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Check the OIG work plan for insights on areas to shore up for 2001

Feds are planning more than 100 initiatives next year

Practices looking to avoid the long arm of fraud and abuse laws in the coming year should be paying particular attention to the 2001 work plan just released from the Office of Inspector General (OIG).

The plan provides a road map of the areas that OIG investigators will pay particular attention to over the next year, and contains more than 100 initiatives by federal investigators. Practice managers will want to study the plan for areas that might relate to their organizations, then identify policies and procedures that may need shoring up. You may even consider launching internal audits in specific areas to test for compliance problems, and educating staff and physicians about regulatory rules, advise experts.

Hot spots in the OIG's work plan include:

• **"Incident to" services.** The OIG plans to look at the conditions doctors use to bill for care given "incident to" their professional services. The OIG is particularly interested in the quality and appropriateness of these claims, and the types of "incident to" services being billed.

• **Advanced beneficiary notices.** ABNs are documents on which patients attest that they know or believe Medicare won't pay for a treatment before they receive the service. There isn't a standard protocol for how physicians hand out these notices to Medicare beneficiaries, particularly for noncovered laboratory services.

• **Critical care coding.** The OIG wants to see if physicians are billing appropriately for common critical care codes when a patient is critically ill and requires constant doctor supervision.

• **Home health.** The OIG plans to examine the extent of physicians' involvement in approving and monitoring home care for Medicare patients. Investigators will look at the extent of physicians' medical relationships with their home health patients, and how much they rely

on the home health agency to determine what care a patient receives, all in light of the new home health prospective payment system.

• **Nonphysician services to seniors.** Given the expanded role nurse specialists, nurse practitioners, and physician assistants have taken on in many heath care settings, the OIG wants to see if these nonphysician providers are practicing within legally set limits, and what effect their care has had on patient care and costs. ■

Review areas outlined for Part A payments

Hospitals, home health under OIG microscope

The 2001 work plan for the Office of Inspector General includes several hospital-, home health- and hospice-related areas that will be examined. An review of these areas by the Foley & Lardner law firm of Washington, DC says the hospital targets will include:

• **DRG-related payment window.**

The OIG will review hospital compliance with settlement agreement provisions that prohibited duplicate billing for nonphysician outpatient services under the prospective payment system (PPS). The OIG will also initiate a companion review to determine whether Part B service providers, such as laboratory services, submitted duplicative claims for services provided to inpatients.

• **Patient transfers.**

The OIG will check for improperly reported transfers between PPS hospitals, and seek to recover overpayments related to those transfers. One of the new transfer-related projects involves an assessment of utilization patterns for 10 DRGs. For these DRGs, federal law requires that postacute services be treated as transfers and not discharges for payment purposes. According to Foley & Lardner, the OIG will review provider utilization patterns, such as whether the provider issues notices of noncoverage to beneficiaries or codes inpatient stays to fall into other DRGs, to determine whether providers are attempting to circumvent the new rule.

• **Outpatient services.**

The OIG will review implementation of hospital outpatient PPS, specifically the effectiveness of internal controls used to ensure services are adequately documented, coded, and medically necessary. One OIG project will evaluate whether outpatient pharmacy and medical supply services were appropriately billed in periods before implementation of outpatient PPS. Specifically, the review will focus on charges for self-administered drugs, which are generally not covered under Medicare Part B, and charges for undocumented, unnecessary, and noncovered medical supplies and services.

In the home health field, areas that Foley & Lardner expect to be examined include:

— compliance programs;

— impact of the new home health prospective payment system;

— physician certification of medical necessity for home health patients.

For skilled nursing facilities, areas being examined include:

— quality-of-care reviews at these facilities, especially the role of medical directors;

— PPS billing requirements;

— ineligible stays;

— physical therapy services;

— quality standards.

For hospice care, review areas include:

— plans of care;

— payments to nursing homes;

— continuous home care. ■

Tips for avoiding a Medicare Audit

ACP-ASIM advice for avoiding trouble

It's no secret that the government is paying much more attention to physician coding and billing practices in an effort to ferret out fraud and abuse.

This means it's even more important than ever that practices pay close attention to their coding and claim filing procedures. As those practices that have been there will tell you, having to go through even a small-scale audit by a local Medicare carrier can be a painful process.

Here are some tips from the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) on keys to avoiding the specter of a Medicare audit.

• **Get the codes right.** Make sure that your CPT codes indicating services rendered match the services actually rendered — and that your ICD-9-CM codes indicate diagnosis support of any ancillary services ordered.

• **Don't bill all office visits at the same level.** Nothing raises a red flag for auditors like a physician who over uses one particular level of service.

Tip: Even intentionally under-coding patient visits in an effort to avoid scrutiny can attract the auditors, since they expect to see a variety of different codes being filed.

• **Pinpoint responsibility.** Many experts say only a physician should write down the appropriate code. This eliminates the hassle of having your staff guess what codes were intended based on sparse notes or past practice. Bottom line: When the doctor delegates coding to other people, you end up with more coding mistakes.

• **Write everything down.** A few words on a scratch pad won't work when it comes to documentation. In today's compliance climate, you must be able to prove the scope of the medical history covered, the extent of the physical exam, and the complexity of your medical decision making.

When making progress notes, for instance, you should discuss assessments, diagnoses, and plans for care. If you asked for a family history say so in the notes. "Document the negatives," says **Alice G. Gosfield**, a health care lawyer in Philadelphia. "If you looked at some system and it was normal, write it down. For example: 'Heart rhythm and rate regular.'"

• **Beware of templates.** Because they find the documentation requirements for HCFA's evaluation and management (E/M) guidelines so burdensome **(see story p. 181)**, some practices use template encounter forms that list various systems or procedures.

Warning: Simply checking off all the items on a template — or running your pen from the top of the form to the bottom to indicate that you covered all areas — may be as risky as not documenting at all, advises the ACP-ASIM. In fact, a government auditor might even assume you just routinely check off such items and start wondering if your forms really reflect what happened in specific encounters.

That's why it's critical to add handwritten notes if you use a checklist. You don't even have to use complete sentences. But it is critical that physicians actually hand write something at each of the locations on the template where they're documenting the service, advise most experts.

• **Demonstrate medical necessity.** In addition to recording encounters, carefully document the reasons for all ancillary services, including what you ordered and the diagnosis that prompted you to order them, suggests the ACP-ASIM. You want to do this because you can't assume your reasoning for ordering a particular test or service will be clear to an auditor who might be reading the file months, even years, later.

Spell it out

"A lot of physicians think the reason a test is ordered can be inferred from the progress note," says **William A. Sarraille**, a partner with the Washington law firm Arent Fox. "The reality is that the people doing the auditing have different backgrounds than physicians. What they will infer and what the doctor [implies may be] different things. Go the extra step and make it explicit."

Tip: Include the results of all tests in the

Time for a compliance pop quiz for your staff

Now that the OIG has unveiled its compliance guidance for solo and small practices, it's time to get serious implementing these guidelines. Here's a short set of questions developed by **Roy Snell**, a health care consultant with PricewaterhouseCoopers, to gauge the familiarity of your employees and physicians with your compliance efforts.

• Are you aware of the compliance program and its function within the organization?

• What are the basic elements of our code of conduct?

• Do you know how to report a compliance problems?

• Do you trust the reporting mechanism?

• What are the principal risk areas or compliance problems in your department?

• Can you give any examples of actions the office has taken over the past six months to promote compliance? ■

patient's record. If an auditor asks for information, send everything you have."

• **Audit your practice regularly.** A baseline audit — done internally or with the help of a consultant — can help uncover documentation problems. **(See related story, p. 181.)**

• **Create a compliance program.** Now that the OIG has issued its compliance guidance for solo and small practices, there's no excuse for not using these guidelines to start an organized in-house compliance program.

• **Maintain good patient relations.** Outside of knowing their specialties, one of the best things physicians can do to protect themselves is to stay on good terms with their patients, says **M. Gregg Bloche**, professor of law at Georgetown University. A patient who is upset with his or her doctor is more likely to complain to Medicare about their treatment, he says. ■

Develop a plan to handle investigative intrusions

How to respond to warrants and subpoenas

As the pressure to ferret out fraud and abuse continues, government investigators and prosecutors find themselves under professional and political pressure to close big cases.

As the Office of the Inspector General's work plan for next year shows, "billing practices, cost reporting requirements, and referral relationships are among the top general issues the government is focusing on," notes **Susan V. Kayser**, a health care attorney with Arent Fox Kintner Plotkin & Kahn, in New York City.

With no end in sight for the present high pace of investigations and prosecutions at the federal, state, and local levels, the "current environment is a hostile one for health care providers," stresses Kayser.

Do you know what to do should you discover your organization is the subject of a government investigation?

Here's some tips from Kayser on how to address such situations to minimize any disruptions to your operations while protecting your legal rights.

• **Have an effective early response.** Effective handling of a government investigation is critically important, stresses Kayser. Since these investigations can take months, even years, it's critical to take a streamlined, "business as usual" response early on that minimizes the disruption to the facility's daily routine.

More importantly, "An efficiently handled investigation can substantially reduce the risk of a criminal indictment or civil charge," she notes.

• **Dealing with search warrants and subpoenas.** These are perhaps the most intimidating of the investigative tools available to the government, especially when armed agents arrive unannounced with a search warrant demanding to see and search provider documents. Whether you are hit with a subpoena or simply receive a telephone call from an auditor asking for certain information, remember that the OIG has the power to exclude a provider from the Medicare program if it fails to grant "immediate access upon reasonable request" to government officials. Obstruction-of-justice charges also can be leveled against providers who don't cooperate with government audits and formal investigations.

• **How to respond.** Creating set procedures for responding to a possible government investigation should part of your overall formal compliance plan, Kayser recommends.

An effective way to develop a response plan is to designate a response team directed by someone from the management team.

One product of this planning process should be a set of guidelines outlining what rights and responsibilities employees have if you are ever investigated.

"These guidelines should begin with a reaffirmation of the facility's commitment to high ethical standards and then advise employees that, as a routine matter, government representatives may wish to interview them on the facility's premises during the course of an audit, when a subpoena is served, or when a search warrant has been executed," says Kayser. Employees should also be aware that:

— Government agents may contact them at home, unannounced.

— They should not destroy or alter documents once an audit or investigation has begun.

— They should talk to the response coordinator before trying to create documents in an attempt to respond to government investigators.

— They have the right to speak with an investigator, but they're under no legal obligation to do so. In turn, if an employee consents to questioning, he or she also has the right to be interviewed

in the presence of a facility representative or an attorney employed by the facility.

— If an employee wants his or her own lawyer, the facility will help arrange that.

If contacted by an investigator:

— Ask employees to inform the facility's response coordinator of the contact.

— Before speaking with an investigator, employees should first ask for the investigator's identification.

— Remind employees that they have the right to choose the time and place of an interview and may terminate the interview at any time.

• **Dealing with search warrants.** Should you be served with a search warrant, the designated response coordinator should immediately contact the organization's lawyer. If your attorney is not immediately available, "the response coordinator should request that agents delay the search until counsel can be contacted, even though such a request is likely not to be granted," advises Kayser.

Monitoring the search

Whether or not an attorney is involved in the situation, the person acting on behalf of the facility should then:

— obtain agents' identification and agency affiliation, and verify credentials;

— identify the agent in charge;

— communicate key information and requests only with the agent in charge;

— ask for a copy of and examine the search warrant, noting the specific areas of the facility designated for the search;

— ask for the name and telephone number of the supervising prosecuting attorney;

— ask what the agents are seeking, and attempt to ascertain the nature of the inquiry and the alleged violations that are the basis for the investigation;

— treat the agents courteously;

— urge employees to remain calm and reiterate the advice set forth in the facility's written guidelines for employee communications with investigators, discussed above;

— advise employees not to make small talk with the agents;

— send nonessential employees home;

— monitor the actions of the search team, making notes of areas searched and the general description of items seized;

— object if agents stray outside the physical space identified in the search warrant;

— identify for the agents documents sought that fall under the attorney-client or self-evaluation privileges;

— attempt to convince the agents to take only computer files, not the entire computer hardware;

— be careful that any statements made to the agents during the course of the search are accurate;

— at the close of the search, ask for an inventory of documents taken;

— request the opportunity to make copies of all documents to be taken by agents;

— compare the list of seized documents on the government's receipt (to be signed by the facility) with the list created by the facility during the course of the search;

— after the agents have departed, immediately inform the facility's compliance officer of all activity in connection with the search.

While it's important that you ask for information about nature of the investigation, "the facility should take care not to interfere with the search," Kayser stresses. Additionally, the response coordinator needs to ensure that:

— employees do not volunteer documents or information not specified in the search warrant;

— documents are not hidden, destroyed, or altered in any way;

— documents are not be created to "cover" missing documents;

— employees are not be prohibited from speaking with the agents;

— no statement, other than the government's receipt for seized records, is signed without consulting with an attorney familiar with investigative practices.

• **How to handle subpoenas.** While subpoenas are less dramatic than search warrants, you still use many of the same principles to respond to them. For instance, if served with a subpoena, immediately contact your lawyer and don't discuss anything with government agents until talking with your counsel.

Designate one person to coordinate — in consultation with your lawyer — the search for documents specified in the subpoena. Do not turn over any documents not requested in the subpoena.

All documents gathered by facility employees should be returned to the coordinator, then forwarded to your lawyer who'll review them to determine which are not responsive to the

subpoena or whether a privilege applies. No documents should be turned over to the government without final approval from counsel.

Tip: If the subpoena demands original documents be produced, make a copy for the facility's file, using a distinguishing color of paper to identify it as a replacement for the original.

• **Handling telephone, letter, and on-site requests.** Less threatening and disruptive than a search warrant or a subpoena, "inquiries from government agencies that appear to be informal should not be taken lightly, especially in today's enforcement climate," Kayser advises.

In these situations:

— Identify the agency requesting the information.

— If the inquiry is made by telephone, refer the call to the facility's coordinator to ask about the reason for the call.

— If possible, then refer the caller to your attorney for a response. ■

How to waive fees and avoid legal trouble

Here's a policy that may work for you

One of the most sensitive compliance questions for providers is how to help patients with financial problems by charging them less for a particular treatment, or offering a colleague a professional courtesy discount without getting into potential fraud and abuse trouble.

In fact, "Most providers find that the intent of laws and regulations affecting what has been called the practice of "courtesy discounts" to be so onerous that they have completely eliminated the practice of providing discounts on a courtesy basis, and have adopted a policy of only providing discounts based on patient financial need," notes **Scott Jones**, author of the *Medical Practice Compliance Manual*.

Here is a sample courtesy discount policy developed by Jones showing how providers can safely waive fees for patients with financial troubles; or as a professional courtesy for a colleague.

1. The practice will not waive fees or allow discounts based on the potential that the individual(s) receiving discounts may be in a position to directly or indirectly influence patients or otherwise refer patients to the practice, in accordance with federal anti-kickback statutes.

2. The practice will under no circumstances waive co-insurance, deductible payments, or other out-of-pocket expenses for the patient and subsequently bill the patient's insurance carrier, in accordance with 42 U.S.C. 1320a-7a(a)(5) and the Civil False Claims Act.

3. If the practice chooses to waive all fees charged a patient as a "courtesy discount," the following criteria should guide this process:

• The patient or patient's immediate family should not be in a position to influence patients, refer patients, or otherwise provide services that may be considered to be of financial benefit to the practice or practice physicians.

• The entire fee is waived, and no insurance carrier is billed any amount for the services rendered.

• The patient does not receive a significant financial benefit from the waiver of fees.

4. The practice may elect to establish a "hardship waiver of fees" for patients who are in financial need. The following criteria should guide the process of extending a hardship waiver:

• The process of determining financial need and authorizing waiver of fees should be confidential and managed by practice administration rather than physicians, in order to establish that waiver of fees has no impact on the provision of medical services.

• The practice uses a generally acceptable measurement tool to determine financial need. A suitable tool may be the U.S. poverty guidelines (available via the Internet at www.aspe.hhs.gov/poverty, and from the *Federal Register*).

The poverty guidelines used should be the same guidelines established and issued by the Department of Health and Human Services (as opposed to the poverty measure issued by the U.S. Census Bureau), and are the same guidelines used to establish eligibility in certain federal health care programs. The guidelines are updated annually and the practice should maintain the current year guidelines as its measurement tool.

• The practice establishes a policy in which any patient may apply for and receive a hardship discount through a specific review of documents that establish the patient's eligibility. The

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Physician's Coding Strategist™

Mine the patient history for vital chart data

Better documentation means better coding

Properly documenting a patient's history is fundamental to correct evaluation and management coding. Here are some tips from **Brett Baker**, a coding and reimbursement expert for the American College of Physicians-American Society of Internal Medicine, on what to do and not do when documenting a patient's medical history.

First, it's important to remember that besides the data gathered from the medical exam and the physician's decision-making skills, the level of service selected is primarily influenced by the information gathered when taking the patient's health history, says Baker.

The CPT 2000 recognizes four types of history for E/M service codes. A history can be:

- problem-focused;
- expanded problem-focused;
- detailed;
- comprehensive.

Each type of history includes some or all of the following elements:

- chief complaint (CC);
- history of present illness (HPI);
- review of systems (ROS);
- past family and/or social history (PFSH).

"You should use your clinical judgment and the nature of the presenting problem to determine the extent of the history of present illness, review of systems, and past family and/or social history," advises Baker.

In documenting the history of a present illness physicians can use either the 1995 or 1997 E/M guidelines until HCFA releases a new set of instructions. Both the 1997 and 1995 E/M guidelines state that history of present illness is a chronological description of the development of the patient's present illness from the first sign or symptom, or from the previous encounter to the present encounter. It includes the following elements:

- location;
- quality;
- severity;
- duration;
- timing;
- context;
- modifying factors;
- associated signs and symptoms.

"According to the 1995 guidelines, a brief history of present illness consists of one to three elements, while an extended history of present illness consists of four or more elements," says Baker. "You should describe these elements in the medical record."

According to the 1997 guidelines, a brief history of present illness consists of one to three elements (identical to the 1995 guidelines), while an extended history of present illness consists of at least four elements, or the status of at least three chronic or inactive conditions. Baker also advises describing these elements in the medical record.

The following questions are good for determining the extent of the history of present illness:

- Where does it hurt? (location)
- How is the pain incapacitating? (severity)
- Does it increase in the evening? (timing)

The history of present illness elements listed in the E/M guidelines (location, severity, timing, etc.) generally pertain to patients with acute problems. For documenting the history of present illness of a patient with a chronic or inactive condition, the 1997 E/M guidelines specifically refer to chronic conditions when discussing an extended history of present illness.

"Although you will not necessarily touch on the

same elements in the guidelines that fit more closely with an acute problem [location, quality, severity, etc.], you should ask other questions to determine whether your history of present illness for a patient with a chronic condition is brief or extended," he says. Sample questions could include:

- Are your symptoms recurring?
- Are you sticking to your medication regimen?
- Has your blood sugar been normal?

Since the current two sets of guidelines don't spell out specific elements or questions relating to chronic or inactive conditions, Baker says you should just ask what you feel is most appropriate under the clinical circumstances.

Many practitioners are not sure if the time that they spend counseling a patient's family member or other care decision makers can be considered when deciding on a level of E/M service.

"Before answering that question, it helps to first review the criteria determining when a physician can choose a level of service based on time spent counseling," recommends Baker. CPT 2000, for instance, states that time spent with a patient can be the key factor in selecting a level of E/M service when counseling or coordination of care accounts for more than 50% of the encounter.

Baker's advice is to select a level of service by determining the "typical time" assigned to most of the E/M service codes that corresponds to the amount of time you spent with the patient.

CPT 2000 defines counseling as a discussion with a patient or family concerning one or more of the following:

- diagnostic results, impressions, or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction;
- patient and family education.

Here's an example. If you spent 20 minutes of a 30-minute face-to-face encounter counseling an established patient during an office visit you would qualify to bill CPT code 99214 because the 30 minutes of face-to-face time exceeds the "typical time" of 25 minutes, says Baker. "You could bill CPT code 99214 regardless of the extent of history, examination, and medical decision making."

Then there is the issue of time spent counseling a patient's family member or decision maker. "Medicare recognizes time a physician spends counseling a family member and/or other care decision maker only if the patient is present," he notes. Time spent counseling without the patient present cannot be used as the key factor in determining which level of E/M service to bill.

Here's something to remember: Medicare's policy of requiring the patient to be present is more restrictive than the CPT 2000 definition of counseling. As such, Baker recommends excluding the time you spend counseling family and/or other care decision makers when the patient is not present if you are using counseling to determine the level of service billed.

"Of course, Medicare also recognizes the time a physician spends counseling a patient directly," he adds.

An exception

Medicare makes one exception to the requirement that a patient must be present for time spent counseling a family member or other caregiver when the physician is providing critical care. The exception states that time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options may be counted toward critical care time only when:

1. The patient is unable or incompetent to participate in giving a history and/or making treatment decisions.
2. The discussion is absolutely necessary for treatment decisions under consideration that day.
3. All of the following four elements are documented in the physician's progress note for that day:

- the patient was unable or incompetent to participate in giving history or making treatment decisions, as appropriate;
- the necessity of the discussion (e.g., "no other source was available to obtain a history" or "the patient was deteriorating so rapidly I needed to discuss treatment options with family immediately");
- the treatment decisions for which the discussion was needed;
- the substance of the discussion as related to the treatment decision.

HCFA memorandum B-99-43 to its Medicare carriers provides them with these instructions. For a copy of the memo, go to www.hcfa.gov/pubforms/transmit/pmemos.htm. ■

Pick an E/M guideline and stick with it

Self-audits can find holes in your operation

Selecting the correct evaluation and management (E/M) code can be more art than science This is especially true given the current state of flux over issuing a final set of revised E/M guidelines. Until finalized — which may take two more years — the Health Care Financing Administration (HCFA) says that practices can use either the 1995 or 1997 E/M guidance when making coding decisions.

Barb Pierce, a coding consultant with Professional Management Midwest, in Des Moines, IA, advises that you "pick whichever guideline works best for you, then stick with it."

She prefers the 1997 guidelines because the 1995 guidance is more vague in specialty-specific issues. For instance, the 1995 E/M guidelines provide no related definitions, but still require a comprehensive multi-organ system exam.

No matter which E/M version you choose, unless there's proper documentation to go along with your codes you risk triggering bells and whistles in the HCFA audit office.

One sure way to set yourself up for an audit is to code E&M consultation consistently at a level 4 or 5. Always claiming a high consultation level will put your claims outside the curve compared to what other physicians are submitting for similar situations, which is just the kind of thing auditors look for.

Prospective reviews help spot errors

Conducting so-called prospective reviews of claims before they are filed is a powerful way to cut down on costly errors and prevent hassles with HCFA and its intermediaries.

Here are recommendations from Pierce to help improve your prospective review of E/M codes:

• **Don't take the physician's word that the documentation is adequate.** Do regular sample reviews to spot any patterns of improper coding.

• **Make sure medical records are complete and legible.** "It's not whether you can read them, but whether a consultant or outside auditor can read them," Pierce stresses.

• **Document patient encounters.** This needs to include the reason for the encounter and relevant history, physical examination findings and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and legible identity of the observer. If there is no documentation, the rationale for ordering diagnostic and other ancillary services should be easily inferred. "Medical necessity must be proved. You must link diagnosis with procedure code," she emphases.

• **Other past and present diagnoses need to be available to the current treating and/or consulting physician; appropriate health risk factors should be identified.** The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

• **The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.** "If the physician did a 99214, there must be documentation for a 99214," she says.

• **Encounter forms and the medical record should relay the same information.** "Oftentimes, the physician doesn't do documentation for days or weeks or longer," which creates the possibility of a conflict, she notes.

Tip: One way to avoid this situation is to create a "progress notes" system for physicians who don't immediately dictate their notes. This is a system in which they simply check appropriate boxes on a form when they see a patient. It is somewhat crude, but it also "prompts the physician to document certain procedures," notes Pierce. ■

How coding reviews could save you $30 million

Good reviews can save you bundles

Is precise coding really that important? If you're still asking that question, even just occasionally to yourself, consider this: "The University of Pennsylvania is now in the process of paying $30 million to settle an action that grew out of a government review of just 100 of its medical records," notes **Lynne Northcutt-Greager**, a coding expert with the Medical Group Management Association (MGMA) in Englewood, CO.

Add to that the fact that quality coding helps minimize delayed or incorrect reimbursement and

reduces denials based on lack of documented medical necessity, which improves fast flow.

"The best mechanism for improving your coding performance is a coding review," stresses Northcutt-Greager. Regular coding reviews need to be a basic part of your compliance program. Whether or not you're already doing scheduled reviews, here are some suggestions from Northcutt-Greager and MGMA on how to structure a coding review for maximum effectiveness:

• **Set goals.** What are the goals of the review? Should it be prospective or retrospective? What types of services should be looked at? Which payers will you focus on? Are there multiple locations that need to be reviewed?

• **Choosing a reviewer.** The criteria for selecting a coding reviewer depends on the areas on which your organization needs to focus. Different reviewers will approach the review from different perspectives, depending on whether their backgrounds are in accounting or insurance, for example. Consider the reviewer's qualifications, expertise, education, and training. Make sure the reviewer knows your specialty and the issues on which you want to focus.

• **Scope.** Once the reviewer has been chosen, you need to decide on the scope of the review. The reviewer and administrator should work together to decide whether the reviewer will: examine physician production; review forms used in the organization; compare medical record documentation to actual services provided; compare payer billing requirements to specific patient records; and review operational areas like billing processes and information flow.

"There's no standard reviewing format that covers all the bases for every practice," notes Northcutt-Greager. Reviews will vary depending on the organization's size, specialty, and payer contract requirements. That's why it is important that the reviewer gears the review to the issues affecting your organization.

• **Post-review.** After the review, you'll have to start thinking about how to implement the reviewer's recommendations. Be prepared; this could involve further evaluation, training sessions, software upgrades, corrected billings or refunds, or even consultation with legal counsel, she advises.

Basically, "you'll need to respond to anything that's a potential compliance problem."

Here are some other recommendations from the MGMA for immediately upgrading your coding:

• Make sure current copies of coding books and reference materials are available to everyone involved in the coding process.

• Send staff to seminars on coding.

• Hold periodic staff meetings to discuss coding issues.

• Communicate updates and make Medicare and other payer bulletins available.

• Make sure everyone responsible for accurate coding understands the material. ■

Coding assessment offered

The American Health Information Management Association (AHIMA) in Chicago has developed a web-based program with the educational coding needs of health care organizations in mind.

"Coding Assessment and Training Solutions" provides an opportunity for organizations and coders to assess coding skills and knowledge, and to keep abreast of the latest coding practices and policies. The program allows organizations to validate the coding skills of staff members, and to discover where improvement is needed.

The initial phase of the interactive program addresses the area of assessment. This portion provides resources to assess and validate individual coding skills and identify areas requiring improvement. The results of the testing allow organizations to assess their need for ongoing and future coding training.

After assessing knowledge in such areas as coding principles, coding guidelines, document analysis, problem solving, and data management skills, training needs may be outlined. The online training materials include instructional information, exercises and actual case applications.

Training includes coursework in up to 19 different specialty areas. Online access and self-administration will allow users to learn at their own pace, dependent on initiatives and time available. All training allows users to accrue continuing education hours.

For more information about "Coding Assessment and Training Solutions," contact AHIMA at (312) 233-1158. ■

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practice may request copies of the patient's most recent tax return or employee W-2 income statement to determine actual income of the patient's family unit.

• The actual income of the patient's family unit is compared to the U.S. poverty guideline. If the patient's family unit income falls below the established poverty level in the guideline, fees may be waived.

• The practice widely publishes or posts information on the process and the availability of fee waivers and offers access to the process to all patients who wish to apply.

5. The practice will not claim fee waivers as "bad debt" for cost accounting purposes that may affect federal healthcare programs.

6. The practice will not waive payments from patients who do not qualify as being financially needy.

7. Documentation will be maintained in a separate patient business file, rather than the patient medical record, as to the qualification for financially needy status and any waiver of payments.

8. Practice physicians will not reduce, limit, or withhold treatment in any way for patients who qualify as financially needy. ■

HCFA offers reassurance about hospice certification

Don't fear long-living patients

The Health Care Financing Administration (HCFA) is putting out the word that physicians won't automatically be in trouble if their elderly hospice patients outlive their doctor-certified eligibility for Medicare's hospice benefits.

According to the law, a Medicare beneficiary becomes eligible for hospice benefits when the person chooses palliative or other care from a hospice, and when a physician and a hospice medical director certify that the patient has a medical prognosis of six or fewer months to live.

Some physicians have been audited for not properly diagnosing patients then inappropriately enrolling them in a hospice. "Nevertheless, that is very different from situations in which a terminally ill patient has had the good fortune to live longer than predicted by a well-intentioned physician," notes a HCFA official.

Under HCFA rules, hospice patients can continue to receive Medicare benefits after six months as long as a physician "properly and conscientiously" recertifies the end-of-life prognosis. About 10% of Medicare patients receive hospice benefits longer than six months, according to HCFA.

To minimize future confusion over this six-month requirement, HCFA plans to develop a voluntary program in which physicians and hospice directors can turn to Medicare contractors for advice on a patient's hospice eligibility. This, in effect, would be akin to getting pre-authorization to enroll that senior in a hospice program. ■

Form 855 changes would ease red tape

Enrollment form would be more user-friendly

After months of negotiating with physician representatives, the Health Care Financing Administration (HCFA) has finally developed its proposed changes to the Medicare enrollment form, Form 855.

Key changes include:

• Institution of new separate applications for individual health care practitioners; health care organizations that will bill Medicare carriers; and health care providers that bill Medicare intermediaries.

• Obtaining the education compliance information it needs from attachments submitted with the application. As a result, individuals will not be required to duplicate this information within the application.

• Improving the Change of Ownership (CHOW) section to help capture when a CHOW has been made and how a current owner can terminate its enrollment.

• Eliminating the requirement to use Form HCFA-855C to make changes.

• Eliminating the requirement to collect prior information about the applicant's Medicare billing numbers, or carrier/intermediary. HCFA has also eliminated the board certification requirement.

• Eliminating the need to capture information on the same person if he or she was an owner

and managing or directing employee.

• Allowing a practitioner to state that all of his or her services are being provided in a group setting. As a result, the individual practitioner will have fewer data elements to complete, and most information will be captured on the group's application. Rendering services in a fixed location will be separated from those rendered in a mobile or portable setting.

• Eliminating information concerning parent or joint venture or subsidiary information.

• Eliminating the need to request a billing agreement with every application. The application incorporates specific billing agreement questions to determine if an applicant understands and is meeting the appropriate regulation. ■

Look before you leap into practicing via e-mail

Monitor your telephone communication policies

While studies show that patients are eager to communicate with their doctors on the Internet, many physicians are reluctant to take the plunge into patient e-mail and web pages for fear they'll be opening up themselves to a host of problems.

The Internet can be an efficient and effective tool for communicating with patients, but physicians should take some precautions, advises **Bob Waters**, a health law attorney with Arent Fox Kintner Plotkin & Kahn in Washington, DC.

"The fundamental issue that any physician or health care provider has to face in dealing with a patient in person or on-line is whether they have the information necessary to render a diagnosis or prescribe an appropriate treatment," Waters says.

As Internet technology progresses, physicians are likely to be able to practice interactive medicine over the Internet by video streaming or videoconferencing that makes the experience more like face-to-face contact in the office, Waters says.

But even now, patient-physician e-mail can be a time-saver for both parties in many instances as an alternative to phone tag. "The current way of leaving a message and having the doctor call you back is very inefficient. E-mail could be a very efficient way to deal with questions and problems," he adds.

Physicians who use the Internet to communicate with patients must have the same kind of safeguards in place that they would use if the patient called into a doctor's office — plus a few others, warns **Karla Kelly**, an attorney with San Diego-based Luce, Forward, Hamilton & Scripps.

"The [key to] Internet communication is that the professional remains cognizant at all times that he needs to exercise the same kind of judgment and discretion as in any other kind of communication," Kelly says.

Before establishing a web site or e-mail communication system, see a health law attorney and work out some of the issues that might come up so your exposure will be minimized, Kelly suggests.

Check with your insurance carrier to make sure you will be covered under your malpractice policy for Internet communication. Make sure if you are communicating with patients over the Internet that you are also complying with the policies of any institution, such as clinic or hospital, with which you are affiliated.

The same issues come up for other professionals who talk to clients over the Internet. The issues are different if you are talking about established patients whom the physician has seen and treated or people who are simply part of a response to a web site. **(For details on how to respond to e-mail from people on your web site, see related article, p. 185).**

Confidentiality issues

"One reason physicians are reluctant to communicate on the Internet is the physician-patient confidentiality issue," Kelly says. For instance, once you or the patient is on the Internet, anybody coming into the room at either end can see the screen. This could violate confidentiality laws, particularly since in most states the relationship between patient and physician is even protected from family members, Kelly says.

Put some mechanisms into place to ensure that the person sending the e-mail is the patient and that the information coming across the line is protected, she advises.

There is no method of accurately determining that you are, indeed, communicating with your patient unless you employ a system of codes,

which would be cumbersome, Kelly says. Instead she advises physicians to get their patients to sign a release form before they communicate by e-mail. The release form should release physicians from an inadvertent breach of confidentiality, if it occurs on the patient side of the communication.

The form should make patients responsible for monitoring the information on the computer screen and for making sure that they are the only ones in their household who communicate with the physician about their medical condition.

The biggest difference in answering a patient inquiry by e-mail and answering it by telephone is the patient's expectation that e-mail will be answered more quickly, Waters says. That's why you should carefully define the nature of the e-mail service your are providing and set criteria for how often it will be answered, he says.

Tell patients upfront how quickly they can expect an answer so that patients in a life-threatening situation aren't sitting around waiting for an e-mail to be answered, he advises.

Obligation to respond

Physicians have the same obligation to respond to e-mails as they have to respond to telephone calls, Kelly points out. "Doctors should have someone monitoring their e-mail just as they have someone monitoring the telephone."

If you come up with an arrangement to contact patients by e-mail, make sure you set standards for retrieving the messages similar to your standards for answering the telephone. Keep in mind that communicating by the Internet does not release you from the ongoing obligations to treat patients as you would normally, Kelly points out.

If it's an existing patient, recognize that you may be operating on less information than you would if you see the patient in person, Waters adds.

"The Internet cannot take the place of appropriate face-to-face meetings. Physicians still must make sure they physically see the patients when they need to do so," Kelly says.

Set up the same type of triage-type mechanism you have for telephone calls so that your staff can determine which patients e-mailing a question or concern need to come in for an appointment.

If you customarily charge your patients for telephone consultation, you should be able to charge for an e-mail consultation, Kelly says.

When you do correspond with a patient by e-mail, make sure you print out a copy of the correspondence and insert it in the patient file. "Proper documentation is essential for any kind of communication," she says. ■

Avoid relationship roles in your web site practice

Don't give specific advice to questions on the web

If your practice has a web site and you routinely answer e-mail from people who go to the site, you should make it clear that you're not entering into a physician-patient relationship, health law attorneys advise.

"Physicians don't want to casually participate in an Internet chat group or host a web site that is supposed to be informational, and then find out through a lawsuit that someone perceived that they had a more formal relationship than the physician intended," says **Bob Waters**, an attorney with Arent Fox Kintner Plotkin & Kahn in Washington, DC.

Approach giving advice over the Internet as if you were asked for medical advice at a cocktail party, advises **Karla Kelly**, an attorney with San Diego-based Luce, Forward, Hamilton & Scripps. "You have to be very careful how you respond. If you give advice based on specific facts, you can be setting up a physician-patient relationship," Kelly says.

Having an informational web page with e-mail capabilities is an ongoing problem for many professions, Kelly says. If you have a web site or get an e-mail from a someone who isn't an established patient, make it clear that you are providing only general information, and not patient-specific information

"To the extent that web sites are crafted to invite people to ask questions about their medical conditions, physicians are opening themselves up to allegations that the physician-patient relationship is being established," Kelly says. The danger in physicians responding to e-mail from people who go to their web site is that they are creating a relationship with a lot of obligations attached, she adds.

"If you establish a physician-patient relationship through the Internet, it means you have an obligation to manage and not abandon the patient.

But to the extent that a physician merely sends out general advice about a particular condition, it's like publishing a medical article. If you're not dealing with a specific problem for a specific person, you are pretty safe," Kelly says.

Waters cites hypothetical example of a cardiologist who receives an e-mail from someone who is having chest pains but adds that he had a pepperoni pizza for dinner. The questioner wants to know if he could be having a heart attack or is merely experiencing indigestion.

If this isn't your patient, you could say that you can't answer the question and advise him to call his or her own physician. Or, you could explain in general the symptoms of a heart attack, and advise that person that if he is experiencing any of those symptoms he should go immediately to the emergency room.

Your web page and your e-mail correspondence resulting from a web page should have a disclaimer that you are not giving medical advice and that people with whom you are communicating should see a physician if they need treatment.

Patient-generated disclaimer

Waters suggests going a step further than just a disclaimer to protect yourself. He advises against a common Internet mechanism in which a person scrolls through the text and clicks a button to show he or she agrees.

"When a person merely clicks that he's read the disclaimer, it is still uncertain whether he's actually read or paid attention to the text. It's unclear to what extent that would be interpreted as providing informed consent," Waters says.

Instead, he suggests a mechanism for logging into the site or sending an e-mail that requires the person to actually type a statement that they agree that no physician-patient relationship is being established.

"It is protection for the provider and it makes it clear to the person asking the question that they cannot construe the reply as medical advice," he says. ■

Aetna budges on some rigid capitation issues

Is a kinder, gentler era coming?

The ice between capitated physicians and insurers may be thawing a bit. Just recently physicians in two states scored some policy changes they've been pursuing for quite some time.

In Georgia, the Atlanta-based office of Aetna announced these changes, effective Jan. 1, 2001:

- Independently contracted primary care physician practices with 200 or fewer Aetna U.S. Healthcare HMO members will receive fee-for-service payments.
- Physicians will receive 90 days advance notice of significant payment or administrative changes to provider contracts, which will have a material adverse financial impact.
- Regular meetings will be scheduled with the Medical Association of Georgia to discuss ongoing issues.
- Computer discounts and free Internet access will be available to all physicians, dentists, nurses, and medical students across the country via an agreement with Hewlett-Packard Company and NetZero, Inc.

HMO enrollees will see some new flexibility, given these changes:

- simplification of the precertification process, including the areas of outpatient surgery, most durable medical equipment, and many types of injectable drugs;
- the option to use specialists as a principal physician for members with serious illnesses.

'More collaborative' doctor-HMO tie

Georgia physicians called upon Insurance Commissioner John Oxendine to achieve these changes. "These policy changes are just the beginning of our overall efforts to strengthen relationships with Georgia physicians and,

COMING IN FUTURE MONTHS

- Do you have to accept more Medicare patients? A physician's options
- Evaluation and management field tests
- Revisions to the Stark Law rules
- Finding the best compensation combination for your practice
- "Incident to" considerations to keep in mind

indeed, with all our constituents," says Aetna's Georgia-based general manager **Mary Louise Osborne**. "My sincere hope is that these initiatives will form a more respectful and collaborative relationship with the medical community."

Oxendine describes the changes as a move in the right direction. "We have been working for some time to improve the relationship between doctors and HMOs for the ultimate benefit of consumers," Oxendine says. "I'm glad our work is paying off. Aetna's announcement represents a significant first step."

Two weeks earlier, Aetna made a peace offering to California physicians who have vociferously protested high drugs costs amid what they decry as rigid, underpaid capitated agreements. Aetna announced that it will immediately pay doctors the cost of any new vaccines recommended by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention. This includes payment for the newly released vaccine Prevnar, which protects infants and children from pneumococcal infections that can cause ear infections and meningitis.

Once the appropriate capitation increases are determined and Aetna and the physician medical groups sign the new contracts, the medical groups will regain financial responsibility.

New 'corporate attitude'?

"Through our conversations with the CMA [California Medical Association] and the AAP, we were made aware of the financial challenges physicians are facing to provide the new vaccines to their patients prior to the change in their contracts," says **Howard Arkans**, MD, regional medical director for Aetna in San Ramon, CA. "This policy will ensure that our [policy holders] in California receive the appropriate immunizations for their children and that physicians are compensated accordingly for the cost of providing the vaccine to our members."

Aetna officials are touting these changes as significant shifts in corporate attitude. "This commitment by Aetna shows that health plans and physicians can sit down together to find solutions that are in patients' best interests. Our discussion and Aetna's decision could mark the beginning of a new kind of managed care — one in which physicians, patients and health plans can work together toward the best care within a financially sound, quality health care system." ■

Reimbursement ROUNDUP

Discrepancies found in pay times

The Office of Inspector General has found what it calls a series of serious discrepancies in records tracking how fast the Health Care Financing Administration (HCFA) pays physician claims.

HCFA's National Claims History File, for instance, shows the agency paid more than 80% of

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its Part B claims before expiration of the mandatory 14-day waiting period. But the OIG researchers also found HCFA's Contractor Reporting of Operational and Workload Data (CROWD) system reported less than 1% of Part B claims were paid before the waiting period closed.

The OIG's report, "Inconsistent Medicare Data Concerning Carrier Payment Dates (OEI-03-00-00350)," is available on the web at http://www.dhhs.gov/progorg/oei. ▼

HCFA approves biofeedback pay

The Health Care Financing Administration (HCFA) has announced it will cover biofeedback treatments for Medicare beneficiaries with urinary incontinence.

According to an Oct. 6 coverage decision memorandum, biofeedback therapy is for the treatment of stress and urge incontinence in patients who fail to benefit from or are unable to perform pelvic muscle exercises.

"HCFA's decision is an important victory for physical therapists and their patients with urinary incontinence," says American Physical Therapy Association President **Ben Massey**.

The coverage decision memorandum is available at http://www.hcfa.gov/quality/8b3-x.htm. ▼

Basing pay on 'man-days'

Here's an interesting approach for paying physician-partners at Rehlen Bartlow & Goodman MDs, a single-specialty dermatology practice in Southern California. This practice's compensation system is based around days worked by its doctor shareholders, with consideration for individual production. It works like this:

• Add up each partner's "man-days." In addition to the number of days each physician works each month, the practice uses two adjustments — a larger one for conducting in-office skin cancer surgery; a smaller one for performing hospital consults. A busy physician working 20 days in a month who also performs a lot of surgery can end up with 27 man-days.

• Calculate a dollar value for each man-day. Each quarter, the practice determines its profit without considering the partners' pay, then divides that by the partners' total of man-days. to get a man-day dollar value.

• Multiply the man-day dollar value by each partner's man-days to arrive at an overall pay level. ▼

Cap rates rising, study finds

Nearly 70% of providers and HMOs report their capitation rates have increased this year, and 78% say they are either seeking more capitation or maintaining their current level of risk agreements for global coverage, primary care, hospital services, and ancillary services, finds a National Health Information survey. The study also found:

— On average, 2000 global per member per month rates increased 7.4% compared with the 1999 average, rising from $107.88 pmpm to $115.95 pmpm.

— Average commercial primary care rates increased 8.8% compared with last year, rising from $11.07 pmpm to $12.05 pmpm.

— Twenty-six of 35 specialties saw their commercial cap rates rise this year. Specialties with hikes in the double digits included endocrinology, laboratory, neurology, psychiatry, and radiology.

— Sixty-nine percent of providers said their capitation-related business is more profitable than their discounted fee-for-service business. ■

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