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INSIDE

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Does your data quality management include improvement processes?

If not, here are some tips on getting started

Data quality assessment and management is a lot easier when you have a database that contains information from multiple locations, such as information submitted by large health care networks.

Donna Fletcher, MPA, RHIA, data quality manager of Child Health Corporation of America (CHCA), has access to a database that includes more than 30 hospitals, including some of the largest nonprofit pediatric hospitals in the United States. This wealth of information from CHCA's owner hospitals has enabled the organization to incorporate solid data quality assessment and management into its performance and clinical improvement processes.

Fletcher has shared guidelines on establishing such a process with other HIM professionals, including speaking about the subject at the 74th National Convention and Exhibit of the Chicago-based American Health Information Management Association (AHIMA), held Sept. 21-26 in San Francisco.

CHCA, based in Overland Park, KS, is a business alliance of 38 children's hospitals nationwide, and the database used by Fletcher has detailed information on everything from the dosage of drugs prescribed to X-rays ordered.

When a particular hospital's data appear to be out of the ordinary, Fletcher will investigate its practices and find out why the facility is doing things differently from its peers. Through her investigations and tracking of outcomes, she has developed strategies for improving data that are used for research and clinical purposes, as well as for reimbursement. Here are some of her recommendations:

• **Draw upon any applicable database.** HIM professionals working for smaller hospital systems may be able to use a state database for comparison purposes, Fletcher suggests.

First, they should make certain the state database has clinical data, diagnoses, and procedure codes, all of which might be found on billing documents. "These will allow you to make sure coding is consistent," Fletcher says.

Also, it's a good idea to learn how conditions are defined in a particular region. In some places, physicians may describe a patient as having angina, whereas doctors in another region might describe the same condition as a heart attack, Fletcher says.

If the hospitals listed in a benchmarking database use different definitions from your own hospital, the coding will be different and not comparable, Fletcher says.

"So even if you have a patient with the same condition, you'll have codes for one for an angina and codes for another for a heart attack," she says.

Since this sort of definition discrepancy could be true even within one hospital system, it's wise to make certain there's a process in place to ensure that all physicians define them the same way, Fletcher adds.

Coding roundtables address problems

• **Ask physicians to explain coding issues.** Coders often come across some description or definition that seems strange. When this occurs, it's a good idea to have physicians meet with coders to explain why they are using unusual terms.

"We'd have coding roundtables where a physician would come in and tell us what was meant by a particular item," Fletcher says. "If there is any discrepancy in what the physician says, then we'd take it to the medical staff and ask for guidelines on coding that diagnosis or condition."

Those guidelines would be passed out to coders for future reference. They're also distributed to everyone who is using the data, including clinical staff, she adds.

"The people who are collecting data and assigning codes need the information the most," Fletcher says. "However, anyone using the data needs to know the limitations and parameters of data before they draw conclusions."

• **Be proactive in developing coding guidelines.** Bring physicians together with HIM staff to discuss coding guidelines, Fletcher suggests.

"Have health information management folks ask physicians, 'How do you code XYZ?'" she says.

Or, when there's some discrepancy in how clinicians and HIM staff believe a condition or diagnosis should be coded, the group will work on developing a consensus that can be put into guidelines.

Those guidelines are documented and made available to everyone through e-mail or posting them on a facility's web site, Fletcher says.

"You can use the guidelines as a training tool for coders," she adds. "Any kind of reference documentation or coding clinic guidance also are included in the document, so people can follow up and check how we reached that consensus."

• **Take a closer look at absent codes or codes used disproportionately by a particular physician or facility.** Whenever you find this pattern, don't automatically assume either overutilization or underutilization, as the codes might lead you to do. This kind of irregularity in code distribution often is an artifact of how facilities code various services.

Fletcher once discovered this kind of problem with the drug nitrous oxide, which is administered by respiratory therapy. She noticed that some hospitals appeared to be using the drug consistently, while others appeared to be not using it at all over a two-year period. That omission suggested to Fletcher that the drug really was being used, but that it was being coded in some odd place. After doing some digging, Fletcher learned that some hospitals coded the drug with respiratory therapy, while others coded it in pharmaceuticals.

"So we had our hospital come to a consensus on where it should be coded, and then we remapped or reassigned codes so that now everyone is coding it in the same area," Fletcher says. "They decided it would be coded in pharmacy because it's administered hourly."

HIM directors should encourage their staff and others in the hospital system to use the coding data for quality purposes. "Our organization tries to develop ways for our members to use data so that when they find something inconsistent, they'll bring the information to me," Fletcher says.

It's when a hospital's data are heavily used that data quality issues arise, Fletcher notes.

• **Prioritize data elements, but work toward error-free documentation.** "We have an advisory group that says these elements are so important that if the hospital doesn't have them at 100%, it's an issue," Fletcher says. "So each year I assess quality and completeness for those data elements, and our members then have information by data element."

Using these complete data, Fletcher is able to compare hospitals according to such details as admission hours.

By setting data collection priorities and reviewing them for errors, HIM professionals will find problems that previously were overlooked.

For instance, one hospital's data included periods in the ZIP code numbers, Fletcher discovered during the course of a review.

Fletcher investigated why this punctuation mark was appearing erroneously in a data element, and then she asked the hospital to take corrective action to eliminate it.

The dot in the entry field wasn't easy to discover, and the hospital itself had no idea why it was appearing there. "Sometimes you have to look at a printout of a list to see what looks weird," Fletcher says. "You have to do research for completeness, meaning there's a value in every field and it's valid.

"What I'm looking for is any one of the data elements that are not right for any reason," Fletcher says. "It's important to have this level of precision now because of the number of databases that this information is fed into."

Even when HIM departments choose not to do benchmarking comparisons of coding data, it's very likely that someone else is doing these comparisons, Fletcher notes.

"If the data are not consistent and accurate in your own facility, then that is a poor reflection on your hospital," Fletcher says. "If you're singled out in any way, then that may be an issue for you, so the goal is 100% accuracy."

• **Keep open communication lines with physicians.** "Whenever you're looking at an issue, look at the high-volume cases where you're going to get the biggest bang for your bucks," Fletcher says. "Then find the population, obtain information, and routinely ask the physician head of the medical staff or someone else to look at it."

Show the medical expert the coding book and ask whether there is anything the hospital's coders should do differently.

"Our physicians were very happy to do this, and we had no problem with asking for their help," Fletcher says.

Doctors were asked what needs to be documented to support certain diagnoses and procedure codes among the high-dollar cases, as well as for high-volume cases, she adds.

• **Accept feedback from outside sources.** Another strategy that has worked well for CHCA is an area-wide coding roundtable where coders from a CHCA hospital meet with coders from six or seven other hospitals in the area to discuss coding issues and provide coders with continuing education.

Also, HIM departments often will be alerted to data quality problems from the data warehouse vendor, who will send an error report back to the hospital, Fletcher says.

"I would prefer people to be more proactive, and if you are collecting data, then proactively review data to make sure it's what you wanted," Fletcher says. "Most databases have an error threshold, so if you're over the threshold it won't accept the data, but if you're under it, then there will be some errors that are not discovered."

But if a hospital first learns of a data problem from a vendor's report, then the HIM staff should review the report and make quality improvements, she adds. ■

Improving CPT compliance requires HIM initiative

Develop coding responsibility matrix

If your HIM department does not take outpatient coding seriously, now is the time to start, because coders working with CPT codes will need to have as much and perhaps even more training than inpatient coders, according to an HIM expert.

"There has been a change in the way we think of outpatient coding," says **Melinda Stegman**, MBA, CCS, manager of Clinical HIM Services for HSS Inc. in Germantown, MD. HSS Inc., based in Hamden, CT, is a health care consulting company.

"It used to be that outpatient coding wasn't thought to be as important as inpatient coding, so we'd take the newest, least experienced coders and put them on outpatient," Stegman says. "But while the outpatient cases aren't as long as inpatient, CPT is an entirely different animal than ICD-9 codes, so we need to make sure all coding staff have the training they need, plus additional resources."

Another consideration is that while coders can learn a great deal from ICD-9 coding clinics and books, with CPT coding they likely will need other types of resources to help them understand

the different terms and guidelines, Stegman says.

And it would be a mistake for HIM directors to assume that the smaller the hospital, the less attention needs to be paid to CPT coding, Stegman says.

"What we're finding is that the smaller hospitals may be driving a greater percentage of the total reimbursement on the outpatient side than on the inpatient side," Stegman explains. "They may not have very complex services on the inpatient side, because they transfer these patients right away to a bigger facility."

Outpatient procedures growing more complex

On the other hand, these same small hospitals might be the biggest providers of outpatient services for their region, she adds.

Add to this trend the fact that health care providers are continuing to see more complex outpatient procedures, even in smaller hospital settings, and it's clear that CPT coding should be a top priority in training and continuing education of HIM staff, Stegman says.

"I was at a tiny hospital in the Midwest, and I thought I'd see typical procedures for treating cataracts," Stegman recalls. "Instead there was an eye surgeon doing state-of-the-art types of things, so even at a small hospital HIM staff need to make sure they're aware of the services their hospital provides."

Stegman spoke recently about CPT coding compliance at the recent 74th National Convention and Exhibit of the Chicago-based American Health Information Management Association (AHIMA), held Sept. 21-26 in San Francisco.

Here are some of Stegman's suggestions for improving CPT coding compliance:

• **Develop a coding responsibility matrix.**

HIM departments need to develop a coding responsibility matrix that will show every outpatient coding or outpatient service area in a facility, along with who has the responsibility for assigning these diagnosis, CPT, and level two codes, Stegman says.

"Typically, no one person has answers to all of it," Stegman says.

So the matrix will force HIM departments to be disciplined about seeing who really is responsible for coding services and who is responsible for different service areas.

• **Review the chargemaster.**

"There are a lot of hospitals out there that haven't had their chargemaster reviewed since the inception of APCs, or they think if they have someone come in to review it every couple of years that's good enough," Stegman says.

"But with regulatory changes, that probably isn't good enough," she adds.

HIM departments should have a streamlined revision policy in place so that it doesn't take two to three months to make revisions or changes, she says.

"I went to a small hospital a couple of weeks ago, and it was practically impossible to make changes," Stegman recalls. "They showed me the form, and the form required six signatures."

Just keep in mind that the rules about updating chargemasters have changed, and there needs to be a much more flexible, ongoing process rather than a once-a-year check-up of the charge description master, Stegman advises.

What services does your facility offer?

• **Know your top procedures by CPT code.**

"One thing we do at HSS is build some tools and database programs to help facilities look at their own internal data and benchmark themselves against other providers," Stegman says.

"Before you can benchmark yourself against better outpatient providers, you need to get a good idea of all of the types of services your facility offers," she adds. "I think there still is a lag in the reporting capabilities that hospitals have on the outpatient side compared with the inpatient side."

For instance, Stegman says she sometimes will go to a hospital and ask for outpatient reports only to find that the hospital cannot run the report that day. Obtaining a report probably wouldn't be a problem for inpatient data, which is why HIM staff need to make sure that their reporting capabilities are as up to date on the outpatient side as on the inpatient side, she says.

HIM departments need to be able to pull up reports based on volume, as well as other factors, she adds.

"I want to be able to run a report that will tell me by month what are my top 10 or 25 procedures by CPT codes," Stegman says. "Then I'll want to make sure the coding staff is very comfortable with those top services."

Also, HIM directors could make certain that clinical staff and other departments are aware of any coding changes or clarifications that might affect those top services, she says. ■

Final HIPAA privacy rule will be less burdensome

However, sweeping operational changes expected

Organizations now can move ahead and comply with the Health Insurance Portability and Accountability Act (HIPAA) now that the final privacy rule, which will be less burdensome, has been published.

"In general, I feel that the Department of Health and Human Services' updates to the HIPAA regulations improve our ability to provide treatment and protect the privacy of our patients' information," says **Janice Roach**, executive director of Tri-City Regional Surgery Center in Richland, WA.

The Chicago-based American Hospital Association, however, warns that the rule still requires "sweeping operational changes."

"Because it will affect every department, employee, and business associate of the hospital, it will take intense education of hospital workers and patients," the association warns.[1]

A previous version of the privacy rule was published on Dec. 28, 2000, and proposed modifications were published on March 27, 2002. The final rule was published Aug. 14, 2002, in the *Federal Register*. The deadline for compliance is April 14, 2003, or April 14, 2004, for small health plans.

Here are the areas with major changes:

• **Privacy notice.**

The rule omits the requirement for written consent from patients before disclosing patient information among providers. Instead, patients should be asked to sign or otherwise acknowledge that they have received information about their privacy rights and the providers' information practices.

"I am happy about the reduced expectation for the patient consent requirement," Roach says. "It will be easier for us to administrate and also easier for the patients to understand."

The privacy notice must be given during the initial patient encounter and any time patients request it, Roach says. "Of course we make a good-faith attempt to make sure that our patients understand their rights under HIPAA, but not by having to provide them a 20-page legal document," she says.

• **Initial use and disclosure.**

The final rule allows uses or disclosure of patient information that are incidental to a use or disclosure that is otherwise permitted. For example, surgery centers may keep patient charts at bedside, physicians can talk to patients in semiprivate rooms, and physicians can confer at nurses' stations without fearing that they violate the rule if a passerby overhears them, according to a statement from the Department of Health and Human Services.[2z]

The relaxation of the regulations for incidental disclosures actually will make it easier for outpatient surgery providers to take good care of patients, Roach says. "Medical personnel need to be able to discuss a patient's condition and treatment, without having to constantly worry about breaking the law," she says. "Staff at the [Tri-City Regional] Surgery Center understand the patient's need and right for confidentiality, but this change makes it easier for the nurses and doctors to do their job."

• **Marketing.**

The final rule said providers must obtain a patient's specific authorization before sending them marketing materials.

General newsletters still can be mailed if they have general health information and they aren't labeled "information for patients," says **Mark Mayo**, executive director of the Illinois Freestanding Surgery Center Association in St. Charles. Mayo received this advice at the recent HIPAA conference sponsored by the Alexandria, VA-based Federated Ambulatory Surgery Association. "The recommendation is that the mail packet not be too obvious," Mayo says.

The final HIPAA security regulations still are uncertain.

"We are still a little nervous about the fact that the final security regulations are not yet finalized, yet we are supposed to ensure the privacy of our patients' information," Roach says. "We expect to make some minor changes to improve security of patient data, but we already have had to begin staff awareness and training." Her awareness includes discussion at monthly staff meetings, she says. Privacy training for all employees is mandatory under HIPAA.

"We are also reviewing our policies and procedures to make sure that we are protecting the privacy of patient information," Roach says.

[Editor's note: The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) will continue to conduct outreach and education targeted to providers affected by the privacy regulation. These efforts include technical assistance materials and

responses to frequently asked questions. HHS also will hold national educational conferences in the fall to address issues related to key parts of the privacy regulation. Technical assistance materials will be posted on OCR's privacy rule web site at www.hhs.gov/ocr/hipaa/.

Copies of the Federal Register *can be found at www.access.gpo.gov/su_docs/fedreg/frcont02.html. Click on "Wednesday, Aug. 14," and look under the "Health and Human Services Department." Or, you can view the* Federal Register *at many libraries. To order by mail, the cost is $10. Specify the date (Aug. 14, 2002), and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or MasterCard number and expiration date. Send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Credit card orders can be placed by telephone: (202) 512-1800, or by fax: (202) 512-2250.]*

References

1. American Hospital Association. AHA News Now Special Report — HHS issues final HIPAA Medical Privacy Rule. Chicago; Aug. 9, 2002.
2. Department of Health and Human Services, Press Office. Modifications to the Standards for Privacy of Individually Identifiable Health Information — Final Rule. Washington, DC; Aug. 9, 2002. ■

EDs would benefit from new outpatient payment system

EDs could claim more using new relative weights

Attention emergency department (ED) managers: There may finally be some good news on the reimbursement front.

Marty Karpiel, MPA, ambulatory care consultant for the Karpiel Consulting Group in Long Beach, CA, which specializes in operational and financial process improvement for EDs, points to the proposed rule from the Baltimore-based Centers for Medicare and Medicaid Services (CMS) for the Outpatient Prospective Payment System (OPPS).

Karpiel says that overall, hospitals would receive over $500 million more in 2003 than this year, because of a overall 3.5% pay increase for outpatient services. Payments to rural hospitals would increase an estimated 7.6%. However, EDs would see a much greater percentage increase, due to the new proposed method for recalculating the relative weights using "multiple procedure" claims data from 2001, he says.

Here are the key changes for the proposed OPPS rules:

1. The 2003 payment rates were developed using actual data from claims submitted by hospitals under OPPS.

This is a significant change, Karpiel says, because rates for the prior two years were based on cost information from 1996.

2. CMS would set relative rates based on data from multiple-procedure claims instead of claims with a single procedure.

As a result of this change, Karpiel says the percentage of claims used to set relative weights would nearly double, from 42% for 2002 to 82% for 2003.

He calculates that ED visit level payments would increase more than 20% in total, assuming an average acuity.

"We've been urging hospitals to accurately report visit levels and charges to make certain the database is populated by accurate distributions of the various levels," he says.

3. Separate codes would be established for outpatient evaluation and management services.

However, Karpiel notes that these would not be used for enforcement until 2004.

4. New "G" codes would replace the 9928x series.

"Happily, this would eliminate the potential for Medicare payers to deny or downcode physician levels because they don't match hospital claims," says Karpiel. "However, it remains to be seen whether non-Medicare payers will use the new level coding system. Some type of crosswalk will likely be necessary."

5. Payment would be given for observation cases for congestive heart failure, chest pains, and asthma for patients admitted directly from a physician's office.

Karpiel notes that the proposed rule would ensure payment for intravenous therapy for observation patients, whereas the current rules deny this separate payment when observation is claimed.

6. Certain pass-through services would be reassigned to associated ambulatory payment classifications (APCs).

The proposed rule would cut 95 categories of devices and 240 drugs from the pass-through payment system. Instead, these items would be

included in associated APCs, with separate APCs created for the higher-cost drugs.

For example, there would be a separate payment for drugs used solely to treat a rare condition or disease, blood and blood products, and vaccines such as those for flu and hepatitis B vaccine.

"While the news is good for emergency medicine overall, it's particularly good for hospitals who are accurately assigning ED visit levels," Karpiel stresses. Most hospitals still undervalue emergency visit levels by an average of 30%, he says.

He refers to additional revenue from coding for reportable procedures, such as intravenous therapy, injections, laceration repair, splinting/strapping, fracture care, and critical care. "The ED can now show a profit, where in years past it was considered only a loss leader for the hospital," Karpiel predicts.

The CMS proposed rule, titled "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports" [CMS-1206-P], was published in the *Federal Register* on Aug. 9, 2002. The proposed rule can be viewed on the CMS web site at: cms.hhs.gov/regulations/hopps/. ■

ED diversions reduced by tight monitoring

Industrial processes allow real-time reaction

Using a combination of techniques that benchmark best practices from other industries, **Roger Resar**, MD, pulmonologist and change agent at the Luther Midelfort-Mayo Health System in Eau Claire, WI, has gained tighter control on monitoring patient flow and, based on preliminary results:

- reduced emergency department (ED) diversion hours from 12% to less than 2%;
- slashed the cost of diversions from about $250,000 a month to less than $30,000;
- increased from 23% to 40% the percentage of patients who were put to bed within one hour.

In addition, since nurses were given greater control over processes, staff vacancy rates dropped significantly and satisfaction rose, Resar says.

Resar says a trip to Boston in January 2001 helped set things in motion. At that time, he and his CEO participated in an Institute for Healthcare Improvement-sponsored session on hospital flow.

"They set up a group of experts to talk about what we might start to do to improve the problem," he recalls. "Our problem was not as acute as the one they had in Boston, but there were still times when the ED shut down, operations were cancelled, and so on."

Resar and his CEO eventually met Eugene Litvak, MD, professor of health care and operations management at Boston University, an expert in the field, and also involved one of their senior vice presidents in charge of nursing in the process.

"What we heard from that group of experts tweaked our interest, and we felt we could probably use some of their ideas," notes Resar. "So we came back and tested some of these ideas."

One realization that emerged very early on was that the hospital had no good way to measure flow through the organization. "We measured bodies that went through in a month or a year, but we had no real-time measurement of flow," Resar explains. "Every industry, every airport, any kind of large organization that deals with production measures flow at various points; they know where their bottlenecks are and what to do in contingencies. In hospitals, we don't do that at all."

Benchmarking these other industries really opened Resar's eyes. "My CEO, myself, and several vice presidents went to a local power company that serves a large area of the Midwest," he recalls. "Their office has a huge control board with a panel that runs all around a huge room. They can tell at any time almost down to a single telephone pole how much power is going through, how much is needed, and how much should be changed if there is an increase in demand. It struck me that at any given time in a given hospital, you can't tell what's going on; nobody knows."

Another instructive visit was made to Northwest Airlines' hub at the Minneapolis airport. "They really need to understand flow," notes Resar. "If you notice, airplanes very seldom circle airports anymore before landing. That's because you can't take off from Boston, for example, until you have a landing slot in Minneapolis. In hospitals, we just take patients without knowing where they will 'land.'"

The first thing Resar and his front-line staff did was set up a measuring system that involves all

patient floors of the hospital. "We started out very small, using a pilot area, and did it all on paper, before we moved to an electronic [computerized] system," he explains.

The system is based on the stop-light concept, designating red, orange, yellow, or green states of patient flow. "We set it up so that each unit would report on a regular basis, or if something changes drastically, what their color was," says Resar. "If you tell someone you're having a red day, you really don't have to go into a long description for other departments to understand you."

A given unit's color is determined by using a measurement tool — a paper assessment anchored in several objective measures — the end result being the reporting of a color. This is done by the front-line staffers.

By April of 2001, says Resar, everybody in the hospital was using the system, which was accessed through its Intranet.

Practical Recommendations for Improved Flow Monitoring and Control

- Institute a front-line staff-designed and staff-run rapid assessment tool.
- Utilize an assessment tool to "smooth" demand from hour to hour.
- Utilize management tools to plan resource use on a quarterly or yearly basis.
- Institute a Capping Trust Policy.
- Study upstream recognition of downstream resource use for natural and random variation.
- Coordinate all hospital bed use through one person or team.
- Identify critical downstream units and develop pull systems.

Source: Roger Resar, MD, Luther Midelfort-Mayo Health System, Eau Claire, WI.

Ensuring action

One of the unique aspects of the changes instituted at Luther Midelfort, and a key to its success, was a mechanism to ensure action. "You can't have a measurement system if people can't act on it," Resar explains. "The first action we put into place was that when a unit reached a point — usually red — which in the front-line staff's estimation meant they could not accept another patient, they capped the unit." This policy, he says, was called the Capping Trust Policy.

"If you were a front-line staffer and assessed your unit as completely saturated, you were allowed to cap your unit for safety reasons," Resar observes. "This was what Litvak was talking about: the limitation of elective procedures so that you could end up smoothing the artificial variability."

A lot of admissions to hospitals are artificial variations, Resar asserts. "What if I get a call from a doctor at another hospital who says he'd like to send a patient over? In my former life, I would have sent him over. Now, I think about the airport. If I said yes without knowing there was a bed available, the patient ends up in the ER with no landing spot [and] waits for a bed."

Now, when a patient can't go on a unit, the only way for physicians to have him or her admitted is to go through an admissions coordinator, who functions very much like an air-traffic controller. "We are a level 2 trauma center; we will bring in a patient if it is an emergency," notes Resar. "But if the patient is 100 miles away, has pneumonia, and needs tests done, they can come in a couple of hours, not right away."

The measurement initiative, Resar notes, "allowed the Capping Trust Policy, allowed us to shut down, and forced us to think about how to handle people coming in."

Another key element of the new system is what Resar refers to as upstream evaluation for downstream resource use. It addresses certain facts you must have in hand before scheduling an elective procedure."

"If I'm a surgeon doing a procedure that requires an ICU bed and a ventilator after surgery, and if I have four operations on Monday and all will require a breathing machine for at least two days, those four will totally plug up the ICU," he observes. "Instead, I might want to schedule just two procedures for Monday and two for Wednesday, and fill in the operating time with patients who don't need breathing machines. We never did that until now. You can't schedule procedures willy-nilly without realizing what the downstream effects will be."

A big plus for morale

The new system has had a profound effect on nursing morale, Resar says. "In 2001, we had a nurse vacancy rate running somewhere around 8% to 10%," he recalls. "About six months after

we started the Capping Trust Policy, it went down to 1% to 2%, and each unit shows the same dramatic change."

Resar has no doubt there is a connection. "When front-line nurses get empowered to have a say-so in their work, it improves morale considerably," he asserts.

He also notes that despite the new system, admissions did not drop. "We were able to hire more nurses, but the other thing is this: We found out these nurses and other folks who work in our hospital are dedicated people. We don't see them slacking. Yes, when it gets to the point where they just can't take any more patients, they shut down for a few hours. But they are not taking advantage of the policy." ■

Cash discounts surface as major government concern

Don't try to eliminate out-of-network penalties

Cash discounts are showing up on the government's radar screen, warn health care attorneys, who point to the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) special advisory on inducements issued in late August. "Whether and to what extent cash discounts to patients are permissible continues to be a source of frustration for physicians, ambulatory surgery centers, and other providers," says **Allison Shuren**, JD, of Arent Fox Attorneys at Law in Washington, DC. While cash discount arrangements are permitted in many situations, she says there is no shortage of potential land mines.

Bill Sarraille, JD, also of Arent Fox, says pitfalls include Medicare reimbursement limitations, state anti-kickback laws, the anti-beneficiary inducement provision of the Health Insurance Portability and Accountability Act, the Medicare exclusion provision that relates to Medicare and non-Medicare charges, and state insurance anti-discrimination provisions.

Sarraille says the term "cash discounts" is sometimes used to incorrectly suggest an appropriate reason for improperly waiving out-of-network penalties required by a patient's managed care insurance. "Providers in these situations are looking for a means of eliminating the out-of-network penalties that would otherwise apply, without reducing the amount that the insurance company pays," he explains.

According to Shuren, another potential problem with a cash discount in connection with Medicare patients is that Medicare pays the lesser of the applicable percentage of the fee schedule allowable or the actual charge for the service. "If a cash discount is offered in connection with a Medicare-covered service, the effect of this will typically be to take the actual charge below the Medicare allowable," she explains.

Give written notice of cash discount policy

If that fact is not reported on the claim form submitted to the Medicare program, she says the provider will receive an overpayment.

Similar issues may be raised with respect to patients covered by private insurance, says Shuren. She notes that some commercial payer provider agreements have language that follows the Medicare payment rules with regard to the distinction between fee schedule allowables and actual charges.

State insurance fraud and state false claims acts, which generally apply to all payers, can have the same effect on discounts in a private-pay context that the federal False Claims Act has on a federal level, warns Shuren. In these situations, she says providers are well-advised to notify payers, in writing, of the providers' cash discount policy.

In some respects, discounts are already over-regulated, argues **Robert Homchick**, a partner with the law firm Davis Wright Tremaine in Seattle. He points out that Congress included a statutory exception for discounts in the anti-kickback law, and almost everyone would agree that discounting is a good thing and should generally be permissible.

There are certain issues such as swapping that are legitimate concerns on the part of the OIG, says Homchick. But the discount safe harbor is too narrowly drawn, particularly if the government is taking the position that the only permissible discounts are those that meet the safe harbor's specific requirements.

According to Homchick, the dynamics of the marketplace make the OIG's attempts to rein in discounting practices difficult, and the aggressive stance of the regulators on this issue appears to be inconsistent with congressional intent. ■

Medicare appeal process called untapped opportunity

There's a good chance to overturn, expert says

By **Linda Fotheringill**
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When a Medicare intermediary or a carrier denies payment for a claim, a provider may appeal the denial. The chance of overturning a wrongful denial in the appeal process is high, yet providers are apparently not taking advantage of the appeal process.

How do I know this? The Office of the Inspector General (OIG) issued a report on Medicare administrative appeals in September 1999 for purposes of evaluating the administrative law judge (ALJ) appeal process for Medicare Part A and Part B fee-for-service claims. The report indicated that of the 142,086,669 claims processed in 1996, 13,547,514 were denied. Only 60,680 reconsiderations were sought by providers for these denied claims, and fewer than .1%, or 12,155 claims, went on to be appealed at an ALJ hearing.

According to the OIG report, the rate of reversal during the appeal process in the mid-1990s was high enough to cause concern for the Centers for Medicare and Medicaid Services (CMS) and its contractors. Amazingly, at least from my perspective, the OIG appeared to conclude that the high rate of reversal was due to providers taking unfair advantage of the carriers in a system that is weighted in favor of the providers. For instance, the report stated: "According to [CMS] representatives, the high rate of reversal may provide an incentive for uninformed or abusive providers to submit claims for services and items that are not covered."

The report went on to say that "contractor staff are increasingly demoralized by a high incidence of ALJ reversals. Contractors report seeing providers who have been in the Medicare program for years use the administrative appeals process to 'beat the system' and obtain payment for services and supplies which are not payable under contractor guidelines."

From my perspective as an attorney who represents providers in the Medicare appeals process, the most plausible explanation for the high rate of reversal at the ALJ hearing level is the fact that the contractor/intermediary improperly denied the claim in the first place. Nevertheless, this is not even suggested by the OIG as an explanation for its high rate of reversal.

If you find that your hospital is receiving inappropriate denials from your Medicare intermediary, I suggest that you appeal those denials, for two reasons. First, your voice should be heard by Medicare. Second, you stand a good chance of getting an inappropriate denial overturned if you implement the process.

The rules for Medicare appeals currently are found in Chapter 42 in the Code of Federal Regulations, Part 405.701 through 405.753 for Part A appeals, and Part 405.801 through 405.877 for Part B appeals. However, the recently enacted Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA) significantly revises the Medicare appeals process.

The new appeals process set forth in BIPA provides the same rules for Part A and Part B appeals, eliminating the current distinctions between the two. Section 521 of BIPA establishes a uniform process for handling all Medicare Part A and Part B appeals and specifies time frames for filing appeals and rendering decisions. Significantly, BIPA mandates that at least 12 qualified independent contractors (QICs) conduct reconsiderations. The QIC promptly would notify beneficiaries and Medicare claims processing contractors of its determinations. A beneficiary could appeal the decision of a QIC to an ALJ. In cases where the ALJ decision is not rendered within the 90-day deadline, the appealing party would be able to request a Departmental Appeals Board hearing.

Although BIPA took effect Oct. 1, 2002, Congress has not appropriated the necessary funds to implement the program. QICs do not currently exist. I have been informed by Medicare's Division of Hearings, Appeals, and Dispute Resolution that providers should watch the *Federal Register* for instructions on how to proceed in the appeals process after Oct. 1, 2002.

COMING IN FUTURE MONTHS

- New ICD-9-CM codes require more documentation
- Learn more about hypertension coding
- Prepare for a successful Joint Commission survey
- Ways to increase reimbursement

It is not necessary to be an attorney to pursue the appeals process or to participate in an ALJ hearing. However, it is recommended that you retain an attorney for this purpose, as it should increase your chance for success. A provider should be able to locate competent counsel who will handle Medicare appeals on a contingency-fee basis.

[Editor's note: Linda Fotheringill is a partner in Siegel & Fotheringill, a law firm that specializes in using contract law to help hospitals get paid, and is a founder of the Denial Management Institute. She can be reached at The Susquehanna Building, 29 W. Susquehanna Ave., Baltimore, MD 21204. Telephone: (410) 821-5292 or (800) 847-8083. E-mail:sfllc@excite.com.] ■

Discharge planning is not optional, expert cautions

Here are laws defining the process

Discharge planning is the law. While giving a presentation at a recent national meeting in Las Vegas on the rules and realities of discharge planning, veteran discharge planning and case management consultant **Jackie Birmingham**, RN, MS, CMAC, vice president of professional services for Curaspan Inc. in Newton, MA, was shocked to discover that many in her audience did not know there were laws mandating discharge planning.

What Birmingham came to realize, she says, is that this phenomenon was a function of the widespread hospital re-engineering efforts of the 1990s, during which many organizations decentralized services and laid off middle managers.

When hospital administrators noticed that the changes resulted in less desirable patient outcomes, including longer lengths of stay, they reestablished discharge planning departments, but put people in charge who had no discharge planning legacy, Birmingham explains. "So [the managers] are doing the right thing, but have no idea why they're doing it."

With that in mind, she has taken on the mission of disseminating information on the laws that support discharge planning. The major impetus for discharge planning and case management, Birmingham notes, can be found in the following laws, which are listed below along with her interpretation of their provisions.

• **Social Security Act (SSA).**

As stated in the Conditions of Participation for Hospitals (*Federal Register*, Dec. 19, 1997), the SSA makes a number of provisions regarding discharge planning. It directs health care providers to:

— identify patients who need discharge planning;

— provide an evaluation for patients;

— evaluate patients on a timely basis to ensure appropriate plans;

— include an evaluation of need for post-hospital services, including hospice;

— include an evaluation in the medical record and discuss results with the patient and/or the patient's representative;

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Editorial Questions

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

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— develop an initial implementation of the plan;

— develop the plan under the supervision of a registered nurse, social worker, or other qualified person.

• **SSA Amendment (Utilization Review).**

This amendment came about a few years after the establishment of Medicare sparked an increase in the usage of health care, Birmingham explains. "Utilization review was mandated because this was the first time there had been coverage for medical care, and the utilization of services and the cost of the program were beyond what had been expected." The government decided to start evaluating the quality and outcome of the services it was paying for, to be sure there was appropriate care for patients, she adds.

• **Tax Equity and Fiscal Responsibility Act of 1982.**

This act, which applies only to inpatients, changed the way Medicare reimbursed hospitals, looking at groups of diagnoses and paying according to length of stay and cost per case, Birmingham says. "That's when discharge planning became critical, because if hospitals began to discharge patients earlier, there needed to be a way to plan for patients who were leaving 'quicker and sicker.'" A process was needed to connect the post-acute providers with patients who had more medical care needs, she adds.

• **Emergency Medical Treatment and Labor Act.**

Passed in 1987, this legislation — often referred to as the "anti-dumping law" — specifies that a patient cannot be discharged or transferred from an emergency department until he or she is stabilized. "Stabilization," Birmingham points out, means that no significant medical deterioration is likely after the patient is discharged or transferred, and it is judged on professional standards of practice, not on the hospital standard.

A "nonstabilized" patient, she continues, may be transferred only when the medical benefits outweigh the risks, the patient (or family) consents, and there is medical treatment by the transferring hospital to minimize risk during transfer. The receiving hospital must agree to the transfer, all medical records must be sent, and the transfer must be accomplished with qualified personnel and equipment, Birmingham adds.

• **Preadmission Screening and Annual Resident Review (PASARR).**

Another 1987 piece of legislation, PASARR was passed to ensure that patients who have mental health needs are identified before admission to a nursing home, Birmingham says. It addresses the issue of whether patients being admitted to a skilled nursing facility have the medical/nursing needs to warrant the admission.

• **Medicare as Secondary Payer (MSP).**

The MSP rules, passed in 1990, state that Medicare will not be the primary payer when another payer is available, such as when a patient's spouse is employed and has insurance coverage, when the treatment is the result of an automobile accident for which there is insurance coverage, or when workers' compensation applies.

Providers must review the MSP rules for every admission, as well as for outpatient cases and laboratory tests, Birmingham notes. Hospitals are liable for recovery of money for up to 10 years after the admission or service.

• **Health Insurance Portability and Accountability Act (HIPAA) of 1996.**

This legislation, for which regulations are still being written, also burdens those involved in discharge planning with needing to know as much about laws as they do about diseases, Birmingham says. The privacy section of HIPAA will affect how referrals are made and how information about patients is transferred from one level of care to another, she adds, as well as what will need to be documented even about referral sources that don't take the patient. **(See story on HIPAA, p. 143.)** ■

DRG CODING ADVISOR.

AHIMA director discusses 2003 DRG coding updates

Trend is toward more specificity

The Centers for Medicare & Medicaid Services (CMS) is moving coding away from the previous trend of permitting coders to group a variety of diagnoses under unspecified codes. Now there's an emphasis on finding a very specific code to describe the diagnosis, says **Sue Prophet-Bowman**, RHIA, CCS, director of coding policy and compliance for the American Health Information Management Association (AHIMA) in Chicago.

Under the changes for fiscal year 2003, which took effect Oct. 1, 2002, most of the new DRGs and all of the ICD-9 codes require better documentation and understanding of the medical record, medical processes, and procedures, Prophet-Bowman says.

"So it definitely emphasizes the need for well-educated, qualified coding staff," she notes. "All of the complexities point to the need for greater coding skills because there are getting to be a lot more nuances in discriminating between selected codes."

"It just helps us to have better data about what conditions patients have, so we see it as a very positive trend," she adds.

One of the more interesting changes to the DRGs has been the revisions to the stroke DRGs. CMS decided that the code for the generic, nonspecific stroke should be moved to the previous coding for transient ischemic attack, Prophet-Bowman says.

"They did this mainly because data showed that patients who did not have specific cerebrovascular accident codes, indicating cerebral hemorrhage, didn't consume as many resources," she explains. "It doesn't mean that you have a lesser stroke, but it just has not been identified which kind of stroke you had."

This change means it is critical for coders to have complete and accurate documentation of the nature of a stroke, because without the documentation the coder will have to use a lesser DRG, Prophet-Bowman says.

AHIMA's complete analysis of the final rule for fiscal year 2003 DRG revisions to the hospital inpatient prospective payment system (PPS) are described on the AHIMA web site at www.ahima.org/dc/DRGanalysisFY03.html.

In her analysis, Prophet-Bowman offers these examples of DRG coding changes that offer clearer descriptions and may require more specific information and better documentation:

- **DRG 1:** Old DRG description read: "Craniotomy Age >17 Except for Trauma." The new DRG description reads: "Craniotomy Age >17 with complication/comorbidity."
- **DRG 2:** Old DRG: "Craniotomy for Trauma Age >17." New DRG: "Craniotomy Age >17 without complication/comorbidity."
- **DRG 14:** Old DRG: "Specific Cerebrovascular Disorders Except Transient Ischemic Attack (TIA)." New DRG: "Intracranial Hemorrhage and Stroke with Infarction." Also, codes 437.3 for cerebral aneurysm, nonruptured, and 784.3 for aphasia have been moved from DRG 14 to DRGs 34 and 35.
- **DRG 15:** Old DRG: "Transient Ischemic Attack and Precerebral Occlusions." New DRG: "Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction." Also, code 436 for an acute but ill-defined cerebrovascular disease has been moved from DRG 14 to DRG 15.
- **DRG 524:** Old DRG: none. New DRG: "Transient Ischemia." Also, this new DRG is now assigned codes that previously were assigned to DRG 15, including the following:
  - — 435.0: basilar artery syndrome;
  - — 435.1: vertebral artery syndrome;
  - — 435.2: subclavian steal syndrome;
  - — 435.3: vertebrobasilar artery syndrome;

— 435.8: other specified transient cerebral ischemias;

— 435.9: unspecified transient cerebral ischemia.

• **New code 277.02:** This new code for cystic fibrosis with pulmonary manifestations has been assigned to DRG 79, which is described as "Respiratory Infection and Inflammations Age >17"; to DRG 80, which is described as "Respiratory Infections and Inflammations Age >17 without complication/comorbidity"; and to DRG 81, which is described as "Respiratory Infections and Inflammations Age 0-17."

• **New code 277.03:** This new code for cystic fibrosis with gastrointestinal manifestations has been assigned to DRG 188, which is described as "Other Digestive System Diagnoses Age >17 with complication/comorbidity;" DRG 189, described as "Other Digestive System Diagnoses Age >17 without complication/comorbidity"; and DRG 190, which is "Other Digestive System Diagnoses Age 0-17."

• **New code 277.09:** This new code for cystic fibrosis with other manifestations has been classified to the same DRGs as code 277.00.

• **New DRG 525:** This new DRG is for implantation of heart assist systems. It consists of any principal diagnosis in MDC 5, plus one of the following surgical procedures:

— 37.62: implant of other heart assist system;

— 37.63: replacement and repair of heart assist system;

— 37.65: implant of an external, pulsatile heart assist system;

— 37.66: implant of an implantable, pulsatile heart assist system.

• **Code 86.07:** This code for insertion of totally implantable vascular access device has been assigned to DRG 315, which is defined as "Other Kidney and Urinary Tract OR [operating room] Procedures."

• **Code V10.53:** This code for the history of malignancy, renal pelvis, has been assigned to DRG 465, which is defined as "Aftercare with History of Malignancy as Secondary Diagnosis."

• **DRG 483:** This code has been revised with definition of "Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnoses Except Face, Mouth, and Neck." As part of its change, code 96.72, covering all cases involving a tracheostomy and a diagnosis of face, mouth, and neck diagnosis that also have been on continuous mechanical ventilation for greater than 96 hours, has been moved from DRG 482 (Tracheostomy for Face, Mouth and Neck Diagnoses) to DRG 483, a higher-weighted DRG.

• **New DRG 526:** Defined as "Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with Acute Myocardial Infarction," this DRG has been created for the insertion of drug-eluting coronary stents. This code will not be effective until discharges occurring on or after April 1, 2003, because the procedure has not yet been approved by the Food and Drug Administration (FDA).

• **New DRG 527:** This code is defined as "Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without Acute Myocardial Infarction." It will not be effective until discharges occurring on or after April 1, 2003, because the procedure has not yet been approved by the FDA.

• **New code 00.11:** Defined as "Infusion of drotrecogin alfa [activated]," this new code will be used in cases where Xigris, approved for an add-on payment as a new technology, is administered. Xigris is used to reduce mortality in adults with sepsis associated with organ dysfunction and who have a high risk of death. It's a biotechnology product that was approved by the FDA in November 2001.

• **New code 00.50:** Defined as "Implantation of cardiac resynchronization pacemaker without mention of defibrillation, total system [CRT-P]," this code has been assigned to DRG 115, which is for "Permanent Cardiac Pacemaker Implantation with Acute Myocardial Infarction, Heart Failure, or Shock, or AICD Lead or Generator Procedure," and DRG 116, which is "Other Permanent Cardiac Pacemaker Implant."

• **New code 00.51:** Defined as "Implantation of cardiac resynchronization defibrillator, total system [CRT-D]," this code has been assigned to DRG 514, which is "Cardiac Defibrillator Implant with Cardiac Catheterization," and DRG 515, which is "Cardiac Defibrillator Implant without Cardiac Catheterization."

• **Code 57.87:** Defined as "Reconstruction of urinary bladder," this code has been assigned as a major bladder procedure to DRG 303 (Kidney, Ureter, and Major Bladder Procedures for Neoplasm), DRG 304 (Kidney, Ureter, and Major Bladder Procedures for Nonneoplasm with complication/comorbidity), and DRG 305, which is "Kidney, Ureter, and Major Bladder Procedures for Nonneoplasm without complication/comorbidity."

• **Code 398.91:** This code for rheumatic heart failure has been moved from DRG 125 to DRG 124, which is "Circulatory Disorders Except Acute Myocardial Infarction with Cardiac Catheterization and Complex Diagnosis." ■