



FHIMA

Florida Health Information Management Association

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President's Message

September/October 2001

Mario A. Perez, III, RHIA, CCS, CCS-P



As my term of office as president of FHIMA begins to get on track, the furnace of our locomotive Board of Directors and Committees are already in the fueling process for a pioneering, creative and enthusiastic year. As president I am most fortunate and grateful to serve with such dedicated, talented and supportive volunteers. It is they who take full credit for a progressive and evolving organizational infrastructure. You the members the lifeblood, make this infrastructure, viable, your functional role is priceless and the backbone of FHIMA.

This past July, I had the pleasure of attending the 2001 AHIMA Summer Team Talks and Leadership Conference in Chicago, IL, with Sharol Pausal Noblejas and Michelle Mock, your president-elect and chief delegate, respectively. The three of us participated along with other Component State Associations (CSA's) leaders in being oriented to AHIMA's current and future directives, and as well as allowing us the opportunity to express our opinions and concerns from a CSA perspective.

The major AHIMA initiatives to impact the membership are:

(Detailed on the AHIMA web www.ahima.org)

- 2001 Imaging Marketing & Recruitment
 - AHIMA Raising the visibility of HIM
 - Check out the AHIMA web site for 5 eye-catching images you can download.

- Community of Practice (CoP's)
 - Going live on October 2001 at the unveiling at the AHIMA National Convention
 - Update your member profile on the AHIMA web site

- Current National Advocacy Activities
 - Legislative and Regulatory Issues
 - Standards
 - Consistency of Health Care Diagnostic and Procedural Coding
 - Privacy and Confidentiality of Health Information
 - HIPAA Rules
 - HIM Workforce in 2001 and beyond
 - E-Health

- House of Delegate
 - Combination of continuing education units and self assessments

The issues presented and discussed during the AHIMA three-day conference will be presented at our forthcoming 2001 FHIMA Leadership Conference on August 24 - 25, 2001. Your regional presidents and president-elects at the invitation of FHIMA attend this conference. It is our obligation to provide the regions timely and updated information with issues affecting our organization and profession, while at the same time receiving feedback from your elected representatives on how FHIMA can continue to enhance member services.

Every two years FHIMA reviews its strategic plan, and this year we will begin to develop, formulate and complete the organizational strategic plan for 2001 - 2003. Your elected leaders based on addressing member's needs will be instrumental in its design; FHIMA Board of Directors is instrumental in its implementation and you the members instrumental in its perpetuity. This will ensure that our organizational infrastructure continues to evolve with current and future HIM industry trends and assure our members are informed, educated and have provisions for

professional enhancement.

The pioneering spirit is quite evident within our association as we explore the boundaries of a new emerging and evolving HIM professionals and roles, as we technologically and politically chart new frontiers in Health Information Management. I wish to entrust FHIMA to be part of this pioneering spirit, to be a voice, to be involved, to enact change and to conquer what yet has to be discovered. We must ensure a profession and organization worthy of future prospective pioneers.

This year the AHIMA National Convention will be held on October 13 - 18, 2001 in Miami Beach, FL. Irene Tramonte (Irene@codeinrecordtime.com) our AHIMA liaison has been doing a wonderful yearlong effort of coordinating the FHIMA hospitality for this event. Make every effort to attend this convention and join me in volunteering some of your time at the hospitality area to welcome members throughout the country. Your presences as a FHIMA member will advocate our commitment to our association both at the State and National level.

In closing, I share with you this quote by Oliver Wendell Holmes, which in my opinion describes a pioneering spirit:

"Greatness is not where we stand, but in what direction we are moving. We must sail, sometimes with the wind and sometimes against it---but sail we must, and not drift, nor lie at anchor."

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CALLING ALL VOLUNTEERS!



FHIMA MEMBERS & STUDENTS

**AHIMA NATIONAL CONVENTION
OCTOBER 13-18, 2001, MIAMI, FLORIDA**



The AHIMA National Convention will be held in Miami, Florida, October 13-18, 2001. FHIMA members will be hosting the Hospitality Suite. Volunteers are needed to staff this area throughout the convention. Staffing times will be in 2-hour blocks and the area will be manned by at least 2 volunteers per block. If you are interested in volunteering contact Irene Tramonte at Irene@codeinrecordtime.com or Lori Eytel Lucas at fhima@naples.infi.net.



FHIMA SHIRTS FOR SALE!



Don't miss out on purchasing the new FHIMA shirts. The white polo shirts are embroidered with the FHIMA logo and are available for \$28. Show your support for FHIMA and wear them at the AHIMA National Convention in Miami Beach! Click here for an [order form](#).

MID-YEAR 2002

Date:

January 25-26, 2002

Place:

Holiday Inn Select
Orlando International Airport
5750 T.G. Lee Blvd.
Orlando, FL 32822
407-851-6400

Registration Fees:

\$125 Full Registration
\$ 85 One Day Registration

Room Rates:

Single/Double - \$94

For more information, please contact Lori Eytel Lucas, RHIA at fhima@naples.infi.net or (941) 597-1751.

FHIMA ANNUAL CONVENTION - 2002

Date:

June 4-7, 2002

Place:

[Caribe Royale Resort Suites & Villas](#)
8101 World Center Drive
Orlando, FL 32821
407-238-8000

Rates:

Single/Double - \$135
Standard King - \$135

King Deluxe - \$155
 Executive Suite - \$235
 Villas - \$235

For more information, please contact Lori Eytel Lucas, RHIA at fhima@naples.infi.net or (941) 597-1751.

FHIMA LEADERSHIP CONFERENCE



The FHIMA Leadership Conference was held in Orlando on August 24-25, 2001. With 10 regions represented for a total of 28 in attendance. The first day of the conference was spent discussing proposed bylaw amendments to be voted on at the AHIMA HOD. Next, Sharol Noblejas gave a presentation on the FIRE Committee and the AHIMA Image Marketing Campaign. Lastly, Daniel Land presented this year's goals for the Editorial/Electronic Communication Committee. The second day Margaret Stewart, AHIMA Past President, facilitated a brainstorming strategic planning session on developing the FHIMA Strategic Plan for 2001-2003.

2001 FHIMA HOUSE OF DELEGATES ISSUE GROUP RESULTS

*Sharol Noblejas, MBA, RHIA, HCRM
 FHIMA President-Elect*

Four issues were discussed at this year's House of Delegates on June 19th, 2001.

Issue #1 Presented by: Frank Garcia and
 Iliana Magunagoucochea.
 Facilitated by: Pamela Rollins and Julie Shay

Should AHIMA adopt the proposed revisions to the Standards for Maintenance of Certification? How can we enhance the value of our credentials?

The Vision 2006 plan for AHIMA involved designing alternative models for the maintenance of certification. At the 2000 AHIMA HOD, a revised working model was developed. This model combined self-assessment with continuing education. Members with the CCS and/ or CCS-P credential will be required to take a self-assessment worth 5 CE's. Self-assessment will be optional for RHITs and RHIAs. Continuing education would still be required for maintenance of AHIMA credentials. Those individuals with multiple credentials will have the same reporting cycle for

all credentials.

Members will be provided CE credit and have a 2 year reporting cycle.

The discussion group did not feel that the proposed revision to the Standards for Maintenance of Certification should be adopted. They felt that the increase in the CE's required for maintenance of both the AHIMA credential and CCS/CCSP credentials may prove to be cost prohibiting. Employers may also experience a loss of productive work hours as members attend more seminars to gain CE's. As a result, members may choose to drop a credential. Ultimately, a membership drop may also occur. However, the group was in favor of CCS and CCSP to have mandatory CE's. Again, due to cost, those members holding multiple credentials should not increase the number of required CE's.

Suggestions for how to enhance the value of our credentials were as follows:

- Be aware " back door programs"
- Offer to be on advisory committees
- Electronic / Distance Learning effect.
- AHIMA / FHIMA should offer on-line CE's that are less costly
- Increase marketing the HIM profession before "raising the bar"
- Explore lobbying legislature on the importance of HIM credentials.

Issue #2

Presented By: Peggy Meli

Facilitated By: Pat Schnering and Sue Hitchens.

How can we ensure HIM's leadership in the coding industry?

The current coding industry finds many healthcare institutions with the inability to attract and retain credentialed coders. Due to the shortage, poor quality coding education programs are appearing everywhere. Graduates of coding programs are often inexperienced and have difficulty gaining employment. Coders in physician's offices are credentialed by the American Association for Procedural Coding.

This issue group was in agreement that there was fragmentation in the Coding arena. In order to ensure leadership in the coding industry, the following suggestions

were made:

- Keep AHIMA promoting CCS-P CCS website
- Keep the pass rate for coding examination high
 - Keep coding in the HIM department
- Provide education and communicate the importance of coding skills
- Assure the accuracy and quality of coding software
- Remain current on legal reimbursement and compliance
- Explore Starting Coding education in high school
- Educate the community about credentials
- Broaden IS to include Data Quality Managers for coding
- Offer training for Database management education

Issue #3

Presented By: Denise Brimm

Facilitated By: Ashlyn Dellinger and Liz Hurst

How can the regional, state and national associations best work together to serve members?

This year, FHIMA successfully implemented e-Coastlines, the electronic FHIMA newsletter. The group was asked to cite their pro's and con's of electronic communication.

PROS:

Increased access

Users can select what information to view

Increased speed of dissemination of information

CONS:

Some members still do not have access

Do not always remember to go in and read after e-mail prompt

Some members do not get electronic notification of new e-Coastlines due to changes in e-mail addresses.

Recommendations were made to enhance e-Coastlines.

These will be submitted to the Chairman of Electronic Communications Committee.

- Link FHIMA database with AHIMA database so that changes to member e-mail addresses can be standardized.
- Make format more user friendly for printing. Currently selection print will print the entire article section.
- Add table of contents index to left of page

The group also discussed communities of practice. Communities of Practice would act as Chat Rooms for members to build on professional relationships and form a sense of belonging with common experiences. Two members of the House of Delegates had participated in AHIMA's Communities of practice. There was some concern that the information in the COP's may not be accurate. Currently, there are no controls in place to monitor the quality of information. FHIMA has petitioned to become a pilot for a COP.

The structure of the House of Delegates was discussed. The facilitators informed the issue group that Florida is one of the only states left to hold a House of Delegates. In addition, most regions had difficulty-finding delegates. Questions were raised as to how other states make decisions. A recommendation was made to research this issue. The group felt strongly that the current structure of the House of Delegates should be kept until an alternative was found for members to make decisions. A suggestion was made to offer incentives to members to increase participation. Some suggestions were to offer CE's for leadership development and provide hotel and mileage reimbursement.

Issue #4

Presented By: Peggy Beck

Facilitated By: Coleen Buchinsky and Diane Evangelista

How can AHIMA and FHIMA help our members seize the important opportunities afforded HIM by the new privacy regulations?


With the new HIPPA regulations, new opportunities now exist for HIM professionals to serve as privacy officers. However, HIM professionals are not aggressively pursuing these new careers.

Several suggestions were made for AHIMA and FHIMA to

assist its members:

- Share information learned about these regulations with other members
- Educate vendors on how HIPPA will impact their software.
- Take advantage of trade journals
- Implement an electronic communication committee to disseminate information on HIPPA.
- Be persistent with employers about HIM background and experience to monitor HIPPA.

The AHIMA delegates representing Florida this year are: Mario A. Perez, III, RHIT, CCS, Jacquie Jones, RHIA, Michelle Mock, RHIA, Holly Woemmel, RHIA and Sharol Pausal Noblejas, RHIA. Any concerns, comments and suggestions with regards to the proposed dues increased would greatly be of benefits to your representing AHIMA delegates, please feel free to contact us prior to October 13, 2001 as this is when the AHIMA HOD is scheduled to meet.





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HAPPY ANNIVERSARY APC's!!! 😊

OR

HAPPY ANNIVERSARY APC'S!!! 😞

*Kristin Hodkinson RHIT, CPC, CPC-H
APC Coordinator
Orlando Regional Healthcare*

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It has been a little over a year now since the inception of APC's on 8/1/00. How are we doing? Have we survived? For those of us in positions whose responsibility is the 'coordination' of APC's, survival takes on a whole new meaning! There have been several changes and updates since 8/1/00: Removal of procedures from the inpatient only list, addition and deletion of pass-through codes, and more. It can be difficult to get through some of the CMS memoranda. The real challenge, however, lies in knowing where to find the information, understanding the information, and getting it distributed - all in a timely manner.

Here are some examples that facilities are using to meet the challenge of managing under APC's.



Establishing an APC Task Force. This has been the most widely utilized and effective component of APC management. The group consists of representatives from

the following hospital departments: Finance, Billing, Coding, Administration, Ancillary areas (ie. X-ray, Lab, Pharmacy, Surgery), Information Technology, Charge Master maintenance, and Compliance. The group's meeting frequency tends to vary based on facility size. Initially meetings were scheduled weekly, but then tapered off to monthly 'touch base' type sessions. Some facilities have even started meeting on a quarterly basis. Again, your facility sizes and needs, would have to be examined to determine your particular meeting frequency.



Development of the APC Coordinator Position, also called the "Outpatient Revenue Cycle Specialist." This position truly involves every aspect of the hospital's revenue cycle, from knowing the types of products/vendors/supplies on the Charge Master side, to having a thorough background in CPT coding principles and guidelines. Understanding the 'systems side of things' (processes and interfaces) is also a critical attribute to possess. The responsibility of obtaining, understanding and distributing all of the CMS program memoranda lies with the APC Coordinator as well. Monitoring, auditing and education are also key functions of this individual. The APC Coordinator typically reports to HIM, Finance, Coding or Administration.



Creation and/or Implementation of an Ancillary Feedback Tool/Report. There has been a consistent statement made by almost all of the Ancillary departments in the facilities. "We don't know what and/or if we are doing anything incorrectly! We have no feedback from Billing!" (*Be careful what you wish for!*) Some facilities have had to develop their own report in order to identify OCE (outpatient code editor) edits at the front end before the claims hit Billing. However many systems lack a report that would run after both the Abstracting and Charging systems interfaced (e.g. where the supplies/drugs etc. from the Charge Master would combine with the HIM Coded procedures.) The facilities' systems seem to have a report for one or the other, but not for both. The facilities that have created this type of report have benefited greatly. Ancillary departments now have a way to identify charges that need corrective action. The result - "Cleaner Claims" out the door!!



Development of a Charge Management Team. Prior to APC's, the department manager was primarily responsible for maintaining their department's Charge Masters. Not anymore!!! The need for a team of individuals to handle this function, has greatly increased with the

complexity introduced with APC's. This team should be comprised of each department's personnel that are responsible for input and maintenance of charges. The team is responsible for procedures, updates, additions, and deletions related to the entire facility's Charge Master. They develop an action plan to implement the procedures, return to their respective departments to implement the action plan and to educate their peers. This greatly increases the inter-departmental communication within a facility. The result: The Charge Master is updated in a more accurate and timely fashion to ensure proper and timely reimbursement of applicable APC's.



Development of an ER Evaluation and Management Level Charging Tool. In the initial months of APC's, there was little guidance available for creating this new "tool." The CMS put the responsibility on the facilities to develop with their own guidelines, leaving a lot of room for variables. As one Director of Coding stated; "We have been brought up in Coding/HIM to *always* follow the established rules and guidelines. This is a whole new ball game...not being told what to do or how to do it. No Coding Clinic, CPT Assistant or HCFA memo to go by! It's scary, but exciting." The most widely utilized "tool" appears to be a spin-off of the traditional 'Nursing Acuity' levels. Procedures are listed under each specific ER E/M level. The level hierarchy corresponds with the types of procedures rendered to the patient. For example:

99282-Dressing changes, Single X-ray
99283-Heplock, I&D, Breathing Tx

Other facilities have chosen to go with a 'point system,' equating each type of procedure with a point value. For example:


X-ray=5
Venipuncture=3
CT scan=10


The points are then tallied, and a level is chosen based on total score.


99282= 20 points
99283= 30 points


Whatever system your facility has chosen to utilize, be sure there is consistency when assigning ER E/M levels.



Being able to effectively manage your facility under APC's, has no doubt been extremely challenging. However, the benefits have been overwhelmingly positive ones!

 An increase in effective communication between departments. (When was the last time you heard of Compliance, Billing, Coding and Administration sitting in the same room and agreeing??!!)

 Much more education and re-education facility wide.

 Improved feedback mechanisms put into place.

 Better understanding of the entire "Outpatient Revenue Cycle."

Happy Anniversary APC's!!!  or Happy Anniversary APC's???  You decide!

MY TURN, AN EDITORIAL COMMENT - THOUGHTS ON THE REVOLVING INPATIENT CODING CRISIS!

Peggy L. Meli, MS, RHIA



Need a coder at your acute care facility? What kind of bonus will be offered? What's the turnover rate for your coders? How many coders is your facility using from an outsider provider?

In June, at the FHIMA House of Delegates, much discussion once again centered on two areas:

- 1) Today's urgent need for coders in acute care settings, and
- 2) The future for coding as suggested by the Merida Johns, PhD, RHIA, article: "Crystal Ball for Coding."

There was much discussion centering on the American Academy of Professional Coders (AAPC) credentials and the general lack of qualified coders available from the traditional RHIA & RHIT programs. In addition, "new programs" are being offered from Florida's 28 Community Colleges, which provide 111 Certificate programs, including

Coder Specialist. The consensus of the practitioners at the HOD discussion group seemed to be that all of current these educational programs are inadequate to prepare for inpatient coders.

So, what should the acute care facility do for coders? And what does the future hold for coders?

Educators say that the near future (within 10 years) will bring rapid technology change as well as expansion of the nosology/medical vocabularies. In addition, information technology and regulatory requirements will change the way coding will be done in the future. The educators want coders to expand their knowledge of these areas, to expand their knowledge of data, rather than to continue to work at coding medical records. On the other hand, HIM directors and managers are more worried about how to get their records coded and keep the billable record numbers down to an acceptable minimum.

The answer would seem to be to develop more acceptable training programs for coders. How could this be achieved? Previously, I have suggested the possibility of training coders in magnet high schools. It has also been suggested by educators that a special coding tract be offered with our current RHIA and RHIT programs. Additional practical experiences of 6-9 months would have to be negotiated with acute care facilities. Several local acute care facilities near Orlando are offering their own educational training program for coders.

AHIMA must take the lead to answer the needs of the acute health care sector for inpatient coders. Our experience with outpatient/physician coding has taught us the consequences of a slow response to an intense need. In 1988, the AAPS was developed when AHIMA did not respond quickly enough to meet the need for outpatient/physician coder training. It currently has more than 20,000 members. We have worked hard since then to regain our leadership role. The inpatient coder shortage presents us with a unique opportunity to be ahead of the field.

I urge you all talk to our AHIMA Delegates and our FHIMA directors and let them know your personal views. It would be a tragedy if FHIMA and AHIMA miss this opportunity to become the definitive source for inpatient coders. As members of FHIMA and AHIMA, we must call for action now. We must have acceptable training programs for inpatient coders in the near future or we could lose the strength of our inpatient coding specialty.

HOW DO YOU FIND IMA CODER?

*Sharon Boyer, RHIA
Coding Education Coordinator
Orlando Regional Healthcare*



We all want her. She is Ima Coder, RHIA, CCS, CPC-H. She has over fifteen years of experience and expertise in Inpatient and Outpatient coding, can quote all Coding Clinics, CPT Assistants, consistently scores at over 98% on any coding audit and has amazing productivity. Her personality is sparkling, she gets along well with everybody and learns at warp speed. All this, and she is satisfied with \$10.00 per hour. Where is she?

Back in reality, we all realize that Ima doesn't exist as described in the above scenario. There are Ima's with all that experience, but they will cost you considerably more. Some may work for pay in that range, but typically lack the desired experience. The time has come to look at what our expectations are when trying to staff our Coding positions. The competition is fierce and it may seem that there is no end in sight to alleviate the shortage of qualified individuals. Even though many hospitals are offering sign on bonuses, incentive pay and higher salaries, it does not seem to be enough to attract the coders you need.

One option is to simply "grow your own". Many individuals have what it takes to become the coder you need and want, however they lack experience. This is not to say that everyone who wants to be a coder should be one, but let's take a look at the pool of available trainees out there. One advantage of developing your own coders is that you are dealing with "clean slates". You can train them in the way you code for your particular facility. Another advantage is that there simply is not a shortage of people who have the desire to become coders. With a solid prescreening process, the top candidates can be selected for training.

Who are you targeting?



Recent RHIT/RHIA graduates. Most programs offer an excellent foundation in basic coding. In addition,

students have a more global picture of how Coding interacts with other departments.



Graduates of a Technical College/Certificate program. Again, these students have a foundation in coding, as well as some practical experience.



Internal employees (non-Coders). Many Coding Managers have fielded phone calls from other department's employees who want to know how to "get into Coding". These employees provide a great pool of potential coders. A large percentage already has the basic medical knowledge required. They just lack a formal Coding education.



Internal employees (Coders). Some of the Coders that you currently have can do either only Inpatient or Outpatient. Consider using a formal program for cross training.



Community. If you actually have a shortage of applicants for a Coding program, advertise in local trade journals or with health care groups with which you have professional affiliations. Word of mouth from current employees can also direct a prospective student to you. Just be clear on what type of person you are looking for and what basic skills are required.



The person with a GREAT ATTITUDE. The team-oriented person with a positive attitude can make the difference between the person who will succeed at coding and the one who does not.

What skills will be required?

Solid requirements include: Courses in anatomy and physiology, medical terminology, computer skills and a basic understanding of what Coding is. A pre-test should be administered as well as proof of completion of any previous coursework.

How long should your Coding program be?

This should be tailored to your facility's needs and demands. Remember though, learning coding is not a quick and easy process, so be realistic in your timeframe.

A minimum 4-6 months allowing for some flexibility is reasonable. In addition, an extended probationary period to apply the skills learned may be necessary.

How do you begin your program?

First you must get the approval of your administration. Develop the specific criteria needed and an application process. Assign or hire a person dedicated to doing the training and develop a course syllabus. Encourage people to apply. Research what other facilities have done that have worked for them. Determine if these will be paid positions or an "after hours" type of class with the opportunity to be hired after completion of the program. If this is a paid position, will the trainees be required to sign a contract to stay with your facility and for how long? How will you handle the student that is not successful in their coursework? These are questions that need to be answered before you begin.

Developing your own Coding Education program can help you to acquire Ima Coder. In the past, many coders were trained on the job. The trend has moved away from that as regulations increased, coding became more complex, and more was demanded of Coders. Now there are more open coding positions than the current educational system can fill. Perhaps in-house training will be a solution to help keep the coding positions filled in your facility.

CODING RECRUITMENT AND RETENTION

Sonya Waters, RHIT, CCS, CPC-H

Calling all Coders... Where are all the qualified Coders?



Since the implementation of Prospective Payment and cost containment efforts for healthcare, Coders have become one of the most sought after professionals. However, there does not seem to be an abundance of them waiting to fill all the open positions. It's found that more than 75% of all advertisements in HIM publications are for Coding positions. Coders, Coding Technicians, Coding Consultants, Clinical Coders, Clinical Data Analysts, etc. are just a few of the titles these professionals work under.

Coding professionals must juggle their medical/clinical

knowledge set with the coding guidelines, fiscal intermediary requirements, and legislation & regulatory requirements. At the same time they must interpret medical record documentation (including deciphering chicken scratch) for translation and application of correct ICD-9-CM and/or CPT-4 codes. In other words, Coders are required to subjectively accomplish a seemingly objective task. As you know, these codes are then used for statistical data, internal management such as contract negotiations, proposals for new services, revenue forecasting, external reviews, meeting regulatory requirements, and reimbursement.

So where are these individuals with excellent concentration skills who are independent, multi-tasked, detective-like, and flexible? Current HIM and coding professionals must recruit them. We must do more to market the profession, assist in meeting the educational requirements, provide job training, and even "create" the experienced professionals needed to do the job.

We must first communicate with and educate our Chief Finance Officers and Allied Health Recruiters. Get your current HIM and coding staff involved. Not only do nice sign-on bonuses work, but classifying Coding positions as "hard to fill" positions and offering current employees a referral bonus can prove to be a winning combination. This is because the HIM profession is still a very close-knit community. Even across the country, we tend to know who's who in our profession. And odds are, an employee will not recommend someone they wouldn't want to work with. This benefits the employer as this approach can help minimize any potential personnel issues.

Next, network, network, network. Network with your local schools. Schools are producing professionals, but they lack the needed experience. So we need to meet them half way. Affiliations with colleges and offering internships can help to provide the experience needed to take on a full-time coding job. The internships should be comprised of more than just an introduction to the department and staff. It should be comprised of hands-on coding using actual medical record documentation. Start with one body system so that there is concentration on one area before going to another. Also, there should be an experienced Coder, if not the supervisor or manager, whom the intern can buddy with for advice and questions.

Once we have our qualified coders on board, an equal amount of effort must be taken to retain them. It's a given that written policy and procedures must be available. But some mechanism (electronic or paper) for communication should be in place as well. During the initial orientation and anytime as a refresher, make sure Coders see the "big

picture". They should understand how what they do fits into your specific business. Emphasis should be placed on the medical record flow, the revenue cycle, medical necessity, and compliance. You should also have reasonable productivity standards based on your specific work requirements. Be sure provide an atmosphere conducive to getting the job done (limit the distractions). Ensure your coders have up-to-date reference materials including, but not limited to, dictionaries, coding manuals or software, *AHA Coding Clinic*, and *CPT Assistant*.

Coders need continuous education. Efforts must be taken to ensure educational opportunities are always available. External seminars & workshops can be a financial burden. Teleconferences and videoconferences may prove to give "more bang for the buck". Live interaction, however, should not be totally replaced, so bring in an external consultant as a refreshing viewpoint. To help keep the budget in check, invite your internal experts such as specialty nurses, business office manager, compliance officer, staff physicians, etc. to give an inservice at your department meetings.

From a financial perspective, make sure salaries are equitable for the position. Have your Human Resource department conduct periodic local, regional, and national salary surveys. Incentives for performance in quality and/or productivity are a must as well. And just as sign-on bonuses attract new coders, a retention bonus after periodic designated service time frames can make a positive difference in your turn over rate.

And now that we are in the new millennium, consider remote coding or coding from home. Many coders are married with children. Allowing your staff to work from home has the possibility to create wonders. It reduces travel time spent on interstate parking lots, allowing more productive hours in the day. This can lead to many more benefits resulting in a satisfied Coder.

Whether in the office or at home, offering flexible work hours is a must. There is no need for Coders to work 9 to 5, Monday through Friday. As long as productivity standards are in place for a specific time frame (i.e., a week), coding can be done around the clock. So why not have your Coders create a custom schedule?

With the above efforts, your Coding positions are sure to be filled.

Identity Management Strategy: The Key to Accurate Customer Identification and Data Integrity

Tracy L. Peabody, RHIA



As healthcare organizations continue to merge, it's imperative to accurately link the vast amount of clinical, demographic and financial data collected for each customer. In today's competitive healthcare environment, the patient, long the center of the healthcare delivery system, is viewed as customer as they "shop" for the best care at the most affordable prices. The inability of a healthcare provider to consistently identify a customer's entire data record affects both internal and external operations. Quality of care suffers when data integrity is compromised. This results in poor outcomes, threatening licensure and risking legal liability with negative financial impacts. Consequently, it is very important for healthcare organizations to implement a strong and comprehensive Identity Management Strategy that integrates and manages customer data across the whole enterprise.

In order for a healthcare delivery system to be effective, it must be able to accurately and consistently identify its customers over time throughout the entire system. Achieving this goal in today's healthcare environment is particularly challenging because most of the recently merged healthcare organizations were built by merging independent indexing systems that contain disparate and non-standardized data fields. This combination of circumstances is ripe for record duplication; registrars commonly and understandably fail to accurately identify a customer in this setting. For example, Karen Jones registers at the Diagnostic Center in 1999. Then in 2000 after her marriage, she registers at the Outpatient Clinic as Mrs. Karen Thompson. Unable to locate her previous record, a new one is created, automatically fragmenting her clinical history. When she is brought unconscious via ambulance to the Hospital Emergency Room a year later, the staff, unaware that she has records under different names, may miss crucial information from her visit to the Diagnostic Center, thus potentially jeopardizing her care. This is a common case of failed Identity Management.

Most of the newly merged healthcare delivery systems face several hurdles as they attempt to manage their disparate indexing systems. They need to decide how to elevate their independent systems from a single-facility view to an enterprise, data-sharing level. They need to synchronize

their source systems seamlessly, which can be especially difficult in the absence of standardized data and corporate level policies and procedures. .

No matter which path and what priorities they take toward integrating their data (EMPI, CDR, single vendors, or best-of-breed systems), a sound Identity Management Strategy depends on exceptional **file linkage capabilities**. Some vendors have been very successful in linking disparate systems by using a probabilistic linkage method that does not depend on exact-match logic. Instead, the probabilistic model, which is widely recognized as the standard for optimal person linkage, specifies that in addition to the simple agreement or disagreement among attributes being analyzed (name, date of birth, gender, social security number, etc.), the *relative frequency* of those attribute values should also be taken into account. For instance, a match on "Jones" should not be weighted as highly as a match on a less common name like "Seitchek." The most successful vendors take that method several steps further by enhancing their probabilistic linkage algorithms to fit an organization's specific needs, taking into account customized thresholds based on client preferences and risk evaluation.

Healthcare organizations nationwide are beginning to reap the benefits of an effective Identity Management Strategy. Clinical records, billing and research initiatives rely on accurate demographic information for each customer. Denver Children's Hospital recently implemented an enterprise-wide patient identifier initiative. CIO Jim Turnbull explained that "an enterprise-wide and longitudinal view of the patient depend upon accurate patient identification as a *cornerstone of data integrity*." Reliable customer identification capabilities allow for rapid and accurate registrations, thereby improving the quality of care along with customer/staff satisfaction. With careful preparation and planning, implementing a robust Identity Management Strategy will protect and maintain the integrity of customer data to facilitate accurate customer identification.

Part Two of this article reveals how to implement a successful Identity Management Strategy.

Tracy Peabody, RHIA, Madison Information Technologies, Inc, is a member and volunteer of AHIMA and FHIMA. Madison is a leading provider of Identity Management solutions using their ALTA™ algorithms, Web-based Aligndex® EMPI Technology and consulting services. Ms. Peabody served in a variety of management positions in healthcare and has significant experience in the field of Identity Management.

Thoughts from a Compliance Officer...



*Christina Brown, RHIA
Corporate Compliance Officer
Kforce.com*

Could I go to jail? If you are a coder, you may have asked yourself this question. With ever-increasing emphasis on fraud and abuse, you may be concerned that the codes you assign may one day precipitate a visit to your local jail.

What can you do to protect yourself? The answer is simple...documentation, documentation, documentation.

Coding documentation is as important as physician documentation. For example, if a physician instructs you to assign a particular code, you should document the physician's name, date, time and the code that was used, along with any additional comments that describe the situation. If possible, have the physician sign the statement. If the validity of the code is ever brought into question, you would have an explanation of why the code was assigned. This documentation process should be applied to any coding information that you receive from facilities or outsourcing firms.

In a fraud and abuse investigation, you, the coder, could be questioned. Because you do not have any financial gain in the code assignment, you will not be the one going to jail. But your written documentation could be a crucial piece of evidence.

As always, you should code the record to the best of your knowledge. In the decision-making process of correct code assignment, provide assistance to physicians with copies of coding references. It is truly a collaborative effort to ensure compliance with the numerous regulations in force.

S.P.A.C.E. The Final Frontier

*Cyndi Thomas
National Sales Director
Comforce Coding Services*



Did you know there are 8,760 hours in a year? Wow! Almost nine thousand hours each year, and I can't find one hour in my week to clean off my desk! I meant to clean it off last month, in fact I even made a note on my desktop calendar. The problem is that I can't find my calendar under all the clutter and I haven't seen my desktop in weeks. Forget spring-cleaning. If I wait until springtime, I will be buried under an avalanche of sticky notes, phone messages, coding books, folders, paper clips, etc. etc. etc. Maybe it is time for me to take some of those 8,760 hours and make time for getting organized. But where do I start?

Does that sound familiar? Is your workspace such a cluttered mess that you have trouble finding phone numbers or important notes? If you are anything like me you need plenty of room to work, yet you have that nesting instinct to save everything until your desk becomes one giant cluttered mess. Well, by using a unique organizing system that I saw on the Oprah show, I think I have finally found a remedy. The system is based on a clever way to use each letter in the word *space*:

Sort
Purge
Assign
Contain
Evaluate

The first step is to *SORT*. This will be the hardest and most time consuming step in the process. But fear not, the results are well worth the time. In order to *SORT*, you must touch every piece of paper and item on your desk and make a determination of its identity and necessity. In other words, ask yourself "What is this? Do I really need it?". If you are a nester, this will be a challenge because nesters believe that they need to keep everything. They believe that the broken orange pencil from the 1997 AHIMA National Convention will come in handy one day. Perhaps that two-month-old phone message is really important. They know the email they printed about the HIPAA guidelines will make sense soon. After determining an item's importance, make piles of like items and keep only the items you need. The operative word here is *NEED* not want. Keep only the items that you need for work and *PURGE* the rest.

That is step two, *PURGE!* For the organizationally challenged, this means to throw away, to toss out, to put

in the garbage, to get rid of. This is where the meek are separated from the mighty. Don't let yourself be controlled by the clutter. If you need help at this stage, enlist the help of some coworkers. Get rid of anything that you do not currently use, need, or have space for. Throw it away.

Step three is to *ASSIGN*. Everything that you have decided to keep must fit into a category. In Step 1, you made piles of the like items on your desk. For example, one pile might be loose paper. Take that pile, then organize the papers into specific categories. For example, group all the meeting notes for one specific project together. Professional journals and magazines should be grouped together. Get the picture? Chances are that you will have five or six main categories of items, and an untold number of subcategories, if you are a real nester. Try to reduce the number of subcategories by merging them into main categories.

You are now ready for the next step: *CONTAIN*. This is where you get all of these items off your desk and into brand new homes. Papers belong in file folders that are clearly labeled. File folders belong in desk drawers or a file cabinet that is arranged in a system that works for you. I like the green pendaflex folders that hold several manila folders. Phone numbers belong in rolodexes, phone logs, or, if you are computer literate, put them in a computerized phone book. No more little scraps of paper to get lost. Pens, pencils and paperclips are easy to contain with small drawer dividers or plastic bins. Tape, scissors, staplers and other desktop items can also fit into plastic bins that fit nicely into desk drawers. Professional journals should be stored in boxes or on bookshelves. Many department stores carry lines of organizers designed specifically for periodicals that fit neatly onto a shelf. My advice is to get as much as you can off your desktop and into an assigned container or place of its own.

The final step is to *EVALUATE*. Only you can decide if the system you have just developed works for you. Take a week or two and determine if the filing system meets your needs. Make changes if you need to. For example, you may find that you still collect phone numbers on scraps of paper, creating new clutter. It is time to re-evaluate. I suggest that you use a single sheet of paper called a "phone log". At the end of each day, transfer any important numbers from the scraps of paper onto this log. Throw away the scraps immediately. Soon you will get into the habit of eliminating the small pieces of papers on your desk by writing the numbers directly onto the log sheets. This method worked for me, but it took some getting used to. I now have eliminated all the small sticky notes that would clutter up my desk and start me down

the clutter road. I can actually find things with relative ease.

Once you can finally see the desktop, and all of your papers are in user friendly files, don't get too comfortable. Some people have a nesting instinct that makes them want to create clutter again. In order for this system to work, at the end of each day you must conduct a mini S.P.A.C.E. session. Before you leave for home, make sure you sort everything on your desk into like categories, purge the items you don't need, assign any new categories, contain the items into folders, drawers or bins, and evaluate how the system is working. This will soon become a routine. Your workspace will be transformed from rubble heap to clutter free, sending the message to everyone that you are organized. Good luck!

Cyndi Thomas is a freelance writer and works for Comforce Coding Services as their National Sales Director for contract coders nationwide. You may reach her at codecyndi@msn.com or toll free 866-302-4678.

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September/October 2001

AHIMA 2001 Annual Convention

AHIMA's 73rd Annual National Convention and Exhibit is scheduled for October 13-18, 2001 in Miami Beach, Florida. For registration information just go to AHIMA's website at www.ahima.org.

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AHIMA Testifies for ICD-10

AHIMA was honored to be the first group to testify in May to the ICD-9-CM Coordination and Maintenance Committee on implementation issues concerning ICD-10-PCS (procedural coding system). "The replacement of ICD-9-CM, Volume 3, with a new procedural coding system for inpatient services is absolutely necessary and ICD-10-PCS meets the criteria for such a replacement system. The ICD-10-PCS implementation question is not separable from that of ICD-10-CM. While this requires further study, our judgment is that the two systems should be implemented at the same time." said Linda Kloss, MA, RHIA, AHIMA's executive vice president and CEO. Kloss also noted that "any system adopted as a single procedural coding system must have the complete support and commitment of all federal and private health insurance programs and providers identified in the Health Insurance Portability and Accountability Act [HIPAA]. For a copy of AHIMA's testimony, go to AHIMA's Web site at www.ahima.org.

HIPAA Legislation

New legislation to delay and coordinate HIPAA compliance dates was introduced by Senators Craig, Dorgan, and Crapo. Supported by the Blue Cross/Blue Shield Association, the legislation delays compliance dates to October 2004, or 24 months after all HIPAA regulations have been issued. The legislation calls for a report by the Comptroller General on the effect of HIPAA on "health plans, healthcare providers, the Medicare and Medicaid programs, and the Department of Health and Human Services."

Federal Grant Proposed for Hospitals, SNFs

Senators Graham and Snowe have introduced legislation to establish a federal grant program for hospitals and SNFs to upgrade their information systems to combat medication errors. Between 2002 and 2011, the legislation would annually make \$93 million available to hospitals and \$4.5 million available for SNFs. The funds would be used to purchase automated medication order entry systems and computer-based patient record training. For a copy of the legislation, go to the Library of Congress Legislative Web site at <http://thomas.loc.gov>

National Health Information & Technology Week

When:

November 4 - 10, 2001

Theme :

National Health Information & Technology Week:
"Celebrate, Innovate, Educate"

Materials Available:

AHIMA's free HI&T Week planning kit includes: a fact sheet; event ideas; information about commemorative merchandise; a press release; a logo sheet; and a presentation on timely topics HIM professionals can adapt and use.

For More Information:

To request an HI&T Week planning kit or for more information, contact AHIMA at 312/233-1100 or visit the association's Web site at www.ahima.org/hitweek/

Upcoming Audio seminars:

September 11, 2001, Industry Trends: Learn the Lingo and

Understand the Hot Topics

September 20, 2001 - Clinical Update--Coding for Laboratory Services, presented by Betty Hatten

September 27, 2001 - E/M Preventive Medicine Coding presented by Deborah Neville and Elizabeth Contant

October 3, 2001, @ 12:00 - 1:30 pm CST, "DRGs and ICD-9-CM Coding Changes for 2002", Sue Prophet, and Co-sponsored with Dornfest: Information Technology in Focus, a new audio seminar series brought to you by AHIMA and Dornfest Associates

October 4, 2001 - Advanced E/M Coding and Compliance Issues under APCs presented by Lolita Jones

October 9, 2001, The Medical Records Problem: How Can Technology Help?

October 11, 2001, Application of Procedural Principles from CPT Assistant presented by Joan Zacharias

October 25, 2001, ICD-9 Coding Changes presented by Lizabeth Fisher

November 13, 2001, The Right Way to Purchase Technology: Evaluation, Selection, Negotiation, and Implementation

Reminder:

Please keep your AHIMA contact information current, either by updating your member record on-line via the AHIMA (enter your member record via the AHIMA Web site) or by notifying our customer service team phone 312-233-1100;
[email info@ahima.org](mailto:info@ahima.org).

Contacting AHIMA

For general queries, email info@ahima.org. For professional practice questions, go to the AHIMA Online practice forums at <http://www.ahima.org/bibs/index.html> or send email to: proprac@ahima.org.

If you'd like to update your mailing address or email address, include your full name, member ID number and your new information - send to: info@ahima.org. For general questions, contact [AHIMA Online](#).