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C H A P T E R 2

Hospital-Based Ambulatory Care

ANSWERS TO KNOWLEDGE-BASED QUESTIONS

1. What has been the trend in the utilization of hospital-based services? What factors help to account for this trend?

   Answer:

   The use of hospital-based ambulatory services has increased dramatically in recent years. Advances in medical technology and changes in reimbursement systems that encourage delivery of care in the least costly setting are the driving forces behind this trend. Other trends include the utilization of hospitalists to care for hospital inpatients. Programs linking quality of care and payment are a recent trend. Acceleration in the adoption of electronic health records is

occurring, partly because of ARRA incentives. Increased numbers and scope of auditing initiatives represent a trend linked to cost savings programs for Medicare and Medicaid.

2. List and describe five different types of outpatient services.

   Answer:

   - ambulatory surgery services—surgical procedures performed on an outpatient basis

- emergency care services—emergency care in which the patient is treated and released
- observation services—services provided by a hospital that involve the monitoring of patients on an outpatient basis to determine if inpatient care is needed
- ancillary services—testing services provided by the hospital on an outpatient basis
- partial hospitalization program—an intensive treatment program in which patients receive services for part of each day. These patients would otherwise require inpatient psychiatric care.

3. List and describe three different types of hospital outpatients.

   Answer:

   - clinic outpatient—an outpatient treated in an organized clinic of the hospital in which hospital staff evaluate the patient and manage his or her care
   - referred outpatient—an outpatient who is referred to the hospital for specific services such as laboratory or radiology examinations
   - emergency outpatient—an outpatient evaluated and treated in the emergency department of the hospital

4. What organization accredits the majority of hospitals in the United States? Which accrediting organization most recently received "deeming authority" from CMS for its hospital accreditation program?

Answer:

The Joint Commission accredits the majority of hospitals in the United States. DNV Healthcare most recently received "deeming authority" for hospitals for its National Integrated Accreditation of Healthcare Organizations (NIAHO) program.

5. What key components must both inpatient and outpatient records contain in the documentation of surgery?

Answer:

The record of a surgical patient includes a history and physical examination report, an operation report, anesthesia records, postoperative recovery notes, and pathology reports when appropriate.

6. What are the key issues with regard to documentation of services rendered by teaching physicians?

Answer:

For health care rendered in a teaching hospital, physician fee schedule payment is made only if documentation reflects that the teaching physician was present during the key portion of any service or procedure for which payment is sought.

7. What is the hospital chargemaster or charge description master?

Answer:

The chargemaster, also called the charge description master (CDM), is a comprehensive listing of code numbers and associated charges for services

provided to hospital patients such as procedures performed by care providers and professional staff, room and board, laboratory testing, radiological imaging, drugs, medical equipment, and supplies used by the patient.

8. What are DRGs? What are APCs?What is their impact on hospital reimbursement?

   Answer:

   Both diagnosis-related groups (DRGs) and ambulatory payment classifications (APCs) are groupings of cases or services that are similar clinically and in consumption of hospital resources. DRGs are the unit of payment for Medicare inpatients and APCs are the unit of payment for Medicare hospital outpatients. The hospital receives one DRG payment per inpatient stay, but can receive multiple APC payments for services rendered during an outpatient encounter. DRGs are now called Medicare-Severity DRGs (MS-DRGs).

9. What coding systems are used in hospital-based care?

   Answer:

   Health information services generally assign the latest version of ICD, HCPCS Level I (CPT), and HCPCS Level II codes. Revenue codes are usually assigned automatically by the chargemaster.

10. What is EMTALA?

    Answer:

    EMTALA is the Emergency Medical Treatment and Active Labor Act—a

federal law that imposes a legal duty on hospitals to screen and stabilize, if necessary, any patient who arrives in the emergency department. The purpose of EMTALA is to prevent the "dumping" of patients who may not be able to pay for emergency department services.

11. What is ARRA?

Answer:

The American Recovery and Reinvestment Act (ARRA) is a federal law passed in 2009 that, among other things, created an incentive program for health care providers to utilize EHRs for improved patient care.

(Note to the instructor: The chapter discusses the proposed rule to identify "meaningful use" for the purpose of the EHR incentive program. The final rule for Stage 1 "meaningful use" was published July 28, 2010, and is available at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf. The instructor should also note that in this final rule, CMS announced plans to publish Stage 2 criteria by the end of 2011 and Stage 3 criteria by the end of 2013. These dates have been amended. An instructor who wishes to provide the latest information to students on meaningful use should monitor professional publications and CMS for information on the gradually increasing requirements for "meaningful use"). A helpful site is www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html

12. What factors should be considered to avoid legal risk in hospital-based care?

Answer:

There are many factors that should be considered, so students may provide a variety of answers. (See the "Risk Management and Legal Issues" section of the chapter for details.) However, one key point that should be made is that legible, complete documentation is essential in all areas of the hospital. Using outpatient services as an example, documentation of all services including telephone contacts is important. For example, after ambulatory surgical procedures, a properly documented follow-up telephone call verifies that the patient was given correct instructions and provides evidence of the patient's condition after surgery. A follow-up phone call can be a good public relations tool as well, which is also an important element in risk management.

13. Describe various roles of the HIM professional in hospital-based care.

Answer:

There are many roles that an HIM professional may take in hospital-based care. There are traditional roles in Health Information Services as well as nontraditional roles in other areas of the hospital. An HIM professional could serve as a compliance officer or serve on the compliance staff to make sure that the hospital is meeting various legal and regulatory mandates ranging from coding and billing issues to HIPAA compliance.

The HIM professional could be involved in a position related to the hospital's revenue cycle. There are a variety of roles in this category, including supervision of chargemaster maintenance, clinical documentation improvement, charge capture analyst, or working with various software applications that move

the revenue cycle along.

Other possible roles include performance improvement, utilization management, and medical staff services, to name a few.

ANSWERS TO CRITICAL THINKING QUESTIONS

1. If The Joint Commission requires that "the hospital initiates and maintains a medical record for every individual assessed or treated," what factors allow a hospital to maintain minimal data, such as test results in the case of some referred outpatients?

   Answer:

   A referred outpatient is not assessed and treated by the hospital. The physician who referred the patient is responsible for the assessment and treatment of the patient, not the hospital. However, the hospital must maintain orders for every test performed and must have sufficient information regarding the patient's diagnosis and/or signs and symptoms to justify the medical necessity of the services provided.

2. Select two of the three hospital accrediting organizations mentioned in this chapter, and write a brief essay comparing and contrasting the two organizations that you selected. Use outside resources, if necessary, but remember to think critically and avoid relying heavily on marketing or promotional information.

   Answer:

   The three accrediting organizations from which students may choose are The

Joint Commission, the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association, and DNV Healthcare, Inc. (National Integrated Accreditation of Healthcare Organizations). Examples of points that students may include in their essays are as follows:

All three organizations have deeming authority to certify that hospitals meet the federal *Conditions of Participation for Hospitals*. If the students have done further research, they may find that DNV Healthcare, Inc. is a tax-paying entity organized as a foundation, and that The Joint Commission and the HFAP are tax-exempt. The vast majority of hospitals are Joint Commission accredited, whereas the number of hospitals accredited by HFAP and DNV is much smaller. Joint Commission and HFAP provide on-site surveys every three years, whereas DNV surveys hospitals on site annually. Joint Commission and HFAP standards have evolved over many years. DNV utilizes international standards based on the ISO 9001 quality management system requirements. Both The Joint Commission and DNV have international accreditation or certification branches, whereas HFAP is focused on U.S. health care providers. The Joint Commission and HFAP offer certification or accreditation to various health care providers other than hospitals. DNV offers certification programs to other industries, including energy, food and beverage, maritime, oil and gas, automotive, aviation, and finance, to name a few. The Joint Commission and HFAP are based in the United States, whereas DNV is based in Norway.

CASE STUDY

Grace Greene, RHIA, has been offered a leadership position at Greater Good Hospital to assist in improving the hospital's revenues. The hospital recognized that her knowledge and experience in coding and clinical documentation would be valuable in this effort, but these are not the only skills that will be needed to fine-tune the hospital's revenue cycle. Recognizing that many components of the revenue cycle and that many hospital departments have a role to play, what are some of the processes that Grace and her team should examine in assessing where the hospital currently stands and in looking for possible areas of improvement?

SUGGESTED RESPONSES TO THE CASE STUDY

Answer:

Grace and her team will need to examine all processes that are a part of the revenue cycle. Starting at the beginning, accurate information about the patient's name, address, contact information, insurance, and other identifying information must be obtained from the patient or others and entered into the hospital's information system when the admission or encounter is scheduled. Electronic verification systems are available to verify the patient's insurance status. If precertification is required, the hospital must ensure that it has been obtained. If the stay or encounter is for a noncovered service, the patient must be notified of this and be made aware that the bill will likely be his or her full responsibility.

The hospital needs to be aware of the expected length of stay for the patient's condition and may use case managers and/or performance improvement techniques to help make sure that the care follows an efficient and effective path

and that timely arrangements are made for the patient's discharge when appropriate. Grace and her team may want to establish a clinical documentation improvement program to make sure that all of the necessary documentation is completed to justify the medical necessity of the services provided and to enhance the accuracy and completeness of the diagnosis and procedural codes submitted to the payer. After the patient is discharged or the encounter is over, the health information services area will need to supply accurate codes in a timely manner to avoid a large backlog of unbilled cases. Accurate coding requires good documentation and timely transcription of dictated reports, so these processes may need to be examined. Codes that are generated by the chargemaster may need to be reconciled with codes assigned by Health Information Services. The chargemaster also needs to be up to date and accurate. Claims need to be scrubbed before they are submitted to the payer so that the hospital is confident that it is submitting clean claims that are less likely to be denied. This involves running the claims through internal audits and tracking and reporting failed audits.

After the bill is submitted to the payer, the hospital needs to follow up on denied claims and resubmit or appeal denials as appropriate. The hospital also needs to monitor whether or not the payer is paying according to their contract with the hospital. Patients either pay up front or are billed later for their deductible amounts and copayments—the portion of the bill for which they are responsible. Follow-up on patient debt is part of the revenue cycle and monitoring the level of bad debt is a component of managing the revenue cycle.

Monitoring performance in the preceding areas can be accomplished by

collecting data on various measures in each department. Grace may want to set up a revenue cycle committee, with representatives from all relevant departments, that meets monthly to discuss the various performance measures. Areas of improvement can be targeted and action plans can be developed to address problem areas. Ongoing monitoring and continuous improvement should be the goal.

Highlights from AHIMA Curricular Competencies

I. Domain: Data Content, Structure & Standards (Information Governance)

Chapter 2 describes the type of care provided in hospitals including inpatient short-term acute care, hospital-based ambulatory care, observation services, partial hospitalization programs, and long-term acute care. Chapter 2 presents a generalized discussion of documentation in the hospital record along with the accreditation standards and federal regulations affecting documentation and information management in the hospital setting. Classification systems including ICD, CPT, HCPCS, and coding edits is discussed. The impact on hospitals of national health information initiatives such as those found in ARRA is presented.

II. Domain: Information Protection: Access, Disclosure, Archival, Privacy & Security

Chapter 2 addressed risk management and legal issues in hospitals. Potentially compensable events, policies, and procedures instituted to identify risk areas within the health care organization are discussed.

III. Domain: Informatics, Analytics, and Data Use

The flow of the patient's record from registration to discharge is provided. The purpose of the master patient index and its uses is included in Chapter 2. The electronic health record is detailed including the relationship between the EHR and ARRA. Chapter 2 provides details about meaningful use of electronic health records. (See the *Federal Register* for final rules for Stages 1, 2, and 3 of "meaningful use" as they are published.) The chapter introduces data sets, specifically UHDDS, UACDS, and DEEDS. Voice recognition technology and HIPAA eligibility transaction systems are also described in this chapter. The chapter provides an overview of quality management issues, including CMS data quality reporting requirements for hospital inpatients and outpatients. Utilization and resource management in the hospital setting as well as risk management and case management are also covered.

IV. Domain: Revenue Management

Chapter 2 covers reimbursement issues for hospital inpatient and outpatient care as well as for long-term acute care. The following topics are covered in this chapter: Chargemaster or CDM, DRGs, MS-DRGs, Medicare, MACs, Medicaid, IPPS, OPPS, APCs, MS-LTC-DRGs, LTCH PPS, Uniform Bill, along with the Health Insurance Reform: Modifications to the HIPAA Electronic Transaction Standards Final Rule, and Revenue Codes and the HIPAA Eligibility Transaction System. The purpose of revenue codes and

how these codes are used for billing and reimbursement is presented.

V. Domain: Compliance

The chapter provides information regarding hospital-wide performance improvement programs. CMS reporting programs (IQR, HOP QDRP) are presented in this chapter. The role of health information in compliance, including HIPAA compliance, is discussed. Payment systems including PPS, DRG, MSDRG, Medicare, Medicaid, and commercial insurance are presented in Chapter 2.

VI. Domain: Leadership

Chapter 2 introduces the Emergency Medical Treatment and Active Labor Act (EMTALA). Roles that an HIM professional can acquire in hospitals are presented in detail.