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# HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

## INSIDE



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American Health Consultants® is A Medical Economics Company

# Ding-dong! JCAHO calling: No advance notice on unannounced surveys

*OIG report finds 'major deficiencies' in oversight*

Hospital compliance officers and health information professionals who depend on advance notice when preparing for an accreditation survey had better be getting their Ps and Qs in order.

Not only has the Joint Commission on Accreditation of Healthcare Organizations increased the time period surveyors can appear unannounced at a health care facility, but surveyors also are expected to switch to a more regulatory mode of oversight.

In early August, the Oakbrook Terrace, IL-based Joint Commission announced that effective Jan. 1, 2000, health care organizations will no longer receive advance notice for random unannounced surveys. This policy does not apply to laboratories. In addition, the surveys will be conducted nine to 30 months following the triennial full survey.

Previously, the Joint Commission conducted unannounced surveys at randomly selected accredited organizations at the midpoint of their accreditation cycles. It also provided 24 hours advance notice of these surveys and communicated the standards to be reviewed prior to the survey.

> *"I think the question is — What is the value of the collegial approach vs. the 'gotcha' policeman approach?"*

Now the scope and focus of the review will vary from organization to organization and will be based on information relating to recommendations made during the organization's previous triennial survey, known sentinel events, and other relevant information regarding the organization's performance.

The Joint Commission also will be pilot testing the extension of the on-site survey to evening, night, and weekend periods. The pilot testing will begin during the last quarter of 1999 and extend through the first quarter of 2000 and will involve a 10% sample of the triennial accreditation surveys during this period.

Joint Commission president **Dennis S. O'Leary**, MD, says the change in policy stems from research conducted with accredited organizations, various groups who rely on Joint Commission accreditation decisions, and Joint Commission surveyors. "We believe they will make our overall accreditation process more meaningful and credible."

## OIG finds oversight deficiencies

The Joint Commission announcement, however, came shortly after the publication of a series of four reports that cited major deficiencies in the external oversight system of hospitals.[1-4] The two-year study was conducted by the Health and Human Services' Office of the Inspector General (OIG) in Washington, DC.

According to the report, the nation's 6,200 hospitals rely on two types of reviews to meet the requirements for participating in Medicare. Eighty percent of the hospitals are accredited by the Joint Commission; the remainder are certified by state government agencies.

In the reports, the OIG identified these deficiencies in current accreditation and certification practices:

❒ Although Joint Commission surveys help reduce risk and foster improvement in hospital care, they are unlikely to detect substandard patterns of care or individual practitioners with questionable skills, the reports say. "Quick-paced, tightly structured, educationally oriented surveys provide little opportunity for in-depth probing of hospital conditions or practices."

❒ State agencies rarely conduct routine, not-for-cause surveys of nonaccredited hospitals. About 50% of nonaccredited hospitals in 1997 had not been surveyed within the three-year industry standard. In some cases, nonaccredited hospitals, most in rural areas, have gone as long as eight years without a survey.

❒ The hospital review system has been shifting toward a "collegial mode of oversight," which focuses on education and improved performance, and away from a "regulatory mode of oversight," which focuses on investigation and enforcement of minimum requirements. This shift could result in "insufficient attention to regulatory approaches intended to protect patients from poor care," the reports state.

The OIG also criticized the Health Care Financing Administration (HCFA) in Baltimore, saying it did little to hold either the Joint Commission or the state agencies accountable. In dealing with the Joint Commission, HCFA is "more deferential than directive," the report added.

As part of its recommendations, the OIG advised HCFA to "steer external reviews of hospital quality to ensure a balance between the collegial and regulatory modes of oversight."

The American Hospital Association (AHA) in Chicago, however, is concerned about the shift to the regulatory mode of oversight. "I think the question is — What is the value of the collegial approach vs. the 'gotcha' policeman approach?" asks **Mary Grealy**, JD, senior Washington, DC, counsel for the AHA. "It's a fine balance, and we need to collaborate on improving things."

In its reports, the OIG says HCFA should negotiate with the Joint Commission to accomplish the following:

❒ Conduct more unannounced surveys.

❒ Make the "accreditation with commendation" category more meaningful or abolish it.

❒ Introduce more random selection of records into the survey process.

❒ Provide surveyors with more context (information?) about hospitals they are surveying.

❒ Determine year-to-year survey priorities.

❒ Conduct more rigorous review of hospitals' continuous quality improvement efforts.

❒ Enhance surveyors' ability to respond to complaints during surveys.

The Joint Commission has since announced that the accreditation with commendation policy is under review by the accreditation committee of its board of commissioners. The committee is considering alternatives for recognizing outstanding organizations; the board is expected to review and act on the committee's final recommendations in November.

## COMING IN FUTURE MONTHS

- Software allows sign-in to multiple applications
- Providers prepare command centers for Y2K
- How indestructible are electronic media?
- The confusion over observation status
- How secure are electronic signatures?

The OIG also encouraged HCFA to take the following measures:

❒ **Provide performance feedback and policy guidance to the Joint Commission and state agencies.**

In response, HCFA says it is in the process of developing new, evidence-based quality measures. This initiative is part of HCFA's "Hospital Quality Oversight Plan." HCFA has directed peer review organizations to establish and develop measures that will provide benchmarks of quality hospital care.

Three of the performance measures under development include the rate of beta-blocker drugs prescribed for patients hospitalized after a heart attack, mortality rates following surgery, and infection rates following surgery.

❒ **Increase public disclosure of the performance of hospitals, the Joint Commission, and state agencies.**

HCFA says it is currently exploring several approaches to provide more information to Medicare beneficiaries and other consumers. One pilot project will examine how to develop and distribute hospital performance data so that consumers can compare the quality of care among hospitals.

❒ **Determine an appropriate minimum cycle for conducting certification surveys on nonaccredited hospitals.**

HCFA says it plans to determine this cycle.

HCFA also plans to revise its condition of participation regulations "to reflect advances in quality improvement that are occurring in both the public and private sectors," says **Nancy-Ann DeParle**, HCFA administrator. The final regulations are expected to be completed by fall 2000.

*(Editor's note: The OIG's four reports are available on the OIG Web site at www.os.dhhs.gov/oig.)*

### References


1. Office of the Inspector General. *The External Review of Hospital Quality: A Call for Greater Accountability*. OEI-01-97-00050. Washington, DC; July 1999.
2. Office of the Inspector General. *The External Review of Hospital Quality: The Role of Accreditation.* OEI-01-97-00051. Washington, DC; July 1999.
3. Office of the Inspector General. *The External Review of Hospital Quality: The Role of Medicare Certification.* OEI-01-97-00052. Washington, DC; July 1999.
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# Be proactive in JCAHO's questions about Y2K prep

*Don't make surveyors look for evidence of a plan*

Don't be caught without a plan. If Joint Commission on the Accreditation of Healthcare Organizations surveyors don't see ample evidence of year 2000 (Y2K) preparation this year, hospitals may find themselves receiving type I recommendations. That's why hospitals should bombard surveyors with Y2K information before surveyors even ask, information and compliance managers say.

The intent statements of standards in the "Leadership", "Management of the Environment of Care", and "Management of Information" chapters in all Joint Commission manuals call for an organizational strategy to address issues that would include Y2K compliance. The Joint Commission advises hospitals to identify and assess the implications of Y2K on their operations, including computer systems, medical equipment, and utility systems; and to determine whether suppliers are also addressing the Y2K issue.

In its surveys, the Joint Commission is trying to judge hospitals' awareness of potential Y2K problems and to ensure they have developed a plan, says **Susie McBeth**, associate director in the department of standards for the Joint Commission.

Surveyors are asking questions at interviews such as, "What are you doing to protect and ensure continuing accessibility to information in the year 2000?" she says. "They'll ask the leaders what resources they have provided for this. How have they educated their staff about Y2K? Have they checked with their suppliers [about Y2K preparation] — what are they doing? Can they still supply you?"

### Emphasis on supplies and contingencies

When preparing for 1999 surveys, the Joint Commission said it would focus on evidence that hospitals or health care organizations have a Y2K program in place and are aggressively pursuing a successful conclusion to year 2000, says **Dwain Shaw**. In 1998, Shaw, who is director of information services and year 2000 project director at the Medical College of Georgia in Augusta, was

asked to join the faculty of the Joint Commission as its year 2000 spokesman. He has traveled with peers from several health care organizations doing presentations and educational programs for the Joint Commission.

"The Joint Commission said it would be placing specific interest in supply inventories and project plans and contingency plans," he adds.

In a statement about Y2K preparation, the Joint Commission said it would ask hospitals if they are involved in these activities:

1. **engaging in efforts to identify their Y2K vulnerabilities;**

2. **upgrading software programs and equipment to make them Y2K-compliant;**

3. **identifying corrective manual alternatives when necessary;**

4. **considering possible community disaster scenarios related to Y2K in their emergency preparedness planning;**

5. **developing contingency plans to handle Y2K disruptions, which are not identified ahead of time or are outside the hospitals' control.**

Surveyors will look at any Y2K plan that the hospitals provide, McBeth says. Surveyors, however, will not critique the adequacy of the plan. "It's mainly that they are looking for the absence or presence of a plan." If surveyors do not make a recommendation on a plan, this does not mean that they are endorsing it, she adds.

Questions asked by the surveyor will be dependent upon his or her technical knowledge. Shaw says. "[Surveyors] who are computer literate will probably get into this [issue]. [Surveyors] who are not will look for the evidence, and if it's there, that's great. If it's not there, they have been instructed to look and dig a bit more for the evidence."

Shaw encourages hospitals to be proactive in their surveys. Don't make surveyors look for evidence of Y2K preparation; show it as they walk in the building, he says. "It can be something as simple as a countdown sign that changes every day."

Surveyors accrediting Chestnut Hill Healthcare in Philadelphia did not ask to see a formal Y2K plan, says **Jane B. Danihel**, RN, BSN, corporate compliance officer and risk manager. The plan, however, was included in the documents given to the surveyors for review.

In the information and environment of care interviews, hospital staff were asked what their Y2K plans entailed, what testing has been completed, how they determined if equipment was Y2K-compliant, and what they did about equipment that was not compliant.

Chestnut Hill had formed a Y2K task force two years ago that has since formalized into a committee. Danihel says the surveyors reacted positively to the organization's activities.

In its survey, the Community Health System in Fresno, CA, wanted to show surveyors that it was treating Y2K like a quality improvement project, says **Terri Lutz**, RN, director of information systems. Like Shaw advises, she gave surveyors plenty of information about the organization's Y2K strategy at the beginning of the survey.

"I felt that if we gave [surveyors] enough information ahead of time, before they actually went out and did the survey, they wouldn't get confused as to what we were doing. They'd be able to validate that we were on track," she says. Inundating surveyors with data up front also made them feel comfortable that the organization was striving to do as much as humanly possible to make sure it finished in time, she adds.

Lutz tried to make the Y2K effort apparent visually, too, such as placing Y2K stickers on computers, which read "Y2K compliant," she explains. "It validates what we are already talking to surveyors about."

## *Show surveyors you're serious*

Lutz and staff went over the Y2K project with the Joint Commission surveyors, talking about the project's status, time lines, organization, and chain of accountability. Surveyors responded with questions about contingency planning but didn't seem interested in ways to validate the truth of the information in the plan.

"I think the main thing they were looking at was to make sure that we were not only aware [of Y2K], but that we were following through with checking all of our equipment and software and that we had a plan in place," Lutz says.

She advises organizations preparing for an upcoming survey to do a presentation about their Y2K plans. "You have to do various performance improvement (PI) presentations anyway. Doing it in a PI format shows that you take it seriously."

The presentation at Community Health System

was so comprehensive that the surveyor in the information management interview said that most of his questions about Y2K planning had already been answered. "He talked a little bit about security, and we left. The whole interview lasted about half an hour," Lutz adds.

To prepare for next year's Joint Commission surveys, especially if more changes are made in the survey process, Shaw recommends that hospitals prepare for the possibility of sentinel events related to Y2K. **(See related cover story.)**

As defined by the Joint Commission, a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

As part of the preparation, organizations should train a Y2K team in the possibility that a sentinel event does occur or can occur, Shaw says. "I recommend that as part of any organization's preparations process and to ward off the litigation." If such an event does occur, the team can then do a root cause analysis, which is the procedural follow-up to a sentinel event.

"This gives you a pretty good idea of what went wrong, first of all," he explains. "Secondly, you can cite the training that you have given to this specialty team in year 2000 failures. Thirdly, it will play well in court." ■

# What's in a name? AHIMA votes on title changes

*HIM professionals say industry needs education*

What's in a name? A lot, if you listen to the debate about the possible change in certification titles for health information management (HIM) professionals.

This month, the 1999 House of Delegates for the American Health Information Management Association (AHIMA) in Chicago will likely vote on new HIM certification titles. The current titles are registered record administrator (RRA) and accredited record technician (ART).

## Making the title fit the job

Last spring, the AHIMA board of directors, along with the council on certification, decided upon new titles: registered health information administrator (RHIA) and registered health information technician (RHIT). The word "registered" was chosen as the most appropriate designation for HIM certifications. "Health information" was said to describe the domain of the profession's knowledge and expertise, and "administrator" and "technician" were added to lend a sense of continuity to the new titles.

Before voting on the acceptance of the new titles, the association and its 186 delegates will hear the opinions of AHIMA members on the issue. If the changes are affirmed, current RRAs and ARTs would not have to reapply for their credentials, retake a certification examination, or participate in classes.

Many members support a change because they feel that the current titles don't accurately reflect the scope of emerging HIM roles, the association says. Ever since AHIMA changed its name from the American Medical Record Association in 1991, members have also shared concerns that the certification titles don't match the association's name.

Participants in focus groups also echoed dissatisfaction with the current titles. The groups, comprised of professionals who represent the employers of HIM personnel, said the titles were inaccurate in representing the skill sets and roles of today's HIM professionals. The RRA and ART titles implied paper records, the participants said. They thought that these titles were out of date, difficult to understand, and limiting in their description of the work performed.

Many who work in the HIM field applaud the possible certification title changes, saying that the term "health information" makes more sense in today's HIM world. Others, however, say the term "records" is not as limiting as it may seem.

## Records or information?

Using the federal definition of "record," RRA and ART best define and capture the many faces or specializations of the profession, says **Godwin Odia**, MBA, RRA, director of health information management with the U.S. Public Health Service. Odia is currently assigned with the Indian Health Service in Whiteriver, AZ.

"Federal records regulations are contained in Title 36, Chapter 12 of the Code of Federal Regulations and are administered by the National Archives and Records Administration of the United States. A record is defined as 'all books, papers, maps, photographs, machine-readable

materials, or other documentary materials, regardless of physical form,'" Odia says.

The definition further defines "physical form" or characteristics as including records created on magnetic tape, punch card, disks, computer, core, microfilm, maps, and tab cards as well as paper. "To those who say the word record in our credential is limiting, the definition above says otherwise," he adds.

Instead, RHIA and RHIT are the limiting credentials, Odia adds. "These proposed names do not take into account members of the profession who engage in other areas."

Another HIM professional, though, says he can see why the term information may be preferred to record. Information is also the "organization of raw data," which is a large part of what HIM professionals do, says **Doug Zwiebel**, RRA, assistant director of health information management at New York Presbyterian Hospital — Columbia Center.

> *"That name, letter recognition, is what we have all strived for within our own circles; changing it, just because it doesn't fully identify what we do, makes little sense to me."*

"Isn't information at the soul of [our responsibilities]? Don't all the individual pages of notes, reports, and summaries — written or virtual — combine to give information?" he asks. "And don't all those thousands of individual [patient record] data points combine to give researchers knowledge?"

In the last 10 months of his previous job, Zwiebel says he designed more than 175 different electronic reports that required sifting through records to yield the desired information. At his current position, he says he is doing more of the same. "It's my belief that this is the thrust of the initiative for a modified credential.

"The job skill set is advancing in terms of technological ability. What we manage or administer results in information, which yields knowledge. Keeping records for the sake of an archive alone or for the individual patient's needs adds nothing to the growth of knowledge," explains Zwiebel.

A primary concern is that the HIM profession hasn't done a thorough job of educating the health care industry on the value of the current credentials. "How many of us have had people ask what we do and then had to explain for 20 minutes what health information was?" asks **Jennifer Conner**, of Valley View Surgery Center in Dallas. Conner is taking the credentialing exam this month.

Some gains of recognition in the industry have been made, though. If the credentials are changed, will these gains now be lost?

To address this concern, AHIMA is developing a multi-year image marketing campaign that will promote the HIM profession to the health care industry, says **Belinda Brunner**, MS, RRA, director of certification for AHIMA. The campaign will begin next year, regardless of the outcome of the credential vote. In addition, AHIMA members will be asked to promote their credentials through advocacy and education at their workplace.

One HIM director who has worked to develop and foster an awareness and recognition of the current professional credentials says she is finally seeing some results from her efforts.

"A very short time ago, few people, including most personnel department staff, knew what the credentials stood for — or for that matter, what a credentialed individual could provide to the organization," says **Audrey L. Semrow**, MS, RRA, of Waukesha (WI) Memorial Hospital.

"Now, I am very confident that our personnel department and most other departments know our credentials and are aware of their associated expertise. However, I also believe that very few people, if any, know or care what each individual letter represents or stands for," she says.

Semrow adds she doesn't want to spend the energy and time needed to educate these people about the new credentials just because "some folks think that the newly proposed credentialed initials more accurately reflect what we exactly do.

"That name, letter recognition, is what we have all strived for within our own circles; changing it, just because it doesn't fully identify what we do, makes little sense to me," she says.

The individual, not the credentials, has to perform to project the image of the profession, Odia says. "The question we must ask ourselves is what do we as a profession expect to benefit from this change? Will the change enhance our profile? Will the change make members take on additional

*(Continued on page 155)*

DRG CODING ADVISOR®

# It's time to look at the nitty-gritty of EDI

By **Tim Stunz**
President
SBPA Systems
Houston

**Q:** What are the most common misconceptions health care organizations have about electronic standards?

**A:** Electronic data interchange (EDI) in itself is not the panacea some may believe. While many larger organizations have achieved productivity gains by switching millions of transactions from paper processing to EDI, some expected efficiencies have not been realized.

For example, numerous large health care organizations have been using a standard EDI format for several years. However, up until the Health Insurance Portability and Accountability Act (HIPAA) of 1996, there wasn't much incentive for small to medium-sized health care organizations to adopt EDI. In fact, for most, the reported benefits just didn't appear to justify the incremental costs of translating native formats to EDI formats.

Consequently, those companies that have adopted EDI can't always count on their trading partners to have the standards in place. Sporadic implementation has resulted in mixed efficiencies.

**Q:** What standards do you think will be accepted by the Department of Health and Human Services in Washington, DC?

**A:** I expect the suggested X12 standards will be accepted. With the many different standards in practice to date, the proposed X12 standards seem to show the most promise regarding data content. The biggest challenge is getting everyone prepared and trading data this way.

The most important thing to remember here is when the final rules are published, there is a 24-month implementation grace period. I believe all evolved parties should at least have a plan in place before then.

**Q:** How difficult do you think it will be to implement the standards for providers who don't use standard EDI formats now at all?

**A:** Many health care organizations that haven't yet implemented EDI believe that once they adopt the standard, transaction processing will magically fall into line cleanly and without a hitch. The reality of an EDI implementation can hold more than a few surprises. Our advice always is to start as soon as possible and make sure your system is configured correctly before trying to implement EDI.

We have been working hard on integrating EDI with our system software product for many years. It's a challenge to do it right from the start, but we think that the benefits of adopting EDI standards will be worth the work up front for all health care organizations.

**Q:** Are there common steps to follow?

**A:** Establish your current capabilities in trading data electronically. Determine the clients you can trade electronic data with. Pick a client who most represents your core business interest to start trading with, preferably one who is currently doing electronic business. Run a parallel system until you're comfortable that the electronic data are at a good level. This time frame should not be more than eight weeks, but this depends on the quality of the data being sent. When the trading partners agree, then "flip the switch" and stop the paper flow.

**Q:** What implementation surprises do you expect providers to have?

**A:** We initially developed an EDI module for our clients in 1994, but they were not ready for it. We have since put the product into production and

are currently customizing it for several clients.

We are finding that each of our clients faces unique challenges with regard to implementing EDI. And all of these challenges have to be handled individually before EDI is implemented.

Most health care organizations can expect to spend considerable time and resources working out many kinks. EDI implementation is generally a slow process because effective use of EDI requires that data being exchanged from one trading partner to the other must be clean and consistent.

**Q:** What special challenges will face providers who already use other standards?

**A:** Many providers who already use other standards may not know what standards they are currently using. A significant challenge to providers who submit data electronically will be their software vendor. The provider needs to find out if the software vendor they are using has a plan in place to address HIPAA issues. One must remember, though, that clearinghouses can receive data in any format but must re-format these data into the chosen standard.

**Q:** How long should it take for most providers to implement the standards?

**A:** Implementation of the EDI standards could take anywhere from several months to a year or more. Variables that would impact the amount of time required include: the current level of expertise with EDI, the ability of their software / systems to handle the emerging standards, the willingness to bring in additional expert resources, and the level of electronic automation of the providers' current processes.

**Q:** Who should be involved in the implementation project, what kind of equipment will they need, and what kind of cost should they expect?

**A:** In addition to the obvious membership of experts in information technology and EDI on any EDI project team, the team also must include representatives from parts of the organization that are the source of and users of EDI transactions. In many cases, it will be necessary to alter systems and processes throughout the organization. Therefore, it is essential for individuals who use and are impacted by those systems and processes to be a part of the team.

Due to the fact that equipment and part costs vary due to the nature of customization, we can't specify an average dollar amount.

*(Editor's note: SBPA Systems is a health care benefits administration software company.)* ■

# Schedule outlines dates for release of HIPAA rules

The U.S. Department of Health and Human Services (HHS) in Washington, DC, has released a tentative schedule for its final standards on electronic health information, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Notices of Proposed Rule Making (NPRMs) that already have been published and their expected final dates are: Transactions and Coding, November 1999; National Provider Identifier, December 1999; National Employers Identifier, December 1999; Security, December 1999.

Here is the schedule for NPRMs still in development: National Health Plan Identifier, tentative rule December 1999, final rule May 2001; Claims Attachments, preliminary rule September 1999, final rule September 2000.

HHS says the length of time from the publication of the NPRMs to the publication of the final rule is needed to review and respond to the large number of comments received on the NPRMs. In addition, the rules need to be reviewed not only within HHS and a number of its subordinate agencies, but also by several other federal departments affected by the rules.

Standards are required to be implemented within two years of the effective date of the final rule, generally 60 days after publication of the rule. However, the effective date for the National Provider Identifier is planned to be no earlier than July 2000, to give HHS enough time to develop the system for implementing the identifier.

## *Start preparing now*

The American Health Information Management Association (AHIMA) in Chicago has updated its checklist of how to prepare for some of the categories, and has added steps to prepare for the electronic signature standard. Here is the new version, as prepared by **Sandra Fuller**, MA, RRA, vice president of practice leadership, and **Julie J. Welch**, RRA, an HIM practice manager for AHIMA:

**General**

• Assign responsibility for tracking the progress of regulations as they develop.

• Continue to inform key internal stakeholders about HIPAA and its impact on your information

systems and processes.

• Seek current information on the industry's approach to HIPAA compliance.

• Develop resources — such as publications, seminars, Web sites, and professional networking — to facilitate development of your approach to meeting HIPAA requirements.

• Plan internal educational programs to describe HIPAA requirements to those responsible for implementing the changes.

• Obtain and read copies of the proposed rules from the *Federal Register,* which can be accessed via the Health Care Financing Administration's (HCFA) Web site at http://www.hcfa.gov.

• Read the reports and recommendations from the National Committee on Vital and Health Statistics (NCVHS). The NCVHS serves as the statutory public advisory body to the Secretary of Health and Human Services in the area of health data and statistics. (The reports and recommendations can be accessed via the NCVHS Web site at http://aspe.os.dhhs.gov/ncvhs through NCVHS Reports and Recommendations.)

• Obtain and read a copy of the Internet Security Policy from HCFA's Web site.

• Meet with key staff in information services to discuss the requirements, identify the people who need to be involved, and develop a plan of action. Share sections of the *Federal Register* with individuals who need to be involved in preparing for the regulations.

• Perform a gap analysis of your existing policies and procedures compared to the requirements of the proposed standards.

• Have individuals who need to be involved send you copies of their policies and procedures that address the requirements.

• Develop a checklist to help identify those policies and procedures you will need.

**Standardization of code sets**

• Monitor payer compliance with official coding guidelines.

• Perform regular coding quality control studies.

• Provide feedback on documentation issues that have an impact on the quality of coded data.

• Routinely train coding staff on current coding practice.

• Provide access to resources on coding guidelines and best practices. Efficiently update the ICD-9-CM codes in October and the CPT-4 codes (for both transaction and analysis systems) in January.

**Health care identifiers**

• Become familiar with the Notice of Proposed Rule Making for the employer identifier number, the taxpayer identification number for employees that is assigned by the Internal Revenue Service.

• Read the Notice of Proposed Rule Making for the national provider identifier.

• Assess the quality of the master person index (MPI).

• Perform required cleanup and eliminate duplications in the MPI.

• Institute procedures to maintain the integrity of the MPI.

• Train staff on the importance of data quality in an MPI.

• Make necessary data quality improvements in registration systems.

• Assign responsibility for the maintenance of MPI data integrity.

• Perform routine data integrity checks on the provider database.

• Develop effective procedures to maintain provider tables.

• Integrate or interface provider tables with necessary systems.

• Monitor data quality for unique personal identification numbers (UPINs) on billing documents.

• Provide easy access to UPIN tables.

• Maintain current, complete payer tables.

• Perform data quality checks on payer data entry.

• Develop feedback loops from the billing process to data collection processes regarding payer data.

**Claims transactions**

• Maintain effective communication regarding claims processing with all affected parties.

• Perform routine maintenance on the charge master.

• Use electronic claims processing and electronic data interchange.

• Explore feasibility of converting to electronic claims processing or outsourcing that function.

• Have comprehensive documentation of claims processing.

• Routinely monitor remittance information against claims data.

• Have an effective process for handling rejected claims.

• Aggregate data about rejected claims to improve claims processing.

• Become familiar with transaction standards and standards development organizations.

**Information security**

• Review the proposed standards and assess your organization's level of compliance by performing a gap analysis.

• Become familiar with the information security standards and standards development organizations.

• Identify existing organizational structures to aid development and implementation of an information security program.

• Ensure that policies exist to control access to, and release of, patient-identifiable health information.

• Ensure that users of electronic health information have unique access codes.

• Ensure that each user's access is restricted to the information needed to do his or her job.

• Outline the physician responsibilities for protecting the confidentiality of health information in the medical staff bylaws or rules and regulations.

• Outline employee responsibilities for protecting the confidentiality of health information in the employee handbook.

• Train everyone with access to health information about confidentiality and their responsibilities regarding confidentiality.

• Review vendor contracts for outsourcing of health information to ensure that they include provisions regarding confidentiality and information security.

• Ensure that system managers, network managers, and programmers do not have unlimited and unrecorded access to patient information.

• Monitor access to information and put corrective action plans in place for violation of organization policy.

• Perform risk assessments to prioritize and continually improve the security of the systems.

• Maintain current knowledge of information security issues and industry response to these issues. Read books and publications, and attend seminars.

**Electronic signature**

• Identify the use of the electronic signature in your organization.

• Perform a gap analysis for electronic signature applications to assess compliance with proposed standards for electronic signatures.

• Become familiar with the electronic signature standards and standards development organizations.

• Discuss the proposed requirements with current vendors who may be supporting your organization's information systems.

• Familiarize yourself and employees with new and emerging information security technologies.

• Research various certificate authorities to determine costs and identify a potential candidate. ■

# HIPAA implementation guides released

The Department of Health and Human Services (HHS) has announced that the final versions of the nine ASC X12N EDI Implementation Guides and the Health Care Data Element Dictionary are complete.

The guides and dictionary are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification provisions. It is expected that the department will adopt these standard implementation guides in the final rule.

The following final guides were released on June 3, 1999, and can be downloaded from the Washington Publishing Company's Web site at www.wpc-edi.com / HIPAA. Guides posted include:

• Health Care Claim Status Request and Response;

• Payroll Deducted and Other Group Premium Payment for Insurance Products;

• Benefit Enrollment and Maintenance;

• Health Care Claim Payment / Advice.

The remaining five final guides were posted on the Web site on June 10, 1999. These were:

• Health Care Eligibility / Benefit Inquiry and Information Response;

• Health Care Claim: Institutional;

• Health Care Claim: Dental;

• Health Care Claim: Professional;

• Health Care Data Element Dictionary.

A tentative schedule issued by HHS indicates that the final rule will be published in November 1999. Standards are required to be implemented within two years of the effective date of the final rule, generally 60 days after publication of the rule. This makes the required implementation date February 2002. ■

(Continued from page 150)

responsibilities that are likely to project the image of the profession?"

Semrow would like AHIMA to put its efforts into several areas. These include:

• promotional and educational efforts aimed at the general public with the focus on what current HIM credentialed personnel offer;

• the education and development of relationships with other professional organizations, which are facing many of the same issues, such as electronic medical records development and management, confidentiality and security-related issues, and database and system development / management;

• additional research into other avenues of opportunities that HIM professional expertise, education, and training would lend itself to by using already developed skills.

AHIMA members should let the association know where they stand on the credential title change issue. Members can voice their opinions at Summer Team Talks, in the Vision 2006 issue forums on the association's Web site, and through their state HIM associations. ■

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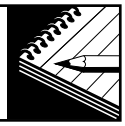
GUEST COLUMN



# Free audio, pictures over the Internet: Coming soon

By **Steve Gilheany**, MBA
Senior Systems Engineer
Archive Builders
Manhattan Beach, CA

The local loop of the telephone line defines the speed of the Internet for most people. The local loop, though, has lacked the speed to make flipping through pages in books or full-motion video available over the Internet. Storage systems for electronic documents also have defined large-scale document storage and video storage as too slow, too unreliable, and too expensive to be consistent with the free paradigm of the Internet.

## *The next three years on the Internet*

But as the cost of switching and transmission over the Internet continues to drop, more and more types of documents can be delivered over it. E-mail is currently a given. Color pictures from Web sites are expected to be high-quality art. Next to come are audio and free phone calls over the Internet. When phone calls become free, telecommuting will become commonplace and travel-disabled individuals will be able to work at many more types of jobs from home.

Ultimately, any job that is limited to answering a phone and viewing a computer screen can be moved to any location in the world. Adding video for free Internet-based videophone calls will even further reduce the need for the physical meetings that are seen as essential for conducting business today.

Two processes are occurring in this area simultaneously:

1. The first process is the use of low-cost digital video cameras for low resolution, low frame rate and intermittent (choppy transmission) videophones.

2. The second process is commercial activity by telecommunications vendors. Telephone equipment vendors such as Nortel Networks in Brampton, Ontario, Canada, and Lucent Technologies in Murray Hill, NJ, are moving to design and manufacture switches and transmission equipment to provide phone service over the Internet.

The latest step in this commercial process was Lucent Technologies' $20 billion purchase of the computer-networking vendor Ascend in January 1999. This process will introduce "quality of service" protocols on the Internet. The quality of service protocols will eliminate the intermittence of current Internet phone calls.

Quality of service protocols will pave the way for broadcast TV, broadcast HDTV (high-definition television), and finally on-demand TV and on-demand HDTV. The introduction of commercial quality on-demand TV is likely to pay for great technical advances on the Internet without requiring additional payments by users for the technology.

In the case of the Internet's near-term evolution, the minutiae (technical details that are difficult to make use of) are in the reports that today's commercial fiber optic transmitters can send 320

Gigabits per second. Transmitters that were under development in March 1998 by Lucent technologies can send 1 Terabit (1 trillion bits) per second, and Internet switches currently being designed can switch 1 Terabit per second (announced by Nortel Networks in October 1998). The Internet switching and transmission infrastructure is almost ready for all the video we could want. The local telephone loop is the last obstacle.

### *DSL equipment increases connection speed*

It is likely that DSL (digital subscriber line) equipment and cable modems will increase the speed of local loop Internet connections available to most users by a factor of 10 to 100 in the next three years. These improvements are possible using the physical cable and telephone plant that is currently in place. However, these changes depend on decisions made by the users' cable and telephone vendors.

Local loop replacement could occur in a timely manner or at a much slower rate. If local loop vendors place political obstacles in the way, it would then be necessary to build a complete new infrastructure. This would be the equivalent of laying TV cables in urban areas, a process that took about a decade in the United States. The difference in cost between laying a copper and optical fiber link to the home and laying a copper link without fiber is about $10.

Fiber optic local loops have the additional advantage of having the physical capacity to be 10,000 to one million times faster than most users' existing local loop Internet connections. The actual speed of the fiber optic connection depends on the transmitters and receivers used, just as the speed of copper wire connections depends on the transmitters and receivers used.

Also, as in the case of copper links, the speed of fiber optic links can be increased by upgrading the transmitters and receivers, which will continue to drop in price because of their similarity to computer electronics which quickly are becoming cheaper.

DSL is an example of upgrading the transmitters and receivers on existing copper wire links. For optical transmitters and receivers, there is very substantial headroom in the physical optical fibers for increasing data rates by improving optical transmitters and receivers. Even the 1 Terabit per second data rate mentioned above is still far below the optical fiber carrier frequency (baud rate) of 230 THz (TeraHertz, trillion cycles per second) for fibers designed to carry 1,300 nm (nanometer) light.

Also waiting in the wings, and which might add a measure of destabilization to the market, is Teledesic in Bellevue, WA, backed in part by investor Bill Gates, CEO of Microsoft. By 2003, Teledesic plans to provide up to 64-megabit signals to laptop-sized, roof-mounted antennas and up to 2-megabit up-link signals from the antennas, worldwide, using 288 low earth orbit (850 miles) satellites. The pricing is expected to compare favorably with both local loop and cellular service. Teledesic also plans to make 64-megabit per second up-links available at a higher cost.

The spread of new technologies has always been extremely fast, and it is getting faster. This accelerating rate of change is another problem in minutiae: We have had enough change on the Internet, and we are not ready for any more. Many people already are planning their systems as though the Internet will stay forever the way it is today.

This is not the case. The Internet is going to change more in the next three years than it has changed in the last three years, and for most people, the Internet did not exist three years ago.

*[Editor's note: Gilheany holds certifications for document imaging and information technology from several industry associations and has 17 years' experience in document imaging. He can be reached at (310) 937-7000 or through e-mail at SteveGilheany@Archive Builders.com. For more information on this topic and others, visit the company's Web site at www.archive builders.com.]* ■

# Could HCFA cuts close your doors?

*New rules may reduce outpatient reimbursements*

Proposed outpatient billing regulations for Medicare patients in areas such as emergency services could have an unprecedented impact on a hospital's bottom line, experts say. These regulations could lower reimbursement and put some hospitals and emergency departments in financial jeopardy.

"Obviously, if you cut up to 15% of patient

reimbursement for emergency services, that will have a significant financial impact on the hospital," predicts **Michael Bishop**, MD, FACEP, vice president of the American College of Emergency Physicians (ACEP) in Dallas. "If your costs are going up, and your payments are cut, then it's a double whammy." The result: Emergency departments will face the challenge of providing the same services for less money.

The financial impact may be so devastating that some hospitals may have to close their doors. "You need to be concerned about the financial viability of your institution," warns **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine. "There could be huge shifts in the volume of outpatient surgery in competitive markets. The need to meet the competitive price may affect the financial viability of the institutions, and it will definitely affect their cash flow."

*"If the payment levels are insufficient, you might not only see hospitals closing, but some hospitals may pull out of outpatient and emergency services."*

The plan from the Health Care Financing Administration (HCFA) in Baltimore will shift outpatient reimbursement for hospitals into ambulatory patient classifications (APCs) similar to the diagnosis related groups (DRGs) for inpatient payments.

The proposed system groups more than 5,000 outpatient codes into 346 payment groups, or APCs. "Each APC has been constructed to include a related group of clinical services for which Medicare will reimburse hospitals at a single, predetermined rate," Smith explains. "So APCs substantially reduce the number of payment levels that need to be tracked."

To define the clinical services included in each APC, HCFA will use the same coding system currently used to reimburse physician services for Medicare patients, known as the current procedural terminology (CPT) system.

"This would be a major change in how billing is done. It represents the same magnitude of change as the switch DRG has had on the inpatient side," says **Charlotte Yeh**, MD, FACEP, medical director for Medicare policy at the National Heritage Insurance Co. in Hingham, MA.

This is the biggest reimbursement change in Medicare billing since 1982, when the Tax Equity and Fiscal Responsibility Act was passed, Bishop says.

The regulations will control the growth of Medicare expenditures for hospital outpatient services the way the DRG reimbursement system controlled inpatient expenditures. "The Medicare strategy is simply to treat hospital outpatient services exactly the same way as they treat physician office services, which is a totally new approach," Smith says.

"This is a move by HCFA to decrease Medicare costs, which is not a bad thing, but there are potential problems," explains Bishop. Emergency departments can't control the patients they see, so they see the sickest patients, he says. "If the amount of revenue goes down for the hospital, we will have less money to provide the same services."

As a result, patient care could be affected. "This can certainly affect patient care if there is not as much money coming in to the hospital. Decreased payment could result in decreased staffing, equipment, and supplies," Bishop says.

Some hospitals will be affected more than others, he warns. "Teaching institutions and large inner-city hospitals — any hospital that has a high percentage of high-acuity or Medicare patients — will be hit the hardest."

### Expect less $$ for outpatient services

Hospitals should expect less payment for outpatient services provided to Medicare beneficiaries, both from Medicare payments and copayments from beneficiaries, says Smith. "HCFA predicts reductions in direct payments from the Medicare program amounting to 3% to 15% of current revenue. The actual impact on individual hospitals will vary based on the hospital's current cost-to-charge ratio."

Although emergency department patients already are guaranteed access to care under the Emergency Medical Treatment and Active Labor Act (EMTALA), financial ramifications could create barriers to care, Yeh stresses. "If the payment levels are insufficient, you might not only see hospitals closing, but some hospitals may pull out of outpatient and emergency services," she

predicts. "If that happens, it will create an access problem."

Copayments will be reduced from current levels by an unspecified amount. "Estimating the amount of this reduction is very difficult," says Smith. "Comparing the maximum and minimum copayment amounts for common procedures suggests that the eventual reduction will average 13% of total payment. More than 50% of the revenue reduction will result from lower beneficiary copayment."

The impact on hospitals will depend on the amount of copayments they charge. "A hospital has to choose whether to charge the maximum or minimum allowable copayment, or some number in the middle," says Smith.

### *Keep on top of this issue*

Keep your staff and hospital administrators informed so the change doesn't take them by surprise, urges Bishop.

Also, keep abreast of new developments, Yeh recommends. Managers should stay in touch with hospital administrators and work with trade associations like the American Hospital Association in Chicago and ACEP to make sure their voices are heard, Yeh adds.

Many managers are unprepared for this change, says Smith. "It is a sleeping issue because it's been expected for so long and has been put off so many times," he explains. Implementation originally was scheduled for Jan. 1, 1999, but the date has been moved to April 2000.

A draft of the proposed regulations was published by HCFA, and comments on the preliminary rules are being reviewed, notes Smith. The final rules will be published 90 days before implementation. The delay is due to HCFA's problems with the Y2K bug.

"Hospitals will need the intervening months to prepare for the operational changes required for billing of outpatient services and to plan their response to the market changes that the new Medicare payment system is certain to cause," says Smith.

*[Editor's note: The complete regulations can be reviewed on the* Federal Register On-line *(Sept. 8, 1998). Web site: www.nara.gov./fedreg. Information also can be obtained from the American Hospital Association's Web site at www.aha.org.]* ■

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## GAO report details abuses in use of False Claims Act

The Chicago-based American Hospital Association (AHA) says a Government Accounting Office (GAO) report, published Aug. 6, vindicates AHA's position that abuses are occurring in the use of the False Claims Act against hospitals.

In its review of the five U.S. Attorneys' offices that were conducting the lab unbundling investigation, the GAO found that, at the time allegations were made against hospitals, "most of the offices had not sufficiently analyzed the claims data to determine if the pervasiveness and magnitude of the apparent errors were sufficient to warrant a False Claims Act violation."

The GAO report (GAO/HEHS-99-170) also states that, a year after establishment of the Department of Justice guidelines, four of the five U.S. Attorneys' offices reviewed by the GAO had not corrected their mistakes and have yet to comply with the guidance. In one of these districts, GAO discovered that there was never evidence of fraud or abuse by the accused hospitals and that the hospitals "had actually been selected primarily because they were the largest billers of Medicare in the state."

"This is an outrageous abuse of prosecutorial power and the [Department of Justice] should take all necessary steps to stop it," says **Dick Davidson**, AHA president. ▼

## HCFA announces Medicare payment increases

The Health Care Financing Administration (HCFA) has announced that more than 5,000 acute care hospitals in the United States will receive an average 1.1% increase in Medicare payment rates in fiscal year 2000. The recommended

payment increases are contained in a final rule published in the July 30 *Federal Register*.[1]

The rate increases, which are authorized by the Balanced Budget Act of 1997 (BBA), affect acute care hospitals participating in Medicare.

Medicare pays for most inpatient hospital care through a prospective payment system (PPS), which pays hospitals a predetermined amount for each Medicare discharge based on the patient's diagnosis. Hospitals in large urban areas — cities with populations of more than one million — receive slightly higher payment rates than hospitals in other urban and rural areas.

The BBA allows for an increase in FY 2000 of 1.8 percentage points less than the projected growth in the inflation rate for goods and services — known as the marketbasket — purchased by hospitals. The latest forecast of the 2000 marketbasket is 2.9%, up from the estimate of 2.7% in the proposed rule. According to the formula included in the BBA, payments to PPS hospitals, sole community hospitals, and Medicare-dependent rural hospitals will increase on average by 1.1%.

### *Reference*

1. 99 *Fed Reg* 19,334 (July 30, 1999). ▼

# Report compiles state privacy laws

States have passed a broad array of laws to protect the privacy of medical records, but those laws apply unevenly, even within states, according to a report released in July.

The report from the Georgetown University Health Privacy Project in Washington, DC, is the first to attempt to compile in one place state laws on medical record confidentiality, says project director **Janlori Goldman**. The project is part of Georgetown's Institute for Health Care Research and Policy.

That fact that some states have fairly comprehensive laws while others have only minimal protections was not a surprise, says **Joy Pritts**, the report's principal author.

What was surprising, Pritts adds, was that state laws tend to focus only on certain entities or certain conditions. "In some states, you can see your hospital records, but not those kept by doctors or insurance companies."

The complete report is available on the project's Web site: www.healthprivacy.org/resources. ▼

# Database offers data from hospitals, managed care

A new database that combines comprehensive hospital data with the latest managed care information is now available from the Chicago-based American Hospital Association's (AHA) subsidiary Health Forum and InterStudy, a supplier of managed care data.

**Hospital Payment & Information Management**™ (ISSN# 1074-8334), including **DRG Coding Advisor**®, is published monthly by 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.

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**Editorial Questions**

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The Duet Database provides health care leaders and researchers with a wide variety of information about hospitals and managed care in local markets, at every metropolitan statistical area (MSA) level. MSAs are geographic areas defined by the U.S. Census Bureau, which generally contains a city with surrounding suburbs over 50,000 in population.

The hospital information comes from the AHA annual survey. The managed care data, which come from InterStudy, focuses on "public" HMOs — which are open to the public — vs. employer-owned HMOs. The CD-ROM product allows users to look at multiple cities and compare the penetration rates of managed care companies and hospital admissions.

The database is available in three formats at varying prices:

- **hospital and managed care data** for $3,000;
- **hospital data only** for $1,800;
- **managed care data only** for $1,800.

The database will be updated twice a year. To order, call (800) AHA-2626 or Interstudy Publications at (800) 844-3351. ▼



# Health care Y2K guide available for consumers

An information technology research firm in the health care industry has produced a 24-page booklet aimed specifically at helping consumers understand the year 2000 (Y2K) date change.

In developing the booklet, Odin Group LLC, in Nashville, TN, worked with more than 40 health care companies. In addition, Odin received help from the Department of Health and Human Services, the Health Care Financing Administration, the Food and Drug Administration, and health care trade organizations and consumer groups.

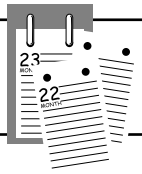
The *Personal Planning Guide* will be available to consumers in a variety of ways. Many of the organizations involved in developing the booklet, in addition to pharmacies, physician groups, and hospitals are planning to distribute it, with the bulk reaching consumers over the next two months.

The booklet describes the efforts of various segments of the health care sector to prepare for the Y2K computer issue — the inability of some computers and electronic chips to properly recognize dates after 1999.

Also in the booklet are practical recommendations for all consumers to follow to determine how ready their personal health care providers expect to be. In addition, the booklet contains a basic health care checklist and a worksheet to record important personal health information for consumers and their families.

The booklet also is available on the Internet at www.healthcarey2kguide.com, or by calling (888) 353-7807. ■

## CALENDAR



• **The 1999 Annual Compliance Institute of the Health Care Compliance Association** (HCCA) in Philadelphia is scheduled for Oct. 24-27 in Chicago. This year's Institute, "Advanced Compliance: Discovering the Hallmarks of Effective Compliance Programs, a Critical Step in Compliance," is designed to provide practical workshops for experienced compliance professionals. The institute will also devote an entire track to case studies, offering specific examples on various aspects of compliance programs.

For more information, call (888) 580-8373 or visit HCCA's Web site at http://www.hcca-info.org. ■