AMERICAN HEALTH CONSULTANTS®

HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

INSIDE

JANUARY 1999

VOL. 17, NO. 1 (pages 1-16)

American Health Consultants® is A Medical Economics Company

Happy new year: Fraud and abuse investigators try a different approach

Former prosecutor warns not to underestimate the feds' resources

Letters threatening legal action under the False Claims Act may no longer be appearing in many provider mailboxes, but don't get too comfortable just yet, a former state and federal prosecutor warns.

That's because investigators have more resources than ever to search for health care fraud, abuse, and waste.

Since the outcry of last year's mass mailing initiatives, the U.S. Department of Justice in Washington, DC, agreed to tone down its demand letters. **Mary Grealy**, JD, senior Washington counsel for the American Hospital Association's office in Washington, DC, says she has not heard of any new mass mailing initiatives although rumors are surfacing that some providers are receiving letters about the outpatient lab unbundling investigation.

"I would be surprised to see 400 letters go out in [one] state with the same tone and same requirements [as the former initiatives]," she says.

"I'm hoping that as the result of the legislative push and the guidelines that have been issued, the investigations will be much more focused and there will be an attempt to establish that legally and factually [the letters are being used for a] violation of the False Claims Act as opposed to being used for an overpayment collection system," explains Grealy.

Grealy says she has seen a different tone in more recent letters. "There has been a recognition that they needed to change the way they were approaching the investigations and the type of letters they were sending. [But], we want to make sure that at the end of the day, we are not just talking about form over substance."

In the normal course of business, providers are going to be overpaid as well as underpaid, she continues. "Even under the OIG's [Office of the Inspector General's] False Claims Act enforcement guidelines, if an overpayment is below a certain threshold, it should be repaid to the fiscal intermediary or the carrier. You don't need to bring in the OIG or the Department of Justice. We think that the resources of the Department of

Justice and the use of the False Claims Act are serious things that should be used for serious matters." **(For information about the OIG's 1999 work plan, see p. 3.)**

Resources abound

The Department of Justice and Congress added resources to health care fraud investigations and prosecutions through legislation such as the Health Insurance Portability and Accountability Act (HIPAA) of 1996, says **Mark A. Cameli**, a shareholder in the litigation department at Reinhart, Boerner, Van Deuren, Norris & Rieselbach, in Milwaukee.

Cameli was an assistant U.S. attorney in both the criminal and civil divisions of the U.S. Attorney's Office in the Western District of Wisconsin. He also served as chief of the Civil Division in that office.

"Offices have hired additional staff such as investigators. U.S. attorneys' offices have hired investigators, auditors, and prosecutors who are dedicated just to health care fraud and abuse cases," he adds.

Providers should keep these additional resources in mind, as well as legislation that criminalizes actions that in the past were not considered criminal on a federal level, Cameli explains.

"Under HIPAA, new crimes have been codified that carry stiff penalties depending on whether the fraud is in connection with someone being hurt or [killed]. Depending on the consequence of the action, penalties can range up to life in prison," Cameli says.

"Other penalties include fines, restitution, civil judgments, injunctive relief, and disbarment from participation in [federal health care] programs," he says. **(For information about the new Healthcare Integrity and Protection Data Bank, see p. 4.)**

Providers also should be aware that although investigators are focusing on Medicare, fraud allegations can extend to any federally funded health care plan, such as one that covers veterans' or military benefits. "It's a far-reaching jurisdiction for types of offenses, and HIPAA has even expanded that into private health care plans," warns Cameli.

In addition, providers should be aware of parallel proceedings in which criminal and civil actions are pursued in tandem. This can give a provider exposure in both areas, criminally and civilly.

The additional resources and penalties for fraud and abuse investigations underscore the need for providers to invest in preventive health care in the context of fraud and abuse, Cameli says. "Minimize your liability starting with ensuring that you are in full compliance with the terms and conditions of the participation in the Medicare program."

Structure a plan

A structured plan is an important part of the compliance effort, notes Cameli. A plan should incorporate continuing education of staff and a process for reporting and remedying fraud and abuse. **(For more information about the American Health Information Management Association's new health information management compliance guide, see p. 7.)**

Cameli also strongly recommends that providers seek legal counsel. "I can't underscore the importance of having counsel involved, someone who is experienced in these areas and understands how civil, criminal, and regulatory aspects of health care fraud and abuse are interrelated," he says.

"Steps can be taken that not only minimize the incidence of fraud and abuse but protect you in the event that you are accused of committing fraud and abuse," adds Cameli.

Providers also should review their compliance plans on an annual basis, he says. Guidelines are released on a fairly regular basis, and they might render provisions of a compliance plan obsolete or incomplete. "It's important that you not only position yourself so that your services are in

COMING IN FUTURE MONTHS

- Update on system acceptance of CPT and HCPCS modifiers
- Are you financially prepared for HCFAs Y2K problem?
- How to maintain a common patient link
- Technology that delivers radiologic images to PCs
- Reduce errors in medical records

compliance with the law, but that your plan is reviewed periodically by people who have experience in this area."

Providers who become involved in a dispute or a fraud and abuse case may find assistance from Reinhart, Boerner, Van Deuren, Norris & Rieselbach's Trial Science Institute. The institute uses a courtroom inside the law firm to try mock trials in front of representative juries.

The courtroom can become a laboratory where lawyers are trained to become better trial attorneys. For providers charged with criminal and civil fraud, the firm can try the case to see whether the jury is likely to be swayed into finding that fraud exists or doesn't exist.

The courtroom setting also allows the firm to do what is called a discovery focus. "We ask a jury what kind of information they would like to have and what information would make a difference in their view as to whether someone was committing health care fraud," Cameli says. "Then we can tailor and streamline our trial preparation so as to make that [information] the centerpieces of our defense."

The courtroom also provides a venue for alternative dispute resolutions. "If a provider is charged with health care fraud, we can do a mediation or use other tools that are offered under alternative dispute resolutions," he explains. In addition, the institute provides a private venue to adjudicate grievances between providers. "This is for companies that don't want to air their dirty laundry in a public courtroom."

Editor's note: For more information about the Trial Science Institute, contact Mark A. Cameli or Ralph Weber at Reinhart, Boerner, Van Deuren, Norris & Rieselbach, Milwaukee. Telephone: (414) 298-1000. ■

What's up with the feds in '99?

Use this plan to evaluate your program

In October, the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) in Washington, DC, released its 1999 work plan.

The plan outlines the projects OIG sees as most important in its mission of eliminating fraud, abuse, and waste in federally funded health care programs.

Although the plan gives information about the OIG's projects, it doesn't contain a lot of detail, says **Mary Grealy,** JD, senior Washington counsel at the American Hospital Association's office in Washington, DC.

OIG may interpret fraud differently

Also, providers should be aware that the OIG could possibly interpret an issue differently than the Health Care Financing Administration (HCFA) in Baltimore or the fiscal intermediaries, she adds. **(For more information about fraud and abuse initiatives, see cover story.)**

Grealy advises providers to use the work plan to see what areas concern the OIG. Then providers should look at their own operations and see if these areas could be problems for them, too.

Here are some of the areas that the OIG will examine, not all of which are scheduled for completion in this fiscal year:

Hospital projects

- ❒ HCFA's oversight of private accreditation and state certification activities, as well as the role of private accreditation and state licensure;
- ❒ the relationship between hospital costs and revenues;
- ❒ the extent to which hospitals purchase services under arrangement and which services hospitals purchase most frequently — and the fiscal effects of these arrangements;
- ❒ the potential vulnerabilities to Medicare arising from the proliferation of hospital-owned, provider-based physician practices;
- ❒ the financial impact of trends in hospital-owned physician practices;
- ❒ the recovery of Medicare overpayments to prospective payment system (PPS) hospitals that incorrectly reported PPS transfers;
- ❒ cases in which patients are transferred from acquired PPS hospitals to acquiring PPS hospitals without leaving their hospital beds;
- ❒ PPS hospitals that routinely report that Medicare patients left the hospital against medical advice (self-discharged);
- ❒ Medicare claims for beneficiaries who were discharged and subsequently readmitted on the same day to the same PPS hospital;
- ❒ the process by which HCFA updates DRG codes;

- ❒ the extent and quality of HCFA's monitoring of diagnosis-related coding by hospitals;
- ❒ whether psychiatric services rendered on an outpatient basis are billed and reimbursed in accordance with Medicare regulations;
- ❒ whether hospitals and other providers are inappropriately billing Medicare for items or services provided to beneficiaries as part of research grants and experimental drug trials.

Medicare contractor operations

- ❒ methods and approaches contractors use to identify potentially fraudulent providers and assess HCFA oversight in this area;
- ❒ the extent of inappropriate or unnecessary services for beneficiaries who receive a large number of medical services in a short time period;
- ❒ the costs claimed by various contractors for processing Medicare claims, especially costs claimed by terminated contractors;
- ❒ whether information associated with Medicare provider numbers and unique physician identification numbers is accurate and up-to-date;
- ❒ potential improvements in the appeals process for Medicare providers, particularly those related to Part B claims and claims under the Part A home health benefit.

Physician projects

- ❒ whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding;
- ❒ compliance with the Medicare rules governing payment for physician services provided in the teaching setting and to ensure that claims accurately reflect the level of service provided to the patient;
- ❒ whether errors found in Medicare billings for physician services are associated with providers' use of automated encoding software;
- ❒ a sample of physicians' patient billing records to identify and obtain refunds for Medicare and Medicaid overpayments;
- ❒ contracts between providers and billing service companies to determine if they comply with Medicare regulations;
- ❒ Medicare claims prepared and submitted to billing service companies to determine if they are properly coded in agreement with the physician service provided to patients.

General administration projects

- ❒ the adequacy of HCFA's planning, management, and assessment of the year 2000 system compliance problem and assess the risk that HCFA's mission-critical, internal information systems may not operate effectively and efficiently on Jan. 1, 2000.

The OIG also said it planned to release compliance program guidance documents during the first half of fiscal year 1999 pertaining to independent third-party billing companies, coordinated care plans in the Medicare+Choice program and durable medical equipment companies.

To view the complete work plan, visit the HHS site on the Web: http://www.dhhs.gov/progorg/oig/. ■

Big Brother gets in the data collection business

Provider self-disclosure protocol also is published

Big Brother wants a closer look at what's going on in the fraud and abuse arena and wants to start a data bank of that very information.

The Health and Human Services Office of the Inspector General (OIG) in Washington, DC, proposed a rule in the Oct. 30, 1998, *Federal Register* to implement a national health care fraud and abuse data collection program.

The Healthcare Integrity and Protection Data Bank (HIPDB) is a provisional requirement of the Health Insurance Portability and Accountability Act of 1996 and will report and disclose certain final adverse actions taken against health care providers, suppliers, or practitioners.

Database of adverse actions

HIPDB also will act as a database of final adverse actions taken against health care providers, suppliers, or practitioners. (**For more information on the OIG's focus on fraud and abuse in 1999, see cover story.)**

The final adverse actions include:

1. civil judgments against a health care provider, supplier, or practitioner in federal or state court, related to the delivery of a health care item or service;

Provider self-disclosure protocols also published

The Office of the Inspector General (OIG) also published new guidelines for its program establishing protocols for voluntary disclosure of Medicare and Medicaid fraud to the government. Published in the Oct. 30, 1998, *Federal Register*,[1,2] the Provider Self-Disclosure Protocol replaces a pilot program that was established as part of the OIG's 1995 Operation Restore Trust project.

The protocol is meant to encourage health care providers to make voluntary disclosures about fraudulent, abusive, and wasteful activities. It gives detailed guidance to the provider on what information is appropriate to include as part of an investigative report and how to conduct an audit on the matter.

Self-disclosure will not protect the provider from civil and criminal prosecution under the False Claims Act, but it may facilitate a resolution. A lack of cooperation with the OIG may be considered an aggravating factor in the resolution of the investigation.

Intentionally submitting false or misleading information or omitting relevant information may result in criminal and/or civil sanctions, as well as exclusion from participation in the federal health care programs.

To view the text of the Provider Self-Disclosure Protocol, go to http://www.dhhs.gov/progorg/oig/modcomp/oigdis.pdf.

References

1. 63 *Federal Register* 58341 (Oct. 30, 1998).
2. 63 *Federal Register* 58399 (Oct. 30, 1998). ■

2. federal or state criminal convictions against a health care provider, supplier, or practitioner related to the delivery of a health care item or service;
3. actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, or practitioners;
4. exclusion of a health care provider, supplier, or practitioner from participation in federal or state health care programs;
5. any other adjudicated actions or decisions that the Health and Human Services Secretary establishes by regulations.

The range of reportable final adverse actions indicates that Congress intends to interpret the term "health care fraud and abuse" broadly, the proposed rules states. It says that reportable final adverse actions include, "actions related to provider, supplier, and practitioner practices that are inconsistent with accepted sound fiscal, business, or medical practices, directly or indirectly, resulting in: unnecessary costs to the program; improper payment; services that fail to meet professionally recognized standards of care or that are medically unnecessary; or adverse patient outcomes, failure to provide covered or needed care in violation of contractual arrangements, or delays in diagnosis or treatment."

The proposed rule intends to avoid duplication with the reporting requirements for the National Practitioner Data Bank (NPDB), which contains licensure and malpractice information. Therefore, only NPDB state licensing information effective after Aug. 21, 1996, will be included in the HIPDB.

The proposed rule also notes that some settlements, such as those including no admissions or finding of liability, will be excluded from the reporting process.

Information to come with a price

Groups that will have access to the new data bank system include federal and state government agencies, health plans, and self-queries from health care suppliers, providers, and practitioners. An undetermined fee will apply to most requests.

Federal agencies are exempt from the fees, and a free copy of every record automatically will be provided to each health care provider, practitioner, or supplier who is the subject of a report.

The proposed rule requires that information be submitted to the HIPDB within 30 calendar days from the date the final adverse action was taken, the date when the reporting entity became aware of the final adverse action, or by the close of the entity's next monthly reporting cycle, whichever is later.

To view a copy of the proposed rule, visit the *Federal Register's* Web site: http://www.access.gpo.gov/su_docs/aces/aces140.html. ■

Transcription system knows you by your voice

Challenges: Work-flow issues, physician reluctance

An integrated system that combines speech recognition technology with transcription and dictation capabilities for radiology departments promises dramatic cost savings and faster report turnaround. How dramatic the results are, though, depends on how physicians at a health care facility use the system.

"The average results [of the PowerScribe Radiology system] are tremendously driven by the style of implementation of the customer," explains **Peter Durlach**, executive vice president of fonix corporation's HealthCare Solutions division in Boston. HealthCare Solutions first offered the PowerScribe Radiology system to providers at the beginning of 1998.

To achieve PowerScribe's maximum efficiency, a physician dictates a report using the speech recognition technology. The text is immediately available for the physician to edit. Once the edits are made, the physician approves and signs the report, and the report is sent through an interface to the facility's radiology system or health information system.

The entire process can take only minutes for each report. **(For more technical information about PowerScribe, see related story, p. 11.)**

Health information managers at Emory Healthcare in Atlanta, for example, saw the turnaround time for the transcribing of reports decrease from an average of 30 hours to under 10 for attending physicians using the software. Emory was a beta site for PowerScribe Radiology and started the final implementation of the software in July 1998.

"We have seen some dramatic decreases in our turnaround time," says **Greg Cassimus**, administrator for radiology at Emory.

Using initial figures, Emory estimated that it might realize immediate savings of 65% of its annual transcription costs. When Cassimus examined the cost factor between the hospital and its clinic, he decided the system would pay for itself in little more than a year.

Emory has had ongoing challenges in implementing the system, though, including physician-resident work-flow issues and some physicians who are reluctant to use the system.

Physician-resident work-flow issues are common in teaching institutions such as Emory, Durlach says. Depending on how the teaching site is set up, a resident's dictated report goes into the attending physician's queue, unless he or she is available to review and sign the report immediately. If the attending physician decides not to correct the report for a day or more, then it stays in the preliminary queue until he or she accesses it.

Deciding when to sign reports is a user training issue, Durlach says. "Historically, doctors are used to dictating and then approving them eight, 24, or 36 hours later."

When resident dictation times are figured into the equation, the turnaround times at Emory almost double, Cassimus says. "But it's still a lot better than where we were before." As one way of resolving the issue, Emory is considering allowing physicians to sign reports from home, since many residents dictate reports at night.

To ease work-flow problems, physicians have to get into the rhythm of signing all of their reports every day or every few hours, Durlach says. Prompt approval of the reports is important since billing and distribution of reports to referring doctors don't occur until after they are signed.

How much users are able to decrease turnaround times depends on how aggressive the site wants to be in implementing the technology, and how forceful the leadership of the group is in getting people to sign the reports, he says.

To edit or not to edit

Another challenge facing Emory Healthcare has been encouraging physicians to use the new system. Physician utilization is now up to 60%, Cassimus says. "We still have some physicians who don't want to use it. They say that we have turned them into transcriptionists, and it increases their time."

With the old system, the radiologist would dictate a report and a transcriptionist would make the edits. The report would then come back to the radiologist, and the radiologist would review and sign it. The quality of the transcriptionist's work would determine the amount of work the radiologist had to put into the report.

Under the PowerScribe radiology system, physicians are encouraged to make their own edits. The more they edit and approve their own

(Continued on page 12)

What is the PowerScribe Radiology system?

The PowerScribe Radiology system has been available from fonix corporation's HealthCare Solutions division in Boston since the beginning of 1998.

Through the end of the third quarter of last year, the company had more than 30 accounts signed in various stages of implementation to use the system, which offers both speech recognition and dictation and transcription in one product.

These accounts include Emory Healthcare in Atlanta, Duke University Medical Center in Durham, NC, University of Alabama-Birmingham, and Cornell Medical Center in Ithaca, NY.

(To find out more about how Emory's use of PowerScribe, see related story, p. 6.)

Interfaces with most systems

As part of these installations, Salt Lake City-based fonix has developed interfaces to information systems for major radiology system vendors including Shared Medical Systems (SMS) in Herndon, VA; Cerner Corp. in Kansas City, MO; ADAC Laboratories in Milpitas, CA; and IDX Corp. in Burlington, VT.

"We have a bidirectional HL7 interface to these radiology information systems or to the hospital information system (HIS)," explains **Peter Durlach**, executive vice president of HealthCare Solutions."Radiology orders are downloaded to PowerScribe via HL7 to get the patient name, demographics, and the type of study, such as MRI of the brain or CT of the chest," he adds.

This information is stored in the PowerScribe database. When physicians begin to dictate a report, they use the order number generated by the radiology system to bring the patient's information onto the screen. After they have finished their dictation and the reports have been edited, the test results will be sent back to the radiology information system or the HIS by HL7.

Here are some of the specifications of the system:

- ✔ **Multiuser and multi-station capability** — the system supports an unlimited number of users and dictation stations.
- ✔ **Client-server design** — the system is designed with a flexible distributed architecture that enables the use of standard PCs for dictation and correction stations.
- ✔ **Open database connectivity (ODBC).** With minor modification, the system can run on any ODBC complaint database, such as Oracle, Sybase, and Redmond, WA-based Microsoft's SQL Server.
- ✔ **Microsoft SQL Server as the standard system database** — the system provides data storage and access to tools for database management and reporting.
- ✔ **Standard WAV files** — the system works off a standard SoundBlaster compatible sound system.
- ✔ **Compressed audio** — the system compresses audio files to minimize utilization of available network bandwidth.

Last October, fonix corporation announced that the PowerScribe Radiology system had been selected as the winner for the Microsoft Healthcare Solution Award in the acute care clinical systems category.

Emergency component available

Microsoft annually sponsors the Healthcare Industry Solutions Award through the Microsoft Healthcare Users Group to select and promote health care applications that provide the most significant and demonstrable business benefits to health care customers and which run on key Microsoft technologies.

The Microsoft Healthcare Solution Award category winners were selected from approximately 75 entries, 22 of which made it to the final round.

Fonix also announced in October the introduction of PowerScribe EM, an integrated dictation and transcription system designed exclusively for emergency medicine departments. The system became available last November.

Editor's note: For more information about either PowerScribe product, contact The MRC Group, Cleveland. Telephone: (800) 342-8283. ■

(Continued from page 6)

work, the faster the turnaround time. Plus, transcription costs decrease. Some physicians, however, see the new process as time-consuming.

"They are having to do more work, but it's up-front work as opposed to back-end work," Cassimus says. "It's a different way of doing business. I think it reallocates their time," he continues. "They have not fully realized it, since we have not implemented the full benefits of the system yet."

Once the work-flow issues are resolved, Emory plans to switch totally from its old transcription system and use the PowerScribe Radiology system only.

HealthCare Solutions realized that physicians would vary in how they wanted to use the system, so PowerScribe Radiology is designed to handle all of their differences, Durlach says. "The real issue is who is going to do the editing of the report."

The radiologists who want to do things in the old style and who don't want to correct their own work can do it the same way in PowerScribe. For example, the radiologists can dictate the reports, and then the reports go to transcriptionists or medical editors.

The transcriptionists review the physicians' reports, which already have been speech recognized. They make the edits. The records go back into the radiologists' queues, and the radiologists sign them. "The amount of work that radiologists do is identical to what they did before with the old dictation/transcription paradigm."

Radiologists also can decide at any time whether they want to do their own editing. If they are busy, for example, they can send some reports to medical editors. "We made it so you can fully integrate transcription and third-party editing into the process so that the doctors can adopt a new technology and the new work flow at their own speed," says Durlach. ■

Need help developing your compliance plan?

AHIMA program focus: Documentation, coding

Corporate compliance plans address issues across the board, but details of health information management (HIM) compliance programs often are left for the staff to develop.

To help with this effort, the American Health Information Management Association (AHIMA) in Chicago recently introduced Health Information Management Compliance: A Model Program for Healthcare Organizations.

Elements may be there already

The program was written by **Sue Prophet**, RRA, CCS, AHIMA's director of classification and coding, with guidance and input from the association's eight-member fraud and abuse task force. The program was introduced at AHIMA's 70th annual convention in New Orleans last October.

"[The program] expands on the concept of facilitywide compliance and focuses specifically on HIM issues related to documentation and coding," Prophet says. Many elements of an effective compliance program are already incorporated in policies and procedures but are not as detailed as explicitly as they need to be, she explains. "It creates some confusion on what you do in particular circumstances."

Prophet wrote the HIM compliance program to work across all settings, not just in acute care hospitals. "We tried to include other types of examples to show that a lot of the concepts and the points about complete documentation and coding and how to do auditing applies to whatever setting you are working in."

The plan is timely in that many hospitals are in the process of developing an HIM compliance program, she says. The document, however, should be used as a guide, not as a final plan. "This is not intended as a document that people could purchase and stick on a shelf and say, 'Now we have one.' It is intended as a document that they can take and examine. It reminds them of all of the points and issues that they need to address and consider within their own HIM compliance program."

Since the document is intended as a guide, points in the document don't give formal instructions. Instead, they might recommend that HIM staff "consider how they are going to answer the following questions when they develop their plan."

"It doesn't necessarily have all of the answers because that depends on the culture and the way your organization is organized," Prophet says. "There is no 'right' answer, but you have to

remember to address that particular situation in your compliance program."

Prophet says she broke the program into nine elements, which are based on the key elements within the Office of Inspector General (OIG)'s Compliance Guidance for Hospitals. The Washington, DC-based OIG, released its guidelines in February 1998. These elements are:

☐ **Mission statement.**

An organization should have an HIM mission statement as well as a mission statement for the entire facility, Prophet says. For example, an HIM mission statement may begin, "HIM staff are committed to ethical and legal business practices, and committed to developing policies and procedures that are consistent with reimbursement regulations and official coding rules and guidelines."

☐ **HIM code of conduct.**

Every employee, including contracted consultants and independent contractors, should be asked to sign and date an HIM code of conduct, she says. "We recommend AHIMA's Standards of Ethical Coding as the basis for one's code of conduct regarding coding practices."

☐ **Oversight.**

Just as an organization has a corporate compliance officer, someone should be charged with the responsibility of oversight of the HIM compliance initiative, Prophet says.

The HIM compliance specialist should be responsible for monitoring the HIM compliance program and ensuring that staff are adhering to it. A separate position, however, does not have to be created for the oversight responsibility.

☐ **Policy and procedures.**

Comprehensive policies and procedures for coding, documentation, record retention, contractual arrangements, and outsourcing should be included, says **Gloryanne Bryant**, ART, CCS, with Tenet Health System in San Ramon, CA. Bryant spoke about HIM compliance programs at AHIMA's convention.

☐ **Training and education.**

Required qualifications and experience for coding positions should be described, Bryant says. Ongoing education must be provided to coding personnel, independent contractors, and clinical personnel responsible for documenting in the medical record.

☐ **Communication.**

A procedure for communicating regulatory changes as well as a mechanism for reporting perceived compliance violations should be established, she says. Mechanisms should also be in place to communicate with physicians on coding and documentation issues and to obtain clarification regarding policies and procedures.

☐ **Auditing and monitoring.**

Organizations should conduct focused reviews on OIG target areas and structure a formalized audit process to review established baselines and process any identified variations, Bryant says. Coding accuracy should also be monitored regularly.

☐ **Enforcement.**

Violation of the organization's standards of conduct, policies, and procedures, or federal or state laws should be addressed by appropriate and consistent disciplinary mechanisms, she says.

☐ **Problem resolution and corrective action.**

Any potential problems should be promptly investigated and appropriate corrective action should be initiated, if necessary, Bryant says.

Appendices offered, too

Also in the publication are appendices that HIM staff may find helpful, Prophet says. The appendices include "a list of HIM skills that are fundamental to effective compliance. We realize that some people who use this document might not be HIM professionals," she explains. "We tried to include information that explains what the HIM expertise is, how they can be involved, and why they are so important to the organizational compliance initiative."

The following are included:

☐ sample outlines for educational program topics — topics that could be included in internal educational programs for other departments, such as the admitting department, the business office, or the medical staff;

☐ a sample job description for the HIM compliance specialist;

☐ sample audit forms;

☐ sample communication tools for working with the medical staff;

☐ other AHIMA resources, such as practice briefs and information on coding competencies.

Editor's note: Health Information Management Compliance: A Model Program for Healthcare Organizations *by Sue Prophet, RRA, CCS, is $32 for AHIMA members, and $40 for nonmembers. This price does not include shipping and handling.*

For more information, call AHIMA. Telephone: (312) 787-2672. World Wide Web: http://www.ahima.org/products/publications.html. ■

Strategy prepares employees for Y2K

Also addresses impact outside workplace

Everyone has an opinion on the year 2000 (Y2K) issue. Some think that all electronic devices are going to shut down at the stroke of midnight. Others think nothing will happen and that it's all hype. Whatever opinions hospital employees and patients hold about the upcoming millennium, one certainty is definite: Health information management (HIM) staff who fail to update employees and patients on the facility's Y2K progress and address their concerns are guaranteed chaos as the year 2000 approaches.

To meet this challenge and avoid certain chaos, some providers are establishing a strategy to consistently inform employees and patients about Y2K issues.

Here is a program provided courtesy of the Southwest Washington Service Area of Providence Health System in Olympia, WA:

Philosophy

We believe our staff, physicians, and volunteers are critical partners in helping to minimize year 2000 (Y2K) impacts within Southwest Washington Service Area health care facilities. The success of this project, and ultimately the safety of our patients, is heavily dependent upon having the human resources available to carry out contingency plans in the event of system, facilities, and supply chain interruptions.

We are committed to providing Y2K information to staff, physicians, volunteers, and their families. This will assist them in making informed decisions about Y2K preparations at home. We believe preparation and planning for possible Y2K impacts outside the workplace will ultimately lead to reduced interruptions of service to our patients during transition to the year 2000.

Goal

To provide staff, physicians, patients, volunteers and their families with consistent information and communication that can be used as an aid toward personal preparedness for potential Y2K complications at their home and workplace.

Methodology

Promote an awareness and informational campaign where the project team members are easily identifiable through the use of consistent promotional materials, such as:

✔ Identification of internal contacts (staff) for Y2K information through use of:

— team shirts to be worn by year 2000 project staff on the same day, such as Fridays and casual days;

— badge buttons that are worn daily.

✔ Conduct surveys with staff, physicians, and volunteers to identify information needs and make sure we are addressing the concerns and issues they have about Y2K.

✔ Conduct open forums / education to give staff access to information about:

— how to deal with patients who have Y2K questions / fears;

— how to better prepare at home;

— what to expect within the hospital with contingency planning, etc.

✔ Devote time in new employee orientation to the hospital's Y2K project and available resources.

✔ Distribution of a comprehensive brochure outlining major topics:

— what is Y2K?

— service areas project status;

— project team membership / roles;

— possible public reactions, such as denial, panic, disbelief, frustration and mistrust;

— how to successfully handle interactions with patients about Y2K issues;

— preparing your family and home;

— further resources.

✔ Have regular follow-ups to keep the awareness high:

— mini-flyers will be stuffed into payroll checks at three-month intervals throughout 1999.

✔ Run regular articles in our service area newsletters and other communications to help keep the issues visible to our staff.

✔ Use Miss Information column in newsletters to address rumors and provide answers to staff's questions.

✔ Establish an intranet site that contains Y2K information and links to Y2K resource sites.

✔ Coordinate outside speakers on Y2K preparedness to offer to our physicians' offices and affiliate sites to help ensure their successful transition into year 2000.

✔ Place table tents in patient rooms during December 1999, which direct concerned patients to request the informational brochure if they have questions about the hospital's status. The informational brochure will also be included in all admissions materials (including pre-admission materials) during December 1999. ■

NEWS BRIEFS

The devil's in the details

On Oct. 21, 1998, President Clinton signed the Omnibus Spending Bill into law. The measure included spending bills for the following: Labor, Health and Human Services (HHS), and Education; Agriculture; Commerce, Justice, State; District of Columbia; Foreign Operations; Interior; Treasury and Postal Service; and Transportation.

Here are details of the bill, as analyzed by the Joint Healthcare Information Technology Alliance:

• Includes a measure that prohibits the secretary of HHS from promulgating or adopting standards providing for a unique health identifier (UHI) without first obtaining explicit congressional approval. Thus, two years after directing the secretary to create such a unique identifier, Congress has indicated that it intends to review the issue again, and many observers anticipate the introduction of legislation next year that would repeal this provision of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Earlier, the Clinton administration announced that no UHI would be implemented until comprehensive privacy legislation is passed by Congress.

• Includes substantial across-the-board funding for HHS (substantial increases for AIDS treatment, disease prevention, and biomedical research); hastens phase-in of full tax deductibility of health insurance for the self-employed; and provides a fix for Medicare's home health interim payment system.

• Includes the Internet Tax Freedom Act that establishes a moratorium that no state or political subdivision may impose any of the following taxes from Oct. 1, 1998, and extending for three years from the date of enactment on Oct. 21: taxes on Internet access, unless such tax was generally imposed and actually enforced prior to Oct. 1, 1998; and multiple or discriminatory taxes on electronic commerce.

• Establishes an Advisory Commission on Electronic Commerce that shall conduct a thorough study of federal, state, and local, and international taxation and tariff treatment of transactions using the Internet and Internet access and other comparable intrastate, interstate, or international sales activities. The Commission shall provide a report to Congress within 18 months reflecting the results of the study, including any recommendations for legislation.

• Provides $45 million for the Health Care Financing Administration transition to a single Part A and Part B processing system and year 2000 conversion requirements of external contractor systems.

• Provides $1 million for the National Bipartisan Commission on the Future of Medicare for fiscal year 1999. ▼

Hospital Payment & Information Management (ISSN# 1074-8334), including **DRG Coding Advisor**fi, is published monthly by American Health Consultantsfi, 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.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, Hours of operation: 8:30-6:00 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $250 per year; 10 or more additional copies, $150 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

Editor: **Sue Powell Coons**, (614) 848-5254 (suby33@aol.com).
Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Managing Editor: **Kevin New**, (404) 262-5467, (kevin.new@medec.com).
Production Editor: **Ann Duncan**, (404) 262-5463.

Editorial Questions

For questions or comments, call **Kevin New** at (404) 262-5467.

AHA CD for easier access to clinical coding info

The Chicago-based American Hospital Association (AHA), in partnership with 3M Health Information Systems, announced a new product that will provide health care billing and medical records personnel easier access to clinical code information.

The new product is a CD-ROM version of the quarterly publication *Coding Clinic* on ICD-9-CM. Widely used for research and insurance purposes, ICD-9-CM is a classification system for coding patient medical information and grouping patient diagnoses and procedures. The CD improves coding productivity by allowing users to quickly and easily access and search 14 years of coding advice.

The *Coding Clinic* CD-ROM provides users with electronic linkages to relevant coding-related issues, quarterly updates, and 3M Health Information Systems' notes and correction notices about the system. In addition, users can print hard copies of the information that they need.

The CD-ROM is available in stand-alone and a multi-user/network versions. The annual subscription includes quarterly updates and a hard copy version. To order or request additional information, call (800) 242-2626 or visit the AHA's on-line catalog at www.aha.org/shoppingcart. ▼

Partnership expands year 2000 resources

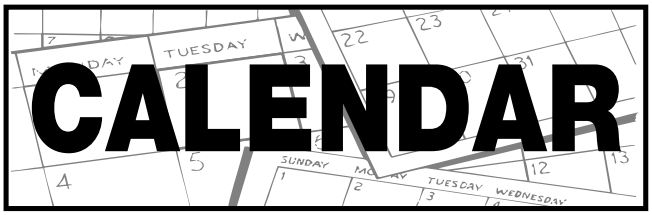
A partnership between Rx2000 Solutions Institute, a member-supported organization helping the U.S. health care system prepare for year 2000 (Y2K), and MedSeek, Internet and intranet specialists, will provide institute members free use of database tools and inventory compliance testing results through a custom on-line system.

The Rx2000 Solutions Institute's Rx2000 Healthcare Products Database, available to members since July, reviews compliance data from a variety of sources, including on-site hospital test results, for thousands of biomedical devices. Using remote communication and data management provided by modern Web technology, the MedSeek product will offer members their own custom database tracking tool for management of Y2K product assessment.

Institute members receive password-protected access to a private Y2K site where on-line administration allows the members to post unlimited inventory records and maintain testing results for their own use.

Simultaneously, each member anonymously contributes that data to a common data pool for comparison. For example, before testing a specific piece of biomedical equipment, an Institute member could immediately search the database and know in advance if other hospitals found the equipment failed Y2K testing.

The Rx2000 database is Web-based and accessible free of charge to members of the Rx2000 Solutions Institute at www.rx2000.org. ■



The American Hospital Association's 1999 annual meeting, "Coverage, Quality, Trust: Cornerstones for a New Century of Community Care," will be held Jan. 30-Feb. 2, 1999, Washington, DC.

For registration information, call (888) 447-2343 or visit the Web site: http://www.aha.org/annualmeeting. ■