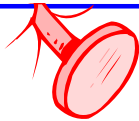


Bama Chatter

HFMA ALABAMA CHAPTER

VOLUME XXXX, NO. 6

MAY / JUNE 2001



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Attention Members!!! We've Stopped the Presses

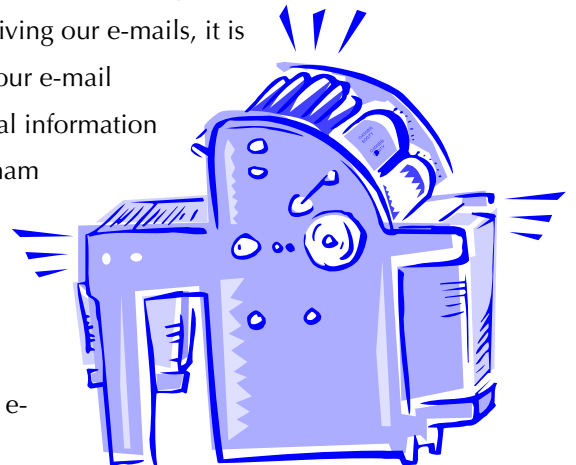
Beginning with the July/August 2001 issue, *Bama Chatter* will no longer be printed. Instead, Alabama HFMA members will receive a link to *Bama Chatter* on the Alabama HFMA web page through their e-mail. You should have been receiving a printed copy of *Bama Chatter* in the mail as well as a link through e-mail. Because of the continually rising costs of postage and printing and the increased convenience of the internet, we have decided to discontinue the printed version. The response from our latest membership survey indicated that an overwhelming majority would like this best. This change to *Bama Chatter* will provide our membership with a more effective member communication!! Be sure to keep your e-mail information current and click on your *Bama Chatter* link to receive the latest news from our Chapter.

If any member has not been receiving our e-mails, it is probably because we do not have your e-mail address. Please update your personal information with National HFMA, call Paul Graham (205-838-3343) or e-mail the webmaster at **webmaster@thevalenciagroup.com**.

For members who do not have internet access or do not have an e-mail address, a pdf file or faxed copy can be provided. Please call

the newsletter editor or e-mail the webmaster for these special requests.

If you have any questions or comments, please call Dawn Walton at 205-939-9073.





2000 - 2001

Officers

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Annette N. Baker, FHFMA
(205) 220-4111

President-Elect

Paul T. Graham, FHFMA, CPA
(205) 838-3343

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Philip L. Cusa, FHFMA
(334) 990-1510

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Mitzi C. Winters, CHFP
(205) 599-4912

Parliamentarian

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(205) 226-7309

Immediate Past President

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(205) 226-7328

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(205) 250-8503

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Nancy R. Strachan
(334) 990-1550

Winter Institute

Sydney Rountree, FHFMA
(205) 934-4811



Alabama Chapter Website: www.alhfma.org

Address communications to: *Bama Chatter* Editor

Dawn Walton, CPA
CACH HMO, Inc.

1600 7th Avenue South • Birmingham, Alabama 35233

Phone: (205) 939-9073 • Fax: (205) 939-6865

E-Mail: dawn.walton@chsys.org

Please contact National HFMA with address, employer, or title changes at 1-800-252-HFMA, ext. 350

Committee Chairpersons

AHA Liaison	Annette Baker, FHFMA	(205) 220-4111
Constitution & Bylaws	W. Curt Miller, CPA	(205) 226-7328
Nominating	Paul T. Graham, FHFMA, CPA	(205) 838-3343
Awards	Jolee Bollinger	(205) 521-8231
Information Technology	José Antonio Valencia	(205) 939-9239
Member Service Directory	Tracy L. Berke	(205) 934-2604
Member Recruitment	Pollyanna Brannan	(800) 264-2700 ext. 213
Past Presidents' Advisory	W. Curt Miller, CPA	(205) 226-7328
Pro-Action! / GRIP	Sydney Rountree, FHFMA	(205) 934-4811
Professional Excellence	Kathy Pitts, CPA	(205) 254-1608
Projects	Donna DaSilva, CPA	(334) 705-1827
Programs	Paul T. Graham, FHFMA, CPA	(205) 838-3343
Publications	Dawn Walton, CPA	(205) 939-9073
Quality	Laura Kelly	(205) 934-7391
CFO Forum	Libby D. Bailey, CPA	(205) 325-8565
PFS Forum	JoAnn Hudspeth	(256) 571-8039
Compliance Forum	Yolanda D. Rich	(205) 923-1467
Rural Meeting	Wes Sigler	(205) 226-7337
Tax Meeting	John Thrasher, CPA	(205) 254-1602

Advertising Information

Quarter page: \$100 per issue—Half page: \$175 per issue—Full page: \$300 per issue
Special discounts for long-term arrangements. Contact the editor for details.

Please send your ad and graphics on plain white paper or slicks. Deadline for publication is the 20th of the month preceding the month of publication. *Bama Chatter* is published bimonthly and is circulated to approximately 650 recipients.

Publication Schedule

ISSUE	DEADLINE	ISSUE	DEADLINE
September/October . . .	August 20th	March/April	February 20th
November/December. .	October 20th	May/June	April 20th
January/February	December 20th	July/August	June 20th

The statements and opinions appearing in articles are those of the authors and are not necessarily those of HFMA, the Alabama Chapter, or the editor. The editor strongly encourages submission of material for publication. Articles should be typewritten and double spaced, and submitted to the editor or the awards council chairperson by the 20th of the month preceding the month of publication. The editor reserves the right to edit materials and accept or reject contributions whether solicited or not. Readers are invited to comment on any of the published material. Letters to the editor must be signed and are subject to condensation and editing. All rights reserved.

A Great Year Ends, A New One Begins

Wow - this HFMA Chapter year has gone by so quickly! I have very mixed emotions as I recognize that in a few short weeks my duties as 2000-2001 President of the Alabama Chapter will come to an end. It has been an incredible year and I want to take this opportunity to say thank you for giving me the opportunity to serve as President of this truly great Chapter during this past year.

The Helen M. Yerger Award applications were recently submitted, and I would like to thank those members who helped me with this process: Paul Graham, Eastern Health System, Inc.; Nancy Strachan, Thomas Hospital; Jose-Antonio Valencia

and Chris Wylie, The Valencia Group, Inc.; JoAnn Hudspeth, Marshall Medical Center North; Libby Bailey, Callahan Eye Foundation Hospital; and Yolanda Rich, Baptist Health System, Inc. Your help was very much appreciated! We had eight submissions for Yerger Awards and will find out at the Annual National Institute in San Antonio in June whether any of these are selected for National recognition.

The CFO Forum "APCs...The Aftermath" was a huge success. Congratulations go to Libby Bailey for hosting such a successful meeting. Thanks for all the hard work!

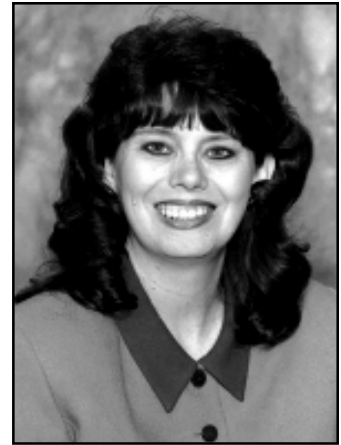
I am very excited about the certification results

achieved this year by Chapter members. Members are taking the test and passing! Special HFMA congratulations to the members who have been successful in passing part or the entire exam.

I want to thank the officers, Paul, Phil & Mitzi, for all their support during this past year as well as the Board of Directors, Committee Chairs and all the other many Chapter volunteers.

It's been a great year, and this truly is one of the premier Chapters in the country because of the membership's high level of volunteer commitment.

I encourage you to continue to stay involved as we head into the upcoming new year. Your 2001-2002 officers are



Annette N. Baker, FHFMA President, Alabama Chapter HFMA

already off and running with plans for another outstanding year for the Chapter. Phil has planned a terrific meeting to kick off our new year. I hope you have made your plans to join us at the Annual "Beach" Institute. I look forward to seeing everyone in Sandestin and at all the other Chapter activities for the upcoming year.

Thanks for a great year!

Annette



Certification Successes!

Special HFMA congratulations to **Kemberly Blackledge** and **Marty Franklin** who have successfully passed both the CHFP Core Exam and a Specialty Exam!

Also, congratulations to the following members who have achieved the conditioned status by successfully passing either the Core Exam or a Specialty Exam this year. They are:

Kathy Pitts	Kimberly Shrewsbury
Richard Byerly	Byron Trahan
Donna DaSilva	William Wood





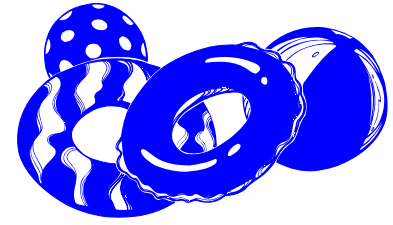
THE ALABAMA CHAPTER

Healthcare Financial Management Association

Annual Institute

May 29 - June 1, 2001

Sandestin Beach Hilton Golf and Tennis Resort



Join us for our first educational session Tuesday as we find ways to reduce accounts receivables, then on to pool-side as we kick off the annual meeting with a Welcome Reception. Wednesday's topics will include information on Municipal Bond Disclosure & Compliance and Customer Service before the Golf Tournament, which is sponsored by Franklin Collection Service and Zarzaur and Schwartz, P.C. Thursday's educational topics will include an APC Workshop, information on managing claims and websites and Medicare bad debt. Then "Family Beach Fun & Games," sponsored by Draffin & Tucker, will prove enjoyable to all ages. At Thursday evening's banquet, enjoy the comedy of featured speaker, David Glickman, one of the most popular corporate humorists in America today. His topic, "A Dose of Healthcare Humor" promises to hit home with all those attending.

Friday morning's topics will include information on HIPAA and accounts receivables. The Alabama Annual Institute is a "must attend" event with all the fun and education mentioned here **and much more!!!**

CPE Credit: This program will be approved for CPE credit by the Alabama State Board of Public Accountancy for continuing professional education credit.

Hotel Information: You may make reservations directly with the Sandestin Beach Hilton Golf & Tennis Resort by calling (850) 267-9500. Our room block was held only through April 26.

Registration Form *(please print or type)*

Full Name _____

First Name (as you want it to appear on name badge) _____

Title _____

Organization _____

Address _____

City _____ State _____ Zip _____

() _____
Daytime Phone

() _____
Fax

E-mail Address _____

Dress code for all events is casual.

Registration Fees

Please Note: Register by May 20, 2001 and receive a discount on registration fees.

Registration	Member	Non-Member	Total
Early Registration	\$235.00	\$250.00	_____
Registration after May 20	\$245.00	\$260.00	_____
<input type="checkbox"/> Golf	\$ 50.00	\$ 50.00	_____

Please indicate which events you will attend :

- Tuesday Welcome Reception (# _____) N/A
- Guests at Thursday Banquet (# _____) N/A

TOTAL FEES ENCLOSED _____

Make checks payable to: Alabama Chapter-HFMA

Mail to: **Philip L. Cusa, HFMA**
Thomas Hospital
P.O. Drawer 929 • Fairhope, Alabama 36533
Phone (334) 990-1510 • Fax (334) 990-1498

HFMA Certification At the ANI

While there will be a great deal of certification activity at the ANI this year, as every year, there is something new! Computer-based testing will be available on Monday June 18, all day by appointment. If you want to take your exams at the ANI, please make your appointment early so that you can have a computer reserved for you when you want to test. The Core exam and all specialty exams will be available all day on Monday, and you will know your scores immediately. The charge for the Core exam is \$100; the specialty exams are \$70. You can sign up for an exam on the ANI registration blank and be contacted by the certification staff, or you can indicate your preferred examination time and the certification staff will confirm your registration. For more specifics, contact bclark@hfma.org, or pzenger@hfma.org.

National Coaching Course


The National Coaching Course will be available on site at the ANI on Sunday June 17. The Core Course will be available from 8 - noon, the specialty courses (Accounting and Finance, Financial Management of Physician Practices, Managed Care, and Patient Financial Services) will be available from 1-5 p.m. Plan now as to whether you want to be provided with a copy of the appropriate self study course on site, or purchase it in advance and use the course as a pretest review. The courses will be based on the 2001 - 2002 editions of the self-study courses, and those are the exams that will be administered on Monday June 28.

	National Coaching Course	Bring your own 2001-2002 self study course & deduct
Core Review	\$399	\$200
Specialty Section	\$375	\$200
Both	\$750	\$400

Need More Information?

Stop by the Certification Information Reception on Monday June 18th, even if you are already certified, this is a good time to get information on chapter-based testing, and what it means to be a proctor. Information on all aspects of the certification program will be available.

Already Certified?

Join other certified members for lunch, and a chance to see old friends and meet new ones. Take this opportunity to get away from the hustle of ANI and enjoy the entertaining offerings of a comedian chosen to provide the right touch at this sit-down lunch. This activity is restricted to HFMA certified members only. 



NEW MEMBERS

Miriam Hubbard

Southeast Alabama Medical Center
sponsored by JoAnn Hudspeth of Marshall
Medical Center North

Linda Maddox

Baptist Health
sponsored by Debbie Young of NCO

Member Get A Member Sponsor Standing

SPONSOR	TOTAL RECRUITED
TOTAL WITH NO SPONSOR LISTED	19
Joel T. Barnett, CPA	1
JoAnn Hudspeth, Marshall Med. Ctr. No.	1
Robert P. Levesque, FHFMA	1
Linda Maddox, Baptist Health	1
Kathy B. Nelson, Marshall Med. Ctr. So.	1
Catherine G. Norwood, Marshall Med. Ctr. So.	2
Yolanda D. Rich, Baptist Health System	2
Vicki L. Winters	1
TOTAL RECRUITED FOR 2000/2001	29

To receive applications for new members or additional information, please call Pollyanna Brannan at 1-800-264-2700 ext. 213. If she is away, please leave your name, number, address and fax on the voice mail and she will respond ASAP!

Member-Get-A-Member Contest Update

Catherine Norwood of Marshall Medical Center South and Yolanda Rich at Baptist Health System are still tied for TOP RECRUITER, but you only need 2 recruits to tie, and 3 to WIN a 3 DAY/2 NIGHT stay at Sandestin.

Time is running out, so be on the lookout for prospective members and share HFMA!

Thanks to all those participating.

Healthcare Financial Management Association Alabama Chapter 2001 Member Survey

As we anticipate our upcoming annual meeting at Sandestin in May, we reflect on our current year. Your chapter leadership has worked hard to provide you with what you need and want in education and networking opportunities.

We have had excellent education programs at all our institutes this past year and want to continue to provide the kind of quality programs you desire as a member. So that we can continue to do that, we need your input.

Attached is our annual membership survey for you to complete. It should not take long to fill out and will be worth the time spent in doing so. As you know, the healthcare environment today is very challenging to say the least and your Alabama HFMA Chapter wants to be there as a resource for you.

Please take the time to complete your survey and fax to Laura Kelly, Chair, Quality Council at (205) 975-6093. If you have any questions, please contact Laura at (205) 934-7391 or at wkelly@uabmc.edu.

1. How satisfied are you with the following aspects of education programs and services sponsored by the HFMA Alabama Chapter? (One response for **each** item)

	VERY SATISFIED	SATISFIED	DISSATISFIED	VERY DISSATISFIED	DON'T KNOW
a. Education programs overall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Topics addressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Speakers at education programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Location of programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Cost of programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Frequency of programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Social activities overall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Opportunity for involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Rank the top three most important factors in your decision to attend chapter meetings. (Write one through three)

_____ Location of meetings	_____ Speakers
_____ Topics offered	_____ Family activities offered
_____ Time of month meeting held	_____ Social events
_____ Cost of hotel	_____ Networking opportunities
_____ Registration costs	_____ Type of site (hotel, resort, hospital meeting facility)

3. Does the HFMA Alabama Chapter need to improve those factors that you ranked 1 through 3? (Check one response for **each** item.)

	NO IMPROVEMENT NEEDED	NEEDS IMPROVEMENT	IF NEEDS IMPROVEMENT PLEASE OFFER SUGGESTION
a. Item ranked #1	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Item ranked #2	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Item ranked #3	<input type="checkbox"/>	<input type="checkbox"/>	_____

4. Concerning educational programs in general, should more time be allotted per speaker so they can (one response for **each** item):

a. Go more in depth in their topic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Offer more time for discussion/question & answer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

5. If you have not attended any chapter programs this year, check each item that has prevented you from attending (select as many as apply):

- a. Inconvenient timing of programs: can timing be improved? _____
- b. Work obligations _____
- c. Program locations: suggest locations? _____
- d. Program costs _____
- e. Lack of relevant programming: what topic would be relevant? _____

6. How interested would you be in attending an HFMA chapter education program on the following? (One response for **each** item):

	VERY INTERESTED	SOMEWHAT INTERESTED	NOT INTERESTED
a. Patient Financial Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Managed Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Integrated and other forms of complex delivery systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Government and other Third Party Reimbursement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Strategic Planning and Budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Capitation Accounting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Accounting and financial reporting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Professional and personal development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Long Term Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Ambulatory Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Physician Relations/Medical Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Policy and legislative issues (HC reform)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Utilization/Quality Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Medical Ethics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Re-engineering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Education toward certification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Rural Health Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Leadership development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Other Specify: Fraud & Abuse APCs; Outsourcing; Internet Opportunities; HIPAA; System Solutions; Front-end eligibility	_____	_____	_____

7. Please indicate your level of awareness and satisfaction with each of the following services of the HFMA Alabama Chapter (one response for **each** item):

CHAPTER SERVICE	NOT AWARE OF	AWARE OF DISSATISFIED	AWARE OF NO OPINION	AWARE OF SATISFIED
a. Newsletter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Directory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. AL Chapter Website	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Employment Referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. How interested would you be in an electronic, rather than printed, version of the following? (One response for **each** item):

	VERY INTERESTED	SOMEWHAT INTERESTED	NOT INTERESTED
a. <i>Bama Chatter</i> newsletter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Chapter Membership Directory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is Patient Safety A Top Priority For You?

by Dawn Walton, CPA

"Never has patient safety been more urgent than it is now," as reported in the April cover story at Hospitals & Health Networks. Much of the interest in patient safety has been fueled by the Institute of Medicine's (IOM) 1999 report on medical errors, *To Err is Human: Building a Safer Health System*, which opened the public's eyes with alarming statistics about avoidable injuries and deaths occurring in health care. The report claims that as many as 98,000 people die each year as a result of medical errors. The IOM released its follow-up report in March 2001, *Crossing the Quality Chasm: A Health System for the 21st Century*. This latest report looks beyond medical errors and examines the quality of the healthcare delivery system as a whole. Patient safety

has become a focus for many and sweeping changes are expected.

What Action Has Been Taken?

- JCAHO released in January 2001 revisions to its standards in support of patient safety and medical error reduction. The standards emphasize the importance of healthcare leaders taking an active role in reducing medical errors as well as being held accountable.
- NCQA announced last year modifications to its accreditation program to encourage health plans to focus on patient safety.
- Eight states now have mandatory reporting requirements for hospital incidents and errors.


Congress Ready to Act?

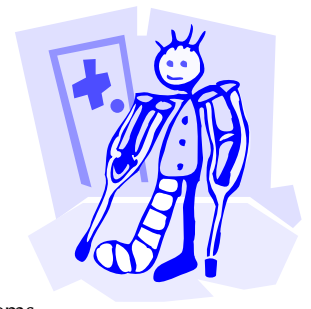
The stage is now set for the 107th Congress to act.

Six bills were introduced during 2000 regarding patient safety but many were reluctant to act in an election year. However, politicians in both parties have called for action. Efforts are underway to collect and define the best practices from around the country, and several legislative proposals will be molded into bills for introduction in 2001. This will accelerate research, dialogue, and progress in an area that has seemingly been neglected. We will see legislative activity on both state and federal levels. With legislated barriers to ensure that information remains confidential and that physicians and their colleagues are protected from embarrassment, blame, and punishment for system malfunctions, we can hope that the health care industry

will develop safer systems quickly. The next Congress is likely to approve such legislated protection, on the federal level.

What's To Come?

Health care systems are expected to protect patients from medical errors, even if it means costly changes for the industry. Many are acting on their own, but the IOM's report is calling for "a sweeping redesign of the American healthcare system and overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers and others." There are still many unanswered questions. Don't be caught off-guard, patient safety needs to be a top priority in your organization. Prepare now. 



Patient Safety Resources for the Financial Manager

Commentary

"*The Financial Manager's Role in Preventing Medical Errors*," by Richard L. Clarke, FHFMA — April 2001 issue of *Healthcare Financial Management*.

Education

"*Link Medical Errors Reduction and Patient Safety with Gain Sharing Arrangements*" HFMA Audioteleconference, May 23, 2001, 2:00-3:45 Central Time.

"*The Financial Manager's Role in Keeping Patients Safe and Reducing Medication Errors*," ANI Session (E03) HFMA Annual National Institute, June 17-21, 2001, San Antonio, Texas.

Reports

"*To Err is Human: Building a Safer Health System*," Linda T. Kohn et al., Committee on Quality of Health Care in America, Institute of Medicine, 2000. www.nap.edu/catalog/9728.html

"*Crossing the Quality Chasm: A Health System for the 21st Century*," William C. Richardson et al., Committee on Quality of

Health Care in America, Institute of Medicine, 2001.

www.nap.edu/catalog/10027.html

Useful Internet Sites

Black Ink - Patient safety resources created through a partnership of GE Healthcare Financial Services, HFMA, the American Hospital Association, and *Hospitals & Health Networks*.

www.gemedicalsystems.com/services/financial/hfs_online/hfs_ink_main_intro1.html

Institute for Healthcare Improvement (IHI) Patient Safety

Resources Home Page - Web site resources include full text of the report "Reducing Adverse Drug Events: Lessons from a Breakthrough Series Collaborative," by Lucian Leape et al. www.ihf.org/resources/patientsafety/

National Patient Safety Foundation - Web site features include full text news and reports, including the overview report "Current Research on Patient Safety in the United States." Also, an extensive bibliography of patient safety literature since 1979 and book reviews. www.npsf.org

HCFA Issues Update to Most Recent Version of E & M Documentation Guidelines



Tony Mistretta, Editor-in-Chief, Coding and Medicare Updates
The Medical Management Institute

At the December 11, 2000 meeting of the Practicing Physicians Advisory Council (PPAC), HCFA unveiled the newest incarnation of evaluation and management documentation guidelines. The update was made based on nearly 80 suggestions made by physicians and specialty societies. Most of the text of the June 2000 release was kept intact, but there were significant changes made to the draft which are summarized below:

- 1) Emergency room staff can continue billing a high level of E&M service even if the patient is unconscious or incoherent and thus unable to provide a comprehensive history. The June 2000 release required that doctors "should document efforts made to obtain a history from the patient, accompanying family members, friends or attendants, or emergency personnel (e.g., paramedics) or available medical records." ER physicians complained that this would make it nearly impossible to bill a high level of E&M service for non-communicative patients.
- 2) Requirements of past, family, and/or social history (PFSH) have been altered slightly. In order to reach an expanded

- problem focused history, no PFSH is required (under the June draft, a pertinent PFSH was required), and to reach a detailed history, only a pertinent PFSH is required (as opposed to a complete PFSH in previous guidelines). The more stringent PFSH requirements were added in the June release, but strong opposition by the specialty societies resulted in the return to the previous terms.
- 3) Provided the physician personally performs the review of systems (ROS) and documents all pertinent negatives, an extended or complete ROS can be reached. In the past, even if the physician noted that several systems were negative, only the systems actually documented with the positive and pertinent negatives could be counted toward the leveling of the ROS.
- 4) The new guidelines take into account physician supervision requirements in determining the level of history that can be billed. For instance, "... if the physician personally performs the review of systems (ROS) ... then this would suffice as an extended or complete ROS." However, "if the patient or ancillary staff

- completes a form and there are only 8 documented systems and no indication that other systems are negative, then this would not qualify as a complete review of systems."
- 5) For documentation purposes, the term "non-contributory" is now considered equivalent to the term "negative."
- 6) Documentation of 3 special examinations (e.g., Struthers, Allen's, pivot, Adson's, etc.), tests, maneuvers, functional assessments is comparable to one body area or organ system when leveling the examination portion of an E&M visit.
- 7) The documentation of the status of chronic or inactive conditions can factor into the leveling of the history of present illness (HPI). HCFA and the specialty societies are continuing to work on the clinical and medical decision making vignettes to give physicians a reference point for the selection of the proper level of visit. They hope to release this information by mid-2001. HCFA has already stated that they will not begin the pilot testing of these new guidelines until these clinical vignettes are released. In the meantime, the AMA and certain physician groups are pushing to gain stronger

- influence in the creation of these vignettes. The 600 proposed vignettes (covering 20 specialties) are based upon retrospective chart review. Because these visits were coded under previous versions of the E&M documentation guidelines, they could create unrealistic examples for coding under the new guidelines. Also, the AMA is beginning to campaign that physicians not participate in the pilot testing of these new guidelines until HCFA and the OIG promise immunity from prosecution or protection from Medicare postpayment review audit for participants. In addition to the legal risk this poses for physicians, it also has the potential to skew the testing of the revised guidelines. Without immunity, only physicians who can afford electronic medical records with built-in computer edits would participate. This segment of the physician population would not accurately represent the whole spectrum of medical practice. Insiders speculate that HCFA, in conjunction with the AMA's CPT Editorial Board, may shake up the whole system by reducing the number of levels of E&M service from the current five to three. Coding and Medicare Updates will continue to monitor this important process.



The CPT-5 Project

Tony Mistretta, Editor-in-Chief, Coding and Medicare Updates
The Medical Management Institute

Our instructors and consultants have noticed that there is a lot of confusion surrounding the CPT-5. Contrary to popular belief, the CPT-5 project is not a top secret government operation as the name may imply, nonetheless, it will bring about significant change to many in the healthcare industry in the next few years. The plan behind this project is to develop an enhanced version of the CPT-4 (Current Procedure Terminology). What was the impetus for this change to occur? The need for change was initially spelled out in the Health Insurance Portability and Accountability Act of 1996 which called for "national uniform standards for electronic transmission of financial and administrative information" to be created. In response to this statement in the HIPAA, the American Medical Association (AMA) began the CPT-5 project to address these issues and set forth new coding standards for the healthcare industry.

Project Participants

There are many participants in the CPT-5 project including government agencies such as HCFA, National Center for Healthcare Statistics (NCHS), Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO), specialty societies,

AMA, AHIMA, Blue Cross/Blue Shield and numerous others. The members from these organizations will be divided into six main workgroups that will focus on various CPT issues. These workgroups will report their recommendations to the Executive Project Advisory Group (PAG) who is in charge of overseeing the project. The final decision-making on the recommendations presented by the workgroups will be the responsibility of the CPT editorial panel.

CPT-5=CPT 2003

It is important to keep in mind that this is not a completely new version of the CPT-4, only a modified or enhanced version of the existing CPT-4. As a result, the new text will not be titled CPT-5, instead it will simply be known as "CPT 2003". The changes to CPT-4 will be phased in over the next three years with the rollout occurring in Fall 2002. Therefore, 2003 will be the first year that the changes take effect and will be available for use by the healthcare industry. Since the CPT-5 project has begun, there have been numerous questions arise such as, "Why change the CPT-4?", "What will the new changes entail?", and "How will they improve upon current procedural coding standards?".

Project Purpose

According to the AMA, the premise behind the CPT-5 project is not to create a new coding system, only to modify and enhance the existing one. The idea is to create a more specific coding system that is applicable and useful to many different segments of healthcare such as managed care organizations, hospitals, clinical specialty societies, and even healthcare researchers. At the same time, the intent of the CPT-5 project is to maintain some of the same inherent qualities of CPT-4 such as the 5-digit numeric codes. Moreover, it is not the intent of the AMA to cause a disruption in the usage of CPT by healthcare providers and payors and other organizations such as the AAPC that recognize CPT as the current coding standard. The ultimate goal of the CPT-5 project is to ensure that CPT is the "national procedure code standard" recognized by the Secretary of Health and Human Services (HHS) for the reimbursement and analysis of health care information. Another reason behind the enhancement of CPT-4 is due to increased technological advances and changes in the methods of health care delivery. Historically, medical coding has never kept pace with new treatment methods and medical equipment being

utilized in numerous settings by healthcare providers. Furthermore, the move to electronic medical records has also created a need to revise the current system. In response to the trend toward electronic medical records, the CPT-5 project members are also developing an electronic version of CPT that would utilize a programming language called Extensible Markup Language or XML to put the structures and symbols of the CPT into a readable format.

Areas of Focus

How will the CPT-5 project bring about these changes and what will these changes entail? There are several areas in which the CPT-5 project workgroups will focus to improve and update CPT-4.

- ☑ One of the main areas of focus is eliminating numerous ambiguities and inconsistencies that are presently found in CPT-4. For example, phrases included in the descriptions of codes such as "and/or" and "with or without" are difficult to interpret.
- ☑ Other terms used in CPT-4 such as "separate" procedures and concepts such as "starred" procedures have also caused a great deal of confusion for payors and providers alike. These descriptors and terms will be eliminated and

clearer language will be implemented.

✓ Other information that will be removed from the CPT descriptions is diagnostic information. Code 58240 in CPT-4 gives a primary example of the “with or without”, “and/or” phrases, and diagnostic information that the CPT-5 project is working on changing to simplify and clarify. The current definition reads: “Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(S), with removal of bladder and

ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof”

Confusing enough?

✓ In addition to ambiguous terms in the current CPT-4, it is also lacking a hierarchical structure that would create a more logical flow of information for coding purposes. The plan is to list the families of CPT codes such as “musculoskeletal” starting with general category descriptions and working down to descriptions with a higher level of specificity.

✓ Another main change in the enhanced version

will involve new “code sets”. There will be two new categories of code sets entitled “Codes for performance measures” and “Codes for new and emerging technologies” that will be Category II and Category III codes, respectively.

✓ Finally, some of the other enhancements to CPT include: codes for counseling/preventive medicine, and a new format to address the increased variety of services currently being performed by non-physician practitioners including clinical social workers, clinical psychologists, physician

assistants, and nurse practitioners.

As you can see, the enhanced CPT will be designed to meet the needs of various individuals in healthcare and the needs of an evolving healthcare system. The enhanced version should be a more comprehensive listing of codes designed in an increasingly user-friendly format. At the same time, it is a change that will not involve an extensive learning curve to make the necessary adaptation. So, take comfort in the knowledge that this change should help improve coding standards and make all of your lives a little easier. 🙌

Common Issues Affecting Medicare Reimbursement & Compliance in the Outpatient / APC Environment

by Gretchen Evans, RN, MBA, CCS
and Shirley Smith, CFO/ECO

As a component of the Outpatient Prospective Payment System (OPPS), Ambulatory Payment Classifications (APCs) have been with us for more than 9 months, and most facilities are still experiencing a multitude of billing issues. This article addresses commonly identified issues discovered during multiple billing / compliance and coding audits by an outpatient reimbursement / compliance and coding consultant.

Identifying common

billing and compliance issues early in the process can save many man-hours and result in a more accurate accounts receivable. Obviously, correcting issues still requires a team approach, and the best team for this area is your APC Compliance team, meeting at least quarterly in a full review of the operation.

Identifying common billing and compliance issues early in the process can save many man-hours and result in a more accurate accounts receivable.

The following issues are subdivided into hospital department categories to allow the reader an opportunity to make a smooth transition to the action plan mode without having to switch subjects /departments.

Emergency Department

The first focus of this

article is the Emergency Department since this area presents a complexity fostering a diverse number of issues.

– E & M Levels

Federal Guidelines mandate that each facility is responsible for developing their own internal controls for establishing the facility’s Evaluation and Management levels (E&M). And it is these internal controls that the Office of Inspector General (OIG) will be using to determine if all patients

are assigned E&M facility levels uniformly. Through the audit process, it has been identified that many facilities have combined their old methods (subjectiveness based on patient conditions) with the newer method of assigning a point value for nursing services required for that patient. It is strongly recommended that each facility utilize a 'five point system' established to assign a facility E&M level. This level will represent those services provided by nursing personnel to each patient while they are in the Emergency Department.

The E&M level assigned must reflect the documentation of nursing services provided to the patient. Many times the level is not supported by the available documentation. It is recommended that the ED staff regularly select 10 charts randomly and validate the E&M levels assigned / billed with the documentation in the medical record. An independent form should be used to define the E&M facility level and this document should be maintained with the ED nursing documentation to validate the level billed. However, the level encounter form should in no way be used for documentation of services provided.

Frequently a charge for Pulse Oximetry is noted without supporting documentation from Respiratory Therapy. Most times Pulse Oximetry is a component of vital signs performed by nursing staff. When this is performed by the nursing staff, it is a non-billable service, as it is inclusive in the nursing service which is billed under the general charge.

- Critical Care

An area that is often misbilled is Critical Care services provided within the ED. Many ED's, when developing their ED facility E&M (Point System) levels, forgot about the Critical Care level, assigning the highest ED level available (99285) with a lesser reimbursement of \$ 158.21 at the national payment. The definition of Critical Care services by AMA directs the Critical Care code to be assigned for services that are of a duration 30 minutes or greater. A review of each facility's E&M levels should be conducted to determine appropriateness of levels assigned a patient. In addition to the Critical Care code (CPT 99291, national payment of \$426.53), CPR (CPT



code 92950) and Endotracheal Intubation (CPT code 31500) procedures were often under-charged or not billed despite existence of nursing documentation. Both of these procedures are reimbursed under APC 0094 for a national payment of \$223.68.

- IV Treatment

Are you billing for Intravenous Infusions for the treatment of conditions such as dehydration? Q0081 can be used to bill for this service. The definition of this HCPCS code reads: "Infusion therapy, using other than chemotherapy drugs, per visit". Accordingly, it should be used to report therapeutic and diagnostic infusions. The APC national payment rate is \$82.33 per visit. If you are not billing for this service just think of the loss of reimbursement your facility may be experiencing while your nursing resource utilization increases.

- Immunizations

Administration of immunizations is a commonly performed service in the ED today, but are you capturing the

charges accurately? When an immunization is performed, a charge for the specific immunization and the injection procedure should be billed. Both of these will require CPT codes. How many tetanus toxoid injections were missed? You probably billed for the tetanus toxoid medication but not the injection procedure performed by nursing. Be sure to use the CPT code 90703 for tetanus toxoid (APC 0356, national payment of \$17.86) and CPT code 90471 for the injection (packaged service).

- Radiology

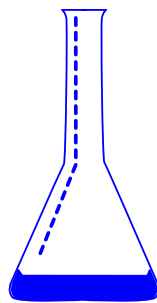
Often orders for radiology services written by the ED physician are vague. Educate your ED physicians to document their requests thoroughly and accurately. Each order for an X-ray should read "right ankle, 2 views or 3 views or complete". This would validate the performed procedure by the radiologist thus supporting the service billed. Here is an example of vague documentation: "(Rt. ankle" is difficult to interpret to mean "X-ray right ankle, complete. However, the UB-92 documentation was CPT code 73610, x-ray ankle, complete and the X-ray report supported the UB-92, but the order does not

support either one. According to the Code of Federal Regulations, section 410, sub-section 410.32: "All diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician treating the beneficiary are not reasonable and necessary". It means the radiologist can only perform those procedures ordered by the treating physician. The radiologist can perform additional x-ray views when the radiologist has conversed with the treating physician and this is supported by appropriate documentation. In this situation, a protocol had been established in the radiology department for all requests from the ED to be of the highest level. To comply with this regulation, a change in the process involving additional services for patients from the ED in the Radiology Department would be beneficial.

— Complete Orders

Above we have discussed a major issue involving Radiology.

However, it is important to explain where the process often breaks down. And it is usually within the order process. When an X-ray order is received, (written, verbal or electronically), the order must be complete. And a complete order must specify the procedure requested. For example, is the procedure to be performed with or without contrast, or both, or is it a 1 view, 2 views, or 3 views of an anatomical portion of a body? Clarification should be made, and properly documented, prior to the procedure being performed. If the radiologist determines additional views not ordered by the treating physician are necessary, documentation in the medical record of communication between the ordering physician and the radiologist is necessary to validate the billed services.



Outpatient Laboratory

One of the most frequently missed Laboratory procedure for Medicare outpatients is the venipuncture. HCPCS code G0001 is often missing from UB-92s

because many Laboratory Departments have eliminated the individual charge by bundling it into procedure charges. This separate OP procedure is valid, and the billing for venipuncture is appropriate for outpatient laboratory services. It is reimbursed under the laboratory fee schedule.

A frequent issue with outpatient laboratory orders is the incomplete requisition. This document originates from many different places, such as the local Hospice, a home health agency, nursing home, or from a physician outside of the hospital setting. It is important that the demographics of the form be completed by the originating requester, the diagnosis be complete, or the reason for the test to be performed, and the procedure to be performed clearly documented. In review of random laboratory requisitions, the issues are similar from facility to facility. Surprisingly, many diagnoses are documented with an ICD-9 code, without a narrative sign / symptom or disease. Often the ICD-9 code is not valid for a multitude of reasons; the most common being the resource used to select the ICD-9 code is outdated. Simple lack of accurate information can delay the procedure for the

patient, or disallow reimbursement to the facility.

Local Medical Review Policies (LMRP) by each facility's Fiscal Intermediary must be used to validate the medical necessity of the requested laboratory procedure. If the submitted diagnosis does not meet the LMRP guidelines, the Advance Beneficiary Notice (ABN) must be signed by both the beneficiary, and the facility representative, prior to the procedure being performed.

Another area of concern are the 'canned' Operative Reports for Same Day Surgery patients. These reports need to be reviewed for accuracy of information. Frequent discrepancies are noted between the History & Physical documentation and the Peri-operative records in the medical record. These discrepancies need to be identified timely so that an addendum can be entered into the medical record according to the facility's policies / procedures.

Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Pathology) is a department under scrutiny by the OIG and the PROs. Why this level of review? Documentation of provided services does not match the billed services! Im

proving several areas of documentation will assist the provider in billing for services that are supported in the medical record.

Perform a review of 5 medical records and detailed bills in the following areas to compare your documentation with your billed services:

- The Evaluation / Plan of Care (Certification) must be signed by the ordering physician prior to each billing date. The initial order only applies to the evaluation.
- Has the Re-certification been signed by the ordering physician for each 30 day period and does the documented date of signature validate the timeliness?
- There must be a documented diagnosis with the order for rehabilitation services. If the order does not specify a diagnosis, then the physician needs to be contacted for the missing information. Without the diagnosis, medical necessity is missing.
- Modalities / Treatments / Procedures provided must be fully documented within the patient's medical record to support billed charges.
- The start and stop times of each modality / treatment / procedure

should be documented to validate the number of units billed. It is appropriate to document the total amount of time for the specific modality; however, when using the statement of time "15 minutes", this brings doubt into the auditor's mind, questioning did each patient receive exactly 15 minutes of therapy on every visit for each modality as the documentation provides?

- If the modality / treatment / procedure was performed immediately after the initial evaluation has been completed, was the Modifier 59 appended to the identifying CPT code for that modality? The modifier signifies that the sessions were provided on the same date but at a different session. The timed documentation of the Evaluation and modality should support the billing of these separate services. Without the modifier, the modality would be edited as a bundled services provided at the same time as the initial evaluation.
- Review Medicare Program Integrity Manual, Chapter 6, Sections 5-7. Maintaining accurate

and complete documentation of provided and billed services is the only way to decrease and eventually eliminate the level of auditing that is currently being conducted by third party entities. Accuracy with documentation is the name of the game.

Pass-Through Biologicals and Medical Devices

Pass-through biologicals and medical devices using HCFA's 'C' and 'J' codes has been a challenge to bill accurately. Documentation within the medical record must support the use of the biological(s) and / or device(s) billed.

With general pharmaceuticals 'packaged' under APCs, only those biologicals that will generate an APC require the HCPCS Level II code. These biologicals must be reported with revenue code 636 or if otherwise directed by request of your Fiscal Intermediary. Facilities need to ensure that all biologicals requiring the HCPCS Level II codes are identified, correct codes assigned with the correct revenue code and the correct number of units are billed based on the dosage

administered.

The Pharmacist needs to review the 'J' codes for proper description and usage. Often the unit of storage of the biological is different than the HCPCS Level II description dosage. The facility could be losing reimbursement by under charging units based on the biological storage units versus the HCPCS code dosage.

Correct billing of pass-through biologicals is very important. For example, a commonly used biological, Viscoat (J7315, Sodium Hyaluronate 20mg.) is frequently used during a cataract extraction. J7315 can be found in the HCPCS Level II manual; however, the description indicates the

use of the biological is intended for the treatment of osteoarthritis as an intra-articular injection. Therefore, billing for

Viscoat under revenue code 636, for use during cataract surgery would be inappropriate. The correct billing of the biological would be to report it under revenue code 250, general pharmacy.

Devices need to be billed based on the pass-through description provided by HCFA and



billed under the appropriate revenue code. If an item has more than one function, only that function describe by HCFA can be submitted under the pass through guidelines. All other items need to be billed under the respective revenue codes. The following is one example:

- A facility billed for a Medtronic dual chamber pacemaker model number SSR203 under the Pass through code C1118. The correct code for this model was C1132 as the model documented was a single chamber pacemaker. The facility would have inaccurately reimbursed at a lesser rate..
- In addition, the facility did not bill for the ventricular lead, model 5076-52 as a pass through code C4604, thus under billing the provider.

Observation

Observation continues to be a documentation and billing nightmare but can be simplified into three areas. The reporting of the service is very important as facility resources are consumed by the patient during this event. Additionally, data continues to be collected by HCFA under revenue code 762 to determine if a separate APC should be added for

the service.

- Orders by the physician need to clearly state the reason / medical necessity for the observation service.
- The time of the order needs to be documented for both start and ending of the observation service. This time documentation is then used to calculate the time units to be billed. It does not affect the time the patient entered or leaves the hospital.
- If the order for discharge states: discharge patient after chest x-ray, then the nursing staff needs to document the time the patient leaves after the procedure. It would be that time that is used to stop the billing clock for observation units.
- Observation can begin at any station the patient is located. The patient does not need to occupy an 'Observation bed' to receive nursing service.

System Integration

Most facilities have

several systems that are connected, or integrated, into the billing system. A logging system in the Business Office which estimates reimbursement from the third party payer is one example. It has been discovered that the logging system may not be as accurate as expected, with discrepancies noted with Remittance Advice processing. For the Health Information portion of the assigned HCPCS codes, have the outpatient coders print out the expected reimbursement with their Outpatient Coding Summary (Abstract) on a few randomly selected accounts a each month.


This information could assist in validating the accuracy of the logging system and the Remittance Advices.

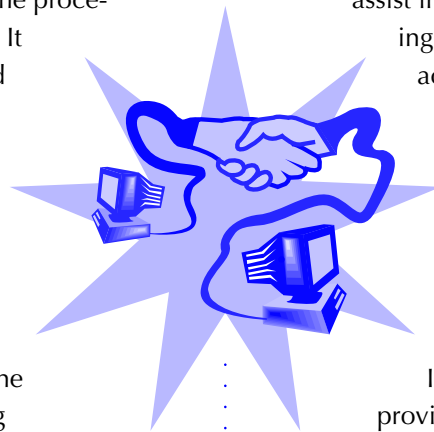
It also provides an opportunity for the HIM staff to understand the financial impact of coding under the OP PPS program.

Another system is the HIM coding system that should be fully integrated with the facility's billing system. Opportunities exist between these two systems which require on

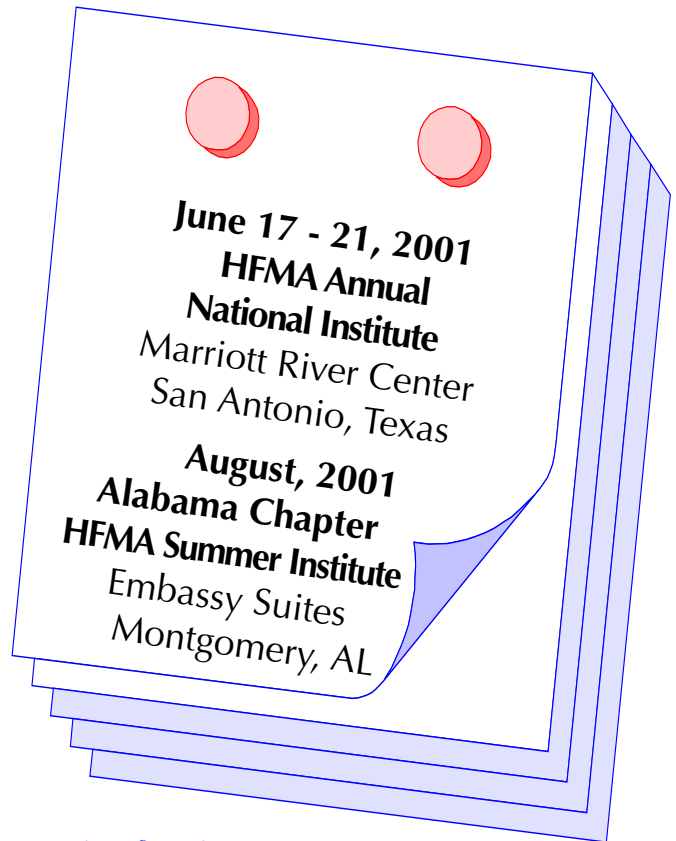
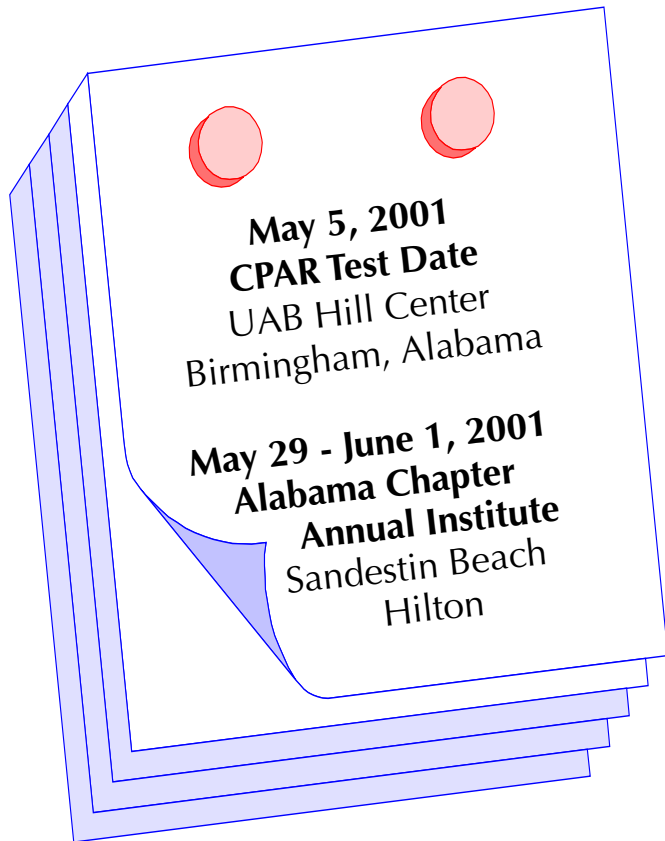
going monitoring. Often it is discovered when reviewing the outpatient coding abstract with the UB-92 that there are discrepancies because information has not properly 'crossed over', thus causing many unnecessary edits and re-work to obtain an accurate / clean claim.

Charge Description Master Index should be updated with new HCPCS Level II pass-through codes as they are issued. Both HCPCS and CPT codes need to updated annually by deleting outdated codes, and entering new codes when the revised manual is issued. Often it is found that old codes are not deleted from the CDM thus causing edit errors because the staff who select the services / codes are not aware of the changes, or that an outdated manual was utilized. New manuals should be obtained at time of issue and the old manuals discarded.

The OPPS implemented is a complex and often frustrating system deviating in many areas from long-established methodologies familiar to most facilities. I foresee continuing modification by HCFA as the system matures, and additional operational data is amassed, thus each facility should develop procedures to remain abreast of these changes. 



Mark Your Calendars Now & Make Plans To Attend ...



LOOKING AHEAD

Next *Bama Chatter* will be full of plans for the new HFMA year and a review of the Alabama Chapter's "Beach" meeting.

Dawn Walton, CPA

Editor

CACH HMO, Inc.

1600 7th Avenue South

Birmingham, Alabama 35233

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