



# HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

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## Keep skilled IS personnel where you want them — on staff

*Hospital slows exodus, changes salary structure*

For two years, **Karen Ondo** watched skilled employees leave North Broward Hospital District in Fort Lauderdale, FL, for other organizations. “We were seeing about a 25% annual turnover,” says Ondo, North Broward’s vice president and chief information officer.

The health information employees weren’t leaving because they didn’t like their jobs or because they didn’t like the facility. Instead, they were acquiring nine to 15 months of knowledge and experience and then leaving for higher salaries at other organizations.

She could only watch their departures. “Once employees were hired and in their positions [at North Broward], they would have to stay with us about three more years to get to the same figure that someone would be offering them on the outside.”

### *Pay structure, policies needed total revamp*

But if Ondo rehired them at their present skill level, she could match the salary of the outside company. Unfortunately, the hospital’s policy and procedures prohibited her from rehiring the employees for six months unless they returned under the same salary as they had when they left.

“We were bound in what we were able to do,” Ondo says. “Plus we didn’t have a mechanism to see if we could stay somewhat competitive in that arena. Our organization was paying at the 60th percentile at the time, regardless of the position, and that’s what I had to learn to live with.”

To decrease the turnover rate, the hospital tried sign-on bonuses, retention bonuses, and project bonuses. The bonuses worked but were limited to the term or the scope of the bonus. “A sign-on bonus wasn’t enough, because if you didn’t stay long enough and the bonus was forfeited, the company on the outside would make up the difference,” she explains. The problem was aggravated by a lack of qualified applicants to fill the open positions.

The next step North Broward took was to completely overhaul the way it categorized and paid its information technology staff. North Broward previously categorized positions by job families. For example, a candidate who was hired as a systems associate could be promoted to systems specialist in 15 months to two years if he or she progressed and such a position became open.

Ondo and North Broward's human resources department decided to try the career-banding approach, which makes job families obsolete. Career banding is a system or process of grouping jobs with similar responsibilities and impact. Career growth is defined in terms of skill and competency development rather than through upward advancement through grades and titles.

*"If employees are being compensated more than their competencies, we have policies that give them an amount of time to improve their competencies or we will structure their pay accordingly."*

For example, someone hired as a systems analyst would stay in that analytical band as that person's career progressed, unless that employee transferred out of that band. As the person acquired skills, management would rate those skills and pay competitively for them. "I budget dollars to do things called analytical work, and as long as I work within parameters, it's not material whether [a higher] position is available," she says. "As soon as the skills are there, I have a method to pay for them."

In the traditional position-control type of arrangement, jobs often have a somewhat fixed pay width, such as a 50% width or 60% from low to high, Ondo explains. The pay bands in the new arrangement have a 150% width.

Employees in the band don't have to change

titles to get to the top of the salary range. "If you're acquiring the skills you need to do that job, and you're still in the analytical band — you haven't made a career change into something like management — you just stay on that track," she says.

"In essence, you can determine your top end instead of it being a fixed salary range for that job. There is obviously a limit, but it's 150% width as opposed to the more traditional narrower width," Ondo explains.

With the new system, managers are obligated to evaluate everyone at least on an annual basis, but employees can request a rating of their skills or a manager can initiate a re-rating of someone every six months. During the evaluation, employees are rated using seven different skill sets on a career development matrix.

The matrix determines the four stages of the employee's development:

1. apprentice;
2. colleague;
3. mentor;
4. sponsor.

These stages encourage employees to share their experience, Ondo says. "A lot of times people hoard their knowledge because they think they are more valuable to the organization because they are the keeper of the keys. Now to get credit and get rated higher on a skills acquisition, you have to prove that you are mentoring other people and sharing that information."

Employees are evaluated as to whether they are accomplishing their tasks as designed or whether they are still stretching to that level of competency. "The stretch [measurement] gives us a way to distinguish someone who is absolutely doing the job from someone who is stretching and showing signs that he or she is almost to the next step but not quite."

Once the evaluation is complete, the employees are assigned a number that is matched to the pay zone for their career band. The system analyst, for example, may be rated in the \$55,000 to \$60,000 pay zone for that career band.

If that is more than the employee's current

## COMING IN FUTURE MONTHS

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■ How will Vision 2006 titles be implemented?

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■ The concern over electronic signatures

# How hospital made the switch to career banding

*Some surprised by the change in salaries*

**N**orth Broward Hospital District in Fort Lauderdale, FL, knew that employee education came first when the facility decided to switch from a traditional job family position-controlled salary structure to one that compensated based on skill and competency.

In the traditional system, employees were placed into one of 25 job descriptions in 14 salary grades.

In career banding, health information employees are assigned one of nine functional job titles: director, manager, systems consultant, systems administrator, systems analyst, systems specialist, coordinator of operations, and operations technician. The job title was then assigned into one of the five career bands: operational, technical, analytic, consultant, and leadership.

## *Fitting the right person to the right job*

“It was a way to take the old job descriptions and identify where employees fit in the new scheme,” says **Karen Ondo**, North Broward’s vice president and chief information officer.

The new system took about six months and about 1% of Ondo’s salary budget to implement,

including creating job descriptions, policies, procedures, and new forms. Ondo kept employees informed of the implementation process.

“At key decision points in the new process, I would communicate to them our thoughts, our [goals], and how they would be affected,” says Ondo. All employees were evaluated for the new system at the same time. **(To see how the rating process works, see cover story.)**

Managers matched employees’ skill acquisition to competitive salaries for those skills. Some employees were pleasantly surprised at their raises. One employee, for example, received a \$16,000 increase. Other employees found that their salaries were higher than warranted by their skills.

“In theory, some people were being paid too much because they generally had been here a long time and got an annual increase every year,” Ondo explains. “When we rated them according to our new scheme and to their skills, they were being paid a lot of money but their skills acquisition was on the low end. There was quite a difference in what we should be paying them as opposed to what they were being paid.”

North Broward made a commitment to educate these employees and to provide them opportunities to acquire the skills they needed to stay close to the salary they were making. Some chose that route, but others decided to leave the organization. “They decided to leave because they did not want to acquire the skills and did not want their salaries lowered.” ■

salary, he or she receives a raise.

The reverse is true, also. “If employees are being compensated more than their competencies, we have policies that give them an amount of time to improve their competencies or we will structure their pay accordingly,” Ondo says. **(To see how North Broward employees reacted to the restructuring of their salaries, see related story, above.)**

Ondo doesn’t post jobs if an employee is progressing up the career band since the person doesn’t change job titles; she simply pays for the additional skills. But if someone switches to another business unit, such as from analyst to technical work, she has to post the job first. “The posting allows us to function as an employee advocate. Everyone has equal opportunity to

[the new job],” she explains.

Since implementing the career-banding system, Ondo has seen her turnover rate fall to single digits. “It’s done exactly what we needed it to do,” she says. She still loses some employees who want management positions when none are available. Jumping ship to get compensated more for technical skills, though, is not as common. “People don’t think they have to change jobs and change employers to improve their salaries.”

Overall employee reaction has been positive, she adds. “The new system (1) gave employees the opportunity to be recognized for their skills, (2) gave us a more objective way to value their skills as to the marketplace, and (3) created good discussion about career planning and what skills were really important to accomplish any given task.” ■

# Feds go to great lengths to fight potential fraud

*Acquittal shows providers can fight back and win*

If you don't believe the government is becoming more aggressive in fighting health care fraud, consider the case of **Anthony F. Valdez, MD**.

Valdez is a licensed psychiatrist in El Paso, TX, who specializes in pain management. A significant portion of his medical practice involves the administration of reconstructive anesthetic block injections to patients suffering from chronic pain.

While the Valdez case involves a physician practice, the government's pursuit of a case involving private insurers could signal a different course for fraud investigators. And that could indicate the need for making your ship-shape compliance program even tighter.

Valdez reported to police that his former office manager had embezzled more than \$50,000 from him. However, the office manager soon told government authorities that she and the doctor had schemed together to submit fraudulent bills to private insurance companies.

## *Moving in quickly*

Government prosecutors moved quickly. "When they started the case, they were originally looking for any Medicare fraud. They didn't find any," says **Frederick Robinson**, an attorney in the law firm of Fulbright & Jaworski LLC, in Washington, DC. Robinson, along with Lori-Ann S. Peters, another attorney with Fulbright & Jaworski, and Michael R. Gibson, an attorney in El Paso, represented Valdez in the court case.

The government did find insurance claims submitted by Valdez's office for services that had not been provided. These discrepancies, however, accounted for less than 1% of the claims submitted by his office during the relevant time period. In addition, although Valdez had personally signed each claim, the evidence showed that he signed more than 150 claim forms in a 10-minute period approximately once a week and did not review their contents. The fraudulent claims amounted to \$37,000, the government said.

"Sometimes when the government spends a lot of resources on a case and they don't come up with what they think they're going to get, it's hard for them to let go of it," Robinson says.

"This private insurance billing was all they had at the end of the day."

Some experts are encouraged that the Valdez verdict could prompt more defendants to fight in court rather than simply pay to settle charges — as is more common. Others, however, note that the Valdez case is part of a troubling trend in which federal prosecutors pursue charges against physicians even when the alleged fraud doesn't concern Medicare.

In December 1997, a federal grand jury indicted Valdez on one count of conspiracy to commit mail fraud and six counts of mail fraud, in violation of 18 USC Sections 371 and 1341, respectively. The indictments alleged that Valdez had billed several private health insurance companies and workers' compensation insurance companies for services not rendered and that he had overbilled for the supplies used in the injection procedures. If convicted, Valdez would face two to three years in prison and a fine as high as \$250,000.

Most fraud litigation cases are settled by health care providers, Robinson says. "Most doctors can't risk litigation because they are afraid their Medicare or Medicaid benefits will be suspended by the government during the litigation."

Valdez, however, felt he hadn't done anything wrong, and he didn't want to settle.

The case was tried in the U.S. District Court for the Western District of Texas, El Paso Division. At the trial, the defense argued that the former office manager had "slipped" improper insurance claims into the stack of claims the doctor signed each week and then "siphoned off" the payment from insurance companies. The office manager, her husband, and her sister who also worked in Valdez's office, acted as the government's main witnesses.

On the issue of the supplies, the evidence showed that the doctor used a wide variety of supplies in the treatment of his patients and that the amount of reimbursement he received for the supplies in question was comparable to the cost of other supplies.

## *Valdez acquitted*

The federal jury apparently did not find the government witnesses credible. When it came time to deliberate on March 28 after eight days of testimony, the jury deliberated 40 minutes and acquitted Valdez of all charges.

The cost of trying the case was much greater

than the \$37,000 the government said was netted from the fraudulent billing. "The government is becoming more and more aggressive in bringing health care fraud cases to court," Robinson says. "Five years ago, no prosecutor would have touched this particular case."

Valdez, however, left himself vulnerable with his hiring and billing practices. Although it's difficult to monitor every claim that goes out of the office, providers need to make sure that they are hiring people who have appropriate training, and that they periodically audit their billings, Robinson suggests. "Any time you have mistakes in the way that you bill, an aggressive investigator can try to turn it into a criminal case."

If providers do end up face-to-face with federal prosecutors, they need to determine if they are going to fight the charges or settle the case. "First,

you have to determine if mistakes were made in your billing," Robinson explains.

"You may have a difference in opinion with the government as to whether there were mistakes. If mistakes were made, you have to look at what percentage of your total billings were affected by the mistakes to see if it's statistically significant. Then you have to see if you can give a reasonable explanation for why mistakes could have been made. If you have good information available to you, you should stick to your guns," he adds.

"You don't have to have perfect billings to have a defensible case," he continues. "You just have to have a credible explanation for why you could have made mistakes. Even though the government may not want to accept that explanation, sometimes a jury of regular people might." ■

## Give me your card

*Technology allows quick access to records*

A pregnant woman walks into the emergency department complaining of bleeding. Triage staff ask what her blood type is, but the patient doesn't know. A nurse can take a blood sample — or she can ask for the patient's smart card and immediately look up the women's medical records.

Washington University School of Medicine in St. Louis recently began a pilot study to see how effective the use of smart cards can be in the treatment of pregnant women. The smart cards look like conventional credit cards and contain microchips that provide access to the medical information, which is stored on a Web server.

The study began last December and will involve 250 pregnant women. The project will end after all the women complete their pregnancies. Half of these women will receive a smart card that will be used to access their records during visits to the hospital's obstetrics clinic. The other half will be "control subjects" and have their paper records accessed the traditional way. All patients will receive the same level of care at the facility.

The study aims to measure several things, says study leader **Gilad A. Gross**, MD, assistant professor of obstetrics and gynecology at Washington University School of Medicine and director of obstetrics at Barnes-Jewish Hospital in St. Louis.

"When the women come to the hospital, we

measure time that they actually spend in the hospital — card vs. no card," he says. Staff also measure how much time it takes to develop a patient disposition, how much time it takes for patients to be admitted if necessary, and whether the cards are preventing redundant labs, X-rays, and ultrasound tests.

### *Patients are enthusiastic*

The study is funded by a benefactor in St. Louis who is interested in card technology. "He wanted to know if we could apply it to the medical field," Gross says. "We felt that pregnant patients would be perfect for this because their charts grow every week, and different things are added and subtracted. We decided to try and make it work using the new technology over the Internet."

Since the study began, Gross and his staff have randomly approached 156 pregnant women who plan to deliver at Barnes-Jewish Hospital. "About everyone accepts enthusiastically," Gross says. "It's a nice concept for them. We've only had two people say no for religious reasons."

The study uses two types of cards. The patient card contains vital data. "You put the card in the computer and a screen comes up with the information just related to the patient." The physician then puts in his or her card, and the system goes to a Web server over the Internet where the database is stored. The Web server is maintained by Site-C, an Internet developer company in St. Louis.

The database holds patient information such as medications, medical problems, insurance

coverage, and lab results. Information about hundreds of thousands of patients can be kept there, Gross says.

"We wanted to be able to develop a good electronic chart," he explains. "Many now are limited by the amount of space and the speed in which you can access it. We felt that this technology was a way to cut through all those problems."

Each time a patient visits the clinic, information is keyed into the system by a data entry employee. "It's put on paper first," Gross says. "In the future, maybe it won't be."

To maintain standards of care, the hospital still uses the patient's paper chart during the pilot study. "No one is being sent home until the paper chart is seen."

### **No more waiting for admissions**

Hospital staff do not wait for the paper records, however, when the patients are admitted. "The time it takes to access the information in the [electronic] chart is seconds compared to the hours that are sometimes spent waiting for paper charts," he says.

"When patients are admitted, [staff] aren't as afraid to not wait for the paper chart. They know people are still going to be in the facility." He anticipates tremendous time savings when the electronic system is used when the patients leave the hospital, too.

The electronic records also contain links to any diseases that are in the patient's chart. Selecting the links will take physicians to information pages on the Web. "The chart is not only just a chart; it's a tool, like a medical encyclopedia," Gross says.

Security always is a concern with medical records, but Gross and his staff built measures into the system to ensure security. "First, you need a card to get into the system," he explains. "Second, every card is password protected."

Each smart card has different levels of security. Gross can enter the system and make changes, whereas other people have read-access only. "You can't go into the chart, make a change, or print anything without me or the systems operator knowing it," he says. "Everything is archived and tracked, and all changes are recorded."

So far, the pilot study has recorded 91 visits to the hospital and 12 deliveries. Preliminary data show that patients using the smart cards spend about an hour less being admitted.

The next step is for the study is to expand

outside the pregnant patient group and into pediatrics and then female well-patients. "Then we can try to apply it to the entire patient population," Gross says.

In the future, patients also may be able to travel with their medical information on a card in their pocket. As the system is set up now, other providers must have a card reader and authorization to enter the system.

The study has generated a lot of interest, Gross says. "The minute I show the cards to someone, they're sold. It's such a wonderful record."

*(Editor's note: A survey conducted for the Smart Card Forum, a Washington, DC-based multi-industry trade group, found that three-quarters of respondents showed interest in the smart card concept. A significant number of respondents said they would want to use the cards for functions including bank access and ATM services, to carry a record of driver and health insurance information, and as credit cards. They would be willing to pay up to \$50 for the card itself and a \$25 annual fee.*

*In general, the survey showed that potential smart card users are younger, have higher incomes, and own a PC, the classic profile of the early technology adopter.) ■*

## **Education can reduce the risk of security breaches**

*Proper documentation reduces threat of lawsuits*

**T**he next virus might be more damaging than Melissa, but information technology (IT) personnel know that the biggest threat to the security of a computer system may be someone sitting in an office down the hall.

"If we look at the larger picture, hackers tend to be mosquito bites," says **Frederick Tompkins**, information security advisor for Unisys Corp. in McLean, VA. "Our biggest problem is with the authorized insiders. They characterize anywhere from 55% to 75% of the problem."

Since IT personnel can't avoid risks, they instead should learn to manage it, he says. One way to manage risk is to identify the vulnerabilities of the system. Tompkins says he hears about

*(Continued on page 91)*

# DRG CODING ADVISOR<sup>®</sup>

## Aging of population means more cardiac procedures

By **Rita A. Scichilone**, MHSA, RRA, CCS, CCS-P  
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**C**ardiology is one of the biggest challenges for coding professionals. CPT coding in the cardiovascular system requires detailed knowledge of cardiac and vascular system anatomy and physiology and close attention to specific coding guidelines. Because of the aging of the population and the prevalence of arteriosclerosis, cardiac procedures are becoming more frequent.

A basic diagnostic service in cardiology is cardiac catheterization, which is often performed during the same episode of care with a percutaneous transluminal coronary angioplasty (PTCA) procedure with or without stenting, or a coronary artery bypass graft procedure.

Cardiac catheterization is performed on either the left, right, or both sides of the heart. A code will be assigned for left, right, or combination, injections for associated angiography, and imaging supervision and interoperation services. This can result in up to eight CPT codes submitted for a complete procedure that is post-coronary artery bypass graft, or three procedures in a patient undergoing left cardiac catheterization with injection for coronary angiography and the associated supervision and interpretation of the angiography.

A left catheterization is usually performed via the femoral, brachial, or occasionally the axillary or radial artery with sterile technique in a catheterization lab with local anesthesia and appropriate patient sedation. The procedure involves:

- percutaneous insertion of a needle into the target artery followed by placement of a flexible guidewire;
  - removal of the needle and insertion of a sheath/dilator system over the guidewire;
  - removal of the dilator and the guidewire;
  - subsequent insertion of an appropriate catheter through the sheath into the arterial system under fluoroscopic guidance;
  - advancement of the catheter retrograde through the arterial system into the left ventricle;
  - pressure measurement and blood samples when indicated;
  - positioning for angiography in various sites.
- The patient's arterial pressure and electrocardiogram are monitored continuously throughout the procedure. Following completion of the catheterization, the catheter and sheath are removed and homeostasis achieved at the entry site.
- The following components are included by reporting CPT code 93510:
- vascular access;
  - sedation and monitoring;
  - insertion and positioning of left heart catheter;
  - measurement of pressure in various positions;
  - cardiac output and oxygen saturation, and removal of catheters;
  - report generation.

A right heart catheterization is performed by introduction of a cardiac catheter into the venous system either by percutaneous puncture or cut-down via the femoral, internal jugular, brachial, or subclavian veins in a cath lab with sterile technique, local anesthesia, and appropriate sedation. Most right heart catheterization is performed percutaneously. Typical components include:

- needle insertion into target vein;

- placement of flexible guidewire;
- removal of needle;
- insertion of sheath/dilator system over the guidewire;
- removal of dilator and guidewire;
- insertion of right heart catheter under fluoroscopic guidance;
- direction of catheter through venous system into the right atrium, right ventricle, pulmonary artery, and pulmonary capillary wedge positions;
- baseline measurements and blood sampling in each chamber and cardiac output measurement;
- repeat measurement when indicated following exercise, oxygen administration, or other interventions;
- removal of catheter;
- preparation of report.

CPT code 93501 includes vascular access, sedation and monitoring, insertion and positioning of the right heart catheter, measurement of pressures in various positions, cardiac output, oxygen saturation, removal of the catheter, and report generation.

Injection procedures are coded separately and may include injection for arterial conduits in a patient who has had coronary artery bypass grafting performed previously. CPT codes 93539-93545 are for the injection component of cardiac catheterization and include native arteries and bypass grafts. The codes are distinguished by the location and type of the artery involved.

Imaging procedures also are coded separately with CPT codes 93555 and 93556, depending on the structure involved. When ventriculography and coronary arteriography are both performed, both codes will be reported.

### ***Pacemakers and defibrillators***

For pacemaker or defibrillator placement, it must be known whether the procedure is an initial service or a replacement. The specific type of the device must be documented for accurate code assignment. Many of the CPT codes in the 33200 series include the phrase “insertion or replacement.” This does not indicate that the physician work for removing the device is included, and separate codes should be selected for removal of an existing device when this circumstance occurs.

A pacemaker always includes a pulse generator and one or more electrode “leads” inserted in one of several ways. Pulse generators can be placed in a subcutaneous “pocket” created in a subclavicular

or intra-abdominal location. Electrodes can be inserted through a vein (transvenous) or on the surface of the heart (epicardial). Transvenous application is the most common method and is described in CPT codes 33206-33208. If the leads are implanted without the generator, the service may be reported by appending modifier -52 for reduced service.

When a single-chamber system is used, a pulse generator and one electrode are inserted in either the atrium or the ventricle of the heart. A dual-chamber system also has a pulse generator, but one electrode is inserted in the atrium and one electrode is inserted in the ventricle.

Defibrillator systems also include a pulse generator and electrodes for implantation. The pulse generator can be placed in a subcutaneous pocket and the electrodes will be inserted either transvenously or epicardially.

When the medical record documents a battery change, it is the pulse generator that is being replaced. Report Code 33212 is used for single-chamber devices and report code 33213 for dual-chamber devices. Use code 33240 for battery replacement for an implantable cardioverter/defibrillator. Replacement of the pulse generator for pacemaker or defibrillator systems requires assignment of a code for removal of the pulse generator and another code for insertion of the new one. Repositioning within the first 14 days of the insertion or replacement is included in the service and would not be reported again per the CPT code manual instructions.

### ***CABG procedure coding***

When a coronary artery bypass is performed, the most comprehensive code describing the procedure is the one that should be reported. Only one code in the range of codes 33510-33516 (venous grafting) and no other bypass codes are correctly reported with these codes. One code in the range of 33517-33523 (combined arterial-venous grafting) and one in the range of 33533-33536 (arterial grafting) can be billed together to accurately describe combined arterial-venous bypass. When only arterial grafting is performed, one code from the range of 33533-33536 is reported.

When a median sternotomy is performed to accomplish cardiothoracic procedures, the repair of the sternal incision is part of the primary procedure. CPT codes 21820-21825 (treatment of sternum fracture) also are not separately reported,

and it is not appropriate for a physician to separately code removal of embedded wires should a repeat procedure be performed.

Procurement of a venous graft is integral to the performance of coronary artery bypasses that employ venous grafts and is not reported separately with a CPT code. Therefore, CPT codes in the range of 37700-37775 (ligation of saphenous veins) would not be assigned when a code from 33510 to 33523 is reported for the primary procedure.

When an intervacular shunt procedure is performed as part of another procedure requiring vascular revision, the service for the shunt procedure is not coded separately from CPT code range 36800-36861 (intervascular cannulization/shunt). CPT has designated these procedures as "separate procedures."

Aneurysm repair may require direct repair with or without graft insertion or use of thromboendarterectomy and/or bypass techniques. When a thromboendarterectomy is undertaken at the site of the aneurysm and it is necessary for an aneurysm repair or graft insertion, a separate CPT code is not reported for the thromboendarterectomy. If only a bypass is placed (requiring an endarterectomy to accomplish), only the bypass is coded. If both an aneurysm repair and a bypass are performed at separate sites, both CPT codes can be assigned, but modifier -59 should be appended to denote a separate procedure on the second code.

### ***Open procedures include closure, repair***

When an open vascular procedure such as a thromboendarterectomy is performed, the closure and repair are included in the code for the vascular procedure. CPT codes 35201-35286, which are for reporting repair of blood vessels, are not appropriate to report in addition to a primary vascular procedure for this reason. Also, when a percutaneous vascular procedure is unsuccessful and is followed by an open procedure during the same operative session, only the CPT code for the open procedure should be reported. If the percutaneous procedure was performed for a lesion at one site and the open procedure is performed for a procedure at another site, then separate reporting would be appropriate. Modifier -59 will be used to indicate the separate and distinct nature of the second reported procedure.

Venous access procedure codes 36000, 36406, 36410, and 36415 are used for phlebotomy, prophylactic intravenous access, infusion therapy, chemotherapy drug administration, and other

procedures. When intravenous access is performed in the course of performing other medical and surgical procedures or is necessary to accomplish the procedure, such as for infusion therapy, it is inappropriate to code the access in addition to the greater procedure because the venous access is integral to the other code. In the case of transcatheter therapy services (i.e. code 36201, 36202), the placement of the needle and the catheter are included in the primary service. When existing vascular access lines are used to procure arterial or venous blood samples, coding for the sample collection using a separate CPT code also is inappropriate.

### ***Angioplasty procedures***

Transluminal angioplasties, like cardiac catheterizations, include introduction, positioning, and repositioning of the catheters; procurement of blood samples; pressure recordings; and other manipulations required to accomplish the procedure. Assigning a separate code for these services is incorrect.

With PTCA, code 92982 describes angioplasty, while 92984 is used to report each additional coronary vessel upon which balloon angioplasty is performed. If two or more occlusions or blockages in the same major artery are treated, they are collectively coded as singular using code 92982. If lesions are treated in more than one of the major arteries during the same session, the service is reported with code 92982 for the first procedure and 92984 for "each additional" procedure. The 1999 version of CPT has marked this code with the "+" symbol to indicate it is an "add-on" procedure that is listed separately. When procedures are performed on branches of main coronary arteries, it may be appropriate to append modifier -22 and send documentation with health plan claims to seek additional reimbursement for the extra physician work involved in treating multiple lesions in multiple branches.

CPT codes 92995 and 92996 are used in reporting procedures employing Food and Drug Administration-approved catheters such as the Atherocath, TEC (transluminal extraction atherectomy catheter), and rotational atherectomy catheter (Rotablator). These catheters remove plaque in the arteries by cutting, suctioning, or abrading it. Some cases combine atherectomy and balloon angioplasty to adequately reduce blockage. The code descriptions include the angioplasty when performed, but are also

appropriate for atherectomy without angioplasty. A single-vessel procedure is reported with 92995, while code 92996 is reported for each additional vessel involved.

In stent placement, CPT codes 92980 and 92981 include angioplasty as well when performed in the same vessel. After the procedure is completed, an antithrombotic may be administered to prevent thrombosis of the newly placed stent. Coding professionals should remember the CPT coding guidelines that govern the use of different therapeutic modalities in different coronary arteries during the same operative session by the same physician:

- Report the most highly valued service with the initial vessel CPT code.
- Report other therapeutic procedures performed in a different vessel or vessels using the most appropriate “each additional vessel” code.

Performance of a diagnostic cardiac catheterization is not part of angioplasty or atherectomy services and always should be reported separately. Medicare reimbursement rules determine that the angioplasty/atherectomy is paid at 100% of the allowance, and the cardiac catheterization allowance is reduced by 50%. Coronary artery procedures that are performed during a therapeutic procedure and that are integral to the procedure are not reported separately in this situation.

### ***Peripheral vascular bypass***

Peripheral vascular bypass CPT codes describe bypass procedures that use venous grafts (designated by CPT codes 35501-35587) and other types of bypass procedures, such as arterial reconstruction. At a given site of reconstruction, only one type of bypass is performed, so the groups of codes are mutually exclusive. When different sites are treated with different bypass procedures within the same operative session, then the CPT codes for both procedures may be reported, but modifier -59 should be appended to designate the second procedure as distinct from the first.

Codes 35470-35476 describe balloon angioplasty of peripheral and visceral arteries and veins. These codes should be reported in conjunction with codes from the range 75962-75968 to designate radiological supervision and interpretation of arterial procedures. Code 75978 is used to designate supervision and interpretation for venous angioplasty.

The 1998 edition of CPT implemented two new

codes, 92997 and 92998, for pulmonary artery balloon angioplasty. These codes are structured the same as the other angioplasty codes, so 92997 is assigned for the first vessel and 92998 for each additional vessel.

Codes 92986-92990 will be reported for percutaneous balloon valvuloplasty procedures performed on the aortic valve, mitral valve, and pulmonary valve.

This procedure is conducted in a cardiac catheterization laboratory. Hospitalization prior to the procedure may be required for intravenous heparin therapy. The right and left femoral areas are prepared so the left femoral artery and vein and the right femoral vein may be cannulated. If no cardiac catheterization was performed prior to the procedure, a complete right and left heart catheterization, coronary angiography, and left ventriculography are performed, when indicated. These procedures are coded separately.

Here is a clinical description of CPT code 92987:

- A pigtail catheter is placed via the left femoral artery in the left ventricle, and a right heart catheter with cardiac measurement capability is placed via the left femoral vein into the pulmonary artery. From the right femoral venous puncture, transeptal cannulation of the left atrium via puncture of the intra-atrial septum is performed.
- A spring-tip guidewire is placed through the transeptal catheter into the left atrium, and the left atrial sheath is removed. A 14-French dilator is passed over this wire to dilate the subcutaneous area at the right femoral puncture site and the puncture in the intra-atrial septum. The dilator is removed over the exchange, and the Inoue catheter is elongated and passed over the guidewire and into the left atrium through the transeptal puncture.
- The balloon is unstretched and the guidewire removed. The operator introduces a steering stylet into the shaft of the balloon catheter, and, with the distal portion of the balloon inflated, manipulates a catheter across the mitral valve into the left ventricle. The balloon is withdrawn until the partially inflated distal portion engages the mitral valve.
- Full inflation of the balloon follows, using a solution containing saline contrast to expand the balloon. The balloon is then deflated by withdrawing the saline contrast solution and the catheter is withdrawn. ■

(Continued from page 86)

security assessments that reveal networks at risk because the IT personnel responsible for them haven't applied all of the current security patches.

"Security is not an event. It's a process. You can't do it one time and think you're safe two days from now," he says. "You're going to operate systems with some degree of risk anyway. What's critical is knowing the risks and making informed decisions about the potential impacts and consequences of doing or not doing things."

### ***Uneducated employees pose great risk***

Health care providers may consider the risk of viruses and unauthorized access by authorized users when they attempt to secure their computer systems. But have they considered the potential risk of not properly educating their employees about their responsibilities as system users?

"If you don't tell people what is expected of them, how can you expect them to follow the rules?" Tompkins asks. Consider these points:

**1. Employees who use the computer system should understand the general concept of security issues, he says.**

**2. Employees should be trained in the responsibilities that they and other common users have.**

To accomplish this, Tompkins recommends holding security briefings for the users who have various levels of system access. For example, the first briefing may be for senior management. The second may be for mid-level management, and the third for day-to-day users of the system.

In these briefings, the users should be asked to sign a policy statement from senior management saying what is expected of system users. The statement, which should be general in nature, should outline their fundamental responsibilities, such as protecting their passwords and not sharing them.

Also, the statement should inform employees that they may be audited on both an announced and unannounced basis. Laws in some states require this notification.

"It's best to inform people that they are going to be audited on their use of the Internet and the corporate system," Tompkins says. "They also

should [be told in the briefing and on the statement] that using a personal computer at work doesn't mean they own it or anything that's on it. What's on the computer belongs to the company. The company provides the resource and is paying employees to use it.

"Misuse of corporate resources may be a termination offense providing you have the right policies in place," he adds.

Tompkins always holds annual security briefings and has employees re-sign the policy statements. The signed statements should be a condition of giving new employees a user ID, too, he says.

The statements have settled authorization disputes for Tompkins several times. "I had some inside people who tried to exceed their authority in the system. They said they didn't know they didn't have access." To challenge their claims, he went to the human resources office and pulled the signed statements out of their files.

Additionally, Tompkins says some states require a front banner on computer screens that warns that use is limited to owner-authorized access. Some states also require that the banners warn that the system is protected by a security system.

"If you don't have that notice, if employees do something wrong, you cannot take them to court because there wasn't sufficient notice," he points out. ■

## **The future's so bright at the end of the millennium**

### ***Hospitals optimistic about Y2K readiness***

**M**ost hospitals are not too worried about the approaching millennium. Either, they expect to be year 2000 (Y2K) compliant or don't expect their noncompliance to adversely affect critical operations, according to a survey conducted by the American Hospital Association (AHA) in Chicago.

"The survey results reinforce the message that we've been hearing from our members — that they are working aggressively to prepare Y2K and that their primary focus is to reassure patients that the systems critical to patient care will run smoothly," says **Fred Brown**, AHA chairman.

## OIG releases Y2K survey results

The Department of Health and Human Services' Office of Inspector General (OIG) in Washington, DC, also released a report giving the results of its nationwide year 2000 (Y2K) readiness survey.

The OIG surveyed 5,000 providers (hospitals, nursing facilities, home health agencies, durable medical equipment providers, and physicians) to see how prepared they were to meet the Y2K transition and its potential computer problems. The Medical Group Management Association (MGMA) in Englewood, CO, had the chance to review the report before it was disseminated.

Here are some results of the survey:

- ✓ About 50% of respondents reported that their billing and financial systems were compliant. More than 90% of hospitals that said they were not compliant expected to be by Dec. 31.
- ✓ 50% to 63% of providers report that they are now able to enter an eight-digit date on electronic claims.
- ✓ Less than 66% of providers had replaced or renovated their computer systems for Y2K compliance.
- ✓ Less than one-third of the responding providers indicated that their biomedical equipment was currently Y2K compliant.
- ✓ Less than 60% of respondents state that their Medicare contractor had sent them Y2K information or offered to provide assistance.
- ✓ Only 10% to 20% of providers had requested Y2K-ready software from their Medicare contractor. ■

The AHA surveyed a nationally representative sample of 2,000 members in February on their Y2K readiness by the end of the year in three areas: information systems, medical devices, and infrastructure/physical plant. The responses from 583 members indicate that almost all of the nation's hospitals expect to meet the Y2K challenge. (The survey defines Y2K compliance as an institution's performance

and/or functionality not being affected by dates prior to, during, and after the year 2000.)

Here are some of the survey's findings:

### INFORMATION SYSTEM READINESS

- ☐ 65.7% of surveyed hospitals' information systems are expected to be Y2K compliant by year end.
- ☐ 31.9% are not expecting to be fully compliant by year end, but do not anticipate any adverse effect on critical operations.
- ☐ 0.5% of surveyed hospitals expect information systems to be Y2K noncompliant at year end with possible adverse effects on critical operations.
- ☐ Rural hospitals are slightly more likely to achieve Y2K compliance by year end than urban hospitals (66.3% vs. 64.5%, respectively).

### MEDICAL DEVICE READINESS

- ☐ 57.9% of surveyed hospitals' medical devices are expected to be Y2K compliant by year end.
- ☐ 38.2% are projecting to not be totally compliant, but are expecting no adverse effect on critical operations.
- ☐ 0.5% of hospitals surveyed expect medical devices to be noncompliant, with possible adverse effects on critical operations.

### PHYSICAL PLANT/INFRASTRUCTURE READINESS

- ☐ 66.7% of surveyed hospitals' physical plant and infrastructure are expected to be Y2K compliant by year end.
- ☐ 28.8% are not expecting full compliance but are also not foreseeing any adverse effect on critical operations.
- ☐ 0.4% of surveyed hospitals expect their physical plant/infrastructure to be noncompliant, with possible adverse effects on critical operations.

### BARRIERS TO READINESS

- ☐ Survey respondents say that lack of information from suppliers is the No. 1 barrier to total Y2K readiness.
- ☐ Only 14.2% of urban hospitals surveyed reported a lack of funding as a barrier to Y2K compliance, compared with 26.9% of rural respondents.

### COMMUNITY PLANNING

- ☐ Hospitals are working with their community partners to assist in planning for potential Y2K

compliance disruptions.

□ 66% of hospitals have initiated contact with utilities, followed by other hospitals (43.6%) and fire/police (37.9%), ambulance services (35.8%), and city governments (34.8%).

#### MEDICARE CLAIMS READINESS

□ 74.8% of hospitals are already submitting their Medicare claims in Y2K-compliant format.

□ Those not currently using a compliant format anticipate that their claims will be compliant within an average of three months. (Hospitals were required to submit Y2K-compliant Medicare claims as of April 5, 1999.)

Of the hospitals that responded to the survey, 46.2% were under 100 beds, 40.1% represented hospitals in the 100 to 399 bed range, and 13.7% were in the 400-plus bed range. About 53.8% of the respondents were rural. ■

## Congress tackles health info confidentiality

### *Association concerned about provisions in bills*

Everyone, it seems, is concerned about the confidentiality of health information, but one association is saying that Congress is taking the wrong approach to the issue.

The problem exists in three bills introduced to Congress on March 10.

Senate bill 573 and its House of Representatives counterpart, HR 1057, include provisions that ultimately could endanger health information — not protect it, attests **Linda**

**L. Kloss,**

RRA, executive vice president and CEO of the American Health Information Management Association (AHIMA) in Chicago.

*“HIM professionals know that waving a red flag over certain portions of a record in the name of protection may have the opposite effect. People are curious by nature and may be drawn to a record’s flagged portions.”*

S. 573 is sponsored by Sen. Patrick J. Leahy, (D-VT). H.R. 1057 is sponsored by Rep. Edward J. Markey, (D-MA). The bills, both named the Medical Information Privacy and Security Act, have the following goals:

**1. provide individuals with access to health information of which they are a subject;**

**2. ensure personal privacy with respect to health care-related information, impose criminal and civil penalties for unauthorized use of protected health information;**

**3. provide for the strong enforcement of these rights and protect states’ rights.**

However, S. 573 and H.R. 1057 contain provisions that would fail to comprehensively preempt state health information confidentiality laws, leaving in place the current patchwork quilt of state laws and rules federal intervention is supposed to remedy, Kloss says.

### *Inconsistent laws add to confusion*

She also is concerned that these bills would treat various types of health information differently and make it impossible to maintain uniformly high standards for the management of records.

“Currently, each state has different laws and rules for maintaining health information confidentiality. Some states have none,” Kloss explains. “As health information management (HIM) professionals, AHIMA members know that the confusion caused by this lack of consistency can lead to errors and potentially breaches of confidentiality.”

A third bill, S. 578, the Health Care Personal Information Nondisclosure Act, also known as the PIN Act, fails to include comprehensive preemption language, she notes.

S. 578 is sponsored by Sen. Jim Jeffords (R-VT) and aims to ensure confidentiality with respect to medical records and health care-related information and for other purposes.

“One of the goals in the effort to develop federal confidentiality laws or rules is to create a single national standard that establishes a high level of protection for everyone,” Kloss says. “These bills fall short of that goal.”

In addition to the preemption issue, provisions in S. 573 and H.R. 1057 that codify different levels or methods of protection for various kinds of

patient information are problematic, Kloss says.

"All health information is important and deserves equal protection. Treating mental health information, genetic information, and other health information differently would add to the confusion and increase the potential for errors. It also incorrectly implies that one type of health information is more important than another," Kloss explains.

"HIM professionals know that waving a red flag over certain portions of a record in the name of protection may have the opposite effect. People are curious by nature and may be drawn to a record's flagged portions."

### ***Should patients have a choice?***

Kloss also says that one provision's concept of giving patients the choice of computer or paper-based records is unrealistic.

"The premise of this provision is a fallacy. Computer-based patient records are safe and no less prone to confidentiality breaches than paper records," she says. "In fact, it's possible to build safeguards into computer-based patient record

systems that limit access to records and/or keep a record of who has attempted to access them. These kinds of safeguards cannot be built into paper-based systems."

The mentioned provision also does not take into account the many benefits of computer-based patient records, notes Kloss. Those benefits include:

- **enhanced patient care;**
- **more accurate data for research;**
- **greater overall efficiency and cost effectiveness;**
- **technology-based confidentiality protections.**

"It's also important to note that no other type of businesses are mandated to give customers a choice between doing business electronically or on paper."

Even with the problems with the current legislation, AHIMA will continue to work with Congress and the Clinton administration as it has over the past several years. The goal is "to produce meaningful, effective confidentiality legislation," Kloss says. ■



## **Medicare claims must now be year 2000 compliant**

All bills submitted by health care providers for services to Medicare beneficiaries should now be year 2000 (Y2K) compliant. On Jan. 13, the Health Care Financing Administration (HCFA) in Baltimore notified Medicare contractors that, beginning April 5, claims not submitted in the Y2K format would be returned to providers as not processable. On Feb. 1, 1999, the Medicare contractors issued bulletins to all providers detailing this compliance deadline.

To be reimbursed for Medicare claims, doctors, hospitals, and other health care providers must now submit bills that use eight-digit dates to be paid by the private insurance companies that process and pay Medicare claims.

HCFA also has been conducting an outreach

effort to inform and help providers meet the Y2K challenge. Software has been made available through Medicare contractors, and HCFA has established a toll-free telephone line [(800) 958-HCFA] and posted materials and information on the Internet (<http://www.hcfa.gov/y2k>).

Callers will be able to get answers to Y2K questions that relate to medical supplies, their facilities, and business operations as well as referrals for more specific billing information relating to Y2K issues. The toll-free line will also update callers on HCFA's Y2K policies as well, and provide general assistance to help callers prepare their own computer systems for the millennium. HCFA also is holding educational conferences throughout the country. ▼

## **AHIMA develops HIM master's curriculum**

The Chicago-based American Health Information Management Association's (AHIMA) new HIM master's curriculum should give health information management (HIM) professionals access to education programs designed

specifically for advancement in practice.

"The curriculum is designed to prepare HIM professionals for a variety of career opportunities and help them identify and establish new roles and pathways as they progress," says association education and certification vice president, **Merida L. Johns**, PhD, RRA.

### **Preparing for multiple roles**

Developed by AHIMA's curriculum model work group, the curriculum addresses advances in information technology, changes in the health care marketplace that have an impact on business operations and patient care, and increases in the demand for HIM practitioners who have competencies in both information management and computer applications.

According to Johns, the curriculum is designed to prepare HIM professionals for several roles, including:

- executive health information manager;
- medical language and classification expert;
- data quality improvement expert;
- information security expert;
- information resource planner;
- data analyst/research specialist;
- information systems user liaison;
- project manager.

AHIMA is in the process of disseminating the curriculum to the nation's universities.

"We expect that within the next five or so years, several HIM master's programs will be in place," Johns says. "Our goal is to make master's education available to as many HIM practitioners as possible." ▼

## **HCFA has new fraud-fighting plan**

**T**he Health Care Financing Administration (HCFA) in Baltimore has released a comprehensive plan for fighting fraud in the Medicare and Medicaid systems. The Comprehensive Plan for Program Integrity outlines 10 initiatives that focus on both HCFA's internal process and the health care industry.

The five initiatives that target HCFA program integrity management are:

- increasing the effectiveness of medical

review and benefit integrity activities;

- implementing the Medicare Integrity Program;
- implementing payment safeguards for Balanced Budget Act provisions;
- promoting provider integrity;
- initiating program integrity millennium contingency planning.

The plan also lists five high-risk areas:

- inpatient hospital care;
- congregate care;
- managed care;
- community mental health center care;
- nursing home enforcement.

For more information about the plan, visit HCFA's Web site at <http://www.hcfa.gov>. ▼

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### **Editorial Questions**

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

# AHA report: Inpatient days could drop 25% by 2002

A recent report predicts that by 2002, hospital inpatient days will drop by up to 25% as patients are shifted to lower cost services and settings and health plans develop tighter utilization controls and more restrictive fee schedules.

The report, from the American Hospital Association's Society for Healthcare Strategy and Market Development and Division of Trustee and Community Leadership, is based on a survey of hospital trustees, CEO, and other executives. The report says Medicare HMO enrollment could rise to 25% of seniors and 40% of the general population. It also predicts more state regulation of for-profit conversions of tax-exempt hospitals and health plans.

To order a copy of the report, call (800) AHA-2626 and request item no. 127100. The report costs \$15 for members and \$45 for nonmembers. ■



• **Internet and Healthcare — The Future of E-Health**, the eighth annual conference of the Computer-based Patient Record Institute (CPRI), will be held June 7-8, 1999, in Washington, DC. The conference is targeted for CPR system administrators, health care providers, information technologists, and vendors.

For more information about the conference, contact CPRI at (301) 657-5918 in Bethesda, MD, or visit the Web site at <http://www.cpri.org/meetings/99annual/index.htm>.

• **Leading with Integrity: The Bottom Line**, the 1999 Annual National Institute of the Healthcare Financial Management Association (HFMA), will be held June 20-23 in Anaheim, CA.

The program features four keynote speakers, more than 90 skill-building sessions, and an exhibition area. For more information, contact HFMA in Westchester, IL, at (708) 531-9600 or visit the Web site at <http://www.hfma.org/visitors/ani/ani.htm>.

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• **Chart Auditing for the Coding Professional**, a four-day workshop for chart auditors of physician services, will be held in four different locations and times this year. The workshop is sponsored by Howrey and Associates in Jefferson, MA, and is presented by Linda M. Howrey, CPC, CCS-P.

The locations for the workshops are:  
Baltimore, July 14-17, Holiday Inn Inner Harbor; Kansas City, MO, Aug. 11-14, Radisson Suite; Salt Lake City, Sept. 22-25, Wyndham Hotel; San Diego, Oct. 20-23, La Jolla Marriott.

For more information about the workshops or to register, call MPC Management at (800) 734-7331. Registrants receive an early-bird discount if the reservation is received six weeks prior to the start of the scheduled program. ■

## Send us your thoughts

Do you have a coding question for our *DRG Coding Advisor* columnist or want to share a success (or not so successful) story? If so, we want to hear from you. Send your comments, suggestions, and questions to *Hospital Payment & Information Management*, P.O. Box 740056, Atlanta, GA 30374. E-mail: [kevin.new@medec.com](mailto:kevin.new@medec.com). ■