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HCFA details several changes in APC regulation — final rule expected any day

July 1 implementation date still on track

Even if the Health Care Financing Administration (HCFA) in Baltimore doesn't provide a whole rule, at least it sometimes hands out a few hints. Providers received several new details in March about the prospective payment system (PPS) that will use ambulatory payment classifications (APCs) to reimburse hospital-based outpatient services. The proposed rule was published in the Sept. 8, 1998, *Federal Register*, and the final rule is expected any day.

HCFA's Program Memorandum Transmittal A-00-09, written as instructions to fiscal intermediaries, revealed several changes made to the proposed rule as a result of the Balanced Budget Refinement Act of 1999 (BBRA), which President Clinton signed last November. Don't expect these changes to push back implementation of the final rule, however.

"One of the most significant things about the Program Memorandum is that it reiterates the scheduled date for implementation — July 1, 2000," says **Laura Frazier**, RHIT, manager of APC solutions for QuadraMed Corp. in San Rafael, CA. Frazier says she expected HCFA to use the changes as a reason for delaying implementation. "Instead, [HCFA] says, 'Full steam ahead. Fiscal intermediaries, here are your instructions.'"

SPECIAL REPORT:
GET READY FOR PPS

Some of the changes outlined in the memorandum are going to mitigate the financial impact to facilities, but not as much as people predict, she says. Some of these changes would:

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News Briefs

COMING IN FUTURE ISSUES

- Software designed to reduce medical errors
- The final APC rule has arrived
- Company puts PCs in patients' rooms
- PDA captures billing and dictation at point of care
- HHS releases its first final HIPAA standard

• Extend the 5.8% reduction in operating costs and 10% reduction in capital costs (which was due to sunset on Dec. 31, 1999) through the first date the PPS is implemented.

"The ability to ameliorate some of the financial impacts for the first half of the calendar year is going to be extended," Frazier says. "However, it will sunset, obviously, when the prospective payment system is implemented. I believe that will be July 1. After that, there will be a reduction in the capital costs that will be billable."

• Require annual updating of the PPS payment weights, rates, payment adjustments, and groups.

"In the initial proposed rules, HCFA says, 'We will update them but we haven't determined in what time frame.' This provision says it will definitely happen annually," she says.

• Require annual consultation with an expert provider advisory panel in the review and updating of payment groups.

According to this provision in the BBRA, there is going to be an interceding process that will help mitigate any of the changes HCFA might put in place "willy-nilly," Frazier says.

• Establish budget-neutral outlier adjustments based on the charges, adjusted to costs, for all services included on the submitted outpatient bill for services furnished before Jan. 1, 2002, and thereafter based on the individual services billed using the appropriate department-specific cost-charge ratio for each services.

• Provide transitional pass-throughs for the additional costs of new and current medical services, drugs, and biologicals for at least two years but not more than three years.

There are several types of drugs and services not reimbursed under the Medicare program that will be covered under PPS during the transition process, Frazier says. These might include experimental drugs that the U.S. Food and Drug Administration (FDA) in Rockville, MD, has not approved but that have been clinically shown to significantly reduce problems with diseases. Therefore, caregivers may decide to continue administering those drugs to patients even though they are still pending FDA approval and won't be covered under Medicare unless they are approved, she explains.

The PPS proposed rule stated that it would

not cover any drugs or biologicals, other than chemotherapeutic agents that treat cancer.

Frazier says the new provision is the result of an effort on the part of pharmaceutical companies and cancer treatment specialists who lobbied HCFA for reimbursement.

A comprehensive list could be forthcoming

She says HCFA could release a list of exactly which services and drugs will be covered very soon, including the J codes that identify particular drugs.

• **Include under the PPS payment for implantable devices durable medical equipment, prosthetics, and items used in diagnostic testing.**

That is another example of additional services being included that were not considered eligible for reimbursement under the proposed PPS rule, Frazier says.

• **Establish transitional payments to limit hospitals' losses under the PPS; the additional payments are three years for most hospitals and low-volume rural hospitals (100 beds or less) and are permanent for the 10 cancer hospitals exempt from the inpatient PPS.**

• **Limit beneficiary copays for services paid under PPS to the inpatient hospital deductible.**

Another significant provision in the memorandum is this statement: "Acute dialysis, e.g., for poisoning, will be paid under the PPS," Frazier says. In the proposed rule, HCFA had thought it was effectively providing cost control under the composite rate paid for dialysis patients in end-stage renal disease.

The BBRA, however, differentiated between chronic dialysis, which will be paid under the composite rate, and acute dialysis, which will be paid under the prospective payment system. "That's another change in what is considered to be an eligible service under the system," she says.

(In response to a lawsuit filed to force HCFA to release the final PPS rule, HCFA affirmed in March 17 court documents that the final rule would not be delayed beyond July 1.) ■

Reduced revenue 'is going to happen' with PPS

Are your cost-control measures in place?

With the implementation of the prospective payment system (PPS) for outpatient services looming in a few months, it's time for providers to ensure their cost-control measures are in place, advise experts.

Providers must prepare soon because reduced revenue is a definite," says **Laura Frazier**, RHIT, manager of APC solutions for QuadraMed Corp. in San Rafael, CA. "It's going to happen, although there will be a higher loss for some more than others, based on their geographic area."

The question for facilities then becomes, "What do they do with the piece of pie they are given from Medicare to make their services, operations, and processes efficient enough to offer them on an ongoing basis?" she says.

Frazier says this operations-evaluation process is similar to what providers went through during the switch to using diagnostic-related groups (DRGs) for inpatient services. "While they were going through that [five-year] implementation window, facilities came up with strategies for managing the revenue differently. In the same vein, they will need to start providing that focus for outpatient services. They have the capability. They have the staff, and they have the expertise, but they've not had the reason to have to yet," she says.

Many hospitals have used the delays of the PPS implementation date as a reason to put preparation on the back burner. Frazier calls this "systemic denial disease." Other facilities are complaining that the Health Care Financing Administration (HCFA) is not giving the amount of time to phase in the system as it did for inpatient cost controls.

"Actually, HCFA is," she says. "HCFA has graciously extended the time frame many times, and while providers have said it's never going to happen, they have also wasted the time that they could have spent implementing operational efficiencies and fixing the process steps to get ready proactively. If facilities wait for it to 'really happen,' then it will be too late."

SPECIAL REPORT:
GET READY FOR PPS

QuadraMed offers these tips to providers who are interested in preparing for the ambulatory payment classifications (APCs) used for reimbursement in the PPS:

✔ Add PPS compliance to your strategic plan.

✔ Begin educating hospital and medical staff on the requirements of APCs.

✔ Conduct an organizationwide assessment of your current outpatient coding practices to identify problems and develop an action plan to address them.

✔ Ensure that your current or future vendors/contracts are obligated to comply with the legislation.

✔ Purchase new or modify current information technology systems that satisfy APC requirements.

✔ Monitor Web sites with up-to-date APC information.

✔ Coordinate a multidisciplinary approach to communicate how you are going to get ready.

Creating a task force is crucial step

The creation of a multidisciplinary team or task force is one of the most important steps, Frazier says. "The issue is that we tend to operate as isolated departments. Whatever we do in our own department is fine. Any problems that are caused in the facility are someone else's problem, not ours because we do a good job."

All departments that use or rely on outpatient service delivery should be brought together to discuss current processes and how they can be made more efficient, she says. If the appropriate departments are not included, reimbursement could suffer if they have unvoiced expectations of each other.

The cancer treatment center, for example, could be relying on patient registration to check on eligibility for certain drugs. Patient registration, however, might think another department was checking on the drugs. Only during the discussion involving both departments would the misunderstanding be discovered.

"We make quantum-leap assumptions and isolate ourselves in little cocoons within a facility instead of actually getting to the table to discuss the problems," Frazier says.

At a minimum, the group needs to include the following employees or departments, she says:

✔ Patient accounts or billing.

✔ Chief financial officer.

"He needs to understand why his fiscal budget that is projected for two years is already wrong [because of PPS implementation] and the operating budget needs to be changed accordingly," Frazier says.

✔ Utilization review.

"They are going to have a whole new workload [as they become] the APC coordinators, and they are going to have to make sure the operational efficiency machine continues to work," she says.

✔ Health information management/medical records coding.

✔ Other departments that need coding services, whether it is Charge Master entry coding or an outpatient service coding.

✔ A physician.

Facilities need a champion who can go back and explain the need for change to the physicians at medical staff meetings, Frazier says. "You can't make any assumptions about who not to include in the group. It hits about every department."

These department representatives are the best "experts" the facilities can use in the evaluation process. "They can identify your current processes and exactly what they expect from other departments," she says. "Communicating at the same table with all parties hearing what is said helps everyone unveil the reality." ■

Code of ethics drafted for Web health care info

Final version of code is expected in May

Organizations that share health care information on or over the Web are feeling the pressure to step up their privacy efforts. Now an Internet health constituency has created a code of ethics that it hopes many of such organizations will adopt as a standard.

Much of the spotlight on the organizations stems from a negative report on health-site privacy concerns issued in early February by the California HealthCare Foundation in Oakland. According to the report, many health sites that have official privacy policies don't adhere to them. **(For more information about the report, see *Hospital Payment & Information Management*, April 2000, p. 52, or read about it at the Web site http://ehealth.chcf.org.)**

Since publication of the report, the Federal Trade Commission has announced it is investigating the privacy practices of health Web site owners as part of its overall Internet privacy review.

International e-Health Code of Ethics

Vision statement

The Internet is changing how people receive health information and health care. All who use the Internet for health-related purposes must join together to create an environment of trusted relationships to assure high-quality information and services, protect privacy, and enhance the value of the Internet for both consumers and providers of health information, products, and services. The goal of the "e-Health Code of Ethics" is to ensure that all people worldwide can confidently, and without risk, realize the full benefits of the Internet to improve their health.

Introduction

Health information has the potential both to improve health and to do harm. All people who use the Internet for health-related purposes must be able to trust that the sites they visit adhere to the highest ethical standards and that the information provided is credible.

Because health and health care are critically important to people, the organizations and individuals that provide health information on the Internet have special, strong obligations to be trustworthy, provide high quality content, protect users' privacy, and adhere to standards of best practices for on-line commerce and on-line professional services in health care.

Guiding principles

1. **Candor and trustworthiness**
   Organizations and individuals providing health information, products, or services on the Internet have an obligation to candidly disclose:
   — factors that could influence content;
   — potential risks of providing personal information on the Internet.

2. **Quality**
   Organizations and individuals offering health information, products, or services on the Internet have an obligation to:
   — provide high-quality information, products, or services;
   — provide means for users to evaluate the quality of health information.

3. **Informed consent, privacy, and confidentiality**
   Organizations and individuals providing health information, products, or services on the Internet have an obligation to:
   — safeguard users' privacy;
   — obtain users' informed consent when gathering personal information.

4. **Best commercial practices**
   Organizations and individuals who sponsor, promote, or sell health information, products, or services on the Internet have an obligation to:
   — disclose any information a reasonable person would believe might influence his or her decision to purchase or use products or services;
   — be truthful and not deceptive;
   — engage in responsible business relationships and affiliations;
   — guarantee editorial independence;
   — disclose the site's privacy policy and terms of use.

5. **Best practices for provision of health care on the Internet by health care professionals**
   Health care professionals and organizations who provide health information, products, or services on the Internet have an obligation to:
   — adhere to the highest standards of professional practice;
   — help patients understand how the Internet affects the relationship between professional and patient while adapting the highest professional standards to the evolving interactions made possible by the Internet.

Source: Internet Healthcare Coalition, Washington, DC.

The Internet Healthcare Coalition in Washington, DC, is hoping to allay consumer fears about the privacy of health information on the Internet by calling on industry representatives to create the code of ethics.

The coalition used its e-Health Ethics Summit in January to produce the first draft of this "International e-Health Code of Ethics." The draft code was created with the input from key Internet health participants including consumers and patients, health care professionals, ethicists, dot-com entities, academicians, special-interest societies, manufacturers of regulated drugs and medical devices, governmental agencies, and international representatives. **(See draft of the code, above.)**

The Hastings Center, an independent, nonprofit research institute in Garrison, NY, that

addresses ethical issues in medicine and the life sciences, reviewed, organized, and edited the minutes of the working summit to develop the current draft code. While developing the draft, both the summit steering group and The Hastings Center preserved the original language of the working summit.

After an eight-week period of public comment and consultation, the draft is scheduled to be revised for final publication about the middle of May.

Now that the code has been drafted, the coalition is working on methods by which the code can be implemented and promoted, says **John Mack**, coalition president. The coalition's e-health ethics steering committee has been using a schedule of speaking engagements to tell people about its initiative.

The initial reaction to the draft code has been positive, Mack says. "We have been very gratified by the response we have received from many Internet companies."

The coalition also is considering calling upon a broad range of organizations to endorse and promote the code and work with accrediting organizations to develop measurable, universal standards based upon the code.

Standards organization will audit

Once standards are established, a standards organization can audit and accredit sites and educate employees, Mack explains. "Our process of [building] consensus among a broad base of stakeholders [not just for-profit dot-coms] and open, public debate and commentary already goes a long way to establishing standards that will be meaningful."

Although the coalition is working with other organizations to establish standards, it is not a standards' enforcement body, Mack emphasizes.

"Our mission is primarily educational, and we will focus on educational activities in support of the code and standards that may derive from the code," he says.

Planned educational activities include publication of a book on e-health ethics, privacy, and fraud that includes contributions from notable authors; ethics workshops to educate employees of Web sites about good ethical practices; and the coalition's annual meeting in October: "Quality Healthcare Information on the 'Net 2000: Establishing Trust, Ensuring Privacy, Enabling E-Commerce." ■

A privacy group reacts to the new code of ethics

An organization that fights for patients' rights to privacy would like to see a code of ethics for the transmission of health care information go even further. The National Coalition for Patient Rights in Andover, MA, recently consulted with Internet experts to make an initial review of the "International e-Health Code of Ethics," published by the Internet Healthcare Coalition in Washington, DC. Here are the organization's comments. **(See the code of ethics draft, p. 69.)**

• **The initial log-in to a health care Web site should be anonymous**.

"You should be warned before data collection begins," says **Peter Kane**, MSW, LCSW, BCD, executive director of the National Coalition for Patient Rights. Sites usually can identify visitors through their Individual Service Provider (ISP) number. "The site should destroy your ISP if you just log on and off."

• **Consumers should be able to read and electronically sign a release of information waiver form or informed consent.**

"It should raise the issues talked about in the policy," Kane says.

• **Business partners should be held to the same level of privacy as the initial heath care Web site, particularly in terms of information re-disclosure.**

"Once the information starts to go downstream, no one has any control over it anymore," he says.

• **Sites should only ask visitors for minimal information.**

"A site should only be asking for the information that it needs to perform its service," he says. "It shouldn't be asking for [purposes of] prospective data collection."

• **A data security standard should be set.**

"It's not clear [in the code] that there is a high standard for data security — just that there is security," Kane says.

• **Consumers should be informed about the policy regarding information storage.**

The code asks for an audit trail on the use of information. Instead, health care Web sites should have an audit trail for any access of information, Kane says. Also, will the site ever

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destroy the information, and if so, how? "Is there an expiration date on the information? What happens if the site goes out of business?"

(The draft code of ethics can be fully accessed with additional notes and definitions via the coalition's Web site: www.ihealthcoalition.org/community/ethics.html.) ■

AHIMA issues standards of ethical coding

Ethics is on the mind of more than just Internet privacy experts these days. The American Information Management Association (AHIMA) in Chicago has recently revised its ethics policy for coding practices, as well.

AHIMA initially developed its "Standards of Ethical Coding" in 1991. The association says it revised the standards because of the increasingly important role quality coding plays in complying with regulations governing payment for health care services and in curbing fraud and abuse. The newly developed standards are:

1. Coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality health care data.

2. Coding professionals in all health care settings should adhere to the ICD-9-CM coding conventions, official coding guidelines approved by the Cooperating Parties,* the CPT rules established by the American Medical Association in Chicago, and any other official coding rules and guidelines established for use with mandated standard code sets. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable health care settings.

3. Coding professionals should use their skills, their knowledge of the currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.

4. Coding professionals should only assign and report codes that are clearly and consistently supported by physician documentation in the health record.

5. Coding professionals should consult physicians for clarification and additional documentation prior to code assignment when there are conflicting or ambiguous data in the health record.

6. Coding professionals should not change codes or the narratives of codes on the billing abstract so that the meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because the payment or insurance policy coverage requirements will be affected. When individual payer policies conflict with official coding rules and guidelines, those policies should be obtained in writing whenever possible. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer's policy.

7. Coding professionals, as members of the health care team, should assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, resequencing, or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and occurrence of events.

8. Coding professionals should participate in the development of institutional coding policies and should ensure that coding policies complement, not conflict with, official coding rules and guidelines.

9. Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of any changes in codes, coding guidelines, and regulations.

10. Coding professionals should strive for the optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means, which contradict regulatory guidelines.

** The Cooperating Parties are AHIMA, the American Hospital Association in Washington, DC, the Health Care Financing Administration in Baltimore, and the National Center for Health Statistics in Hyattsville, MD.* ■

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HCFA considering changes to Form 855

All sections may be in for revision

The Health Care Financing Administration (HCFA) in Baltimore is considering making changes to all 18 sections of controversial Form 855 that providers must complete to participate in Medicare.

Sources at the Medical Group Management Association (MGMA) in Englewood, CO, who have seen an internal HCFA memo say HCFA is prepared to make changes to all 18 sections.

The form is considered too complicated and burdensome by many providers, and health care groups have been lobbying HCFA to simplify it.

What may change

While nothing is official yet, the changes being considered, according to the MGMA sources, include the following:

- Instructions would provide examples of how to enroll providers and suppliers for situations that have resulted in questions and problems in the past.
- Applicants would be given an overview of the enrollment process and a list of whether they are enrolled by a carrier or intermediary.
- Instructions for each section would be interspersed within the form itself, making it easier to keep track of what information goes where.
- Check-boxes would be provided to indicate when a section is not applicable.
- Requests for prior Medicare numbers would be removed.
- Requests concerning affiliated units, off-site clinics, etc., would be removed from section 1B.
- Prior practice information on organizations and individuals (section 7) would be eliminated, as would section 10 (parents and joint ventures).
- Applicants would have to provide information on contractors with whom they have conducted $25,000 worth of business or more during a year. Different limits may be set for larger providers.
- Information on surety bonds for an individual would be eliminated.
- The enrollee would be clearly defined as the "provider/supplier" and not the entity that employs the physician.
- Form 855 may be broken into three distinct forms: one for practitioners, one for facilities, and a third for suppliers of durable medical equipment, prosthetics, orthotics, and supplies.
- Applicants would be allowed to skip sections 11 (chain, organizational data) and 12 (contractor information). ■

Charity can bring its own punishment

OIG has providers worried about copays

Concerns by the Office of the Inspector General (OIG) that the unusual charitable practices of a few providers and ambulance services could be considered illegal has many providers worried that they could be busted for occasionally waiving copayments for poorer patients.

"Not to worry," says OIG spokeswoman

Alwyn Cassil. The OIG does not plan any kind of organized investigation into copay waiver practices, she promises.

Providers are permitted under Medicare Part B to waive copayments once they have made a good faith effort to determine financial condition of a beneficiary. The OIG was concerned that routine waiver of copayments could be associated with more serious violations of reimbursement rules.

An objective standard

When considering a workable definition of financial hardship to justify waiving a copay, "I recommend my clients use an objective standard, preferably one set by another entity," notes health care lawyer **Mike Carlson** of Carlson and Associates in Birmingham, AL.

"For example, I have clients who have used their state's Medicaid eligibility standard. Others have used the food stamp program's standards and the federal poverty guidelines," he notes. The financial hardship line starts to blur, however, when it comes to what could be considered a temporary situation resulting from an unusual personal circumstance such as divorce, loss of a job, or catastrophic illness. ■

HCFA bends same-day rule for cancer patients

Congressional pressure pays off

A U.S. Senate coalition has convinced Medicare officials to make an exception to a rule against same-day consultations for medically necessary services for beneficiaries treated at multidisciplinary cancer clinics.

Medicare has a policy against paying for multiple consultations by different specialists for the same patient on the same day. But, "in case of oncological care, such coverage rules are outdated and inappropriate since cancer patients inherently require multi-modality care," Sen. Jesse Helms, R-NC, and 11 other lawmakers wrote to Nancy-Ann DeParle, administrator of the Health Care Financing Administration (HCFA) in Baltimore.

As a result of current coverage rules, "patients are often required to make several appointments over several days in order to obtain all the necessary consultations from all the various specialists," the letter stated.

HCFA's exemption is good news, according to **Christian Downs**, director of provider economics at the Association of Community Cancer Centers in Rockville, MD. "It is critical, especially, for cancer patients to be able to come to a cancer center and to be able to receive their services all at one time."

When it comes to consultations, "Medicare policy does not stipulate a frequency limit on the number of consultations provided by physicians for a single patient on any given day. The determining factor is the medical necessity of the services provided," DeParle wrote in a letter informing Helms of HCFA's new policy clarification.

For multiple, concurrent same-day consults, "payment may be made for the services of more than one physician during a given time when such services are considered by the Medicare Part B carrier to be reasonable and necessary," she wrote. To qualify, each physician must play an active role in the patient's treatment, and physician services must not be duplicative.

When carriers are deciding if such services are reasonable and needed, they should consider the physicians' specialties, the patient's condition, and the medical necessity of the particular services, wrote DeParle. ■

HCFA delivers: Risk adjustment for capitation

Payment changes will span four years

The year 2000 marks the beginning of technical shift in Medicare capitation payment methodology that — over the next four years — will move payments toward a significant conceptual change aimed at reducing capitation's riskiest aspects.

You may not notice much difference so far this year in your Medicare capitation payments. A 5% increase is projected overall, although that varies widely by county.

Over the next four years, the new payment system, which factors in principal inpatient diagnostic cost groups, or PIP-DCGs, will pay higher rates for patients statistically predicted to be at

greater health risk. Simultaneously, payments will be lower for HMO enrollees who do not clinically qualify for a PIP classification.

Beneficiaries receive 'risk scores'

Until Jan. 1, 2000, all Medicare HMO patients were paid under the adjusted average per capita costs method, which essentially amounted to an average Medicare fee-for-service rate adjusted for geographic location. Other adjustments also existed — age, gender, Medicaid eligibility, and institutional status.

Starting in the new calendar year 2000, all Medicare HMO beneficiaries were assigned a "risk score" based on their clinical history. Those who are predicted to be at the greatest risk for intense services are identified as such and assigned a risk category (PIP-DCG).

The following formula and accompanying examples explain how to make the new capitation calculation:

- Add Part A and Part B age rates (basic Medicare payment levels), or the Part A and Part B disabled rates (for enrollees with disabilities); **the chart on p. 74** shows an example drawn from four counties in Kansas, with "rescaling factors" representing demographic adjustments.
- Multiply the corresponding re-scaling factor.
- Multiply by the risk score. **(See examples of the risk scores for DCGs 5-20, for males, p. 74.)**
- Apply the blend percentage (10% for the year 2000, with rising percentages over the next four years).

HCFA examples of two beneficiaries

Here are two examples the Health Care Financing Administration (HCFA) offers in its "45-day Notice Letter for 2000 Medicare+Choice Payment Rates":

1. Beneficiary A was hospitalized twice during the base year (1999). The diagnoses assigned were asthma (PIP-DCG 8) and staphylococcus pneumonia (PIP-DCG 18). The highest PIP-DCG category for the beneficiary would then be PIP-DCG 18. As the sample PIP score chart indicates, PIP-DCG 18 carries a factor of 2.656. The beneficiary also would be placed in its demographic group. In this case, the patient is male, age 82. This age group carries an age factor of 1.077.

Also, the patient had been Medicare-eligible because of a disability, which carries a factor of 0.287, but he is not eligible for Medicaid (so no Medicare factor is applied). Adding those incremental factors, the risk factor for Beneficiary A is 4.02, which indicates a high expected cost individual.

2. Beneficiary B had no inpatient admissions during the base year. Thus, no specific PIP-DCG would be added. Beneficiary B would be placed in the appropriate age and sex grouping, and any relevant Medicaid and disable factors would be added.

Each year, insurers are required to forward up-to-date enrollee data to HCFA for risk factor analysis. HCFA computes the risk factor for the beneficiary as well as the capitation payment for that patient. The risk factor is computed for each individual beneficiary for a given year. That factor follows the beneficiary regardless of which insurer the beneficiary chooses.

The current DCG-PIP classification currently has 15 capitation payment categories for 89 different diagnoses. HCFA experts expect that the current PIPs will represent about 12% of Medicare HMO beneficiaries. More are likely to be added in the future as the PIP-DCG system is tested over the next four years.

Under PIP, capitation payments will be based on a combination of diagnostic and demographic factors, with increasing emphasis on diagnostic factors as the phase-in moves toward its fourth full year.

Phase-in schedule

In summary, here is how HCFA will roll out the new payment system in its first year:

- Assign each Medicare HMO enrollee risk adjusters, or PIP-DCGs, based on inpatient data.
- Apply individual enrollee risk scores to determine fully capitated payments.
- Utilize a prospective PIP-DCG risk adjuster to estimate relative beneficiary risk scores.
- Apply separate demographic-only factors to new Medicare enrollees for whom no diagnostic history is available.
- Use six-month-old diagnostic data to assign PIP-DCG categories (as opposed to using the most recent data and making retroactive adjustments of payment rates part way through the year).
- Allow for a reconciliation after the payment year to account for late submissions of encounter data.

2000 Medicare+Choice Monthly Capitation Rates and Re-scaling Factors*

State County Code	County Name	Age Rates			Disabled Rates		
		Part A	Part B	Re-scaling Factor	Part A	Part B	Re-scaling Factor
17000	ALLEN	$233.53	$178.55	0.972505	$214.10	$182.02	1.011688
17010	ANDERSON	$231.51	$177.02	0.980956	$214.10	$182.02	1.011688
17020	ATCHISON	$243.82	$186.43	0.931435	$214.10	$182.02	1.011688
17030	BARBER	$254.70	$194.74	0.891665	$214.10	$182.02	1.011688

* Example shown is for four counties in Kansas. *Source:* Health Care Financing Administration, Baltimore.

Medicare's New Capitation Formula Adds PIP-DCG Factors

Factors for People with One or More Years Experience					PIP SCORES	
Male	Age cate.	BASE	PREV. DISABLED	MEDICAID	DCG	Factor
	0-34	0.367	-	0.125	5	0.375
	35-44	0.380	-	0.283	6	0.458
	45-54	0.487	-	0.370	7	0.697
	55-59	0.615	-	0.397	8	0.822
	60-64	0.760	-	0.418	9	0.915
	65-69	0.541	0.415	0.440	10	1.170
	70-74	0.705	0.398	0.457	11	1.271
	75-79	0.907	0.334	0.461	12	1.662
	80-84	1.077	0.287	0.445	14	2.000
	85-98	1.258	0.237	0.404	16	2.438
	90-94	1.376	0.189	0.331	18	2.656
	95+	1.357	0.141	0.242	20	3.392

Note: This chart illustrates risk adjustments for male Medicare populations and only for DCGs 5-20. Separate factors exist for female populations. *Source:* Health Care Financing Administration, Baltimore.

• Phase-in effects of risk adjustment, beginning with a blend of 90% of the demographically adjusted payment rate and 10% of the risk-adjusted payment rate in the first year (FY 2000).

• Implement processes to collect encounter data on additional services and move incrementally to a full risk adjustment model.

One of the areas of controversy for PIP-DCGs surfaced in the clinical area of congestive heart failure. "We have received many comments raising concern about the need to reimburse plans for the outpatient management of certain chronic conditions, especially congestive heart failure [CHF]," HCFA officials explained in a press release. "As one of the most frequently billed inpatient diagnoses, CHF is unique in its prevalence and to the degree to which it can be successfully managed on an outpatient basis." Some experts are urging HCFA to make special capitation payments for CHF treated in outpatient settings, but to date, HCFA says it needs more time to research how that could be done in the PIP model. ■

Should your facility move your coding department?

Coders benefit from reimbursement knowledge

Many coders know the stress that can occur while they are working in the medical records department. They feel pressure to improve the quality of their coding, while noncoding personnel grumble that the coders should also help with the phones and filing. This leads some coders to wonder — would the grass be greener under the direction of the billing department?

Having coding personnel in the financial department rather than medical records is logical, says **Colleen Albert**, RHIT, CCS, a contract coder from California. "It is always useful to expand your knowledge [and career potential], and familiarity with insurance/reimbursement issues. And the role coding plays may best be accomplished by more direct exposure to such. Medical record offices are often noisy and cramped, and coding requires a high level of concentration to work not only accurately but quickly."

Some billing and financial managers also may see a good match, thinking that if they had control of coding, then accounts receivable (A/R) would decrease, says **Allan P. DeKaye**, MBA, FHFMA, president and CEO of DeKaye Consulting in Oceanside, NY. Since medical records' coding is both an art and a science, however, placing it in the financial department could have the opposite effect.

"Billing, and for that matter, the A/R functions, certainly have enough open accounts of their own to devote their attention to lowering their investment in A/R, without the added worry of all the clinical and physician interaction that would likely occur with coding in the billing department," he says.

DeKaye says the coding function appropriately belongs in the medical records department, but should be staffed with qualified credentialed staff. "The biggest challenge is, of course, overcoming the inadequate numbers of available skilled personnel. This becomes especially difficult with increasing outpatient volumes."

Most medical record departments will, of necessity, use their most qualified coders for inpatient accounts, he says. This often leaves less experienced personnel taking on the most voluminous activity. "Private ambulatory services have increased vulnerability given Medicare's requirement that a relevant diagnosis be provided when ordering laboratory and X-ray services.

"With APCs [ambulatory payment classifications] looming on the horizon, coding will take on even more significance," he continues. "If hospitals are prepared to invest in coding infrastructure, therefore, let the investment be in medical records."

[DeKaye also offers the Patient Accounts Management Listserver (PAMLIST). For more information, visit the Web site:www.dekaye.com.] ■

Universal chart order aids HIM professionals

Hospitals should dictate their record sequence

Organizing patient charts once was a time-consuming and complicated process. Patient care units generally placed the charts in reverse chronological order. Physician orders and current test results were often in front; dictated reports tended to stay more in the back. Some reports might be color-coded; users memorized these color codes so they knew where to quickly find the information in the chart. It was common for each patient care area to establish its own chart arrangement.

After discharge, the user focus changed with less emphasis on detail, more emphasis on summary information. The chart was then rearranged into chronological order by section when it arrived in the health information management (HIM) area. Some of the dictated reports that would be the most in demand from release of information requesters would now be positioned in the front of the chart for easier dismantling, copying, or for a reviewer who might just want summary information.

"User convenience dictated the order in each hospital area," says **Beth Hjort**, RHIA, HIM practice manager for the American Health Information Association (AHIMA) in Chicago.

Then universal chart order was introduced to HIM personnel through benchmarking as a best practice — a policy or procedure that enhances the quality of care, increases efficiency, and lowers costs. (**For information on how to enter**

AHIMA's Best Practices Awards Program, see story, at right.) Hjort has used universal chart order at hospitals where she was employed. "We saw the value and so did the other hospitals in our comparative group."

Universal chart order saves staff hours in the HIM area, eliminating the need to completely rearrange the chart at discharge, Hjort says. "[The transition] was an excellent time to take a look at the arrangement of the chart, its logical sequence, and the most convenient arrangement. We let the change be directed through the cumulative opinion of the many record users in the hospital. We accomplished that through the Medical Record Committee."

With universal chart order, hospital personnel rely on the use of chart order guides. "We had a set of 10 or 12 different tabs," she dds. Chart holders have top clips or three-ring binder arrangements, and tabs that identify a chart section project from the bottom or the side. "[The tabs] allow someone to quickly glean and find what they need. That was different from the old process where there were no tabs," Hjort says.

Creating a user-friendly system

The tabs identify the separate chart sections and eliminate the need for the record forms to be color-coded. The universal chart order also allows the chart to stay in the same basic order once it comes to HIM; anyone reviewing the chart, familiar or not with the system, can use the tabs to find a particular section.

With chart guides, facilities can custom-design a convenient arrangement since the guides create the user-friendly feature, and order is no longer important, Hjort says.

After discharge, one approach is to leave the guides in the records, even the empty ones. "Our plan was to take them out at microfilming as a complete set so they could be recycled. We wanted to be able to use them later without a lot of rebuilding of the tab set." If hospitals cluster patients with similar problems in patient care units, special chart guides can be part of the tab set for that unit; likewise, other units may use the specialty tab only occasionally and can add it as needed.

The purchase of the customized tab sets is a significant expense upfront, Hjort says. However, that expense is generally offset over time by savings realized in decreased staff hours, the elimination of colored forms, and the ability to recycle tab sets.

Hjort says she was pleased with the change offered by the universal chart order. "It was much more user-friendly for new caregivers or those moving between patient care units. Plus, it reduced HIM staff hours and confusion that can come from training staff [in the old system]. I could see an added benefit to applying the universal chart order concept in health systems where physician providers might be moving between hospital entities." ■

AHIMA accepting 'Best Practices' for awards

Although the deadline is near, health information management (HIM) professionals may still have time to submit their best practices to the American Health Information Management Association (AHIMA) in Chicago.

The Best Practice Awards, funded through AHIMA's Foundation of Research and Education (FORE) recognizes HIM professionals who strive to develop new and innovative, or best, practices. Best practices are the policies, processes, and procedures that lead to exceptional performance in HIM.

Best practices have a broad impact on management, operations, and clinical practice in health care organizations. Plus, they enhance the quality of care, increase efficiency, and lower costs. **(For information about a former Best Practice, see story, p. 76.)**

Applicants for a Best Practice Award must be an active, associate, or student AHIMA member in the HIM field. Submissions require details of how and why the best practice was developed, how it was implemented and assessed for effectiveness, and how it improved the management of health information.

A panel of HIM experts will judge the submissions. Multiple submissions from individual participants are allowed. The deadline for submissions is May 1, 2000. Prizes include $3,000 for first place, $2,000 for second place, and $1,000 for third place.

For an application, visit the FORE page of the AHIMA Web site at http://www.ahima.org/fore/index.html. AHIMA members can also call the association's FaxLink service at (888) 424-4040 and request document #762. For more information contact Alison Feinberg at (312) 233-1168 or by e-mail at alisonf@ahima.org. ■

Management staff have little HIPAA knowledge

Your management team may still be in the dark about regulations governing electronic health information, a new survey shows.

The survey was conducted by *HIPAAlert*, a free e-mail newsletter published by Phoenix Health Systems. The survey asked about respondents' "first steps" in complying with the long-awaited standards on electronic health information, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). About 425 organizations responded to the on-line survey, more than half from hospitals. Other respondents included payers, vendors, and consulting firms. About half of the respondents said they play a role in HIPAA compliance in their organizations.

Here are some of the highlights from the survey:

• Senior and middle management knowledge of HIPAA in all responding organizations are low, indicating a serious need for education and training. More than half of all respondents ranked their senior management's knowledge of HIPAA as low. Over two-thirds ranked the department heads' knowledge of HIPAA in their organizations as low. This indicates the need to better educate the leaders of the health care community.

Respondent comments included, "There are still only a few of us who try to keep up with HIPAA," and "Y2K was bad enough. . . . Management seems to want to turn a deaf ear on HIPAA."

HIPAAlert did find the survey encouraging in that most respondents indicated that HIPAA training is under way in their organizations. However, this response may be skewed by the possibility that respondents to this survey (and therefore, their organizations) may be more advanced in their interest in, and attention to, HIPAA issues, the newsletter reports. Typically, HIPAA training is being performed by internal staff, rather than by outside experts or consultants.

• In provider organizations, the compliance/security officers or the CIO are most frequently asked to take the leadership for HIPAA compliance. Among the 199 provider respondents answering this question, approximately 25% have given their compliance/security officers responsibility for HIPAA compliance. Another 25% of the providers have given responsibility to the CIO, 10% to the medical records director, and just under 10% to the risk manager. The remaining 30% have selected other individuals.

• A large portion of all organizations responding are already working on risk assessments and action plans, or will be within the next three months. Two-thirds or more of respondents' organizations are taking the following specific actions within the next three months: budgeting funds, taking inventory of systems, and alerting vendors and partners. However, 20% of providers are waiting at least six months to do their plans, thereby eating significantly into the time allowed to achieve compliance. Most vendors are working on an action plan now.

HIPAAlert says it finds the 20% of providers waiting at least six months before developing an action plan to be somewhat worrisome. Even taking into account the current delays in publishing the final regulations, these providers may end up spending a substantial portion of the two-year compliance period on planning, at the risk of leaving insufficient time for implementation and testing, *HIPAAlert* says. Some providers are taking their time. As one person responding to the survey explained, "Things haven't heated up yet — let's wait for the regs!" That wait may be a costly one, *HIPPAlert* comments.

• So far, vendors are more aggressive in planning and taking actions such as budgeting, taking inventory of systems, and alerting partners.

The survey shows that as a group, vendors have more immediate plans for action than all other respondents.

(For more information about the survey or to subscribe to HIPAAlert*, visit the Web site: www.hipaalert.com.)* ■

HIPAA regulations delayed again

The final regulations for several standards in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have been delayed once again. In mid-March, William R. Braithwaite, MD, PhD, FACMI, senior advisor on

health information policy for the Health Care Financing Administration, told attendees at a HIPAA conference that the Department of Health and Human Services would publish the transaction and code sets regulation by the end of June. He also said the security regulations would be delayed until the third quarter of this year.

Braithwaite made his comments at the 2000 HIPAA Conference in McLean, VA. The conference was sponsored by the Joint Healthcare Information Technology Alliance in Washington, DC. ▼

OIG urges providers to disclose improper conduct

Health care providers who promptly disclose their own improper conduct to the government may be eligible for favorable treatment in the resolution of their cases, including less rigorous corporate integrity agreements, Inspector General June Gibbs Brown told the health care community in an open letter dated March 9.

Typically, all corporate integrity agreements include a provision to exclude a provider from participation in the federal health care programs if the Office of Inspector General (OIG) determines that the provider has materially breached the terms of the agreement. The OIG may forgo the exclusion remedy in appropriate self-disclosure cases where the providers demonstrate sufficient trustworthiness to allow the OIG to conclude that the federal health care programs can be safeguarded without the exclusion remedy.

Additionally, if a self-disclosing provider has demonstrated that its compliance program is effective and agrees to maintain its compliance program as part of a False Claims Act settlement, the OIG may not even require a corporate integrity agreement. The decision on whether to impose a corporate integrity agreement is influenced by a number of variables, including the scope and seriousness of the misconduct, the risk of recurrence, whether the disclosed matter was identified and reported as a result of the provider's compliance measures, and the degree of the provider's cooperation during the disclosure verification process.

The self-disclosure protocol is designed only for providers who believe a potential violation of the law may have occurred. Matters exclusively involving overpayments or errors that do not indicate that violations of the law have occurred should be brought directly to the attention of the entity responsible for claims processing and payment. ▼

AHIMA offers HIM scholarships and loans

As part of a mission to support professional education through the Foundation of Research and Education (FORE), the American Health Information Management Association (AHIMA) in Chicago is offering scholarship and

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Subscription rates: U.S.A., one year (12 issues), $529. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $317 per year; 10 to 20 additional copies, $212 per year. Call for more details. 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 $88 each. (GST registration number R128870672.)

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loan awards to full-time graduate and undergraduate students pursuing degrees in health information management (HIM) and health information technology (HIT). The awards range from $1,000 to $5,000.

The application deadline is May 30, and awards will be presented in August. Submission of one application creates eligibility for all applicable scholarships and loans. In addition to a completed application, students must also provide proof of acceptance into an HIT or HIM program or related graduate program and evidence of their AHIMA membership. If applicants are not currently members of AHIMA, they can simultaneously apply for both an AHIMA student membership and for the available scholarships and loans.

For an application or more information, visit the AHIMA Web site at http://www.ahima.org and follow links to FORE and then to scholarships and loans. Alison Feinberg can be contacted via telephone at: (312) 233-1168. E-mail: alisonf@ahima.org. AHIMA members also can call the association's FaxLink service: (888) 424-4040. Request documents 503 and 504. ▼

Report asks HCFA to review Medicare policy

The Health Care Financing Administration (HCFA) soon may be reviewing hospitals with a high number of Medicare same-day readmissions.

A report released in February by the Department of Health and Human Services' Office of Inspector General found that same-day readmissions were a cause of concern regarding quality of care issues, in addition to billing and overpayment problems.

The report, "Analysis of Readmissions Under the Medicare Prospective Payment System for Calendar Years 1996 and 1997," (A-14-99-00401) also recommended that HCFA:

- make the data in its report available to peer review organizations for use in determining the scope of their peer review activities;
- perform beneficiary-specific reviews on the claims of beneficiaries who had multiple continuous same-day readmissions;
- review a sample of same-day readmission claims in which the same-day readmission was coded with the same DRG as the first hospital stay.

HCFA generally concurred with the recommendations but noted that only 61 providers had 30 or more readmissions in 1996 and 1997. HCFA will ask peer review organizations to investigate. HCFA, however, may suspend payment for same-day readmissions pending verification of their appropriateness. The full report is available at www.hhs.gov/progorg/oas/cats/hcfa.html. ▼

Hospitals can access Medical Encyclopedia

A partnership between adam.com, a medical information Web site based in Atlanta and MedSeek, a Solvang, CA-based developer of Web sites and services for health care, will bring adam.com's Medical Encyclopedia to many hospitals, clinics and physicians.

adam.com's proprietary library contains more than 10,000 pages of medical and health content covering over 1,500 topics, and includes archives of medical illustrations, interactive animations, 3-D models, broadcast-quality video, and fully dissectible male and female bodies. adam.com's content and products are also used in the education, broadcast, legal, and print publishing markets. ■