

# HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

## INSIDE

■ **Backtracking:** HCFA will reverse policy and allow data to be transmitted over the Net . . . . . 163

■ **Fact or fiction:** Preparing for year 2000 problems requires dose of reality . . . 164

■ **Steps for success:** Pointers for your year 2000 contingency plan . . . . . 166

■ **DRG Coding Advisor** . . 167

■ **Web sites:** Get help with year 2000 contingency planning . . . . . 172

■ **Paperless trail:** Surgery center uses latest technology to keep track of patients . . . 172

■ **Overview of the AdvanTRAX process.** . . . . . 175

■ **News brief:** HHS plans to issue Medicare/Medicaid fraud disclosure guidelines . . . . 176

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## Brace yourself: HCFA releases maligned Medicare outpatient PPS

*Rural and cancer hospitals may suffer the hardest hit*

**P**rovider organizations are concerned that the proposed Medicare prospective payment system (PPS) for outpatient services may result in some providers fighting for financial viability.

The system, published in the Sept. 8 *Federal Register*, proposes payment reductions, a volume expenditure cap for the year 2000, and costs passed along from reduced beneficiary coinsurance.<sup>1</sup> The good news is that organizations have time to work with the Health Care Financing Administration (HCFA) in Baltimore on the proposal because potential year 2000 problems will push the implementation of the outpatient PPS back until at least April 2000.

The American Hospital Association's (AHA) Washington, DC, office has several concerns about the proposal, says **Linda Magno**, interim vice president for policy. The volume expenditure cap, for example, will reduce the hospital update to offset higher-than-expected increases in volume.

"The business of projecting future outpatient volume is messy, not precise," says Magno. "[Projections] are only as good as what you know at any given time."

The future level of outpatient services is unpredictable, especially since the impact of future scientific advances isn't known, she adds.

## Special report

**T**his month's *Hospital Payment & Information Management* includes a special insert for our readers containing the Health Care Financing Administration's proposed hospital DRG changes for fiscal year 1999, which began Oct. 1. This includes the new list of DRGs and their weighting factors; new diagnosis codes, procedure codes, table diagnosis codes, invalid procedure codes, revised diagnosis code titles, and revised procedure code titles; Medicare percentile lengths of stay; and a comparison of total payments per case. ■

“On any given day, a new therapy or a new drug allows patients currently treated in an inpatient setting to be treated in an outpatient setting. You may create tremendous growth in an outpatient area. It’s appropriate and desirable.”

“We do the right thing by our patients,” Magno adds, “and we get penalized in the future because outpatient volume is higher than HCFA predicted it would be.”

Another concern is HCFA’s decision to pass on to hospitals a \$570 million reduction that will result from reduced beneficiary coinsurance. “Instead of capping beneficiary coinsurance at the national average, [HCFA] went to a national median, which is lower than the average,” Magno says. “As a result, the system, rather than being budget-neutral, which we believe Congress intended the system to be, takes 3.8% of outpatient revenue out of the system.”

HCFA seems to believe that provider behavior will change under the new payment system to offset losses in revenue, she says. For example, the agency may think that hospitals may make efforts to increase volume. “Hospitals don’t generate volume,” she says. “We’re not clear what behavior change they expect.”

### ***The hit on rural and cancer hospitals***

The 3.8% revenue is what HCFA estimates that the reduction in payments to hospitals overall will be relative to current law. However, the actual reduction varies by hospital type, location, types of services, and special mission, such as teaching or serving a disproportionate number of poor, Magno notes.

Redistributions also may occur as a result of current payment methods. The new system redistributes the current total Medicare payments, based in part on cost-based payments and in part on blended-payment amounts, across all services. Hospitals, in the aggregate, will receive proportionately less for services that are currently paid based on costs and more for services that had

been paid under blended payment methods.

“Our concern about redistribution is that we don’t know why it’s occurring,” Magno says. “We don’t know if it is a flaw in the way cases are classified, a flaw in the classification of [ambulatory payment classification] APC, [a flaw in the way] it is coded, or a flaw in not adjusting for legitimate differences in hospital costs or for certain types of hospitals. So we need to get below the surface and find out why there are redistributions.”

In addition, if a group of hospitals is losing 9% of outpatient revenues, some in that group will lose 15% or 20% and some will lose no revenues under the new system, she says. “Some have to change the mix of services they offer.”

The hit may be too much for some hospitals. If the outpatient system is funded at less than cost, and then beneficiary coinsurance and expenditure caps are taken out, the system is now that much more below cost and the remainder is redistributed, Magno says.

This may result in access problems for some hospitals and communities, she adds. For example, a hospital in a rural area may find itself no longer viable because it’s heavily dependent on outpatient revenue and would take a big hit in moving to prospective pay. “It may eliminate one source to Medicare care in that community,” warns Magno.

HCFA acknowledges that rural and cancer hospitals seem to take the brunt of the new payment system. Low-volume hospitals — 75% of which are rural — appear to lose 17% of their payments and cancer hospitals lose 29.2%. The low-volume hospitals also receive a greater percentage of their Medicare income from outpatient services compared to their average-volume counterparts. HCFA is further analyzing the payments to both groups and may phase in the payment system or adjust the payments otherwise. Major teaching hospitals are also expected to take a big hit, at 9.4%.

HCFA is sending mixed messages to rural hospitals, says **Darin Johnson**, director of government affairs for the National Rural Health Association in

## ***COMING IN FUTURE MONTHS***

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Washington, DC. "We are hearing contradictory communications and commitments from HCFA in that they want to expand Medicare+Choice and create more availability of services for Medicare beneficiaries. Yet they are putting rural hospitals in a difficult situation by asking them to do more with a lot less money."

The cut in payments will further keep rural hospitals from being able to sign risk contracts and negotiate contracts with managed care organizations, which also ask those hospitals to do more with less. "There's just no place else to find the dollars," Johnson says.

"I think we are putting rural Medicare beneficiaries in a vulnerable position," he adds. "The reality of all these changes is going to be that these beneficiaries are not going to have access to health care services."

Next year should be a crossroads for rural health care delivery if HCFA does not consider how it can make an investment in these providers, he says. As the association previously testified to a commission on the future of Medicare, "maybe in the short term, HCFA and the federal government and state governments need to put some extra dollars into rural health care infrastructure to make sure that it's going to be there and be able to provide the services of Medicare and Medicaid in five or 10 years."

### ***Recommendations heeded***

AHA is pleased, however, that HCFA did respond to some of its recommendations. At AHA's request, HCFA withdrew a proposal requiring hospitals to bill for all diagnostic tests ordered for outpatients, including those furnished outside the hospital, AHA states. HCFA also revised a proposal requiring hospitals to bundle diagnostic tests with surgery or medical visits.

The rule only requires hospitals to bundle related costs, such as those that result from the use of an operating room, recovery room, drugs, and blood. And also at AHA's request, HCFA left flexibility in the process by which it determines which off-site clinics are part of a hospital and which are not. This is significant because, according to the proposal, clinics deemed part of a hospital are eligible for higher Medicare payments.

### ***Reference***

1. 63 *Federal Register* 47552 (Sept. 8, 1998). ■

## **HCFA may allow cyber-communication**

*New guidelines for security and appropriate use*

**T**he Health Care Financing Administration (HCFA) in Baltimore may be reversing its policy precluding the transmission of HCFA data over the Internet.

In a meeting last month, HCFA showed representatives of the Joint Healthcare Information Technology Alliance (JHITA) the draft of a policy that will allow the transmission of data — provided that proper steps are taken to maintain an acceptable level of security for the information involved, JHITA reports.

Previously, HCFA had prohibited the use of the Internet for the transmission of its Privacy Act-protected and other sensitive information because of security risks as well as the need to research security requirements. The Privacy Act of 1974 mandates that federal information systems must protect the confidentiality of individually identifiable data.

The Internet is an inexpensive way to transmit data, though, and the demand for its use has resulted in HCFA reconsidering its policy.

The draft policy is intended to establish the basic security requirements for transmission of HCFA data. The draft also addresses the means of documenting that those requirements are met through a self-certifying process. Alliance members who attended the meeting were pleased with the draft, says **Chuck Meyer**, informatics standards liaison for HBO & Co. in Atlanta. "The policy is straightforward. It makes use of existing technologies, and it should not be overwhelming for users in that it accepts readily available commercial solutions."

HCFA hoped to have **Gary G. Christoph**, PhD, HCFA CIO and director of the Office of Information Services, approve the draft, complete final staffing and release the new policy within a few weeks, JHITA says.

This policy covers "all systems or processes that use the Internet, or interface with the Internet, to transmit HCFA Privacy Act-protected and/or other sensitive HCFA information." Non-Internet Medicare/Medicaid data communication processes, such as the use of private or value-added networks, are not changed or affected by the Internet policy.

The draft permits the use of the Internet for transmission of HCFA Privacy Act-protected and/or other sensitive HCFA information, as long as “an acceptable method of encryption is utilized to provide for confidentiality and integrity of this data and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive such information.”

As of September 1998, a level of encryption protection equivalent to that provided by an algorithm such as Triple 56-bit DES for symmetric encryption, 1024-bit algorithms for asymmetric systems, and 160 bits for the emerging Elliptical Curve systems is recognized by HCFA as minimally acceptable, the draft explains.

The acceptable encryption approaches listed in the draft include the following:

#### **Hardware encryption**

While likely to be reserved for the largest traffic volumes to a very limited number of Internet sites, such symmetric password “private” key devices are acceptable.

#### **Software-based encryption**

**Secure Sockets Layer (SSL).** Sometimes referred to as Transport Layer Security (TLS). Implementations — at a minimum SSL level of Version 3.0, standard commercial implementations of PKI, or some variation thereof, implemented in the Secure Sockets Layer.

**S-MIME** — Standard commercial implementations of encryption in the e-mail layer.

**In-stream** — Encryption implementations in the transport layer, such as pre-agreed passwords.

**Offline** — Encryption/decryption of files at the user sites before entering the data communications process. These encrypted files would then be attached to or enveloped within an unencrypted header and/or transmission.

The draft also details acceptable authentication and identification approaches. The acceptable approaches for authentication include:

**Formal Certificate Authority-based** use of digital certificates.

**Locally managed digital certificates**, providing all parties to the communication are covered by the certificates.

**Self-authentication**, as in internal control of symmetric “private” keys.

**Tokens or smart cards** — In-band tokens involve overall network control of the token

database for all parties.

The acceptable approaches for identification include:

**Telephonic identification of users and/or password exchange.**

**Exchange of passwords and identities by U.S. certified mail.**

**Exchange of passwords and identities by bonded messenger.**

**Direct personal contact exchange of passwords and identities between users.**

**Tokens or smart cards.**

Out-of-band tokens involve local control of the token databases with the local authenticated server vouching for specific local users.

Once the final policy is released, any organization wanting to use the Internet for transmittal of HCFA Privacy Act-protected and/or other sensitive HCFA information must notify HCFA of this intent, the draft says. The draft includes an e-mail address that should be used for that acknowledgement.

*(Editor’s note: For more information on the HCFA Policy on the Use of the Internet for HCFA Data, visit JHITA’s Web site at <http://www.jhita.org>.)* ■

## **Is your facility prepared for year 2000 ‘reality’?**

*Plans should account for multiple failures*

**I**t’s Jan. 3, 2000. The electricity is still on, but some equipment thought to be year 2000 (Y2K) compliant has shut down. Staff are stressing out and running tests by hand. Sterile supplies are low, and another facility is trying to transfer over 20 of its patients.

Then to add more fuel to the fire, the Health Care Financing Administration (HCFA) in Baltimore announces that payments for Medicare and Medicaid patients may not be processed for at least six months.

Welcome to the new millennium.

“More and more executives are wrestling with the following ‘truths,’” says **Patricia Okita**, a senior systems consultant with Superior Consultant Company, in Southfield, MI, that specializes in year 2000 risk quantification and management, compliance planning, contingency planning, and business

## Take these four steps to Y2K success

This contingency plan provides a guide for hospitals in four phases.

The Business Continuity and Contingency Planning Approach (BCCP) outline (see box, p. 171.) was developed to help facilities structure an approach to address the continuation of business operations and contingency planning for impending disturbances, says **Ginger Campbell**, RN, PhD, a consultant in Tampa, FL, who works with a variety of health care organizations. "Its focus is on the implementation of efforts at that facility level."

The BCCP is a compilation of Campbell's own ideas as well as bits and pieces she has gleaned from other organizations' public-access contingency plans. "The BCCP is a guide," she says.

"It should be incorporated into the process and tailored to meet the unique needs of the client. Once the plan is developed, it must be kept current, and staff must be educated on a concurrent basis in order to remain prepared." (For more information about contingency planning, see related story, p. 164.)

To facilitate acceptance and implementation of the BCCP and related processes, Campbell addresses the contingency planning process in the following four phases, which should be supported by program and project management activities:

1. **initiation;**
2. **business impact analysis;**
3. **contingency planning;**
4. **testing.**

Campbell would like to hear from any providers who implement this format. To talk to her about this or to receive a more detailed version of the BCCP, call (602) 674-3299. Or e-mail her at [cgcamp@gte.net](mailto:cgcamp@gte.net). ■

continuity planning.

"It is highly unlikely that health care institutions will be able to make all mission-critical, noncompliant systems Y2K compliant. It is highly unlikely that health care institutions will be able to test all replacements and all renovations before the occurrence of Y2K-invoked failures," she warns.

"There continues to be more and more delays, failures, and virtually fruitless attempts to get a good grip, or just a grip, on how to solve the Y2K problems. The reality is that it is highly likely that mission-critical services — patient care, revenue collection, and revenue generation — will be disrupted by predictable and unforeseen year 2000 failures. The reality is that the survival of a health care institution is at risk," she adds.

A contingency plan helps hospitals determine what to do in the event of these failures. "In general, a contingency plan provides a reasonable series of activities to enable mission-critical business processes to be resumed at a 'minimum or acceptable level' in the event of predictable and unforeseen year 2000 failures," Okita says. "Contingency planning is simply planning for reality." (For tips on contingency plans, see related story, p. 166.)

Although hospitals are not required by law to have a Y2K contingency plan, more insurance companies and surveyors are asking their providers for one, says **Kerry A. Kearney**, partner and co-chair of the year 2000 practice group of the firm Reed Smith Shaw & McClay LLP in Pittsburgh. "Within the next quarter, you will start to see more health care entities gearing up to have them."

### *Envision all scenarios*

Providers should look at contingency planning as a process rather than a project, Okita says. "Year 2000 contingency planning is a continuous, dynamic process that assesses risks or liabilities associated with potential failures or disruptions of mission-critical businesses."

The minimum essential components of a contingency plan should answer these questions, she says:

- What could happen if the risk materializes?
- What can be done to mitigate the probability of occurrences?
- What are the essential actions to prevent, control, or eliminate the exposures?
- How much lead time is needed to invoke the contingency?
- Who is operationally responsible for activating a contingency?
- What is the life cycle of the contingency?

"Address year 2000 as a risk-based business challenge," advises Okita. "Consider a risk quantification strategy that enables management to

*(Continued on page 171)*

## Y2K rules of thumb

Listed here are some rules of thumb for health care providers to keep in mind when preparing Y2K contingency plans. This information is provided by **Kerry A. Kearney**, in her paper, *Y2K Update for Health Care Lawyers*,<sup>1</sup> and by **Alyssia Chapman**, JD, BSBA, NMCM, a supervisor with Uniband and contractor with Indian Health Service in Albuquerque, NM. Kearney is partner and co-chair of the year 2000 practice group of the firm Reed Smith Shaw & McClay LLP in Pittsburgh. **(For Web resources for contingency plans, see p. 172.)**

✓ Have management involvement. In the event of serious Y2K problems, choices will have to be made about what are the hospital's most important departments and priorities. These choices cannot be made by technical employees.

✓ Plan to have a SWAT team of employees on hand at the century date change who can determine what is not working and what can be fixed.

✓ Have backup phone equipment in case the phone lines are down. Cell phones are essential. In the event that cell phones don't work, consider using a ham (short-wave) radio.

✓ Do a department by department inventory of possible failures and determine whether the expected failures are mission-critical and what work-arounds are possible. Plan now for the cost of such work-arounds and consider again which departments are mission-critical and which are not, in light of work-around costs.

✓ Train employees now that they may be called on to work without reliable power and "essential" biomedical equipment.

✓ Empower employees to suggest ways to work around expected failures.

✓ Make arrangements with employment agencies to secure a contingent of qualified nursing and support staff for that time.

✓ Make sure the backup generator is working and the hospital has a supply of fuel. Consider using alternative energy sources such as solar power or passive wind-generating systems.

✓ Have on-site portable water sources in case normal sources are not available.

✓ Consider whether the hospital's cost-saving "just-in-time" inventory system should be modified in 1999 to stockpile key supplies. Stockpiling three to five times your normal

inventory is a good idea.

✓ Contact blood services to arrange for incremental deliveries throughout the last week of the year.

✓ Install perimeter security monitoring systems and lock all nonemergency and non-ED doors during this time to minimize unmonitored access.

✓ Inform the community in 1999 that there may be disruptions in 2000 in the delivery of health care services. Patients should be asked to keep copies of their bills and medical records in the event of Y2K computer glitches.

✓ Start keeping hard copies of transactions in 1999 in case of computer glitches.

✓ Determine what the hospital will do if its payment stream is interrupted because Medicare, Medicaid, or private insurers are not paying.

"Find out what kind of financial status you need to be in — in terms of liquid cash and credit — to cover your operational expenses," says **Ginger Campbell**, RN, PhD, a consultant in Tampa, FL, with a variety of health care organizations. "You will have to continue to maintain operations. What will be your break-even point? What patient volume can you sustain and not get reimbursed?"

✓ Decide what will trigger aspects of the contingency plan. For example, when will the hospital cut off suppliers if they miss deadlines to disclose their year 2000 plans?

✓ Expect the hospital's contingency plan to be the focus of litigation. For example, hospitals could be sued by patients injured because nurses had not been trained to perform manual tasks or by hospital suppliers that are cut off because they are not year 2000 compliant.

If hospitals do not have a contingency plan in place, now is definitely the time. "You need to have the plan on-line at least eight months before the D-day," Campbell says. "You need to have time to test ideas to see if the processes that you built in your contingency initiatives work. If they don't work, you have to allow yourself room to tweak them and replace them with other processes that do work. It's a business continuity issue."

### Reference

1. Kearney K. *Y2K Update for Health Care Lawyers*. Pittsburgh: Reed Smith Shaw & McClay LLP; 1998. ■

# DRG CODING ADVISOR.

## Accurate coding takes center stage under proposed PPS

By **Rita A. Scichilone**, MHSA, RRA, CCS, CCS-P  
Professional Management Midwest  
Omaha, NE

Coding professionals soon will take the limelight again, as CPT skills will be in high demand for the APC (ambulatory patient classification) system to be implemented by Medicare in the year 2000.

At first, a Jan. 1, 1999, implementation date was expected. The Health Care Financing Administration has announced that the delay is necessary because of system concerns for intermediaries related to the year 2000 computer processing problems. The actual implementation date will be published 90 days beforehand.

The proposed rules were published in the Sept. 8, 1998, *Federal Register*, beginning on page 47552. The prospective payment system (PPS) will apply to all hospitals, even cancer hospitals. The only hospitals exempted are certain Maryland hospitals that are paid under a reasonable cost system. All other hospitals will be reimbursed under the proposed system, including outpatient psychiatric service facilities that have excluded inpatient units.

Services that currently are paid prospectively by fee schedule or other prospective payment rates such as clinical diagnostic laboratory services, orthotics and prosthetics, and end-stage renal disease dialysis services, will not be affected by PPS. Hospital outpatient services provided to inpatients of a skilled nursing facility also will be excluded, since these services are furnished "under arrangement" and will be billable only by the skilled nursing facility for a covered stay under Part A Medicare. Services that are not packaged into the consolidated

billing rules, such as CT scans, MRIs, and surgery, would be paid separately by an APC. Physical, occupational, and speech therapy, as well as ambulance services also already are paid prospectively, so the APC system will not apply to those services. (See the list of hospital outpatient services excluded from PPS, and list of services included in the PPS, p. 168.)

### *CPT coding paved path for PPS*

CPT coding implementation in 1987 mandated by the Omnibus Budget Reconciliation Act (OBRA) 1986 laid the groundwork for a prospective payment system for outpatients. Reporting of HCPCS codes now is required for all outpatient services, which enables Medicare to determine the specific procedures and services that were being rendered to beneficiaries.

According to the *Federal Register*, of the 10,500 HCPCS codes available, more than 500 of them describe services that will be paid in the future under the APC system. Government research shows that as few as 100 HCPCS codes account for more than one-third of all coded services billed within a year. It makes sense that groups of codes would have associated payments, rather than each code having an allowed amount associated with it.

The proposed rules include additional requirements for bundling of some services, but they do not contain as extensive "packaging" as they could have. The system proposed does not include bundling related diagnostic testing conducted preoperatively for outpatient surgery. Also, there is no requirement that diagnostic testing be bundled into emergency department (ED) visits or hospital outpatient clinic visits. Any

diagnostic tests performed in these encounters will be paid separately. (See list of what is included in APC codes, p. 169.)

Packaged services by revenue center care are listed in the proposed regulations under the categories of surgery, medical visit, diagnostic, radiology, and other APC groups. A review of these

### Hospital Outpatient Services Excluded from PPS

- Physician services
- Nurse practitioner services
- Physician assistant services
- Certified nurse-midwife services
- Services of qualified psychologists
- Clinical social worker (per legal definition)
- Rehabilitation services (as defined by the law)
- Ambulance services
- Prosthetics and prosthetic supplies
- Durable medical equipment provided for home use
- Clinical diagnostic laboratory services
- Dialysis services furnished to end-stage renal disease patients
- Services not safely provided in outpatient setting (inpatient stay required)
- Services specific to other sites such as nursing homes
- Services provided to skilled nursing facility inpatients furnished "under arrangement"
- Services not covered by Medicare by statute
- Services not reasonable or necessary for diagnosis or treatment of disease

### Services Included in Hospital Outpatient PPS

- Partial hospitalization services furnished in community mental health centers and hospitals
- Outpatient surgical procedures
- Radiology procedures, including radiation therapy
- Outpatient clinic visits
- Emergency department visits
- Diagnostic services and tests
- Surgical pathology
- Chemotherapy
- Screening tests that are covered, such as colorectal screens
- Medical services such as antigens, splints, and casts; covered vaccines such as pneumococcal, influenza, and hepatitis B

shows that revenue code 250 (pharmacy) is packaged into all of the categories, along with other items that would be expected to go along with the major service, such as medical and surgical supplies.

The proposed rules outlined several approaches for setting the prospective rates for visit services such as ED and clinic visits:

- Approach one uses only the diagnosis codes in the grouping methodology.
- Approach two ignores the diagnosis code and uses the CPT codes only to drive the payment rates.
- Approach three combines diagnosis codes and procedure codes. This system employs 31 CPT codes that describe physician encounters with patients and groups them into seven APCs. Three groups are for clinic visits, three are for ED, and one is reserved outpatient critical care. This is accomplished by collapsing more than 12,000 diagnosis codes into 20 MDCs (major diagnostic categories). Use of this system results in a matrix of 121 CPT and MDC combinations.

Because facility resource use is not equal to physician effort, which the evaluation and management (E/M) codes are intended to document, some codes such as 99201 and 99202 result in the same APC group (APC 11), which is the lowest level of clinic visit. This creates some concern about the effect of a method that pays for hospital clinic visits at a different rate than physician office settings, due to the introduction of a diagnosis coding component. An example is provided of how this would work:

A new patient, an elderly woman who has recently come to live with her family in the area, presents to the primary care clinic complaining of fatigue, shortness of breath, swollen ankles, and loss of vision. The physician spends 45 minutes eliciting the patient's medical, family, and social history and performing an extensive physical examination. Suspecting cataracts as the cause of her loss of vision, the physician suggests she make an appointment in the eye clinic. Suspecting congestive heart failure as the cause of her other symptoms, but also suspicious of diabetes and hypertension, the physician orders laboratory tests and an electrocardiogram (ECG) to be performed that day, and schedules an appointment in the cardiovascular clinic for a later date.

If payment to the hospital were made on the basis of the CPT code/ ICD-9 code matrix system, the hospital would assign a level 4 new patient E/M service with 99204, with a code of 401.1 for

benign hypertension. Payment would occur through mapping the CPT code to APC Group 915 (Levels 4 and 5 clinic visit) and to MDC 36 (Cardiovascular system diseases). The payment would result from a hybrid group identifier 91536. An addendum is provided that lists the proposed payment rates for the hospital-based clinic and ED services. For example, in the mid-level clinic visit, hybrid groups code 91131 for ENT diseases has an expected payment rate of \$47.63, compared to a payment of \$52.70 for a mid-level clinic visit for kidney, urinary tract, and male genital diseases, which goes to group of 91353.

For the ED, this system places increased emphasis on accurate levels of E/M and concise and thorough ICD-9 coding. A high level ED visit in the APC group 95599 that results from codes that communicate an unknown case of mortality receives a payment of \$66.38, compared to a high level visit with "Major signs, symptoms, and findings" that has an allowance of \$347.09.

Good coding will make a tremendous difference in reimbursement. It also will result in a need to have a system to evaluate the levels of service for E/M services and make sure the correct code is assigned. In the current system, the "visit" code level does not affect reimbursement amounts at all.

### ***Screening exams in the ED***

There also is a provision in the proposed rules for patients who present to the ED for screening exams. These patients may be referred to a clinic or may receive screening services from the ED. These will be paid at a low level since no emergency treatment is involved. Critical care, of course is paid at a high rate and is identified by E/M code 99291.

The five-digit numbering scheme used to illustrate the hybrid methods is not expected to appear in the final rule. For claims processing purposes, these would be converted to three-digit APC groups. The use of the five digits makes it easy to see the relationship between CPT coding and ICD-9-CM coding and how the group results from the code assignments.

Medical visits may be currently reported by hospitals by the use of a single visit code 99201, although many hospitals report services such as ED visits with the greater specificity available in codes 99281-99285. In this system, the level of visits will have to reflect actual resource utilization. According to the 1997 *Federal Register*, code 99201 accounted for 22% of visits, which is likely due to

### **APC Codes Include the Following Items**

- Operating room
- Recovery room
- Anesthesia
- Medical and surgical supplies
- Pharmaceuticals
- Observation services
- Blood
- Intraocular lenses
- Casts and splints
- Donor tissue
- Incidental services such as venipuncture

automatic reporting of this code by Chargemasters.

Since the HCFA/American Medical Association documentation guidelines are currently under revision, it will be interesting to see what, if any, set of guidelines apply to hospital assignment of levels for facility services. Then there will be a question of who drives the code level: the physician conducting the service or the hospital who is billing for the service. When physicians are not hospital employees, will the levels of codes have to match up? Will anyone be comparing what the hospital submits with what the physician reports regarding the levels of E/M services?

It will be possible for larger medical centers to bill for more than one medical visit in a day, if a patient visits more than one clinic. Separate claims will have to be filed for each one, with the diagnosis specified to the reason for the visit to that clinic. In the previous example, the elderly lady could have received services in the ophthalmology clinic after the primary care visit, and a medical visit APC would be allowed for both services. It is not likely that a medical visit will be paid on the same date as outpatient surgery. In those cases in which a service is performed as the immediate result of an outpatient clinic visit, such as might occur with skin lesion removal following a dermatology clinic visit, modifier -25 could be used to show a separately identifiable service was provided.

This must mean that there are more modifiers that will be acceptable and/or required for hospital reporting than were provided to use earlier this year. Modifier -25 was not listed in Transmittal 272 in *Hospital Pub. 10*, part of the *Medicare Manual* published by HCFA, that outlined the use of CPT modifiers by hospitals.

Within the comments for calculation of the

group weights and rates, HCFA mentions that hospitals now will have an incentive to code more accurately for payment.

Competent and motivated coding professionals always strive for accuracy, but it is possible that skills and abilities of exceptional coders now will be recognized and appreciated. The important of data quality management and providing continuing education for coding staff should be made clear to hospital administration. I hope that the days of coders paying for education sessions from their own resources, on their day off, will be a thing of the past.

Data collection and management are very important functions that directly affect hospital financial viability and success. The implementation of APCs again will allow health information management professionals to play a significant role in hospital operations. ■

## HCFA lists proposal for surgical APCs

According to the proposed hospital outpatient prospective payment system published in the Sept. 8 *Federal Register*, it is Medicare's intent to use the same surgical groups in the payment systems for hospitals performing outpatient surgery and freestanding ambulatory surgical centers (ASCs). It is stated that they do not intend to reclassify procedures from one group to another routinely, but restrict changes to additions, deletions, and revisions in the coding systems.

Any changes to ambulatory patient classifications (APCs) will maintain budget neutrality. Under the proposed rules for ASC prospective payment, published in the June 12 *Federal Register*, cataract surgery code 66984 is grouped to APC 668 with a proposed rate of \$863 (down from current rate of \$928). For the hospital, code 66984 is grouped to APC 668 also, with a projected payment rate of \$976.91. In both settings, the intraocular lens reimbursement is included in the payment for the surgery.

A cystoscopy with biopsy code 52007 groups to APC 522 in both settings. Performed in an ASC, the allowance is \$393 (down from \$422), while the hospital performing this procedure would receive \$530. Payment amounts are based on proposed rates only.

When more than one procedure is performed during a single session, Medicare would pay the

full amount for the first procedure, then reduce the second procedure by 50% for the others.

As expected, the hospital modifiers are used to communicate discontinued or terminated procedures that are not carried out as planned. Modifier -53, which is assigned when the patient has undergone anesthesia and the procedure is under way when it is terminated, allows 100% of the payment for the APC. Modifier -52 is used for those patients who are prepared for surgery and have been sedated, but not to the point of anesthesia induction. For these patients, 50% of the APC payment will be made. ■

## Requirements published for provider-based facilities

Along with ambulatory payment classification (APC) information, the proposal for a hospital outpatient prospective payment system (PPS) published in the Sept. 8 *Federal Register* discusses "provider-based" services. Some requirements are listed that must be met before an entity can be designated as provider-based for Medicare reimbursement purposes.

There would be licensure requirements for facilities or organizations seeking provider-based status. Included in a list of requirements are integrated billing functions and medical record integration with a unified information retrieval with the main provider. Medicare will place restrictions on who can qualify for this status and will prohibit hospitals from receiving allocation for costs more than once per entity.

A scenario is mentioned in which providers may be paid three times for the same overhead cost for a clinic:

- The first payment is made through the PPS as an outpatient service.
- The second comes through using the cost of a management service organization to manage the clinic.
- The third results from an allocation of a share of the main provider's overhead cost to the department or provider-based entity.

The regulations mentioned were drafted to prevent this result. To receive APC payments, a hospital-owned clinic would need to receive a designation of provider-based status. If the clinic does not conform to the requirements, then the clinic will be paid under the physician fee schedule amounts as a physician's office. ■

(Continued from page 165)

identify, quantify, prioritize, manage, monitor, and minimize year 2000 exposures.”

This strategy applies across the board, from deciding what gets fixed (compliance planning), to what gets an emergency backup (contingency planning), and to how to survive in the midst of the Y2K event (business continuity planning).

Contingency planning does not require providers to have alternative plans for every possible failure, Kearney says. Rather, the plan must evaluate what failures are most likely to occur despite providers' best efforts at remediation. Then those expected failures must be ranked by management according to seriousness.

“Contingency plans should be prepared for the high-likelihood, high-impact failures,” Okita says. “The health care [provider] should have written documentation of which contingencies it will plan for, why it chose those contingencies, and why it decided not to plan for other contingencies.”

When devising a Y2K contingency plan, hospitals must consider multiple failures occurring at the same time rather than single failures occurring over an extended period of time, says

**Ginger Campbell, RN, PhD**, a consultant who works with a variety of health care organizations. **(For a look at Campbell's Y2K contingency plan outline, see box, below.)**

The sum of even minor Y2K failures or problems can debilitate an institution, says **Anthony P. Strande, PhD**, a regional program manager for Science Applications International Corporation (SAIC) in Falls Church, VA. Strande works with hospitals on Y2K issues.

“In my experience with hospitals, all of the operational procedures are tightly linked to the information systems,” he says. “To quickly make a change in an operational procedure in a hospital is difficult because everything is wrapped up together.”

Part of the contingency planning process is deciding what would happen if a preferred solution to the contingency also failed, Strande says. “What happens if the power fails and you have to go on emergency generators? What happens if that fails?”

SAIC advises its clients to plan their own programs cooperatively with their neighbor institutions. “What happens if you run into a situation where a skilled nursing facility's contingency

## Business Continuity and Contingency Planning Approach

### Phase I: Initiation

- ✓ Establish business continuity work group.
- ✓ Develop high-level business continuity planning strategy.
- ✓ Identify core business processes.
- ✓ Define roles and assign responsibilities.
- ✓ Develop a master schedule and milestones.
- ✓ Implement a risk management process.
- ✓ Assess existing business continuity, contingency, and disaster recovery plans and capabilities.
- ✓ Implement quality assurance reviews.
- ✓ Attain executive commitment.

### Phase II: Business impact analysis

- ✓ Define information requirements, methods, and techniques to be used in developing the BCCP.
- ✓ Define year 2000 failure scenarios.
- ✓ Perform risk and impact analyses for each core business process.
- ✓ Assess infrastructure risks.
- ✓ Define acceptable levels of outputs and services for each core business process.
- ✓ Structure enterprise templates.

### Phase III: Contingency planning

- ✓ Assess costs and benefits of alternatives and select contingency strategy for each core business process.
- ✓ Identify contingency plan templates and implementation modes.
- ✓ Define triggers for activating contingency plans.
- ✓ Establish a business resumption team for each core business process.
- ✓ Develop a zero day strategy and procedure.
- ✓ Follow steps in developing the contingency plan: facility level.

### Phase IV: Testing

- ✓ Validate business continuity strategy.
- ✓ Develop contingency plan tests.
- ✓ Establish test teams and acquire resources.
- ✓ Prepare and execute tests.
- ✓ Validate the capability of contingency plans.
- ✓ Rehearse business resumption teams.
- ✓ Update the business continuity plan.
- ✓ Update disaster recovery plans.

Source: Ginger Campbell, RN, PhD, Tampa, FL.

## Web Sites for Planning Help

Here are some Web sites that include information on year 2000 contingency planning. Much of this list was compiled by **Ginger Campbell**, RN, PhD, a consultant in Tampa, FL, who works with a variety of health care organizations. (For Campbell's contingency plan outline, see p. 171.)

### Business continuity and contingency planning sites

- ❑ Department of Information Resources for the State of Texas — Guidelines for contingency planning: <http://www.dir.state.tx.us/oops/ctgyplan/index.html>.
- ❑ Disaster Recovery Institute International — Professional Practices for Business Continuity Planners: <http://www.dr.org/ppover.htm>.
- ❑ *Disaster Recovery Journal* — <http://www.drj.com>.
- ❑ *The Journal of Business Continuity* — [http://www.business-continuity.com/business\\_continuity.html](http://www.business-continuity.com/business_continuity.html).

### Federal year 2000 Web sites

- ❑ Federal Deposit Insurance Corporation — Guidance concerning contingency planning: <http://www.fdic.gov/banknews/fils/1998/fil9851b.html>.
- ❑ The Mitre Corporation Year 2000 homepage — Y2K contingency management plan outline: [http://www.mitre.org:80/research/y2k/docs/CONTINGENCY\\_PLAN.html](http://www.mitre.org:80/research/y2k/docs/CONTINGENCY_PLAN.html).
- ❑ The President's council on year 2000 conversion — <http://www.y2k.gov>.
- ❑ The Department of the Army — contingency planning document: [http://www.army.mil/army\\_y2k/Contingency.htm](http://www.army.mil/army_y2k/Contingency.htm).
- ❑ Social Security Administration — business continuity and contingency plan: <http://www.gsa.gov/gsacio/ssay2kb1.htm>.
- ❑ Electric utilities and year 2000 contingency planning: <http://www.euy2k.com/cp.htm>.

### Year 2000 Web sites

- ❑ Health care's year 2000 information clearinghouse — <http://www.rx2000.org>.
- ❑ The Gartner group — <http://gartner5.gartnerweb.com>.
- ❑ The Odin Group — <http://www.odin-group.com>.
- ❑ The Year 2000 information center — <http://www.year2000.com>.
- ❑ Managing Year 2000 hospital risks — <http://www.2000legal.com/hospital.htm>.

plan is to send all of its patients to the hospital and the hospital's contingency plan is to send all of its patients to the skilled nursing facility?" Strande asks.

"[Both facilities] are being subjected to the same set of external forces," he continues. "The idea of shipping your patients someplace else is not an alternative because the other facility will be experiencing those same forces. You can't blindly rely on someone else to solve your problem for you." ■

## Software helps maintain orderly, efficient facility

### *Bar codes track patients from start to finish*

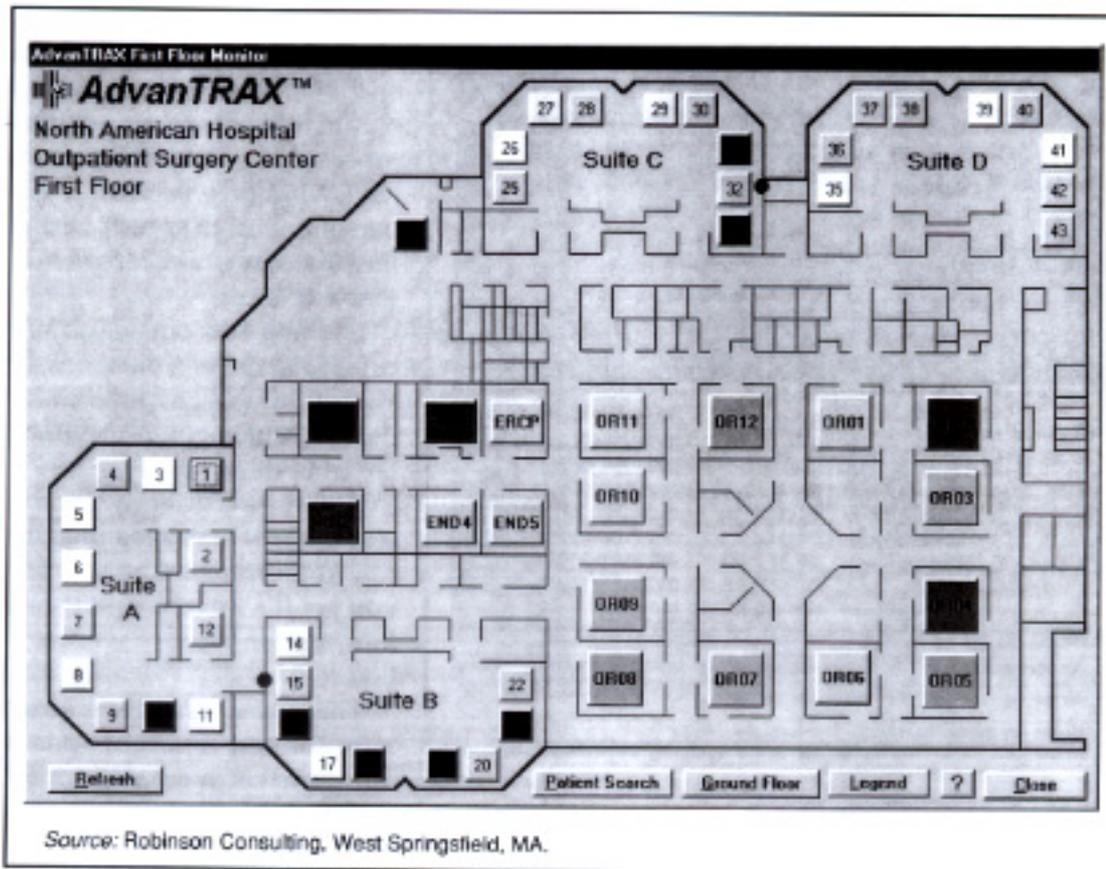
Trying to manage and track 100 patients daily through an outpatient surgical center can be chaotic and expensive. That's why Baystate Health Systems in Springfield, MA, turned to the latest technology when it opened its new center last June.

"One of the challenges we had upfront was making [the facility] operational without making it too costly. We made a commitment to try to leverage as much technology as we could to make the whole building run efficiently," explains **Liz Thiebe**, RN, MBA, director of perioperative services at Baystate.

Thiebe thought it was important to have different methods of communicating between caregivers at the center without the work interruptions caused by telephones. She also wanted to make it easier for patients and their families to use the building. With this in mind, she and other Baystate managers visited other health care facilities across the country to see how other facilities managed their patient flow.

One facility used a colored bar graph to show patient status. That started the wheels turning, Thiebe says. "We thought it was interesting and wondered if we could broaden that idea to expand beyond just knowing the status of these patients."

Baystate asked Robinson Consulting, also in Springfield, to work with them to develop a work-flow manager and patient-tracking system using color-coding and bar-coding technology. A core team comprising Robinson director



Source: Robinson Consulting, West Springfield, MA.

bar code scanner or entered into the system through keyboard strokes. Then a staff member scans the bar code of the appropriate event on a procedure chart at each location. The two-step scanning process enters five pieces of information into the system:

1. the unique ID for the patient;
2. the current date;
3. the current time;
4. the current location of the patient;
5. the current task/procedure

**Renee Lizotte-Broadbent**, software developers, Thiebe, a Baystate anesthesiologist, and the director of surgical services, worked on the specifics of the software.

The prototype made the rounds of the health system and elicited heavy clinical input. Modifications were made and the AdvanTRAX system was up and running when the center doors opened.

"The application has exceeded our expectations," Thiebe says. The system, which uses Baystate's network, tracks the patients from the moment they check in at the center to the time they are discharged. Through a variety of data representations, the system displays the location and status for each patient, a schedule for each physician, plus a daily schedule for each of Baystate's 12 operating rooms in the surgical center.

The tracking takes place through bar codes. The day before the patient's visit, the patient's medical information is manually entered into the system. When he or she checks in the next day for surgery and enter the reception area, the patient is given a wristband that has a bar code with the medical record number on it.

Each time the patient proceeds to the next step through the surgery process, the wristband is either scanned with a radio frequency hand-held

being performed on the patient.

The system has a preassigned color to indicate each step in the process. For example, one color indicates that the patient has arrived in the operating room. The color of the operating room displayed on the screen will change to indicate that the patient is ready for anesthesia. The color changes are particularly noticeable on the systems' floor monitor screen. **(For an example of this screen, see box, above.)**

"One of the nice things the system does is give you a visual presentation of the entire unit," Thiebe says. "It's like a map on a screen."

The floor plan monitor screen refreshes every five seconds, Broadbent adds. "As things are happening to patients, and transactions in the database are getting updated, the screen is constantly in flux as the colors change."

Users can also get more information from the screens by selecting a certain area on them. From the floor plan monitor or the OR summary screens, for example, users can select a patient and get a detailed list of everything that has happened to that patient since he or she walked in the building. **(For an example of the patient tracking screen, see box, p. 174.)**

Selecting a particular operating room on the OR summary screen gives users the entire

**Patient Tracking**

**Patient Information**

Patient Name:  MO:   
 Account #:  Anesth:   
 MedRec #:   Appointment:

**Tracking Information**

Current Location:  Current Room:   
 Current Status:

Task Description	EPS	Location	Room	Task Date/Time
Patient Arrived East Floor Waiting Area	1	East Floor	Waiting Room	09/20/1998 07:46:13
Patient In Suite	1	Suite D	Room 41	09/20/1998 08:42:11
Anesthesia Consent Signed	1	Suite D	Room 41	09/20/1998 08:42:20
Patient Ready For OR	1	Suite D	Room 41	09/20/1998 08:56:41
Patient In OR	1	Operating Rooms	OR - 11	09/20/1998 08:59:21
Anesthesia Ready	1	Operating Rooms	OR - 11	09/20/1998 09:17:00
Incision Made/Procedure Begins	1	Operating Rooms	OR - 11	09/20/1998 09:21:00
Start To Close	1	Operating Rooms	OR - 11	09/20/1998 10:32:00
Suite Reservation	1	Suite D	Room 17	09/20/1998 10:32:03
Last Sitch/Procedure Ends	1	Operating Rooms	OR - 11	09/20/1998 10:47:00

Source: Robinson Consulting, West Springfield, MA.

"A lot affects the operating room efficiency. Some of them are: Did the surgeon show up on time? Was the equipment processed correctly? Did staff have what they needed? Were personnel up to speed? Did the procedure take longer than expected?"

Looking at room activity comparisons on a daily basis allows the charge nurse and the floor manager to try different options to get a room to run more efficiently. "Some teams work better together, too. You can pick that up as you go. It's interesting. It's information we've never had before."

The system also generates an automatic report of operating and recovery room

schedule for that room on that day — including patients, surgeons, times, and procedures. And if users hold the mouse down over a room on the floor plan monitor screen, a balloon appears with the name of the patient in that room. Users then have the option of seeing all the activity for that patient or the schedule for the room for that day.

The system also gives physicians a daily report of their schedules. They can see where their patients are in the process, what time they are scheduled for surgery, and in what operating room.

### Families get quick updates

Families of the patients like the system because they can get quick updates, Thiebe says. "We have four suites with 10 beds in each suite that surround the surgery areas. The patient's family is told which suite to go to and which bed the patient is in. It's easy for them to find."

Patients, though, were an initial concern. "We were concerned that the patients would feel that they were in an assembly line with the bar codes on their wristbands," she says. This hasn't been the case. "They're hardly aware of the process we are going through in terms of updating the events."

The system also produces a variety of reports, of which Thiebe says she is just beginning to use.

charges. Without the system, nurses would have to manually write down the time the patients entered the rooms and what time they left and then bill on a per-minute basis.

Now the bar codes log it automatically. Since Baystate doesn't have an interface yet with its billing department, the report is printed out daily. "It has eliminated the need to tally numbers," Thiebe says. She adds that Baystate hopes to soon add an interface between the AdvanTRAX system and the operating room scheduling software and the billing system.

Thiebe says without the system, she would probably need three or four additional secretaries to answer the phones and track patients. "That's something you can't afford in health care today — added cost without adding any value."

"A lot of money is tied up in operating rooms," Thiebe continues. "The equipment is expensive, and the personnel costs are high. A lot of resources are spent. Anything you can do to make it more efficient is the way to go."

"The key to the success of this program is that we had a clear vision. Then we found programmers who could translate our vision into something great."

[Editor's note: AdvanTRAX is now commercially available and can be customized for different facilities. For more information, call Renee Lizotte-Broadbent at (413) 746-6392.] ■

# Tracking patients with AdvanTRAX process

The following is an explanation of how the AdvanTRAX system, designed by Robinson Consulting in Springfield, MA, works for Baystate Health Systems, also in Springfield.

**1. Data entry of patient information.** Patient-specific data are entered into the patient wristband screens. Data are primarily used for placement on the physical wristbands and input for the scheduling components of AdvanTRAX. This information is usually entered prior to the day of a patient's visit.

**2. Data entry of schedule information.** Scheduling information is entered into the assign OR/procedure room info and staff screens. Data (also entered prior to the day of a patient's visit) are used for both the scheduling and reporting components of AdvanTRAX.

**3. Printing of wristbands and labels.** It is easiest to print both the wristbands and labels from the scheduled patients screen. System users can select multiple patients and print out an entire day's worth of wristbands and labels at once.

**4. Patient arrival.** Patients arrive at the facility on the day of their scheduled surgery, and the receptionist uses the on-line patient arrival task entry screen to create the initial arrival entry in the transaction diary table. Once the arrival task has been created, the patient's name appears in the list that accompanies the reception area on the floor plan monitor screen.

**5. Preoperative tasks.** Staff in the nursing areas use the floor plan monitor screens to monitor the reception area and bring their patients into the pre-op rooms at the first opportunity. Once in a room, patients receive their wristbands, and their second entry into the transaction diary table records the exact time and location of their entry into the pre-operative treatment process. Generally, all of the pre-op transactions are done using the scan guns.

**6. Perioperative tasks.** Using AdvanTRAX, physicians and nursing staff within the OR rooms can monitor their patients' progress and know exactly when their patients are ready for surgery. Patients are scanned out of their pre-op rooms and brought into the appropriate OR/minor procedure room.

During the peri-operative process, transactions are usually entered through keyboard entry on client workstations. As the procedure nears

completion, the physician can reserve a post-op recovery room for the patient.

**7. Postoperative tasks.** The nursing staff use the floor plan monitor screens to monitor the ORs and are able to coordinate the arrival of patients into the postoperative treatment process. Patients are scanned in upon arrival into their recovery rooms and usually proceed through primary and secondary recovery stages, with scanned events marking each transition.

**8. Patient discharge.** Patients are discharged into one of several categories:

- to home;
- to 23 hours (will stay overnight at the facility);
- to a reception area within the medical facility;
- to an inpatient unit (only applicable in an ambulatory setting). ■

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ACGME Executive 2004, 3-7-04, Page 10

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## HHS to issue Medicare/Medicaid fraud disclosure guidelines

The Department of Health and Human Services (HHS) in Washington, DC, announced in September it would soon issue new guidelines for its program aimed at setting up protocols for voluntary disclosure of Medicare and Medicaid fraud to the government, reports the Medical Group Management Association (MGMA) in Englewood, CO. According to **Lewis Morris**, HHS assistant inspector general for legal affairs, the “new protocols will address audit methodology and reporting steps that providers must take to bring problems to the Inspector General’s attention.”

The new protocols are expected within the next two months. “It is unclear, however, as to the effectiveness of such voluntary programs as providers are often reluctant to disclose such information out of fear of prosecution by the federal government. As a result, perhaps the most important aspect of the new guidelines will be how HHS addresses this issue of provider immunity in its final proposal,” says the MGMA in a news release. ■