LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

FOCUS

The Quarterly Newsletter for Physician Office Staff

Route to:

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In This Issue . . .

News from the AMA

The American Medical Association is pleased to report the following victories for organized medicine in the appropriations process:

Prevented from Inclusion:

⇒ **User Fees:** President Clinton's FY '99 budget proposal included a variety of new "user fees," i.e., taxes, that effectively would have shifted more than $395 million in HCFA program administration costs from general revenues to physicians, hospitals, and other providers. The AMA strongly opposed the imposition of these new taxes in the form of "user fees." **Successfully excluded from the FY '99 spending package.**

⇒ **Lethal Drug Abuse Prevention Act:** Sen. Don Nickles (R-OK) shelved his attempt to attach his legislation (S. 2151) to the omnibus spending package. This legislation, strongly opposed by the AMA, would have expanded the Drug Enforcement Administration authority into the prescribing practices of physicians. **Successfully excluded from the FY '99 spending package.**

⇒ **Centers of Excellence Demonstrations:** Two congressional proposals that would have funded pet projects through an expansion of the so-called Centers of Excellence demonstrations were defeated through aggressive AMA lobbying. The proposals would have extended these competitive bidding type arrangements, which now involve heart bypass and hip replacements, to several other orthopedic and cardiac procedures. **Successfully excluded from the FY '99 spending package.**

Successfully Included:

⇒ **Full Funding for Claims Processing:** The AMA lobbied successfully for adequate funding for Medicare Carriers, precluding the need for the inclusion of user fees (see above). As a result of the AMA's efforts, Congress has provided the full funding level for claims processing. We are optimistic that at this funding level physicians will not experience delays in payment of claims. In addition, we were able to derail a HCFA proposal that would have eliminated the "Dear Doctor" letter, a letter sent annually by the Medicare carrier to every physician who treats Medicare patients; the letter provides essential information about the changes in store for the Medicare program during the coming year. This is information upon which physicians make the decision to participate, or not, in the Medicare program. We were also successful in getting HCFA to continue to provide free of charge a physician-specific fee schedule, which accompanies the "Dear Doctor" letter.

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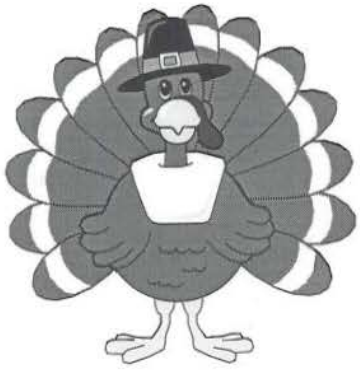
⇒ **Funding to NIH and CDC:** The legislation allocates to the National Institutes of Health $15.6 billion, nearly $2 billion, or a 14% increase, over FY '98. The Centers for Disease Control will receive $2.6 billion.

⇒ **Health Coverage Deductibility:** Self-employed individuals who purchase health insurance will be able to deduct fully (100%) the cost of the insurance for themselves and their families, beginning in the year 2003; this is a more accelerated phase-in of the 100% deductibility called for in the Balanced Budget Act of 1997.

⇒ **Contraception Coverage:** This language, originally proposed by Sen. Olympia Snowe (R-ME), Sen. Harry Reid (D-NV), and Rep. Nita Lowey (D-NY), mandates that health plans serving federal employees cover five types of contraception if the plans also cover prescription drugs. The provision does exempt a handful of plans affiliated with religious organizations. Doctors who object to contraceptives on religious or moral grounds are not required to prescribe them; this is called the "conscience clause" language, advocated by Rep. Tom Coburn, MD (R-OK).

⇒ **Mastectomy Language:** Originally authored by Sen. Alfonse D'Amato (R-NY), this language stipulates that if a plan provides medical and surgical benefits for mastectomies, then the plan also must provide reconstruction (and symmetry) if the patient elects reconstructive surgery. All medical decisions will be made in consultation with the attending physician, a provision of great importance to the AMA.



HAPPY THANKSGIVING

Medical Records -- Patient Access To/Ownership of Records*

Ownership - Pennsylvania has not, either by statue or regulation, addressed ownership of a physician's medical records. Neither has this question been determined by the courts. However, there are regulations relating to ownership of hospital records. In the absence of a statutory or regulatory rule for physician medical records, it may be prudent to follow or be guided by the regulations on hospital medical charts.

Those regulations provide that a hospital's medical records are the property of the hospital. The original records are not to be removed from the hospital premises except for court purposes. Copies of these records may be sent to authorized recipients for purposes such as insurance claims and physician review. In addition, a patient, or his or her designee, must be given access to the patient's records or a copy of those records. Similarly, the estate of a deceased patient, or the patient's next of kin, must be given access to the medical records of the decedent. Photocopying costs incurred must be reasonably related to the cost of making the copy.

Request for Release of Records - As a general proposition, the information learned by a physician and subsequently documented in his records is privileged. Because of this privilege, records cannot be shared with others unless certain requirements are satisfied.

Prior to releasing a patient's medical records, the physician-patient privilege makes it incumbent upon the physician to determine that the request is accompanied by the appropriate documentation. Requests for the release of medical records are generally documented by either an authorization or a subpoena.

* Information provided by Lehigh County Medical Society

Don't Delay to Vaccinate -- Influenza and Pneumococcal Vaccines

Influenza and pneumococcal pneumonia continue to be major causes of illnesses leading to hospitalizations. Both, however, can be prevented with a safe, effective vaccine. The trivalent influenza vaccine prepared for the 1998-99 season will include A/Beijing/262/95-like(H1N1), A/Sydney/5/97-like(H3N2), and B/Beijing/184/93-like hemagglutinin antigens. Pneumococcal vaccine is cost-effective and potentially cost-saving among persons aged 65 years or older for prevention of bacteremia.

Influenza Vaccine is strongly recommended for persons at high risk for complications of influenza as well as health care workers (physicians, nurses, personnel in hospital, outpatient and long term care facilities) and household members (including children) in close contact with persons in high risk categories.

High Risk Persons

- All persons 65 years of age or older (represent >90% of all flu deaths)
- Persons >6 months of age with chronic illness
  - Pulmonary
  - Cardiovascular
  - Metabolic disease (including diabetes mellitus)
  - Renal dysfunction
  - Hemoglobinopathies
  - Immunosuppression (including immunosuppression caused by medications)
- Residents of long term care facilities
- Persons 6 months to 18 years receiving chronic aspirin therapy (due to risk of developing Reye Syndrome after influenza)
- Women who will be in the second or third trimester of pregnancy during the influenza season

Pneumococcal Vaccine recommendations target essentially the same groups as the influenza vaccine.

High Risk Persons

- Persons 65 years of age or older
- Persons aged 2 to 64 with
  - √ Chronic illness listed for influenza
  - √ Chronic liver disorders
  - √ Functional or anatomical asplenia
  - √ Kidney disorders
  - √ Alcoholism
  - √ CSF leaks
- Persons in long term care facilities
- Immunocompromised persons

Recommendations for Pneumococcal Revaccination

- Routine revaccination of immunocompetent persons is not recommended
- Revaccination is recommended for those at highest risk of serious pneumococcal infection
- Candidates for revaccination
  - Asplenia
  - Immunosuppression
  - Chronic renal failure
  - Nephrotic Syndrome
  - Persons 65 years of age or older if they received vaccine 5 or more years previously and were less than age 65 at the time of vaccination.
- If indicated, single revaccination 5 years or more after previous dose
- For children 10 years of age or less, revaccinate 3 years after previous dose

The National Immunization Program (NIP) has a wealth of information available to aid the clinician and their staff in patient education. Vaccine safety sheets for a number of vaccines are currently available, some of which are appropriate for public distribution while others are more technical and targeted specifically to the clinician. Materials can be ordered by phone, fax or the Internet.

CDC Immunization Hotline
1-800--232-2522
ACIP statements and other printed materials sent or faxed, call 1-800-CDC-SHOT
To receive a NIP resource list, fax your request to
(404) 639-8828
NIP Website
www.cdc.gov/nip
NIP Internet Address
nipinfo@dc.gov

Ordering Outpatient Services

As insurance companies begin to compare hospital and physician claims for similar information prior to payment based on appropriateness and medical necessity, hospital coders and physician office coders must work more closely together to ensure that the ICD 9 CM and CPT codes assigned by each match.

In order to meet external requirements, hospital registration personnel have been placing phone calls to physician offices to clarify diagnosis or symptoms for outpatient services ordered. In order to decrease these phone calls and continue to meet requirements, we are asking all physicians to assist us by providing ICD 9 codes, if available, or complete diagnosis and symptoms on all outpatient orders. The following information related to outpatient coding is followed by LVH Medical Record coders and should be used as a guide for the information required from physicians when ordering outpatient services.

According to the American Hospital Association's (AHA) Coding Clinic, 4th Quarter, 1995, guidelines for reporting of inconclusive diagnosis, e.g. rule outs, suspected, probable, were developed for the use within the inpatient setting and are not applicable for outpatient/physician office setting. As an example, "rule out fracture" is not acceptable without "leg pain" listed as the symptom. A diagnosis of "leg pain, rule out fracture," can be coded as a fracture if the x-ray is positive or as leg pain if negative. "Urinary frequency, rule out UTI" can be coded as a UTI if UA is positive or coded as urinary frequency if UTI is ruled out. The following additional AHA's guidelines which govern coding practice within the outpatient and physician office setting are:

- Coders should derive ICD 9 CM codes for outpatient encounters. The ICD 9 CM code range for outpatient encounters includes diagnoses, symptoms, conditions, problems, complaints, or other reasons for the visit. Signs/symptoms codes are applicable when a diagnosis has not been confirmed.

- Code conditions described as probable, suspected, rule out, questionable or working diagnoses are not acceptable within the outpatient setting. Code to the highest degree what has been established for the encounter; signs, symptoms, abnormal test results, etc., are acceptable.

- Chronic diseases should be provided each time the patient receives treatment and care for the condition, i.e., Coumadin test, therapy for CHF/SOB.

- When ambulatory surgery is performed, the reason for the surgery is required, i.e. Cholecystitis, abdominal pain/for laparoscopic cholecystectomy.

Your cooperation in providing the required information when ordering outpatient services is greatly appreciated as we work together to meet external requirements. If you have any questions regarding this issue, please contact Arlene Lampart, Manager, Medical Records Technical Area, at 402-5035.

Please Use Suite Numbers

When addressing mail to physicians' offices located in medical office buildings located at any of the hospital's sites, please remember to include the Suite numbers. The hospital's Mailroom receives hundreds of pieces of mail each day that are couriered to physicians' offices within these medical office buildings. By including the Suite numbers, a significant amount of time will be saved while sorting the mail.

Thank you.

Radiology Renovations Complete at 17th & Chew

An open house was held on Monday, October 26, to "show off" the newly renovated Radiology Department at 17th & Chew.

The "new" department, which is located on the ground floor around the corner from the Emergency Department, contains two ultrasound rooms, a CAT scan room, and three diagnostic rooms including a fluoroscopy room.

Hours are Monday through Friday, 7 a.m. to 7 p.m., with coverage for emergencies in all modalities 24 hours a day, seven days a week.

To schedule appointments, call 402-2214.

If you have any questions or concerns regarding clerical or film library issues at 17th & Chew, please contact Val Hunsicker, Operation Coordinator, at 402-0393. For technical issues, please contact Barb Toczek, Operation Coordinator, at 402-8241.

Upcoming PAHCOM Meetings

- November 17 - 7:30 a.m.
  Networking and
  Executive Committee Elections
- December 15 - 5:30 p.m.
  Holiday Party

Both meetings will be held at the Ambassador Restaurant on Hamilton Boulevard, Allentown.

For more information, please contact Maggie Theys at 776-8220.

Who's New

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For more information, please call Janet at 402-8590.