AMERICAN HEALTH CONSULTANTS® A Medical Economics Company

HOSPITAL PEER REVIEW®

THE HEALTH CARE PROFESSIONAL'S TOP SOURCE FOR ACCREDITATION, REGULATION, AND CREDENTIALING INFORMATION

CELEBRATING 25 YEARS OF SERVING THE HEALTH CARE QUALITY PROFESSIONAL 25

IN THIS ISSUE

Continued on next page

FEBRUARY 2000
VOL. 25, NO. 2 (pages 17-28)
NOW AVAILABLE ON-LINE!
www.ahcpub.com/online.html

Involve physicians *and* coders in measuring and improving clinical outcomes

Innovative program helped slash complication rates

A creative and comprehensive project to bring physicians and coders together to better measure clinical outcomes has helped one Texas hospital slash its complication rate by dramatically improving the quality of physician documentation. But the changes leading to the turnaround weren't easy, and the fix wasn't quick. At the heart of the solution was the need to create an atmosphere of trust and understanding between physicians and coders.

Five years ago, Covenant Medical Center in Lubbock, TX, began a project to benchmark clinical outcomes data with peer facilities in Texas and the Southern region. Results from that project indicated that the medical center could improve length of stay, mortality rate, and cost and complication rates for at least some of the 25 top diagnosis-related groups (DRGs) and procedures identified as being part of the hospital's strategic priorities. The problem was, when the data were presented to the medical staff, physicians questioned their accuracy — particularly the accuracy of the complication rates, which were based on coded data entered into the hospital's data repository.

"Basically, our physicians had a tendency to blame the coders for data quality," says **Janice R. Noller**, RRA, CCS, CPHQ, quality improvement specialist in the quality management department at Covenant. Back then, Noller says, the coders had been sending occasional notes to the physicians

IN THIS ISSUE

COMING IN FUTURE MONTHS

- Job security: How to tip the odds in your favor
- A special report on medical errors and how you can prevent them
- Conscious sedation: The next accreditation battleground?
- Root-cause analysis software: How to make the right choice

requesting clarification on certain coding issues based on the physicians' documentation in the medical record. "They met with resistance from the physicians. It may just have been a communications problem," she says. "Coders and physicians have a problem communicating anyway, no matter where you go. They speak different languages, and they have to reach a common language somewhere."

Reaching common ground was a difficult proposition, however, because the physicians blamed the hospital's coders for inflating complication rates by "just picking everything up as complications," Noller says. "Evidently, there was not a whole lot of communication explaining to physicians when and why things are coded as complications. As a result, they felt that there were too many issues with the coding, the documentation, and the whole communication process. We felt there was definitely an opportunity there to investigate and see what was going on."

The dispute was troubling to the quality management department, because it wasn't yet clear whether the hospital's high complication rates were driven by coding or by physician documentation. Quality managers wanted to ensure that data used in clinical outcomes monitoring were accurate and consistent. To investigate the complication rates, they first sought to define the term and the codes to be monitored on an ongoing basis. They reached a consensus with the director of medical records and the coding supervisor to use the ICD-9-M code range 996.00-999.9 in calculating the facility's complication rate. In June 1996, a certified coding specialist was added to the quality management department to help with the project.

DRGs and complications studied

Noller used the hospital's decision support system to list every DRG for a six-month period and the number of complications in the 996.00-999.9 code range for each. **(See table for sample data, p. 19, top.)** Then she looked at the total number of cases for each complication regardless of the DRG. **(See table for sample data, p. 19, bottom.)** After comparatively analyzing the two lists, she determined that her first priorities should be DRG 358 (uterine and adnexa procedures for nonmalignancy with CC, including hysterectomies), DRG 148 (major small and large bowel procedures with CC), and code 997.4 (digestive system complications).

TOTAL CASES BY DRG

DRG	Complication Code	Complication Code Description	Total # of Comps	Total # Cases in DRG	Comp Rate per DRG
001	996.2	Mechanical Complication of Nervous System Device	1	78	1.28%
	996.78	Other Complication due to Other Internal Orthopedic Device, Implant, Graft	1		1.28
	997.02	Iatrogenic Cerebrovascular Infarction or Hemorrhage	1		1.28
TOTAL for DRG 001:			**3**	**78**	**3.85%**
002					
003					

Etc.
(Sample data only)

COMPLICATIONS RANKED BY DRG AND OCCURRENCE

DRG	Complication Codes										Total Comps
	998.1	997.4	997.3	998.89	998.2	998.5	997.5	997.1	998.3	996.62	
001				1				1			2
148	3	9	2	5	8	3	2	1			33
TOTALS	3	9	2	6	8	3	2	2			35

(Sample data only)

Source: Covenant Medical Center, Lubbock, TX.

Quality management performed an extensive medical record review on all the cases in DRGs 358 and 148 with the secondary diagnosis code of 997.4. As a result of that review, Noller identified two trends:

- Accurate code assignment had been made due to physician documentation of the term "postoperative ileus."
- A physician documentation pattern in discharge summaries was noted: "Patient's postoperative course was complicated by ileus."

Quality management staff sought to determine if the clinical treatment of patients coded with this complication differed from those not coded with the complication. In most cases, those patients did not require more sources, additional length of stay, or additional monitoring. Given those facts, Noller questioned why the physicians documented the ileus complication in their discharge summaries. The physicians replied that the coding technicians weren't familiar with the clinical aspects of ileus, as well as other conditions that commonly occur postoperatively but aren't necessarily complications, such as atelectasis, hemorrhage, hematoma, and fever.

"The physicians were very adamant that some of the things that the coders were coding as complications were actually clinically things that normally occur after an open abdominal procedure," Noller says. Meanwhile, "[the coders] wanted me to be able to go to the physicians on a regular basis and say, 'This is the data, this is why it appears this way, and this is what we'd like you to do to help the coders. Meanwhile, the coders will try to help you in understanding why they're asking what they're asking for.' This was not an overnight process. It was probably anywhere from a year to a year and a half before I even got a few physicians to finally give me some positive responses."

One of the biggest obstacles to improving the communication process was the physicians' idea that the coding of a complication meant they had done something wrong. Noller reports that it took almost a year to convince them otherwise.

(Continued on page 21)

Chart Review for Coding of Complications

Goals

1. To determine accuracy of ICD-9-CM codes in the database as they relate to complications of surgical and medical care and the medical record documentation of those complications.
2. To determine possible trends in other related information as requested by QM Department, physicians or others, as needed.

Determine Assignment based on:
1. Pathway Presentations
2. External Benchmarking
3. Target DRG's
4. Core Business Groups
5. Other DRG's based on QM Tracking Charts

↓

Run Encounter report on TSI to obtain baseline information and patient Medical Record Number.

↓

List Medical Record Numbers in Terminal Digit order to pull records more efficiently.

↓

Record basic information from the Medical Record into the Complication Analysis database.

↓

Read the patient's H&PE for Reason for Admission and any chronic conditions undergoing continuous treatment.

↓

Read Operative dictations for documentation of potential intraoperative complications.

↓

Read Progress Notes for any potential postoperative complications and the accuracy of the documentation.

↓

Review Discharge Summary for documentation accuracy of any identified complications.

↓

Compare Medical Record documentation of any complications with the ICD-9-CM code assignment.

↓

Research as needed the coding guidelines or clinical information in the ICD-9-CM codebook, Coding Clinic, or other references as needed.

↓

If the Coding Technician code assignment does not accurately translate from the documentation, document suggested codes or action in Complication Analysis database and attach copy of database worksheet to chart.

↓

Refer the record to the Coding Supervisor for review.

↓

Coding Supervisor will refer record to appropriate Coding Technician who will also review and make any revisions needed, with response on same database worksheet.

↓

When the record returns from the Coding Section, the QM CCS will enter the Coding Technician response into the Complication Analysis database.

↓

If any trends are noted in the database results, the QM CCS will refer them to the Coding Supervisor, who will discuss with the Coding Technicians at their monthly meetings.

↓

Any continued non-resolution of the coding issue will be referred to an outside authority, i.e., Coding Clinic.

↓

No coding issues will be discussed outside of QM until responses are returned from the Coding Technicians.

↓

Vague documentation resulting in potentially inaccurate code assignment will be noted in the Complication Analysis database.

↓

Summary of findings are made based on any trend noted in the review and the goals of the assignment.

↓

Findings and recommendations are reported to Medical Staff specialty meetings or others as needed.

Source: Covenant Medical Center, Lubbock, TX.

To facilitate greater cooperation among the physicians and coders, Noller initiated a three-pronged action plan:

1. She started a coding newsletter in January 1997 to improve communication and educate the medical staff, their office staffs, and hospital staff on coding and documentation issues. Noller writes the newsletter, titled *Quality Notes*, which is edited by a physician champion. Currently, the newsletter has expanded its focus to include other health care issues, such as case management, fraud and abuse, and state and federal health care legislation. About 1,000 copies are distributed every other month.

2. Noller formed an ad hoc group of physicians to work with her and the coding supervisor to determine a set of basic clinical guidelines to assist the coding technicians in making decisions when it came to coding a condition as a complication. The group concentrated on the "complications" regarded as problematic by the physicians: ileus, hemorrhage, hematoma, atelectasis, and fever. The group was formed about the same time the newsletter was launched, six months after Noller came on board at Covenant. "I thought that a six-month period was pretty good, to get these docs willing to work with us instead of being antagonistic," she says.

3. A few months later, Noller helped to develop a coding subcommittee of the hospital's resource steering committee. The resource steering committee handles information management for the entire facility, including medical records, coding, and data quality. "It was felt that because of all the coding and billing issues out there, a coding subcommittee would be useful in discussing these issues and working through them," Noller says.

Also, a process was formalized for referring coding discrepancies found on medical record reviews performed by the quality management department. **(See flowchart illustrating the chart review process, p. 20.)** Two databases — one to assist in communicating coding and documentation trends from quality management to medical records, the other to help quality management keep track of all individual record reviews and results — were also constructed.

The results so far have been dramatic. For example:

- Within six months, the incidence of code 997.4 in DRG 358 decreased from 12.6% to 3.03%. A further review discovered that physician practice patterns in documenting ileus as a complication had changed.
- As a result of the various education efforts directed toward physicians, doctors are now actually requesting presentations on coding guidelines.
- Noller reports that the quality management department now believes the data used in clinical outcomes monitoring and reporting are much more accurate and consistent.

"I think the physicians are starting to understand where the coders are coming from," Noller says. She credits the hospital's medical staff leadership for helping to facilitate the change. "Our medical director of quality improvement has always been able to work with our other medical staff leaders to get the medical staff involved in quality improvement housewide."

Also helpful was a medical staff leadership group called the Clinical Outcomes Improvement Team, made up of physician section chiefs. "They were the first to hear some of this information," Noller says. "At the time, they were concerned from a monetary standpoint, because our hospital was undergoing talks of a merger with one of our main competitors. Administration was saying, 'Listen, guys, if documentation will help improve our financial picture, then that's what we need to do.' Like every other quality initiative, it has to start from the leadership on down. So, through that leadership role and our physician champions, and showing the physicians that it's not just the hospital that's affected but their office and business health as well, it finally sank in a little bit." ■

APCs will make accurate documentation more crucial

New billing rules demand doctor/coder cooperation

Although the exact timetable for implementation of the final ambulatory payment classifications (APCs) for hospital-based outpatient facilities and ambulatory surgery centers is still up in the air, this much is certain, experts say: When APCs do become a reality, physician cooperation in the coding process will be crucial to your organization's success.

Final regulations for the Health Care Financing Administration's (HCFA) outpatient prospective payment system (PPS) could come as early as this month, with an expected implementation date of July 2000. As *Hospital Peer Review* went to press,

however, Congress and representatives from the Clinton administration were still considering several proposals that phase in the new system more slowly. The existing inpatient PPS, after all, was phased in over a five-year period. But talk of phasing in the system shouldn't make health care facilities complacent, says **Dave Fee**, product marketing manager with 3M Health Information Systems in Salt Lake City, which initially developed the APCs on which the outpatient PPS will be based. He emphasizes that Congress and the White House aren't trying to discontinue implementation of APCs. "Phase-in doesn't mean delay," he says.

Don't wait too late

Even so, the final rule is expected to contain some significant changes from the proposed regulations published in the Sept. 8, 1999, *Federal Register*. These changes are likely to center around ways to minimize the initial financial risk to outpatient programs. Nevertheless, experts warn, if facilities wait until the final rule is published before preparing for the advent of APCs, they could be overwhelmed with the coding changes they have to make.

Currently, hospitals are reimbursed for outpatient services in a variety of ways, explains **Rita Scichilone**, MHSA, RRA, CCS, practice manager in coding products and services for the Chicago-based American Health Information Management Association (AHIMA). Some services, like laboratory tests, are reimbursed via a fee schedule, with surgical procedures paid via a combination of ASC reimbursement and the Medicare cost report. HCFA's new PPS will shift outpatient reimbursement for hospitals into APCs, which are similar to diagnosis-related groups for inpatient payments.

The proposed system groups more than 5,000 outpatient codes into 346 APCs, each of which includes a related group of clinical services for which Medicare will reimburse hospitals at a single, predetermined rate. That approach will dramatically reduce the number of payment levels that need to be tracked. But don't expect that to make your job easier; the consolidation of codes will make coding accuracy more important than ever, Scichilone says.

"I don't know that it would be a whole lot more labor-intensive, except for the fact that hospitals will now want to run their CPT [Current Procedural Terminology] codes through a grouper so they can make sure that they receive all of the potential APCs that they're entitled to, and that's an extra step in the coding process," Scichilone says. "And then there's the fact that these CPT codes are going to be so important in accurate payment that it may slow down the process somewhat."

Because of the importance of coding accuracy, complete and accurate documentation by physicians will be crucial, Scichilone adds. Unfortunately, influencing physician behavior can be difficult at the best of times, and it can be especially problematic when it comes to coding issues. "Physicians are reimbursed from Medicare based on RBRVS [resource-based relative value scale], which means they also get reimbursed on the basis of CPT codes," Scichilone says. "And in the case of outpatient surgery, you'd like to think that the physician and the hospital are reporting the same CPT code. But that's not always the case, because the documentation that the physician provides the hospital may or may not explain exactly what he did and what he chose to bill for his professional services."

In addition to creating reimbursement problems, such discrepancies could put your facility at risk of fraud and abuse charges, Scichilone warns. "The reason why you may have a discrepancy is that documentation may either be misinterpreted by the coder, or the physician may not be documenting what he's doing. He knows it in his head, and he bills for it on his HCFA 1500, but he doesn't get it communicated through his operative report accurately enough so that the hospital gets the right code."

The solution, when it comes to ambulatory care, is to give physicians better tools for capturing the documentation, Scichilone recommends. "The ambulatory part has been difficult, because sometimes the encounter is fairly short. Sometimes it's just a radiology exam that gets ordered, for example. So the documentation there is directed mainly at justifying the test."

For surgical procedures, the quality of coding can sometimes be improved by using a well-designed form. "That way, the physician has a look at the possible CPT codes and is able to direct his or her documentation toward specific codes and is documenting in the same language the CPT is written in," Scichilone says. She adds that she's seen this approach work effectively for endoscopy procedures as well as for pain management.

Scichilone also recommends conducting internal studies to compare how physician Part B and hospital Part A coding match up for particular procedures. ■

THE QUALITY - CO$T CONNECTION

Part 2 of a 3-Part Series

How to formalize your grievance response

Procedure should spell out time frames for action

By **Patrice Spath**, ART
Brown-Spath Associates
Forest Grove, OR

The Medicare Conditions of Participation (CoPs) require that hospitals have a process for handling patient grievances. In last month's column, the definition of a grievance was discussed. It is clear that hospitals must carefully describe the difference between an informal complaint and a grievance. Otherwise, the formal review process may be triggered more often (or less often) than it should be.

The governing board is responsible for ensuring the grievance process is prompt and effective. The grievance procedure must be explicit and include the elements required by the CoPs. It is unlikely that the mechanism used in many facilities to handle patient complaints is as well-defined as it needs to be to meet the CoP requirements. A grievance procedure must include the following elements:

1. name of the hospital representative the patient should contact to file a grievance;
2. specific time frames for review of the grievance and the provision of a response;
3. a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate peer review organization;
4. a provision for notifying the patient of the results of the grievance review — the notification must be made in writing and include the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion;
5. a provision for appeal if the patient is not satisfied with the outcome of the grievance investigation.

This month's column will describe the first steps in the grievance process, when a grievance is filed and the hospital responds.

Whenever possible, the hospital should try to resolve patient questions or concerns quickly and informally. If this is not possible, patients must be afforded the opportunity to file a formal grievance. It is essential that physicians and hospital staff who may come into contact with patients understand the basic grievance procedures, as they may be the first point of contact for patients.

Ideally, any member of the hospital staff can start the grievance process and help the patient figure out how to file his or her complaint. Written procedures should be developed to explain how to receive and initiate the processing of grievances. These procedures should include the form patients can use to make their complaint and the name of the hospital representative who will coordinate the grievance investigation. **(A sample grievance form is shown on p. 24.)** The hospital person who coordinates the grievance process may be the patient advocate, quality manager, risk manager, or another person designated to fulfill this role.

Is a formal grievance really needed?

When the hospital receives a grievance (either oral or written), several determinations need to be made by the grievance coordinator. First, can the issue be quickly resolved without the need for a formal investigation? The dissatisfied patient may not have known what to do in a particular situation, and a formal grievance may not really be needed to get the problem solved. However, even if the complaint is informally resolved to the patient's satisfaction, the issue and its resolution should be recorded on a complaint log so that information on the volume and nature of patient complaints is available for internal performance measurement functions.

Next, the person who receives the grievance must determine if the hospital is the right organization to investigate the grievance. The patient may have a valid complaint, but the issue may deal with something outside of the hospital's control, e.g., insurance coverage, problem with another provider, etc. In these instances, the patient should be counseled about where the complaint should be directed. Be sure to offer the patient help in filing the grievance with the correct agency or organization.

Patient Grievance Form

Any staff member can take your grievance. You can file in any way you want: in writing, by phone or fax, or in person. If you are unable to file the grievance yourself, a patient advocate is available to assist you or your representative.

Name: _____
Phone: _____
Address: _____

Person filing form is:
☐ Patient ☐ Patient Advocate
☐ Family ☐ Other:_____

- Please give a detailed description of the issue or problem you would like the hospital to address.
- Include any specific names, dates, places, or other details that will help us look into your concerns.
- Also describe what outcome(s) you would like to see as a result of this process.
- If you need more room, please attach additional pages.

_____

_____

_____

_____

_____

_____

Describe what would be an acceptable outcome for you:

_____

_____

_____

☐ Check here if you'd like the hospital's patient advocate to work with you during the grievance process.

_____ _____
Signature of person filing form Date

Return to: **XXX Hospital**
Address
Phone and fax number

Source: Patrice Spath, ART, Brown-Spath Associates, Forest Grove, OR.

If the grievance is one that should be handled by the hospital, then the grievance process is initiated. The hospital representative should acknowledge receipt of the issue and explain to the patient the process that will be followed in investigating the complaint. If the patient is currently in the hospital, this explanation can be given in person, but the patient also should receive a written notice. If the patient is no longer hospitalized, send a letter explaining the grievance process steps. The written notifications should provide a clear explanation of how the grievance will be resolved, describing each step in the process, the time frame for each step, and the patient's rights or responsibilities at each step. Include in the written notice an offer

to assist the patient as needed in completing forms or taking other necessary steps to achieve resolution of the issue.

Be sure to inform the patient of any additional methods for resolving the issue external to the hospital's own process. For example, Medicare patients have the right to submit a quality of care complaint to the state peer review organization. Medicaid patients can present issues of coverage and nonpayment to the state agency. Some states have issue-resolution mechanisms that are available to enrollees of commercial insurance maintained by the Insurance Commissioner or another state agency. These external mechanisms supplement, but do not replace, the hospital's grievance process. If the grievant is a Medicare patient and she is concerned that her doctor is discharging her too soon, make certain that the state peer review organization (PRO) is aware of the grievance. Also, offer to help the patient or her representative request an immediate review from the PRO.

Define time frames

The hospital's procedure for handling grievances should include time frames that spell out how quickly each step will occur. Ideally, acknowledgement letters should be mailed to discharged patients within three working days of receipt of their grievance. Hospitalized patients should be visited as soon as possible. Many hospitals try to complete the initial grievance investigation process within 10 business days. At the time this article was written, the interpretive guidelines for the patient grievance regulations issued by the Health Care Financing Administration had yet to be published. Once these are available, hospitals should consult these guidelines to determine if HCFA has established time limits for each step in the resolution of a complaint or grievance. Interpretive guidelines are usually posted on the HCFA Web site, which is located at www.hcfa.gov.

It is not uncommon for providers and health plans to have a two-stage process for handling grievances. The first stage involves only a limited number of decision makers in the review. If patients are dissatisfied with the outcome of the first-level review, there is a second stage involving a Grievance Committee. The last installment of this three-part series, appearing in next month's issue of *Hospital Peer Review*, will describe this two-stage grievance mechanism. ■

What you need to know before you talk to a CVO

Make sure the CVO can work with your needs

Traditionally, credentialing verification organizations (CVOs) have been the almost exclusive province of managed care organizations and large hospital systems. But an increasing number of mid-sized hospitals are now taking advantages of the services provided by CVOs to reduce the cost and slow turnaround time often associated with performing primary source verification in-house.

According to **Kristen Scholl**, CVO operations manager at Novalis Credentialing Verification Organization in Albany, NY, some large hospitals and hospital systems have already moved to create their own CVOs. "Maybe one of the larger hospitals in the entity will perform all of the credentialing functions on behalf of the others," she says. Meanwhile, smaller hospitals with less of a credentialing burden are usually more inclined to keep the credentialing process in-house. "It's probably more the mid-sized hospitals that are willing to outsource," she says.

Their reasons for doing so usually include reducing the burden placed on the hospital's medical staff office, which typically has a number of responsibilities in addition to credentialing, Scholl says. For those hospitals, "CVOs would typically do the primary source verification piece, but the hospital still has quite a bit of responsibility as far as determining which areas of the hospital physicians work in and which kinds of surgeries and procedures they can perform. This is just one administrative task that can be done somewhere else. Sometimes hospitals like to take advantage of that."

Despite the obvious benefits of outsourcing, however, it's important for facilities to do their homework before making the decision to use a CVO and identify exactly what their needs are for credentialing services.

Physicians Hospital and Physicians Healthcare Network is a physician-hospital organization (PHO) in Columbus, OH, co-owned by the hospital and 400 physician partners. For some time, the PHO had delegated its credentialing function to the hospital. While the hospital did a good job meeting the credentialing standards set by the Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) in Oakbrook Terrace, IL, it did not meet the standards of the National Committee for Quality Assurance (NCQA) in Washington, DC. In addition, there were some issues regarding confidentiality and sharing of information, says **John Hamilton**, manager of operations at the PHO. "There have been some legislative changes recently that make it more difficult for [the hospital] to share information with an outside entity," he says. "Even though they're a partner in our organization, legally we're separate. So, legitimately, there were some concerns there."

At that time, however, there wasn't enough revenue coming in to pay for a full-fledged internal credentialing program at the PHO. "So we started to review all of our options," Hamilton says. Ultimately, the PHO evaluated 11 CVOs, using cost, turnaround time, and NCQA accreditation as their primary criteria. "We wanted to know that they had the staff on board to meet our needs and that there was a contract to hold them to that," Hamilton says.

Another important consideration was the fact that the system housing the PHO's credentialing information was a homegrown access database, says **Lori Anthony,** administrative coordinator. "It's pretty much maxed out, and we were looking for someone who could provide us with a system to use. There was only one company I found at the time that had the ability for us to use its systems."

The PHO finally contracted with a CVO that provides an on-line, Internet-based credentialing system that allows them to track and monitor the credentialing process. "We became very enamored with that particular program," Hamilton says. "We've been working with them almost six months, and we've credentialed all of our physicians under the new program in that period of time."

In the past, when credentialing was still performed by the hospital, turnaround time could take anywhere from 30 days to six months. "It depended on when the committees met," Hamilton says. "[The committees] had to not only obtain the information, but [the data] had to go through all the hospital committees before we could put them through ours." With the CVO, the average turnaround time has been 28 days.

One function the PHO decided not to outsource was site visits. "We have nurse site reviewers who are contingent staff for the PHO who have gone out and performed our initial site visits, which is something that the hospital traditionally never did for us," Hamilton says. "We just didn't have that function delegated to us by the contracted health plan. We've kept that in-house, and coupled with the program we have through our current CVO contract, it has been very good for us. I think it would be hard for us to go back to using the hospital again."

In fact, Hamilton and Anthony have begun working with the hospital medical staff regarding the possibility of outsourcing their primary source verification to the same CVO. "That would allow us to have one application that would meet the needs of the PHO as well as the hospital credentialing function," Hamilton says. "By having the CVO perform all of the primary source verification by using one application, we would avoid a lot of duplication for the physicians."

Before you select a CVO, be aware that they can differ widely in the options they offer and in

the quality of service they provide. Anthony recommends checking references carefully. "I did a pretty thorough check and learned a lot in talking to the references," she says. "There were a couple that didn't come back as positive as I had anticipated. Also, when talking to references, ask them if they've heard of other CVOs that you might not be aware of."

Hamilton recommends taking careful stock of the services your organization requires before approaching a CVO. "Understanding exactly what you need and what you're looking for from a CVO up front and asking them to respond to each of those items will save you a lot of heartache in the long run," he says.

Be aware that asking a CVO to customize its services to fit your needs can increase costs. "We were fortunate that we didn't have a lot of history, so there weren't a lot of customized things that the PHO needed from the CVO," Hamilton says.

Look for hidden costs as well, such as mailing costs, Hamilton advises. Also, ask specific questions, such as: "'When do you get the file? What does the file look like?' Be very thorough in your evaluation," he says. "A lot of these companies have turnkey programs that are very easy for them to administer. But when you talk about being flexible and being able to customize the program to your organization, that's where it can be costly." ■

House OKs standards for electronic records

The U.S. House of Representatives addressed the movement toward electronic commerce in early November when it passed legislation creating standards for electronic signatures and records. The Electronic Signatures in Global and National Commerce Act (HR 1714) would set national standards for electronic signatures and records and give them the same legal validity as written contracts and documents. It would prohibit the enactment of any state law denying the legality of agreements that are electronically signed.

The legislation passed by 356-66, enough to override a possible presidential veto. The administration has opposed sections of the bill, saying they would undermine consumer protections.

The Electronic Industries Alliance (EIA) in Arlington, VA, praised the House for its "overwhelming bipartisan vote" to approve the legislation. "Passage of HR 1714 is a critical step in establishing confidence in electronic commerce, which will promote jobs, stimulate the economy, and create savings and opportunity for America's consumers," says EIA president **Dave McCurdy**, former chairman of the House Intelligence Committee. ▼

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6:00 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $399. Approximately 18 nursing contact hours, $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $319 per year; 10 to 20 additional copies, $239 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

American Health Consultants® is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

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

Associate Managing Editor: **Russ Underwood**, (803) 252-0427, (russ.underwood@medec.com).
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com).
Managing Editor: **Paula Stephens**, (404) 262-5521, (paula.stephens@medec.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.
Editor, *Discharge Planning Advisor*: **Lila Margaret Moore**.

Editorial Questions

For questions or comments, call **Russ Underwood** at (803) 252-0427.

AHCPR promises to improve research oversight

The Department of Health and Human Services' (HHS) Agency for Health Care Policy and Research (AHCPR) in Rockville, MD, is developing recommendations, or "guiding national principles," for helping institutional review boards and similar groups protect against the disclosure of personal health information in research that could be used to identify individual patients.

The recommendations will help provide guidance to research reviewers as they review research projects using identifiable information and as they implement the department's privacy regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Proposed regulations for this act were announced by President Clinton on Oct. 29, 1999. Under HIPAA, a final rule is to be issued by Feb. 21, 2000, with a two-year implementation period for most covered entities.

The guiding national principles will be based on a study by the Institute of Medicine of the National Academy of Sciences in Washington, DC, which is expected to be completed in summer 2000. HHS' Office of the Assistant Secretary for Planning and Evaluation is co-funding the contract with AHCPR. ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review*, CE participants should be able to meet the following objectives after reading each issue:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and / or based on independent recommendations from clinicians at individual institutions.

If you're not an *HPR* CE subscriber and would like to sign up, call customer service at (800) 688-2421. ■

Special offer for alternative medicine newsletter

American Health Consultants, publisher of *Hospital Peer Review* and *Alternative Medicine Alert*, is pleased to announce the publication of a new monthly newsletter for nurses on alternative medicine and holistic nursing. Each issue will contain review articles of specific alternative therapies and modalities; abstracts and commentaries from current medical and nursing journal articles; and columns on controversies in holistic nursing, applying therapies to clinical nursing practice, and legal and ethical issues surrounding holistic nursing and alternative medicine. Subscribers will be eligible to receive approximately 12 contact hours of nursing continuing education credits at no extra charge.

As a subscriber to *Hospital Peer Review*, you will be able to purchase an annual subscription at $149 — $50 off the regular subscription price of $199. To reserve your subscription, please contact our customer service department at (800) 688-2421 or e-mail: customerservice@ahcpub.com. Reference No. HNA 61760 to take advantage of this special offer. ■

SourceKit

Janice R. Noller, RRA, CS, CPHQ, quality improvement specialist, quality management department, Covenant Medical Center, Lubbock, TX. Telephone: (806) 725-1011.

Rita Scichilone, MHSA, RRA, CCS, practice manager in coding products and services, American Health Information Management Association, Chicago. Telephone: (712) 647-2646.

John Hamilton, manager of operations; **Lori Anthony**, administrative coordinator, Physicians Hospital and Physicians Healthcare Network, Columbus, OH. Telephone: (614) 268-8164.

Dave Fee, product marketing manager, 3M Health Information Systems, Salt Lake City. Telephone: (801) 265-4200.

Kristen Scholl, CVO operations manager, Novalis Credentialing Verification Organization, Albany, NY. Telephone: (518) 862-3400. ■