MRB asked HIM and release of information (ROI) professionals about their ROI practices for its first quarterly benchmarking survey of 2015. (The survey was completed in October 2014.) Half of survey respondents are HIM directors or managers (52%). Other respondents identified themselves as non-managerial HIM staff members (18%) or ROI directors or managers (4%). The majority of respondents (65%) work in hospitals.

MRB asked respondents to check off all listed ROI issues that presented a challenge for their organization. Survey respondents said that the most challenging aspect is handling requests from adult children that are not noted on the patient’s record as next of kin or contacts (38%). (See the figure on p. 3.) Other challenges include:

- Requests from quality organizations (35%)
- Requests from divorced parents for children’s records (34%)
- Requests from adult children for expired patients’ records (26%)
- Requests from journalists or others for records of famous patients that expired more than 50 years ago (1%)

Some respondents wrote in other challenges, including:

- Requests that are not completed correctly
- Requests for behavioral/mental health and substance abuse records
- Determining the legally authorized representative
- Legal requests, subpoenas, warrants, and court orders
- Requests from Social Security Disability
- Requests from domestic partners

Paper, electronic, and hybrid records

Since MRB last conducted this survey in October 2012, the percentage of respondents from organizations using hybrid records (scanned pages and electronic) increased from 41% to 56%. Comparatively, the number of respondents whose organizations use hybrid (paper
and some electronic) records decreased from 41% in 2012 to 29% in 2014. The percentage of organizations that are fully electronic increased from 7% in 2012 to 10% in 2014. (See Figure 2 on p. 4.) The percentage of respondents who scan paper portions of the record into the EHR 1–2 days following discharge and promptly update the record with any loose items increased from 39% in 2012 to 50% in 2014. (See p. 4 for a comparison between scanning paper records into the EHR in 2014 and 2012.) Others with hybrid records employ the following strategies:

- Hybrid record is partially paper and partially electronic, but the paper portion has never been scanned into the EHR (13% in 2014 and 20% in 2012)
- Paper records are not scanned into the EHR until after the record is completed by the physician (12% in 2014 and 8% in 2012)
- Paper records are not scanned into the EHR for several weeks or months after the record is completed (1% in 2014 and 2012)

Some 2014 respondents (13%) wrote in to specify their strategies for scanning paper into the EHR, which included:

- Scanning the same day as discharge
- Scanning within 24 hours of discharge
- Scanning within three days of discharge
- Scanning within seven days of admission and ongoing after that
- Scanning some documents upon discharge, as they are attempting to store records in EHR and scanned images
- Scanning paper records within six hours of receipt to HIM department
- Scanning paper during care, prior to discharge

This data indicates that organizations may be moving away from a definition of hybrid that involves paper and electronic records, and are instead making an effort to quickly scan paper records into their hybrid record. Although 24% of respondents don’t store paper records off-site, others opt for the following storage solutions:
- We store paper records through an off-site storage service (40%)
- We store paper records in a warehouse owned by our organization (19%)
- We store paper records in a combination of locations (17%)

**Workforce dedication to ROI**

The percentage of organizations that employ internal staff to take care of ROI functions decreased slightly from 65% in 2012 to 61% in 2014. (See p. 7 for a comparison between ROI staffing in 2014 and 2012.) Hospitals with an electronic data management system that houses the complete legal health record can often complete their own ROI tasks, says Darice M. Grzybowski, MA, RHIA, FAHIMA, president of HIMentors, LLC, in Westchester, Illinois. “It’s an easy process, and a best practice to bring release in-house these days, [as it] decreases turnaround times to meet meaningful use standards and has a big return on investment to the organization,” she says.

Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, chief operating officer and founder of First Class Solutions, Inc., in Maryland Heights, Missouri, agrees that ROI can be successful when completed in-house.

“With the expansion of EHR usage, facilities should be thinking about internalizing the ROI function to take advantage of the technology and provide directly that service to their patients,” Dunn says. “However, it is understandable if a facility is tight on cash that labor must be trimmed or if it doesn’t have the capability to monitor receivables that it may seek assistance from an outsource ROI firm.”

The percentage of organizations outsourcing this function increased from 12% in 2012 to 14% in 2014, as did the percentage of organizations using a combination of internal staff and outsourced help (23% in 2012 and 25% in 2014). In addition, one respondent said that outsourcing ROI allowed her organization to turn requests around in a timelier manner, which indicates that outsourcing may work for some organizations but not for all. For example, one respondent said that her organization’s outsourced vendor is better able to release records in an electronic format than the organization’s internal staff.

In 2012, more than one-third (37%) of respondents reported that their organization assigned one individual to the ROI function. This figure decreased to just under one-quarter (24%) in 2014. One respondent noted that having just one person dedicated to ROI can present challenges with turnaround times, especially if the person is on vacation.

The percentage of organizations using 2–5 individuals for ROI remained steady at 44% whereas the percentage using more than five increased slightly from 12% in 2012 to 13% in 2014. More than one-quarter of 2014 respondents reported that their organization’s staff devotes 31–40 hours per week to the ROI function. More than half of respondents (59%) reported that their ROI workforce is not credentialed (e.g., RHIT, RHIA, CHP, CHPS).

### Figure 1: ROI challenges

What are the most challenging ROI issues your team deals with? (Check all that apply.)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requests from divorced parents</td>
<td>40%</td>
</tr>
<tr>
<td>Requests from adult children of expired patients' records</td>
<td>35%</td>
</tr>
<tr>
<td>Requests from journalists or others of famous patients</td>
<td>30%</td>
</tr>
<tr>
<td>Requests from adult children that are not noted on the</td>
<td>25%</td>
</tr>
<tr>
<td>patient’s record as next of kin or contacts</td>
<td></td>
</tr>
<tr>
<td>Requests from quality organizations</td>
<td>20%</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: MRB’s 2014 ROI benchmarking survey.
Requests for records

Respondents reported a variance in the number of requests for copies of records per week, with one-fifth (20%) reporting that their organization receives 141–150 requests per week and 17% reporting 1–10 requests per week. (See p. 5 for a full breakdown of weekly requests received by organizations, and see p. 6 for a comparison between requests for copies and turnaround times in 2014 and 2012.)

“Depending on the number of requests received in a given day, it is not always possible to be compliant with requests,” one respondent said.

The majority of 2014 respondents (87%) said their organization does not staff for routine requests (i.e., non-emergency/hospital requests) on Saturdays or Sundays, a decrease from the 92% that did not staff for these requests in 2012. The percentage of organizations that staff for routine requests on both Saturdays and Sundays increased from 7% in 2012 to 10% in 2014. (See p. 7 for a comparison between ROI staffing in 2014 and 2012.)

Dunn says it is refreshing to see an increase in the number of hospitals that are staffed for routine requests on weekends. “Having weekend hours can be a customer satisfier because so many individuals work more than one job and can’t make it to the ROI area during normal business hours,” she says.

The average turnaround time for record requests was relatively unchanged, with 26% of 2014 respondents...
turning requests around in 1–2 days compared to 28% in 2012. Similarly, 30% of 2014 respondents turn requests around in 3–4 days compared to 26% in 2012. Less than half (48%) of 2014 respondents are not concerned about turnaround times stated in meaningful use criteria, which is down slightly from the 51% that were not concerned in 2012. (See p. 6 for more information on all these survey questions.) The stage 2 meaningful use requirements involve encouraging patients to access the information electronically or have the information transmitted, Dunn says.

“An impressive 56% of the respondents reported their turnaround time at four or less days,” she says. “While a few expressed concern with the meaningful use turnaround time, it appears like the majority will be able to easily accommodate the meaningful use requirements.”

The percentage of respondents that only supply patients with paper copies of their records decreased from 56% in 2012 to 38% in 2014. Respondents who avoid making paper copies were asked to indicate all of the electronic solutions they use in lieu of paper records—many of which increased from 2012 to 2014, including:

- CDs/DVDs (41% in 2014 and 34% in 2012)
- Thumb drives (12% in 2014 and 6% in 2012)
- Electronic faxes (36% in 2014 and 27% in 2012)
- Patient portals (29% in 2014 and 7% in 2012)
- PDF email attachments (18% in 2014 and 10% in 2012)

“With the meaningful use requirements encouraging patients to use the patient portal to access pertinent information, perhaps the number of requests being handled by HIM and other personnel will decline in the future,” Dunn says. “I don’t anticipate this happening until several years from now because of the limited information that is required to be available in the portal and the number of organizations that continue to have a hybrid record.”
Figure 5: Now and then: 2014 vs. 2012 requests for copies

In order to respond to a request for copies, do you still need to copy paper or microfilm records that are not yet in your electronic record?

**NOW**
- Yes: 72%
- No: 20%
- I don’t know: 8%

**THEN**
- Yes: 82%
- No: 16%
- I don’t know: 2%

What is your average turnaround time for responding to a request for patient records?

<table>
<thead>
<tr>
<th>Turnaround Time</th>
<th>NOW</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–2 days</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>5–6 days</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>7–8 days</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>9–10 days</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>5%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Are you concerned about the turnaround times stated in the meaningful use criteria?

<table>
<thead>
<tr>
<th>Concerned</th>
<th>NOW</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>No</td>
<td>48%</td>
<td>51%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>22%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Source: MRB’s 2014 ROI benchmarking survey.
Figure 6: Now and then: 2014 vs. 2012 ROI staffing

Do you employ your own ROI staff or is the activity outsourced to a release of information service?

<table>
<thead>
<tr>
<th>NOW</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>We use a combination of internal staff and outsourced help</td>
<td>25%</td>
</tr>
<tr>
<td>We outsource our ROI activities</td>
<td>14%</td>
</tr>
<tr>
<td>We take care of our ROI with internal staff</td>
<td>61%</td>
</tr>
</tbody>
</table>

How many individuals are assigned to the ROI function?

<table>
<thead>
<tr>
<th>NOW</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>We source this function</td>
<td>10%</td>
</tr>
<tr>
<td>More than 5</td>
<td>9%</td>
</tr>
<tr>
<td>5</td>
<td>13%</td>
</tr>
<tr>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>1</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>24%</td>
</tr>
</tbody>
</table>

Is the ROI function staffed for routine requests (i.e., non-emergency/hospital requests) on Saturdays or Sundays?

<table>
<thead>
<tr>
<th>NOW</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Saturdays and Sundays</td>
<td>10%</td>
</tr>
<tr>
<td>Sundays only</td>
<td>1%</td>
</tr>
<tr>
<td>Saturdays only</td>
<td>2%</td>
</tr>
<tr>
<td>Neither Saturdays nor Sundays</td>
<td>87%</td>
</tr>
</tbody>
</table>

Source: MRB’s 2014 ROI benchmarking survey.
In 2014, we asked respondents for the first time whether they encrypt the media used for making paper copies of records, and 62% said yes. Dunn advises organizations to encrypt media devices as they can be easily lost and encryption may protect PHI.

Nearly three-quarters of 2014 survey respondents (72%) need to copy paper or microfilm records that are not yet in the electronic record when responding to requests for copies, a slight decrease from the 82% of respondents whose organizations employed this practice in 2012. “Our challenge is the requests for microfilmed records,” one respondent said. “Our current computer system does not show the date of service on microfilm. We have to use off-site equipment to view/copy microfilmed records. We are looking to get such equipment in-house to manage these records.”

To dig a bit deeper into microfilm requests, MRB asked 2014 respondents what percentage of weekly requests are for copies of microfilm. The majority of respondents (83%) said less than 1% (fewer than one in 100 requests) per week are for copies of microfilm. In addition, respondents were asked whether their organization destroys microfilm for dates past their retention period. More than half of respondents (55%) simply said no, whereas 18% said they do not destroy this microfilm but have also stopped honoring requests for copies from microfilm older than their retention period.
TJC quarterly update

Recommendations for Improvement down, but medical record still important during surveys

by Jean S. Clark, RHIA, CSHA

RC.01.01.01, Content of the Medical Record, did not top the list of the survey findings for hospitals in the first half of 2014, according to the September 2014 issue of Joint Commission Perspectives. Nor was it on the list for critical access hospitals at all! However, 49% of hospitals surveyed received a requirement for improvement for this standard, primarily in the EPs related to timing and dating entries. This indicates hospitals are still using a lot of paper records. That said, the downward swing is encouraging as more and more hospitals fully implement the EMR.

Keep a close watch

The medical record continues to play an important part in surveys, and accurate, complete, and timely medical records will only help your survey. Continue to monitor the ability of workforce members at the point of care to locate information in the EMR during surveys. Regularly monitor the following EMR components, and make them part of your regular tracers and chart reviews:

- Correct information in the correct medical record, especially the EMR
- Care plans
- History and physical reports and updates
- Pre- and post-anesthesia evaluations
- Operative/procedure reports
- Postoperative progress notes
- Restraints
- Assessments and reassessments

New for 2014

In 2014, there was only one revision to the Record of Care chapter for hospitals that use The Joint Commission for Medicare deemed status; it was effective July 1, 2014. This revision was designed to align the Record of Care chapter with the Medicare Conditions of Participation.

In RC.02.01.02, EP 2, complications and hospital-acquired infections were added to the diagnoses and conditions that hospitals must include in the medical record. The Joint Commission released revisions to the Comprehensive Accreditation Manual for Hospitals in August 2014. The revised manual includes two additions for hospitals with deemed status that have swing beds used for long-term care. The first addition is RC.02.04.01, EP 1, which states that the medical record must include the discharge information provided to the resident and/or receiving organization. The second is RC.02.04.01, EP 2, which added a list that the hospitals must include in residents’ discharge information. Both additions were effective September 29, 2014. More detail can be found in the August 25, 2014, E-dition of the Comprehensive Accreditation Manual (www.jcrinc.com/e-dition).

At the time of publication, The Joint Commission had not released revisions to the Record of Care chapter for 2015.

Tips for compliance

Take the following steps to ensure compliance with Joint Commission standards:

1. Stay current with changes by reading:
   - Perspectives and Joint Commission Online
   - Briefings on The Joint Commission (www.hcmarketplace.com/briefings-on-the-joint-commission-1)
   - CMS Conditions of Participation transmittals that reflect changes to regulatory compliance

2. Have a robust ongoing medical record review process that identifies and corrects poor medical record documentation.

3. Keep the documenters updated on medical record requirements.

4. Be part of any EMR design and implementation. You may be the only one on the team who knows the requirements!

Remember the medical record’s real purpose is to promote and provide quality patient care and communication among the caregivers. Happy New Year!
The intersection of information governance and the EHR

by Darice M. Grzybowski, MA, RHIA, FAHIMA

For as long as I have been in the profession, HIM professionals have asked: How do we define who we are, and what is unique about what we do? As the medical record becomes increasingly electronic, the need for the unique skill of the HIM professional becomes greater. Why then, do the answers to those two questions remain elusive? This month I attempt to offer an explanation and possible solution.

What we did

Like many others, I entered the field of medical record administration (now HIM) seeking a vocation that did not require hands-on clinical contact but emphasized organizational skills, patient advocacy, and leadership skills as well as a focus on statistical analysis and attention to detail. In the early 1980s, the promise of EHRs and computerization was just on the horizon, although email, digital communications, document workflow software, Internet access, and faxing hadn’t yet evolved into the public sector.

In those days, the responsibilities of HIM professionals included:

- Office space planning for large permanent file rooms and workstations
- Management of budget and staffing resources
- Coding
- Abstracting/data collection
- Medical transcription
- Forms design
- Incomplete record processing
- Filing, retrieval, and archive of records
- Maintaining the cancer registry
- Release of information

As the custodian of the legal health record (LHR), the HIM professional was a critical coordinator whose management of the documentation produced from each episode of care served to protect patient information and ensure its availability for future care, research, education, reimbursement, legal defense, and archival. HIM professionals were there to ensure the record would tell the story of the patient in a clear and functional way. This need is still present today.

What we do

Fast forward 30+ years. In the United States, the adoption of coding as a core piece of data supporting the prospective payment system forever linked the HIM department with finance. Various software and system technologies such as barcoding, digital dictation, scanning, and data repositories allowed file rooms and shelves to morph into electronic record management, document interfaces, and workflow queues for processing and accessing the LHR and linking HIM to IT.

The skill set of the HIM professional evolved into, among other aspects, managing a hybrid environment of paper records and automated systems, while still maintaining oversight of traditional functions. Complex management functions required in working with advanced technologies and software came to include:

- Record processing (electronic)
- Clinical documentation improvement and completion
- Release of information
- Digital dictation
- Word processing, (electronic) forms management
• Workflow design
• Decision support via data warehousing
• Multiple coding and classification systems
• Severity and risk adjustment

One thing remains constant: The custodian of the LHR—the HIM professional—is still critically committed to both document and data integrity, and he or she acts as the advocate in operationalizing information governance to support the design, maintenance, access, and control of the patient’s record.

What makes HIM professionals unique?
A unique profession should present its workforce with many opportunities, including:
• Educational programs designed to train professionals in standard techniques (i.e., CAHIIM)
• Certifications or licensure to be granted upon testing of skills that demonstrate proficiency and upheld through rigorous continuing education requirements (i.e., American Health Information Management Association (AHIMA))
• Evolving and advanced theories and publications reflecting best practice standards through which to educate other professions (i.e., AHIMA Body of Knowledge)

People who select the HIM career path must be confident in their skill set and comfortable with the ways in which the aforementioned opportunities differentiate HIM from similar fields. For the HIM professional, understanding the opportunities and translating the responsibilities into policies, procedures, standards, and management of EHR functions within the HIM department and throughout the healthcare organization is the key to a successful career and to differentiating HIM from other similar fields.

What not to do
HIM professionals do not need to try to fill other health informatics or technology-related roles and chase down positions and titles in other fields. HIM leaders have plenty to do in their own right, and those functions aren’t going away any time soon, even if HIM moves from a physical department to a largely virtual and remote entity. HIM professionals should stop trying to become software programmers and database analysts (unless they want to work in the IT department) and focus on data and document integrity by doing such tasks as reducing the amount of duplicate medical record numbers, correcting erroneous patient type statuses from observation to inpatient, improving the poor documentation in the EHR, and assisting in the cleanup of chargemaster errors.

Stop trying to become a clinical informaticist (unless your goal is also to become a clinician) and instead help educate clinicians on correct principles of documentation. Help design input and output forms for consistency, content accuracy, and to reduce redundancy in workflow. Perhaps next time the question of what fields to capture and display when a physician is exposed to a potential Ebola case won’t be an issue if the record is designed to properly capture the best information and reflect current treatment protocols and paths. In other words, stay in your lane and do what you do best.

There’s a message in here for the educators as well. Perhaps it’s time we take a critical look at curriculum modification. Are we teaching skills at the associate
or baccalaureate level that are really intended for the master’s level? Are we attempting to create technical skills in informatics and accidentally ignoring classroom work related to key clinical and management skills needed to lead HIM functions?

A clear skill set for the future

To the HIM professionals who have been practicing 10–30 years: Congratulations, you made it. You are the generation that helped the profession transition from paper to hybrid to electronic (it’s still in flux, so don’t think about retiring just yet). In fact, there’s quite a bit of cleaning up to do. We have (non-)meaningful use going on in records. We’ve rushed EHRs in the door too quickly so as to achieve a financial incentive, and we are paying for it in terms of poor workflow and content integrity.

It’s back to basics for this group. We need to modify standards, rethink core systems, and ensure a solid base of document management to support the LHR. We must strategize how to provide solid, enterprisewide policies and procedures that don’t erode patient privacy or documentation accuracy through abuse of open access or cutting and pasting.

New students are well armed for the future, though they must maintain their credentials and certifications and keep up with continuing education. They have already been trained in ICD-10-CM/PCS; they have grown up with a mouse and a keyboard in their hands and don’t remember a time where cell phones didn’t exist. They may need a little assistance understanding terminal digit filing to help with paper records—but don’t worry, seasoned staff members should be happy to explain it along with the importance of color coding. New professionals should remember that not every function need be outsourced; if they aren’t sure how to manage some aspect, they should find an HIM consulting expert to explain it and save some money along the way.

Those poised to enter the HIM profession have a future filled with options and opportunities. The growth in expected HIM positions has remained in double digits for more than 30 years. The profession has survived such events as the introduction of Medicare, Medicaid, prospective payment systems, health maintenance organizations, HIPAA, electronic billing, HL7, Y2K, Recovery Audit Contractors, meaningful use, and (soon) the ICD-10 transition.

Through it all, the ability to collect and aggregate record documentation in an organized manner was a constant needed to facilitate communication in care and serve as the source of archived LHRs. This future generation will need to ensure the integrity of the record itself—in its electronic and paper forms—and the integrity of the data within it.

Conclusions

In an electronic environment, record data may reside in a repository or warehouse. The technical components of the LHR may dynamically flow and be reported and stored in different formats. However, HIM professionals must continue to supervise the documents themselves—containing the static output that may be reviewed, printed, replicated, and stand as a business record—as the custodians of the record. HIM staff members must advocate for both clinicians and patients throughout the life cycle of the LHR. For HIM staff who are standing at the right intersection and know which way to go, information governance isn’t just a buzz word for the New Year.
Changes to the EHR Incentive Programs and EHR certification criteria

In September 2014, CMS and the Office for the National Coordinator (ONC) released a final rule that offers enhanced flexibility for eligible professionals, eligible hospitals, and critical access hospitals using certified EHR technology (CEHRT) and working toward meaningful use attestation (https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-21021.pdf). The final rule regulations became effective October 1, 2014.

Providers who cannot fully implement 2014 CEHRT are permitted to use the 2011 edition of CEHRT, a combination of the 2011 and 2014 editions, or the 2014 edition for the 2014 EHR meaningful use reporting period. These providers are required to attest to their inability to adopt 2014 CEHRT if they select one of these options. The final rule also sets requirements for reporting meaningful use objectives, measures, and clinical quality measures based on the CEHRT option that a provider selects for the 2014 reporting period.

Providers would still be required to use the 2014 edition of CEHRT through calendar and fiscal years 2015 and beyond. The rule extends the timeline for stage 2 meaningful use through 2016, which means the earliest providers could attest to stage 3 would be in 2017.

CMS designed several resources to clarify changes to 2014 participation, including:

- The CEHRT Rule Tool, which displays 2014 participation options based on users’ response to questions about their meaningful use progress (www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CEHRT_Rule_DecisionTool.pdf)
- The 2014 CEHRT Flexibility Chart, which provides an overview of all participation options (www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CEHRT2014_FlexibilityChart.pdf)

Days after releasing the aforementioned final rule, ONC published another final rule in the Federal Register, this time stating that it would make changes to its 2014 edition EHR certification criteria in lieu of adopting its proposed 2015 edition criteria (http://s3.amazonaws.com/public-inspection.federalregister.gov/2014-21633.pdf). ONC stated that, instead of adopting all of the 2015 edition criteria outlined in a proposed rule, it would adopt small subset of the proposals as optional 2014 edition EHR certification criteria. ONC refers to the latest version of this criteria as 2014 Edition Release 2 or 2014 Edition Release 2 EHR certification criteria. Developers do not need to update or recertify products to meet this criteria, and organizations will not need to upgrade their certified technology based on 2014 Edition Release 2 options (see Table 1 of the final rule for a complete list of optional and revised criteria).

The 2014 Edition Release 2 EHR certification criteria includes 10 optional and two revised certification criteria for inclusion in the 2014 edition. Optional certification criteria include changes to computerized provider order entry and transitions of care certification criteria.

ONC also changed the naming conventions for these criteria. Going forward, rulemaking similar to that of the final rule that adopts an edition of certification criteria would be referred to as “[current edition year] Release #X.” This was done to avoid potential confusion that could be caused by linking an updated certification criteria edition’s year to any other program’s compliance date.
HIPAA Q&A

Fax logs, training, privacy, and incidental disclosures

by Chris Simons, MS, RHIA

Q I was recently hired for a position at a long-term care facility. Upon getting acclimated, I learned that the facility has completed handwritten logs for every fax that was sent out since 2003. This document is referred to as the HIPAA fax log and contains the date the fax was sent, to whom it was sent, by whom it was sent, the number of pages, and whether a cover sheet with confidentiality statement was included. I would like to do away with this form since fax machines can generate their own logs. However, if this is a necessary process then I would like to follow official guidelines and update the facility’s policies and procedures accordingly. Does the HIPAA Privacy or Security Rule require these logs? If so, what information must we include?

A Organizations are not required to retain fax logs. However, in accordance with the Accounting of Disclosures requirement, you must be able to respond to a patient’s request for a list (account) of disclosures other than for treatment, payment, or operations reasons (with certain other exceptions) going back six years. Most organizations keep the release of information form or similar document in the patient’s record with details about the information provided (e.g., information faxed or mailed, send date, staff initials). Some also document this information in the electronic release of information log. I recommend doing both.

Q The agency I work for wants to purchase magnetic signs with our name and logo to place on vehicles of case managers when they make home visits. This would identify our case managers as being in a neighborhood for legitimate business purposes. Does this practice violate our patients’ rights under HIPAA since anyone walking or driving by would know the resident is receiving care from our agency?

A You should perform a risk analysis before making this decision. Consider the reason for purchasing signs, the size of the signs, whether you will remove the sign if a patient objects, and the nature of your agency. Using a sign for an agency that provides in-home psychiatric or addiction counseling services might be of more concern than one for a home health agency, for instance. When you have answered all these questions, decide whether the small risk to privacy is worth the benefits your agency foresees.

Q Is it necessary for organizations to provide HIPAA training for all workforce members, even those who are not involved in patient care (e.g., janitorial staff, administration, nonclinical roles)?

A Yes, absolutely. In addition to the aforementioned roles, don’t forget to train volunteer and contracted staff. You might be surprised how often these nonclinical staff members are in a position to access PHI. They must be trained in how to handle it just like all other staff and must understand the importance of not sharing any information with those who do not need to know it. I recommend annual, documented training.

Q I went to the dentist for a crown. A computer screen in the treatment room showed all of the day’s appointments for the dentists and hygienists. The screen showed patient names, phone numbers, and procedures. It was clearly visible and the dentist and hygienist left me alone with that information twice. Does this constitute a HIPAA breach?

A This is incidental disclosure, which covered entities are required to mitigate. The best practice is to use initials or partial names on the calendar, or at least reconfigure the computer so
patients and others without a need to know can’t see the information. Another option would be to purchase a privacy screen to fit over the monitor so only those directly in front of it can access or view information.

I suggest you bring this issue up with your dentist or his or her office manager. It’s possible they may not be as familiar with mitigating incidental disclosures are you are, and they should welcome your thoughts.

EDITOR’S NOTE
Simons is the director of health information and privacy officer at Cheshire Medical Center/Dartmouth-Hitchcock in Keene, New Hampshire; she is also an MRB advisory board member. This information does not constitute legal advice. Consult legal counsel for answers to specific privacy and security questions. Send your questions related to HIPAA compliance to Editor Jaclyn Fitzgerald at jfitzgerald@hcpro.com.

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Help wanted for ICD-10: Let’s get some practical code sets

The last “Minute for the Medical Staff” column covered some issues with ICD-10 and how lack of participation might influence payments. The focus on laterality, which many providers already document (e.g., Which side of the body was the left radius fracture located? Which trimester was this visit at 32 weeks’ gestation?) may worry or frustrate some people. Generally, if you are a provider who thoroughly describes a patient’s disease, its cause, and its effects on the body, then you’re ready for ICD-10. However, in certain areas of daily use, ICD-10 isn’t ready for us.

Over the past decade, nephrologists began to recognize that a patient’s renal function may stay stable for a prolonged period of time or may deteriorate to a point that intervention is needed. Through study and investigation, they defined the stages of chronic kidney disease (CKD) and methods to identify these stages with algorithms and computations.

We have these five stages of CKD in addition to the designation of end-stage renal disease (ESRD). We know that systemic manifestations of CKD are evident in the middle of stage 3 when the glomerular filtration rate is about 45 ml/minute, so there may come a day when we split stage 3 into 3A and 3B, but that’s not even on the table yet. Acute renal failure (acute kidney injury) can be stratified as well based on the likelihood of making a full recovery, a decrease in renal function, or total need for long-term dialysis or transplant. The National Kidney Foundation, the Kidney Disease Improved Global Outcomes, and the Acute Kidney Injury Network reviewed their respective criteria and created algorithms. The concepts have been submitted to the folks who create ICD-10 codes, and this classification may be translated to codes. This is good because international evaluation of medical statistics is often based on ICD-10 code set abstraction, which helps determine where disease is prevalent throughout the world. This data shows the outcome of various disease interventions.

Well, here’s the rub. Kidneys that become worse in function deserve more of a physician’s time, and physicians should be appropriately paid for that time. ESRD identifies patients who are in need of renal replacement therapy in the form of dialysis or transplantation. There are no ICD-10 codes that represent similar stages for patients suffering from diseases of the lungs, liver, and heart. The patient who has mild, early onset of lung, liver, or heart failure is assigned the same ICD-10 code as a patient who has an end-stage disease of these organs and needs a transplant to survive. There’s no way to capture any of that data in the current or upcoming code sets.

This lack of data specificity is a problem. The time physicians spend in a follow-up visit for a well-managed patient with heart failure due to chronic systolic dysfunction should not be compensated at the same rate as a visit with a patient with end-stage chronic systolic heart failure who needs a left ventricular assist device as a bridge to transplant or a visit with a patient who needs a heart transplant.
In addition, medical centers that treat end-stage heart failure patients have a disproportionately high death rate from heart failure than hospitals that send their sick patients to the heart failure center. So one hospital looks great, and the other looks like it’s unable to keep patients alive.

Facilities that treat patients for end-stage lung disease with thoughts of long-term use of ventilator support or considerations of lung transplantation are reimbursed the same as a facility that treats mild COPD patients. Similarly, liver centers treating patients with end-stage hepatitis C receive the same reimbursement as facilities that treat early-stage hepatitis C patients and send their sick patients to the liver center.

There are no end-stage codes for these conditions. Yes, if you look at the code book, you will find a code for end-stage liver disease, but it’s the same code as is used for liver disease unspecified because there are no specific codes for this severe condition.

Do we not have stratification designations in these specialties, like the renal folks do? Sure we do! We have the New York Heart Association’s functional classes of chronic heart failure, with Stage 4 essentially representing advanced disease with severe limitations at rest (http://tinyurl.com/27xkc46). Under the American Heart Association’s stages of heart failure, Stage D is identified as end-stage heart failure. These patients are considered candidates for a heart transplant, yet from a coding perspective they have the same level of heart failure as a new failure patient with Class B limitations.

The pulmonary folks have the GOLD Staging System, with Stage 4 representing a severe condition when the patient is identified as having chronic respiratory failure (www.copd-international.com/Mobile/includes/stages.html). Unfortunately, the term chronic respiratory failure alone doesn’t indicate “end-stage requiring consideration of transplant.” So we have severity levels 1–4 based on activity limitations and forced expiratory volume at one-second calculations. Yet, per the codes, the earliest COPD patient is as sick as the one with the most advanced lung dysfunction.

Liver conditions are different because the staging is dependent on the cause of the liver failure (e.g., inflammation, fibrosis, cirrhosis, failure for some causes and fatty infiltration, fibrosis, cirrhosis, failure for others). Regardless of etiology, liver failure is uniformly identifiable as end-stage when the provider considers the patient for hospice care or a transplant.

Here’s what I suggest: Instead of being the target of an onslaught of ICD-10 codes, as many perceive the situation, take ownership and lead the development of ICD codes. We need some way of tracking lung, heart, and liver disease advancement just as those who treat patients with renal conditions have for kidney function. We need these for the purposes of tracking the severity of illness of the patients we are treating, for the ability to track treatment modalities in large numbers of comparative patients, and to be appropriately reimbursed for the efforts and time we spend with patients at different stages of disease progression. I challenge those of you who care about this to work with your American Colleges and Associations to get these codes designed and implemented. Are you ready for it?

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EDITOR’S NOTE
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