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AHC Media LLC

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NOVEMBER 2008
VOL. 27, NO. 11 • (pages 121-132)

Don't make a mistake when asking for technology dollars

Know your facts before you commit

If you are being inundated with sales pitches from technology vendors these days, it's not too surprising. A number of solutions are aimed at improving patient access processes, such as compliance with new admission/registration requirements.

You can either invest in technology to manage regulatory requirements, improve accuracy, increase collections, reduce precertification denials, improve throughput, and reduce wait times — or you will fall behind your competitors. Without electronic solutions, you run the risk of having to hire scarce resources able to correct problems that are leading to precertification denials, for example.

"We've got so many gizmos on the road map for patient access," says **Katherine Murphy**, CHAM, director of access services for Nebo Systems, a subsidiary of Passport Health Communications in Oakbrook Terrace, IL. Murphy is also a delegate to the National Association of Healthcare Access Management (NAHAM) and the president of the Illinois Access Association. "Everything you read about is for the front end.

"We are being called upon to create a new, better way of doing business," says Murphy. "Consumer-driven health care and consumer demographics are also driving the urgency for these changes."

Without electronic solutions, you won't be able to correct problems that are causing precertification denials, for example. "The only other way to do it is manually, and if you do that, you will be so far behind the trends," says **Tim Carney**, manager of outpatient financial arrangements at Shands at the University of Florida in Gainesville. "By the time you have gotten 1,000 charts together and find out where your denials are coming from, you've got six months more of bad data coming in."

If you don't know where your denials are coming from and you're trying to figure it out on paper, "you'd better be the only game in town," says Carney. "Otherwise, your competition is going

to squash you."

But making the wrong move with technology could cause you other problems. You risk a financial disaster if you are too far removed from the problems you are trying to solve.

"When you are trying to sell administration on a $300,000 project and you're doing it on the backs of an FTE savings or an ROI promised by a vendor, it's time to get your hands dirty and be sure you really understand what you're trying to fix," says Carney. "If you don't, you really better trust the people that are giving you the data. Because if it goes bad, they're not going after those people, they're going after you!"

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Hospital Access Management***™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions

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When lobbying for a new technology purchase, do these things first:

- **Make sure your numbers are correct.**

"One of the things I recognized early in my career was that if you make any kind of claim, you better have something to back it up. Because somebody is going to challenge it," says Murphy.

When selling your CFO on a technology tool, Carney says "make it a money deal." "If you say, you give me $300,000 and I'll get you a million, why wouldn't he do that deal?"

But you've got to be sure of a few things before you make a promise like that. First, be certain that the implementation's total cost isn't more than you claim. To verify this, you'll need to bring in your IT department.

"Don't listen to the salesman — you need your IT in there," says Carney. "You may find out that he hasn't told you you've got to hook it up to a LAN, or a server, or whatever, which will cost you another $30,000 or so. Bring everybody in. If you do this in a silo, the silo is going to fall on you."

Your case should be "all about numbers" says Carney, without getting personal. "Know the data inside and out. And make sure that your hospital-based HIS system and your IT department can support this," he adds.

Shands has a 150-person IT department, but if your hospital will need high-priced consultants for the implementation, all your figures will go out the window.

"If all of a sudden they are are going to bring in consultants at $150 an hour, plus airfare and room and board, and they're going to be there for months, your $300,000 project went over a million dollars real quick," says Carney.

Your CFO won't comprehend the day-to-day operations of patient access, but he or she will know about the bottom line. "If you keep it to figures, they understand that better than anything," says Carney. "But if you come in there and say, 'If you give me $300,000, I can make you $700,000,' you just better be right. And if you are right, the next time you come you will be questioned less."

The next step, he says, is that you'll be getting calls from your CFO asking you to recommend patient access technology solutions to improve the hospital's bottom line.

Shands is currently examining the ROI that would result from recording phone calls between patient access staff and payers, something that

When the time is right, make your business case

A solid business case can move your request for technology to the "top of the pile," says **Kathryn Stevens**, PhD, MBA, CHAM, manager of the Epic ADT Project at UW Medicine in Seattle.

"Most of my career, I've been required to provide a business case to get funds for new programs or to purchase and implement technology solutions," says Stevens. "I know from experience that presenting a strong ROI can make a difference when competing for limited capital resources during budget time."

It is not easy work, especially the first time you do a business case, says Stevens, but it does get easier. More often than not, vendors will provide you with ROI and testimonials from other clients and calculator tools you can use to populate with your volumes and prices to get bottom-line results specific to your institution.

"It is important to pay attention to the details," says Stevens. "This is an investment of time that pays off by eliminating resistance and facilitating the conversation when called by the budget committee to defend your request."

Several years ago, Stevens implemented an automated error tracking tool, tracking 100% of the 20,000 registrations completed every month. "It was a real-time system, so errors could be redirected and corrected immediately by the user who made the error," says Stevens. "We reported accuracy rates each week to department supervisors, which facilitated targeted training and error remediation actions."

Initially, there were few nationwide users of this system, so the ROI for this system implementation was based on a "sophisticated guess," says Stevens. "We developed baseline data regarding mail returns and bad debt," she says. "When we compared the actual to the baseline, we reported a significant improvement over our estimate. Mail returns were reduced from 11% to 4%."

ID a bad investment

Data provided by an error tracking technology system helped Stevens avoid a waste of resources. "You want to focus process improvement initiatives on the right problem," says Stevens.

In early 2007, a senior leadership group commissioned a performance improvement project to increase the accuracy of registration. At the time, however, the accuracy rate was already between 98% and 99%, as demonstrated by the automated system reports.

"They were unaware of this improvement, which was up from 85% reported from the manually created sample report," Stevens says. "Their perception of errors was fueled by anecdotal accounts, and their reaction was emotional. By providing them current data and demonstrating the high-level accuracy rate we had achieved, I was able to redirect their energy to focus on some real problems, rather than spend resources on so small a return for our efforts." ■

insurance companies routinely do. Carney estimates the cost at about $50,000 to $75,000 and is trying to determine how much would be saved if patient access could prove that a call was made, or an amount specified by a payer, and also, the reduction in staff errors as a result of being recorded.

"But they are going to give me this money only if I can make that money back or more. So I'm seeing right now how much true dollars I can get back," he says.

During the last fiscal year, Shands lost more than $150,000 in pre-certification denials due to payers stating services exceeded authorization, the date of service did not match date of authorization, the CPT codes differed from what was authorized, and incorrect authorization for facility. "Our records show those errors did not occur, but then it was our word against their word," says Carney. "With the recording device, we'll be able to see if it's our error or theirs and get paid."

• Talk to patient access professionals who have recently implemented the same system.

When Shands was looking for a bedboard system, they were approached by Navicare. Carney asked for a list of hospitals using it and of the four he was given, he contacted the patient access department that was most similar to Shands, and went to see it. Carney asked them:

- What do you like about it?
- What don't you like about it?
- What would you improve if you were doing this all over again?

After getting these answers, Shands made the decision to purchase the system, which is now in use housewide at two facilities. "We got down to, 'Did you like your installer? What was his name?' If they like him, then we'll probably like him and we want that guy," he says.

Buying technology is like buying a car, says Carney — you can't buy into what the salesman says without looking at all the consumer reviews. "You've got to listen to people using it. They're going to tell you the good, bad, and the ugly," says Carney. "They might say, 'It's not as good as they're saying, but it's so much better than nothing.'"

• **Make sure that you really understand what you're trying to fix**.

"If you let some vendor sell you on ROI or staff reduction, and you don't really know what your problem is, you're going to be in trouble," says Carney.

Get input from patient access staff and the departments they serve before you make a decision on a solution. "I have been the victim myself of having to implement something without any input, and I have seen the backwards processes that it produced," says Murphy.

Murphy recalls that someone once decided to have a cost estimate pop up in the middle of registration. "Well, all that did was upset the registrar," she says. "It got the person unfocused and instead of data gathering, they were collecting balances. It didn't allow a positive relationship to come to a closure, and created chaos in throughput."

On the other hand, taking the time to truly comprehend the processes that you want to improve pays off. "If good processes are put in place and then automated, the results are astounding," says Murphy. "Both staff and patients recognize and appreciate great processes. This builds loyalty, respect, and confidence all around."

When Carney dug into the data on precertification denials, he was surprised to find that only 31% were due to patient access staff. Another 31% involved radiology. After the doctor ordered one view of a magnetic resonance imaging scan or computerized tomography scan, patient access staff would obtain the precertification. But the radiologist would realize that to show the doctor what he wanted to see, two views were needed. "So guess what? It comes back as a precert denial, because we ordered one view, not two views," says Carney.

Take these 7 steps before you commit

When making your case for a technology investment, use these seven tips from **Kathryn Stevens**, PhD, MBA, CHAM, manager of the Epic ADT Project at UW Medicine in Seattle:

- Be specific about your goal and how it benefits the organization.
- Be conservative. Cut any vendors' estimates by three-quarters.
- Don't overestimate ROI or overinflate benefits, as is the tendency of most vendors.
- Do research with local or regional clients. Tell their stories about benefits and lessons learned.
- Get solid baseline data on your current process.
- Be able to defend your numbers.
- Find out if there are other similar or conflicting initiatives by other departments in your organization. ■

Another reason for denials involved divorced parents giving the wrong insurance for their child to patient access staff. "The parent might come in and say the kid has Blue Cross, but the problem is that the dad is the primary — but we didn't know that because the mom just gave us her insurance card," says Carney. "She gets the bill and it's denied, and by contract if we bill it, then we fall under those rules."

Knowing these underlying reasons for precertification denials becomes very important if you are looking for a technology tool to reduce these. "If someone comes down and says, 'Tim, if I get your team this great precertification tool, can you reduce denials by 50%?' and I say, 'Sure I can,' and they buy me this, the problem is, I wasn't responsible for all the denials."

In a situation like this, the promised results won't happen and the patient access manager likely will be blamed.

"The problem is that you weren't even aware there was a broken process in your radiology department," Carney says. "Stay connected to your day-to-day operations. I'm not saying you've to go down there and register, but you've got to understand your problem before you make a commitment." ■

Be 'in the know' on patient access tools

"Unfortunately, not all access professionals take advantage of the opportunities to learn what's outside their world and the technological tools available," says **Kathryn Stevens**, PhD, MBA, CHAM, manager of the Epic ADT Project at UW Medicine in Seattle. Attending conferences, for example, may be cost-prohibitive, your boss may not value external learning, or you may get caught up in "fighting fires" instead of looking for more long-term solutions.

Here are some ways to find out the latest and greatest technology offerings:

• **Attend local, affordable workshops.**

These may be offered by vendors or national professional associations. "In addition to journals, these workshops and webinars are prime sources of information about the technology tools and the efforts under way to support access improvement," says Stevens. "While this takes me away from the job, the investment in time and the amount paid by my employer has been value-added."

Stevens says she attends at least four professional association sessions a year, but as a national board member of the National Association of Healthcare Access Management (NAHAM), most of her sessions are free, especially when she volunteers to be a speaker.

"I used to attend a lot more national events, but time away is costly in terms of workload, and flight costs have increased substantially," says Stevens. "It has been cheaper and more effective to arrange for vendors to come to my organization and demonstrate new products."

• **Meet with vendors at conferences.**

Carney says he attends the National Association of Healthcare Access Management conferences every year, and listens to what the vendors have to say, but then goes to the hospitals where the solution has been implemented for "the true story."

• **Participate in user groups for your hospital's HIS system.**

"I'm on a Siemens system, so I like to go to a Siemens user group with other hospitals that are using my system. It doesn't help if they've got McKesson, because they are different," says **Tim Carney**, manager of outpatient financial arrangements at Shands at the University of Florida in Gainesville.

• **Contact your patient access counterparts at other hospitals**.

Carney says he finds hospitals with patient access departments similar to his own to compare notes with. These include Vanderbilt University Medical Center, Ohio State, and University of Alabama at Birmingham. "These are people that are doing my job with the same kind of concerns. I look at myself against them, and ask, Are these people having the exact same problem that I'm having?'" he says.

Carney says he couldn't go talk to patient access at a local hospital since they're a competitor but that other hospitals will openly share their problems. "I'm not going to divulge my innermost secrets to the hospital that's two blocks over," he says. "But Baylor will tell me anything I want to know because I'm not 20 feet away from them trying to steal their business."

• **Compare yourself only with similar departments**.

What patient access does on the front end varies widely, and so do technology needs.

"For some people, their job is to make sure there is an account out there, get the signature, armband the patient, and do proper ID and that's it," says Carney. "But where I'm at, I have to verify the insurance, obtain the precerts, collect the cash, and work the denials. I do everything but put the bill out the door."

If a denial comes back, the billing department has it on its denial database and it goes back to the front end to resolve. "They figure that if the back end is working your denials, then the front end doesn't know what it's doing wrong," says Carney. "Since we obtain precerts, we also do the follow up."

In contrast, patient access staff at a community hospital in the Shands health care system verify insurance and confirm the precertification, but don't actually obtain it. "You've got to watch when you are trying to compare an apple to an orange, even though we all call ourselves 'access,'" says Carney.

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Rounding means payer requirements are met

Staff get their questions answered

Patient access staff often overlook or misinterpret payer requirements, which can cost the hospital thousands of dollars. Yet keeping staff current with all the various rules is a full-time job in itself.

"Keeping up with payer requirements is a daily challenge," says **Gayle Dickerson**, patient access director at Baptist Hospital East.

Part of the problem is that many companies change precertification and notification procedures within a contract period. "They also write contracts to be employer-specific, so even with the same payer, the rules may be different depending on the employer's wishes," says Dickerson.

To address this problem, patient access managers now do regular rounds to answer the questions of employees in the emergency department, ambulatory surgery, outpatient surgery, radiology, and endoscopy. "We visit each work area where we have registration staff and talk about the issues of the day," says **Vicki Lyons**, the hospital's patient access manager.

For example, staff might have process questions related to a particular insurance or need answers to questions raised by patients. "One question related to signatures in Medicare's Important Message and how to obtain acknowledgement of receipt if the patient was unable to sign," says Lyons.

Rounding also is a chance to give staff tips on customer service and patient interactions. "Many patients are in highly stressful physical conditions on entry into the hospital. Remaining calm while acquiring all the necessary information for care, treatment, and billing is important," says Lyons.

Here is what a patient access trainer does

Below is a description of the responsibilities of a full-time patient access trainer position at Baptist Hospital East:

Job Summary: Provides registration training specific to each staff member's duties in all registration areas and responsible for auditing all staff performance to ensure competency in the registration process. Will share feedback with appropriate managers regarding additional training needs as well as conduct the additional training.

Principal duties and responsibilities:

- Demonstrates working knowledge of daily/weekly/monthly reports.
- Develops and reinforces ongoing competency with staff, utilizing results of tracking.
- MSP.
- Insurance.
- COB issues.
- Guarantor.
- Maintains database for tracking staff competency.
- Presents at least one in-service quarterly related to areas of high financial impact or high error volume causing patient dissatisfaction or billing errors/rework.
- Develops training manual and keep updated with system upgrades.
- Develops orientation schedules and precept new employees for all registration areas in hospital.
- Assists with data collection for registration function.
- Assists with project development as directed by management.
- Ongoing auditing of registration outcomes to develop process improvement recommendations (monthly – rotate schedule by department).
- Flexibility in shift worked to accomplish training.

In addition to rounding, patient access at Baptist has made these changes:

- **A formal trainer was hired.**

This is a full-time position responsible for both the initial training process and ongoing updates

given to patient access staff. (**See job description on p. 126.)**

"The trainer is an experienced full-time staff member who also has good interactive skills," says Dickerson. Staff are taught using scenarios with fictitious patients, such as labor and delivery patients and Medicare patients who require additional completion of the MSP form.

Staff are taught how to use the computer system for registration, and how to use other resources built into the system, the differences in inpatient vs. outpatient registration, understanding insurance plans and codes, and how to read insurance cards.

"Updates are given whenever there are changes to any of the above, new plans added by managed care in contracting or plans termed," says Dickerson. "Our goal is for claims to be clean, so electronic submission is fast and accurate."

Since patient access staff also are responsible for up-front collections, the staff are taught how to explain co-pays and deductibles, and how to take payments by phone through the automated payment processing system.

• Payer-specific requirements are kept online through the hospital's intranet, so they are always available for staff reference.

"We have a staff member who is responsible for keeping the intranet resource up to date," says Dickerson. "Payers have newsletters and regular transmittals to the hospital, which are reviewed and updated on the intranet."

• Edits are placed within the hospital's information systems.

These flag cases that may represent errors in staff interpretation of guidelines to allow both correction prior to billing and ongoing staff education. For example, a policy number might be missing or incorrect, or an out-of-state Blue Cross plan might have been entered incorrectly. "Sometimes if it is a miscellaneous insurance, the insurance address will be left off. These are all opportunities to correct billing," says Lyons.

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Staff are first to use palm scanners to ID patients

Misuse is virtually impossible

Instead of asking a patient to show you a driver's license, how about identifying patients by the unique vein patterns in their hands? A new palm scanning device is used by patient access staff at Carolinas HealthCare System, the first health care provider in the United States to implement this technology.

The palm scanning device, manufactured by Fujitsu, is used with a software system designed by the hospital that enables the scanner to interface with the hospital's patient registration database.

The scanners use near-infrared light to map the vein patterns in a patient's palm, which are considered more unique than a finger print. The digital image is converted into a number that correlates with the patient's medical records.

Before choosing the palm scanner, Carolinas looked at retinal scanners, but thought they would be too invasive for patients. Finger printing was considered, but wasn't chosen because of the wear and tear on the equipment caused by repeated cleanings, and the fact that actual fingerprint images are stored in those systems. Since a number, not an image, is stored with the palm scanner, there is no

chance an image could be stolen and illegally reproduced.

The palm scanner is currently used at admitting, the emergency department, one-day surgery, and all inpatient and outpatient registration points. "Most recently, we have begun a rollout to physician practice settings for our physicians network," says **Steve Burr**, vice president of patient financial services.

This is the process: First, registration staff ask if patients have been scanned previously. If they have, patients are asked for their date of birth and their palm is re-scanned. Once patients are pulled up, staff verify that this is the correct person — thus far, it always has been — and make any updates to the registration data. If patients are not found, staff begin searching via normal demographic data.

If patients have not been scanned before, they are directed to place their middle finger between two metal prongs, to make sure their palm is properly positioned, and the scan is taken.

"Once the patient is located and verified, we can then scan the palm and link it to the record," says Burr. "Or, we can create a new registration and link the palm scan if the patient is not found or if they have never been here before."

Patients are safer

Patient safety was the primary motivation for this new technology. "With today's increasing use of electronic data in the delivery of health care, the need for linking the correct patient to the correct medical record has never been more important," says Burr.

Clinical decisions are being made through the use of multiple electronic systems, and most of them are dependent upon an accurate registration into the HIM system. "The use of the palm vein scanner allows us to ensure that we have selected the correct patient," says Burr. "This assists in alleviating patient overlays or use of incorrect information."

The system virtually eliminates the possibility that a person's personal information could be misused during the patient registration process. "Previously, we had no other validation process, other than checking ID or asking for pertinent demographic data, to ensure we had the correct patient," says Burr. In an emergency, a positive identification can now be made even if the patient is unconscious.

Another motivation for implementing this product is to increase efficiency for patients on return visits. "It is often commented that patients have to fill out numerous documents of the same information at any of our sites," says Burr.

However, with palm vein scanning, the patient's information is accessed via a global database on return visits. The patient only has to review the information that's already on file, instead of filling out new documents.

For subsequent visits, patients give their birth date and have their palm rescanned for a positive identification. The new process makes it impossible for anyone to hear or see sensitive personal information when it's given to the registrar, and prevents an individual from using someone else's Social Security number or health insurance card to obtain services.

Glitches were minor

It wasn't difficult for patient access staff to get used to the new device. "Patients have to be instructed where to place their hand, and to remain very still," Burr says. "The registrar then enacts the software at their desktop and if the scan is acceptable, it is linked to the record, and that is it."

A bigger obstacle was getting the registration staff to begin using the product at each registration. "Most of the push was due to it just being different," says Burr. "Once we began measuring the use, we motivated staff by competition and recognition."

Use of the scanner also has become one of their required functions that is measured and compensated in the employees' monthly goals.

As for patients, most didn't have a problem with the new system. "Some patients were scared of the product at first, and many refused for fear or religious beliefs," says Burr. "However, most patients have no issues with using the device now and we have very few refuse."

Initially, the percentage of patients scanned was in the 20% range, and it is now more than 85%. "If patients refuse, we then re-educate about the safety reasons for scanning. If they continue to refuse, we do not force them," says Burr.

There were some technology glitches at first, with the device coming unplugged and with the weight of the device. However, later models have been made much lighter and with better wiring and have not posed any problems.

"All in all, the issues were very minor considering this was new technology being deployed for widespread use at a hospital system of our size and volume," says Burr. "We have seen increased efficiency on return visits and decrease in potential overlays, which leads to increased patient safety."

The scanner has made the registration process much faster. In the past, registrars would input information, and then select the correct patient from a list of patients with similar names or birthdays. The palm scanner zeroes in on the right patient immediately.

Burr says that Carolinas is still working on the best ways to measure improvement in terms of efficiency, so no metrics are available yet to demonstrate improvements.

"The big win will be once the physician practices are online with the technology," he says. "Most of our referrals come from our physician's network, and the patients will already be scanned and registered."

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Morale boosts don't need to have a big price tag

Some of the best ideas cost nothing

Improving morale of patient access staff is difficult, but it doesn't have to be expensive. "If you care about your staff and their work environment and you are genuine in your praises, morale takes care of itself," says **Antionette Anderson**, CHAA, CHAM, director of patient access & centralized scheduling at Skaggs Community Health Center in Branson, MO. Here, Anderson shares some of her secrets:

• Every day, she rounds on patient access staff and the departments they serve.

"It takes about 30 minutes out of my day, but it is well worth it," she says. "I feel that rounding with them shows them you care." During the rounds, she covers these five points:

• What is working well today?

Staff tell Anderson things like "No one called in sick," "We are fully staffed," "I love our new insurance card scanners, they save so much time," or "IT came down and fixed our printer."

• Are there any issues or concerns that I can help you resolve today?

Recently, a staff member told Anderson: "Sally really needs some training in scripting for collections, as well as insurance training. She seems to be struggling." Another staff member told her, "Endoscopy keeps calling to see if the patient has arrived. This is very disruptive to our patient flow. Please let them know that we send the patients directly up that have pre-registered and don't owe any money. Only the ones that need to pay their co-pay stop by registration, and we send them right up after we have collected."

• Do you have the appropriate equipment for doing your job?

If you asked staff what equipment they would like you to give them, you might expect them to ask for the impossible, but Anderson says the requests are surprisingly basic.

"Sometimes their equipment needs are as small as 'We need pens' or 'My laptop won't hold a charge,'" she says. "I get them what they need."

• Is there someone that should be recognized today for a job well done?

• Tough questions.

"This covers anything that is out of your control, such as 'I feel that we are underpaid,' 'We need a raise,' or 'We need a bigger office,'" says Anderson. "These are items that take time and need to have others involved in resolving, or cannot be resolved."

Every week, she follows up on the concerns that were voiced during the rounds, and then communicates back to staff to let them know what she has done.

• When staff tell her one of their co-workers has done a good job, Anderson sends a thank you card to that employee's home.

She gets very specific about why the person is being thanked. For example, she might write, "Susan in the radiology department said that you went out of your way on Monday when a patient needed help with obtaining a ride home," or "Megan, your co-worker really appreciated that you traded shifts with her so she could attend her child's school play."

"By sending the thank you card to their home, it means more to them," she says. "They are

proud to show it to their family."

• When staff reach a goal, she buys the entire department pizza.

A collection goal might be $50,000 per month for a specific department, such as the emergency department, outpatient or inpatient, or $150,000 combined for hospital collections per month.

"I also celebrate reached goals such as 85% pre-registration of all scheduled patients, or 95% accuracy, either per individual or per department," says Anderson. "I will also buy lunch for an individual when I know they went above and beyond."

• She compliments staff on good communication.

Anderson listens as staff interact with patients, and if she likes what she hears, she says so. "I immediately tell them, 'Cathy, I overheard you talking with your patient, you did a great job resolving their problem,' or 'The way you handled that situation was excellent.' I do this in front of other employees."

• She gets rid of troublemakers in the group.

Anderson keeps an eye out for problem behaviors — turning one employee against another, gossiping, constant complaining, or talking behind a employee's back.

"That really brings the staff down," says Anderson. "Sometimes the troublemakers are good workers, but they drag down the rest of the group."

[For more information, contact:
***Antionette Anderson**, CHAA, CHAM, director of patient access & centralized scheduling, Skaggs Community Health Center, PO Box 650, Branson, MO 65616. Phone: (417) 335-7701. E-mail: AGAnderson@Skaggs.Net.]* ■

Is quick reg process best for transfers?

Transfer patients pose unique issues

Patient transfer admissions pose a "bittersweet" issue for patient access managers, says **Terry D. Long**, RN, BSN, MBA, NEA-BC, director of the patient transfer center at Texas Health Resources in Arlington.

With more facilities utilizing computer documentation systems, the need for rapid admit of patients is paramount. "Clinical staff cannot provide any services to the patient prior to this patient access function," says Long. "The patient cannot receive diagnostic testing, supplies or procedures urgently needed. Clinical staff cannot document care performed or patient condition."

While transfer volume is needed to maintain volume and revenue, transfer patients have some specific issues not present in other patient populations. "Most patient transfers occur due to specific critical needs a patient experiences that cannot be met at their current hospital. This results in the need for a transfer," says Long. "These patients are usually critically ill and need services the moment they arrive at the accepting facility."

The patient arrives via helicopter and is rushed to surgery, the cardiac catheterization lab, or neonatal intensive care unit. How does the patient access staff admit this patient?

One common approach is to utilize a centralized bed control or transfer center to pre-admit the patient or utilize a reservation function in your admission/discharge/transfer (ADT) system.

"By having bed control or the transfer center enter the information into your ADT system prior to the patient leaving the sending facility, the admission can be processed utilizing your quick registration process," says Long. "This process is usually utilized in the emergency department. It works equally well in this case."

Other smaller facilities may have processes that include all transfers entering the facility via the emergency department, where access staff are accustomed to time-sensitive admission processes. "In hospital systems with one ADT system, most patients can be admitted to only one facility," says Long. "If a transfer moves to a second facility and is not discharged or transferred, then care may be affected at the second facility. "

Clinical input is key

At the Cleveland Clinic, a "throughput team" looks at the list of possible transfers to determine the order in which patients are sent, for all patients who don't qualify as a "come on down" for immediate placement. "We assess clinically what is going on with the patient. If you know the right clinical questions to ask, sometimes you get more accurate information," says **Eileen**

Jamieson, RN, nurse manager of the throughput team.

"We look at that list constantly to judge and triage who needs to get here first. We want to get the sickest ones here sooner," says Jamieson.

When the Cleveland Clinic's nurse speaks to the nurse from the referring institution, the plan may change. "The nurse might say, 'This patient sounds really sick and needs to get here before the other one.' The clinical decision she makes would trump the decision that registration has made."

For the "come on down" patients who get a bed immediately, the financial clearance process is bypassed. But for other patients the referring facility calls about, the team makes sure that they have the correct patient and medical record number, and this is then faxed to the financial counselors.

"If the patient is out of network and has a condition that can be treated in network — if it's not something we offer that they can't get somewhere else — then the financial counselor tells them 'We'll be glad to take you, but you will incur a bill that you will be responsible for.'"

To ensure that transfer patients are placed in the appropriate status — observation or inpatient — nurses at Barnes-Jewish Hospital's patient placement center are trained to use an established set of criteria for the severity of illness and intensity of service that is required for hospitalization.

"Because we are a large academic medical center, we receive numerous referrals. Sometimes you have to balance the customer service aspect for the referring physicians over the payment issues," says **Karen Gist**, MSN, RN, ONC, director of patient placement and access at Barnes-Jewish Hospital in St. Louis, MO. "Sometimes we need to accept patients quickly and work on the care management issues on the back end."

For example, if a call comes in from a referring facility to transfer a patient to Barnes-Jewish, the physicians accept the patient based on the clinical picture. "And if they believe we are the place this patient needs to receive care, there is never a mention of the patient's insurance coverage," says Gist.

Once the transfer patient is admitted, case managers work with insurance carriers to try and ensure payment is received. "If they do not have insurance, they try to link them into a financial assistance program," says Gist. "But all of this takes place after the patient has been transferred to our organization. Patients are accepted based on their clinical need, not the ability to pay or have their insurance company pay."

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1. Publication Title	2. Publication No.	3. Filing Date
Hospital Access Management	1 0 7 9 - 0 3 6 5	10/01/08
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$399.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Robin Salet
Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Robert Mate, President and CEO
AHC Media LLC, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Jill Robbins, same as above

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Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400 Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	805 15th Street, NW, 3rd Floor Washington, D.C. 20005

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Hospital Access Management
14. Issue Date for Circulation Data Below: September 2008

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			840	742
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	626	546
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	1	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	3	3
	(4)	Other Classes Mailed Through the USPS	27	92
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			657	641
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	11	13
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			20	20
f. Total Free Distribution *(Sum of 15d and 15e)*			31	33
g. Total Distribution *(Sum of 15c and 15f)*			688	674
h. Copies Not Distributed			152	68
i. Total *(Sum of 15g, and h.*			840	742
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			95%	95%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2008 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or OwnerDate
President and CEO 9/27/08

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HIPAA Regulatory Alert

Supplement to *Healthcare Risk Management* and *Hospital Access Management*

Threat modeling to protect patient information

You can't afford not to

A health care organization might have in place the best information technology (IT) protections available, but complacency can be a dangerous thing considering the gold mine of personal information stored by a hospital.

Consider this: One Atlanta-based security services provider says it's blocking an average of 15,543 attempted hacker attacks a day per health care client, compared to an average 1,581 attacks per day per bank client.

To thwart an information thief, and thus comply with HIPAA requirements to protect personal health information, SecureWorks information security expert **Jon Ramsey** suggests thinking like an information thief.

"Sit your two best IT guys down for a while, and ask them how they'd break into your system, where they'd [attempt access], what they'd look for, and you'll come up with a pretty good threat model pretty quickly," Ramsey says. "Threat modeling means considering who is going to attack you, how, and what are the assets they're going to go after," says Ramsey.

Threat modeling has proved its value for a long time in the banking industry, and now is doing the same work in health care.

Threat modeling an ongoing process

While it would be nice to construct a mathematically precise threat matrix that, once put into place, would serve as a permanent threat model, in real life, threats change daily, so preemptive measures against those strikes have to change daily, too, Ramsey says.

Implementing HIPAA includes preventing privacy breaches and reacting to ones that occur, and since technology changes with each day — and hackers' knowledge broadens at the same pace — staying ahead means constant vigilance to anticipate potential problems.

When threat modeling for potential privacy vulnerabilities, health care organizations should consider some general questions:

- What's the nature of potential threats? (Are disclosures likely to be made accidentally, or is information likely to be stolen for profit, or both?)
- Who is the source of the threat? (Employees, visitors, vendors, outsider gaining access illegally.)
- How might access be gained? (Hacking into a computer, stealing a laptop, breaking into an office.)
- What data are vulnerable?
- How many data are vulnerable?

And now is a good time to think "threat model," as the stakes recently increased. The Department of Health and Human Services (HHS) sent a clear signal earlier this year that it takes the safeguarding of patients' personal information very seriously when it took enforcement action against Seattle's Providence Health & Services over the theft or loss of health information of more than 386,000 patients. **(See "HHS fines health system for breach of privacy," p. 2.)**

Providence's patient information was compromised because electronic media, such as backup tapes and laptops that contained unencrypted information, were left unattended and eventually lost or stolen. While HHS has received more than 6,700 reports of breaches under HIPAA, the Providence case was the first time HHS imposed a fine ($100,000) for a data breach, and industry observers have written that it signals more to come.

Because "you can't protect everything from everyone," Ramsey points out, no security plan can monitor every single bit of data and every

access point to those data; so it makes sense to put your greatest efforts toward the greatest risk.

In other words, he added (quoting former National Security Advisor McGeorge Bundy), "If you guard your toothbrushes and diamonds with equal zeal, you'll probably lose fewer toothbrushes and more diamonds."

Threat modeling allows a health care organization to take its limited IT and security budgets and use them to the greatest effect by narrowing down the areas of greatest vulnerability.

"You want to spend each dollar in a way that will make it more expensive for a threat to access your information," Ramsey adds.

Providers' need for quick access adds risk

Coupled with the attractiveness (to hackers) of the tremendous amount of personal identification data that's available from a health care patient record system is the vulnerability that's inherent when that information has to be readily and quickly accessible by those who legitimately need it — physicians, nurses, account managers, etc.

"It's the ubiquity of information; if you're an emergency room doctor and you need a patient's record, you get it right away," Ramsey says. Making that information easily administered and, at the same time, secure is why the field of IT in the health care setting has exploded in the last two decades.

"It's an organic thing; the threats change every day, so our clients have new threat models every day," Ramsey says. "What you need to say is, 'If I'm secure today and not tomorrow, what has changed?' and you have to ask yourself that every day."

With each new technology, there are new vulnerabilities; those multiply when you consider how many data systems within a hospital integrate or "map" to one another.

"The ubiquity of information and the need to integrate data across these systems leaves a lot of openness," Ramsey cautions.

And health care's use of existing technology is a boon to the "business" of information theft.

For example, Microsoft Windows has been around for 25 years, giving hackers a generation of time to learn its capabilities and vulnerabilities; now that the operating system is used in health care, "criminals have whole new business models to invade," Ramsey points out.

"We know from industries more advanced [than health care] in information security that threat modeling makes a whole bunch of sense," he concludes. "It's proven itself in other industries — you can't not do it."

[For more information:

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Department of Health and Human Services. Resolution agreement between HHS and Providence Health & Services; available online at http://www.hhs.gov/ocr/privacy/enforcement/resolution.html.] ■

HHS fines health system for breach of privacy

On July 15, 2008, the Department of Health and Human Services (HHS) entered into an agreement with Seattle-based Providence Health & Services to settle potential violations of HIPAA privacy rules.

Under the agreement — the first time HHS has levied a fine for a data breach — Providence agrees to pay $100,000 and implement a detailed corrective action plan (CAP) to ensure that it will safeguard identifiable electronic patient information against theft or loss. Providence's data breach resulted from electronic record backups and laptop computers being left unattended, eventually leading to their loss or theft.

HHS says the breaches occurred when the backups and laptops were removed from Providence premises (in Oregon and Washington) and left unsecured; some thefts occurred when the items were left in Providence employees' cars.

While HIPAA does not specifically address transportation of personal health information via laptop (or car), the rule does require covered entities to safeguard portable media or devices, including paper charts being moved between offices.

Under the resolution agreement — also the first HHS has required from a covered entity — Providence agrees to take remediation steps, including:

- Revising its policies and procedures regarding physical and technical safeguards (e.g., encryption);
- Governing off-site transport and storage of electronic media containing patient information, subject to HHS approval;
- Training workforce members on the safeguards;

• Conducting audits and site visits of facilities.

According to HHS, it has received more than 30 complaints related to the loss or theft of patient information from Providence's data systems. The resolution agreement alleges that protected information of more than 386,000 patients was exposed by the breach.

(To read HHS guidance on HIPAA's security rule pertaining to electronic devices, go to www.cms.hhs.gov/SecurityStandard/Downloads/SecurityGuidanceforRemoteUseFinal122806.pdf.) ■

HHS guidance emphasizes what *can* be divulged

The Department of Health and Human Services (HHS) has issued new guidance for providers on talking about patients' health information with and in the presence of other parties — with an emphasis on what *can* be discussed.

Even though HIPAA requires health care providers to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient's family, friends, or others involved in their care or payment for care.

The guidance is intended to clarify HIPAA privacy requirements so that health care providers don't unnecessarily withhold information from those who are permitted to have it.

Among examples discussed in "A Health Care Provider's Guide to the HIPAA Privacy Rule: Communicating with a Patient's Family, Friends, or Others Involved in the Patient's Care," released in September 2008 by the HHS Office of Civil Rights, are the following examples of permitted discussions of health information:

• An emergency room doctor may discuss a patient's treatment in front of the patient's friend if the patient asks that her friend come into the treatment room.

• A doctor's office may discuss a patient's bill with the patient's adult daughter who is with the patient at the patient's medical appointment and has questions about the charges.

• A doctor may discuss the drugs a patient needs to take with the patient's health aide who has accompanied the patient to a medical appointment.

• A doctor may give information about a patient's mobility limitations to the patient's sister who is driving the patient home from the hospital.

• A nurse may discuss a patient's health status with the patient's brother if she informs the patient she is going to do so and the patient does not object.

["A Health Care Provider's Guide to the HIPAA Privacy Rule" is available free for download at www.hhs.gov/ocr/hipaa/provider_ffg.pdf.] ■

Privacy hindered by not so private hospital rooms

Despite increasing demand for privacy surrounding health information, North American hospitals lag behind European counterparts when it comes to one of the most visible impediments to privacy — multi-bed hospital rooms.

"Considerable attention is paid to the privacy of health information, yet multi-bed rooms do not provide such privacy," write the authors of a recent paper published in the *Journal of the American Medical Association*.[1]

According to **Michael E. Detsky**, MD, and **Edward Etchells**, MD, both of the University of Toronto, single-bed hospital rooms were recognized as the ideal setting for patient care early in the last century; however, while patient safety, dignity, and privacy have gained attention in hospital medicine, multi-bed rooms have remained.

Besides providing privacy, the authors suggest, single-patient rooms inhibit the spread of nosocomial infection and reduce the need for in-hospital transfers; on the other hand, they point out, one patient per room means more walking and time for hospital staff, and new construction costs are inherent in converting from multi-patient rooms to single-patient rooms.

Nonetheless, the privacy protection afforded by a private room is demanded by a health care system that prizes patient privacy.

"Patients may not share sensitive medical history, such as sexual practices or illicit drug use, in a room where strangers can listen," Detsky and Etchells write. "Discussions about life-sustaining treatment or a serious diagnosis with a poor prognosis are inappropriate with other parties present when separated only by curtains."

While North American hospitals lag behind, for example, in French hospitals, which have

designed single-patient rooms as standard for hospitals for the last 20 years, single-patient rooms are becoming standard in new construction of medical/surgical wards and obstetrical units.

"Single-patient rooms are permanent physical features that potentially could improve safety and patient satisfaction without the need for ongoing staff training, audits, or reminders," the authors conclude.

Reference

1. Detsky ME, Etchells E. Single-patient rooms for safe patient-centered hospitals. *JAMA* 2008;300:954-956. ■

HHS lacking in approach to health info privacy

The Department of Health and Human Services (HHS) may have given rise to — and oversees — HIPAA privacy regulations, but according to a report by the General Accounting Office (GAO), the agency's approach to ensuring the privacy of health information still needs some work.

A report released in September 2008 by the GAO is a follow up to recommendations made by GAO in 2007 on the status of efforts by HHS to ensure the privacy of personal health information exchanged within a health information network. At the time of the 2007 report, the GAO recommended that HHS define and implement an overall privacy approach for protecting information that's exchanged or stored electronically.

The GAO reported in its follow up that HHS has taken steps toward meeting the recommendations, including identifying goals, ensuring key privacy principles are addressed, and addressing challenges associated with nationwide exchange of health information.

Still, while the GAO report credits HHS with taking steps that "contribute to an overall privacy approach," it finds HHS has fallen short of implementation; in particular, the report finds that HHS's privacy approach doesn't include a defined process for assessing and prioritizing privacy initiatives, causing gaps in policies and guidance needed by stakeholders to ensure adequate privacy protection measures.

The recommendation of the GAO is that HHS needs to prioritize; it suggests that HHS ask the national coordinator for health IT to include in the HHS overall privacy approach a process for assessing and prioritizing its privacy-related initiatives. ■

New rule would update rules for *e*transmissions

On Aug. 22, 2008, the Department of Health and Human Services (HHS) published a proposed rule that would adopt updated versions of the standards for electronic transactions under HIPAA. The rule also would adopt a transaction standard for Medicaid pharmacy subrogation and two standards for billing retail pharmacy supplies and professional services, and would clarify who the "senders" and "receivers" are in the descriptions of certain transactions. Comments on the proposed rule closed in October.

Updated versions of current HIPAA electronic transaction standards require the use of the ICD-10 code sets for claims, remittance advice, eligibility inquiries, referral authorization, and other widely used transactions. The proposed version, version 5010, adds the ability to designate certain information as confidential and restrict access to member information. This new function provides privacy protection by safeguarding confidential information, according to HHS.

Health care stakeholders, including the American Hospital Association and Blue Cross/Blue Shield, have asked HHS to forestall requiring implementation of ICD-10 until HIPAA electronic transaction standards have been modified to keep up with the massive coding changes.

"Before the transition to ICD-10 can begin, the industry must move to the next generation of HIPAA transactions [Version 5010] because the current version [4010] will not work with ICD-10," Blue Cross/Blue Shield stated in response to the proposal. "Version 5010 is a major re-write of the HIPAA transaction standards, with more than 850 individual changes. There is wide industry consensus … that upgrading to version 5010 is too significant to be done in conjunction with ICD-10."

The ICD-10 changes are scheduled to become effective Oct. 1, 2011. To read the entire proposed rule regarding version 5010, go to edocket.access.gpo.gov/2008/pdf/E8-19296.pdf. ■