Eastern Michigan Chapter

HEALTHcents

February 2003

Volume 1,Issue 11

Upcoming Member Meeting—March 20, 2003

The Insurance & Reimbursement Committee Presents

What's Happening in the Reimbursement & Regulatory Industry?

The 2003 Annual Insurance & Reimbursement Update

Thursday
March 20, 2003

DoubleTree Hotel-Novi
27000 Sheraton Drive
Novi, MI 48377
(248) 348-5000

Agenda

7:30 - 8:30 AM	Awards Breakfast (Invitation Only)
8:00 - 8:30	Registration/Continental Breakfast
8:30 - 9:00	Member Meeting - Awards/2003 Election results
9:00 - 10:30	What's Happening in the Reimbursement & Regulatory Industry?
10:30 - 10:45	Break
10:45-12:30	Insurance & Reimbursement Annual Update
12:30 PM	Adjournment

Member Meeting Seminar

What's Happening in the Reimbursement & Regulatory Industry?

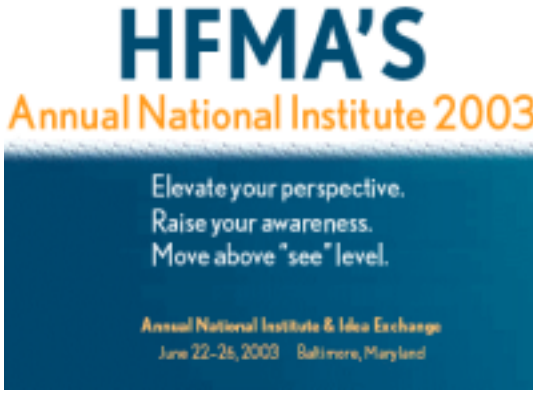
Speaker: Trinita C. Robinson, MA

Trinita C. Robinson, MA is HFMA's Technical Director for managed care and other regulatory issues. She received her Masters degree in healthcare administration and personnel management from Central Michigan University. Trinita has 29 years of healthcare administration experience to include managed care contracting and HMO development. At HFMA, Trinita divides her time between responding to questions relating to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and other health system and regulatory issues.

Join us for an overview of what's happening in the reimbursement and regulatory industry. This will include discussing the current developments in Medicare reimbursement and HIPAA readiness. Plus a sharing of any new updates on Privacy, Security, and the Transaction Standards and Code Sets and how HIPAA impacts the revenue cycle.

2003 Insurance & Reimbursement Annual Update Speakers

Medicare Update
Speaker: Dean Ziemendorf
Supervisor -Reimbursement
United Government Services
Medicaid Update
Speaker: Brenda Fezatte
Director of Rate Setting Division
BCBSM Update
Speaker: Gerald Noxon
Director of Provider Contracting & Reimbursement
Legal Update
Speaker: Maria Abrahamsen



You can register for the ANI institute on-line at www.hfma.org. On the sidebar click on Education and then click on Annual National Institute. Sign up today to raise your awareness.

Thank You Chapter Champions!!!

The "*Chapter Champions*" Sponsorship Program offers sponsors the option of being a "Superstar", a "Winner", or a "Player" for $1,500, $1,000, and $500, respectively. If you would be interested in the "*Chapter Champions*" Sponsorship Program, please call Jim Birchler, 734-477-9270 or Cindi Long, 248-652-5634.

Thank You!! Oakwood and Henry Ford for being our "*Chapter Champions*" for the 2002-2003 fiscal year!

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Correction to December Healthcents

The December Heathcents included an article entitled “PPS Capital-Related Cost Reporting Changes and Impact on Michigan Hospitals”. The authors were not included with the article and need to be recognized: Mary Ann Beyer and Ron Horwitz

MEDICARE teaching physician guidelines revised

Submitted by Maria Abrahamsen. Ms. Abrahamsen can be reached at (248) 203-0818 or mabrahamsen@dykema.com.

Late last month CMS revised the section of the *Medicare Carriers Manual* (Section 15016) that governs Part B Medicare payment for the professional services of teaching physicians ("TP"). In general, this Manual section defines the degree of TP involvement in services performed by an intern or resident that is required in order for the TP to claim a professional fee from Medicare for the services. Highlights of the revision include the following:

- The status of a physician who otherwise fits in the definition of "resident" is not changed by the fact he/she receives a staff or faculty appointment or participates in a fellowship.
- There is a new definition of "critical or key portion" which makes it clear that the **TP** determines what is/are the critical or key portion(s) of a service. (The TP must be physically present during the key or critical portion(s) of a service in order to bill for that service.)
- "Documentation" is now defined. Documentation must be dated and include "a legible signature or identity." Documentation must identify the service furnished, participation of the TP in providing the service, and whether the TP was physically present.
- A TP is "physically present" when a service is performed if the TP is in the same room (or a partitioned or curtained area of a subdivided room) as the patient and/or performs a face-to-face service.
- To quality for Medicare payment, a TP must **personally** document the following with respect to each E/M service: (a) that the TP either performed the service or was physically present while the resident performed the key or critical portions, and (b) the TP's participation in the management of the patient. A TP may refer to a resident's note, rather than duplicating its content. However, requirements (a) and (b) cannot be satisfied by the resident's documentation.
- CMS has added to the Manual specific examples of medical entries by a TP which would satisfy Medicare's documentation requirements in various circumstances.
- CMS has also added examples of unacceptable E/M documentation, such as "Discussed with resident. Agree." Or "Seen and agree." These entries fail to describe the key patient care services personally performed or observed by the TP, and also fail to document how the TP participated in management of the patient.
- The only medical record entries by a student (in contrast to a resident) which a TP may incorporate by reference into the TP's own documentation are entries of the student's review of systems and/or **past** family/social history. Any other functions performed and/or documented by a student must be performed and redocumented by the TP in order for the TP to bill for the service.
- Facilities that bill under the special provisions for primary care teaching centers "must maintain records demonstrating that they qualify for the exception."
- Patients treated at a primary care center should consider it to be their "primary location" for health care services.
- If a teaching surgeon bills for two overlapping surgeries, the Manual now clearly requires the TP to *personally* document in the medical record that he/she was physically present during the key or critical portion(s) of both procedures.
- A teaching surgeon must be "immediately available to return to the procedure." If the TP is performing a second procedure while the resident completes the non-critical portions of the first surgery, the TP must arrange for another qualified surgeon to be immediately available to the resident.
- The provisions regarding teaching anesthesiologists no longer expressly define the key portions of a procedure as including induction and emergence.
- The provisions regarding teaching psychiatrists formerly stated that the TP was deemed to be physically present for **all** psychiatric services if the TP concurrently observed the resident's service via a one-way mirror or video equipment. The revised Manual states that teaching psychiatrists are subject to the same requirements as other TPs and that concurrent observation satisfies the physical presence requirement "for certain psychiatric services," although the Manual does not specify which services may be observed in this manner.
- The definition of an "assistant at surgery" in a teaching hospital has been expanded to include a nurse practitioner, physician's assistant, or certified nurse specialist, who is authorized to perform such services under state law.

Teaching hospitals and physicians should review the revised *Carriers Manual* to assure their compliance with the revised requirements for TP billing, with particular attention to the modified documentation requirements.

The following summarizes a presentation made at the Western Michigan Chapter of HFMA in Grand Rapids, MI made by Robert Alpiner on November 21, 2002 on "THE BENEFIT OF ADDITIONAL REIMBURSEMENT FOR TELEMEDICINE SERVICES". Part 1, in the December, 2002 "Health Cents", discussed the current reimbursement issues. Part 2 covers privacy, legal, governmental and other Telemedicine issues.

I. Privacy

Despite the best intentions of providers involved in the Telemedicine services, there is no guarantee that the treatment or the related records of the service (such as Teleradiology service) will be kept from intrusive parties. As long as we have computer hackers and other intrusive parties and the air and sound waves are used in the Telemedicine services, there is a risk that the wrong parties can either interfere or intercept these services. This is not a unique problem, as it occurs with traditional hospital services also. Nonetheless, this has not prevented patients from seeking Telemedicine services because there are always legal remedies available if the treatment or corresponding records are improperly viewed or disclosed by the wrong parties. For example, one of the purposes of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 implemented in 2003 is to penalize improper parties from invading the patient privacy for such medical treatment.

2. Legal Issues

In other countries, the legal issues described below are not as pervasive and Telemedicine services are more commonplace. The flip side is that there is less governmental intervention where it might be needed on privacy and licensing.

a. Licensing

Many times the consulting physician is in another state or another country from the patient not within the range of the treatment state's regulation. The individual state regulatory department will then assert the physician is practicing medicine without a license for treating patients. This becomes a bureaucratic nightmare as the patient is receiving needed services, but the physician has not met the licensing requirements to consult or perform the service. The physician may be licensed in State or Country "A", but needs more training or must pass examinations to be licensed in State "B" for the limited Telemedicine services performed. Many times, in bordering states (such as Virginia and Maryland bordering the District of Columbia), this is not a problem as the states will many times grant reciprocity on a limited basis for physicians who are not licensed to practice medicine in the treatment state. In non-bordering states' situations, however, the regulation involves a policing function that many states do not want to do in this era of limited state resources. On the one hand, regulating the health and safety of a state's citizens is delegated by the United States Constitution. On the other hand, the extent of the licensing is up to each state. Because there is not a universal-licensing requirement for each state, this causes much confusion on the technical competence of the consulting physicians for Telemedicine services.

a. Malpractice

In any tort action, the elements involve duty, breach, causation and damages. The element of breach of the standard of care is called into question when something goes wrong in Telemedicine treatment, with the question of who is liable? In a normal provider setting it is easier to determine these elements due to the face-to-face encounters of the patient and the physician (or other health care professional). In Telemedicine, the professional (physician) does not have the typical face-to-face contact with the patient. Thus, the question is: When is there a breach of the required standard of care to merit the patient suing for malpractice in case something goes wrong in the Telemedicine treatment?

Because Telemedicine is a relatively new service, the case law is not extensive. Instead, the court cases use conventional law in determining when malpractice occurs; i.e. if the doctor owed a duty of care to the patient. The court cases vary as follows:
1) Lopez v.Aziz (825 S.W. (Reporter) 2d (Page) 303; Texas Court of Appeals, (1993)) ruled that no liability existed when one doctor consulted another for the benefit of the patient as no consensual relationship existed between the consulted doctor and the patient.
2) Reynolds v. Decatur Memorial Hospital (660 N.E**. (**Reporter) 2d (Page) 235; Illinois, (1996)) ruled that no liability existed when a second physician suggested a certain test be performed as the examining physician misdiagnosed the necessary treatment on a child. When problems occurred on the child, the court ruled the second physician was not liable. The second physician only gave an informal opinion, had no request to see the patient, performed no review test, did not order laboratory or other tests and did not bill the patient for any physician services performed.

These two court cases are contrasted with the following:
1) Webb v. T.D. et.al. (951 Pacific (Reporter) 2d (Page) 1108; Montana, (1997)) ruled that a physician retained by a third party to do an independent medical examination needed to exercise ordinary care to discover a medical condition posing danger to examinee's physical or mental well being in a workers' compensation case. The physician needed to take reasonable steps to communicate to the examinee any such condition to comport to the required standard of care.

We look for a clarified position by the courts regarding the standard of care and when it is breached as Telemedicine services emerges.

Continued

c. Credentialing of Health Care Professionals
Not every health care professional will necessarily be technically competent to render Telemedicine service (both physicians and other professionals such as nurses and physical or occupational therapists). Because this is a specialized service, more credentialing requiring technical competence on the Telemedicine equipment (such as "Telemedicine Emergency Room Physician") will be as important as technical competence in patient care.

We look for specialized designation of Telemedicine health care professionals as the service continues.

d. Accreditation of Providers
The Joint Commission of Healthcare Organizations (JCAHO) now makes Telemedicine services departments part of the surveys and accreditation process of providers. JCAHO credentialing requirement alone makes Telemedicine services important enough for providers to review for procedures and processes as much as they do for the Emergency Room department.

3. Government Regulations
As with other hospital departments rendering services to patients, Telemedicine services are also accountable for various government regulations including:

a. Health Insurance Portability and Accountability Act of 1996 (updated) on preserving transmission on the privacy and security of patient billing and financial records.
b. Gramm-Leach-Bliley Act on assuring medical billing records cannot be used for other than the purposes intended (to not discourage patients from receiving Telemedicine services).
c. Freedom of Information Act.
d. Food and Drug Administration on regulating medical devices used in Telemedicine software.

With patient privacy and treatment more pervasive, we look for harsher penalties to those parties harming Telemedicine services either through patient privacy violations or furnishing unsafe equipment to treat patients.

4. Joint Working Group on Telemedicine
This is a federal interagency group that coordinates members' telehealth activities so that advances learned from one agency group can be passed on to another group to prevent duplication of innovations in Telemedicine services.

We expect greater refinement of Telemedicine services equipment now that more groups are involved in testing equipment and its uses for the service.

5. Other

a. Bandwidth
Bandwidth is defined by Maheu, Whitten and Allen in **E-Health, Telehealth and Telemedicine** (2001 edition) as a measure of a communication channel's range of frequency that a signal occupies. Telemedicine services use a lot of bandwidth. Generally, higher bandwidth carries information faster than lower bandwidth in transmitting information. The problem is that the Telemedicine equipment bandwidth competes for airspace with cable television, cell phones and satellite transmissions. This causes potential problems for health care professionals in clarity readings of data sent over airwaves in Telemedicine.

b. Life Cycle of Treatments
We also note that certain clinical applications of Telemedicine services face the same product development stages as other consumer goods (i.e., emerging, maturing and mature). In **Telehealth and e–Health Journal**, Spring, 2002, Chapter 2 on "Clinical Applications in Telemedicine/Telehealth", authors Krupinski, Nypaver, Poropatich, Ellis, Safwat and Sapci differentiate the stages for the Telemedicine treatments

We can expect more of the emerging uses of Telemedicine services to occur in the future.

c. Robotics
Maheu. et. al. also notes what we are seeing in local Detroit-area hospitals on robotics in Telemedicine surgery. This is a treatment that has occurred and is occurring with more frequency as noted in the newspapers. Robots do not become fatigued and are becoming refined enough so that they can perform suturing procedures while controlled by monitoring physicians at a work station similar to how robots perform spray paint jobs in auto factories.

6. Summary and Conclusion (Covers Parts 1 and 2)
Telemedicine services will only continue to the extent that the cost of these services is covered. The services are relatively new, but the technology today makes it possible for patients to demand this service. A technologically oriented mix of today's patients possesses the ability to appreciate what this service can do to save time on receiving follow up treatment. Whether the patient is rural or urban, the time is right for added Telemedicine services to occur. As more third party payers realize that this is a needed service to pay providers, this will eventually occur.

Continued

In the past, Telemedicine services would occur and then expire once the source for the funding (such as grants) of the services terminated. This service is becoming more commonplace for third party payment such as Medicare. We need legislative initiatives such as furnishing passthrough reasonable cost treatment for reimbursing providers who furnish Telemedicine services. We acknowledge the legal environment is not as settled as we would like as the case law has not established legal liabilities for treatment of patients by physicians for Telemedicine services. This will come in time. Government regulations and JCAHO credentialing impact provider Telemedicine services to the same extent as the regulations and credentialing impact other provider services.

We are on the cutting edge of the future of health care with Telemedicine services and can look forward to further refinements in later years as the reimbursement allows providers the ability to cover the providers' costs.

NEWSLETTER SUBMISSION DEADLINES

March 7, 2003 **April 7, 2003** **May 2, 2003**

Please note that the Newsletter will be published monthly with your cooperation. Any information for inclusion should be sent to Maryanne VanHaitsma (248)549-2703 mvanhait@dmc.org

MEDICARE PHYSICIAN PAYMENT CHANGES

Maria B. Abrahamsen
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On the eve of the New Year CMS published final regulations that will reduce the Medicare physician fee schedule by 4.4%, effective March 1, 2003. Only quick action by Congress can avoid the impending cut in physician payment. The regulations contain the following additional significant changes:

Surgical Assistants. CMS refused to increase payments to surgeons for the cost of office staff brought to the hospital to assist in surgery. CMS reasoned that Medicare already pays for such personnel via (1) direct payments to PAs as assistants-at-surgery, (2) facility payments to hospitals, and (3) work RVUs reflected in physician payments.

Site of Service. Medicare pays for certain physician services at a lower rate when they are performed in a health facility rather than in a non-facility setting. Medicare makes this distinction because the physician does not pay the facility's overhead costs and Medicare makes a separate payment to the facility. CMS announced that psychiatric residential treatment facilities and psychiatric facility partial hospitalizations will now be deemed "facility" sites of service. CMS also clarified that physician services to a beneficiary during a covered inpatient stay in a SNF are furnished in a "facility" (Code 31-Skilled Nursing Facility) and therefore paid at a lower rate. However, if a SNF resident has exhausted benefits and Medicare is no longer paying for institutional services, the site of service is "non-facility" (Code 32-Nursing Facility).

Therapists in Private Practice. Physical and occupational therapists employed by a physician group may now be enrolled as "therapists in private practice," which permits Medicare payment without the need to satisfy "incident to" requirements.

Therapy Cap. The $1,500 annual per beneficiary caps on non-hospital PT and OT services became effective on January 1, 2003. However, CMS has advised carriers and intermediaries in a recent letter that the cap will not be implemented until appropriate systems are in place.

"Incident To" Services. If a service is expressly covered by Medicare in a specific benefit category (e.g. x-rays and other diagnostic tests), then the service may not be billed as a service "incident to" the services of a physician. Physical therapy and the services of certain mid-level providers are exempted from this rule because the Medicare law expressly allows either "incident to" or separate billing for these services. The Stark law allows "group practices" to vary compensation to individual physicians based on the volume or value of designated health services that are "incident to" the physician's services. CMS' narrowing of the definition of "incident to" services will consequently effect Stark compliance.

The Twelve Missing Links in Revenue Cycle Management

No new band-aid is likely to fix your receivables problem. More than likely it will be a contribution of strategies – all orchestrated by the receivables manager to overcome the "sins of omission" that contribute to high days and bad debt.

Here are the sins of omissions and how to correct them.

Sin #1 – Loose control prior to service
What to do: Develop a well organized system and train personnel to obtain information prior to medical service given in order to negotiate potential problems, make good decisions and obtain all necessary information needed for billing and collection follow-up. Have admission program under A/R manager. "Do it right, upfront."

Sin #2 – Sloppy controls of patient discharge
What to do: Set up a tight discharge control system to gather and control necessary data, improve collections and firm up all arrangements. Train cashiers to collect more at discharge. Maintain cashier productivity reports.

Sin #3 – Letting small balance accounts eat you alive
What to do: Neutralize outpatient and emergency room accounts by developing a specific collection system and strategy that isolates their type of high volume, low dollar accounts, allowing you to concentrate on the larger balance accounts. Design collection notices and billing cycles that will work on smaller balances.

Sin #4 – Lousy one-on-one collection skills
What to do: Improve one-on-one collections with debtor and third-party insurance accounts. Train and motivate employees.

Sin #5 – Little time and effort spent on collecting insurance
What to do: Concentrate your forces on collection from insurance – the factor that will make the most contribution to lowering days revenue outstanding and improved cash flow. Build up your knowledge of insurance companies as it relates to payment of your bills. Maintain various billing reports. Tolerate integral billing backlogs or extended delay from third-party payers.

Sin #6 – Carry self-pay accounts on installment
What to do: Try to avoid carrying your self-pay accounts on an installment basis. Use credit cards, bank notes and payment in full policy. The more you have to follow-up on installment accounts, the less time you have to spend on other more profitable accounts.

Sin #7 – Using collection letters that don't work
What to do: Gain a good understanding of how to design collection letters that will pay off. Keep them to a minimum. Use them in special spots.

Sin #8 – A computer system that doesn't collect
What to do: Get the most mileage from your computer in terms of accurate reporting, creative exception reporting for good decision-making and in productive collection notices. Pay close attention to cycles and color coding of your notices as well as use of automated collection system.

Sin #9 – Don't take time to analyze
What to do: Perform the kind of analysis of your collection system receivables that will tell you what has to be done for cash flow improvement.

Sin #10 – Forget good public relations
What to do: Maintain favorable public relations through employee awareness, training and constant procedure/policy review.

Sin #11 – Never mind staff motivation
What to do: Use individual and team goal setting to provide direction, thrust and motivation. Set up brainstorming meetings, encourage employee involvement and provide report feedback to staff. Restructure jobs so they are more self-motivating.

Sin #12 – Don't make your collection agencies pay-off dividends
What to do: Get the most from your collection agency by proper choice, evaluation, monitoring and auditing. Consider the most effective use of agencies in conjunction with your collection system.

This article is reprinted from the February 2003 *Revenue Cycle Manager* newsletter published by Zimmerman & Associates, a leader in healthcare revenue cycle management. If you would like further information call 800-525-0133 or newsletters@zimm-assoc.com

Calendar of Events– HFMA

FEBRUARY 2003

2-25 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

2-27 Financial Analysis/Decision Support (BCN Building; 8:30AM)

MARCH 2003

3-7 Healthcents Submission Deadline

3-20 Member Meeting - Annual Ins. & Reimb. Update (DoubleTree, Novi; 8:30AM)

3-20 Membership Committee Meeting (following I & R Update- Double Tree)

3-25 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

3-26 Managed Care Committee Meeting (CSB, Warren Rm S-101; 8:30AM)

3-27 Financial Analysis/Decision Support (BCN Building; 8:30AM)

APRIL 2003

4-7 Healthcents Newsletter Submission

4-17 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

4-22 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

4-24 Financial Analysis/Decision Support (BCN Building; 8:30AM)

MAY 2003

5-2 Healthcents Newsletter Submission

5-15 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

5-15 Managed Care Committee Meeting (CSB, Warren Rm S-101; 8:30AM)

5-22 Financial Analysis/Decision Support (BCN Building; 8:30AM)

5-22 Membership Committee Meeting (prior to Member Meeting at Fairlane Club)

5-22 Member Meeting - (The Fairlane Club, Dearborn; 5PM)

5-27 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

JUNE 2003

6-12 Annual Golf Outing – Shenandoah Country Club

6-16 Principles of Hospital Reimbursement (Fisher Ctr., Providence Hospital, 9-5)

6-17 Medicare Hospital Cost Report Workshop (Fisher Ctr., Providence Hospital, 9-5)

6-19 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

6-24 Physician Practice Committee Meeting (CSB, Warren Rm S-101; 9AM)

6-26 Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

Dates subject to change if necessary.

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FY 2002-2003

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