code doesn't exist, you must use the unlisted code," she says. "In the past, people have been reluctant to use unlisted codes because of the documentation required, but this gives instructions to us to not use the next closest thing, even though we think it might come close to describing a service."

Kirschner outlines some other changes in coding practices:

• **Documentation requirements:** Audits of physicians at teaching hospitals have changed many health care systems' documentation practices, Kirschner says.

"Services were being provided that were not complying with Medicare regulations. While residents were providing the services, attending physicians were billing for them even when they were not in the hospital at the time the services were provided," she explains. "The documentation that goes along with teaching hospitals, as a result of these investigations, really started bringing home to people that they have to follow the rules."

Another cause for documentation changes was the implementation of Medicare documentation guidelines for evaluation and management services for physicians, Kirschner says.

"This brought to light a lot of deficiencies in documentation when folks started having the level of service they reported downcoded because they didn't have adequate documentation in the record to support what they said they were providing," Kirschner says.

"Those were the two biggest changes in modifying behavior, and while it's not 100% at this time, people have been paying a lot more attention to it than they have in previous years," Kirschner says.

• **Category 3 CPT codes:** These are codes for new and emerging technology, and the coding takes a different path than traditional coding for CPTs.

"These are a temporary set of codes for services that do not meet the requirements for a Category 1 CPT code, such as approval from the Food and Drug Administration [FDA], or FDA

approval is anticipated very shortly," Kirschner says.

While category 3 codes are there for data-collection purposes so people can demonstrate that the service is well-established in the medical community, the insurance industry has been largely unsure about what to do with these codes, Kirschner says.

"The federal government in the *Federal Register* says they don't exclude category 3 codes, and that it's on a case-by-case basis," Kirschner says. "They'll look and see if they want to cover it, making individual determinations about what the payment will be. So just because it has a CPT code, it doesn't mean you'll get paid for it."

• **Unlisted codes:** When there is no code that precisely identifies a procedure, the coder now must assign an unlisted code to that service, and this will means submitting additional documentation.

"If it's an operative procedure, most people would submit an operative report, and that's a document that they're already producing anyway," Kirschner says. "Where an operative report is not generated, then what you would do is one of two things: either submit a copy of the day's progress or clinical notes, or submit a written explanation of the procedure."

If the service didn't have a category 3 code, the coder would submit a statement on what the service was and what the documentation was. It's then up to the payer to decide whether it is covered under the patient's contract or whether it is a contract exclusion, Kirschner says. "There's no standard way to say whether this is always covered."

Coders will need to obtain the physician's notes and make certain this unlisted code doesn't fall through the cracks without appropriate documentation.

"If the coder normally files electronically, then depending on the computer system and process, there usually is a way to have a paper claim printed that can be mailed with the documentation," Kirschner says.

Since Medicare changed the philosophy behind using unlisted codes for physician services, HIM departments should expect to see an increase in the number of unlisted procedure codes that are being used.

"In a community-based facility, you'll probably see less of it because you won't have as many people developing new procedures in that environment as you would in an institution affiliated with a university," Kirschner says.

• **Pediatric surgery changes:** This is one of the more interesting CPT changes because it will require coders to determine an infant patient's age from conception, instead of just from birth.

"In the pediatric surgery area there were some new codes for hernia repair, and the most important is in surgery for premature infants," Kirschner says.

The changes to coding for these procedures reflects the new reality that premature infants are surviving at greater rates than in the past, so they are undergoing surgical procedures that are much more complex than they would be if the child was a 2-year-old, Kirschner explains.

Check medical records for maternal history

"So how do we capture and describe the level of complexity that is happening with perinatal procedures?" Kirschner asks. "One concept that was introduced this year is fairly complex: It's the concept of post-conceptual age, basing the age of the infant on the date of conception rather than the date of birth."

Coders will need to know this precise date because it will affect the code. So coders will need to check the medical records for the maternal history, which usually will state the estimated date of conception.

"It might be on the medical chart, or they might have to go back and ask for it from a pediatric surgeon or specialist," Kirschner says.

Here are some examples of how the coding for certain procedures differs according to post-conceptual age:

— **CPT 49491:** This is repair of initial inguinal hernia for a pre-term infant less than 37 weeks gestation at birth, performed from 35 weeks up to 50 weeks post-conceptual age; incarcerated or strangulated.

— **CPT 49492:** This is repair of initial inguinal hernia for a pre-term infant less than 37 weeks gestation at birth, performed from birth up to 50 weeks post-conceptual age, with or without hydrocelectomy; reducible.

— **CPT 49495:** This is repair of initial inguinal hernia for an infant under age six months or a pre-term infant over 50 weeks post-conceptual age and under six months from date of birth at the time of surgery; incarcerated or strangulated.

— **CPT 49496:** This is repair of initial inguinal hernia for full-term infant, under age six months or pre-term infant over 50 weeks post-conceptual

age and under six months from date of birth at the time of surgery; with or without hydrocelectomy; reducible.

For coders who need assistance in calculating gestational age, there is a web site with information on this at http://members.aol.com/winston/index.htm. ■

AHIMA wants to move from ICD-9-CM to ICD-10-PCS

A look at AHIMA's testimony

Calling the ICD-9-CM procedural coding system outdated and unable to meet the needs of today's health care industry, a HIM industry representative asked a national health statistics committee to replace the system with the new ICD-10-PCS system.

"The ICD-9-CM procedural coding system is obsolete and must be replaced," testified **Sue Prophet**, director of coding policy and compliance of the American Health Information Management Association (AHIMA) of Washington, DC, and Chicago, on April 9, 2002, to the National Committee on Vital and Health Statistics.

System on 'brink of collapse'

"Today, we are using a procedure coding system on the brink of collapse and unless this situation is addressed quickly and in concert with other coding system decisions that must be made, there will be serious consequences to the industry," Prophet testified.

"This coding system was designed and implemented over 20 years ago, and since that time dramatic advances in medicine and medical technology have occurred that were not anticipated and have not been adequately accommodated," Prophet told committee members. "For example, laser and laparoscopic surgery were not performed at that time, but are now utilized for many types of procedures."

Prophet discussed how AHIMA served on a technical advisory panel throughout development of the ICD-10-PCS system and how the system was formally tested by AHIMA-credentialed HIM professionals employed by the two Clinical Data Abstraction Centers.

"The results of the ICD-10-PCS testing by AHIMA were generally positive," Prophet said. "Individuals involved in the testing indicated that it is a clinically elegant and logical system, and that the system can be understood relatively quickly, resulting in reduced training time."

The problems with the ICD-9-CM coding system include a lack of granularity which causes a mingling of procedures that violates all normal coding system requirements, Prophet testified.

"We have run out of codes, and we are faced with choices such as replacement or a gerrymandering of coding rules and concepts just to keep the system going," Prophet said. "Such choices and delays in considering the obvious are decisions that only lead to more errors and more cost."

Prophet offered these examples of the coding system's vagueness and problems:

- A variety of different knee surgeries, including both open and arthroscopic repairs, are classified to code 81.47, "Other repair of the knee."
- Numerous types of aneurysm repairs are classified to code 39.52, "Other repair of aneurysm."
- Excision of skin lesions and all types of destruction of skin lesions (including that by laser, cryosurgery, cauterization, and fulguration) are classified to code 86.3, "Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue."

Other problems with the ICD-9-CM procedure coding system are the following, according to Prophet:

- contains overlapping and duplicative codes;
- includes inconsistent and outdated terminology;
- lacks codes for certain types of services;
- lacks sufficient specificity and detail (such as laterality or surgical approach);
- has insufficient structure to capture new technology.

Also at issue are the goals and philosophy behind coded data, Prophet said.

While coding systems initially were designed as statistical analyses of mortality and morbidity and were used for indexing and retrieving medical and epidemiological research, education, and medical audits, they have many more uses today, Prophet testified. Here are some examples she gave the national health statistics committee:

- payment system design and processing claims for reimbursement;
- measuring the quality, safety, and efficacy of care;
- managing care and disease processes;

• research, epidemiological studies, and clinical trials;
• setting health policy;
• operational and strategic planning and the designing of healthcare delivery systems;
• monitoring resource utilization;
• identifying fraudulent practices;
• tracking public health and risks;
• providing data to consumers regarding costs and outcomes of treatment options.

"As I have noted, nothing has changed to negate the problems cited in this report, with the exception that now the problems have grown worse, such as the fact that we are running out of codes and these problems are impacting the healthcare industry at an even higher level," Prophet said.

The ICD-9 is an obsolete system that also is causing day-to-day problems for health care facilities, Prophet said. These are:

• There are increasing requirements for submission of documentation to support claims.
• Accurate data on new medical advances cannot be collected.
• Requirements of the 2000 Benefits Improvement and Protection Act cannot be implemented; therefore, new services and technology cannot be accurately accommodated.
• There is a lack of data to support performance measurement, outcomes analyses, and cost analyses.
• There is an increasing need for manual review of medical records for research and "data mining" purposes.
• The opportunity for fraud/abuse (due to the number of different procedures categorized to the same code, such as covered and noncovered procedures) keeps increasing.

Although AHIMA strongly recommends a switch to the ICD-10-PCS system, the organization acknowledges that this will require considerable training for coding personnel because the new system is substantially different from classification systems currently in use.

"After an initial learning period to familiarize themselves with the new system, AHIMA-credentialed coding professionals understood and applied the system with relative ease," Prophet testified. "The degree of specificity in ICD-10-PCS facilitates identification of the correct code."

Also, ICD-10-PCS requires a more extensive knowledge of anatomy and physiology than the ICD-9-CM procedural coding system, so some coders may need additional training in this area, Prophet said. ■

New coding credential may interest access staff

It covers 'basic instruction'

The Chicago-based American Health Information Management Association (AHIMA) recently announced a new entry-level coding credential. The certified coding associate (CCA) credential is designed for people 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.

The CCA credential, she adds, will encompass the basic conventions and principles of the coding system — the ICD-9-CM and CPT/HCPCS codes. People who attain this credential should be able to assign codes and enhance up-front 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, AHIMA is attempting to address what it sees as a nationwide shortage of coding expertise, Scichilone explains. "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, Scichilone says. 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. ■

(Continued from page 86)

particular procedure or diagnosis. After the speaker is finished, HIM professionals discuss how the procedure should be coded.

"When we talk about it, we get different opinions," Scott says. "So many times there's not one right way to code something. It's more how someone interprets it."

• **Audio seminars:** These are growing in popularity because they are relatively inexpensive and allow flexibility in scheduling educational sessions.

"You listen to the conference over telephone lines while watching a PowerPoint slide show on the computer screen," Scott says.

The way these typically work is that a company will put the slide presentation on a web site that can be accessed through a password, which is given to facilities when they buy the service.

Then the facility has a number of staff taking the conference through the telephone lines while watching the web site slide presentation on either a big screen or individual computer monitors.

"You can have 40 people in the room and pay one set fee," Scott says. "Usually these are one or two hours long, so they're not taking staff away for a whole day, and there are no travel costs."

Another advantage is that the facility may select audio conferences that provide precisely the education or training that is needed, Scott adds.

• **Physician query sheets:** Most facilities have physician query sheets as a way for coders to ask doctors questions about diagnoses, coding, and charts.

What's new is that CMS now says that these forms can be used, but they cannot be considered adequate documentation on which to base coding. In other words, coding has to be based on what's documented in the medical record. So if a physician left something out, he or she has to return to the medical record to make the change.

"The whole reason we use query sheets is [doctors] didn't write it down and it's hard to call them up on the phone or catch them in the hall."

Coders can let physicians know what is needed by leaving a query sheet or notes with the medical chart where physicians will view it, Scott says. You can write, "Here's clinically what we found in the chart. Can you comment on the appropriate diagnosis?" Scott says.

"We need to educate physicians about doing this," Scott stresses. ■

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 in Baltimore undertook a comprehensive revenue recovery initiative that doubled its recovery rate on denied days, explains **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.

Denials are another way of discounting

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."

Pay attention to contract to avoid denied claims

Make use of your provider manual

There are several things that billing 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.

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 Fotheringill's experience, she 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." ■

"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, the hospital first looked internally for help, he explains. "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." ■

Don't take no for an answer: Write an appeal letter

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 about how hospitals are using contract law to get reimbursement denials reversed.

"We don't seem to be having as much luck [with appeal letters]," Smith says. "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 a sample appeal letter **(see sample letter, p. 93)**, 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

Sample Letter

[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.

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.

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.

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 staff in your hospital's managed care department, who can refer to the provider manual or contract. If information on the appeals process and addresses is not available or 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 — 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.** 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. ■

You can reduce delays with wireless registration

Bedside registration can cut delays by 5-7 minutes

At Methodist Hospital in Indianapolis, ED patients are registered on a Compaq computer with a wireless network card, all mounted on a platform with wheels.

"This allows us to bring patients back to the room, if space is available, and register them at the bedside," says **William H. Cordell**, MD, a faculty physician at the hospital's emergency medicine and trauma center.

Previously, a line often formed in the ED waiting room so patients could register before being placed in a room for evaluation and treatment, which increased overall length of stay, says **Kathy Hendershot**, RN, MSN, CS, director of clinical operations for the ED. To eliminate the "bottleneck" of registration, the decision was made to switch to bedside wireless registration.

COMING IN FUTURE MONTHS

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"The goal was to help with our throughput and patient satisfaction," she explains. "We wanted to get away from the perception that we were more worried about insurance and money than caring for the patient."

Here are effective strategies to use when implementing wireless registration:

• Invite resistant individuals to help implement the new system.

There was some difficulty "selling" the wireless system to the business and financial office, which registration clerks report to, says Hendershot. "There was additional cost of equipment, more physical demand on their staff and changing a process that worked for them," she explains.

The solution was to get key individuals involved early on in the process so they could participate in designing it, she says.

• Consider cost issues.

The ED spent approximately $25,000 to update the six workstations, Hendershot says. "The cost was for top-of-the-line hardware and some software upgrades for our system," she explains. Hendershot adds that costs depend on the equipment you select and the square footage you need to cover.

• Consider that the patient may be treated before registration is complete.

In some cases, the ED nurse and physician may have treated the patient before registration is completed, Cordell notes. "Thus the patient may have to wait until the discharge papers, which require registration, are completed."

Patients also must be registered into the system before X-rays can be obtained, he adds.

• Track delays.

After the ED switched to the wireless system, a savings of 5-7 minutes per patient was demonstrated. "This does not seem like a lot, but it is when you are seeing volumes in the 300 per day range like us," she says.

She notes that a "straight-back-to-registration" process can accomplish a similar time savings for most EDs as long as beds are available, whether or not it is wireless.

To track progress, a specific performance indicator was identified. "We choose 'triage to room' time as our first indicator to trend for improvement," says Hendershot.

Minimal improvement was shown, but a more dramatic change occurred in the "triage to physician" times. "This may be the best performance marker to keep," according to Hendershot. ■

AHIMA publishes new health IT book

The American Health Information Management Association (AHIMA) has published a new book, titled *Health Information Management Technology: An Applied Approach.*

Hospital Payment & Information Management™ (ISSN# 1074-8334), including **DRG Coding Advisor**®, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Payment & Information Management**™, P.O. Box 740059, Atlanta, GA 30374.

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Editorial Questions

For questions or comments, call **Alison Allen** at (404) 262-5431.

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The book includes AHIMA's set requirements for the accreditation of HIT programs and the certification of HIT graduates. It's written for associate degree students who are starting out in a health information technology program.

Its topics range from the functions of the health care record to information security, and it includes discussion of concepts and principles.

Each chapter has a list of learning objectives, key terms, application exercises, real-world case studies, and review questions, followed by a quiz.

The book is edited by Merida Johns, PhD, RHIA, and is written by 22 health information management experts and educators.

The book costs $60 for AHIMA members and $75 for others. For more information, visit AHIMA's web site at www.ahima.org/commerce, or call (800) 335-5535. ■

RAND looks at standards for e-prescription systems

A team of researchers from the Santa Monica, CA-based think tank RAND is working on a set of standards for electronic prescription writing. The group reported in March that there are several issues that need to be addressed, including:

- privacy and security of patient data;
- full disclosure of the criteria used to label drugs;
- full disclosure of funding source for product;
- the quality and completeness of the data on which assessments of drug interactions or drug safety are based;
- user interface design.

An independent panel of nationally recognized experts is providing guidance in developing the standards and will review the final recommendations. The panel, chaired by Donald M. Berwick, MD, the president of the Institute for Healthcare Improvement, also includes leaders from medicine, nursing, pharmacy, medical informatics, health policy, and law.

In the last three years, dozens of new electronic prescribing products have appeared on the market, including programs for hand-held devices, Internet-based applications, and systems designed to interface with office management software and electronic medical records. Some of these systems simply provide printed prescriptions; others recommend drugs based on a patient's insurance coverage or warn about potentially dangerous drug interactions. The most sophisticated systems suggest drugs tailored to the patient's medical condition and even initiate lab tests to monitor the patient's response to therapy.

Order of names can influence choices

Whether this powerful decision-support technology actually improves patient care depends on how it is implemented and how it is used, says RAND's initial report on the topic. For example, the order in which drug names appear in a menu of choices or the wording in alert screens may bias doctors' drug choices or introduce new types of prescribing errors. The RAND team currently is classifying existing systems and will choose six to 10 exemplary systems that span the range of available features. In-depth review of these systems will be the basis for developing standards, which should be ready for dissemination within 12 months.

This study is underwritten by a grant from Pfizer Inc. For more information, including a listing of the expert advisory panel members, visit the project web site at www.rand.org/health/eRx. ■