

HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

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Best practices will rest on improving coders' clinical practices knowledge

Use time, resources a little differently

For HIM departments to successfully navigate the new Medicare and health care territory of the 21st century, it's important that directors look at managing time, resources, and intellectual capital a little differently than they have in the past. This can be done by establishing best practices for data management and coding quality.

"Coders need to become a lot more familiar with clinical practices," says **Nancy Hirschl**, CCS, vice president of revenue management services for Integrated Revenue Management of Carlsbad, CA.

"Twenty-five years ago, I was basically self-taught as a coder, and I knew that the whole classification system was a puzzle, and that's what appealed to me about it," Hirschl says.

Now the medical field views coders differently. They need education and training, and even the term "coder" itself is outdated, Hirschl notes.

"Coders are people who put numbers on abstracts by looking in a computer program or book and putting a number on it," Hirschl says. "But we've done ourselves a significant injustice and disservice as DRGs evolve, because we're really clinical data analysts — not coders."

As such, coders need to act like clinical data specialists, and this can be accomplished if an HIM department follows best practices in managing data and training staff, she adds.

Hirschl offers these suggestions for establishing best practices in data management and coding quality:

- **Organize charts more efficiently.**

Rather than giving each coder a stack of randomly assembled charts to code, an HIM department could take a little extra time to have the charts sorted according to body specialty, Hirschl suggests.

This is a method Hirschl first developed when she was a coder and now recommends to others.

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"Say I have 50 charts, and I want to produce and do it right, so I'll put all of my cardiac cath charts together, then all urologies, and then bronchial biopsies," Hirschl says. "I take five minutes to look through each chart and then group them according to disease or condition, medical specialty, or body system."

In Hirschl's experience, this was a very efficient process to follow, and she found that it worked with other coders as well, when she implemented the process as a coding manager.

"This is the beginning of what I believe we should implement as a best practice," Hirschl says.

This type of system two important things. First, it helps coders become more familiar with

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clinical practices because they are working on one disease or body specialty at a time, and the unbroken repetition reinforces their learning process. Second, this method allows coders to become more familiar with the physicians who are responsible for most of the documentation and charts in a particular area, Hirschl says.

"You're increasing your speed because you are becoming more familiar with each case type and the whole function," she adds. "When coders work on charts by order of body part, they learn how to ask a question or query, and they become familiar with documentation and familiar with the clinical disease processes."

For example, after a coder has worked on five cardiac cases, he or she will begin to notice the same lab results, same tests, and same terminology, which improves the coder's medical knowledge.

"This applies to coding outpatients as well as inpatients," Hirschl says. "I group all of my knees, colonoscopies, orthopedics, digestive, etc., together."

In Hirschl's experience, coders love this system once they've learned it. "It increases their productivity, and the five minutes it takes to sort cases is not intrusive," she says.

• Improve workflow process.

An HIM director needs to identify practices that affect coding, such as whether the coding is from assembled or analyzed records and when it becomes time for a coding process to occur, Hirschl says.

"The department has to improve the workflow process around coding," Hirschl says.

For example, when records are retrieved or brought down for each discharge, they need to be placed in order and assembled in a consistent order of data information for each chart before they are given to the coders, Hirschl says.

"Coders generally look at a record like a book, starting with chapter one and following through to the end of the book," Hirschl says. "So it's difficult for them to extract information when what is on page 10 should be on page 100."

• Encourage better physician documentation.

One best practices strategy to improve physician documentation is to have a physician liaison who understands coding and who can be used as a conduit to deal with the medical staff around documentation issues, Hirschl suggests.

"In addition, there needs to be a process where nurses or HIM coders work with physicians while patients still are in the hospital," Hirschl adds. "They can ask physicians questions about

the lack of documentation or misunderstandings related to documentation."

- **Focus on revenue cycle management.**

Hospitals need to better manage their accounts receivable. This requires that coding managers and even coders understand the final discharge bill or chart from the hospital computer system, Hirsch says.

"We need to identify high-dollar cases and designate some kind of work processing where those charges might get coded first," Hirsch says. "We also should understand the difference between 'uncoded' and 'unbilled.'"

Some charts are uncoded because the chart never got to the HIM department or because the coders cannot code it until they receive the dictation or transcription of significant reports, Hirsch says.

"And sometimes we can't code because we have to ask the doctor a question," she adds.

Likewise, there often are cases where coders will apply a code, but the case is not billed. An unbilled record could be one that is sitting in a holding file because the payer requires an adjustment, Hirsch explains.

"A whole series of things might have been coded but still aren't billed, and until it's billed, it's considered as an outstanding accounts receivable," Hirsch says. "So as a coding manager of best practices, I would want to find out the difference between uncoded records and unbilled ones."

An HIM department should know how to use the data and reports generated from the hospital's HIM system and how to identify those cases that are not yet billed and/or coded, Hirsch suggests.

"Go find them and find out why they haven't been coded or billed, and then correct them and get them coded," Hirsch says. "Find out why a case hasn't been billed when, in fact, we coded it, and find out what we have to do to facilitate the bill."

While HIM managers might protest that this is the job of the business office and that their department has enough to do, there is a good reason for taking on this extra responsibility, Hirsch says.

"It's a function that a sophisticated and mature coder would want to get involved with because,理想istically, it is what management looks at and thinks is best for the organization," Hirsch says.

Also, due to time constraints, it's common to require cases to be charted and billed within three days of discharge, even though there often isn't adequate information at that time, Hirsch says.

"I don't agree that coding a chart that's not ready is a good thing, but that's what accounts receivable is all about," Hirsch says. "The billing department will drop bills quickly so there are no outstanding payments, but that's not the best way to manage coding, so there's a disjoint between cash flow and coding quality."

If at all possible, coders should make sure there's enough time to obtain all of the necessary documentation before completing a chart's coding and letting it be sent out for billing, Hirsch adds. "Also, help the billing department get rid of the backlog, because that helps both departments." ■

ASPs can expand the resources of HIM

Expert offers suggestions on choosing right one

Sooner or later, your HIM department probably will begin the process of moving documentation, communications, and transcription to an electronic process, and may decide to use an application service provider (ASP).

ASPs are Internet-based companies that own and operate servers (computers with large amounts of storage and activity memory) and software applications. These service providers give subscribers access to software applications via the Internet, charging on a per-use, monthly, or annual basis.

ASPs can assist with emergency department data, transcription data, and everything else that can be handled electronically. By using an ASP, a facility does not need to have its own information technology department, because the entire operation of managing servers and information management infrastructure can be outsourced, explains **V. Juggy Jagannathan**, PhD, chief operating officer and chief technology officer of Careflow/Net of Morgantown, WV, a company that has a software product that is used by companies that want to host ASPs.

Jagannathan, who also is an associate professor of computer science at West Virginia University in Morgantown, spoke to HIM professionals about ASP technology at the 74th National Convention and Exhibit of the American Health Information Management Association of Chicago,

held in San Francisco on Sept. 21-26, 2002.

"This way they won't have the headaches of maintaining a system," Jagannathan adds. "So you are basically sharing the space, the framework, and infrastructure across multiple companies, and it can be a huge cost savings for different enterprises."

Jagannathan offers these guidelines to selecting and using an ASP in a health care setting:

- **Ask the potential ASP contractor for answers.**

There is a complex set of requirements necessary for successful deployment of an ASP, so it's important to make certain the potential contractor can answer various questions, including these:

- Can the ASP support your processes?
- How flexible is the ASP in supporting your particular processes?
- Does the ASP contractor adhere to security requirements?
- How reliable is the ASP?
- Does any information get lost or mangled, and how reliable is the infrastructure? Is it fire-proof and protected?
- What guarantee is given of the system being repaired as needed?
- What is the policy regarding the ASP's availability? "How long will the system be available for use, and what are the guarantees?" Jagannathan asks. For example, an ASP that has a downtime of five minutes per year is 99.999% available. "Most people might not need that level of availability, but every organization needs to know what their availability requirements are," Jagannathan adds.
- What happens if there are more users on the ASP and more volume?
- How easy is it to upgrade the infrastructure, and are the hardware needs excessive?
- What benchmarks are available, and how much time does it take to submit and retrieve reports when the system is under a heavy load?
- Can the user manage its own support needs, and is it Web-based?
- Who maintains the software, and how are maintenance and software evolution managed? "Nothing remains static," Jagannathan notes. "Even the small hospital must plan for changes, so you want to know how the ASP will handle these things and what kind of performance guarantees are given."
- What is the technology basis that facilitates maintenance? "ASPs will require routine maintenance to make sure things are handled,"

Jagannathan says.

— How easy is it to interface to the system, and what kind of data exchanges are supported? "How will it integrate with existing infrastructure and how does it work?" Jagannathan says.

— What is the platform used (e.g., Windows or Unix), and does the system support leveraging the strengths of both platforms?

Keep Internet standards in mind

- **Make certain it meets Internet standards.**

For example, XML, or extensible mark-up language, is emerging as an important technology, Jagannathan says.

XML-based content tagging has important uses, such as data mining, role-oriented display customization, intelligent searching, and other value-added elements, he says.

For example, all documents could be marked with a tag, and XML permits the user to define which tags are allowable, Jagannathan says. "This allows programs to manipulate information as opposed to having human beings review the data, and this is a fundamental change."

With XML, the user has information that is structured and readable and that is, at the same time, easily manipulated within various programs.

"This is a technology that I look at as one in the future of ASP industries, and it's evolving," Jagannathan says.

Also, an ASP should meet standards of the common object request broker architecture (CORBA), Jagannathan says.

"This pertains to how programs can communicate over the Internet," he explains.

The advantages offered by CORBA are that it has hardware and operating system independence, language independence, and location independence. Also, the standard specifies the Interface Definition Language that is used to describe interfaces that client objects call and object implementations provide, Jagannathan says.

"These are all technological underpinnings for developing ASP solutions or enterprise-class solutions and those types of technologies," Jagannathan says.

- **Look for an ASP solution that supports coding and transcription.**

"There are outsourced coding solutions available now," Jagannathan says.

"There is an ASP for coding, which basically is saying that somebody else is doing the coding for

your hospital," Jagannathan adds. "Health care providers also are interested in transcription solutions, and there are a number of ASP transcription vendors."

Also, health care providers will want to make certain the ASP meets all privacy regulations, including new rules established under the Health Insurance Portability and Accountability Act (HIPAA).

"HIPAA is a moving target," Jagannathan says.

However, ASPs typically will not permit unencrypted documents to be transmitted over the Internet, and most use a browser device that signifies that the communications between a facility's browser and the server are encrypted, he says.

"You do have other issues with HIPAA, such as making sure no one outside the organization has access to the information, so there is a concern about access control," Jagannathan says.

An ASP may provide an audit trail that tells who looked at the information and why.

"When considering security issues, this is something that needs to be addressed with the ASP contractor," Jagannathan says. "How they address it is all related to security and making certain HIPAA mandates are being followed." ■

Your ED could be losing \$250,000 each year

You can, however, improve revenue flow

Would it surprise you to know that your emergency department (ED) may be missing out on \$250,000 per year of legitimate payments?

Due to high patient volumes in EDs, minor billing errors can result in significant revenue loss, says **Jeffrey Bettinger, MD, FACEP**, founder of Bettinger, Stimler, & Associates, a Pinecrest, FL-based organization specializing in health care reimbursement.

Bettinger estimates that many EDs are losing \$10 of net revenue per encounter.

"For EDs with an annual volume of 25,000 patients, that equates to \$250,000 of lost revenue per year," he says.

Here are four ways to improve your revenue:

1. Don't undervalue the ED level of service.

Selecting the level of service is a surprisingly subjective process in most EDs, according to **Marty Karpel, MPA**, ambulatory care consultant for the Karpel Consulting Group in Long Beach, CA, which specializes in operational and financial process improvement for EDs.

"Oftentimes, nursing staff are expected to not only care for the patient, but also to determine the appropriate level of service," he adds.

As a rule, clinicians tend to undervalue services, says Karpel, adding that you need a methodology that accurately assigns the level of service. He notes that the physician level of service may differ from the facility's. For example, with conscious sedation, the physician provides the orthopedic or laceration repair care, and a nurse subsequently has to monitor the patient for an hour.

"Clearly, in that situation, the resource intensity is significantly greater for the facility than the physician," says Karpel. However, he says some facilities will use the physician level of service regardless. "I often find an incredible variance between the services provided and the way the hospital charges for them," he says.

Karpel recommends using a point-based system to allocate a certain amount of points to each nursing activity, with the sum of those points determining the level of service.

2. Make sure there are no missing procedures.

Poorly documented records are a major source of revenue loss, says Bettinger. "Each provider should be trained on the most effective ways to accurately describe the patient encounter," he says.

Nurses usually chart medications consistently because they have to draw and administer these, but they don't always document procedures that are more physician-involved, such as laceration repairs, fracture reductions, or splint applications, he says.

A person who understands what goes on in the ED, such as a former nurse or paramedic or ED tech, should review all your charts, says Karpel. "If services are missed or not documented, that feedback should be provided to nursing staff on an individual basis," he advises.

3. Avoid lost billing for patients.

Often, not every patient seen by the ED physician has a bill generated, says Bettinger. "Records can disappear prior to being sent to the billing agent," he says. "This typically happens on admitted and transferred patients, or those that have transcribed medical records."

2 ways to catch underpayments

Even with appropriate, timely documentation, it's all too common for EDs to receive insufficient payment from the payer, according to **Jeffrey Bettinger, MD, FACEP**, founder of Bettinger, Stimler, & Associates, a Pinecrest, FL-based organization specializing in health care reimbursement.

"There needs to be a detailed system in place to catch these underpayments and to effectively attempt to collect the balance owed," he says.

Here are two solutions for this:

1. Use a billing software system programmed to display the expected payments for each charge.

This is a time-consuming process that needs to be performed every year, says Bettinger. For all payers, the contracted amounts per individual charge code need to be loaded into the system, he says. Then, when a payment is being posted on the billing system, the payment poster has instantaneous capability to assess whether the remitted payment is correct, he adds.

"Some billing agents have even gone so far as blocking the posting of any payment that does not meet the pre-set expected payment amount for the individual charge code," he says.

2. Create a spreadsheet that lists the expected payment amounts for all contracted payers.

This method can be used if your software system doesn't have the capability to display expected payments, Bettinger explains.

"Unfortunately, if the payment poster does not have access to the expected payments, underpayments often will be accepted as correct, with corresponding inaccurate adjustments to the invoice," he notes. ■

Use the ED log as a control document, and have a process in place to account for 100% of all ED visits, Bettinger recommends.

He suggests performing a 100% reconciliation with the ED log and the number of records sent to the billing agent. However, because a complete set of records is often not available until several

days after the date of service, Bettinger notes that someone needs to perform the laborious, detailed job of tracking down the medical records for every name on the ED log.

"If this job is not performed in a diligent manner, many medical records will not be sent to the billing agent, leading to significant loss of revenue," he warns.

4. Don't exceed time limits for billing.

Exceeding time limits for billing often is a problem when EDs have a high turnover rate of physicians, because many payers, especially Medicare and Medicaid, require all invoices to include the Provider Identification Number (PIN), Bettinger says.

"Often, the PIN takes months to be obtained," he says. "If there is not tight control of the process, many invoices will become too old to allow them to be submitted to the payers."

Typical problems are provider delays in filling out the forms, lost paperwork, and inaccurate submission of information, Bettinger says.

"Someone needs to take ultimate responsibility for walking the application completely through the process," he says. "It's really a matter of using simple tracking mechanisms to make sure that no one is dropping the ball." ■

Electronic technology improves operations

Making switch is slow, but worthwhile

Spaulding Rehabilitation Hospital in Boston first implemented its new electronic data system two years ago, solely to replace the existing hospital information system for business operations.

The initial focus was on implementing billing and accounts receivable replacement, medical records and admission data, and discharge and transfer system information. Completed Oct. 1, 2001, the first full year of implementation resulted in a positive \$6 million yield in cash receipts, says **Rick Mason**, corporate director in information systems department for Partners HealthCare Systems in Boston, an organization created when MassGeneral and Brigham and Women's Hospital merged, creating the parent company of Spaulding Rehab. Mason is the site chief information officer at Spaulding Rehab.

"The electronic system worked so effectively that the accounts receivable people have told me that our effective return on investment was six months, as the cost of the installation was \$3 million," Mason says. "We brought in \$6 million above and beyond what we would have expected from prior years results."

Spaulding had used an electronic system called created by Medical Information Technology Inc. (MEDITECH) of Westwood, MA. The MEDITECH software applications can be used for financial, clinical, data storage, and other needs of a health care system. After that initial success, the rehab hospital began a second phase and implemented an executive support system in March 2002, and a pharmacy system in June 2002, Mason says.

"Then on July 23, 2002, we went live with a number of clinical applications, including clinical labs, microbiology, radiology, order entry, and patient care inquiry," Mason says. "The system looks at an aggregate of patient data from all the ancillary departments I mentioned and puts them into a series of screens that a physician can access easily using nothing more than arrow keys."

Saving space with laptop computers

The hospital also switched to a hospital-wide wireless system, which included 30 carts with battery-powered laptop computers that could run all of the applications of a typical desktop computer over the wireless infrastructure for 16 hours straight before the batteries needed recharging, Mason says.

"The driving force to install it was the fact that we were limited for space, so placing desktop computers on nursing stations was not an option," Mason says. "The secondary limitation is that our heating and air system in the building are operating nearly at capacity."

Desktop computers generate significant heat, and adding the necessary number of these computers to the hospital would require the heat and air conditioning system to undergo a \$1.5 million upgrade, Mason says.

"Because we were battery-powered, there was no power drain during critical hours, and laptops don't generate the heat that the typical monitor does, so the laptops were not straining the heating and air system," Mason explains.

The wireless alternative to desktop computers cost about \$120,000 to install, Mason adds.

From the basement through the hospital's 10th floor there are several antenna access points

on each floor, making it possible for clinicians to roll the laptop into each patient's room, into the solarium, the therapy gym, and even the restroom, and still stay logged onto the network, Mason says.

"The added benefit is that physicians can use this system with laptops that are not cart-based, and they can walk floor-to-floor and in and out of patients' rooms without having to log in and log out each time, Mason adds.

"The wireless system paves the way for a hand-held solution, which we plan on implementing within the next 24 months," Mason says. "That will be tied into our wireless system."

Mason offers this description of some of the other features of the wireless electronic system, including some future clinical applications:

- **Clinical labs:** The computer system supports the diagnostic analyses of specimens from patients, and these can be entered into the system and viewed from any of the computers. This way, physicians easily can check the lab results as they enter patients' rooms.

- **Microbiology:** Again, clinicians can obtain information about blood, urine, and tissue specimens that has been entered by lab techs into the wireless system.

"Prior to implementation of MEDITECH, we did have a lab system that wasn't integrated and had a stand-alone microbiology system that wasn't integrated into a single result reviewer," Mason says. "Now the orders are entered into one system, and they're directly mapped into microbiology or labs, and the results all are viewable in a single area of the single application.

- **Patient data:** Patient demographics are completely integrated into the system, so whenever a particular patient's file is reviewed on the system, whether the information sought is clinical or financial, the patient's demographics are included.

"It provides you with a tremendous source of value, and the true benefit to this application is a single source of truth," Mason says.

- **Data integration:** The electronic system provides greater efficiency and data integration, which in turn improves communication between departments, Mason says.

"Integration has a side benefit, as well," Mason adds. "Because when you start to develop interdisciplinary applications that reside with each other functionally, you start as a side benefit to force departments that have never worked closely with each other to understand how each works

and to develop higher methodologies of communicating with each other."

For example, a physician was concerned that when a secretary was entering an order for him that a previous order had disappeared off the system, and he wanted to append the previous order, but not delete it, Mason recalls.

The normal process is to call the lab to append the order, and if you want to change the order then you delete the series already in the system and create a new series.

However, due to the electronic system's data integration, this process wasn't necessary. And, as a result of the data integration and the physician's inquiry into it, what happened is that the physician, along with nurses, pharmacists, and others, gained a better understanding of how the lab functions. What they discovered was that the lab automatically does a complete blood test whenever a more limited blood test is ordered. So if a physician wants to ask for more information on the blood drawn from a patient, most of the time that information already is available within the lab, Mason explains.

"The lab simply needs to post additional results, and nobody really understood that before," Mason says.

- **Radiology:** The radiology department previously had no scheduling system, but with the electronic system changes, it now has a built-in scheduling system that permits radiologists to transcribe reports to the MEDITECH System, Mason says.

"We are working on a web-based imaging solution so that physicians network-wide can view a patient's radiology results or images from anywhere on the system, including wireless networks," Mason says. "We're working on the imaging portion and expect to have that finished in a year."

- **Order entry:** When a physician wants to order a lab test, radiology test, or microbiology test for a patient, all that is necessary is to put the order into the electronic system, and the order can be reviewed by the appropriate ancillary departments, Mason says.

"As a result of that the ancillary departments will work on processing those results and have a timely turnaround of putting the results into the system so that physicians and nurses can access the data quickly and easily," Mason says.

"The system allows us to communicate more quickly with ancillary departments, and it allows us to have higher-level analytical skills in planning

upgrades or new operational changes to our hospital's environment," Mason adds.

- **Pharmacy:** The pharmacists, like nurses and physicians, now use wireless laptops. This frees them physically from being stationed solely in the pharmacy, so the hospital now has clinical pharmacists operating on the floors, available to provide enhanced clinical support to nurses and physicians, Mason says.

"The drug orders are placed the night before, and the pharmacist comes in early in the morning to work on them," Mason says.

Eventually, the system will permit physicians to place medication orders directly to the pharmacy through the electronic system.

Pharmacy techs prepare individual doses based on the orders, and the pharmacists check the orders before they're placed on carts that go directly to the patient floors, Mason explains.

Then the pharmacists are free to visit the floors, where they can answer questions by clinicians and handle any issues that might arise, such as adverse reactions to a drug or allergic reactions. Occasionally they'll even speak with patients, Mason says.

"The biggest advantage is safety because of the fact that they're supporting care providers on the floors," Mason says.

Another safety feature is that the electronic system will provide checks and balances for physician medication orders. It will permit physicians to review their drug orders, and it will assess the order for safety and appropriateness according to the patient data. If the system detects something unusual, it will provide a prompt to the physician, asking, "Are you sure you want to recommend this medication, based on the following," Mason says. ■

Track supplies, save money by computerizing inventory

Designate staff, prepare preference cards

As reimbursement levels fall, hospital managers are faced with the task of improving profit levels. Because increasing volume can increase profits, managers often look toward increasing the number of cases that can be handled within the workday.

Inventory system should include these features

Electronic purchase orders save time

When shopping for an inventory system, look for one that addresses the specific needs of your facility, suggests **Terri Gatton, RN, CNOR**, administrator of the Zanesville (OH) Surgery Center. Otherwise, you'll invest too much time and money in a new system to try something that may not be designed for surgery, she adds.

"There are many practice management systems that have an inventory system," says **Scott Palmer**, group vice president for SurgiSource, a product that includes inventory management, produced by Birmingham, AL-based Source Medical Solutions. Palmer and Gatton suggest that you look for the following features to make sure you have a system that will save you time and money:

- **Item master.**

Your item master should support multiple vendors, manufacturers, and locations, says Palmer. The system also should be able to generate purchase orders as needed and even send them electronically if your vendor supports that capability, Palmer says.

Electronic purchase order transmission is a must, says Gatton. "This feature saves a lot of

By computerizing your inventory and integrating it with your scheduling and billing systems, you can improve your efficiency and enjoy a cost savings, says **F. Craig Veach**, associate vice president for Source Medical Solutions, a health care software company based in Birmingham, AL.

"A computerized inventory system with a perpetual inventory means that you know what you have on a day-to-day basis and can order every other day rather than weekly or biweekly," he says. The ability to order more frequently without having to do a manual inventory means less stock is kept on hand, and this situation improves cash flow, he points out. For example, a facility that spends \$1.2 million each year on supplies when ordering on a weekly basis can order every other day and reduce spending to \$700,000, he says.

A good inventory system will utilize preference cards as a way of tracking supplies that are

time and manpower," she explains.

- **Preference cards and pick lists.**

Preference cards need to be integrated into the system because they are the basis for the ordering advice, says Palmer. Preference cards cut down on staff time because only the exceptions must be entered, he adds.

Although some department managers choose to create preference cards for the procedures performed most often, Gatton suggests cards for each physician and each procedure. "This keeps our ordering process accurate and nurses don't have to list as many exceptions," she adds.

- **Reporting systems.**

You should be able to get reports that show current costs in relation to historical costs, as well as to industry standards, suggests Palmer. This helps you make informed decisions and to identify trends that need to be investigated, he adds.

- **Physical count reconciliation.**

You should plan on a quarterly manual count to verify your computerized inventory, says Gatton. Updating your computerized inventory to reflect actual, manual counts should be a simple process, she says.

- **Alerts when supplies are low.**

Using par levels set by the department manager, a computerized inventory system should alert the materials manager that a certain item has dropped below a predetermined level, Palmer says. ■

used and also will monitor your stock and alert you when a supply falls below your pre-set par level, says Veach. The system should help you identify supplies that are not used so you can evaluate whether you should continue stocking them, he adds.

While many managers may cringe at the thought of developing preference cards to integrate with the inventory and scheduling systems, the effort is worthwhile, says **Terri Gatton, RN, CNOR**, administrator of the Zanesville (OH) Surgery Center.

Her facility is only three years old, so developing the preference cards was part of the start-up, she explains. "I have gone through a conversion from a system that did not use preference cards to one that did, and I still recommend that preference cards be developed to ensure the best use of the inventory system," she adds.

Although Gatton chose to develop preference cards for all 40 surgeons and their procedures, Veach suggests that managers who are converting to a computerized system consider producing preference cards for their highest-volume procedures. "Because 20% of your cases produce 80% of your revenue, focus your efforts on them," he says. Other cases such as eye procedures may require generic procedure cards that can be edited as needed, he adds.

Another time-saver can come from your vendors, says Veach. Most vendors can supply you with a downloadable supply and equipment list so you don't have to enter all the information, he explains.

Gatton knew what features she was looking for in a system, but she believes that the key to successfully using your inventory system is to have

a dedicated materials management coordinator.

"Don't expect a staff member to assume these responsibilities on top of other jobs," she says. By having one person who manages inventory, purchasing, and receiving, you can keep a close control on your inventory, she says. Quarterly manual inventory counts that are done to double-check the inventory show that the computerized system is usually within \$2,000 of the actual count, she adds.

The materials management person doesn't have to be a clinical person, but Gatton has found that there are advantages if you find a nurse to handle the position, as she has. "Not only does she understand medications and recognize inconsistencies, but she can also filter out vendor representatives who want to see me," she says. ■

Preprinted forms gone; data flow is enhanced

Embosser cards, bulky machine also gone

Palmetto Health Baptist Hospital in Columbia, SC, has replaced its old embosser card technology with a Patient Link Up Enterprise (PLUE) system that has eliminated costly preprinted forms and increased the clarity and accuracy of the patient data flow, says **Charlene Cathcart**, director of admissions and registration.

The system, a product of Standard Register, went live at Palmetto Health Baptist in May 2002, and is scheduled to be in place at Palmetto Health System's two other hospitals by early spring, Cathcart says.

The PLUE system "gives us the ability to print any piece or the entire admission kit directly to a printer located at the nursing station," she adds. Cathcart notes that while many hospitals choose to have those documents print in the admissions area, sending them straight to nursing is in line with a Sentinel Alert issued

by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

"Sentinel Alert No. 10 talks about nurses writing information by hand and the need for bar code identification," she says. As she was researching PLUE, Cathcart notes, she discovered that not only could the system send documents directly to the nursing station, it could print labels with bar codes.

Realizing she could get rid of the embosser cards and their accompanying technology — an expensive machine that broke down every two weeks or so — sold her on the Standard Register product, she says.

The bar code labels "allowed us to be a little more creative," Cathcart explains. "We do bedside glucoses here, and before, clinicians had to manually type in a 10-digit account number for that patient. Now they can just take the glucose meter and scan it from the patient's armband, and the bar code reader downloads the [account number] into the lab system."

Although there are no hard data available yet on the cost-effectiveness of the new system, Cathcart says her sense is that "the savings are

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pretty significant. One box of the old multipart admission forms costs \$286, and we use about three boxes a week. The cost of a box of blank paper is virtually nothing."

In addition, "we no longer have to have a staff person go into the workroom, break down an admission packet, and sort out the pieces for different places," she points out. "The only pieces that print in the admissions area are the admission, consent, and assignment of benefits form."

Some ancillary departments at Palmetto Baptist also receive face sheets directly, Cathcart notes, and that practice will be more widespread at the Palmetto Richland campus, which is more decentralized. "There will be printers in more ancillary departments, and if they need another copy, we will let them print it."

Unlike at Palmetto Baptist, which has a very centralized operation, she says, a large number of patients at the Richland campus are sent directly to the appropriate ancillary department. "They would need to have [access to the system] where they are, so they can print and reprint as needed."

Patient safety enhanced

A major advantage of the PLUE system is that patients are identified more quickly and accurately because their identifying information is not written by hand or added with an embosser card, Cathcart says.

The system also provides the ability to fax physician orders directly to the pharmacy, she adds. "The physician is on the unit, [the printer] spits out a blank form with the bar code [identifying the patient], and he writes the order on that form, which is faxed to the pharmacy," she explains.

In the past, Cathcart says, the second part of the multi-part physician order — a smeared duplicate page — would have been sent by pneumatic tube to the pharmacist, who often would have had trouble reading the information and would have had to look up the patient in the computer system. With the new system, she adds, the process is enhanced because, in effect, every copy is an original.

The price of the system varies, she notes, "based on how you decide to roll it out. It can be done inexpensively, or you can choose to put printers on all the nursing units. Based on my last calculation, I should be able to cost-justify it in two to five years."

Implementation of the PLUE system went particularly smoothly at Palmetto Baptist, Cathcart adds, because nursing and the ancillary departments were an integral part of the process from the beginning.

It also helped that a multidisciplinary team drove the project, she says. "A lot of times information technology makes the decisions and you live with them, but this time we made the decisions together. We got input from the medical staff, did a lot of education of physicians, and it went extremely well." ■

Registrars' cash incentive raises hospital collections

Figures double in just one year

Brown County General Hospital more than doubled its up-front cash collections over the past year by offering incentives to both registrars and their bosses, says **Barb Dailey**, patient access director at the Georgetown, OH, facility.

Fifteen registrars who cover the admitting, outpatient, and emergency areas at the 50-bed hospital had collected close to \$15,000 by mid-November 2002, compared to \$7,000 for 2001 and \$5,000 for 2000, Dailey says. The goal for 2002 was \$10,000, she adds.

Beginning in January 2002, the hospital began offering registrars 3% of whatever they collect in up-front co-pays and deductibles, Dailey explains. Dailey and a supervisor each get 1.5% of the total collected. Clinic fees charged by the specialty physicians in the hospital's outpatient pavilion are included, she says.

"We keep track of it through the business office," Dailey says. "Receipts are printed out in the system and added up at the end of each quarter. [The business office staff] figure up the bonuses and [registrars] get them with their paychecks."

Depending on the assertiveness of the registrar — and to a large extent the shift and area in which she works — those bonuses can be as little as \$2 or \$3 or as much as \$40 or \$50, Dailey notes. "Those on third shift don't collect much, because they don't have as many patients to see."

Registrars make note of insurance cards to see the kind of plan to which patients belong, she

says. They have suggested scripts to use during collection efforts, Dailey adds, which include statements such as, "How would you like to pay your co-pay today?" and "We accept checks, credit cards, or cash."

Hospital administrators are looking toward an eventual bonus payout on \$100,000 in collections, she says, which probably would be close to 100% of the money due, according to Dailey.

"Our biggest trial is to get patients used to paying up-front," Dailey points out. "We've posted signs saying that if you're a self-pay [patient] or have a copay on an MRI [magnetic resonance imaging], payment is expected up front," she adds. "That is starting to help."

In some cases, patients actually want to pay but can't because the appropriate amount has not been determined, Dailey notes. "We're hoping that we can set a figure of \$50 or so [to be paid] toward whatever the deductible is. We're coordinating with information systems and patient financial services on the charges [for various procedures]."

ED procedure changed

Up-front collections in the emergency department (ED) alone have increased by about 80%, Dailey says, in part because of a change in the triage process that occurred during the quarter that ended June 2002. The new procedure, she adds, was implemented after careful examination of the provisions of the Emergency Medical Treatment and Labor Act.

After the nurse triages the patient and determines that his or her condition is not an emergency, Dailey explains, registrars are free to register the person and collect the co-pay. In the past, she says, registrars waited until the end of the ED visit to attempt to collect the payment. "That didn't work because the patient never got back to us. Now we get them before they go back to be treated."

Most patients have a set co-pay for ED treatment, Dailey notes. "If it's a 20% deductible, we don't try to collect those." Eventually, however, the hospital plans to work out the deductibles and collect accordingly, she says.

In the case of emergent patients, payment is not mentioned until the patient has been treated and stabilized, Dailey says. At that point, registrars may attempt to collect, she adds. "With the incentive bonus, more of them go back and ask [for payment], where they didn't before." ■

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Final OPPS rule increases spending

The 1,000-page final outpatient prospective payment system rule, which takes effect this month, provides the congressionally mandated inflationary update and increases overall spending, but still pays hospitals only 83 cents for every dollar spent on outpatient care, the Chicago-based American Hospital Association (AHA) points out.

The rule gives the mandated 3.5% increase, but the net effect of all provisions in the rule results in a 3.1% increase from last year for urban hospitals and a 6.2% increase for rural hospitals, according to a report in the on-line service *AHA News Now*.

The rule does not include a pro-rata reduction in pass-through payments for some new and high-cost devices, drugs, and biologicals. It lowers the outlier threshold from 3.5 to 2.75 times the ambulatory payment classifications amount, enabling hospitals to reach the outlier threshold sooner. Still, outlier reimbursement will drop from 50% to 45% of costs above the threshold amount. ■

DRG CODING ADVISOR®

Special Report: Hypertension Coding

Knowledge leads to coding accuracy and better quality

Speak physicians' hypertension language

(Editor's note: This second part of a two-part DRG Coding Advisor series on hypertension coding offers suggestions about how coders can overcome obstacles through better understanding of hypertension diagnostics and through use of a hypertensive coding chart.)

If coders better understand hypertension diagnoses, they will be in a better position to ask doctors for more precise information and to code hypertension diagnoses more accurately, says a coding and medical expert.

"Coders need to be diagnosticians," says Kelly Butler, MD, CCS, owner of Dr. Coder & Associates of Murray, UT. "If they aren't, then they can't go to the doctor and say, 'I found these symptoms, and I wonder if this is what you meant to say.'" If coders can speak confidently with physicians in their own language, then physicians are less likely to brush coders' concerns under the rug, Butler adds. Toward this goal, Butler offers coders this educational advice on hypertension:

1. Understand hypertensive disease.

Hypertension, which affects 50 million Americans, is blood pressure that is 140 or greater systolic and 90 or greater diastolic, Butler says. Of the 50 million Americans with hypertension, only 68% know their diagnosis, Butler adds. "Of those that know, only 53% with a hypertension diagnosis are receiving treatment, and of those receiving treatment, only 27% have their blood pressure under control."

Hypertension patients often won't take their medication because they don't feel sick until they do, Butler says.

"With this silent disease, there is progression, and it progresses to the point where it stops being silent and starts to scream," Butler explains. "And it screams by congestive heart failure, renal failure, and blindness."

2. Know the stages of hypertension.

The stages of hypertension are as follows:

- **Stage 1, mild hypertension:** 140-159 systolic and 90-99 diastolic.
- **Stage 2, moderate hypertension:** 160-179 systolic and 100-109 diastolic.

- **Stage 3, severe hypertension:** 180 or greater systolic and 110 or greater diastolic.

Below hypertension, there is high normal blood pressure, which is 130-139 systolic and 85-89 diastolic. Blood pressure readings optimally are less than 120 systolic and less than 80 diastolic, although the normal range extends up to 129 systolic and 84 diastolic.

"When you hear 'mild,' 'moderate,' or 'severe,' you know their blood pressure is out of control," Butler says. "But that's all it says, because a coder cannot assign accelerated hypertension or malignant hypertension codes just based on a blood pressure reading."

Also, although hypertension coding permits a code for benign hypertension, that code is so rarely used that it should be a red flag to coders if the word 'benign' appears in a physician's notes, Butler says. (See chart on hypertensive disease, next page.)

3. Know the hypertensive emergencies.

Proper coding also depends on which of the following hypertensive emergencies apply:

- **Accelerated hypertension:** This is a significant increase in blood pressure over previous levels and can entail vascular damage on funduscopic exam without papilledema.

• **Malignant hypertension:** The systolic reading is greater than 200 and the diastolic is greater than 140. This diagnosis occurs in about 1% of hypertensives, and more often in men than women. It can result in encephalopathy or nephropathy, severe headache, vomiting, visual disturbances, transient paralysis, convulsions, stupor, coma, cerebral vascular spasm and edema, and presence of papilledema. It's usually accompanied by retinal hemorrhages and exudates. Progressive renal failure can occur if malignant hypertension goes untreated.

- **Hypertensive encephalopathy:** This also is a significant increase in blood pressure over previous levels. Its symptoms include headache, irritability, confusion, and altered mental status due to cerebrovascular spasm.

• **Hypertensive nephropathy:** Again, this is a significant increase in blood pressure over previous levels, and it can result in hematuria, proteinuria, and progressive renal dysfunction due to arteriolar necrosis and intimal hyperplasia of the interlobular arteries. ■

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