FIFTH EDITION

Health Information Management

Principles and Organization for Health Information Services

Margaret A. Skurka, Editor

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PREFACE

Health Information Management: Principles and Organization for Health Information Services, Fifth Edition, recognizes the continuing need for guidance in developing efficient health information management (HIM) systems for health care institutions. This important revision of the 1998 edition is designed to capture the significant changes in the HIM field and profession in recent years.

The first edition of this book was published in 1984, and it replaced *Medical Record Departments in Hospitals: Guide to Organization,* which had originally been published by the American Hospital Association in 1962 and revised in 1972. Second and third editions of the book were published in 1988 and 1994, respectively, under the title *Organization of Medical Record Departments in Hospitals.*

This book serves as a comprehensive general reference to patient records and HIM. It is useful to a health care institution's chief executive, chief operating and financial officers, and information systems technology personnel. It is also essential reading for health professionals who need a general overview and understanding of HIM practices. The text covers appropriate information for faculty and students in health information administration and technology educational programs, and it serves as an introduction to HIM practices and issues for information systems (sometimes called informatics or information technology) programs. In addition, individuals in smaller health care institutions will find this book useful in applying the basic principles of HIM. As the appropriate application of

these basic principles requires a careful analysis of the individual health care institution's needs, various operations in HIM are discussed herein.

The health care industry continues to undergo change, and the technology used in managing health information has experienced very rapid change. The electronic patient record is in place in many institutions, and the Internet has had a significant impact. The HIM managers of the future will manage data electronically, oversee document and repository systems, coordinate patient information, secure all electronically maintained information under HIPAA (Health Insurance and Accountability Act), supply senior management with information for decision making and strategy development, ensure data quality, and direct enterprise- or facilitywide HIM departments.

Throughout this book, the term *health information management* will be used to encompass both the registered health information administrator (RHIA) and the registered health information technician (RHIT), because professionals at both levels hold a variety of positions within the discipline. Specific references are made to the department director as a "HIM manager" who may be an RHIA or an RHIT. Because *health record* and *health information management* have almost completely replaced *medical record* and *medical record management,* only the current terminology will be used in this book.

The American Health Information Management Association (AHIMA) has more than 42,000 members. In addition to the credentialing of RHIAs and RHITs, the organization sponsors examinations leading to the advanced coding credentials of CCS (certified coding specialist) and CCS-P (certified coding specialist-physician). Entry-level certification as a CCA (certified coding associate) is also available, as is certification in the field of health care privacy as a CHP (certification in health care privacy). Together, all these individuals provide the expertise necessary to develop and maintain the health information systems necessary in this new millennium.

ACKNOWLEDGMENTS

A significant thanks goes out to my contributing authors for this edition of *Health Information Management: Principles and Organization for Health Information Services.* Without their assistance, this work would not have been possible. They each contributed their experience in the specific areas of health information management in which they work, which gives this text a real hands-on feel. They were timely and on point—consistently. Thank you Nancy Coffman-Kadish, Elizabeth Contant, Linda Kiger, Desla Mancilla, and Faye Pickett.

A special thank-you goes to my family, as always—husband Richard and children Erik, Kirstin, and Erin—who again, during my fifth revision of this work, showed patience, understanding, and support for long hours and weekend time spent at the computer. They've always understood and accepted my intensity and commitment with regard to this profession, and for that I am grateful. This book is dedicated to them and to my very wonderful parents, Edward and Ella Flettre Galvanek. They instilled in me both a strong work ethic and an appreciation of life.

THE EDITOR

Margaret A. Skurka, MS, RHIA, CCS, is professor and director of the Health Information Management Programs at Indiana University Northwest in Gary. She received her baccalaureate in health information management from the University of Illinois and was a warded a master of science in education from Purdue University. Skurka is actively involved in the American Health Information Management Association, having served as national president in 2000. She served a six-year term on the board of directors. Skurka has served as an accreditation site surveyor, is a past president of the Indiana Health Information Management Association, and was named that association 's distinguished member in 1987. She was named the Alumnus of the Year in the Allied Health Professions at the University of Illinois at Chicago in 2002. She is the author of many ICD-9-CM physician coding reference products. As a consultant, Skurka has worked for numerous physician practices, ambulatory care centers, and surgery centers and has conducted ICD-9-CM and CPT coding seminars across the nation.

THE CONTRIBUTORS

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Faye Pickett, MPA, RHIA, was a clinical assistant professor in the School of Biomedical and Health Information Sciences, College of Applied Health Sciences, University of Illinois at Chicago. She was the recipient of the college's Excaliber Award for Teaching Excellence in 1999 and 2000. She received her baccalaureate in health information management from Stephens College and was awarded a master's in public health from Indi-

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Health Information Management

CHAPTER 1

Health Information Management and the Health Care Institution

Faye Pickett

The terms *medical record* and *health record* are sometimes used interchangeably in referring to the document that captures the health information of a patient. However, a distinction should be made between the two types of records. *Medical record* implies that physicians participate in and supervise the medical care provided to patients in health care institutions. *Health record* is a term that encompasses not only the record of medical care provided but also a listing of services provided by nonphysician health care practitioners. This accounting may include records of an individual's health status that are kept on file with an agency, third-party payer, non–health care institution, or even by the patient. Such health records may be used in health benefits administration, applications for insurance coverage, research studies, and employment records, as well as in social service plans for individual or family care.

As the health information management (HIM) profession shifts its focus from the hard-copy paper record to an electronic patient record,

data elements become the critical component of the record. In the paper record, data elements were found on various forms. Because there are no forms in a true electronic patient record, these data elements convey the patient's encounter through computerized means.

The health record is a valuable tool in providing high-quality patient care, preventing disease, and promoting health. Health records assist the preparation of the health service statistics used to evaluate the efficiency and effectiveness of care and to substantiate the provision of patient care services and treatment. The health record supports medical education, health services, and clinical research, and it provides documentation for the reimbursement of expenditures for health care services. It is also used in developing public policy on health care, including regulation, legislation, accreditation, and health care reform.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a voluntary organization that accredits hospitals. A hospital must demonstrate substantial overall compliance with the Joint Commission's standards for hospital operations. JCAHO also accredits other types of health care facilities such as long-term care, mental health, and ambulatory care.

The Commission on Accreditation of Rehabilitation Facilities (CARF) may accredit rehabilitation facilities. Included in both CARF and JCAHO standards are requirements for the maintenance and adequacy of health records. A facility may also be certified for Medicare and Medicaid reimbursement through federal regulations, as published by the Center for Medicare and Medicaid Services (CMS). Facilities should also be licensed by the state they are in. Directly or indirectly, the board of trustees, the CEO, the medical staff, and the HIM professional all share responsibility to meet these standards, regulations, and policies regarding the health record. This chapter provides an overview of each group's role in the creation, maintenance, and protection of health information to ensure that it is accurate, timely, and complete. (See Figure 1.1.)

RESPONSIBILITY OF THE BOARD OF TRUSTEES AND CEO FOR HIM

An institution's governing body, or board of trustees, typically comprises individuals who are recognized leaders in their field and have a responsible standing in the community. Trustees may be appointed or elected by the existing board or by the corporate office to serve for a specific term.

The board of trustees is responsible for establishing policy, maintaining high-quality patient care, and providing institutional management and planning for the health care institution. To fulfill its responsibilities, the board establishes mechanisms for performing necessary policymaking, planning, and administrative functions, including functions related to HIM. These mechanisms include appointment of a CEO, support for the medical staff in quality management, and creation of appropriate committees.

The board holds the CEO responsible for implementing established policies for the operation of the institution and for keeping the board well informed about day-to-day operations. The CEO is also responsible for informing the board about federal, state, and local events that may affect the planning and operation of the facility.

The board holds the medical staff responsible for the development, adoption, and periodic review of medical staff bylaws and rules and regulations that are consistent with the facility's policy. The medical staff, as well as the staffs of other departments, are required to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care. The purpose of monitoring and evaluating is twofold: (1) to identify opportunities for improving patient care and (2) to identify and resolve patient care problems.

Although the board of trustees is ultimately responsible for the health care institution, the optimal operation of the facility requires the combined effort of the board, CEO, and medical staff. This is typically accomplished through the establishment of a joint committee to address activities and problems of mutual concern.

Figure 1.1. Responsibility for Health Information

Board of Trustees

- Corporate planning
- Maintaining quality care
- Establishing policymaking, planning, and administrative mechanisms
- Appointing the Chief Executive Officer
- Having ultimate responsibility for the health care institution

Chief Executive Officer

- Approving the budget for implementing systems for maintaining health information
- Providing direction, staffing, and facilities for HIM
- Enforcing information management regulations, policies, and standards
- Protecting health information
- Running day-to-day operations for the health care facility

Medical Staff

- Reviewing health information rules, regulations, policies, and standards
- Participating in decisions regarding health information systems format or forms content
- Specifying medical staff membership qualifications
- Delineating clinical privileges qualifications
- Authenticating medical record entries

HIM Department

- Maintaining a health information storage and retrieval system
- Preserving health information confidentiality, security, integrity, and access
- Coding and classifying health information
- Managing all patient health information
- Organizing, producing, and disseminating health information

Figure 1.1. Continued

HIM Professional

- Coordinating data collection
- Monitoring information integrity
- Ensuring access to health information by qualified individuals
- Organizing, analyzing, and evaluating health information
- Consulting on information management issues for other departments
- Compiling administrative and health statistics
- Coding diagnoses, therapies, and other procedures
- Inputting and retrieving health information
- Monitoring standards and regulations regarding information management

Maintenance and Protection of Health Information

The health record is maintained for the purpose of providing quality care. Proper maintenance of this health information serves the patient, health care professionals, and the facility. The CEO is responsible to the governing body for implementing a system for maintaining adequate health information, whether a hard-copy medical record or an electronic patient record. The CEO is also responsible for safeguarding the record and its content against loss, defacement, and unauthorized use. Federal regulations mandate the privacy and security of health information.

The CEO and the HIM Department

In addition to maintaining systems, the CEO is also accountable for the administrative functions of the institution and for delegating duties and responsibilities to subordinates. This management function includes providing the HIM department with proper direction, staffing, and facilities to perform all required functions. Therefore, it is important that the CEO know the skills and competencies of the HIM professional.

RESPONSIBILITY OF THE MEDICAL STAFF

A facility's bylaws, rules, and regulations dictate each medical staff member's responsibility for maintaining timely, accurate, and complete health records. The institution's CEO and its organized medical staff share the responsibility for ensuring that the facility's health records are complete and in accordance with the bylaws and rules and regulations for self-government approved by the board. Health record rules and regulations apply to the entire medical staff and should be uniformly enforced.

Medical staff should also actively participate in decisions regarding the maintenance of health information, including the format and design of the paper medical record or the information system in an electronic medical record. Members of the medical staff may participate in the medical record committees or forms committees.

Rule Compliance Review and Monitoring

As part of the health care facility's performance improvement activities, the medical staff is responsible for the regular review of all rules, regulations, and policies related to medical record requirements. A clinical pertinence documentation review consists of evaluating the completeness, adequacy, appropriateness, accuracy, and quality of documentation.

The objective of a review process is to ensure that each health record includes (1) sufficient documentation of the patient's condition, progress, and outcome of care, (2) documentation for the administration of tests and therapy as ordered, and (3) documentation for notification and acceptance in any transfer of patient responsibility from one physician to another. The review process should also consider the adequacy of the health record for the institution's performance improvement, utilization, and risk management activities. The standards of JCAHO imply that a quality improvement process is in place in all departments. Therefore, professionals from HIM, nursing services, medical staff, and all others involved in health record documentation should take part in the record review process.