AMERICAN HEALTH CONSULTANTS®

HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

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Now hiring: Industry scrambles to fill critical positions despite competition

Shortfall of IT workers reaching at least 100,000 per year

Unless your facility has a large information technology (IT) budget and is located in an attractive part of the country, you're probably struggling to fill your IT and health information management positions. What's more, the problem may get even worse.

"It is becoming more difficult to fill IT positions for a couple of reasons," says **Kirsten Bardeen**, an executive recruiter for Snelling Executive in Altamonte Springs, FL. Snelling focuses on filling IT positions from the programmer to the CIO level.

"A lot of [facilities] are trying to retain their employees during the year 2000 (Y2K) challenge. Information technology people across the nation are also not entering the marketplace as much as they are needed. There is a shortfall of at least 100,000 people every year based on information that we have from 1998," explains Bardeen.

Although meeting the Y2K challenge has been a catalyst for staffing problems, the primary issue is the industry's rate of change, says **Sandra R. Fuller**, MA, RRA, vice president of practice leadership for the American Health Information Management Association in Chicago. "Employees may have been qualified and good workers and well-skilled five years ago, but unless they personally [have had more training] or their employer has done something to keep their skills current, they're not going to be very valuable now. That's a remarkable rate of change if you think about other professions, other types of jobs. It is a unique environment."

The rate of change might keep some people from entering the IT field, Fuller says. "There is probably some hesitancy on their part to invest a lot of time into a field where the rate of change is so great."

Not only do health care facilities have to deal with a shortfall of IT workers, but they have to compete with other industries for them. "The unique thing about IT professionals, in particular, is that they can work in other industries. You're not just competing in the health care industry," she says.

For example, health care facilities in Seattle must compete for IT

employees with such companies as Microsoft, which can offer its employees stock options.

Although facilities don't have to compete with corporations such as Microsoft for health information management professionals, they are struggling with meeting this demand, too. "The demand keeps increasing and is at fevered pitch right now between the spread of prospective payment and all of the different delivery mechanisms, which require more coding," Fuller explains.

The number of two-year technical programs training these professionals are growing, but health care facilities must increase the pay scale of these positions — which have not been historically well-paid — to attract more employees.

Right now, health information management professionals also must endure pressure to produce a lot of work combined with the issues of compliance. "You are increasing the level of demand on accuracy and individual accountability. That's having a fair amount to do with the shortage," Fuller says.

How do you compete?

To compete for these scarce workers, health care facilities first and foremost must be competitive in the salaries they offer, Fuller says.

Employers also must take responsibility for training their employees. Many facilities are sending employees to school to keep their skills current, such as getting Microsoft or UNIX certifications. The institutions are paying for the training and allowing employees to train on company time. "Facilities are trying to invest in their employees' skills," adds Fuller.

Training goes hand-in-hand with another recommendation from Fuller, which is to match employees' skills to the job. "That is critical — set up people to succeed rather than to fail," she says. "We believe that to be successful, an organization ought to appropriately use a blend of both the skills of an information technician and of an information manager." For example, don't assign a person interested in working with computer technology to work with information management, such as systems analysis and implementation. "They are not going to be as successful nor as happy, and you probably are wasting a resource that's in short demand."

Often the success of matching employees with positions involves finding out what employees want to achieve next and training them to meet that goal.

"I don't think that [employers] in the past have done a good job of asking what employees want to do next and then trying to position them for that job. I see some of the more successful facilities doing that, taking a longer-term view of keeping employees trained." Management also needs to be aware of the kind of computing environment it is providing employees, Fuller says.

The working environment of the entire facility should be considered when hiring new IT employees, Bardeen says. Employees in smaller, rural facilities, for example, may be required to do a variety of different tasks. "You have to find a person who thrives on that challenge and who wants to cut his or her teeth on it."

A good match of employee to position may be short-circuited, though, by a lack of flexibility in working conditions. "Health care is going to have to address [workplace] flexibility," Fuller says. Flexibility issues include telecommuting and the availability of working different hours.

"A lot of places routinely expect huge amounts of overtime and for employees to be married to their jobs," she says. "You can do that for a short period of time, but over the long haul, it's not a successful strategy. Employees burn out; you need to find a better staffing plan."

Managers also should think about what their staffing needs will be after the Y2K frenzy is over. "I think there will be a lot of shifting [in workload] sometime in the second quarter of next year," Fuller says. "That will be an opportunity to hire some employees."

COMING IN FUTURE MONTHS

- The concern over electronic signatures
- Meet the challenges in multicampus HIM coordination
- How one hospital handled an unexpected power outage
- Two hospitals re-evaluate their staffing strategies
- The questions of billing for observation status

IT employees will be needed to take on other jobs to get back to regular business. "Anticipate what kind of skills you'll need and what kind of work you will have later next year at this time," Fuller says. Now is the time to learn what employees want to do next year and how prepared they are to do it, she adds. "Maybe you can't send them off to school right now or before the end of the year, but you can start to investigate your options."

And don't forget to tell employees that you have a post-Y2K plan and that they are a part of it. "Frequently, employees are frustrated with not knowing what is happening," Fuller says. ■

Inaccurate dictation gives providers headaches

Education helps improve patient documentation

Maybe the physician knew what he meant when he dictated this sentence: "Patient is a 26-year-old mother of seven who apparently was in the operating room for some reason, but fell asleep when it was discovered that she was pregnant at another hospital."

This may be amusing to some, but would you laugh it if were in a family member's chart? Would you be amused if the confusion delayed your reimbursement?

Unfortunately, the problem of incomplete or inaccurate dictation is not uncommon, says **George Heymont**, managing partner of Alert & Oriented Medical Transcription Services in San Francisco. Some physicians often don't make sense in their dictation. "They are either distracted or tired or not paying attention," he adds.

Some common transcription problems include:

✔ wrong dates;

✔ wrong lab figures;

✔ medication names that don't exist;

✔ incomplete contact information, such as a letter addressed to Dr. Smith in Pennsylvania;

✔ muffled dictation, often the result of a physician eating while dictating or trying to dictate on a cell phone;

✔ random substitution of the words left and right to indicate the location of a procedure.

For example, a physician operates on a patient's left leg. "All the way through the dictation the physician says the left leg. Suddenly he starts saying he is operating on the right leg," he says. "Sometimes the physician even changes the location of the operation in every sentence."

Other common dictation problems include:

✔ **Switching gender-specific pronouns.**

This can be a problem for doctors who are using English as a second or third language. A Chinese physician, for example, may be thinking in Chinese while trying to speak in English. "Because he is thinking in Chinese, he is not using gender-specific pronouns," notes Heymont. As a result, the notes may state that a 58-year-old man is having a hysterectomy.

✔ **Omitting gender-specific pronouns on patients whose names do not indicate a gender.**

Although dictation errors mostly involve physicians not including the information needed to support a particular diagnosis and level of reimbursement, the problem can involve the inclusion of too much material in the record, as well.

"Some doctors document too much," says **Catherine Baxter**, vice president for encryption re-engineering services for Diskriter in Pittsburgh. "They dictate far more than is required. They bury the important information."

Aiding and abetting

Perhaps part of the blame can be placed on the system. Many physicians used to rely on one or two transcriptionists who knew the patients and the physicians' idiosyncrasies. But times have changed.

"Many physicians have sloppy [documentation] habits, and they have always depended on everyone to pick up after them," Heymont says. The problem is exacerbated when physicians sign off on reports without reading them.

The facilities with the highest occurrence of incomplete or inaccurate dictation are those that are afraid to confront the guilty physicians. "No one wants to tell the doctor he made a mistake," he says. "There is a lot of denial."

Third-party companies that handle outsourced transcription also may be afraid to ruffle the feathers of a client and possibly lose the account. But if the Health Care Financing Administration (HCFA) in Baltimore kicks back the record for incomplete documentation, the responsibility begins and ends with the health care facility — not the physician or third-party company.

"When you outsource the function, you can outsource the task but you cannot outsource the responsibility or the quality of that task," Baxter

says. "Ultimately, the facility is still responsible for the quality of that work. It's often the case that not all the work comes back in excellent quality."

Some third-party transcriptionists, however, don't hesitate to send records back to physicians with blanks in areas where they couldn't understand what the doctor was trying to say.

"Then we have to take that report back to the doctor and ask for his or her help to fill in the blanks. If physicians have to do that often, some of them will often slow down and take the time to try to get it right the first time," says **Mary Brandt**, MBA, RRA, CHE. Brandt is vice president for professional services in the health information solutions division for QuadraMed Corp., a health care information technology company based in Richmond, CA.

She says she often finds when a facility chooses to outsource, it outsources everything. "It does not maintain a qualified medical transcriptionist to do [quality assurance]. It may have a clerk or someone like that to look over the reports."

That is not an acceptable alternative, she adds. "There are some valid reasons why you can't complete a report. You should have a quality assurance person in place to review the records."

Looking for solutions

Some industry associations say they are hoping formalizing standards for transcription will help increase record accuracy. Heymont doesn't agree. "You are not necessarily getting [the dictation] right and you are still not solving the problem, which is teaching doctors to communicate."

Heymont, who recommends the book *Dictation Therapy for Doctors*, suggests requiring physicians to take a certain amount of continuing medical education on how to properly create documentation. He also suggests doctors keep their certificate of completion on file with the medical records director of any hospital where they have admission privileges.

The cost of inaccurate or incomplete records is increasing every day. If hospitals don't have the right documentation and the right elements in that documentation before the codes are applied to patient visits, two things could happen, Baxter says:

✔ Hospitals will experience delays in reimbursement.

✔ HCFA will challenge the level of coding facilities assign.

"They'll either have to respond with more documentation, which is going back to the doctor for additional clarification, again delaying the reimbursement," she explains, "or [HCFA will tell them], 'This is not clear, and we're not going to pay that much.' The primary reason for this is a failure to document what's necessary and in a proper format that can be readily understood and found within the documentation."

Both Baxter and Brandt emphasize physician education as one part of the solution. Diskriter's director of education and training, for example, will be working with corporate compliance officers to develop a program that will help instruct the physician on what to document and what to delete.

Facilities also can educate physicians about the liability that they have if their dictation is inaccurate or incomplete, Brandt says. "Hospitals that are having a significant problem with that might consider bringing in an attorney or an expert to do a seminar for the medical staff about liability issues involved in documentation. Physicians do care about liability, and they do care about patient care."

Giving physicians guidelines for dictation can be helpful, too, she adds. For example, some hospitals give physicians handouts for what should be included in a history and physical, a discharge summary, a consult, and an operative report. "Some hospitals even make small laminated wallet-sized cards that physicians can carry with them and refer to."

Physicians also are taking more notice when they are penalized for records that have faulty documentation. "The only way to wake them up is to hit them in the pocketbook," Heymont says.

Peer pressure works, too, Brandt says. Records from physicians who routinely document next to nothing or make statements that are possibly inaccurate should be reviewed and taken to a committee of peers. "For example, if you have someone in surgery who never dictates what he or she should in an operative report, then I would suggest reviewing those records and taking them to the surgery service and asking if this is acceptable documentation for this service. Generally the service chief will say no.

"Then the service chief can take action with that particular physician. That is usually more effective since it's physician to physician," she says.

(Editor's note: For more information, contact: Alert & Oriented Medical Transcription Services, San Francisco by e-mail: www.wwma.com/alert.html.) ■

Will Y2K testing save your equipment or destroy it?

Some experts advise you not to test most items

If you test your equipment and information systems to ensure they are year 2000 (Y2K) compatible, will it give you peace of mind or drive you to the brink of mental breakdown?

One hospital tried to test an entire OR and ambulatory surgery center by shutting it down on a Friday night, says **William McDonough**, MPAH, ARM, FASHRM, vice president and national health care risk management practice leader for Johnson & Higgins National Health Group in Boston. The tests went fine over the weekend, and it opened for business on Monday morning. However, an infection control nurse did a routine check and found a significant number of insects and mold in the OR.

The problem? The hospital had shut down the heating and air conditioning system during the test, and the normally stable OR temperatures fluctuated. "They had to close the OR and ambulatory surgery center for nine days, and their CEO was very upset," McDonough says. The hospital learned its lesson the hard way: "Always include the infection control nurse in plans like this," McDonough says. "It's an example of how far reaching the Y2K problem can be."

The potential exists for broad consequences from Y2K testing, warns **Tony Montagnolo**, vice president for technology planning at ECRI, a nonprofit research agency providing information and technical assistance to the health care community, based in Plymouth Meeting, PA.

"What I suggest is to have a year 2000 committee with risk management, biomedical engineering, operational people, and clinical people," he says. "Do some broad-based communication with any staff who might be around that particular device or area so you can become aware of any 'downstream' consequences."

Some same-day surgery managers want to test all of their equipment, even if they've received compliance information from the manufacturers. Others are testing only when they can't obtain the compliance information or when they think the compliance information is inadequate. Which procedure is correct?

Consider these suggestions from experts:

❒ **Consider not testing.**

"From our perspective, we've not advocated strongly user testing for year 2000," Montagnolo says.

The reason? Testing may take time and money away from other higher Y2K priorities, such as obtaining compliance information and developing contingency plans, ECRI says in its position statement.

And here's some additional reasons: The basic type of Y2K testing — a date roll-up — isn't likely to detect subtle problems that might occur only under certain circumstances, such as logging an error code, ECRI maintains. More detailed tests may be beyond your program's capability, the agency advises.

You might need specialized test procedures from the manufacturers, but they may be unwilling to supply these procedures. If the manufacturer does the testing, they might charge you, ECRI warns. Some manufacturers prohibit testing of their products, so you could void the warranty if you do so, the agency advises. You also risk damaging the device if you test it, ECRI says.

ECRI suggests you obtain advice from several sources, including legal advisors, risk managers, clinical engineers, information systems staff, key clinicians, and top administrators before making a decision about whether to test. **(See related story, p. 70.)**

Consider testing in these situations

Testing may be appropriate under certain circumstances, ECRI maintains. For example, when devices are interfaced as a system, they may not be Y2K compliant, even if the devices are compliant individually. In same-day surgery, an example of an interfaced device would be a video colonoscope interfaced to a video processor and monitor. Input and output date formats may differ, so obtain this information from the manufacturer, ECRI suggests. If the formats are different, test the devices as a system, the agency adds.

Also, if you don't have good compliance information from the manufacturer, consider testing, Montagnolo advises. "Clearly, if you do testing, check with the manufacturer and find out if you do what you plan to do, is there the potential for

Health system decides to test everything

At least one health care system isn't taking the manufacturer's word for it when it comes to the year 2000 (Y2K) compatibility of its equipment.

The legal department for Catholic Healthcare West, a San Francisco-based system of 46 acute care facilities, says all critical medical devices should be tested. Period.

Jack Beebe is director of medical devices and facility control equipment at Catholic Healthcare West Year 2000, a project management office set up to address Y2K issues.

"If you look at the information provided by most of the manufacturers, on their Web sites or to the FDA, they tell you device is compliant or noncompliant, or it's compliant with minor implications or effects," Beebe says. "There's no description of minor effects."

Beebe's office has tested more than 15,000 devices, and he says 2,700 are at risk. For example, one sterilizer manufacturer states all its equipment is Y2K-compliant. However, there is a problem with the load record that prints at the end of every sterilization cycle. That record must be kept for accreditation and infection control purposes.

"That date and time will be incorrect after year 2000," Beebe says. "We're going to have to make a manual intervention and new policy, and probably have two people sign off on the correct date on load records. This is one of those things: It doesn't affect the functionality of the sterilizer, but it does affect the people that run it."

He offers this additional piece of advice: Make sure you check the backup batteries on medical devices. "We've found thousands of devices in which backup batteries are dead."

Backup batteries frequently have not been replaced on a regular schedule, Beebe explains. "The date and time are incorrect because of the lack of a backup battery." ■

a problem," he emphasizes.

Don't test devices connected to patients, he advises. "That seems obvious, but with things being networked, you may not realize it."

Be wary about outside testing. Companies will claim high degrees of failures after they perform testing, Montagnolo says. "Often what they've done is found problems that manufacturers already have found."

Some groups, including the Health Care Financing Administration (HCFA), suggest that your shouldn't rely on someone else's word when it comes to Y2K testing. On Jan. 12, HCFA sent a letter with the following advice: "Do not assume that a system or a program is Y2K ready just because someone said it is," says **Nancy-Ann DeParle**, JD, MA, administrator. "Test to make sure."

Track your test plans and outputs in case a problem occurs later, HCFA suggests.

Despite earlier concerns, HCFA assures providers they will be ready on Jan. 1, 2000, to process claims. If you aren't already using compliant electronic claim formats, the agency suggests you consider testing your electronic data interchanges (EDI) with one or more payers, including Medicare. "This will ensure that your payer can accept your EDI transactions, especially claims," DeParle says.

❒ **Get the vendor involved, if possible.**

Dave Hall, senior consultant at ACS Technology Solutions, a provider of information technology services, software solutions, and Y2K project services, based in Oak Brook, IL, says, "In our experience, the ideal case is to have the vendor or your service provider develop formal testing procedures and have them accomplished in conjunction with a clinical engineer or whoever does the maintenance of your equipment."

Think of this testing as an "add-on" to the acceptance test or functional test that the manufacturer normally performs for new equipment, Hall explains. He acknowledges that in a significant numbers of cases, vendors won't do the testing or tell you how to do it yourself.

Of the approximately 50% of equipment or systems with Y2K impacts, "realistically, you may have to decide whether it's worth testing to you, if the vendor won't tell you how," Hall

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DRG CODING ADVISOR®

Government makes Medicare recipients special agents

By **Rita A. Scichilone**, MHSA, RRA, CCS, CCS-P
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Recently the government put a bounty on health care providers and started offering weapons to senior citizens receiving health care.

This bounty is a $1,000 per-case reward the government is offering Medicare recipients to identify fraud in the health care system. The charge has been issued in a series of meetings. The government has enlisted the American Association of Retired Persons (AARP) to hold information sessions, where Medicare program participants will be given instructions by FBI agents and deputized by the federal agents to report suspected Medicare billing abuses on a toll-free hotline.

The evidence patients may use is found on the Medicare Summary Notice (MSN) provided when a payment for health care has been made on behalf of beneficiaries to a hospital or other provider. Health care organizations should arm themselves by understanding the communication tools that are used by Medicare and by health service providers to address coverage for care and who should pay for it. **(See sample MSN, inserted in this issue.)**

Coding professionals have a key role to play in this process, so it is important to understand what the forms contain and how they relate to the billing process that uses our coding system.

The law regarding Notice of Medicare benefits is covered by Section 1804 of the Social Security Act. The notices provided since Jan. 1, 1998, include this pragraph: "A statement which indicates that because errors do occur and Medicare fraud, waste, and abuse is a significant problem, beneficiaries should carefully check any explanation of benefits or itemized statement furnished pursuant to section 1806 for accuracy and report any errors or questionable charges by calling a toll-free number."

That telephone number is maintained by the Office of the Inspector General to receive complaints and information about waste, fraud, and abuse in the provision of billing of services.

That elderly patient you treated last month could trigger a full-scale investigation of your organization if the complaint has validity and a pattern of errant billings emerges. For hospitals, this usually has its roots in coding, whether it's caused from an inaccurate Chargemaster with incorrect CPT-4 code maps or inadequately trained coding personnel.

There is good news, however, despite the vigilant efforts of the government. An adequate coding compliance program and aggressive data quality processes can prevent a hospital from an attack by the "gray panthers" of the Medicare set. An understanding of what is contained in the MSN may help coding professionals become more knowledgeable of the outcome of their work and how it may impact consumers.

Every hospital should include reviews comparing what was paid to the expected reimbursement for a case, so that underpayments — as well as overpayments — or other errors can be identified and steps taken to prevent recurrence. Coding professionals should be familiar with the various formats so that this can occur efficiently.

The MSN is used to notify Medicare beneficiaries of action taken on intermediary- and carrier-processed claims. The statement provides the beneficiary with a record of services

received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights. The Medicare Intermediary furnishes an MSN to beneficiaries in most situations to describe health services claims made on their behalf to participating hospitals and other types of health care providers eligible for Medicare Part A benefits.

The notice replaces these documents:

• Part A Medicare Benefit Notice, Form HCFA 1533, also known as the Part A Notice of Utilization sent for inpatient services.

• Explanation of Medicare Benefits Notice, sent for outpatient claims;

• Form HCFA 1954, Benefit Denial Letter (BDL) sent for partially denied claims;

• Form HCFA 1955, BDL sent for totally denied claims.

Since the Health Care Financing Administration (HCFA) eliminated benefit denial letters, Medicare beneficiaries will receive the information previously conveyed via BDLs through narrative messages contained on the MSN.

Providers will no longer receive a separate written notification or copy of the BDL. Providers must use the coding information (such as ANSI reason codes) conveyed via the financial remittance advice to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

The MSN is specifically designed as a summary notice to beneficiaries and was meant to be presented in an easily understood format. Coding professionals and health information managers should note that CPT-4 codes are included in the section where services provided are outlined for outpatient facilities.

Providers receive a summary voucher and check under procedures described in the Medicare Intermediary Manual §3702. This notice replaces the previous documents:

• Part A Medicare Benefit Notice (HCFA 1533), also known as the Part A Notice of Utilization sent for inpatient services.

• Explanation of Benefits Notices sent to the patient for outpatient services.

• HCFA 1954, BDL, sent for partially denied claims.

• HCFA 1955, BDL sent for totally denied claims.

Notices are sent to beneficiaries for outpatient and inpatient claims combined into one notice every 31 days. The Intermediary must have the capability to issue the MSN in Spanish, per beneficiary's request. Since the BDLs are no longer sent to patients, they receive this information through narrative messages contained on the MSN.

There are various messages that appear on the MSN:

• help stop fraud messages;
• claims processing messages;
• deductible messages;
• general information messages.

Each of these is briefly described to explain differences between them:

Help stop fraud messages, found in the help stop fraud portion in the title section of the MSN, are to alert beneficiaries of local fraud scams. For example, if someone is illegally offering free food or other service in exchange for Medicare numbers, the Intermediary may design a message telling beneficiaries not to give out their Medicare numbers in exchange for free goods or services. Since space is limited in the help stop fraud section, the Intermediary may use the general information section for lengthy messages.

Claims processing messages are specific messages related to the claims. They are found in the notes section of the MSN.

Deductible information messages inform beneficiaries of the status of their deductible throughout the year. When the deductible has not been met, the patient will be responsible for payment for the amount up to the deductible.

The general information section is designed to inform beneficiaries of local health fairs and Medicare seminars, as well as to list those messages provided and those mandated by HCFA.

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Clarification

The December 1998 issue of *Hospital Payment & Information Management's DRG Coding Advisor* incorrectly described the indications for ReoPro, a glycoprotein IIb/IIIa platelet inhibitor manufactured by Centocor and marketed by Eli Lilly and Company. In 1997, the U.S. Food and Drug Administration expanded the use of ReoPro to include a broad range (not just high risk) of patients undergoing percutaneous coronary intervention (PCI), as well as unstable angina patients not responding to conventional medical therapy when PCI is planned within 24 hours. The editors apologize for the incorrect indication. ■

Proposed Form Language

Notice Of Discharge & Medicare Appeal Rights

Enrollee's name: Date of notice:
Health insurance claim (HIC) number:
Admission date:
Attending physician:
Discharge date:
Hospital:
Health plan:

Your immediate attention is required.
Your doctor has reviewed your medical condition and has determined that you can be discharged from the hospital because: (check one)
☐ You no longer require inpatient hospital care.
☐ You can safely get any medical care you need in another setting.
☐ Other: (fill in details)

This also means that, if you stay in the hospital, it is likely that your hospital charges for (specify date of first noncovered day), and thereafter will not be covered by your health plan. The hospital has developed a discharge plan which explains any follow-up care or medications you need. If you have questions about this follow-up care, you should discuss them with your doctor. If you have not received a discharge plan and wish to do so, please contact your nurse, social worker, or doctor.

If you agree with your doctor's discharge decision, you can either read further to learn more about your appeal rights, or you can skip to the end of this notice and sign to show that you have received this notice. However, if you disagree with your doctor's discharge decision, Medicare gives you the right to appeal. In that case, please continue reading to learn how to appeal a discharge decision, what happens when you appeal, and how much money you may owe.

If you think you're being asked to leave the hospital too soon, request an immediate review.

How do you get an immediate review?

The (name of PRO) is the name of the peer review organization — sometimes called a PRO — authorized by Medicare to review the hospital care provided to Medicare patients. You or your authorized representative, attorney, or court appointed guardian must contact the PRO by telephone or in writing: (Provide name, address, telephone and fax number of the PRO.)

If you file a written request, please write, "I want an immediate review". Your request must be made no later than noon of the first working day after you receive this notice. The PRO will make a decision within one full working day after it receives your request, your medical records, and any other information it needs to make a decision.

While you remain in the hospital, your health plan will continue to be responsible for paying the costs of your stay until noon of the calendar day following the day the PRO notifies you of its official Medicare coverage decision.

What if the PRO agrees with your doctor's decision discharge decision?

If the PRO agrees, you will be responsible for paying the cost of your hospital stay beginning at noon of the calendar day following the day the PRO notifies you of its Medicare coverage decision.

What if the PRO disagrees with your doctor's discharge decision?

You will not be responsible for paying the cost of your additional hospital days, except for certain convenience services or items not covered by your health plan.

What if you don't request an immediate review?

If you remain in the hospital and do not request an immediate review by the PRO, you may be financially responsible for the cost of many of the services you receive beginning. (Specify date of first non-covered day.)

If you leave before (specify date of first noncovered day), you will not be responsible for the cost of care. As with all hospitalizations, you may have to pay for certain convenience services or items not covered by your health plan.

What if you are late or miss the deadline to file for an immediate review?

If you are late or miss the noon deadline to file for an immediate review by your PRO, you may request an expedited (fast) appeal from your health plan. A fast appeal means your health plan will have to review your request within

(Continued)

72 hours. However, you will not have automatic financial protection during the course of your appeal. This means you could be responsible for paying the costs of your hospital stay beginning (specify date of first noncovered day).

How do you request a fast appeal?

You may call or fax your request to your health plan: (Provide name of health plan, address, telephone, and fax number.)

If you filed a request for immediate PRO review but were late in filing the request, the PRO will forward your request to your health plan as a request for a fast appeal.

If you're filing a written request, please write, "I want a fast appeal." If you or any doctor asks your health plan to give you a fast appeal, your health plan must process your appeal within 72 hours of your request.

Your health plan may take up to 14 extra calendar days to make a decision if you request an extension or if your health plan can justify how the extra days will benefit you. For example, you should request an extension if you believe that you or your health plan needs more time to gather additional medical information. Keep in mind that you may end up paying for this extended hospital stay.

Please sign to let us know you have received this notice of discharge and appeal rights. By signing this notice, you do not give up your right to appeal this discharge.

(date and signature of Medicare enrollee or authorized representative)

cc: Health plan

The appeals section shows the patient or their representative what to do if they disagree with the claims decision and the time frame that would be required to initiate the process.

Another Medicare notice form is being revised that is routinely used by hospitals to inform patients of noncoverage of services. The Operational Policy Letter (OPL) available via the HCFA Web site (www.hcfa.gov). You may download the OPL in either WordPerfect 6.1 or in PDF format.

There is some revised language for the Notice of Discharge and Medicare Appeal Rights (NODMAR) **(see p. 73)** which previously was known as the Notice of Noncoverage (NONC). This notice is used to inform beneficiaries in advance that Medicare does not cover the service ordered and that subsequent charges will be the patient's responsibility. This may include routine preventive care, or laboratory tests that are for screening rather than diagnostic purposes.

The sample form appears to address only inpatient notice of impending discharge. It is not clear in this letter how the notice would be applied to outpatient facility circumstances where noncovered services are provided. Physicians use the Advance Beneficiary Notice format for this purpose, but Intermediaries require a NONC for facility use. Some hospitals have revised this form for outpatient use in addition to the inpatient notices.

Complaints were received at HCFA that the language contained in the current NONC is confusing to beneficiaries enrolled in Medicare managed care plans. In addition, the many variations of this notice have been reported to impose administrative burdens on both health plans and hospitals.

Therefore, HCFA has decided, after consultation with beneficiary groups, managed care plan, and provider communities, the model language for the NONC has been revised and its name changed to create a more "beneficiary-friendly" notice.

The Notice of Discharge and Medicare Appeal Rights (NODMAR), formerly known as the NONC, is designed to inform Medicare enrollees, in a more streamlined and accurate manner, of their rights when they have received a hospital inpatient discharge decision. The NODMAR meets the notice requirements set forth in the existing Medicare regulations at 42 CFR 417.440(f) and the Medicare+Choice regulations at 42 CFR 422.620

HCFA says hospitals may use this model language or develop your own, but any NODMAR must include the following:

- the reason why inpatient care is no longer needed;
- the effective date of the enrollee's risk of financial liability;
- the enrollee's appeal rights.

Lastly, all NODMARs must be approved by your HCFA regional office plan manager. In the near future, HCFA will submit the model NODMAR to consumer testing to ensure that enrollees are able to understand their rights and how to exercise them when necessary. Upon completion of this testing with beneficiaries, HCFA intends to develop this model language into a standardized NODMAR form and proceed with the OMB clearance process. ■

(Continued from page 70)

says. "We've run into cases in which it's easier to buy a new piece of equipment rather than figure out how to test, especially with older equipment and/or complicated equipment — especially if you don't have all the manufacturer's documentation."

For example, if you don't know the microcode, line by line, it will be resource-intensive to develop tests, he warns. "So it's basically an exercise in risk management. How much risk are you willing to take vs. how long it will take you to catch everything?"

❒ Evaluate what the manufacturer tells you about your equipment.

Be careful about accepting a vendor's certification, Hall warns. "Normally it will say, 'You will use equipment this way with this kinds of inputs and this kind of date formatting.' Also [you] must use it hooked up to other Y2K-ready equipment. Otherwise, they don't guarantee anything." Read the certification closely, he suggests.

❒ If necessary, develop your own formal testing procedure.

Have a formal test procedure before you turn any system's date forward, Hall advises. Turning the date forward may "freeze up" the equipment or cause the software license to become expired, which will require going to the vendor to have the equipment made operational.

A formal test procedure should include exactly what you're going to do, your expected results, and a process for making the equipment operational in the event that you run into problems, he says.

"I've seen people turn dates forward, watch the equipment lock up, and they have to get the vendor to give them — sometimes for extra money — the key to unlock software, or the system has become a boat anchor," he says. ■

Bug advice available over the telephone

ECRI, a nonprofit research agency based in Plymouth Meeting, PA, has developed a series of interactive telephone seminars to provide a forum so that health care facilities and experts on year 2000 (Y2K) topics can share their perspectives. Four seminars have been held. Three more are scheduled for 1999, and each will address a different Y2K concern.

The seminars will be from 1 p.m. to 2:30 p.m. Eastern time on the following dates; topics may be subject to change:

- May 12 — The Many Legal Issues of Y2K.
- Oct. 13 — Y2K Staff Awareness and Media Relations.
- Nov. 10 — It's a Quarter to Midnight: Are you Ready for Y2K?

The cost for each seminar will be $109 for members of ECRI programs and $129 for nonmembers. This fee allows the connection of one telephone line from your site. Anyone within your organization can listen on that line and participate.

To register, contact ECRI's Communications Department, 5200 Butler Pike, Plymouth Meeting, PA 19462. Telephone: (610) 825-6000 Ext. 5888. Fax: (610) 834-1275. E-mail: info@ecri.org. ■

Y2K conversions cited as No. 1 priority in 1999

Staffing problems could be barrier

Although Senate investigators report that many health care facilities have a limited awareness of the year 2000 (Y2K) computer problem, health information technology professionals indicate otherwise.

According to the Tenth Annual Healthcare Information and Management Systems Society (HIMSS) Leadership Survey, 39% of the survey respondents say that implementing a Y2K conversion is the most important health information technology priority over the next 12 months. This percentage is triple the number who cited Y2K as their main priority last year.

Three-quarters of the respondents of the survey, which was sponsored by IBM in Somers, NY, also expect their health information technology (IT) budgets to increase over the coming year. This should help IT professionals implement their Y2K conversion plans; however, recruitment and retention of high-quality IT staff could be a barrier that might prevent these plans from being met on time.

The survey was completed by more than

1,100 senior executives, IT managers, operations and financial managers, and other provider organization professionals.

The survey was available to those professionals who attended the HIMSS annual meeting in Atlanta and IT professionals who participated from their office or home via a special site on the Web. Questions in the 1999 survey covered topics such as overall IT utilization, IT budgets, computer-based patient records, data security, Web applications, telemedicine, and emerging IT technologies.

Of the total respondents, 46% are members of Chicago-based HIMSS. Forty-eight percent of the survey respondents work for a multi-entity health care network with hospitals. Another 16% work at stand-alone hospitals. The remainder are employed at a wide variety of health care organizations including long-term care, home health care, group medical practices, and HMOs.

After Y2K conversion implementation, the second most frequently mentioned priority (18%) was integrating systems in a multivendor environment. Recruiting and retaining high-quality IT staff, which was last year's top IT priority at 17%, dropped to 8% this year.

However, 23% of the 1999 survey takers say the difficulties involved in recruiting and retaining IT staff is the No. 1 barrier to successfully implementing IT. Fourteen percent of the respondents say both the lack of financial support and difficulty in proving IT quantifiable benefits were also significant implementation barriers.

Although lack of financial support for IT is cited as a significant barrier, 72% of health care organizations' IT budgets are still expected to increase in the next 12 months. Forty-six percent of this year's respondents report that their organizations' IT budgets will definitely increase. Another 26% say that their budgets will probably increase. Only 5% report an expected decrease in IT budgets over the next 12 months. **(For information on what hospitals expect to spend on Y2K compliance, see related story, at right.)**

Here are other findings cited by the survey:

• **Outsourcing.**

Eighty-one percent of this year's respondents are outsourcing key IT functions, compared to 66% in 1998, a 23% increase. Applications support (15%) is the top outsourced function. At 12% of the responses each, other key functions include technical support, Web site support, and PC support.

• **Computer-based patient records.**

Health care organizations in this country are making faster progress toward implementing computer-based patient records (CPRs) this year.

Y2K compliance could cost hospitals billions

Hospitals will spend up to $8.2 billion to ensure uninterrupted delivery of patient care during the year 2000 (Y2K) transition, according to a survey conducted by the American Hospital Association (AHA) in Chicago.

"The billions that hospitals expect to spend this year come on top of already significantly declining Medicare reimbursement brought by the Balanced Budget Act of 1997," said Fred Brown, AHA chairman, during testimony before the House Ways and Means Committee. Brown also is vice chairman of BJC Health System in St. Louis.

AHA surveyed 2,000 hospital and health system CEOs in January 1999. Five hundred and six surveys were returned, which was a 25.3% response rate. According to the results, on average:

1. **Hospitals with 100 beds or fewer will spend $436,000 each.**
2. **Hospitals with 100 to 300 beds will spend $1.2 million each.**
3. **Hospitals with 300 to 500 beds will spend $3.4 million each.**
4. **Hospitals with 500 beds or more will spend $8.6 million each.**

Most of the expense (68%) from becoming Y2K-compliant comes from capital expenditures, such as modifying operational expenses or replacing information systems hardware.

The other 32% represents operational expenses, such as assigning personnel to work on Y2K changes and hiring consultants. Respondents report that most of the expenditures for Y2K fixes will likely be incurred in 1999.

Urban hospitals also expect to spend more than rural hospitals. More than 69% of rural hospitals anticipate spending up to $500,000; 75% of urban hospitals will spend more than $500,000. ■

Compared to only 2% in 1998, 10% of this year's respondents say that their organizations have a fully operational CPR system in place. Twenty-four percent say that they have developed a CPR implementation plan, and 29% have begun to install a CPR system. Twenty-eight percent have not yet begun to plan for a CPR system.

• **Internal security threats.**

When it comes to the security of computerized medical information, the respondents' biggest concern (30%) continues to be internal breaches of security. This is similar to the 31% cited last year. Other security issues respondents mention include the limits of existing security technology (21%, up from 18% last year) and external breaches of security (14% in both 1998 and 1999).

• **Web applications.**

Only 2% of this year's respondents indicate that their organization does not have a Web page. For those who do, the top applications of the Web are organizational promotion (29% in both 1999 and 1998), employee recruitment (19%), and consumer health information (17%).

• **Web-based functions.**

Fifteen percent of respondents report an online physician / provider directory (up from 6% in 1998) and 2% are conducting electronic vendor transactions via the Web, up from 1% last year.

• **Telehealth applications.**

Medical image transmission is the No. 1 telehealth application in 1999, used by 24% of the survey respondents. Use of telehealth systems for management or business-related video conferences is reported by 19%, and professional continuing education applications are cited by 16% of the survey respondents. Patient interviews and consultation are mentioned by only 8%, patient education by 9%.

Sixteen percent of the respondents say their organizations are not currently using any telehealth applications.

• **HIPAA compliance.**

When it comes to security requirement compliance for the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 15% of U.S. health care organizations have not started developing plans. However, 23% say their organizations have already assessed organizational compliance, 21% have document security policies and procedures, 17% have implemented these policies and procedures, and 12% have actually hired a security officer.

• **Wireless information appliances.**

When asked which emerging information technologies their organizations are most likely to begin using in the next year, 20% of the survey respondents mentioned wireless information appliances, supplanting voice recognition from the top spot (16% this year). In 1998, wireless appliances are cited by 13% of the respondents and voice recognition by 31%.

The other top emerging technologies for the next year include Web-enabled business transactions (19%, up from 14% last year) and data mining (14%). ■

GAO expresses doubt in HCFA's Y2K readiness

Not all internal systems will test before next year

In another chapter of "Yes, it's ready. No, it's not," the Government Accounting Office (GAO) in Washington, DC, recently reported that the Health Care Financing Administration (HCFA) in Baltimore has overstated its readiness to handle year 2000 (Y2K) computer problems.

The testimony was delivered to the House of Representatives Ways and Means Committee on Feb. 24. As recounted by the Medical Group Management Association (MGMA) in Englewood, CO, the GAO is concerned that HCFA's failure could delay both Medicare and Medicaid reimbursement payments to providers and the implementation of the year 2000 scheduled fee updates. In addition, HCFA may experience problems processing provider claims in the first quarter of 2000.

Here are details of the GAO's concerns:

❒ **Incomplete independent testing of internal systems.** HCFA has indicated to Congress that all of their 54 mission-critical systems were now Y2K-compliant, with the exception of a few "minor problems." Conversely, the GAO contends that none of the 54 mission-critical systems are truly compliant.

The independent testing contractor, hired by the government to verify Y2K compliance, has concluded that it will only be able to test eight internal systems, down from the 22 that HCFA

previously stated would be independently tested. This independent testing will not be completed until late summer, which is very late to implement system changes or develop contingency plans.

In addition, the GAO reports that HCFA has not established an integrated schedule to track all of the agency's major internal systems or a formal risk management system. The GAO is concerned that without this integrated schedule, HCFA's management team will not be able to properly identify important system dependencies and prioritize the remaining work in the limited time before 2000.

❒ **Noncompliant data exchange systems.** The GAO testimony, as reported by MGMA, indicates that of HCFA's 3,418 internal data exchange systems, 309 are not Y2K-compliant, and of 255,000 external data exchange systems, more than 37,000 are not compliant. In addition, HCFA has several internal systems scheduled for a software upgrade in 1999 — several that are legislatively mandated. All of these upgraded systems will require testing and certification.

❒ **No definite plan for "end-to-end" testing.** In addition to testing individual systems, HCFA must also perform what is termed "end-to-end" testing, which involves testing interrelated systems that collectively support an organizational business function. The GAO is concerned that HCFA has yet to develop a comprehensive plan that fully discloses how these tests will be completed and a specific schedule for conducting them.

❒ **No appropriate contingency plans.** The GAO also is concerned that HCFA has not constructed an appropriate contingency plan should HCFA or its contractors be unable to either process claims or distribute payments in the Y2K transition. The GAO points out that this might affect the quality of health care and urges Congress to pass legislation authorizing a contingency plan for HCFA. The suggestion has also been made that HCFA issue payments in advance of Jan. 1, 2000, based on past payment levels, allowing providers to continue operating should Y2K interrupt reimbursement payments. ■

NEWS BRIEFS

Report offers Y2K health care contingency plans

Health care organizations looking for detailed and practical year 2000 (Y2K) planning advice for mission-critical systems now have another resource — *Five Minutes to Midnight: Practical Y2K Contingency Plans for Healthcare Facilities.*

The report is published by ECRI, a nonprofit international health services research agency based in Plymouth Meeting, PA. It covers a wide range of topics, including clinical support of patients, medical device compliance, documentation, year 2000 liability exposures, media relations, staff fears and anxieties, and Y2K best practices.

Five Minutes to Midnight features Y2K contingency plan templates for mission-critical systems in health care facilities. The report also includes action recommendations for preparing for a Y2K-induced event.

ECRI also offers a Year 2000 Medical Device Knowledgebase, an inventory collection and management system that allows health care facilities to match their medical device inventory to a Y2K database. This is accomplished through software provided on CD-ROM and through ECRI's Y2K Web site, located at http://www.ecriy2k.org.

For more information about these services, contact ECRI at 5200 Butler Pike, Plymouth Meeting, PA 19462-1298. Telephone: (610) 825-6000, ext. 5372. Fax: (610) 834-1275. ▼

Web site offers coding and payment info resource

A software provider recently announced the availability of "Insider Information," an Internet destination that gives regulatory information and interpretation on coding, classification, and reimbursement.

The Internet resource (www.hssweb.com) is an extension to the Web site of HSS, a Hamden, CT-based firm that specializes in software for coding, reimbursement, and profiling in hospitals, managed care organizations, and payers.

"Our current focus is facility-based inpatient

and outpatient regulations on a federal level, as well as for numerous states. If you're looking for information on Grouper changes, ICD-9-CM or CPT-4 updates, or modifications to payment methodologies, you'll find the answers in the Industry Insights section of the HSS Web site," says **Dean Farley**, PhD, vice president of health care policy and analysis at HSS. "If you need access to the key economic indicators that drive reimbursement, you'll find them in The Library. HSS even provides a portal to other important governmental and industry sites."

"The site is organized in a fashion that puts the information at your fingertips. You can browse high-level industry trends or drill down through regulatory analyses into the regulations themselves," adds **Robert J. Leary**, founder and CEO of HSS. ▼

Are providers ready to send itemized statements?

As of last month, the federal government began requiring most Medicare carriers and fiscal intermediaries to print Advisory On Benefit Statements, which tell patients of their right to request an itemized statement. The Health Care Financing Administration (HCFA) in Baltimore is warning physicians, hospitals, and providers to be ready to send out such itemized statements free of charge when requested.

The new policy, part of the Balanced Budget Act of 1997, was designed to help Medicare beneficiaries understand their statements so they can more readily report suspicions of fraud, waste, and abuse. Providers and suppliers have 30 days from the receipt of a request to provide information such as a description of services provided, the date of service, provider / supplier charges, an internal tracking number, and a telephone contact for more information. **(For more information, see *DRG Coding Advisor,* p. 71.)**

The deadline for printing advisories on benefit statements has been delayed until July 1 for the Arkansas Part A Standard System. The deadline to begin providing the itemized statements has been pushed to July 1 for Medicare Part A institutional providers in Alaska, Maine, New Hampshire, New Jersey, North Carolina, Vermont, and Washington, and for those served by FI Mutual of Omaha. ▼

University medical records posted on the Internet

Thousands of patient records at the University of Michigan Medical Center in Ann Arbor inadvertently lingered on Internet sites for two months until a student discovered the problem.

"Luckily, we were notified and able to stop it this time before real damage was done," says spokesman **Dave Wilkins**. "Still, on all fronts, we're taking it very seriously."

The problem was discovered in mid-February when a university student who was researching a doctor on the medical center's Web site was linked to files containing private patient records.

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The records contained names, addresses, phone numbers, Social Security numbers, employment status, treatments for specific medical conditions, and other data. The information was used to schedule appointments, Wilkins says. He adds that no one had accessed the records before the student. ▼

New network offers free Web-based medical record

Another company is offering consumers Web-based personal medical records, this one led by C. Everett Koop, MD, former U.S. surgeon general.

The drkoop.com Personal Medical Record (PMR) will be introduced in the second quarter of 1999 and will be free to all Americans. Koop is chairman of Empower Health Corp., an Internet-based consumer health care network, which is based in Austin, TX, and develops, markets, and distributes drkoop.com.

To develop the PMR, drkoop.com entered into a strategic technology partnership with HealthMagic, a Web-based technology company based in Columbia, SC, and into a distribution agreement with Physicians' Online (POL), a medical information and communication network for physicians based in Tarrytown, NY.

The drkoop.com PMR will support all the latest industry standards for data security and interchange, including Microsoft ActiveX for Healthcare.

Health care organizations that are a part of Koop's Community Partner Program will be able to offer co-branded versions of the PMR to their patients or covered lives and can be fully integrated into their consumer Web initiatives. ▼

Health care Y2K reference resource available

With the year 2000 deadline fast approaching, hospitals, other health care providers, and the medical device industry are scrambling to complete a process that in many cases was started too late.

What may have once been a logistical issue is burgeoning into an overwhelming problem, compounded by the scarcity of time, rising costs, and a lack of programming resources and expertise.

As the Y2K issue moves far beyond a mere "technological" issue, American Health Consultants, publisher of *Hospital Payment and Information Management*, has published the *Hospital Manager's Y2K Crisis Manual*, a compilation of resources for nontechnical hospital managers.

This 150-page reference manual includes information, in nontechnical language, on the problems your facility will face, the potential fixes, and the possible consequences, including:

- Will your computers and software work in 2000?
- What does Y2K mean for patient care?
- What will happen to your medical devices?
- How can you make sure your vendors are Y2K compliant?
- Are you at legal risk due to Y2K?
- Are you prepared if Y2K delays Health Care Financing Administration's payments?

Jan.1, 2000 is not a moving target. Either your computer systems, medical devices and suppliers can handle the date change and maintain business as usual, or they can't — in which case your entire organization may face serious problems.

The Hospital Manager's Y2K Crisis Manual is available now for $149. To order, contact American Health Consultants' customer service at (800) 688-2421. ■