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INSIDE

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Special Coverage: AHIMA's 74th Conference in San Francisco

Care and detail go a long way in preparing for Joint Commission survey

One HIM department sails through process

[Editor's note: Hospital Payment & Information Management *newsletter is providing special coverage of the 2002 National Convention & Exhibit of the American Health Information Management Association, which was held Sept. 21-26 in San Francisco. Look for stories next month also about accreditation, coding, quality, reimbursement, and other key issues.]*

Every HIM director would like to receive praise from a surveyor of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) of Oakbrook Terrace, IL, following a survey.

This may not always occur, but for at least one hospital's HIM department, this is exactly what happened.

Audio conference tackles HIPAA privacy concerns

The recently released final privacy rule under the Health Insurance Portability and Accountability Act (HIPAA) makes significant changes to the existing regulations. With the April 14, 2003, compliance deadline fast approaching, is your staff receiving the proper training?

The American Hospital Association says implementing HIPAA will require "sweeping operational changes" and will take "intense education of hospital workers and patients." To help you and your staff prepare, American Health Consultants offers **HIPAA's Final Privacy Regulations: What You Must Know to Comply**, an hour-long audio conference on Dec. 4, 2002, from 2:30-3:30 p.m. Eastern time.

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"The Joint Commission praised us highly this past year at the survey in February 2002, and said we do a very good job at addressing legibility during our reviews," says **Ray Pinder**, MS, RHIA, director of medical records at Holy Redeemer Hospital and Medical Center in Meadowbrook, PA. Pinder spoke about preparing for a Joint Commission survey at the 74th National Convention and Exhibit of the Chicago-based American Health Information Management Association (AHIMA), held Sept. 21-26 in San Francisco.

"The Joint Commission is concerned about legibility. The way we do things is to have a reviewer look at all handwritten documentation, such as patient's history, the physical, progress notes, and physician orders, to see if they are timely, dated, signed, and if the information is legible," Pinder explains.

"If the reviewer says, 'Yes, it's fine,' then it's OK," Pinder says. "If the reviewer says it's not legible, then we pass it on to another reviewer."

If the second reviewer disagrees with the first reviewer, then a third reviewer would be engaged. The third reviewer's finding is the one the HIM department would act on, Pinder says. For example, if the third reviewer decided that the information indeed is not legible, a letter would be sent to the person responsible for the documentation to explain the problem and to ask him or her to review and come up with recommendations for improving documentation, such as dictating these notes in the future, he says.

It's this level of care and detail that has helped to make Pinder's organization well-prepared when a Joint Commission surveyor walks through the door.

Prepare well ahead of time for survey

Pinder offers these suggestions for other ways that HIM departments might prepare for a Joint Commission survey:

1. Prepare 12-15 months before the expected survey.

For at least 12 to 15 months before the anticipated Joint Commission survey, Holy Redeemer Hospital starts to prepare, beginning with looking at the previous survey report, Pinder says.

"We look to see if there were any Type I recommendations from the Joint Commission at the last survey, and we make sure these have been fully addressed before the Joint Commission comes back for their upcoming survey," Pinder says.

These Type I items should have been addressed within six months of the previous survey through a corrective action plan.

"If you submitted a corrective action plan to the Joint Commission, but have not actually corrected the problems, then it won't look very good," Pinder notes. "So it's clear that everyone in an organization, and not just the HIM department, should take a good look at previous recommendations and make sure those have been corrected or at least improved during the 12-month period prior to the next survey."

Also, the organization should review its safety precautions, patient safety, medical records, human resource records, and other documentation at least

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Editorial Questions

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a year before the survey, Pinder says.

Each month, Holy Redeemer Hospital has a record review in which medical documentation is checked for completeness by a medical record review team.

"We do a sampling of all record types, both inpatient and outpatient," Pinder says.

2. Review the 19 standards regularly between surveys.

Holy Redeemer Hospital's record review uses the Joint Commission's part one and part two documentation tool as a master document. Because this document has over 150-plus criteria, it can be used to do several smaller, focused reviews, including the 19 standards required by the Joint Commission, as the medical record review tool, Pinder says.

These 19 standards must be reviewed at least four times throughout the three-year JCAHO survey cycle, Pinder says. "If you don't receive a three-year accreditation, then you have to make sure you review those 19 standards four times during whatever cycle in which you will next be evaluated."

During the documentation review, reviewers will look for the same sort of items that the JCAHO surveyor would examine, such as operative notes and history and physical exams, and HIM professionals will do a quantitative analysis to make certain the history and physical exam have all of the required components. These include a review of system, past medical history, presenting illness, family history, and a physical exam that includes a quantitative analysis to make certain each body system has been examined and addressed, Pinder says.

"At Holy Redeemer, we use coders as part of the review team, so it's a learning experience for them," Pinder says.

While coders look for specific data elements, they also begin to think about items they see daily on the medical record, such as face sheet, physical, history, operative notes, consultations, and documentation, Pinder says.

"So those reviews are very critical to the medical record review portion of the Joint Commission survey," he adds.

3. Evaluate medical record charts for necessary information.

"We ask to have all diagnoses and procedures identified within the medical record on the face sheet or coding sheet," Pinder says. "So we do a review of that to make sure we can report back if we are evaluating on a given month that X percentage of records do not have all the diagnostic information needed."

A coder will work through the documentation, pulling out additional diagnoses, calling clinicians, and getting their approval to use the diagnoses, Pinder says.

Pinder notes that an industry standard is that a good coder can do three to four charts an hour, provided the coder has good documentation and all ancillary reports for evaluating diagnoses and procedures.

When an HIM director has coders review medical records to improve data and coding quality, this is something that can be quantified to supervisors about why coders are not meeting the average productivity standards, Pinder adds.

"It's justified because of the time spent to track down the additional information prior to completing the coding session," Pinder says. "You want to bill for everything you legitimately can, and many times it could take more than one call to a clinician to get that information."

Pinder says the ongoing record review system has significantly enhanced the hospital's coding program. "Documentation is addressed, and we are trying to make improvements so that we do meet the Joint Commission standards, but more importantly so that we can provide information that is needed to provide care," Pinder says.

The reviews also make it easier for other health care workers to review medical records and perform their jobs with a focus on quality.

Mock surveys give chance to practice

4. Hold mock surveys.

During the survey, there may be 12-15 people available to answer the surveyor's questions. Pinder is usually the team leader of the interdisciplinary team.

"We have rehearsals called mock surveys three months prior to the survey," Pinder says. "One month prior to the survey, we have the medical director and administrator act as surveyors and quiz us on questions, as we do a show-and-tell."

A mock surveyor might ask the team to describe how they measured improvement in verbal orders, so the team would open a binder and show a graph that demonstrates a three-year trend of improvement, Pinder says. **(See story on additional hints for survey preparation, p. 154.)**

"These rehearsals are very valuable. Even if they are not the real thing, they are intimidating for the team members," he says. "So when the

real thing happens, they're a little more relaxed and answer questions appropriately."

5. Tie loose ends as survey time approaches.

Although the Joint Commission survey dates are usually pre-announced, they now can do unannounced surveys. Even so, there should be plenty of time to complete last-minute preparations within the month before the anticipated survey time, Pinder says.

"If you are using the 12 months prior to the scheduled survey, then your organization should be in a state of readiness," he says. "I make sure I have 12 months of records and documents up to date."

Then, within the month before an anticipated survey, Pinder will pull the HIM staff together to discuss survey interviews and to make sure they feel comfortable with answering questions about any of the 10 information management standards.

"I try to give them a little pep talk about how we're ready and we can do this so they should just do their very best," Pinder says.

"I believe if the HIM director has done everything to prepare for the 12 months prior to the survey and particularly during the month prior to the survey, then during the week of the survey the HIM director and the HIM staff should be doing business as usual," Pinder says. ■

Special Coverage: AHIMA's 74th Conference

Go beyond requirements; make positive impression

Evidence binders show you really care

It's not always easy to make a good impression on a surveyor for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) of Oakbrook Terrace, IL, but it can be done.

Ray Pinder, MS, RHIA, director of medical records at Holy Redeemer Hospital and Medical Center in Meadowbrook, PA, has found that sometimes it takes an added measure of preparation to show surveyors that an organization has made quality a top priority. Pinder spoke about preparing for a Joint Commission survey at the 74th National Convention and Exhibit of the American Health Information Management Association (AHIMA) of Chicago, held Sept. 21-26 in San Francisco.

Pinder offers these hints for making a JCAHO surveyor take positive notice of your facility:

• **Presentations:** "When we have a Joint Commission survey, we put together a storybook presentation," Pinder says. "We bring examples of things that will demonstrate improvements and put these on display so that the surveyor can look at these if there is time."

Pinder also prepared a PowerPoint presentation to demonstrate the full Ongoing Record Review (ORR) process.

The presentation highlighted Holy Redeemer's ORR process from beginning to end. Included in the presentation were a few documentation improvement projects that were highlighted for surveyors.

Presentations may spur questions

During a 90-minute medical record interview, there typically is a 15-minute time slot allotted for an overview of the facility's ORR process, Pinder says.

"At that point, the team leader should ask if it would be okay to do a PowerPoint presentation," Pinder says. "Our survey team agreed, and enjoyed the 15-minute presentation."

However, be aware that such a presentation may lead to more questions: "As the surveyors were watching and listening, I noticed lots of jotting of notes," Pinder recalls. "At the conclusion of my PowerPoint presentation, the surveyors asked several questions, some that were about details within the presentation."

Pinder says the surveyors made positive comments about the presentation and about how their questions were answered appropriately, which emphasizes the fact that a presenter should be well-prepared to explain all details.

• **Evidence binders:** Pinder is an advocate of evidence binders as tools that are kept up to date. These provide an organized look at how well a facility is prepared for a survey.

The Holy Redeemer Hospital's evidence binder has 10 sections, including one for each standard. These include intent statements, answering the question of how an organization would meet a standard, and a definition of the evidence that would demonstrate it has met that particular standard.

The medical record review evidence binder contains 12 months of a review tool, completed

studies, any deficiencies noted, any letters to the medical staff or ancillary departments regarding documentation, and requests made to submit action plans with regard to deficiencies, Pinder says.

For example, the information management standard for ongoing record review would include, in the binder, copies of monthly study results and action plans from those studies for all items that need to be addressed, Pinder says.

"And those reports are sent to the various committees, the hospital quality improvement committee, and all the way up to the medical executive committee," he says.

• **Original tools and forms:** "Many times surveyors are impressed by a new type of form or documentation, and they may ask how it was devised and improved and whether it has improved outcomes," Pinder says.

Surveyors at times have even asked Pinder if they could have a copy of the form that was created at Holy Redeemer Hospital so that they could share it with their own facility, Pinder says.

"Most surveyors do surveys on the side, and they like to keep an original form in a file so that when they go out to other facilities, they can say, 'I came across this form and it may help you as well,'" Pinder explains.

• **Higher goals than what's required:** Although the Joint Commission sets a goal of having 50% of a facility's records being completed within 30 days, the HIM department should raise the bar to 90% to 95%, Pinder suggests.

"The Joint Commission will ask for four quarterly measurement periods, the last four quarters, to see what were the percentages of delinquent medical records," Pinder says. "They use the threshold that you must be above 50% on time."

Sometimes it's difficult to obtain completed records from physicians and other health care providers within 30 days, but if a facility would like to impress a Joint Commission surveyor, it's a good idea to do far better than the 50% threshold, Pinder says.

Holy Redeemer sometimes had on-time percentages above 70% to 80%, he adds. "The surveyor was pleased with that."

However, the organization's goals are even higher. "Our goal would be that at least 95% of the documentation elements, such as diagnoses on the discharge summary, would be completed on time," Pinder says. "If the level is at 90%, then we will send out letters of how we've fallen five points below our acceptable standard." ■

GUEST COLUMN

No isn't always the last word; appeal denials

Some Medicare Part A denials can be reversed

By **Linda Fotheringill**
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So your carrier/intermediary has denied too many Part A Medicare claims, and you are ready to take action. That's great. The Medicare Part A appeals process currently found in chapter 42, Code of Federal Regulations (C.F.R.), Part 405.701-405.753 only *appears* to require a rocket scientist to decipher; in actuality, it's pretty straightforward. Generally speaking, follow the steps below and you stand an excellent chance of overturning the denial:

• **Carefully read the carrier's initial determination.**

The written notice of the carrier/intermediary's determination should state in detail the basis for the determination and should inform the provider of its right to reconsideration. The notice also should state that the carrier/intermediary has made a finding that the patient did not know, or could not reasonably have been expected to know, that the expenses incurred for the services were not reimbursable. Regardless of whether the denial was administrative or clinical in nature, determine if the denial was unfair or inappropriate, and formulate your response.

• **File a request for reconsideration within 60 days.**

Your request for reconsideration must be filed in writing within 60 days of receipt of the written notice of determination. You should include an explanation of why the initial determination was wrong, along with supporting documentation such as medical records, hospital account notes, case management notes, and any other evidence that will help to show the inappropriateness of the initial determination. Your written request for reconsideration should be filed at an office of the Social Security Administration or the Centers for Medicare & Medicaid Services (CMS), or, in the case of a qualified railroad retirement beneficiary,

an office of the Railroad Retirement Board. (If you miss the 60-day requirement, there is a chance that CMS will grant an extension if you can show "good cause" for the delay.)

• Carefully read CMS' notice affirming or revising the initial determination.

CMS will make a determination affirming or revising the initial determination and advise you by written notice, stating the specific reasons for the reconsidered determination and advising your hospital of your right to a hearing if the amount in controversy is $100 or more. If the reconsidered determination is unfavorable and the amount in controversy is $100 or more, plan to request a hearing. Remember that under certain conditions, the dollar amounts of several claims may be aggregated to meet the threshold. Likewise, regardless of the amount in controversy, multiple claims with similar issues could be aggregated for ease of handling.

• File a request for hearing within 60 days.

The written request for hearing must be filed within 60 days of receipt of the reconsidered determination at an office of the Social Security Administration, the CMS, or with an Administrative Law Judge (ALJ), or, in the case of a qualified railroad retirement beneficiary, an office of the Railroad Retirement Board. If you miss the 60-day deadline, an exception can be made if "good cause" is shown. Once you are at the level of requesting a hearing, it would be helpful, although not necessary, to have your in-house counsel handle the appeal or to retain a qualified attorney to do so.

There are several factors favorable to the provider in the hearing process:

— First, providers may present their case at the hearing and be represented by attorneys and expert witnesses. Medicare is represented only by a written record. Although an administrative law judge can invite a Medicare contractor to a hearing, this rarely occurs. When invited, contractors typically will send a physician or a nurse, rather than an attorney, to represent them.

— Providers are allowed to rebut testimony contained in the contractor's written record.

— ALJ decisions do not set precedent. Further, the Departmental Appeals Board, the highest level of Medicare administrative appeals, does not have precedent-setting authority.

Inappropriate denials more than likely will be overturned if your hospital utilizes the Medicare appeals process. Accordingly, proactive providers should incorporate the Medicare appeals process in their denial management strategy. ■

Hospital achieves 100% usage of CPOE system

All patient orders are entered electronically

Montefiore Medical Center, in Bronx, NY, has achieved a rare milestone: All inpatient orders — including medications, lab tests, diagnostic tests, and all other clinical care orders — are being entered electronically. In the process, Montefiore has achieved a 60% reduction in the time elapsed from writing a prescription to a patient receiving the medication, and a 50% reduction in the number of potential prescribing errors.

"We wanted to reduce the hand-offs you have when working in the paper world, and give the information to the physicians when they place their orders," explains **Dorrie Napoleone**, director of clinical information systems. "It's much more effective if you tell them up front about patient allergies, potential drug interactions, or lab values that represent a contraindication."

Seeking to improve quality

"We had and we have excellent leadership," notes Napoleone, explaining the impetus behind this transformation. "They are pretty visionary, and they realized that the best way to improve quality of care is to get information into the hands of the decision-makers — in this case, mainly physicians."

The search for a system that could do this began in 1994, but the serious planning started in 1998. "There was a lot of preliminary work we had to do to set the foundation," explains Napoleone. "We needed to implement other systems first, such as automating the pharmacy, and patient registration in some areas [the Montefiore system includes about 1,100 beds in two hospitals]. A stand-alone CPOE [computerized physician order entry] system wouldn't realize nearly the same quality benefits as an integrated one."

After integration, the following steps were required:

- system selection;
- securing funds and board approval;
- contracting with the vendor.

The vendor was chosen by a group of 25 staffers — 14 physicians as well as representatives from nursing, pharmacy, and administration.

Change is slow, steady in CPOE market

Systems more advanced than five years ago

While hospitals have not exactly fallen over themselves to install computerized physician order entry systems (CPOEs), a growing number are beginning to recognize their value, says **Nick Beard**, MD, MS, vice president of Health Informatics for Seattle-based IDX Systems Corporation, a provider of CPOE systems.

"Although the overall number of institutions that have adopted CPOEs is still uncomfortably small, it is growing," he says. "The market is increasingly recognizing that poor physician handwriting is no longer a joke; it's a liability."

For hospitals currently in the market, they can consider systems more advanced than they were even five years ago. "In general, over the past five years there has been a growing recognition that organizations need to have integral components of an institutionwide computerized patient record system," says Beard. "Without that, you will still have improved quality and safety, but there is an extra level when the physician has complete access to information stored, for example, in the nursing and pharmacy systems."

In the end, he says, the patient care process in the core clinical arena is about physicians, nurses, and pharmacists. "If you have a completely integrated CPOE, you can not only demonstrate safety improvement, but also quality improvement in areas like helping to provide physicians with reminders and alerts — almost point-of-care, just-in-time education," Beard explains.

What should a hospital expect from a CPOE system today? "It needs to meet very rigorous demands in terms of response time and reliability guarantees," says Beard. "That doesn't just mean assertions from the vendor; they need to be held accountable in strong contractual language."

For example, he says, a vendor should contractually guarantee system availability well in excess of 99%, and sub-second response time. "These are easily measurable," he notes, "but you should also look for advice from an external, independent source, such as The Leapfrog Group."

What further advancements can we look forward to in the near future? "The big thrust today is about increasing the amount of knowledge in systems," says Beard. "We want to go beyond knowing the proper dosage, to real knowledge about what the best medication is, current sensitivity profiles of bugs in a specific community, drug/lab interactions, and so forth. We want to bring to bear real, meaningful, contextually relevant guidance to supplement the clinical expertise of practitioners." ■

"We educated them as to what their charter was: to go out and get a system that would work across the Montefiore integrated delivery system to support an on-line network that would be physician-friendly," says Napoleone. "Then, we took them out on site visits and vendor demos."

Vendors who did not provide the requisite technology were automatically eliminated. "We are a large-volume system, and response time is very important," says Napoleone, who points out that Montefiore staff write over 60,000 orders a week. "From a technology standpoint, we wanted a system that would have rapid response time and run 24-7. If you eliminate paper, you need a system that runs all the time."

The LastWord system from Seattle-based IDX Systems Corporation stood out. "It had the foundation of an on-line record across a delivery system," Napoleone explains. "It was designed to be a birth-to-death record, whether the patient was seen in the ED, in the doctor's office, or in the hospital. Being created by physicians, it also has a strong clinical foundation." The IDX system is still in use by Montefiore, although LastWord has been replaced by a new generation called Carecast.

The system is activated when a physician places an order, which can be done from the office, from home, or from any one of 4,000 workstations around the medical center. "Some physicians have wireless units, so they can do it at the bedside, the nursing station, in the hallway — anywhere on campus where the Internet can be accessed," says Napoleone.

The order could be for medication, labs, or imaging. The physician opens the patient record on the computer, looks at the lab values and meds given, and writes the order. He or she

selects options from a drop-down menu and fills in the required information, such as the dose. Then the physician hits the "process" button, and the order is electronically transferred to the next area — for example, to the pharmacy, and to the nurse with a "to do" list. "So, the nurse knows immediately that they have a dose to give, and the pharmacy knows they have a dose to deliver to the nurse's station," says Napoleone. "This is an enormous streamlining in what has traditionally happened. The doc would have had to find the paper chart, get it, flag it, and someone would need to interpret his order."

In addition, as soon as the order is entered, a big pop-up window may come up that says the patient is allergic to a certain medication. "In almost all cases, the doc can override this if they want, but they get the alert box and have to respond to it," Napoleone explains. "We don't necessarily want to stop the doc from doing what he thinks is right, especially if it's an emergency."

Training the staff

To date, about 1,300 physicians and 1,800 house staff (residents), 2,000 nurses, and another 1,000 employees in ancillary areas such as registration and scheduling have been trained in use of the system.

The physicians were offered classroom training or given one-on-one classes in their offices. The training took one or two hours, "depending on how good they were with a PC," says Napoleone.

For nurses, the system was rolled out unit by unit via classroom training. However, that training was not entirely uniform. "We identified what was unique about each unit and worked with the physicians and nurses to make sure we accommodated those uniquenesses," says Napoleone.

While a computer can automate the care process of a patient, "What a day is like in the life of an oncology patient is very different than the one for a patient going for dialysis or being treated for a broken leg," she explains. "Different things need to happen and different kinds of orders are given." These can be customized in the IDX system so that pull-down menus offer the most appropriate options.

"There are also huge differences in dosages, for example, between adults, neonatal, and pediatric patients," adds Napoleone.

At a time when only about 5% of all hospitals nationwide have a functioning CPOE system, how is it that Montefiore was able to achieve 100% usage?

"A lot of it is attitude," says Napoleone. "Lots of people will give you lots of reasons why they can't do it, but most of the reasons are not valid. If you actually sat a person down and said, 'We have a tool to improve your efficiency by 50%,' they'll probably say it's great, but lots of places think that docs won't like it, that they'll rebel and go somewhere else."

That fact that Montefiore is a teaching hospital does make things easier, she concedes. "We do have residents who place orders, and this makes us a little more open to innovation and change," she says. "We are a very mission-driven organization; from the top we decided this was something we had to do. We would not have been successful without executive leadership fully supporting us; they are 1,000% behind the project. After that, it was a matter of teach, educate, and then activate." ■

Is your documentation lacking key information?

Experts: You may be missing out on reimbursement

Do you realize that the way you document can have a significant impact on the reimbursement your emergency department receives? This is especially true with ambulatory payment classifications, according to **Candace E. Shaeffer**, RN, MBA, vice president of coding/quality management at Lynx Medical Systems in Bellevue, WA.

Shaeffer reports that many emergency departments (EDs) are missing out on reimbursement because of inadequate nursing documentation. She points to the proposed rule from the Baltimore-based Centers for Medicare & Medicaid Services (CMS) for the outpatient prospective payment system (OPPS), which includes significant increases in payment for some procedures. "Capture of these charges depends on sufficient documentation," she underscores.

Here are some ways you can improve nursing documentation:

• **Develop your own system for facility coding.**

Shaeffer notes that CMS has directed EDs to develop their own systems for facility coding, with the following requirements:

— that the services furnished be documented and medically necessary;

— that the system maps the services to the different levels of effort represented by the codes;

— that the code assigned should reasonably relate the intensity of hospital resources used.

These requirements may be fulfilled by using a point system, a clinical intervention model, or another method that clearly differentiates the levels of service, she explains. Whatever system is selected, it must be tested to determine how reliable it is, says Shaeffer.

Review the requirements of hospital policies, state law, and accreditation organization requirements, says Shaeffer, and outline documentation guidelines for the ED. "This can serve as the basis for education and auditing," she adds.

According to the proposed OPPS rule, CMS will allow facilities to continue to use their own coding methodology for assignment of visit levels instead of establishing a standard methodology, Shaeffer notes.

"The documentation and method go hand in hand," she says. "If facilities have not adopted or developed a method, they should do so, since CMS is not planning to devise theirs until 2004."

Document route of administration

• **Make sure all charges are captured.**

Your documentation must be thorough to avoid loss of reimbursement, says Shaeffer. She gives the example of documenting "meperidine 50 mg" without documenting the route of administration. "If the medication was given intravenously, this would result in a $43.17 lost charge next year," she says.

Inadequate documentation also can cause your ED to lose out on the appropriate visit level, she adds. She explains that if you are using a point system to calculate the facility visit level, resource points are added to arrive at the total number of points, which is compared with the minimum point requirement for each visit level. Additional resource points are added for specific tasks or services, such as a visit from social services, says Shaeffer.

Therefore, if a service was performed but not documented, a lower level of service would have to be assigned, she says. She gives the following example: If additional points are earned when the patient arrives by advanced life support transport, then you must document this means of arrival.

Use this checklist when you document

You should include the following elements in your documentation, according to **Candace E. Shaeffer**, RN, MBA, vice president of coding/quality management at Lynx Medical Systems in Bellevue, WA:

☐ Timed and initialed entries
☐ Means of arrival
☐ A triage note or presenting problem and pertinent history of the illness or injury
☐ Allergies and current medications
☐ Important factors that put the patient at high risk per hospital policy (such as potential abuse)
☐ Weight, visual acuity, or other factors (if appropriate for age and presenting problem)
☐ Initial vital signs and a reassessment if abnormal or changed during the emergency department course of treatment
☐ All interventions and patient responses
☐ Some type of pain assessment scale
☐ Orders noted and initialed per hospital policy
☐ An assessment of the patient's psychosocial needs and ability to understand teaching and instructions
☐ Discharge status
☐ Disposition and time
☐ Referrals and communications with other caregivers or providers regarding the patient
☐ A patient's leaving against medical advice
☐ Nurses' signatures

"Likewise, if additional points are earned when a patient is placed in restraints, this should be documented," says Shaeffer.

• **Give feedback to nurses.**

Whatever methods of documentation and coding are implemented, the records should be audited for documentation as well as coding quality, Shaeffer notes.

"Feedback should be given to the nursing staff about documentation deficiencies," she says.

• **Develop a nursing documentation tool.**

Shaeffer recommends using nurses' notes that are bar-coded and generated from a computerized system. "After care is delivered and documented, the nurses' notes can be scanned into the system, where they are automatically matched to the patient encounter," she says.

Once optically imaged, the nursing documents and others can be accessed for subsequent patient

visits, callbacks, coding, and quality assurance, notes Shaeffer.

The advent of APCs was a strong incentive to improve nursing documentation, says **Shawn Keenen**, director of the ED and float pool at Mongalia General Hospital in Morgantown, WV.

"Government institutions are making reimbursement tighter and are refusing payment for lack of documentation," he says. "We felt a tool was needed to assist the nursing staff in ensuring their documentation was complete."

All ED nurses listed interventions provided for patients, which were incorporated into a single-page form, he says. The nurse circles the points indicated for the intervention, and the biller/coder adds them and determines the level of charge by the total points.

"While the form is not exhaustive, it covers just about everything," says Keenen, adding that the form jogs the memory of busy nurses who may have forgotten what they have done for a patient. "Essentially, the form becomes an audit trail for their documentation." ■

PPS training helps make transition easier

Georgia facility commits to ongoing education

Preparing and training staff for the rehab prospective payment system (PPS) over the past year has been a challenge for Glancy Rehabilitation Center in Duluth, GA, but the rehab hospital has met its goals.

The rehab staff's documentation has improved significantly in the past year, and everyone has become skilled in the new charting style and strategies of determining patients' functional measurements, says **Janet Patrick**, RN, PPS coordinator for Glancy Rehabilitation Center - Inpatient Rehab Program, which is part of Gwinnett Hospital System.

"We've had to change the style of documentation, and that's one of the areas I looked at prior to our switching to PPS," Patrick says.

Also, the staff have always had a team approach to rehab, but under PPS they've had to improve on this and involve more disciplines in documentation of patients' scores, such as having nurses assess some functional improvement measures, Patrick adds.

Here are some of the strategies the rehab facility has used to make the PPS transition run smoothly:

• **Address department communication and team involvement.**

A committee involving nursing, management, case management, medical records, billing, and the various therapy disciplines began meeting in 2001 before PPS was implemented.

"They would get together to plan ahead and see how the communication lines would go and try to make adjustments to how the different departments would interact," Patrick says.

In January 2002, Patrick became the PPS coordinator, and the committee and she developed a process for how she would interact with the different departments as she assisted the staff in making the transition to PPS.

Patrick daily contacted the medical records department to discuss coding, and she worked on making certain the PPS forms were properly completed.

Look for missing items, incomplete data

• **Check scores for precision and accuracy.**

Patrick audits every chart, pulling information from the documentation and looking for missing items or incomplete data.

"If there's information I'm not certain is realistic, then I'll go to that therapist or nurse and just confirm it," Patrick says.

For example, if a person scored a patient as independent on the functional improvement measure (FIM) for lower body dressing, Patrick may remind the staff that if the patient is wearing Ted hose stockings, the score needs to be adjusted because Medicare considers that the patient could not put on the hose without assistance.

"I have a FIM book with guidelines in every department and also some scenarios that people might go through when treating a patient," Patrick says.

She will use the book to show staff why they may need to adjust a score to include a patient's limitation or a nuance that previously wasn't considered.

"There are simple things that tend to affect the score that we may not have been thinking about from the beginning, and now everyone is thinking about these and looking at it in a different light," Patrick says.

• **Encourage staff to change their rehab mindset to include PPS concerns.**

Patrick interacts with staff on an individual basis to help them focus on how the information they collect affects reimbursement.

"We focus on what's required of a facility and how it's a requirement of their job to provide accurate information," Patrick says.

"In the very beginning it was difficult because we went through different processes along the way," she notes. "I had a worksheet on the chart, and I showed people what I was looking for."

Staff would fill in the chart, and then Patrick would look at it and make certain that it reflected what was required. The rehab unit was divided into five zones, and each zone was responsible for achieving 100% complete and accurate documentation in these PPS exercises.

Success rewarded with ice cream party

When staff in a particular zone showed that they were filling in all documentation correctly, the facility held an ice cream party in recognition of their success.

"Each zone made sure their team members filled out the information correctly on the worksheet," Patrick recalls.

This provided a peer support that encouraged individual staff to succeed, and it created a healthy competition, Patrick says.

It took a little while to change employees' mindsets about the documentation, but now everyone is doing well and realizes that documentation is at the forefront of their work, Patrick adds.

• **Provide ongoing education.**

Each new employee watches educational tapes about completing PPS documentation.

Also, if employees have a question about a particular documentation item, or if Patrick finds a new point that must be emphasized, these are brought to everyone's attention.

"I ask key people in each discipline if they've found something new to make sure their whole discipline is aware of it, so there's a lot of interaction within the discipline itself," Patrick says. ■

(Continued from cover page)

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The HealthTrust Purchasing Group (HPG) recently announced plans to offer members outsourced health information management services. Working with Precyse Solutions, HPG says member facilities may procure clinical coding, oncology data management, cancer registry, HIM consulting, HIPAA gap analysis, and special projects (backlog filing, purges, etc.) services.

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ICD-9 code update requires more investigation by coders

The key is: Be specific, document

Coders will be required to learn a variety of new ICD-9-CM codes for fiscal year 2003, as well as change the way they were using some existing codes. These changes are part of the recent trend of the government and the HIM industry moving toward more specific and better documented coding of diagnoses and services.

"A lot of the ICD-9 changes are related to increased specificity and needing documentation to support more specific codes," says **Sue Prophet-Bowman**, RHIA, CCS, director of coding policy and compliance at the American Health Information Management Association (AHIMA) in Chicago. Prophet-Bowman spoke about ICD-9 coding changes, effective Oct. 1, 2002, at AHIMA's 74th National Convention and Exhibit, held Sept. 21-26 in San Francisco.

Changes expand diagnostic concepts

For example, there are changes in coding for systolic and diastolic heart failure, Prophet-Bowman says. "We have new codes to identify the distinction."

There are 12 new codes for systolic heart failure. Previously, coders would have used ICD-9 428.0, she adds.

"Pretty much all of the code changes expanded some diagnostic concepts," Prophet-Bowman says. "What was coded nonspecifically in the past, now is broken down into more specific codes."

Furthermore, physicians will need to document these differences. The medical record will have to state what type of heart failure a patient has experienced, whether it's chronic or not chronic, she says.

AHIMA favors greater attention to detail in coding because, from a data-quality perspective, it will enable coders to code more accurately, and hopefully this will result in appropriate reimbursement, Prophet-Bowman says.

Another area in which ICD-9 codes have changed involves codes in the 700 category, including codes that apply to premature infants.

"In the past, we had codes for prematurity based on birth weight, a combination of birth weight and/or the number of weeks of gestation," Prophet-Bowman notes. "Now they've split that out so you can be more specific with two codes with both aspects: One will show the baby's birth weight, and the second code will show the different ranges and what the completed weeks of gestation were."

Also, there are additional perinatal conditions added to the coding, including primary apnea for a newborn, respiratory failure, bacteremia, urinary tract infections, septicemia, and others.

"Before, those were all lumped into a general infection code, and now it's broken down into individual conditions so you can tell what kind of infection a baby has," Prophet-Bowman says.

New code for anthrax

Not surprisingly, coders also will see new codes for diagnoses that previously were almost never anticipated or seen, such as for anthrax.

"They have a code for just having a positive test for anthrax, without symptoms, and a code for contact or exposure to anthrax," Prophet-Bowman says. "There's also a code for observation for suspected exposure to anthrax, such as when someone seeks diagnostic testing because

they are concerned they might have been exposed to anthrax, and then it turns out they have not been exposed."

There already exists a code for anthrax as a diagnosis, but the new codes, which are not located near the existing code, are all V codes.

New V codes cover post-acute setting

Coders also should be aware of the whole series of new V codes to describe various services, such as aftercare. These V codes are used when an acute condition is no longer present, but the patient continues to receive aftercare, such as physical therapy, in a post-acute setting like a nursing home or home health.

"I think this reflects the growing population receiving care in the post-hospital setting," Prophet-Bowman says. "We have a lot of members who work in the post-acute setting, and they have been advocating to have better data in those settings."

It's not enough to have good data on the acute side, because when patients are moved from the acute setting to the post-acute setting, the coders no longer can use the more specific acute codes, she adds.

"The data loss was significant, so a lot of people were coding the acute condition anyway, even though the coding rules said you shouldn't code it after the acute phase was over," Prophet-Bowman says. "So we were advocating improved data on the post-acute phase so people would adhere to coding rules and not feel like they had to capture the acute condition code, because the post-acute code didn't tell them anything."

Here are some of the changes made to ICD-9 codes, effective this year:

1. V code changes:

- **V71.82:** Observation (without need for further medical care) for anthrax.
- **V71.83:** Observation (without need for further medical care) for biological agent NEC.
- **V01.81:** A new code for contact with anthrax.
- **V58:** New codes include V58.43 for aftercare following surgery NEC for injury or trauma; V58.42 for neoplasm; V58.73 for circulatory system; V58.75 for digestive system; V58.76 for genital organs; V58.76 for genitourinary system; V58.78 for musculoskeletal system; V58.72 for nervous system; V58.75 for oral cavity; V58.74 for respiratory system; V58.71 for sense organs; V58.77 for skin; V58.77 for subcutaneous tissue; V58.75 for teeth; and V58.76 for urinary system.

2. Heart failure coding changes:

- **428.40:** a new code for combined systolic and diastolic heart failure.
- **428.41:** a new code for combined systolic and diastolic acute heart failure.
- **428.43:** a new code for combined systolic and diastolic acute on chronic heart failure.
- **428.42:** a new code for combined systolic and diastolic chronic heart failure.
- **428.30:** a new code for diastolic heart failure.
- **428.31:** a new code for acute diastolic heart failure.
- **428.33:** a new code for acute on chronic diastolic heart failure.
- **428.32:** a new code for chronic diastolic heart failure.
- **428.20:** a new code for systolic heart failure.
- **428.21:** a new code for acute systolic heart failure.
- **428.23:** a new code for acute on chronic systolic heart failure.
- **428.22:** a new code for chronic systolic heart failure.

3. Infant coding changes:

- **765.22:** Gestation of liveborn infant with 24 completed weeks.
- **765.23:** Gestation of liveborn infant with 25-26 completed weeks.
- **765.24:** Gestation of liveborn infant with 27-28 completed weeks.
- **765.25:** Gestation of liveborn infant with 29-30 completed weeks.
- **765.26:** Gestation of liveborn infant with 31-32 completed weeks.
- **765.27:** Gestation of liveborn infant with 33-34 completed weeks.
- **765.28:** Gestation of liveborn infant with 35-36 completed weeks.
- **765.29:** Gestation of liveborn infant with 37 or more completed weeks.
- **765.21:** Gestation of liveborn infant with less than 24 completed weeks.
- **765.20:** Gestation of liveborn infant with unspecified completed weeks. ■