

# VitalSigns

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It's time for the annual ritual of spring cleaning and, in this issue of *VitalSigns*, we discuss several areas in your practice that might need a good "cleaning." Ensuring that you're in compliance with regulations, tightening your billing policies and analyzing fixed costs are just a few examples of things that might be on your annual list to review.

When it comes to regulations, HIPAA is huge, and it covers so much more than privacy. We outline the main areas of focus of this important regulation. Also, Medicare just eliminated payment for remaining consultation services, so we offer advice on how your practice can adjust to these changes. In addition, this issue discusses the importance of copayments and deductibles to your financial health and why you shouldn't overlook your staffing costs.

Whether you choose to do your spring cleaning now or at another time during the year, it's important to review some of the critical areas of your practice on an annual basis.

## HIPAA: Not just a privacy act

Say the word "HIPAA" and most of us think of the privacy laws enacted to protect our health record information. But if you're a physician or an employer providing health insurance coverage to your employees, the complexity and required understanding of the act go much deeper.

New rules, obligations and potential violations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require everyone to stay informed. The act has four main areas of focus: 1) administrative simplification, 2) fraud and abuse, 3) insurance reform and 4) companion legislation. Let's take a look at each, as well as what's new with HIPAA.

### 1. Administrative simplification

This area is broken down into electronic health transaction standards and code sets. It's the national standard developed to transmit health data electronically that describes diseases, injuries and other health problems. In addition, it includes a system of unique identifiers used to identify employer, health plan, payor and health care provider. The security portion of this section involves privacy, which limits the use and disclosure of protected health information to a minimum standard. That portion also addresses the safeguard and storage, access, and transmission of electronic patient information.

### 2. Fraud and abuse

The focus of this area is to reduce behaviors that point to:

- Overutilization,
- Underutilization,
- Misreporting, and
- Unnecessary use of medical services based on a comparison to accepted medical standards.

For both public and private health plans, the fraud and abuse area of HIPAA is enforced by the Attorney General of the United States and the Secretary of the Department of Health and Human Services.

### 3. Insurance reform

HIPAA-based insurance reform was designed to provide accessible and portable coverage. This led to the development of certificates of creditable coverage so that a record of prior coverage exists when someone moves to a different employer.

Prior to the recent passage of the health care reform bill, a maximum waiting period of 12 months for pre-existing conditions was established, along with rules on breaks in coverage, special enrollment provisions, and the availability and renewability of health coverage. Also established were pre-emption provisions mandating that HIPAA federal regulations take precedence over existing state law when state law doesn't meet the federal standard. The health care reform bill has eliminated pre-existing condition insurance clauses.

### 4. Companion legislation

Covered under this legislation are increasing specific health benefits and enforcing specific coverage standards, such as a minimum stay

requirement following childbirth (48 hours for vaginal delivery and 96 hours for cesarean section).

There is also companion legislation that regulates the amount you can save per person pretax for medical savings accounts. Also regulated are deductions for company-owned insurance premiums under income tax.

### What's new under HIPAA

The most important new area of HIPAA is the Genetic Information Nondiscrimination Act (GINA), which was signed into law in May 2008. As the science of genetic testing continues to advance, and public access to obtain personal genetic profiles through private genetic testing corporations is made available, the importance of protecting the interests of the public is apparent.

GINA was enacted to protect individuals from discrimination based on their genetic information in health coverage and employment. In October 2009, the Office for Civil Rights (OCR) proposed a modification to the Privacy Rule. The purpose of the modification is to prohibit the use and disclosure of genetic information by health plans for underwriting purposes defined as:

- Eligibility determination,
- Premium calculations, and
- Application of a pre-existing condition exclusion.

Employers are also prohibited from disclosing or using genetic information in hiring practices and benefit exclusions.

When the OCR proposed the changes, the rule went under a 60-day public comment period that expired on Jan. 5, 2010. It's important to look for updates about whether and how GINA will affect you personally and publicly under compliance of privacy provisions as a physician.

GINA defines who, what, where and how genetic information can and cannot be requested and used. For example, GINA has exceptions to the request provision for individual or family member genetic information. The first exception allows a health care professional providing services to a patient to request that the patient undergo genetic testing. The second exception allows health plans to be provided genetic information for the purpose of process-related medical claims.

### Not new, but evolving

HIPAA can hardly be considered new anymore, but that doesn't mean the law isn't constantly evolving. For the well-being of your practice, it's important to learn about and responsibly manage all information related to HIPAA compliance.



# Medicare cans consultations

Medicare started 2010 with a bang by eliminating payment for the few remaining consultation services still in existence. Official notification was given on Dec. 14, 2009, when Medicare released transmittal MM6740. It reads: "Effective January 1, 2010, local Part B carriers and/or A/B MACs will no longer recognize AMA CPT Consultation codes (ranges 99241-99245, and 99251-99255) for inpatient facility and office/outpatient settings where consultation codes were previously billed for services in various settings."

Given nearly a decade of problems with consultation codes, this was a predictable change. In 2001, Medicare reimbursed significantly more than it should have for services that were billed as "consultations." Approximately 75% of services allowed as consultations that year didn't meet all applicable program requirements, resulting in \$1.1 billion in improper Medicare payments.

In January 2006, confirmatory consults (99271-99275) and follow-up inpatient consultations (99261-99263) were deleted from the Current Procedural Terminology (CPT) book, and the codes were no longer reimbursed by any third-party payor (commercial or governmental).

Shouldn't physicians have expected that hospital and office consults would follow? A Medicare audit published in 2007 identified consults as contributing \$493,186,803 in paid claim errors — a number that grew to \$516,912,824 in 2008.

## What happened?

Simply stated, providers didn't follow the rules. The Centers for Medicare and Medicaid Services sent out many educational transmittals and provided online education regarding the correct documentation required for billing consultation codes. Appropriate consultations needed to follow the Three Rs: 1) Requested, 2) Rendered and 3) Responded (back to the requesting provider).

Unfortunately, "referrals," "transfers of care" and "consultations" were used interchangeably and inconsistently by providers in the clinical setting. This resulted in improper payments and led to the elimination of these codes.

## Where do providers go from here?

Many specialty providers, along with the AMA, have asked for a delay in implementation of these changes in consultation codes. Concerned parties cite the limited time to educate providers. Also, the total impact the change would have on physicians isn't clear.

Another concern is the absence of a clean crosswalk from the eliminated consult codes to the admission and daily hospital codes that physicians would need to use to obtain reimbursement for their services. The amendment to change the enactment date for the elimination of consult codes, however, was tabled and H.R. 3590 was signed by President Obama as Public Law No. 111-148 on March 23, 2010 without the desired change.

## Is there more to the story?

Further highlights from transmittal MM6740 include:

- In inpatient hospital and nursing facility settings, providers who perform an initial evaluation may bill an initial hospital care visit code (CPT code 99221-99223) or nursing facility care visit code (CPT 99304-99306).
- The principal physician of record or admitting provider will append modifier "AI" (Principal Physician of Record) to the evaluation/management (E/M) code when billed. This modifier will identify the physician who oversees the patient's care as distinct from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient may bill only the E/M code for the complexity level performed. *It's important for Medicare beneficiaries to understand they may be billed for multiple initial hospital codes — your staff should be prepared for the ensuing confusion.*
- In office or other outpatient settings where an evaluation is performed, providers should report the CPT codes (99201-99215) depending on the complexity of the visit and whether the recipient is a new or established patient. *It's important to understand the difference between new and established patients and to document accordingly.*
- For hospital inpatients, follow-up visits in the facility setting should be billed as subsequent hospital care visits. For patients in nursing facilities, subsequent nursing facility care visits should be billed likewise.

- In order for physicians to bill at the highest levels of visit codes, the services furnished must meet the requirements for the code. (For example, to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history.)

*It's also important to remember that there is no code for "admitting" the patient to the hospital. The 99221-99223 services are defined by CPT as "the initial service provided by the physician to the patient in the inpatient setting." Your office may have patients calling stating they were billed for multiple "admission" charges. Look at your software to make sure your definition for 99221-99223 is "initial service," not "admission."*

In place of the consultation codes, CMS increased the work relative value units (wRVUs) for new and established office visits, increased the RVUs for initial hospital and initial nursing facility visits, and incorporated the increased use of these visits into the practice expense (PE) and malpractice calculations. CMS also increased the incremental

wRVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes.

## How will other payors respond to Medicare's changes?

When the follow-up consultation codes were deleted from the Medicare Fee Schedule, they were also deleted from the CPT book. But this isn't the case with the remaining initial consultation codes. They're listed in the CPT Code book for 2010. Many other payors still recognize the codes (99241-99255) and will continue to reimburse for these services. It's the responsibility of the provider and coding staff to contact a payor for clarification on its policy and identify the patient's insurance to determine the appropriate code to use when the provider is asked to see a patient.

If Medicare is the secondary payor, providers have two options:

1. Bill the primary payor an E/M code that's appropriate for the service and then report the amount actually paid by the primary payor, along with the same E/M code, to Medicare for determination of whether a payment is due, or
2. Bill the primary payor using a consultation code that's appropriate for the service and then report the amount paid by the primary payor, along with an E/M code that's appropriate for the service, to Medicare for determination of whether a payment is due. *It's important to contact your local Part B carrier, however, regarding its recommendations.*

If Medicare is the primary payor and commercial carriers are secondary payors, practitioners can't bill Medicare for the consult codes, so bill the code that best represents the service. Some payors may allow a change to the consult code, but this may hold up claims processing. *It's important to contact your main payors for clarification.*

## Emphasis on accurate coding and documentation

With the elimination of consultation reimbursement from Medicare, possible future elimination from other payors, and no clear crosswalk from the consultation codes to the other evaluation and management codes, simply down-coding visits will affect the financial health of your practice now more than ever. Understanding the documentation requirements for each level of service will not only increase your reimbursements, but also bolster your office's confidence in its coding and billing procedures and ease stress about the possibility of an audit.

*"Effective January 1, 2010, local Part B carriers and/or A/B MACs will no longer recognize AMA CPT Consultation codes (ranges 99241-99245, and 99251-99255) for inpatient facility and office/outpatient settings where consultation codes were previously billed for services in various settings."*

# Waiving copayments and deductibles

## Bad business or fraud?

**Trick question: The answer is both!** Copayments and deductibles are on the rise and have been for several years. Through statistical evaluation, insurance carriers have learned that patients are less likely to schedule a visit for unnecessary reasons or utilize an emergency room out of convenience when they are responsible to contribute to their own health care cost. Hence, it's understandable that copayments continue to increase.

In 2004, only one in five people with employer-provided health insurance had a copayment of more than \$25. Yet, by 2009, that ratio had jumped to one in three, according to the Kaiser Family Foundation's *Employer Health Benefits 2009 Annual Survey*. Specialist copayments and deductibles are usually much higher.

Let's assume that a primary care physician provides service billable as 99213. The total allowable amount by the insurer is \$59.59. There's a \$25 copayment, and the insurance pays the remaining \$34.59. The copayment represents 42% of the physician's income for this service. Obviously, a practice can't afford to lose income from copayments and deductibles.

### Collecting copayments

Rising copayments and deductibles have shifted the physician office's responsibility from collecting from the insurer to collecting from the patient. Unfortunately, many offices haven't caught up with the trend and are not sure how to collect effectively, especially in person. Be advised that the chances of collecting from a patient drop 16% as soon as the patient leaves the office.

Most offices find it easier to simply send a statement. But, in addition to reducing your chance of collecting, there's a hidden cost associated with sending statements. Nearly a decade ago, *Medical Economics* magazine published a report citing the average cost of sending a statement as slightly greater than \$3. And about five years ago, the Medical Group Management Association released results showing the cost was closer to \$8 per statement. In 2010, the cost likely exceeds \$10.

### Defining fraud re: copayments and deductibles

Except in limited circumstances, Medicare and Medicaid don't allow the waiver of copayments or deductibles to their patients. Providers *must* collect these amounts from the patient; routinely waiving them may be interpreted as program abuse. After all, sending a claim to government programs for

patients in which a copayment or deductible was waived is misrepresenting the true charge for the service.

Federal health care fraud generally involves an individual's or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another individual or entity to obtain payment for, items or services payable under a federal health care program. Under the Civil Monetary Penalties Law (CMPL), you can't offer or give anything of value to a Medicare or Medicaid beneficiary that you know or should know is likely to influence his or her selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services. Violations are subject to penalties of up to \$10,000 for each act.

CMPL allows waiver of copayments only if three conditions are met:

1. The waiver isn't part of an advertisement or solicitation,
2. The physician doesn't routinely waive copayments or deductibles, and
3. The waiver is offered after making a good faith determination of the patient's financial needs.

A waiver may also be allowed under CMPL if a physician fails to collect after making reasonable efforts to do so.

Out-of-network providers sometimes waive copayments for commercial health plan patients for strategic reasons. Doing so levels the playing field on which an out-of-network provider and in-network provider are competing in regard to the particular plan. No federal law expressly bars these waivers, but several legal considerations need to be analyzed if a provider wants to waive copayments under these circumstances.

HIPAA makes it a crime for anyone to falsify a material fact or make a false statement to a health care benefit program in connection with the delivery of or payment for health care, benefits, items or services. A health care benefit program is any public or private plan under which any medical benefit

or service is provided to any person. It includes any person or entity that provides a medical benefit or service for which payment may be made under the plan.

Providers who waive copayments are exposed to HIPAA risk because, arguably, the provider is misstating its charge to the commercial plan. For example, assume a \$100 total charge where the patient has an 80/20 plan. If the provider waives the patient's obligation to pay 20%, then, again arguably, the commercial plan owes only 80% of \$80.

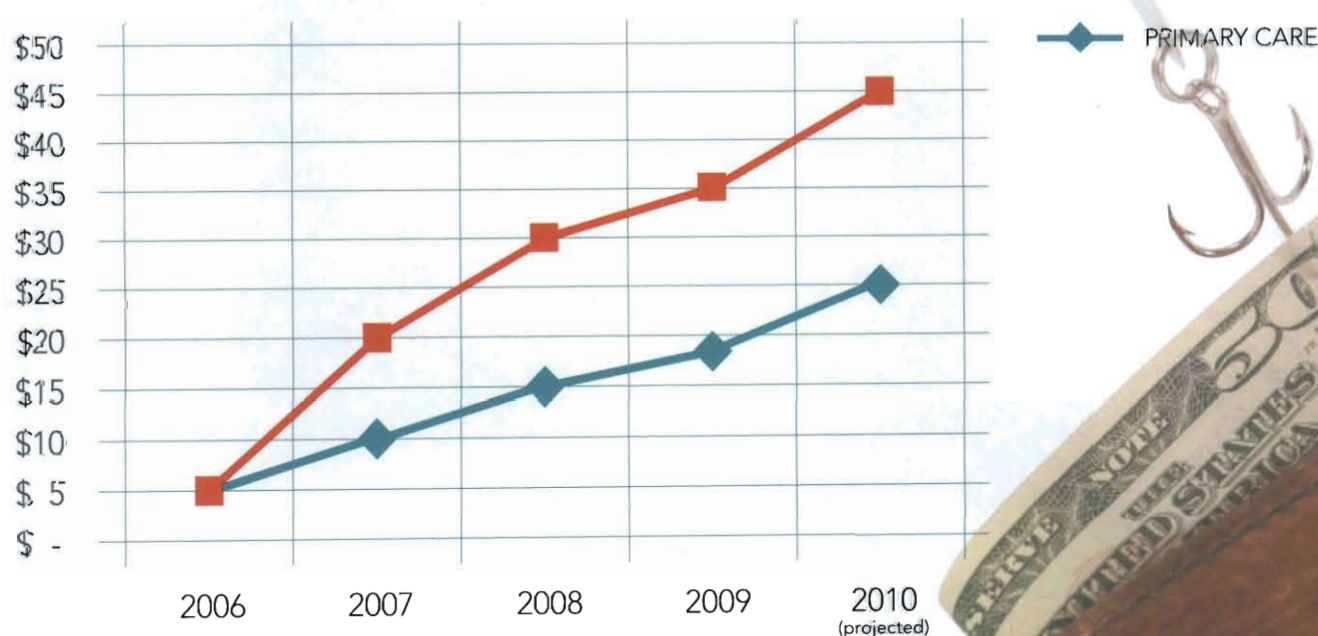
For commercial insurance patients, some states define insurance fraud as "presenting to, or causing to be presented to, an insurer a claim for payment pursuant to a policy or a claim for any other benefit pursuant to a policy knowing that the statement or any part of the statement is false or deceptive." A "statement" here includes a bill for services, diagnosis or prognosis. When a physician sends a claim to a carrier, the carrier assumes the patient has paid the copayment or deductible. If it has actually been waived, the physician may be guilty of insurance fraud.

Other states specify that "the payment of benefits under an assignment does not relieve the covered person of contractual responsibility for the payment of deductibles and copayments. A physician or other health care provider may not waive copayments or deductibles by acceptance of an assignment."

### Reviewing your policies

It's important for you to review your policies and procedures regarding copayments and deductibles. If you routinely waive these or offer "insurance only," you're hurting the financial health of your practice and may even be committing fraud. Now's the time to create and implement sound policies and procedures that address this issue.

COPAYMENT AVERAGE





**We're Moving!**

As of June 2010, we will be relocating our offices to:

**13616 California Street, Suite 300  
Omaha, NE 68154**

This move will give us room to support our continuing growth and serve our clients better.

**Please note:** All emails, phone numbers and the Web site address will remain the same. Only our physical mail address is changing.

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**VitalSigns**

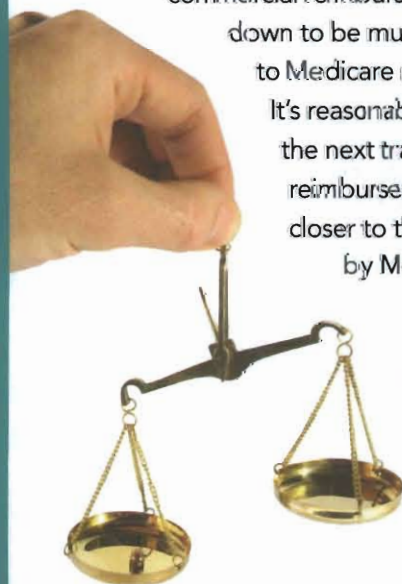
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**Don't overlook fixed costs**

**Budget-conscious practices can save by reviewing staffing**

Even with the recent passage of health care reform legislation, there remain many uncertainties in regard to future trends. One trend appears to be continuing: declining third-party reimbursement levels for services that physicians provide.

In the "good old days," physician practices needed to worry only about keeping costs within the limits of commercial third-party reimbursement levels. As time progressed, commercial reimbursements were whittled down to be much more approximate to Medicare reimbursement levels. It's reasonable to expect that the next transition will move reimbursement levels much closer to those currently paid by Medicaid.



This means that it's time to take inventory and see how the cost profile of your practice measures up against Medicaid reimbursement levels. Controlling costs is vital to the long-term success, and maybe even survival, of a practice. All expenditures should be reviewed for savings opportunities. Although variable costs can often be addressed more quickly, practices focusing on only variable costs are potentially missing longer-range opportunities to reduce fixed costs as well.

**Finding a staffing balance**

The largest cost for most practices relates to staffing. These expenses should vary with volume in a well-managed office. Too much staff will result in wasted resources, while too little can be very costly in terms of overtime. Having the correct number of staff members and working with staggered or flexible shifts is the most effective method to control costs. Consider the value of hiring part-time staff who will be flexible in covering for others who are on vacation or sick.

**Monitoring the time**

Overtime is a cost that should be closely monitored and shouldn't be allowed without express managerial permission on a case-by-case basis. Take notice of those who clock in early or stay late. A key strategy to reduce this cost is cross-training staff to support one another instead of everyone performing only limited functions. Doing so will reduce downtime and better meet immediate demands during busy office hours.

**Filling empty spaces**

Serious consideration should be given before automatically filling vacant positions, as this is an opportunity to re-evaluate workflow and efficiency. Use temporary staffing agencies

only when there is a critical need, as they're often quite expensive. And, if you do go this route, carefully evaluate the quality of staff provided.

**Achieving the right mix**

It's imperative that your office have not only the right number of staff members, but also the right mix. A careful review should be done to see whether the most cost-efficient resource is performing each of the necessary functions of your practice. For example, given your clinical needs, do you really need an RN? Or could an LPN or medical assistant perform the clinical functions necessary? Are you paying for a billing specialist when a charge entry clerk is all that you need? Is your office manager performing functions duplicative of those your accountant provides? Do you need a midlevel provider to free you for more complex patient visits and hospital rounds?

**Pressures will continue**

In summary, revenue pressures for physician practices will continue. Even if you've been cost-conscious for a long time, an in-depth review of your staffing costs may yield just enough savings to keep your income stable as reimbursement rates limbo lower toward Medicaid levels.