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PHYSICIAN'S PAYMENT UPDATE™

INSIDE

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Hospitals leery of owning practices; physicians leave with blessing

Give yourself time to re-establish a private practice

Systemwide integration may have been the mantra of health care gurus during the 1990s, but these days disintegration is growing in popularity as more physicians leave the hospitals that purchased their practices to return to private practice.

Discouraged by the poor profits of practices they often paid a premium price for, many hospital owners are encouraging their physician-employees to make the move back out on their own.

Hard numbers on how many hospitals are divesting their physician practices are difficult to come by. However, some experts contend up to one-third of health systems are considering paring down at least part of their physician networks.

Tenet Healthcare Corp., for instance, plans to slash its stable of practices by 75% nationwide. At its peak in 1998, Tenet owned 1,000 doctor practices. By May 2001, it expects to own only about 250.

Harry Anderson, Tenet's Arizona-based vice president of corporate communications, said Tenet is losing $100 million a year on its physician practices. "We're not alone," he observes. "Virtually every hospital chain has reported the same experience. Obviously, something was wrong with the model because everyone has failed with it."

Losing proposition

In 1999, hospital-owned multispecialty group practices lost more than $50,000 per full-time equivalent physician, found the *2000 Cost Survey* by the Medical Group Management Association (MGMA). In contrast, similar practices not owned by a hospital earned a profit of just over $2,000 per full-time physician, says the Englewood, CO-based organization.

Wanting to cut their losses while staying on good terms with the local physician community, many systems are engineering so-called "soft

landing" strategies to help the doctors in their captive practices move out on their own. In the Philadelphia area, for instance, Tenet has helped organize an independent practice association to assist former employee-physicians with everything from group purchasing of malpractice insurance to negotiating managed care contracts.

In Wilkes Barre, PA, another hospital system has used a similar strategy to cut loose some of its physician practices. Mercy Health Partners has created an alliance with the largest privately owned medical group in the area to give its 45 employee doctors the option to join that group and to acquire stock in a management services organization company jointly owned by the hospital chain and the physician group.

Other hospitals have developed generous outplacement programs that turn over any outstanding accounts receivable, let doctors buy back equipment at its fair market value, and toss in six months' severance pay to physicians who decide to end their employment contract.

Prepare your exit strategies

Most experts say physicians planning to leave their hospital-owned practice to start their own shop need to allow at least it three to six months to plan their exit strategy properly.

Here are some tips from the American College of Physicians-American Society of Internal medicine in Philadelphia on putting together an effective exit plan:

• **Practice valuation.** Your practice will need to be valued and sold back at a fair market price — which probably will be significantly less than what it was worth five years ago — to avoid questions from federal regulators and the IRS.

Warning: The Office of the Inspector General is concerned that some hospital "give-backs" of physician practices are little more than illegal kickbacks intended to encourage physicians to continue referring patients to the hospital.

• **Furniture and equipment.** Hospitals are frequently willing to sell back office equipment to doctors. After the hospital does a valuation, you can usually negotiate a price. Be aware, however, that hospitals cannot legally just give you back your equipment.

• **Payer contracts.** You'll have to renegotiate all contracts with insurance companies, HMOs, and other payers, so get started early on that. Also, expect to wait three to six months for a new Medicare provider number.

• **Accounts receivable.** Although you will start billing patients from day one, collections will not start coming in for 60 to 90 days. Depending on whether you expect to be paid or whether you want to cover your operating expenses and pay staff, MGMA consultant **Robert C. Bohlmann** recommends that primary care physicians who are starting over borrow $75,000 to $150,000 per doctor.

One of your top priorities, therefore, should be to develop a good relationship with a bank, because you'll probably need to borrow a fair amount of money the first few months. Be sure to have enough funds to pay for rent, equipment and buying back the practice from the hospital, reminds the ACP-ASIM.

• **Patient notification.** If your present contract prohibits you from telling patients or staff you are leaving and asking them to come with you, you may want to re-negotiate this provision. ■

Physician pay based on bottom-line performance

Benchmarking becomes a popular tool

Most physician practices are basing doctor salaries on how much each contributes to the group's bottom line, reports the Medical Group Management Association (MGMA), of Englewood, CO.

MGMA's *Performance and Practices of Successful Medical Groups: 2000 Report Based on 1999 Data*, also found there are a wide variety of ways to measure a physician's production and profit contribution.

Some payment programs tie physician compensation to such production indicators as collections, gross charges, or units of physical work like relative value units or visits, notes MGMA consultant **Bruce Johnson**.

Typically, the profit-contribution approach starts with the physician's baseline production numbers then subtracts some measure of the costs the group incurs to support the practice. Among the more popular ways to measure physician-related costs in production-oriented pay system include:

— Strict cost allocation, which allocates costs based on use.

—- Modified cost accounting, which groups costs into "buckets" that are then charged off individually, by individual production, or by equal shares.

—- Market norms, where costs are allocated based on a how each provider ranks on a pre-set benchmark.

Benchmarks becoming popular

Benchmarking is an increasingly popular tool in designing physician compensation programs. While the majority of practices simply use benchmarks to ensure their pay rates are competitive, others build them right into their compensation calculations.

Benchmarks are especially popular in production-based pay programs. According to the MGMA, for instance, some practices:

—- Rank physicians according to their productivity compared to their peers in their own specialty, using RVUs and gross charge data — then deduct their overhead costs using MGMA overhead ratios, with lower ratios for higher-ranking producers.

— Pay physicians a pre-set rate per encounter, determined by dividing the median national compensation for each specialty by the national medians for ambulatory and hospital encounters for that specialty.

— Pay each physician the median national pay rate per relative value unit.

— Use a ratio derived from a variety of benchmark sources to be sure a physician generates enough revenue to cover his or her base salary plus a full share of overhead, before paying out any bonuses. ■

Specialist shortage likely in some disciplines

Specialty limits being reconsidered

Mounting evidence of a physician specialist shortage is prompting a federal advisory committee to reconsider work force recommendations that seek to limit the number of physicians in training.

"The growing swell of anecdotal information is prompting us to review our assumptions," says **David Sundwall**, MD, past chairman of the Council on Graduate Medical Education. "A number of specialties have contacted us with concerns of dire shortages." Among the specialists forecasting a shortfall of practitioners: anesthesiologists, gerontologists, cardiologists, pulmonologists, urologists, oncologists, gastroenterologists, hematologists, and a variety of intensive care physicians.

"It's not just a problem, it's a crisis," says **Stuart Siegel**, MD, director of the Children's Center for Cancer and Blood Diseases at Children's Hospital in Los Angeles. State medical associations in Michigan, Ohio, West Virginia, Washington, Oregon, and California also have reported physician specialist shortages.

As a result, salary increases and incentives intended to lure sought-after specialists have more than doubled while primary care physician salaries have remained flat, says the American Medical Association.

The American College of Cardiology estimates demand for cardiologists will rise 66% by 2030. However, the number of cardiologists is only expected to increase by about 30%.

Meanwhile, the Dec. 6, 2000, issue of the *Journal of the American Medical Association* reported that while the number of doctors who specialize in intensive care will decline "slightly" by 2030, the demand for their services will rise 66%, which it said will hurt the elderly in particular. ■

Changes in Medicare notice applauded

Elimination of 'unreasonable' clause hailed

Proposed changes in the wording of Medicare's advance beneficiary notice to make it more patient-friendly are receiving kudos from physicians.

"The proposed changes are better than what's been there," says **Bruce Bagley**, MD, board chairman of the American Academy of Family Physicians. "We want the form to be relatively simple and straightforward so that everybody can understand it."

After several years of effort, the Health Care Financing Administration (HCFA) hopes to have a final revised version of the notice ready

sometime this year. Medicare rules say physicians must give patients a the notice telling them that certain services, which are usually paid for by Medicare, may not be reimbursed in a particular situation. For example, this may include a laboratory test that is not covered for a patient's specific diagnosis or extra visits to a nursing home.

While HCFA provides a model notice physicians can use, it has allowed providers to craft and use their own versions in the past. However, this practice is expected to stop once HCFA finalizes its new form.

A major complaint about HCFA's current advanced beneficiary notice is that it contains "insurer-speak" language that many physicians say interferes with the doctor-patient relationship. Specifically, the notices tells patients that Medicare pays only for services that it decides are "reasonable and necessary" under existing law.

"This can imply to some people that their doctor may be ordering a test that is not necessary," says **Stephen Imbeau**, MD, a member of HCFA's Practicing Physicians Advisory Council.

"What the government really means by that is that it's considered by Medicare not to be medically necessary, which means it's not covered by Medicare. That's two different meanings of the same words," he notes.

HCFA's proposed form eliminates the "reasonable and necessary" language, replacing it with a short explanation of Medicare's coverage policies. The form makes clear, for example, that "there may be a good reason to receive a service that your doctor recommended, even though Medicare does not pay for it."

Similar language is also expected to be included in a new notice that the agency is developing specifically for lab services.

Length seems to be the biggest current roadblock to revamping the form to everyone's satisfaction. It presently is two pages long and many providers say that is too long to be useful.

The American Medical Association would like to shrink the notice to just one page. To do this, it is lobbying to edit out what it says is a wordy and confusing explanation of the Medicare appeals process.

"The form should simply inform beneficiaries that they have a right to appeal if the patient receives the services and Medicare does not pay, and that beneficiaries can contact Medicare for further information on appeals," the AMA noted in a comment letter to HCFA.

Consumer advocates, however, say patients should be given more detailed information up front about filing an appeal.

"The patient should have this responsibility, especially since this would provide the physician and the patient with an opportunity to discuss any alternative course of treatment in the absence of the tests declined by the patient," according to the AMA. ■

Modified gainsharing plan wins OIG approval

Agency grants one-year exception to ban

The Office of the Inspector General (OIG) has given the green light to a narrowly structured gainsharing proposal that permits a group of cardiac surgeons to share in the savings produced as part of a hospital cost-cutting project, despite an existing ban on such arrangements.

This move in January (Advisory Opinion No. 01-1) was the first exception issued by the OIG since it effectively banned gainsharing arrangements between hospitals and physicians in July 1999. Under such arrangements, individual providers or practices can receive a percentage of any cost cuts they generate for the a hospital.

In announcing the ban, OIG said hospitals and physicians could legally enter into certain personal service arrangements in which hospitals pay physicians based on a fixed fee that reflects fair market value for services rendered, rather than a percentage of cost savings.

Over opposition from providers, the OIG also directed hospitals to "expeditiously terminate" such gainsharing programs.

Despite several legal questions about the January proposal, the OIG decided to approve an arrangement based on the fact it was of "limited scope" and because numerous safeguards had been built into the arrangement.

Even then, the OIG's blessing was conditional since it limited its approval to one year. After that year, federal regulators will review the agreements to determine if the related financial benchmarks need to be revised before deciding if it will approve a renewal or extension of the arrangement.

Here's how the arrangement is structured: The gainsharing arrangement identified 19 "specific cost-savings opportunities" where participating

surgeons would be rewarded with a percentage of any related savings they could generate, according to the OIG.

Under the agreement, cost savings would be measured based on the surgeons' use of specific supplies and medications during designated cardiac surgery procedures. The proposal also linked any financial give-backs to the surgeons' group practice to specific cost-saving activities, not general savings, the advisory opinion noted.

The OIG also stated that, under the proposal, the cost savings would be independently verified and that only currently employed surgeons (not those subsequently hired) would be eligible to take part in the arrangement.

In addition, each surgeon included in the proposal shares equally in the savings distribution, thereby eliminating an incentive for an individual surgeon to generate disproportionate cost savings or reduction in services.

The proposal applies to services for all patients, both those privately insured and Medicare and Medicaid beneficiaries.

Safeguards were added

One key factor in gaining the OIG approval was that various safeguards were included to protect against inappropriate reductions in services, the OIG opinion noted. For instance, the proposal will use objective historical and clinical measures "reasonably related" to the practices and the patient population at the hospital to establish a "floor" below which no money would be paid to the surgical group.

Another critical safeguard was the decision to include statistically valid quality of care indicators and objective clinical indicators to calculate the cost savings being measured.

To review the OIG's advisory opinion, go to: www.hhs.gov/oig/advopn/2001/index.htm. ■

See yourself through claim review eyes

What payers look for when reviewing claims

Whether they work for the government or a commercial insurer, all auditors look for basically the same types of things when reviewing health care claims for payment. Knowing what these audit keys are and how plans use them to avoid paying a claim can help your practice avoid snags in payment progress.

Key factors to be aware of include:

• **Automated edits.** Carriers use automated methods to edit or quickly check claims for obvious inaccuracies or incomplete information that will kick the bill back to the provider to be fixed.

Be warned that a pronounced pattern of extensive or similar mistakes can prompt a carrier's computer to "red-flag" the practice for a more extensive audit. Depending on the pattern identified, investigators might decide to look at all the recent claims submitted by a particular provider, focus on a certain kind of claim filed by a specific physician, or tag all the claims submitted for an individual beneficiary.

Some of the common mistakes carriers look for in these first-level edits which can get your claim denied and kicked back include:

— Provider or beneficiary ID number is wrong.

— Patient has other insurance.

— Procedure and the place of service do not match, i.e., a hospital code was used for an office visit.

— Procedure codes and the diagnostic codes do not match.

— Diagnostic codes are incomplete.

— Medical services that should be included as part of a global fee are unbundled and billed separately.

Carriers often collect this kind of information on a specific provider for 18 months to four years to try to identify a particular pattern of questionable denials — or a billing profile that is out of sync with other providers.

If a red light does go off, auditors may want to pull your records for a closer look at your billing history.

High on the list of activities that make investigators suspicious is the appearance of an unusually high claim volumes for a specific CPT code or kind of service. What looks to be a superhuman level of billings for one person during a given 24-hour period or work week for certain services or individual patients will also raise eyebrows among claim examiners.

• **Prepayment review.** The next step in the audit food chain is the prepayment review, where the carrier sets aside certain types of claims by a particular provider for closer

examination before payment.

The good news is that if you do not receive further communication from the carrier fairly quickly asking for more information about a claim, it probably found nothing and the bill is being paid. But if reviewers find what they feel are questionable claims, these will be set aside for a closer look — and possible fraud and abuse investigation. ■

Changes in Stark II greeted warmly by physicians

Final rule considered more physician-friendly

The Health Care Financing Administration's Jan. 3 release of the first part of the long-awaited Stark II final rule "should allow physicians and health care businesses to stay competitive in a rapidly changing industry while protecting beneficiaries and taxpayers," says **Robert A. Berenson**, HCFA's acting deputy administrator.

Under the Stark II statute, if a physician or a member of a physician's family has a financial relationship with a health care entity, the physician may not make referrals to that entity for services such as radiology and all inpatient and outpatient hospital services, under the Medicare and Medicaid programs, unless an exception applies. The statute also prohibits an entity from presenting or causing to be presented a Medicare claim or bill to a third-party payer for the services provided under a prohibited referral, according to the document.

The Stark II statute was passed in 1993 and became effective in 1995. But due to the complexity of the law and physician referral issues in general, HCFA did not release a proposed rule until January 1998, and that was met by a storm of criticism. The Jan. 3 final rule was revised in many aspects to reflect this criticism.

The Stark II law built on the "Stark I" statute, which made it illegal for physicians to refer Medicare patients to clinical laboratories in which the physicians have a financial or compensation interest.

The final rule for the Stark II law will be divided into two parts. Phase I was published in the *Federal Register* Jan. 4 (66 *Fed Reg* 855). HCFA says that Phase II of the rule will be published soon after the comment period for the Phase I rule is closed on April 4. The Phase I rules are scheduled to go into effect Jan. 2, 2002.

The Phase I rule includes substantial improvements in the provisions relating to group practices and academic medical centers, says **Sanford V. Teplitzky**, an attorney with Baltimore's Ober, Kaler, Grimes & Shriver law firm.

"The rule seems to acknowledge that teaching and research physicians affiliated with medical schools require funding from teaching hospitals. Before this, there was no such acknowledgment," he says.

Bill Sarraille, an attorney with Arent Fox Kintner Plotkin & Kahn, in Washington, DC, says he is "cautiously optimistic" about the new regulation. He says he particularly likes the more flexible approach to the rigid "direct supervision" requirement under the in-office ancillary services exception.

The final rule eases the criteria for qualifying as a group practice and conforms the supervision requirements to coverage and payment policies for the specific services published by HCFA.

Under the original proposed rule, a physician in a group practice would have had to meet stringent supervision requirements to be able to refer a patient for a designated health service. However, the final rule makes the supervision standard consistent with Medicare coverage and payment rules.

Sarraille also applauds changes that allow a group practice to have site-specific cost or revenue centers, and one that allows productivity bonuses to physicians based on designated health services that they personally perform.

Other significant measures in the rule include:

• **Outsourcing hospital services.** According to Sarraille, the final rules appear to eliminate a major obstacle to the outsourcing of hospital services under arrangement entities owned by physicians.

In reaction to the new outpatient prospective payment system, in which reimbursements for some services have been cut dramatically, many hospitals may be looking to outsource parts of their outpatient services to entities that will come into their facilities and provide those services under arrangements with the hospital. In these situations, the outsourced entity provides the services subject to the utilization review of

(Continued on page 43)

Physician's Coding Strategist™

Here's some help with LMRPs, ABNs

Educate all players, consultant says

Local medical review policies (LMRPs) are among the more challenging aspects of complying with Medicare medical-necessity criteria. They're also another potential reimbursement headache, points out **Jim Smith**, senior health care consultant for Accelerated Receivables Management Ltd. in Park Ridge, IL.

LMRPs, developed by local fiscal intermediaries and carriers under the direction of the Health Care Financing Administration, address tests and procedures that have a higher likelihood — based on claims histories — of not meeting the Medicare criteria for being medically necessary and reasonable, Smith says.

Certain medical indicators, in the form of appropriate diagnosis codes, must be documented and accompany the physician's order for the tests and procedures affected by LMRPs, he notes. "Should the diagnosis code not support the LMRP medical indications for the test or procedure, local fiscal intermediaries and carriers have edits built into their claim systems, which render the claim denied for payment."

38 LMRPs and counting

In Illinois, for example, there are 38 LMRPs in existence and nine more in development, Smith adds. "One of the LMRPs is for an electrocardiogram. Should the patient be sent to a hospital for an EKG with the diagnosis of 'chest pain NEC [not elsewhere classifiable],' the test would be covered according to the existing Illinois LMRP for electrocardiogram."

However, he explains, if the physician also orders lab tests — a complete blood count, electrolytes, and blood glucose, for example — the diagnosis does not justify those tests according to the LMRP and the charges would be denied. Additional signs or symptoms, such as "fatigue and malaise," would be required to justify medical necessity, Smith adds.

Uncovered services

Medicare guidelines will not allow providers to bill patients for uncovered services based on LMRPs unless an advance beneficiary notice (ABN) is signed by the patient before the service is performed, says Smith. He emphasizes that providers may not obtain ABNs on all Medicare patients for all tests ordered to prevent themselves from lost revenue. "ABNs are to be obtained only when the test or procedure ordered is impacted by an LMRP."

Providers must keep proof of signed ABNs on file — hard copy or on-line — to satisfy Medicare auditors, he adds. If the provider bills patients for noncovered services and is not able to demonstrate that an ABN was secured before the service, Medicare can hold the facility liable for violating its contractual agreement and may impose significant financial penalties, Smith cautions. "Dollars associated with tests and procedures provided that do not meet LMRP medical-necessity criteria are lost unless an ABN is signed in advance. The dollars cannot be written off to bad debt or charity."

Failure to manage LMRPs and obtain ABNs appropriately, he points out, can result not only in lost reimbursement, but in charges of fraud being brought against the provider. ■

Make your claim denials work to your advantage

Tracking remittance notices spotlights problems

Since commercial and Medicare payers keep detailed profiles of questionable claims submitted by each provider it deals with, a physician practice can use this information to spot patterns and weaknesses in its own coding and billing operations.

One of the easiest and best ways to start accumulating this information is by tracking the reasons for denial cited on the Remittance Advice Notice received from your Medicare contractor.

Based on data from the Health Care Financing Administration, some of the leading reasons for denying claims are:

• **Poorly documented or outdated diagnostic codes.** To avoid mistakes, make sure your diagnosis codes have been both updated, for physicians and in your computer systems. Stress that they need to be as complete and specific as possible.

The more detail and documentation you have to backup your coding choices, the less likely your claims will be denied.

If you have had problems with frequent denials based on questions of medical necessity, for instance, you may want to check with the carrier and get its latest policies regarding coding for those particular conditions or services. Also get a list of the medical protocols it considers appropriate for how these services should be performed or what it feels are legitimate alternative treatments for these conditions.

• **Medicare is this beneficiary's secondary payer.** One of Medicare's new policing priorities when it comes to processing claims is to ensure it does not get struck paying the bill for patients who should have been covered by private insurance. This makes it important that you have patients update their information, including their most recent employment or retirement status and any alternative coverage each time they come in for a visit.

Tip: To avoid possible denials, consider asking patients to call Medicare and update their files themselves.

• **Duplicative claims.** If you are have a significant number of claims returned because they were duplicates of bills already submitted or currently being processed, check your computer software and billing system for possible bugs. If no problems are found there, you may have simply resubmitted too quickly a bill that needed additional information.

• **Incomplete or inaccurate physician ID and referral numbers.** A simple cross-check of your claims processing software will validate whether the various physician identification and referral numbers required by Medicare have been correctly entered for each physician in your practice.

• **Referrals.** Well-designed forms and office procedures will help eliminate any referral-related payment problems.

Tip: Patient registration forms should have a space to list the physician who referred them to the practice. The same is true for charge slips so the treating physician has enough room to clearly write to whom they referred a patient. This information should be automatically logged into the patient's computer file, with a cross-check to ensure the data are complete and included on the claim. ■

HCFA creates panel on APC groups

The Health Care Financing Administration (HCFA) in Baltimore is establishing an advisory panel on ambulatory payment classification Groups (APCs), which are used in Medicare's prospective payment system (PPS) for hospital outpatient services. The Balanced Budget Refinement Act of 1999 required that the panel be created.

The APC panel, created in adherence with the Federal Advisory Committee Act, is being established to review the clinical integrity of the APCs and their weights. The panel's advice will be considered by HCFA as it prepares the annual proposed rule updating the outpatient PPS to be published in the spring. The final outpatient PPS update rule for the following calendar year is scheduled to be published in late fall.

The panel will also help to ensure seniors and disabled Americans receive appropriate outpatient care by making recommendations on how Medicare classifies these services when it determines payment rates under the APCs. The panel will consist of up to 15 members who must be representatives of Medicare hospitals (including Community Mental Health Centers) that are

subject to the outpatient PPS.

The panel will provide technical advice and will concentrate on operational aspects of the APC system. It is not a policy-making body. The Panel must consult with entities and organizations, such as the medical device and drug industries, with expert technical knowledge of the components of the APCs. ■

New claim clearinghouse may begin this summer

But will it really speed payments?

With a lot of hoopla last year, seven large insurers announced they were collaborating to form a new Internet-based electronic claims clearing house to process healthcare bills.

The San Diego-based MedUnite says its system will permit practices to securely submit about half a dozen health care administrative transactions and receive responses in real time over the Internet. The startup is funded by Aetna U.S. Healthcare, Anthem Inc., CIGNA HealthCare, Health Net Inc., Oxford Health Plans, PacifiCare Health Systems, and WellPoint Health Networks.

Once the pilot phase is over, MedUnite hopes for a nationwide rollout this summer.

When fully operational, practices will be able to submit paperwork for claims, claim status, eligibility verification, benefits determination, patient referrals, and treatment authorization for a flat monthly fee.

MedUnite's CEO, **David Cox**, says one advantage of the system is that it will be able to immediately tell doctors whether a claim they have submitted is "clean" — contains no errors — rather than have to wait for the traditional review process, which is typically 14 days, before learning if there are any problems with a claim.

However, since MedUnite clients will not be paid electronically, at least at first, they must still wait for snail mail to bring their money.

If you are filing claims electronically, you probably use a so-called claims clearinghouse to process your submission. These clearinghouses "edit" and format the claims according to individual insurers' standards. If a claim contains "technical errors" —- i.e., it can't be read by insurers' information systems or data elements are missing — the claim is rejected and must be resubmitted.

Claims that are clean are forwarded to the insurer in question where they are edited or reviewed for patient-specific criteria, including patient eligibility. If the insurer has a question, or feels the claim has not been properly formatted or documented, it gets kicked back for correction. As a result, it is often several weeks after submission before a practice learns a claim is not going to be paid.

According to MedUnite, only about half of all claims submitted to insurers are considered clean.

Many experts says the real advantage of being able to file claims electronically will come when physicians are able adjudicate claims on-line in real time with insurers — then be paid electronically. Such a system would mean practices could depend on receiving their money within a few days after a claim is submitted, instead of the average 45 days —or more — it takes now.

Indeed, Empire Blue Cross Blue Shield of New York says it will soon test a program in which it will pay claims electronically within 48 hours. Other insurers are considering using the e-mail systems to handle reimbursement. ■

Medicare has toll-free lines for billing and claims

The Health Care Financing Administration announced in December that toll-free telephone service is available to physicians, hospitals, and other home health providers who care for Medicare beneficiaries, to answer their questions about billing, claims processing, and other Medicare-related issues.

Previously, providers paid long-distance phone charges to call the private insurance companies that process and pay Medicare claims.

Providers will also get information at no cost from the 68 Medicare call centers, bringing the toll-free service to providers in every state, the District of Columbia and U.S. territories. The toll-free lines serve all Medicare physicians, home health agencies and durable medical equipment suppliers.

Each center has its own toll-free phone number, which contractors are publicizing through bulletins and Web sites. Messages informing providers

about the availability of the new toll-free service have been placed on all existing toll lines. ■

HCFA postpones UB-92's 6.0 implementation date

The Health Care Financing Administration has delayed the implementation date for version 6.0 of the UB-92 until April 1, 2001, due to problems that delayed providers' ability to test, according to Transmittal A-00-100, dated Dec. 22. In April 2000, HCFA had announced that versions other than 6.0 would not be supported after Dec. 31, 2000.

The instructions applied to all providers in addition to all coordination-of-benefits trading partners. In the meantime, fiscal intermediaries will need to support both versions (6.0 and 5.0) of the UB-92.

Providers should not wait until March 31, 2001, to manage the conversion. To monitor progress made by the facility, reports must be submitted weekly on Tuesdays.

The entire transmittal is available at www.hcfa.gov/pubforms/transmit/A00100.pdf. ■

AHIMA develops Internet guidelines

The American Health Information Management Association (AHIMA) has developed a set of fundamental principles and list of operational tenets it recommends as a blueprint for protecting the security of patients' health records and ensuring the quality of that information on the Web.

The three fundamental principals are: E-health organizations should provide an easily understandable notice of their health information practices that informs consumers what personal health information is being collected, who is collecting it and how it is being used; these organizations should make it easy to collect authentic, accurate, timely and complete individually identifiable personal health data; and they should maintain individually identifiable personal health information in such a way that ensures it is private, secure, and retained or destroyed only in accordance with the consumer's authorization or applicable law.

AHIMA's list of 39 tenets and how they apply to providers, consumers and third parties is available in the November/December issue of the Journal of the AHIMA, and on-line at www.ahima.org/infocenter/guidelines/tenets.html. ■

HCFA codifies payment for education programs

On Jan. 10, the Health Care Financing Administration released a final rule creating a new Medicare policy for the payment of costs of approved nursing and allied health programs, as well as a proposed rule for costs related to clinical psychology training programs.

The regulation clarifies and restates payment policies for nursing and allied health education programs, in addition to registered nurse anesthetist education programs, contained in the *Provider Reimbursement Manual* and other documents. The regulation codifies rules in the manual and adds little new guidance, and so is not expected to have a major effect on Medicare spending or the number of professionals trained, indicate HCFA officials. ■

HCFA accepts new code for cryosurgery

The Health Care Financing Administration now accepts a new CPT code for cryosurgery of the prostate gland, according to transmittal 1689, dated Dec. 22, 2000. The new code is 55873, which is new to CPT 2001.

As the new code includes not only the cryosurgical ablation procedure but also the ultrasonic guidance for interstitial cryosurgical probe placement, it replaced the previous two HCPCS codes, G0160 and G0161, on Jan. 1, 2001. Providers may continue to use G0160 and G0161 codes for claims with dates of service through March 31, 2001. This change requires an update in Sections 4174.3 and 4174.4 of the *Hospital Medicare Manual.*

To view the entire transmittal, go to: www.hcfa.gov/pubforms/transmit/R1689B3.pdf. ■

(Continued from page 38)

the hospital, while the hospital does the billing, notes Sarraille.

The initial proposed rule had threatened to eliminate arrangement relationships that involved physician owners, Sarraille says, because they considered the physicians to have both an investment interest and a compensation arrangement.

In contrast, the final rule should encourage relationships involving physician owners (especially in areas such as lithotripsy, vascular ultrasound, echocardiography, and related specialties).

However, if there is any abuse of these new arrangements, HCFA may want to impose stricter rules, Sarraille cautions.

• **Group practices.** Sarraille says another extremely important reversal concerned the definition of a "group practice" under the Stark statute. The final rule reverses an earlier suggestion that a group practice could not have site-specific cost or revenue centers and had to treat costs and revenues on a practicewide, integrated basis, he says.

• **Incidental benefits.** The final rule creates a new exception for incidental non-cash compensation provided by hospitals to physicians on their medical staff. The final rule sets a maximum value for each "incidental" gift that a hospital can give a physician, such as for parking and meals, of $25 per gift. The final rule does not provide a maximum aggregate amount that can be offered.

• **Compliance training.** The final rule also provides guidance to hospital administrators struggling over whether and how to provide compliance training to physicians. The issue concerns whether a hospital that offers the training free, or for a nominal fee, would be considered "compensating" the physician through free or under-priced training. In response, the new rule specifically permits hospitals to provide compliance training to physicians.

• **Other Changes.** The final rule makes it clear that the in-hospital use of lithotripsy, a noninvasive medical procedure to break up kidney stones or gallstones, is a designated health service exempted from Stark coverage. The rule also acknowledges that relationships between hospitals and physician-owned lithotriptors may be eligible for other enforcement exceptions under Stark.

Other noteworthy changes in Phase I from the proposed rule include:

— expansion of the in-office ancillary services exception to cover certain durable medical equipment provided in physicians' offices to patients to assist them in ambulating, and to cover blood glucose monitors;

— clarification of the definitions of designated health services;

— clarification of indirect financial relationships and the creation of a new exception for indirect compensation arrangements.

The changes take effect Jan. 4, 2002. ■

Medical privacy standards mean dawn of a new day

Business as usual, isn't

Comprehensive standards governing when, how, and to whom you can release medical record information of your patients has been unveiled by the Department of Health and Human Services.

The new privacy regulations stem from the Health Insurance Portability and Accountability Act and protect the medical records and other personal health information maintained by health care providers, hospitals, health plans and health insurers, and health care clearinghouses.

"For the first time, all Americans — no matter where they live, no matter where they get their health care — will have protections for their most private personal information, their health records," former HHS Secretary Donna Shalala said when the standards were released in January. The regulations take effect in 2003.

Congress mandated the regulation after it failed to pass comprehensive medical privacy legislation. The new standards:

• limit the non-consensual use and release of private health information;

• give patients new rights to access their medical records and to know who else has accessed them;

• restrict most disclosure of health information to the minimum needed for the intended purpose;

• establish new criminal and civil sanctions for improper use or disclosure;

• establish new requirements for access to records by researchers and others.

The final regulation covers paper, oral, and

electronic health related information and communications.

The final rule also requires that most providers get their patients' consent for both routine use and disclosure of health records and non-routine disclosures. The earlier version had proposed allowing routine disclosures without advance consent — disclosures for purposes of treatment, payment, and health care operations (such as internal data gathering by a provider or health care plan).

The requirements for advance written consent for routine purposes are similar to the practice most patients are accustomed to when they visit a doctor or hospital today, said Shalala. However, the regulation provides additional protection by requiring that patients also be given detailed written information on their privacy rights and how their information will be used.

Among other changes the proposed rule:

• **Allows disclosure of the full medical record to providers for treatment purposes.** For most disclosures, such as health information submitted with bills, providers may send only the minimum information needed for the purpose of the disclosure. However, for purposes of treatment, health care providers need to be able to transmit more detailed information to other providers. The final rule gives providers full discretion in determining what personal health information to include when sending patients' medical records to other providers for treatment purposes.

• **Protects against unauthorized use of medical records for employment purposes.** Companies that sponsor health plans will not be able to access personal health information from the sponsored plan for employment-related purposes, without authorization from the patient.

Here are some basics of the new regulations:

• **Who's covered.** The regulation covers health plans, health care clearinghouses, and health care providers who conduct certain financial and administrative transactions (e.g., billing and funds transfers) electronically.

• **Information protected.** All medical records and other individually identifiable health information held or disclosed by a covered entity in any form, whether communicated electronically, on paper, or orally, is covered by the final regulation.

• **Patient education.** Providers and health plans are required to give patients a clear written explanation of how they can use, keep, and disclose their health information. Patients must be able to see and get copies of their records, and request amendments. In addition, a history of most disclosures must be made accessible to patients.

• **Receiving patient consent before information is released.** Patient authorization to disclose information must meet specific requirements. Health care providers who see patients are required to obtain patient consent before sharing their information for treatment, payment, and health care operations purposes.

In addition, specific patient consent must be sought and granted for non-routine uses and most non-health-care purposes, such as releasing information to financial institutions determining mortgages and other loans, or selling mailing lists to interested parties such as life insurers. Patients also have the right to request restrictions on the uses and disclosures of their information.

• **Ensuring that consent is not coerced.** Providers and health plans generally cannot condition treatment on a patient's agreement to disclose health information for non-routine uses.

• **Providing recourse if privacy protections are violated.** People have the right to complain to a covered provider or health plan, or to the Department of Health & Human Services, about violations of rule.

• **Boundaries on medical record use and release.** With few exceptions, individual health information can be used for health purposes only. Patient information can be used or disclosed by a health plan, provider, or clearinghouse only for purposes of health care treatment, payment and operations. Health information cannot be used for purposes not related to health care — such as by employers to make personnel decisions, or by financial institutions — without explicit authorization from the individual.

• **Providing the minimum amount of information necessary.** Disclosures of information must be limited to the minimum necessary for the purpose of the disclosure. However, this provision does not apply to the transfer of medical records for purposes of treatment, since physicians, specialists, and other providers need access to the full record to provide best quality care.

• **Ensuring informed and voluntary consent.** Non-routine disclosures with patient authorization must meet standards that ensure the authorization is truly informed and voluntary.

• **Security of personal health information.** While the regulation establishes privacy safeguard standards that covered entities must meet, it leaves detailed policies and procedures for

meeting these standards to the discretion of each provider. However, providers must:

— adopt written privacy procedures. These must include who has access to protected information, how it will be used within the entity, and when the information would or would not be disclosed to others. They must also takes steps to ensure that their business associates protect the privacy of health information.

— train employees and designate a privacy officer. Covered entities must provide sufficient training so that their employees understand the new privacy protection procedures, and designate an individual to be responsible for ensuring the procedures are followed.

— establish grievance processes. Covered entities must provide a means for patients to make inquiries or complaints regarding the privacy of their records.

Exceptions. The standard also creates specific exceptions that permit the disclosure of health information without individual authorization under the following circumstances: oversight of the health care system, including quality assurance activities; public health; research, generally limited to when a waiver of authorization is independently approved by a privacy board or institutional review board; judicial and administrative proceedings; limited law enforcement activities; emergency circumstances; identification of the body of a deceased person, or the cause of death; facility patient directories; and activities related to national defense and security. ■

Here are dos and don'ts of preparing for HIPAA

Don't wait until the last minute

Compliance may be two years away, but you're well advised to start now making sure your practice will comply with the new Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

"The last thing physicians want to do is to wait until the last minute, then make an all-out effort to comply," says **Peter Adler**, JD, a health care attorney with the Washington, DC, office of Foley & Lardner.

Information on the specific requirements for compliance is sketchy now because the regulations are so new. But within three months, there is likely to be a plethora of information available, including some package plans for compliance, predicts **Janice Cunningham**, JD, an attorney with The Health Care Group, a Plymouth Meeting, MA, consulting firm.

However, there are some steps that you can take now to make sure you will be in compliance when the Feb. 29, 2003, deadline rolls around.

Start by examining your current policies and procedures for protecting patient information and comparing them to the HIPAA regulations, suggests **Jon Zimmerman**, senior manager for HIPAA and e-business initiatives for Siemens Medical Solutions Health Services Co. (formerly Shared Medical System) in Malvern, PA.

"Once physician practices understand their policies, procedures, and practices, they can determine where the gaps are and what they need to do vs. what they are actually doing now," Zimmerman says.

Look at where the gaps in patient privacy occur in your office and take steps to close them up, he adds. In some instances, it may be as simple as moving your files to a locked room.

"The rule is that identifiable patient information is supposed to be inaccessible. If that means building a wall or moving the documents to a secure location, that's what the practice will have to do."

A small practice can probably make a good start toward establishing HIPAA compliance in a short time. It will take a large physician group a lot more time, Zimmerman says.

"The requirements of HIPAA are scalable. Other than the privacy rights notices and the consent, small practices don't have to do the same level of things as large organizations do," Adler says.

Here are some other do's and don'ts for HIPAA compliance:

• **Understand whom you communicate patient information to.**

Determine which entities you do business with qualify as a covered entity or a business associate under HIPAA regulations.

Review all your forms, policies, procedures, and contracts with your business partners to make sure they are HIPAA compliant.

Understand what steps your covered-entity partners are going to make and what steps your business associates are going to make to become compliant, and coordinate with them.

If you do business with a hospital on a regular

basis, you should define your policies and make sure they coincide with the policies of the hospital.

• **Start developing a HIPAA compliance plan.** Your policies and procedures to protect patient privacy should reflect how all communications will be handled, even conversations in the hall. Set up a checklist of issues that have to be resolved for your practice to be in compliance.

• **Appoint a designated privacy officer.** This staff member will be in charge of formulating and compiling your privacy policies and procedures and keeping up with documentation.

The privacy officer will also deal with patient questions or complaints about your privacy policies and procedures.

• **Develop a plan for training your staff on privacy regulations and come up with a way to document the training.**

Training should cover topics such as who has the right to identifiable patient information, what consent form is required for distributing the information, patient rights to access their information, and other privacy and confidentiality issues.

If you practice just has a blurb covering privacy and confidentiality in your policies and procedures manual, that won't be sufficient. You must document that every employee has received the training in your office, even if they previously worked for another medical practice. All employees must be re-certified every three years.

• **Determine whether your state's privacy regulations will pre-empt the federal regulations.** If your state already has privacy laws that are more stringent than HIPAA, the state laws will take precedence.

If you are practicing across state lines or involved in telemedicine, look at the laws in all the states in which you practice.

• **Before buying a packaged compliance plan, make sure it can be tailored to meet the needs of your individual practice.**

The problem with canned plans is that one plan can't possibly cover medical practices ranging from solo practitioners to 100 or more physicians, Cunningham says.

• **Don't go it alone.** Consult with your health care attorney to make sure you are doing what you need to do within your particular practice. Professional organizations and the large payers in your community may be able to provide sample consent forms or checklists to aid in compliance, Adler suggests.

• **Include money in your budget over the next two years to cover the cost of HIPAA compliance.** ■

The health seekers emerge on the 'Net

No face time with docs? Patients go elsewhere

Half the people who have used the Internet to get health and medical information say the information has improved the way they take care of themselves, and many report that on-line information has directly affected their decisions about how to treat illness and deal with their doctors, says a report from the Pew Internet & American Life Project in Washington, DC.

These are some of the key findings of several surveys taken by the Pew Internet Project and released in the report, "The on-line health care revolution: How the Web helps Americans take better care of themselves." The report found that 52 million American adults have sought health and medical information on the Web. These Americans are labeled "health seekers." A majority of them go on-line at least once a month to get health information, the report says.

"The emergence of this group — the health seekers — illustrates perhaps the most profound and dramatic impact the Internet is having on Americans," says **Lee Rainie**, director of the Pew Internet Project. "In an era when the face time a patient gets with a doctor during an average appointment has dipped below 15 minutes, many are turning to the Web get the information they

COMING IN FUTURE MONTHS

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crave so that they can make decisions about how to care for themselves and their loved ones."

One survey in the study asked Internet users to describe the most recent time they had gone on-line for health information. About 47% of the people who were seeking health information for themselves say the on-line material influenced their decisions about treatment and care, and 36% of those seeking information on behalf of others say it influenced their decisions.

These Internet users say the information drawn from the Web helped them decide how to treat an illness, prepped them to ask more questions of their doctors or seek second opinions, and helped them decide whether to go to the doctor.

They worry about privacy, too

Even though they indicate a growing reliance on the Internet for health information, most Internet users are worried about their on-line privacy, especially when it comes to the sensitive subject of their medical information. In the study, 89% of health seekers say they are worried that Internet companies will collect and share data about the Web sites they visited; 85% say they fear that insurance companies might change their coverage after finding out what on-line information they accessed; and 52% fret that their employers might learn what kind of medical material they accessed.

Most report that the last time they went hunting on-line for health information they got the facts they needed. But they relied on Internet searches without the benefit of professional advice and often visited Web sites new to them before they began the search.

"This should be a wake-up call to medical professionals: Patients are action-oriented when they go on-line for health information, and they will search for it any way they can," says **Susannah Fox**, director of research at the Pew Internet Project and the principal author of this study. "[Patients] would probably like help from their doctors in pointing them to the best places for these Internet searches, and they really want doctors to answer the questions that emerge during that research about how to treat the sick."

Some other key findings from the Pew Internet Project report include:

• Twenty-six percent of health seekers have gone on-line to get information about mental illness, and 16% of health seekers have used the Internet to get information on a sensitive health subject that is hard to discuss.

• Very few health seekers use the Internet to interact with their doctors (only 9% have exchanged e-mails with them). Few health seekers have purchased medicine or vitamins, and few have consulted on-line doctors.

• Asked about their most recent search for health information, 54% of health seekers said they were looking on behalf of someone else; 43% were looking for themselves.

• Eighty-one percent of health seekers think people should be able to sue a health or medical organization if it gives away information about its customers after saying it would not.

Information about the health seekers habits

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came from surveys conducted last March 1 to Aug. 20. Those surveys interviewed 12,751 adults age 18 and over, 6,413 of them being Internet users. Findings about privacy came from questions asked in a survey in July and August of 2,109 persons, some 1,101 of whom were Internet users. Finally, a special survey of 521 health seekers was conducted in August, with a special focus on the search they conducted during the last time they went on-line for health information. ■

Reimbursement ROUNDUP

Telemedicine gets boost from lame-duck Congress

Maybe you missed it in the flurry of attention given to the so-called "give-backs" in the health care budget bill passed by Congress late last year, but lawmakers also passed legislation increasing Medicare reimbursement for telemedicine services.

Most experts agree that the technology for proper telemedicine consultation is already here. What has been lacking is an adequate and reliable source of reimbursement to make it financially viable. Many health care insiders feel this action goes a long way toward expanding such services across the country. As such, it maybe time for your practice to start researching a telemedicine option.

Among other things, the bill:

• expands eligible service areas for covered telemedicine services from restricted rural health shortage communities to include all non-metropolitan counties and existing urban Medicare demonstration sites;

• expands the eligible telemedical services that can be billed to Medicare;

• eliminates a required fee splitting requirement between presenting health professionals at the local and referring sites;

• includes a new $20 facility fee;

• allows store-forward services to be billed for services provided in Alaska and Hawaii;

• keeps in place existing Medicare reimbursement for teleradiology, remote cardiac monitoring, and related services that are available throughout the country.

The provisions are scheduled to go into effect Oct. 1, 2001. ▼

Medicare will begin nutritional coverage

Medicare patients have a new benefit that gives them access to medical nutrition therapy to help manage diabetes and kidney disease. Included in the omnibus appropriations measure approved by Congress last December, the provision also makes registered dietitians official Medicare providers.

"The elderly, who struggle with diabetes and kidney disease, will now be able to work with registered dietitians to manage their disease and to prevent further complications through medical nutrition therapy," notes **Jane V. White**, PhD, president of the American Dietetic Association.

"Medical nutrition therapy" refers to the comprehensive nutrition services provided by registered dietitians as part of an overall health care team. Patients who receive these services require fewer hospitalizations and medications and have reduced incidence of complications. The new Medicare benefit starts Jan. 1, 2002. ■