AMERICAN HEALTH CONSULTANTS®

Hospital Access Management™

Admitting ● Reimbursement ● Regulations ● Patient Financial Services ● Communications
Guest Relations ● Billing & Collections ● Bed Control ● Discharge Planning

INSIDE

APRIL 1999

VOL. 18, NO. 4 (pages 37-48)

American Health Consultants® is A Medical Economics Company

Establish 'critical hierarchy' before 2000 to avoid Y2K bug's bite

Once your house is in order, call suppliers, develop contingencies

Establishing a "critical hierarchy" — placing anything that can affect patients at the top — is the first step toward an effective strategy for year 2000 computer compliance, says **Michael Lauffenburger**, Y2K manager in information services at ScrippsHealth in San Diego. Next in line after patient care issues is anything that can affect key business operations, such as billing or other financial functions, he adds. "Then, once you have your own house in order, start contacting suppliers and begin developing contingency plans, because even if you're compliant, if your key suppliers and vendors are not, you could have problems."

At ScrippsHealth, the move to ensure Y2K compliance is well under way, he says, with tentative planning and strategy talks crystallizing in May 1998 into a formal project with a multimillion-dollar budget. Scripps' program, Lauffenburger says, is divided into six components:

- biomedical devices;
- computer hardware;
- computer software;
- external data or system interfaces (including electronic billing and any data interfaces with non-Scripps entities);
- facility systems (elevators, fire alarms, heating, air conditioning, and other facility systems that are date-sensitive);
- networks and telephones.

"How much risk are you willing to live with?

Remediation efforts for each component are moving along, he says, with assistance and consulting from Science Applications International Corp. (SAIC), a San Diego-based high-technology company that has assigned 27 full-time employees to the Scripps job.

The first step was to do an enterprise assessment of Scripps' six hospitals and numerous secondary facilities "to get our arms around what areas we needed to look at," Lauffenburger explains. During this three-month process, Scripps identified and categorized the areas of risk and

estimated the work that would be involved.

A standard process for remediation was developed for all of the components, he notes, which involved the following:

1. Inventory.

"We visited every facility and identified every device, every PC, every piece of business-critical software," he says. The inventory process was completed last December. It revealed, among other things, some 3,300 date-sensitive biomedical devices, such as defibrillators, and about 2,800 personal computers.

2. Detailed assessment.

Using basic input-output system testing software that is commercially available, Scripps checked the PCs for Y2K compliance, and 1,700 failed the test. Most of those will be replaced, he says, although some of the newer ones that failed will be upgraded. "The majority of the Pentiums are OK, but the sub-Pentiums will usually fail," Lauffenburger adds. Assessment of the other items was to be finished about mid-March.

3. Planning, remediation, and validation.

"Now that we know what our inventory is and what assets are not Y2K-compliant, the question is, 'What is the most cost-effective course of remediation?'" he says. "We'll either repair, replace, or retire the noncompliant devices."

4. Implementation.

Remediation and testing will be completed in September, Lauffenburger notes, and in October, Scripps will implement whatever has been fixed and tested. One caveat to the above timetable involves critical components, those that could directly affect patient care or financial or regulatory functions, he points out. "Those items are on a fast track that is to be completed by the end of July."

As part of its Y2K planning, he says, ScrippsHealth has "had a lot of dialogue" with other local and national health care organizations. "Because there is, of course, no precedent to Y2K, our intent is, at least in San Diego, to establish best practices — what's appropriate, what's overboard, what's due diligence."

For example, when it comes to storing diesel fuel for backup generators in case of utility company problems, he says, a year's supply was deemed excessive, but a week's supply may not be enough. "We're trying to find the appropriate median."

As a result of these dialogues with other organizations, Lauffenburger says, Scripps has found it is ahead of many other health care entities in Y2K planning.

"The absolute key to that is executive management buy-in. Fortunately, the Scripps' executive team is totally supportive. [Y2K preparation] is the No. 1 priority."

Software tested in laboratory

Scripps is leaving nothing to chance when it comes to ensuring its software and business operations are Y2K compliant, he notes. Using up to a dozen different tests, the organization is simulating what will happen when the calendar rolls over to 2000, Lauffenburger says.

"We have mirrored our major computer systems in a stand-alone laboratory. We have separate hardware and are making copies our production software systems to ensure that our testing environment is totally representative of our production environment. All of our testing efforts will be fully documented as part of our due-diligence process."

And when it comes to critical components, particularly those affecting patient care, Scripps is taking "an extremely conservative approach," he says. "We're contacting vendors and, even if they say [their products] are compliant, we're going ahead and testing them."

That approach certainly is not universal among health care organizations, some of which take the vendor's word that an item is compliant, he says. "What is justifying [the conservative approach] is that a small but significant number of medical

devices that we were told were OK actually failed our Y2K tests. The consequences of a device Y2K-malfunction could obviously be severe."

SAIC's health care clients vary greatly in the progress they've made toward Y2K remediation, says **Greg Baker**, MBA, assistant vice president and the company's year 2000 national practice director for health care. Those clients, he notes,

> **"There's still a fairly big area of unknown."**

include such organizations as Kaiser Permanente in Oakland, CA, the University of Maryland Medical Systems in Baltimore, and Mercy Health Services in Farmington Hills, MI.

"Some are more ahead than others, but most will not fix everything, nor could they expect to fix everything," Baker says. "The discovery effort has been very difficult, particularly in the areas of medical devices and desktop applications. There's still a fairly big level of unknown, a chunk of inventory as yet undiscovered, and if they don't know about it, they sure can't fix it."

A spreadsheet on an older version of Excel, for example, or a homegrown database, are problems the hospital information systems department will have to continue addressing, he notes. "Some support critical business processes even though they're homegrown."

In addition to these internal concerns, there are the external suppliers, partners, and payers over which an organization has little control, Baker says. "There's not a lot that can be done to avoid having a supplier stop shipping, although you can do some things to be ready to deal with it."

Beef up those cash reserves

Most hospitals also are concerned about a possible breakdown in the electronic payment process, he says, which has caused some organizations to take a hard look at cash flow and at beefing up cash reserves.

Because it is impossible to fix everything, Baker emphasizes, health care organizations should shift their focus to business continuity while they continue — within constraints — down the path of remediation. "For a long time, the traditional remediation program focused on fixing components, applications, facility systems, medical devices, and network systems," he says. "The thing to realize now is that the continuity of business operations will be threatened for most, if not all, health care organizations." Figure out how much and where and focus on what's most important and most exposed.

"In a way, [Y2K] always was about business continuity," he adds. "But now we've got the raw materials through inventory and remediation to build the bridge. Now companies can reprioritize their efforts — where to do contingency planning and where not to. Without focus, you could write contingency plans forever."

He likens the concept to a financial advisor's asking, "How much risk are you willing to live with, and based on that, where do you want to make your investment?" Hospitals won't necessarily spend more than they planned, although they may, Baker says, but they will redistribute funds to the most important areas.

Spending hundreds of millions

The laboratory function, for example, would be a critical function for most hospitals, he points out, because it supports a number of other areas, including inpatient care, surgery, and the emergency department. One of SAIC's roles, Baker says, is to help companies identify and prioritize the various business elements and determine how much each is at risk.

"Instead of saying an application is in good shape, ask whether a business element — meaning a department or a major business process — is in shape," he advises. This prioritization is necessary, he says, because health care organizations are faced with constraints not only in time, but also in resources.

SAIC's largest clients are spending "hundreds of millions" on Y2K remediation efforts, and the smaller ones are spending under $10 million, he says. "I don't know of any that are spending less than a million."

Even so, there is still a fairly prevalent attitude among health care organizations that Y2K is an information technology problem, Baker notes. "It now needs to be treated as a business problem, which it always has been." ■

Need More Information?

Greg Baker, SAIC, 1340 Treat Blvd., Suite 600, Walnut Creek, CA 94596. Telephone: (925) 296-1226.

Will HCFA checks be in mail when year 2000 hits?

Problems likely to impact Medicare, experts say

Reports have been flying out of Washington that the Health Care Financing Administration (HCFA) in Baltimore is woefully unprepared for updating its systems to comply with the year 2000 (Y2K) transition.

Last September, the technology subcommittee of the U.S. House Government Reform and Oversight Committee gave the Department of Health and Human Services an "F" for its efforts to fix the Y2K problem. Then, a report published by the General Accounting Office (GAO) in Washington said HCFA's repairs lag far behind schedule.[1]

"Because of the magnitude of the tasks ahead and the limited time remaining, it is unlikely that all of the Medicare systems will be compliant in time to guarantee uninterrupted benefits and services into the year 2000," the report says.

More than 50 million codes

HCFA, however, is singing a different tune, points out **Glenn M. Pearl**, MHSA, editor of *Rate Controls* newsletter, a statistical and opinion resource for hospital chief financial officers in Phoenix. "[HCFA chief information officer Gary G. Christoph, PhD,] is saying that 95% of code has been revised for external systems — the intermediaries and contractors," Pearl says. HCFA has more than 50 million lines of code to revise in its 99 mission-critical systems.

Christoph even indicated that HCFA is now less inclined to provide additional payments in late 1999 to prevent disruptions in cash flow, Pearl says.

And Joseph Broseker Jr., HCFA's Y2K coordinator, said at the Rx2000 Healthcare Year 2000 Special Interest Group conference, held Feb. 5 in Nashville, TN, that while much work remains, HCFA is moving toward Y2K compliance. To help address the problem, HCFA has increased its financial resources, added independent verification and validation and independent testing, and increased oversight, Broseker said.

"You can see there are divergent views between what Congress is being told and what HCFA is reporting at this point," Pearl adds.

Although Christoph says that HCFA's Y2K compliance efforts are more on schedule than other government sources report, Pearl says, most contingency planning experts say health care financial managers should prepare for all scenarios, including the possibility that HCFA system problems could disrupt cash flow in the year 2000.

Here are some steps hospital financial personnel can take to prepare for a possible disruption in cash flow in the year 2000:

- **Conduct a cash-flow analysis.**

This analysis will help hospital financial personnel know how much cash is needed per day, says **Frank Tucker**, president of Catalina Software in Dana Point, CA.

Next, personnel should estimate how much HCFA might disrupt cash flow if the government interrupts benefits for a period after the turn of the century. Armed with the knowledge of how much cash is needed by their hospitals per day, financial personnel can better estimate how much cash they need to get through that time.

- **Don't neglect any cost centers.**

"You need to make arrangements for every area where cash is needed," Tucker says. "Decide what you are going to do in each area and how you are going to cover the cash-flow disruptions for each."

- **Investigate your state payroll laws.**

Some hospitals may decide to delay the staff payroll for a few days to ease their cash-flow problem. They should consult their legal counsel first because it may result in penalties from the state. "Some states have strict laws on meeting payroll," Tucker says.

- **Keep everyone informed.**

Vendors need to be advised of possible temporary disruptions in cash flow so delivery of goods won't be stopped if payments are late, Tucker says. "Everything should be worked out ahead of time. The sooner and the more you keep people informed of a cash flow problem, the better chance you have of getting through it. If you're not talking to your suppliers and your employees, then real problems may develop."

- **Consider lines of credit.**

Lines of credit from financial institutions can help cover a temporary cash crisis, Tucker says. Given the possibility that a bank also may experience some Y2K difficulty, however, hospitals may want to pursue lines of credit from several different financial institutions.

Hospitals don't have to turn only to outside sources for extra cash. They also can attempt to warehouse cash by reducing receivables, advises

Allan P. DeKaye, MBA, FHFMA, president and CEO of DeKaye Consulting in Oceanside, NY.

"If you start accelerating your work now to get to a lower receivables level, you'll create more cushion, he says. "You don't want to get fatter with your receivables; you want to get leaner. It's like losing weight before you go on a cruise. You take off some weight because you know you're going to gain some on the trip."

Hospitals should start a process of accounts receivable management and reduction, he says. "It's something you should be doing anyway, but people play to averages and don't necessarily try to take receivables down to a much lower level."

To say "60 days in accounts receivable" usually means a payment in 60 days is the average, DeKaye says. "To me that means anywhere from 40 to 80 days. You certainly want to bring down the payer who is paying you in 80 days to your average of 60."

An average of 60 days also is not adequate if creditors are asking for payment in 45 days. "[Hospitals] need to set reasonable targets that should be related both to what is normal for the industry, and to their case mix, and to their budgetary requirements," he explains.

He recommends that providers look at which payer is the most prompt in its payments. "Are you actually getting paid in the minimum amount of time from that payer?" he asks. "For example, Medicare has a two-week holding period. Is Medicare paying you 14 days after you submit a claim?"

Fault HCFA for slow payments

As another example, providers may have a managed care contract that specifies payment in 30 days from the date of "clean claim" — the date a claim is submitted with all the correct information. "If payment is in 40 days, what was wrong with your claim that you didn't get paid in 30 days? If you left off some information, then it's your fault. But if they were slow on the uptake, fault them."

Many providers are content with the amount of time it takes to receive payment, even though it may take longer than the contract states. "Why have a contract then?" DeKaye asks. "You have to know that you're not getting paid when you should. Some providers don't check at all."

Providers can call payers to ask about the payment periods or, better yet, can visit the payers' offices. "Many times providers are not as aggressive [as they could be]," he says. "[They can say], 'I'm coming to your office and would like a check ready for me for the claims I have sent you.' Or, 'I am coming to your office and want to review the accounts not being paid. If you don't pay me, you're going to be in default of your contract.'"

Most providers, though, aren't that aggressive because they fear losing the contract, DeKaye says. "This may mean there should be more safeguards, such as performance guarantees, in the contract. People shouldn't use Y2K as a reason to lower their investment in receivables. They should lower their investment in receivables because it is good business sense."

Reference

1. General Accounting Office. *Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy*. GAO / AIMD-98-284. Washington, DC; September 1998. ■

If the OIG makes a visit, don't be caught off-guard

Subpoenas can be settled sans penalty, expert says

What will you do if representatives from the federal Office of the Inspector General (OIG) come to your hospital seeking information? Will you start crying, call your attorney, or refuse to talk?

Claudia Jones, access manager at Scripps Memorial Hospital in Chula Vista, CA, faced just that dilemma recently when the OIG contacted her hospital's health information management (HIM) department and asked for the medical record of a specific behavioral health patient. The OIG visit apparently was part of an audit of patients who had received outpatient care for behavioral health problems.

Jones says she later learned that another of ScrippsHealth's six hospitals was contacted. That hospital was asked for four records, while her facility had just one record request, she adds. Other facilities throughout San Diego County also got visits.

"My first reaction was fear," says Jones, who was serving as acting HIM director. "What was freaky for me was that I don't know anything about behavioral health records. They have

different requirements than regular medical records. I wanted to make sure all my billing dates matched up with physician or therapist documentation."

During the visit to Scripps Memorial, she says, the OIG representative, who was accompanied by another government official, sat in a closed office. The OIG representative gave her his business card and a copy of the federal regulation giving him the authority to view the record, Jones adds.

"If it happened again, I would also get a signed authorization," she says. "There is a regulation that states we must give them the chance to view and get a copy of the record, but for my own protection, I would get [the representative's] badge number and have him sign a standard release and keep a copy of that with the record."

The OIG representative requested a roster of all the hospital's physicians and a document from the medical staff office, to check a physician's signature against the record, Jones recalls. He also asked for the UB-92 form for the account in question, she notes.

The visit occurred around the first of February, she says, and there's been no further word on the investigation. "I couldn't even guesstimate when we'll hear back from them. They did say these [investigations] were going to become more frequent."

Don't fear 'simple errors'

Despite the new climate of investigation and the initial panic it sparked, health care managers shouldn't be afraid of penalties for making a simple error, says **Melissa Ferron**, principal of Melissa Ferron Healthcare Consulting in Redondo Beach, CA. "For the most part, hospitals are doing the right thing," she says.

"Be afraid if you discover upcoding to game the system for additional reimbursement," she cautions. "The recent OIG investigations are a warning to everyone that your staff needs to be educated on how important it is to be error-free and to follow official guidelines.

"None of the hospitals I've been through an investigation with are nervous about having to shut their doors," Ferron says. "Even those who have paid back a lot of money don't feel their doors will be closed."

She says she has helped clients through a couple of different fraud and abuse investigations in Southern California, including one targeted at

Search Warrant Checklist

Health care providers faced with a search warrant as part of a federal fraud and abuse investigation may want to consider the following steps, suggested by attorneys with the law firm of Davis Wright Tremaine in Seattle:

- ❑ Find the person in charge of executing the warrant and ask to see identification.
- ❑ Have a responsible manager ask for a copy of the warrant and read it carefully. Also, ask for a copy of any affidavit submitted to a court or other body to obtain the warrant.
- ❑ Call the hospital's attorney and provide the time the warrant was served, the law enforcement and regulatory agencies involved, the areas to be searched, and the types of evidence to be seized.
- ❑ Be businesslike and courteous, but do not volunteer information.
- ❑ Consider sending all non-essential employees home until the search is completed.
- ❑ Designate one employee to deal with the agents executing the search warrant and to take notes during the search.
- ❑ Closely monitor the search, but do not interfere with it.
- ❑ If the persons executing the warrant seize privileged documents, advise them that the documents are privileged. Request that they be sealed in an envelope and segregated from the other items seized until counsel can seek their return.
- ❑ Take careful notes of the type and location of the evidence seized, including any documents, computer records, photographs, videotapes, and audio recordings.
- ❑ Advise employees not to interfere with the search.
- ❑ Advise employees of their rights regarding questioning by government investigators, including the following:
  - Employees have the right not to talk.
  - Employees have the right to have an attorney present.
  - Employees have the right to have a representative of the hospital present.
- ❑ Obtain a detailed receipt of all of the evidence seized.
- ❑ Ask for the opportunity to copy all documents or other records seized.
- ❑ Advise employees not to discuss the search or any related events with the press.

diagnosis-related group (DRG) miscoding. That investigation, which began more than 18 months ago, looked specifically at 482.89, the code for bacterial pneumonia, when it is used instead of the lower-weighted code 486, which is for unspecified pneumonia, she explains.

California was one of 12 states chosen for the investigation, she says. "Apparently, the national average for coding 482.89 is 3% of all pneumonia cases. Hospitals deviating from this average are the facilities that are being subjected to the investigation."

Includes additional documents

The subpoenas served as part of the investigation requested not only copies of medical records, which numbered in the hundreds, but also outlined an assortment of additional documents, Ferron notes. "The list of medical records comes with admission and discharge dates and HIC number. That's it — no names. And the records date back to October 1992, which was when the code 482.89 first came into use."

The documents requested for each case included, in part, "the patient's admission report, discharge summary, physician notes and orders, lab reports, culture reports, and any other documents used by the hospital billing department to determine the appropriate diagnostic and DRG billing codes," she adds, quoting from the extensive list accompanying the subpoenas.

The subpoenas also asked for, from January 1991 to the present, all organizational charts for the billing department and all documents containing job descriptions or detailing the responsibilities for each employee involved in billing and/or coding, Ferron says.

Requesting a plethora of paper

In one lengthy paragraph, the subpoena requests, among other items, "reports, correspondence, notes, memoranda, guidelines, directives, training materials, minutes of meetings, analyses, audits, manuals, policies, calendars, working papers, contracts with consultants, charts, graphs, drawings, electronic mail, voice mail message recordings, facsimiles, telegrams, videotapes . . . relating to the hospital's billing and/or coding of Medicare claims for the treatment of patients with pneumonia."

Hospitals were given a month to gather the information and provide it to the OIG, Ferron says. "You do the best you can and hope you gave them everything."

One hospital, she recalls, had used an outside consultant for coding, and the company had since become defunct. "Nobody can find them, but the hospital still may be ultimately responsible."

In some cases, she says, the hospitals involved conducted internal audits to assess their liability and paid back the money owed. "It may be possible to settle with the subpoenas without penalty."

The government has designated California Medical Review Inc., the peer review organization (PRO) for California, to identify and reduce errors in Medicare inpatient claims. That may include auditing registration and discharge processes, billing, and coding at the hospitals the PRO oversees, Ferron points out.

An increased effort at reducing errors has made government officials realize just how complex coding is, she suggests. "The government wants the PRO to look for a pattern of upcoding on a more concurrent basis. Charts will be requested and reviewed, and statistical analysis may be performed to identify facilities falling outside the norm."

Turn it in on time

For a health care organization served with a subpoena that requests medical records or other documents, Ferron says, her first piece of advice is to get the material to the specified address on time.

"You're normally given a time limit, and you need to be pretty well-organized to meet it," she explains. "It's best to identify one person to send it all out, whether the material is from the business office or from medical records. This can be the risk manager, the compliance officer, the health information manager, or the business manager. Don't have too many hands stirring the pot." ■

Need More Information?

Melissa Ferron, Melissa Ferron Healthcare Consulting, 2211 Pullman Lane, Redondo Beach, CA 90278. Telephone: (310) 937-6999. E-mail: SMFerron @mail.telis.org.

Managers seek relief from new HMO headaches

Identifying the right plan poses challenge

Just when access managers thought Medicare and Medicaid regulations couldn't get any more troublesome, they were faced with a new twist — working with the Medicare or Medicaid patient in a managed care plan.

As more and more seniors select Medicare HMOs and states seek to increase Medicaid managed care as a cost-saving measure, registrars face several potential headaches at the point of service.

Although MeritCare Health System in Fargo, ND, doesn't deal with managed care for its own state's Medicare and Medicaid beneficiaries, it gets its share from a neighboring state, says **Karen Duffy**, MS, manager of patient services. "We are a border city, and we get lots of Minnesota Medicaid patients. They're almost all in a managed care plan, and the problem is determining exactly which plan."

"You almost have to verify . . . coverage on every visit, so it's very time-intensive."

Most patients aren't used to having regular health insurance and are unfamiliar with the practice of showing a card when they receive health care services, she notes. In some cases, patients don't even know what plan they chose. "We end up doing education for the state of Minnesota."

If the registrar is able to identify the managed care plan but discovers that the patient is out of network, there's a new challenge, she points out. "Those patients are required to sign a form saying they're responsible for paying the bill themselves. But if they're on medical assistance, they probably don't have the money to pay. We know that even if they sign it, you can't get blood out of a turnip."

The registrar is faced with tactfully suggesting that the patient wait to get a referral or seek care at an in-plan facility, Duffy says. "If we choose to see these patients, it's free care. We can't bill them unless they sign, but what is the agreement worth if they don't have money?"

At Burdin Riehl Ambulatory Care Center, part of Lafayette (LA) General Medical Center (LGMC), the challenge also lies in identifying the Medicaid or Medicare patient as a true HMO member, says **Jeri Pack**, admissions/diagnostics manager.

"Another kicker is that they can move in and out of that HMO on a monthly basis," she notes. "You almost have to verify their coverage on every visit, so it's very time-intensive."

In fact, a state requirement — effective in July 1998 — that Medicaid eligibility must be checked on every visit prompted some technology solutions that are helping her staff get a handle on the problem. "Starting last summer, no longer did [Medicaid beneficiaries] have a paper verification card issued monthly by family," she explains. "Each individual was issued a plastic ID card that is good indefinitely, but we have to check eligibility on every visit."

Because it wasn't feasible for registrars to stay on the phone, checking eligibility for every patient at the point of service, the decision was made to purchase Medifax on-line verification software from the Potomac Group in Nashville, TN, Pack says. "The software is being interfaced with our HBOC patient registration system by our information management technology systems department." HBOC software is manufactured by HBO and Company in Atlanta.

Automatic inquiries made

Once the system is operational, Pack says, there will be a pop-up screen on every registrar's computer on which the patient's social security number or name and birth date can be entered. As the registration proceeds, the Medifax system will make an automatic electronic inquiry to the appropriate fiscal intermediary or payer.

"The information [on eligibility] will come back and populate the screen," Pack says. "[The registrar] doesn't have to leave the computer, doesn't have to place a call, doesn't have to leave the registration."

There's some time-consuming preparation required, however, before the automated system will be functional, she says. In addition to the interface with the HBOC system, preparation includes installation of a value-added network (VAN) line and construction of a firewall to protect the VAN line. To handle the Medicaid requirement in the interim, LGMC purchased some Medifax point-of-service verification machines.

Using those machines, which are placed in key registration areas, registrars swipe the patient's card and get a printout that verifies Medicaid

Need More Information?

Jeri Pack, Burdin Riehl Ambulatory Care Center of LGMC, 1211 Coolidge St., Lafayette, LA 70503. Telephone: (318) 289-8299.

coverage, Pack says. Just recently, it became possible to access the Medicare intermediary through this system, as well as three commercial payers.

Because of the time it takes to swipe the card and get the printout, and because she can afford to have the machines only in major locations, Pack says she is hopeful the on-line system will be up and running by late spring or early summer of 1999. Negotiations are under way to bring other payers, besides Medicare and Medicaid, into the on-line system.

"Ultimately, my goal is to have as many payers as possible able to be verified by this method," she says. "It's the most productive and most accurate and most timely system."

(Editor's note: Next month's issue of Hospital Access Management *will explore the comprehensive continuous quality improvement program, focusing on access services, developed by LGMC.)* ■

Laying groundwork crucial to electronic verification

Bringing local carriers on-line is one step

As hospitals continue to push business operations to the front end, access managers seek new forms of technology to help them deal effectively with the additional functions and responsibility that move entails.

Automated electronic verification of patients' insurance benefits is coming to the fore in recent months as one time-saving solution for overburdened access departments. An increasing number of software vendors are offering a way to do more work with less staff while speeding up the reimbursement process.

But as the vendors come in to show their electronic verification wares, it's important to be aware of the preparation necessary before such a system is up and running, says **Joseph Denney**, CHAM, lead for the patient management system implementation at The Ohio State University (OSU) Medical Center in Columbus.

"There are several things that should happen simultaneously," Denney says. His hospital is in the midst of bringing up a new patient management and accounting system as well as a new clinical system, and will follow that with the installation of an electronic verification system from Healthcare Data Exchange (HDX) in Malvern, PA.

"When the [software] vendors come in, if they don't already have clients in your area, there is lots of groundwork to be laid," he points out. "They might say they have national carriers such as Travelers and Aetna on board and some sort of deal with Medicare, but how about — in our case — the Ohio Department of Human Services? That vendor has no access to Ohio Medicaid right now, so a deal needs to be worked out with them."

Major local insurance carriers likely would not be part of the software company's national system, he says. "The carrier that handles all of our insurance for OSU, for example, is a local company that does not have a contract with HDX. But because this company covers all of the OSU employees and their beneficiaries, it's a significant amount of our business. If those employees choose the PPO [preferred provider organization] product, they have to come to us for health care services."

If vendors such as HDX can't work out such issues, they can't continue to sell their product, he says. And it's to the local insurance company's advantage to cooperate. "They've said, 'We would much rather not get that telephone call [asking for manual verification] that you don't want to make,'" Denney says.

Such cooperation notwithstanding, the parties still must come to the table to negotiate the details, he says. "The carrier could have some financial outlay upfront, but in the long term, that could be offset with savings in employee time. [The hospital] is a third party in laying the groundwork. It is to our benefit to see that it occurs, so if a middle man is needed to get these groups to the table, we need to do it."

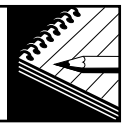
Another factor to be considered, he says, is whatever modification might be required of the patient management (registration) system. "We set up the patient management system at the model level, what routinely would be installed at other institutions," he explains. "That means our insurance screens are at a certain point in the registration pathway when it would be too late to enter data into the system and get it back before the registration is finished."

That means, Denney adds, that hospital programmers must make changes in where those screens lie, to put them near the front of the pathway. When those changes are made and the system is in place, there will be an interface with HDX that is totally non-viewable to the registrar, he explains. "The registrar doesn't have to enter additional information, execute a special command, or enter another screen to initiate the verification process. It's seamless and can be built into the pathway."

Besides performing this function during the actual registration process, patient access services personnel also place precertification telephone calls for elective admissions and surgery cases following the manual calls to obtain insurance verification, he says. "The new system will eliminate one whole step of this process, too."

Denney estimates that OSU's insurance verification system will go on-line sometime after Jan. 1, 2000, because of the priorities of year 2000 testing. For those considering such a system, he emphasizes the importance of advance planning: "Don't let it get too many months down the road before you start doing some of these things." ■

GUEST COLUMN



MSDS software makes data accurate, accessible

By **James Runde**, President
ImageTrak Software Inc.
Greenville, SC

Providing on-demand access to Material Safety Data Sheets (MSDS) for personnel safety, regulation compliance, and environmental protecting is undeniably important. However, lack of a universal form for MSDS records and numerous suppliers providing volumes of information has challenged records managers to provide a cost-effective updating, storage, and retrieval solution.

Prior to MSDS software solutions, companies re-keyed data or relied on paper-based archives. Complicating the issue for MSDS records managers is the requirement from departmental users of controlled substances to have efficient access to reliable MSDS data, while the central office is assured of accurate data with audit trail accountability.

Many employees are not familiar with document maintenance procedures, and it can be counterproductive to try and deal with paper duplication, out-of-date information, obsolescence, and new document requests.

The number of MSDS documents and the number of employees who need access to the data can be daunting and time-consuming. The federal Occupational Safety and Health Administration's 30-year archival record-keeping requirement warrants a more sophisticated MSDS tracking and storage system. Centralized control of the information is essential. Consolidated information increases productivity by allowing centralized updating, duplication, and maintenance of MSDS records.

About three years ago, a 1,500-bed medical center in Illinois started an evaluation of MSDS software solutions. Prior to its evaluation, management at the medical center discovered MSDS information was not readily adaptable to spreadsheets, databases, or word-processing solutions. Generic solutions with over-the-counter software programs have shortcomings that prevent them from dealing practically with all the MSDS requirements. Limitations include data entry and data access.

Whether the full text is being entered or information is being adjusted to fit in a database, manual entry is required. Manual entry increases administrative time and the likelihood of operator error. When text is excerpted, reworded, or manipulated to fit into a traditional database format, the transcription process can make it useless or even harmful if the original meaning is changed.

During the evaluation process, the hospital underwent an accreditation review. "The Joint Commission of Accreditation of Healthcare Organizations [JCAHO] inspects our hospital every two to three years," says the hospital's plant service supervisor. "The commission reviews every aspect of the hospital, including the availability of MSDS records. The faster the MSDS records are located, the better."

A problem occurred for the hospital during the review inspection. "A doctor, who was working on a project, moved a lab chemical into surgery," the supervisor explains. "The lab chemical was selected by the JCAHO, and surgery did not have the MSDS report for that chemical. Eventually,

Need More Information?

James Runde, ImageTrak Software Inc., P.O. Box 26106, Greenville, SC 29616. Telephone: (800) 446-7089. Fax: (864) 370-3405.

the report was found, and the hospital easily passed the review. However, the incident underscored our need to find a centralized software solution for our MSDS reports, and we sped up the evaluation process."

The hospital studied five MSDS software solutions over a 12-month period. They were looking for one that centralized the information and was easy to use. MSDS ExPress was selected because of its functionality. MSDS forms can be inserted into the database digitally from CDs, diskettes, bulletin boards, the Internet, or by scanning.

MSDS ExPress enables users to enter an unlimited number of MSDS documents, tag them with custom information, and adapt the database to fit future needs. Users are capable of searching for documents by a specific compound, products by percentage of a given compound, record identification number, distributor source, product location, or by a custom tag that is entered.

Recently, hospital personnel were performing routine maintenance on its computer system, when the data files for MSDS ExPress were mistakenly erased. The hospital lost more than 1,300 MSDS records that almost 800 employees in 50 different departments needed access to. The responsibility of rebuilding the entire database fell upon the plant supervisor.

"With MSDS ExPress software, we simply scanned all the documents into the system," she says. "All work, with the exception of emergencies, was put on hold while the scanning took place. Rebuilding the entire database took only 157 hours over a 12-day period. Without MSDS ExPress, the rebuilding would have taken exponentially longer."

Scanning documents into a high-resolution image file with a flatbed scanner dramatically reduces the time for the data entry and eliminates keyboarding errors. Scans are quick and require only basic clerical skills. Two problems immediately arise with any imaged-based program. First, for clarity, a relatively high-resolution scan is required. This consumes a relatively large amount of storage space compared to text-based programs. Second, the data-compression technology needed to overcome the space problem must be reliable.

These issues can be overcome with current technology gains. The availability of high-speed Pentium-based personal computers enables fast decompression of high-resolution scans. The user is able to view a clear image of the document on the screen, print a legible document, and the entire process is invisible to the user. The advent of inexpensive high-capacity disk storage makes the issue of large files moot.

"With the MSDS ExPress database rebuilt, the time necessary to update the system is minimal," the supervisor says. "Typically, only five MSDS reports require updating a week."

The hospital prints all applicable MSDS reports for each department on a quarterly basis. This ensures employees have up-to-date information on all chemicals that are used. The long-term plan is to put MSDS ExPress on the hospital network, allowing users to access information directly

Hospital Access Management (ISSN 1079-0365) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Access Management**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $200 per year; 10 to 20 additional copies, $120 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

Editor: **Lila Margaret Moore,** (404) 636-9264.
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com).
Managing Editor: **Kevin New**, (404) 262-5467, (kevin.new@medec.com).
Production Editor: **Terri McIntosh**.

Editorial Questions

For questions or comments, call **Kevin New** at (404) 262-5467.

from a computer terminal, thus eliminating the need for printing 50 department reports.

"The ease of entering records and the speed with which MSDS ExPress locates reports will be useful when accreditation time rolls around later this year," explains the supervisor. "We went through a mock review in early 1999 that went real well, and we expect our accreditation to go smoothly. If we have a problem similar to the one that occurred during our last audit, we will be able to locate the MSDS record in a matter of minutes."

The benefits of a centralized MSDS scanning software system are numerous. Information is scanned into the system, reducing the probability of operator error and saving time by eliminating data entry. Duplicate forms are unnecessary when the information is held at one central location, and searching for the documents is easier, faster, and increases the company's productivity. ■

ACCESS FEEDBACK

AM wants more than orientation 'checklist'

Jayne Flores, admissions manager at Mission Hospital Regional Medical Center in Mission Viejo, CA, is looking for colleagues who have put together a comprehensive orientation for admitting representatives.

"I've gotten some examples of clinical orientations for registered nurses in the emergency department and for triage nurses, but I don't know of anyone who has a clerical one," she says. The most common orientation method for admitting reps, she adds, is to say, "Here's a checklist. Learn this."

"I have a checklist now, but it's not involved enough and doesn't take employees away from the work setting. [Experienced employees] try to train while doing their own job," she explains.

Flores says she has in mind a more detailed program, about three weeks in length, in which specific skills would be covered each day.

"Day one, there would be these jobs to learn, and on day two, something else," she explains. "The second week might cover forms or different ways of admitting patients. The third week, there would be a review of everything and a competency test. If some employees need more help, we would see that and give them more attention."

Quarterly competency examinations would be given on an ongoing basis for both new and veteran employees, she adds.

Also on the wish list is a training and development person who would perform quality assurance on finished products to make sure accounts are worthy of billing, Flores says. "That person would meet one-on-one with employees. There's more self-esteem and pride when you're told one-on-one what needs to be done."

A hospitalwide preceptor program being developed by the education department will provide some help for her department, Flores notes. Meanwhile, she'd like to see some examples of an orientation program to provide guidance as she designs her own.

[Editor's note: If you have an admissions orientation program to share with Flores, please call Lila Moore at (520) 299-8730 or send e-mail responses to lilamoore@mindspring.com. Flores can be reached at Mission Hospital Regional Medical Center, 2700 Medical Center Road, Mission Viejo, CA 92691. Telephone: (949) 365-2118. Fax: (949) 365-2334.] ■