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TEXAS HEALTH INFORMATION MANAGEMENT
ASSOCIATION

August/September/October 2001

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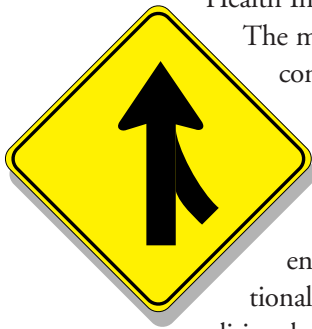
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The Road To Ethical Decision Making Guidelines

By Sharon J. Randolph, JD, RHIA

In January 2000, I was asked to be a contributing author of a book chapter for a new textbook for HIM programs. The textbook publication is titled "Ethical Challenges in the Management of Health Information".



The majority of the contributing authors are HIM professionals with experience in traditional and non-traditional roles. Chapter

topics include privacy and confidentiality; compliance, fraud and abuse; coding; quality review; research and decision support; public health; managed care; electronic patient record; drug, alcohol, sexual, and behavioral health information; information security; software development and implementation; e-health; genetic information; adoption information; entrepreneur. After receiving a copy of the publication, I reviewed a number of the chapters. My main reaction to the book was it should have been written for HIM practitioners, because at some point on our professional career, we have been challenged with making ethical decisions. Some have been easy and some have been rather difficult. Hopefully, when we were faced with the challenge, we made the right ethical decision.

Reviewing this book from the standpoint as a good source of reference, the chapter that has gotten me

to rethink my approach to addressing/resolving ethical issues was on ethical decision making guidelines. The author recommends a seven-step process when faced with making an ethical decision. They are as follows:

Step 1: Identify the ethical question

- What is being asked of me to do or not to do
- When the question is not clear cut, look at what should or ought to happen according to norms or standards

Step 2: Determine the facts in the case

- Known facts – what is already available
- Facts to be gathered – what additional facts are needed to make an informed intelligent decision

Step 3: Determine what values are at stake from the perspectives of all stakeholders

- Identify who are the stakeholders (those who will be affected by the decision to be made)
- What is their perspective – what do they have to gain or lose

Step 4: Identify the available options in the case

Step 5: Determine what you should do, based on the best

available data (best available documented facts and additional facts gathered)

Step 6: Justify your choice by providing reasons to support it based on values at stake

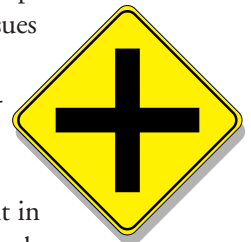
- Example – coding based on documentation in medical record vs. upcoding for maximum reimbursement for the hospital

Step 7: Explore how this ethical problem might have been prevented

You may want to ask yourself:

- Am I keeping my knowledge and skills up-to-date on coding guidelines to address most coding issue
- Am I up-to-date on the newest state and federal regulations/requirements (HIPAA, Patient Privacy)
- Do I support my institution's philosophy on specific compliance issues

By incorporating this seven-step process you may feel more confident in addressing the ethical challenges that will present themselves in your professional career. ∞



Reference: Ethical Challenges in the Management of Health Information by Laurinda Beebe Harman, PhD, RHIA, Aspen Publishers, Inc., 2001, pp. 25-38.

Off and Running!

It is already October. The summer vacations are over and the school children have gone back to school. Summer is the time that some people relax a little and slow down more than normal. However, I suppose the hot days of summer take a toll on everyone toward the end of the season. As much as we like the summer, we all look forward to the closing.

The Fall season is a time that I always look forward to the most. Fall is right around the corner. I can feel it in the air and see it in the trees. I can almost touch it. Fall always brings a renewed spirit to me. It is a time to get into new routines for the upcoming year. It is also a time for celebration and family gatherings during the Thanksgiving and Christmas holidays. What a wonderful, wonderful time of the year.

At TxHIMA, we are getting into our new routines and our new roles. We are preparing for the upcoming year. We closed the preceding year with a bang. The annual meeting in June was probably one of our best. The feedback we received was overwhelmingly positive. We did have some excellent speakers and the meeting was so well organized. Our hats are off to all those volunteers that worked on the meeting and for all of you who were able to attend. You made the meeting what it was.

TxHIMA's financial position continues to be strong. The fiscal year-end figures indicate that our revenues surpassed our expenses. We strive for a positive financial outcome each year. Even with the money we allocated for the new web-page development and additional money allocated to the executive office in Austin, TxHIMA succeeded. The TxHIMA Board is to

be congratulated for their hard work and commitment to the organization and to the membership. I have never seen a group of people take their roles more seriously.

We have started TxHIMA's educational calendar off with a bang as well. Just since June, we have already conducted several educational sessions for the TxHIMA membership with numerous other educational opportunities forthcoming. The Release of Information Series has been a huge success. Each of the programs that have been offered as of to date have

“...TxHIMA is off and running at a rapid pace this year.”

far exceeded the expectations set regarding attendance. The feedback from the audiences has been extremely positive. As everyone can see on TxHIMA's web page, several more Release of Information Programs are being offered around the state. At the request of various cities and organizations, we have to add some additional sessions on to the calendar. There are HIPAA presentations coming along with other programs as well. Education is TxHIMA's top priority. Making sure the membership is up-to-date with the latest knowledge is important.

In addition to the educational opportunities offered by TxHIMA, many of board members are going out into the districts and offering assistance with their program. The board members truly enjoy this since

they have an opportunity to meet so many people.

If you haven't gone to TxHIMA's new web page, please do. It is state-of-



Donna Bowers, JD, RHIA

art and we are very proud of what ZMAC Technologies has done for TxHIMA. This was a very positive relationship that was developed. Online registration is about to be introduced. The acceptance of credit cards is a goal of the organization and it will be rolled out very soon as well. The TxHIMA membership has been asking for this kind of technology for a long time.

Since TxHIMA cancelled the Fall Symposium and House of Delegates meeting in September due to the national tragedy, the Board of Directors has rescheduled the Board of Directors' meeting for early November. There will be a general board meeting, but also a strategic planning meeting. This is a time for the board to set new goals and objectives for the upcoming year and for years to follow. The organization is still on target in meeting goals already established even with the delay.

As you can see, TxHIMA is off and running at a rapid pace this year. We anticipate that we will not slow down any time soon. Our goal is to meet your needs. Your input is critical. Please do not hesitate to give us feedback on how we are doing. Come June of 2002, we may be dragging, but we are planning on having a great meeting in Corpus. Our goal is to do better and better each year. ☺

New Directions Health in the Electronic Era

by Richard J. Mata, M.D.

Because the electronic era is reshaping medicine, I would like to discuss some of its implications on general health care. The introduction of HIPAA (Health Insurance Portability and Accountability Act) regulations and implementation has become the medical Y2K focusing event of the century and has caused the entire health care system to study the ramifications of electronic health information. Gunther Eysenbach, the editor of the Journal of Medical Internet Research has defined e-Health as follows:

e-Health is an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the Internet and related technologies. In a broader sense, the term characterizes not only a technical development, but also a state-of-mind, a way of thinking, an attitude, and a commitment for networked, global thinking, to improve health care worldwide by using information and communication technology.

I will also summarize his "ten e's in health care" :

- 1. Efficiency** – one of the promises of e-health is to increase efficiency in health care, thereby decreasing costs. For example, the formation of medical error database, electronic health claims submission and through enhanced communication possibilities between health care establishments, and through patient involvement.
- 2. Enhancing quality** of care – increasing efficiency involves not only

reducing costs, but at the same time improving quality. E-health may enhance the quality of health care by being able to compare costs and services of health providers.

- 3. Evidence based** – e-Health interventions should be evidence-based. Scientific evidence of intervention effectiveness would replace regular health assumptions. There are many public companies, collaborating with academic centers to provide the medical community with evidence based medicine models.



- 4. Empowerment** of consumers and patients – Health care can be patient and evidence based as access to health care knowledge has become available. The AMA, though, recently did a review of health information web sites and concluded that not all medical information is reliable, and that you would need to visit multiple sites to get a correct view of a particular medical condition.
- 5. Encouragement** of a new relationship between the patient and health professional, towards a true partnership, where decisions are

made in a shared manner.

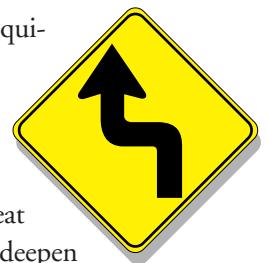
- 6. Education** of physicians and health care providers through online sources (continuing medical education) and consumers (health education, tailored preventive information for consumers)

- 7. Enabling** information exchange and communication in a standardized way between health care establishments. HIPAA implementation will definitely standardize health information communication formats and health coding conventions.

8. Extending the scope of health care beyond its conventional boundaries. For example, you may want to participate in a clinical trial in Europe or information from across the world can apply to your particular health situation.

- 9. Ethics** – e-Health involves new forms of patient-physician interaction and poses new challenges and threats to ethical issues such as online professional practice, informed consent, privacy and equity issues. In a recent survey the reason physicians are NOT using e-mail is because of liability and security reasons. The Department of Health & Human Services has recently issued a HIPAA security mandate that all e-health web sites must conform to.

- 10. Equity** – to make health care more equitable is one of the promises of e-health, but at the same time there is a considerable threat that e-health may deepen



the gap between those who have technology access and those who do not. It is estimated that the health sector that would benefit the most from e-health technology will not be able to access the system, and a political lobby is being formed to address this issue.

Along these same lines, Thomas R. Eng, has written a book called "The eHealth Landscape: A Terrain Map of Emerging Information and Communication Technologies in Health and Health Care". In this book, Eng outlines both the benefits and pitfalls of e-health. He mentions the millions of Americans without health insurance vs. the 68% of Americans who access the Internet for health information. The topics he covers include:

- Current status of the e-health sector
- Perspective of major e-health stakeholders (For example who might profit from this industry and who would influence health policy)
- Overview of major e-health issues

- Quality
- Privacy, confidentiality, and security
- Access and the digital divide
- Content and application

“...a "public library" of non-proprietary, evidence-based medical knowledge code...”

- development
- Research & Evaluation
- Data standard development
- Integration of e-health segments
- A cautionary view of e-Health
- Internet related trends and their implications for e-health tools
- Key questions for e-health (What will be the ultimate impact of emerging information and communication technologies on the future of health and

health care?)

Also to note, a distinguished group of leading U.S. clinicians, medical academicians and other healthcare professionals announced, on July 19, 2001, the creation of the Institute for Medical Knowledge Implementation (IMKI), a not-for-profit organization dedicated to the development and maintenance of medical knowledge application content that can be used in clinical information systems to promote improved healthcare outcomes.

To accomplish its mission, the Institute will operate a "public library" of non-proprietary, evidence-based medical knowledge code that is available to and can be implemented by all healthcare information technology (HIT) system vendors and individual users. Tools for authoring and submitting medical knowledge application content will be provided in 2002 via the Institute's recently launched Web site, www.imki.org.

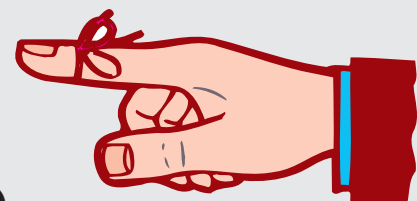
Everyday there is continual medical information ported to the web, and we should find ways to make this information available to those who may benefit from it the most. ☺

Don't Forget!

Your next issue

(November/December 2001/January 2002)

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Directors 2001-2002

Meet Your Board

CONVENTION & MEETINGS DIRECTOR



Name:
Kimberly
Suggs, RHIA,
CCS

Employer:
HCA – The
Healthcare
Company

How long: 1 year

Job title: Senior Health
Information Management
Services Consultant

What other positions have you held within the HIM field?

For the last six years, I've worked as a consultant in the national HIM arena. Prior to that I taught in the RHIA program at the University of Texas Medical Branch in Galveston. Before moving into the education field, I was Director of the HIM department in an acute care med/surg facility.

How did you become interested in a career in HIM?

I've worked in the medical record field since I was a junior in high school. I started out as a clerk and after graduation, I continued to work as a coder while I completed my BBA. I often laugh and say that I've performed every function in a HIM department at one time or another. My boss at the time then convinced me that since I already had so much experience in the field, it would be a breeze to get my degree in HIM and complete the RHIA

exam for my credential. So, I went through the post-baccalaureate program at UTMB and sat for the RHIA exam. The rest, as they say, is history.

Describe someone that you feel was an important influence in your HIM career.

I've actually had several "mentors" who have influenced my career in HIM. My mom, who is a supervisor in a medical record department, is an ongoing influence on my career. Another influence of course, was my boss, who many years ago convinced me that HIM was the field for me. A professor in the RHIA program, who later on was my peer when I entered the education arena. All of these people have greatly influenced my career decisions and made huge contributions to whatever accomplishments I can take credit for.

What led to your interest in serving on the Board of Directors for TxHIMA?

I think it's very important to support our profession in some personal way, either by volunteering your time or supporting our educational programs. When I worked in a facility, I



always accepted HIM students in my department to assist them in completing their clinical rotations. My current employer is very supportive of my decision to volunteer for consideration of a TxHIMA board position and I felt it was a good time in

my professional development to take on these responsibilities.

What is a major goal that you would like to achieve during your current term as a TxHIMA Board member?

My major goal in my tenure as a board member is to perform my assigned tasks and responsibilities to the very best of my ability. I want to always keep the interests of our members in mind as I function in my role as Meetings and Convention Director.

LEGISLATION DIRECTOR

Name:
Gwendolyn L.
Duffie, RHIA

Employer:
Baylor
University
Medical Center,
Dallas, TX



How long: 5 months in current position

Job title: Director, Medical Staff Services

What other positions have you held within the HIM field?

Associate Director, HIM, Baylor University Medical Center (2000-2001) – Dallas, TX
System Analyst, HIM, Baylor University medical Center (1999-2000) – Dallas, TX
Associate Director, HIM, Baylor

University Medical Center (1994-1999) – Dallas, TX
 Assistant Director, HIM, Swedish American Hospital (1993-1994) – Rockford, IL
 Instructor, Medical Records – Rock Valley Community College (1993) – Rockford, IL
 Supervisor, Information Processing and Release of Information, HIM, Swedish American Hospital (1991-1993) – Rockford, IL
 Record Processing Manager, HIM, Baylor University Medical Center (1989-1991) – Dallas, TX
 Evening Shift Supervisor, HIM, Baylor University Medical Center (1989) – Dallas, TX

How did you become interested in a career in HIM?

I became interested in a career in HIM in high school. At that time, I had a relative who was a nurse and

worked part-time coding in medical records. I saw it as a way to get into healthcare without being a nurse, because up until that time, I thought everyone in healthcare had to be a physician or a nurse.

Describe someone that you feel was an important influence in you HIM career.

I had two people (Edra White, RHIA and Marilyn Green, RHIA) who were important influences in my early HIM career. To describe them, I would use words such as, motivated, determined, task oriented, detailed oriented, self-confident, ability to delegate, politically astute, effective manager, knowledgeable, teacher, friend and English teacher!

What led to your interest in serving on the Board of Directors for TxHIMA?

I wanted the opportunity to serve

the members of TxHIMA. My interest included the ability to network, which means that I needed to get involved in the association, as well as, meeting and helping others in this profession.

What is a major goal that you would like to achieve during your current term as a TxHIMA Board member?

A major goal is to plan more educational (ROI and HIPAA) workshops in those districts that request a need for their area. Also, each board member has been assigned districts to mentor. It is a goal to get those districts vibrate and communicating with TxHIMA.

A Favorite Quote:

Don't be afraid to learn, knowledge is weightless, a treasure you can always carry easily. ~

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A Roadmap to Medical Privacy under HIPAA

The following is a statement presented to the National Committee on Vital and Health Statistics by Melinda Hatton, the AHA's Vice President and Chief Washington Counsel.

On behalf of the American Hospital Association (AHA), I want to thank you for the invitation to participate in the NCVHS hearing on medical privacy.

The specific topic you have asked the AHA to address today is the serious patient care and operational issues raised by the consent provisions in the final rule on medical privacy issued by the Department of Health and Human Services (HHS) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The AHA and its nearly 5,000 member hospitals, health systems, networks and other providers are committed to safeguarding patients' medical information and ensuring that patients understand and have appropriate access to their medical records. The final HIPAA privacy rule, however, threatens to compromise patient care and essential hospital operations in a number of significant respects; chief among them are the written consent requirements.

The July 6, 2001 Guidance indicates clearly that HHS is aware of some of the serious unintended consequences of the written consent requirements. For example, the Guidance includes the following exchange:

"Can direct treatment providers,

such as a specialist or hospital, to whom a patient is referred for the first time, use PHI [protected health information, i.e., name] to set up appointments or schedule surgery or other procedures before obtaining the patients written consent?

[A]s written [the rule] does not permit the uses of PHI prior to obtaining the patients written consent for TPO. This unintended problem potentially exists in any circumstances when a patients first contact with a direct treatment provider is



not in person. As noted above, the Secretary is aware of this problem and will propose modifications to fix the rule."

To be sure, the as yet unaddressed need to use and disclose information without written consent prior to the first contact between patient and provider is a serious issue that must be resolved. However, the obstacles to a providers ability to provide high quality and cost effective care created by the written consent requirements go beyond the issue of uses prior to first patient contact. Indeed, we believe that on balance, the written consent requirements will provide minimal, if any, enhanced privacy protection and that its primary effect will be to compromise both patient care and essential hospitals operations.

To ensure that neither patient care nor essential hospital operations are compromised by the written consent requirements, the AHA recommends that they be discretionary rather than mandatory and urges NCVHS to make the same recommendation to HHS.

As the Department noted in the original Notice of Proposed Rulemaking, requiring individual consent for use of information prior to treatment gives patients little actual control over their health information. Indeed, because in virtually all cases the patient will be required to sign a consent form as a condition of treatment, the consent will be, in fact, little more than written verification that the patient has received the notice of privacy practices. The protections for patient privacy found in the regulation are embodied in provisions like the notice requirement. These protections are not advanced in any meaningful way by requiring providers to obtain individual written consent for the very uses and disclosures within the health care system that patients expect. The AHA believes that the notice requirement – which ensures that patients be provided with a notice describing the health care providers privacy practices – should be retained and that the additional written consent requirements should be made discretionary for providers, as it is for other covered entities.

AHA's concerns about the written consent requirements are twofold. First, as currently written, the privacy rule will prevent a hospital from using any information about a patient to schedule inpatient or outpatient procedures – ranging from x-rays to surgery – until the patient receives the hospital's privacy notice and reads and returns to the hospital a signed consent form. Patient care will be severely undermined, and a hospital's ability to provide effective services will be jeopardized, unless there are significant changes to the current rule. The AHA developed a HIPAA-based model privacy notice for hospitals that is 10 pages long, even before the addition of any notice provisions required by state law. (A copy of the AHA's model privacy notice is available to AHA members at www.aha.org/hipaa/resources/Content/ModelPrivacyNotice.doc) Under the regulation as written, in order to simply schedule hospital care, patients must obtain a 10-or-more page privacy notice and a separate consent form, read both documents, and sign and return the consent form to the hospital. For many patients, in particular the elderly or disabled or those who live in rural areas, obtaining and returning those forms could present a significant and frustrating burden that delays or impedes their ability to obtain timely care.

Second, it appears that a significant number of hospitals intend to require that patients sign a consent form, and therefore receive a notice, each time they receive care at the hospital. Although technically this is not required under the rule, among many teams looking at this issue from a liability and systems perspec-

tive, this approach appears to be emerging as a preferred policy. For example, in its comments on the final privacy rule in March 2001, Intermountain Health Care (IHC) an integrated health system in Utah and Idaho that includes 22 hospitals, clinics and affiliated physicians, reported that after careful study, it expected to require patients to provide a written consent at every patient encounter. IHC explained that because it uses a single, integrated patient record to coordinate care throughout a diverse health care system, there are only two feasible options under which it could ensure a valid consent was on file, as required by the rule. They could ask patients to sign a new written consent each time they present for care, or they could build an expensive new computer application to track consents, revocations and requests for restrictions and merge them into its existing systems including scheduling, billing and master patient index subsystems. As IHC noted in its comments, [e]ither alternative...represents a very significant investment in resources for training, implementing, operating, programming and oversight. But those resources will produce no benefits for patients.

Similarly, we understand that the SNIP (Strategic National Implementation Process) privacy working group in Nebraska will recommend to hospitals in that state that patients be required to sign a new written consent form each time they present for care. This recommendation is based on the perceived risks associated with relying on prior consent and the administra-

tive difficulty of tracking variations in the process. In light of the advice being given by leading law firms and consulting firms specializing in HIPAA compliance, we anticipate that for similar reasons, many hospitals throughout the country will adopt the same policy on written consent.

Hospitals everywhere are looking to reduce unnecessary paperwork. According to *Patients or Paperwork?*, a recently released study by the AHA examining the regulatory burden facing America's hospitals, these health care institutions are already providing care under extraordinary paperwork demands. The study found that "[p]aperwork adds at least 30 minutes to every hour of patient care provided and, in some settings, adds an hour of paperwork to every hour of patient care. The addition of new and burdensome consent form paperwork in response to the privacy regulation is sure to add to these dire statistics. All this, without enhancing privacy protections in any significant way. The written consent is in essence a signed confirmation that a patient has received the notice of privacy practices. Requiring the provision and content of such a notice accomplishes virtually the same results, but with less additional paperwork.

Moreover, although patients may find it helpful to obtain a notice of privacy practices that includes information on their rights, it is unlikely that signing a consent form and receiving a privacy notice at every visit will be well received. As this panel may be aware, the Gramm-Leach-Bliley Act of 1999 (GLB) required financial institutions, such as banks, credit card companies, insur-



Continued on page 12

ance companies and others, to send consumers written notices of their privacy policies. Last spring, millions of GLB privacy notices were mailed to consumers. According to press reports, the average consumer received 15 to 25 such notices of various lengths. The outcry from consumers was immediate and fierce. The New York Times summarized consumer reaction in its headline that read "Privacy Policy Notifications Are Called Too Common and Too Confusing." One important lesson to be drawn from the experience of the financial community with privacy notices is that consumers do not want to be barraged with an excess of paperwork even if the intent is to protect their privacy. The goal at this point in time is to operationalize the privacy rules and make them work for patients and the health care system. A requirement that patients receive a notice of privacy practices on the first visit and making individual consent discretionary for hospitals, as it is for other covered entities, will help inform patients of the privacy protections offered and help minimize the privacy paperwork burden associated with operationalizing the rule.

To avoid compromising patient care, institutionalizing a frustrating and costly new administrative and paperwork burden for patients and hospitals, and undermining public support for the privacy rules themselves, the AHA recommends that the written consent requirements be discretionary and urges this panel to make the same recommendation to HHS. ☺

Presentation by the American Hospital Assoc. to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee hearing on Privacy and Confidentiality – Panel on Consent; Aug. 21, 2001, Washington, DC

Streamlining the Registration Process

Online Registration

Jerry Hopgood, ZMAC Technologies

Up to now, the process has been the same at TxHIMA as it is at many other associations. To register for an upcoming conference, you would fill out a paper form, and mail or fax it to the Executive Office. With it, you'd attach a check to pay for the registration. With all the potential headaches that come along with lost mail, incomplete information, or illegible handwriting this process can be more efficient.

TxHIMA realizes this, and has taken actions to improve seminar registrations. Via the TxHIMA website (www.TxHIMA.org), TxHIMA members, non-members and AHIMA students alike can register online for conferences, seminars and annual meetings, and can pay for them with a credit card. The primary goal of this online registration functionality was to provide an automated method for registration, eliminating all of the problems mentioned above. TxHIMA now accepts MasterCard® and Visa® and allows members the ability to instantly register and pay for a seminar, with the confidence that the transaction is secure.

The registration process is quite simple:

- The TxHIMA Web Page describes the seminar or conference for which you'd like to register
- Click on the Online Registration button
- You'll be sent to our online store and asked for some basic demographic information and your credit card information.
- Once this is done, you'll be given an online invoice that you can print.
- You'll also receive an email copy of your invoice.

It's just that simple. Look for more seminars to become available for online registration soon. If you have any questions, please contact the Executive Office @ 512-465-1077 or e-mail txhima@aol.com. ☺

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PEPP Task Force Update


By Larry Dunham, RHIA-TMFPEPP Task Force


The PEPP Task Force of the Texas Medical Foundation held its quarterly meeting in September. The various agenda items and information are as follows:


 **1 CMS 18th Month Evaluation:** TMF will undergo its service evaluation under the Centers for Medicare and Medicaid Service contracts. TMF will be evaluated on services provided as the Peer Review Organization of Texas and will ultimately be followed up with another survey evaluation as they approach the end of their 6th Scope of Work Contract.


 **2 Update on PEPP Projects:** DRG 127 Congestive Heart Failure Project is being prepared for release within the next couple of weeks. The data will profile the results of the study and will request plans for improvements from hospitals with identified opportunities for improvement. TMF noted that they will not report findings to the Fiscal Intermediary if errors are identified. Hospitals will need to rebill if they choose to, however, any technical denials from the reviews by TMF will be reported for repayment by the facilities.


 **3 PEPP Project Development:** Additional projects are being developed and preliminary data are being reviewed from the state data. More information will be made available through the TMF web site.


 **4 Hospital Responses to DRG Monitoring Reports:** Eighty-three hospitals were issued letters to request improvement plans from the last PEPP Project. Of those, only seventy-one have actually sent in plans to address the payment errors and to revise processes to proactively improve the integrity of the coding. It should be noted that non-improvement from these plans for improvement can result in notification to CMS/OIG.


 **5 New Format for Data Distribution-PEPP Project Data and DRG Monitoring:** The distribution of the PEPP reporting is being transitioned to an electronic format. The process will allow for more interactive reporting and will allow for the hospitals to manipulate their data on-line. There are plans in place for distribution security and for on-line training. Look for details to come via the TMF web site and Progress Notes.


 **6 PEPP Data Abstraction Tool:** The Texas Medical Foundation will be offering FREE abstraction software via various mediums in order to service facilities with tools to collect, track, and trend incidences of coding errors and opportunities for improvement. More information, demonstrations and training are forthcoming.

 **7 TMF Coding Workshops:** The coding workshops have had great attendance, in fact, most areas are already full and extended dates may need to be scheduled. The training is being focused on the top 20 Medicare DRG's and other at-risk DRG's noted in the State.

 **8 Coding Audiopresentation for cardiovascular DRG's:** CD's have been mailed out to the primary contacts of each facility. Additional CD's are available from TMF upon request. This information is intended for Coding Staff and are developed as a resource to improve coding errors.

 **9 Documentation Prompters** have been developed for Observation clarification and also documentation prompters for key diagnoses have been printed on "post it" not type pads available for use. It was suggested that TMF print cases of how various hospitals are using these tools in their different environments.

 **10 TMF Screening Criteria Manuals** will not be available on CD. This should assist access to the various parties within the hospital.

 **11 Utilization Review Workshops** are being planned for early Calendar year 2002. Information to follow on the TMF web site and through mailings. ∞



Senate Bill 11: The Texas Extended Arm of HIPAA

By Larry Dunham, RHIA, Director, Health Information Management at Baylor University Medical Center in Dallas

Confidential health and medical data are now collected, analyzed, distributed and accessed in large quantities. Health care providers can access records to diagnose, treat, obtain payment for services, and monitor treatment from other health care providers. Clinical researchers use medical records to gather valuable data on the course of a disease and track response to a treatment. Insurers refer to medical records to determine coverage, make payments on claims, conduct utilization reviews, and for underwriting purposes in an attempt to manage rising health care costs. An employer may use employee health care data to track worker compensation claims and overall health care costs incurred by employees.

The Senate Health Committee was charged with reviewing the type, amount, availability, and use of patient-specific medical information, including prescription data, and current statutory and regulatory provisions governing its availability. This bill explores whether statutory and regulatory provisions are consistent and adequately enforced. Senate Bill 11 amends the Health and Safety Code to require certain persons who collect protected health information to comply with the federal Health Insurance Portability and Accountability Act standards (HIPAA) relating to an individual's access to protected health informa-

tion, amendment of protected health information, uses and disclosures of protected health information, and notice of privacy practices.

The bill authorizes a covered entity or health care entity to:

- disclose protected health information to a person performing health research for the purpose of conducting health research

“This bill explores whether statutory and regulatory provisions are consistent and adequately enforced.”

- only if the person performing health research has obtained individual consent or authorization for use of the information or a waiver granted by an institutional review board or privacy board;
- sets forth provisions relating to the composition and conduct of a privacy board;
- authorizes a covered entity or health care entity to disclose protected health information to a person performing health research if the covered entity or

health care entity obtains from the person performing the health research certain representations



Larry Dunham, RHIA

- as to the use and necessity of the information;
- authorizes a person who is the subject of protected health information collected or created in the course of a clinical research trial to access the information at the conclusion of the research trial;
- authorizes a covered entity to use or disclose protected health information without the express written authorization of the individual for public health activities or to comply with the requirements of any federal or state health benefit program or any federal or state law;
- authorizes a covered entity to disclose protected health information to certain public health authorities or state agencies.

The bill prohibits a person from re-identifying or attempting to re-identify an individual who is the subject of any protected health information without obtaining the individual's consent or authorization if required by state or federal law. The bill also prohibits a covered entity from disclosing, using, selling, or coercing an individual to consent to

the disclosure, use, or sale of protected health information for marketing purposes without the consent or authorization of the individual who is the subject of the information.

The bill sets forth requirements and clarifications for:

- written marketing communication;
- provisions relating to civil penalties, disciplinary action, exclusion from state programs, and other remedies for a violation of these provisions;
- state agency that licenses or regulates a covered entity to adopt rules as necessary to carry out the purposes of these provisions;
- requires a covered entity to comply with the provisions no later than September 1, 2003.

Except for provisions relating to marketing uses of information, the bill provides that the provisions relating to medical records privacy are also extended to parties not currently addressed by HIPAA such as the holder of an insurance license, an entity established under the Texas Workers' Compensation Insurance Fund, or a covered entity as defined in this bill with respect to the activities of a financial institution. The provisions do not prohibit the American Red Cross from accessing any information necessary to perform its disaster duties or emergency leave verification for military personnel like in the case of the World Trade Center tragedy in order to prepare soldiers for war or for accessing information to identify victims in the disaster.

Senate Bill 11 amends the Insurance Code to provide that an insurance carrier or agent must obtain an authorization to disclose any nonpublic personal health infor-

mation before making such a disclosure. The bill also addresses provisions relating to the requirements for a written or electronic request for authorization. The bill provides that the right of the patient or their representative to revoke an authorization at any time but does not including any release carried out prior to receiving the notice of revocation. The bill authorizes a request for authorization to be delivered to a patient or their representative in a clear and easily understandable format. The bill does authorize an insurance company/agent to disclose nonpublic personal health information to the extent that the disclosure is necessary to perform certain specified insurance functions on behalf of the regular business. The bill authorizes the commissioner of insurance to

adopt rules to implement provisions related to privacy of health information. The bill also allows the commissioner to delay the date for compliance if the commissioner determines that an entity needs more time to establish policies and systems.

Provisions amending the Health and Safety Code relating to medical records privacy take effect September 1, 2001. Provisions amending the Insurance Code relating to privacy of health information take effect January 1, 2002. ∞



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Health Information & Technology Week

November 4 - 10, 2001

by Karen Kanaway, RHIA

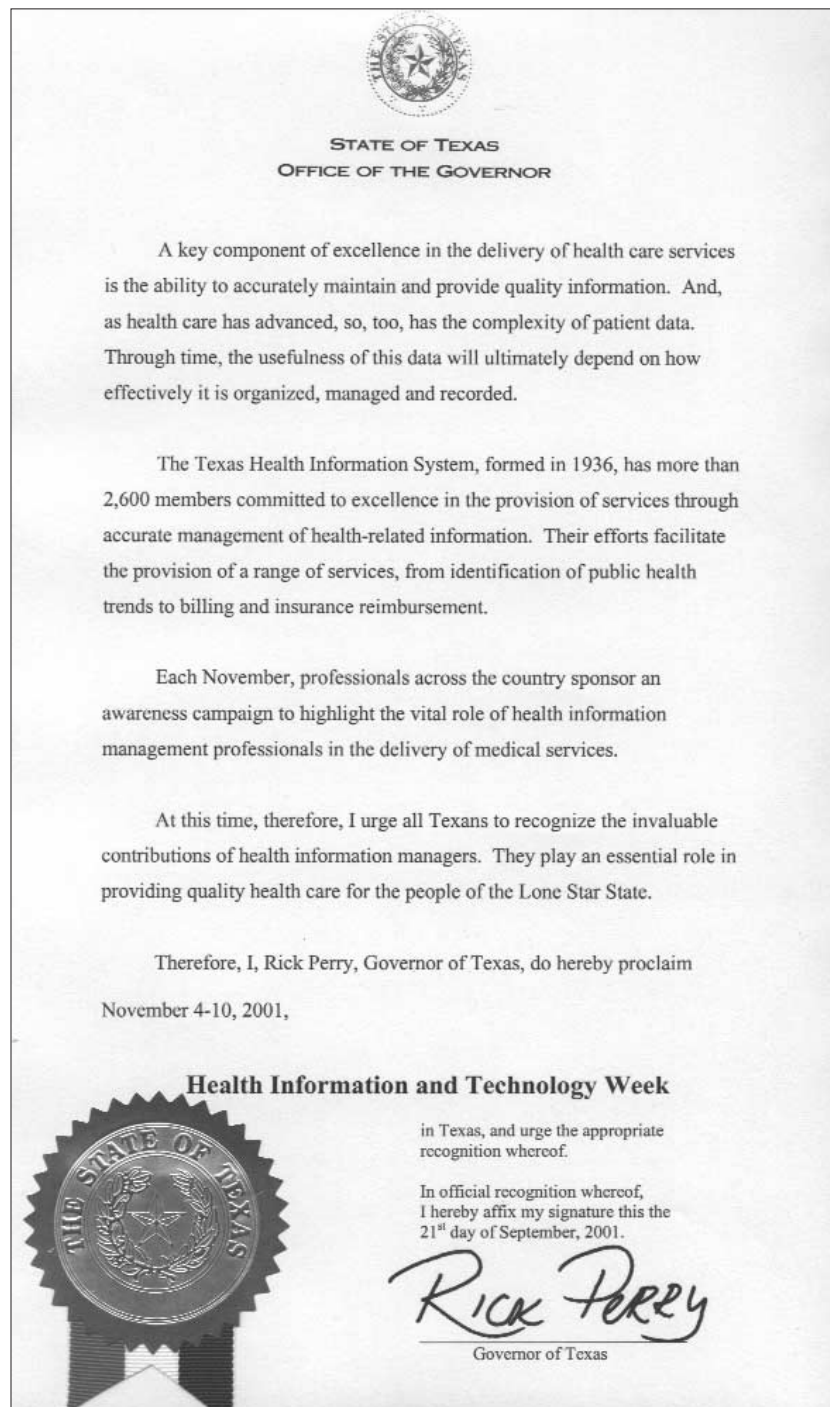
The American Health Information Management Association, AHIMA, came up with the idea for a Health Information and Technology week a few years ago. The basis for this was the many questions that were being asked about the role of technology in the everyday life of a Health Information professional. From this beginning, TxHIMA welcomes this week as a time to reflect on the role of technology in Health Information Management, and how different organizations can leverage technology to better perform their jobs, ultimately providing higher quality services less expensively to our health care providers.

To this end, we at TxHIMA want to recognize those departments that have utilized technology to better themselves and that of their organization. To do this, we need your help. To recognize you, we need to know what you've done. So, please take a minute to complete the survey on the TxHIMA web site. We'll use this to determine whose story best reflects the nature of the relationship between Health Information and Technology.

The winning department will receive a very nice plaque, and will receive some assistance in providing snacks to the staff as a way of saying thanks for sharing the information with TxHIMA and all of our association members. Another benefit, regardless of winning first prize, is that you get to tout the efforts of your department and facility, giving a tap on the back to those who have

made your department a success. We'll also post some of the resulting stories so that others in the associa-

tion can see and be proud of what's being done to advance our profession. ∞



Travels of a Medical Record

Sue Hope, MS, CMT

Wow! What a life! I'm 12 days old and I've met so many wonderful people. My name is Ima Record.

I was born as an ER nursing form in triage and then began my journey to becoming an inpatient record. Before most of you knew me, the transcriptionists in your department were already helping me grow by sending me documents. It was very fast and convenient, because they printed out at the nursing station on my floor. Eventually I wasn't needed on the floor anymore and I came downstairs to live in HIS.

I was a little nervous when I got here, someone took my binder and I had gone to pieces! I met my first HIS person at the Inpatient Admission Desk. She checked me off of a dismissal list to make sure I was in the right place and then gave me a brand new folder!

Next I went to wait with a bunch of other records on the Analysis Shelves. An analyst put me back in order and made notations in the front of my record for different doctors to dictate or sign my pages. I even got a lot of pretty colored flags to dress up my new folder!

My next adventure took place in Coding. I met a very thorough coder who looked me over carefully to make sure that all of the diagnoses and procedures documented in my pages were coded so the hospital would be properly reimbursed. One of them called a doctor to clarify a diagnosis. They put all of my codes into a computer, very high tech!

I had to leave HIS temporarily to go to Continuous Improvement. I

got a clean bill of health from that department and soon came back to HIS.

Once the coders were through with me, I journeyed to the Physician's Lounge. I got moved around a lot in there, from one physician's stack to another and back to the shelves again, but that was okay. I made a lot of new friends! Every time a physician finished with me, a physician's lounge person checked me over to make sure the doc did everything he needed to, so I felt very well taken care of.

I had hoped to go to the Scan area so I could be a part of the imaging process, but they're only accepting ER records right now. Maybe one of my younger brothers or sisters

will have better luck in the future!

All along the way, from the first day at the Inpatient Admission Desk until I got to the Physician's Lounge, transcriptionists were transcribing reports and the transcription clerks were bringing me documents that helped to fill me out and make me complete!

Today is the big day for me. The last lounge person looked me over and declared that I was complete. That sounds just about perfect, doesn't it? Then I moved to my new home in the File Room. It's nice to be quiet for a while, but what really feels good is knowing I have everything in place if I am needed in the future. I'm ready for my next challenge! ☺

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A mapping for... Prospective Payment System for Inpatient Rehabilitation Facilities

by Beverly Rhodes, MSHP, RHIA

Prospective payment has finally come to physical rehabilitation after many years of promises—or threats—from the federal government, depending on how you choose to look at it. When Diagnostic Related Groups (DRGs) became effective in the early 1980s, some providers branched off into psychiatric and/or rehabilitation care because it was "safe" from DRGs. The Health Care Financing Administration (HCFA), now the Center for Medicare and Medicaid Services (CMS), did not believe that rehabilitation patients would fit under DRGs because these cases generally involve longer lengths of stay, and the system could not accurately account for the resource costs nor the types of treatment for these patients. HCFA's interest in establishing a prospective payment system (PPS) for rehabilitation grew as aggregate Medicare operating payments to rehabilitation facilities grew 18% annually between 1990 and 1996, from 1.9 billion to 4.3 billion. In the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act of 1999 (BBRA), Congress mandated that the HCFA implement a prospective payment system for inpatient rehabilitation to control escalating costs.

As early as 1984, the RAND Corporation was investigating the feasibility of PPS for inpatient rehabilitation facilities (IRFs), and in

1994, HCFA contracted with RAND to analyze and evaluate rehabilitation patient data. RAND is a nonprofit institution with extensive health care background in improving policy and decision-making through research and analysis. In July 2000, RAND published an Interim Report on an Inpatient Rehabilitation Facility Prospective Payment System, updating a previous release in 1997.

An Overview of Rules & HIM Role

Their extensive research was based on FIM (Functional Independence Measure) data from Uniform Data System for medical rehabilitation (UDSmr) and from the Clinical Outcomes System (COS) data. In addition, RAND used Medicare data, such as cost reports and discharge abstracts, as part of their research efforts. On July 31, 2000 HCFA enacted a prospective payment system for skilled nursing facilities (SNFs) called Resource Utilization Groups (RUGs). Rehabilitation facilities were concerned that the government would view all post-acute care as the same or similar and would group rehabili-

tation into the skilled nursing system. In actuality, many of the original proposed rules for IRFs mirrored requirements under RUGs.

HCFA published the proposed rules in November 2000 and gave rehabilitation facilities an opportunity to respond, and many did respond, explaining to HCFA the differences in skilled nursing facilities and acute rehabilitation facilities. IRFs also explained, among other issues, the burden that the assessment tool, the MDS-PAC, utilized in SNFs would have on IRFs, the confusion of using a different functional measurement tool than has been commonly used in IRFs, and the burden of complying with several submission dates for the lengthy MDS-PAC assessment.

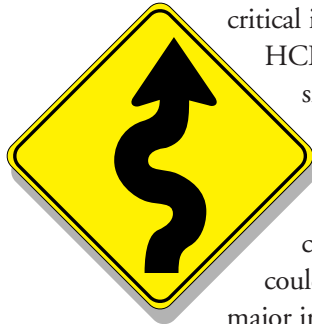
The final rules were released on August 7, 2001, with many positive changes compared to the proposed rules. The MDS-PAC assessment form, seven pages of over 500 items, was replaced by the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI), which is three pages of about 30 items. The final rules require use of the FIM scale to score the patient's functional level. This scale is commonly used by IRFs; this will allow facilities to utilize years of data and free them of the burden of retraining clinical staff. The final rules require submission of the IRF-PAI assessment form only on admission and

discharge. The effective date of the rules is January 2002; compliance for your facility will begin at the start of your fiscal year in 2002.

The patient classification system called Case Mix Groups (CMGs) is based on FIMs and on rehabilitation impairment groups, which are based on diagnoses supported by ICD-9-CM codes. To group a patient in a specific CMG, first the patient is placed in a major group called a RIC (rehabilitation impairment category) based on the patient's primary reason for inpatient rehabilitation, such as a stroke or hip fracture. Next the patient is placed into a CMG within the RIC, based on ability to perform specific activities of daily living and in some CMGs, the patient's cognitive ability and/or age. The rules provide for 95 CMGs, 21 RICs, and five special CMGs to include very short stays (under 3 days) or patient

death. These CMGs were based on 1998 and 1999 data, utilizing the methodology identified by RAND Corporation.

Just as comorbidities play an important role in correct reimbursement under DRGs, so will they be critical in CMGs. HCFA's analysis found that the presence of a comorbidity could have a major impact on the cost of providing care in certain RICs, although in some RICs, comorbidities did not increase costs. The original list of comorbidities published in the proposed rules was modified in the final rules to eliminate comorbidities that can be prevented by good medical care and



comorbidities determined to be inherent in specific RICs. CMS may refine this list in the future if needed to ensure appropriateness.

CMGs also take into account relative weights, including facility-level adjustments of wage index variations, disproportionate share hospital (DSH) percentages, and location in a rural area, as well as case-level adjustments applying to short stays, transfer cases, interrupted stays, deaths, and outlier cases. Comorbidities are divided into three tiers, affecting reimbursement and length of stay at three different levels, with tier one being the highest. Comorbidities identified at the time of admission or during the admission up to the day before and the day of discharge, may be used to determine the comorbidity tier. Comorbidities identified on the day prior to or the

Continued on page 20

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day of discharge should not be included on the discharge assessment IRF-PAI.

The final rules address patient transfers similar to the way transfers are addressed under DRGs, with a goal to prevent premature discharges and to prevent facilities from not admitting certain patients into the rehabilitation facility. The transfer policy reduces the full CMG payment when a Medicare beneficiary is transferred less than the average length of stay for the CMG and is discharged to another rehabilitation facility, long-term care hospital, inpatient hospital, or a nursing home that accepts payment under the Medicare and/or Medicaid program.

Patients who stay less than three days and are not transferred are considered short stay outliers. These cases are paid on a lower weight. Other special cases under CMGs include deaths and interrupted stays. Deaths are split into two categories, one for orthopedic patients and one for all others. Expirations that occur in less than three days fall into the short stay CMG. The others are divided by diagnosis and length of stay, and payment is based on weights accordingly. Interrupted stays occur when a patient is discharged and returns to the same IRF within three consecutive calendar days; these patients are paid under one CMG payment, rather than two separate ones. If a patient is discharged to an acute care facility and returns the same day, the acute care facility will not receive a DRG payment. If, however, the patient does not return to the IRF by the end of the day of transfer, the acute care hospital can receive a DRG payment. Health information management (HIM) will find a similar phenome-

non occurring in rehabilitation facilities as occurred in acute care in the 1980s, in that the impact of the operations of this department are suddenly very clear to the entire organization. HIM staff will find administrators, financial staff, clinicians, and information systems staff, previously only moderately interested in coding functions, accurate documentation, and good data management systems, now extremely interested. Obviously, accurate and timely coding will ensure correct CMG placement and level of reimbursement. What may not be clear are the other roles the HIM professional will

“I encourage you to see this as an opportunity for your department to shine...”

need to fill to help the facility be successful under prospective payment.

Success under PPS for rehabilitation will require a full team effort, which includes case managers, clinical staff, physicians, and financial and administrative support staff, including HIM. If your facility has not yet taken steps in this direction, you need to get busy. Reading the rules is one of the most important steps. You can access the rules several ways, but one is www.hcfa.gov/medicare/irffinal2001.htm. You will need Adobe Acrobat Reader to access this file. The rules are found in the Federal Register dated August 7, 2001, 42 CFR, Parts 412, 413, pages 41315-41430. The final rules list all CMGs

and the comorbidities by reimbursement tier.

The next critical step is to obtain your facility's historical data and understand your patient population completely. What types of patients have you served in the past, and how will you fare under CMGs with your current case mix? Start assigning your patients into CMGs and see how you are doing with length of stay and costs. According to your data, what comorbidities are you currently treating, and which are these affect reimbursement under CMGs? Are your costs especially high for certain patients? Is there variation between physicians, units, or facilities (if you are a multi-hospital organization)? By understanding what your current case mix and management looks like, your team will know better how to steer your organization into a survival and eventually "thrival" mode for PPS. Do you need to market certain specialty physicians to secure referral sources for populations that you manage well but see a decline in volume? Do you need to discontinue a subspecialty or a service that is costing your facility a lot of money but is not serving a real community need?

After you have evaluated your data and initiated your action plans based on team evaluations and analyses, dig deeper into your medical records. Why did certain patients exceed length of stay norms under CMGs? If you have a discharge planning issue or a clinical team coordination or communication issue, you can start working to improve these processes now.

Another action needed is to look at possible staff training issues. Are your HIM coders adequately



trained? Have they been capturing comorbidities that will increase your documentation? Are

they sequencing those comorbidities appropriately? Evaluate your clinical staff, including your physicians. Are they documenting the patient's care, progress, and condition accurately, consistently, and timely? As we found under DRGs, pre-existing documentation problems were exacerbated by PPS. If you find in medical record review that there are discrepancies in documentation of the patient's condition, you may have a future reimbursement or compliance issue that you need to correct immediately.

It will also be necessary to solicit staff concerns about the ethical issues involved in moving into a PPS environment, especially if you are using care maps or paths for the first time. Clinical staff may see the focus on length of stay and/or care maps as eliminating the individual-approach to care that has been a hallmark of rehabilitation. Administrative and financial staff may need education on using CMGs as guides not absolutes, so that clinical staff are not put into a position of prematurely discharging a patient just to ensure correct length of stay.

A good relationship with your Information System department is more important than ever. IRFs will be required to submit data on Medicare patients to CMS via their software, Minimum Data Set for Post-Acute Care Tool (MPACT), or other software that conforms to the

requirements by CMS. The software will help users in encoding, editing, and transmitting the data. CMS will establish a hotline to assist users with

“A good relationship with your Information System department is more important than ever.”

this software and will be conducting training seminars. Many see PPS as yet another transition into comput-

erized patient records due to the documentation requirements and standardization required, yet another reason to be on good terms with your IS department.

The choice is yours. As an HIM professional, you may view prospective payment as a huge bump in your already bumpy road, or you may see it as a tremendous but inspiring challenge. I encourage you to see this as an opportunity for your department to shine, as you take on a leadership role in your organization in gearing up for a system that will change how we do business, how we get paid, and how we treat our patients. ∞

ROI (in Texas) Series

Presented by
Donna Bowers, JD, RHIA
Larry Dunham, RHIA



For more information
Check out **TXHIMA.ORG**

Students To Graduate From SWT Web-Based HIM Program

The Distance Education RHIT Progression Program at Southwest Texas State University was started in the summer 2000 in response to the many RHIT's in Texas desiring a BSHIM degree and thus be eligible to sit for the RHIA exam. Few opportunities existed for individuals to progress without moving away from family and jobs and/or incurring a great deal of expense. The HIM faculty at SWT had explored several means of offering a RHIT progression program over the years but wanted to make sure the integrity of the academic preparation was not compromised. The ability to incorporate web-based instruction as the major means of delivery provided the vehicle to provide a program consistent with the HIM degree program offered on campus.

The Distance Education RHIT Progression Program is offered for those who already have completed an associate degree in health information management and hold the RHIT credential. The students' previous RHIT coursework will be counted for some of the requirements towards the SWT BSHIM. The student can complete outstanding general education courses at their local community college. The remaining coursework, the professional phase of the curriculum, is then available through the various means of distributed education – web-based instructions, independent study, and clinical assignments. There are required once a semester

1-3 day seminars on the San Marcos campus. The purpose of these visits is to allow the program faculty to get to know the students and for the students to get to know their "classmates", the faculty and to establish their identity as a SWT student.

Twenty one students are currently enrolled in this distance education program. These students are all RHIT's living and working in locations around Texas from Brownsville to Gainesville, from Pecos to Houston and points in between. Some have only been

First group of students to graduate in May 2002.

RHIT's for a few years, some for quite a number of years. All of these students have maintained their employment in their local community and are completing the SWT BSHIM requirements as offered via the various means of distance education. Several of the students are expected to graduate in May 2002 and thus then be eligible to sit for the RHIA exam soon thereafter.

The Traditional Campus-Based Program is a two plus two program with completion of general education core curriculum and program prerequisite coursework during the first two years. Following application and acceptance into the program, the final two years consist of the pro-

fessional coursework on the San Marcos campus reinforced with professional practice experience assignments in hospitals and other health care related facilities and organizations throughout Texas.

The Health Information Management Program at Southwest Texas State University in San Marcos was started in 1976 with the first four students graduating in May 1978. The 25 students graduating in May and August of 2001 brought the total number of SWT BSHIM graduates to 467. **Sue Biedermann** has been program director since May 1984. Other full-time members of the faculty are **Linda Thomas, MSHP, RHIA; Jackie Moczygemba, MBA, RHIA; and Barbara Hewitt, MBA.** Also joining the faculty this fall are **Lillian Polanco-Valdez, RHIA,** as a part-time faculty, **Cathy Hess, RHIA,** adjunct faculty, and **Audrey Salazar,** BSHIM May 2001, graduate instructional assistant.

Additional information on earning the BSHIM degree at SWT in either format can be found at the SWT web-site www.health.swt.edu/HIM/HIM.html (or link from TxHIMA web-page) or by calling the HIM Program Office at 512 245-8242. Applications for both programs are accepted during the spring semester to begin the program in the fall semester. Anyone considering applying should seek academic advisement as soon as possible. ☺



2001-2002 TxHIMA Leadership



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CALENDAR

2001-2002 CALENDAR of EVENTS

October 26	ROI, Hendrick Health System, Tom Roberts Conference Center, 1242 N 19 th St., Abilene
November 4-10	HIT Week
November 7	HIPAA – How to Prepare, East Texas Medical Center, 1000 S. Beckham, Tyler
November 9	ROI, Thomason Hospital, 4815 Alameda Ave., El Paso
November 19	Modifiers & Emergency Room Coding, Southwest Methodist Hospital, 7700 Floyd Curl Dr., San Antonio
December TBA	ICD 9 CM Coding, Houston
January 11, 2002	ROI – Clear Lake Regional Medical Center, 500 Medical Center Dr., Webster
TBA	ROI Teleconference
TBA	Professional Development, Austin
February TBA	ROI Teleconference
TBA	HIPAA, The Methodist Hospital, Houston
TBA	CPT Coding, Dallas
March TBA	ROI Teleconference
TBA	Long Term Care, Austin
April TBA	CCS Review, San Antonio
May TBA	HIPAA, San Antonio
TBA	Management, Houston

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