



# HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

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## NY records department hit with two floods during major clean-up project

*HIM staff with contract help persevered*

Imagine daring to take a look at your hospital's dungeon where a decade or more of medical records are stored and then deciding to clean up the mess as efficiently and cost-effectively as possible.

Now imagine that a couple of weeks into the clean-up, when boxes still are blanketing the storage room floor, your hospital is flooded and already-sorted records are soaked. Then, picture the scene a month later when it happens again, only this time the records were sorted and stored in a temporary location.

Does it seem like a plot from an HIM horror flick? Well, this scenario actually occurred last year to the State University of New York's (SUNY) Downstate Medical Center in Brooklyn.

**Shoshana Milstein**, RHIA, CCS, was new to the job of director of medical records when she decided in the summer of 2001 to take on the hospital's backlog of 15 years' worth of stacked medical files.

"We had a very old filing system with shelves in front of shelves," says Milstein, who now is the hospital's privacy director.

"Each one of those shelves was stuffed, so we couldn't move one shelf to get to the one behind it," Milstein adds. "Boxes were piled high on the floor, in aisles, and blocking shelves."

The apparent strategy had been to archive records in that basement office and to not keep track of what was down there and when it needed to be purged.

Plus, the 50-employee department was short 11 people, and Milstein was pregnant, expecting a baby in December.

"I had just begun the job and wanted to do my best, but it seemed like an impossible task," Milstein says. "None of the administrators knew what was going on in the basement, so I showed them the area, and they knew a Joint Commission [on Accreditation of Healthcare Organizations] survey was coming up."

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The hospital's administration gave Milstein the go-ahead to seek bids from medical records contractors who could take care of the reorganization and clean-up.

One bid came back at \$500,000 just to handle the emergency department records. Another bid was based on an estimated number of man-hours the project would take to complete. Milstein presented the second bid to administration, and it was sent through a lengthy bureaucratic process before finally receiving approval.

The Joint Commission survey was scheduled for October, and that time was fast approaching, but when terrorism struck New York City in

September 2001, the survey was postponed until early 2003, Milstein says.

Even so, it was late October before the contracting company, Precyse Solutions of King of Prussia, PA, was able to begin the work.

"We were on site a couple of weeks when the first flood occurred," says **David Wright**, director of HIM services for Precyse Solutions.

"A couple of weeks into the process, we were just beginning to make a dent in the file area, just getting into the process of discovering that the age of documents was considerably greater than we anticipated," Wright recalls. "Unfortunately, because of the overflowing shelves, the most recent charts, which were the ones we were trying to prepare for scanning, were greatly affected by the flood."

Milstein was overwhelmed by the disaster. "I remember walking in there, and I just felt like I was going to cry," she says.

By law, the hospital needed to maintain those charts, so Milstein and Wright figured the best solution was to find a vendor to freeze-dry the records and reproduce them through copying to generate a new original record.

The flooding disaster also meant that the total cost of the project would rise by at least \$20,000 for the freeze-drying process, Milstein says.

Plans were to scan onto a CD-ROM all records from 1998 and 1999 and keep the records dating from 2000 forward in the storage department for fast retrieval. Anything dating before 1998 would be sent to an off-site storage location, Wright explains.

"The normal process is to continually purge records to make room for new charts, and that process had been neglected for years," Wright adds. "When talking about the volumes of charts this facility was dealing with, the cost of backlog scanning is astronomical."

To expedite the process of making the basement records room cleaner, the Precyse crew moved the records being prepared for scanning to a second location on the first floor near the cafeteria. This occurred as the crew was making fast progress in sending older records to off-site storage.

"It was a holding area so it wouldn't impede the process in the main medical department, and so it would look like something was getting done there," Milstein says.

During this second phase of the project, the medical records department began to look clean and organized, which was the image Milstein wanted

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to present to the Joint Commission surveyor, whom she figured might or might not take a look at the area.

In the temporary storage space, boxes were stacked high for scanning, and then the unthinkable happened in December 2001: There was a second flood, and this time it soaked the bottom boxes in the temporary storage area, Milstein says.

"At that point, we realized we were way over the amount of man-hours we should have had for that point," Milstein says.

This presented a major problem because the project was given a budget cap that could not, even under these circumstances, be exceeded, she says.

Wright outlined several options and alternatives to their original plan, and they decided to reduce the number of files scanned and simply store the remainder. One of the most important goals, making the records storage area neat and accessible before the Joint Commission survey, was being met.

"When the Joint Commission walked through the door, it was orderly, and everything was off the floor and onto the shelves," Wright says. "We purged 70% of that department."

The second batch of wet files was handled similarly to the first, and the project continued.

"When we did this project, there were 65,000 inpatient charts purged and 86,000 ED records, and it was such an insurmountable task," Milstein says. "It's much easier to do this on an ongoing basis and have the staff scan older records regularly."

Although this project was unusual because of the amount of the backlog of files and the two floods, it does serve as a learning lesson for other HIM departments, Wright notes.

"Give yourself enough time to clean up old files," Wright recommends. **(For tips on cleaning up a medical records department, see story at right.)**

As it turns out, Milstein's planning and preparation paid off. The Joint Commission surveyor had decided to visit the records storage area and made the trip in the evening when Milstein was off work.

"I was so thrilled," Milstein recalls. "I walked in the next morning and didn't even know they had come in the evening before, and then the surveyor said at the 9 a.m. meeting that the medical records department had been visited."

The surveyor had no negative comments about the department, and the hospital received a 98 rating on the survey, Milstein adds.

Milstein then called Wright, who was at a

meeting in Atlanta, and thanked him for the successful job and survey.

"I had known the Joint Commission typically didn't do walk-throughs of medical records storage areas, so neither of us was anticipating they'd do a walk-through," Wright says. "But of course if it wasn't prepared, we knew they'd walk through it." ■

## Expert offers these tips on cleaning up records area

*Allowing enough time is crucial*

It doesn't matter whether a natural disaster, an accreditation survey, or simply the growing avalanche of files prompt a hospital's HIM department to plan a major clean-up of medical records, because there are certain strategies that can make this job easier and more efficient.

**David Wright**, director of HIM services for Precyse Solutions of King of Prussia, PA, a company that specializes in medical records clean-ups, offers these tips for making sure the job is done well:

### 1. Give yourself enough time.

Precyse does backlog management, including assembly, analysis, merging, purging, and chart conversions. The company typically is called in when the backlog of files indicates years of neglect, Wright says.

If this is an HIM department's situation, Wright's advice is to start the clean-up project as early as possible, preferably a year prior to the Joint Commission survey. Starting late makes the cost much greater, Wright adds.

### 2. Know how bad the problem is.

The HIM and medical records directors need to know how big of a problem the backlog poses.

"It comes down to making sure they fully understand what their needs are when they contact a backlog management contractor," Wright says. "But we're more than happy to come in and do an assessment for them."

Backlog management companies, such as Precyse, also can offer analysis services and Joint Commission preparedness services.

### 3. Prioritize what you want done.

Typically, a hospital will have a limited budget for what can be spent to fix the problem, so the

HIM staff in charge will need to know what the most important goals to be accomplished are.

"You really need to know what the Joint Commission expectations are," Wright says. "Have these written into the budget so they won't reach a crisis point; know what the repercussions of neglect are over time."

If some top priorities are left out of the project because of the cost, then the hospital may end up paying more for these problems somewhere down the road, Wright adds.

#### 4. Be aware of privacy concerns.

A backlog management project, whether done by a hospital's own staff or a contractor's staff, should include training and education for staff on the federal privacy regulations of the Health Insurance Portability and Accountability Act.

"We educate all staff members in confidentiality requirements and have them sign confidentiality covenants and statements so they're fully aware of the repercussions of a breach of confidentiality, and we work with the facility on that," Wright says. ■

## AHIMA asks CMS to standardize E/M codes

*G codes, E/M service coding changes needed*

Many G codes are outdated and overlap other coding sets, and coding for evaluation and management (E/M) services needs to be standardized once and for all, according to the American Health Information Management Association (AHIMA) of Chicago.

AHIMA wrote the Centers for Medicare & Medicaid Services (CMS) of Baltimore in early October, asking CMS to make changes to these and several other troublesome coding areas. CMS had not replied to AHIMA's suggestions as of the end of October 2002.

"Consistency in medical coding and the use of medical coding standards in the U.S. is a key issue for AHIMA," wrote **Dan Rode**, MBA, FHFMA, vice president of policy and government relations for AHIMA, and **Sue Prophet-Bowman**, RHIA, CCS, director of coding policy and compliance for AHIMA, in an Oct. 3 letter to Thomas A. Scully, administrator of CMS.

AHIMA points to changes to the Hospital

Outpatient Prospective Payment Systems (PPS), published in the *Federal Register* on Aug. 9, and the calendar year 2003 rates and notes that there continue to be problems that need to be addressed.

"While many of the issues raised in the Aug. 9, 2002 proposed changes are important, two issues — the assignment of new codes and the coding for evaluation and management — are very troubling to AHIMA and shall be addressed first," the letter states.

Here are the issues and proposed changes:

#### • G codes.

There is a continued proliferation of G codes, despite the fact that they often overlap or duplicate other code sets and are inconsistent with the requirements and goals of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and lack basic data integrity, the AHIMA letter says.

"Under PPS there is a G code creep, where we get more and more G codes, escalating our concern about them," Prophet-Bowman says.

"G codes are of greater concern since HIPAA regulations related to electronic transactions and code sets talk about non-duplication," she adds.

While G codes may be necessary to identify new technology and medical advances for which Medicare and some other payers have agreed to reimburse (although these new procedures haven't yet made it through the CPT coding process), the G codes often are not needed for the many other reasons they are used, Prophet-Bowman says.

G codes are a way to code temporarily until a CPT code is established, and AHIMA doesn't have a problem with that use of G codes, she adds.

"But the other way they're used is to capture specific information, and there's no process in place to make sure they're temporary," Prophet-Bowman says. "Some G codes have been around for years, and there's no mechanism in place to say that by a certain time period there is a process to change it to a CPT code."

Plus, G codes usually are so specific to Medicare reimbursement that they are not used by other payers, which means facilities have to use duplicate codes for these services, which is both time-consuming and inefficient with regard to coding consistency and quality, Prophet-Bowman says.

Also, there are some cases where G codes are duplicated in CPT codes, which goes against the heart of HIPAA and coding data integrity standards, she says.

One example described in the AHIMA letter

is of a new G code created for 2003 to describe a bone marrow aspiration and biopsy. This new code duplicates a CPT code that already exists for bone marrow aspiration and biopsy.

- **Evaluation and management services coding.**

“Our chief concern is the whole issue of national consistency in coding practices,” Prophet-Bowman says.

“If each facility is developing its own reporting process for E/M services, then it will be difficult, if not impossible, to compare code utilization and E/M services from one facility to another because they won’t mean the same thing,” Prophet-Bowman explains. “It makes data comparability across organizations pretty much nil.”

For these reasons, AHIMA asks CMS to implement a standardized coding process for facility reporting of E/M services.

“We endorse the proposed establishment of unique codes to describe facility E/M services rather than continuing to use CPT E/M codes,” the letter states. “We agree with CMS’ conclusion that the CPT E/M codes do not describe well the range and mix of services provided by facilities to clinic and emergency patients.”

AHIMA recommends that CMS create a broadly representative panel to create these national standards.

While such standards need not be so rigid as to lack room for flexibility on the part of individual facilities, they could provide a standardized process that gives direction and that all hospitals could find worthwhile, Prophet-Bowman says.

- **Inpatient-only list.**

AHIMA also asks CMS to closely monitor the inpatient-only list and the ambulatory surgical center list of covered procedures to ensure consistency and to promote expeditious updates when medical practice changes.

Health care facilities are concerned that Medicare’s requirement that certain procedures only be reimbursed if they are provided in an inpatient setting unfairly regulates and restricts providers who may have found more efficient and better ways of providing these services, Prophet-Bowman says.

“A lot of our members don’t feel CMS should be in the business of regulating which setting patients should be treated in,” she adds. “To regulate it in the guise of a reimbursement system is not where the issue should be addressed.”

For instance, the setting in which many procedures are performed depends on regional practice. A Northeastern hospital may perform a

certain procedure routinely in an outpatient setting, but a Southern hospital may still perform the same procedure on an inpatient basis. If Medicare is restricting reimbursement only to patients who have the procedure done on an inpatient basis, then this unfairly limits the options available to patients and physicians, Prophet-Bowman explains.

Medicare may argue that the agency doesn’t tell physicians where to perform procedures, but by restricting reimbursement the effect is essentially the same, Prophet-Bowman adds. “If you tell a patient, ‘I would like to do this procedure on an outpatient basis, but Medicare will only pay for it as an inpatient service, so you’ll have to pay for it yourself,’ there are not a lot of people who’d say, ‘OK, I’ll pay for it myself.’” ■

## Here’s how one system is using new ABN form

*Lay language and translations required*

Hospitals that have long designed and used their own advance beneficiary notices (ABN) to inform patients that a service is not likely to be covered by Medicare now should be using a form released by the Centers for Medicare & Medicaid Services (CMS).

Most access managers have longtime familiarity with the ABN, which is a written notice given to a Medicare beneficiary before services are provided when it is determined that Medicare probably won’t pay for the service. Beneficiaries then have an option either to receive the service and assume responsibility for the charges if indeed Medicare does not pay, or to decide not to have the service.

Although making the transition to use of the new form has been pretty routine for staff, there are some things that access managers should keep in mind, suggests **Liz Kehrer**, CHAM, system administrator for patient access at Centegra Health System in McHenry, IL.

The ABN (CMS-R-131-G) form, which hospitals were required to use on Oct. 1 of this year, can be used for all hospital services, including laboratory services, Kehrer notes, although there is another template (CMS-R-131-L) that is specifically for lab services. “We opted not to have two ABNs,” she explains, “so we use the generic form

for both purposes.”

Except for attaching the hospital’s name or logo, she says, providers may modify the ABN form only within two sections near the top of the form. Copies may be downloaded at <http://cms.hhs.gov/medicare/bni>. Questions and answers regarding the use of the ABN form also are available at <http://cms.hhs.gov/medlearn/refabn.asp>.

“What I did within those [two open sections] is to put the most common services for which ABNs are issued to Medicare beneficiaries at my facility and the most frequent reasons why we believe those services won’t be covered,” Kehrer explains. “Depending on what they see in their areas, hospitals can fill in the boxes [accordingly].”

There are small boxes to the left of each service or reason that may be checked, she adds, and a line at the bottom of each of the two sections where another service or reason may be added.

### **Don’t get beneficiaries to sign blank ABNs**

To be acceptable, according to Centegra’s training material developed from CMS releases, an ABN “must clearly identify the particular item or service, must state that the physician or supplier (hospital) is likely (or certain) to deny payment for the particular item or service, and must give the physician’s or supplier’s (hospital’s) reasons for its belief that Medicare is likely (or certain) to deny payment for the item or service.”

The training material goes on to explain that the ABN must include a written explanation in lay language. Simply stating “medically unnecessary” or the equivalent is not an acceptable reason, it says. “The ABN must give the beneficiary a reasonable idea of why the provider is predicting the likelihood of Medicare denial,” the training document continues, and it states in bold-faced type that “a provider is prohibited from obtaining beneficiary signatures on blank ABNs and then completing the ABNs later.”

Providers also are required to have forms available in Spanish, says Kehrer, who had both the services and reasons her facility provides translated into that language. When looking for ways to fill in the “other” line with the proper translation, Kehrer found an extremely helpful web site. By going to [www.freetranslation.com](http://www.freetranslation.com), access managers can have information translated not only into Spanish, but other languages as well. “You click on the tab for free translation, and you are asked from which language to which,” Kehrer explains. “It’s listed as a global business site.” ■

## **Electronic tracking of clinical pathways growing**

*The transition has its challenges*

Advancing technology continues to reshape the way acute care case management is practiced. One example of that is the growing trend toward automation. However, early experience shows that technology is no guarantee for physician buy-in at the front end, much less patient compliance at the back end.

Several large institutions such as New York University (NYU) Medical Center in New York City now are using automated systems. However, even for a large sophisticated system such as NYU, automation is no easy task. It is not primarily the hospital information system that is the problem, according to **Barbara Delmore**, RN, a nurse case manager on the NYU surgery unit. She says the biggest challenge is getting certain physician groups to use it.

“Right now, there are only two surgical groups using it faithfully,” she says. “The others prefer not to use the care plan that gets loaded each day.” Instead, she says they tend to use the order sets, which are also a component of the pathway.

NYU began automating in its surgery department using a system called CareMinder, which takes the user through a series of order sets. Based on the written pathways that the hospital had used for years, and set up with the help of nurse specialists working in information systems, the automated pathway takes physicians or case managers through patient care step by step, using different screens on the computer.

When the patient comes out of surgery, physicians execute all the orders at once instead of on a daily basis, according to Delmore. The CareMinder version is put into suspense by the nurse who sends the patient to the operating room (OR), she says. Once the patient comes out of the OR, the resident starts to execute the orders for the OR day, which is referred to as Day Zero.

The process is very interactive; one step triggers the next, Delmore says. There is also an option to go outside the pathway’s guidelines, she says. Caregivers can order lab tests or antibiotics directly on the computer.

“The clinical pathway is supposed to be looked at every single day,” Delmore says. “That is the whole purpose.” However, she says the system is

not user-friendly in certain areas. "The technologies could be a little easier to deal with," she says.

"Unfortunately, if someone goes into the OR and they were not put on the clinical pathway when they left and nobody put them on between the time the patient went to the OR and came to the recovery room, then you have lost the whole pathway," she says.

The software is all physician-driven, Delmore says. "Some groups use it and have no problem with it, and some do not," she notes. In short, she says it has become more of a practice issue than a technology issue.

"The bottom line is that the clinical pathways are still there," she says. "They are still present, just in a different form." Delmore says NYU continues to push the system. Eventually, she wants nurses to be able to chart the outcomes. She says NYU also would like the system to be Windows-based, which it is not. "That, to me, would be cutting-edge," she says.

Emory University Hospitals in Atlanta also has begun the automation of care pathways, according to **Rosalie Przykucki**, RN, MSN, coordinator of clinical performance improvement. One benefit of the Emtex system, currently in place only on Emory's intensive care units (ICU), is that it has some graphing capabilities. "Some of the physicians want to see trends, like 'What has his temperature been for the last 24 hours?' and it actually builds a graph for you," she adds.

"I wish our systems were completely automated, but they are not," she says. Instead, Emory has been structuring its paper pathways to be the same at both Emory University Hospital and Crawford Long Hospital, the result of the merger of the two Atlanta facilities.

Currently, when a patient leaves the Emory ICU, all the pathway information is downloaded and printed onto a readable chart copy, which then follows the patient, she says.

On the one hand, Przykucki says the automatic aspect of the new technology gives physicians even more reason to call it "cookbook medicine." In fact, the opposite is true, she argues. Przykucki says having pathways on the computer makes it much easier to change and modify them to fit individual patients' needs. In addition, more physicians are buying into the pathway process through this technology, she says. "I think as more and more physicians go through their medical training, they are going to find that this is a tool that really helps them," she explains.

She agrees with Delmore that the real state of

the art will be when the automated pathways and order sets become electronically linked to outcomes. "Everybody would love that," says Przykucki.

Przykucki says she looks at the overall flow of various pathways in the system, how well patients are doing in terms of the lengths of stay and any complications. "I also work with the physicians in the pathway teams on implementing changes for any new technology and new protocols that have come along," she adds.

### ***Pathways focus on patient education***

When a patient is ready to leave the hospital, Przykucki says caregivers know where the patient should be and what they can do at home. "This will give the caregiver and patient an idea of what he should be able to do or what he may need help with," she explains. Patient pathways have been around for a long time, but there is now a lot more emphasis on the aspect of patient education, she explains.

For example, she says caregivers now can tell patients the kinds of procedures taking place for specific diagnoses such as diabetes or coronary artery disease. "Then we move the patient through the hospital process to the point where he or she is ready to go home and we have given them patient education to take beyond the hospital walls," she says.

Przykucki says because a patient's stay in a hospital typically is short, it often is difficult to cram everything into that short period of time. She says that is why it is important to give patients something to take home that is easy to read and that has a link to the Internet or a 24-hour hotline at the hospital or the physician's office to help get their questions answered.

"Unfortunately, in the period of time in the hospital, their mind is not concentrating on everything," she explains. "It is racing ahead or thinking about what the doctor just said." She says the patient pathway can help translate the message into something the patient can take home.

Przykucki reports that certain services such as surgical services also have clinical coordinators who call patients at regular intervals after discharge. "Our nurses routinely call the patient to follow their progress," she says. Emory also has a 24-hour hotline in case there is an emergency and patients need to contact a physician.

According to Przykucki, a lot of this information is automated in the links that are available

on the Internet sites. Some of the clinical programs for developing pathways and many of the major software companies now have programs that can be tailored to both clinical pathways for the hospital and the clinical pathway for patients based on evidence-based pathways.

"In general, any pathway that is worth its salt needs to have a basis in evidence-based medicine," Przykucki says. "Basically that is nothing more than looking at the body of clinical trials that are out there and trying to utilize them in a way that will bring about the best results for your patients." ■

## Team manages bed crunch with systemwide approach

*Admission sources analyzed*

While many hospitals face the same problem in terms of bed shortages, the solutions to this challenge are as varied as hospitals themselves. Hoag Hospital in Newport Beach, CA, opted to address the problem by forming a Bed Utilization Management (BUM) team that took a systemwide comprehensive approach.

Hoag is a not-for-profit hospital with four centers of excellence including cardiac, OB/GYN, cancer, and orthopedic. "We enjoy a fair amount of success," says **Raymond Ricci**, MD, emergency department chair at Hoag, noting that the hospital ranks first in Orange County in terms of patient choice and is the market leader in admissions, with 250,000 visits to the hospital and satellites.

"The problem was fairly straightforward," says Ricci. "We had too many patients and not enough beds." In addition, Ricci says the hospital census was increasing by about 6% per year, and the admission rate from the emergency department was increasing at roughly 12% per year. "We also had sicker patients coming to our emergency department," he adds.

In 2001, Hoag had about 70 hours per month of paramedic diversion in the emergency department, compared to 10 or 15 hours a month the year before. That figure represents the number of hours it was closed to paramedics. "This was worrisome," Ricci says. "That was a signal that we were not providing access to the community."

In short, Ricci says Hoag was being bombarded.

Patients were coming in from everywhere, including other hospitals, health maintenance organizations, surgery and same-day services, and direct admissions from physicians. "It felt like we were getting hit from all directions," he says.

When hospitals fail to manage patients properly, patients in the emergency care waiting area often leave, Ricci notes. "When we close to paramedics, our patients go to other hospitals," he adds. "That does not make patients happy, and that does not make physicians happy." In addition, surgeries are postponed and the staff are overwhelmed. "They are unhappy and dissatisfied and they want to leave, and that is not a good thing in an era of staffing shortages," he says.

To address this problem, Hoag formed the BUM team with a charter to improve access to the hospital and improve bed utilization and availability. Ricci says the team used a combination of short-term quick fixes that could be implemented immediately and long-term goals and solutions.

According to Ricci, the composition of the team was a key element of its success. It included people from administration, medical staff, the emergency care unit, case management, social services, nursing, admitting, support services, same-day services, and recovery room. "One of the keys to our success is that all these people had a stake in what we were doing," he says.

The BUM team started by analyzing admission sources and space. According to **Jackie Jordan**, RN, BSN, Hoag's director of case management, because the overall effort was a complicated process that affected the entire hospital, the BUM team tried to identify certain boundaries. "We tried in a very organized way to look at the process from the time when the physician decides to admit the patient until the time the patient is discharged," she reports.

For example, if a patient is in critical care and must be moved to medical surgery, a bed must be ready, transportation must be available, and the nursing unit must be ready to accept the patient.

Likewise, when a patient is discharged, the physician must make rounds, the discharge order must be written, and a destination must be secured. "Once the patient is discharged, you have to turn the bed around and start the process all over again," she adds.

According to Jordan, the BUM team felt it required some measures of how bad the problem really was. "We didn't know how many patients were being blocked from admission or how long it took to turn over a bed," she explains. "We needed

to spend some time putting metrics to the process.”

One of the first things the BUM team did was send a group to Virginia Mason Medical Center, a hospital in Seattle that had undergone a bed shortage situation several years before when a nearby hospital closed. “They were running at 99% capacity every day,” says Jordan.

To address the problem, Virginia Mason established an operation center made up of a centralized area with admitting support services and supervisor. “It was very organized,” Jordan reports. “It really made you feel like you had a pulse on what was going on in the [hospital].”

Virginia Mason also designated an access nurse to facilitate patient admission, transfer, and discharge. Because the hospital received many surgical admissions from outside the state, it had to stay on top of who was being admitted and discharged, she adds.

In addition, Virginia Mason established weekly meetings with managers, supervisors, and charge nurses from all departments in the hospital to address the bed shortage.

Hoag had its own formidable set of challenges. For example, the hospital experienced up to 150 bed cleanings a day, depending on the number of admissions, discharges, and transfers. In terms of bed utilization efficiency, Jordan says the BUM team came up with several issues that it wanted to focus on.

One key issue was patient flow. “We felt that we needed something to help with patient flow and bed control,” says Jordan. That meant establishing an infrastructure that did not then exist, along with a centralized communications system. “We wanted to engage our physicians in helping us with utilization and discharge because they help move the patients,” she adds. “We can’t do it without them.”

The BUM team initiated a bed-cleaning tour, which meant helping support service staff clean the room, turn the beds over, move the equipment, and report to the nursing station. “We found a lot of opportunity by going out and really learning the process,” Jordan says. “Unless you go out there and do it, you really don’t have an appreciation.”

### ***Team pinpointed communication problems***

The BUM team also sent out surveys to the medical staff, nursing staff, and various other departments. One problem that surfaced was multiple phone calls to find out the bed status. Jordan says that was due largely to the bed board,

which was a manual system with magnets. “It is the only place in the house that tells you what the house really looks like, and you have to physically come down and look at it,” she explains.

The BUM team also realized it had to establish a communications infrastructure to connect all the departments. In the short term, the team employed some quick fixes, such as revising the bed placement guidelines. “Nursing directors helped prioritize who should get in a bed first in various scenarios,” says Jordan. “We also made sure we had daily charge nurse case manager rounds to ensure strong communication about discharge.”

The BUM team also developed a patient discharge brochure and advertised an 11:00 a.m. discharge policy along with a lunch-to-go program designed to encourage patients to leave on time.

Hoag also initiated a daily bed status report, which was an e-mail sent to about 50 people at 6:00 a.m. and 6:00 p.m. “In a very quick way, it tells you the unit, the census, available beds, discharges out or transfers, admits, surgeries, any in the emergency room,” she explains. “It is a very quick and easy way to get a picture of the house, and it is communicated and updated twice a day.”

According to Jordan, one of the challenges was to get everybody to focus on the entire hospital and realize they are part of a bigger picture. She says the BUM team focused on communications to physicians with specifics on how they could help, such as by using urgent care centers instead of the emergency department when appropriate, making early rounds, and initiating early discharge planning.

“You can write discharge orders the day before so if the patient is stable the nurse can discharge them the next day instead of waiting for the doctor to come in to write the order,” she says.

The BUM team also made a presentation at the general staff meeting, which about half the 800 physicians attended, and reinforced the 11:00 a.m. discharge with physicians.

In addition, the team added something called the Triad, which was made up of the house supervisor, the admitting supervisor, and the manager of support services. “They came together as a team and really helped troubleshoot at the bed board,” she reports. That group met weekly to address issues and work together on a daily basis.

Eventually, the BUM team implemented an automated bed cleaning and tracking system. “We felt we needed centralized viewing of what beds are dirty, what needed to be cleaned, and the status,” says Jordan.

According to Jordan, it has been a challenge to employ that system because volunteers, nurses, and support staff all use it. She says there is currently 40% to 50% compliance, but the goal is 80% or 90%. "We are turning beds over faster," she reports. "There are fewer phone calls and there is less frustration."

Hoag then established a utilization medical director who implemented physician profiles, beginning with internal medicine. The risk-adjusted profiles give physicians feedback about high-volume patients, their length of stay, and their charges, Jordan says.

According to Jordan, managing admit-to-observation is an ongoing challenge. Because it often is difficult to get physicians to write admit-to-observations, the utilization medical director sent out a communication on that subject. The BUM team also has an order set including samples of diagnoses that facilitate this process.

Another idea the utilization medical director came up with was a continuing care liaison. Jordan says the manager of social services now is designing a continuing care liaison pilot program. Hoag does not own its own home care, but it made four agencies part of its outpatient development team. "Our goal is to increase the confidence of the physicians in using home care," she explains. In addition to patient surveys, the team surveys physicians about home care utilization.

### ***Fast-track system revised***

According to Ricci, because space continued to be a major obstacle, Hoag also revised its emergency care fast-track system. "What we used to do is mix our fast-track patients with medical patients because all the beds were the same," he says. However, the BUM team realized that the fast-track patients' turnaround time could be reduced to the two- to three-hour range, and if four or five beds were put aside, the hospital could take 30% of its population in the emergency care unit and turn them around in 45 minutes. That boosted capacity in the emergency department, he says.

Hoag also created an emergency care admit nurse position. Since there was no additional space, the hospital brought the nurse to the emergency care unit, and that helped free up the emergency care nurses from doing all the admissions paperwork, he says. It also helped free up the receiving nurse from some of that paperwork. "This was a win-win and increased our virtual capacity in the emergency care unit and up on the floor," says Ricci.

According to Ricci, measurements and goals were critical to the process. "We needed to know where we were [in order] to figure out where we needed to go," he asserts. Ideally, he says, the BUM team wanted to know how it was doing on a moment-to-moment basis.

The outcomes were broken down into categories such as operational emergency care unit capacity, bed tracking, utilization and discharge, and patient satisfaction. Ricci says the BUM team realized the only thing it could control in terms of the number of patients coming to the hospital was elective surgeries. A forecasting model was developed that estimated the number of elective surgeries, and these data were used to help influence hospital administration in this area.

Since the BUM team was established, Ricci says the emergency care unit volume has been trending up, but the transaction time is flat or diminishing. That is considered an important measure of efficiency, and in this case, an improvement, he adds.

According to Ricci, paramedic diversions essentially were eliminated. The BUM team also implemented an Emergency Saturation Triage, known as a "Code EST," that was used to get everybody's attention regarding bed availability. This is used only when there are patients in the emergency room waiting to be admitted.

Jordan says results were shared with stakeholders to show them how it benefited them. "It was important to have high-level sponsorship," she says. As a result, the CEO was invited to the first meeting, along with the chief of staff. "You could not get more high-level support than that," she asserts. "It really sends a message." ■

## ***COMING IN FUTURE MONTHS***

■ How to evaluate an Applications Service Provider

■ Teach staff Chargemaster 101

■ Expert offers guidance to educating physicians on coding and documentation

■ Can cash discounts come back to bite you?

■ How to obtain reimbursement for admission holds

# Smallpox vaccinations imminent for hospitals

*Know the consequences for your facility*

The Atlanta-based Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) recently approved a plan that calls for smallpox immunization of 510,000 health care workers.

The plan suggests that all hospitals should designate a "smallpox care team" that will be immunized prior to any release of the virus. The committee recommends that the team include a minimum of 40 health care workers per hospital, with some hospitals vaccinating 100 or more, including emergency department physicians and nurses, infection control professionals, intensive care unit nurses, infectious disease consultants, radiology technicians, respiratory therapists, engineers, security, and housekeeping staff.

To help you prepare for sweeping procedural changes, American Health Consultants offers **Imminent Smallpox Vaccinations in Hospitals: Consequences for You and Your Facility**, a 90-minute audio conference Wednesday, Dec. 11, from 2-3:30 p.m., EST. This session is designed to help you and your staff answer serious questions and prepare your facility for the inevitable. How will being vaccinated affect you? How do you protect yourself, patients, and family? What are the logistics of implementing a smallpox care team? How do you deal with vulnerable populations? How do you minimize side effects?

This panel discussion will be led by **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University Medical Center in Nashville, TN. A veteran, award-winning epidemiologist who has seen actual cases of smallpox and currently oversees a volunteer smallpox vaccine study at Vanderbilt, Schaffner began his distinguished medical career as a medical detective in the CDC's Epidemic Intelligence Service. He also is a liaison member of ACIP. Schaffner and an expert panel of emergency and infection control professionals will help you prepare for this critical task.

The second speaker, **Jane Siegel**, MD, is a professor of pediatrics at the University of Texas Southwestern Medical Center in Dallas. The author of several books on infection control issues, Siegel has emerged in recent years as a key CDC advisor. As a member of the CDC Healthcare Infection Control Practices Advisory Committee, she is on a bioterrorism working group that reviewed the critical issues regarding smallpox vaccine. Showing a clear knowledge of the pros and cons of the various options, Siegel presented the working group's research to ACIP.

The cost of the program is \$299, which includes 1.5 hours of free CE, CME, and Critical Care credits. ACEP Category I credit approval for the conference is pending. You can educate your entire facility for one low fee. The facility fee also includes handout material, additional reading and references, as well as a compact disc recording of the program for continued reference and staff education. For more information, or to register, call customer service at (800) 688-2421. When ordering, please refer to the effort code: **65341**. ■

# Joint Commission unveils changes to survey process

*Changes include mid-term self-assessments*

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is significantly revamping its accreditation process to answer its critics and sharpen the focus of its accreditation process. The new initiative, "Shared Visions - New Pathways," will allow hospitals to conduct self-assessments and let surveyors focus on actual patient care experiences.

According to the Joint Commission, based in Oakbrook Terrace, IL, Shared Visions represents agreements among JCAHO and health care organizations about what a modern accreditation process should be able to achieve, while New Pathways represents a new set of approaches or pathways to the accreditation process that will support fulfillment of the shared visions. The initiative will be implemented in January 2004.

The new initiatives include the following:

- streamlined standards and a reduced documentation burden to focus more on critical patient-care issues;
- a self-assessment process to support organizations' continuous standards compliance while

freeing up survey time to focus on the most critical patient-care issues;

- a priority focus process that integrates organization-specific data and recommends areas for the surveyor to focus on during survey;
- a new survey agenda with six basic components: an opening conference, a leadership interview, the validation of the self-assessment results, the focus on actual patients as the framework for assessing compliance with selected standards, discussion and education on key issues, and a closing conference;
- an enhanced role for surveyors in the new process, facilitated by extensive surveyor training;
- revised decision and performance reports providing more meaningful and relevant information;
- the use of ORYX core measure data to identify critical processes and help organizations improve throughout the accreditation cycle;
- better engagement of physicians in the new accreditation process;
- a new approach to surveying complex organizations.

### ***New process should eliminate ramp-up***

The new survey process will be more continuous and will eliminate much of the ramp-up that often takes place before a scheduled survey, says **Dennis O’Leary, MD**, president of the Joint Commission. “We’re consolidating, saying things in a lot fewer words, and moving standards to the most appropriate sections,” he explains. “We have reduced the number of scorable elements, and that has a significant impact in terms of the burden on accredited organizations.”

Accredited organizations will complete the self-assessment at the 18-month point in their three-year accreditation cycle, rating the level of compliance with all standards applicable to that organization. There will be no on-site surveyor visit at the 18-month point.

In the self-assessment, if an organization finds itself not compliant in any standards area, it must detail the corrective actions that it has taken or will take to comply. These actions will be entered into the self-assessment and submitted to JCAHO for review. This activity will not result in any change in accreditation status for the organization.

A JCAHO staff member will follow up with the organization to review its findings, approve the corrective actions, and provide advice or assistance on those actions. At the 36-month point, or the triennial survey, surveyors will go on-site to

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verify that the organization has implemented the corrective actions as laid out in its self-assessment.

JCAHO reports that, during pilot testing, organizations strongly approved of the self-assessment process to help maintain continuous standards compliance. Organizations reportedly required no new resources to complete the assessment, and most already were completing self-assessments using other tools. All the organizations that took part in the pilot completed the self-assessment in the eight weeks allowed. The majority of the organizations indicated that they would prefer three to six months to complete the assessment.

JCAHO says it will contact organizations three to six months in advance of their accreditation midpoint with information on the self-assessment tool, so organizations have adequate time to complete the assessment.

At the triennial survey, surveyors will validate an organization’s compliance over a minimum 12-month track record with all standards involved in its corrective actions. The corrective actions will also drive appropriate on-site education with surveyors.

A special 16-page edition of *Perspectives*, the Joint Commission’s official newsletter, takes an in-depth look at the new accreditation process and is available at Joint Commission Resources’ web site at [www.jcinc.com/perspectives](http://www.jcinc.com/perspectives). Questions may be e-mailed to [sharedvisions@jcaho.org](mailto:sharedvisions@jcaho.org). ■

# DRG CODING ADVISOR.

## *Special Report: Hypertension Coding*

### **Hypertension presents unique coding challenge**

*Hypertension coding can pose problems for MDs and coders*

*(Editor's note: Hypertension coding can be challenging for coders, especially when physician diagnoses lack the detail necessary to obtain the most precise codes. This two-part DRG Coding Advisor series on hypertension coding offers suggestions about how coders can overcome obstacles through better communication with physicians and better understanding of hypertension diagnostics. Look in the January 2003 issue of Hospital Payment & Information Management's DRG Coding Advisor for an article on how coders can learn more about coding diagnostics and for a hypertensive disease coding chart.)*

Too often, a physician's charts will stop at the word "hypertension," leaving the details for coders to obtain through careful detective work.

"What we need to communicate to doctors are the elements required for a complete and accurate diagnosis of hypertension," says **Kelly Butler**, MD, CCS, owner of Dr. Coder & Associates of Murray, UT. Butler spoke about coding essential hypertension and target organ disease at the 74th National Convention and Exhibit of the American Health Information Management Association of Chicago, held Sept. 21-26 in San Francisco.

#### ***'Hypertension is just the beginning'***

"Twenty years into DRGs and we're still not teaching doctors about one of our most common diagnoses: hypertension," Butler says. "Hypertension is just the beginning of the diagnosis."

There are three other elements that are needed once a physician writes the word "hypertension," Butler says. "We need them to say what is the degree of control or lack of control," she says. "If it's controlled, then it's OK, but if it's uncontrolled, then we need to know how severely it is out of control, and they need to use terms like 'malignant' and 'crisis.'"

Also, it's important that physicians document whether there are any organ disease problems affecting the brain, heart, vascular system, renal system, and retina, and how severe these problems are, Butler says.

For example, if there is renal involvement, it could be either renal failure or renal insufficiency, Butler adds. "And we need to explain to doctors that insufficiency and failure are not the same things," she says.

#### ***Let physicians know what you need***

Butler offers these tips for improving hypertension coding:

##### **1. Let physicians know what you need in order to code correctly.**

Physicians need to document whether there is a medical necessity for the patient to be seen, as well as the severity of illness, because the severity of illness with hypertension probably is grossly underreported, Butler says.

"This is a way we justify those expensive services we have for the patient," Butler notes. "Not only for the DRG assignment does it give the greater severity and higher illness, but also for evaluation and management and office billing."

Physicians might note any of these clinical

findings, which offer clues to the severity of the disease, Butler says:

- **Symptoms:** Headache, which usually occurs only with stage 3 in the sub-occipital region; dizziness; palpitations; confusion; easy fatigability; somnolence; impotence; blurred vision; nausea and vomiting.

- **Heart:** Left ventricular hypertrophy (LVH); severe LVH disposes to myocardial ischemia, ventricular arrhythmias, and sudden death; exertional and/or paroxysmal nocturnal dyspnea are possible.

- **Brain:** Stroke: due to thrombosis; hemorrhage from microaneurysms of penetrating arteries; hypertensive encephalopathy, caused by acute capillary congestion and exudation with cerebral edema.

- **Kidneys:** Failure of circulation due to narrowing of arteries; nephrosclerosis.

- **Eyes:** Narrowing of arteries; hemorrhages; papilledema.

- **Peripheral arteries:** Progression of atherosclerotic disease and narrowing of arteries.

- **Hypertensive vascular disease:** Epistaxis; hematuria; blurring of vision due to retinal changes; weakness or dizziness; angina; dyspnea due to cardiac failure; pain due to dissection of the aorta or leaking aneurysm.

## ***Goals of physicians and coders aren't identical***

### **2. Know your own motivations, and those of physicians.**

Coders should keep in mind as they communicate with physicians that the goals of coders and physicians are not identical. Coders work toward obtaining the best coding documentation and the best reimbursement for the facility, and physicians are concerned about obtaining the most reimbursement for their private practices, Butler says.

"If we ask physicians to focus on how to make the office physician billing work better so that they can get more money, then they will change and adjust behavior faster than when we focus on the hospital," Butler explains. "And we get the information we need either way."

### **3. Make your goal to understand hypertension and obtain the most accurate documentation possible.**

In Butler's experience, there are vast amounts of inaccurate documentation of hypertension and other diagnoses, and this leads to underbilling.

"In my last 200 chart reviews, I have found as

much as \$35,000 in incorrect DRG assignments due to inaccurate documentation," Butler recalls. "I focus just on documentation because the coders were fine; they billed what was there."

For example, it's important not to let target organ damage documentation slip through coding cracks. Butler outlines below some major complications and descriptions that coders should know and look for in what is either included or omitted in physician documentation:

- **Hypertensive cardiovascular disease:**

- Cardiac complications are the major cause of morbidity and mortality in the hypertensive patient.

- Prevention of cardiovascular disease is the major goal of therapy.

- Left ventricular hypertrophy is found in 2%-20% of chronic hypertensives.

- Left ventricular diastolic dysfunction and congestive heart failure are common in patients with long-standing hypertension.

- Synergistic when combined with coronary artery disease — powerful predictor of subsequent complications.

- **Hypertensive cerebrovascular disease:**

- Hypertension is a major predisposing cause of stroke, especially intracerebral hemorrhage, but also cerebral infarction.

- More closely correlated with elevated systolic than diastolic elevations.

- Complications are markedly reduced by antihypertensive therapy.

- Preceding hypertension is associated with higher incidence of subsequent dementia — both vascular and Alzheimer's types.

- **Hypertensive renal disease:**

- Chronic hypertension causes nephrosclerosis, a common cause of insufficiency leading to failure, and it can be diminished by aggressive pressure control.

- In hypertensive nephropathy with proteinuria, blood pressure should be less than 130/85.

- Hypertension plays an important role in accelerating the progression of other forms of renal disease, including diabetes.

- Angiotensin-converting enzyme inhibitors are particularly effective in preventing the latter complications and appear to prevent the progression of other forms of nephropathy.

- **Aortic dissection:** Hypertension is a major cause and exacerbating factor in aortic dissection.

- **Atherosclerotic complications:** Most hypertensives die of complications of atherosclerosis. ■

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