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Coding professionals don't come a dime a dozen, so retention is key

In a coder's market, incentives can help you get and keep good people

Jobs are in short supply in many industries throughout the country, but health care is looking for a few good workers — and not just nurses. Hospitals are finding it hard to locate and keep medical coders.

In fact, the national vacancy rate for billers and coders in 2001 was around 8.5%, according to the American Hospital Association. The Bureau of Labor Statistics projects that the number of medical records and health information management positions will grow by more than 36% by 2010.

Given the outlook for this job sector, recruiting and retaining quality coding professionals is essential. However, doing so in today's tight labor market requires thoughtfulness, consistency, and investments of both time and money.

Step one is identifying suitable candidates. The process of taking a physician's written notes regarding a patient's diagnosis and treatment and converting that information into numeric code can be quite a challenge. "You have to have a good screening tool to identify the people who are appropriate for you to try to recruit into your organization," says **Bill French**, MBA, RHIA, CHQ, vice president of Madison, WI-based Metastar's Hospital Payment Monitoring Program.

An applicant must be suited to a career that requires him/her to work quickly and accurately while relying on notes that may lack pertinent information. The absence of crucial information hinders the coder in his or her efforts to code properly, which reduces the coder's productivity rate. Ascertaining that a coder has the ability to deal with problems in a positive way is important, French says.

Not surprisingly, a coder's clinical background — or lack thereof — can be an issue during the recruitment process. "If you have clinical experience, it makes it easier to convert what you know medically to a code," says **Steve Verno**, CMBS, NREMT-P, CMMB, CMMC,

compliance director for the Medical Association of Billers in Las Vegas.

Whether a coder's prior experience comes from years of clinical training or years of coding, his or her resulting knowledge base is very attractive to health care employers. "The coder, typically, is in a health and information management department, which is typically not close to the source of patient care," says French. Having a good working knowledge of conditions and treatment modalities — whether the category is OB/GYN, emergency medicine, or radiography — can certainly help an employee code faster and more accurately.

Of course, there is always room for someone who has trained specifically as a coder. **Darice Grzybowski**, MA, RHIA, FAHIMA, encourages hospitals to "take an active role in recruiting students from local colleges and universities with HIM education programs." In addition, Grzybowski, who is National Industry Relations Manager for 3M Health Information Systems, recommends creating intern positions, so students will have some coding experience when they graduate.

Susan Cohen, RHIA, CCS, is responsible for both off-site and outsourced coding operations for Provider HealthNet Services (PHNS) in Allentown, PA. Among other services, PHNS provides coders, coding support, and auditing to hospitals. While Cohen says PHNS likes to recruit people from four-year programs, the firm also looks at nontraditional students if they have the right clinical background.

In particular, PHNS is always interested in people who have been nurses. Although she says PHNS "prefer[s] that employees go through a four-year program," hiring someone from a two-year coding program isn't out of the question. "We would take someone with a two-year degree and mentor them" via testing, analysis/critique of the coder's work, and continuing education, says Cohen. "Two-year programs give people a base — [they] learn the basics and the rules. A small community hospital would hire someone from a two-year program."

Grow your own

Two years ago, Baylor University Medical Center in Dallas faced a medical coder shortage: There were several vacancies and no people in the area to fill them. So the hospital created a six-month paid training program that has completely solved the shortage issue, says **Dana Choate**, RHIA, associate director for health information management at Baylor.

The program has seven spots each semester, she says. That number of spots was chosen because that was how many coder vacancies there were when the first class started. "We wanted to be out of hot water," she says. That was also the number that could be accommodated for the practical work experience part of the class, and it was the number for which Choate was able to justify the expense.

The first time the course was offered, there were 56 applicants. The second time, 83 people applied. By the third course, the hospital had 174

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applications. With needs met for the time being, Baylor didn't offer the course for two sessions. It is just getting ready to offer its fourth course.

"Initially, it was for people who worked in the hospital already and were looking for an opportunity to grow professionally but couldn't afford to quit work and go to school." Aimed at clerical-level employees, the pay was higher than minimum wage, but about on a par with an entry-level administrative job, says Choate. The students also receive benefits.

Things have changed, however. Now, applications come in from across the country. "There are highly skilled individuals — nurses, nursing assistants, transcriptionists — who wanted to stay in health care but were looking for a different track," Choate says.

The course includes classroom work on medical terminology and ICD-9 and CPT codes, as well as classes in anatomy and pathophysiology. It also includes hands-on experience in a health information management department. "We think the work experience part of the class is critical to helping them understand what they will be doing in the real world," says Choate.

Those who make it to the course have to promise to work in the Baylor system for two years after graduation. The first graduates have now been at Baylor for more than two years and seem content to stay there, says Choate. "We even did some employee satisfaction testing with the students and asked if they would still be working here if they hadn't had to sign the two-year agreement. The answer was an overwhelming yes."

Once the students complete the course, they are eligible to work toward an entry-level coding credential from the American Health Information Management Association (AHIMA) in Chicago, says **Jessica Rudd**, RHIA, coding instructor for the course. After coders have two or three years of experience, they can sit for a certified coding specialist exam.

The cost of the program wasn't insubstantial, says Choate: some $300,000 for books, computers, salaries, and the cost of educational consultants to design the course.

Was it worth it? From an accounts receivable perspective, the ability to fill vacancies has allowed the hospital to drop some $2 million from outstanding A/R. In addition, there hasn't been a real need to go looking outside the hospital for coders — something that would make many hospitals green with envy. "It was a risk," Choate says. "But it was definitely worth it."

Overall Value and Economic Benefits of Improved Retention — Case Study for 180-bed Hospital

Replacement costs as a percentage of total payroll base compensation	22%
Average replacement cost per skilled employee	$28,977.08
Annual replacement cost savings if overall turnover is reduced from 31% to 25%	$814,045
Annual replacement cost savings if overall turnover is reduced from 31% to 20%	$1,424,578.75

Source: Tomorrow's Work Force: A Strategic Approach. VHA, Irving, TX.

Keep what you've got

Turnover is costly, so why not keep the employees you have? **(See chart depicting the cost of employee turnover at one hospital, above.)** In order to keep good coders, employers must first understand why coders leave.

Coding can be very stressful, says Verno of the Medical Association of Billers. "Burnout is a problem. A lot of them have a tendency to burn out in a few years because [coding] is a monotonous task, and it's difficult to read the charts sometimes," he says.

Additionally, money matters. According to AHIMA's on-line membership profile information (data compiled beginning in 2001, representing more than 17,000 people), 42.5% of respondents make between $30,000 and $39,999 per year. Another 17.5% earned from $40,000 to $49,999, while 29.2% earned $20,000 to $29,999. Those who ranked in the $30,000 to $39,999 range were almost equally divided in their work settings among long-term care, physician offices, integrated delivery systems, and acute care hospitals.

"In the past, coders have not been highly paid, but coder salaries are becoming more competitive," says Grzybowski. "The minute you increase salaries, you'll probably see improved retention."

But money alone won't guarantee retention. "To keep coders, you've got to have a good

environment," says Verno. "You've got to put them in a quiet room, keep them away from phones and interruptions so they can meet their quota," he says. "If you pay them a decent salary and give them a decent working environment, they'll stay."

French suggests taking it one step further. "You have to provide some communication system for the coder — some intermediary to ask a question in such a way to get an answer from a physician. Not all coders are capable of or desirous of doing that," he says. Establishing a liaison between physicians and coders is like building a bridge between the clinical and health information management sides of the river. "It all boils down to a communication challenge," says French.

Grzybowski doesn't stop there. To keep good coders, "offer flexible working hours," she says. "Many coders are parents, and many are single parents. Some flexibility in work schedules can create employee loyalty and improve retention and recruitment," she says. "Also, consider offering both part-time and full-time positions."

Telecommuting can be a viable option for coders as well. "There are all kinds of reasons to have at-home coding, but you have to extend the support system to that person working at home," French cautions.

"In some HIM organizations, especially those with electronic records, there may be an opportunity to establish a remote coding program and offer coders the alternative of coding from home," Grzybowski agrees.

The role of incentives

Cohen says part of her firm's success is due to providing coders with various career options. "We don't limit what coders can do: They may code, they may audit, they may take further training," she explains. "We have a nice ladder where somebody can move to a higher level based upon their performance." This tiered promotion apparatus gives employees a concrete way to build their careers.

PHNS invests in continual training programs to help employees ascend this internal career ladder. "We have an in-house training program," says Cohen. "It's great for people to be mentored and receive training from highly seasoned coders."

Continuing education is an area that, while necessary, often gets cut when budgets are tight. "Many hospitals have been forced to cut back on travel budgets for coders to attend industry seminars, but there are less expensive alternatives for coder education," says Grzybowski. She mentions on-line courses, audio seminars, videos, and books as good sources of education. "Providing ongoing training is an important benefit that will help you retain and recruit coders," she says.

In addition to continual training opportunities, Cohen says hospitals should consider offering "a system of recognition for performance."

Grzybowski agrees. "As long as you balance coder productivity incentive programs with a continued emphasis on coding quality, there's nothing wrong with having these programs in place," she says. "Give [coders] an incentive for high achievement as long as that achievement isn't measured in 'increasing case mix,' which can be interpreted as fraudulent upcoding," she warns. ■

Scanning system boosts registration efficiency

Document history available instantly

Registrars at the University Hospital of Arkansas in Little Rock are saving time and paper and creating more accessible records by scanning patients' insurance and health information into the hospital's computer system, says **Mary Nellums**, CHAM, admissions manager.

"We're scanning the documents on the front end, [including] insurance cards, driver's licenses, and any kind of health information, such as letters saying a patient is approved for worker's compensation," she adds.

At present, scanning is being done in central registration, the emergency department (ED), and by two registrars in the preoperative area as a pilot project, she notes. "Outpatient and off-site clinics are not included at this point."

The pilot began in early 2003, Nellums says, with the purchase of small, individual scanners for each registrar's desk. Documents are scanned into different folders, depending on their use, she explains. "Everything that is an insurance document, such as a workers' comp letter or an out-of-network exception, goes into the insurance folder."

Before, registrars put hard copies of the various

documents in patients' files, Nellums says, keeping them for six months to a year.

Under the new system, she points out, registrars can see the history of a document immediately. "After they scan in the driver's license the first time [a patient is registered], when the person comes in again, [the system] will show it has already been copied once."

Registrars still ask for the license, but then compare it with the existing file and scan again only if something has changed, she notes. "It's the same way with insurance cards. If there's a change, [the file] will pop up and show us the previous one."

Changes in insurance coverage thus are preserved in the file in order of occurrence, Nellums explains.

"It's good for the billing department," she says. "[Billers] don't have to call us and say, 'Do you have a copy of the insurance card for this patient?' or 'Do you have a referral on this patient?' Everyone who has EPF [electronic patient file] access can go into the account and pull it up."

Nellums developed a process tree showing which documents should be scanned into which folder. As registrars are scanning a document, she says, they are given the opportunity to select a folder for that document. "They just click, and it scans the document into the folder."

"For two or three weeks, people were putting [documents] in the wrong place or not understanding [the process], but now it's part of the routine," she adds. "It saves me a lot of time, because they know [if something's wrong] I'm going to come back and ask them to fix it."

There previously had been one large scanner in the central registration area, Nellums notes. Besides not being convenient for ED staff or staff in other areas to use, she adds, it often was not operational, so hard copies were routinely made and filed.

With the individual scanners, Nellums says, employees don't have to wait until they have documents from several patients to make a trip to the scanner.

A few days before this year's April 14 deadline for implementation of the Health Insurance Portability and Accountability Act privacy standard, registrars began scanning privacy notices into the system after patients had signed them, Nellums notes.

There was some initial confusion with that process, she says, having to do with indicating the different ways of providing the notice. Registrars may enter "notice provided," "notice mailed," or "urgent situation," for example, to describe the interaction.

The majority of the time, Nellums explains, registrars use "NP," for "notice provided," meaning they gave the notice to the patient, who in turn signed it. "Urgent situation" was created, she adds, to be used when the patient has been in an accident or is unable to acknowledge the notice for some other reason.

"In the beginning, it was hard to choose which one," Nellums says, "and [registrars] would use 'urgent situation' with obstetrics patients."

ED registration revamped

In another innovation involving the ED, University Hospital instituted a new registration process in August 2003, with the dual aim of enhancing customer service and ensuring compliance with the Emergency Medical Treatment and Labor Act.

In the past, Nellums explains, ED patients — except those who had chest pain or another life-threatening condition — came to the registration desk upon arrival, where an account was established and a full registration was done. Patients then were sent to triage, where a nurse evaluated them, she says.

Now all patients go first to the triage nurse, who does a quick registration, obtaining just the patient's name, date of birth, arrival date and time, Social Security number, race, sex, and chief complaint, Nellums says.

The quick registration sheet prints out in the registration area, she notes. The sheet will say, "Patient has gone to Room 7," for example. Registrars actually can see patients walk up for triage, as well, Nellums adds, and often are waiting at the printer so they can go immediately to do the registration.

"Our people go to the bedside and use the update function to fill in the additional registration information," she says.

Providing adequate registration training for the nurses is crucial to making the process work efficiently, Nellums advises. "I'm not sure our nurses received enough training to prevent [the issuing of] duplicate medical record numbers. We did a lot of cleanup on the back end.

"Nurses are geared more toward making sure the patients are taken care of than getting demographic information," she says. "At the beginning,

they felt, 'We don't want to worry about that.'"

Now, she adds, the number of duplicate records has "finally slowed down. We're down to a couple of patients every other day for which we may find a duplicate."

Although instituting a quick registration process had been discussed several times in the past, Nellums says, the plan came to fruition with the arrival of a new ED manager. "It's a big change for the staff not to have the patient come to them, but the majority of them now are geared to do it. They realize it's more patient-friendly to go to the bedside."

Patients, in turn, "seem to feel they're being treated better, having people come to them rather than sitting in front being asked a lot of questions," she notes. "What I've observed is that once they're in a bed and have had their blood pressure checked, [patients] are more prone to go ahead and give all the information more freely."

Once they're more at ease and feel they're being taken care of, Nellums adds, the patients aren't as likely to try to limit the conversation. ■

What you don't know about APCs can hurt you

By **Caral Edelberg**, CPC, CCS-P
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(Editor's note: This is the second of a two-part series on improving emergency department reimbursement under ambulatory payment classifications. Last month, we covered nursing assessment criteria, emergency department chargemasters, billing for evaluation and management services, and observation services. This month, we cover staff physicians, supplies and medications, local medical review policies, and proper use of modifiers.)

Although ambulatory payment classifications (APCs) require the coordinated efforts of multiple departments, the emergency department (ED) manager must take a leadership role in addressing the multitude of issues that require ongoing attention.

Because the instructions and clarifications change almost daily, it is crucial that Medicare's transmittals and memoranda be monitored at least weekly to ensure that the latest instructions are incorporated into the ED's coding and billing program. Generating a general task list for these items can go a long way toward improving ED revenue and ensuring that claims are sent correctly.

Use these strategies to significantly improve your reimbursement:

• **Ensure accurate capture of services provided by staff physicians.**

Under Medicare payment guidelines, services performed by ED physicians and other medical staff consultants should be identified. Proper billing of each service requires that each physician (as well as nursing staff) complete the clinical record with detailed documentation of the service.

This documentation allows coders to differentiate services performed by the ED physician from those performed by consultants, and it facilitates identification of the support services provided by ED staff. These "over and above" support services provided separately from the specific procedure are used to identify the appropriate evaulation and management code level.

• **Make sure supplies are documented separately as appropriate.**

APC payment for procedures and other medical services includes the value of most associated supplies and medications. Certain incidentals may be separately payable, however. Billing for the procedure generally ensures compensation for all related products. However, additional items, such as blood and blood products, should be detailed on the UB-92 claim form to ensure that these can be paid when appropriate.

• **Provide thorough documentation.**

Payment for many diagnostic tests and other services is determined by medical necessity criteria developed by Medicare under the Local Medical Review Policies program. This program bases payment on the reporting of one or more diagnosis codes that illustrate the medical necessity of the service.

Because coding is determined by the documentation provided by clinical providers, it is important for providers to understand how "words on the record" translate to "codes on the claim form"

and generate payment to the facility.

This is not to say providers should attempt to document services to increase the likelihood of meeting medical necessity criteria when the clinical indications are not present. However, documentation should be complete and thorough to provide a detailed discussion of signs, symptoms, underlying medical complications, historical data, ED course, diagnostic tests and results, and final diagnosis to establish the medical necessity of services performed in the ED setting.

• Use modifiers properly.

Numerous modifiers are required to identify services for payment, increase levels of specificity, and describe situations that typically are not included in the description of a service.

Without maintaining a current directory of these modifiers and their descriptions to ensure their correct use, claims may not pass billing edits and ultimately may be rejected for payment.

Three modifiers critical to ED payment are -25, defined as a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service"; -27, defined as "multiple outpatient hospital evaluation and management encounters on the same date"; and -59, required when a bundled service is performed separately and is payable as a separate procedure.

• Understand which services can be billed separately.

Medicare requires that providers follow established guidelines when billing for procedures and services. In each "package," Medicare includes numerous associated services that cannot be billed separately. However, in certain circumstances, although certain services are "bundled" into the overall service package, they must be identified separately as markers for medical necessity.

For asthma observation, pulse oximetry must be separately identified as a "marker" in order to pass edits for observation payment, although it is not separately reimbursable.

It is imperative that coders understand the rules governing when to package services and when to identify them separately. The ED's role is to ensure that documentation provides the needed detail to allow coders to identify these services accurately.

• Document accurately for ED injections, intravenous lines (IVs), and infusions.

Coding rules for injections, IVs, and infusions continue to confuse coders and providers. The required codes can be Current Procedural Terminology (CPT) codes or specially assigned Healthcare Common Procedure Coding System (HCPCS) codes with unique definitions for their use.

For example, Q0081 describes infusion therapy performed in the ED or other outpatient site on a per-day, per-diagnosis basis, regardless of the number of infusions administered. This code does *not* include the drugs administered that must be identified separately.

Injections also are additionally recognized for Medicare payment but are identified with CPT codes such as 90782 (therapeutic, prophylactic, or diagnostic injection); 90783 (intra-arterial); 90784 (intravenous); and 90788 (intramuscular injection of antibiotic).

As type "X" procedures, payment is allowed under APCs. The number of injections must be accurately identified. Coding errors often are made, however, when billing for drug dosage does not follow APC allowable units. ■

Think you're exempt from the therapy cap?

Think again; satellite clinics may not count

Here's an issue you may not have considered amid all the headaches of Medicare's pending $1,590 outpatient therapy cap. The Balanced Budget Act of 1997 built in a safety valve for patients who exceed the therapy cap; they still can receive services at an outpatient hospital department. But facilities must apply for the exemption, and the requirements are extensive.

"Congress was told there were a number of hospitals building satellite clinics that were not attached to the hospital and may not even be on the same campus. The question had to be asked, 'Is that a hospital outpatient department?'" says consultant **Ken Mailly**, PT, of Mailly & Inglett Consulting in Wayne, NJ. "So they created the notion of a provider-based entity, which could still be considered part of the hospital so long as it met certain requirements."

The requirements take up a 30-page application and include such items as having a physician on site, having an arrangement to take care of emergency needs without calling 911, and

having the same governance and payroll as the hospital. "This isn't the only requirement, but for instance, if you have to call 911 when someone has a heart attack at your facility, you're freestanding," Mailly says. "In a hospital, you would just send them over to the emergency room. If you're 10 miles away, you're going to need an ambulance. If you're a freestanding entity, you're subject to the cap just like everybody else is."

The provider-based rules make no difference without the cap, Mailly says. But with the pending implementation of the cap, they do make a difference. "This becomes a very important issue. Nobody's talking about this yet, and it's simply because, quite frankly, they forgot," he says. "The focus was very much on the cap and whether it would be re-implemented. The whole issue of provider-based entities just slipped off the radar screen. Now — guess what — it matters again."

The way a facility is originally certified by the Centers for Medicare & Medicaid Services (CMS) is how it will remain certified unless a new application is submitted, Mailly says. "If you've changed something, you have to come back and say that to CMS. If you don't do that, the way they certified you 10 years ago is how they recognize you now."

Fraud is an issue here, Mailly says. "If you build a satellite one mile away and pretend it's attached to the hospital, that's fraud."

CMS' instructions on this issue (read them at www.riverbendgba.com/prov/audit&reimb/pbinst.doc) say a facility is not entitled to be treated as provider-based just because the main provider is. "The facility or organization must be determined by CMS to be provider-based before the main provider bills for services of the facility or organization as if it were provider-based, or before it includes costs of those services on its cost report," the instructions read. "A facility that is not located on the campus of a hospital and is used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a freestanding facility, unless it is determined by CMS to have provider-based status."

Even if a facility does meet the requirements and is able to see patients who would otherwise have their services capped, that doesn't solve the problem, says **Tracy Gregg**, PT, president of SunDance Rehab in Alexandria, VA. "If a skilled nursing facility patient had a family member who could take them to the hospital, they could get therapy. But they would have to be transported, and that's difficult for elderly patients," she says. "It's brainless when you have a therapist right next door to their room."

Gregg says this issue is what bothers her the most about the cap. "The ones it impacts are the ones who are least able to advocate for themselves. It's only a problem for people who don't have the ability to move around and get to a hospital," she says. "We have a decision to make as citizens about how we'll take care of our elderly." ■

Take a deep breath; then prepare for EDI deadline

Testing should already have begun

Just as hospitals take a breath after rushing to make sure they are in compliance with the privacy standard, it's time to get in gear for the upcoming transaction code-set deadline mandated by the Health Insurance Portability and Accountability Act (HIPAA), which is Oct. 16, 2003.

The HIPAA transaction standard establishes the content and format to be used in the electronic submission of claims and other administrative data transmitted between health care entities, including providers and health plans.

Although that deadline is a few months away, **Gillian Cappiello**, CHAM, senior director for access services and chief privacy officer at Chicago's Swedish Covenant Hospital, points out that hospitals were to begin testing their electronic data interchange (EDI) processes on April 16, 2003.

"You have to have a file or something out there to start sending to clearinghouses or [other health care entities]," she says. "We use a company called Nebo Systems Inc. [based in Oakbrook Terrace, IL] for on-line insurance verification and eligibility. It has a product called eCare that puts edits on the billing side. So we have to make sure [that company] is compliant."

Most of what had been holding up progress is that Medicare and most state Medicaid programs were not ready to proceed with EDI, Cappiello notes.

Liz Kehrer, CHAM, system administrator for patient access at Centegra Health System in McHenry, IL, has been focusing extensively on

HIPAA compliance preparations.

One of the paths she followed during her research into transaction and code-set regulations began with the reference in a HIPAA guidebook to ISO (International Organization for Standardization), the Geneva, Switzerland-based organization that was cited as the source for the codes to be used in referring to various countries in electronic health care transmissions.

"Every business that interacts with the processing of the claim must follow a standard format," Kehrer notes. That ensures that all health care entities communicating about, say, the hospital care received by a person on vacation or someone studying abroad, are speaking the same language, she adds. "When submitting a claim, they all must refer to a country with the same identifier."

The most difficult thing about the HIPAA regulations, Kehrer points out, is that they don't explain how to go about doing that. While communicating with her peers across the country on a listserv, she discovered that many were not aware of the HIPAA guide from Washington Publishing Co. that has been instrumental in her preparation.

It's titled "National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional," and is available through www.wpc-edi.com as either a bound document or an electronic document, Kehrer adds.

By using an Internet search engine, Kehrer adds, she ultimately found that the ISO country codes are kept current by the United Nations, which has a listing of codes and abbreviations on its web site.

"We had to go into our computer system and update [the abbreviations] we had, so [communications are accurate] if we have a patient from a particular country who has insurance in that country," Kehrer says.

The guide also addresses such issues as what information in the UB-92 paper claim needs to be passed over to the electronic claim, she adds.

"Another piece is the requirement for the weight of a newborn," Kehrer points out. "Some [providers] may be using pounds, some grams, but remember that because we're standardizing, the information needs to be on the claim in consistent format.

"We're educating the staff in our obstetrics area that when a newborn is registered, the weight is part of that communication," she adds. ■

Technology helped facility with HIPAA compliance

Train-the-trainer approach saved money

For Baystate Health System, a $1 billion integrated health system operating in western Massachusetts, compliance with the privacy standard of the Health Insurance Portability and Accountability Act (HIPAA) has been seen as more than a technology issue. It also is a major cultural and operational issue that has an effect on system-wide operations and the way the system and its staff interact with patients.

Baystate HIPAA project manager **Jim DiDonato** described the organization's compliance efforts in a presentation at the Sixth National HIPAA Summit in Washington, DC. DiDonato said Baystate's approach to following the regulations includes technology solutions, new and revised policies and procedures, new and revised contracts, workforce training, and ongoing maintenance and reinforcement.

Named one of the nation's 100 leading integrated health care networks, Baystate is based in Springfield, MA, and includes an academic medical center, two community hospitals, numerous outpatient facilities and programs, an ambulance company, home care and hospice services, an employed primary care provider group with multiple sites, and other support services.

Included in Baystate's HIPAA compliance planning were the medical practices and ambulatory care services, administrative support, the ambulance company, the three hospitals, visiting nurse association and hospice, infusion and respiratory services, and the employee health plan. Not included were the for-profit HMO in which Baystate has a majority interest and other affiliated organizations that are joint ventures.

Assessment identified many gaps

DiDonato said a steering committee and project teams initially performed an assessment that identified gaps between the HIPAA regulations and Baystate's current practices. The security and privacy assessment revealed many items needing to be addressed, he says, such as contracts that were not compliant, patient consents and authorizations not compliant, patient information found in the trash, patient charts exposed

on hospital hallway walls and counters, fax machines and printers left unattended, medical records not adequately secured, computer terminals viewable by the public, employees and physicians not aware of existing policies, a need to designate a security officer and a privacy officer, a need to conduct security certification, doors left unlocked in medical practices, hospital stairwells, and other "secure" areas, and a need for new policies governing passwords and workstation use.

Following the assessment, the committee agreed on a strategy to examine compliance options with a focus on costs, risks, and resource needs. They developed and implemented work plans to obtain compliance by specified dates, and they established accountabilities and processes to ensure ongoing compliance.

With more than 8,200 employees spread across four states, Baystate made a significant effort to help people become aware of HIPAA's requirements and the activities that would be undertaken to achieve compliance. The purpose of administrative simplification under the HIPAA regulations was stated as "improving the efficiency and effectiveness of the health care system by standardizing electronic data interchange for administrative and financial transactions, and enhancing the security and privacy protections over patient information."

Presentations to many groups

Presentations outlining the purpose, project organization, and schedule were made to boards of trustees and the board compliance committee, senior executives, management teams from operating units, community hospital medical staffs, teaching hospital surgeons and residents, community practice managers, and others.

Consultants were brought in to train selected Baystate staff in a train-the-trainer approach that saved money relative to using consultants to train all staff. A budget in excess of $1.6 million was set for both capital costs and operating costs related to necessary changes.

DiDonato shared with the Summit audience Baystate's security and privacy workplans and time charts showing completion dates. He also provided information on the approval process used for new privacy policies, and a listing of the policies and communications that were involved.

Training included an initial heads-up session that HIPAA was coming, followed by "HIPAA Lite," Phase I training that included a manager's guide, a handbook for employees, a quiz, and an educational video tape. Phase II provided specific training on privacy policies and included a manager's guide, an employee handbook, and use of Baystate's Intranet for policies and forms and other resources. Role-playing examples were built into the privacy training.

According to DiDonato, the group planned to assess the situation after its April 14 compliance date to see what had been missed and which procedures were not working as planned. An additional follow-up is scheduled for fall 2003, including compliance reviews by the system privacy workgroup and any necessary modifications of policies, procedures, or processes. ■

Payment processes could be changed under HIPAA

Encryption requirements eliminated

Medical Banking Project founder **John Casillas** says one of the changes in the final Health Insurance Portability and Accountability Act of 1996 (HIPAA) security rule eliminated any requirement to encrypt electronically transmitted protected health information, even over the Internet or other open networks. Encryption is now an "addressable" implementation specification, which means a provider or payer organization must determine whether it is appropriate to use the technology.

Encryption was one of many required procedures or technologies in the proposed rule that now are addressable as the Department of Health and Human Services seeks to make the final rule more scalable for health organizations of all types and sizes.

Encryption still a good idea

Casillas says many providers implementing the security rule likely will decide encryption is a reasonable and appropriate way to protect data, but their trading partners may not agree. One area providers will have to consider is the electronic transmission of payment information, including protected health information, between providers, payers, and financial institutions.

For instance, an insurer may electronically

transmit to its bank a payment file containing payment instructions for a batch of claims from multiple providers. The bank will transmit the file to the banking industry's automated clearinghouse network, which transmits the payments to the appropriate banks serving the providers listed in the payment file. The individual banks then will transmit electronic remittance advices that contain protected health information to their provider customers.

Technically, under the final security rule, none of these transfers of information need to be encrypted. But to protect themselves from liability, providers will have to demand that their payers and financial institutions adequately encrypt the data. "That's inevitable," Casillas has said. "Providers are the ones on the line and will want to make sure their data is protected throughout the entire banking system." ■

New privacy issue not about HIPAA

CA law affects Blue Cross policies

There's a new patient confidentiality development that HIM personnel should know about, and it has nothing to do with the Health Insurance Portability and Accountability Act privacy standard.

A California law that took effect July 1, 2002, and is being implemented in phases puts measures in place to protect the integrity of the Social Security number (SSN), among them the prohibition of using the SSN as an insurance identifier, says **Liz Kehrer**, CHAM, system administrator for patient access at Centegra Health System in McHenry, IL.

In anticipation of a Jan.1, 2004, deadline for entities providing or administering health care or insurance, Blue Cross Blue Shield (BCBS) is issuing insurance cards for new accounts/policies in 2003 in which a generic number, not the subscriber's SSN, is used as an individual identifier, Kehrer explains. Beginning July 1, 2005, those entities must comply with all requirements of the law for all individual and group policyholders in existence prior to Jan. 1, 2004.

"Managers need to start looking at having registrars really double-check those Blue Cross cards and the accuracy of that subscriber ID number," she cautions. "We're already seeing instances in which the change has been made."

What can happen, Kehrer notes, is that with all other insurance information — group number, mailing address, etc. — being the same as on a patient's last visit, the registrar may neglect to make note of the different subscriber identifier, thus resulting in inaccurate claims.

Her research on the subject, she adds, suggests that it is only a matter of time before similar laws protecting the SSN are enacted in other states.

Under the California law, which is found in Civil Code Sections 1798.85-1798.86 and 1786.60, companies may not do any of the following:

- post or publicly display SSNs;
- print SSNs on identification cards or badges;
- require people to transmit an SSN over the Internet unless the connection is secure or the number is encrypted;
- require people to log onto a web site using an SSN without a password;
- print SSNs on anything mailed to a customer unless required by law or the document is a form or application.

Providing background on the unique status of the SSN as a privacy risk, the Office of Privacy Protection in the California Department of Consumer Affairs explains on its web site that the SSN was created by the federal government in 1936 to track workers' earnings and eligibility for retirement benefits.

Now, however, the SSN is used in both the public and private sectors for myriad purposes totally unrelated to that original purpose, the site points out. That broad use and public exposure of SSNs, it adds, has been a major contributor to the tremendous growth in recent years of identify theft and other forms of credit fraud.

For more information, go to www.cdc.gov/nchs/. ■

COMING IN FUTURE MONTHS

- Nursing documentation for inpatient holds
- Update on ED reimbursement for E/M services
- Expert advice on denial management
- Universal consent form useful, but limited

NEWS BRIEFS

More help sought for rural hospitals

The Rural Community Hospital Assistance Act, introduced in late April by Sens. **Sam Brownback** (R-KS) and **Ben Nelson** (D-NE), could give relief to financially troubled rural hospitals.

The act enhances the Critical Access Hospital program, which provides special Medicare reimbursement for certain rural hospitals with 15 or fewer inpatient beds; helps rural hospitals with 50 or fewer inpatient beds by allowing them to use cost-based reimbursement instead of the prospective payment system; ensures that these hospitals will receive 100% compensation for treating Medicare patients who fail to supply their copay; and provides additional funding for technology and infrastructure needs.

The bill is a companion measure to H.R. 937, introduced by Reps. **Jerry Moran** (R-KS) and **Jim Turner** (D-TX) in February.

For more information, go to www.aha.org. ▼

HCA changes policies to give more financial aid

The Nashville, TN-based hospital chain HCA recently announced plans to change its charitable care policies to provide financial relief to more of its charity patients and give need-based discounts to uninsured patients who receive non-elective care at its hospitals.

The planned changes, which are subject to approval by the Centers for Medicare & Medicaid Services, would allow patients receiving non-elective care at an HCA hospital who have income at or below 200% of the federal poverty level to be eligible for charity care, a standard HCA said about 70% of its hospitals already have been using.

HCA also issued a revision of its criteria for filing liens or garnishment of wages of patients who have not paid their hospital bills. The policy prohibits placement of liens on primary homes worth less than $300,000 or garnishment of wages for patients who have a proven inability to pay.

For more information, visit the HCA web site at www.hcahealthcare.com. ▼

HHS funds centers to serve uninsured

Thirty-one new community health centers are to be funded through $16 million in grants recently awarded by the U.S. Department of Health and Human Services (HHS).

The centers are expected to provide health care services to an estimated 254,000 people, including many who are uninsured, according to an announcement by HHS.

The grants are part of a five-year Health Centers Initiative by the Bush administration to add 1,200 new or expanded health center sites by 2006. The centers will provide preventive and primary care services to patients regardless of their ability to pay.

For more on the grants, including a list of recipients, go to www.hhs.gov. ■

DRG CODING ADVISOR®

Critical care billing requires careful documentation

Assessment of patient condition and treatment received are determining factors

By **Myra Wiles**, CPC
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When does critical care become just another emergency department (ED) visit? When you fail to document it properly. You may do all the right things for a patient in crisis, but if the paperwork isn't done properly, you don't get paid for your efforts.

Many physicians think that if the patient is in the intensive care unit (ICU) or critical care unit (CCU), they should bill those services with critical care codes. Others imagine that you can bill critical care in the ED if the patient dies or comes in via ambulance in critical condition. This is not true. Critical care is not a *place* of service; it is a *type* of service. While critical care most often occurs in the ICU or the CCU, it can occur in the ED, on a regular hospital floor, or in a skilled nursing facility. I know of one instance when it occurred in a clinic waiting room. And while the patient's condition must be critical (or imminently so), that is not the only criterion to be met to bill critical care services.

Highly complex decision-making required

Critical care codes should be used to describe situations in which the physician is personally caring for or directing care of a patient that is critically ill or injured. There should be highly complex decision-making required to assess, manipulate, and manage this patient, who likely has impairment of one or more vital organ systems and faces imminent life-threatening deterioration without your involvement.

Proper documentation is not difficult, but it is seldom found in the medical record. There are three things that must be well-documented in order to bill critical care:

- **Patient condition.** The chart should show that the patient's condition is deteriorating or is likely to do so without intervention. The auditor will look for such conditions as circulatory failure; central nervous system failure; shock; or renal, hepatic, metabolic, or respiratory failure.
- **Time spent in care.** How long were you there? The time doesn't have to be continuous, but it must exceed 30 minutes for the day during which you devoted your full attention to the patient. You can show this as your exact times in and out, or you can approximate how long you were involved in care. (Caution: Don't rely on your nursing staff or anyone else to document this fact for you.)

Time spent outside unit doesn't count

What activities can be included in the time calculation? Services such as:

— Time spent at bedside caring for the patient.

— Time spent in the unit or at the nurse's station engaged in work directly related to care of the patient. This includes reviewing test results, documenting charts, or discussing care with other medical staff. (Note: Time spent in activities that occur outside the unit or off the floor may *not* be included in the critical care calculation, because you were not immediately available to the patient).

— If the patient is unable or clinically incompetent to participate in discussions, time spent with

family members or other decision-makers to obtain a history, review prognosis, or discuss treatment limitations or options should be included, *provided that the conversation bears directly on the management of the patient*. However, time spent in activities that do *not* directly contribute to care of the patient, such as team conferences, courtesy, or compassionate care for the family, may not be included — even if they happen in the unit.

— Time spent performing procedures that will be separately reported (such as CPR, endotracheal intubation, insertion of Swan-Ganz catheter, etc.) should be excluded from your time calculation.

• **Activities involved.** It's not enough to show the patient's condition was critical. Critical care can be billed only if both the patient's condition and the treatment provided meet the above criteria. Thus, your note should specifically state which of the above services were provided during your encounter.

> Time spent in activities that do *not* directly contribute to care of the patient, such as team conferences, courtesy, or compassionate care for the family, should not be billed as time spent providing critical care.

Bill it right

Some facilities keep very detailed logs of activities occurring during critical care times, much like the Code Blue logs that are kept. Those critical care notes document who was present and what was being done. While this certainly helps, it should not be relied on to document your physician services, because many of those services are provided away from the patient bedside and without involvement of other team members. Thus, the physician should record in the progress note those facts necessary to support his or her services.

Codes 99291 and 99292 should be used to bill for critical care activities. The CPT has an excellent chart that shows what codes should be billed based upon how long you were with the patient. Use the CPT chart, but keep these rules in mind when billing those codes:

— Only one physician can bill for a specific episode of critical care. This is true even if two physicians of different specialties are involved at the same encounter. If two physicians bill for different episodes of critical care on a given day, they should be prepared to submit notes documenting that care was provided at separate times. (Don't forget that different physicians of the same specialty in the same clinic are considered one physician.)

— Code 99291 represents the first hour of critical care and should be billed only once per day by the physician.

— Do NOT bill extra for services such as reading chest X-rays or EKGs, ventilator management, pulse oximetry, blood gases, analyzing data stored in computers, gastric intubation, temporary transcutaneous pacing, and insertion of simple vascular access devices like IVs.

— DO bill extra for services such as CPR (that you perform), endotracheal intubation, insertion of complex vascular access devices, and similar services. Be sure to add modifier -25 to the critical care codes if you bill any of these procedures to avoid denial of the critical care as a bundled service.

— Don't bill separately for a hospital visit on this date *unless that other visit occurred at a separate encounter during the day that was not included in this critical care calculation*. Such a visit must be fully documented to support the evaluation and management code you bill for the visit.

— Be sure the diagnosis code you use on your claim reflects the severity of the patient's condition. This may have a bearing on coverage.

— Don't bill 99291 or 99292 for time the physician spends during the transport of critically ill or injured patients to another facility. Instead, use 99289 and 99290.

Sample note

"Patient critical with multiple trauma due to MVA. I directed CPR and inserted T-tube. X-rays and labs reviewed. Orders written and IVs placed. Discussion with family about pt's condition and decision made to proceed with care. Calls were made requesting consults from orthopedics, neurosurgery, and pulmonology. Dr. Smith called to admit. Total time in care: 80 minutes excluding time spent in above procedures."

What can you bill? You bill for:

- CPR (92950);
- placement of T-tube (31500);
- critical care (99291-25 and 99292-25). ■