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IN THIS ISSUE

Special Section: A Look Toward the Next Century

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American Health Consultants® is
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Information key to patients' relationships with physicians

Consumers will turn in greater force to e-health sites

When Helen Smith visited her physician, she left frustrated that the hospital clinic didn't give her more information about her illness. So she turned to the Internet, surfing Web sites that offered medical content. Not only did she find the information she wanted, she also found other patients with the same condition. One of these patients gave her the name of a more sympathetic physician.

Donald Jones arrived at his doctor's appointment armed with a stack of material he downloaded off several e-health Web sites. He was then surprised to find the physician defensive when he tried to discuss what he had learned about his treatment options. The Internet can be a double-edged sword. "Connected" consumers can become more active participants in their care. They also can be much more impatient and demanding with their health care providers.

Connected consumers can be misinformed, too. "Sometimes physicians have to dispel information that people find out about their situations," says **Arky Pollokoff**, a partner in Arthur Andersen's Central Region Healthcare Consulting practice in Chicago. "Most of the dispelling involves treatment protocols."

SPECIAL SECTION: **A LOOK TOWARD THE NEXT CENTURY**

After surveying consumers through interviews and roundtable discussions, Deloitte Research and Cyber Dialogue in New York City proclaimed that "e-health consumers are set to transform the health care industry."

The companies identified five forces accelerating the evolution of a new e-health consumer. These are:

(Continued from cover page)

DRG Coding Advisor

Company begins real-time adjudication of claims

An Indianapolis-based company is actually adjudicating and resolving claims in real time. The company is currently targeting the top 10 largest and progressive payer organizations in the country in its effort to provide end-to-end resolution of claims at the point of service. The system is used primarily in outpatient environments 43

Web users want on-line management of insurance

According to a study conducted by Cyber Dialogue in New York City, 78% of Internet users want to manage their insurance benefits on the 'Net. 44

Case studies give HIM knowledge a real-life test

Didactic training in coding doesn't always prepare students for real-life situations. That's the strength of using case studies, which also develops a bond between the instructor and students, as well as students and other students 45

News Briefs

COMING IN FUTURE ISSUES

- PDA captures billing and dictation at point of care
- HHS releases the first of its final HIPAA standards
- Software to help guard against medical errors
- Utilization management goes to the Web
- Study shows technologies may intimidate health care workers

• Increased financial responsibility for consumers.

• Developments in public policy.

New legislation acknowledges increasing consumer demands for access to care, open communication with their physicians, and more overall choice in health care decision making.

• Emergence of comparative quality and performance indicators.

As consumers are eager to gain access to scientific information that will help them make informed decisions, more consumer-friendly versions of scientific data are being created, according to the survey. A number of information sources, such as TheHealthPages.com and HealthGrades.com, have begun offering Web sites that provide comparative data on hospitals, physicians, and treatment options.

• Social/demographic changes.

A larger percentage of workers will have greater accountability for their health care decisions and are likely to be more self-reliant in making decisions regarding their care. The aging baby boom generation will also demand more clout in their health care decisions.

• Connectivity.

Many consumers feel the Internet enables them to become more involved with their own health care, and such involvement increases their tendency to challenge their physicians.

"There is an enormous gap between what e-health consumers want and what they're able to get, and there is a tremendous opportunity for those who can bridge it," says **Graham Pallett**, a principal with Deloitte Consulting Health Care Practice. "The underlying question remains: Who will understand e-health consumers best, react to them most effectively, and embrace e-health consumer readiness as a strategic advantage?"

Stay one step ahead

It's understandable that many consumers are turning to e-health sites for health information. A study conducted by VHA, a national alliance of physicians and community-owned health care organizations based in Irving, TX, reports that 70% of patients surveyed did not receive any materials or referral to available information

Check out These Top e-Health Sites

Here is a partial list of popular e-health Web sites.

- ✔ **ADoctorInYourHouse.com** (www.adoctorinyourhouse.com)
  This site features celebrities discussing the serious illnesses they have experienced along with leading medical experts providing health information.
- ✔ **allHealth** (www.allhealth.com)
  This site is run by the women-oriented iVillage, and offers features on health care issues, as well as special-interest communities and support groups.
- ✔ **AMA Health Insight** (www.ama-assn.org/consumer.htm)
  This site was launched in 1997 by the American Medical Association in Chicago. All of the information is approved by an editorial board.
- ✔ **America's Doctor** (www.americasdoctor.com)
  This site provides free access to board-certified or board-eligible physicians 24 hours a day.
- ✔ **drkoop.com** (www.drkoop.com)
  This popular site is led by C. Everett Koop, MD, former U.S. surgeon general.
- ✔ **Drug Infonet** (www.druginfonet.com)
  This site includes details from package inserts and consumer pamphlets for many drugs.
- ✔ **Emd.com** (www.emd.com)
  This site is integrated with an Internet-based medication management and charting system designed to help physicians improve patient compliance and outcomes.
- ✔ **Hardin Meta Directory** (www.lib.uiowa.edu/hardin/md/index.html)
  This site is sponsored by the University of Iowa. It groups medical links by category.
- ✔ **HealthAnswers.com** (www.healthanswers.com)
  This site includes news plus a drug database.
- ✔ **Health Central** (www.healthcentral.com)
  This site offers general-interest information as well as reports from TV and radio physician Dean Edell.
- ✔ **Healthfinder** (www.healthfinder.gov)
  This site is the government's directory of authoritative health information.
- ✔ **HealthAtoZ.com** (www.healthatoz.com)
  This site allows users to personalize the home page with news and features targeted to their interests.
- ✔ **Healtheon/WebMD** (www.webmd.com)
  This site offers information for both physicians and consumers. Companies such as Microsoft have invested in this site.
- ✔ **InteliHealth** (www.intelihealth.com)
  This site is a joint venture of Aetna U.S. Healthcare and Johns Hopkins University Hospital and Health Care system in Baltimore.
- ✔ **Mayo Clinic Health Oasis** (www.mayohealth.org)
  The editors of this site are physicians at the Mayo Clinic in Rochester, MN.
- ✔ **MediConsult.com** (www.mediconsult.com)
  This site, run by an independent consumer-health marketing company based in New York, provides peer-reviewed educational materials.
- ✔ **MedHelp International** (www.medhelp.org)
  This site is run by an independent, nonprofit organization.
- ✔ **MedicineNet.com** (www.medicinenet.com)
  This site claims all of its health news and resources are produced by doctors.
- ✔ **Medscape** (www.medscape.com)
  This site is geared toward physicians and is organized by medical specialties. It offers a consumer link through CBS *HealthWatch*.
- ✔ **OnHealth** (www.onhealth.com)
  This site offers information from major medical journals and hospitals.
- ✔ **ThriveOnline** (www.thriveonline.com)
  This site is a subsidiary of Oxygen Media, a women's Web and cable TV company. It is targeted to women's health issues.

when they visited their health care provider.

Providers will find it a challenge to know everything or more than the connected patient does, Pollokoff says. "This e-phenomenon places increased demands on doctors to stay current on available information and to provide greater insight and clarification when recommending courses of treatment."

Providers also have to determine if the patient is accessing credible information.

E-health sites sponsored by medical associations, hospitals, medical centers, and schools, should offer reliable information. InteliHealth.com, a venture of Aetna U.S. Healthcare and Johns Hopkins University and Health System in Baltimore, is one example. Patients also should evaluate the credentials of the people on the site

who are giving the information. In addition, the patients need to ascertain if the information is current. Users may look for an "HON Code" symbol on the Web site, which means the site adheres to the "Health on the Net Code of Conduct." For example, these sites can only post information given by medically trained and qualified individuals.

"With more than 16,000 health-related Web sites, competitive advantage will go to those that have the most credentialed and trusted information," Pollokoff says. Consolidation of these "infomediaries" already is beginning to occur, as in the merger of WebMD and Healtheon in Atlanta.

Some sites might contain one or two items related to a patient's particular condition that the provider may never have heard of or may not think are valid, Pollokoff says. "The patient will have to decide whether all the time invested in seeking that information was worth it compared to [speaking directly to the physician]. He or she may decide to call another doctor."

Pollokoff recommends that providers follow one Web site. **(For a selected list of e-health Web sites, see p. 35.)** Some providers, for example, are accessing Medscape to keep up to date on their medical reading. From this same site, they can now access Medscape's link to consumer health information, CBS *HealthWatch*.

Providers who ignore the amount of consumer health information on-line may be sticking their heads in the sand. "I predict that upward of 100 million consumers will consume health care information during the year 2000," he says.

Don't forget e-mail

Another way for physicians to communicate with connected consumers is through e-mail. But e-mail can quickly overwhelm a physician or a hospital's Web site, experts warn.

"There has to be the ability to control the e-mail received," Pollokoff says. "[Providers] can sit and answer e-mail all night, answering questions that people should not be asking their doctor about or questions that are simple and could have been answered with a quick call to the provider's office.

E-mail helps a provider give information better but also makes it more difficult for the provider to manage its time, he continues.

When providers give patients their e-mail addresses, they need to indicate that patients may not always get a response in the time they want. "Tell them the kinds of things you can e-mail them about and when they should contact you. It might help in a preventive mode, too." ■

The health care industry won't be recognized

Internet changing the way providers do business

Not only is the Internet changing the expectations of consumers about their health care providers, but it's also transforming the way providers conduct their business.

"Electronic commerce conducted via the Internet, although it is in its early stages of emergence, already is revolutionizing the conduct of business in virtually all sectors of health care," says **Arky Pollokoff**, a partner in Arthur Andersen's Central Region Healthcare Consulting practice in Chicago.

"E-business is not just an information technology issue — it represents a new way of doing business that requires changes in business strategy, process, and people."

Give yourself a Web presence

First of all, the Internet is changing the way providers market themselves. Many hospitals know that if they don't have a strategy to help them maintain or increase market share, patients may go elsewhere. That is just one reason why most hospitals now offer Web sites.

Although patients may use the Web site to gain information about their present physicians, they may also use it to evaluate a provider's worthiness. "They look for a stickiness to the Web site," Pollokoff says. If patients don't have an opinion of one provider vs. another, they may choose the one with the best Web site.

A good site, for instance, should provide information about the organization and its physicians, allow patients to ask a nurse or doctor a question, tell patients what services are provided, and detail employment and volunteer opportunities. It also should provide directions to the facility and may even allow patients to schedule appointments over the Web. Some sites even publish

research conducted by their physicians.

Consumers, however, often find hospital Web pages difficult to navigate, Pollokoff says. And they might not be able to find more health information about a certain condition or treatment plan. "The sites don't always have a compelling interface that leads consumers to pertinent information."

That's why hospitals such as the University of Maryland (UM) Medical Center in Baltimore have chosen to partner with firms like the health information Web site drkoop.com. In exchange for a fee, drkoop.com gives the medical center geographic exclusivity to the greater Baltimore metropolitan area.

"That's important for the University of Maryland because Johns Hopkins is also in that area," Pollokoff says. On UM's Web site (www.umm.edu), therefore, users see information about the University of Maryland as well as a link to drkoop.com.

"When you click on that link, you go to a drkoop.com page, but you still see a University of Maryland logo on that page. That links you back to UM," he explains. "That's the only hospital in the Baltimore area that is allowed to do that."

Instead of having to invest in providing general health and wellness information, the University of Maryland uses drkoop.com to provide it. Hospitals are realizing the value of such e-business partnering, Pollokoff says. "Hospitals have to make the decision whether they want to gather and maintain the information themselves."

Physicians also are going to be increasingly Web savvy, Pollokoff says. "They will understand what they need to do as individuals and as part of their groups to figure out the best way to keep market share, to deliver information, and to get information so they can maintain credible information for their patient population and potential patient population."

Regular business transactions also are changing through the use of the Internet. For example, companies are working with hospitals and hospital providers to facilitate on-line claims processing. One company, RealMed in Indianapolis espouses real-time adjudication and resolution of claims. **(For more information on RealMed, see story, p. 43.)**

Hospitals also have to figure out which transactions they want to use in this electronic business world, Pollokoff advises.

Ordering materials is one way hospitals will be using the world of e-business. Healtheon/WebMD Corp., an Internet health care company in Atlanta, and medibuy.com, an e-commerce solution for health care supply procurement based in San Diego, have entered into an agreement to design and operate an integrated e-commerce marketplace for the procurement of medical and nonmedical supplies by physicians.

Hospitals can use e-business in planning construction and renovations, too. "The Web site Neoforma.com lets you do a panoramic tour of a room or building," Pollokoff says. "Then you can click on a piece of equipment in that room and order that piece of equipment just like ordering an item from amazon.com." The site also gives providers the ability to sell or auction used equipment. "You can sell a three-year-old MRI to a third-world country through the Internet."

The Health care industry can learn from other industries who are more proficient in these new technologies, he says. "Instead of reinventing the wheel, look to other organizations that are leaders in customer service, sales, and the processes they use and benchmark yourself against those other industries." ■

Over the main Y2K hurdle!

Questions on Y2K spending make providers bristle

The bug afflicting hospitals across the country Jan. 1 wasn't from Y2K problems. The flu took that honor instead.

As emergency departments filled with flu-ravaged patients, providers breathed a collective sigh of relief as 2000 arrived with only a few computer glitches.

"Our transition from the 20th to 21st century was, with just a few minor disruptions, smooth and seamless," says **Sen. Christopher Dodd**, (D-CT). Dodd is the vice chairman of the Senate's Special Committee on the Year 2000 Technology Problem.

"We saw that it was business as usual — a nonevent event," says **Dionne Dougall**, assistant director of media relations for the American Hospital Association's (AHA) Washington, DC, office. "The successful outcome was a tribute to the number of hours that people all the way from the CEO down to each and every hospital

employee put in toward that goal."

The reports of problems received by the U.S. Food and Drug Administration (FDA) in Rockville, MD, have been minimal. As of close of business on Thursday, Jan. 6, the FDA had received 24 reports regarding possible Y2K problems with medical devices, only five of which were direct reports to the FDA. Two reports were determined to be false. Four reports were determined to be not Y2K-related.

The remaining 18 reports on medical device problems related to Y2K were followed up by the FDA's Center for Devices and Radiological Health. Five of these devices were known to be noncompliant by the FDA. None of the problems discovered in the 18 devices were safety issues either because the problem did not affect the functionality of the device (it was a date display or printed date issue only) or a manual reset or date reset option was available.

Problems with Medicare payments occurred, too, but not because of problems with the Health Care Financing Administration's (HCFA) computer systems. A Y2K-related problem at a Chicago area bank temporarily interrupted Medicare payments to providers in at least eight states, including Oregon, Washington, and California. The problem only affected electronic funds payments.

Medicare contractors worked around the problem by sending diskettes containing processed claims to the bank by courier or Federal Express so that the payments could be made. The glitch was reported to be fixed by Jan. 6, according to HCFA.

Other widely reported problems in sectors other than health care included multiple charges of credit card purchases from retailers using noncompliant payment software. The Pentagon also shut down one of its key intelligence-processing computers while testing for a Y2K correction. The shutdown interrupted the flow of spy satellite data for several hours.

Both the U.S. Office of Management and Budget and American Hospital Association estimate that the costs of Y2K preparation will reach the $8 billion range. Providers have done such a good job preparing for the Y2K transition, though, that the media and some members of the public question the urgency of the situation.

If, critics contend, computer systems were so vulnerable, why weren't more problems reported? Could the entire situation have been a lot of hype or even a hoax? Was the money spent wasted?

These questions anger many involved in the Y2K preparation process. First of all, they say, the problem still isn't resolved. "The fact that there continue to be date-change glitches reminds us that the Y2K challenge was very real," says **John Koskinen**, chair of the President's Council on Year 2000 Conversion. "The hard work of thousands of dedicated employees in the public and private sectors is the reason why what we have seen thus far are minor difficulties and not serious national problems."

Did hard work make transition look easy?

Maybe providers did too good a job, says **Dwain Shaw**, director of information services at the Medical College of Georgia in Augusta. "Most of us who worked so diligently understand what would have happened had we not tackled the problem. I think the real question is — Would we have been greater heroes if there had been more catastrophic failures?

"My personal take is that the media wanted to see failures at the stroke of midnight and when they didn't happen, the obvious [reaction] was for the whole episode to be labeled as a hype and a hoax. The fact that it was overhyped was actually a blessing in disguise because it kept people at home, giving us [in health care] the time to devote to any failures that did arise."

The media and hoax theorists are looking at the current results with negative thoughts, he adds. "Did we spend too much? I don't know because if we had spent less, even one dollar less, how will we ever know if that dollar would mean the difference between success or failure, life or death? In retrospect, I would do the same things I did, as I believe would my peers, to prepare," explains Shaw.

The money and resources spent on Y2K preparation were definitely not wasted, Dougall says. "Y2K was an issue that was identified early on as a challenge. Hospitals would have been remiss if they had not looked at the possible implications [Y2K problems] might have on patient care."

A largely seamless transition was not the only benefit of the Y2K preparation. Providers are much more in control of their computer systems now.

Providers did a technical "cleansing," replacing old technology with new. "In the process, we corrected those things we found wrong," Shaw

(Continued on page 43)

DRG CODING ADVISOR®

Safe harbors extended to four types of ASCs

A newly published regulation will allow safe harbor exceptions to federal fraud and abuse laws for four types of ambulatory surgery centers (ASCs): surgeon-owned ASCs, single-specialty ASCs, multispecialty ASCs, and hospital-physician ASCs.

"This is good news," says **Michael Blau**, Esq., partner in charge of the Boston health law department for McDermott, Will, and Emery. "At least we have relative specificity for various categories of ASCs."

For example, the government has said that a hospital-physician ASC can quality for safe harbor protection. "In the original [proposed] safe harbor, we were unsure whether any hospital-physician ASC could fall under a safe harbor," he says.

Not everyone is pleased

Others aren't so upbeat. The Federated Ambulatory Surgery Association (FASA) in Alexandria, VA, released a statement saying, "Although FASA believes finalizing the safe harbor is an important step forward, we recognize that the safe harbor is limited and in some ways more restrictive than warranted. FASA will continue to work to improve the interpretation of this law."

The proposed additions to the safe harbors, which covered only ASCs that were entirely owned by surgeons, were published Sept. 21, 1993.

The interim final rule on the safe harbors additions was published in the *Federal Register* Nov. 19, 1999. *(The interim final rule can be obtained from www.dhhs.gov/progorg/oig/ new.html or from the* Federal Register *in most public libraries.)* Comment was received on the interim final rule until Jan. 18, 2000, and the interim final rule is subject to change.

Some of the most important changes between the proposed and final safe harbor additions are:

1. It's now clear that safe harbor protection is allowed for physician-hospital ASCs, multispecialty ASCs, and single specialty ASCs in which only some of the physicians are surgeons.

2. For single-specialty ASCs, not all physicians must be surgeons. They simply have to all practice the same specialty. "That's a significant improvement from the proposed safe harbors," Blau says.

3. There's now a disclosure requirement for physicians who have an investment interest in an ASC and refer patients to their facility. Patients must be fully informed of the investor's interest.

The disclosure must be documented, Blau emphasizes. "From a physician standpoint, it's another piece of paper in the registration process that patients are going to have to sign. Make sure it says they read it and understood what they read."

Think of it as an opportunity

This requirement is an opportunity for surgeons, says **Stephen W. Earnhart**, MS, president and CEO of Earnhart & Associates, a Dallas-based ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.

"I would put a picture of the surgery center on my office wall and probably laminate my

ownership share and tack that up there beside it," Earnhart says.

"I would tell every one of my patients that, 'I am an owner of the Earnhart Surgery Center, and I hand-picked every staff member there, approved all the equipment purchases, and oversee all the supplies we use. Therefore, I am proud to book your surgical procedure at this great facility,'" he explains.

Earnhart's firm encourages its physician partners to let their patients know that the surgery is going to be done in a facility where the surgeon has an opportunity to influence the quality of care and patient safety. "This is golden opportunity for the physician to market not only the surgery center, but themselves," he says.

New one-third requirement

For all four types of surgery centers, there is a new requirement that at least one-third of each physician investor's medical practice income during the previous 12 months has to be derived from the surgeons' performance of ambulatory surgery procedures, but not necessarily in the ASC where he or she has an investment interest.

The reason is that the Health Care Financing Administration (HCFA) and the Office of Inspector General (OIG) view the ASC safe harbor as a workplace exception, Blau says. "If the physician or surgeon is referring him- or herself, and the surgeon is going to perform the surgery on his or her own patient, the surgeon is really using the ASC as an extension of the practice — really his or her own workplace," he says.

The one-third requirement won't disqualify very many, Blau says. "On the other hand, it will draw a line and allow one to distinguish passive investors who aren't surgeons, who might otherwise be people interested in an investment interest simply to get a financial return and who are in a position to refer to surgeons. That's what OIG is trying to carve out."

There is another "one-third" test that applies only to multispecialty ASCs under the new safe harbor. For those facilities, at least one-third of the *procedures* performed by each physician investor during the previous 12 months needs to have been provided in an ASC where the physician has an investment interest.

The reason for this requirement is that in multispecialty ASCs, the OIG was concerned that an investment interest might create incentives for surgeons or physicians to cross-refer among each other, rather than using the ASC as a workplace exception.

"All it does it cut out those who would be more passive investors, in a position to refer, in contrast to surgeons using the ASC on regular basis," Blau says.

Safe harbors can be helpful in some cases

For hospitals that are interested in becoming partners with doctors in ASCs, safe harbors are helpful, Blau says. "There were serious questions about whether this was permissible."

There is one touchy area for hospitals. The OIG made it clear: If a hospital is going to be a partner

HCFA wants suggestions to improve Medicare

The Health Care Financing Administration is seeking suggestions from the public on ways to make Medicare more efficient. The requirements for submitting the suggestions are as follows:

- ✔ Anyone can make a suggestion, except Medicare contractors, employees of federal agencies, federal contractors, employees of federally sponsored research and demonstration projects, any federal officer or employee, or immediate families of any of those groups.
- ✔ HCFA has sole discretion to determine whether a suggestion has merit, whether it will be implemented in part or in whole, and whether the individual making the suggestion will receive an award.
- ✔ Suggestions must be submitted in written form and include:
  — description of an existing problem;
  — method for solving the problem;
  — if known, an estimate of potential savings to Medicare.

Send suggestions to: HCFA, Suggestion Program, 7500 Security Blvd., Baltimore, MD 21224-1850. ■

in an ASC, and the ASC wants safe harbor protection, the hospital has to disqualify itself from being able to refer to the ASC, Blau says.

The hospital can address this concern by entering into a written stipulation under which the hospital contractually agrees that it won't refer or attempt to influence referrals to the ASC, he says. Examples of violations include patient overflow that is sent to a joint venture ASC or a situation in which a hospital-based physician or members of a hospital-affiliated group practice refer to the ASC. Such referral decisions are imputed to the hospital.

"It would be as if the hospital made those referrals," Blau says.

The impact of these safe harbors additions should be a "call for action" for hospitals to start taking care of their surgeons as well as they have been taking care of the patients, Earnhart says. "Like it or not, the patients will stay with the physician — not the hospital — when forced to chose between the two."

Many hospitals find it difficult to compete with physician-owned ASCs, Earnhart says. "Hospitals and surgeons need to start working together on ambulatory surgery programs, or the industry will become so fragmented and unprofitable, with surgery centers on every corner, that everyone loses."

A safe harbor isn't required

Even if your situation doesn't fall within one of the safe harbor additions, you haven't necessarily violated any fraud and abuse laws, Blau emphasizes. "Safe harbors are limited definitions of financial transactions that OIG has specifically said has such a small or no potential for fraud and abuse that they'll immunize from prosecution or sanction or penalty."

However, just because you don't meet the narrow definitions doesn't mean your conduct is illegal. "It just means it's outside the safe harbor and subject to scrutiny," Blau says. "Many financial transactions don't meet every standard and parameter of safe harbor, but are completely legally defensible arrangements."

In fact, an ASC might fall under another safe harbor, such as the small entity or underserved area safe harbors.

So what's the bottom line, according to Blau? "Is the arrangement intended to induce referrals, inappropriately, particularly from physicians who are in a position to refer and not perform surgery on their own patients, or is it a legitimate workplace where physician can provide quality care at a cost-effective price for patients as an extension of their practice?" ■

HCFA to phase in APCs for surgery centers

Tremendous victory for outpatient procedures

In a tremendous victory for outpatient surgery programs, Congress on Nov. 19, 1999, ordered the Health Care Financing Administration (HCFA) to phase in ambulatory patient classifications (APCs) over three years for ambulatory surgery centers (ASCs).

Congress ordered that these new reimbursement rates, the foundation for an outpatient prospective payment system (PPS), be blended with current rates at a 1/3:2/3 ratio the first year, 2/3:1/3 ratio the second year, and full implementation the third year.

Preventing erratic changes

"The obvious advantage of this provision is that it requires HCFA to slowly phase in changes, so that ASCs don't experience abrupt and erratic reimbursement changes," says an advisory memorandum from **Michael Romansky**, JD, partner in the health law practice at McDermott, Will, and Emery in Washington, DC.

Congress' choice of words — If [HCFA] implements a revised prospective payment system . . . — indicates that Congress disapproves of the payment rule and prefers that HCFA not proceed, he said. "HCFA may choose to forgo implementation of the payment update rather than wrestle with a complicated and time-consuming phase-in mechanism."

And there's more good news, according to McDermott, Will, and Emery's publication, *Health Law Update* (1999; 16:1-2). Hospital-based same-day surgery programs will receive supplemental payments, in addition to APC payments, during the first three years of an outpatient PPS, if the PPS payments are less than the payments that would have been made prior to PPS (i.e., calendar year 1996).

These three years of supplemental payments

for hospitals are being referred to as the "transitional corridor."

Cancer hospitals will be held harmless under the outpatient PPS indefinitely, which means the reimbursement for cancer hospitals under the PPS will not be less than they received prior to the Balanced Budget Act, which would be calendar year 1996. Rural hospitals with fewer than 100 beds will be held harmless through calendar year 2003.

Congress wants impact study

Congress has ordered the Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment issues, to study the appropriateness of an outpatient PPS for Medicare-dependent hospitals, sole community hospitals, rural referral centers, rural health clinics, and other types of rural hospitals.

"This study reflects Congress' concern with the ability of these entities to remain viable under an outpatient PPS and signals possible future Congressional action in this area," according to *Health Law Update*.

Congress has ordered HCFA to make additional payments for new drugs, devices, and biologicals — those not paid for on an outpatient basis before 1997. Congress also has limited beneficiary copayment liability for outpatient procedures to the amount of the inpatient deductible that year ($776 in fiscal year 2000). Medicare will offer supplemental payments to hospitals to compensate for the difference between the copayment and this limit.

Many of the changes made to reimbursement for hospital outpatient services are budget-neutral, "which means one hospital's gain may be another's loss," the article stated.

Implementation delayed again

If HCFA does proceed with the phased-in period for surgery center reimbursement, implementation will be delayed beyond the previous estimate of July 2000, Romansky predicted. "Assuming HCFA maintains the link between the [ambulatory surgery center] and hospital outpatient payment systems, it may be 2001 before HCFA can possibly implement these regulations."

In other news, the Medicare bill also requires MedPAC to study the cost-effectiveness and efficacy of extending Medicare reimbursement to post-surgical recovery care centers. ■

Fraud alert addresses outpatient surgery billing

The Health Care Financing Administration (HCFA) has issued a fraud alert (No. 99-09) stating acute care hospitals are billing outpatient surgery services as one-day inpatient stays.

According to the fraud alert, claims are being submitted using the inpatient type of bill (TOB) 11X with the "from date" equaling the "through date." Hospitals are using a patient status code of 01 (discharged from home or self-care / routine discharge). Ambulatory surgery claims should be billed using TOB 83X or 13X, according to HCFA.

"By billing Medicare for these services as inpatient, the hospital can increase their reimbursement by 83%, since payment is based on the diagnosis related group (DRG), rather than the applicable ambulatory surgical center (ASC) fee schedule (83X TOB) or the cost of charge percentage (13X TOB)," the fraud alert says.

"In addition, the beneficiary would be responsible for the current inpatient deductible, as opposed to the outpatient deductible and / or coinsurance amount, according to the alert. ■

• **Risks and Rewards: Implementing The HIPAA Privacy And Security Standards, presented by Health Information Privacy Alert**, will be held March 7, 2000, in Washington, DC.

Attendees can discover how the new privacy and security standards will affect their health care organizations, and what they must do to comply with the new rules. They can also learn how to cope with the new data collection and privacy issues presented by electronic communications, electronic commerce and the Internet.

For more information, call Michele Krueger, McKenna & Cuneo, LLP, at (202) 496-7555 or through e-mail at michele_krueger@mckenna cuneo.com. ■

(Continued from page 38)

says. "We will never have a better handle on our inventory than we do right now. We will never again review our business processes with such diligence."

"Assessments of information technology systems and inventories have resulted in streamlined processes, leading to increased efficiency and productivity," Dodd says.

Hospitals also were able to develop and fine-tune their contingency plans and make sure they had disaster drills in place, Dougall says. "We like to pride ourselves on being prepared for the unexpected." In reviewing the plans, hospitals were able to establish and possibly maintain tighter relationships with some of their community partners.

Y2K also helped increase public awareness and opinion of health care providers. "From my perspective, the consortium of our area hospitals led the charge to dispel the doomsayers and help educate the community with the truth about Y2K," Shaw says. "In so doing, we instilled a level of confidence in our community probably higher than it has ever been before.

"At the national level, the health care industry had to rely on trust and good faith that everyone was going to do their part of the job to see to it that Y2K was a yawner," he continues. "In the process we found out who was dependable and who was not. At the international level, we led the charge to help the rest of the world prepare their systems so no harm would come to the patient for what we did or did not do in preparation for Y2K.

"I am unaware of even one patient suffering because of Y2K, and that is one heck of a report card for us." ■

Company begins real-time adjudication of claims

Here is what you owe

Providers would love to reduce the number of days it takes to have claims paid. Now a company is actually adjudicating and resolving claims in real time.

RealMed Corp., based in Indianapolis, is currently targeting the top 10 largest and progressive payer organizations in the country in its effort to provide end-to-end resolution of claims at the point of service. The system is used primarily in outpatient environments.

"To bring value to the provider, you need enough of their payers so that it warrants them using a new system," says **Todd Morris**, RealMed's vice president of marketing. "Typically we look to payer organizations that have 25% to 30% of a specific geography's patients. Once we have that, we go out and make the offer [of the system] to the health care provider organizations."

After RealMed has successfully integrated all the major payers, it expects the adoption of the platform to weave across the health care industry.

"It will take some time, but we are starting by focusing on the large payers that deliver the greatest number of claims for our specific providers," Morris says. RealMed has actively integrated with three of the payers, and is in varying stages of discussion with others.

Real-time claim resolution is attractive to payers that want to increase their level of service to payers and members, he says. In addition, payers find they can save more on administrative costs by using such a system than they can by holding the money. Actuarial firm Milliman & Robertson in Seattle estimates RealMed's system will save payers more than 75% in per-claim processing and customer service costs up to $8.25 per claim.

Building a network

RealMed electronically links insurance and managed care companies, physicians, and health care providers, and ultimately, patients through its RealMed Network. The network processes data and dollars much like a retail credit card transaction.

Components of the network include:

- **RealMed for health care providers.**

This is a claims resolution package that includes software, a smart card reader, office smart cards, and help desk support. RealMed for health care providers links the provider to the network and offers real-time patient check-in, eligibility verification, referrals, precertification, claim submission, claim repricing, interactive adjudication, credit/debit card transactions and printing of explanation of benefits (EOBs) at the point of service.

- **RealMed for payers.**

This integration interfaces with a payer's current claims adjudication engine to enable interactive

adjudication directly with health care providers. Typically, this requires a multimillion dollar, six-month integration effort.

• **Insured smart card.**

This is a plastic card containing a microchip that functions both as a microprocessor and as a storage device for a unique patient identifier. If a payer elects not to provide smart cards to its members, the system may be accessed using a unique identification number.

"The [provider] logs on to the system in the morning using its RealMed smart card," Morris explains. "The card unlocks the payment plan. When the member comes in, the provider can either enter the smart card or can key in the unique identifier for the patient. That sets off our linking with the payer organization to let the claim be resolved."

Taken as a whole, the visit to the health care provider becomes more like a standard retail transaction. Bills for services provided are settled at the point of care. "The providers link directly with the insurance company's membership files, find out if the patient is indeed covered, how much of the deductible has been met, and what the copay is," Morris says.

By showing how much insurance will pay on a claim, providers can collect from the patient or make arrangements for the collection of payment face to face as opposed to using letters and billing statements. "This reduces write-offs from patients," he says. **(For information on patients who want to manage their health insurance benefits on-line, see story at right.)**

The process step by step

Here is an example of how the RealMed process might work when a patient comes in to a provider's facility for treatment:

• **Check-in.**

The patient presents a health insurance smart card or current ID card; an electronic check-in file is opened and presents the precise demographic and insurance information from the payer's Legacy system.

• **Eligibility verification.**

The office staff verifies eligibility on-line in real time by connecting to the universal RealMed payment center.

• **Treatment.**

The patient sees the provider for diagnosis and treatment.

• **Claim submission.**

Someone from the office staff files an electronic claim form to the payer organization. (Hospitals can submit both their HCFA 1500 and UB92 claims.) Comprehensive on-line edits ensure the claim is complete.

• **Repricing and adjudication.**

RealMed for Payers links with the payer's existing adjudication engine to reprice and adjudicate the claim and returns the claim to the health care provider for acceptance within seconds; if an error is found, the office immediately receives an on-line notice.

• **Resolution and payment.**

An electronic funds transfer is then ordered from the payer to cover treatment costs, and a customized EOB is printed for both the provider and patient records. The physician can collect the copay / co-insurance from the patient on the spot.

Coming soon to your town

Providers who are wondering if they can use real-time payments should check with their payers to see if they are considering offering the system.

"For so long, providers have been fighting just to get paid at the base levels that they have negotiated," Morris says. "We're happy to help them collect on that."

[For more information, contact RealMed at (877) REALMED or go to the Web site at http://www.realmed.com.] ■

Web users want on-line management of insurance

The majority of Internet users (78%) who are covered by health insurance have an interest in managing their benefits through a payer's Web site, according to a study conducted by Cybercitizen Health for the Internet marketing company Cyber Dialogue in New York City.

"This high level of interest reflects deep levels of consumer frustration with health care red tape and bureaucracy," says **Scott Reents**, manager of health care strategies at Cyber Dialogue. "It also represents an enormous opportunity — on-line benefits management is a strong candidate to become the 'killer app' for Internet health."

In particular, 67% of on-line users would like to be able to check the extent of their coverage for various procedures and physician office visits. Other features showing a high interest rate include:

❒ checking status of filed claims (56%);

❒ finding in-network doctors and hospitals (47%);

❒ looking up information on alternative or supplemental health plans (47%);

❒ filing claims (40%).

Only 8% of the insured Internet users, however, actually have used their insurer's Web site, and 68% aren't aware if their insurer even has a Web site.

These findings are based on interviews with more than 2,700 adults in the United States. The study was fielded in July 1999. ■

Case studies give HIM knowledge a real-life test

Book offers quantitative cases, too

The call came one afternoon from the incomplete chart area. A physician was demanding to see the person who had coded one of his charts. "Dr. Mitchell is furious with these codes," the caller said. "He doesn't want a complication code as a principal diagnosis. Get over here!"

The 20-year-old coder thought she had mastered much of the coding process, but nothing she had learned in school had prepared her for handling an irate physician.

Hard to prepare for all scenarios

"None of your didactic training in coding prepares you for these kinds of situations," says **Susan Pritchard Bailey**, MBA, RHIA, a consultant with Bailey & Associates in Lenox, MA. That's why Bailey wrote a book about case studies in health information management (HIM), so students could apply their practical knowledge to real-life situations, she explains.

"The case method takes practice, but it develops an interesting bond between the instructor and students, and students and other students," she says. "It is a different teaching method that allows everyone to relax and talk and discuss how they feel about things and how they would approach problems. It also pulls in a little psychology."

This kind of discussion can spice up a teaching format that includes lectures and multiple-choice tests. "A lot of our HIM material is geared that way because the certifying exams are multiple choice."

The American Health Information Management Association (AHIMA) in Chicago advocates the use of case studies in the classroom, says **Bob Garrie**, MPA, RHIA, AHIMA's director of education and accreditation. "They provide a way to do problem solving and critical thinking. They also provide students an avenue of taking all the pieces and formulating ways to solve health information problems."

Bailey used other books about case studies while on the faculty of Ithaca (NY) College. These books, however, were usually oriented toward for-profit corporations. "There wasn't really anything relevant to HIM."

To fill a perceived void in HIM education, Bailey collected her own case studies in a book and added worksheets and an instructor's guide. The book, *Problems and Cases in Health Information Management*, was published in 1997. **(For a look at one of the cases in the book, see p. 46.)**

The book includes 13 case studies, although the first case is broken down into four smaller cases. "This gets students used to the case method," she says. "Many instructors have never used or been exposed to the case method. I wanted to start with something small so instructors could begin to work with their students."

The cases involve practical application of the student's knowledge of health information science, logical thinking, mathematical ability, and common sense. Most of the cases involve decision making at the frontline supervisor level or above.

Bailey chose the topics of her cases through her teaching experience. As one focus, she chose quantitative measurements. Exercises in quantitative measurement aren't prevalent in HIM, she says. "Sometimes as a supervisor or manager you have to get out your calculator and do some math."

In the book, for example, the student has to evaluate quality management in the transcription unit. "It's a fairly simple case for someone who has been a transcription supervisor, but not for a student," she says. ■

A story of confidentiality

Here is an example of one case study in *Problems and Cases in Health Information Management*, written by **Susan Pritchard Bailey**, MBA, RHIA, a consultant with Bailey & Associates in Lenox, MA. Bailey calls "The Patient's Story" case the "soap opera of HIM." This case addresses the threat of inappropriate release of information even when the information is being used appropriately.

In "The Patient's Story," Jane Doe is a 20-year-old woman who has been married to her high school sweetheart for one year. One day she visits her gynecologist in her small city for her annual checkup. She has been seeing this physician since she was 16. During the post-examination interview, Doe confides that she has been having trouble in her marriage. She also confides that an uncle abused her when she was a little girl. This is the first time she has told anyone of the abuse.

The gynecologist, George Smith, suggests Doe see a woman psychologist to whom the doctor has made successful referrals in the past. At Doe's request, Smith agrees to set up an appointment with the psychologist, Dorothy Jones. That afternoon, Smith asks his secretary to set up the appointment with Jones' secretary, giving sexual anxiety as the diagnosis, and promising a follow-up letter introducing Jane Doe and her problem. After Smith dictates the letter, it is transcribed and a signed copy is placed in Doe's medical record.

Before her appointment with Jones, Doe then fills out several forms and signs a "general consent" form. To keep her problem confidential, Doe chooses to pay for her sessions herself.

Back at Smith's office, however, the coder sees the letter to Jones and her reply to Smith and assigns codes related to situational anxiety instead of those relating to a routine office visit. The bill is mailed to the HMO, which kicks it out of the system because of the "mental illness" diagnosis.

The scenario continues until Doe's husband opens a bill asking for payment for Smith's office visit. He demands to know about her "mental illness."

After reading this case, instructors can then discuss ways that the risks of disclosure through appropriate access could have been reduced.

"The cases do not pretend to be perfect academic exercises," Bailey says. "They have flaws, omissions, tricks, and red herrings — just like real life.

"Students are forced, as in actual practice, to make decisions and solve problems in an environment of imperfect information," Bailey continues.

"This produces a challenge to the instructor, as well. The instructor must help the student accept and understand the frustration of having to work with inadequate or insufficient information. Sometimes some quick thinking and the inventing of additional 'information' is required to keep discussions moving. Every time the cases are used, the results will be different. This keeps the process fresh and interesting," she adds.

[For more information about the book, Problems and Cases in Health Information Management, *contact the Lenox Publishing Company at (888) 261-9648. Or visit the Web site at www.lenoxpublishing.com.]* ■

States gain billions of dollars from new DSH rule

Several states will either retain existing or receive additional Medicare disproportionate share hospital (DSH) payments — estimated to be $2.14 billion between fiscal years 2001 and 2005 — because of a technical change in the government's DSH calculations, according to a rule issued by the Health Care Financing Administration (HCFA) in Baltimore.

The change affects New York, Delaware, Hawaii, Massachusetts, Missouri, New York, Oregon, Tennessee, and Vermont, says *AHA News*. HCFA issued the rule to clear up confusion among fiscal intermediaries, who may or may not have paid hospitals for including certain types of patient days in their DSH calculations. This rule affects DSH payments prospectively; HCFA previously cleared up the issue for past cost reports. ▼

JCAHO publishes guide to sentinel events

Providers wondering how to handle sentinel events can now refer to a guide published by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

"What Every Hospital Should Know About Sentinel Events" provides statistics on the most prevalent adverse events in health care, including where these events tend to occur and who is usually affected, to assist health care leaders in identifying high-risk activities, and populations before a sentinel event occurs.

Chapters address the causes of sentinel events, strategies for prevention, the development of a root cause analysis and an action plan, ethical considerations, and legal issues. In the guide, providers can also find:

- comparisons between Joint Commission data on sentinel events and other sources of data regarding adverse medical events;
- information regarding liability and the Joint Commission's Sentinel Event Policy;
- a detailed explanation of the Sentinel Event Policy and the alternative procedures to filing a root cause analysis.

For more information on the guide, call the Joint Commission's Customer Service Center at (630) 792-5800. ▼

Implementing compliance program top concern

Getting a compliance program implemented was the top concern mentioned in a survey of corporate compliance officers. Healthcare Management Advisors in Alpharetta, GA, received 400 responses to the question, "What is the most pressing compliance problem facing your organization?"

Here are the other problems cited by the compliance officers:

- getting education programs for staff (24.6%);
- responding to technical questions (13.2%);
- deciding about possible self-disclosure (11.7%);
- starting and managing a hotline (8.0%). ▼

AHRQ seeks best practices for patient safety

The Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, announced that the agency is seeking investigators to test the effectiveness of the transfer and application of "best practices" to improve patient safety by reducing preventable medical errors.

AHRQ will award up to $2 million in fiscal year 2000 to support four to six projects under this request for applications (RFA) titled "Systems-related Best Practices to Improve Patient Safety." Letters of intent are due by March 10, 2000, and

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applications are due by April 27, 2000. Public and private for-profit and nonprofit organizations, including universities, clinics, state and local government units, nonprofit firms, and nonprofit foundations may submit applications.

Projects funded under the RFA should use rigorous research methods to test the transfer and application of best practices that reduce medical errors, and determine tangible and measurable improvements in patient safety across a variety of settings that result from their use.

Partnerships speed up process

To speed the translation of these best practices into safer patient care in as many health care settings as possible, applicants are encouraged to form partnerships or consortia that provide a wide range of multidisciplinary, technical expertise. These partnerships can include academic, public, and private health care organizations that offer a laboratory in which to evaluate error reduction and improved patient safety strategies.

To obtain a copy of the RFA, see "Systems-related Best Practices to Improve Patient Safety" on AHRQ's Web site http://www.ahrq.gov/fund. The RFA and application forms are available from the AHRQ Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907. Telephone: (800) 358-9295. Faxed copies are available from AHRQ Instant Fax by calling (301) 594-2800 from a fax machine with a telephone handset. ▼

CCS-P certification exam offered twice in 2000

The American Health Information Management Association (AHIMA) in Chicago will be offering the Certified Coding Specialist — Physician-based (CCS-P) certification exam twice this year.

The exam recognizes physician-based clinical coders who pass a mastery-level exam measuring their competence in CPT, ICD-9-CM, and HCPCS Level II coding systems. Exam dates are June 10 (early application deadline is April 21; late application deadline is May 5) and Sept. 16 — early application deadline is July 21; late application deadline is Aug. 11.

For more Information, contact AHIMA at (312) 233-1160 and request the CCS-P certification guide, or visit the association's Web site at http://www.ahima.org and follow links to "certification." ▼

CSI announces seminar schedule for 2000

The Computer Security Institute (CSI) Educational Resource Center (ERC) in San Francisco has announced the publication of its Information Security Seminars 2000 schedule. The institute has scheduled more than 60 two-day seminars for 2000, in cities across United States and Canada.

Topics include Internet security, encryption, secure Web commerce, PKI, Windows 2000, Windows NT, firewalls, advanced network security, intrusion management, forensic investigation, awareness, risk analysis, intro to computer security and more.

The CSI ERC has added new classes and new instructors to focus on the challenges and threats brought about by the trends toward e-commerce, increased network intrusions, and the need for forensic investigations, as well as the release of Windows 2000.

To receive a copy of the CSI Information Security Seminars 2000 catalog with class descriptions, contact CSI at (415) 905-2626, e-mail at csi@mfi.com, or go to the Web site http://www.gocsi.com. ■