Transaction Standards:

Frequently Asked Questions

1. **What is date of onset of current illness?**
   The current illness is the primary issue for which the patient is being seen today (example: bronchitis). If you are familiar with documentation categories, "current illness" is similar to "present illness." The date of onset is the date on which the problem, issue, or illness began. For admitted patients, this may be the date of admission. When submitting a claim, the date of onset of current illness MUST be expressed as a calendar date (month, day, and year. For example, 07/28/03).

2. **What is date of onset of similar illness?**
   A similar illness is a similar or related condition that may have been treated before and that contributes to the primary illness (example: asthma). If you are familiar with documentation categories, this is similar to "contributory illness." When submitting a claim, the date of onset of similar illness MUST be expressed as a calendar date (month, day, and year. For example, 07/28/03).

3. **What if the patient does not provide a calendar date for date of onset of current illness or date of onset of similar illness?**
   If the patient cannot remember the calendar date, you should enter "Unknown" in this field.

4. **What if the date of onset provided by the patient and entered onto a charge ticket does not match the date of onset recorded in the patient's chart?**
   If this occurs and the error is discovered (by the payor, for instance, or by an auditor), consequences might be: the claim is denied; the claim was paid, but we now have to pay it back; and/or we are subject to federal fines and penalties for violating the HIPAA TCI standards. Ensuring consistent data is extremely important.

5. **How will the HIPAA data be captured?**
   Different areas currently collect patient data using different methods, and this will not change. Areas that use fee/charge tickets will capture HIPAA data on revised fee/charge tickets. Order entry screens in A2K are being modified to include fields for capturing HIPAA data. Methods will vary by area based on current practice and the most workable solutions. Check with your area manager for more information.

6. **Which data will impact my area?**
   This will vary, and is spelled out in a document posted at: http://ozone.ohsu.edu/cc/hipaa/tci/tci_impact.doc. Both professional and institutional billing are affected by the HIPAA TCI standards.

7. **How do we capture HIPAA data when a patient is admitted?**
   When scheduling elective admissions, staff in the ambulatory practice will enter the HIPAA clinical data in the reservation pathway in A2K. For patients coming through Admitting, the Registration staff will enter the HIPAA clinical data in the reservation pathway in A2K. For patients admitted directly in Labor & Delivery, unit staff will enter the HIPAA clinical data. For patients admitted through the ED, ED Registration will enter the data on the HIPAA screen.

8. **What is a pre-existing condition? Does this affect reimbursement for services?**
   A pre-existing condition is a health condition that a patient had prior to becoming insured by a health plan. Health plans may not cover a pre-existing condition and will pend the claim until they determine whether the patient is eligible to be covered for the service. This process delays reimbursement, requires submission of additional information and may result in denial of the claim.

9. **In A2K, what is the difference between "Data Not Available" and 'Unknown per Patient"?**
   "Data Not Available" is an option for Onset Date Current Illness/Symptom and Onset Date Similar Illness/Symptom. This allows staff to proceed with the order entry process and storing of data in LCR when the date of onset information is not available to them. This is different from "Unknown per Patient," which is to be used when we have queried the patient but the date is unknown to the patient. "Data Not Available" is to only be used when there is absolutely no other option. We need to make a good faith effort to obtain the data, if applicable to the patient. Managers will receive reports regarding selection of "Data Not Available"; this will allow them to follow up to ensure that HIPAA data is being captured appropriately.

10. **Do I need to fill in the pregnancy data when ordering a test if the patient is pregnant?**
    Only if it is a pregnancy-related visit.

11. **Some areas are wondering how to proceed with their verification of orders during the transition time between September 3, 2003 (OHSU's implementation of the TCI changes) and October 16, 2003 (the federal deadline for meeting the TCI standards.) If there is no previous HIPAA data in A2K, what is the process?**
    Obtain the patient data from this point on. One of the reasons we started TCI implementation early was to have six weeks before the compliance deadline to get new orders and new admissions into the system with the proper HIPAA data. We knew that we would have some patients and orders that would pass through without the HIPAA data in these early days. If you don't have HIPAA data from the ordering provider, skip it. We will have reports in place that will track the user ID & the provider names so we can assess trends.

All new orders/admissions as of September 3, 2003 should capture the HIPAA data. "Unknown per patient" is the correct choice if a patient says they don't know e.g., the date of onset of their current illness. "Skip HIPAA Data" is the correct choice if the information is not provided to the person transcribing the order/doing the admission.

12. **I verify orders at the end of the day. What about obtaining HIPAA data if I work in the back office and do not interact with patients? What if there is no HIPAA data in A2K?**
If HIPAA data is not available in A2K, you are not expected to search for it. Reports will be generated back to managers reflecting "Data Unavailable" trends. These will indicate if HIPAA data is not being captured as it should be. You are not expected to contact the practice.

13. **What about capturing HIPAA data for non-OHSU patients seen in ancillary areas?**
Ancillaries need to update their requisition forms for both internal and external OHSU referrals to include the HIPAA data.

14. **I work in Radiology and sometimes need to order additional supplies for completion of an order. Do I need to re-enter HIPAA data when I do this?**
HIPAA data should have already been entered. You do not need to re-enter it.

15. **I thought that HIPAA dates would be required or would be filled in automatically in the case of inpatients. What do we do on the OHSUMG billing sheet if HIPAA data was not filled in when it should have been? Also, it appears to me that the dates do not print out on the requisition. I'm not sure whether I'm supposed to go back into the A2K system to try to find the data and then transcribe it onto the OHSUMG form?**
Date fields are not required so that staff are able to place orders or proceed in their processes if HIPAA data is missing or unavailable. They then have the opportunity to address this when they are able to get the data from the clinician for input. For the purposes of completing the fee ticket, if HIPAA data is not available (e.g., date of onset, date of similar illness, etc.) send it blank to OHSUMG and they will advise the department as appropriate. The HIPAA data should print on the requisition forms.

16. **For serial appointments (e.g., allergy shots, ot/pt, hemonc visits), is the referring provider data required on all visit fee tickets (or billing information)? Or just on the first consult?**
The referring practitioner data is required for all consults. OHSUMG will send charge tickets back to the departments (and always have) if that information is not on the charge ticket. The Auth/Referral #/Practitioner Name and Number fields are situational so the information is only reportable if known. Not all health plans require a referral or an authorization and those that do have a list of which services require referral/authorizations and which do not. Therefore, we would not know when this data should be expected and when there would be no need of it by the health plan.

Reporting an authorization number once is, in our opinion, sufficient. If an authorization has been obtained for a series of services reported on the first charge, there won't be an authorization issue unless the series exceeds the authorization. This needs to be monitored on the front end and an extension must be requested. As always, we can look in the system to locate authorization information not reported up front and will provide feedback to departments who had the information but neglected to include it.

If the information is on the ticket we will enter it and it will appear on the billing. But it is not required and will not cause a claim to be kicked out nor will UMG return tickets that don't have it, except for Consults.

17. **For serial appointments, where we've received authorization numbers for 'x' number of visits, we're ok as long as the office visits are within that number for that authorization. What about when we go over that 'x' number of visits? Do we need new authorization numbers, and need to add those to the tickets?**
Yes, that is what OHSUMG is anticipating. We have, for years, entered any authorization/referral information that shows up on the charge tickets and will continue to do so. When a charge denies for 'no authorization' we look in the system to find the numbers, talk to the clinics etc. to resolve the issue and will continue to do that as well. Where we determine that authorization numbers have existed all along and were not sent, we will educate regarding the need to include it.

18. **Since I have been using the new referral/authorization screens I noticed that the place where you put the actual # is still one character short of fitting most authorizations. Is there anyway to make it one character longer?**
If you're referring to the Facility authorization number, 15 characters is the system limitation as dictated by Siemens software. The limit for professional authorization numbers is 20 characters. OHSUMG indicates that that is sufficient. According to Ambulatory practices, the longest authorization number they receive is 14 characters.

19. **I do all the ordering for my department. We used to be able to "zero" out the attending Dr. field and enter in the referring physician because this is the information that the sonographers use as the referring physician. Now this screen forces you to enter in an OHSU Dr. number. This is a BIG**

problem for us. We do enter the referring physician in Decrad, but the sonographers have been looking at the OHSU Dr. number (that has nothing to do with that particular patient) and have been sending all the reports to our OHSU Dr.'s over here. Since these screen changes took effect, NONE of the referring physicians have received their reports. What should we do?

The screen builders had to change that edit. This is because charges were kicking out of FMS because the doctor number did not have the correct self-check-digit. We need to have people use the 000001 number if the attending doctor is not an OHSU doctor. That is also used for that purpose, and it will force people to enter the physicians name in the name field. We will update the doctor master help screen to assist people with this change.

20. **Is HIPAA data required for pacemaker maintenance? It is billed as durable medical equipment (DME), on the professional side, so is the HIPAA data is required?**

UMG is not billing any DME related claims; therefore the HIPAA data for professional bills is not applicable for UMG. The only DME related data we currently need is for immunosuppressant drugs & VAD machines for charges to PBS.

21. **We have providers who see patients for a consultation in the hospital. I've noticed that our (professional fee) hospital charge tickets do not have fields for Date of Onset of Current Illness, Date of Onset of Similar Illness, or the pregnancy info. I thought these data elements were required for professional billing. Why are there no fields for this on the charge tickets?**

The above data elements are required for professional billing. The fields were not included on the hospital charge tickets because we are capturing the date of onset information in A2K at the time of the admitting reservation. This information will be accessed by UMG when they submit the claims for professional fees generated during the hospital stay. This is yet another reason why it is so important to accurately fill-in the HIPAA screens when placing a reservation. Other professionals, besides your own, will rely on this data in order for us to be reimbursed for services during a hospital stay.

22. **Why do we have to complete the HIPAA screens when placing a reservation for a patient to be admitted?**

There is information about the patient that we need in order to bill for services rendered during that hospital stay, including:

- o Name of Referring provider
- o Referral Number
- o Facility Authorization Number
- o Professional Authorization Number
- o The above data elements are required for both institutional (hospital) and professional (UMG) billing. In addition to the above, the following data elements are required for professional billing:
- o Date of Onset of Current Illness, if known
- o Date of Onset of Similar Illness, required when claim involves services to a patient experiencing symptoms similar or identical to previously reported symptoms.
- o For pregnancy-related service: LMP and due date

It is likely that a number of professional services will be provided during a patient's hospital stay and we need to be able to bill for these. The date of onset information, collected at the time of admission or when placing the reservation, will be used to submit claims to the carriers for services incurred during the hospital stay. If you have staff that routinely place reservations for patients to be admitted, please educate them about the importance of completing the fields in these screens. Inaccurate or missing information could delay our billing processes and ability to get reimbursed for hospital stays.

23. **Why do we need a date of onset?**

Collection of the date of onset standardizes billing data, and is required by law. It also allows insurance companies to make coverage determinations. The date of onset needs to match the date of onset in the chart notes. The referring provider needs to include this information in the intake process.

24. **Should the front desk staff be the ones collecting HIPAA data from patients?**

In some areas, front desk staff may assist in the collection of some HIPAA data. However, typically the medical staff should collect this information. See http://www.ozone.ohsu.edu/cc/hipaa/amb_tip6.doc for some approaches that ambulatory practices are taking to address this issue.

25. **Can the date/time of appt/request default to today's date?**

No, because we need to match the HIPAA data with the appointment date that generated the need for the test. Often that will be different than today's date.

26. **Why is HIPAA data on hospital reservations?**

HIPAA data is on hospital reservations so that it can be included for any pro fees that are generated while the patient is in the hospital. This information is collected up front, and then that same information is used throughout the patient's stay.

27. **What should I put in the appt/request date/time?**
    You should put the date and time of the patient's appointment with the provider that generated the need for the test.