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Changes in health care and HIM field make staff education a top priority

Good training programs help coders keep up

HIM professionals need not look far to see that staff education will be more challenging and important in coming years. Already on the horizon is the Health Insurance Portability and Accountability Act (HIPAA), and there are new regulations and policies with regard to the various prospective payment systems (PPS) now in place.

Add to these educational needs the fact that there is a nationwide shortage of coding professionals that is being partially met though newly certified recruits, and it's clear that staff training and education should be a top priority of every HIM department.

The Chicago-based American Health Information Management Association, along with the State University of New York at Albany, is conducting a workforce study to identify new curriculums and educational content areas for HIM staff, says **Claire Dixon-Lee**, PhD, RHIA, president of MC Strategies Inc./WebInservice of Atlanta. MC Strategies is a health care consulting company for compliance and financial services, and WebInservice provides web-based staff training.

"There is a growing need for professional coding specialists," Dixon-Lee says. "Getting these people into the workforce and helping them gain experience is an issue and problem."

Also, there has been a recent trend in which hospital system HIM professionals are being asked to serve as educators to clinicians, case managers, and other health care staff to help them better understand documentation, coding, and reimbursement.

Other factors contributing to the greater need for HIM education are the trend of health care services moving to outpatient sites and the anticipated changes under HIPAA, Dixon-Lee says.

With a greater migration of health care services to the ambulatory care level, health care systems are seeing a greater role for trained HIM

personnel in outpatient facilities, clinics, and physician offices, Dixon-Lee says.

"Issues like HIPAA will affect every member of the workforce, so how will you train staff?" Dixon-Lee asks.

Training may include sending staff to seminars and conferences, but this method can be expensive. Also, not all of the training that is needed may be available at area seminars.

"Seminars are good sources of information on a subject," Dixon-Lee says. "Seminars are what most of us use to get a pulse on what's happening in the industry, but when you want to get some of the fundamentals of a billing system or new technology, you need to have hands-on training."

Another strategy is to give inservices to staff at quarterly or other regular intervals, but this would require employees to take hours of work time away from their jobs, and in today's busy PPS climate this method may not be productive and practical. **(See story on creating an effective training program for HIM staff, at right.)**

A third strategy is to encourage or require staff to do self-learning modules through videos or computer/web-based training courses. Many HIM departments and health systems have found this to be a simpler method from a productivity perspective, Dixon-Lee says. As quickly as most HIM information changes, video training may be too dated to be effective for long, she says.

Inservices can remain timely, but if these are offered in lecture formats, there is a risk that people will attend and not really listen or learn. "I've been a teacher for over 20 years, and I can do a lecture and people will walk away with a fragment of what I was saying," Dixon-Lee says. "But if I give them homework, role-play, or offer interactive opportunities, they'll remember the concept at least."

People are more apt to learn when they are participating in their educational experience through some sort of interaction with the educator or material being presented. This is why computer-assisted training works, Dixon-Lee notes.

"Web-based training is an efficient way of delivering training and keeping it current," Dixon-Lee adds. "Participants are asked questions and they receive immediate feedback and can go back and learn more about the subject."

For other educational needs, such as HIPAA training, the health system itself should have an annual review of privacy and policy procedures and refresher courses, she adds.

"There are other areas where something new occurs, and HIM departments will need to do specialty training on an as-needed basis," Dixon-Lee notes. "Of course you can't be training staff every minute, but you should keep it current with web alerts and other sources of information."

Whichever method HIM directors select, it's important to assess the training program's effectiveness on a quarterly basis by checking coders' accuracy or through other means of determining how well staff have learned a particular subject, she says.

Coding changes and clarifications are issued frequently by the Centers for Medicare and Medicaid Services, so if the HIM department's staff are not keeping up with these, the evidence will be seen in coding mistakes.

"I'd say there should be a minimum of quarterly reviews of inpatient and outpatient coding, and I'm really emphasizing outpatient right now because the changes are so frequent," Dixon-Lee says. "And there should be some kind of internal check once a month of a small sample." ■

Improve staff education using this training outline

Provider billing errors could make hospital liable

However HIM professionals plan to train staff, there are some basic strategies and an outline that will better organize the training plans.

Claire Dixon-Lee, PhD, RHIA, president of MC Strategies Inc./WebInservice of Atlanta offers these guidelines for creating an effective and efficient training and educational program:

1. Determine specific training objectives.

Decide who your educational audience will be, what you will teach, when this training will take place, and how you'll present the necessary information, Dixon-Lee suggests.

"Be very specific and consider the competing needs for particular training and education," she says. "You may be focused on coding training, but there also may be a compliance officer or information technician who wants to train people on new systems. So be clear on your objectives."

2. Synchronize training.

"Essentially, once you prioritize your needs and objectives, you have to identify who the

learners are going to be, and it's important to synchronize training within the daily workflow, looking at costs and benefits," Dixon-Lee advises.

For instance, what does it mean to the department if certain groups of people are taken away from the work environment to be trained in a separate place?

If this could have a negative impact on daily work objectives and productivity, then it might be wiser to synchronize education within the daily work flow, offering time for educational updates within 15-minute or 30-minute time slots, Dixon-Lee says.

Another strategy could be to encourage staff to educate themselves through reading outside of the daily work schedule, which may work depending on the HIM department's delivery method.

3. Assess the educational delivery method.

HIM directors need to decide which educational delivery method would work best for their staff and department.

For example, the HIM department might have language and cultural differences to contend with, or a department's staff may be poorly motivated to learn new ideas and information.

"We see a lot of people start out with great ideas to deliver training, but there might be no way to motivate people to do it," Dixon-Lee says. "You could mandate the training, or you could offer bonus plans or some other method such as a competition or game."

Consider whether the training is necessary for continuing education or to meet regulations or corporate requirements. In these cases, it may be appropriate to simply mandate the education and expect employees to comply.

Or, perhaps the HIM director would prefer to entice staff to participate in learning by offering incentives for completing the educational requirements.

"Within our company, we have a corporate compliance plan. Every year we've required that staff review the corporate compliance plan, which we put into web-based lessons," Dixon-Lee says. "We give out little prizes, dividing people into teams that compete with one another."

These small teams, which also can be called learning leagues, are told that if they complete their lessons within the designated time, they can win gift certificates to restaurants or other awards.

The advantage of tying prizes to team participation is that it takes advantage of peer pressure in which members of a team will push a slower or less-motivated member to finish the work so that everyone might win the award, Dixon-Lee says.

"I've seen that done in HIM departments with coders, where they're given little prizes or points to purchase something in a gift shop," she adds.

"When you ask someone to do something on personal time, you really have to motivate them," Dixon-Lee notes. "But even in the HIM department, where there are productivity standards, you have to motivate staff to learn new information and keep up their productivity."

Educational competition can make learning fun and improve staffs' attitudes toward mandatory training, as well, Dixon-Lee says.

Track improvements in accuracy rate

4. Keep guidelines for learning interventions.

"Keep track of who's learning and keep records," Dixon-Lee says. "You can take that further and also look at improvements in staff's actual work, when the education is job-related."

With coding, this strategy is easy because supervisors can quickly find out if the coding accuracy rate has improved.

"With issues like privacy and patient confidentiality, you can see if there have been any reported breaches or errors," Dixon-Lee says.

It's also a good idea to give employees feedback from the record on a regular basis because this may give them some satisfaction in their efforts to learn new information or skills, or it might help them improve on their weak areas.

Some HIM departments might want to tie these records to an employee's annual review, but that isn't necessary, Dixon-Lee says.

"If it was an objective listed as something the individual would accomplish in the next year, like a new credential or a promotion that requires additional learning, then you would want to measure to see if they've accomplished that as a work-related objective," Dixon-Lee notes. "But I'd tread carefully on that, because sometimes learning is just part of the basic job."

Employees should expect that lifetime learning is their responsibility, and this is especially true in coding, Dixon-Lee says.

HIM professionals need to learn all of the new regulatory information as it is distributed, and they should value this education, she adds.

5. Identify the learner's benefits.

"Learners have to realize that there are potential benefits for them and it's not just something they are being made to do," Dixon-Lee says.

"Clarify your expectations if you are leading the training, and make it clear if the lesson requires a passing score," she adds.

For example, some HIM departments might expect to see an overall increase in staff productivity and coding accuracy, but choose not to use this information for individual evaluation or to take disciplinary action when an employee doesn't meet the objectives after training, Dixon-Lee says.

On the other hand, training may have objectives that require the student to demonstrate what has been learned in some tangible way. If this type of assessment is going to take place, then the educator needs to let students know this from the start. ■

New inpatient rehab PPS not compatible with UB-92

Rehab industry group requests CMS changes

The new prospective payment system (PPS) for inpatient rehabilitation facilities has begun to cause coders a number of problems related to how the PPS assessment instrument differs in language from the UB-92 coding guidelines.

The American Medical Rehabilitation Providers Association (AMRPA) of Washington, DC, has requested that the Centers for Medicare and Medicaid Services (CMS) change the inpatient rehabilitation facilities patient assessment instrument (IRF-PAI) and the UB-92 to ensure that the two forms better match.

"If the codes in the two forms matched, or in the very least cross-walked, providers would be able to develop electronic links so that the codes entered into one system would drop into the other," writes AMRPA in an April 24, 2002, letter to CMS.

Some of the UB-92 codes do not even have an equivalent on the IRF-PAI, indicating that the coding instrument is outdated. For example, the UB-92 code 61 reads: "Discharged to Medicare approved swing beds." There is nothing comparable on the IRF-PAI.

Also, the UB-92 code 05 for "discharged to another facility" could apply to any number of IRF-PAI codes, and the UB-92 code 71 for "discharged to another institution for outpatient services" could be the IRF-PAI 01 code for home, but this assessment item does not contain sufficient detail for a coder to make that translation.

These problems have presented unnecessary challenges to providers, and they require HIM professionals to painstakingly audit procedures to make certain the codes on the IRF-PAI correspond to the UB-92, according to AMRPA's complaints to CMS.

In a recent letter responding to AMRPA's concerns, CMS writes, "We are aware of the issues surrounding potential duplication and overlap with the UB-92. This is an issue that touches all of our payment systems. However, CMS considers it to be premature to make modifications to the instrument."

CMS continues, "Potential of collection processes is only one of the issues that must be considered in instrument revision. We have been using this instrument to implement the PPS for a very short time, i.e., implementation began on 1/1/02. Data regarding the completion of the instrument, as well as analysis of the data to assess the implementation, is not currently available." ■

More cash, fewer denials with roving registrars

Decentralized registration program works

Shands Hospital at the University of Florida gradually is changing the face of registration and, in the process, improving the financial health of the Gainesville-based organization, says **Beverly Varshovi**, associate director of admissions.

The change started five years ago when registrars were placed in the hospital's ancillary departments and continues this year with the rollout of registrars to the physician offices and clinics that are not owned by the hospital, but rather associated with the University of Florida College of Medicine.

The shift away from a traditional outpatient registration department — where any patient new to the system passed through a central area — began in 1997, when a continuous quality improvement

(CQI) team took a hard look at financial functions in the outpatient arena, she notes.

With the change in payer mix as HMOs became prevalent, failure to get pre-certification for accounts was resulting in large financial losses for the hospital, adds **Tim Carney**, assistant manager of outpatient financial arrangements.

"Nothing was being pre-certed on the outpatient side unless the physicians did it, and they were doing it for their procedures but not for [hospital procedures] like MRIs [magnetic resonance imaging]," Carney says.

The 18 or so employees who worked in outpatient registration were calling patients in advance of their appointments to get demographic information, but were not verifying accounts, he notes. "When they called patients and asked for insurance information, they were getting the layman's version, which might mean the wrong insurance or the wrong plan code."

While the inpatient side — where financial representatives had handled all accounts for many years — had a denial rate that was less than 1%, Carney says, the outpatient denial rate was closer to 50%.

Varshovi did a CQI presentation illustrating the money being lost to outpatient pre-certification denials and the cash she believed could be collected at the point of service, she says. "I initially asked for 22 full-time equivalents to be added or upgraded [to financial representatives] and decentralized to these locations."

Upgrading to financial representative, Varshovi says, means that in addition to data collection, account creation, and minimal electronic verification, the employee's duties also include verification of benefits and eligibility, precertification, estimate of charges, point-of-service collections, and sponsorship referral. The latter, she explains, means that if the patient can't pay, the financial rep takes a credit card application or, based on the person's income and liabilities, determines if he or she is eligible for Medicaid, Medicare, Supplemental Security Income, or another aid program.

After getting approval for an eight-person pilot project that began in July 1997, she came back to hospital officials in January 1998 with the results, she adds. "They were so pleased that they asked us to roll out the program in six months, instead of the two years we had proposed."

"We had to find an additional 15 staff members — making a total of 23 — and it took us about eight months to do that," she says. "There were a number of things involved in each placement [in an ancillary department]. We were moving into clinical locations, and the people there didn't always look at it as a collaborative effort. You have to build relationships."

Despite a lack of space and clinicians' concerns that services were being delayed, Varshovi notes, the program was very successful. In 1997, point-of-service collections for her entire department — inpatient, outpatient and emergency department registration — totaled $900,000, she says. In 2001, the figure was $4.4 million.

In 1997, the hospital wrote off $3.3 million in denied payments due to lack of pre-certification, Varshovi adds. That figure was down to $1 million in 2001. Through April, precert denials for 2002 had totaled only $322,000, she notes.

The next step

Two years ago, Shands decided to take the next step in its decentralization process, Varshovi says, which started with empowering the staffs of the clinics that report to the College of Medicine. "We spent last year training up to 300 staff members to issue a patient identification or medical record number so their patients don't have to go through us [to be registered]."

That process, she explains, involves creating a master patient index screen with 25 data elements, including name, date of birth, race, home address, and other key elements. "They can't create a full account, because we don't want to take up space in the database with accounts that have a zero balance."

The creation of this kind of account, Varshovi says, signals that the person is known to the system but has not used hospital services.

Up until this point, she notes, any patient new to the Shands system — even if no hospital services were involved — had to go through the hospital registration process to get a medical record number.

"Before, there were 128 people who could issue a new ID number and they all reported to me," Varshovi says. "Then there were 300 additional people who could issue an ID, and they didn't report to me. We want to see if we had an increase in duplicate medical record numbers as a result."

Although her department will track the accounts — following up if there is a match on three or more data elements — with the support of the information systems department,

she notes, no results were available as yet.

Reducing the number of superficial accounts and data collection by 50%, she explains, allowed the remaining outpatient employees who had been doing telephone registration to become candidates for financial representative positions in the next phase of the decentralization process.

Those employees — after passing an eight-week training session to upgrade their skills — became eligible to perform the same functions in the physician clinics that their outpatient colleagues did in the ancillary departments, Varshovi says.

Putting financial representatives in the clinics, she adds, will relieve the long lines that sometimes occur when patients from several different specialty clinics line up at the lab to receive services. "We wanted to place [financial reps] at the site where the tests are ordered, if the volumes warrant it."

At the dermatology clinic, which orders two tests a day, the placement isn't needed, she notes. But a surgical specialty clinic or a pediatric clinic warrants two financial specialists, Varshovi says.

Another benefit of having financial reps on-site at the clinics, she points out, is that they can try to keep patients from having tests done at laboratories that are not included in their insurance plans.

"If we can be in the clinics where the tests are ordered, we can tell the patients where they need to go and educate the physicians as to what the [managed care] contracts call for, so they will stop sending patients to [labs] where contracts are not honored," she adds.

Shands began placing financial reps in the clinics in May 2001, Varshovi says, and was to finish the process in July 2002.

A success story

Part of the education piece, she notes, has meant serving in an advisory capacity to physicians and notifying them that Shands will not be paid if it performs a particular test. "You have to understand, this is a culture in which physicians have been king and can do what they want, and suddenly we're telling them they can't move forward."

One of Varshovi's favorite success stories about the physician education effort has to do with a patient who was referred to Shands' nuclear medicine department for testing. The drug that was to be used cost $1,200, she says, and the procedures another $3,600.

"When the [financial specialist] saw that it was self-pay, she looked for other options," she adds. "She explained to the physician that the patient would have to pay for this, and that it would take a long time [to do so]."

The physician said that while the expensive drug was necessary, a series of less expensive tests could be substituted for the ones he had originally ordered, she says. In the end, the cost for the tests was reduced from $3,600 to $800.

"The physician would never have known [that the patient would have incurred the expense] if we hadn't told him," Varshovi adds.

The education process is ongoing, she notes. "There are still things [physicians] don't understand — how they can be contracted with a payer when the hospital is not." And sometimes, she says, the physician will elect to have tests done at Shands regardless of payer considerations.

"Our medical records are on-line, so any of the tests done here, [physicians] can pull up on-line," she adds. "They send a patient to X-ray, and two hours later they can see the results. If they send the patient [to another facility], they can't do that."

In such cases, Varshovi says, the financial reps inform patients and have them sign a waiver. "They need to know up front, so they can work out a way to pay." ■

Is your ED ready for HIPAA? How to protect privacy

You'll need strategies to avoid being noncompliant

Patient records left on a desk in full view. Interviewing a sexual assault patient in easy earshot of others. Answering a caller's question about whether a certain person is being treated in your emergency department (ED).

These may be common occurrences in your ED, but as of April 2003, they also may be violations of the Health Insurance Portability and Accountability Act (HIPAA).

"It's this year's Y2K," says **Jeanne McGrayne**, director of emergency department strategies for VHA Consulting Services, a nationwide network of community-owned health care systems, based in Charlotte, NC.

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DRG CODING ADVISOR.

Coders may have difficulty dealing with rehab coding

Medicare documentation requirements confound most coders, errors result in denials

Coders whose work includes coding for an inpatient or outpatient rehabilitation facility may find that their work is complicated because of some of the documentation and coding conflicts that arise when facilities seek reimbursement.

"Medicare is so specific about what [it wants] to see, and therapists are still behind the curve on their documentation," says **Danna Mullins**, PT, MHS, president of Encompass Education Inc., a rehab education consulting company of Palm Harbor, FL.

Mullins offers these suggestions for improving rehab documentation across the care continuum:

1. Focus on the regulations.

Coders need to know what Medicare is telling fiscal intermediaries to look for in therapy documentation.

"You have to understand that Medicare is no longer looking at Part A claims as a single service," Mullins says. "Medicare doesn't review physical therapy in a rehab claim; the agency looks at the entire claim to see that the patient got what was needed from the facility."

Under the new regulations governing skilled nursing facilities, rehabilitation hospitals, and other health care entities, Medicare now asks for more than the therapy notes. Facilities will have to provide nursing notes, discharge history, and the doctor's notes.

"Medicare wants to make sure that the order sheet matches what the therapist is doing, and if there are discrepancies between the therapy notes and nursing notes, then Medicare will dig into that chart," Mullins explains.

2. Consolidate progress notes.

"We've also been made aware recently that there are times when Medicare is looking at a chart where therapy notes don't show progress for a patient," Mullins says. "But the nursing notes show the patient needed help initially and now does not need maximal assistance, so the patient is showing improvement."

Coders need to be aware of how nurses have coded these activities and make certain they fit together. "Patients may have reached a leveling off point in therapy, but they may have improved during the other 23 hours of the day," Mullins says. If that's true, then it should be coded in a way that reflects patient improvement.

3. Identify primary diagnosis.

Medicare has very specific requirements for making diagnoses and setting functional goals.

"A big source of confusion is the diagnosis," Mullins says. "The primary diagnosis for Part A Medicare is a different diagnosis for Part B."

In Part A, the primary diagnosis has to be the diagnosis for which the patient was receiving hospital care or treatment. Under Part B, the primary diagnosis is the medical diagnosis that has resulted in the therapy disorder.

For example, suppose a patient is admitted to the hospital for coronary artery bypass graft. The patient also has rheumatoid arthritis and begins to have difficulty with bed rest. It's likely the patient will need physical therapy at the nursing home when the heart surgery is finished, Mullins says.

It's obvious that the therapist will not be treating the patient's heart disease, but that's the primary diagnosis in the skilled nursing facility under Medicare Part A.

On the other hand, if the same patient is receiving outpatient therapy services, the primary diagnosis is rheumatoid arthritis under Medicare Part B.

4. Watch for red flags.

Coders may catch possible coding errors by being aware of some of the more common problems that Medicare says are primary diagnoses and not procedures.

Coders should remember: If it's Medicare Part A, the primary diagnosis, regardless to whether it's related to the treatment described, is what has to be coded. For Medicare Part B, the primary diagnosis should be something that can be treated with therapy if therapy is the service described.

"On the other hand, there are diseases, and diabetes is a good example, where codes will go beyond the diabetes," Mullins explains. "There's a code for diabetes with neurological manifestations that a therapist might be involved in treating, and there's a code for diabetes-related peripheral circulation disorders, and a physical therapist might be doing wound care because of this."

In these cases, coders would not want to use the general diabetes code, but would instead use the codes that better describe the particular diabetic problem.

5. Understand the gray areas.

Often there is no easy way to determine which code will work best.

For example, one common dispute is about how to code cerebral vascular disease. Some coders don't want to use ICD-9 438 code because it's called the "Late effects of cerebral vascular disease."

"There's this misinformation out there that late effects means something that happens weeks or months down the road, when in fact the way the coding works it can [mean] anything that happens after a cerebral vascular attack (CVA) is a late effect," Mullins explains.

So aphasia or hemiplegia are all late effects because they didn't happen at the moment the CVA occurred, she adds.

Then there is the ICD-9 436 code which is for acute, but ill-defined cerebral vascular disease. This code includes a CVA that can't be attributed to a specific cause, such as aneurysm or thrombosis.

Coders also need to find out enough detail to be very specific with the 438 codes, as these are dependent on which side is affected by hemiplegia and other effects of CVA, Mullins says.

For example, ICD-9 438.10 denotes aphasia after a CVA; 438.11 refers to dysphasia. When the hemiplegia affects the dominant side of the body, the code is 438.21, and when it affects the non-dominant side the code is 438.22.

"If hemiplegia affects the dominant side then it's likely that therapy will continue longer because this will affect handwriting, eating, dressing oneself, and all of the activities of daily living will take longer to regain full function or potential," Mullins says.

Describe goals in real-life terms

6. Clarify functional goals.

It's important to show functional goals for Medicare patients.

"By this we mean something that is practical for that patient to be able to do in his daily life," Mullins says.

For example, if the goal is written down for the patient to have knee flexion from zero to 120 degrees, that would not be a functional goal.

Instead the therapist's notes should say that the patient will be able to stand independently, which is a functional goal.

Likewise, it's not enough to say that the patient will walk 75 feet. Instead, it should be stated that the patient will walk 75 feet from the bedroom to the kitchen.

Also, Medicare wants the plan of treatment to include reasonable estimates of when the goals will be reached and what specific modalities and procedures will be used.

When coders are presented with incomplete therapy notes and information, they need to return to the therapists and tell them exactly what Medicare requires them to include in their plan of treatment, Mullins suggests.

This won't necessarily require a new documentation form, but it does mean that clinical staff need to understand what Medicare wants and how to modify any information that doesn't include these objectives.

For instance, all progress notes and plans of treatment should include at least these three items:

- identification of skilled services provided;
- patient response to those services in objective terms;
- progress made toward functional goals.

7. Use Medicare's instructions.

Coders who would like to learn more specifics about Medicare's requirements may download the chapter six of Medicare's program integrity manual from the web site: www.hcfa.gov/pubforms/progman.htm. ■

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"Ultimately, we're all going to have to comply, just like with the Joint Commission [on Accreditation of Healthcare Organizations]," she says. "And the bottom line is: It's the right thing to do."

Violations of HIPAA are a major concern, especially since the criminal penalty for disclosing patient information without malicious intent is up to $50,000, plus one year in prison.

The biggest challenge for ED managers, says **Jonathan Kent**, RN, CEN, assistant director of the emergency center at Medical Center of Central Georgia in Macon, is protecting privacy in a crowded, noisy ED.

"Patients have as much desire for the world to know their medical complaints as they have to show them the color of their underclothes, but we are still not perfect at protecting the privacy of our patients," he says.

Here are effective ways to comply with HIPAA requirements for patient privacy:

• **Protect patient records from view.**

You will need to have a secure place for all patient records, McGrayne says. She gives the example of digital X-ray systems that list patient names at the bottom and may be viewed at various workstations. "You need to consider where you put those screens and ensure that the patient's name is not visible," she says.

She notes that one hospital has a practice of delivering medical records to the ED for all patients being treated. "This is a best practice because it's better for the patients if their clinical history is available to providers."

However, HIPAA will require records to be secured, she says. "Right now, they are laying all over the place," she says. "Anyone could walk through the ED, pick up one of the records, and walk away with it. It can be very serious."

The front page of a patient's chart may be visible, since many EDs keep charts at the bedside or the front desk, McGrayne says.

She offers the following solutions:

— scanning and automating access to old records;

— centralizing records;

— putting a cover page over demographic information;

— using binders that protect patient information.

Emergency Department Protocol for Patient Pagers

Goals:

• To maintain confidentiality of patients in the waiting room of the Trauma and Emergency Center.
• To be able to call family members back to the treatment area, allowing them more mobility during extensive waits.

1. The triage nurse will give each patient a pager after they have been triaged.
2. The number of the pager will be written on the nurse's note in the upper right area of the form.
3. Patients and family members present will instructed on the use of the pager, such as: "The pager is used to let you know when we are ready to take you back to the treatment area to see the doctor. The pager will make a buzzing (or vibrating) sound. We are using them so that we do not announce patient's names in the waiting room, and that provides privacy for you."
4. Patients will be instructed to come toward the registration desk to meet the staff who will take them back to the treatment area.
5. Patients in wheelchairs will be instructed to raise their hand in acknowledgement so that the staff member can then wheel them to the treatment area.
6. The pager then can be given to a family member/friend, and instruct that person to come to the treatment area when it buzzes to re-join their family member.
7. The staff person should introduce him/herself to the patient and family and explain that you are going to take the patient to a room to prepare the patient to see the doctor.
8. Do not use the patient's name until you are out of the public area. Then using the patient's name is important in order to ensure proper identity of the patient.
9. Pagers will be returned by placing them in the basket on the registration desk or by placing them back in the charger.
10. Pagers will be wiped off with a disinfectant after patient use, as needed, and all pagers will be cleaned once a day.

Source: Gunderson Lutheran Medical Center, La Crosse, WI.

• **Use a sign-in sheet that conceals patients' names.**

Medical Center of Central Georgia's ED uses a triage sign-in sheet consisting of a multipart form with individual tear-off tickets. As each patient signs in, a list that is concealed behind a cover sheet is generated with the name, time, and chief complaint.

The form includes a place to write a telephone contact number, should the patient decide to leave prior to being seen by the triage nurse, Kent adds.

• **Limit what other patients can hear.**

McGrayne warns of the common practice of ED physicians dictating patient outcomes in open workstations, which discloses sensitive information to those standing around the desk. "If planning for a new facility, ensure there is adequate space for dictation or telephone discussions, to allow for privacy," she says.

Another solution McGrayne offers is investing in automated documentation features that eliminate verbal dictation altogether. She suggests using the HIPAA requirements as leverage to obtain this resource from administrators.

Calling out names of patients waiting to be seen is another potential problem, McGrayne says. She refers to her own consulting experiences, when asked to pose as a patient to evaluate ED processes first-hand.

"When I have done mystery patient visits and someone yells out my name while I'm sitting in a crowded waiting room, I cringe," she says. "Regardless of HIPAA requirements, I feel it's very inappropriate."

To address this concern, ED patients at Gunderson Lutheran Medical Center in La Crosse, WI, are given pagers by the triage nurse so they can be contacted confidentially, says **Stephanie Swartz**, RN, administrative director of emergency medical services. **(For the ED's protocol for use of patient pagers, see box, p. 119.)**

There also is an added benefit because patients can leave the ED waiting room area and wait in the lobby, cafeteria, or outside, Swartz says.

She notes that the cost for a pager is $140 including the charger units and transmitters, and she says the ED has not had much of a problem with the loss of pagers.

"Our customer feedback shows that patients like the privacy and the increased mobility," Swartz says.

• **Give staff inservices specifically about privacy.**

Use this checklist to ensure privacy

The emergency department staff at Medical Center of Central Georgia in Macon are regularly inserviced on the following instructions to ensure patient privacy:

- Do not share any information with friends or family members of the patient or other employees that do not have a need-to-know to adequately perform their job.
- Do not attempt to access any information on a patient that *you* do not have a need-to-know for your job.
- Do not have discussions about patients in hallways, elevators, the cafeteria, or outside the organization while off-duty.
- Do not use your code to look up information for anyone else. They should have their own code that allows them access they need.
- Always log off before leaving a workstation unattended.
- Never share your password with others or allow them to use a workstation logged on with your password.
- Never take any information outside the organization, including photocopies, printed pages, or faxed pages.
- Use cover sheets on all charts and clipboards. ■

The way you educate staff about privacy requirements will be the biggest factor in determining whether you are HIPAA-compliant, according to Kent. "They are the ones who control information at the outset," he emphasizes. **(See checklist of privacy practices ED staff are instructed to use, above.)**

All ED staff are required to complete an annual competency assessment on privacy issues and receive regular inservices on this topic, he says.

• **Dispose of health information properly.**

Kent recommends placing receptacles wherever a document with the patient's name or other identifying information is produced. He suggests using a document destruction company to empty them.

Staff are instructed to dispose of all protected health information, including embossers, plastic identification cards, floppy disks, CD-ROMs, and name bands, in one of the 10 locked receptacles located throughout the facility.

Kent notes that it's very important to place a receptacle at the automated medication dispenser. "If a receipt is generated and not used for documentation, it must be destroyed, as it has the patient's name and drug listed on it," he says.

• **Use a special code for increased privacy.**

Kent says that ED patients at his facility are offered a No Press, No Info (NPNI) special code. "Patients under this designation will have their presence in our facility neither confirmed or denied by phone or in personal contact with visitors," he says.

He explains that if any ED staff member feels a patient may desire increased privacy, such as a community VIP or a victim of violence, the NPNI designation is offered. "The patient can choose to have zero information available even regarding his or her presence in the hospital, except on an absolute need-to-know basis for caregivers," Kent says.

Interviews require privacy, too

• **Make every attempt to increase privacy by shifting the location of patients.**

Kent says his ED staff make every possible effort to ensure audio and visual privacy for all patients, including shuffling placement in rooms and holding at least one room open for private interviews and exams.

He notes that staff may be used to needing a private space for physical examinations to protect a patient from being exposed to onlookers, but it's important they understand that interviews also may require the same level of privacy.

"It is difficult at times to make these arrangements, but we do it to the absolute limit of our capability," he says.

[Editor's note: Proposed changes to the "Standards for Privacy of Individually Identifiable Health Information," part of HIPAA, were published in the March 27, 2002, Federal Register. *To view the proposed rules and a side-by-side comparison of this new proposal, go to: www.aishealth.com/Compliance/HIPAARegs032202.html. A final rule will be published later this year. To order a copy of the* Federal Register *with the proposed rule, contact New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date requested. Credit card orders also can be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $10. The* Federal Register *is available at many libraries and on the web: www.access.gpo.gov/nara/index.html.]* ■

Benchmark results spur action in hospital ED

Staff addresses 'Left without being seen' issues

Sometimes benchmarking can do much more than show you where your facility stands compared to other facilities; sometimes it can help you see a problem that you assumed did not exist.

That's exactly what happened several years ago at Mary Bridge Children's Hospital & Health Center in Tacoma, WA. As part of the BENCH (Bench Marking Network for Children's Hospitals) project, Mary Bridge had been participating with a group of 25 to 30 similar facilities. One of the areas BENCH examined was the number of patients who left the emergency department (ED) without being seen. It was an area in which the staff at Mary Bridge thought they were doing relatively well.

"We always had a busy children's ED, although after going through managed care our volume had dropped," notes **Ted Walkley**, MD, FAAP, FACEP, medical director of Mary Bridge. "We were having a resurgence of volume in the department and began noticing our 'left without being seen' going up, but we felt that was because we were seeing more patients."

Looking at the rate

Still, Walkley and other members of the administration wondered whether they indeed had a problem in this area. "We had been participating in BENCH for about year, so the first thing we did was begin looking at the rate," he recalls. "Like all statistics collected at a hospital, we had raw numbers. But we found our rate was increasing faster than our volume."

Being part of a benchmark project had changed the mentality "from absolute numbers to rate-based," Walkley explains. "Then, we thought there had to be somebody worse than us, so we looked at the rates for a two-quarter period."

In one of the quarters, Mary Bridge ranked dead last. In the other, it was next to last. But for Walkley, the news was not all bad. "Benchmarking gave us the ability to compare, to look at demographics, to compare volumes," he says. "It essentially gave us the tool that not only told us that we were getting worse, but that somebody

else was doing a better job than we were."

So the turnaround effort began in part with conversations with representatives from hospitals that were outperforming Mary Bridge. But that was just the beginning. "We did a lot of very detailed analyses — when did patients leave, why, what doctors were treating them, and on what shift," Walkley says. Both a customer service survey and group analysis were conducted. "Many causes, but no root" were found, he says.

It was determined that the problem was not owned by a specific individual or group of individuals; it was everyone's problem. The large problem was then broken into parts, so that some fixable parts could be identified.

By and large, they found the problem was staffing-related, says Walkley, and more physician-related than nurse-related, he says.

Changes in MD staffing included:

- elimination of 12-hour weekend shifts;
- change in shift times in coordination with nursing;
- increase in MD coverage from 24 to 30 and then 32 hours per day by overlapping shifts;
- more judicious use of backup;
- individual feedback;
- additional physicians.

"We created a feedback loop so that each month staff could look at the number of patients who left without being seen, at what time, and so on," says Walkley. "Each quarter they could see how they did against other hospitals."

This was an additional incentive to change, he says, because physicians are highly competitive. "The ability to create a ranking and feed it back to them gave them information not only on relative change, but on absolute change," he adds. "By the next quarter, we got to the middle of the rankings. After the third quarter, we were number one, and have consistently ranked as the best of the children's hospitals."

As important as creating change is, "the fundamental issue is sustaining it," says Walkley, who notes that the volume challenge at Mary Bridge is ongoing. In the recent past, the department typically saw between 1,800 and 2,000 patients in a winter month. "This year, it was 3,000, and we know we won't be No. 1 for the first quarter, but we maintained that ranking for three full years despite having grown 15% a year in terms of volume. Part of the reason is because, as we grow, our feedback loop changes; we now have almost four years of information."

Each month Walkley can show physicians how they are doing, what the rate was the previous month, and when people came in. "When the number [of 'left without being seen'] got small enough, we could even give physicians information on each person who left and when, so the physician could ask what was going on when that particular patient left," he notes. ■

Anesthesia billing gray areas can cause problems

Code time, CRNA supervision with care

In 1999, a Michigan anesthesiologist with a busy pain medicine practice was convicted on 33 counts of mail fraud, sentenced to 36 months in prison, and ordered to pay a $25,000 fine, a $3,300 assessment, and $411,060 in restitution to Medicare, Medicaid, and other third-party payers. The mail fraud charges were the result of the physician improperly billing Medicare and other payers for anesthesia services.

The conviction of an anesthesiologist and the imposition of prison time are rare, but some of the activities for which the physician was convicted are not uncommon, say experts.

Anesthesiologists with pain management practices have to be careful not to bill for medical direction at the same time they are personally performing procedures such as spinal injections and nerve blocks, says **Karin Bierstein**, JD, assistant director of governmental affairs for the American Society of Anesthesiologists (ASA) in Park Ridge, IL.

Even without a pain management practice,

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anesthesiologists have to pay attention to how they handle billing for time spent in the operating room, says **David Vaughn**, Esq., managing partner of Vaughn, Dupree, & Miller, a Baton Rouge, LA-based law firm that represents 1,500 anesthesiologists.

"We've only had 20 cases in which our clients were either investigated, audited, or prosecuted for billing fraud related to anesthesia, but the risk is there for all anesthesiologists," warns Vaughn.

There is also a risk to the hospital if the anesthesiologist is an employee and if the billing mistakes were made as a result of ignorance, negligence, or reckless disregard for the regulations during the normal course of the job, Vaughn says. If, however, the anesthesiologist intentionally charges incorrectly with no knowledge or involvement of the facility, the hospital may not liable, he says.

If a hospital is handling the billing for a group of anesthesiologists acting as independent contractors, there is no risk because the surgery program is not the employer, he adds.

If an anesthesiologist is audited and ordered to repay charges that were filed incorrectly, the hospital is responsible only for paying back the percentage of the charges that constituted the billing fee, he says. For example, if an anesthesiologist pays 5% of total charges for the facility to handle billing, and the anesthesiologist is ordered to pay back $100,000 of fraudulent charges, the facility owes $5,000, he explains.

Even when the billing mistakes are made innocently, a pattern that could indicate intentional fraud might emerge if they are made often enough, he adds.

Cases that are prosecuted can be costly for anesthesiologists found guilty, Vaughn says. The fine is usually $11,000 per fraudulent claim plus penalty fees that are triple the amount of the claim, he says. This is in addition to any sentence that might include prison time, probation, and community service time, he adds.

New members of an anesthesia group also are financially liable for any infractions of group members' actions even before the physician joined the group, Bierstein says. "Anesthesia groups that are indicted for fraudulent claims must pay the fines and penalties from corporate funds," she explains.

Even if the majority of members of the anesthesia group were not members of the group when the fraud was committed, they will suffer financially, she adds.

"We have a group of anesthesiologists in Michigan that have been held liable for their predecessors' actions," she points out.[1]

The No. 1 issue for anesthesiologists is how to bill time, says Vaughn.

Some anesthesiologists will just add 15 to 20 minutes at the beginning or end of a surgery to cover their time outside administration of anesthesia, he explains. "This can't be done," he says.

Anesthesiologists should be familiar with the definition of Medicare base units for anesthesia billing and make sure they are billing the appropriate time for each case, he says. "You cannot bill extra time for patient identification, chart review,

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Editorial Questions

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

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patient examination, and determination of the type of anesthesia to be used, because these activities are included in the base unit," he explains.

Supervision of certified registered nurse anesthetists also requires that the anesthesiologist meet specific criteria, Vaughn says. "An anesthesiologist may medically direct up to four cases at a time, but the anesthesiologist must be present at the beginning of the case and at the emergence from anesthesia," he says.

The anesthesiologist also must be available during the case if needed, he adds.

Availability during a case varies from facility to facility, Bierstein says. "If an outpatient surgery program is a department within the hospital, does the anesthesiologist have to be in the outpatient department, or can he or she just be on campus?" she asks.

This is a gray area that has to be defined by the facility, she explains. "The best approach is to ask yourself if you're comfortable explaining the anesthesiologist's location to the patient's family members," Bierstein says. If you can do that and not worry that the family members will believe that patient safety is compromised, then you can be sure that your policy regarding the proximity of the anesthesiologist is reasonable, she adds.

Billing for preoperative visits is another question that has resurfaced, she says. "This is a gray area, even though it is clear that the standard preanesthesia visit for all surgical patients is not billable," Bierstein says.

If an anesthesiologist sees a patient in order to evaluate the patient's risk for perioperative complications and to optimize perioperative care, the visit can be billed separately if some important qualifications are met, she adds.

The visit must be medically necessary and must meet the documentation requirements of the type and level of visit billed, Bierstein says. One example of a preoperative evaluation that can be billed separately would be a comprehensive history and physical performed by the anesthesiologist for a nonphysician provider, such as a podiatrist, who is not licensed to perform a medical evaluation, she explains.

Timing is important when billing for a separate preoperative visit, says Bierstein. A claim for a visit on the same day as the surgical procedure is likely to raise questions, she adds.

In addition to reviewing anesthesia billing practices regularly and comparing them to requirements of the Medicare Carrier Manual, it is a good idea to ask your state's Medicare director to clarify in writing his or her office's definition of regulations about which you have questions, Vaughn suggests. Because many of the regulations are open to interpretation, it is best to have gray areas defined by the people doing the interpretation, he says.

The ASA also has several publications and articles, including a Practice Advisory for Preanesthesia Evaluation, that can help anesthesiologists review their billing practices, Bierstein says.

Because there are several areas that are open to interpretation, it is important that anesthesiologists and outpatient surgery providers review their billing practices to make sure they are compliant, she says. An ongoing process of reviewing practices and educating all members of the anesthesia group about accurate billing and documentation can prove that any mistakes in billing are just mistakes, not intentional fraud, she says.

"We're not targets," Bierstein adds. "The Department of Health and Human Services isn't looking for innocent errors to prosecute."

Reference

1. *United States of America v. Traverse Anesthesia Associates, PC, and Pain Consultants, PC,* No. 1:01-CR-125, United States District Court, Western District of Michigan, Southern Division (May 25, 2001). ■