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 TxHIMA Executive Office, 300 CM Allen Pkwy.,
 #206A, San Marcos, TX 78666, FAX to
 (512) 878-197 or email to
 TxHIMA@grandecom.net.

www.txhima.org

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February/March/April 2003

Articles

The Life of a Privacy Officer4
 Medical Staff Privileging.....5
 2003 Cardiovascular Coding Changes.....6
 Long-Term Acute Care Hospitals Prepare
 For Prospective Payment.....8
 Authorizations and HIPAA.....10
 HIPAA Enforcement: This Dog Can Bite13
 Are You Considering Bringing Back ROI In-house?15

Departments

President's Message2
 Call To Session12
 Willingness to Serve16

The *TxHIMA Journal* is the official publication of the Texas Health Information Management Association (TxHIMA), a professional association chartered under the State of Texas non-profit corporate law. Views expressed in the *TxHIMA Journal* are those of the author(s) and do not necessarily reflect the policies or opinion of the Texas Health Information Management Assoc., Editor, or Publication staff.

A Journey Back in Time

Texas Health Information Management Association (TxHIMA) is an organization of growth and change. Many aspects of our profession have changed over the decades, although the core goals of the association have remained constant. The core goals have always been to promote the profession and to provide a network of growth and opportunity within our membership; to provide education to members; and to be a voice and link to the national association.

“Each of us should be active in the recruitment of personnel for the profession.”

Changes in our profession, and, concomitantly in our leadership structure, have been numerous. One of the most tangible signs of change for TxHIMA is our state convention. For many years, TxHIMA enjoyed uniting with Texas Hospital Association (THA) and sharing speakers and expenses with them at the annual THA convention. As our organization and the focus of our profession grew, it became apparent to the board that it was time to branch out from THA and hold our

own convention. In 1996, TxHIMA held its first independent annual state convention in Corpus Christi, and in spite of the many challenges, the board and the membership agreed that it was a success. The success was in part the springboard for TxHIMA to continue to strengthen as an organization. As the years passed and operations increased in range and complexity to support a growing membership base, we found that we were outgrowing our office in the THA building in Austin.

During the last few years, the board began discussions on moving the TxHIMA office to a location that would allow us to expand operations and improve functionality. Late in 2002, the board began reviewing current expenses associated with residing in our THA location and various options and expenses involved in moving to other locations. The board decided that to be able to serve the membership more effectively with as little increase in annual operating expenses as possible, the optimal location would be San Marcos, Texas; therefore, in February 2003 TxHIMA opened its new office at 300 CM Allen Parkway in San Marcos, Texas. For those of you who are familiar with San Marcos, the new office is off Interstate 35, across the street from the Little League fields. It is close in proximity to Southwest Texas State University, which offers a Health Information Management program. Because real estate is cheaper in San Marcos than in Austin, we obtained more square footage (2 times the

square footage of the THA office) without raising our monthly lease payment substantially (increase of \$181/month). If you would like



Beverly Rhodes,
MSHP, RHIA

additional information on the new office, the rationale for the move, or more cost information, please contact the Executive Office.

Madeline Perrett, the Executive Director, and **Ruthie Smith**, her part-time assistant, worked diligently to arrange and execute the move, putting in many hours of their own time and at great personal expense. The Saturday following the move, I went to the office to help Madeline make some “retain or throw away” decisions on the contents of several boxes of organization information. What we discovered was a venture into our history. True to our profession, the originators of the Texas state association of “Medical Record Librarians” were excellent record keepers. Here are just a few of the historical facts and occurrences in our association’s history:

- In 1936, the charter meeting of the TAMRL (Texas Association of Record Librarians) was held, with Martha A. Johnson, R.R.L., presiding.
- In 1945, no annual meeting was held because of war conditions.
- In 1946, an “institute” was established for record librarian students. There were 107 stu-

Continued on page 3

dents from 20 states and two from “old Mexico”. The American Hospital Association and the American Association of Medical Record Librarians underwrote the institute for \$2,500.

- In 1954, Texas had 98 members (an increase from 85 the previous year) with five delegates to the national meeting. National dues were \$15/per member.
- In 1970, AAMRL changed its name to the American Medical Record Association (AMRA) to better reflect the focus of the organization.
- In 1973, Texas had 743 members, an increase of 104 from the previous year.
- The 1980s, of course, brought us prospective payment and DRGs.
- 1991 was a very busy year:
 - The national association voted to change the name from AMRA to the American Health Information Association, or AHIMA.
 - Legislators gave us the Patient Self-Determination Act, and the Trauma Registry was proposed.
 - Our state board began discussing restructuring a fairly complex board structure with downsizing and realignment of job duties.
- In 1992, TMRA voted to change our association name to Texas Health Information Management Association, or TxHIMA.
- In 1996, TxHIMA held its first annual state convention.
- In 2003, our membership is a booming 3476, which includes

all categories of membership. Look back up at the top of the previous page to the quote, “Each of us should be active in the recruitment of personnel for the profession.” Although this quote could be mine or any of the previous TxHIMA presidents, it belongs to **Mary McReynolds**, RRL, state president in 1951, who told the membership that we should be more active in marketing our profession. Ms. McReynolds was clearly a forward thinker, also penning the comments that the medical record field is a “profession not a job” and that the field is wide open, and there is “not only a need in the hospital but in the other institutions”. I’d like you

“...the medical record field is a ‘profession not a job’...”

to take her thoughts with you as TxHIMA seeks membership support of AHIMA’s current recruitment programs.

We have indeed seen many changes in our profession, and yet, as I stated before, many aspects have remained constant. I leave you with some of the speaker topics for our association meetings in the early years. I know you will find humor in the relevancy of these topics in today’s world.

“The Record Department—Liability or Asset” (1937); “Records and their Value to Research” (1939); “Record Problems Encountered by the Medical Staff from the Nursing Department and the Medical Records Library” (1940); “Symposium with Reference to the

Use of Medical Records by Insurance Companies” (1940); “Legal Aspects of Medical Records” (1949); “Birth Certificate Problems” (1949); “Proposed Code for Release of Information from Medical Records” (1952).

And the final burning question is did our predecessors experience difficulty with delinquent physicians? A paper titled, “Function of Record Committee” dated December 1935 by Dr. E.A. Majors, states, “For (its) own welfare (the) hospital should be interested in keeping its clinical records with the utmost completeness and accuracy in as much as these records constitute the principal protection against malpractice suits.” Dr. Majors lists the following methods of getting doctors to comply with record completion:

1. Personal contact of their record librarian with the doctor.
2. Writing personal letter to the delinquent doctor signed by the chairman of record committee.
3. Telephoning delinquent doctor.
4. Making personal visits to the office of those doctors.
5. Meeting those doctors in the hospital and taking them to the record library.

Dr. Majors adds, “Regardless of the interesting subject matter, many doctors will not take time to complete records.”

I hope that you enjoyed this brief journey back in time as much as I enjoyed putting it together. The board agrees that the membership would enjoy viewing some of the association’s archival information, and we will be considering ways to display it at the state convention in June in Ft. Worth. I hope you are planning to attend, and in the meantime, may God bless and keep you.



The Life of a Privacy Officer

*Leigh Chiuminetta, RHIA, Privacy Officer/HIPAA Coordinator
Seton Healthcare Network, Austin, Texas*

In an integrated healthcare delivery network of 22 locations and 7,500+ employees, life is hectic as a Privacy Officer. Although we all realize that maintaining the privacy, confidentiality and security of patient health information is nothing new, the HIPAA Privacy Regulation is now requiring that our patients be informed of what their rights are and how we use their health information. In addition, we are required to standardize many processes that may have already been in place. This can be challenging and at times overwhelming for one facility much less multiple facilities.

The analysis of how activities have been performed in the past and how they need to be changed to meet the requirements is a constant factor in achieving compliance. In the analysis, it is crucial that the right questions are asked to get the correct facts. How each individual, work group, department, component, and facility functions and interrelates is essential because they are the key to making the implementation successful.

The determination of how your organization represents/designates itself to the public takes thorough examination, review and planning. We reviewed our network as if it were a puzzle. All of the components were broken out and reviewed individually and then re-connected to establish and document our designation. As a result, we are designated as an Organized Healthcare

Arrangement (OHCA) within an OHCA as well as Affiliated Covered Entities and Hybrid Components.

In addition, identifying the applications that process Protected Health Information (PHI) within the organization is extremely eye opening. This is due primarily to the number of independent/stand alone applications. Appropriate documentation of where gaps exist with regard to minimum necessary, role based access, audit trails, etc. of each application and a work plan for how to address the gaps is essential for compliance.

“We reviewed our network as if it were a puzzle.”

One of the more frustrating elements is dealing with misinterpretations of the regulation. Another frustrating element is dealing with individuals who attempt to communicate how a particular facility is choosing to handle a certain situation which they view is the only possible way. There are many ways that facilities will be addressing what is “reasonable” and how they interpret certain portions of the regulation. What is reasonable for one institution may be very different than another within or outside the same city and/or state. The framework regarding why decisions are made

can vary for a multitude of reasons. Although learning what others are doing is extremely valuable, it is essential that you know what is required by law and what choices you can make in your implementation. It has also been very beneficial to be connected with others who are in the midst of dealing with the same situation because everyone’s frame of reference and life experiences can be different, which can be of great benefit to your organization.

The integration of the appropriate communication plan and training program for the workforce is extremely time-consuming. Taking an inordinate amount of information and trying to “Keep It Simple” for the entire workforce was very important for our organization. In addition, we constantly assessed the need to strike a balance with communicating information that is essential for those workforce members needing additional training versus not overwhelming them with too much information all at one time. We preferred to provide the workforce with avenues and opportunities to gain additional information that can be referenced as needed.

When all is said and done, all workforce members have been trained and know that they are personally responsible and accountable for protecting patient health information. In addition, each individual should know who to go to and how to get information at their facility for ensuring compliance of the privacy regulation. ∞

Medical Staff Privileging

By Gwendolyn Duffie, RHIA

Medical staff privileging continues to be one of the most complex issues facing today's medical staff, medical staff offices and hospital administrations. The problem has become very complex because of technology changes. The question that prompts debate and questioning has to do with new procedures and/or new techniques for performing old procedures. When should physicians have to be privileged for new procedures or new techniques? What constitutes a new procedure or a new technique?

In addition to the aforementioned dilemma, we now have privilege issues because of expanding roles of physicians. Procedures that were once done by a very specific discipline may now be performed by other disciplines. The reason for this could be multifactor, but financial reasons are probably the top of the list. Physicians are having to do more because of cuts in reimbursement. Training and education play a big role as well. This creates difficult issues between disciplines. When working through the issues, this usually means getting into the middle of major political hotbeds that exists in health care organizations.

It is funny how health care makes a full circle. It is like the rest of life. Years ago physicians practiced in with a broader focus and over the years most physicians eventually went to specialization. Now, physicians are going back to a broader practice pattern because of the financial situation

as well as the education and training.

Health care organizations adjusted then and will make the necessary adjustment once again based on the practice patterns of physicians.

Unfortunately, many health care organizations have no medical staff policies or privileging criteria to fol-

**“It is funny
how health care
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low when these questions arise. Most health care organizations do not have medical staff bylaws that provide guidelines necessary to ensure privileging is done in an efficient, objective and reasonable manner. Many of these questions arise when:

- a medical staff member requests a new privilege
- a medical staff member wants to use a new piece of technology
- a medical staff member has received training to do a procedure using a new technique
- the operating services scheduler notices something new on the schedule

- the operating services staff is requested to set-up differently than in the past
- a medical staff services professional or chief of department brings up the issue
- someone reads in the newspaper that your hospital is the first to introduce this new patient technique.

To assist health care organizations with this process, it is critical that they develop a policy that outlines that all privilege cards will be reviewed by the department chief and credentials committee at least annually. Also, this policy should address the process that if a new procedure is to be performed as determined by the Chief, the privilege card shall be updated prior to performing the procedure unless in an emergent situation exist or the Chief determines an exception is required.

By having this policy and procedure in place, health care organizations can prevent scrutiny from accrediting agencies such as TDH, CMS, JCHAO and others. This is a good policy for all health care organizations to develop today if one is not already in place. If health care organizations have not been forced to deal with this issue yet, it is only a matter of time because of the fast paced changes related to technology.



2003 Cardiovascular Coding Changes

Lynn Marlow, BS, RHIT, CCS

Hypertension

402 Hypertensive heart disease

404 Hypertensive heart and renal disease

Categories 402 and 404 have codes for heart failure. Since there are different types of heart failure the term congestive has also been removed from the fifth digit descriptions. The Use Additional Code note has been added to assign the specific heart failure code.

Ischemic Heart Disease

414.06 Coronary atherosclerosis of coronary artery of transplanted heart

Transplant patients are living longer. Therefore, the transplanted coronary arteries may also develop atherosclerosis. The current codes are only for native arteries & bypass graft. The transplanted arteries are not native to the patient. The development of atherosclerosis is a disease process not a complication of the transplant.

Aneurysm and dissection of heart

414.12 Dissection of coronary artery

The dissection of an artery is defined as blood coursing within the layers of the arterial wall. It is not an aneurysm. Arterial dissection is a common complication of interventional procedures. ICD-9-CM has a code for dissection of the aorta, which is the most common location for dissections, but they may also happen in other arteries.

Heart Failure

428.0 Congestive heart failure, unspecified

428.2 Systolic heart failure

428.3 Diastolic heart failure

428.4 Combined systolic and diastolic heart failure

Fifth digits

0 Unspecified

1 Acute

2 Chronic

3 Acute on chronic

Kaiser Permanente proposed this code change to include code specific codes for acute and chronic systolic and diastolic heart failure. Many people are concerned that the documentation will not be in the medical record. It has pointed out that this information affects the treatment and that new physicians are being taught to document heart failure this way.

Late Effects of Cerebrovascular Disease

438.6 Alterations in sensation

Use additional code to identify the altered sensation

438.7 Disturbances of vision

Use additional code to identify the visual disturbance

438.8 Other late effects of cerebrovascular disease

438.83 Facial weakness

Facial droop

438.84 Ataxia

438.85 Vertigo

The American Academy of Neurology requested the addition of these codes. Facial droop is a common residual after a CVA. There is no specific code for this late effect. It was requested it be titled facial weakness rather than facial droop. It was also requested that ataxia and vertigo also be given late effect of CVA codes.

Other arterial dissection

These are some additional dissection of artery codes that have been added.

443.21 Dissection of carotid artery

443.22 Dissection of iliac artery

443.23 Dissection of vertebral artery

443.29 Dissection of other artery

445 Atheroembolism

This is also known as “cholesterol embolism” and has also been called “blue toes” because of its manifestations. It occurs when plaque in the aorta disrupts and sprays debris into the circulation where it clogs the small terminal arterial branches. The patient often experiences

Continued on page 7

purplish splotches in the skin of the extremities, often the toes. They can be very painful and can also lead to gangrene.

While the extremities are the most common areas atheroemboli has been found in virtually all tissue. When wide spread there is a high mortality rate from renal failure and progressive failure to thrive. Medical treatment uses antiplatelet agents not antithrombolytics. Antithrombolytics may cause additional plaque to disrupt. Surgical treatment involves surgical bypass or endarterectomy.

Varicose Veins With other complication

There are codes for ulceration and inflammation of varicose veins, but not for other symptoms. New codes have been assigned to other complications of this condition.

- 454 Varicose veins of lower extremities
 - 454.8 With other complication
 - Edema
 - Pain
 - Swelling
 - 454.9 Without mention of ulcer of inflammation
 - Asymptomatic varicose veins
 - Varicose veins NOS

Other Disorders of Circulatory System

These are conditions resulting from the destructive effects of thrombosis, including destruction of valves of the deep veins, and obliteration in severe cases. These codes would include chronic venous hypertension with deep vein thrombosis, but not without deep vein thrombosis. The documentation should specifically link the complication (ulcer or inflammation) with the syndrome *Other disorders of Circulatory System*

- 459.1 Postphlebotic syndrome
 - Chronic venous hypertension due to deep vein thrombosis
 - Chronic venous hypertension without deep vein thrombosis (459.30-459.39)
 - 459.11 with ulcer
 - 459.12 with inflammation
 - 459.13 with ulcer and inflammation
 - 459.19 with other complications

Chronic venous hypertension (idopathic)

A new subcategory and subcategories have been created for chronic venous hypertension.

Other Disorders of Circulatory System

- 459.3 Chronic venous hypertension (idopathic)
 - Stasis edema
 - Chronic venous hypertension due to deep vein thrombosis (459.10-459.19)
 - 459.30 without complications
 - 459.31 with ulcer
 - 459.32 with inflammation
 - 459.33 with ulcer and inflammation
 - 459.39 with other complications

Dieulafoy lesion

537.84 Dieulafoy lesion (hemorrhagic) of stomach and duodenum

569.86 Dieulafoy lesion (hemorrhagic) of intestine

Dieulafoy lesion is an abnormally large and tortuous (twisted) submucosal artery that protrudes through a small mucosal defect surrounded by essentially normal mucosa. Usually occurring in the stomach they have been reported in other parts of the GI tract. Massive gastrointestinal hemorrhage may result requiring several transfusions. It is difficult to diagnose, and may not be recognized until it is bleeding. They are often confirmed by endoscopy and angiography. Nonsurgical treatment includes endoscopic sclerotherapy, electrocoagulation as well as hemoclip and band ligation of the protruding or bleeding artery. Prior to these technologies surgery was the only treatment and mortality was 80%. The new treatments have improved survival rate. ∞

Sources:

- Coordination and Maintenance Meeting Minutes May 2001, Nov 2001, May 2002
- Federal Register May 9, 2002, Aug 1, 2002

Long-Term Acute Care Hospitals Prepare For Prospective Payment

Larry Dunham, RHIA

Overview:

Long term care hospitals (LTCHs) are certified under Medicare as short-term, acute care hospitals which have been excluded from the Inpatient Acute Care Prospective Payment System. For the purposes of Medicare payment, LTCHs are defined as having an average length of stay greater than 25 days. The LTCH PPS replaces the reasonable cost-based payment system under which the LTCHs were paid.

These changes have affected some LTCHs already. Those that have fiscal years beginning on or after October 1, 2002 have already felt the impact of this change. Otherwise, the hospitals will begin with this new PPS system upon the beginning of their new fiscal year following the October date. Prior to the October 1, 2002 or their start of their new fiscal year, each LTCH was paid on a hospital-specific basis under the TEFRA system. When PPS is totally phased in, after the five year transition period, all payments to LTCHs will be based on a standardized amount per patient discharge. This standardized rate is based off of the average LTCH costs in a base year with an update based off of inflation. This PPS system will be updated annually as is done for Inpatients and Rehab currently. Additional adjustments to payment include cost outliers, case level adjustments for patients who transfer from one hospital to another, facility

level adjustments to include wage adjustments/cost of living adjustments and short-stay outliers. One factor to watch out for is the adjustments for interrupted stays. These "furlough" days have specific time-frames allowable under the regulations. They are:

- Acute Care Hospitals – 9 days or less
- Inpatient Rehab Facility – 27 days or less
- Skilled Nursing Facility – 45 days or less
- Swing-bed Hospitals – 45 days or less

Important to keep in mind is how your mainframe systems can accommodate these days of no activity within the LTCH, yet pick back up when the patient returns to the facility. If the length of stay at the receiving provider is equal to or less than the applicable fixed period of time prior to returning to the LTCH, it is an interrupted stay. An interrupted stay is treated as one discharge for the purposes of payment and only one LTCH PPS payment is made.

Getting Ready In HIM:

The objective of this article is to provide information on coverage criteria, coding, and medical review related to the prospective payment system for long-term acute care hospitals (LTCH PPS). Additionally, the Health Information Management Departments will need to understand

their impact to the hospital's bottom-line through improved coding practices through enhanced documentation, physician/case manager education, timely processing, and making sure information is available at the time of coding.

The clinical treatment programs noted under LTCHs have not changed with this implementation. However, the importance to understand the intensity of services within LTCH hospitals is paramount. This misunderstanding as to the special needs has not been as apparent to those outside the long term acute environment. The coding guidelines for coders within these hospitals have always seemed to work in conflict as to why the patient is really in the hospital. An example of this is a patient with an Acute Stroke who is transferred for intensive service at the LTCH in their special Stroke Program. The guidelines direct the coders to use the Late Effects of Stroke code since the "so-called" acute phase is over...having been discharged from the acute care hospital to the LTCH. This is one example of why efforts were undertaken by the Coding Taskforce of the National Association of Long Term Care Hospitals to readdress these guidelines with Medicare since these intense treatment programs are focused on improving from the acute care phase of the diagnosis. I was fortunate to serve on this Taskforce

continued on page 9

along with other HIM professionals across the country.

The example of stroke is just one of many scenarios that become a dilemma for coders under prospective payment because these late effects or residual codes from the acute diagnosis tend to group to a lower paying DRG which not only reimburses less money to the hospitals but truly inappropriately profiles the patients episode of care. These variances that play off of guidelines that do not address the Long-term Acute hospitalization are grounds for incorrect assumptions related to this patient population. Additionally, as lessons learned for Inpatient Acute hospitals, the data that was used to establish the working DRG/PPS program was highly flawed because under the old reimbursement system, the sequencing and capture of co-morbidities did not influence the reimbursement for services rendered. This being said, attention to these details early on in the implementation of LTCH PPS is imperative.

On 3/7/03 the final rules were published in the Federal Register. The stance of coding late effects has eased somewhat when the acute care phase is truly evident in the long term acute care setting. The new language includes:

To improve medical record documentation, LTCHs should be aware that if the patient is being admitted for continuation of treatment of an acute or chronic condition, guidelines at Section I.B.10 of the Coding Clinic for ICD-9-CM, Fourth Quarter 2002 (page 129) are applicable concerning selection of principal diagnosis. To clarify coding advice issued in the August 30, 2002 final rule (67 FR 55979-55981), we would like to point out that, at Guideline I.B.12,

Late Effects, a late effect is considered to be the residual effect (condition produced) after the acute phase of an illness or injury has terminated (Coding Clinic for ICD-9-CM, Fourth Quarter 2002, page 129). We have received question regarding whether a LTCH should report the ICD-9-CM code(s) for an unresolved acute condition instead of the code(s) for late effect or rehabilitation. Depending on the documentation in the medical record, either code could be appropriate in a LTCH. Since implementation of the LTCH PPS, our Medicare fiscal intermediaries have been conducting training and providing assistance to LTCHs in correct coding. We have also issued manuals containing procedures as well as coding instructions to LTCHs and fiscal intermediaries. We will continue to conduct such training and provide guidance on an as-needed basis. We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 final rule (67 FR 55979-55981).

These changes/clarifications noted in this recent print of the Federal Register are a major step in improving coding and profiling of cases served by these LTAC facilities.

Other factors that will play a role in making the LTCH PPS program a success is the understanding of how the DRGs are influenced by the service utilization with the hospital as well as the capture of secondary diagnoses, patient's age, sex, and discharge disposition and their influence on the final DRG. Surgical DRGs are assigned to discharges that have a procedure of some significance performed (not EKGs, Scans, Phlebotomy, etc). Surgical DRGs are assigned based on surgical hierarchy that orders individual procedures or groups of procedures by resource

intensity. Medical DRGs do not have significant procedures performed and are reflective of the diagnoses that the patient is admitted with.

The influence on these DRGs is driven by the ICD-9 Coding Profiles of the patient. These codes must accurately reflect what is going on with the patient in order to arrive at the correct DRG. Attention to the standard coding guidelines is essential to accurately reflect the principal diagnosis. The definitions outlined within the final rules help the coder in the appropriate sequencing of codes under PPS.

The Cooperating parties (AHIMA, AHA, CMS, NCHS) continue review of cases being treated in the Long Term Acute Care setting to hopefully keep open dialogue in making sure that the PPS system established will be workable and comprehensive to the needs of this special niche industry. The National Association of Long Term Hospitals along with these Cooperating parties of the Coding and Maintenance Committee continue efforts to make positive change.

You are encouraged to refer to the resources noted in this article for details, further explanation and/or reference of the LTAC PPS Rules. ☺

Resources available:

AHIMA Long Term Acute Care
Community of Practice (CoP)
National Association of Long Term
Hospital (www.nalth.org)
Federal Register 3/7/03, 8/30/02
(www.gpo.gov/su_docs/aces/aces140.html)
AHA Coding Clinic Fourth Qtr
2002
www.ahacentraloffice.org
www.cdc.gov/nchs.icd9.htm
cms.hhs.gov/providers/longterm/default.asp

Authorizations and HIPAA “Major Changes for Release of Information Departments”

E. Earl Hauss, B.S.N., R.N., Owner and principal “PRS of Texas,”

Disclosure of Protected Health Information and Medical Records Privacy with a Focus on Proactive Risk Management.

April 14, 2003 is the compliance deadline mandated by HIPAA “45 CFR Parts 160 and 164 - Standards for Privacy of Individually Identifiable Health Information” (the “HIPAA” or “Privacy Rule” herein). One major impact HIPAA will have on the day-to-day operations in release of information departments pertains to the implementation of Section 164.508(c) “Core Elements and Requirements”. This section mandates specific requirements for the content of authorizations received by health care providers. These requirements include very specific data elements and statements. Health care providers receive several, if not numerous authorizations on a daily basis for the release of protected health information or medical records. Currently, most authorizations, including those created and utilized by health care providers and covered entities do not comply with the Privacy Rule requirements.

The Texas Legislature in the Texas Health & Safety Code and the Texas State Board of Medical Examiners in the Board Rule pertaining to medical records have previously addressed the content of authorizations for the release of health care information. HIPAA appears to require the same basic content but also contains additional

requirements for very specific language that must be contained in the authorizations.

This article will focus on a review of the required elements and content for authorizations under the privacy rule.

Preemption Analysis

When first implementing any section of the privacy rule, a review and

“This article will focus on a review of the required elements and content for authorizations under the privacy rule.”

comparison of applicable state laws must be made in order to determine which rule or statute applies. The privacy rule requires covered entities to comply with both federal and state privacy laws and regulations when they can. However, the privacy

rule preempts state law when state law is contrary to the privacy rule. This process is often referred to as making a preemption determination. There are exceptions, one of which is the circumstance in which the state law is more stringent than the privacy rule requirements.

Currently authorizations in Texas are primarily regulated by the Texas Health & Safety Code § 241.152. Written Authorization for Disclosure of Health Care Information and the Texas Occupations Code: Chapter 159. Physician-Patient Communication §§ 159.005. Consent for Release of Confidential Information.

When reviewing these two statutes and comparing them with the privacy rule it does not appear that the state laws are either contrary or necessarily more stringent. Therefore, compliance with HIPAA or the privacy rule is generally agreed upon to be the appropriate guidelines to follow.

Specific Elements Required by HIPAA

Section 164.508(c) “Core Elements and Requirements” of the privacy rule states, “A valid authorization under this section must contain at least the following elements” and then identifies the following six (6)

Continued on page 11

specific data elements.

1. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
3. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;
4. A description of each purpose of the requested use or disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement “end of research study”, “none”, or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.
6. Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative’s authority to act for the individual must also be provided.

Specific Statements Required by HIPAA

Furthermore, Section 164.508(c) states “In addition to the core ele-

ments, the authorization must contain statements adequate to place the individual on notice of all of the following” and then proceeds to identify the following three (3) specific required statements that must be contained within the authorization.

1. The individual’s right to revoke the authorization in writing, and either:
 - (a) The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or
 - (b) To the extent that the information in paragraph (c)(2)(i)(A) of this section is included in the notice required by §§ 164.520, a reference to the covered entity’s notice.

“The deadline for compliance with the privacy rule is here...”

2. The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:
 - (a) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph (b)(4) of this section applies; or
 - (b) The consequences to the individual of a refusal to

sign the authorization when, in accordance with paragraph (b)(4) of this section, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.

3. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this rule.

Additional Requirements and Issues under HIPAA

There are two additional requirements under this section of the privacy rule. The first states, “the authorization must be written in plain language” and the second states, “If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.” The plain language requirement is interesting in view of the difficulty often encountered in reading and interpreting many aspects of HIPAA.

One of the important points in this section of the privacy rule is that the authorization “must contain” these data elements and statements. This means that the authorization signed by the patient or authorized representation must contain all of these items. While this information may also appear in a cover letter or correspondence accompanying the authorization, if the required elements and statements are not contained within the authorization, then the authorization must be rejected since it does not comply with the

Continued on page 12

requirements of the privacy rule. This will probably be one of the more contentious issues facing release of information departments as they implement this section of the privacy rule and educate their requestors on the content of authorizations.

Two additional questions that have surfaced regularly involve whether the authorization must be notarized and whether a copy, including a faxed copy of an authorization acceptable under the privacy rule. At this point, there is no requirement that the authorization must be notarized. In addition, available commentary on the privacy rule has indicated that both a copy and a faxed copy of an authorization are acceptable under the privacy rule as long as the authorization contains all of the required elements and statements.

However, a covered entity is not prohibited from implementing either of these requirements if they choose to do so. Some covered entities even no longer accept outside authorizations, but instead require completion of their internally created authorization before releasing protected health information.

Summary

The deadline for compliance with the privacy rule is here and health care providers must address the required content of authorization mandated by HIPAA. A number of health care providers have already begun rejecting authorizations which do not comply with the privacy rule or have been sending notices to requestors that their authorizations will be rejected after April 14th and providing them with information and references regarding this issue.

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References

- Texas Health & Safety Code
Subchapter G. Disclosure of Health Care Information Ch. 241.151 – 241.156;
- Texas State Board of Medical Examiners Board Rule – Medical Records 165.1-165.4
- 45 CFR Parts 160 and 164
“Standards for the Privacy of Individually Identifiable Health Information”
- OCR HIPAA Privacy, December 2002 – Guidance on 45 CFR Parts 160 and 164 “Standards for the Privacy of Individually Identifiable Health Information”

Mr. Hauss has over 20 years experience in health care, professional liability litigation and release of information. He has authored publications and presented seminars to the medical and legal community on release of information, medical records and health care liability issues. The author may be contacted via email at eehauss@charter.net

National Cancer Registrars Week

April 7-11, 2003



Cancer Registrars Working Together Toward A World Free of Cancer

OFFICIAL CALL TO SESSION

BY BEVERLY RHODES, MSHP, RHIA, TXHIMA PRESIDENT

TXHIMA Annual Meeting – June 1-3, 2003
Radisson Plaza Hotel, 815 Main Street, Fort Worth, Texas

In accordance with Article VI, Section 6.2 of the Texas Health Information Management Association Bylaws.

HIPAA Enforcement

This Dog Can Bite

Jerry Hopgood, Director, Office of HIPAA Compliance, Baylor Health Care System

For more than two years, we've been hearing that "HIPAA is coming, HIPAA is coming". Well, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is no longer coming. It is here. As TxHIMA members are fully aware by now, there are many requirements that HIPAA places upon healthcare providers and other covered entities. While everyone is working diligently to meet these requirements, one question that is often asked is "What will happen if we violate HIPAA?"

Congress, when passing the HIPAA legislation, felt that penalties and enforcement were required to ensure that covered entities followed the requirements that HIPAA set forth. The following are the types of penalties that HIPAA (and Chapter 181 of the Texas Health and Safety Code) provides.

Federal HIPAA Penalties

SEC. 1176. (a) General Penalty

(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than \$100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed \$25,000.

Wrongful or Negligent Disclosure of Individually Identifiable Health Information: HIPAA SEC. 1177.

- (a) OFFENSE.—A person who knowingly and in violation of this part—(1) uses or causes to be used a unique health identifier; (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person, shall be punished as provided in subsection (b).
- (b) PENALTIES.—A person described in subsection (a) shall — (1) be fined not more than \$50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than \$250,000, imprisoned not more than 10 years, or both.

Texas Penalties

§ 181.201. Injunctive Relief; Civil Penalty

- (a) The attorney general may institute an action for injunctive relief to restrain a violation of

this chapter.

- (b) In addition to the injunctive relief provided by Subsection (a), the attorney general may institute an action for civil penalties against a covered entity for a violation of this chapter. A civil penalty assessed under this section may not exceed \$3,000 for each violation.
- (c) If the court in which an action under Subsection (b) is pending finds that the violations have occurred with a frequency as to constitute a pattern or practice, the court may assess a civil penalty not to exceed \$250,000.

§ 181.202. Disciplinary Action

In addition to the penalties prescribed by this chapter, a violation of this chapter by an individual or facility that is licensed by an agency of this state is subject to investigation and disciplinary proceedings, including probation or suspension by the licensing agency. If there is evidence that the violations of this chapter constitute a pattern or practice, the agency may revoke the individual's or facility's license.

§ 181.203. Exclusion From State Programs

In addition to the penalties prescribed by this chapter, a covered entity shall be excluded from participating in any state-funded health

Continued on page 14

care program if a court finds the covered entity engaged in a pattern or practice of violating this chapter.

§ 181.204. Availability of Other Remedies

This chapter does not affect any right of a person under other law to bring a cause of action or otherwise seek relief with respect to conduct that is a violation of this chapter.

Of note here is that the above penalties are “per violation” penalties. This means that multiple non-compliance infractions of the same standard can create fines up to \$25,000 for each standard. If additional standards are also not met, each standard can create a fine of up to \$25,000. These fines quickly add up.

With the publication of the final security rule on February 20th, 2003, the Department of Health and Human Services created the Office of HIPAA Standards under the Centers for Medicare and Medicaid Services. Both enforcement agencies under HIPAA (CMS and the Office

for Civil Rights (OCR)) have stated that their method for enforcing HIPAA compliance will be reactionary. That is, they will respond to complaints against a covered entity rather than to actively seek verification of compliance. From a Privacy Rule perspective, individuals will likely make complaints to DHHS, which will trigger a compliance review by OCR.

CMS has the authority to delegate investigation of complaints related to Medicare’s Conditions of Participation. In Texas, the Texas Department of Health (TDH) can become involved in the investigation, and complaints made to CMS will probably also trigger a separate (though similar) investigation using TDH standards. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) may also be involved once they become aware of a complaint related to a JCAHO standard.

From a Security and Transaction/Code Sets Rule perspective, complaints will likely be made

“What will happen if we violate HIPAA?”

by the trading partners of a covered entity, and will be made to CMS for a compliance review. The additional implication for non-compliance with a HIPAA Transaction/Code Set standard is exclusion from participation in the Medicare program. This can be an extremely serious implication for hospitals or practices that rely on Medicare as a source of their business.

In summary, all healthcare providers and other covered entities should implement an effective complaint resolution programs to limit the number of complaints that are made to DHHS. The implications on a healthcare provider can be numerous. One complaint may cause a healthcare provider to endure accreditation reviews, surveys, fines, penalties, and lawsuits. ☺

Remember, every time you place an ad in FOR THE RECORD, you not only reach the largest readership of HIM professionals, but you also support our state’s health information management association.

Are You Considering Bringing Back ROI In-house?

By Suma Chacko, RHIA, CCS

A constant struggle for HIM Directors is deciding to keep release of information in-house or outsource. As with any decisions in outsourcing, one of the many aspects of concern is cost effectiveness and efficiency. Release of Information is an area that has the potential to generate revenue for the Health Information Management Department. ROI is a crucial area within the HIM department due to all the federal and state statutes for releasing patient information as well as complying with HIPAA regulations. For those of you who are considering bringing ROI in-house, the following steps will assist you in your assessment.

One facility recently conducted an analysis of transitioning an outsourced ROI back in-house. Is it beneficial for HIM to take over this area? In order to answer this question, an assessment of the ROI area should be conducted. The following areas need to be evaluated:

- Capital expenses
- Staffing
- Operational expenses
- Revenue

First, take an inventory of all capital items in ROI. This will illustrate a need for future purchases or leasing of equipment. These items include copier, microfiche reader (if applicable), PC's, and a fax machine. If your current vendor is providing these hardware, only include this as a one-time budget for the first year. Maintenance of hardware should

only be included as part of operational expenses. A database can be created or purchased to handle all release of records, however, it will need to be HIPAA compliant. Second, take an estimate of the number of employees needed to maintain the area. If the current outsourced ROI staffing has functioned

“As with any decisions in outsourcing, one of the many aspects of concern is cost effectiveness and efficiency.”

well, then use that as a baseline. Staffing should be adequate in order to obtain proper authorization, copy numerous requests (billable versus nonbillable), pulling and filing records. A current manager can oversee this area or an ROI manager should be budgeted with staffing. Additional costs such as copy paper, toner, mailing supplies and postage will need to be added to the projected expenses. The revenue for ROI can be determined by evaluating your billable accounts which include

fees from attorneys, insurance companies, patients, etc... In order to ascertain the profit margin, the total annual expenses (excluding one time capital expenses) should be deducted from the annual revenue. The results can assist in making the decision of transitioning ROI in-house versus keeping the current outsourcing company.

There are still other factors that are challenging in operating ROI. The staff will need continuous education to keep up to date on the latest rules and regulations. The cost-fee schedule must be updated frequently to comply with state laws. The issue of non-billable accounts may exceed the billable accounts. In essence, it could be wise to outsource ROI unless the profit margin was considerably high for the HIM department. The resources considered necessary to operate ROI are extensive. It is a critical area due to not only handling confidentiality of patient records but also the prompt nature of releasing medical information for continuing treatment of care. The ultimate decision is left to the Director on taking ownership of the area or the comfort level of outsourcing with a reputable vendor. ∞

Willingness to Serve

TxHIMA is asking you to actively participate in the continued growth and leadership of the association. Please give thoughtful consideration to submitting your name as a possible nominee for a position on the Board of Directors or as a volunteer to assist an officer or director with one or more of the responsibilities listed below:

President

- _____ serve as Parliamentarian
- _____ serve as Financial Advisor

Past President

- _____ assist with advertisement solicitation for web page
- _____ member of the Ethics and Conduct Committee (committee activated only if needed)
- _____ participate in Coding Roundtable discussion

Education Director

- _____ coordinate RHIA/RHIT Exam Review
- _____ coordinate CCS or CCS-P Exam Review
- _____ coordinate the Long Term Care Seminar
- _____ coordinate Coding Seminar
- _____ coordinate Technology Seminar
- _____ assist with any seminar held in your area

Convention & Meetings Director

- _____ assist with Convention
- _____ assist with Fall Symposium

Public Relations Director

- _____ chair/member of Student Recruitment Committee
- _____ chair/member of HOSA Committee
- _____ chair/member of HIM Week Committee

Legal Director

- _____ chair/member of Legislative Monitoring Committee
- _____ chair/member of Drafting Legislation Committee
- _____ assist with editing the Health Record Information Manual
- _____ coordinate Legal Seminar
- _____ coordinate HIPAA Seminar

Yes, I would like to be a Nominee for:

- _____ President (3 year term)
- _____ Director (2 year term)
 - Education
 - Legislation
 - Public Relations
 - Convention & Meetings

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