

HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

INSIDE

- **Troublesome device:**
What might go wrong with two pieces of medical equipment 35
- **High-tech medicine cabinet:**
Company reinvents first aid for the cyber-age 36
- **Admit mistakes:**
It's better to be honest in millennium madness 38
- **DRG Coding Advisor** 39
— Stereotactic radiosurgery
— 'Add-on' CPT codes
- **Out of the closet:** Coding moves center stage and out of the broom closet 44
- **Electronic myths:** Answers to questions about electronic data interchanges 45
- **News Briefs** 47

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Millennium bug makes a surprise appearance with early 1999 visit

FDA issues advisory; Rx2000 establishes response center

So much press has been given to the year 2000 (Y2K) transition that glitches in a few medical devices caught the health care community by surprise — in what may become known as year 1999.

“I think most people were amazed that there was the possibility of some malfunction this early,” says **Cassandra Junker**, senior vice president of Rx2000 Institute Solutions in Minneapolis. The institute is a non-profit, member-supported organization helping the U.S. health care system prepare for the year 2000. “January '99 was not on most people's radar screen.”

Based on information provided in electronic messages posted on the Rx2000 listserve, the U.S. Food and Drug Administration (FDA) in Rockville, MD, issued a medical device malfunction advisory on Dec. 29. The messages raised concerns that 15 medical devices from eight manufacturers would not work correctly after Dec. 31, 1998. **(For a list of products that were named in the listserve, see p. 35.)**

“The FDA monitors the Rx2000 Web site and listserve so it can stay alert to what the providers are saying,” explains **Ronald Hanser**, president of Hanser & Associates, a public relations firm in West Des Moines, IA, that works closely with Rx2000. “[After the messages had been posted], the FDA contacted the eight manufacturers of the 15 devices to confirm if there were problems.”

Two manufacturers confirm devices' problems

The manufacturers of two of the medical devices confirmed that these devices may have problems in the transition to 1999. The rest of the manufacturers, however, said their products should not have a problem with the transition. The FDA noted that inclusion on the list does not mean a problem was confirmed and that providers should keep in mind that a product may have been incorrectly identified on the listserve. In addition, the FDA said some of these products still may have problems with Y2K transition.

The two products with confirmed problems are the Palo Alto, CA-based Hewlett-Packard's 43100A/43200A external defibrillator and the Pleasanton, CA-based Invivo's Millennium 3500 multiparameter patient monitor.

The problems relate to the ability of the device to display, print, or store the correct time and date of the device's operation. They still will work in direct use so immediate patient care will not be affected, the FDA said. **(For more information on the confirmed problems, see story, p. 35.)**

Manufacturers with products mentioned on the listserv are Datascope in Montvale, NJ; Cadwell in Kennewick, WA; Baxter in Deerfield, IL; Sequoia-Turner (now Abbott) in Abbott Park, IL; and Instrumentation Laboratories in Lexington, MA.

"I think the FDA did the right thing [in listing the products]," Junker says. Some companies were not even aware that the FDA had issued a press release.

"Manufacturers are good testers, but everything is a work-in-progress picture," she explains. Since most manufacturers are working diligently to give Y2K compliance assurances to providers about their inventory, the 1999 transition might have caught them off guard.

And why would the transition from 1998 to 1999 be a problem? "Programmers had to put some date at an end of file, or an expiration date, or a date unknown, and they seem to choose '9,'" she says. She expects more problems to arise throughout the year such as those experienced by the two products.

Rx2000 is still compiling reports on any actual 1999 transition problems that may have occurred. "Several health systems did report some events," she says. One health system had a command center where hospitals could report events that happened on any of the listed pieces of equipment. The health system could then alert its other hospitals to the possible problems.

There is a positive side to the 1999 transition problems. "They can be used as early warning systems," Junker says. The lion share of problems, however, will still take place during the Y2K date changeover.

With device problems beginning in 1999, provider and consumer concerns about the Y2K changeover are increasing. "Several of us [at Rx2000] get more than 300 e-mails a day," Junker says "Some of them are from consumers who see our Web site. They are dependent on drugs and are concerned [about Y2K]. Most of the e-mails are from providers looking for answers to all sorts of questions."

Between the focus of the media and the impending Y2K transition, Rx2000 is anticipating a tremendous demand for information and put a communicative mechanism in place to handle the volume. Therefore, it established a Rapid Response Communications Center to alert hospitals and health care clinics to Y2K and year 1999 problems identified with computers and medical devices.

Providers can call toll-free and leave a message regarding any year 1999/2000 problem they encounter. The institute then collects the information and makes it immediately available as an e-mail to its health care members and the worldwide health care community through postings on the Rx2000 message listserv and Web site. **(See end of story, below, for phone number and Web site.)**

If it can raise the funds, Rx2000 also wants to provide a response center for consumers.

"We are already getting input that beneficiaries don't know where else to go [for Y2K information]," Junker says. "We're concerned that if people are trying to take a responsible attitude and get prepared, there is no mechanism in place where they can get their questions answered."

The consumer response center, however, is a massive undertaking, she adds. "It's on the drawing board. We know what it needs to look like; we know how it needs to be manned, and we know whom we would get to do that." Rx2000 is in the process of raising funds for it now, she says.

[To contact RX2000, call (888) 835-4478 or (612) 835-4478. Or access the organization's Web site: <http://www.rx2000.org>.] ■

COMING IN FUTURE MONTHS

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Medical Devices with Possible Problems in 1999 Transition

Devices that might not transition from 12/31/98 to 01/01/99 in the *On* state

Description	Manufacturer	Model Number
Defibrillator	Hewlett Packard	43100A
EKG Recorder	Hewlett Packard	4765A
Pagewriter Recorder	Hewlett Packard	78571A

Devices that might not transition from 12/31/98 to 01/01/99 in the *Off* state

Description	Manufacturer	Model Number
Monitor	Invivo Research	Millennium 3500
NIBP	Datascope	2100
NIBP	Datascope	Accutorr 1A
EEG Machine	Cadwell	Spectrum 32
Monitoring System	Baxter	VGS
Blood Gas Machine	Instrumentation Labs	BGM 1312
Monitor	Datascope	Passport
Cell Counter	Sequoia Turner	CD-1600CS
Coagulation Analyzer	Instrumentation Labs	8100
Coagulation Analyzer	Instrumentation Labs	482
Coagulation Analyzer	Instrumentation Labs	ACL-100
Coagulation Analyzer	Instrumentation Labs	ACL-300

Note: This list was compiled from electronic messages posted on the RX2000 Solutions Institute listserve. Inclusion on this list does not mean that a problem has been confirmed. Medical devices may also have been incorrectly identified in posted messages.

Source: RX2000 Solutions Institute, Minneapolis.

The year 1999 transition problem pair

More on devices that had confirmed problems

The following information on these devices was provided by the U.S. Food and Drug Administration in Rockville, MD.

1. Hewlett-Packard 43100A/43200A external defibrillator.

The product will defibrillate properly but will print out "set clock" rather than the month, day, hour, and minute on the paper event record. On trying to reset the clock, the CRT will display a 1985 date.

The manufacturer advises to reset it to 1998 (not 1999), after which the unit will work properly for the year 1999. (The event record does not print the year — only the month, day, hour, and

minute.) At the end of 1999, it will need to be reset again, from 1998 to 2000, after which it should work properly.

2. Invivo's Millennium 3500 multiparameter patient monitor.

This monitor has a potential New Year's Eve problem for every year including both 1998 and 1999. For products manufactured before December 1998, if the display clock is tested or reset as the year turns over, then the display and internal clocks become asynchronous until the product is powered down and restarted.

The display clock and paper record can then show different times and dates. Products manufactured after December 1998 are not affected, according to the manufacturer.

The manufacturer advises the problem will not occur if the clock is neither tested nor reset on Dec. 31, 1999-Jan. 1, 2000. Invivo has a software upgrade available to customers that can fix the problem. ■

Company brings medicine cabinet to the Web

Site wants to be one-stop health care shop

Last October, *Hospital Payment & Information Management* told readers about a service that offered a secure site for consumers to keep their medical records on the Web. Now another company is offering a medical history registry service but is adding medical resources, products, and physician information to the site, as well.

"We want to be the one-stop shop on the Internet for all of a consumer's health care needs," says **Stanley Stern**, chief operating officer for Integrated Medical Technologies (IMT) in Lawrence, NY. IMT's Medical Edge Web site (<http://www.medicaledge.com>) offers medical information resources, an on-line medical history registry, an on-line pharmacy resource, a planned national physician referral system and inquiry service, and a medical bookstore. Some of the services are in operation now; while others are planned to be operational soon.

The Web site will bring the best in medical resources, products and services to consumers and health care professionals who need them most, says **Murray Friedman**, DDS, chief executive officer of IMT. Friedman co-founded IMT with David Steiner, MD, now president of the company. "The Medical Edge represents a focus of all these energies in one [site]."

Health care professionals can use this site to encourage patients to take better care of themselves and also to keep up with what information is available to patients, Stern says.

What it offers

The Medical Edge Web site officially launched in November. Services available at the site include the following:

Medical registry.

Consumers who want more control over their medical records and want them available in emergency situations can place them in their entirety on the Medical Edge Web site. All types of patient information can be included in the registry, such as X-ray images, and all data transmission is encrypted for security.

Once the account is set up, the consumer's medical history can be accessed via the Internet

or through a fax service. (To see a sample registry, see box, p. 37.)

The on-line registry account also is linked to a unique identification number. The registry user is provided with a personalized bracelet that contains his or her identification number and a toll-free number to call for fax-back retrieval of medical information.

Medical Edge charges for the registry service, account setup, maintenance, and updates. The setup fee for on-line entries, however, has been waived for a limited time, and on-line updates carry no charge.

The drug stop.

IMT has an affiliation with a mail-order pharmacy, allowing consumers to order generic or brand name drugs through the Web site for home delivery.

The site offers the most common prescription drugs, Stern says. Consumers can go onto the site, which is organized by drug category, and choose a prescription drug. The site gives them a choice of 30- and 90-day quantities. For this reason, the primary marketplace for the pharmacy is for maintenance drugs, Stern says. IMT has chosen not to fill prescriptions for controlled substances or those in liquid form since the drugs are mailed.

Consumers can pay with a credit card. The site then provides them with toll-free numbers for either faxing their prescriptions or having the physician call them in to the pharmacy. The drugs are generally shipped through two-day service via United Parcel Service.

In addition, the Web sites provide links to pharmaceutical-related sites on the Internet.

Medical supplies.

Through a network of suppliers, Medical Edge offers almost any medical or surgical supply. As with the pharmacy services, orders are taken over the Internet and products are shipped to the consumer's home.

Other services that are or will be operational soon on the Medical Edge Web site include:

Select doc.

This physician referral service has two parts, Stern says. The standard service is a link to the general site to the Chicago-based American Medical Association's physician database.

The Medical Edge also offers a premier service, which will be a more select subset of physicians. For a fee, physicians will be able to provide more in-depth information about themselves to the consumer.

Sample Medical History Registry

This sample medical history registry, which would be stored on the Medical Edge Web site, is for a patient named Rosa DelRosario. **(For more information about the Web site, see story, p. 36.)**

✓ **Patient Information:**

Most recently updated: 5/19/98 at 3:45 p.m.
DOB: 2/14/41
Name: Rosa P. DelRosario
Address: 555 Main Street, Anywhere, USA
11221
Home Phone: (123) 555-1212
Work Phone: (123) 534-1212
Emergency Contact: Jose DelRosario (husband)
— also at above home phone number —
husband's work number: (123) 432-1212

✓ **History of Present Illness:**

Rosa is a 56 year-old Hispanic female with a past medical history of hypertension for the last 20 years under fair control with medication, angina for the last five years, and arthritis that bothers her on an intermittent basis for which she sees a rheumatologist. Rosa's angina has been self-limited, and a stress thallium test done on 7/4/97 revealed an ejected fraction of some 54% with no ST or T wave changes having achieved 75% of maximal heart rate. At baseline she has no shortness of breath or chest pain with exertion. She can perform age-appropriate activities of daily living without any restriction and with ease. She sees cardiologist John Roseman, MD, of Edgemont Hospital in Edgemont, RI, at (123) 434-1212 for her angina and her internist is Paul Rhoades, MD, at (123) 343-1212.

✓ **Past Medical History:**

Hypertension x 20 years
Angina x five years
Arthritis — intermittent over last three years

✓ **Past Surgical History:**

Tonsillectomy age 8

Appendectomy age 23
Cesarean x 2 age 34, 36
Tubal ligation age 36
Medical allergies: None known
Tobacco: None
Alcohol: Only socially
Street drugs: None
HIV risk factors: None, tested negative in past for life insurance purposes

✓ **Medications:**

Norvasc 5mg po qD, Tiazac 180mg CD qD, Ecotrin 325mg qD, Naprosyn 375 qID prn joint pain, Sublingual Nitroglycerin 1-2 tablets SL prn angina pain

✓ **Social History:**

Married, two grown children who live outside the home, works part-time as cashier in local hardware store

✓ **Family History:**

Mother died of lung cancer age 64 (+ smoking history). Father died of myocardial infarction, age 56. One sister with high blood pressure, other siblings without medical problems. Children alive and well.

✓ **Relevant Diagnostic Testing/Procedures/Labs:**

SMA20 done 2/3/97 with outstanding values of SGOT of 64, Alkaline phosphates of 212, and cholesterol of 232. CBC on 2/3/97 with outstanding values of 11 basophils and MCV of 93. EKG from 3/23/97 with normal sinus rhythm, nl axis with nonspecific ST/T wave changes but no q waves, normal QRS and PR intervals. Stress thallium done 7/4/97 revealed an ejected fraction of some 54% with no ST or T wave changes having achieved 75% of maximal heart rate. All areas were well perused on thallium infusion.

Source: Integrated Medical Technologies, Lawrence, NY.

For example, a consumer might select a subset of doctors based on their specialty. Then each of those doctors might have a profile that includes information such as languages spoken, insurance plans accepted, affiliated hospitals, and their philosophy of medicine. The profiles also include hours of service, handicapped access, on-site services, and Web addresses, if they have a site. "This is information that a consumer would like

to know but generally is not told without a lot of questioning," Stern says.

□ **Answer doc.**

Answer doc allows consumers to ask medical information questions to board-certified physicians. Consumers can contact the physicians by telephone or through an e-mail message. The e-mail response time is about 48 to 72 hours.

These physicians will not offer a second opinion

or give medical advice, Stern says. "Answer doc will allow consumers to get the answers to questions that are bothering them when they can't reach their doctor or when they might be too embarrassed to ask their doctor or they feel their doctor won't take the time to talk with them." The proposed fees for the service are \$29 for e-mail and \$39 for a phone conversation.

□ Medical reference.

This service provides medical information updated by medical professionals and information technologists. The resources in this section include Medline, a database of published medical literature. "We placed Medline on the site primarily for health care professionals," Stern says. This section also includes links to other medical sites and a medical dictionary.

□ Medical news.

This service checks industry news leaders for medical news and includes medical news links.

□ Profiles in medicine.

This service features various physicians and scientists who have made a substantial contribution to the world of medicine.

□ Support networks.

This service provides contact information and links to support groups.

□ Medical bookstore.

The bookstore is offered in affiliation with Barnes and Noble in New York, one of the world's largest bookstore chains.

□ Health quiz.

Consumers can take a health quiz, offered in three different levels of expertise.

Just the beginning

IMT will be adding more services to Medical Edge in the future, Stern says. "We have a list of projects in various stages of development that is quite extensive."

IMT also hopes to soon offer some of the services, such as the medical history registry and the mail-order pharmacy, to consumers who aren't comfortable using the Internet. "Consumers will soon be able to sign up for the registry through a manual form and be able to order from the pharmacy through fulfillment centers."

Currently, however, everything is offered through the Medical Edge site. With this site, IMT wants to give users a sense of health care community, Stern says. "Our intent is to provide consumers with the ammunition they need to be an educated consumer in the health care field." ■



Open communication lines to the public

Enhance your reputation in the Y2K crisis

By **Ronald Hanser**
President
Hanser & Associates
West Des Moines, IA

What happens to corporations when they are in a crisis? Research performed in 1993 showed that 80% of the general public shunned companies such as Pepsi, Exxon, Sears, and Dow Corning when they were in a crisis.

To translate that into what it means for your hospitals in a year 2000 (Y2K) crisis: People will tend to stay away, and your revenue will crash.

Why? Because people become angry if they think an organization has refused to accept responsibility for its actions. They also believe that an organization is being less than forthcoming if it provided incomplete or inaccurate information. Additionally, they believe the institution is putting profit before public interest, patient safety, and patient health.

Defining a crisis

A straightforward definition of a crisis is anything that disrupts the normal flow of business, and Y2K already is disrupting normal activity. During the year 2000 transition, the outside world will be considering the organization externally, in terms of its behavior, activities, and values.

To not talk about a seemingly obvious problem, such as Y2K, especially in the light of public opinion, can reflect negatively on your organization. You can be perceived as not working in the public interest.

The objective throughout the Y2K remediation process is to do the right things for the right reasons — to ensure you are able to continue to provide high-quality health care services to the people in your community who depend on you.

(Continued on page 43)

DRG CODING ADVISOR.

New codes for stereotactic radiosurgery

By **Rita A. Scichilone**, MHA, RRA, CCS, CCS-P
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For FY 1999 there are new codes in category 92.3 for procedures involving stereotactic radiation use in surgery. This is performed to treat benign and malignant brain tumors and arterio-malformations.

Stereotactic biopsy procedures are excluded from this category, and are coded to the specific anatomical site, as they always have been. The new codes are as follows:

- 92.30 — stereotactic radiosurgery not otherwise specified;
- 92.31 — single source photon radiosurgery (a form using one beam of radiation that is retargeted by using a moving gantry, such as linear accelerator [LINAC]);
- 92.32 — multisource photon radiosurgery (a form using multiple beams surrounding the target, such as Cobalt 60 radiation and gamma radiation);
- 92.33 — particulate radiosurgery (a form using a particle beam source modulated to deliver a high dose at the target, such as cyclotron or proton accelerator);
- 92.39 — stereotactic radiosurgery not elsewhere classified.

Remember the difference between not otherwise specified (NOS) and not elsewhere classified (NEC) when coding in ICD-9-CM. NOS means there is not enough information in the record to classify the procedure to an existing code. NEC means the details of the procedure are available in the record, but no category exists that specifically fit the procedure performed.

This procedure allows very precise delivery of radiation to the tissue. Tools for localization

of the target include the stereotactic head frame, a CT or MRI scanner, a computerized system to calculating the dose of radiation, and the system to deliver the radiation. Radiosurgery sometimes is used in the treatment of functional disorders such as Parkinson's and intractable epilepsy.

These procedures are not considered valid OR procedures for DRG purposes, so the cases will be grouped according to the diagnoses present. ■

An overview of 1999 CPT code changes

It's that time of year when revised CPT code books roll off the presses and health care organizations gear up for a new year in coding and reimbursement processing of patient services.

The 1999 version of CPT contains additions, deletions, and revised to code descriptions.

Two new appendices were added to show which codes are considered "add-on codes" (Appendix E) and which codes are exempt from modifier -51 use (Appendix F). **(For ordering information, see resource box, p. 40.)**

Add-on codes cannot stand alone since they are intended to be additional, rather than primary, procedures. For example, the first one on the list is CPT code 11101, now marked with a plus symbol and a description of "each separate/additional lesion (list separately in addition to code for primary procedure)". The primary procedure in this case is 1110 — Biopsy of skin, subcutaneous tissue, and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion.

As you can see, code 11101 would not stand alone. It would only be used when more than one biopsy of the skin was performed. Modifier -51 would not be appended since, by definition, it is an add-on code. To make sure coders understand, the manual provides instructions to “use 11101 in conjunction with code 11100.”

Many of the revised descriptions in the 1999 version of CPT include similar language to clarify when you should report additional codes separately. Last July, Medicare implemented the use of hospital-specific modifiers. Two of the modifiers, -52 and -53, had descriptions from the Health Care Financing Administration (HCFA) that were at variance from the CPT definition.

The 1999 version of CPT makes it easier to distinguish hospital-reported modifiers by creating a special section titled Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use. It is interesting to note that two modifiers were created so the CPT definitions can remain constant. Modifier -73 and -74 have been added to CPT with the HCFA definitions. The new language follows:

- **-73 Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia:** Due to extenuating circumstances, or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block[s] or general).

Under these circumstances, the intended service that is prepared for, but canceled, can be reported by the usual procedure number and the addition of modifier -73 or by use of the separate five-digit modifier 09973. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

For physician reporting of a discontinued procedure, see modifier -53.

- **-74 Discontinued Outpatient Hospital/ASC Procedure After the Administration of Anesthesia:** Due to extenuating circumstances, or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block[s] or general) or after the procedure was started (incision made, intubation started, scope inserted, etc).

Under these circumstances, the intended service that is started but terminated can be reported by the usual procedure number and the addition of modifier -74 or by use of the separate five-digit modifier 09974. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.

Modifier -53 does not appear in this listing; it is now restricted to physician use only. Modifier -52 for reduced services is listed as a hospital modifier. The language in 1999 CPT follows:

- **-52 Reduced Services:** Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier -52.

Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or canceled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers -73 and -74.

It is not clear under which circumstances modifier -52 would be used since HCFA regulations include anesthesia as the determining factor for reduced services. It could be assumed that hospitals would use these modifiers only on occasions when services were reduced and the use of anesthesia would not apply, such as radiology. It should be noted that the use of five digits to communicate modifiers is not permitted for HCFA patients. The directive requires use of the two-digit modifiers appended to the CPT codes on the UB-92.

For the first time in CPT history, HCPCS modifiers have been added to Appendix A in the ASC/Hospital section. This is a list of the approved national modifiers required by HCFA for reporting after July 1, 1998. This is not a complete list, since only hospital modifiers are included, rather than the full set used by other

RESOURCE

The CPT 1999 Professional Edition may be ordered from the American Medical Association, Order Department, P.O. Box 7046, Dover, DE 19903-7046. Telephone: (800) 621-8335. Fax: (312) 464-5600. World Wide Web: www.ama-assn.org. Cost for the spiral-bound edition is \$54.95 for members, and \$64.95 for nonmembers. The three-ring binder costs \$59.95 for members and \$72.95 for nonmembers.

types of health care providers.

The most recent draft of the revised Evaluation and Management (E&M) Documentation Guidelines is available on the American Medical Association's World Wide Web site: www.ama-assn.org. These guidelines may be used by hospital outpatient departments or hospitals in the ambulatory payment classification (APC) system to determine appropriate levels of E&M code selection and corresponding payment.

These documentation guidelines are not applicable to the Preventive Medicine Services, Critical Care, or Neonatal Intensive Care codes. Any format for documenting history (including preprinted history forms completed by the patient and reviewed by the physician) is acceptable. The chief complaint and reason for the

encounter requirements are not applicable to inpatient hospital services. Definitions of chief complaint, reason for encounter, and brief/extended history of present illness have been added. Some health information management professionals involved in current auditing for documentation to support coding levels believe the revised documentation guidelines will be easier to apply than the current ones.

At this point, no date of implementation or application for these guidelines for audit by Medicare has been offered. Currently, the 1995 or 1997 guidelines are used, whichever most benefits the health care provider.

The details of the proposed changes can be obtained from draft. **(See new framework used in the ED evaluation note, below.) ■**

ED evaluation note

• **Chief complaint.** Chest pain, cough, fever, and "not feeling well."

• **History of present illness.** The patient is a 91-year-old male brought to the ED [emergency department] from the nursing home for evaluation. Apparently he was in his usual state of health the day before yesterday, but late in the day yesterday; he began to have some chest tightness, a slight cough, and a low-grade temperature in the evening.

This morning the nursing home staff reported that he was more congested and had several bouts of emesis, preceded by nausea soon after eating. He had an elevated temperature this morning. Dr. Jones was consulted by telephone, and a CBC [complete blood count] and chest X-ray was obtained. The CBC was abnormal, with 21.0 of WBC and a differential of 63 segs, 2 bands and 1 eosinophil. She believed he may have a bronchitis or pneumonia and sent him here for further evaluation. While in the ED, he vomited twice.

• **Current guidelines.** Four elements are mentioned, so the History of Present Illness is considered extended (location, timing, duration, context, and associated signs and symptoms).

• **New framework.** The assessment would stay the same: extended HPI met by four items.

• **Review of systems.** Please refer to nursing assessment. Negative, except for current respiratory complaints and chronic obstructive pulmonary disease.

• **Current guidelines.** Complete level may be met, if the nursing assessment includes review of at least 10 systems. Since the physician has indicated the required "all others negative," this is validated.

• **New framework.** Positive responses and clinically relevant negatives for at least five systems are needed

for complete Review of Systems (ROS). A notation such as "ROS negative" is adequate.

• **Past medical history.** Significant for Type II diabetes mellitus and hypertension. The patient has had COPD for the last five years and continues to smoke, whenever he can. He has no known allergies.

• **Current medications.** A diuretic, Dyazide, and subcutaneous insulin.

• **Current guidelines.** Items are included from only one history area, so the requirements for a complete Past, Family, and Social History (PFSH) are not met. PFSH is "pertinent," not "complete."

• **New framework.** "Complete" requires at least one item from any two of the three history areas, so in this case, it is also not met due to the omission of social and family history.

• **Discussion.** In the current system, three of three history requirements must be met to carry the history portion of E&M coding. Using the new framework, only two of the three categories is required to meet the requirements. Since the HPI and the ROS requirements were met, we could count this history as complete instead of detailed.

Physical examination:

• **Vital signs.** T 100.3, P 88, R 20, BP 116/84. Head, eyes, ears, nose, and throat is relatively unremarkable except for bilateral ptosis of the eyelids of longstanding duration. Pharynx is mildly erythematous. Neck is remarkable for slight lymphadenopathy. Chest shows increasing effort with respiration, has diffuse crackles throughout, but no rales appreciated. There are scattered wheezes, but no tenderness to palpation. Heart is sinus rhythm with no murmurs or S3. Abdomen is obese, without masses or ascites. Bowel sounds negative. Extremities: No clubbing, cyanosis, or edema in legs and feet. Neurologic

examination is grossly normal. Patient is alerted and oriented to time, place, and person, and answers most questions appropriately. Mood and affect are appropriate to circumstances.

• **Current guidelines.** Detailed examinations require six systems to be examined with at least two elements covered and comprehensive examinations require nine or more systems be examined or a complete examination of a single system be met. In our case, seven body systems were documented, and five body areas were covered. The general multi-system exam criteria require two elements identified by “bullets” from each of nine areas/systems. Nine systems were touched on, but requirements for “two elements” were not clearly identified. The highest level of exam support is detailed.

• **New framework.** In this system, detailed exams require 12 to 17 items be present; and a comprehensive exam requires 18 elements. The new framework says that checklist formats are acceptable for this purpose. It says that a brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings, which eliminates the requirement to document actual elements. The draft document also contains examples of “simplified” documentation examples such as HEENT neg” [Head, Eyes, Ears, Nose and Throat neg] counts as three exam items. More comprehensible tables are provided with useful examples to outline the examination “items.” In this case, we earn:

- one item for the constitutional system;
- one inspection of head;
- one examination of neck;
- one examination of eyelids;
- one examination of oropharynx;
- one inspection of chest;
- one palpation of chest;
- one auscultation of lungs;
- one auscultation of heart;
- one palpate lymph nodes in neck;
- one inspection of abdomen;
- one palpation of abdomen;
- one auscultation of abdomen;
- one examination of leg;
- one examination of feet;
- one neurologic evaluation of higher function;
- one psychiatric assessment of orientation;
- one assessment of mood and affect.

Using this system we have the 18 items required for the comprehensive examination.

Medical decision making:

• **Impression.** Viral bronchitis and/or pneumonia with possible influenza.

• **Plan.** I suspect this patient likely has a viral syndrome, flu-like in nature. The main concern I have is his inability to keep anything down. I have discussed

the case with Dr. Jones, and we believe he should be admitted for further observation and care. We will start him on ancef I.V., one gram every eight hours. In the meantime, I will hold his daily doses of insulin and do accuchecks after each meal and at bedtime and put him on a sliding scale. We will start D5 1/2 normal saline to run at 75 cubic cc per hour, and we will check a general profile. If electrolyte abnormalities are present, we will correct appropriately.

• **Current guidelines.** The current system requires evaluation of the amount and complexity of the data to be considered, the number of diagnoses and treatment options, and the risk of morbidity and mortality. Using this system, we note that these are new problems to the examining physician and additional workup is needed to make a definitive diagnosis. The risk of morbidity or mortality would be considered moderate, and the amount and complexity of data are limited. Using the grid for assessment, we find that decision making is supported at the moderate level.

• **New framework.** The new framework requires less work to arrive at the same conclusion, since three categories collapsed into one grid. Three levels are possible: low, moderate, and high complexity. Each levels has sample “number of diagnoses and/or risk of complications,” “diagnostic procedures/tests ordered and/or amount of data to be obtained or reviewed,” and “management options selected” listed. The level is selected from the appropriate category based on the criteria provided. In our case, we have an acute illness with systemic symptoms in a patient to be hospitalized. The data to be reviewed and obtained is expected to require at least 10 minutes of physician time.

• **Conclusion.** Using current guidelines for Emergency Room service coding, a detailed history, detailed examination, and decision making of moderate complexity results in the selection of code 99283. Using new framework guidelines, we can validate a complete history, a comprehensive examination, and decision making of moderate complexity. This makes it possible to select 99284. In the proposed APC system, hospital prospective payment would move from APC group 953 to 955, based on the E&M code level assigned, increasing the reimbursement.

Although these draft guidelines may not be the same as required in the future, it is important for hospital-based coding professionals to begin watching the development of guidelines. This is an area hospital-based coders will need additional education and development to understand. Current systems should be fine-tuned to capture required documentation. As new systems are implemented, reimbursement is optimized, and documentation methods remain efficient and adequate for claim validation. ■

(Continued from page 38)

Unfortunately, many health care organizations don't tell people they are doing this. Your values — whether they be openness and connection to the community or something else — will be communicated by your actions.

Because the public is going to be paying attention to the external view, you need to be "out front" before you have a crisis. Preparing your public helps them perceive your organization as being one of the good guys. You are doing things to protect the public safety. And, attorneys point out that you are also talking to the potential jury pool.

You also can reduce Y2K's influence by considering all the things that may go wrong with Y2K. Anticipation and preparation help you catch many potential problems. Seize those opportunities for your organization to assess the risk, and you will be able to achieve your communication objectives while better utilizing your resources.

Creating a Y2K plan

The basics of a plan include objectives and strategies, because the tactics of what your organization will do in a crisis are situational. They can change from day to day and from hour to hour as new information becomes available. The objectives include defining what success in January 2000 will be. Do you want to be where you were, in a better position, or nowhere at all?

Your CEO should be directly involved in developing your plan. There are certain instances in which the public expects the CEO to step up to the podium and explain what has happened. He or she also is expected to express sadness and concern and say the organization has always placed the health and safety of its patients, employees, and others in the community as its highest priority. The board of directors also should have input regarding defining the optimum legal and financial reputation outcomes.

In addition, you will need a mechanism that helps you declare there is a crisis and you're moving at a quick pace. You will need one or more letters stating clearly what you are going to say during and after a crisis. You'll also need to have all your resources ready. These resources include people, the facilities to handle a crisis, communications, and even the money necessary so staff can buy whatever they need.

Organizations that have successfully weathered a crisis have taken the initiative. Glendale

(CA) Adventist Medical Center, for example, had a respiratory therapist publicly admit to killing 50 terminally ill patients in March 1998. Then the therapist recanted his story. A full-blown investigation ensued, and Advent kept the public fully aware of its progress. The staff associated with the employee were put on suspension so they could fully cooperate with the investigation and the patients and families wouldn't be concerned.

Advent also set up a hotline staffed by four retired physicians. Those physicians fielded calls from patients and concerned family members.

As health care providers, consider talking to your important constituents when you know a major problem is looming. Become the source of information rather than someone else. Why? Consider the environmental and public relations disaster of the Exxon Valdez supertanker oil spill that took place off the coast of Alaska in 1989.

The oil spill became a significant public relations' problem because of a lack of CEO involvement coupled with outright resistance of the executive team to become involved, to go to the scene, to take responsibility, and to publicly admit that the accident was a terrible thing.

Always tell the truth

The essential components of success in a crisis, therefore, are to actively communicate, never speculate, and always tell the truth. Your public relations staff know that; they will need your support as year 2000 approaches.

Also, use multiple channels of communication during a crisis. You can use the media to get your message out. Many of the major trade publications and metro newspapers are going to do extraordinary jobs because they take the time to understand the issues.

At the same time, you should never totally rely on the news media to spread your story. You need redundant communication systems that can move large volumes of information accessible to your most important constituents. This includes broadcast faxing to prepared lists. A crisis communications expert also can show you how to use advertisements, Web sites, and hotlines to communicate your unfiltered message. The important thing is to do — not just say — the things that your stakeholders expect you to do.

In summary, your health care organization can maintain its positive reputation during Y2K by behaving in a way that people expect. You must care, take action, prevent recurrence of the

problem, be accountable and responsible, and be a part of the solution. And above all, remember to tell the truth.

(Editor's note: Ronald Hanser is a member of the Rx2000 speaker's bureau, a service provided by the Rx2000 Solutions Institute in Minneapolis. The institute is a nonprofit, member-supported organization helping the U.S. health care system prepare for the year 2000.) ■

Coding: No longer the red-headed stepchild

Administrator's role can affect the bottom line

Coding once was an abbreviated way to get claims processed. Now, as many providers begin to experience a cash pinch, coding administrators are being asked to identify areas related to coding that can affect cash flow. Consequently, although many administrators don't realize it, their roles are expanding into all parts of the organization.

"The trend is when the money isn't coming in, it must be coding," explains **Lynne Northcutt-Greager, CPC**, a consultant with Medical Group Management Association in Englewood, CO.

However, this can be a correct assumption. For instance, coding obviously affects reimbursement and a provider's vulnerability to fraud and abuse charges. And if a provider starts getting claim denials and has to file appeals, both staff and physicians will spend more time on the claims and will incur additional costs.

There are other reasons to make sure your coding department is in tip-top shape, notes Northcutt-Greager. Other areas that coding can affect include:

- **Configuration of computer information files.**

"You have to know if your master files are loaded correctly," she says. "You have to have a system in place for getting coding updates into the system, and you have to have your pricing linked to coding."

- **Employee training.**

Providers have to consider audits to ensure the coding is accurate, and staff needed to perform them, she says. "Can you handle it internally, or do you have to bring in someone from outside? If you do it internally, what kind of expertise do the

auditors have to have and do you have to invest in additional education for these people?"

- **Allotment of office space.**

"How much space in the office do you have to allocate for functions related to what we normally think of as billing?" she asks. Providers need to have resource books for coding manuals and bulletins that come from the various payers so staff can follow appropriate coding guidelines. "More and more [providers] are finding they have less and less space because of all the coding materials."

Even with many of these considerations, many administrators still operate with blinders, she says. "[In their eyes], the coding people are just supposed to look at a service and assign a three-to five-digit diagnosis code and a five-digit procedure code and send it on its way. They are supposed to assign so many per hour that they have set up for their standards."

Isolation breeds problems

This view of coding employees working in isolation from other areas in the organization can keep administrators from recognizing common coding-related problems. For example, Northcutt-Greager says she is seeing more of the problem of outside billing services changing procedure codes. The providers often don't realize the codes are being changed until an auditor or Medicare representative finds the problem. "Maybe [the billing services] can't get a code in the system because the charge ticket hasn't been updated because someone hasn't coordinated printing. So they look back in the system and see that the person was in for low back pain before, and they use that code when the person had a foot X-ray. They don't realize it's not even related."

She also suggests providers keep an eye on coding completed by physicians. "Right now, a lot of physicians are getting reimbursed based on productivity that is contingent upon relative values. If not because of fraud and abuse issues, you want to make sure your physicians are coding accurately so their compensation is accurate."

Some providers have more of a problem with physician coding inaccuracy than others, she adds. Physicians, for example, may be coding accurately based on current coding guidelines. Or they may be coding higher levels of service since their compensation is being based on productivity. They may also be "downcoding" and using lower levels of service because they want to stay out of trouble with Medicare.

The end result is that physicians may adversely affect their compensation by not showing their true productivity. The inaccurate coding affects administrative decisions, as well.

“Some administrators are looking at relative values or production and trying to determine staffing and budget needs,” Northcutt-Greager says. “If physicians are not coding correctly or if the rest of coding isn’t taking place accurately through coders or billers, then administrators don’t have valid data to make these decisions. Then they wonder why their decision-making processes don’t seem right.

“Everything you turn around, it is something else that is tied into coding,” she continues. “The more you think about it, the more it mushrooms.”

Be the focal point

In today’s health care environment, administrators should have an awareness of all the areas that impact coding and vice versa, Northcutt-Greager says. For example, here are some questions administrators should have asked themselves regarding the changes from the 1999 updates:

- Do any of the new or deleted diagnosis or procedure codes impact us?
- If so, what are we doing to set our fees?
- Do we have the codes in the computer system?
- Do we need to have them on our charge tickets?
- Do we need to do training related to them?
- Do Medicare or other payers have any special benefit limitations?
- Are some of the payers going to delay activating that code until the second quarter of the year?

Administrators also need to get feedback from the employees doing the coding. “Ask them what they are seeing,” Northcutt-Greager says. If administrators are finding problems in turnaround and production, try to discern why.

“Is it because a code isn’t loaded in the system?” she asks. “If the code isn’t loaded in the system, why not? Is it because there is a problem with the process, and maybe you only have someone assigned to do coding updates when they don’t have anything else to do? And how are you ensuring that all of these activities take place in a timely manner?”

Administrators should act as the focal point so everything related to coding works through them, Northcutt-Greager advises. That way, they can get the overall picture of how well the pieces are working together. ■

Is your hospital prepared for EDI challenges?

By **Tim Stunz**
President
SBPA Systems
Houston

Q: What are the most common misconceptions health care organizations have about electronic standards?

A: Electronic data interchange (EDI) in itself is not the panacea some may believe. While many larger organizations have achieved productivity gains by switching millions of transactions from paper processing to EDI, some expected efficiencies have not been realized.

For example, numerous large health care organizations have been using a standard EDI format for several years. However, up until [the requirements of the] Health Insurance Portability and Accountability Act (HIPAA) of 1996, there hasn’t been much incentive for small- to medium-sized health care organizations to adopt EDI. In fact, for most, the reported benefits just didn’t appear to justify the incremental costs of translating native formats to EDI formats.

Consequently, those companies who have adopted EDI can’t always count on their trading partners to have the standards in place. Sporadic implementation has resulted in mixed efficiencies.

Q: What standards do you think will be accepted by the Department of Health and Human Services in Washington, DC?

A: I expect the suggested X12 standards (a set of uniform standards for interindustry interchange developed by the American National Standards Institute in Washington, DC) will be accepted. With the many different standards in practice to date, the proposed X12 standards seem to show the most promise regarding data content. The biggest challenge is getting everyone prepared and trading data this way.

The most important thing to remember here is

when the final rules are published there is a 24-month implementation grace period. I believe all involved parties should at least have a plan in place before then.

Q: How difficult do you think it will be for providers to implement the standards for providers who don't use standard EDI formats now at all?

A: Many health care organizations that haven't yet implemented EDI believe that once they adopt the standard, transaction processing will magically fall into line cleanly and without a hitch.

The reality of an EDI implementation can hold more than a few surprises. Our advice always is to start as soon as possible and make sure your system is configured correctly before trying to implement EDI.

We have been working hard on integrating EDI with our system software product for many years. It's a challenge to do it right from the start, but we think that the benefits of adopting EDI standards will be worth the work upfront for all health care organizations.

Q: Are there common steps to follow?

A: Establish your current capabilities in trading data electronically. Determine the clients you can trade electronic data with. Pick a client who most represents your core business interest to start trading with, preferably one who is currently doing electronic business. Run a parallel system until you're comfortable that the electronic data are at a good level. This time frame should not be more than eight weeks, but this depends on the quality of the data being sent. When the trading partners agree, then "flip the switch" and stop the paper flow.

Q: What implementation surprises do you anticipate providers having?

A: We initially developed an EDI module for our clients in 1994. But they were not ready for it. We have since put the product into production and are currently customizing it for several clients.

We are finding that each of our clients faces unique challenges with regard to implementing EDI. And all of these challenges have to be handled individually before EDI is implemented.

Most health care organizations can expect to

spend considerable time and resources working out numerous kinks. EDI implementation is generally a slow process because effective use of EDI requires that data being exchanged from one trading partner to the other must be clean and consistent.

Q: What special challenges will providers have who already use other standards?

A: Many providers who already use other standards may not know what standards they are currently using. A significant challenge to providers who submit data electronically will be their software vendor. The providers need to find out if the software vendor they are using has a plan in place to address the HIPAA issues. One must remember, though, that clearinghouses can receive data in any format but must re-format this data into the chosen standard.

Q: How long should it take for most providers to implement the standards?

A: Implementation of the EDI standards could take anywhere from several months to a year or more. Variables that would impact the amount of time required include the current level of expertise with EDI, the ability of their software/systems to handle the emerging standards, the willingness to bring in additional expert resources, and the level of electronic automation of the providers' current processes.

Q: Who should be involved in the implementation project, what kind of equipment will they need, and what kind of cost should they expect?

A: In addition to the obvious membership of experts in information technology and EDI on any EDI project team, the team also must include representatives from parts of the organization that are the source of and users of EDI transactions. In many cases, it will be necessary to alter systems and processes throughout the organization. Therefore, it is essential that individuals who use and are impacted by those systems and processes be a part of the team.

Because equipment and part costs vary due to the nature of customization, we can't specify an average dollar amount.

[Editor's note: SBPA Systems is a health care benefits administration software company.] ■



Annual stats show hospitals keep costs low

Despite enormous economic pressures, the nation's hospitals and health systems continued to keep their costs low in 1997, according to the latest Chicago-based American Hospital Association's (AHA) Annual Survey. Survey highlights of more than 5,000 member and non-member hospitals and health systems are found in *Hospital Statistics*, which is published by AHA's subsidiary Health Forum.

For the third year in a row, the survey found little or no growth in hospital costs. In 1997, the growth in hospitals' costs to care for patients within the hospital and on an outpatient basis (total adjusted expense per admission) was 0.6%. Five years ago, that number was about 8%.

"Hospital leaders have had real success in keeping costs down for their patients while improving the overall health of their communities," says **Dick Davidson**, AHA president. "But it's unclear how long this trend can continue. With the resources needed to meet the year 2000 technology challenges and skyrocketing drug prices, keeping costs low will become more difficult for hospitals and health systems across America."

Hospitals will feel even more financial pressure in the years to come, with Congress reducing payments to hospitals by about \$44 billion over five years beginning in 1998. In addition, the Medicare Payment Advisory Commission in Washington, DC, estimates that Medicare payments to hospitals will drop from 90 cents per dollar of outpatient care to 78 cents for care after the Balanced Budget Act of 1997 is fully implemented.

The survey results also suggest that a major focus of hospitals is promoting the wellness and health of its community. In 1997, nearly all respondents reported that their hospital's mission included a focus on community wellness. About six out of 10 hospitals responded that they disseminate reports to their community on the quality and costs of health care services.

Some additional highlights from the survey include:

- The average length of stay for patients continued to drop, declining to an all-time low of 6.1 days.
- Outpatient visits continued to climb. In 1997, community hospitals saw a 2.3% increase in outpatient visits over 1996. Over the past five years, outpatient visits increased about 29%. During that same period, the overall days patients spent admitted to the nation's hospitals (inpatient days) have dropped 12.9%.
- The number of full-time equivalent personnel employed by community hospitals increased to 3.79 million in 1997, up from 3.62 million in 1992.
- About 23% of hospitals were involved in developing an HMO insurance product

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independently or through a joint venture in 1997, up from 19% of hospitals in 1994, the first year when data were collected.

[Editor's note: This year's edition of the survey includes tables highlighting aggregate utilization, personnel, and financial data by metropolitan statistical areas as well as detailed hospital facilities and services information, which allow users to determine how many hospitals in a given area offer a certain service. To order the book, call (800) 821-2039. The price is \$105 for AHA institutional members and \$200 for nonmembers.] ▼

AHIMA awards innovative HIM practices

Health information management (HIM) professionals who strive to enhance their skills and expand their base of knowledge often are the ones who develop new and innovative, or best practices.

In an effort to identify these practices, which can benefit health care organizations and the industry as a whole, and to recognize the members who create them, the American Health Information Management Association (AHIMA) in Chicago developed its "Best Practices Awards" program.

"Not only will the program help us identify a host of new practices and our colleagues who create them, it will give us important practice information we can share with all of our members," says **Claire Dixon-Lee, PhD, RRA, AHIMA** president.

A nominated best practice must apply primarily to HIM, and it should relate to the nominee's practice area or another area in which he or she has been working. Submissions require details of how and why the best practice was developed, how it was implemented and assessed for effectiveness, and how it improved the management of health information.

A panel of HIM experts will judge the submissions. Participation in the awards program is open only to AHIMA members. Multiple submissions from individual participants are allowed.

The deadline for submissions is May 1, 1999. Send submissions to Best Practices Award, c/o Practice Leadership, AHIMA, 919 N. Michigan Ave., Suite 1400, Chicago, IL 60611-1683.

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Submissions also can be sent via e-mail to best-practices@ahima.org.

The prizes include \$3,000 for first place, \$2,000 for second place, \$1,000 for third place, and \$50 for 20 honorable mentions. Winners also will be recognized at the 1999 AHIMA National Convention and Exhibit and in the Journal of AHIMA.

For more information, contact AHIMA at (312) 787-2672 or visit the AHIMA Web site at www.ahima.org. AHIMA members also can call the association's FaxLink service at (888) 424-4040. ■



• **The Healthcare EDI Coalition's national 1999 conference and technology exposition, Building the Electronic Data Infrastructure (EDI) for the 21st Century**, will be held April 7-9 in Dallas.

H. Ross Perot, president and CEO of Perot Systems in Dallas, will deliver the keynote address. For more information, call the coalition headquarters at (800) 905-4583 or visit its Web site at <http://www.hedic.org/HEDIC99.html>. ■