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OIG preparing to provide guidance with model compliance plan

Plan will help practices' problems with investigators

High-priced representatives from physician and specialty societies continue to meet with lawyers from the Office of the Inspector General (OIG) to hammer out the details of a much-anticipated OIG model plan to help physician practices comply with federal health care regulations.

Word from inside the OIG is that the guidance officially announced last fall should be out "soon." Once floated, the model plan will be the latest in a series of six previous provider-type specific guidelines developed by the OIG. They serve as a template for establishing what government officials will accept as a creditable and good-faith effort by practices to comply with federal health care payment and contracting rules. Adhering to those guidelines will be important because the existence of a well-run compliance program promotes a presumption on the part of auditors and prosecutors that payment problems are innocent mistakes rather than knowing efforts to defraud the government. In other words, providers that have what auditors feel are questionable billing patterns but also have an OIG-sanctioned compliance program in place will not automatically be considered con artists. Those without an OIG-sanctioned plan may be presumed to be crooks or at least to be hiding something.

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Thus far, the OIG has built all its model compliance plans around the seven concepts its feels form the foundation of a good compliance program. **(See related story, p. 18.)** A major issue has been whether the OIG will continue to follow that seven-point blueprint — which it is inclined to do — or take another approach.

Prior compliance plans provide physician model

To date, the Office of the Inspector General (OIG) has issued specific compliance guidelines for hospitals, clinical laboratories, home health agencies, third-party medical billing companies, durable medical equipment companies, and hospices. Each of the guidelines was based on these seven elements:

1. development of written policies and procedures;

2. designation of a compliance officer and other appropriate compliance bodies;

3. development and implementation of effective training and education programs;

4. development and maintenance of effective lines of communication;

5. enforcement of standards through well-publicized disciplinary guidelines;

6. use of audits and other evaluation techniques to monitor compliance;

7. development of procedures to respond to detected offenses and to initiate corrective action.

When the OIG releases its physician model compliance plan, the American Medical Association wants the agency to provide details on the following topics:

- who can and can't be a compliance officer;
- what the expected duties of a compliance officer will be;
- what constitutes adequate employee compliance training;
- how specific compliance policies and procedures must be;
- the kind, frequency, and number of specific compliance information practices that must be communicated to employees;
- how practices should discipline employees who violate compliance procedures;
- what constitutes an appropriate compliance audit or evaluation technique;
- how a practice can demonstrate acceptance of responsibility when problems arise and show it is taking corrective actions, including steps to prevent similar problems from happening again;
- whether physicians can share plan information or plan initiation and implementation costs with other independent physicians. ■

During negotiations with the OIG, physicians' representatives have argued for a set of simple straightforward guidelines that stress assistance and a presumption of innocence instead of a rigid set of rules providers must follow. At the same time, physicians have asked the OIG to provide extensive details about what each guideline means, which the OIG has declined to do in previous guidelines in order to promote flexibility.

Taking the position that size matters, organizations like the American Medical Association have lobbied for the guidelines to be sensitive to the size and specialty of practices and to make distinctions between individual and small/larger group practices.

Arguing for an "outside the box" approach to writing the compliance guidelines, the American Society of Internal Medicine-American College of Physicians (ASIM-ACP) has taken a "please don't make this too complicated; we're just a bunch of physicians" approach. For instance, in a letter to Inspector General June Gibbs Brown, ASIM-ACP noted that besides not having the staff or time to implement a complex compliance plan, "the OIG needs to be aware that . . . the vast majority of physicians do not know what a compliance plan is, and some may only have a vague idea of what OIG does."

Stripped-down plan sought

ASIM-ACP is pushing for a stripped-down approach to compliance for physicians that will accomplish these goals:

- help physicians identify internal weaknesses in claims submission accuracy and completeness;
- provide up-to-date information on any areas the OIG feels are most vulnerable to fraud and abuse and, therefore, intends to make an enforcement priority.

Here's where the needs of the typical practice and the OIG's fraud busters come into conflict. While it makes good sense for the OIG to identify potential problem areas, dishonest providers can use that information to bilk the government. OIG officials also say they already provide enough information in the agency's annual work plan and its advisories to identify enforcement areas it will focus on during the coming fiscal year.

To promote a "presumption of innocence" attitude in the guidelines, some physician groups want the OIG to develop a checklist or other mechanism to help practices identify internal weaknesses in their claims submission process.

"One key component of a physician compliance guidance should be a mechanism for identifying patterns of problem billings, either an in-house tracking system for the nature and volume of rejected claims or a profile of claims payment history for each practice generated by the carrier, says ASIM-APC president **Whitney W. Addington**, MD.

The goal would be to identify and correct problem claims faster and earlier in the process to minimize errors, denials, and, in turn, the need for audits and investigations. Another option would be to help carriers standardize reporting to physicians on specific claims coding and documentation problems, and to identify possible remedies supplemented by face-to-face physician/carrier educational sessions, says the ASIM-ACP.

Because the seven basic compliance program elements are based on federal sentencing guidelines, insiders are saying the OIG will not eliminate them simply to accommodate physicians.

"Physicians are feeling inundated with regulatory requirements," says AMA spokesman **E. Ratcliffe Anderson, Jr**., MD, arguing that the AMA wants the OIG to keep its guidance as simple and flexible as possible. ■

Claim problems bugging you? You can avoid them

Tips from HCFA and the experts

Based on studies from the Health Care Financing Administration and interviews with coding experts, here is a list of the most common reasons reviewers give for denying Medicare claims — and what you can do to avoid them.

• **Incomplete/poorly documented diagnosis.**

Perhaps the most common denial and the easiest-to-fix coding oversight is using the wrong diagnosis code or not enough documentation to support the code. To avoid having your claim kicked out for review, be sure the coding paperwork is specific, complete, and current.

• **Duplicate claim/service.**

Failing to bill correctly for services performed multiple times on the same date of service is likely to get your bill labeled a duplicative claim and dumped in the denied pile. To avoid that occurrence when you have multiple same-date services, enter the service procedure code just once, then note in block 24G of the HCFA 1500 the number of units provided.

• **Resubmitting claims too quickly.**

Many carriers wait at least 14 days to process electronic claims; 27 days for paper claims. If you are getting a lot of claims kicked back for being duplications, check your software for glitches.

• **Service not medically necessary.**

Medicare looks for several criteria to determine if a service is medically necessary. The most common reason claims are denied for lack of medical necessity is that the official diagnosis does not support the treatment provided. Auditors also look for unusually high numbers of similar or other procedures performed during a short period of time, higher-priced treatments when obvious and equally effective alternative approaches are available, and procedures Medicare considers to be experimental and unproved.

• **Not a separately billable service.**

When Medicare rejects a claim because it says the service or procedure cannot be paid separately, the most likely cause is a modifier problem. When that happens, check all the codes used against the *Correct Coding Initiative Manual* to determine if they are for comprehensive or component codes; a component code is part of a comprehensive one. If it turns out they are component codes, then you can only bill for the comprehensive code(s).

Where justified, you can to use modifiers -25 (separate evaluation and management on same date of a procedure) and -59 (significant, separate procedure) to justify a separate payment. But be sure the diagnosis and accompanying documentation support the claim that they were separately performed services.

• **Wrong physician's name and/or unique personal identification number.**

One of the standard checks on any claim before it leaves the office should be who referred the patient. An easy way to get that information into your system is to design registration forms so patients can write down the physician who referred them, then enter that information in the patients' electronic files. For charge slips, include a block where the physician seeing the patient can note the referring provider. When there is no referring physician, make sure to list the treating physician's name and his or her ID number on the claim.

To avoid problems with mismatching physician identification numbers, regularly check to ensure all necessary physician ID numbers are

correct, for both the group and each individual provider. Also, make sure new physicians apply for a number before you start submitting claims for their services.

• **Medicare is not the primary payer.**

Federal auditors are now paying extra attention to this area. Therefore, it is vital that your records accurately reflect each Medicare patient's present employment / retirement situation and third-party coverage. If your records are right, along with your response, have the patient contact Medicare to update the file.

It is also a good idea to ask each time patients come in if they have joined a new health plan since their last visit. If so, get their member numbers and research their coverage.

Finally, it may sound simple, but regularly check to see if you have the patient's correct Social Security number on file. For best results when submitting a claim, include a copy of the patient's Medicare card, and if they have a supplemental carrier, that card, too. Make sure the claim contains the patient's correct ID number and that the patient's name is written as it appears in his or her Medicare file. ■

Proposed rule would speed appeal process

Telephone appeals may be instituted

If you decide to challenge a claim denial, remember that the Health Care Financing Administration in Baltimore has proposed new rules for speeding the process by instituting a telephone appeals procedure.

Under the HCFA rule change, providers, patients, suppliers, and carriers can challenge Medicare Part B initial claim determinations by telephone. Currently, claim appeals and responses must be submitted in writing and filed with HCFA and the carrier.

After its initial decision, the carrier must give the provider — or anther party — six months to request a review of the action. Upon the provider's request, this initial review period can be extended an additional six months.

Under HCFA's new rule, the current review time frames still stand. However, both providers and carriers have the option of asking for a decision review by telephone.

Knowing the different kinds of audits Medicare conducts and what auditors tend to look for in each one can help when a claim is denied or you learn your practice has been selected for review. The most basic kinds of audits are:

1. Electronic claim submission review.

This is a common low-level audit in which Medicare will send you a letter asking for a sample of up to 10 patient charts. Generally, federal auditors are looking to see if:

— dates indicating when the patient was treated and when services were provided match;

— all the appropriate authorizations have been checked off and physician identification numbers are correct;

— adequate and proper documentation exists that the service being billed was indeed performed and appropriate.

Even if you clear those hurdles, other potential problems might be found later with such things as coding discrepancies and evaluation and management documentation. With any audit, it is important to send along any and all information referred to in your claim, such as patient histories and medication lists.

2. Focused review.

Focused reviews generally are launched when the auditor's computer system notices a provider is billing an unusually large number of claims for a particular code or set of codes. Basically, Medicare wants to know why this is happening and will ask for up to eight charts for review.

If Medicare concludes there may be a problem, it will send you a letter noting a deviation in your billing patterns and give you six months or so to change things. Once that happens, you are put on Provider Audit List (PAL). Being placed on the PAL automatically increases the odds of your becoming the subject of a comprehensive medical review audit.

3. Comprehensive medical review.

If you are targeted for a comprehensive review, Medicare will take a close look at the charts of 15 or more of your patients — including tests, labs, evaluation and management services, and billing of preventive services as covered services — over the past six months, searching for any possible questionable or actual overpayments.

If the examiners determine you owe Medicare a refund, you have these options:

• Write a check and go back to work.

• Question the finding and gather additional documentation backing your position.

• Request a statistically valid sampling, which will mean gathering and subjecting to an audit several hundred patient charts for each physician in question.

Before you take any action, be sure to consult your lawyer. ■

What to do if the feds have overpaid you

Honesty is the safest policy

One one of the most ticklish problems providers may encounter is what do do if they discover Medicare has unintentionally overpaid them.

From a strictly legal point of view, "laws like the Stark II statute contain an explicit requirement to refund overpayments and, thus, require disclosure," says **Anita D. Lee**, a lawyer in the Los Angeles office of Foley and Gardner. However, she notes, "most sections of the Social Security Act do not contain an express obligation either to disclose an overpayment or to repay it."

Disclosure also is favored by a provision in the Social Security Act that makes it a felony to fail to disclose facts affecting an initial or continued right to payment, if the failure to disclose is done with "an intent to fraudulently secure" such benefits.

There also is the matter of the quarterly Medicare credit balance report all providers must file, which requires disclosure of known overpayments. However, "there are issues regarding the level of certainty a provider must have as to the existence of an overpayment before there is an obligation to include the matter on a credit balance report," says Lee.

One upside to voluntary disclosure is that the federal Civil False Claims Act provides for reduced penalties when a provider promptly discloses illegal payments and cooperates with any subsequent government investigation.

"Even where the reduction in the level of punishment is not required by statute, voluntary disclosure may be advisable, as most enforcement agencies are more forgiving of those providers who self-disclose their compliance failures," points out **Robert D. Sevell**, another Foley and Gardner health attorney. On the other hand, are you willing to bet that the government would never discover the error in the first place, making any debate about fines and penalties moot?

Let's say you decide to report the problem and repay the money — where do you go? Sevell says the simplest action is to approach the fiscal intermediary, carrier, or whoever initially made the improper payment and tell him or her you discovered the error on your own and you want to return the overage.

However, if the mistake involves more than just a few claims that were accidentally overpaid, you might have to deal directly with either the U.S. Department of Justice or the Office of the Inspector General (OIG).

"In this kind of situation, such a course of action should only be undertaken after serious consideration and consultation with your lawyer," Lee advises.

There also is a question of how quickly you should act. Under OIG guidelines, if a provider reports a compliance situation within 30 days of receiving credible evidence of a potential problem, most fines and penalties are reduced or eliminated, depending on the nature of the problem.

Rather than acting too fast, Lee cautions you to remember that disclosure before an internal investigation has been fully conducted involves risks and potential difficulties that should be weighed carefully. ■

How to hunt down lost paper claims

Tips for speeding collection of overdue claims

About 80% of Medicare claims are submitted electronically. An all-too-common problem for the other 20% of paper-based bills is having the carrier lose or misfile a claim. As a rule, carriers generally hold clean paper claims at least 26 days before paying. Here are some tips on speeding up payment for paper claims still outstanding after 30 days.

Most Medicare carriers have an Automated Response Unit (ARU) line to help you determine the payment status of a particular claim. To

make most efficient use of the ARU system, you should have the this information at hand when you call: Medicare provider identification number, your patient's health insurance claim number, the date of service, plus any other pertinent information.

If the carrier says it has no record of receiving such a claim, all you can do is resubmit it as a new claim. And while you have the carrier on the line, it is a good idea to double-check the mailing address — including the post office box number and extended zip code — against the one on your claim.

If the ARU operator says the unit's records show the claim has been paid, make sure you get the following data for your files: the provider remittance notice number, the paid amount, and the date the carrier says it paid the claim. However, if you still have not received payment after allowing adequate time for the check to arrive in the mail, call the carrier again and ask for a copy of the remittance advice. If the carrier says the check has been sent and cashed, ask for a copy of the canceled check.

Handling pending claims

More than likely, rather than saying the ARU did not receive the claims, the ARU representative will tell you the claim in question has been held up pending a review because of a question regarding the coding, the amount, or eligibility requirements.

Find out as much as you can about what in the claim has been questioned and when the review may be finished. Make a note of the date, time, and to whom you spoke. Also make sure the billing and collection department gets a copy of your notes and the patient's financial records are updated.

Many experts suggest it is probably best to simply do nothing if the carrier is performing an eligibility or nurse review until the review is done and a decision made to either pay or deny it.

If the reviewer wants more data before making a final decision, you will receive a letter asking for additional information. Remember: It is in your best interest to respond immediately to that request because the carrier is going to hold the claim until it receives the information it requested. The carrier also may reject the claim if it feels you did not respond in a timely manner. ■

Hearings sought to soften feds' investigative zeal

Can we have a 'kinder, gentler' HCFA?

Pushed by physicians fed up with what they say are harsh tactics by federal investigators and a growing set of egregious reimbursement rules, the American Medical Association and other medical organizations want congressional panels to hold hearings calling the Health Care Financing Administration on the carpet.

Other items providers want to place on the agenda include:

1. HCFA's decision to reduce AMA-recommended work values for services used to treat critically ill Medicare patients without first seeking public comments;

2. a new rule excluding practice expense payments to physicians who bring their own staffs to hospitals to help treat patients;

3. use of secret, proprietary commercial "black box" edits to detect improperly coded claims.

If the hearings are held, they will be modeled after a recent series of Capitol Hill investigations into how the Internal Revenue Service treats taxpayers. Those hearings convinced the IRS to adopt what has been called a "kinder, gentler" attitude when dealing with taxpayers.

Will the strategy work for HCFA?

While the hearing strategy worked with the IRS, some Washington insiders say trying to duplicate this campaign with HCFA will not fly. First, they say that while every American knows about and tends to resent the IRS, the general public has no idea what HCFA is all about.

Perhaps more importantly, a good government spin doctor can turn even the most honest grievance around to make such hearings sound like a bunch of rich physicians complaining about rules set up to stop unscrupulous providers from lining their pockets with increasingly scarce Medicare money at the taxpayers' expense. That could force physicians to try to prove their innocence, which is very difficult from a public relations perspective. ■

Physician's Coding Strategist™

MedPAC expected to frame next stage of E/M debate

Practice management mavens are anxiously waiting to see what position the powerful Medicare Payment Advisory Commission (MedPAC) takes on a series of critical coding and reimbursement issues in its annual report to Congress scheduled for delivery in March. At the top of the curiosity list is what will MedPAC say about the Health Care Financing Administration's (HCFA) much-debated evaluation and management (E/M) guidelines.

In a December draft of its recommendations, MedPAC pushed HCFA to get moving on its long-promised but delayed California pilot test of its proposed E/M guidelines and other possible "alternative" approaches. However, sources say there is a strong contingency within MedPAC that favors a more hands-off approach, instead urging HCFA just to make the E/M guidelines as simple as possible.

"If the guidelines are too complex to be applied, then they are no good to anyone," says **William A. McBain**, an Ithaca, NY, managed care consultant and MedPAC member.

Other MedPAC commissioners, such as **Ted Lewers**, MD, who also chairs an American Medical Association (AMA) panel on the issue, wants the advisory board to deliver a more forceful message.

Indeed, the AMA has been rattling its political saber since its mid-December meeting in San Diego, where it passed resolutions reaffirming the group's opposition to "counting." Counting is the numeric method of evaluating physician services, a scheme HCFA has backed. The AMA also underscored its desire to get the agency's E/M field tests launched.

Meanwhile, the AMA is pressuring HCFA to suspend prepayment and post-payment audits of E/M claims until it implements final E/M regulations. The AMA also wants Medicare to let physicians use the guidelines it proposed last May, as well as the 1997 and 1995 guidelines, "until such time that there is final agreement with HCFA on a documentation system that is consistent with AMA policy," the organization said in a statement.

Also on the AMA's coding agenda for 2000 are these items:

- have HCFA provide more detailed descriptions and specific examples of services in the next Current Procedural Terminology (CPT) manual;
- support the concept of a "time-based charge" for coding administrative duties, such as phone pre-certification and utilization review activities;
- pass legislation forcing insurers to recognize and pay for all published CPT codes, including modifiers;
- prepare a report for the AMA 2000 annual meeting on the addition of CPT codes that recognize the different work components involved in treating pediatric patients;
- develop a proposal requiring Medicare carriers to reveal detailed reasons for rejecting claims.

E/Ms: The proposal time forgot

Last May, the AMA's CPT editorial panel voted support for a measure asking HCFA to implement its own alternative set of E/M guidelines rather than the agency's 1998 proposal, which has been on hold because of protests from providers that it is unworkable.

Ever since then, the AMA has been waiting for word from HCFA about when it will test its proposal and set a date for ruling on it. In the meantime, HCFA has said practices can use either its 1997 or 1995 E/M guidelines for coding purposes.

Last December, Robert Berenson, MD, director of HCFA's Center for Health Plans and Providers, told HCFA's Practicing Physicians Advisory Council that HCFA had a commitment with the California Medical Association to test its so-called "California Plan" as an alternative to the CPT panel's recommendations. A main difference in the two proposals is that the California Plan uses a peer review system rather than Medicare carrier staff to resolve E/M claim disputes.

Before moving on the test, Berenson also said HCFA wanted to finish a feasibility study of the idea. That would mean the pilot program would begin later this year, and changes and the revised proposal probably would be floated next year. By that time, practitioners will have been waiting for a finalized E/M rule for at least five years. ■

APC implementation delays appear to be over

Last-minute changes possible, but prepare now

Health information management (HIM) professionals have been warned to be prepared, but the deadline for implementation of the final ambulatory payment classifications (APCs) for ambulatory surgery centers and hospital-based outpatient facilities keeps changing.

The date was set for January 1999 then pushed back to July 1, 2000. Providers, though, have reason to heed the deadline. Conversations with officials from the Health Care Financing Administration (HCFA) in Baltimore still indicate a commitment to the July 1 date, says **David Fee**, MBA, product manager for ambulatory care products for 3M in St. Paul, MN.

"All HCFA has to do is publish its final rule and give us 90 days notice," says **Danelle Kelly**, RN, CPC, CPC-H, a consultant with D J Kelly & Associates in Schaumburg, IL. "That could literally be any time."

She does not think it will happen before July, though. "HCFA said it wanted to implement the editing of the modifiers starting in April and get that cleared up before it started on APCs."

Both Fee and Kelly expect some significant changes to the final rule from the proposed regulations published in the Sept. 8 *Federal Register*. If providers wait until the final rule is published to start their preparations, however, they will be overwhelmed with the coding changes they have to make.

That's why providers should determine what codes can be added to their chargemasters now and what codes, such as those for surgical procedures, must be coded by the medical records department at a later date, Kelly says.

"Are you identifying all the procedures that can be done within your emergency rooms and outpatient clinics?" she asks. Some clinics may be doing procedures routinely that could easily be coded and put in the chargemaster.

"That's how your reimbursement is going to be driven — off your CPT [common procedure terminology] codes," Kelly says. "You have to start with the ones that can be done in your chargemaster vs. those that must be done by medical records. If you don't have some of them in your chargemaster, your medical records department is going to have an overwhelming amount of work [when the final rule is implemented]."

She also recommends that providers make sure they have all of the modifiers in place for their radiology procedures. "Radiology and any of the 90,000 series of CPT codes are usually the ones that are already in your chargemaster." The modifiers for physical therapy, occupational therapy, and speech therapy also are easily put into the chargemaster, she adds.

Make sure you have the diagnosis code

When Fee talks with providers about APC preparation, he says the key issue is not to provide any service without having the diagnosis code or a reason for providing that service. "Hospitals write off thousands of dollars of billing that they could submit if they had a diagnosis code," he says.

Fee also advises providers to form an APC preparation committee, comprising key decision makers in the organization. This committee should dig into the detail of the regulations and make a financial analysis of what it means to that facility. "In the end, they need to understand the detail."

When analyzing the impact APCs will have on the facility, committee members should compare their numbers against those of other hospitals around the country because much of the reimbursement is built around national averages, Fee says. "Whether the regs change or remain the same, when you start comparing yourself to other hospitals to see how you fare, the answers

How are you using your observation codes?

Do an analysis to pinpoint problem areas

When you are looking at your ambulatory payment classification (APC) preparation, you might want to check the utilization of your observation codes and how you bill for chemotherapy.

First, do an analysis to determine which physicians are always ordering observation, advises **Danelle Kelly**, RN, CPC, CPC-H, a consultant with D J Kelly & Associates in Schaumburg, IL. What type of diagnoses are most common for these physicians?

"I like to give this example: What if you have 10 cardiologists on staff and two of them are always admitting patients for observation?" she asks. "Why don't the other eight? How many truly become inpatient? How many go home? It's important to do an analysis of what your observation usage is now."

Medicare's reimbursement for observation is up to 48 hours, Kelly says. "They prefer 24, but they do say you can do 48."

The problem is that many observation claims do not meet the criteria for reimbursement by Medicare. "That's where we are seeing a lot of abuses," she says.

To receive reimbursement for observation, Medicare requires the following:

- Providers must show active observation and evaluation. "You can't write 'condition stable, vitals per routine' and then turn around and order a.m. labs for the next day," Kelly says.
- Providers cannot show an intent to keep the patient overnight.
- Providers cannot use observation for chemotherapy and blood transfusions.
- Providers must have post-surgery patients in recovery for four to six hours before making the decision to admit them to observation. "You can't decide two hours into your recovery period," she explains.

(Those criteria are general rules. Check with your local fiscal intermediary or carrier for more details.)

Use the J code

As for reimbursement for chemotherapy, providers should have all of their chemotherapies "J-coded" according to the dosage amount, she says. "Make sure you are billing in the same amount as the J code. That's probably going to be different than the amount you're going to be dispensing."

The providers will have to bill in units, Kelly explains. "For example, the J code might be 30 mg, but you are giving 90 mg of the drug. If you don't bill three units of the 30, you will lose two-thirds of your reimbursement if you bill the total amount at once. You need to do it according to the description in the HCPCS [Health Care Financing Administration's common procedure coding system] book." ■

will be close enough that you can start making some changes."

One tool that might help with the financial analysis is a forecast of APC reimbursement impact by state, published in a report last July by San Francisco-based Market Insights. One of the co-founders of the company says he was "shocked" by the differences among states.

For example, the changes ranged from 8.8% in Delaware to -49.9% in Alaska. (For more details on the report, see the Web site http://www.marketinsights.com or call [800] 693-9976.)

Because information flow will change with the final regulations, providers also should understand what technology they will need and how they are going to use the new data so they can start modifying their systems or working with their vendors to accommodate those issues.

And finally, providers can't omit another important piece of the puzzle when talking about APC preparation: physician education. "Physicians need to be educated so they all have the same information," Fee says. "You must try to make the physicians understand how the payment system works and what that means to the institution."

Physicians respond well to data, especially if the data show how they compare to other physicians. "Physicians believe data; they don't believe hearsay," Fee says.

"You can have information that says, 'Here's how all the physicians are performing.' You don't put names on it, but you start publishing it and

soon everyone has figured out where they stand. That type of feedback is very effective."

While providers may be hurrying to prepare for APC implementation, Kelly doesn't think many will take advantage of the copay reduction in the first year. HCFA is allowing providers to reduce the copayment to their Medicare beneficiaries and use it as a marketing tool for outpatient services.

"There is so much to do with APCs. And they're so different from what providers have done in the past that I don't think copay reductions starting in the middle of the calendar year will have as big of an impact as those that start the following January 2001," says Kelly. "Because APCs are starting in the middle of the year and not in January, additional instructions need to come from HCFA with regard to the 90-day notification to the FI [fiscal intermediary]."

Providers need to realize that if they elect to reduce the copay on an APC, they must reduce it on the entire APC, not just a portion of it, she adds. And they have to inform their FI of any intended reductions within 90 days of the beginning of the calendar year, although many providers have fiscal years ending in July or October. "Halfway through their fiscal year, they would have to make this copay reduction. That's why I think most of them will wait during the first year."

Once providers make the decision to reduce any copays, their FIs will find themselves bogged down in making all the changes. "The FIs have to tailor that information into their system for each hospital that they service. That surprised them. That's a lot of detail," Kelly says.

[The complete regulations can be reviewed on the Federal Register *On-Line (Sept. 8, 1998). Web site: http://www.nara.gov./fedreg.]* ■

Government report cites DRG 014 overpayments

Targeted hospitals will be investigated

A government report released by the Office of the Inspector General (OIG) in Washington, DC, says 35 hospitals had "abnormally high" rates of the diagnosis related group (DRG) 014 code compared to national figures. DRG 014 is coded when patients have principal diagnoses that include cerebrovascular accident and intracerebral hemorrhage.

The Health Care Financing Administration (HCFA) in Baltimore contracts with two Clinical Data Abstraction Centers to collect this clinical data from hospital medical records. The centers validate a random sample of claims from all Medicare inpatient hospital discharges.

Results of 1996 validation work found that 4% of DRG 014 discharge samples should have been coded to a lower-weighted DRG. The OIG then analyzed the Medicare Provider Analysis and Review file to identify hospitals with unusually high billings in fiscal years 1993 to 1996.

The OIG review found 35 of 4,883 hospitals had either a large proportion of DRG 014 discharges to total discharges in 1996 or a significant increase in the proportion of DRG 014 discharges to total discharges between 1993 and 1996. The 35 hospitals exceeded the national norms of the number of DRG 014 discharges by 1,403 cases. Using a average per discharge difference of $1,716, the OIG estimates that the potential overpayments could be as high as $2.4 million, or 14% of the $16.6 million paid to those hospitals in 1996.

The 35 hospitals have been referred to the OIG's Office of Investigations.

Earlier this year in a report to HCFA, Inspector General June Gibbs Brown expressed concern about the potential for abuse of the DRG system and about HCFA's oversight of the accuracy of the DRG coding system. "The DRG system is vulnerable to abuse by providers who wish to increase reimbursement inappropriately through upcoding, particularly so within certain DRGs," the inspector general said. These DRGs included 014; DRG 79, respiratory infections; and DRG 416, septicemia.

The OIG found that in a focused sample of 299 hospitals, the average rate of upcoding was not statistically different from the average downcoding rate. Those hospitals that computer software predicted would have a high rate of upcoding, though, had an average upcoding rate of more than twice that of downcoding. To the OIG, the difference indicated instances of intentional abuse by some providers.

In the report, the OIG also recommended that HCFA perform "routine monitoring and analysis of hospital billing data and clinical data to proactively identify aberrant patterns of upcoding." Since the publication of the report, HCFA has agreed to this recommendation. ■

Discounted pathology services may violate law

OIG issues warning

The Office of the Inspector General (OIG) has determined that arrangements in which physicians receive pathology services at a discount below the actual cost of providing the services might violate federal anti-kickback laws.

Here's the scenario the OIG painted: Company A, a professional corporation comprising three pathology specialists, offered its "account billing" customers discounts "that are greater than its cost savings, in order to match the prices of its competitors," the OIG noted.

In addition, "Company A's profit margin for the non-federal health care program business . . . [was] less than the profit margin on the services that it billed directly to federal health care programs," the OIG noted.

In that case, account billing customers were physicians billed directly for pathology services for which the pathologists "accepted that payment as payment in full." Physician clients then billed the third-party payers and patients for the purchased pathology services.

Company A argued this account billing arrangement typically produced cost savings that were passed on to the physicians, a discount that was "not . . . conditioned upon the physicians sending Company A its federal health care program business," the OIG reported.

The problem: "Company A . . . assumed that the physicians receiving discounts under the proposed arrangement will send virtually all of their patients to [it]," noted the OIG.

In turn, the OIG concluded, the "circumstances surrounding the proposed arrangement suggest that a nexus may exist between the discount to the physicians for non-federal health care program business and referrals of federal health care program business."

In other words: While not official, there was a strong possibility of an implied understanding that in exchange for performing deeply discounted pathology services, physicians would refer their Medicare business to those pathologists.

Federal anti-kickback law includes an exception for "a discount or other reduction in the price of . . . services . . . under a federal health care program if the reduction is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity."

However, the OIG noted that this arrangement qualified for the safe harbor because the "statutory exception for discounts . . . does not protect price reductions like those at issue here offered to one payer but not to Medicare or Medicaid." ■

What new safe harbor rules mean for practices

Chances are you'll be affected

On Nov. 19, the Office of the Inspector General (OIG) issued eight new safe harbors to the anti-kickback statute — along with clarification of six existing safe harbors and two new interim, final safe harbors.

"Virtually everyone in the health care industry will be affected to one degree or another by these new safe harbors," notes **George Root**, a health care lawyer in the San Diego law offices of Foley and Gardner.

If they are not already doing so, providers need to re-examine and revise payment arrangements that fall within the safe harbors, as well as their internal compliance manuals, policies, and standards, say reimbursement experts.

"Early indications are that the new safe harbors will provide their greatest benefit to managed care relationships, physician investments in ambulatory surgery centers, and a variety of arrangements in medically underserved areas — physician recruitment, joint ventures, and hospital acquisitions of physician practices, for instance," says Root.

The clarification of certain existing safe harbors also should help when it comes to creating discount arrangements, leases, and personal services contracts, says **Jeff Micklos**, an attorney with the national law firm of Foley and Lardner.

Arrangements that come within a safe harbor are immune from prosecution under the Stark statute. Arrangements outside of any safe harbor do not automatically violate the law but may be subject to scrutiny and potential prosecution, note legal experts.

Here are the new safe harbor rules:

• **Investments in ambulatory surgical centers.** This safe harbor protects investment interests in

Medicare-certified ambulatory surgical centers (ASCs) that are surgeon-owned, single specialty (such as those owned by gastroenterologists), multispecialty, and hospital/physician. In each case, physician investors must disclose their investments to their patients.

This safe harbor is generally designed to protect ASCs that function as extensions of physician office practices, says Root. However, it does not protect investments by physicians who might refer to the ASC but do not personally perform ASC-covered procedures. As such, under the new rules, physician investors are generally protected only if they are in a position to refer to the ASC, he says. In contrast, to meet the safe harbor for hospital/physician ASCs, hospital investors must not be in a position to make or influence referrals to the ASC, he adds.

More clarification needed

"The exact meaning of this requirement is not clear yet," Root says. For example, the preamble to the safe harbor says ASCs may be located near or even on the hospital's campus (if rent is fair market value and other conditions are met), thus begging the question of when the OIG thinks a hospital can "make or influence referrals."

"Unfortunately, the OIG offers little guidance on this issue, other than suggesting that hospitals may be able to influence the referrals of physicians employed by the hospital or by a medical practice owned by the hospital," he says.

• **Investments in group practices.** This protects physician investments in their own medical group, provided the group meets the Stark definition of a group practice. "Unfortunately, the Stark definition of a group practice is intricate, complex, and not yet established in final regulations," says Micklos.

However, the safe harbor does not protect investments made by the group in other entities like laboratories and imaging centers. As such, "this new safe harbor potentially creates as many problems as it resolves," he notes. For instance, before Stark, it was widely accepted that for anti-kickback purposes there was no such thing as a "referral" among physicians within an integrated medical group because the patients belonged to the group.

While the OIG notes that it does not consider ownership in a group practice "suspect per se," it also says Stark "is implicated" by physician ownership interests in medical groups, and even ownership interests in single shareholder professional corporations.

• **Specialty referral arrangements between providers.** This protects arrangements in which one provider (which may be any individual or entity) refers a specific patient to another provider for specialty services with the understanding that the specialist will refer the patient back to the original provider, assuming it is clinically appropriate, when the course of treatment is completed.

Among other things, the safe harbor requires that the services be within the expertise of the referred party and not the referring party; the parties receive no payments from each other for the referral; and the only payments either party receives are from the patient or third-party payers for services that party performs.

• **Joint ventures in underserved areas.** Recognizing that "medically underserved" areas (MUAs) often have difficulty attracting the capital necessary to build and operate health care facilities, the OIG has relaxed the conditions for the existing small-entity investment safe harbor.

The new rules allow joint ventures in MUAs to have a higher percentage of physician ownership (up to 50% instead of the 40% limitation applicable to other geographic areas) and allow the ventures unlimited revenues from referring investors, instead of the 40% limitation applicable in other geographic areas. The new safe harbor applies to underserved urban and rural areas.

• **Practitioner recruitment in underserved areas.** This safe harbor protects payments to recruit new and relocating physicians who establish their practice in rural or urban health professional shortage areas (HPSAs). While the safe harbor limits the time period for recruitment payments to three years, it does not regulate the nature of the payments, such as whether they may include income guaranties, moving expenses, etc.

However, the OIG specifically refused to protect payments by hospitals to existing group practices to recruit new physicians to the group or payments to retain physicians.

For example, a Jan. 9, 1998, OIG exception for physician recruitment permits payments by a hospital to an existing medical group to recruit physicians, even though those payments are specifically excluded from the new anti-kickback safe harbor.

• **Sale of physician practices to hospitals in underserved areas.** This allows a hospital in an

HPSA to buy and "hold" the practice of a retiring physician pending recruitment of a replacement. The safe harbor requires that the purchase be completed within three years and the hospital undertake good faith efforts to recruit a replacement physician.

• **Subsidies for obstetrical malpractice insurance in underserved areas.** This permits hospitals (and other entities) in primary care HPSAs to pay some or all of the obstetrical malpractice insurance premiums for practitioners engaging in obstetrical practice, including certified nurse midwives as well as physicians. If a practitioner engages in obstetrics part time, the safe harbor protects only payments attributable to the obstetrical portion of the practitioner's practice.

• **Cooperative hospital services organizations (CHSOs).** This protects CHSOs that qualify for tax exemption under Section 501(e) of the Internal Revenue Code. CHSOs are formed by two or more tax-exempt hospitals to provide certain shared services (such as purchasing, billing, or clinical services) to the hospitals that form them. The safe harbor will protect certain payments between the CHSO and the hospitals that form the CHSO from scrutiny under the anti-kickback statute. ■

OIG offers clarifications on existing safe harbors

Investment guidelines change

The Office of the Inspector General (OIG) has offered clarifications of existing safe harbors that could affect how you do business. Here are the ramifications according to an analysis done by Foley and Lardner, a law firm that operates on a national scale.

• **Large- and small-entity investments.** The existing safe harbor for investments in large and small entities has been refined in these ways:

✔ Only assets or revenues relating to health care will count toward the $50 million asset requirement for large entities or the 60-40 revenue test for small entities (i.e., no more than 40% of revenue may come from referrals or business generated by investors).

✔ Prohibition of small entities loaning funds to investors to acquire their interests is extended to prohibit loans to an investor from other investors or persons acting "on behalf of" the entity or an investor.

✔ The current prohibition of no more than 40% of "each class" of a small entity's investors being in a position to refer to the entity has been modified to permit equivalent classes of investments to be aggregated.

✔ The 60-40 revenue test for small entities has been modified so only referred business is counted toward the 40% limitation (i.e., it no longer counts revenue from items or services furnished by an investor to the venture);

✔ Interests acquired in large entities must be on terms available to the general public with regard to restrictions on transferability, and price.

• **Space and equipment rentals and personal services and management contracts.** The OIG makes the same two changes to the space rental safe harbor, the equipment rental safe harbor, and the safe harbor for personal services and management contracts.

The first change expands the existing requirement that the lease or contract specify the premises, equipment, or services covered with a requirement that the lease or contract cover all of the premises, equipment, or services leased or provided between the parties during the term of the lease or contract. This new requirement is designed to prevent "schemes involving the use of multiple overlapping contracts," says the OIG.

The second change is a new requirement that the aggregate space, equipment, or services provided must be reasonably necessary for "commercially reasonable business" purposes. This requirement is meant to prevent parties from renting space or equipment or purchasing services that have no intrinsic value to the lessee or purchaser other than as a way of paying for referrals.

Additionally, the OIG says contracts that specify conditions under which they can be terminated for cause also qualify for safe harbor protection.

However, the OIG refused safe harbor protection for "without cause" termination provisions on the grounds that such clauses "could be used by unscrupulous parties to create sham leases and contracts."

• **Referral services.** This changes the safe harbor from prohibiting referral service charges based on "referrals to or business otherwise generated by the participants for the referral service" to a prohibition of charges based on referrals of business generated by either party for the other party.

• **Discount arrangements.** One of the most complex and confusing safe harbors, discount arrangements have been modified significantly to make them easier to use and broaden their application.

Recognizing that some parties offering discounts are intermediaries and not strictly speaking buyers or sellers, this safe harbor has been expanded to include "offerors." All parties to discount transactions — buyers, sellers, and offerors — can now come within the safe harbor by meeting the separate requirements applicable to them.

One of the greatest concerns raised by the original safe harbor was that a seller's ability to come within the safe harbor was contingent on the buyer's compliance, which, of course, is not within the seller's control.

Says Micklos, "a seller can satisfy the safe harbor, even if the buyer does not, as long as the seller 'informs the buyer in a manner reasonably calculated to give notice to the buyer' of their reporting obligations under the safe harbor, and the seller does nothing 'that impedes the buyer from meeting its obligations.'"

Another change permits discounts to be offered to a beneficiary if other requirements of the safe harbor are met. Previously, discounts to beneficiaries were ineligible under the safe harbor. Routine waivers of deductibles or co-insurance, however, are not protected.

Another significant change modifies the old prohibition of discounts offered on a good or service to induce the purchase of a different good or service. As modified, the rule permits mixing discounts on different goods and services as long as the goods and services are reimbursed by the same federal health care program using the same methodology and the reduced charge is fully disclosed and accurately reflects the current reimbursement methodology.

The OIG also issued two interim final safe harbor rule changes concerning shared risk arrangements. The first protects virtually any financial arrangement between an eligible managed care organization compensated on a capitated basis by a federal health care program and any of its direct contracting providers and their "downstream" subproviders as long as the agreement between the "upstream" provider and the downstream subprovider:

✔ is set out in writing and signed by the parties;

✔ specifies the items and services covered by the agreement;

✔ is for a period of at least one year;

✔ specifies that the downstream provider cannot claim payment in any form from a federal health care program.

In addition, no remuneration under or outside of the agreement may used to induce referral of Medicare or Medicaid covered business (other than that covered under the arrangement) for which payment is made on a fee-for-service basis.

"This rule will protect a substantial portion of managed care arrangements involving federal health care program business," says Foley and Lardner lawyer **George Root**.

The second final interim rule protects contracting arrangements between certain qualified managed care plans and their contractors and subcontractors when those contractors and subcontractors are at "substantial financial risk" for the cost or utilization of items or services they provide or order for federal health care program beneficiaries.

"Substantial financial risk" is defined in two basic ways under the new rule: by payment methodology (e.g., capitation, percentage of premium, and DRG payments) and by a numeric standard (i.e., if a certain percentage of the provider's compensation is subject to a withhold).

The numeric threshold is met for hospitals and nursing homes if their total potential compensation is at least 10% greater than their minimum compensation. For all other providers, maximum potential compensation must be at least 20% greater than minimum compensation. ■

COMING IN FUTURE MONTHS

- How to avoid a Medicare audit
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- Changes coming in how physicians can organize to negotiate contracts
- Make the best use of electronic charts
- Organize your waiting room for peak efficiency

HCFA sets new rules on evaluating contractors

Speed, customer service among criteria

Providers can expect better service from Medicare contractors as a result of a new set of carrier performance evaluation standards issued by the Health Care Financing Administration in Baltimore. Under the new performance standards, contractors will be evaluated based on the following criteria:

1. **Claims processing**.

Contractors will be evaluated based on how fast they process claims, accuracy of explanations of Medicare benefits, percentage of electronic claims paid, and percentage of bills HCFA has to pay interest on because of delays in getting clean claims.

2. **Customer service**.

HCFA will look at the completeness of the service to provider customers based on such standards as the rate of cases reversed by an administrative law judge, timeliness of intermediary reconsideration cases, accuracy and timeliness of carrier reviews, and hearings, accuracy, and timeliness of carrier replies to beneficiary telephone inquiries.

During the year 2000, HCFA also will ask providers for feedback about where it can improve operations in such areas as beneficiary relations, provider education, appropriate telephone inquiry responses, and the tone and accuracy of all correspondence.

3. **Payment safeguards**.

Hoping to further reduce inappropriate payments, HCFA will pay extra close attention to carrier performance when it comes to medical review / necessity and Medicare secondary payer issues.

Other specific areas of performance interest include:

— accuracy of decisions on skilled nursing facility demand bills;

— timeliness of processing the Tax Equity and Fiscal Responsibility Act target rate adjustments, exceptions, and exemptions;

— core standards for medical review and benefit integrity.

4. **Fiscal responsibility.**

HCFA will evaluate how well contractors manage Medicare funds when it comes to benefit payments and administration, institution of proper financial and budgetary controls, and adherence to the Chief Financial Officers Act.

5. **Administrative activities.**

HCFA will measure how efficiently and effectively contractors manage their operations to ensure constant improvement in the way they do business; HCFA also will check systems security, automated data processing maintenance, and disaster recovery plans. ■

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Tips for surviving shift to empowered consumers

By **Ruth Colby**
Vice President-Account Management
Sachs Group, Evanston, IL

Given the speed and complexity of change in today's health care environment, physicians may be tempted to view their challenge as one of survival. Our research shows that at least one of these changes, increasing consumer choice, is creating new opportunities for physicians.

Physicians who understand and meet the needs of empowered consumers will do more than just survive — they will thrive.

Today's health care consumers have more choice than ever before. They have choice in plan type, and most plans have broad provider panels. Sachs' research shows that 70% of surveyed respondents in HMOs had choice of plan. We also found that 51% of respondents in indemnity plans, 62% in preferred provider organizations, and 65% in point of service plans had choice.

Health plans nearly always form the link between physician and patient, but the key relationship is the one between physician and patient without involvement of the health plan. As plans offer wider panels of physicians and more hospital choices, the patient has a choice of whether or not to remain with a particular physician. If the physician is not meeting the patient's needs, that patient can and will seek another physician.

Sachs' research shows that 42% of the surveyed population in Chicago changed primary care providers last year. Although 26% of these consumers changed primary care providers because insurance required them to do so, 20% changed because they were dissatisfied with care and 16% were dissatisfied with the physician's manner. On three criteria — wait time for appointment, in-office wait time, and physician manner — Chicago had the lowest satisfaction scores in the nation.

Satisfaction drives loyalty and retention, and tremendous opportunity exists for improving patient satisfaction in Chicago and nationwide. Yet, merely satisfying patients isn't enough to create loyalty. In fact, consumers who are merely satisfied are shown to be rather indifferent. Only by moving satisfaction levels from "satisfied" to "very satisfied" can physicians create the kind of loyalty that results in retention.

To achieve the kind of satisfaction levels that result in loyalty, physicians must enlarge their understanding of what matters most to health care consumers in their market. For example, many physicians think a degree from an impressive institution is of primary importance to consumers. But our research shows that excellence in physician education and training are givens in the minds of most consumers. Convenience (of hours and location), office wait times, and ease of communication have a bigger impact than the diploma on the wall.

Based on our research, we recommend that physicians who want to acquire, retain, and satisfy today's health care consumer must:

- **Offer services at times convenient to the consumer.**
- **Make sure the environment the consumer comes into is comforting and comfortable.**
- **Ensure that office staff treat the consumer in a manner that enhances their experience.**
- **Understand the importance of a good bedside manner.**
- **Develop excellent communication skills.**

The development of excellent communication skills deserves special attention. Dissatisfaction with care and with a physician's manner is closely related to communication.

By listening to patients and engaging in meaningful dialogues, physicians are enhancing patient satisfaction and loyalty. The physician who responds to patient needs is more likely to be the one patients choose and the one they stay with. ■