Call for Preparedness and Political Activism

by Dan Rode, MBA, FHFMA

As I read and heard stories about the emergency support and rescue efforts after September's terrorist attacks, three things came to mind. First, I thought about our medical systems' preparedness. Those in hospitals and other healthcare facilities often go through disaster preparedness drills, but we will never respond to a drill in quite the same way again. Although hospitals in New York and Washington did not receive the casualties they expected, they did what was necessary to prepare for them and support the teams at the crash sites. This preparedness was critical.

I also thought about disasters within our healthcare organizations, whether from fire, flood, earthquake, tornado, or man made. Currently, our records and data are spread across organizations in a variety of media. As facilities move toward a fully computerized patient record, are we prepared to reconstruct the full medical record in or after a disaster? Do we have the back-up systems we need? Are they separate from the facility site?

In recent discussions with congressional staff, the issue of capital investment in healthcare information services has been raised. The healthcare industry is known for its conservative approach to operational and capital investment in information services, and one of the questions is how to provide incentives to invest in such data systems and processes. It is difficult, when you are busy with daily HIM activities and functions, to think about investment in back-up and disaster software and storage and other necessary technology. But perhaps this is the time to begin such planning and investment. Congress is understandably engaged in discussions and legislation related to our recent tragedy, but soon it will turn back to the issues of medical errors, patient safety, privacy, and healthcare data. If we are going to be prepared for disasters of all kinds, we need to address capital investment in information technology, both in our institutions and as a country.

Finally, I observed the outpouring of American kindness in the aftermath of this tragedy. The renewed fervor of patriotism and involvement demonstrates the public's ability to get involved with government. This sort of involvement is always needed and I encourage AHIMA members to direct some of this vigor to HIM issues that need attention at the national and local levels in the future. We need to educate policymakers about HIM roles, functions, and processes and about the key issues we have discussed here and elsewhere.

Over the next 16 months, Congress and the Bush administration will deal with key issues that affect HIM. Among these will be HIPAA as we currently know it, plus healthcare and Internet privacy issues, medical errors and patient safety, healthcare work force shortages (including HIM) and training solutions, and healthcare data management and coding issues. In these discussions, members of Congress will ask how these issues affect not only the nation, but their own constituencies. Are you willing to respond to these questions? Will you be able to add to these discussions by educating members of the healthcare industry and Congress about the needs, problems, and solutions to these HIM issues? Full and active participation in the legislative process is one of the best ways to ensure that problems are addressed. Let's stay involved and together we can address any challenge.

CMS Accepts AHIMA's Recommendations on New Technology

One of the items AHIMA recently addressed with the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) was CMS' proposal for "payments for new medical services and new technologies under the acute care hospital inpatient prospective payment system" (PPS). As part the proposed rule published in the May 4 *Federal Register*, CMS made recommendations that included changing the processes used by the ICD-9-CM Coordination and Maintenance Committee and use of codes under ICD-9-CM, Volume III.1 AHIMA and 60 other individuals and groups responded to CMS's suggestions in written comments in June.

In the September 7 *Federal Register*, CMS responded to these comments with a final rule that generally follows AHIMA's recommendations.2 Future ICD-9-CM Coordination and Maintenance meetings in 2002 will be changed to an April and

December timetable to expedite the inclusion of new technology. Updates to the ICD-9-CM codes will continue to occur once a year given the current constraints of the coding system, as well as provider and CMS processes and systems.

On a short-term basis, codes will be assigned from ICD-9-CM, Volume III categories 00.00 through 00.99 and 17.00-17.99. CMS recognizes the limitations of using these categories and the problems that they present to coders, but until the full issue of a new procedural coding system can be addressed, they will have to suffice.

AHIMA also suggested that CMS separate the issue of new technology (devices) versus new procedures, keeping the former out of the procedure coding system. CMS has acknowledged this concern, but has not indicated how it will deal with new technology in the future.

The issues regarding new procedures and technology will not go away. Over the last few month we worked with Congress on problems and possible solutions. You can expect that these will be addressed in the coming months. Comments like those submitted by AHIMA on new technology come from active communication with and education of our legislative representatives.

Notes

1. The May 4, 2001, *Federal Register* can be accessed online at www.access.gpo.gov/su_docs/fedreg/a010504c.html.
2. The September 7, 2001, *Federal Register* can be accessed online at www.access.gpo.gov/su_docs/fedreg/a010907c.html.

Dan Rode (dan.rode@ahima.org) is AHIMA's vice president of policy and government relations.

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