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INSIDE

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Hotel-like service philosophy results in quality; turns patients into guests

Colorado hospital rolls out the red carpet and gets results

By treating patients as guests and employees as partners, hospitals can create a culture of patient-centered care that resonates throughout the organization, says **Becky Jessen,** MEd, vice president of marketing at Community Hospital in Grand Junction, CO.

What won't be successful, she cautions, is trying to cut and paste the idea onto your organization. "Unless you have that culture, have everybody on the same path, you don't get anywhere," she explains. "Some people want a quick program or one little concept, but you can't do it without starting at the beginning."

Extending that philosophy from "check-in" — it's no longer called "admitting" — to the billing process resulted in Community Hospital being awarded a benchmark designation for patient satisfaction by the Colorado Health and Hospital Association in 1998, 1999, and 2001. The awards, which are based on a survey tool of the Picker Institute and cover eight western states, were not issued for 2000, Jessen explains.

Audio conference clarifies final EMTALA regulations

The final version of the recently proposed changes to the Emergency Treatment and Labor Act (EMTALA) is expected to become effective on Oct. 1. Issues in the final regulations could include changes to physician on-call requirements, "comes to the emergency department" definitions, later-developed emergencies, nonhospital entities, and prior authorization. With all the confusion surrounding the proposals during the past year, make sure you know what it takes to comply with the final regulations.

To keep you on track, American Health Consultants offers the **EMTALA: Complying with the Final Regulations** audio conference,

*(See **Audio conference** on page 113)*

The 78-bed hospital received the designation in all four categories — emergency department, inpatient, outpatient tests and treatment, and ambulatory surgery, she adds.

"We have seen the hospital continue to grow and do better and better in terms of satisfaction surveys," Jessen notes, "but it comes down to the fact that the folks that work here want to work here."

Although Community Hospital always had a customer-service focus, the culture of partnership was created three years ago when the current CEO came on board, she explains. "He has an incredible vision of where the hospital is going as far as improving the patients' experience."

The discussion about the hospital philosophy and how employees treat patients and each other begins in the hiring process, Jessen says. "Our whole orientation program is called 'Partners,' so [potential employees] understand at the beginning this is not like most hospitals. Most people find it refreshing."

In the initial interview, the job candidate is told that if he or she doesn't feel comfortable with the partners / guest philosophy, it would be best not to pursue employment at Community Hospital, she adds. "If [the individual] is not willing to work on a team or put the customer first, we know it's not a good match."

One of the things that promotes teamwork, Jessen notes, is that while many hospitals are very compartmentalized, her organization strongly supports what it calls "cross-education" to break down the barriers between departments. Not using the more common term "cross-training" is a very deliberate choice, she points out. "We consider training something you do to a seal or a dog."

Along the same line, the word "leader" is preferable to "manager" or "director," says **Erica Eng,** patient advocate and director of guest services. "You manage things, but you lead people," adds Eng, who was hired about a year ago to fill her newly created position. **(See related story, p. 112.)**

"It's so important to remember the power of language," Jessen says. "We always add 'partner' to 'employee' or 'volunteer.'" People coming in for treatment are "patient guests," she adds. At "check-in," guests are greeted in a "reception" — not "waiting" — area.

The idea behind these hotel-like terms, she explains, is to change the hospital-patient paradigm. "A patient is someone who's awaiting medical treatment, someone who will be 'done unto,' who will be at our mercy," she notes. "A guest is someone who is invited into a home or facility, and that's how we want them to feel."

Community Hospital's tag line, she points out, is: "Where you are your physician's patient, but always our guest."

Continuing that theme, a freestanding surgery center that opened in 2001 has "no OR [operating room] suites," but rather "procedure areas," Jessen says. "We call first-stage recovery 'wake-up' and second-stage recovery is 'sit-up.'"

Although the guests / partners philosophy started with the hospital's CEO, once it caught on, other people began coming forward with suggestions, she adds. Like in a hotel, stands with little cards that say "cleaned by so-and-so" are placed in guest rooms, as are decorative cellophane bags containing lotion, soap, pen, and notepad, Jessen says. "That idea came from the environmental services department."

"Our CEO really wanted each of the departments to come up with its own service standards or expectations, how we as a group want to approach each of our guests so they feel comfortable and welcome," Eng notes. It is hospital policy, for example, that every guest will be seen within 10 minutes or someone will go back to the guest and explain why this has not happened.

Hospital meals are prepared on a "demand" basis, Eng adds. "Every guest is oriented by staff as to how to order their own food. They can order between 7 a.m. and 7 p.m., and the meals all are different — liquid, diabetic, or normal. The service standard is that your meal will be served, from order to table, in 30 minutes or less. It's usually 10 minutes."

(Continued on page 112)

COMING IN FUTURE MONTHS

- A step-by-step Medicare appeals process
- Working out kinks in the ABN procedure
- Building access from the ground up, continued
- Access and illegal immigrants
- Building morale, decreasing turnover

STATEMENT OF GUEST ACCOUNT

Community Hospital
2021 N. 12th Street
Grand Junction
Colorado 81501

FORWARDING AND ADDRESS CORRECTION REQUESTED

ADDRESSEE:

PLEASE NOTE:
Thank you for choosing Community Hospital for your healthcare needs. Both Medicare and your secondary insurance have paid their portion of your hospital charges. The balance is your responsibility.

BILLING INQUIRIES? PLEASE CALL 970/242-0920 (800-621-0926) AND REFER TO THE PATIENT-GUESTS NAME & ACCOUNT NUMBER

COMMUNITY TAX ID:	PATIENT-GUEST NAME:	ACCOUNT NO:	DATE OF SERVICE:	PAGE:

DATE	TRANSACTION	AMOUNT
06/11/01	Charges from service date	10383.40
07/05/01	Medicare Inpatient adjustment	-2602.96
07/05/01	Medicare Inpatient payment	-6949.04
07/17/01	Medicare adjustment	-39.40
02/05/02	United Health Care payment	-125.00
02/05/02	United Health Care payment	-625.00

ACCOUNT SUMMARY

Charges to date:	10383.40
Payments to date:	7699.04
Adjustments to date:	2642.36

Current Account Balance 42.00

Please reference itemized statement(s) mailed previously

ACCOUNT BALANCE	PAYMENT DUE UPON RECEIPT OF STATEMENT STATEMENT DATE	PLEASE PAY THIS AMOUNT
42.00		42.00

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE

ACCOUNT NUMBER:		PATIENT-GUEST NAME:	
STATEMENT DATE	AMOUNT DUE	DATE DUE	AMOUNT PAID:

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT
☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE
CARDHOLDER NAME	

☐ Please check if the above address or insurance information is incorrect and indicate any changes on the reverse side.

AMOUNT ENCLOSED $ _____

PLEASE MAKE CHECKS PAYABLE TO:

Community Hospital

Community Hospital
2021 N. 12th Street
Grand Junction, CO 81501

Source: Community Hospital, Grand Junction, CO. Used with permission.

Environmental services staff, she says, knock on the patient's room door, introduce themselves, and ask, 'Is it OK if I clean your room now?'"

"During the Partners orientation, we talk about the external and the internal customer, and there is a real emphasis on treating each other with kindness and respect," Eng adds. "With the employee partners feeling that they have input, that their ideas do matter and make a difference, they can't help but turn around and treat guests with the same respect and caring."

The billing process — problematic at most hospitals — also was examined with the partners / guests initiative in mind, she notes. "It was brought to our attention how poorly that process was run. Our vision was to completely change it."

The hospital developed a statement that is visually attractive and easy to read, Jessen says. "The bottom line is very much like you would get from a credit-card company. **(See a copy of the bill, p. 111.)** We have actually received notes saying, 'Thank you for a statement that's easy to read and attractive. I didn't like how much I owed, but at least I could figure it out.'"

To ensure that patients are fully informed about the clinical aspects of their stay, she notes, the hospital has two full-time patient educators — one for inpatients and another for outpatients. In advance of a scheduled procedure, outpatients meet with the educator and fill out a "health record book," Jessen explains. After the procedure, the educator calls the patient to address any remaining questions or concerns, she says.

Health record books are placed in the rooms of all inpatients who are educated throughout their stay, adds Eng. The three-ring binder contains preprinted information about the person's condition, as well as pages to be filled in with patient history and current health information, she says. "There is also a page on [the patient's] medications, and before they leave, we supply any lab or test results."

In addition, Eng says, the binder may include specific educational material the person's physician has ordered.

The patient educator comes to the room to go through the different pieces of information with the patient, she adds, including pain management, how to contact a patient representative, and advance directives. "[Admissions staff] did the advance directives at first, but we found that was not efficient. People aren't really listening at that point."

Every nurse at Community Hospital is trained to be a patient educator, to provide backup for the full-time staff, Eng notes. "With a hospital our size, we had to make sure the nurses on the weekend had the same skill set as the 8 to 5 staff." The nurses have enjoyed adding that kind of patient contact to their jobs, she says, knowing that "it is sanctioned by the organization for them to come in and have more time with the guests."

The patient educators sometimes are referred to as "physician translators," Jessen points out, "because they will go back into the room later to help unravel what the physician has said. We think that's a critical role."

She emphasizes the importance of looking not just at other hospitals, but at the customer service industry when seeking ideas for improvement. "Ask yourself, 'How can that be translated to the patient experience?'"

In the end, Jessen stresses, the success of Community Hospital's customer-service effort comes back to a way of thinking that is fostered from the top down. "It's driven by our board of trustees, which is very engaged in where we're going with this. One of [the board's] strategic initiatives has to do with continuous quality improvement in guest services standards. If you don't have that vision from the top, it's very hard to support and keep it going. One department might be very excited, but if it falls down at any point, you won't be successful."

"We understand that clinical outcomes are critical," Jessen adds, "but we also think there is another piece — that the mind and emotions play such a role in recovery. We've chosen to key in on that."

[Editor's note: Becky Jessen can be reached at (970) 256-6205 or bjessen@gjhosp.org. Erica Eng can be reached at (970) 256-6291.] ■

Guest services director same as hospital concierge

CEO wanted 'a positive outreach'

The CEO of Community Hospital in Grand Junction, CO, "always felt it was a wonderful idea to have one person responsible for helping patient guests before, during, and after their stay," says **Erica Eng,** patient advocate and director of guest services.

That philosophy led to the creation of Eng's job a little more than a year ago. "It

Audio conference

(Continued from cover)

scheduled for Tuesday, Nov. 12, 2002, from 2:30 to 3:30 p.m. Eastern time. The conference will be presented by **Charlotte S. Yeh**, MD, FACEP, and **Nancy J. Brent**, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Co., Hingham, MA. Brent is a Chicago-based attorney, with extensive experience as a speaker on EMTALA and related health care issues. In June of this year, both speakers presented *EMTALA Update 2002*, one of AHC's most successful audio conferences.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the audio conference for $299, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. The conference package also includes, handouts, additional reading, a 48-hour replay of the live conference, and a CD recording of the program.

For more information or to register, call American Health Consultants' customer service department at (800) 688-2421 or (404) 262-5476, or e-mail customerservice@ahcpub.com. When ordering, please reference effort code: **63221.** ■

was conceived as being a kind of concierge [position]," she explains.

Hospitals frequently get calls that have little to do with health care, Eng points out. "If you talk to people at different hospitals, you find their switchboards get calls like this all the time," she adds. Randall M. Phillips, the hospital's CEO, envisioned a director of guest services who could help with those issues, Eng says. "He wanted to make it a positive outreach."

When she gets calls from people who have financial problems, for example, Eng recommends a local nonprofit group that provides free legal services, she says. To those who need help caring for someone in the home but don't qualify for home health services, Eng adds, she might suggest Time Bank, where people put in volunteer time and in turn have time donated to them. Another caller might be directed to a local clinic that provides free or discounted services.

It's not unusual for her to help people who never set foot in the hospital, she says. "Case managers and the emergency department field an amazing number of calls from people who are just in need." ■

Hospital directories, clergy areas of concern for access

Privacy rule may be customer-service issue

As access managers breathe a sigh of relief at the lifting of the written-consent requirement in the final Health Insurance Portability and Accountability Act (HIPAA) privacy rule, many are beginning to focus on the changes they will need to make in response to the law.

After serving for two years on a systemwide HIPAA steering committee and sitting on a couple of related subcommittees, it's a relief finally to have solid information to work with, says **Barbara Wegner**, CHAM, regional director of access services for the Providence Health System in Portland, OR.

What has remained in the final rule is a requirement that hospitals, pharmacies, health plans, and other covered entities must obtain an individual's specific authorization before sending the person marketing materials. Notices informing patients of wellness programs at the hospital would be included, as would putting patients' names on a mailing list used by hospital foundations to ask for donations, she adds. "We have a group working on how to get a specific authorization."

There are several other privacy issues hospitals will need to address, Wegner says, including a couple that directly affect access personnel:

• The release of information to a patient's faith community.

Providence already has a procedure for handling requests from members of the clergy who wish to visit patients, she explains. "Patients are asked specifically either at preadmission or at the time of service if they have a religious preference. We collect that information, and then ask if the person would like a visit from a [member of the clergy] of that faith."

If the person answers affirmatively, his or her name prints out on a list, Wegner adds. If the patient says no, the name won't be there. That's already in place, so we won't need to tweak that."

• Inclusion of a patient's name in the hospital directory.

The handling of this privacy issue likely is to cause some problems, she predicts.

At present, the names of all patients are included in the hospital directory, Wegner notes, although in the case of mentally ill patients, no information is released at all.

Once the privacy rule goes into effect, she says, patients will be asked as they come into the hospital if it's OK to include their name in the directory. If not, the name will not appear on the list.

"The tricky part is that patients themselves will call and talk to friends, relatives, or neighbors on the phone, and then maybe not remember that they had said they didn't want to be in the directory," Wegner says. "The person could call the patient back and be told there is no one by that name in the directory."

The result could be an awkward conversation in which the caller points out that he or she just talked to the patient an hour ago, she adds. Similarly, she continues, an individual visiting one patient on a floor might recall that a neighbor also is in the hospital and ask the nurse for that person's room number.

"This might put the hospital between a rock and a hard place," Wegner suggests, "with the perception that the hospital is not being helpful."

The hospital also would need permission to give out the name of an outpatient who is in for a short procedure, or a person being treated in the emergency department, she points out. That could be a problem if, for example, someone calls to arrange to pick up the patient, and is told the person's name isn't on the hospital list, she adds.

The access services department is putting together a committee to look at how the requirement will be implemented, Wegner says. In addition, there will be an enhancement to the health care system's computer system, which is a McKesson product. "We haven't seen how that will work. We're waiting to see how that will help us from the technology point of view."

Beginning in January, she says, all access personnel will be trained on the use and disclosure of the facility directory.

The process of informing patients about the use and disclosure of their medical information will begin during the preadmission telephone call, Wegner notes. Also at that time, patients will be asked if they wish to have their names released to the clergy or included in the facility directory, she says.

For emergency and other unscheduled patients, Wegner adds, "we'll just have to do the best we can. If we can't do it when patients are admitted, we'll follow up when their condition permits."

[Editor's note: Barbara Wegner can be reached at (503) 215-7525 or by e-mail at bwegner@providence.org.] ■

Providers rework privacy plans for final HIPAA rule

Most 'excited' to have process complete

Around half of the privacy policies Houston-based consulting firm Healthlink Inc. had helped health care providers develop will have to be modified as a result of changes in the final Health Insurance Portability and Accountability Act (HIPAA) privacy rule, says **Mary Staley**, MBA, PT, the firm's vice president of HIPAA operations.

But the organizations were "excited overall" to have the final provisions in place, she adds. "They've been spending their time and resources in a holding pattern, and most are just happy to get the rule published and to make the changes."

Modifications will range from full revisions of plans to changes in definitions, she notes. Issues addressed will include when to disclose patient information and the identification of what is and what is not marketing, Staley says.

"A number of our clients had completed the writing of their policies and procedures — not the training — and we are having to go back and re-evaluate each document," she says.

Most health care organizations are opting out of the written consent requirement for patient information disclosure, as the final rule allows, Staley notes, and going with a more stringent privacy notice policy. In the original rule, providers simply had to give patients the information about their privacy rights, she explains, while in the final rule, "providers have to give it to them and have them sign that they received it."

The final rule allows providers to "either go with [the written] consent requirement for disclosure [of health care information] or [the more stringent] privacy practice," Staley says. The rule's "good-faith" provision takes into account the fact that hospitals may not be able to get signatures when, for example, a patient is comatose when he or she arrives at the hospital, she notes.

Along the same line, the final rule acknowledges that incidental disclosure of protected information will continue to occur, regardless of compliance with the rule, and is permitted, Staley says.

Such incidental disclosures might occur, for example, when a person overhears an access employee talking about a patient on the phone with a nurse, she adds, or when bits of conversation with a patient drift over to the next registration

booth. Hospitals must make "reasonable efforts" to prevent such occurrences, she says.

Hospitals have until April 14, 2003, to comply with the patient privacy rule. Here is a brief look at the various aspects of the final rule, drawn from an executive brief put together by Healthlink personnel and a statement from the Chicago-based American Hospital Association:

• **Consent and notice.**

Hospitals now are required to provide patients with notice of the patient's privacy rights and privacy practices of the hospital and must make a "good-faith effort" to obtain the patient's written acknowledgement of this notice. The acknowledgement must be in writing except in emergency situations, where the provider must document its efforts and the reason acknowledgement was not obtained. As expected, the final rule confirms that obtaining consent for treatment, payment, and health care operations now is optional.

• **Disclosure for treatment, payment, and health care operations to another entity.**

Hospitals can disclose personal health information for the treatment and payment activities of another health care provider without consent or authorization. Protected health information also may be disclosed to another covered entity for certain types of health care operations. Prior to the amendments, the regulations generally prohibited disclosure for use by the recipients for payment or other operational purposes.

• **Authorization.**

Patients must give specific authorization before a hospital or other entity covered by the regulation could use or disclose protected information in most nonroutine circumstances, such as releasing information to an employer or for marketing activities. Core provisions for authorizations are clarified to eliminate separate requirements for covered entities. One form may be used, but patients will have to grant permission in advance for each type of nonroutine use or disclosure.

• **Minimum-necessary standard.**

Any uses or disclosures pursuant to an authorization are exempted from the so-called "minimum-necessary" standard involving communications between medical providers regarding patient care. No changes were made to the fact that the minimum-necessary standard does not apply to treatment, but does apply to both payment and health care operations. Therefore, the intent to make covered entities evaluate their practices to limit unnecessary or inappropriate access to personal health information remains.

• **Parents and minors.**

In general, the final rule gives control of an unemancipated minor's protected health information to the parent, guardian, or person acting in *loco parentis* as state law, or other applicable law, governs in the area of parents and minors. For example, state law governs where explicitly it has addressed disclosure of a minor's health information to a parent, or access to a child's medical record by a parent. In all cases, disclosure of a minor's protected health information will be permitted or denied if necessary to avert serious or imminent threat to the health and safety of the minor.

[Editor's note: More information about Healthlink is available at www.healthlinkinc.com or by calling (800) 223-8956.] ■

AMs told to 'get involved' with smallpox vaccination

Should access workers be immunized?

As hospitals and health systems begin to put together their bioterrorism response plans, access managers should take an active role, asking, "How does this apply to my department and what should I do?"

"All of us need to be leaders in our areas, especially in the emergency department (ED), where the first wave of exposure will be," suggests **Kathleen Ramey**, RN, MN, CEN, director of emergency services for Providence Health System in Portland, OR.

As the government considers recommendations from the Centers for Disease Control and Prevention (CDC) regarding the immunization of health care workers against smallpox, a key question is how many should be vaccinated. Suggestions have ranged from 15,000 to, more recently, 500,000.

"It will be helpful to hear what the final recommendation will be," says Ramey, who is in charge of the safety department and emergency preparedness for the Providence system in the Portland area. "I do feel strongly that access services folks that work in the ED should be put in that first class of health care providers [to be vaccinated]. ED patients would be in the first wave of those affected and when a patient approaches the ED, he may see a triage nurse first or he may see an access employee."

Bioterrorism prep checklist from AHRQ

Hospitals can download a survey on the web site of the Agency for Healthcare Research and Quality (AHRQ) that can be used as a checklist for assessing their capacity to handle potential victims of bioterrorist attacks or for evaluating emergency plans.

The site, which can be found at www.ahrq.gov, gives users access to the 42 questions in AHRQ's Bioterrorism Emergency Planning and Preparedness Questionnaire for Healthcare Facilities. It covers such subjects as procedures to permit rapid recognition of credentialed staff from other facilities, on-call nursing policies, and designated areas of emergency overflow for patients. ■

While taking their guidelines from public health officials, hospital administrators will want to work in concert with those officials, she notes, so that once the vaccine is released, they can have some influence in who gets it. "There was a similar process with the flu vaccine when decreased amounts were available," Ramey points out. "In that case, access services people were considered in the first wave."

Public health officers in the four counties that overlap the Portland metropolitan area have put together a committee to work on a system approach to a variety of issues related to a possible smallpox outbreak, she says. The committee, of which she is a member, includes ED, emergency medical services, and public health personnel, as well as physicians, Ramey adds. "We're working on smallpox scenario planning and part of that planning is the vaccination process itself."

Part of the focus is on how best to inform the public, she notes. "We're trying to work on educational components and figure out communication [strategies] with public relations people. We're all concerned that mass hysteria could break out."

Because there is a significant risk of serious side effects with the smallpox vaccine, part of that educational effort will involve the warning that will go along with each dose, Ramey says. "There will be a form, a questionnaire that each recipient would need to fill out."

As with any other potential recipient group, access personnel with HIV or AIDS would be among those for whom the vaccine is not recommended, she says. Also complicating any decision to vaccinate is the fact that of about 900,000 people living with HIV infection, approximately 300,000 do not know they are infected.

Trying to screen out people who are HIV-infected as part of a smallpox immunization program could open up a legal quagmire of testing and confidentiality issues, it was pointed out at a meeting of clinicians and experts called together in Atlanta earlier this year by the CDC.

Complicating the issue further is the possibility that the HIV-infected person may be a health care worker or one of the other groups recommended for immunization.

If the choice is to immunize, a massive education effort will be necessary to influence physician attitudes and explain the reasoning of the program, **Glen Nowak**, PhD, CDC, associate director for health communications for the CDC, said at the Atlanta meeting.

"As hospitals begin their planning and education and distribution of whatever the plan will be," Ramey adds, "I recommend that access managers take it seriously, that they get involved. In the past, [some managers] have tended to brush off disaster planning." ■

Medicare appeal process is untapped opportunity

There's a good chance to overturn, expert says

By **Linda Fotheringill**
Siegel & Fotheringill, LLC
Baltimore

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 0.1%, 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 Centers for Medicare & Medicaid (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 takes 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 as to how to proceed in the appeals process beginning Oct. 1, 2002.

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 be willing to 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 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. In next month's issue of Hospital Access Management, *Fotheringill will provide a step-by-step description of the Medicare appeals process and the crucial time frames involved.]* ■

Discharge planning is not optional, expert cautions

Here are laws defining the process

Discharge planning is the law. As an access manager integrally involved in the discharge process, you knew that, right? Or maybe not.

Giving a presentation at a national meeting in Las Vegas recently on the rules and realities of discharge planning, veteran discharge planning and case management consultant **Jackie Birmingham**,

RN, MS, CMAC, was shocked to discover that many in her audience did not know there were laws mandating discharge planning. This was true even of those managing case management or discharge planning departments, notes Birmingham, who is vice president of professional services for Curaspan Inc. in Newton, MA.

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 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;

— 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 with 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, the PASARR was passed to ensure that patients who have mental health needs are identified before admission to a nursing home, she 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

worker's 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 still are 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 impact 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 additional articles related to HIPAA in this issue on p. 113 and p. 114.)** ■

CMS proposes process for appealing denials

The Centers for Medicare & Medicaid Services (CMS) has proposed a rule that would establish a process for beneficiaries to appeal local or national Medicare coverage determinations.

Under the proposal, an administrative law judge (ALJ) would initially review appeals of local coverage determinations. The Department of Health and Human Services (HHS) Departmental Appeals Board would review appeals from national coverage determinations and from ALJ decisions on local coverage determinations. The board's decisions could then be appealed to federal court.

The proposed rule would give beneficiaries an additional avenue to challenge the underlying coverage policy. Although beneficiaries already have the right to appeal individual claims denials, CMS says the new proposal is designed to ensure that complaints are reviewed in a predictable, uniform manner. **(For more information on appealing denials, see Guest Column on p. 117.)** ▼

CMS reminds providers to file HIPAA extension

Fewer than 3% of entities covered under the Health Insurance Portability and Accountability Act (HIPAA) have filed for an extension to the Transaction and Code Sets Standards compliance deadline of Oct. 16, the Centers for Medicare & Medicaid Services (CMS) has announced.

The Administrative Simplification Compliance Act allows hospitals a one-year extension, until Oct. 16, 2003, as long as they submit a compliance

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Editorial Questions

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plan by Oct. 15, 2002 "either by paper or, preferably, electronically at www.cms.hhs.gov."

CMS is encouraging hospitals to submit the compliance plans, and implement and test the new standards as soon as possible, according to a statement by CMS chief operating officer **Ruben King-Shaw Jr.** ▼

Prompt-pay law added in Ohio

The state of Ohio has added a new bill to the nation's growing number of laws aimed at making sure medical insurers reimburse hospitals in a timely manner.

A new state Senate bill gives the Ohio Department of Insurance additional authority to ensure that insurance companies comply with Ohio's prompt-payment laws.

The new law establishes a 30-day time frame for processing and paying claims submitted by health care providers, requires insurers to pay 18% interest to providers for claims not paid in a timely manner and gives the Department of Insurance authority to issue fines for late payment.

It also provides a system to aid insurers and providers with the exchange of information necessary to process a claim, and sets a two-year period after which claims are considered final and not subject to take-back practices. More information is available at www.ohanet.org. ▼

Uncompensated care up 60% in Wisconsin

Wisconsin hospitals have experienced a 60% increase in uncompensated care since 1996, and nearly a quarter of them lost money on patient care in 2001, according to the Wisconsin Health and Hospital Association (WHA).

Uncompensated care costs and shortfalls in payments from the Medicare and Medicaid programs together exceeded $1 billion in 2001, reported the Department of Health and Family Services' Bureau of Health Information.

The state's hospitals reported about 565,000 inpatient admissions in 2001, a 2% increase over 2000. Their profit margin on patient care stabilized in 2001, returning to an average 4.5% after dipping to 2.5% in 1999, WHA says. ▼

Survey gives salaries for IT professionals

Hospital information technology (IT) professionals earned an average salary of $88,925 in 2001, according to the latest annual compensation survey by the Healthcare Information and Management Systems Society (HIMSS).

Some 61% of the 1,581 survey respondents worked at a hospital or health system. The average salary for all respondents, including those working outside hospitals, was $91,267. Chief information officers received an average pay hike in 2001 of 6%, to earn an average $126,473. The average pay raise for all health care IT positions was 3.3%, with more than three-quarters of respondents reporting a salary hike.

Salaries ranged geographically from an average $101,458 in the Middle Atlantic states to $86,829 in the East South Central region. Men earned an average salary of $99,171, while women averaged $79,487. Full survey results are on-line at www.himss.org. ■