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INSIDE

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Linking coding and mortality rates helps convince physicians to change

Tip: Point out Internet MD report cards

A major reason it's so difficult to change physician behavior where coding and documentation are concerned is that many doctors see hospital coding as separate from their own practice and experience. So the key is to find a way to tie physicians' coding to their own outcomes.

An HIM compliance manager with Catholic Healthcare West in Rancho Cordova, CA, has found a way to do exactly that by educating physicians about how popular web sites use hospital coding to rate both hospitals and the physicians who practice in them.

"These web sites use one to five stars for their ratings, and we wanted to explain to physicians where the web sites get their data and what the impact is specifically when the public has access to this information," says **Mark Anderson**, RHIT, CCS, corporate coding/HIM compliance manager for Catholic Healthcare West.

"The public can log on to these sites and look up physicians or five-star hospitals in their area and see which physicians are associated with them," Anderson explains. "Their documentation affects their rating, and the hospital's."

When Anderson met with a group of physicians to discuss coding and documentation, he found that this link between coding and the Internet rating systems quickly got their attention.

"We told them we did a search in a certain town for physicians associated with a three-star or lower hospital, and we got 39 names of doctors," Anderson adds. "And then we asked for the physicians associated with a five-star hospital and came up with three names."

Anderson explained to physicians how these web sites come up with their ratings. Basically, the ratings are arrived at by measurements of predicted mortality against actual mortality.

From the Uniform Hospital Discharge Data Set, web site managers

are able to find a hospital's actual mortality rate. For predicted mortality rates, they use the Medicare Provider Analysis Review data, which is derived from ICD-9 codes, Anderson says.

"What the physician writes in documentation gets coded and goes into the government database," Anderson adds. "Web sites get hold of the data, which is public, and they go by the codes using a proprietary formula, and they don't explain how they come up with it."

However, it is clear that the web sites make predictions of how sick a patient is based on the codes. If a doctor fails to document certain items, then that doctor's patient might look healthier than another doctor's patient, even though both patients are equally ill.

"If a doctor just writes down 'pneumonia' and doesn't mention the patient's stroke, urinary tract infection, and aspiration pneumonia, then the risk of mortality for that patient will look lower than it really is," Anderson says. "If all of the information is documented, then the patient's true severity of illness is reflected, the predicted mortality rate goes up, and both the hospital and physician look better."

By explaining this process and how the data could be used to rate the quality of care a particular physician provides, Anderson was able to get physicians to buy in to the idea of improved documentation and coding.

"Improving data quality may be a better incentive than asking physicians to consider financial implications for the hospital," Anderson notes.

"When I was a coder, we used to sit around after a consultant reviewed our coding for a week, and they'd say, 'If the physician stated this then you could have coded it this way,' and it was always 'could have,'" Anderson recalls. "We'd look at each other and say, 'Why are they telling us this, why don't they tell the physicians this, because it would sure be great if the doctors heard it.'"

This is why Anderson has jumped at the opportunity to meet with physicians face to face and talk with them about coding in a way that they understand and which motivates them.

Anderson says that after his presentation, several physicians came up to him and asked, "How do we know how well we're doing on documentation?"

This opened the door for a very receptive audience to Anderson's guidelines for improving physician documentation. He was even asked to meet with the physicians at the hospital's nursing station and to review their notes on a particular day, telling them what they could do differently in their documentation.

This appeared to be such a good idea that Anderson asked the hospital's media specialist to film these interviews with physicians. The unscripted sessions between Anderson and physicians use real charts that doctors had completed after rounds, and Anderson had no prior knowledge about what the diagnoses would be.

"I worked with five different hospitals and physicians, and we would meet at the nursing station at a certain time after they had finished rounding patients," Anderson says.

"We would open the chart and go to the

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progress notes, and as they wrote diagnoses one and two, I would let them write it the way they normally wrote it," Anderson adds. "And then I would inject commentary and let them know how we could make that diagnosis more specific to capture the patient's true risk of mortality and severity of illness."

Teach coding guidelines to physicians

Anderson then gave the doctors a quick lesson on how what they traditionally have written in progress notes is not always reflected in ICD-9 classification because of coding industry guidelines.

For example, if a physician wrote the diagnosis of anemia, Anderson would ask whether that was due to blood loss or some other cause, and the physician might answer that it was due to gastrointestinal bleeding. Then Anderson would say that in the ICD-9 index, the blood loss anemia would default to chronic unless the physician also wrote down the word "acute" next to the diagnosis.

"I'd take them down the path and say, 'This is how you can be really specific and record a patient's data more accurately,'" Anderson adds.

Other physician education methods used by Catholic Healthcare West include posters and flyers, articles in medical staff newsletters, inservice sessions, and continuing education credit presentations.

However, the health system's most effective strategy has been a video of Anderson's discussions with doctors as they were on the unit documenting ongoing cases.

"We had a media specialist edit the film, and using software, we put all the elements together with some commentary and PowerPoint slides in the background," Anderson says. "We showed a comparison of codes that would be assigned on the left side of the screen and codes that occurred after the documentation was improved on the right side of the screen."

The 38-minute film also showed the codes and risk of mortality.

Anderson personalizes the presentation for various Catholic Healthcare West hospitals by downloading a hospital's Web site rating and public data and comparing these with competitors.

Another strategy might be to place copies of the film in medical staff lounges and the medical library and making them available for viewing at staff meetings, Anderson says.

Although one short film cannot teach physicians everything they need to know about improving coding, the idea is to give doctors some small bits of information that can be built upon, Anderson says.

"We give them one or two phrases they can change that will help them, and a week later we put more information in a newsletter," Anderson says.

"I just want to reiterate that it's a multifaceted approach," Anderson says. "For years, hospitals have been trying to figure out a way to do this efficiently."

Other strategies might include using case managers or coders who will work with physicians on the floor and answer their questions about documentation before the files make it to the coding department, Anderson suggests.

"Any time you can get contact with physicians to get information across, you have to try multiple ways of doing it," Anderson adds.

(Editor's note: For an example of an Internet hospital report card and physician listing, go to www.healthgrades.com.) ■

Chargemaster can be key job niche for HIM pros

Staff need to take 'Chargemaster 101'

As HIM professional needs evolve due to the changing health care industry and reimbursement issues, experts say the role of coders also must progress to more than a job that merely requires someone to assign a code.

"They must get involved with billing issues and the Chargemaster," says **Glenda Schuler**, RHIT, senior consultant for Ingenix/St. Anthony Consulting in Salt Lake City.

Schuler and **Jill Giddens**, RHIA, CCS, a technical editor with Ingenix Publishing in Salt Lake City, educate coders about the Chargemaster, its basic data elements, and the UB92 forms, so they can apply this knowledge to their jobs within a hospital system.

They teach coders what they need to do to bring themselves up to speed with the Chargemaster terminology, resources, and references. Schuler and Giddens offer these descriptions of some of the more common problem areas involving Chargemasters and coding:

• **Respiratory services:** Historically, Medicare has defined respiratory care as an area that often does not require the skills of a respiratory therapist, Schuler notes. "And, in fact, RNs can perform many of these procedures."

The result is that respiratory therapists cannot bill for those services and neither can the nursing staff, Schuler adds. "It's part of routine standard patient care."

This is why hospitals need to monitor the respiratory Chargemaster to ensure only the appropriate services are compliantly reported, Schuler explains. **(See story on respiratory coding changes and other coding nuances in *DRG Coding Advisor*, inserted in this issue.)**

In the past, hospital respiratory therapists have been creative in procedure descriptions for services they are providing, Schuler says. "Medicare expects that most of these services are not billable and that nursing can provide them, so those extra charge lines must be eliminated from the Chargemaster and cannot be charged."

• **Radiology services:** This is another area that should be scrutinized closely on the Chargemaster, Schuler says.

"There are about 44 CPT codes reported by radiology departments that should have a surgical code reported with them," Schuler says. "It's a one-to-one correlation."

For example, if a clinician has done a shoulder arthrogram and had to inject contrast media into the shoulder to be able to visualize the joint, then there should be an injection CPT code to accompany that arthrogram code, Schuler says.

There are more complex examples for angiography codes, including CPT codes that could be reported for surgical codes and that are not used one-to-one. Instead, they are reported based on the procedure performed, Schuler says.

"This is where coders come in to play, where they will use documentation in the chart to determine an appropriate CPT code," Schuler adds.

This is one of the more confusing areas of radiology coding, and coders need training to do this right, Schuler and Giddens say.

"A lot of times, a hospital doesn't have a trained coder applying codes for technical/surgical portion of the chart," Giddens says. "Sometimes documentation is not as thorough as it needs to be for the coders to assign them."

What might occur is that the person assigned to do the coding has the technical expertise but doesn't understand the billing/coding end of the business, Schuler adds. "That's where you have the opportunity as a coder to help them."

For example, in some larger institutions, there might be a certified coder who works only in the radiology department and is able to focus on finding the correct code for a particular procedure after reviewing the documentation, Schuler says.

"In smaller facilities they will have these codes in the Chargemaster, and sometimes the radiology technicians need to be taught how to report these other components, procedures," Schuler says.

Make sure surgical component is reported

For example, in the case of an interventional radiology procedure where an injection occurred during a venogram, the physician should document in the report where the injection of contrast media occurred or where the catheter is placed, Schuler explains.

"Anatomy is important here," Schuler adds. "You need clear and distinct documentation of where the catheter was placed, and often the coder doesn't have this information."

There is a variety of ways to report the individual CPT codes in the Chargemaster, and the radiology technician sometimes will select the code or codes that reflect the entire surgical component, Schuler says.

"The important thing here is that the surgical component gets reported on the claim and is supported by documentation from the physician," Schuler says.

But what might occur is that the technicians who attended the procedure will select a CPT code based on what they saw, and the doctor will later dictate the documentation but will leave off the vital information that would support the CPT code that already has been selected, Giddens explains.

This is why the coding department needs to wait until the documentation returns and then compare it with the Chargemaster coding to make sure it's correct so it can be validated as correct based on the physician's documentation, Schuler says.

"That's where hospitals are struggling, because coders are becoming more and more difficult to find," Schuler adds.

Without a trained coder reviewing the Chargemaster to look for errors and discrepancies, the hospital may have a problem with payers when charts are audited.

• **Training specialty coders:** Some hospitals are solving this problem by hiring and training coders to specialize in specific areas, such as radiology, Giddens says.

"One company in Atlanta is hiring its own coders and taking them through rigorous training with a clinical person who specializes in radiology," Giddens says. "So the coders understand the clinical side of interventional radiology."

This type of clinical education can be very important, and it can help a health institution build its business, she says.

Certified coders are very important for a health facility's compliance with regulations because proper reimbursement is essential to avoiding fraud and abuse problems.

Of course, the problem is that finding quality coders is more difficult and has led hospitals to offer sign-on bonuses, Schuler says.

Unfortunately, what sometimes happens at health care facilities that are short of coders is that the documentation is not reviewed and items are billed according to what the clinical staff has sent through on the Chargemaster, Giddens says.

When coders who are knowledgeable about clinical care are able to review the documentation, there may be an addendum added to the documentation to reflect the specific details that are needed to justify a particular code, Giddens says.

Without this expertise, knowledge, and attention, there could be inappropriate billing, Giddens adds.

All it takes is one wrong CPT code to result in a facility being either overpaid or underpaid for a service, Schuler says.

• **Check-off sheets as back-up:** When a hospital is unable to have coders with a particular expertise, an alternative might be to have clinical technicians use check-off sheets that list the various procedures and details that must be documented for coding to be done accurately, Schuler suggests.

"Physicians must document that the procedure was done, but a check-off sheet is a tool that can prompt or remind a physician of what was done and what needs to be documented," Schuler says. "Technicians might use the check-off form, and the physician will review the check-off chart prior to dictating notes, so it's a reminder of what was done and how not to forget to include it in the documentation."

This can save considerable time, says Schuler. If incomplete documentation were to reach the coder, he or she would have to track down the physician and ask for the additional information.

Assigning codes based on incomplete documentation would be worse.

"It's really important to have all procedures documented," Schuler adds. ■

Hefty outlier payments may look like fraud

Some charging structures gouge government

The federal investigation into alleged billing fraud and unnecessary surgeries at a Redding, CA, hospital has also shed new light on potential abuses of an unusual Medicare reimbursement mechanism designed to help hospitals that perform difficult procedures or care for very sick patients.

In addition to charges that two of its heart surgeons performed unnecessary procedures, federal officials allege that Redding Medical Center inappropriately charged more for services in certain diagnosis-related groups (DRGs) to take advantage of higher Medicare outlier payments. These are payments given in addition to standard reimbursement, when charges for specific cases are significantly higher than the amount paid for that DRG.

An analysis performed by the California Nurses Association and the Oakland, CA-based Institute for Health and Socio-Economic Policy found that California hospitals owned by Tenet Health care Corp., including the Redding facility, collected outlier payments as up to 10% of their total Medicare inpatient reimbursement, while national averages for outlier payments to hospitals run around 3% to 4% of total Medicare reimbursement.

Federal regulators allege Tenet hospitals have charged inappropriately high fees for certain DRGs to trigger the outlier calculation for higher payments.

Despite all the negative press outlier payments have received in the national media, it's important to remember that they are not illegal or unusual, says **Renee Leary**, MPH, a hospital billing expert and president and chief operating officer of HHS, Inc., a medical billing software company in Hamden, CT.

"Sometimes there is no DRG that appropriately describes a patient's condition," she notes. "The patient may have something that is relatively rare, and Medicare doesn't have a classification for it. The hospital can report the nearest DRG, but the reimbursement is not really accurate. So the outlier payment would take care of that."

Also, the set DRG reimbursement amounts are based on averages of the cost of care for typical cases in that grouping. Very ill patients or those with complications may end up costing the facility a great deal more than the average amount. The outlier mechanism was set up for those instances.

"Hospitals pay a fixed amount for each DRG," explains **Dean Farley**, MS, PhD, HHS vice president for health policy and analysis. "What goes beyond that — the outlier calculation — starts with the charge reported on the patient's bill, the total charge." The total charge is then multiplied by a set cost-to-charge ratio, a figure pre-set by the regional Medicare fiscal intermediary and which is based on the hospital's prior reporting of costs in previous years. That calculation reveals the cost for that case.

The intermediary then has a set threshold amount above that cost before any other calculation takes effect, he adds.

"If the calculated cost exceeds the base DRG payment plus the threshold amount — which this fiscal year is about $20,000 — the government steps in and pays the hospital the difference," Farley explains. "Before a hospital can receive additional payment, they must incur costs well in excess of the normal DRG payment."

Gaming the system

However, it is true that the outlier payments are directly tied to a hospital's reported charges for each case. Conceivably, hospitals could just hike charges for certain expensive procedures to the point that it would trigger the intermediary's outlier calculation.

Although it is illegal for hospitals to charge Medicare higher rates than it does private insurers, it is unlikely that hospitals have one set charge for a specific service or procedure.

"It is a gray area," Farley notes. "You can have different payment arrangements for different payers. One payer might insist on paying for operating room services in 15-minute increments. Another payer might go along with that but negotiate different prices for inpatient and outpatient surgery. Another payer might want to carve out specific types of surgery. There are different ways of putting the pieces together."

If a hospital knows that its Medicare population uses more inpatient surgery than outpatient surgery, rather than set up a single price for surgical services, they may set up inpatient surgery a little higher, he adds. "All payers pay the same price, but because more of your inpatient surgeries are Medicare beneficiaries, this price differential may disproportionately affect them."

Regulators may take a dim view of pricing structures that appear to disproportionately impact Medicare patients.

Boosting charges

Because the cost-to-charge ratio set by intermediaries typically lags behind current cost data, some hospitals justify charging higher rates until the ratio catches up to current levels.

However, because charges are always reported to the intermediary for consideration in the overall cost calculations, the ratio can skew high over a period of time.

"The problem with that is the cost-to-charge ratio is going to catch up and then you start pushing charges to stay ahead of yourself," Farley says.

A simple example is the way the cost of hospital outpatient services skyrocketed before ambulatory payment classifications (APCs) were established.

"Beneficiaries were paying a flat 20% of the charge," Farley notes. "Hospitals kept pushing charges up and up, getting more money from copayments. Medicare wasn't paying more, but the beneficiaries were."

The government eventually nudged out this practice and cracked down with set APC payments.

Given the attention that the federal Department of Health and Human Services' Office of the Inspector General (OIG) is paying to the "outlier" payment issue, it is both ethical and practical for hospitals to monitor their reimbursement strategies to ensure they are fair, say Farley and Leary.

"Medicare has a set average for what percentage of its reimbursement typically goes through the outlier program," Farley says. "The average now is about 3.5%, and that is a number that a hospital ought to be watching."

If a facility notices that 5% to 6% of its inpatient Medicare reimbursement is in the form of

outlier payments, then they ought to look at which DRGs are receiving the additional amounts.

"Look at the DRGs. Where are your outliers?" asks Leary. "You would expect to see the outliers group in a few DRGs. Hospitals may specialize in providing certain difficult procedures that naturally will mean more complications. Are the outliers in a couple of those DRGs, or are they in all of them? If you start seeing outliers in low-cost DRGs, that would be a much bigger alarm."

Once you notice the DRGs, it might be helpful to go in and pull out some specific cases to determine whether the documentation exists to support the additional payment.

"The worst thing that can happen to you is that the charges were appropriate, but you don't have the documentation support it," she notes.

Hospitals must be sure to tell physicians to only render services that are needed and appropriate, and then to document them thoroughly, advises **Paul Risner**, JD, a health care attorney with the firm Akerman-Senterfitt in Orlando, FL.

"There is a very low tolerance for practitioners or institutions who are pushing the envelope and have no reasonable basis for what they are doing," he states. "They want to punish people for taking liberties with billing or overcharging or overcoding their cases."

CMS: 'Who's been to a seminar lately?'

A few years ago, physicians routinely attended seminars coaching them on what elements of documentation would enable them to report a higher level of service. This is a no-no, Risner reports.

"If a hospital changes its coding or charging practices suddenly, that's the first red flag," he adds. "CMS [the Centers for Medicare & Medicaid Services] may come in and ask, 'Who's been to a seminar lately?' If you just got back from the ABC School of Coding in Las Vegas, that tends to be a signal that you just learned how to code better, not that you've changed the way you practice."

Hospitals may indeed see large percentages of cases that justify the outlier payments, but the key is, they must have the documentation that supports the higher level, he emphasizes.

"That is the underlying principle that will save anyone we are reading about in the newspaper today," he notes. "Do they have their charts in order and can they justify what they charge?" ■

EDs report success with service guarantees

Free visits and movie passes pay off

Imagine promising that every patient who walks through the door of your emergency department (ED) will be seen in 15 minutes. Does this sound like an invitation for a public relations nightmare? You may be surprised to learn that an increasing number of EDs are offering patients similar service guarantees.

At Northern Nevada Medical Center in Sparks, ED patients are guaranteed they will be seen within 15 minutes or the visit is free. The guarantee is posted in the ED and advertised via newspapers, radio stations, notices in telephone directories, and billboards.

If the time limit is not met, the patient complains to the nurse, who reports it to the nurse manager, who then instructs the business services manager not to bill the patient for the ED visit, says **Jean Lyon**, RN, chief nurse executive at the medical center.

"With a designated triage nurse, the only way the guarantee is not met is if several patients arrive in the ED at the same time and can't all be triaged within 15 minutes," she says. "This does not happen very often."

ED patients at Oakwood Hospital Medical Center in Dearborn, MI, are guaranteed that they will be seen by an ED physician and care will begin within 30 minutes of arrival.

"If we do not meet this, the patient receives a letter of apology signed by myself and the ED medical director, along with two movie passes," says **Corinne G. Victor**, RN, CEN, administrator for emergency services.

Each patient's arrival time is entered into the computer by a greeter at the front desk, and if the 30-minute guarantee isn't met, the staff will inform the patient, she explains. If for some reason this delay is overlooked by the staff, it will be caught when the charts are reviewed by the ED billing department, she says. "If we missed the guarantee, those charts are copied and given to the ED clinical manager," says Victor. "She will call the patient and send out the tickets and letter of apology at that time."

The guarantee is in place for all five EDs in the Oakwood Healthcare System and is heavily advertised, with a prominent sign posted in the

ED's waiting rooms, says Victor. "We have also done postcard mailings to our market share, which could be as many as 150,000 for one ED at a given time," she says.

ED managers report that the service guarantees have succeeded in their goal: To set their department apart from competitors. "Our 15-minute guarantee has become Northern Nevada Medical Center's brand in the market," says Lyon.

Here is what EDs offering service guarantees have experienced:

• **Not many patients were dissatisfied.**

Victor reports that from the start of the program in July 2000 through September 2002, all five EDs in the Oakwood Healthcare System have collectively given out movie tickets to only 638 patients out of 361,234 patients seen. "Star Theatres gave us the first 200 tickets at no cost, which was wonderful," says Victor. "We have had to pay for 438 tickets at $6 each, for a total of $2,628."

Likewise, Lyon reports that the ED has written off just a single visit over a two-month period. "The average is five or six a year, in a volume of 1,750 to 1,850 visits a month," she adds.

• **Patient satisfaction has increased.**

Lyon attributes high patient satisfaction in large part to the guarantee program. "Letters, telephone calls, and patient and family comments show that many people come to our ED not because it is closest, but because they have heard from friends and neighbors that they will receive fast and high-quality treatment," she says.

Victor reports, "It had an incredible impact on our patient satisfaction." In fact, patient satisfaction scores rose from 70% to 96% after the service guarantee program was implemented, she says.

• **Most staff responded positively.**

The majority of ED staff were enthusiastic about the guarantee, but not everyone, Victor says.

"In the beginning of the guarantee, we lost some staff," she acknowledges. "These were folks who for one reason or another just couldn't change their way of thinking."

Overall, the guarantee program resulted in greater staff satisfaction, she says. "The staff are happier because patients aren't always upset with the wait," she explains.

• **Census increased significantly.**

Lyons says the ED's volume has increased steadily over the past five years, which made it harder to meet the 15-minute guarantee. As a result, she says additional nurses were hired, including a designated triage nurse.

"This change in the staffing pattern ensures that the guarantee is achieved," she says.

In addition, an ED expansion is under way that will increase the number of beds from eight to 18.

"If the volume continues to increase, we will add more ED nursing staff to make sure we meet the guarantee," she says.

Because of the program, the ED's volume has outgrown its capacity, Victor says.

"Be careful what you ask for! We have experienced a 45% increase in volume since 1999," she reports. "We wanted an increase in market share, but this was phenomenal." ■

Proactive registration leads to hospital's award

Patient satisfaction, physician efforts cited

When Southern Ohio Medical Center in Portsmouth received the Ohio Award for Excellence (OAE) in September 2002, indications were that it had a lot to do with the hospital's proactive registration and central scheduling department.

Outlined in the application for the honor — awarded each year to a winner selected from just one of five categories, including business, education, government, health care, or not-for-profit — were several registration initiatives and achievements, explains **Pam Partlow**, RN, manager of central scheduling and registration.

Mentioned in the award-winning application were the quarterly breakfast that she hosts for the staffs of physician offices and nursing homes in the area, and a newsletter that Partlow writes and sends to physicians each quarter.

Three of the hospital's registration areas had achieved a 99th percentile ranking from South Bend, IN-based patient satisfaction measurement firm Press Ganey, which also was noted in the application, Partlow adds. Wait time in the emergency department (ED) went from a 50% satisfaction ranking to a 99% score, she says, while the hospital also ranked in the 99th percentile in courtesy of registration.

In the category of registration wait time, she notes, the hospital went from a 16% ranking to an 87% ranking.

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Source: Southern Ohio Medical Center, Portsmouth.

Other measurable indicators include the monthly accuracy rate for registrars or schedulers employed six months or more, for which the goal is 97%, Partlow adds.

The primary reason for the dramatic improvement in ED wait times was the implementation of bedside registration about two years ago, she says. Staff now do more than 3,000 ED registrations a month at the bedside using four laptops — three are ready-to-use computers and a fourth is charged for backup, Partlow adds. The department surpassed its goal of 3,163 registrations (using laptops), reaching 3,465 in the third quarter of 2002.

The laptop on wheels is nicknamed Rosie (named after the robot maid from the old *Jetsons* television show), she notes. When doing presentations on ED bedside registration for staff from other hospitals, Partlow says, she often lifts Rosie up and puts an apron on her. "We believe in having fun while we work in our organization." Other laptops are known as R2D2 (from the *Star Wars* movie series) and Johnny 5 (from the movie *Short Circuit*), she says.

"The number of bedside registrations performed in this manner depends on bed availability," Partlow notes. "We could do more if more beds were available." The figures cited are just for bedside registrations using the laptops, she points out. "We have other means of doing bedside registration." **(See graphs, p. 21.)**

Total bedside registrations are not recorded by volume, but rather as a percentage of all ED registrations, Partlow explains. For the last quarter for which figures were available, 41% of registrations were at bedside, with a goal of 50%, she adds.

The hospital approximately has 13,000 ED visits a month, Partlow says, many of which do not require the use of a bed because the patients need only minor treatment.

Partlow credits monthly meetings of a multidisciplinary performance improvement team and the support of the ED medical director for the success of the bedside registration initiative.

"Everyone has to be on board," she says, "including nurses, X-ray technicians, and physicians."

One of the things she also highlights in her presentations is the importance of staff buy-in, Partlow adds.

"It finally dawned on me that just because managers think an idea is wonderful, it doesn't mean staff necessarily want to follow," she says. "You've got to be a cheerleader and set targets for them." In her case, she says, that meant creating an atmosphere of excitement at meeting an initial goal of 50 bedside registrations a month.

Partlow says she recently completed an application indicating she would donate her time and that of her supervisors to present "best practices" under the auspices of the Ohio Award for Excellence program.

"I applied for 'wait-time in registration,'" she adds. "We could present at OAE sessions or at other hospitals."

[Editor's note: Pam Partlow can be reached at (740) 356-8885, ext. 8885 or by e-mail at partlowp@somc.org.] ■

JCAHO unveils major changes to survey process

Changes include midterm self-assessments

The Oakbrook Terrace, IL-based 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 organization, "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 January 2004 for all accreditation programs.

Russ Massaro, MD, JCAHO's executive vice president for accreditation operations, says "Shared Visions — New Pathways" represents the next step in the evolution of accreditation. "It shifts the paradigm from a focus on survey preparation to one of continuous operational improvement," he explains. "In so doing, it enables the accreditation process to become more of a service than a commodity."

The new initiatives include the following:

• streamlined standards and a reduced documentation burden to focus more on critical patient-care issues;

• self-assessment process to support organizations' continuous standards compliance while freeing up survey time to focus on the most critical patient-care issues;

• priority-focus process that integrates organization-specific data and recommends areas for the surveyor to focus on during the survey;

• new survey agenda with six basic components: an opening conference, a leadership interview, validation of the self-assessment results, a focus on actual patients as the framework for assessing compliance with selected standards, discussion and education on key issues, and a closing conference;

• enhanced role for surveyors in the new process facilitated by extensive surveyor training;

• revised decision and performance reports

• providing more meaningful and relevant information;

• 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;

• new approach to surveying complex organizations.

Specifically, the new accreditation process is designed to focus the evaluation to a greater extent on the actual delivery of clinical care; increase the value of and satisfaction with accreditation among accredited organizations and their professional staffs; and decrease costs related to survey "ramp-up" and resource allocation.

It also is designed to shift the accreditation-related focus from survey preparation and scores to continuous operational improvement in support of safe, high-quality care; make the accreditation process more continuous; and increase the public's confidence that health care organizations continuously comply with standards that emphasize patient safety and health care quality.

In addition, 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."

Self-assessment halfway through the cycle

The Joint Commission says a new self-assessment process will be rolled out for ambulatory care, behavioral health care, home care, hospitals, and long-term care in 2004. This process aims to support continuous standards compliance and free up surveyor time during the on-site survey to concentrate on the organization's critical focus areas and provide practical, educational support.

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 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

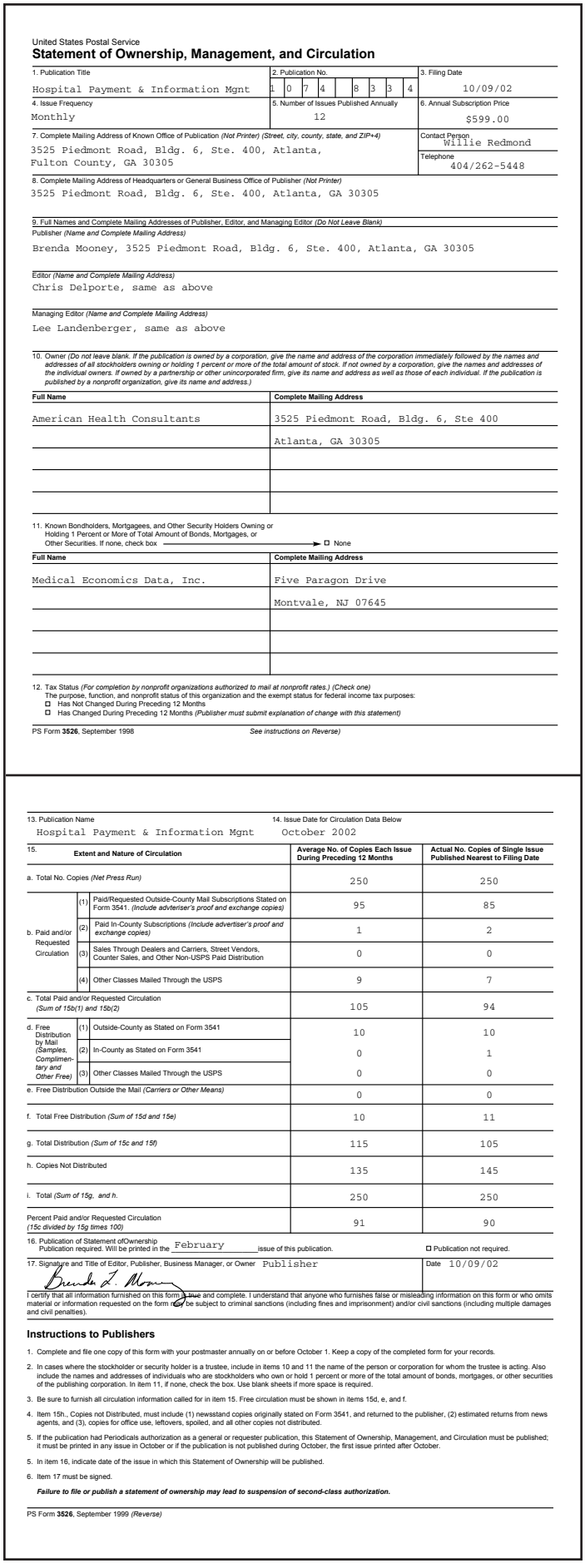
using other tools. All the organizations that took part in the pilot completed the self-assessment in the eight weeks allowed. The majority of the organizations indicated that they would prefer three to six months to complete the assessment.

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.

As long as an organization plans appropriate corrective action, the 18-month self-assessment activity, including the report to JCAHO, will not change the organization's accreditation status. In addition, JCAHO says it will work with each organization, often suggesting appropriate corrective actions.

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.

(Editor's note: 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.jcrinc.com/perspectives. Questions may be e-mailed to sharedvisions@jcaho.org.)* ■



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DRG CODING ADVISOR®

Look for nuances in these coding problem areas

Note the new CPT changes

Chargemasters need to be maintained on a quarterly basis, and coders should be given educational updates at least that often to keep up with the CPT coding changes and the development of new codes by the Centers for Medicare & Medicaid Services (CMS), experts advise.

"Last year we had over 400 program memorandums issued by Medicare that dealt with all aspects of health care reporting, and if you are in a large facility, you need to read every one of them to know and discern and decide if it's applicable to your facility," says **Glenda Schuler**, RHIT, senior consultant with Ingenix/St. Anthony Consulting in Salt Lake City.

"It's a challenge for everyone, and one important thing I want to say is that nobody is doing everything right because it's impossible to do it all correctly," Schuler adds.

Another challenge is making certain that as much attention is paid to outpatient coding as has traditionally been paid to the inpatient side, says **Jill Giddens**, RHIA, CCS, technical editor for Ingenix Publishing in Salt Lake City.

"What APCs have done is level coders for outpatient to the same as inpatient," Giddens notes. "Now they're just as important today as the inpatient coders."

In 2003 there are new CPT coding changes for respiratory services. Several codes have been deleted, and these are listed below:

— HCPCS 94650: Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; initial demonstration and/or evaluation.

— HCPCS 94651: Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication; subsequent.

— HCPCS 94652: Intermittent positive pressure breathing (IPPB) treatment, air or oxygen, with or without nebulized medication, newborn infants.

— HCPCS 94665: Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; subsequent.

For service dates after March 31, 2003, hospitals that use the above codes will cause their claims to be rejected, and there will be no reimbursement, Schuler says.

The description for two respiratory therapy procedures has changed, affecting the method of reporting these CPT codes:

— HCPCS 94640: The new description is: Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g., with an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing [IPPB] device).

— HCPCS 94664: The new description is: Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device.

One area often overlooked concerns arterial blood gas (ABG) analysis, which should be billed along with an arterial puncture, Schuler says.

The ABG is CPT 82803, and then the arterial puncture, which is CPT 36600, is reported in the same quantity as the ABG.

"Medicare doesn't pay for arterial puncture, but it should still be reported as a procedure performed," Schuler says. "Medicare has status indicators on all CPT codes that provide a method of payment for the APC payment system, and CPT 36600 reimbursement is packaged with the ABG procedure."

Interventional radiology also requires reporting of correlating codes. For instance, if a shoulder

arthrogram (CPT 73040) is reported, then there should be an injection CPT code to go with it, such as CPT 23350, Schuler says.

"When you look at the charges generated from a hospital, if they generated 15 shoulder arthrograms, you should see 15 CPT 23350 codes, as well," Schuler says.

"Hospitals are losing out because they're not reporting the surgical component consistently," she says. "CPT 23350 is a packaged component, but you still want to report the revenue, and they're not reporting the charge for the injection."

Another tricky coding area involves venography. The code for a bilateral selective is CPT 75833.

"The parenthetical statement beneath the definition states, 'See 3600 to 3612,' so there are multiple codes between these," Schuler says. "And a technician or coder must decide what procedure was done to warrant one of these code selections."

One challenge is how to deal with modifier -25, which is for determining whether an evaluation and management code should be billed in addition to a procedure, Giddens says.

For example, suppose a patient comes into the emergency room with a cut on the arm that was the result of a kitchen knife wound inflicted during dishwashing. Emergency department (ED) doctors say they had to suture that wound, and an evaluation and management decision was made to conduct a physical exam, Giddens says.

In this case, whether the medical decision-making was a separately identifiable service warranting the -25 modifier is controversial, and documentation would have to support the definition of the modifier, Giddens says.

Just because the service is provided in an emergency setting doesn't mean the modifier always applies. The definition still needs to be met in the documentation, Giddens explains.

Take a second example: A patient is a diabetic and has lost a lot of blood from a knife wound. ED doctors suture the wound and also do a diabetes work-up on the patient. In this case, the coder would report the level of service code in addition to the modifier -25 for the evaluation and management, Giddens explains.

"So the challenge for coders is they have to rely on physician documentation to make the decision of whether they can bill separately for the level of service or not," Giddens says. "If the doctors didn't document the diabetes very well, or if they didn't document what they had assessed for, then they couldn't bill for the CPT modifier -25 for evaluation and management. It's all reliant on physician documentation, and that's subjective from one person to the next, so it's a struggle on the coders' part," Giddens says.

Another tricky issue involves casting and strapping, including applying a splint or strapping for fractures, dislocations, and casts used because of broken bones, Giddens says.

There is a series of CPT codes, from 29000 to 29799, that apply to casting and strapping.

CMS committee will address bundling issues

"The issue is whether they bundle these or not," Giddens says. "It's a point of confusion for a lot of coders, and Medicare is confused about it also."

In fact, CMS has appointed a committee to look into the confusion and to try to figure out when codes will be bundled and when they won't be, Giddens says.

An example of this is when a patient presents to the emergency department with a nondisplaced fracture of the ulna, distal left. The physician applies a splint. This results in a CPT 29125-LT, which is application of short arm splint on the left arm, Giddens says.

"The application of the short arm splint would be reported in addition to the evaluation and management [E/M] code, meaning the doctors evaluated the patient and provided an additional service," Giddens says.

For Medicare billing, the modifier -25 is suggested because code 29125 is an "S" status indicator. According to Medicare billing instructions, a procedure with an "S" or "T" status indicator, when performed on the same day as an E/M visit, should have a -25 modifier to avoid OCE edit 21, Giddens explains.

Another coding example would involve this scenario: A patient who came in with elbow pain was X-rayed and physicians noted muscle strain. So they applied a sling and gave instructions to the patient. The E/M code is the only thing recorded, Giddens says.

"So the sling bundles into the ER department because it's not above and beyond and doesn't require a lot of work," Giddens says.

The coding reported is 99281 to 99285. However, this is not considered a procedure, and because supplies are bundled into the E/M codes and thus cannot be billed separately, the splint cannot be billed separately. However, cast/splint supply items should be reported on the UB92 with a revenue code 27X, Giddens explains. ■