ED DOCUMENTATON & CODING UPDATE

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HIPAA deadline approaches: Is your documentation ready?

HIPAA compliance requires renewed commitment to patient privacy

With the April 14 deadline fast approaching, emergency departments must make sure their processes, procedures, and documentation are fully compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If they're not, the consequences could be severe: civil penalties of up to $25,000 for each requirement violated, and criminal penalties of up to $50,000 and one year in prison for obtaining or disclosing protected health information.[1]

"I think everybody is like they are before a big exam," says **Kathleen Catalano**, RN, JD, director of regulatory compliance with Provider HealthNet Services, in Addison, TX. "They've got things in place; they don't know if they're going to work. They won't know if they're going to work or if they can remember anything until the day of the exam. I think we're going to have the pieces in place; we're just going to have to work out the kinks."

The good news is that emergency departments (EDs) are among the areas most likely to be cut some slack under HIPAA. **Reneé Holleran**, RN, PhD, chief flight nurse at University of Cincinnati Medical Center, says that the emergent nature of the care being provided probably will weigh in favor of EDs when it comes to minor slips under HIPAA.

Even so, successfully complying with HIPAA will require, if not a new approach, then at least a renewed commitment to the principle of protecting patient privacy. "This whole thing is really a culture change," Catalano says. "It's not saying that we should be doing something that we've never done before. The confidentiality mandates have been there for years, but we just didn't follow them. Or if we did, we did it laxly."

Notice of privacy practices

One of the key HIPAA issues for EDs is the use of notices of privacy practices, Catalano says. "If someone's coming in and receiving treatment, they're probably going to be given a notice of privacy practices from the ED, from the admitting area, and probably from same-day surgery," she adds. "The notice of privacy practices is interesting because it has to line up everything

that the hospital is doing. So whatever the hospital's policy is going to be on the use and disclosure of protected health information, it has to be lined up in that document."

Notices of privacy practices, mandated by the HIPAA privacy rule, are "intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights," according to the federal Office of Civil Rights (OCR), which provides guidance on HIPAA.

No standardized notice has yet emerged, although some groups, such as the American Health Information Management Association (AHIMA) in Chicago, have developed sample notices. (To see AHIMA's sample notice, visit http://library.ahima.org/bok/ and search for "Sample Notice.") Many facilities have posted their notices on their web sites. Although they share several elements, they also can vary widely, both in terms of content and length (from as short as three pages to as long as 14).

"I think everbody's doing their own thing, because they don't know how to handle it," Catalano says. "Like reporting child abuse in the ED or rape. We report right to the local authority immediately, because that's the law." But that release of information must be documented somehow, either electronically or in paper form, such as with some sort of log book. Different institutions will have different ways of accounting for and documenting such information transfers. **(For a list of required elements in a notice of privacy practices, see p. 16.)**

Providers also are required to have documentation indicating that the patient received, read, and understood the notice of privacy practices. The acknowledgement form itself might be simple but, as ED professionals know, obtaining simple consents or acknowledgements sometimes can be difficult in an emergent situation.

For example, Catalano posits, "what if a patient is unable to sign [the acknowledgement] because she is comatose. She came into the ED and we don't know who she is. Somewhere the hospital's got to be tracking that patient so that when she comes to and is able, she signs the acknowledgement." That holds true even if a family member initially signs the acknowledgement instead of the patient.

Fortunately, the authors of the HIPAA privacy rule seem to have understood that filling out paperwork isn't the highest priority in an emergent care situation. According to the OCR, "hospitals and other covered health care providers with a direct treatment relationship with individuals are not required to provide their notices to patients at the time they are providing emergency treatment. In these situations, the HIPAA Privacy Rule requires only that providers give patients a notice when it is practical to do so after the emergency situation has ended. In addition, where notice is delayed by an emergency treatment situation, the Privacy Rule does not require that providers make a good-faith effort to obtain the patient's written acknowledgement of receipt of the notice."

Tracking patients to make sure they've received a notice can be difficult, but responsibility for doing so

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Editorial Questions

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

Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: Coles McKagen, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcpub.com).
Production Editor: Nancy McCreary.

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probably won't fall to ED staff, Catalano notes. Even so, the facility should have some sort of "tickler system" in place to prompt whoever's responsible — whether social workers or floor nurses — to provide patients with a notice and secure a signed acknowledgement.

Strategies for compliance

The most daunting aspect of HIPAA compliance is the fact that the rule affects so many different areas, both within the ED and throughout the organization. Indeed, it comes into play as soon as the patient signs in.

To avoid inadvertent disclosures on sign-in sheets, some EDs have instituted a system in which patients write their information on a sticker, which then is transferred to a page shielded from public view. The Medical Center of Central Georgia in Macon uses a triage sign-in sheet consisting of a multipart form with individual tear-off tickets. As each patient signs in, a list that is concealed behind a cover sheet is generated with the name, time, and chief complaint. The form includes a place to write a telephone contact number, should the patient decide to leave prior to being seen by the triage nurse, according to **Jonathan Kent**, RN, CEN, assistant director of the emergency center.

Catalano notes that regulations do no prohibit traditional sign-in sheets as long as they do not ask for the diagnosis or name of physician. However, some state laws are more stringent than the HIPAA regulation, "so people should be aware. For example, Texas state law is more stringent in some areas than HIPAA."

Protecting patient privacy at triage is another important issue under HIPAA. Patients should not have their vitals taken or an assessment performed in front of registration clerks, and patients' responses to questions posed by the triage nurse shouldn't be audible throughout the ED lobby, Catalano says. One solution is to set aside a small room or construct a module in which to triage patients. If your facility does this, make sure curtains are closed and doors are shut. "The Joint Commission [on Accreditation of Healthcare Organizations] has targeted this in a lot of hospitals, and what they've asked is, if you don't have it ready today, let me see your plan for how you're going to revamp your triage area." **(For more on Joint Commission documentation issues, see related story, p. 16.)**

Physicians also must take steps to limit the possibility of inadvertently disclosing private information, particularly when they are documenting through dictation. Some physicians continue to dictate patient outcomes in open workstations, which disclose sensitive information to those standing around the desk. Catalano notes that if a physician is behind a desk using the dictation equipment and is overheard, "that's going to be an incidental disclosure. But if the doctor is standing up . . . and shouting into the machine, as some of them have a habit to do, I would say that there's no safeguard from the hospital that's going to protect them."

Protecting patient records from public view can, in some cases, be done with a few simple fixes, such as using binders that protect patient information, centralizing records, and putting a cover page over demographic information and bedside charts. "If it were me, I would use a cover page," Catalano says. "I think it stops people from wanting to look through it."

Catalano also recommends adding a clause to the conditions of admission in the ED whereby patients agree to have their information listed on the tracking board. "If you do that and they sign it, you're home free," she says. "Because on a lot of them, they say a lot more than just the patient's name. They say what the patient is in for, who's seeing them, and who's assigned."

It's also important to consider what to do should a patient request total anonymity. "If your patient says, 'I don't want anybody to know that I'm here,' that's going to be an issue," Catalano says. "How do you handle that in the ED? I don't think most people think about it."

Still little consensus on HIPAA

Given the sweeping nature of the HIPAA regulations and the approaching implementation deadline, it's understandable if some ED professionals overreact a bit. Holleran says, "they're reacting because they're afraid that if they don't, then somebody is going to come to the hospital and say, 'OK, we're going to fine you $25,000 because you're not HIPAA-compliant.' But they're not really clear on what that means."

Part of the problem is that, even with the OCR guidance, there are some areas of HIPAA compliance in which no expert consensus has emerged. For example, Holleran says, there's some disagreement about the extent to which tracking boards are addressed by HIPAA. "It depends on whose interpretation of the law you look at," she says. "Nobody is really emerging as the true expert. It's sort of going down the road of EMTALA. People in different parts of the country and even different counties interpret EMTALA differently. I think we're seeing some of that with HIPAA."

Holleran views the HIPAA regulations as essentially reinforcing the professional standards of privacy and confidentiality that EDs already should have in place. "If you read [the law], it's essentially more to

Notice of Privacy Practices: Required Elements

Direct treatment providers, including EDs, soon will be required to provide each patient with detailed information about their privacy practices. The notification must be written in plain language, and must contain the following elements:[1]

1. The prominently displayed phrase, *"This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully."*

2. A description and at least one example of how the health care provider can use and disclose protected health information for the purposes of treatment, payment, and health care operations, and a description of how the health care provider can use and disclose protected health information without the patient's consent or authorization. These descriptions must reflect any applicable laws more stringent than the Privacy Rule.

3. A statement that the health care provider will make other uses and disclosures only with the patient's written authorization, and that the patient has the right to revoke authorization previously granted.

4. A statement advising the patient of the following rights:

• The right to request a restriction on uses and disclosures, including a statement that the health care provider need not comply with such requests.

• The right to receive confidential communications of protected health information, as well as the right to request and receive these communication via a specified mode.

• The right to inspect and copy certain protected health information.

• The right to amend protected health information.

• The right to receive an accounting of certain disclosures.

• The right to obtain a paper copy of the health care provider's privacy practices notice upon request.

5. A statement that the health care provider is required by law to maintain the privacy of protected health information; that the health care provider must abide by the terms of its privacy practices notice, and if the health care provider intends to modify its privacy practices, a statement that this right has been reserved.

6. A statement advising patients of the method by which they may complain about privacy violations to the health care provider and to the Secretary of Heath and Human Services, and that privacy complaints will not cause retaliation.

7. The identity and telephone number of an individual or office that can provide additional information about the health care provider's privacy practices.

8. The effective date of the notice.

Health care providers who intend to contact patients with appointment reminders, information about available health-related services, or fundraising requests must include separate statements to this effect in their notices.[2] Privacy practices notices may be delivered via e-mail, but the patient retains the right to receive a paper version of the notice upon request or when the health care provider knows that electronic delivery has failed.[3] Health care providers who post information about their services on a web site must display a privacy practices notice along with that information.[4]

References

1. *See* Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. § 164.520(b)(1) (2002).
2. *See* 45 C.F.R. § 164.520(b)(1)(iii).
3. *See* 45 C.F.R. § 164.520(c)(3)(ii).
4. *See* 45 C.F.R. § 164.520(c)(3)(i). ■

protect your privacy from outside companies getting hold of your information. . . . And in a way, it's kind of nice that insurance companies are not going to have access to certain things that are really none of their business. But it's unfortunate that they had to come up with a federal law, because there are so many multiple interpretations."

Reference

1. 45 CFR § 160.306 and § 160.312 (2000) for Civil Enforcement; 42 USC 1320d-6 (HIPAA Sec. 1177) for Criminal Enforcement. ■

JCAHO documentation: What new process requires

Working with documentation review sheets

For every ED professional who's had to deal with the onerous and time-consuming preparations for a survey by the Joint Commission on Accreditation of Healthcare Organizations, some good news: The Joint

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The Documentation-Coding
CONNECTION

OPPS: The ED Challenge — Part II

Billing for ED procedures

By **Deborah K. Hale**, CCS, President
Kathy Dean, CPC, CPC-H, ED Consultant
Administrative Consultant Service Inc.
Shawnee, OK

EMERGENCY DEPARTMENT PROCEDURE CODES

In addition to E/M facility fees for the emergency department (ED), hospitals must report CPT-4 codes and HCPCS level II codes for all procedures and services to ensure accurate reimbursement from Medicare and many of the commercial payers.

Among the most commonly omitted CPT/HCPCS procedure codes that generate an additional APC payment are injections, infusions, laceration repair with and without tissue adhesive, insertion of NG tubes, wound care, etc. Other billable services common to the ED (to name only a few) are radiology, other diagnostic procedures, clinical diagnostic laboratory services, durable medical equipment (DME), orthotic-prosthetic devices, take-home surgical dressings, therapies, preventive services, and immunosuppressive drugs identified in the *Medicare Hospital Manual,* section 422. The Medicare Hospital Manual, transmittal 747, revised the applicable coding guidelines that apply as of Aug. 1, 2000.

Revisions and corrections to the outpatient prospective payment system (OPPS) have been published in the *Federal Register*, Nov. 1, 2002, Transmittal A-02-129; Jan. 3, 2003 and *Federal Register*, Volume 68, No. 27, Feb. 10, 2003. Highlights from those regulations that impact ED reimbursement are as follows:

1. Pass-Through Drugs

In 2002, there were 236 pass-through drugs, and only 115 remain as of Jan. 1, 2003. Only high-cost drugs will be included in pass-throughs. Drugs that fell below the $150.00 median cost per line threshold were packaged into the procedure APC.

Continue billing the pass-through drugs under revenue code 636, but any drugs removed from the pass-through list should be changed back to revenue code 250 for billing.

Many of the pass-through drug APC payments went down as of Jan. 1, 2003, for example:

- 2002 payment for TNK 50 mg (J3100) was $2,612.50, and the 2003 payment is $1,439.17.
- 2002 payment for Reteplase 18.1 mg (J2993) was $1,306.25, and the 2003 payment is $659.96.

2. Drug Wastage

In the 2003 OPPS update published in the Nov. 1, 2002, *Federal Register,* the Centers for Medicare & Medicaid Services (CMS) stated: "We recognize that some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, we encourage hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded along with the amount administered."

Example 1: Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient.

The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2: An appropriate hospital staff must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

3. Self-Administered Drugs

CMS has clarified instructions for billing self-administered drugs in the 2003 OPPS Final Rule. CMS states on pages 66,767 and 66,776 of the Nov. 1, 2002, *Federal Register* that certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because such drugs are so clearly an integral component part of the procedure or treatment, they are packaged as supplies under the OPPS into the APC for the procedure or treatment. Consequently, payment for them is included in the APC payment for the procedure or treatment of which they are an integral part.

In the 2002 OPPS proposed rule (August 2002), CMS provided some illustrations of situations in which drugs are considered to be supplies. For example, sedatives administered to patients while they are in the pre-operative area being prepared for a procedure are supplies that are integral to being able to perform the procedure. Similarly, Mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic ointments, and ocular hypotensives that are administered to the patient immediately before, during, or immediately following an ophthalmic procedure are considered an integral part of the procedure without which the procedure could not be performed. The costs of these items are packaged into and reflected within the OPPS payment rate for the procedure. Antibiotic ointments such as bacitracin, placed on a wound or surgical incision at the completion of a procedure is another example.

4. Pass-Through Devices

Don't bill devices with C-codes after Jan. 1, 2003. As of that date, ninety-five (95) of the pass-through devices will be deleted, and if the C-code is billed on a claim, it will be returned unpaid (RTP).

If the claim is returned, you will be able to refile the claim without the C-code attached. To avoid the problem completely, leave the C-code off the claim starting Jan. 1, 2003. For claims prior to Jan. 1, 2003, you can continue to bill these C-codes and there are 78 other C-codes that will remain payable in 2003.

If possible, use a cutoff date when your Charge Master would not allow these codes to append to the bill. The costs for these devices should be completely rolled into other APCs in 2003. CMS instructs facilities to continue to report the charges for the devices under the appropriate revenue center code, which could influence your outlier and corridor payments.

5. New Codes for Direct Admits to Observation

Hospitals may bill for patients who are "direct admissions" to observation. A direct admission occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or ED. Effective for services furnished on or after Jan. 1, 2003, hospitals may bill for patients directly admitted for observation services using one of the following HCPCS codes:

- **G0263:** *Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for G0244.*
- **G0264:** *Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma when the observation stay does not meet all criteria for G0244.*

The determination of whether use of G0263 is appropriate will be made after reviewing all diagnoses submitted on the claim (e.g., admission, principal, and secondary diagnoses).

Code G0263 must be billed with G0244. Although code G0263 is treated as a packaged service and will not generate a payment under OPPS, the code will be recognized as taking the place of a visit or critical care code in meeting the observation criteria for patients directly admitted to observation.

Code G0264 should not be billed with G0244. G0264 is assigned to APC 0600 and is paid the same amount as a low-level clinic visit. This code provides a way to recognize and pay for the initial nursing assessment and any packaged observation services attributable to patients that are directly admitted to observation but whose observation services do not meet the criteria necessary to qualify for a separate observation payment.

6. Infusion Therapy in Observation Status

Effective Jan. 1, 2003, HCPCS code G0258, Intravenous infusion(s) during separately payable observation stay, per observation stay (must be reported with G0244), is deleted from the OPPS. Hospitals should bill for infusion therapy provided during a separately payable observation stay (HCPCS code G0244) using Q0081, infusion therapy other than chemotherapy. As with G0258, Q0081 may be reported for infusions started in the ED, clinic or observation area, so long as the infusion continues during the observation stay. An edit has been installed in the Outpatient Code Editor (OCE) to allow payment, effective for services furnished on or after April 1, 2002, for HCPCS code G0244 when billed with Q0081, subject to all other conditions for payment having been met.

SUMMARY

Many hospitals still are not capturing all the billable procedures and services performed in the ED and charging them separately from the ED evaluation and management code.

Hospitals should build their ED chargemaster with all billable procedures along with the corresponding CPT-4/HCPCS level II codes. It is important for HIM

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EMERGENCY DEPARTMENT CHARGE SHEET
HOSPITAL CHARGES ONLY

(ER Level charged on separate form)

PATIENT NAME:_____ **DATE:**_____

PATIENT #:_____

_____ 90782 IM/SQ Injection Administration other than antibiotic
_____ 90788 IM Antibiotic Injection Administration
_____ 90784 IV Injection Administration (IVPush) (IV slow push) ***Please indicate the number of injections given**
_____ 90783 Intra-Arterial Injection Administration
_____ 92977 Thrombolytic clot buster IV Infusion
_____ Q0081 IV Infusion Therapy (other than chemo) per visit
_____ 90471 Immunization Administration (eg, Tetanus Toxoid, Tetanus Diphtheria)

_____ 91105 Gastric Lavage/Intubation
_____ 31500 Endotracheal Intubation (emergency)
_____ 92950 Cardiopulmonary Resuscitation (CPR)

_____ 36430 Blood Transfusion- Administration

_____ 29105 Application of long arm splint (shoulder to hand)
_____ 29125 Application of short arm splint (forearm to hand)
_____ 29130 Application of finger splint
_____ 29505 Application of long leg splint (thigh to ankle or toes)
_____ 29515 Application of short leg splint (calf to foot)

_____Cast Application (coder will code)
_____Cast Removal (coder will code)

_____ 29240 Strapping, Shoulder (eg., sling, immobilizer) (Velpeau)
_____ 29260 Strapping, Elbow or Wrist (eg., ace wrap, tape, elastic)
_____ 29280 Strapping, Hand or Finger (eg., tape, elastic, ace)
_____ 29530 Strapping, Knee (eg., tape, elastic, immobilizer)
_____ 29540 Strapping, Ankle (eg., ace wrap, tape, elastic)
_____ 29550 Strapping, toes (eg, buddy tape)

_____Foreign body removal (coder will code)

_____ 94640 Inhalation Treatment (nebulizer tx, sputum induction, IPPB, metered dose inhaler)

_____ 16000 Burn Tx., first degree burn (ointment and/or dressing applied)
_____ 16020 Burn Tx., Dressings &/or Debridement, initial or subsequent; small (without anesthesia)
_____ 16025 Burn Tx., Dressings &/or Debridement, initial or subsequent; medium (without anesthesia)
_____ 16030 Burn Tx., Dressings &/or Debridement, initial or subsequent; large (without anesthesia)

_____ 51701 Straight Catheterization
_____ 51702 Urinary Catheterization; simple (foley)
_____ 51703 Catheterization; complicated (eg, altered anatomy, fractured cath/balloon
_____ 30901 Control Nasal Hemorrhage (simple, limited cautery &/or packing) if complicated see other codes in CPT book

_____32000 Thoracentesis; intial or subsequent
_____32002 Thoracentesis with insertion of tube; with or without water seal
_____32020 Tube Thoracostomy with or without water seal

_____ Laceration Repair (coder will code repairs)
Laceration Length in cm:_____
_____
_____

_____ G0168 Dermabond Adhesive Skin Closure (also code repair separately)

_____Layer Closure (coder will code)

***Please indicate the number of times procedure was done.**

_____Incision & Drainage (coder will code I&D)
_____ 99141 Conscious Sedation

_____Debridement (coder will code Debridement)

***Copy goes to data processing for charges and original goes to the envelope at nurses station near the ward clerk's desk.**

_____Nail Avulsion (coder will code)

_____ Fracture Treatment performed (specify; closed with or without manipulation)

_____Repair Nail bed (coder will code)
(coder will code)
(specify; open treatment with or without internal fixation)

_____ **Other Procedure Performed, name**_____

Source: Administrative Consulting Service Inc., Shawnee, OK.

What to do now?

- ☐ **Review** the Nov. 1, 2002 OPPS final rule (published in the *Federal Register*, Volume 67, No. 212, pp. 66,717-67,046).
- ☐ **Create** a charge sheet for the ED to report procedures that are performed separately, (i.e., injections, infusion, CPR, intubation, wound repairs, fracture treatment, burn care, etc.) **See example, p. 19.**
- ☐ **Assess** the effectiveness of current charge capture and coding process and make changes if needed.
- ☐ **Keep** the hospital's chargemaster updated and have current chargemaster team meetings to help with this process.
- ☐ **Provide** for an external audit of ED claims to get an "outside" perspective.

coders to realize that when the OPPS was implemented that their range of CPT codes increased from just the 10000-69979 to other billable procedures such as injections (90782-90788), infusion therapy (Q0081), CPR (92950), immunization administration (90471), and many other codes out of the normal range they are used to coding.

In our experience, facilities can manage the coding and billing requirements for the ED APC reimbursement methodology more effectively by assigning a coder or coders to the ED. Then, give them responsibility for review of the total ED chart to capture all documented, billable services and perform final review of the ED codes billed on each claim using an APC pricer software system. The software will help identify any edits or other billing errors prior to final billing. The coder should not rely on the acuity form or ED charge sheet alone to code procedures performed in the ED. With their workstation located in the ED, they can readily access staff for documentation improvement needed to code and bill completely and accurately.

The OPPS is a very complex system, which requires much research and review of guidelines, program memorandums, transmittals, and keeping up with local Part A newsletters from the fiscal intermediary.

Consequently, the keys to accurate coding and billing are education and communication. To be successful, facilities benefit from generosity in their education budget for coders and patient care staff. Coders and patient care staff can learn through teleconferences, reference materials, on-line education, and reputable consulting firms that provide in-house education and training. ■

Compliance with security rule to require vigilance

A looming deadline for the health care industry to comply with privacy regulations gains more significance with release of an additional 45 pages of regulations that include yet another compliance date.

The U.S. Department of Health and Human Services (HHS) has issued the finalized security standards for the Health Insurance Portability and Accountability Act (HIPAA) in the *Federal Register.* The security guidelines are intended to safeguard protected health information (PHI) maintained or transmitted in electronic form.

The security guidelines have a compliance date of April 21, 2005 — following the mandated 60-day comment period after being published in the Federal Register and a 24-month review under HIPAA's own statutes. The rules are being published nearly five years past an original deadline of Feb. 28, 1998.

"Overall, these national standards required under HIPAA will make it easier and less costly for the health care industry to process health claims and handle other transactions while assuring patients that their information will remain secure and confidential," said HHS Secretary **Tommy Thompson**. "The security standards in particular will help safeguard confidential health information as the industry increasingly relies on computers for processing health care transactions."

"We took great care to address every detail and produce a rule that health care providers will find easy to understand and implement," said Centers for Medicare & Medicaid Services administrator **Tom Scully**.

Redundancies eliminated

The new security rules fulfill an HHS promise to mesh the security rules and the privacy rules, according to an analysis issued by Washington, DC-based law firm Davis Wright Tremaine. "The new rules discard much of the proposed security rules" terminology in favor of definitions in common with the privacy rules, the firm said.

A number of redundancies and overlaps have been eliminated from the proposed rules and "streamlines" the security rules in comparison to what was proposed, the report concludes.

The rules are more generic in guidance rather than a list of detailed requirements, the firm said. "This means that the new rules are less a series of checklists and more a description of principles for each covered entity and business associate to evaluate and apply, based on the entity's specific situation," according to its report. ■

(Continued from page 16)

Commission has announced a major overhaul of its survey process intended to reduce both the expense and the documentation burden usually associated with accreditation surveys.

Under the new plan, called Shared Visions — New Pathways, hospitals will conduct self-assessments long before surveyors show up, and the surveyors will focus on actual patient care experiences instead of more theoretical compliance with standards.

"In the past, surveyors might have asked what steps you take to prevent wrong-site surgery, and the organization would talk about procedures, education, and other steps," says **Russell Massaro**, MD, executive vice president for accreditation operations with the Joint Commission. Under the new experience-focused process, however, "we will get at the same information but in a different way. We will choose at random from open records a patient who has just had surgery, and we'll trace that patient through the process. The surveyor will go to the [emergency department] and ask how they X-rayed the patient, how they obtained consent, and so on."

Major components

These are the major components of the new process, according to the Joint Commission:

• Streamlined standards and a reduced documentation burden, with more focus on critical patient care issues.

• Self-assessment process intended to support an organization's continuous standards compliance while freeing up survey time to focus on the most critical patient care issues.

• System for focusing surveyors on specific areas that need attention during their visit. Organization-specific data are used to highlight these areas.

• New survey system with six basic components that will replace the traditional triennial survey format. The system starts with an opening conference between surveyors and hospital leaders, which is followed by a leadership interview, validation of self-assessment results, a focus on actual patients as the framework for assessing compliance with selected standards, discussion and education on key issues, and a closing conference.

• More training, requirements, certification, and an enhanced role for surveyors. Surveyors will have to be certified and then recertified every five years.

• Revised decision and performance reports providing more meaningful and relevant information.

• The use of ORYX core measures data to identify critical processes and help organizations improve throughout the accreditation cycle.

Under the new self-assessment process, ED managers will participate by evaluating their own state of preparedness and sharing what they are and are not in compliance with — "which they should be doing already in continuous survey readiness," notes **Paula Swain**, RN, MSN, CPHQ, director of clinical and regulatory review for Presbyterian Health Care in Charlotte, NC.

One negative of the self-assessment focus — depending on one's perspective — is that it makes last-minute "cramming" for an accreditation survey impossible. "There are three ways of doing self-assessment," Swain says. "One is through documents, one is through interview of staff, and one is through observation. When you do those on an organizational level, every manager picks up responsibility for their own part of the organization – their brick, if you will. Then [ED managers] will go in their area and review documentation in the ED."

The tool you'll be expected to use for documentation, the medical record documentation review sheet, is available on the Joint Commission web site (www.jcaho.org).

"Then what they do is also assess any policies that might be affecting the ED. In addition to these nine or 10 elements, if there's anything on restraints, on point-of-care testing, on initial assessment documentation, any of that stuff, [or if] the policies have been changed, they would add that," Swain says. "Most EDs have some sort of data collection form, so that would be part of it. Then they need to observe the work for the age-specific competencies, things like that. They need to interview staff."

Once each department has completed its own self-assessment, focused on its own set of measures, an overall self-assessment for the facility is compiled, usually by someone in quality or by a designated accreditation coordinator. The overall self-assessment is based on areas of noncompliance. "If I only have one department that isn't doing it right, we're probably OK," Swain says. "But if I have a confluence of people who aren't doing it right, then we have to score ourselves in the "3" range and develop a plan of correction." **(For more on the scoring system, see the Joint Commission web site, www.jcaho.org.)**

If a plan of correction is necessary, ED managers may be involved again through a round of increased documentation review.

Swain stresses that Shared Visions — New Pathways shouldn't represent an increased documentation burden for ED professionals who have kept up and adhered to the principles of continuous survey readiness. But "if

Joint Commission's new survey process timeline

Here is a timeline for how the Joint Commission on Accreditation of Healthcare Organizations will implements its Shared Visions — New Pathways survey process:

- Organizations at the midpoint in their accreditation cycle as of January 2004 and beyond (due for survey in or after July 2005) will receive a self-assessment tool in July 2003. Facilities will have three to six months to complete the assessment and to plan corrective actions for any deficiencies. Although organizations scheduled for survey before July 2005 won't be required to submit the self-assessment, they will receive the self-assessment tool to help them prepare and become familiar with the revised standards.
- An accredited organization will complete the self-assessment at the 18-month point in its three-year accreditation cycle, and it will rate its level of compliance with all standards applicable to that organization. There will be no on-site surveyor visit at the 18-month point.
- In the self-assessment, if an organization finds itself not compliant in any standards area, it must detail the corrective actions that it has taken or will take to comply.
- A Joint Commission staff member will follow up with the organization to review its findings, approve the corrective actions, and provide advice or assistance on those actions.
- At the 36-month point, surveyors will go on site to verify that the organization has implemented the corrective actions as laid out in its self-assessment. The survey also will include a validation of the self-assessment based on review of specific critical areas. ■

they're truly not doing any survey readiness activities, this is going to be different for them," she cautions.

Swain recommends that those managers first seek out the facility's Joint Commission coordinator and learn what the facility's individual survey timeline is. "I can't imagine a place working without a timeline, because there are so many parts to coordinate," she says. "Then I would get the tool they expect me to use so that I'm not missing something and have to go back and do it again. Then, after I establish my baseline, I'll go ahead and do my graphics and keep my record of how I'm improving, if I've found problems."

For an example of how the ED would be involved in an assessment process, Swain cites patient education. "The ED does do patient education," she says. "You usually see it at the bottom of the discharge sheet, but there are other places where they're liable for patients' preferences and readiness to learn, etc., which I find missing in a lot of EDs."

From an ED manager's perspective, an assessment of patient education would include whether the staff had documented the patient's preference for learning, for instance. "If it shows it's not there, then that rolls up into the hospitalwide review of compliance, and it would say, 'We're in compliance everywhere except the ED,' so the ED would do the data collection and graphics at a local level and then send that on."

The new plan will go into effect January 2004 for all Joint Commission-accredited organizations. **(See full implementation timeline, left.)** ■

ED documentation system helps improve patient flow

Automation helps pass information along

At Sarasota (FL) Memorial Hospital, emergency department (ED) case managers have made a significant impact in reducing inappropriate admissions and assuring efficient patient flow, says **Judy Milne**, RN, MSN, CPHQ, director of integrated case management and quality improvement.

Sarasota's "Assessment Team" consists of five RNs (clinical case managers) and four social workers (psychosocial case managers). Daily staffing includes two clinical case managers and two psychosocial case managers covering 15 hours per day, plus two clinical case managers covering the direct admission center and outpatient procedural areas. The team's emphasis is appropriate utilization followed by discharge planning and placement to avoid admissions that may be unnecessary, Milne says. The clinical case managers also focus on assuring correct patient type assignment for patients who are admitted. In 2001, the ED saw 85,000 patients, about 22% of whom were admitted, and the hospital had inpatient admissions of 30,000.

Since more than half of all admissions to the hospital come via the ED or direct admits, "heavy resourcing of case management really starts efficient utilization off

right," Milne says. The ED/outpatient case managers also assist inpatient case managers by documenting key findings and unresolved concerns in the case management database (TQ, produced by Boca Raton, FL-based Eclipsys Corp.).

"We have a very heavy emphasis on data, and all staff contribute by documenting their case management activities," Milne says. "We use these data extensively to support budget requests, to negotiate with community agencies, and to generally demonstrate our impact to the organization."

Benefits of case management

When a case manager in the ED reviews a case, "a couple of different scenarios could occur," she says. If the case manager notices unusual or pending findings, he or she would likely document in the database what those findings were and leave a note prompting the inpatient case manager to follow up on the case or "to keep an eye on a certain finding or a certain issue related to the care of the patient," Milne adds.

A similar scenario exists when the ED is busy and it's important to keep patient flow moving. "They don't really have all the results that they need in order to reach a conclusion about whether the patient is appropriate, but they're getting some pressure to move the patient to an inpatient bed," she says. "They would

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers given to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the June 2003 issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME *questions*

Please refer to the CE/CME instructions, below left. For more information on the CE/CME program, contact customer service at (800) 688-2421. E-mail: customer service@ahcpub.com.

5. List the criminal penalty under HIPAA for illegally obtaining or disclosing protected health information.
A. $25,000 fine
B. $50,000 fine and one year in prison
C. $60,000 fine and six months in prison
D. $100,000 fine and five years in prison

6. According the HIPAA regulations, a notice of privacy practices must prominently display the phrase: "This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully."
A. true
B. false

7. What is the effective date of the Joint Commission on Accreditation of Healthcare Organization's Shared Visions — New Pathways survey process?
A. July 2003
B. December 2003
C. January 2004
D. July 2005

8. In 2002, how many pass-through drugs were included in the outpatient prospective payment system?
A. 115
B. 123
C. 172
D. 236

Answer Key: 5. B; 6. A; 7. C; 8. D

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document in [the database] what they did know about the patient and what was pending, and probably also what they were suspect about." For example, they would document if they weren't sure that a particular patient would meet inpatient criteria.

Milne notes that, "if it's a same-day kind of thing, and they really think someone on the inpatient team needs to be aware of it right away, they probably would follow up with a phone call to the receiving case manager."

For EDs without a sophisticated automated system, she acknowledges that getting good tracking data could be difficult. "Not impossible, but certainly very difficult, and you'd need good clerical support. You probably could design data-collection tools that went along with the flow of case management, but then you'd have to be able to hand off to clerical people to do data entry, run reports, and whatever."

Milne adds, "The other advice I would give is, even if it's hard, try to do it. Because for us, the aggregate data and the way that we've used it has just been very powerful. . . . It's just a lot of uses of the data that really help us manage our continuum and our patient flow."

She says one particular benefit of having a case management presence in the ED has been case managers' ability to work collaboratively with ED physicians and teach them more about appropriateness of admission. "I think that, over time, our ED physicians have been much better at screening admissions more appropriately," she says. "So they're helping us gatekeep at the front door to be sure that we're using the facility correctly. From a clinical perspective, that's definitely a gain, that we are diverting inappropriate admissions."

Social work contribution

The presence of social workers in the ED has had similar benefits. "Working collaboratively with the physicians and the RN case managers, [the social workers] can facilitate the placement or a reasonable discharge plan for a patient who maybe used to get admitted. So, in tandem with the clinical case managers, they help with the utilization from the perspective of being able to handle discharge plans pretty fast — to get placements done, to get paperwork filled out that's required to get a patient to a facility or to get home care or whatever."

In 2001, Sarasota Memorial was named No. 1 in efficient management of Medicare patients by Milliman USA. "My own perspective is that many hospital leadership teams want the results that case management can achieve but frequently do not support the resources needed to accomplish the desired goals," Milne says.

"Our case management program is intensive and successful, but only because it has been resourced for success. Once the resources are committed, then it becomes the case management department's obligation to achieve the results. Part of that obligation is to document what is being accomplished," she says. ■

CE/CME objectives

After reading this month's issue of *ED Documentation and Coding Update*, the CE/CME participant should be able to do the following:

1. List documentation techniques that can be used for reducing claims denials and ensuring proper reimbursement.
2. Describe the latest legal and regulatory developments affecting your documentation and/or coding responsibilities.
3. Cite sample forms and templates that can be used to improve or facilitate emergency department documentation.
4. Describe clinical and financial outcomes in the ED. ■