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# PHYSICIAN'S PAYMENT UPDATE™

## INSIDE



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# Know your rights, and defend them, during a search of your office

*Agents must confine themselves to scope of the warrant*

*(Editor's note: This is the second in a two-part series that began in the July issue on your legal rights when federal or state agents show up at your doorstep with warrants connected to a fraud and abuse investigation. In this segment, we discuss your legal rights related to search and seizure.)*

The scenario is becoming all too common: A special federal agent, accompanied by a dozen stern-looking officers, has marched unannounced into your office demanding to search your billing and medical files, question employees, gain access to your computers, and remove records from the office.

They cannot be dissuaded, and it looks inevitable that the search will proceed. What can you do?

"Unfortunately, there's not much that can be done to prevent the search of your files and premises as described in a proper warrant," says **Philip L. Pomerance**, JD, a health care lawyer with the Chicago firm of Hinshaw & Culbertson.

The agents will search for and seize property corresponding to the description in the warrant. However, there are three key things to keep in mind while you monitor the conduct of the agents during the search, stresses Pomerance:

- **Make sure the agents confine their search to the scope delineated by the warrant.**
- **If agents seize any property, make sure such seizure is proper according to the terms of the warrant.**
- **Know what parts of your records are shielded from discovery by virtue of attorney-client privilege, and defend that privilege during the search.**

Your Fourth Amendment protections allow only search warrants that are "particularly describing the place to be searched and the persons or things to be seized."

"The requirement that the description must be 'particular' has been extensively litigated, especially as it relates to business records," says Pomerance. "A generic description of 'files,' 'business records,' or

'medical records' in conjunction with a well-defined search location will probably pass the test."

At this point, it is important to remember that you are unlikely to prevent or even delay the search based on an allegation that the warrant is insufficiently particular as to items to be seized.

The agents will most likely seize all records they believe could be relevant to the subject of the warrant. "Later, you may argue successfully to suppress seized evidence because of a defective warrant, but during the execution of the warrant, neither the agent in charge nor the supervising prosecutor is likely to withdraw or delay the search based on your claims of a defective warrant," says Pomerance.

There is an exception. If you notice that the warrant is blatantly defective — for instance, it lists the wrong address or business name or is limited to one floor of a multistory office — immediately raise this issue with the agent in charge and the prosecutor, and before a judge if necessary.

## 'Property' includes medical, business records

The federal rule governing seizure under search warrants is quite broad. Property or people may be seized with a warrant. A warrant may be issued under this rule to search for and seize any (1) property that constitutes evidence of the commission of a criminal offense; or (2) contraband, the fruits of crime, or things otherwise criminally possessed; or (3) property designed or intended for use or which is or has been used as the means of committing a criminal offense; or (4) person for whose arrest there is probable cause, or who is unlawfully restrained.

"Medical records and business records are property. If the warrant describes the seizure of business records, patient records, ledgers, charts, logs, and other papers, the agents will take these records, even over your objections," Pomerance points out.

In turn, make sure you have a photocopy of each item seized and a detailed inventory of all items removed from the premises. If the agent in charge refuses your request to inventory or photocopy, immediately contact the supervising prosecutor and argue the matter. It's also wise to document your objection, as it will help in future negotiations over the return of seized documents.

Also make sure you ask the agent executing the warrant to make an inventory of property seized. However, these inventories are often perfunctory.

"If you can, have an assistant make a record of the items being removed," Pomerance recommends. "This may slow the search, but a complete record of what was seized will be invaluable as you argue for return of items and challenge the search in front of the magistrate."

It's important to remember that the agents will number the rooms of your client's premises by hanging or nailing numbered cards on the door to each room. You must make sure someone records the numbering scheme, because all later references to rooms searched and items taken in the official inventory and in any other government documents will refer to the room number assigned by the agents during the search.

Some experts also recommend you take photographs and videotape during the search, and that everything said by the officers executing the search be tape-recorded.

## Make backups of computer data

Before the agents make a copy of what is on your computer, make sure you have backup copies of all disks in case any of the data are damaged.

If the warrant permits the agents to physically seize your computers and if your data is encoded or otherwise does not yield to discovery, the agents may actually remove your machines from the premises.

"To prevent this catastrophe, attempt to persuade the agent in charge that you will help make copies of all data," says Pomerance. Have your data processing team assist the agents in dumping and copying the data.

Instruct your employees not to interpret or analyze any requested data. The agents are only allowed access to the material. You have no obligation to interpret the data for them. If the agents insist on seizing entire computers, insist on copying or backing up all data and software before the machines are seized so you can continue doing business.

Pomerance also recommends paying close attention to the conversations between agents. "Try to take note of what materials they are seizing. Remember, they have planned for, and are executing, the search under a case theory," he says.

"By linking the information contained in the warrant with details you and your assistants pick up during the search, you may be able to learn

that theory, or at least better understand what the agents are seeking.

"Clients, and often untutored attorneys, immediately assume that the role of defense counsel during a search is to assert loudly the various privileges that will, in their minds, cause the agents to cease searching the target site and go away. In fact, there are few relevant privileges, and assertion of a privilege — even a valid one — will not stop the agents from searching," says Pomerance.

Issues of privilege are legal issues, and must be argued first to the prosecutor controlling the search, and often then to the magistrate. Even after you assert a privilege, the agents will likely seize the material. Attempts to persuade the magistrate by telephone to limit the taking of materials for reasons of privilege also usually fail.

### *Keep privileged materials segregated*

Notes Pomerance, "I believe that the most productive course you can follow is to identify the physical locations where you may keep privileged materials, and ask that the search exclude those specific offices, computers, file cabinets or desks."

The agent in charge and the prosecutor will probably deny that request, however. If they do, fallback options include:

• First, ask that the investigators seal the allegedly privileged materials in clearly identified boxes and segregate them from the other materials being seized until the court has ruled on your claims of privilege.

• Alternatively, demand that your lawyer supervise the agents examining the allegedly privileged documents so that you can see what privileged items they are examining and possibly seizing.

This tactic has two benefits, says Pomerance. It allows you to preserve the questions of privilege for later review by the magistrate, and it allows you to concentrate your efforts on monitoring the search.

He also notes that "this tactic delays the search of these prospectively dangerous areas," he notes. "Later in the search, when the agents come to the identified 'privileged' areas, they are likely to be tired and less observant, and therefore less careful, which could let human nature work to your favor."

As a last resort, if the prosecutor ignores all attempts to preserve the privilege, you should demand an immediate hearing on questions of privilege before the magistrate.

A target of a search has significant problems maintaining a claim of Fifth Amendment privilege in connection with a search or subpoena, note legal experts, because they cannot prevent the forcible search and seizure of incriminatory material under warrant. If the privilege applies at all, it applies to subpoenas or records requests, which are directions to a target to produce documents or property that might incriminate the target.

In addition, the Supreme Court has decided that business records (such as billing records, payroll, accounts receivable and accounts payable records, and sometimes medical records created by health care providers in the course of business) are not protected from disclosure by the Fifth Amendment privilege against self-incrimination.

You can also try to claim physician-patient privilege when the search document requires the production of medical records. But, again, this argument generally provides little protection.

"The privilege belongs to the patient, and the physician must honor the privilege only if the patient has not waived his or her rights. A search is not likely to stop, or even to slow, because the target physician asserts patients' privilege," says Pomerance. In many instances, investigators will be seeking specific medical records for which they have already obtained waivers of the privilege from the patient before executing the search warrant.

### *Not every letter from a lawyer is privileged*

The attorney-client privilege can be used to shield certain documents from production under either a warrant or a subpoena. However, these documents must be evidence of privileged attorney-client communications, created and preserved in accord with the rules regarding attorney origination and non-disclosure.

"Not every letter from a lawyer is automatically privileged," says Pomerance. "Further, communications between company employees who are not lawyers about legal issues are usually not privileged. Prosecutors are sensitive to the attorney-client privilege, and you may be able to protect actual privileged communications found in your files from disclosure."

Recommendation: As soon as possible, alert the agent in charge and the prosecutor that certain

areas of the premises being searched likely contain attorney-client privileged documents, and demand that the agents segregate these materials and not search them. If you and your attorneys established a practice of clearly labeling all privileged communications, it will be easier to identify these privileged documents.

Also, remember that privileged documents are not subject to seizure or production, even though they are found in the files of non-attorney employees of the client, so long as steps have been taken to protect the privilege.

The attorney-client privilege also can protect information relating to a client's internal corporate investigations regarding possible criminal conduct if the information has been properly maintained as privileged information.

### *Self-evaluation may confer privilege*

A relatively new legal privilege that could help you involves self-evaluation that promotes candid business self-criticism in the public interest. The privilege — first recognized in a health care setting — states that information gleaned from a business' internal review of its conduct or operations during confidential self-analysis is privileged from discovery if preserving the confidentiality of the information serves the public interest.

Asserting this privilege during a search raises at least three problems.

• It is a new, judicially created idea that most jurisdictions have not adopted and the prosecutor most likely will not recognize. As a practical matter, you may have to raise the privilege to preserve it, although it will not impede the searchers or the prosecutor at all, says Pomerance.

• Jurisdictions that recognize the privilege to some extent often allow the disclosure of information to government agencies and only preserve the privilege against private litigants.

• Despite the fact that some states have adopted some kind of internal audit privilege, other federal agencies have said their policy is to ignore it.

"My suggestion is to be aware of the self-evaluation privilege and raise it during the search, if appropriate," says Pomerance. "However, don't expect this to stop the investigators from seizing the material in question, which means you'll probably end up arguing your right to exclude the allegedly privileged materials after the search." ■

# Medicare hospital cuts could affect physicians

*Recent integration puts doctors at risk*

Many experts worry that cuts in hospital Medicare funds contained in the Balanced Budget Act of 1997 (BBA), combined with proposed changes in outpatient payments, could have a ripple effect on physician practices.

"Recent trends in hospital-physician integration mean more medical group practices are now hospital-based or hospital-affiliated. Often, these arrangements have been structured as part of hospital outpatient departments," notes **Robert Redling**, senior writer at the Medical Group Management Association (MGMA) in Englewood, CO.

This means many group medical services traditionally provided in freestanding physician practices are now provided through hospital outpatient departments.

According to a June report by the American Hospital Association, seven out of 10 hospitals may have negative Medicare margins within three years due to the $71 billion in projected Medicare cutbacks. This is 33% more than the $53 billion predicted by the Congressional Budget Office when the legislation was passed, according to AHA president **Dick Davidson**.

Rural hospitals and home health will be hit particularly hard by these cuts. Medicare margins for rural hospitals may plummet to between -10.4% and -7% in 2002 as a result of BBA revisions, the study stated. Meanwhile, margins for hospital-based home health services are predicted to drop from -4% to -11.6%.

The changes included in regulations proposed by the Health Care Financing Administration (HCFA) would:

• Establish 346 Ambulatory Payment Classifications (APCs) under which HCFA has placed each covered hospital outpatient service. Composition of the APC groups would be based on services' clinical similarities and similar resource costs.

• Create new compliance requirements for provider-based entities. Among the criteria is a rule that would require those seeking provider-based status to obtain a determination to that effect from HCFA prior to billing as a provider-based facility or organization.

• Establish a presumption against provider status for "off-campus" physician practice sites.

• Mandate physician supervision of certain diagnostic tests.

• Create a limited bundling system for outpatient services.

According to another study by Baltimore-based consultants HCIA Inc., the BBA-mandated cuts in Medicare spending could create significant geographic disparities in hospital and related physician finances.

"The BBA could lower hospital profit margins from their current 5% average to less than zero by 2002," says HCIA spokesman **John Morrow**.

Providers on the East and West coasts are the most at risk, estimates HCIA. Specific major metropolitan areas that appear most in danger include Denver, Boston, Atlanta, Washington, DC, Los Angeles, and Seattle. ■

# Medicare reform package gives and takes away

*Includes funds to reduce BBA impact*

The Clinton administration plan to revise Medicare is gaining considerable attention for its proposal to offer prescription drugs to beneficiaries, but it contains a number of provisions that affect physicians. These include:

• **Balanced Budget Act of 1997 provisions.** On the plus side, the proposal sets aside $7.5 billion to restore some of the payment reductions affecting providers included in the Balanced Budget Act (BBA) of 1997.

"On the negative side, the measure extends other cost savings provisions of the BBA that were going to expire after 2000, saving a net of $31.5 billion over 10 years," notes an analysis of the proposal by the Medical Group Management Association.

• **Competitive pricing.** The plan provides new and broader authority for competitive pricing, incentives for beneficiaries to seek care by physicians who provide high-quality care at reasonable costs, and "other best-practice private sector purchasing."

• **Competitive defined benefit.** Proposed reforms in the Medicare managed care program would require plans to offer a "competitive defined benefit" covering Medicare's current benefit package, plus a new prescription drug benefit.

The administration claims this will permit beneficiaries to compare plans "apples to apples." Plus, by letting beneficiaries keep 75% of the savings for plans that offer the core benefits at less than the average cost, the proposal encourages beneficiaries to select lower-cost plans. Beneficiaries selecting higher-than-average-cost plans would have to pay the full difference of the amount exceeding the average.

Plans, however, could continue to offer additional benefits, including vision and hearing care, if offered as a separate supplemental package.

• **Preventive care copayments.** Copays and deductibles for preventive medical care, such as mammograms, prostate cancer screenings, and diabetes management, would be eliminated. "It makes no sense for Medicare to put up roadblocks to these screenings and then turn around and pick up the hospital bills that screenings might have avoided,'' President Clinton said.

• **Medical laboratory tests.** Patients would have to pay 20% of the costs of clinical laboratory services.

• **Teaching hospital disproportionate share payments.** Carves out from current managed care fees Medicare payments to hospitals that serve a disproportionate share (DSH) of low-income and uninsured patients and prevents further cuts to DSH hospitals in the future.

Given the support among seniors for the President's proposed prescription drug coverage, the question in Congress is not whether the new Medicare benefit should be approved, but how and by how much.

### *Benefit would begin in 2002*

President Clinton says his proposed $1,000-a-year prescription drug benefit for older and disabled Americans — at the cost of a monthly $24 premium — "is a benefit our seniors can afford at a price America can afford."

If approved as presented, the new drug benefit would be available as an option for those 65 and older and for the disabled beginning in the year 2002. It would cost the government $118 billion over 10 years, administration officials estimate.

Coverage would start with the first dollar of prescription costs, with no deductible. The government would pay half of the first $2,000 of drug

## Details of the president's prescription proposal

Under the president's proposal, Medicare enrollees above 150% of the poverty level would pay no deductible on prescription drugs but would be responsible for 50% of drug costs up to the spending cap and 100% of pharmaceutical costs after that. The cap would be phased in at $2,000 per year between 2002-2003, $3,000 between 2004-2005, $4,000 for 2006-2007, and $5,000 from 2008 onward.

Medicare beneficiaries below 135% of federal poverty levels would be provided a drug benefit without having to pay premiums or cost sharing. Beneficiaries between 135% and 150% of the federal poverty level would receive "premium assistance" for their drug costs.

In an effort to keep seniors in their exiting retiree benefits, the administration proposal would provide "financial incentives" for employers to continue to offer retiree health coverage. The retiree drug benefit coverage would have to be "at least equivalent to the new Medicare outpatient drug coverage," states a White House fact sheet. ■

costs in a year. Any drug costs above $2,000 in any given year would have to be paid entirely by the beneficiary.

The monthly premium would rise gradually to $44, and the $2,000 cap would rise to $5,000 by 2008. In that year, a beneficiary would pay $528 to have the government pay for up to $2,500 worth of drugs. Part of that premium increase would account for inflation, say White House officials.

Medicare recipients already pay a $45.50 monthly premium to cover doctor's office visits.

Beneficiaries who have annual incomes below $11,000 per individual or $17,000 per couple would pay no premium or cost-sharing for drug coverage up to the annual caps. Other low-income Medicare recipients would get help paying the premium.

About two-thirds of seniors 65 and older already have some drug coverage from benefits offered by former employers, private insurance policies they purchase on their own, or Medicare HMOs.

The administration maintains that the proposed outpatient drug discount would not be obtained through price controls. Instead, reduced prices would be achieved because drugs for the program would be purchased through pharmacy benefit management programs and HCFA's "bargaining power," says White House national economic advisor **Gene Sperling**.

The American Association of Retired Persons supports the concept of a new Medicare prescription drug benefit, but is worried about how much Medicare clients will be asked to pay out of pocket.

Meanwhile, drug makers are concerned about how the government will decide which drugs to cover at what prices. Other health care providers, including hospitals and HMOs, worry that Medicare money to pay for drugs will be squeezed from their own budgets even as they struggle to adjust to payment cuts Congress approved two years ago to help balance the federal budget. ■

## Pharmacy capitation zooms into the national limelight

*Manage drug costs globally, not in isolation*

The best political theater in Washington, DC, this summer may have nothing to do with the brewing presidential campaigns. Experts say the issue to watch in health care is how Congress and Medicare officials handle prescription drug coverage.

"As Medicare goes, so goes private-sector insurance," is a common refrain among veterans of health care management. But will that be the case this time? Can the nation afford it? Can private-sector insurers afford it? Will the market demand it regardless?

Capitated providers are well aware that "pharm-cap," the practice of incorporating prescription drugs within the per-member-per-month payment in capitation contracts, is about as risky as the health care business gets. Drug costs are volatile and almost impossible to predict. Drug utilization patterns can lead to either savings or major expenses in the long run, and they are subject to both visible and obscure market influences.

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Physician's Coding Strategist™

# It's time to look at the nitty-gritty of EDI

By **Tim Stunz**
President
SBPA Systems
Houston

**Q:** What are the most common misconceptions health care organizations have about electronic standards?

**A:** Electronic data interchange (EDI) in itself is not the panacea some may believe. While many larger organizations have achieved productivity gains by switching millions of transactions from paper processing to EDI, some expected efficiencies have not been realized.

For example, numerous large health care organizations have been using a standard EDI format for several years. However, up until the Health Insurance Portability and Accountability Act (HIPAA) of 1996, there wasn't much incentive for small to medium-sized health care organizations to adopt EDI. In fact, for most, the reported benefits just didn't appear to justify the incremental costs of translating native formats to EDI formats.

Consequently, those companies that have adopted EDI can't always count on their trading partners to have the standards in place. Sporadic implementation has resulted in mixed efficiencies.

**Q:** What standards do you think will be accepted by the Department of Health and Human Services in Washington, DC?

**A:** I expect the suggested X12 standards will be accepted. With the many different standards in practice to date, the proposed X12 standards seem to show the most promise regarding data content. The biggest challenge is getting everyone prepared and trading data this way.

The most important thing to remember here is when the final rules are published, there is a 24-month implementation grace period. I believe all evolved parties should at least have a plan in place before then.

**Q:** How difficult do you think it will be to implement the standards for providers who don't use standard EDI formats now at all?

**A:** Many health care organizations that haven't yet implemented EDI believe that once they adopt the standard, transaction processing will magically fall into line cleanly and without a hitch. The reality of an EDI implementation can hold more than a few surprises. Our advice always is to start as soon as possible and make sure your system is configured correctly before trying to implement EDI.

We have been working hard on integrating EDI with our system software product for many years. It's a challenge to do it right from the start, but we think that the benefits of adopting EDI standards will be worth the work up front for all health care organizations.

**Q:** Are there common steps to follow?

**A:** Establish your current capabilities in trading data electronically. Determine the clients you can trade electronic data with. Pick a client who most represents your core business interest to start trading with, preferably one who is currently doing electronic business. Run a parallel system until you're comfortable that the electronic data is at a good level. This time frame should not be more than eight weeks, but this depends on the quality of the data being sent. When the trading partners agree, then "flip the switch" and stop the paper flow.

**Q:** What implementation surprises do you expect providers to have?

**A:** We initially developed an EDI module for our clients in 1994, but they were not ready for it.

We have since put the product into production and are currently customizing it for several clients.

We are finding that each of our clients faces unique challenges with regard to implementing EDI. And all of these challenges have to be handled individually before EDI is implemented.

Most health care organizations can expect to spend considerable time and resources working out many kinks. EDI implementation is generally a slow process because effective use of EDI requires that data being exchanged from one trading partner to the other must be clean and consistent.

**Q:** What special challenges will face providers who already use other standards?

**A:** Many providers who already use other standards may not know what standards they are currently using. A significant challenge to providers who submit data electronically will be their software vendor. The provider needs to find out if the software vendor they are using has a plan in place to address HIPAA issues. One must remember, though, that clearinghouses can receive data in any format but must re-format this data into the chosen standard.

**Q:** How long should it take for most providers to implement the standards?

**A:** Implementation of the EDI standards could take anywhere from several months to a year or more. Variables that would impact the amount of time required include: the current level of expertise with EDI, the ability of their software / systems to handle the emerging standards, the willingness to bring in additional expert resources, and the level of electronic automation of the providers' current processes.

**Q:** Who should be involved in the implementation project, what kind of equipment will they need, and what kind of cost should they expect?

**A:** In addition to the obvious membership of experts in information technology and EDI on any EDI project team, the team also must include representatives from parts of the organization that are the source of and users of EDI transactions. In many cases, it will be necessary to alter systems and processes throughout the organization. Therefore, it is essential for individuals who use and are impacted by those systems and processes to be a part of the team.

Due to the fact that equipment and part costs vary due to the nature of customization, we can't specify an average dollar amount.

*(Editor's note: SBPA Systems is a health care benefits administration software company.)* ■

# Schedule outlines dates for release of HIPAA rules

The U.S. Department of Health and Human Services (HHS) in Washington, DC, has released a tentative schedule for its final standards on electronic health information, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Notices of Proposed Rule Making (NPRMs) that already have been published and their expected final dates are: Transactions and Coding, November 1999; National Provider Identifier, December 1999; National Employers Identifier, December 1999; Security, December 1999.

Here is the schedule for NPRMs still in development: National Health Plan Identifier, tentative rule December 1999, final rule May 2001; Claims Attachments, preliminary rule September 1999, final rule September 2000.

HHS says the length of time from the publication of the NPRMs to the publication of the final rule is needed to review and respond to the large number of comments received on the NPRMs. In addition, the rules need to be reviewed not only within HHS and a number of its subordinate agencies, but also by several other federal departments affected by the rules.

Standards are required to be implemented within two years of the effective date of the final rule, generally 60 days after publication of the rule. However, the effective date for the National Provider Identifier is planned to be no earlier than July 2000, to give HHS enough time to develop the system for implementing the identifier.

## *Start preparing now*

The American Health Information Management Association (AHIMA) in Chicago has updated its checklist of how to prepare for some of the categories, and has added steps to prepare for the electronic signature standard. Here is the new version, as prepared by **Sandra Fuller**, MA, RRA, vice president of practice leadership, and **Julie J. Welch**, RRA, an HIM practice manager for AHIMA:

**General**

• Assign responsibility for tracking the progress of regulations as they develop.

• Continue to inform key internal stakeholders about HIPAA and its impact on your information systems and processes.

• Seek current information on the industry's approach to HIPAA compliance.

• Develop resources — such as publications, seminars, Web sites, and professional networking — to facilitate development of your approach to meeting HIPAA requirements.

• Plan internal educational programs to describe HIPAA requirements to those responsible for implementing the changes.

• Obtain and read copies of the proposed rules from the *Federal Register*, which can be accessed via the Health Care Financing Administration's (HCFA) Web site at http://www.hcfa.gov.

• Read the reports and recommendations from the National Committee on Vital and Health Statistics (NCVHS). The NCVHS serves as the statutory public advisory body to the Secretary of Health and Human Services in the area of health data and statistics. (The reports and recommendations can be accessed via the NCVHS Web site at http://aspe.os.dhhs.gov/ncvhs through NCVHS Reports and Recommendations.)

• Obtain and read a copy of the Internet Security Policy from HCFA's Web site.

• Meet with key staff in information services to discuss the requirements, identify the people who need to be involved, and develop a plan of action. Share sections of the *Federal Register* with individuals who need to be involved in preparing for the regulations.

• Perform a gap analysis of your existing policies and procedures compared to the requirements of the proposed standards.

• Have individuals who need to be involved send you copies of their policies and procedures that address the requirements.

• Develop a checklist to help identify those policies and procedures you will need.

**Standardization of code sets**

• Monitor payer compliance with official coding guidelines.

• Perform regular coding quality control studies.

• Provide feedback on documentation issues that have an impact on the quality of coded data.

• Routinely train coding staff on current coding practice.

• Provide access to resources on coding guidelines and best practices. Efficiently update the ICD-9-CM codes in October and the CPT-4 codes (for both transaction and analysis systems) in January.

**Health care identifiers**

• Become familiar with the Notice of Proposed Rule Making for the employer identifier number, the taxpayer identification number for employees that is assigned by the Internal Revenue Service.

• Read the Notice of Proposed Rule Making for the national provider identifier.

• Assess the quality of the master person index (MPI).

• Perform required cleanup and eliminate duplications in the MPI.

• Institute procedures to maintain the integrity of the MPI.

• Train staff on the importance of data quality in an MPI.

• Make necessary data quality improvements in registration systems.

• Assign responsibility for the maintenance of MPI data integrity.

• Perform routine data integrity checks on the provider database.

• Develop effective procedures to maintain provider tables.

• Integrate or interface provider tables with necessary systems.

• Monitor data quality for unique personal identification numbers (UPINs) on billing documents.

• Provide easy access to UPIN tables.

• Maintain current, complete payer tables.

• Perform data quality checks on payer data entry.

• Develop feedback loops from the billing process to data collection processes regarding payer data.

**Claims transactions**

• Maintain effective communication regarding claims processing with all affected parties.

• Perform routine maintenance on the charge master.

• Use electronic claims processing and electronic data interchange.

• Explore feasibility of converting to electronic claims processing or outsourcing that function.

• Have comprehensive documentation of claims processing.

• Routinely monitor remittance information against claims data.

• Have an effective process for handling rejected claims.

• Aggregate data about rejected claims to improve claims processing.

• Become familiar with transaction standards and standards development organizations.

**Information security**

• Review the proposed standards and assess your organization's level of compliance by performing a gap analysis.

• Become familiar with the information security standards and standards development organizations.

• Identify existing organizational structures to aid development and implementation of an information security program.

• Ensure that policies exist to control access to, and release of, patient-identifiable health information.

• Ensure that users of electronic health information have unique access codes.

• Ensure that each user's access is restricted to the information needed to do his or her job.

• Outline the physician responsibilities for protecting the confidentiality of health information in the medical staff bylaws or rules and regulations.

• Outline employee responsibilities for protecting the confidentiality of health information in the employee handbook.

• Train everyone with access to health information about confidentiality and their responsibilities regarding confidentiality.

• Review vendor contracts for outsourcing of health information to ensure that they include provisions regarding confidentiality and information security.

• Ensure that system managers, network managers, and programmers do not have unlimited and unrecorded access to patient information.

• Monitor access to information and put corrective action plans in place for violation of organization policy.

• Perform risk assessments to prioritize and continually improve the security of the systems.

• Maintain current knowledge of information security issues and industry response to these issues. Read books and publications, and attend seminars.

**Electronic signature**

• Identify the use of the electronic signature in your organization.

• Perform a gap analysis for electronic signature applications to assess compliance with proposed standards for electronic signatures.

• Become familiar with the electronic signature standards and standards development organizations.

• Discuss the proposed requirements with current vendors who may be supporting your organization's information systems.

• Familiarize yourself and employees with new and emerging information security technologies.

• Research various certificate authorities to determine costs and identify a potential candidate. ■

# HIPAA implementation guides released

The Department of Health and Human Services (HHS) has announced that the final versions of the nine ASC X12N EDI Implementation Guides and the Health Care Data Element Dictionary are complete.

The guides and dictionary are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification provisions. It is expected that the department will adopt these standard implementation guides in the final rule.

The following final guides were released on June 3, 1999, and can be downloaded from the Washington Publishing Company's Web site at www.wpc-edi.com / HIPAA. Guides posted include:

• Health Care Claim Status Request and Response;

• Payroll Deducted and Other Group Premium Payment for Insurance Products;

• Benefit Enrollment and Maintenance;

• Health Care Claim Payment / Advice.

The remaining five final guides were posted on the Web site on June 10, 1999. These were:

• Health Care Eligibility / Benefit Inquiry and Information Response;

• Health Care Claim: Institutional;

• Health Care Claim: Dental;

• Health Care Claim: Professional;

• Health Care Data Element Dictionary.

A tentative schedule issued by HHS indicates that the final rule will be published in November of 1999. Standards are required to be implemented within two years of the effective date of the final rule, generally 60 days after publication of the rule. This makes the required implementation date February 2002. ■

(Continued from page 118)

Still, pharmacy capitation is virtually standard in markets where capitation is mature, such as Massachusetts, Texas, and California.

**Donna Shalala**, secretary of the Department of Health and Human Services, recently hailed the prospect of expanding drug coverage to the elderly. "A prescription drug benefit is good health care," Shalala said. "It's prudent policy. It's compassionate government. And the time for action is now," she said in a speech to the National Press Club in Washington, DC.

## 'How can the nation afford it?'

There is no doubt the expanded benefit is in high demand, shown dramatically by the popularity of Medicare risk contracts that offer free or reduced drugs, notes **Gary Plank**, MD, director of pharmacy services for Security Health Plan, a physician-owned HMO operated by the Marshfield (WI) Clinic. "But how can the nation afford it if Medicare solvency already is an issue?" he asks.

Will the rest of the private sector follow Medicare's lead? "Regarding Medicare risk, I'd say yes," Plank predicts. "The private-sector risk will continue to incorporate pharmacy." Beyond that, however, "I don't know how the nation could afford it."

Given all the attention paid to prescription drug benefits today, chances are these benefits will remain a prominent feature of capitation and other managed care and fee-for-service arrangements for the foreseeable future, Plank and other experts predict. Here are three explosive reasons why:

• **Advertising rules consumers.** The pharmaceutical industry increased its spending on direct-to-consumer advertising by 16% between March 1998 and March 1999, according to a report published in June by the London-based information firm IMS Health. Estimated expenditures came to $1.53 billion. This increase was smaller than the 24% increase reported for the 12 months that ended in December 1998, according to IMS analysts, but they say consumer-oriented drug advertising is here to stay because it is effective at stimulating consumer demand.

At the same time, generic drugs aren't wholeheartedly embraced; after all, they aren't advertised. Most Americans still prefer brand-name drugs over lower-cost generic drugs, according to a June survey by CareData Reports, a White Plains, NY-based consumer and health research organization. Based on a sample of 20,000 Americans, the survey indicates that only 45% of respondents are satisfied when switching from a brand name to a generic drug.

• **Consumers rule the market.** Even as brand-name drugs go off the patent list and on to the generic domain, pharmaceutical manufacturers will continue to make more than they lose, say IMS officials in a separate report. Overall, the industry generated revenues of $302 billion in 1998. Some $70 billion is expected to be lost in patent expirations in 1998, but consumer demand will continue to drive new development as well as sales of off-patent drugs.

• **Voters rule politicians.** Medicare proposals for prescription drugs are multiplying. As election season picks up, Congress knows that seniors favor financial support for pharmacy costs. A host of ideas and bills are flooding Congress already. The following four proposals would have Medicare provide:

— up to $1,700 per year for drugs with a $200 deductible and a 20% copayment for all beneficiaries;

— a pharmacy benefit strictly for low-income elders;

— comprehensive pharmacy coverage via group purchasing policies, such as rebates, price ceilings, discounts, or competitive bidding for drugs;

— specific outpatient prescription drugs for several chronic disease conditions, such as hypertension, major depression, diabetes, rheumatoid arthritis, and congestive and ischemic heart disease. The thinking is that pharmacy expenditure over the long term would reduce inpatient and outpatient admission cost.

## Don't separate drug costs from overall costs

How do physicians handle this chaotic mix of market and economic influences? "What many people are trying to do is to look at the drug benefit independent of total health care cost," says Plank. However, that approach gives a false picture, he warns.

For example, Marshfield's second-highest drug expenditure reduces cholesterol levels, which in turn reduces heart disease and stroke. "Increasingly, we're moving out of treatment of a disease to prevention," Plank says. The costs are high on the drug end, but lower in hospital and outpatient admissions. ■

# HCFA plans to offer new enrollment criteria, forms

*Form 855 may be simplified*

Responding to physician complaints, Health Care Financing Administration (HCFA) officials say they plan to revise HCFA Form 855 (the Medicare Health Care Provider / Supplier Application Form) and enrollment regulation.

All Medicare providers, including physicians, hospitals, and durable medical equipment suppliers must complete Form 855 to receive a Medicare provider number under which to bill the program.

Look for the proposed changes to be unveiled in the fall, with the revisions targeted to take effect early next year, says **Penny Thompson**, HCFA's director of the Program Integrity Group.

The new form and accompanying proposed regulations will codify which providers are eligible for — and who may be excluded from — the Medicare program, and on what basis HCFA could make these decisions, notes **Pat Smith** of the Medical Group Management Association's (MGMA) Washington, DC, office

"MGMA met with HCFA officials in early May to express our concerns with Form 855," says Smith. "It appears HCFA has responded to our concerns, such as the complexity of the form and improving processing procedures."

Providers have asked HCFA to correct the following key problem areas with the form:

• **Make the form simpler and easier to understand.** HCFA has indicated it intends to alter the instruction section of the form so each section of instructions is located with the appropriate section of the form, say MGMA officials. HCFA also may rewrite portions of the instructions and include a matrix that explains which enrollees should fill out which sections of the form.

• **Reduce the amount of requested information.** HCFA's Thompson says the agency will try to reduce the amount of information it asks for, while also incorporating such innovations as "check-off" boxes that permit enrollees to avoid having to provide duplicate information.

• **Eliminate or revise "contractor information" sections.** HCFA is re-examining this section to determine what data it really needs.

• **Facilitate electronic filing.** To make filing easier, HCFA is considering placing the form on the Internet. The agency also may use the Internet to list who is excluded from the Medicare program, enabling providers to know which individuals and organizations they should not be contracting with.

• **Simplify the renewal process.** Rather than having to completely fill out the form when it is time to renew an application, HCFA is considering ways providers can simply revise and update already filed information.

MGMA says HCFA is considering having providers complete or update their Form 855 every three years or so, while submitting any "material" changes within 30 days of the change. However, HCFA still is not sure how to define what constitutes a "material" change.

## *Criteria for determining eligibility*

HCFA's expected proposed rule revising Form 855 for deciding a provider's Medicare eligibility will be based on a set of specific criteria. Under HCFA's most recent draft, a provider would be excluded from Medicare if the provider has:

— committed a felony within the last five years;

— been excluded from participation in a federal program;

— failed to disclose information that would otherwise make the provider ineligible;

— failed to submit required cost reports;

— failed to meet requirements for provider type;

— stopped business activities as evidenced by a lack of claims submission for one year.

Additionally, HCFA would have the option to exclude providers if they:

— committed a felony more than five years ago;

— provided any false or misleading information on HCFA Form 855;

— are under indictment for felonies that would serve as the basis for denial or exclusion;

— are under payment suspension associated with another provider;

— previously left the program with outstanding debts;

— have a history of high error rates in claims submissions;

— have not been able to obtain or have lost licensure;

— failed on-site visits due to unqualified technicians conducting tests, required physician supervision not being present, or other reasons such as personnel working outside the scope of their licensure or supporting conditions that may harm beneficiaries;

— failed to provide records needed for payment or for establishing Medicare eligibility. ■

# Physicians admit deception to get patients coverage

*Is 'exaggeration' on the rise?*

Almost 40% of physicians say they have exaggerated a patient's condition to an insurance company to make sure the patient has coverage for needed treatment or time in the hospital, according to a recent survey conducted by the American Medical Association (AMA).

"Physician deception of third-party payers is prevalent and may be rising," according to AMA investigators.

The most common forms of deception include:

— exaggeration of severity of the patient's condition in order to avoid early discharge from the hospital;

— changing billing diagnosis to secure services;

— reporting symptoms that the patient did not have in order to obtain coverage and treatments.

Overall, 39% of physicians reported that they had "sometimes," "often," or "very often" used one of the three forms of deception, according to the 1998 survey of 724 doctors in primary care medicine.

Only 28% of physicians said they had never used any of these forms of deception within the last year, and 53% reported ''rarely'' using them.

In addition, 37% of physicians reported that their patients asked them to deceive third-party payers. This was the group of physicians that was most likely to have used deceptive strategies.

Some 31% of physicians had "sometimes" or more often refrained from offering useful or needed services to patients because of a lack of coverage by the patient's plan.

The data were collected by the AMA from its survey of physicians on "Meeting Patients' Needs in the Modern Era."

The report also found physicians who reported using deceptive strategies were:

— less satisfied with the practice of medicine;

— less financially secure themselves;

— less likely to try to talk patients out of unnecessary procedures;

— more dissatisfied with the amount of time available during patient visits;

— more likely to voice annoyance at intrusion of insurance companies in their practice.

Overall, 55% of physicians said they would be more aggressive in cost-control efforts if they knew that money saved would go toward serving more needy patients.

While physicians' use of deception may benefit individual patients, using deception also may damage the patient-physician relationship, cause moral discomfort for physicians, subvert resource allocation systems, and put physicians at risk of prosecution for fraud, the researchers concluded. ■

# Risk-adjusted payments offer some protection

*Family MDs weigh in on new capitation model*

Medicare's proposed risk-adjustment system offers one credible way to protect physicians in capitated contracts, but be sure to use other protections that already exist if you enter capitation.

That's the advice from researchers at Johns Hopkins University in Baltimore who recently published a study on capitation. Targeted at family physicians, the study focuses on safeguards available to doctors in highly capitated environments.

In part, the researchers are responding to proposals already under consideration. Earlier this year, Medicare officials introduced a major restructuring of how Medicare risk rates are set. They proposed a system called ambulatory diagnostic groups (ADGs) that relies on clinical indicators — ICD-9-CM codes, to start with — to predict resource use. In general, the model looks at a patient's prior year's complications (especially if hospital admission was involved) and other medical expenses to statistically predict the coming year's costs.

As it turns out, the range of payments under the ADG method can be significant, and it can make a beneficial difference to physicians dealing with the high-cost risks of capitation, according to the study's two authors, **Gerard F. Anderson**, PhD and **Wendy E. Weller**, MSH.[1] Both are professors of health care finance at Johns Hopkins.

Payment rates could vary significantly, according to their calculations. **(See chart on p. 126.)** For example, one series of calculations shows that the payment range could vary from $1,212 to $15,715 under the new risk-adjusted formula, while the current system would pay a standard $2,625 for all Medicare patients regardless of clinical history.

## Comparison of Current and Proposed Medicare Capitation Methods

| Patients with health system encounters in the prior year | ADC Model | Current Model |
|---|---|---|
| **Patient A**<br>No prior year encounters | $1,212 | $2,625 |
| **Patient B**<br>Ambulatory Treatment<br>Depression (ADG 23)<br>Gastric Ulcer (ADG 7)<br>Coronary artherosclerosis (ADG11) | $3,480 | $2,625 |
| **Patient C**<br>Depression (ADG 23)<br>Gastric Ulcer (ADG 7)<br>Coronary artherosclerosis (ADG 11)<br>Corneal Edema (ADG 3)<br>Diabetes (ADG 9)<br>Heart Palpitations (ADG 27)<br>2 hospital admissions for circulatory complications (MDC 5)*<br>2 hospital admissions for respiratory problems (MDC 3)* | $15,715 | $2,625 |

*Note: MDC indicates major diagnostic cost group, a classification element in the ADG formula.

*Source:* Anderson GF, Weller WE. Methods of reducing the financial risk of physicians under capitation. *Arch Fam Med* 1999; 8:149-155.

The researchers ran comparisons for three different scenarios. For instance, a patient with no prior hospitalization would carry a capitation payment amount of $2,625 under the current model and $1,212 under the proposed ACG model.

If a patient's record indicated ambulatory care treatment for depression, ulcers, and coronary atherosclerosis in the prior year, the proposed capitation amount would be adjusted upward to $3,480, compared to the $2,625 payment under the current system, which doesn't make adjustments.

If a patient's record reflected all the conditions above, plus corneal edema, diabetes, heart palpitations, two hospital admissions for circulatory problems, and two hospital admissions for respiratory problems, the new formula would pay $15,715, compared to the current $2,625 payment.

The proposed risk-adjusted formula can offer some measure of predictability at the beginning of a contract year, the authors state. Also, it can limit the losses physicians might incur if they have a sicker-than-average patient load.

Capitation risk adjustment is not a panacea, the authors warn. Physicians should update their reinsurance or stop-loss coverage to guard against liability for high-cost outliers. Also, they should consider carve-outs and partial capitation contracts, which identify exactly which services the practice will and be responsible for.

### Reference

1. Anderson GF, Weller WE. Methods of reducing the financial risk of physicians under capitation. *Arch Fam Med* 1999; 8:149-155. ■

### COMING IN FUTURE MONTHS

- New insurance policies cover billing mistakes
- The keys to success in Medicare+Choice
- An update on collective bargaining legislation
- Physicians work to refine proposed changes in HCFA coverage policy
- A comprehensive look at alternative financing options

# Don't peddle products, AMA tells physicians

*Practice likened to 'snake oil' sales*

The American Medical Association has adopted by a six-vote margin a new policy discouraging doctors from selling health-related products such as dietary supplements, skin creams, and child-safety seats in their offices for profit.

The practice is akin to the "snake oil" peddling of the 1800s, maintains former AMA President **Robert E. McAfee**, MD.

However, practices can distribute such products for free or at cost under the AMA's new guidelines, adopted at a Board of Trustees session in Chicago. The new policy also says physicians should inform patients about their financial arrangement with the manufacturer or supplier.

According to the AMA, health-related products include such items as vitamins, dietary supplements, over-the-counter medications, safety devices such as child seats and bicycle helmets, skin creams, sun block, and special foods.

In-office sale of such products "presents a financial conflict of interest, risks placing undue pressure on the patient and threatens to erode patient trust and the primary obligation of physicians to serve the interests of their patients before their own,'' according to a report by the AMA's Council on Ethical and Judicial Affairs.

Many doctors, however, complain the policy is unfair to physicians who supply needed products or who practice in areas where such items would otherwise be unavailable.

"As I read and understand it, this policy precludes me as an orthopedic surgeon from selling a patient a pair of crutches if I'm to make even a dollar on that pair of crutches,'' says **Thomas E. Price**, MD, of Roswell, GA.

In another matter, the AMA's Board of Trustees is considering whether the organization will lobby for the imposition of penalties and interest on health plans that refuse to reimburse providers for emergency on-call services. Also, the AMA is being asked to oppose mandatory universal emergency room coverage as a requisite of hospital medical staff membership.

The American College of Emergency Physicians (ACEP) backs the measure, saying action is "urgently" needed. In turn, look for the AMA to give the measure its support. However, official AMA support will probably have to wait until the next House of Delegates interim meeting in December.

Due to a shortage of providers in some specialties, many hospitals already have a "widespread problem" filling emergency on-call rosters with the required physician specialists, says ACEP spokesman **Harold Vincent**, MD.

Under federal law, medical staff back-up coverage must be available via specific call rosters representing all of the services ordinarily available in each hospital. "But we just can't get the doctors," Vincent says. "If the AMA waits until December, I'm concerned some legislative body will deal with the issue in a way that we won't be happy with." ■

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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.

# NEWS BRIEFS

## Feds OK grants to boost senior fraud patrols

Despite intense opposition from provider groups, the U.S. Department of Health and Human Services (HHS) has recently announced 41 grants totaling $7 million to expand its so-called "senior patrol" program that recruits and trains retired professionals and other seniors to identify potential instances of fraud and abuse in the Medicare and Medicaid programs.

The new grants — 29 new and 12 renewed — will be distributed among 38 states, as well as Washington, DC, and Puerto Rico.

In turn, providers in these jurisdictions should expect to see an increase in questions from their Medicare patients in coming months regarding their treatment and billing procedures.

These Senior Medicare Patrol Project grants were created in 1997 by legislation sponsored by Sen. Tom Harkin (D-IA). Under the program, senior volunteers are trained to scrutinize their Medicare claim statements and question physician recommendations for possible questionable medical and billing practices. These unofficial fraud cops are then to report any suspected questionable charges or inappropriate services to the authorities.

The program already has trained some 6,000 retired volunteer instructors, who have, in turn, trained another 70,000 Medicare beneficiaries in ways to spot potential billing problems. Another 250,000 Medicare patient police are expected to be trained under these most recent grants.

While federal officials and other supporters like the American Association of Retired Persons argue the program simply aims to educate Medicare recipients about their rights, provider groups say it does more harm than good by creating suspicion between patients and their physicians while also generating a potential flood of well-intended but often unnecessary questions from patients, consuming extra time and money to answer.

New grants were allocated in Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Idaho, Indiana, Maine, Massachusetts, Michigan, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Puerto Rico, Texas, Utah, Virginia, and Washington. ▼



## New drug pricing guide available

With all the recent talk about the cost of prescription drugs, practices might want to check out a new drug pricing guide for physicians developed by Mercy Health Services in Detroit.

The guide is not a comprehensive guide to every drug, but a composite of those that are used frequently, and those that have an acceptable generic equivalent.

For more information, contact Camille Purdie Mercy Health Services, (248) 489-6002. The Web site is: www.mercyhealth.com. ■