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Hospital Access Management

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INSIDE

■ **Revenue management:** Looking at access as part of the big picture . . . . . cover

■ **Enhancing revenue:** Committee quizzes 'cost center' managers to get solutions 16

■ **Career paths:** Veteran access director broadens focus 18

■ **Denial management:** Has your hospital tried arbitration to resolve claim disputes? . . . 20

■ **STAR Award:** System decided it was time to honor access staff. 21

■ **News briefs**
— Smallpox information available on various web sites 22
— Outlier payment scrutiny to increase, says CMS 22
— Hospitals still can offer free rides 23
— Here's more guidance on privacy rule 23

Inserted in this issue:
— STAR nomination forms

FEBRUARY 2003

VOL. 22, NO. 2 (pages 13-24)

Everyone involved in the revenue cycle is an important part of the process

AM controls crucial first step, but there's more to impacting the bottom line

Whether your hospital has embraced the methodology associated with the term "revenue cycle management," chances are you've heard the words bandied about. Certainly the crucial importance of accurate and efficient front-end operations to a health care provider's bottom line is emphasized whenever there is a gathering of health care industry leaders.

What may not have crossed your radar screen, however, is the equally vital second phase, the part of the cycle that comes after the access department has performed the scheduling, precertification, insurance verification, preregistration, and registration functions that start the process.

"Charge capture" and "charge description master" are the operative terms for that second piece, explains **Joe Denney,** CHAM, director of revenue management at The Ohio State University Health System (OSUHS) in Columbus, an organization recognized for being on the cutting edge in its implementation of revenue cycle management.

Denney will do a presentation on the subject for his colleagues at the University Hospital Consortium's (UHC) Management and Supply Services Forum, scheduled for Feb. 23-25 in Scottsdale, AZ. OSUHS has been designated by UHC as having "best practice for reduction of late charges."

"We put a program together where we reduced late charges from over $3 million a month to less than $100,000 a month within the past 18 months," he says. The lower figure represents less than 1% of the organization's gross revenues, Denney adds.

OSUHS also received the best practice designation for denial management, he notes.

Hospital Access Management™ (ISSN 1079-0365) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Access Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. -6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $465. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $372 per year; 10 to 20 additional copies, $279 per year; for more than 20 copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

Editorial Questions

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It's important for access managers "to understand that everybody involved [in the revenue cycle] has an extremely important piece of the process," says Denney, who gained extensive experience in access management and patient accounting before assuming his current position. **(See related story, p. 18.)** The full name of the area in which he works, he points out, is department of access and revenue management, which gives special emphasis to the importance of the front end.

"[Access managers], who have responsibility for scheduling, preregistration and registration, and maybe precertification, need to understand how that fits in with the rest of the revenue cycle," he says. "It's not business office accounts receivable management anymore." Instead, Denney adds, the process extends from scheduling through charge capture and denial management. "We all have to work together as a team."

Below, he highlights the different steps in the revenue cycle, as exemplified at OSUHS.

The role of the access department

"Traditionally, when you think 'accounts receivable management,' you think business office," Denney says, "but the key as we've learned over the years is that a lot of the responsibility of getting the claim out faster is on doing a good job upfront in collecting data. That absolutely starts with scheduling."

The object of that first telephone call — probably from a physician needing to schedule a patient for a procedure — is to get just enough information to go to the second step, Denney says. That "minimum data set," as it is known at OSUHS, would be the information necessary to contact the patient, he adds.

The second step, then, in securing payment for the hospital, is for access staff to call the patient to get insurance and guarantor information so that insurance verification and, if necessary, precertification or authorization can be done on the account, Denney says.

OSUHS is considering changing the process so that the physician simply faxes the order for the procedure to the hospital, and the patient calls at his or her convenience to do the preregistration, he notes. "The key there is they have to send the order to us in the first place."

The OSUHS computer system has the capability of running an Advance Beneficiary Notice (ABN) check on the case to see if the diagnosis the physician provided will stand up to Medicare

scrutiny, Denney points out. "When the [access employee] is on the phone with the patient, [the employee] can let the patient know that the test or diagnosis is not supported."

"The important piece is not to have a surprise for the patients when they show up," he adds. "If we can let the patient know up front that the test may not be paid for, then we have all the bases covered. What happens on the day of service is just verifying, getting the consents signed, and making sure we meet HIPAA [Health Insurance Portability and Accountability Act] requirements."

The upfront notification also prevents the waste of a scheduling slot, should the patient decide not to have the procedure after discovering it is not covered by Medicare, Denney says.

OSUHS has ordered a new ABN checker that also includes an on-line requisitioning system, he notes. The new product will be stand-alone initially, Denney adds, but eventually will be integrated with the patient management and patient accounting system.

"There are two components [to the new product]," Denney says. "One is the ABN checker. You put in the ICD-9 diagnosis code and the test or procedure, and it searches for the local medical review policy to see if the diagnosis is a valid reason for the test. If not — and this is true just for Medicare patients — the system prints an ABN that the registrar can present to the patient."

With the second component, the on-line requisitioning system, a physician can — instead of writing by hand a consult for an X-ray — fill out an on-line requisition from his or her office, he explains. "[The physician] can say, 'Here's the diagnosis, here's my electronic signature,' click a button, and the people in radiology will have the order."

If the physician desires, he or she can initiate the ABN checker as well, determining the validity of the order before sending it, Denney adds.

Revenue management

At this point the process leaves the purview of the access staff and moves into Denney's area of supervision. As director of revenue management, he oversees the "charge capture" and "charge description master" mentioned above. He and his staff "work directly with [the health system's] 200-plus revenue-producing centers to make sure they have all of the charges necessary in order to properly bill for the services they provide," he explains.

"If there's a new supply or a new procedure, they contact us and we do research and set up a charge for that supply or procedure," he says. "We collect the cost information and then determine a proper price."

Within the charge description master, Denney says, there not only is a charge code for each item, but a related revenue code and CPT code. "This is all part of the Centers for Medicare & Medicaid Services Correct Coding Initiative."

A mismatch in those codes or a charge master that is not properly maintained so that there are accurate descriptions of procedures can result in bills being rejected, he adds.

One of the things Denney did to facilitate charge capture was to lead a grass-roots effort to bring the various cost centers into ownership of the process. He educated lead people, who in turn worked with their centers to discover opportunities for increasing revenue, explains **Donna Madlener,** manager of the apheresis unit at the system's James Cancer Hospital.

"It was decided at the management level that we should know more about charges that were getting lost, about anything we were not capturing," she adds. **(See related story, p. 16.)**

Rejection and denial management

If all of the above steps have gone well, the result will be a clean claim, Denney notes, which can pass all the edits in the electronic billing system without being caught and without a biller having to touch the account.

"If this all happens properly," he adds, "the claim can go out the door and remittance will come in the door. If it all didn't happen correctly, you have another major piece of the revenue cycle." That piece begins, Denney notes, when the insurance company rejects a claim for one reason or another.

"We have a process that we are fully automating so that when a rejection comes into the business office, [the system] will sort it by activity code," he says. "It will say, for example, that the claim was rejected because it was not precertified or that there was no medical necessity for performing the service, or maybe that we billed too late."

Depending on the reason for the rejection, the business office immediately will notify the appropriate department, Denney says, and that department will research the account. "We will

determine if we can submit a letter to explain [to the insurance company] what went wrong and if we can turn the rejections around."

If the reason given for the denial was lack of precertification, for example, Denney's counterpart in access will have his or her staff investigate the matter, he adds. "Maybe they'll find that we did get a precert and the insurance company is wrong. If so, they'll issue a letter of appeal, and then log what has happened with the account into our electronic system."

Work lists in the system allow staff to see if it's been 30 days, for instance, and the hospital hasn't heard back from the insurance company, Denney notes. Revenue Management Workstation, the denial management piece of Malvern, PA-based computer vendor SMS's admission / discharge / transfer system, gives OSUHS this electronic method of generating and using work lists, he adds.

"If we hear from [the insurance company] that a procedure is not medically necessary, [the information] gets fired off to the medical information management staff, who look through the records and see if they can get more documentation, he explains. "Then they will send a message back to the business office and say, 'Resubmit it.' There are no more manual work lists."

[Editor's note: Joe Denney can be reached at (614) 293-2132 or by e-mail at denney-1@medctr.osu.edu.] ■

Committee seeks ways to enhance hospital revenue

Grass-roots effort leaves no stone unturned

When **Donna Madlener** agreed to lead the Revenue Enhancement Committee for the James Cancer Hospital, which is part of The Ohio State University Health System (OSUHS) in Columbus, she signed on for "a unique experience" that went to the heart of such issues as financial responsibility and internal customer service.

"We interviewed the managers of every cost center in the James Hospital and brought back the information they provided to us," says Madlener, who is manager of the hospital's apheresis unit. "There were suggestions for revenue enhancement and the problems they saw in any processes we had in place. The underlying purpose was to evaluate all processes and systems to identify opportunities for revenue enhancement and recommend strategies for improvement."

The James committee began work in May 2001 and presented its recommendations in January 2002, sometimes meeting as often as twice a week, she says. "It was a long, involved process."

The nine-member committee also included OSUHS director of revenue manager Joe Denney, who spearheaded the effort for the entire health system, and representatives from administration, nursing, outpatient services, and pharmacy, among other hospital areas, Madlener notes. "A multitude of backgrounds were represented."

The committee developed a questionnaire and embarked upon the interviewing process, dividing up the cost centers according to the expertise of individual members, Madlener says. **(See excerpt from questionnaire, p. 17.)** "Through the grass-roots effort of interviewing each manager, we looked at the information we had and defined the purpose and goals we wanted to focus on."

When it came to registration, "a process with huge financial ramifications," the committee looked at, among other things, "different people's roles and job descriptions," she explains. "Did we have people responsible for doing certain things, or were there holes in the system? Were there people in the same role [at different centers] but doing things differently?"

In addressing its task, Madlener adds, the committee used an existing model that looks at how patients go through the continuum of services in a hospital. The first phase, for example, is pre-encounter, which includes inpatient precertification, outpatient precertification and authorization, and scheduling, she says. "We divided the issues into the different phases and from there made recommendations."

Looking at inpatient precert, for instance, the committee found that there was no real policy development, Madlener says. "Everyone was doing their own thing," she notes. "[Employees at physician offices and clinics] were not really part of our hospital, but were responsible for precert. There was no fallout if they didn't do it."

Regarding the registration software program, Madlener points out, the committee's recommendation was that the flow and storage of information be enhanced so the hospital could monitor processes for compliance and determine how many accounts were getting through without

(Continued on page 18)

OSUHS Revenue Enhancement Committee Questionnaire Excerpt

Revenue Enhancement Member's Name:

Cost Center:

Contact person(s)/Manager/Person in charge of the revenue:

OUTPATIENTS ONLY: Where do your patients get registered?
Is the insurance updated every month? _____
Do you use recurrent or single visit numbers?
Explain_____

What do you do with the blue cards that are generated every visit or every month? (Give them to the patient/ keep on the unit/discard/etc.)_____

Is there any reason why you would see a patient who is not registered?

Do you have any concerns about the registration process?

Does the cost center have a hard copy list of patients from which they charge? _____If not, what does the person doing the billing work from?

Obtain a copy of the list.

Does the cost center have a current fee schedule? _____
Date on Fee schedule? _____
Obtain a copy of the fee schedule.
When was the last time charges were reviewed? _____
Are there procedures or supplies that could be charges that are not on the current fee schedule? _____
Are there any concerns about the fee schedule? What are they?

Source: Ohio State University Health System. Reprinted with permission.

precerts being obtained.

When it came to centralized scheduling, she adds, the need was for more information systems resources. "There was no one to call to help you."

Another recommendation had to do with the need for registration personnel — who perform a critical function — to be trained and paid accordingly, Madlener says. "They're doing probably the most important job. When the bill is not correct, [the hospital] spends lots of money correcting it, paying people to figure out what was going on. We thought that was crucial."

Cost center accountability probably was the biggest issue confronted by the committee during the "encounter phase — what happens when the patient is already here," she points out. This had to do with "things like reconciling billing. After you put the charge in, did someone check to see if it was put in correctly? Did you pick the right procedure to charge for? Is the fee schedule updated? Are the CPT [current procedural terminology] codes current? Is the cost of the procedure more than what you're charging? Do the managers know how to read performance and productivity reports?"

Much of the problem, Madlener adds, had to do with the attitude that "it's somebody else's job. As a state institution, [the hospital] didn't really have a culture of financial responsibility and internal customer service."

As a sideline of the committee, members sat down with each of the hospital's nurse managers and went over the fee schedule item by item, she notes. "It was very laborious. On some of the fee schedules there were, for example, 10 different catheters to charge for, and two were identical. A lot of cleaning up and updating of CPT codes was done."

One cost center was charging for drawing blood from a central line, and another wasn't charging for the same procedure, Madlener points out. "They didn't know they could."

Staff turnover was identified as a huge expense with a tremendous impact on the hospital's bottom line, she notes. The negative effects ranged from the cost of formal training and education of new hires to the problems caused by new employees' lack of knowledge, Madlener adds. "A lot of money was spent on staff turnover."

Although the committee's role was to look at the situation and make recommendations, she adds, in many cases it took a more proactive role. "When we would identify things — fee schedules, charge entry — that were huge issues, we would correct the problem right on the spot. In the case of some drugs that were not being billed correctly, we went right to the source and fixed it."

[Editor's note: Donna Madlener can be reached at madlener-1@medctr.osu.edu.] ■

Veteran access pro segues into revenue management

Computer and financial experience were key

Several years ago, when The Ohio State University Health System (OSUHS) decided to convert from its homegrown computer system to a commercial product, **Joe Denney**, CHAM, who was then director of patient access and financial services, was given a choice between two career options.

"My boss said, 'You can stay in the operational world and continue [managing] 24-7, or I will make you project lead for implementation of the new system,'" Denney recalls. "I decided it was time for a change."

That choice set Denney on a course of action that led ultimately to his current position as OSUHS' director of revenue management. His experience overseeing the computer conversion and the knowledge gained from past positions have been invaluable in preparing him for his role in the organization's innovative revenue cycle management effort, Denney explains.

"For the next year, I did nothing but cleaning up the conversion, the bad data, and fixing bugs," he says. "Having had patient access management and patient accounting experience before, I was the lead person in finding the cure for what ailed us. Within a year of when we went live with the new system, we bought a community hospital."

That hospital was found not to be Y2K-compliant, Denney adds, so his next mission

'Pricing sensitivity' one way to optimize hospital revenue

Balance competitiveness and reimbursement

One of the concepts **Joe Denney,** CHAM, has become familiar with in his position as director of revenue management at The Ohio State University Health System (OSUHS) in Columbus is something called "pricing sensitivity," he says.

"Our latest question here is, 'Where do we set our prices?' We want to be competitive, but we also want to optimize our reimbursement."

What's the buzz?

Pricing sensitivity, which Denney describes as "the current buzz in the charge description master world," has to do with increasing the organization's net revenues as much as possible without much increase in gross revenues.

"Where do you get your biggest bang for the buck?" is the operative question, he explains. "If I increase the price of a procedure that we do a huge volume on by just a few dollars, then our gross revenues won't go up that much, and if we get paid well for that particular procedure, we will see a bigger increase in net revenue."

The result is that the organization stays competitive on the pricing, but because of the large volume, gets more reimbursement with just a small increase in gross revenue, Denney adds. "On the pieces you do the greatest volume, increase prices accordingly, but don't go over what the market will endure." ■

became overseeing the purchase and installation of a new computer system for that facility.

"At that point, we had cleaned up a lot of stuff, and we started saying, 'Where do we want to be headed to make sure we're handling accounts receivable in the most efficient way — collecting cash, getting claims out quickly, doing cleaner and cleaner registrations? Fairly quickly, the whole idea of access and revenue cycle management began to evolve."

Although there had been much finger pointing at access departments by business offices over the years, he says, no one had taken seriously enough the idea that if you fix what's wrong on the front end, you fix a lot of the problem.

"We were not unique," Denney says. "Others all around the country started saying, 'Maybe if we got the registration process down better, got precerts, we would solve the clean-claim problem without billers having to touch the account."

Think in terms of patient management

Part of the reason the issue came to light, he suggests, was that many hospitals were buying new computer systems or enhancements in preparation for Y2K. "We started thinking in terms of patient management, and there was more of an emphasis on feeding clean data, and you can only feed clean data if you collect clean data."

At his facility, meanwhile, as Denney was "cleaning up the goofs and data errors involved in computer conversion," it became apparent that the charge description masters (CDM) had not been serviced properly, he adds. "There had never been that kind of attention placed on them."

In addition, the federal government was about to implement the outpatient prospective payment system (OPPS), and the correct coding initiative was coming into play, Denney points out.

"There was more emphasis on compliance," he continues, "so people started saying, 'We have to get this whole middle piece right, too.'"

About that time, the person at OSUHS who, among other things, had been responsible for the charge master, decided to leave the organization to become a consultant, Denney notes. It became clear to hospital leadership, he says, that handling the charge master should be more than a piece of someone's job. It called for a person and probably a team.

"I was made director of revenue management at that point, and I quickly was able to document the need for a staff," he says. "I justified one full-time equivalent to start with and — with OPPS requiring procedure-based billing in the emergency department by August 2000 — quickly justified another. Within a year, we had a third."

With Denney, those three staff members make up what is called the CDM team, he adds. "We have liaison function between 200-plus cost centers and [responsibility to] compliantly bill every hard-coded CPT [current procedural terminology]

and procedure that comes out of the charge description master."

Operational background key

His experience in access management, where he dealt directly with patient care units and ancillary services on a daily basis, has been of great benefit in his current position, Denney says, as has his financial knowledge.

"Given that background, I know the priorities of the people who are out there providing services," he notes, "but I also know, from the financial perspective, that it doesn't do any good to provide service if you're not getting paid for it."

Because he sees both sides of the coin, Denney adds, he asks the question, "How can I go out there and — without disrupting patient care — work with them to see if we can capture more charges?"

The subject of charge capture compliance, he notes, is gaining the attention of the industry. "You wouldn't believe the number of consultants out there who want to help." ■

Arbitration viable option for handling payer denials

It should be final step in appeals process

By **Linda M. Fotheringill**, Esq.
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In October 2002, HCA in Nashville, TN, won an $8.8 million arbitration decision against Humana Medical Plan Inc. of Florida for the late payment or nonpayment of 3,300 patient accounts at 16 hospitals in Florida. HCA alleged that Humana paid hospital bills for patients in its HMO, preferred provider, Medicaid, and Medicare health plans as much as one year late, and that its hospitals sometimes had to rebill the insurer three or four times to receive reimbursement.

This arbitration result should provide inspiration to other hospitals that are subjected to similar alleged business practices. However, chances are that your hospital never has initiated arbitration against an offending payer. If this is so, your hospital has not taken advantage of one of the most effective tools in denial management.

Arbitration should be the final step in your appeals process because it allows your dispute to be decided by an impartial third party who is more likely than the payer to render a fair decision. More than likely, your contract with offending payers will specify that any disputes not settled in the appeals process are to be resolved by binding arbitration.

Arbitration vs. litigation

Arbitration should not be confused with civil litigation. Arbitration is a private, informal process, and generally is faster and less expensive than litigation. A hospital should not require a multimillion-dollar problem with nonpayment and late payment issues before considering arbitration. Indeed, *all* disputes, such as unsuccessfully appealed claims denied for lack of medical necessity, delay of service, lack of authorization / precertification, untimely billing, and underpayments for the contractual terms could and should be grouped for arbitration. Not only will net revenue be increased by overturning more denied or underpaid claims, but the payer will get the message that unacceptable claims-handling practices will not be tolerated at your facility.

Although arbitration hasn't been used much in the past, times are changing. Hospitals that care about their bottom lines and care about the ability to enforce the mutually agreed upon terms of their contracts are giving consideration to arbitration. In fact, some have made arbitration an automatic final step in the appeals process.

Generally, arbitration proceedings are confidential, which prevents publication of the success rate for this activity. Before initiating arbitration, consideration on a payer-by-payer basis should be given to your hospital's market position, payer relationship, and the revenue recovery opportunity. Your hospital may decide that enforcement of contractual terms should not be considered with certain payers due to market position, but definitely should be pursued with others. Even in instances where a decision is made not to pursue enforcement with a particular payer, there may be a change of heart as time goes by and wrongful

denials continue or increase with that payer.

There are decision points where it is not worthwhile to continue a contractual relationship with a particular payer, and it would be advantageous to have the opportunity to go back and recoup money lost through abusive business denial practices.

Grouping a particular payer's low-dollar claim denials together and filing them in a single arbitration can achieve cost effectiveness. A qualified law firm should be willing to pursue the arbitration on a contingency fee basis, thereby decreasing or eliminating out-of-pocket expense to your hospital.

Arbitration is not mediation

Arbitration should not be confused with mediation. While they both are methods of alternative-dispute resolution, mediation generally is associated with a *nonbinding* procedure, in which a neutral third party facilitates the parties' settlement process. In nonbinding mediation, the neutral facilitator can offer suggestions for resolution, but a resolution is not enforceable in a court of law.

The parties can provide for arbitration of *future* disputes by inserting the following clause into their contracts (the bracketed language suggests possible alternatives or additions):

Arbitration. Any controversy, dispute, or disagreement arising out of or relating to this agreement, the breach thereof, or the subject matter thereof, shall be settled exclusively by **binding** arbitration, which will be conducted in [*city, state*] in accordance with the [*insert name of alternative dispute resolution organization of your choice*]'s rules of procedure for arbitration and which, to the extent of the subject matter of the arbitration, shall be binding not only on the parties to the agreement, but on the other entity controlled by, in control of, or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

Arbitration of *existing* disputes where there is no existing arbitration clause in the contract may be accomplished by a separate written agreement that states the following: We, the undersigned parties, hereby agree to submit to binding arbitration administered by the [*insert name of alternative dispute resolution of your choice*] under its commercial arbitration rules, the following controversy: *[briefly describe the nature of the dispute*]. We further agree that a judgment of any court having jurisdiction may be entered upon the award.

There are multiple organizations that administer alternative dispute resolution procedures and provide published rules for the process. Three such organizations are the American Arbitration Association; American Health Lawyers Association; and JAMS, a dispute resolution company. All three have comprehensive web sites that include their arbitration rules as well as downloadable forms.

The benefit of arbitrating against a payer should not be measured only by the potential monetary recovery. A single case can send a message to a payer that your hospital is not willing to tolerate unfair denial practices and is willing to enforce the terms of the contract, thereby deterring future abuses.

[Editor's note: Linda M. Fotheringill, whose firm concentrates exclusively on representing health care providers in third-party payer denial cases, can be reached at 212 Washington Ave., First Floor, Baltimore, MD 21204. Telephone: (410) 296-1552 or (800) 597-7759; Fax: (410) 296-1558; E-mail: L.Fotheringill@fwhealthlaw.com.] ■

'STAR' is first award honoring access staff

Employees nominate their peers

The University Hospital of Arkansas in Little Rock has instituted its first recognition program aimed specifically at access personnel, says **Holly Jones**, revenue integrity specialist and a member of the committee that selects the winner.

The first Striving Together Achieving Results (STAR) winner was chosen in November 2002, and the award is presented to another employee each month, Jones says. "During April, when we observe National Healthcare Access Personnel Week, we will choose a yearly winner from the monthly winners."

Access employees are nominated by their peers, who are asked to write a paragraph explaining why the person should be chosen, she notes. Nominations are given to the appropriate manager, who fills out an evaluation tool for the nominee, Jones adds. **(See forms, inserted in this issue.)** The STAR program is designed to honor employees who

excel in such areas as leadership, team skills, professional appearance, and customer service, she says.

"There are various recognition programs around campus for nursing and other [fields], but we didn't have any way of recognizing registration staff for a job well done," Jones adds. "The idea got sent to a managers' meeting, they loved the idea, and we got a committee."

The STAR committee, which in addition to Jones includes a director and managers of various hospital clinics and departments, meets once a month to choose the winner, she says. All access employees are eligible, Jones notes, including point-of-service coordinators, access representatives, registration and appointment specialists, inpatient and emergency department admission representatives, and chart technicians.

The committee chooses the winner after reviewing the evaluation forms, she adds. "Monthly winners get a 'STAR' pin that goes on their identification badge, a trophy that floats around month to month to keep at their workstation, and a certificate to hang on the wall," Jones says. "We send a letter to the [winner's] manager."

An article about the winner, along with the person's picture, is circulated in campuswide newsletters and alerts, she adds.

[Editor's note: For more information, contact Holly Jones at (501) 603-1132 or by e-mail at JonesHollyR @uams.edu.] ■

HHS: 450,000 health workers may get vaccine

A preliminary review of smallpox vaccination plans submitted by U.S. states and cities in mid-December indicates that close to 450,000 public health and health care personnel may be offered the vaccine when it becomes available, according to the Department of Health and Human Services (HHS).

It is expected that access personnel who work in the emergency department, if not those in other areas, will be among the first group to be offered the vaccine. The plan is voluntary, the HHS says, and eligible individuals will make their own decision on whether or not to receive the vaccine.

Plans submitted so far contain information on the number of people comprising each public health smallpox team and each health care smallpox response team, information on where vaccines would be administered, the number of health care facilities identified to participate, and the number of clinics needed to support the effort.

No two state plans are identical, Centers for Disease Control and Prevention (CDC) officials say. The CDC provided states with guidelines, but also offered the flexibility to design a plan to meet specific needs.

HHS has launched a web site (www.smallpox.gov) that answers questions about smallpox and the president's vaccination plan, which it recommends for those who will be receiving the vaccination or are debating getting the inoculation.

Additional information on steps being taken to prepare for terrorism emergencies that would impact public health is available at www.bt.cdc.gov.

The Chicago-based American Hospital Association (AHA), meanwhile has said that while it supports the Bush administration's voluntary smallpox vaccination program, key unresolved issues remain. They include liability, employee testing, and implementation, according to **Roslyne Schulman**, AHA senior associate director for policy development. ▼

Outlier payment scrutiny to be increased, CMS says

Hospitals receiving large proportions of Medicare revenues as outlier payments will face an increased probability of review, and fiscal intermediaries will be asked to carefully scrutinize all of their billing practices, according to an announcement by the Centers for Medicare & Medicaid Services (CMS).

CMS also said it would increase the outlier payment threshold in 2003 to $33,560, up from $21,052 in 2002.

The American Hospital Association (AHA),

which has encouraged CMS to safeguard the integrity of the Medicare program, said the step — implementing what it calls appropriate scrutiny of billing practices — seems reasonable.

"We're pleased to see CMS acknowledge that hospitals that treat very sick patients who are exceptionally costly to care for should be reimbursed for that care," said **Carmela Coyle**, AHA senior vice president for policy. For more information, go to www.cms.gov. ▼

Hospitals can offer free rides despite gift limits

Provisions that limit gifts to Medicare and Medicaid beneficiaries will not be enforced in the context of complimentary local transportation, the Department of Health and Human Services' Office of Inspector General (OIG) has said.

The position was stated in response to a hospital inquiry regarding free transportation to patients and their families to the hospital and hospital-owned ambulatory surgical centers. OIG has said it is considering a regulatory exception that would allow hospitals to provide some free local transportation valued higher than the current limits of $10 per incident and $50 in the aggregate per year.

The position, announced in a Dec. 10, 2002 letter, will be in force until the OIG makes a decision on whether to issue a new regulatory exception. In the letter, OIG specified that the free transportation may be provided only within the hospital or ambulatory surgical center's primary service area. For more information, go to www.oig.hhs.gov/fraud. ▼

HHS offers guidance on HIPAA privacy rule

A document to address frequently asked questions about the Health Insurance Portability and Accountability Act privacy regulation is available from the Department of Health and Human Services' (HHS) Office of Civil Rights.

According to one section in the guidance document, hospitals are not prohibited from keeping patient charts at the bedside and displaying patient care signs, such as "diabetic diet," if reasonable precautions are taken to protect patient privacy, such as limiting access to patient areas.

Also in the document, the agency commits to continued monitoring of the "workability" of the minimum necessary requirements and to consider revisions where necessary to protect access to and quality of care.

HHS also says that marketing rules that permit communications with patients about products and services for treatment or case management purposes do not modify or otherwise pre-empt the anti-kickback laws. The document can be found at www.hhs.gov/ocr/hipaa/privacy.html. ■

HAM offers more with HIPAA insert

This month's issue of *Hospital Access Management* includes a copy of *HIPAA Regulatory Alert,* an eight-page, bimonthly supplement that covers the complexities of remaining compliant with the Health Insurance Portability and Accountability Act (HIPAA). There have been many changes since the original regulations were released in 1996. This year brings even more changes with HIPAA privacy and security. This supplement will appear again in the March issue of *HAM,* and then will begin its regular schedule every other month. This insert will provide readers with the most up-to-date resource on changes to the regulations and how to implement convenient and painless change within your facility. ■

COMING IN FUTURE MONTHS

- Access and illegal immigrants
- Revamping outpatient registration
- Building access from the ground up, continued
- More on interdepartmental collaboration
- Tips on HIPAA compliance

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(continued from cover)

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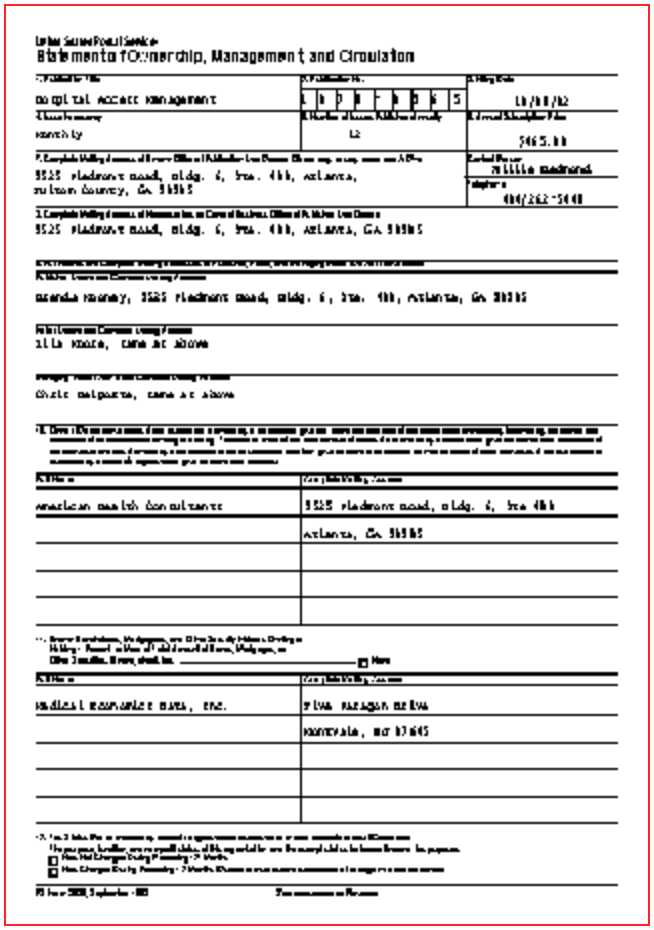

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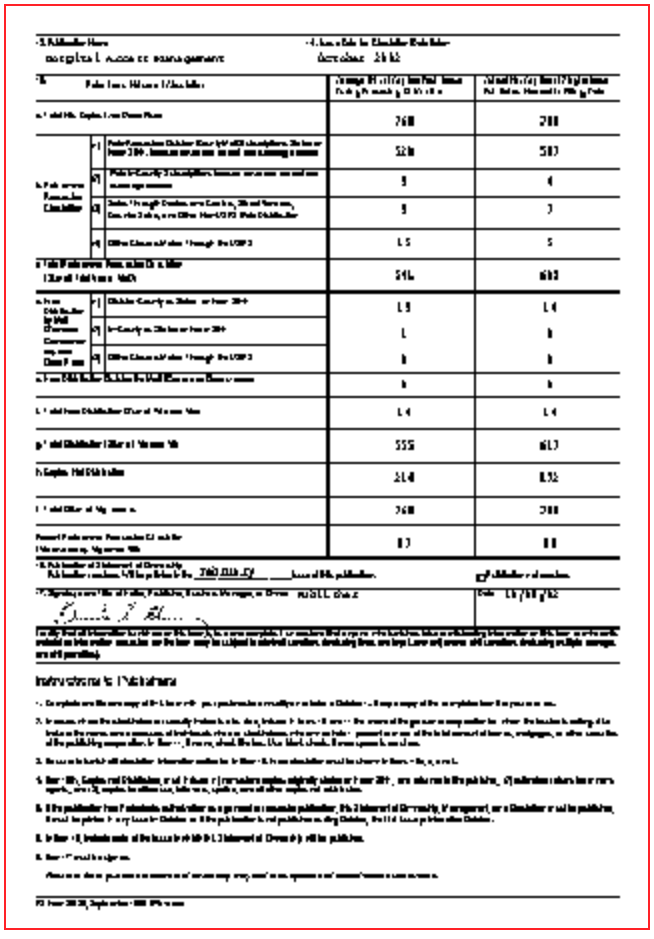

HIPAA Regulatory Alert

INSIDE

■ **Guidance:** HHS releases extensive HIPAA privacy guidance . . . . . cover

■ **Privacy changes:** HHS outlines major changes in privacy 3

■ **Family members:** How to deal with family members under HIPAA 4

— How to deal with minors under HIPAA 5

■ **HIPAA survey:** Survey finds progress toward HIPAA compliance 6

■ **Confidentiality:** Risk managers often walk a tightrope, expert says 7

JANUARY/ FEBRUARY 2003

VOL. 1, NO. 1 (pages 1-8)

HIPAA privacy guidance seeks to maximize voluntary enforcement

Enforcement rule is in drafting stage

In December 2002, the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) released an extensive guidance outlining various aspects of the privacy portion of the Health Insurance Portability and Accountability Act (HIPAA). That follows a recent decision by HHS to place OCR in charge of enforcing HIPAA's privacy mandates.

OCR now is in the process of drafting the enforcement rule, says **Richard Campanelli**, director of OCR. He says that rule will answer questions such as whether it is the company, the chief executive officer, the chief privacy officer, or the person who commits a specific privacy violation who will be fined.

The HHS guidance is not technically binding. "The guidance is not a regulation," says Campanelli. "It is an indication of how we view this and an attempt to clarify and expand on [the rule]," he explains. "It is not a binding document because it has not been published as a regulation."

Paula Stannard, counsel to the general counsel at HHS, points out that the Administrative Procedures Act requires that anything that can impose binding obligations on the public must go through the rule-making process.

According to Campanelli, while the privacy rule implements the foundation of federal protections for protected health information, the modifications released last summer attempt to do that in a way that avoids erecting undue barriers to health care. In short, he says it is the agency's goal to help covered entities understand the rule and maximize voluntary compliance. "The bottom line is that we are looking to maximize voluntary enforcement," he says.

The final modifications were adopted to improve "workability" of the rule and eliminate unintended consequences that may have arisen from the December 2000 version of the rule, he explains. For example, Campanelli notes that the modifications make advance consent voluntary for treatment, payment, and health care operations while strengthening the notice requirements to patients.

The modifications also make it explicit that incidental uses and disclosures of protected health information are permitted as long as reasonable safeguards are in place and the minimum necessary requirements were observed. In addition, they facilitate research

activities and make it clear that public health disclosures are permitted. **(See related story, p. 3.)**

'Voluntary compliance' urged

Since the modifications were released last summer, Campanelli says OCR and its sister agencies have emphasized "voluntary compliance" through expanded education. He says HHS now is in the process of developing technical assistance for targeted audiences for various segments. Those guidance documents will be released on a rolling basis over the next few months, he says.

Campanelli encourages providers to review the new guidance, published Dec. 4, which is posted on the OCR web site along with the complete text of the privacy rule. "That is a very helpful tool so you do not have to keep referring back and forth from the modifications to the prior regulation," he says. Fact sheets on the modification and sample business associate contract provisions also are posted, he adds.

HIPAA Regulatory Alert is published bimonthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **HIPAA Regulatory Alert**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6. Monday-Thursday, 8:30-4:30 Friday EST. World Wide Web: http://www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: Free to subscribers of *Healthcare Risk Management* and *Hospital Access Management*. For nonsubscribers, the price is $149. U.S. possession and Canada, add $30 plus applicable GST. Other international orders, add $30. (GST registration number R128870672.) Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $48 each.

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

According to Campanelli, HHS continues to field thousands of questions regarding privacy. However, many of these questions can be answered by information that already has been released. For example, he says OCR has a covered entities decision tool that is posted on both the HHS web site, which answers many questions about who is a covered entity and how that applies. "We are not saying that will answer all questions," he says, "But it is quite helpful."

Sue McAndrew, senior advisor for HIPAA privacy policy in OCR, says that tool likely will be supplemented to answer additional questions about the definitions of covered entities and how they apply in various situations.

McAndrew says the agency continues to receive numerous questions regarding the status of covered entities and the definitions of health plans and health plan providers. She points out that the primary aim of the guidance is not to address particular scenarios so much as it is to help people learn how to approach those circumstances, understand what they need to think about, and learn how to find the information they require to come to reasonable and correct answers.

According to Campanelli, HHS will continue to provide technical assistance efforts well after the April 14 compliance deadline. Meanwhile, OCR is developing its enforcement program. "At the outset, our enforcement will be compliance driven," he asserts. While OCR has the authority to engage in compliance reviews, that will not be the driving factor at the outset.

Campanelli notes that the privacy rule requires that when OCR investigates complaints, it also provides for notice and an attempt at informal resolution where indication of noncompliance is found. "We certainly intend to do that," he says, "because that is the way we can most efficiently bring about voluntary compliance and the protection of individual's health information."

He also points out that the vast majority of all complaints at OCR are resolved with informal rulings. "That is certainly our goal here," he says. "We anticipate that many issues will just be a question of education and compliance."

While OCR is not yet authorized to pursue investigations, Campanelli says the agency already is receiving many letters on issues such as access to records, which will be required under the rule. "We believe many of these issues can be resolved just by quickly getting in touch and informally resolving it with the organization," he says. "It will be a matter of education."

Campanelli notes that covered entities will have 30 days to cure a violation if it knew or should have known about a violation. "That 30-day period may be extended by the department," he adds, "so there is plenty of opportunity for voluntary compliance."

In the event permission is not granted, the agency may impose civil monetary penalties (CMPs). Penalties amount to $100 per violation or a maximum of $25,000 in a calendar year for repetitions of the same violation. However, CMPs will not be imposed if the penalty is punishable as a criminal offense. "There is no overlapping jurisdiction there," he adds.

Likewise, CMPs may not be imposed if HHS determines that the person did not know and by exercising reasonable diligence would not have known it was a violation. Also, they cannot be imposed if failure to comply was due to reasonable cause rather than willful neglect and if the problem was corrected in the 30-day period.

McAndrew says the agency is using guidance to answer "burning questions" that had been addressed in previous guidance. The agency also added some new topic areas that were not included in earlier guidance. "This is the start of an ongoing process where we will be expanding the guidance material," she says. When OCR is unable to publish guidance, it will continue to answer specifics through its "Frequently Asked Questions," she adds. ■

HHS outlines major changes in privacy

The Department of Health and Human Services (HHS) has said for months that HIPAA would continue to be a work in progress. The agency proved that again last month when it added a new section to the guidance on public health disclosures and another on workers' compensation disclosures. In addition, HHS updated and expanded the guidance with regard to research. These areas shared a common theme, namely that disclosures are permissible in these areas, says **Sue McAndrew**, senior advisor for HIPAA privacy policy in HHS' Office of Civil Rights.

According to McAndrew, HHS heard from many varied sources that the final rule threatened the flow of information. She says the agency wanted to use the guidance to assure people that it is permissible to disclose information for public health purposes as well as workers' compensation purposes.

According to McAndrew, it also is important to cooperate with researchers to keep those activities moving forward. She says there were a number of questions regarding research, and some of them have been addressed in the guidance. For example, the guidance addresses recruitment policies and how the privacy rule may affect recruitment for these studies.

The guidance also addresses questions about ongoing research where consent had been obtained prior to the implementation date. "Those types of research projects will be grandfathered in based on the consent that was received prior to the compliance date," she reports.

HHS makes more changes

Here are several other areas where HHS recently has made significant changes:

• **Marketing.** The definition of marketing is one of the areas that was changed substantially in the modifications, according to McAndrew. If a third party is paying to obtain a list of patients for its own marketing efforts, that clearly is marketing, she says. With limited exceptions, all marketing will require an authorization, she adds.

In addition, CMS has tried to clarify both in the rule and in the guidance material what kind of communications do not constitute marketing. For example, McAndrew says that communications with individuals regarding their own health-related products and services have been expressly carved out. "It is not marketing when they are communicating about their own health-related products or services," she says.

Other carve-outs pertain to communications related to the individual's treatment or care coordination, case management, or alternative therapy recommended to the individual. "All these types of communications can go on freely," she says. "That is not marketing."

• **Incidental uses and disclosures.** Another area that was modified is incidental uses and disclosures. "Clearly, these are permissible provided that they are incidental to another permitted use or disclosure," says McAndrew. This issue arises in many treatment settings where the patient may be in a semiprivate room and the conversation between a patient and a physician may be overheard by other patients or visitors. Likewise, physicians and nurses might confer at areas of the hospital where others

could potentially overhear the conversation.

• **Business associates.** Another area that was the focus of many questions that resulted in the guidance being expanded is business associates. HHS expanded the guidance to try to address more situations where a business associate contract would be required, says McAndrew. The agency also provided some examples of instances where a business associate arrangement would not be necessary. ■

How to deal with family members under HIPAA

Facilitywide culture change may be necessary

One of the many challenges facing providers under HIPAA, particularly in the context of oncology, cardiac surgery, and OB/GYN services, involves health care services provided to a family member. The final HIPAA regulations say that if the patient is present, providers can infer from specific circumstances that the patient wants you to share certain information with the spouse or family member. The more difficult question arises when the patient is diagnosed and a family calls the provider, says health care attorney **Susan Bonfield** of Fox Rothschild in Philadelphia.

Moreover, she says this is a common occurrence. "The problem is that the regulatory allowance that allows a provider to share that kind of information does not apply in the same way if the patient is not physically present in front of the provider," Bonfield explains. For example, a verbal authorization by a spouse over the phone generally is not HIPAA-compliant, she notes.

Bonfield says one way to deal with this problem is through some type of "registration authorization." For example, she says providers might give patients an authorization with checkboxes about what information they are allowed to share with specific family members. Patients then would fill in the rest of the HIPAA-mandated authorization, which would indicate the type of information along with an expiration date or event.

Changing the culture

When using this approach, she says providers should include an expiration date or event. "Oftentimes, there is a term of treatment such as six months for chemotherapy," she points out. "You can also do it on a month-to-month basis to be more specific, but I think it is reasonable to use a course of treatment as an expiration event."

Beyond the simple mechanics involved in questions such as this is the process of changing the culture of an organization. For example, physicians typically walk the patient out and to the front desk, often to schedule the next procedure or appointment, with a waiting room full of patients. Since the physician assumes everyone is there for a similar reason, he or she may not be mindful about what is said. Or the receptionist may be designated to call to confirm appointments. Depending on the amount of information communicated to those patients, this practice may need to be reviewed.

"The point is that everybody is entitled to privacy," she warns. As a result, she says physicians and other providers must learn to conclude the visit in the office. That may mean handing the patient a piece of paper with instructions for the front desk and letting the patient take it to the registration person without the physician verbalizing the information in front of others.

Many organizations maintain they will never get the physicians to change, says Bonfield. However, it is vitally important to get buy-in from management and leadership beforehand so the rest of the staff will follow suit. It will be difficult to impress upon staff that they must embrace HIPAA if the leadership fails to do so.

According to Bonfield, another issue involves the facility's patient directory. Under HIPAA, she says patients have the right to opt in or out of having their name and their identity included in the facility directory. This largely applies to hospitals, nursing homes, and other entities, she adds.

According to Bonfield, the first operational issue in this regard is how to document when patients say they do not want to be in the facility directory. She says providers can either remove the name from the list of the patients or simply flag it. However, there are some problems associated with the latter approach.

Bonfield suggests that providers script this process out for the person who is at the switchboard. "These are people who until now may not have had a lot of responsibility for decision making and following particular policies or procedures," she explains.

For example, she says providers must know what to do if somebody calls and asks for a

How to deal with minors under HIPAA

One of the problems facing providers under HIPAA will be how to deal with minors, including newborns.

Health care attorney **Susan Bonfield** of Fox Rothschild in Philadelphia, notes that the final privacy regulations eliminated the requirement that there be a specific consent to use or disclose protected health information.

Now providers can obtain a written acknowledgement in whatever fashion they like and, in an emergency, document good-faith efforts if they are unable to obtain a written acknowledgement. "They still need to provide a notice," she says. "It made it easier in that it eliminated one mandated document, but the spirit of the requirement is still there."

According to Bonfield, one problem area for providers is newborns, who are people entitled to their own notice. The mother always will be the personal representative, she points out. "You might have a case where a mother is deemed not competent," she explains. "Likewise, the mother might be a minor." In those cases, Bonfield says providers must look to the state law. For example, it may be reasonable to have some sort of waiting period as long as the notice explains what is going to happen.

When it comes to minors covered by their parents' health plans, she says a different set of questions must be addressed. If a minor turns 18 and is covered by the parents' health plan, one of the issues that will arise is whether the minor must be informed about the existence of a notice. "The HIPAA regulations say you don't, but there is a sense among some health plans that you should," she says.

Another issue that providers will confront dealing with minors involves states where the majority age is at variance. For example, the majority age in New Jersey is 18, while it is 21 in Pennsylvania. "This raises the question of what to do when a New Jersey provider receives a Pennsylvania resident for services who is 20 years old," says Bonfield. "There is going to have to be some close scrutiny regarding the different state laws."

She says these are just some of the areas providers should consider when they are drafting procedures on minors and notices. "Once you understand HIPAA, and you start drafting procedures, you suddenly realize that you are going to have to think through some of these real-life situations," she explains.

Bonfield says that if health plans opt to provide only one notice to the person who is listed as the policyholder and it is his or her responsibility to pass it on to everybody else, that is their right under the law. However, she says, plans must provide notice every three years that the notice is available. "The question is whether that should go to all enrollees as opposed to just the enrolled individual," she says. ■

patient's room and a flag shows that the patient wanted to opt out of the directory. "If the name is flagged, and you have them say, 'I am sorry, I show no record of anyone by that name,' that is untrue," she points out. "I am not sure you want to put people in that position."

On the other hand, if the operators are vague about in their response, that may only lead to more questions. Since that will place the person at the switchboard in an awkward position, Bonfield says it is probably better to simply remove the names completely from the list of patients. Then the switchboard operator will not be in a compromising position, she explains.

Ultimately, Bonfield says it depends on what kind of computer system the facility is using and what specific information is accessed. She says that it's essential to train front desk personnel and switchboard personnel, regardless. "They are going to require some specific training," she emphasizes. "You do not want to put them in a position of having to make policy decisions for that facility on an ad hoc basis."

According to Bonfield, this question highlights the broader decision about whether it is easier to take an existing procedure and overlay HIPAA requirements or to take a HIPAA requirement and place existing procedures on top of that. "There are pros and cons to each approach," she says. " One may require more work while the other may require more of a cultural change. I have organizations do it both ways." ■

Survey finds major progress toward HIPAA compliance

HHCA compares old, new responses

According to a survey just released by the Minneapolis-based Health Care Compliance Association (HCCA), the health care industry is continuing to take the necessary steps to ensure compliance with sweeping changes required by HIPAA. The deadline set by the government for the health care industry to comply with new regulation is April 14, 2003. Here are some of the major findings included in the study:

HIPAA Education

Survey respondents indicate that most organizations have held one or two hours of HIPAA privacy training for the majority of the stakeholders such as medical staff, nursing staff, executives, and board members. According to the HIPAA Readiness Survey results, 33% of executive staff received three to five hours of HIPAA training. In all cases, those indicating that no training had been conducted decreased from the previous surveys.

	Survey	
Organizational Steps	11-02	11-01
• HIPAA Task Force has been established	96%	87%
• Indicate that a privacy officer has been designated	93%	73%
• Have designated a security officer	70%	57%
• Have developed organization structure delineating responsibilities for privacy and security	75%	37%
• Privacy and security responsibilities have been assigned to one individual	43%	54%

Fifty-seven percent of respondents have developed cost estimates for the privacy, security, and transaction requirements, according to the survey.

Policies and Procedures

According to the survey, 68% of respondents have developed policies and procedures related to discipline for breach of privacy principles and security. Progress on other policies developed include the following:

	Survey	
	11-02	11-01
• Developed grievance policy for complaints / breaches of confidentiality	66%	40%
• Developed policies related to patient access to records	74%	47%
• Developed disposal of PHI policies	65%	34%

Forty-eight percent of respondents have developed policies addressing the potential exposure of protected health information (PHI) through viewing, paging, or other operational activities, and 55% report having developed policies related to verbal discussions of PHI by authorized persons.

Security

According to the survey, 38% of respondents reporting on Security aspects of HIPAA indicate they have performed a "penetration analysis" to determine where and how security breaches may occur; 52% have assessed the physical location and the type of storage media to be used of all PHI; 36% have addressed how to authenticate users and receivers of health information.

Transaction and Code Sets Preparation

Seventy-eight percent of respondents have identified all transaction standards and code sets. Other survey results related to transaction and code sets preparation include:

	Survey	
	11-02	11-01
• Determined preparedness of trading partners	54%	28%
• Developed a system for maintenance of standards transaction and code sets	46%	25%
• Educated business office on standards and code sets	49%	26%

The rule requires that transaction and code sets be in place by October 2002, but the deadline was pushed back one year to October 2003.

HCCA's Third HIPAA Readiness Survey, released Dec. 11, was conducted in fall 2002 and compares the results to a similar survey conducted in fall 2001. The association developed

the survey to track the industry's progress in preparing for HIPAA privacy and security. It is meant to be a snapshot of the health care industry's progress rather than a statistically valid study.

Complete results available

The association mailed 3,273 surveys, and 289 surveys are completed and returned. According to the respondents, 96 (33%) came from hospitals, 76 (26%) from health care systems, 26 (9%) from physician / clinics, 21 (7%) from nursing homes, 19 (7%) from academic medical centers, 17 (6%) from health plan, and 34 (12%) indicated "other." Seventy-two percent indicated their organizations were not-for-profit, while 18% were designated as for-profit.

Thirty-seven percent of the respondents indicated their facilities are located in urban areas, 29% are in suburban areas, and 18% are in rural areas. The complete results of this survey are available on the HCCA web site, www.hcca-info.org. ■

Confidentiality may involve sticky legal, ethical issues

Think before you share patient-sensitive information

When it comes to confidentiality issues, health care professionals often walk a tightrope, **Mindy Owen**, RN, CRRN, CCM, asserts.

Case managers, for example, have to be careful about what kind of information they share with family members, insurers, employers, and even people who provide outside resources, adds Owen, chairwoman of the ethics committee and a member of the executive board of the Commission for Case Management Certification (CCMC) in Rolling Meadows, IL.

"One of the key skills of a case manager is effective communication, and 90% of communication is listening. Being a good listener means being able to figure out what is necessary to move the case forward and what is their accountability in terms of confidentiality," Owen says.

In addition to looking at ethical issues before they share information, case managers must be aware of HIPAA rules and regulations and how that will affect their practice.

"Case managers are working with health care issues that revolve around medical treatment. So many times they are working with ancillary or adjunct resources that want information on their clients in order to provide a wheelchair or set up a financial account. Case managers have to be careful about what information they give out because of privacy issues," Owen says.

For instance, a payer is having its bills paid by an outside firm that audits the file and pays the bills. The firm requests a copy of the case file for an individual patient.

Without thinking, a case manager may go ahead and send in the information to make sure the bills get paid, but he or she would be sending confidential information to someone who is not a part of the health care team, points out **Susan Gilpin**, JD, chief executive officer of the CCMC.

Dealing with employers

Workers' compensation includes many confidential issues around medical care and treatment and how much information goes back to the employer.

A case manager could be working with a worker who is injured on the job but finds out that the employee has cancer. The employer has the right to know about the injury but does not have the right to know about the cancer.

The issue is a sticky one even in the case of an injured employee who has a potentially contagious disease.

Case managers have to be careful what information they share with the employer. If a case manager is working with someone and reporting back to the insurance company, the same kind of issue may arise if the case manager finds out something that is not directly related to the case for which he or she was hired but that could affect the individual's insurability.

Confidentiality issues also arise when case managers work with a family. For instance, a patient may not want her husband or children to know about her disease.

Computer issues

Computers raise another confidentiality issue that could have implications if ethical issues arise.

Owen tells of a case manager working with a psychiatric patient who did not agree with the psychiatrist's treatment plan and wrote notes to

that effect on her computer.

However, she did not take her concerns up the chain of command. The patient committed suicide. The family sued not only the insurance company but also the case manager for not following procedure in raising questions about the patient's care.

"It goes back to the idea that if it's documented, it happened and if it isn't documented, it didn't happen," Owen says.

Keep in mind that you are not the only one who will read the notes in your computer. Computers can be subpoenaed as easily as hard-copy files. ■

White Paper addresses DM, HIPAA concerns

A comprehensive analysis of HIPAA and its impact on disease management has concluded that the new privacy regulations will not hamper disease management programs, according to the Disease Management Association of America (DMAA) in Washington, DC.

The association's White Paper concluded that the U.S. Department of Health and Human Services has fully safeguarded the ability of legitimate disease management programs to use and disclose protected health information for activities within the DMAA's industry consensus of disease management.

The White Paper's legacy

These include enrolling and engaging patients, teaching patient self-management, coordinating care, providing medication compliance guidelines and reminders, publishing outcomes data, conducting population management and risk stratification, supporting physicians and the plan of care, and promoting other disease management and population management services.

"While a lot of things in HIPAA are still unclear, disease management is not one of them. The White Paper's legacy will be to eliminate any concern that disease management cannot coexist with strong patient privacy protections, that disease manager somehow hinder or is hindered by privacy. Neither is true, and this initiative finally proves it," says **Warren Todd**, DMAA's executive director.

The document may be obtained free of charge from DMAA. See their web site at www.dmaa.org. ■

Feds offer database for record disclosures

The Centers for Medicare & Medicaid Services (CMS) has created a Privacy Accountability Database to aid in tracking, reporting, and accounting the disclosures made from all CMS systems of records permitted by the Privacy Act of 1974 and HIPAA.

Information retrieved from the system will be used to support regulatory, reimbursement, and policy functions performed within the agency or by a contractor or consultant; support constituent requests made to a congressional representative; and support litigation involving the agency.

The announcement appeared in the Oct. 7, 2002, issue of the *Federal Register*, accessible at www.access.gpo.gov/su_docs/fedreg/a021007c.html. ■

Web site answers FAQs about HIPAA

A "Frequently Asked Questions" document about the HIPAA privacy rule is posted on the Department of Health and Human Services' web site.

The document answers questions ranging from privacy rights to compliance dates. "Does the rule create a government database with all individuals' personal health information?" and "If patients request copies of their medical records, are they required to pay for them?" are examples of the subjects covered. The document also reminds health care providers that the compliance date for the privacy rule is April 14, 2003, or April 14, 2004, for small health plans. To see the questions, go to www.hhs.gov/ocr/faqs1001.doc. ■

S.T.A.R. OF THE MONTH
(Striving Together Achieving Results)
Peer Nomination Form

Current Date: _____

Name/Title of Nominee: _____ Dept/Clinic: _____

Name/Title of Peer Submitting Nomination: _____ Dept/Clinic: _____

Length of Time Worked with Nominee: _____

Supportive statements for Nomination:

MANAGER SCREENING TOOL

Nominee/Title _____ **Dept/Clinic** _____ **Date** _____

Nominated by _____ **Number of Nominations to Date** _____

Descriptor	Always	Often	Never	Comments
Adheres to department attendance standards.				
Adheres to department dress code and maintains a neat appearance.				
Demonstrates reliability and dependability.				
Demonstrates good ambassadorship for UAMS.				
Exhibits the 3 C's: Care, Commitment, and Contribution.				
Exceeds expectations and is willing to go the extra mile.				
Accepts change.				
Identifies problems and quality issues.				
Communicates constructively and informatively.				
Uses constructive feedback to improve performance.				
Applies effective communication skills (verbal and nonverbal) in all interactions with patients, peers, other departments and the public.				
Participates in unit/work group organization, evaluation, and growth.				
Demonstrates willingness to shares knowledge with coworkers.				
Provides nurturing leadership.				
Supports others in the performance of duties.				
Demonstrates ability to assist with orienting new personnel.				
Displays qualities of a team player.				

Has nominee been placed on verbal or written warning within the past year? Yes _____ No _____
If yes, reason?

_____

_____

Comment Below:
Document one example of outstanding behavior and/or note any special accomplishments.

_____

_____

_____ _____ _____

Signature of Manager/Title **Unit/Area** **Phone/Beeper**

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