AMERICAN HEALTH CONSULTANTS®

# PHYSICIAN'S PAYMENT UPDATE™

## INSIDE



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# OIG report outlines key components of an effective compliance program

*Round table discussion results in a how-to guide*

A sound compliance program is a little like art: It's hard to define, but you usually know it when you see it. Even then, one provider's definition of a proper compliance effort may mean something totally different to a fraud investigator.

This difference in perception has been the basis for much of the conflict and hard feelings between the provider community and the federal fraud police as the two sides have debated how to distinguish between simple billing errors and overt fraud and abuse in government health programs.

In an effort to help establish constructive dialogue and consensus of opinion on what constitutes an adequate compliance program, earlier this year the Office of Inspector General (OIG) and the nonprofit Health Care Compliance Association co-sponsored a government-industry round table. Over 125 compliance officers, health care compliance consultants, and government representatives attended the daylong event.

One result of the meeting is a recently released report by the OIG, titled "Building a Partnership for Effective Compliance: A Report on the Government-Industry Roundtable," summarizing the key conclusions.

While the report acknowledges that the participants "did not attempt to reach consensus on the many issues that surround compliance with health care program requirements," it does provide additional insight into what's needed to organize an effective compliance program.

Here are the key areas of concern reported by the participants:

• **Cost of compliance.**

The cost of implementing a compliance program was a major concern of most round table members. As one attendee stated, "the more compliance you do, the more you have to do." Representatives of smaller and rural health care providers were particularly concerned about the cost of employee screening, training, and hotline services associated with a comprehensive compliance program.

• **Identifying and responding to risk areas.**

Most participants said they focus their compliance efforts on areas highlighted by government compliance guidances, special fraud alerts,

the OIG's published work plans, and fraud settlements. One downside to concentrating on federal health programs is a tendency to overlook dealings with private payers, participants noted.

The round table report stated that the best way to kick off an oversight program is to perform an internal risk assessment to identify possible compliance weaknesses, starting with any areas where there had been a previous history of poor compliance.

**• Coordinating a compliance program among different departments or subsidiaries.**

Participants generally agreed that a single, coordinated compliance program should be implemented among all units of larger providers. Strong communication on compliance issues among the different divisions was viewed as critical. For mega-practices or groups that are part of an integrated delivery system, one way to do this is to have a compliance person from each business unit be part of an organizationwide compliance committee.

## *Whom to include on compliance committee?*

Generally speaking, individuals who serve on compliance committees are heads of the following departments within an organization: human resources, internal audit, patient accounts, legal, billing, medical practice billing, and information technology. Some chief financial officers and chief executive officers also participate in such committees. Smaller providers, which may not have a designated compliance committee, may want to consider a task force to address compliance concerns as they arise.

**• Addressing human resources issues associated with compliance.**

Participants noted overlaps in the responsibilities of a human resources department and the compliance function. Close collaboration between these two functions in the areas of training, hiring, and disciplining, as well as the establishment of hotlines with complaint follow-ups, is considered necessary by the attendees. Cross-training between the two components would lead to a better understanding of each other's responsibilities and duties. This is especially true in cases where both functions must share responsibilities, such as the hotline and training.

**• Addressing potential conflicts for the compliance officer.**

The participants discussed the possible conflict that may exist when a compliance officer holds other key management responsibilities, especially at small or rural health care providers where such arrangements often are a practical necessity.

Suggestions to avoid possible conflicts included establishing appropriate checks and balances within the organization's compliance structure by creating a strong and active compliance steering committee and assigning the compliance job to well-respected managers who are sensitive to potential conflicts that might arise.

**• Enhancing the effectiveness of the compliance officer.**

Participants noted that compliance officers need to give prompt and clear responses to employee questions to maintain credibility. A compliance office's open-door policy, particularly in smaller entities, can help foster good communication.

However, compliance officers shouldn't just be reactive. "There is a need to reach out to employees using such methods as field visits to work locations and polling employees about compliance and work issues. If employees know the compliance officer, they may be more likely to talk freely with that person," notes the report. Other ideas suggested to improve communications included a strong policy against retaliation, internal newsletters, exit interviews, e-mail, and Internet Web sites.

**• Developing an adequate training program.**

The participants agreed that compliance and human resources training should cover such topics as code of conduct, ethics, compliance requirements, and corporate policies and procedures. Some participants indicated that they do "cascade" training that evolves from the general to the specific, starting with comprehensive training in the areas of billing and coding. Overall, some form of compliance education should take place at least once a year, the report recommends.

**• Assessing effectiveness.**

The round table report says assessment of a compliance plan's effectiveness should be viewed as an ongoing effort. Communication with employees, department managers, and the board of directors is considered a key element in determining the effectiveness of a provider's compliance program.

Round table participants recommended three types of audits as useful measures of a program effectiveness:

— baseline audits (initial audits);

## Software provides compliance help

*Program even insures against billing errors*

As the federal government's campaign against questionable health claims has grown, so has the number of compliance products and services offered to providers.

For instance, the Medaphis Corporation of Atlanta recently introduced ComplyCare Compliance Monitoring, a system that will edit provider claims for possible compliance problems before they are submitted for payment.

ComplyCare is based on a proprietary database of more than 60 million claims powered by IBM's Fraud and Abuse Management System. According to company officials, the system is capable of comparing 100% of a physician group's claims with claims in the firm's database.

"ComplyCare is a potentially important compliance tool for practices of most sizes and types," says **Terry Peltes**, vice president for physician management services at Medaphis. "We provide our clients with a CD containing information and reports that can help physician groups look at their practice similar to how private payers and the government do to spot questionable billing and behavior patterns."

Armed with this information, practices can then try to resolve potential compliance issues in-house, or bring in outside consultants.

Another innovative aspect of the program is that physician groups signing onto the service are eligible for a unique billing errors and omissions insurance program available through a Medaphis strategic partner, the Graham Company in Philadelphia.

The billing insurance plan "provides physicians with protection against civil fines and penalties imposed by the federal, state, or local government and against penalties or liens sought by commercial payers," says Graham spokesperson **Tony McIntyre**. "The program even provides coverage for potentially substantial defense and claim audit costs." ■

— proactive audits (these can be based on the risk areas identified in the OIG's compliance program guidances or special fraud alerts);

— issue-based audits (when the provider knows there is a problem and is trying to ascertain the depth of the problem).

Here are some specific refinements to the audit process that practices might consider:

— Have audit teams composed of nurses review claims both before and after claim submission.

— Regularly gather those responsible for billing to discuss any changes specified in recent Medicare bulletins, then make one person responsible for ensuring the changes are implemented in-house.

Most participating providers said they rely on the OIG's work plan and past investigations by the OIG and the Department of Justice to establish their own internal audit plans.

In addition, many of the compliance officers noted the "chilling effect" that audits tend to have on individual physicians. As a result, the compliance officers noted that they had observed a recent trend toward downcoding to avoid the possibility of an investigation. In turn, many group compliance officers are focusing their auditing and training efforts on promoting proper documentation.

**• Determining the sample size necessary to validate audit results.**

The OIG's "Provider Self-Disclosure Protocol" recommends that an initial probe sample should consist of at least 30 units of documentation, even though the Medicare Carrier's Manual requires a sample of only 10 units. The participants agreed that defining the sampling size depended largely upon the nature of the inquiry.

Another issue raised regarding the design of the audit plan was the use of retrospective reviews as opposed to prospective reviews. In general, the participants favored prospective reviews because they tend to be less costly and less time-consuming.

**• Demonstrating the effectiveness of compliance program.**

Participants agreed that documentation is the key to demonstrating the effectiveness of a provider's compliance program. Proper documentation of the following items was highly recommended: audit results; logs of hotline calls and their resolution; corrective action plans; due diligence efforts regarding business transactions; disciplinary action; and modification and distribution of policies and procedures.

Because the OIG is encouraging self-disclosure of overpayments and billing irregularities, the report highly recommends maintaining a record of disclosures and refunds to the health care programs. Records of employee education, including the number of training hours, the courses offered, and the identities of the attendees, demonstrate to both the employees and outsiders that the provider is committed to its compliance program. Annual reports and Web sites provide other venues to showcase a compliance program.

• **Documenting contractor guidance.**

Many attendees expressed frustration with attempts to reconcile the views of the Health Care Financing Administration's intermediaries and carriers and how to respond to conflicting advice received from them. Providers strongly recommended HCFA develop a better system to permit them to ask questions and obtain guidance on all billing / coding issues.

Until that happens, the general feeling of the participants was that a provider receiving advice should: document all communications with HCFA and its contractors in writing; attempt to seek clarification with the HCFA regional office; if necessary, contact HCFA headquarters for any unresolved issues.

• **Assessing effectiveness**.

Government participants in the round table cited a number of factors they generally take into consideration when evaluating the effectiveness of a provider's compliance efforts. These include:

— management's commitment to, and good-faith efforts to implement, a compliance program as measured by such factors as the amount of funding, training, availability of guidance on policies and procedures, and the background of the individual designated as the compliance officer;

— evidence of open lines of communication and their appropriate use to address employee concerns and questions;

— documented practice of refunding overpayments and self-disclosing incidents of noncompliance with program requirements.

OIG officials emphasized they do not expect a compliance program to prevent all problems from arising. Instead, they are more interested in how the practice reacts when a compliance question presents itself. They also are interested in the program's impact on daily operations and how well employees retain and apply what they learn from their various training activities. ■

# Key questions to ask in setting probe scope

*Here's advice on priorities of an internal probe*

One of the most difficult issues during a compliance investigation is determining the extent of an internal probe. Here is the consensus of compliance officers from around the country and government officials as contained in the report, "Building a Partnership for Effective Compliance, A Report on the Government-Industry Roundtable," published by the Office of Inspector General (OIG):

• **What is the origin of the issue to be investigated?** A billing concern may be the result of a systematic practice, a third-party inquiry, or misconduct by certain individuals. A systematic noncompliant billing practice may have been tied to implementation of a new system or an initiative based on faulty advice from a consultant or Medicare contractor, for example. A third-party inquiry may have been prompted by a whistleblower or submission of an improper claim.

• **When did the issue originate?** A systematic billing practice may warrant internal inquiry into the origin of the practice and the extent of its impact upon an organization. Improper billing by certain individuals may require scrutiny of their entire employment history, an analysis of their effect upon other employees, and a review of the directions they may have received from superiors.

• **How far back should the investigation go?** The participants agreed that a provider should establish reasonable and calculated benchmarks to assist in determining the parameters of an internal investigation. Investigation standards for one organization may not be applicable to another. Some providers may always commence their internal investigations by reviewing a year of previous billing, while others may start with a month of prior billing. Some providers also designate a specific number of claims to review. Regardless of the investigative protocol used, the participants said a provider should determine the parameters of the investigation based upon a reasonable approach that is justified under the circumstances.

For example, regardless of the initial period of time reviewed or the number of clinical services analyzed, the inquiry should be expanded if the

## Compliance corner: What regulators are up to

The health care compliance field obviously is a growth industry. Here is a summary of recent events and actions:

• **The whistle-blower express.** The Health Care Financing Administration has issued a program memorandum (transmittal AB-98-77) instructing that any fraud and compliance issues brought to a Medicare fiscal intermediary by the employee of a provider be immediately referred to the Office of the Inspector General (OIG). "We're anticipating this will put a little more fire under providers to strengthen their compliance efforts," notes a HCFA spokesperson.

• **Docs and DME.** The OIG has released a report, titled *Ordering Medicare Equipment and Supplies: Physician Patient Relationship*, that agrees with HCFA's rule that a physician ordering durable medical equipment also must have treated the patient. The OIG also recommended that the treatment occur just prior to the durable medical equipment order and that the physician's name and specialty and the patient's related diagnostic information be required on all claims forms.

• **Defining reasonable and necessary.** HCFA officials say the agency plans to publish a proposed rule this summer explaining the general criteria it uses to evaluate whether items and services covered under Medicare are medically "reasonable and necessary."

• **New anti-kickback safe harbors on the horizon.** In a speech before a group of health care lawyers, **D. McCarty Thornton**, OIG chief counsel, said the OIG hoped to publish eight new safe harbor exceptions to federal anti-kickback law sometime this summer.

Thornton said the new safe harbors probably would cover:

— physician investments in group practices;

— investments in ambulatory surgical centers by physicians;

— specialty service referral agreements;

— cooperative hospital service agreements. ■

results of an initial review suggest a broader problem. Billing misconduct by one employee may prompt scrutiny of conduct by other employees. Problems with one facility in a large health care organization may warrant review of other facilities. In any case, providers need to document the investigative methods used and the reasons for the investigation decisions made.

• **Can extrapolation of a statistical sample be used?** Some participants rely on statistical samples and extrapolation to rectify reimbursement problems when it is too difficult or costly to ascertain the exact cause of improper billing. Others indicated that they do not rely on extrapolation because samples of improper billing identified may not accurately represent an organization's entire billing practices (e.g., deficient billing may be the product of certain individuals, specific sites of operation, or particular billing procedures).

Once the scope of the investigation is set, issues must be prioritized. Compliance officials participating in the session that produced the report said as they implemented their compliance programs, they often come across a significant number of issues that required additional investigation. The following questions were offered to help compliance officers prioritize their actions:

— Does a corporate integrity agreement with the OIG require that the compliance officer focus on certain issues?

— Does the problem pertain to a discontinued practice or to a current practice with prospective exposure?

— Can certain billing software be used to perform a prompt preliminary review?

— Can deficient billing be suspended or ceased until a review can be completed?

— Could the issue under investigation have a significant impact on the provider's Medicare cost report and interim payments?

— Does an issue present credible evidence of ongoing misconduct that may violate criminal, civil, or administrative law, and should be immediately reported to a government authority?

— Has the organization established its own standards for the amount of time allotted to address incoming compliance concerns?

Another tricky area is how much compliance officers and the provider's general counsel or outside lawyers can work together. While compliance officers generally would like to work openly with the attorneys, some concern was expressed

that lawyers may be included in internal investigations merely to keep the investigative work product secret.

The OIG's position is that when the attorney-client privilege (or the attorney work product doctrine) is improperly invoked to protect the documents involved in an internal investigation, a provider risks losing the privilege. Meanwhile, cloaking all aspects of an internal investigation under the protection of a privilege raises questions about a provider's desire to be forthright and honest, said investigators. ■

# Medicare plans to open up coverage decision making

*HCFA creating formal review procedures*

The Health Care Financing Administration says it intends to open up the process of deciding which treatments will be covered by Medicare.

Under the newly announced procedures, there will be more input from the public into agency decisions on whether to cover certain medical treatments under the Medicare fee-for-service program.

A major reason for the new process is to help unravel Medicare carriers' conflicting policies on which procedures will be paid for and settle disagreements about effectiveness of a treatment. HCFA estimates blanket national payment policies apply to just 10% of the coverage decisions made each year. Local carriers rely on their own internal policies to make the other 90% of pay-out calls.

One area of conflict HCFA is expected to quickly address involves contradictory carrier positions on preoperative evaluations needed to clear patients for surgery. Differences often result in patients either paying these costs themselves or failing to receive medically necessary surgical procedures.

"This will be the most open and accountable process for making national coverage decisions in the history of Medicare," HCFA administrator **Nancy-Ann DeParle** said. "Creating an understandable and predictable process for national coverage decisions is a critical step in preparing Medicare for the 21st century."

"Reform of the Medicare coverage decision process is long overdue," says American Medical Association spokesman **William G. Plested III**, MD.

"HCFA's reluctance to separate its policies on coverage from its policies on fraud and abuse is a major source of the coverage policy problem facing Medicare patients and their physicians," said Plested. "This conflict must be resolved if patients and physicians are to have confidence in the overall integrity of the Medicare program."

### *National review procedures to be instituted*

Under the new process, HCFA will initiate national coverage reviews when appropriate and will field formal requests from external parties for coverage decisions. Under the proposed process, HCFA generally will initiate a national coverage review when:

— there are conflicts between local contractor coverage policies;

— a service represents a significant medical advance and no similar service is covered by Medicare;

— there is substantial disagreement among medical experts about a service's efficacy or medical effectiveness, or the service is currently covered but is widely considered ineffective or obsolete.

Formal external requests for a national coverage decision must be in writing and must contain:

— a complete description of the item or service in question;

— a compilation of the medical and scientific information currently available;

—a description of any clinical trials or studies currently under way. In the case of a drug, device, or service using a drug or device regulated by the Food and Drug Administration (FDA), the status of FDA administrative proceedings must be included.

Once HCFA determines that a formal external request contains all necessary information, the agency will initiate a series of internal deadlines to ensure that requests are processed in a timely manner.

HCFA said it expects to respond to the requestor in writing within 90 calendar days of accepting a request. If the requestor submits additional medical and scientific information during this 90-day period, however, the agency

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will ordinarily respond within 90 calendar days of receiving the additional information. The response will include one of the following:

— national coverage decision without limitations on coverage;

— national coverage decision with limitations on coverage;

— no national coverage decision, which allows for local contractor discretion;

— national noncoverage decision, which precludes local contractors from making payment for the item or service;

— referral to the Medicare Coverage Advisory Committee;

— referral for a technology assessment;

— decision that the request duplicates another pending request and will be combined with the other request;

— decision that the request duplicated an earlier request that has already been decided and there is insufficient new evidence to reconsider the request.

### *Decision process summaries to be published*

If a referral is made to the Medicare Coverage Advisory Committee, HCFA ordinarily will make a decision within 60 days of receiving the committee's recommendation. If a technology assessment is required, the time line for HCFA's coverage decision will be extended, but the agency does not expect that technology assessments would normally take longer than 12 months to complete.

Throughout the coverage decision process, HCFA will publish a list of coverage issues under review, the stage of review each issue is in, an estimate of when the next action will occur, and the major scientific questions that need to be resolved. HCFA also will develop a record for each coverage decision, including a list of all evidence reviewed, all the major steps taken in the coverage review, and the rationale for the coverage decision. The list of issues under review and a summary of the record of coverage decisions will be provided on HCFA's Web site at www.hcfa.gov. Additionally, HCFA will reconsider coverage decisions at any time when new medical and scientific information becomes available or the requestor can demonstrate that HCFA materially misinterpreted the evidence submitted with the original request. ■

# Teaching hospitals decry budgetary cutbacks

*Research, service cuts feared*

The cuts enacted by the Balanced Budget Act of 1997 have gone too far and are threatening the long-term financial stability of U.S. teaching hospitals, asserts the Association of American Medical Colleges (AAMC) in Washington, DC.

The AAMC has launched a lobbying campaign to undo the Medicare-related payment cuts. As part of this effort, the group has released a detailed analysis of the budget act's current and projected impact on teaching hospitals.

"Left unchecked, the . . . cuts could force some of the nation's major teaching hospitals to reduce the scope of their special and unique community services such as burn, cardiac and trauma care centers, as well as care for the uninsured," says AAMC president **Jordan J. Cohen**, MD.

"At a time when the health care marketplace is driven by the goal of cost containment, the BBA imposed reductions that are making a tough financial situation even tougher for teaching hospitals. Federal policy-makers need to make immediate and substantive corrections to the BBA before it is too late and the damage is done," Cohen said in a statement.

Teaching hospitals provide 44% of all indigent care in the country, train 75% of all residents, and conduct most of the clinical medical research. All of that is threatened by the financial instability caused by the budget cuts, says the AAMC.

"Teaching hospitals across the country are being squeezed from all sides. Our institutions play a unique role in America's health care system. We cannot continue to provide critical patient care, teach the next generation of physicians, and conduct the research that will lead to new treatments and cures without the continued commitment of the federal government," **Jeffrey Otten**, president of Boston's Brigham and Women's Hospital, said in a statement.

The AAMC wants to eliminate any further cuts to the indirect medical education (IME) and disproportionate share (DSH) payments as a result of the act.

In particular, the AAMC is lobbying for the IME and DSH payments to return to their former levels. It also says direct medical education and IME payments associated with Medicare

managed care enrollees, which are being paid in 20% increments over the life of the act (1998-2002), should be paid at 100% beginning in fiscal year 2000.

An AAMC analysis of the act's potential impact claims that:

— Medicare reductions resulting from the act could cut the total financial / profit margin for a typical teaching hospital by half or more by 2002.

— Thirty-eight percent of teaching hospitals could be losing money by 2002.

— Projected Medicare payments will be $45.8 million less for a typical general, acute, nonfederal teaching hospital by 2002 than under the previous totals. The cumulative losses for all related hospitals are estimated at $14.7 billion.

— Margins for institutions with a substantial number of residents could fall from an average of 3% in 1996 to an average of 0.3% in 2002. Forty-seven percent or more of these hospitals could be losing money by 2002 or sooner. ■

# Lack of firing procedures can be costly for practices

*Physician wins $1.75 million in lawsuit*

A San Diego jury recently awarded $1.75 million to Thomas Self, MD, for having his employment contract wrongfully terminated by the medical group he worked for (*Self v. Children's Associated Medical Group, 695870 San Diego County Superior Court*).

Although the medical group contended it simply exercised its contractual right not to renew Self's employment, the jury decided that the group wrongfully terminated Self because he pushed for what he felt was appropriate — and more costly — care for his patients.

"This lawsuit sends a powerful message to medical groups: Do not assume that having a 'without cause' termination provision in your employment contracts will always protect the group from a physician's claim of wrongful termination," says **Carol Isackson**, partner in the San Diego law offices of Foley & Lardner.

Self's defense was based on a California statue (Business & Professions Code Section 2056) that says it is a violation of public policy for any entity, including a medical group, to terminate a contract or otherwise penalize a physician principally for advocating for medically appropriate care.

Self had been employed by his 77-member specialty medical group as a pediatric gastroenterologist for over 10 years. In June 1995, the group decided not to renew his employment agreement "without cause."

Like many medical groups, Self's group had no written policies, procedures, or standards for evaluating the clinical and economic performance of group members, although the group had held several meetings with Self in the months leading up to its decision not to renew his contract.

Shortly before Self's departure, the group hired a new physician to help deal with the large backlog of patients. In his lawsuit, Self contended that the group hired a "younger replacement" to see more patients and produce more revenue for the group.

The trial included introduction of a letter from a referring medical group to Self's practice complaining that his "shotgun" approach to testing unnecessarily exposed patients to painful and costly procedures.

Self argued that the tests he ordered were medically appropriate and that the letter was evidence of how his group stressed cost containment over quality patient care.

In turn, Self asserted his contract was not renewed because he spent too much time with patients and refused to make appointments and perform procedures at the rate demanded by the group.

One way groups can avoid similar legal problems is to adopt and implement uniform processes and standard criteria for review of physicians' clinical and economic performance, advises **Julie Ashby**, another health care lawyer with Foley & Lardner.

"If a group can establish that it uniformly evaluates and addresses all clinical and economic issues according to established standards and procedures, it will be in a far better position to defend a decision to terminate a physician for poor clinical care or for under-performing than a group that makes such decisions on an ad hoc basis," says Ashby.

Some common ways of establishing clinical standards include:

• **Credentialing.** Credentialing policies screen a physician's professional training and competence at the time he or she is hired. When followed, a credentialing policy makes sure each

doctor's education, malpractice history, licensing status, clinical skills, and personality are consistent with the group's standards.

The physician's credentials must be measured according to established written criteria to deflect any claim that the group acted unreasonably. Each physician's performance also should be re-evaluated in accord with these written standards at the time of reappointment or contract renewal.

• **Peer review.** Setting corrective-action or peer-review policies will establish standards of practice and require ongoing, routine review of each physician's clinical decisions. "This enables the group to determine whether the physician's professional judgment and performance are consistent with the group's standards," says Isackson.

If the group determines that the doctor's clinical decisions are not consistent with group standards, then it may take "corrective action," requiring the physician to remedy the problem. A group that consistently follows a corrective-action policy must advise its physicians of any clinical issues that may affect their continued affiliation with the group.

• **Hearings.** Fair-hearing plans provide physicians with a set of fair procedures the group must follow before disciplining a physician or terminating his or her contract for quality-of-care reasons. For example, if a group follows a fair procedure process, it permits the physician to challenge an adverse recommendation through a hearing.

## Setting economic performance standards

Just as credentialing, corrective action plans, and fair-hearing plans ensure physician competence and provide physicians with due process rights, economic performance standards also protect both the group and the physician.

"If a group wants to terminate a physician's contract because the group's need for services does not warrant his or her compensation, the physician's professional competence would not be an issue in the group's decision. But if the group simply terminates the physician without cause, it risks a challenge from the physician that the termination was in retaliation for patient advocacy," says Isackson.

Even when a physician's termination from the group is based on economics, there are several ways the group can protect itself from charges the termination was wrongful. These include:

• **Contract language.** Contracts between the medical group and its physicians should explicitly require that the physician meet the requirements imposed by the group's managed care contracts. These contractual requirements may include a ratio of time spent with patients and income generated, among other things.

• **Standard setting.** The group should adopt a practice of reviewing clinical literature, objective data, and actual experience to ensure that its business standards are consistent with good clinical practice. Based on literature review and objective data, for instance, a group may establish that a particular test is required in certain circumstances (or no test at all). "This practice will permit the group to justify its position if a physician deviates from the group's standard of practice," says Isackson.

• **Procedures.** The group should adopt and follow basic procedures for review of economic performance based on the relevant clinical standards of practice, advises Isackson. The group's physician contracts also should refer to these policies and make clear that the physician may be subject to termination if performance standards are not met.

## Standards also protect individual physicians

"You can argue the Self verdict suggests that individual physicians should resist efforts by their groups to implement written policies and standards so that the physicians can preserve their right to challenge medical groups that take retaliatory action because of patient advocacy," says Isackson. "However, these standards and policies, while clearly protecting medical groups, also give the physician greater protection in the contractual relationship."

For example, when following procedures governing assessment of clinical and economic performance, groups will be required to identify issues and initiate a dialogue with a physician sooner rather than later. Physicians will be offered the right to respond to the group's allegations, to correct or improve their actions (if indicated), and to prevent an adverse decision altogether. Written procedures also ensure that a written record is established so that a physician is not subjected to a group's post-hoc justifications for business and clinical decisions. If a group follows these procedures, it will be evident if it is taking retaliatory action against a physician for advocating for patients. ■

# Bill seeks to expand use of telemedicine

*It's a trend, but a slow one*

Sen. Kent Conrad (D-ND) has introduced the Comprehensive Telehealth Act of 1999, which would force the Health Care Financing Administration to expand its current policy of reimbursing physicians who use telemedicine technology to treat Medicare beneficiaries.

One of the bill's main goals is to reverse a HCFA decision to restrict reimbursement of telemedicine services to so-called "teleconsultations," which involve real-time interaction of physician, consulting physician, and patient. Many telemedicine experts say this policy prohibits the most useful form of telemedicine — the capacity to "store and forward" case information to a consulting physician anywhere in the world.

HCFA is reportedly concerned that reimbursement of store-and-forward telemedicine technology would create more opportunities for fraud and abuse in the Medicare program.

Conrad also is lobbying HCFA to expand its definition of telemedicine to include store-and-forward technology, arguing that this was the intent of Congress in the Balanced Budget Act of 1997, which launched a demonstration of the technology and its use in health professional shortage areas.

Provisions in Conrad's legislation include:

• **Reimbursement of telehealth services.** This provision would require HCFA to reimburse under Medicare all regular services, even if these services are received using telehealth technology.

• **Licensure.** While not proposing that the federal government pre-empt state-level licensing of health professionals, Conrad wants the Secretary of Health and Human Services to "look into easing the licensing burdens of telehealth practitioners who now are forced to be licensed in every state they administer telehealth services."

• **Reports to Congress.** This provision calls for a coordinated study effort among the Office of Advancement of Telehealth, the Department of Agriculture, and the Veterans Administration, along with regular reports to Congress on the development of the service.

• **Development of telehealth networks.** The bill would authorize grants and loans administered by the Office of the Advancement of Telehealth to spur the development of local multi-use telehealth systems.

### *Current telemedicine spending modest*

Current industry estimates place the maximum reimbursement level for existing services from U.S. telemedicine programs at only $4.2 million in 1997.

According to Global Telemedicine Group in McLean, VA. the present telemedicine reimbursement landscape looks like this:

— Ten states (Arkansas, California, Georgia, Iowa, Kansas, Montana, North Dakota, South Dakota, Virginia, and West Virginia) reimburse telemedicine expenses under Medicaid, provided the health care agency or institution can document that the use of telemedicine saved the agency money. However, as there is no standard reimbursement fee, it is up to each state to determine how much it will pay.

— Medicare operates four demonstration sites in West Virginia, Iowa, North Carolina, and Georgia. Experts contend these findings will alter HCFA's current stance against home telemedicine reimbursement.

— Commercial insurers have sometimes been reimbursed for home telemedicine when those services are bundled with conventional services.

— A few states have passed legislation relating to telemedicine. However, as of mid-1998, none has specifically targeted coverage for home telemedicine.

### *COMING IN FUTURE MONTHS*

- Provider groups work to eliminate Medicare cutbacks
- Legislative proposals heat up debate over medical record privacy
- Possible changes in Stark anti-kickback rules are on horizon
- Smaller practice groups turn to new sources of financing
- Tips for getting your due from HMOs

— Certain HMOs have started telemedicine programs for selected members, typically those with chronic diseases. To date, no long-term initiatives have been taken.

Total 1998 and 1999 telemedicine service payments are estimated to be less than $10 million annually, according to Feedback Research Services, a Jacksonville, OR, research group that follows telemedicine issues. ■

# Patients changing doctors in record numbers

*Physicians, not health plans, cited as reason*

Half of America's 100 million households changed, added, or selected a physician in the past two years, according to a recent study by VHA Inc., an Orlando, FL-based network of community-owned hospitals.

Contrary to popular assumptions, health plans are not the top reason for this record change, the study concludes. According to VHA's findings, 52% of health care consumers say poor communication is the main reason they are unhappy with their present physicians. Another 25% said they were not satisfied with the quality of care they received.

"In the information age, there shouldn't be barriers to quality communication," says **Kelly W. Breazeale**, senior vice president of VHA. "We learned from the study that patients want access to credible, current information. And they want to be able to communicate easily with their doctor about treatment options."

According to the research, a startling 71% of health care consumers say they were given no health information during their last physician visit. Yet 85% of those who did receive information found it extremely helpful. The study also found that of all the ways to obtain health information, most consumers' first choice is to get information from their personal physician.

"The roles played by quality communication and shared information in improving health cannot be underestimated," says **Roxy Marrese**, MD, who has a private practice in Daytona, FL. "My ability to help my patients, and their satisfaction with me, is directly determined by how well we connect with each other." ■

# More physicians using e-mail to communicate

*It saves time, produces a record*

When it comes to improving communicating with patients, "The telephone is no longer adequate," says **Daniel Hoch**, MD, assistant in neurology and director of neurology operations improvement at Massachusetts General Hospital in Boston. Hoch is running a pilot e-mail program with about 10 patients.

"There are too many calls, and people are not satisfied with a quick answer. The Web-based approach is more convenient, and more information can be given," says Hoch.

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Editor: **Larry Reynolds**, (202) 347-2147.
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Glen Harris**, (404) 262-5461, (glen.harris@medec.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.

**Editorial Questions**

For questions or comments, call **Glen Harris** at (404) 262-5461.

The neurology department has had a service for about a year that allows patients to post a message to Hoch on an electronic bulletin board service. He answers directly to the bulletin board, and the postings are saved to provide a record of the interaction that is easy to review. The site is password-protected and more secure than standard e-mail, he says.

Hoch uses e-mail to answer patient questions, leave instructions for medication changes, and direct patients to Internet sites that might supply more information. He says using e-mail has cut the time he spends on the phone with patients by 25% to 50%.

"We've generally found it more efficient than phone calls. There is the ability to take care of business from remote sites, to do so at odd hours without worrying about waking someone up. And it is often faster than phone tag," he says.

Another benefit is that because e-mail messages can be printed out, there is a written record for both the patient and the physician.

Hoch is on the cutting edge of using a technological tool that could transform the day-to-day practice of medicine. Only about 5% to 10% of physicians currently correspond with their patients by e-mail, up from 1% to 2% one year ago. However, experts predict this number will rise quickly as patients used to e-mailing business associates, friends, and family demand that doctors respond to their e-mail inquiries.

"The small group of clinicians who routinely use provider-patient e-mail say that it has revolutionized their practice in very positive ways," says **Tom Ferguson**, MD, an Austin, TX-based consultant. "In many cases, they can avoid the need for a clinic visit by an on-line exchange. And there is always a full record of the on-line conversation, so it can automatically become a part of the patient's medical record."

Ferguson says 25% to 30% of doctor-patient e-mail deals with follow-up questions after an office visit, a perfect example of the benefits of e-mail. "It's wonderful as a doctor to say, 'Send me an e-mail in 10 days and let me know how you're doing.' You usually don't know what happens to the patient. Think how good that could be for your clinical expertise."

**Paul M. Ford**, MD, an assistant professor of medicine at Stanford University in Palo Alto, CA, who practices internal medicine, has been using e-mail with his patients for about five years.

"E-mail unloads a lot of the administrative stuff you have to do in medicine, " he says. "I really believe if we had more patients using e-mail, it would decrease our overall practice costs. We wouldn't need so many people to answer the telephone, so many people in the file room moving charts around. Also, patients would feel more connected to the practice, which could help financially in the long run."

Ford's practice of 10 physicians has a central e-mail address and a software filtering program that helps automatically route messages to the appropriate people. An automatic reply is sent to tell patients their message was received and who will take care of their request. Sometimes, the practice adds reminders to the automatic message such as information about flu shots.

For more information, the American Medical Informatics Association Internet Working Group has developed "Guidelines for the Clinical Use of E-mail with Patients." The guidelines are available at www.amia.org/positio2.htm. ■