CHAPTER 1

Introduction

ANSWERS TO KNOWLEDGE-BASED QUESTIONS

1. What are some of the changes that have affected hospitals during the twentieth and twenty-first centuries?

**Answer:**

* Increases in hospital costs
* Medicare, Medicaid, and CHIP
* The emergence of health maintenance organizations
* Shifts from independent to network health care providers
* Technological advances in both health care and information management
* Development of a Nationwide Health Information Network (NHIN)
* Average age of the U.S. population is increasing, hence more associated chronic illness
* Shifts from inpatient to other care settings
* Prospective payment systems for most settings
* Legislative changes
* Increased focus on quality of care and pay-for-performance initiatives
* Increased focus on Medicare and Medicaid fraud, abuse and waste
* ICD-10-CM and ICD-10-PCS adoption

Students may also mention that voluntary accreditation began during the twentieth century. They may also note changing patterns in inpatient admissions, such as increasing inpatient admissions during the first part of the twentieth century followed by a reduction in inpatient admissions as care shifted from the inpatient to the outpatient setting.

1. How have payment issues affected health care delivery?

**Answer:**

The implementation of Medicare and Medicaid in 1966 combined with ever-increasing hospital costs helped spark a shift from the standard fee-for-service payment plan to the Medicare prospective paymentsystem, enacted in 1982. Also, Medicare payments to hospitals switched from a per diem basis to a per case basis. With the emergence of HMOs, other payment models, such as capitation, have become a larger factor in health care financing.

Both prospective payment and capitation discourage lengthy hospital stays and excessive services, since the number of services or days of care rendered increases costs without increasing reimbursement. These payment changes have been a factor in decreasing inpatient lengths of stay and in the shift from inpatient to other care settings.

Between 1998 and 2002, prospective payment system (PPS) regulations were implemented for most non-acute settings in which Medicare provides funding. Skilled nursing facilities, hospital outpatient services, home health, inpatient rehabilitation settings, and long-term care hospitals now receive payment based on various PPS mechanisms. PPS methods are under consideration for other settings as well.

A heavy emphasis on compliance issues, improper payments, fraud and abuse has increased the need for precise documentation and coding. Reduced or denied payments can result from inaccurate claim submissions.

A national trend toward incentive-based and pay-for-performance reimbursement models is challenging providers to accurately and completely document the care and services provided in order to maintain adequate reimbursement. This trend is “raising the bar” for the quality of health care services provided.

1. What is fee-for-service payment?

**Answer:**

It is a method of payment for health care in which the health care provider charges and is paid for each item of service provided.

1. What is a per diem payment?

**Answer:**

It is a payment rendered to an institution based on the number of days of service provided.

5. What is pay-for-performance?

**Answer:**

Reimbursement is becoming more closely tied to quality outcomes with the emergence of pay-for-performance (P4P) systems. These incentive-based programs reward or penalize providers based upon their ability to meet pre-established targets for delivery of health care services. Growth of P4P programs is evident within Medicare and Medicaid, as well as private health insurance and managed care companies.

6. As a general rule, what is the basis for payment in a health maintenance organization?

**Answer:**

The general basis for payment in HMOs is the capitation model, in which the health care providers are paid based on the number of patients they agree to treat rather than on the number of services they provide.

7. Explain the administrative simplification provisions of HIPAA.

**Answer:**

There are three major components of the administrative simplification provisions of HIPAA — electronic data interchange (EDI), privacy, and security. EDI is further subdivided into components related to electronic transactions, code sets, and identifiers. Each component of HIPAA has its own regulations and these regulations have been implemented in phases over a period of several years.

The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health information technology. Subpart D amends the HIPAA privacy and security rules by introducing additional privacy regulations, breach notification rules and stiffer civil and criminal penalties for security violations.

8**.** What is the patient-centered medical home model?

**Answer:**

It is a method of delivering health care that addresses preventive, acute, and chronic care needs by having the primary care physician act as a “gatekeeper” to coordinate the patient’s care across providers.

9**.** What impact have the changes in health care had on the health information manager?

**Answer:**

The changes in health care have increased the employment and consulting opportunities available to health information managers. As health care has become more data driven, health information managers who can design, implement, and maintain systems for effective data collection and analysis play a vital role in the provision of high quality, cost effective health care. A shift toward “virtual departments” will require health information management professionals to manage remote employees.

10. Into what health care settings other than hospitals have health information managers moved?

**Answer:**

Ambulatory care facilities, health maintenance organizations, home health care agencies, hospices, dialysis facilities, long-term care facilities, rehabilitation organizations, facilities for the mentally retarded or developmentally disabled, mental health facilities, treatment centers for substance abuse, correctional facilities, dental clinics, and veterinary clinics. Regional extension centers (REC) offer HIM professionals non-traditional opportunities in care settings not directly tied to delivery of patient care.

ANSWERS TO CRITICAL THINKING QUESTIONS

1. How can the health information manager contribute to improved data quality in a variety of settings?

**Answer:**

The health information manager has knowledge and skills that can contribute to improved data quality in any setting. For example, knowledge of systems, policies, and procedures for data collection can be used in many settings to improve the processes by which data are compiled. Health information managers also have knowledge of coding principles that can be applied in many settings. Health information managers can educate caregivers regarding good documentation practices, which can improve the patient record—the source of health care data. Health information managers are also cognizant of the important uses of the data being reported to third-party payers and other agencies. This awareness provides incentive to implement quality improvement processes to assure that accurate data are being reported for the health care facility.

1. Describe common concerns with regard to health information management in health information exchange, telemedicine, and the longitudinal patient record.

**Answer:**

All three of these systems require transmission or linkage of patient information. Therefore, concerns applicable to all three relate to the accuracy and security of the data being transmitted or linked. The use of appropriate technology and the implementation of effective policies and procedures are necessary to prevent unauthorized access to data. Likewise, producing accurate information from transmitted or linked data requires compatible data structures, technology, and procedures that can accurately handle data from diverse sources. The administrative simplification provisions of HIPAA and the HITECH Act should facilitate data exchange in a private, secure manner.

1. Select a health care setting other than a hospital. What would you expect the similarities to be between the role of the health information manager in a hospital and in one of the other health care settings? What would you expect the differences to be?

**Answer:**

Student answers to these questions may vary depending on the setting selected and the background and experience of the student. Since none of the settings have been

described in detail yet, student answers simply may be guesses. Sample responses follow, but this listing is by no means exhaustive.

Procedures for filing and storage of records in **ambulatory care** may be similar. Record activity will follow a different pattern since documentation is completed for an encounter or a visit rather than for a hospitalization. CPT coding plays a larger role in ambulatory care. Analysis procedures will likely be different. Types of statistics kept will be different. Reimbursement systems are different for ambulatory care.

In considering **health maintenance organizations**, remember that many different types of facilities are included in such organizations, so there are many possible features that could be mentioned. One would expect that patient record documentation in an HMO hospital would be similar to documentation in other hospitals. However, the emphasis on prevention of disease may lead to forms and systems that carefully monitor preventive strategies, such as immunization tracking systems. HMO reimbursement systems are different from those of facilities relying more on traditional indemnity insurance payments. Data analysis may be an important responsibility of the health information manager in an HMO.

**Home health agencies** provide care to patients in their places of residence. The patient record, therefore, must be “portable.” Electronic data entry by caregivers would more likely be accomplished with a portable wireless device, such as a notebook computer, whereas in a hospital, the caregivers often use workstations connected to a network for data entry. As in all settings, documentation of orders and services performed is important both for quality of care and for reimbursement. Physician documentation is important in developing and reviewing the plan of care, but otherwise, home health records include less physician documentation than hospital records. Health information managers may be involved in implementing systems to monitor quality of care and of documentation. Telehealth technologies may be used to remotely monitor the patient’s condition, so the health information manager may provide consultation for the documentation, storage and reimbursement of such services.

A **hospice** provides care to terminally ill patients and their families. Record content includes information not only on physical conditions and medical or nursing care rendered, but also on psychosocial issues—not just of the patient, but also of the family and significant others. Volunteers and pastoral counselors play an important role in hospice care; thus, documentation of their participation is important. Documentation of aggressive, curative therapies will be absent from hospice records, since these are not used in hospice treatment. Hospices are required to follow the patient’s family after the patient’s death, so hospice records continue their documentation throughout the bereavement period. Hospice reimbursement is based on a unique per diem method.

The length of stay in **long-term care facilities** would naturally create differences in health information management functions. For example, waiting until discharge to analyze a record for deficiencies would be impractical, since problems discovered could be several years old and impossible to correct. Also the volume of the record would make it impossible to keep the complete record at the nursing unit. Therefore, records on the units are thinned at appropriate intervals. Long-term care facilities are highly regulated; therefore educating caregivers and others about good documentation practices that meet all regulatory requirements is important. The professional health information manager often works in a consulting role in long-term care, although some facilities do employ credentialed health information practitioners on a full-time basis.

**Dialysis facilities** treat patients with end-stage renal disease. Patients come for treatment several times each week, often for many years, so records can be quite voluminous. Because all patients are undergoing similar treatment, the forms contained in each record will be very similar. A dialysis facility may contract with a health information manager on a consulting basis to help provide advice and education for those documenting and maintaining the patient records.

A **rehabilitation organization** is concerned with improving the patient’s function. Therefore, outcome measures that demonstrate improvement are very important in rehabilitation. The health information manager may be involved in developing forms and systems to capture the necessary data to provide information on outcomes. Record storage and retrieval systems generally are similar in rehabilitation facilities and acute care hospitals, so the health information manager’s role in this regard would be similar in both types of facilities.

**Facilities for individuals with mental retardation or developmental disabilities** are concerned not only with providing health care, but primarily with providing education and training for clients to help them gain skills and abilities to live more independently. Therefore, record content will include a great deal of information relating to activities in the plan developed to build the individual client’s skills. Because of the length of time most clients are involved with the facility, the records can be quite lengthy. In addition, training activities take place in a variety of different physical locations around the facility, so developing systems to store and maintain the record would be important concerns for the health information manager. Also, collecting data to demonstrate the level of service required by the clients and their improvements in adaptive function are part of the role of the health information manager.

In **facilities for mental health and treatment of substance abuse**, confidentiality of patient information is tightly guarded. Often special rules for release of information apply in these facilities. Record storage, retention, and retrieval principles are similar to those of the acute care facility.

In **correctional facilities,** basic health information management principles apply. Differences depend on the types of health services offered by a particular correctional facility. Some correctional facilities may offer ambulatory services only, whereas others may have their own hospitals. Telemedicine is used by some correctional facilities, and in these settings, the health information manager may be involved in issues related to transmission of information, such as security of information.

**Dental clinic** records contain some different types of content from acute care facility records. A complete health history is important to the dental practitioner, but the examination is usually limited to the oral cavity. Specialized forms are used to capture data about the patient’s dental health.

**Veterinary clinic** records are different in that the patients are animals and the clients are the animals’ owners. Also, coding systems are different for veterinary health information. Although pet health insurance is available, clients usually pay directly for health services, so issues related to third-party reimbursement are not usually of major concern to the health information manager. Employment opportunities for health information managers in veterinary health care are often found in veterinary teaching facilities.

CASE STUDY

Kerry Kaiser, RHIA, is Getwell Hospital’s HIPAA privacy officer and the chair of its HIPAA Compliance Committee. The committee is concerned with all aspects of HIPAA compliance, including transactions, privacy, and security.

SUGGESTED RESPONSES TO THE CASE STUDY

1. What items might the committee’s agenda include in each of these three areas?

**Answer:**

With regard to transactions, the committee may discuss electronic billing issues and how electronic transactions are working with various payers. The committee will need to address the adoption of ICD-10 codes and upgrade their transaction standards for processing electronic claims. With regard to privacy, the committee will develop and monitor institution-wide policies and procedures to meet the privacy requirements of HIPAA. The committee may also review instances of possible privacy violations that have been reported to the HIPAA privacy officer. The committee will also develop and monitor institution-wide policies and procedures relevant to security issues. The results of security audits and/or “walk-throughs” may be reported to the committee. The committee may also conduct a security risk analysis to discover areas of potentially weak security. The agenda might address the organization’s plans to ensure compliance with additional requirements mandated by the HITECH Act and the breach notification regulations.

1. Where might Kerry find resources to assist the committee in carrying out its duties?

**Answer:**

The CMS web site (http://www.cms.gov/home/regsguidance.asp) has numerous resources regarding all aspects of HIPAA administrative simplification. Similarly, the Office of Civil Rights (http://www.hhs.gov/ocr/privacy/) offers a wealth of information on HIPAA privacy. The American Health Information Management Association (www.ahima.org) provides information on HIPAA issues and offers several HIPAA related communities of practice for its members. The Healthcare Information and Management Systems Society (HIMSS) also provides helpful resources (www.himss.org).

**Highlights from AHIMA Competencies and Knowledge Clusters**

I. Domain: Health Data Management

Chapter 1 provides an introduction to prospective payment systems and federal health care programs.

II. Domain: Health Statistics, Biomedical Research and Quality Management

Regulatory quality monitoring requirements are introduced in this chapter.

III. Domain: Health Services Organization and Delivery

A historical overview of organization of health care delivery in the United States is provided along with selected legislation and federal initiatives, including HIPAA, ARRA, HITECH and their implications for privacy and security.

IV. Domain: Information Technology & Systems

This chapter introduces the learner to health information exchange, telehealth, personal health records, electronic health records, regional extension centers, and so on.

V. Domain: Organizational Resources/Organization and Management

Background information for understanding the move to prospective payment systems is provided. This also provides a background for understanding the revenue cycle of a health care provider. The chapter mentions the role of ARRA in workforce development.