



HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

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E/M upcoding puts your hospital at risk — and you may not know it

Physicians' medical decision making is the weak link

One health information services (HIS) department made a troubling discovery when it took over the billing for evaluation and management (E/M) codes for several of its hospitals.

The company that had handled the outsourced coding functions had often “upcoded” or assigned higher levels of service — and higher reimbursement — than government guidelines permit.

Anita Orenstein, ART, CCS, CCS-P, HIS compliance coordinator, quickly made the decision to have the HIS department take over the coding functions, too. “We wanted to ensure the quality and compliance since we were taking the risk for liability,” she says.

Orenstein’s employer, Intermountain Health Care in Salt Lake City, is a corporation comprised of more than 20 hospitals. The HIS department now takes care of the E/M coding and billing functions for six of those facilities.

“Sometimes there is an incentive for outsourcing services to upcode,” Orenstein says. “They either get a percentage, or they just want to maintain their contract. If they keep their physicians happy with good reimbursement, the physicians are not going to let them go. But if you follow the guidelines the way they are meant to be used, then you don’t have all those higher levels of service. We wanted to ensure that ours were by the book.”

E/M codes are used to report physician visits, consultations, and similar services. The level of service assigned is intended to reflect the

“Some of them don’t have the knowledge. When you are hiring accountants with a little bit of coding background, they are going to figure out that the higher codes bring higher dollars.”

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work involved in providing the service.

Two out of the three primary components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service for the following established or follow-up patient categories or subcategories:

- office;
- established patient;
- subsequent hospital care;
- follow-up inpatient consultations;
- subsequent nursing facility care;
- domiciliary care, established patient;
- home, established patient.

In June, the current procedural terminology (CPT) editorial panel of the American Medical Association (AMA) in Chicago submitted its recommendations to the Health Care Financing Administration for revising its documentation for the E/M codes.

The proposed guidelines are said to be less rigid for physicians to use. But the guidelines also may make it easier for physicians to justify a higher level of service. **(For more information about the proposed guidelines, see *Hospital Payment & Information Management*, September 1999, p. 135.)**

Fault of the system?

E/M upcoding is always going to be a problem, says **Caren Reney**, RN, CCS, owner and technical consultant for HealthCare Quality Consultants in Avon, CT. "It's never going to go away."

Several issues contribute to the upcoding problem, she says. One factor is the push toward increased physician productivity. "We have the government saying physicians have to comply with these guidelines and it's going to pay them X amount [for the services]. Then we have organizations and physician practices saying physicians have to bill X amount of dollars to receive a particular salary in a year.

Both sides are working against each other.

"[Productivity standards] are counterproductive to the physician, but the system is now set up that way," she continues. "I work with academic institutions and private institutions, large groups, hospitals. Everyone has the physician on some sort of productivity standard. The physicians as a general group aren't happy. They are hoping that the new guidelines will give them more flexibility to reach those higher levels of codes."

Another issue pertains to the number of people, such as accountants, who present themselves as coders.

"It's frightening," Reney says. "Some of them don't have the knowledge. When you are hiring accountants with a little bit of coding background, they are going to figure out that the higher codes bring higher dollars. They are trying to meet their customers' requests, which has a tendency to be a problem." Some "true" outside coders refuse to misrepresent the physician services, but Reney calls them "few and far between."

The primary problem that leads to E/M upcoding is a lack of physician knowledge, she says. "Medical necessity is the key to E/M services; a lot of physicians are not being educated to that level. The majority of physicians I speak to about medical necessity don't have a clue what it means.

"They are just being educated on meeting the key components, the documentation requirements — such as doing a history, including family and social history — and so many reviews of systems and so many elements for an examination," she continues. "They are not being educated on medical decision making, which is [contrary to their job as a physician]." **(For more information about educating physicians on E/M coding, see story, p. 163.)**

When coders or auditors review physician E/M service levels, they often find that the physician meets the history and examination requirements. The medical decision-making aspect, however, is "usually down at a low level, in

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around one and two," Reney says. "That is usually the weakest area."

For example, one doctor documented a visit with an elderly patient who had anemia. "The doctor wrote in the chart that the patient had anemia, but the doctor gave no parameters for the anemia. There were no blood levels [in the report] even though a lab sheet was in the medical record." The doctor also never said what he was going to do to treat the anemia. "That's medical decision making." The medical director who reviewed the documentation decided that it was not sufficient to justify the service.

The "bell curve" for E/M coding is at the third level, Reney says, but many physicians feel that their time is worth more than just that third level. "They are not understanding that time isn't playing a role anymore."

To address the coding problem at the outset, physicians should be taught E/M coding and

documentation in medical school, Reney suggests. "The rare school in the United States teaches it at that level."

Physicians with an established practice can teach themselves about E/M coding, too. According to Reney, physicians should use these resources:

□ They can access the AMA Web site (www.ama-assn.org) to review the guidelines.

□ They can purchase pocket guides that spell out the guidelines. "The guides are multipurpose and can go anywhere," she says.

□ They can implement E/M documentation templates for what they see most in their practice.

In recent months, Reney has been providing E/M coding training to residents who have recently graduated from medical school.

"It's been a constant complaint that they have not received any of this training and they are thrown out on the streets to make a living. Then they find out that they can't," she explains. ■

Educate physicians and staff on proper E/M coding

Initiate communication between docs and coders

When Anita Orenstein, ART, CCS, CCS-P, health information services (HIS) compliance coordinator for Intermountain Health Care in Salt Lake City, found upcoding in evaluation and management (E/M) codes from an outsourced coding company, she recommended that the coding functions come in-house. **(For more discussion on the problems of upcoding, see story, p. 161.)**

Once they came under HIS control, Orenstein began to educate her coders on the proper way to arrive at an E/M code. Then she talked to the medical director of the emergency department (ED) so they could make a joint decision on how to involve ED staff in the E/M education process. "For the most part, I've found that they want it as a group."

She conducted a review of E/M documentation and met with a group of physicians to go over the records. "When we first presented them with this, they were very defensive and felt the codes were assigned appropriately," Orenstein says.

That reaction is not unusual, says **Caren Reney**, RN, CCS, owner and technical consultant for HealthCare Quality Consultants in Avon, CT.

"Physicians don't like to be told about medical decision making. They just want a definitive answer about how to code at the two highest levels. Realistically, sometimes you have to say, 'If this is a patient who has a simple pneumonia, it's inappropriate to code at that high level.' They might not see it that way," she explains. "They will tell you what they had to do and what they wrote in the medical record. When you get into established patients in the hospitals, all you need is two out of the three criteria [to meet the requirements of that level]. So they are doing a history and examination to meet that requirement."

Spelling it out in black and white

The hospitals doing the best job are conducting group E/M education for physicians, which is an overall presentation based on some of the reviews the coders or auditors have been making, Reney says. "[The hospitals] are also doing one-on-one audits and one-to-one education with physicians. That seems to work because physicians believe that their specialty is unique and the things they are doing are unique, when in essence some of it is pretty standard."

Orenstein spent a significant amount of time with her physicians, breaking down the requirements for E/M documentation and comparing the requirements to documentation in the record. "When they see it in black and white, they come

to an understanding of why those codes aren't appropriate," she says.

In the medical record, physicians need to zero in on what distinguishes them from other health care providers, Reney adds. For example, medical assistants can complete a history — or patients can fill out their own in the waiting room. Nurse practitioners can do physical exams. "The only thing that is unique to a physician is medical decision making. That's pretty well spelled out in the documentation guidelines and CPT. I know a lot of people consider it to be elusive, and that's because it is geared simply for physicians at that level."

Establish a dialogue

Orenstein says she was able to establish a good dialogue with her physicians. Once they knew the guidelines, she talked about setting up regular communication between the physicians and coders. "If the physician is not documenting appropriately, you will never get the right E/M. It's a partnership that you have to cultivate between the coder and the physician."

She suggests that physicians set up meetings with coders at whatever time interval works best for each facility — weekly, monthly, or quarterly. At these meetings, the coders bring records they find difficult to code, and the physicians explain their process of medical decision making.

"When you have a female of childbearing years complaining of abdominal pain, you have any number of management options available," Orenstein says. "The clinical points of reference that the physician can give the coder are helpful. Then the coder has to say, 'in this scenario, we need to have this information documented in the record.' Together they can come up with a comprehensive document that's going to support the E/M level."

Since the meetings began at her facilities, Orenstein says she has seen an improvement in the quality of documentation. "There is a greater understanding on the physician's part on what's really needed. You have to give the physician an active role to play," she advises. "On the clinical end, physicians need to make the coders understand their medical decision making thoughts, so the coders can better understand what's in the record."

Nothing works individually as well as it does in a team, Orenstein adds. "If you can promote a good team atmosphere with the physicians and

the coding staff, then you will have less frustration, a better-educated staff, and the best reimbursement you can from following the coding guidelines." ■

Q & A Corner

Have you 'stood up' your Y2K command center?

By **Steven C. Davis**
President
DavisLogic, LLC
Simpsonville, MD

Q. How important has contingency planning been for year 2000 (Y2K) preparation?

A. We know now that we are all at risk of some level of Y2K disruptions. Despite massive investments in Y2K remediation, most organizations recognize that they cannot locate and fix all the "bugs" lurking within their internal systems, much less correct those residing in systems of their suppliers, distributors, service providers, and overseas partners.

As a result, by early 1998, many organizations began Y2K contingency planning designed to help them cope with potential failures. By late 1998, some organizations had even conducted exercises to test their readiness.

Many are still vulnerable to Y2K trouble

These Y2K exercises and simulations have underlined the fact that most organizations remain both vulnerable to multiple, concurrent disruptions of their primary operations and liable to lawsuits (from suppliers, business partners, and investors) and/or serious damage to their public image.

Indeed, as zero hour approaches, industry and government leaders recognize that Y2K disruptions — both major and minor — are likely to crop up for months and perhaps even years. Organizations that do not rise to the Y2K contingency management challenge are at risk of production disruptions and systemic failures that will significantly affect their ability to achieve

their goals. For business and industry, that may mean lost revenues. For government, it may mean disruption of public services.

On the brighter side, organizations that do succeed in managing Y2K contingencies will find that the effort expended on this particular problem will provide substantial benefits far into the future by enhancing their ability to cope with all types of natural, technological, and terrorist incidents.

Q. What is the final step in contingency planning?

A. I am assuming you already have taken the fundamental steps to prepare for Y2K such as performing threat assessments of critical areas, then developing and training on contingency plans.

Now you are ready for the final step — you must establish an organizational entity to put contingency management theory into practice. It is time to “stand up” that Y2K command center.

The key to making your Y2K command center a success is to establish a center that is designed with enterprise contingency management as the goal. Therefore, the successful Y2K command center’s mission is to perform these functions:

- **Inform and alert.**

The command center must both give and receive information. It is critical to inform everyone both within the organization’s system as well as throughout the entire supply chain about Y2K preparations and threats. It is equally important to undertake around-the-clock intelligence gathering to identify potential Y2K threats and provide prompt notification to crisis managers, employees, government, and the public.

- **Command and control.**

The command center must provide the command and control functions necessary to put multiple contingency plans into action — triggering them as needed, providing the triage structure required to allocate resources and personnel, and ensuring effective direction of the response operations.

- **Verify and document.**

The command center must create a mechanism to verify the steps taken to respond to a threat and preserve a record of those actions to protect employees, infrastructure, and shareholder value as well as demonstrate adherence to “best practices” by documenting all information received and steps taken.

But how will these responsibilities play out in the course of preparing for and responding to actual Y2K incidents? How, for example, will you offer key players around the world easy access to information on the status of preparedness, threat assessments, event alerts, and countless other elements to make informed judgments? How can the command center track personnel and other resources so they can be deployed at any time? How will you provide employees, executive, board, shareholders, and even the public, with a steady stream of information and updates about incidents and their resolution?

Put your team together

The command center is more than a place; it is the focal point of a complex, integrated process. For that process to work — for your command center to succeed — you must begin with two critical components: the command center team and the command center information system.

Q. How do you build your Y2K command center team?

A. The first step in establishing a Y2K command center is to develop a team. While this team should include Y2K project staff, a separate and dedicated team trained on contingency plans and command center procedures will be needed to effectively respond to the multitude Y2K issues that may develop.

Once the team is selected, it is responsible for establishing a Y2K command center following these steps:

- select a manager and cross-organizational team members;
- establish response teams;
- dedicate a command center location;
- determine physical requirements and layout;
- determine communication procedures;
- select and implement an information management system;
- establish documentation procedures for post-Y2K performance audit;
- exercise plans and procedures;
- activate the command center.

Q. How do you select the right command center information system?

A. The Y2K command center is ultimately a center for information management and decision

making. Its primary purpose is to gather and process all of the information required to plan for and respond — quickly and effectively — to potential Y2K incidents.

The best-prepared Y2K command centers will be ones that have implemented an enterprisewide information system designed specifically for contingency management. It must be robust and flexible enough to perform numerous critical functions yet easy enough to use during a crisis.

More importantly, it must meet the mission objectives of your Y2K command center stated previously.

Viewing Y2K as an opportunity

This is clearly a big job but, with the right management approach and tools, your command center can do it successfully — saving your organization time, money, and aggravation every step of the way.

Y2K is a tremendous opportunity for contingency management to seize the day. If Y2K ends

up having only a small impact on your organization, you will, nonetheless, have put responsible contingency management on the perceptual map for employees, management, executives, and shareholders.

The lessons you learn and steps you take right now will pay long-term benefits by helping you avoid the negative effects of everything from a minor workplace accident to a major fire or other emergency. And if Y2K does result in major consequences, your organization will have protected itself, its employees, and its shareholders from harm by ensuring continuity of your enterprise.

In either case, your organization's experience in dealing with Y2K represents a unique opportunity to improve the way you manage all kinds of potential continuity threats far into the 21st century.

(For more information on contingency planning, visit the DavisLogic Web site at www.DavisLogic.com.) ■

Software leads provider toward HIPAA compliance

Information security a major consideration

Health information management professionals may be counting down the days until the year 200 transition. But another countdown is expected to begin this month, too.

Sometime this month, the Department of Health and Human Services in Washington, DC, is expected to begin releasing the final standards on electronic health information, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The final transactions and coding standard is due first.

The final rules on the national provider identifier, the national employer identifier, and security are expected next month. The standards are required to be implemented within two years of the effective date of the final rule, which is generally 60 days after the publication date.

Two years may seem like plenty of preparation time, but many organizations know that taking a proactive stance is a safe policy.

One example of preparing for HIPAA is United Health in Appleton, WI. The organization decided to make a complete overhaul of

its information system. United Health is a corporation that includes Appleton (WI) Medical Center, Theda Clark Medical Center in Neenah, WI, and United Health of Wisconsin HMO and 800 affiliated physicians within a 100-mile radius of Appleton.

The company began the overhaul by implementing 100 stand-alone PCs and a fiber ring network between the two hospitals and corporate headquarters. It also leased a dedicated (T1) phone line from an Internet service provider in Milwaukee and extended it to other facilities. Finally, it installed a LANS (local area network server) manufactured by Novell, based in Atlanta, at each facility.

Inability to share data was a major problem

One of United Health's technology problems was the inability of some of its best-of-breed systems to share data. To address this, the company implemented a message broker system to noninvasively exchange data between applications and to transform incoming data into the formats required by the receiving system.

United Health also lacked security inpatient information. For example, surgeons received lab results from a terminal that was always logged

(Continued on page 171)

DRG CODING ADVISOR®

Stimulation therapy has many faces, but few codes

Question: Our clinic provides several types of stimulation therapy, including electrical nerve stimulation, osteogenic stimulation, and neuromuscular electrical stimulation. What CPT codes are used for these procedures, and are they covered by Medicare and other insurance plans?

Answer: The use of transcutaneous electrical nerve stimulation (TENS) units for pain management is coded 64550 in CPT. This technique involves attachment of the device to the surface of the skin over the peripheral nerve to be stimulated. The patient uses it on a trial basis for pain control under close monitoring of the physician and/or physical therapist. The patient's response should be carefully documented, because medical necessity will be required for Medicare coverage after the first month. The TENS unit usually is provided by the physician for the assessment period. Because this is equipment used by the patient at home, it is covered under durable medical equipment (DME) guidelines.

Percutaneous electrical nerve stimulation (PENS) units involve stimulation of peripheral nerves by needle electrodes inserted through the skin. Code selections in this range include the following:

- 64553 — percutaneous implantation of neurostimulator electrodes; cranial nerve
- 64555 — peripheral nerve
- 64560 — autonomic nerve
- 64565 — neuromuscular

Medicare covers a PENS procedure only when performed by a physician or when it is "incident to" a physician's service. If pain is effectively controlled by percutaneous stimulation, the

implantation of electrodes would be warranted.

Treatments would not be covered in a physician's office for Medicare patients, as it would be expected that a patient would have a stimulator implanted for home use.

The CPT codes for this service for 1999 are:

- 64573 — Incision for implantation of neurostimulator electrodes; cranial nerve
- 64575 — peripheral nerve
- 64577 — autonomic nerve
- 64580 — neuromuscular

Code 64585 is used for revision or removal of peripheral neurostimulator devices. Two additional codes in this section are for subcutaneous placement, revision, or removal of a peripheral neurostimulator pulse generator or receiver.

The devices are covered by Medicare, when medically necessary for pain control, under durable medical equipment provisions.

Osteogenic stimulation

Electrical stimulation to enhance and augment bone repair can be invasive or noninvasive in nature. Invasive procedures provide electrical stimulation directly at the fracture site by percutaneously placed cathodes or by implantation of a coiled cathode wire in the site. The power pack required for the device is implanted into soft tissue near the fracture location and then subcutaneously connected to the cathode.

In a noninvasive procedure, opposing pads wired to an external power supply are placed over the patient's cast, creating an electromagnetic field between the pads at the fracture site.

The noninvasive procedure is covered by Medicare for the following conditions:

- nonunion of long bone fractures;
- failed fusion;
- congenital pseudoarthrosis;
- as an adjunct to spinal fusion surgery for patients at high risk for pseudoarthrosis due to failed spinal fusion at the same site or for those undergoing multiple-level fusion.

For all types of devices, nonunion is considered to exist only after six or more months have elapsed without healing of the fracture.

The invasive (implantable) stimulator is covered by Medicare for the following conditions:

- nonunion of long bone fractures;
- as an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple-level fusion.

The CPT codes for osteogenic stimulation are:

- 20974 — electrical stimulation to aid bone healing; noninvasive (nonoperative)
- 20975 — invasive (operative)

NMES therapy

Neuromuscular electrical stimulation (NMES) is used to treat disuse atrophy. An NMES device transmits electrical impulses to the skin over selected muscle groups by way of electrodes. Medicare coverage of NMES is limited to treatment of disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing atrophy.

Examples include casting of a limb, contracture due to scarring of soft tissue such as burn patients may suffer, and hip replacement surgery until orthotic training has begun.

The CPT codes for neuromuscular electrical stimulation are found in the neurostimulator section of CPT. Electrodes placed over motor nerves stimulate muscles to prevent atrophy. In code 64565, the electrodes are placed at the neuromuscular junction to stimulate a specific area of muscle tissue.

The analysis of neurostimulators is reported from the medicine section of CPT. Codes in the range of 95970-95971 are assigned for this service.

This section of codes is all new for 1999 in CPT. It involves simple or complex electronic analysis of implanted neurostimulator pulse generator systems. The stimulation affects the pulse (amplitude, duration, frequency) to treat specific disorders such as Parkinson's disease. These codes are only used with implanted devices.

A simple stimulator affects three or fewer variables to include the pulse, electrode contacts, electrode selectability, output modulation, and cycling. A complex stimulator affects more than three of the variables. For complex procedures, when more than one hour is provided, there are codes for the additional time that are reported in addition to the primary procedure. ■

Confidential exchanges in the electronic age

Docs, patients must know how, when to e-mail

Bob Jones needs a referral from his family doctor. Because he doesn't want to wait for the doctor to return his telephone call, he e-mails the request. The next day, he has a reply with the referral.

John Smith sends a message to his doctor complaining of chest pains. The physician is not able to check his e-mail for several days and is alarmed when he gets the message.

The above scenarios show the importance of establishing a policy about how and when to use e-mail communication between physicians and patients.

Whether to allow e-mail communication at all is no longer the question. More and more computer-savvy patients prefer e-mail for nonemergent requests because they can ask their doctors questions directly without having to wait by the telephone for a reply.

This trend will only increase, says **David Sanders**, MD, CEO and founder of Salu.net, a provider of Internet-based private networks for physician practices and health professionals in Portland, OR.

"Communication will migrate aggressively within the next five years to e-mail-based communication," he predicts. "[E-mail] will change the way doctors, staff, and patients communicate."

A medical practice is 90% communication, he explains. About half of that communication is face to face. The other half is communication by other means such as phone or fax.

"The problem with the phone is that it requires the doctor and the patient to be available at the same time," Sanders says. "It's hard to do that when doctors are under such high time pressure."

Encryption available through Medical E-mail

Providers who are trying to navigate the territory of e-mail but don't want to do it themselves might find help through a company named Salu.net. The company offers secure, encrypted messaging through its Medical E-mail; physician-customized Web sites; and permanent message archiving.

"Everything you do in a practice is a legal document," says **David Sanders**, MD, CEO and founder of Salu.net. "It is important you have a record means to track all of those [e-mail] communications. On a real-time basis, we extract all of the data points that go on, and we archive them in a compressed fashion. If a member wants to go back and retrieve documentation, it's there for them."

The messages are archived for 10 years. "Then we contact members and ask them if they want to receive data backups of their systems. At that point, we will begin to discard records."

The Web sites are used for patient education, practice promotion, and customer support. Patients can use them to retrieve educational

materials the physicians have chosen to offer. Patients also can find out more about the practice and even get directions and office hours.

Physicians can access Salu.Net from any system that has Internet capabilities. Salu.net is also integrated, so physicians can access everything in the system by signing on and giving a password.

Salu.net has a training program for users, which urges them to talk to patients about using e-mail. "For example, make it clear to patients that if they are going to use e-mail with you, here is what is considered appropriate content and timeliness," Sanders says.

A newer version of the system will provide a guidance site for patients that tells them how to become an effective user of e-mail with their physicians.

Offering e-mail resources makes physicians seem more current with the times, Sanders says. "Doctors who are on-line are put back in the game. They are more in the partnering mode than an outsider who is not providing information."

[Editor's note: For more information about Salu.net, call (888) 288-SALU.] ■

E-mail separates out the requirements for two folks being in the same place at the same time."

"There is an increasing encroachment of electronic [communication] in the physician-patient relationship," adds **Faith McLellan**, PhD, faculty associate in the department of anesthesiology at the University of Texas Medical Branch at Galveston.

McLellan learned about e-mail communication while researching her dissertation about patients' illness experiences. Even though she found that physician/patient e-mail communication is becoming more common, many physicians are still uncomfortable using it.

"In a larger conceptual universe, it upsets the balance of power," she says. "Suddenly, there is information and information management tools in the hands of people who have usually been the recipients of physicians' power and knowledge."

Many physicians are computer-naive, too, she adds. "They haven't thought about some of the issues such as privacy and confidentiality, and how easy it is to disseminate information to other

people through e-mail and how instantaneous it can be."

Many patients use e-mail so much that they see it as a natural way to communicate with their physicians, McLellan says. A recent article in the *Annals of Internal Medicine* found that patients think of e-mail as creating continuous access to the health care system, something they feel is lacking as physicians spend more time on administrative tasks and less time on personal interaction.¹

E-mail works well when the patient requests general information or sends routine information about a chronic illness. A diabetic patient, for example, might send her physician information about her blood glucose levels. The physician doesn't need to respond right away unless the results are abnormal. "E-mail is the perfect medium for that," McLellan says.

E-mail also provides a way for physicians to filter medical information. Some managed care plans, for example, have a site where they recommend electronic resources on medical information.

In addition, e-mail can allow patients with similar conditions to meet in electronic discussion groups. These groups can be a great relief to both the patient and the physician, McLellan says. "The patients are hooking into a source of support that they don't necessarily get from their personal physicians. It not only provides access — a route of communication between the patient and the physician — but it hooks other people up whose time is better served in discussion, answering questions, and support."

E-mail can be a barrier to patient care, however. Some questions to be considered include: What happens with e-mail communication between patients and their doctors when the doctor is on vacation, not in the office, or not on call? What happens if the physician's or patient's e-mail server goes down? When will the message be received? What kind of messages are appropriate for patients to send?

"Establishing a policy on using e-mail is a good idea," says **Victor S. Sierpina**, MD, an assistant professor of family medicine at the University of Texas Medical Branch in Galveston. For example, patients should be discouraged from sending emergency or urgent inquiries. They should be aware that their messages might not be answered right away.

Be aware of discrimination issues

Physicians should have an office e-mail account that is separate from their personal one. They should not use e-mail to communicate abnormal test results or to give bad news.

"You don't want to be discussing psychiatric history or HIV status — something that could be used to discriminate against the patient," McLellan says.

Physician e-mail users also should ensure that electronic communications do not widen the disparity between the haves and the have-nots. Patients without access to computers should receive the same health information, she explains. "You don't want to create a society where the patients who have e-mail are getting better care than the patients without."

Sierpina has one rule of thumb on the use of e-mail: "Don't put anything in e-mail that you wouldn't want to see on the front page of a daily newspaper."

In his experience communicating with patients, he has found that they usually write short messages and generally don't abuse the system, he says. They don't always think about the lag time

between the sending and receiving of messages, however. One of his patients, the man with the chest pains mentioned earlier, luckily had a condition that did not require emergent care.

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Making histories unique avoids similarity problems

Question: A recent Medicare bulletin states that if visit documentation for a patient "looks similar" from visit to visit, Medicare will deny payment for the visits due to lack of medical necessity. What does "looks similar" mean?

Answer: Looking "similar" means the physician didn't dictate a new note for each visit. This can be a problem when an electronic medical record pulls all the information for each encounter into the next one.

It's not known if the physician actually looks at the information or if the system is simply printing out into the progress note. As a result, every visit looks alike.

The Health Care Financing Administration's concern is that the work isn't being done; the provider is just adding the information with a few clicks of a button, making the work look like a Level 5 service when the provider has not done the work associated with that level of service. The carrier is looking for something that indicates progression, or improvement, or at least what is really happening with the patient at the time of the most current visit.

Documentation guidelines for the progress note say the history should be based on the last encounter. Providers need to update that medical history from the last patient visit and not just repeat history information that is not relevant to today's visit. Some providers bring back complete patient histories every time the patient comes in.

Physicians, therefore, need to make sure their history is unique to that day's visit. They also need to reference anything that is key to treating the patient during the visit. ■

(Continued from page 166)

on to the system, leaving patient information unsecured.

In addition, if another user logged on to a different part of the system from that terminal, the surgeons would no longer be able to access the lab results. When patient information is left on a shared screen, it opens the hospital to civil liability suits, says **Bill Briner**, product manager for New Era of Networks (NEON) in Englewood, CO.

That's one reason HIPAA requires an enterprise-wide security policy. "This means [providers] have to define who in the whole enterprise — not just in a department — has access to patient information. And at what level do they have access? What privileges do they have?"

Another HIPAA requirement is that users of electronic health information have unique access codes and that their access is restricted to the information needed to do their jobs. "There should be no more shared IDs," Briner says. "That's absolutely forbidden under HIPAA. There is no control of them."

Challenging road lies ahead

Health care facilities have a challenge in meeting the HIPAA security requirements. First of all, they have to manage a much larger user population than they did before, Briner notes. In addition, any system they choose must support "nomadic users," or users that move all around the facility. "Oftentimes [these users] will leave one workstation and go to another and then go back to the first workstation and pick up where they left off," Briner says.

The system must be fast, too. Users have often shared IDs because they had to wait so long for applications to load onto the PC.

Finally, they want a system that will automatically create or change user accounts in the end-point applications when new users are added or when their roles change. "Otherwise, the system wouldn't be removing any work from the IT department," Briner says.

To help with its security issues, United Health chose NEONsecure, software that provides each user with secure and simultaneous access to multiple applications through a single password and sign-on. When the users sign on the system, they see the icons on their desktop for the applications that they are allowed to access.

When they choose an application, they are automatically placed in the appropriate location within it, based on their job function. The system insulates users from any passwords required by the changes in applications.

All traffic generated by the users is protected, using a combination of Kerberos authentication and DES (data encryption standards) encryption. Once users have finished at their workstation, they can hit "hot keys" to instantly lock the screen.

United Health has also assigned timeouts that automatically log users out after a specified period of inactivity. Users need to realize the importance of leaving the system, Briner says. "One of the jobs of the security officer under HIPAA is that people have to be educated as to what the security ramifications are for leaving those things up on the screen."

Transmitters and smart cards

Briner says that many providers use "proximity devices" to log users on and off the system, too. One such device activates the system through a power emission sent from a radio transmitter on a user's smart card. Another device requires that a card be placed into a slot in the PC. When the user completes the work, he or she removes the card and the system resets.

United Health employees can gain access to their applications almost instantaneously when they log on. They can access their applications from any workstation, too.

"Our physicians and nurses move around a lot each day," says **Keith Livingston**, United Health's CIO. "It's a considerable benefit for them to be able to access their personal workplace from any workstation."

The health care company's T1 line also allows users to access the Internet at any time. "We created an icon [in the system] for the Internet. When users want Internet access, we assign that icon to them. Thus, they access the Internet the same way they access lab or radiology or anything else," Livingston says.

One of the things becoming important to providers is the transmission of patient information over the Web, whether it's in electronic transmissions or through Web pages, Briner says. "We are providing some new capabilities for our products to tighten down and control those types of transmissions. The rules are changing and are changing fast." ■

Providers work to delay implementation of APCs

Proposed rule needs to include latest data

Providers have begun the push to delay the implementation of the proposed surgical ambulatory payment classifications (APCs) for ambulatory surgery centers (ASCs) and hospital-based outpatient facilities.

The proposed rule would replace the current eight ASC payment groups with 105 groups, or APCs. The Health Care Financing Administration (HCFA) also wants to adopt APCs as its outpatient prospective payment system (PPS) for hospital-based outpatient surgery services.

HCFA postponed the deadline for comments on the proposed ASC rule, published in the *Federal Register* June 12, 1998, and the hospital notice, published in the Sept. 8 *Federal Register*, three times before finally closing the books on July 30.

"We still feel the proposed rule is fundamentally flawed and are strongly urging HCFA to withdraw it for the time being," says **Lynn Shapiro**, JD, an attorney with the Washington, DC, office of Epstein, Becker, & Green, which represents AmSurg, a single specialty surgical center company that owns 52 ASCs nationwide.

Kathy Bryant, JD, executive director of the Federated Ambulatory Surgery Association in Alexandria, VA, says, "We have met with HCFA officials and let them know we feel delaying the final rule until our concerns are adequately addressed is reasonable and in everyone's best interest."

Money's tight because of BBA requirements

HCFA's resources already are stretched thin by a long list of official "to-do" items legislated by the Balanced Budget Act of 1997 — and the APCs are not part of this list. Providers are urging the agency to focus on the statutorily mandated projects it has to finish by legislatively specified dates. Then HCFA can come back to the APC update after it and industry groups have been able to meet and work out their differences, provider groups are suggesting.

"We feel this is an alternative that is workable. And we have communicated that idea to key people on Capitol Hill, as well as HCFA," notes Bryant.

The providers want HCFA to delay implementation of the new APCs while it forms an outside advisory committee to evaluate revising the proposed rule in light of the latest data from the agency's 1999 ASC facility survey.

David Schweer, manager of business development at Washoe Health System in Reno, NV, says, "Personally, I'd be happy if that happened — surprised, but happy."

Basic complaints about the current proposed rule include:

✓ **APCs won't be budget neutral.**

Most groups dispute HCFA's original claim that its proposed APC rates are effectively budget neutral, saving less than 2% over the five years. HCFA now estimates the average hospital would lose 5.7% in Medicare outpatient reimbursement the first year, according to the June 30 *Federal Register*.

However, a study done by The Lewin Group, a Fairfax, VA-based health care economic consulting group, indicates the proposed payment rates would cut overall Medicare ASC outlays by closer to 10%, says **Paul Rohlf**, MD, president of the San Diego-based American Association of Ambulatory Surgical Centers (AAASC).

Hardest hit would be "single-specialty facilities specializing in ophthalmology, digestive gastrointestinal, and urology that would probably see reductions in their Medicare reimbursement ranging between 15% and 25%," predicts Rohlf.

In response to such concerns, Sen. Jim Jeffords (R-VT) and Rep. Mark Foley (R-FL) have introduced bills (S 1263 and HR 2241) that would limit reductions in reimbursement to 5% the first year, 10% the second year, and 15% the third year.

✓ **It was based on flawed data.**

"HCFA's rate-setting methodology is fraught with problems and inconsistencies which clearly prohibit it from making an accurate impact analysis," argues Shapiro. Organizations including the American Gastroenterological Association in Bethesda, MD, complain that the 1994 ASC Cost Survey that HCFA based its proposed ASC rates on was flawed because significant segments of the ASC industry were excluded from the survey's sample.

In turn, the sample does not constitute a truly representative sample of ASCs in operation — and the data it did collect do not reflect today's cost of providing ASC facility services, the groups say.

✓ **It wasn't based on actual costs.**

Providers also argue HCFA is required by law to use "actual costs" when setting payment rates for ASC codes. Yet HCFA's own *Federal Register* notice stated it had to extrapolate a large number of fees because HCFA lacked sufficient cost data for 42% of all ambulatory surgical codes.

✓ **Rates are biased toward less reimbursement.**

AAASC leaders also think the new rates are biased toward lower payments. In fact, The Lewin Group, which was commissioned by AAASC to analyze the APC rates, found a 65% greater chance there would be a reduction in the proposed payment for codes in extrapolated APCs than for those HCFA had adequate actual data available. Meanwhile, there seemed to be a bias toward unusually high rate increases for low-volume procedures.

✓ **There are problems with the hospital outpatient proposal.**

The American Hospital Association (AHA) in Chicago also has numerous problems with the data used and the way rates are formulated, fearing they may provide an unfair incentive to perform procedures in ASC settings.

Schweer agrees. In comments submitted to HCFA, he said, "HCFA's decision to loosen the criteria for determining which surgical procedures can be performed in an ASC, as well as the reduction in payments the revised rate-setting methodology will have on various high-volume procedures, will create an inappropriate incentive to shift some procedures from hospital outpatient departments to ASCs."

To help prevent that from happening, the AHA wants HCFA to reinstate its previous standard requiring covered surgical services be limited to those that do not generally need more than four hours of recovery or convalescent time.

The AHA also wants HCFA to delay implementation until the agency can ensure that all systems are in place for the change. "We believe that HCFA should not implement the outpatient PPS unless all systems — claims processing software and Medicare summary notices — are ready, tested, and installed by the intermediaries well in advance of the proposed start date," the AHA said in a letter to HCFA.

A spokesperson for HCFA, who asked to remain anonymous under agency policy, says, "At this time, I am not aware of any plans to delay implementation of the new proposed rates

for ambulatory surgery centers. However, one reason we ask for outside comments is because a proposed rule is just that, a proposal. In turn, we are taking a look at all the comments."

Roslyne Schulman, senior associate director for policy development at the AHA's Washington, DC, office, says, "Right now it looks like it will be summer 2000 before the PPS is in place." ■

OIG report finds DRG 014 overpayment trend

Targeted hospitals will be investigated

A government report released by the Office of The Inspector General (OIG) in Washington, DC, this summer¹ found that 35 hospitals had "abnormally high" rates of the diagnosis related group (DRG) 014 code compared to national figures.

DRG 014 is used when patients have principal diagnoses that include cerebrovascular accident and intracerebral hemorrhage.

The Health Care Financing Administration (HCFA) contracts with two clinical data abstraction centers to collect this clinical data from hospital medical records. The centers validate a random sample of claims from all Medicare inpatient hospital discharges.

Results of 1996 validation work found that 4% of DRG 014 discharge samples should have been coded to a lower-weighted DRG. The OIG then analyzed the Medicare Provider Analysis and Review file to identify hospitals with unusually high billings in fiscal years 1993 to 1996.

Exceeded the national norm

The OIG review found 35 out of 4,883 hospitals that had a large proportion of DRG 014 discharges to total discharges in 1996 and a significant increase in the proportion of DRG 014 discharges to total discharges between 1993 and 1996.

The 35 hospitals exceeded the national norms of the number of DRG 014 discharges by 1,403 cases. Using an average per discharge difference of \$1,716, the OIG estimates that the potential overpayments could be as high as \$2.4 million or 14% of the \$16.6 million paid to these hospitals in 1996.

The 35 hospitals have been referred to the

OIG's Office of Investigations.

Earlier this year in a report to HCFA, Inspector General June Gibbs-Brown expressed concern about the potential for abuse of the DRG system and about HCFA's oversight of the accuracy of the DRG coding system.² "The DRG system is vulnerable to abuse by providers who wish to increase reimbursement inappropriately through upcoding, particularly so within certain DRGs," the inspector general said. These DRGs included 014, DRG 79 (respiratory infections), and DRG 416 (septicemia).

The OIG found that in a focused sample of 299 hospitals, the average rate of upcoding was not statistically different from the average downcoding rate. Those hospitals that computer software predicted would have a high rate of upcoding, though, had an average upcoding rate of more

than twice that of downcoding. To the OIG, the difference indicated instances of intentional abuse by some providers.

In the report, the OIG also recommended that HCFA perform "routine monitoring and analysis of hospital billing data and clinical data to proactively identify aberrant patterns of upcoding." Since the publication of the report, HCFA has agreed to this recommendation.

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Y2K global impact can be viewed on Internet

At midnight on New Year's Eve in New Zealand, a World Bank-funded organization will begin monitoring any Y2K problems and posting the information on the Internet, reports *Reuters News*. The 17-hour lag time to the East Coast will give companies in the United States advance notice of any Y2K failures.

Using a standardized reporting format, the International Y2K Cooperation Center in Washington, DC, plans to collect data from 170 or more national Y2K coordinators. Its Web site (www.iy2kcc.org) will flash color-coded reports on everything from energy and communications to financial and government services and air, land, and sea transport.

Anyone with access to the Internet will be able to monitor, country by country, the status of the technology-challenging date change — assuming the Internet itself does not go haywire. One goal is to prevent panic and rumor mongering.

The center, which operates on a \$1 million budget and was set up under United Nations

auspices in February, has been stitching together regional discussions to deal with cross-border issues, to swap data, and to prepare contingency plans. ▼

OIG says projects saved more than \$1 million

In their first 18 months of operation, the Administration on Aging's (AOA) health care fraud and abuse control projects reported saving an estimated \$1.24 million in Medicare funds and \$102,000 in Medicaid funds, according to a report from the Office of the Inspector General in Washington, DC.

The projects also generated 133 formal complaints that resulted in some action. Currently, AOA has two separate anti-fraud projects that use differing methods to train Medicare beneficiaries to spot and report health care fraud and abuse.

The report noted, however, that direct evidence of savings was difficult to obtain for several reasons, including the practice of encouraging beneficiaries to directly contact providers or Medicare contractors with their concerns. It also noted that performance among the projects is uneven.

OIG encouraged AOA to continue the projects. A companion report identified common problems with the projects and highlighted which practices are effective. The reports can be accessed at www.dhhs.gov/progorg/oei/whatsnew.html. ▼

Seniors not wowed by on-line pharmacies

Seniors who have visited on-line drugstores and pharmacies are unlikely to return for over-the-counter medications or prescriptions, according to Greenfield Online's July national "Surfing Seniors" study of 1,200 people age 55 and older. Some 32% have visited a drugstore site, but 56% said that they were not very likely or not likely at all to buy products through these sites in the future.

Top sites visited by seniors were:

Site	% Visited Site
Drugstore.com	44%
Mothernature.com	24%
Planetrx.com	22%
Vitaminshoppe.com	17%
Healthshop.com	17%
Greentree.com	17%
Enutrition.com	12%
GNC.com	11%

Only 9% purchased prescription drugs when visiting an on-line store, while more than twice as many purchased over-the-counter products. The study did not specifically ask the seniors why they would not order again from the on-line pharmacies, says **Gail Janensch**, APR, director of public relations for the Westport, CT-based research company. However, researchers believe the results reflect the initial reluctance of older consumers to accept new technology. ▼

Institute launches virtual patient information site

The Cooper Institute for Advanced Studies in Medicine and the Humanities in Naples, FL, announced a Web site, www.cooperinstitute.org, that is designed to prepare consumers to be more active and assertive partners in the management of their health care.

Designed in concert with Imagun in Naples, the Cooper Institute Virtual Patient Education Resource Center includes the following features:

- **Health Brief Tool Kit** — Presents a series of

electronic brochures that illustrate tools and principles that consumers can use to navigate the health care system.

- **Physician Profiler** — Furnishes a comprehensive list of all major health care professional information databases available to the public including links, search costs, and quality/content reviews.

- **On the Hill Legislative Update** — Provides links to sites that track both federal and state health care legislation.

- **Up Close & Personal Interview Series** — Presents in-depth interviews with leading-edge experts, health care professionals, and patients concerning the impact of technology, legislation, business, and societal practices on consumers in health care.

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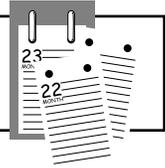
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CALENDAR



• **Hospital Outpatient Coding & Reimbursement Summit: Improve Accuracy & Succeed Under Outpatient PPS** will be held Nov. 3-5, 1999, in Lake Buena Vista, FL. The conference includes a pre-conference workshop on outpatient audit strategies to reduce fraud and abuse risks. For more information, see the Web site www.ucg.com/health/outpatient.html or call (800) 260-1545.

• **The seventh annual Health Technology Assessment Information Service (HTAIS) conference** will be held Nov. 4-5, 1999, in Philadelphia.

The theme of this year's conference, hosted by ECRI of Plymouth Meeting, PA, is "Conflict and Change: How Quality Enters the Coverage Decision." Speakers from a variety of constituencies such as Medicare, private industry, insurance, and health plans will examine the contentious and critical relationship between quality and coverage. For more information on the conference, see ECRI's Web site at: www.healthcare.ecri.org/taconf.html. ■

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