FOR MORE THAN 20 YEARS

HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

■ **New privacy standards:** Here's what you need to keep an eye out for 39
■ **Reimbursement:** Collaborate with coders or risk losing $30 per visit. 40
■ **Seamless service:** New call center serves customers better 42
■ **Make coding a priority:** New access department targets coding 43
■ **Mental health issues go beyond employees:** They affect the whole organization 45
■ **Everyone wants to know why nurses leave:** Why not find out why they stay? . . . 46
■ **News Briefs:** Bush signs funding bill giving more to hospitals; templates could prevent inconsistent CPT-4 coding; feds offer database for record disclosures 48
■ ***DRG Coding Advisor:*** OPPS: The emergency department challenge — part II. . . . . Insert

APRIL 2003
VOL. 21, NO. 4 • (pages 37-48)

HIPAA: If you haven't started, move fast to develop privacy policies

Focus on access to and use of patient information

On April 14, covered entities under the Health Insurance Portability and Accountability Act (HIPAA) are expected to be in compliance with the new Standards for Privacy of Individually Identifiable Health Information.

"This implies that you have to have trained people in what the policies are," explains **Larri Short**, Esq., of Washington, DC-based Arent Fox, which serves as counsel to the Atlanta-based American Association of Occupational Health Nurses on HIPAA matters. "Also you have to begin giving all defined [privacy] rights by April. As an example, AHA's [American Hospital Association's] model notice is 12 pages long — and you have to actually say what you as an organization intend to do."

That being the case, it would have been prudent by now to have thought through the regulations, taken a good first stab at appropriate new policies and procedures, and framed what you need to do to make all of this really happen. "If not, you need to move forward as fast as you can to assess the situation and develop policies," Short advises.

Not all-encompassing

The new requirements are not as broad as some might fear. "You only have to apply these requirements to data that can reasonably be linked back to a person," Short explains. "If the information is aggregated, you don't have to worry about it."

In essence, Short explains, the new regs break down into three major pieces:

• **How providers handle information.** Covered entities are required to have permission to use or disclose individual patient information. This can be written permission from the patient or, in some cases, it can

come in the form of regulatory provisions that allow you to use and disclose information for a designated list of pubic policy issues. Examples would be a response to judicial demands or law enforcement.

• **Patient privacy rights.** The use of information will be restricted to the "minimum necessary" to accomplish the purpose at hand, which maximizes patient privacy. "For the first time, we have a set of privacy rights for the patient at the federal level," says Short. "Every patient has the right to access his or her own medical information. You have the right to have your health care provider give you a notice to explain how they are going to use your information." Some of the rights outlined in the new standards are only a right to ask; for example, if an employee is not happy with what the employer says it will do with the information, the provider can say they can't accommodate the request. If the employer agrees, however, it is then bound to do so.

• **Privacy compliance program.** Covered organizations must appoint an individual who will be responsible for making sure the organization addresses the first two parts of the new standards. There are to be written policies and procedures that can be surveyed and, where feasible, technical safeguards and access controls are to be put in place. The Centers for Medicare & Medicaid Services (CMS) sends surveyors for institutional Medicare providers.

Outside help available

If you do not have the in-house expertise necessary to bring your facility into compliance, there are a wide variety of resources available, says Short. "You can look to the Office of Civil Rights web site, retain attorneys or consultants, or attend workshops. The HHS [Department of Health and Human Services] site [www.hhs.gov/ocr] provides lots of links," Short adds.

A "Frequently Asked Questions" document about the HIPAA privacy rule is posted on HHS' 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. To see the questions, go to www.hhs.gov/ocr/faqs1001.doc.

The good news is that enforcement will be "kinder and gentler" than it is for some other government regulations, she adds. "The government will 'seek to achieve voluntary compliance,' with punishment as a last resort," Short explains. In other words, if all of your preparation is not completed by April 14, you should simply attempt to get it done as soon as possible. "As long as you are cooperative and have made a sincere effort, I don't expect you to get really slammed unless you work in an organization that was certified to participate in Medicare," she adds. Such organizations are subject to some risk outside of HIPAA through CMS; if they do not meet certain quality standards, reimbursements could be threatened. ■

Hospital Payment & Information Management™ (ISSN# 1074-8334), including **DRG Coding Advisor**®, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Payment & Information 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: 8:30-6:00 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), $599. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $359 per year; 10 to 20 additional copies, $240 per year; for more than 20, call (800) 688-2421. 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 $100 each. (GST registration number R128870672.)

Editorial Questions

For questions or comments, call **Alison Allen** at (404) 262-5431.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Managing Editor: **Alison Allen**, (404) 262-5431, (alison.allen@ahcpub.com).
Production Editor: **Brent Winter**.

HIPAA security rule now in final form

Security rule now integrated with privacy rule

Final security standards under the Health Insurance Portability and Accountability Act (HIPAA) for protecting patient health information that is maintained or transmitted electronically have been adopted by the Department of Health and Human Services (HHS). All "covered entities," which includes health care providers, health plans, and health care clearinghouses, must comply with the rule, which was published Feb. 20, 2003, in the *Federal Register*. It includes the following provisions:

- All work force members, including management, must receive security awareness training.
- Organizations must conduct risk analyses to determine information security risks and vulnerabilities.
- Organizations must establish policies and procedures that allow access to electronic protected health information (PHI) on a need-to-know basis.
- Organizations must implement audit controls that record and examine who has logged into information systems that contain PHI.
- Organizations must limit physical access to facilities that contain electronic PHI.
- Organizations must establish and enforce sanctions against members of the work force who don't follow information security policies and procedures.

The electronic signature standard, a component of the proposed rule, was removed from the final version. HHS has said it will publish that standard in a separate final rule, but did not say when.

Some security experts have said the rule, while well integrated with the HIPAA privacy rule, lacks specific guidance in some critical areas, such as the requirement that encryption be used "only when deemed appropriate."

John Christiansen, JD, an attorney with Preston, Gates & Ellis, LLP, in Seattle, has said the HHS accomplished one of its goals, which was to integrate the security rule with the privacy rule. "A number of redundancies have been eliminated, as have some unclear concepts and rules," he said in the *HIPAA Weekly Advisor*, published by HCPro Inc.

For example, the chain of trust agreement, a document that would require business partners to protect electronic PHI received from covered entities, was eliminated. Covered entities are required to accomplish this through business associate agreements, which are required under the privacy rule.

HHS writes in the rule's preamble that the regulations are consistent with "generally accepted security principles."

The regulations will become enforceable for most covered entities, including hospitals, on April 21, 2005. Small health plans will have an additional year to comply.

To view the final rule, go to www.access.gpo.gov. ■

If you can automate, you can save time and money

Michigan facility used existing systems

Compliance with the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) starts with a good assessment, says **Gary Frownfelter**, application team leader at Genesys Health System of Flint, MI. "People probably are more HIPAA-compliant than they think," he says. "We started documenting what we already had in place, started defining what our policies and systems already do."

"Early on we took the tactic of trying to maximize systems already in place," says **Carol L. Joseph**, RN, CCRN, privacy committee provider chairperson for Genesys. "We decided that our systems could be tweaked and used to a greater capacity."

One of the first tasks accomplished, says Joseph, was automation of the tracking and distribution of the privacy acknowledgement form. Joseph says her organization not only got the form down to one page, but they used existing ADT technology to identify patients who had not received and signed the form. "It was very costly from a printing standpoint to print a nine-page privacy form and have patients sign each time they visited one of our facilities. Our system now

autoflags patients and autoprints forms for patients who have not signed a form. After that, they will not be flagged again. Requesting one time was part of our continuing effort to make things convenient for patients and efficient for Genesys."

In addition to automating, Genesys also put audits into place. "The ability to audit and ensure compliance help to identify where we might be having problems or breakdowns," explains Joseph. "It's important to think ahead of time about how you're going to measure compliance. If you wait until after a problem is discovered, it's more complicated and labor-intensive."

Though technology has helped with HIPAA compliance, it is not without problems. One problem that needed attention was the periodic changing of passwords. Genesys has more than 130 different applications, many of which require a unique sign-on ID and password, explains Frownfelter.

"What started happening was employees, many of whom had to access up to eight systems a day, started putting their passwords on sticky notes and sticking them on their computer screens, which of course defeated the purpose of password sign-on," says Joseph.

To improve security and usability, Genesys purchased Coreport, a single sign-on portal system sold by CoreChange Inc. The portal allows a user to access multiple Genesys systems with one ID and password. The system also has an authorization feature that allows the administrator to determine the user's access level. ■

Work closely with coders, or ED revenue may be lost

Good documentation often coded incorrectly

By **Caral Edelberg**, CPC, CCS-P
President/CEO
Medical Management Resources/Team Health
Jacksonville, FL

Without connectivity between emergency department (ED) clinical staff, business office, medical records, and compliance, your ED stands to lose significant revenue.

Streamlining your ED coding and billing system isn't something you can do alone. It takes the expertise and cooperation of numerous individuals working together on each element of the process. However, the rewards are great, both in the areas of improving revenue and in assuring conformance with the hospital compliance program.

The amount of revenue you may be losing depends on many components of your ED coding and billing process. It is not uncommon to find between $15 to $30 per patient in lost ED facility charges on just levels and procedures alone.

The lost net revenue for Medicare patients is quite easy to assess by identifying improperly coded facility levels or procedures that were omitted altogether and then assigning the ambulatory payment classification (APC) payment amount to each.

Here are ways to collaborate with coders to improve reimbursement:

- **Ensure criteria are followed.**

Nursing criteria must accurately and uniformly reflect the services provided to patients by ED staff. Compliance problems will occur without use of objective criteria by the coding team.

It is not uncommon to find excellent documentation by clinical staff that is not accurately interpreted and coded. Coders and clinical providers must work together to develop an understanding of the underlying factors illustrated by the words entered in the medical record.

Providers should earmark select cases that illustrate moderate to high levels of acuity, resources, and patient care. Track these cases through the coding and billing process or work with coders prior to assignment of the codes to discuss how coding will be performed based on submitted documentation. Discuss the differences in how coders interpret the documentation and apply coding rules.

The Center for Medicare & Medicaid Services initially proposed new facility levels codes starting in January 2003, but it didn't implement them in the final rule. It looks as if it will be 2004 before a nationally uniform facility coding criteria will go into effect.

Until then, you must ensure that levels are stratified by acuity and resources, and you must ensure that coding staff follow the criteria. If criteria are too subjective, coders will not be able to

assign levels to services uniformly, which is a problem for revenue and compliance.

• Perform outside audits.

Routine outside audits can help you stay on track and identify areas that need improving. If all seems to be working well but there are no outside audits to ensure that internal criteria are followed and coding and billing are being performed under current rules, there may be a compliance problem that ultimately will result in paying some of that revenue back.

• Work with coders to review denials and suspended claims.

When documentation, coding, and billing are performed appropriately but there is no ongoing review of denials and suspended claims, coders never learn what rules certain payers may follow. In other words, the work is done, but the payer wants it reported in a special language.

• Ensure that coders identify additional procedures.

Coding for surgical procedures performed in the ED is a new concept for facility billing introduced with APCs. Coding of these services depends on documentation provided by clinical staff, and it can be missed easily if documentation is not complete and detailed.

When coded correctly, these procedures add significant revenue to the ED. **(See list of the most frequent coding errors or omissions of facility procedures, at right.)**

Is your ED making costly coding errors?

Beware of mistakes regarding facility procedures

Here is a list of common coding errors or omissions of facility procedures, identified by **Caral Edelberg**, CPC, CCS-P, president and CEO of Jacksonville, FL-based Medical Management Resources/TeamHealth:

- failure to accurately identify facility levels consistent with written criteria;
- coding of simple instead of intermediate laceration repairs;
- coding of simple instead of complicated incision and drainage;
- failure to identify separately identifiable procedures accurately (e.g., fractures, dislocations, splints, cardiopulmonary resuscitation, infusions, and injections);
- coding for intravenous administration and fluids with the wrong codes or omitting them entirely;
- omission of coding for intramuscular antibiotics;
- improper use of the -25 modifier and other facility-required modifiers, without which claims are suspended or denied;
- listing diagnostic tests under the wrong revenue center;
- errors in reporting multiple visits on the same calendar day to the emergency department;
- omitting an appropriate facility level when billing facility procedures. ■

Review chargemaster regularly

• Work with coders to monitor the ED chargemaster.

If documentation and coding are correct but the chargemaster is not functioning appropriately, causing services that are coded to be omitted from the billing form, then revenue is lost.

The ED chargemaster requires ongoing revision to reflect all services that can be performed in the ED — approximately 450 codes. You must review it on a regular basis, communicate with coding staff to identify services that are performed but not included in the chargemaster, and be sure these chargemaster codes appear on the billing forms when used.

• Work with coders to ensure adequate documentation of medical necessity and the service rendered.

You cannot overestimate the importance of documenting medical necessity for the treatment that is provided to ED patients. Under Local Medical Review Policy (LMRP), Medicare determines the conditions and diagnoses that must be identified on the claim for services to be paid.

Often, the services are performed, but documentation does not provide enough detail to allow coders to identify the services to the highest level of specificity required by Medicare.

Clinical staff in the ED won't know that is expected of them in documenting these services unless someone in coding and billing provides the necessary feedback on denied or suspended claims.

To enhance collaboration between coders and ED staff, plan routine meetings to discuss ways to address documentation issues that affect coding. Some ED services that require LMRP monitoring include electrocardiograms, pulse oximetry, troponin, cardiopulmonary resuscitation, and chest X-rays. Without this level of oversight, you can expect billing errors and lost revenue. ■

One call does it all at Portland call center

Hospital, physician billing questions answered

Providence Health System in Portland, OR, has improved customer service and increased staff efficiency by creating a call center that allows patients to handle physician and hospital billing questions with one telephone call.

"We were trying to find a way to be seamless to patients," says **Jessie Hofstetler**, manager of the inbound call center. Another manager oversees the outbound call center, she adds, but employees are now trained to handle both kinds of calls and are located in the same space.

"When patients called about a bill from a clinic that was Providence-based, we wanted to also be able to address their hospital bills, rather than have them make two separate calls to different places," Hofstetler says. "[Before], they'd say, 'Aren't you Providence?' They couldn't distinguish the difference. They'd go to the physician for an exam, but the labs were sent to the hospital."

The newly cross-trained employees handle the inbound and outbound calls regarding hospital accounts and the inbound calls concerning physician office accounts, Hofstetler explains.

Staff handling outbound calls for physician accounts still report to the physicians' billing office (PBO), but they work in the same space, notes **Kristi Gwilliam**, who as supervisor for the inbound and outbound call center reports to both call center managers. Because of their physical proximity, she adds, these employees can now communicate more easily with their hospital counterparts.

Before the consolidation, Hofstetler says, PBO customer services representatives and regional business office (RBO) reps were in the same building, but on two different floors at opposite ends. The first move, in the fall of 2001, brought together the PBO and RBO staffs handling inbound calls, she adds. In December 2002, the outbound reps were added.

When the two groups were combined, "everyone had to be able to understand and learn the other's system," she adds. "There are differences between how the clinics bill and collect accounts and how the hospital does. We were in a growing phase for a while.

"The greatest challenge we had is that [the PBO] system seemed more cumbersome," Hofstetler notes. "If you have to make changes, like an address update, you have to do it in every account. It just takes longer. You just work at finding the positives in it and at encouraging staff to keep learning, to think of ways to streamline the process."

One example of the streamlining that has occurred, she says, has to do with the "standard note" function on a computerized account. Previously, each time a patient called and asked to add an insurance company to the account, Hofstetler explains, the person taking the call would put a note in the computer to that effect, print the screen, and put the printout in the mailbox of someone on the team who handles insurance matters.

"This past year, we created a standard note, so that the employee [taking that information] would punch in a number that meant 'add commercial insurance,'" she says. "That would come out on the note [in the system]. Maybe 30 or so of those [notes] are put on a report that is distributed each morning to the people on the [insurance] team, and they work from that report. It saves time and money."

Other numbers, Gwilliam points out, are entered to indicate Medicare or Medicaid coverage. "It keeps staff from having to distribute these reports, and from having to figure out who they actually go to. There's no more paper passing."

As employees have become more proficient in being able to move around both computer systems, Hofstetler says, efficiency has increased. When the new center was created, there were about 25 full-time equivalents, she adds, "but we're now down to 20."

Because the call center is open from 8 a.m. to 8:30 p.m. on weekdays and 9 a.m. to 1 p.m. on Saturdays, she adds, there are both full-time and part-time employees.

To encourage gains in efficiency, Hofstetler says, the call center tracks the total number of calls received each month — around 35,000 — as well as the number of "two-in-one" calls, where more than one issue is resolved.

In the latter cases, she explains, staff may take a proactive approach. "We get about 500 calls a week where the person wants to know what the bill is with the hospital, and [the customer service rep] checks the physician accounts and sees an outstanding bill there as well."

Using a telephone tracking system, the center monitors how long an employee stays on a call and how long he or she spends in "after call" work, such as making a notation on the account or looking up the explanation of benefits to see if a payment was posted correctly, Hofstetler says. "We look at whether the rep is doing that within three to five minutes."

Each customer service representative is expected to handle between 80 and 110 calls per day, she adds. "We measure all the calls they transfer and say they can't resolve, and those can't exceed a certain percentage. We track all abandoned calls [when the caller hangs up before reaching a representative], which also have to be kept to a certain percentage."

If the percentages aren't acceptable, she says, "we pull other staff to fill in. There is a certain standard we have to meet."

There are five employees from the RBO and PBO staffs who are trained on both computer systems and able to fill in when needed, Hofstetler says. "Their [normal] roles are, for example, a collector for the physicians, or a member of the credit team, but if there are 20 calls in the queue and the call center staff can't keep up with the volume, these are people we can call.

"We've really worked hard at having the offices buy into the belief that the first priority is the customer," she adds.

While the customer service representatives were used to working in cubicles with high sides, Hofstetler notes, those walls have been lowered in the new space to facilitate communication. "[Employees] can see what everyone else is doing, and they can see [managers and support personnel]. We created an elevated area within the new call center, called the support area, for the support team," she adds. "When the staff are handling a tough call and need more help, all they have to do is press a button and a member of the support team is available and will help them get through it."

That support person — who if necessary may be the team trainer or a supervisor or manager — will either walk over to the employee's desk or access the same account and communicate by telephone, Hofstetler explains. "Somebody is always available to help staff. That's really our goal — to support the team."

One of the big pluses of the call center, she points out, is that there are customer service reps who are bilingual in a variety of languages. Callers who are having a difficult time resolving their concerns with the first responder because of language difficulties are asked if they would like to have someone help them in their native language, Hofstetler adds.

Spanish, Vietnamese and Chinese speakers are available at present, she notes. "We want to find a Russian [speaker], but it's hard." If the appropriate rep is on another call when a person needs the language help, the information can be left on a voice message box, Hofstetler says. "We check it whenever the light is on."

"If a person calls in and can't understand and only speaks Chinese, the rep will say something very simple, like, 'I will transfer you to a message, you talk,'" she adds. "We will return the call within 24 hours."

Future plans for the center include using an automated coaching tool that will help reps find ways to increase efficiency, determine which screens to select, and say things more effectively, Hofstetler notes.

From the beginning, she points out, her job has been made easier by a "great team who were willing to experiment. They had a lot of fun with the challenges and would push each other to meet a goal. We would celebrate at the end." ■

Coding needs priority in new access department

Training, coding issues addressed

When **Anthony M. Bruno**, MPA, MEd, took on the challenge of creating an access department at Presbyterian Medical Center, part of the University of Pennsylvania Health System (UPHS), one of his first hires was **Colette Howerton**, who became the new manager for outpatient access services.

A longtime employee of UPHS, Howerton most recently had worked as an admissions supervisor in another of the system's hospitals. Her mission, explains Bruno, was to improve and expand centralized outpatient registration services.

Basically, Howerton has taken a two-pronged approach, he says, providing registrar support in high-volume outpatient registration areas while incorporating small ancillary areas into central outpatient registration.

When she arrived, Howerton says, all outpatient

registration was centralized in one area. Patients endured long waits, and registration quality was often poor, mostly because registrars had not had the training they needed to handle the coding associated with different medical specialties, she adds.

The health system's orthopedic clinic in particular was plagued with problems, Howerton notes. "Patients were getting tied up in a queue in central registration. The complaint was that patients were waiting an hour to register to get an X-ray, another hour to see a physician, and then another hour in radiology."

Shifting a registrar from central registration to the orthopedic clinic, after providing the needed training, greatly reduced that turnaround time, Howerton says. Not only is the chief of orthopedics "ecstatic" at the streamlining of that operation, Bruno notes; removing those patients from the central registration queue dramatically shortened the wait time in that area.

Howerton also has put in place a preregistration system for patients undergoing magnetic resonance imaging, CAT scans, and gastrointestinal services so they don't wait so long when they arrive for their appointments, she says. Another benefit is that technicians also spend less time waiting for patients to come back to the treatment area, she adds.

The Philadelphia Heart Institute (PHI), part of UPHS' cardiology operation, was another area in which Howerton stationed a registrar, he says. The new registrar joined an existing employee who had been splitting her time between registration and tech work, Bruno adds. "The problem there was poor registration, bills going out the door incorrectly and being rejected."

The specialized coding required for the echocardiograms and other procedures done by PHI created a particular challenge, he notes, because registrars had to recognize unacceptable codes and contact physicians for changes or clarification.

To ensure the repositioned registrars wouldn't be missed as much from their original posts, Howerton says, she rearranged work schedules and lunch breaks to ensure more coverage during high-volume times of day.

"The people there were sufficient, but it was a question of how and where to use them best," explains **Raina Harrell**, who recently joined UPHS as manager of revenue cycle. "One of the first people [Bruno] hired was a manager for training, and [that individual] immediately trained the registrars from A to Z. Once it was decided that a person needed to go to an area, specialty training was created for that person."

That training included classes, as well as computer modules with accompanying tests, she adds.

"We have also taken away registration duties from smaller ancillary areas such as phlebotomy and physical therapy," Howerton notes, because the registrations performed there are more generic.

Results have been dramatic, she says. "The overall error rate for inpatient and outpatient registration is going down. Before, it was at 7%, but since the new fiscal year began July 1, 2002, it's gone down to 2%, with a 1% rate for outpatient registrations."

Future projects, Howerton adds, will include a reorganization of the flow of information in the infusion center, where chemotherapy is done.

That area presents its own set of challenges, Harrell notes, including the need to authorize coverage for six months, or six visits, for example. Questions to be addressed include: "How long is the precert good for? How many referrals are needed? Is this one covered?"

Registrars must check to make sure a patient's insurance coverage hasn't changed, she adds, because with drugs priced at $2,000, mistakes can be particularly expensive.

Looking at systems issues

Harrell, who has worked with Bruno at three other health care organizations, will provide another piece of the access department puzzle. Harrell has been charged with overseeing the improvement of all systems — anything having to do with the flow of information. "You can't make the system work if the people don't work," she notes.

Harrell says her focus will be on cleaning up errors created by staff or the computer system. For example, she is addressing the categories of "DNFB," which refers to patients who have been discharged but not sent a final bill, and "OPEX," or outpatient exception reports, which cover outpatient accounts that have not been billed.

"What I've been doing is looking at things that didn't go the way we expect them to go," she says.

"There are IDX systems in our physicians' offices that interface with [the hospital's] SMS system, which is for patient registration and billing," she notes. "We have a Cerner system

in our laboratory for order entry and results placement, and a PA RAD system in the radiology area. That's a real challenge. The information going from registration to billing is another challenge."

"What I do is look at the flow of information from one area to another," Harrell adds. "I will monitor error reports and transmission control errors and see what information passes from one system to another and if that system is matching information correctly. Did the same information come out when passed to the next system?"

The larger the DNFB and OPEX reports, she points out, the fewer the bills going out the door, the higher the days in accounts receivable, and the less money that is being received in a timely fashion.

"We've developed monitoring tools for those two reports, to see how well the hospital is doing, and if [the efforts] bring down overall billing days," Harrell says.

"There will be a report that can be shared on a weekly basis with the different departments that affect the fact that the bills are not dropping," she says, "like medical records, the business office, or any area that does charge entry, like the emergency department. It will say, 'These are the accounts you have been holding. Can you help us correct these errors?'"

Many of the tools Harrell is using were developed in Microsoft Excel and are put on a shared drive that can be accessed by employees in any of the affected departments. "They can be downloaded, so you don't have to hand them out to people," she notes.

"We're also working on a project that has to do with reimbursement for hospital-based physicians," she says. "When a patient has a physician office visit and the physician practice is owned by the hospital, there is a charge the hospital can recover."

The process is called "maps," Harrell explains, "because we 'map' what the physician did, the charge for which the hospital can bill. We get paid and give the physician the money, so we pay them either way. We need to make sure we get reimbursed for all of the services."

Maintaining the chargemaster is crucial to making sure the hospital is being correctly reimbursed, she points out. "We're in the process of going over the accounts of the past year and a half and asking, 'Did we bill appropriately? Did we get reimbursed?'"

The problem that can occur, Harrell says, has to do with the charge entered by the physician office. "They put a code into IDX indicating what they did — whether it was just an office visit or something additional — and the information has to come across to SMS and match to a code saying, 'This is what the hospital gets paid.'"

As with anything else, she adds, codes are not good forever.

"The real thrust for [Harrell] will be the revenue cycle," Bruno notes, "looking at reducing our days in accounts receivable and bringing in more cash. The 'maps' project is a huge one and should be bringing in a lot of revenue."

"We're also looking at level one claim edits," he says. "When we put claims in through software called EZ Claim, it edits out any errors, so we're not sending faulty claims on to the payer."

If the registrar enters the insurance plan code and the identification number doesn't match, Harrell adds, the software will catch it. ■

The big picture counts in mental health, too

Productivity affected across entire organization

Employee Assistance Programs and similar services are available in many organizations to help employees with mental health issues, but not nearly enough attention is paid to mental health on the organizational level, says **Jeffrey P. Kahn**, president of New York City-based WorkPsych Associates. And just as mental health issues can affect the productivity of an individual, they can also affect the overall productivity and performance of an organization.

"Everybody has seen the effects of emotional problems on productivity — from the depressed worker who can't concentrate on the job, to the person with marital problems who ends up arguing with the boss, too," notes Kahn. His services, which include individual and corporate consultation, policy development, prevention programs, and management training, are designed to complement existing management and mental health programs. "What people don't realize is that what is obvious on a small scale is just as real on a large scale, too."

In other words, mental health issues do not occur in a vacuum. "Employees who are happier people tend to be more productive workers.

Everybody knows that on the micro side, but not surprisingly, it's equally important on the macro side," Kahn explains.

There are a variety of ways to look at mental health, ranging from individual problems to organizational problems — from bad office politics to dilemmas of organizational change, notes Kahn, who is co-editor of a new book called *Mental Health and Productivity in the Workplace: A Handbook for Organizations and Clinicians* (Jossey-Bass, San Francisco). Common organizational issues include the following:

- issues of ethics;
- workplace violence;
- leadership and organizational structure;
- organizational change;
- emotional crises in the workplace;
- executive distress;
- job loss and uncertainty;
- working abroad;
- office politics.

"All of these can leave workers unhappy and not as effective as they might want to be," says Kahn, adding that "what happens at the top makes a huge difference in terms of corporate culture."

In order to maximize the productivity of your organization, you need pay attention to a number of different potential problem areas, says Kahn. "For example, you need to look at the corporate culture — if the company is seen as fair or whether people feel trusting in that environment."

It's very important to look at management leadership style, Kahn adds. "Managers who act like [General] George Patton can certainly get things done well and quickly, but only at great emotional cost to employees, and in a situation where it's not easy for them to quit," he points out. "For instance, some unhappy workers on Wall Street are paid an enormous amount of money so they feel they cannot quit."

In the long run, the most effective and productive approach is to try to understand what makes your people tick and what works for them, Kahn says. The emotional component is even important for people with physical medical problems, he asserts. "One recent study shows that if you tried to predict the length of disability for workers with back problems, the best predictor is the level of stress and anxiety they're experiencing," he observes.

Thus, he says, it's useful to keep in mind when certain health issues turn up in the workplace that you may need to understand the psychiatric aspects that can be associated with those illnesses — for example, absenteeism, violence in the workplace, or critical incidents.

Kahn also is a strong advocate of what he refers to as quality mental health care. "It's important to front-load the system with the most skilled clinicians you can for initial diagnosis," he says. "Most companies do the opposite, and use a low-level approach. Often, employee/patients get lost in the shuffle, not getting the help they need, or getting it much later than they should." ■

Find out why people stay and not why they leave

New consulting style cuts turnover rates

Most of health care these days seems to be about problem-solving — figuring out what is wrong with a patient, a process, or a system and fixing it. This is a negative way of viewing things, says **Kathleen Davis**, RN, MBA, vice president of hospital and nursing services for the Lovelace Health System in Albuquerque, NM. Take nurse retention, she says. "Everyone is focused on why people are leaving, not why they stay."

So when Davis got a grant from the Robert Wood Johnson Foundation, she wanted to look at the positive side of the equation and figure out why the best nurses stay at Lovelace. Using a consulting process called Appreciative Inquiry (AI), she did just that. And along with finding out the good things about the system that encourage nurse retention, Davis saw turnover rates decline by about 10%.

Appreciative Inquiry was developed by David Cooperrider at Case Western Reserve University in the 1980s. It is a strength-based approach to consulting in which the positive aspects of an organization are delved into and studied. "It actively seeks that which is good and admired," says Davis. "You have to develop questions based on what you think you value."

Traditionally, an organization that wants to have an impact on something like retention would have taken the medical model technique of finding an area of deficit, analyzing it, and fixing it. "That puts the focus on what is bad, not what is good. This allowed us to determine our

core values in nursing and concentrate on those positive things."

After learning about AI, Davis formed a steering committee that investigated the areas that nurses value in the workplace. They came up with four things to focus on: the privilege of nursing, humor, appreciation, and the exceptional team.

The committee then interviewed nearly 100 people using a cascading process in which those interviewed were then trained to interview others. "We sat down and asked questions one on one. The questions were designed to trigger stories from the nurses." For example, concerning teamwork, nurses were asked to:

- describe a time when they believe their team performed exceptionally well;
- discuss the circumstances during that time;
- share a story about a time when they were proud to be a member of a team;
- describe the elements that made them proud.

What Davis and her team accumulated were hundreds of stories that illuminated just what those four core values meant to the nurses in everyday practice. The committee took these stories and developed a brochure that explains the health system's vision and values and how these are demonstrated at work, and calendars for nurses that include pictures of them at work and quotes from their own stories. "It's real feel-good stuff," Davis says.

Along with creating iconography and literature that emphasized the positive aspects of being a nurse at Lovelace, Davis says the AI project has led to changes in many processes in the system. For instance, interviewing prospective employees has a different tone. "We used to ask about how people would solve a problem. Now we ask questions in a more positive way. We ask them to tell us about when something went really well, or some success they had."

Assessment tools for nurse internship programs also have been reframed to be more positive. In staff meetings, too, Davis says nurses make use of the lessons they learned from the AI project. "In our own monthly meetings when I start, rather than go right into the agenda, I ask the people there to reflect on what has been going well. I'll ask them what lately has made them want to stay at Lovelace."

Some might see the process as a Pollyanna approach to the realities of health care, but Davis disagrees strongly. "We still get issues to come out. We still discuss problem areas, but they surface differently, and our approach to them is more positive." Besides, she adds, with a declining turnover rate, what more proof does she need that it works?

"I think we have to find new ways to approach some of the old problems we have in health care," Davis concludes. "Using the same old techniques to deliver nursing care may be comfortable and may work fine for patients. But I don't think it works as well with environmental issues. To a large extent, high turnover rates relate to work environment issues. If you talk about an issue and people walk away feeling bad, that can't be good for morale. We are trying to work on issues in a purposely positive way. That way, when people walk out of a discussion, even if it was about a problem, they walk away feeling good about themselves, about their work, and about Lovelace." ■

Information resources for Appreciative Inquiry

- Appreciative Inquiry Commons web site: **appreciativeinquiry.cwru.edu**.
- Taos Institute web site: **www.taosinstitute.net/index.html**.
- Cooperrider D, Whitney D, Sorenson P, et al. ***Appreciative Inquiry: Rethinking Human Organization Toward a Positive Theory of Change.*** Stipes Publishing Co., 1999.
- Cooperrider D, Whitney D. ***Collaborating for Change: Appreciative Inquiry.*** Berrett-Koehler, July 2000.
- Hammond SA. ***The Thin Book of Appreciative Inquiry.*** The Thin Book Publishing Company, 1998.
- Watkins JM, Mohr BJ. ***Appreciative Inquiry: Change at the Speed of Imagination.*** Jossey-Bass/Pfeiffer, 2000.

Bush signs funding bill giving more to hospitals

More than $800 million in increased spending for hospitals is included in the omnibus spending bill signed in late February by President Bush.

The legislation includes a $300 million increase from April 1 through Sept. 20 in Medicare payments for rural and "other urban" hospitals through equalization of the standardized rate. It also provides $518 million in bioterrorism preparedness funding for hospitals, $15 million in new funding for the Nurse Reinvestment Act, and $28 million in education incentives for medical schools to incorporate bioterrorism-related information in their curriculums. ▼

CPT-4 coding inconsistent; templates could help

Agreement in coding of emergency charts between coding agencies used by one hospital system was only poor to fair, and the distribution of assigned CPT-4 codes was significantly different among the agencies, according to a study from William Beaumont Hospital System in Royal Oak, MI, published in the *Annals of Emergency Medicine* (Bentley PN, Wilson AG, Derwin ME, et al. Reliability of assigning correct current procedural terminology-4 E/M codes. *Ann Emerg Med* 2002; 40:269-274).

The researchers did three prospective trials, with two interagency audits and one intra-agency audit. In addition to poor agreement in coding, they found that the distribution of CPT-4 codes was significantly different in each group.

"We find this latter observation startling and disturbing, and if generalizable, this will have important economic and legal ramifications," they wrote, pointing to the possibility of prosecution for billing fraud. They suggested the following solutions:

- using templates to reduce variation of documentation;
- requiring more rigorous formatting of dictations for more consistent documentation;
- performing a more thorough review of documentation guidelines provided by the Centers for Medicaid & Medicare Services (CMS) for use in assigning CPT codes. (Editor's note: The guidelines can be downloaded at no charge at the CMS web site: cms.hhs.gov. Click on "Medicare" and "Documentation Guidelines for Evaluation and Management Services.") ▼

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 for the disclosures made from all CMS systems of records permitted by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act.

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 system can be accessed at www.access.gpo.gov/su_docs/fedreg/a021007c.html. ■

DRG CODING ADVISOR.

OPPS: The emergency department challenge — part II

Billing for emergency department procedures

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

In addition to evaluation and management (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 additional ambulatory payment classification (APC) payment are injections, infusions, laceration repair, insertion of nasogastric tubes, and wound care. Other billable services common to the ED are radiology, other diagnostic procedures, durable medical equipment, 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 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 Feb. 10, 2003. Highlights from those regulations that affect ED reimbursement are as follows:

- **Pass-through drugs.**

In 2002, there were 236 pass-through drugs, but only 115 remain as of 1/1/03. 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 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 1/1/03. 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.

- **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.

Example 2: An appropriate hospital staff member 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. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

• Self-administered drugs.

CMS has clarified instructions for billing self-administered drugs in the 2003 OPPS Final Rule. CMS states on pages 66,766 and 66,777 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 OPPS rule proposed in August 2002, CMS gave examples of situations in which drugs are considered supplies. For instance, sedatives administered to patients in the preoperative area being prepared for a procedure are supplies that are integral to performing 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 after 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 placed on a wound or surgical incision at the completion of a procedure are another example of drugs as supplies.

• Pass-through devices.

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

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 cut-off date when your chargemaster 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.

• 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. Though 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 who are directly admitted to observation but whose observation services do not meet the criteria necessary to qualify for a separate observation payment.

• 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 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. ■