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abinsights

Anesthesia Billing, Inc.

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2003 PHYSICIAN FEE SCHEDULE?

The Centers for Medicare & Medicaid Services at the last minute delayed the scheduled Nov. 1 publication of the 2003 physician fee schedule rules and relative value units. Even before the schedule takes effect, CMS is already tweaking payments.

Originally, CMS Administrator, Tom Scully, cited as the reason possible faulty anesthesia work value data (which affects payments of all physicians). Because the time needed to review and fix the data is uncertain, it is difficult to give a specific date for issuance of the fee schedule, he said. And although he cited a "drop-dead" date of Dec. 1 (because that's when Medicare Part B carriers must have the final CF and RVUs from CMS to program into their claims processing computer systems so they can pay physicians the correct amounts beginning Jan. 1), the current date for the 4.4% cut is scheduled for March 1.

This date is now in question if Congress follows the recommendation of the Medicare Payment Advisory Commission (MedPAC). Under its plan, providers would see a 2.5% increase in the 2004 reimbursement as well as the reversal of the 4.4% cut slated for 2003. MedPAC, a non-partisan commission charged with making recommendations to Congress about Medicare payments, is attempting to replace the sustainable growth rate (SGR) formula currently used to set payment rates with a formula based on a projected 3.4% change in Medicare input prices, minus a .9% increase in productivity growth.

The Senate Finance Committee has placed its own provision in the FY 2003 omnibus appropriations bill that would block the pending 4.4% cut by applying the 2002 conversion factor to the 2003 fee schedule. The House Ways & Means Committee, on the other hand, has suggested a block on the implementation of the entire 2003 fee schedule.

We are now learning from Medical Group Manager Association (MGMA) the Senate approved a measure that would halt the pending 4.4% cut and instead freeze Medicare payments at the 2002 levels until October. But this measure must still be approved by both houses and signed by the President. This story is far from over.

How did we get to HIPAA?

The Health Insurance Portability & Accountability Act of 1996, originally known as Kennedy-Kassebaum Act, is Public Law 104-191, which amends the Internal Revenue Service Code of 1986. In it a section titled Administrative Simplification requires improved efficiency in healthcare delivery by standardizing electronic data interchange, and the protection of confidentiality and security of health data through setting and enforcing standards. More specifically, HIPAA calls for standardization of electronic patient health, administrative and financial data, unique health identifiers for individuals, employers, health plans and health care providers, and security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future. In other words, it created sweeping changes in most healthcare transaction and administrative information systems.

All healthcare organizations, including all healthcare providers, even one-physician offices, health plans, employers, public health authorities, life insurers, clearinghouses, billing agencies, information systems vendors, service organizations, and universities, are affected.

Penalties for noncompliance are severe, both civil and criminal. Fines up to $25K for multiple violations of the same standard in a calendar year and up to $250K and/or imprisonment up to 10

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President's Corner

Philip R. Blann
President
Anesthesia Billing, Inc.

"our providers will need a notice to provide patients..."

Most everyone knows that April 14 is an important date this year. It is the date where most covered entities must be in compliance with the privacy rules created by the Health Insurance Portability and Accountability Act (HIPAA).

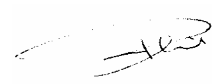
This rule has established a national minimum standard for the protection of each individual's protected health information (PHI) regardless of the format the information is in. If a covered entity receives or creates PHI, it must be in compliance April 14.

The HIPAA privacy rule requires an explicitly written notice to patients about privacy practices and patient rights contained within the rule. It also tells us our providers will need a notice to provide patients, should they ask for it, in addition to, or in conjunction with, what the hospital posts in the facility.

In our office, we have yet to find the perfect Privacy Rule, nor have we found the required exact wording. We have found the specific requirements for the content and several quality examples.

Because all providers must produce the notice upon request of any person, not just patients, and the Department of Health and Human Services (DHHS) has stated it intends for this notice to be a public document, we have enclosed a copy of the sample document drafted by the AMA in this newsletter. We intend to provide this document to any and all parties requesting this notice. Should any of our clients develop their own document, we can provide it instead.

Several hospital-based providers, especially those in the RAP, Radiology, Anesthesiology, and Pathology specialties, have questioned whether they are a covered entity. The staff of ABI cannot answer that legal question and recommends you contact your legal counsel for guidance. BIGGS WILKERSON, L.C. is one firm we feel comfortable recommending to field this kind of question.



HIPAA CALENDAR

February, 2003	Final Security Rule
April 14, 2003	Effective Date for Privacy Rules.
April 14, 2004	Effective Date for Privacy Rules for "**small plans**," defined as health plan with annual receipts of $55 million or less

abinsights Contact Information

abinsights readers are invited to submit comments, questions, tips, and suggestions for articles on any subject related to billing, collections, coding, reimbursement, and compliance. Send to: Anesthesia Billing, Inc., 423 SE 10th Street, Newton, KS 67117-4409. Phone 316-282-4321. Fax 316-282-4322.

Our purpose is to help you meet inevitable challenges. We hope to deliver practical knowledge and solutions drawn from the best business publications in every issue, knowledge you can use today.

Reasonable attempts have been made to be accurate. However, medical billing, collections, coding and compliance are part science, part art, even experts sometimes differ. Neither Anesthesia Billing, Inc., the editors, publisher, contributors, or consultants warrant or guarantee the information contained will be applicable or appropriate in all situations. For information specific to your practice, consult a qualified professional.

The information included in this publication is provided, among other things, to alert you to legal developments and should not be considered legal advice. Specific questions about how this information affects your particular situation should be addressed to your attorney.

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History of HIPAA (cont.)

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years for knowing misuse of individually identifiable health information can be imposed.

The required compliance is not standard because organizations are not. Steps to develop an effective compliance requires organization-wide involvement. They include:

- Building initial organizational awareness of HIPAA.
- Comprehensive assessing of the organization's information security systems, policies and procedures.
- Developing an action plan with deadlines and timetables.
- Developing a technical and management infrastructure to implement the plan.
- Implementing a comprehensive action plan,

including: Developing new policies, processes, and procedures, Building "chain of trust" agreements with service organization, Redesigning a compliant technical information infrastructure, Purchasing new, or adapting, information systems, and Developing new internal communications training and enforcement.

It is the Administrative Simplification provision which has caused more confusion than clarity. The provision is composed of four parts, each of which has created its own rules and standards, some which are still "proposed", but are becoming finalized quickly. The four parts are: Electronic Health Transactions Standards, Unique Identifiers, Security & Electronic Signature Standards, and Privacy & Confidentiality Standards.

The term Electronic Health Transactions includes health claims, health plan eligibility, enrollment and disenrollment, payments for care and health plan premiums, claim status, first injury reports, coordination of benefits, and related transactions. Implementing a national standard will mean we will all use one format, thereby "simplifying" and improving transaction efficiency nationwide. Virtually all health plans will have to adopt these standards. Providers not able to or choosing to use non-electronic transactions will have to contract with a clearinghouse to provide translation services.

Standard Code Sets are also mandated. Coding systems that describe diseases, injuries, and other health problems, as well as their causes, symptoms and actions taken must become uniform. All parties to any transaction will have to use and accept the same coding. Again, in the long run, this is intended to reduce mistakes, duplication of effort, and costs. Fortunately, the code sets proposed as HIPAA standards are already used by many health plans, clearinghouses and providers, and this should ease the transition.

The current system establishing and using multiple ID numbers will be reduced to a single unique ID number and is expected to reduce confusion and costs.

The new Security Standard will provide a uniform level of protection of all health information that is housed or transmitted electronically and that pertains to an individual. Organizations will have to meet a standard ensuring message integrity, user authentication, and non-repudiation. It mandates safeguards for physical storage and

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HIPAA: More Rules and Regulations...

"...privacy is about who has the right to access personally identifiable health information."

The Firm is pleased to have been selected to co-sponsor **abinsights**.

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maintenance, transmission, and access to individual health information. It applies not only to the transactions adopted under HIPAA, but to all individual health information that is maintained or transmitted.

The Final Rule for Privacy was published just as President Clinton was leaving office, on December 28, 2001. A paperwork glitch delayed notification of Congress, so the Congressional Review period didn't begin until February, pushing the effective date of the rule until April 14, 2001. Compliance will be required on April 14, 2003 for most covered entities, marking the end of the allowed 24 months to achieve compliance.

In general, privacy is about who has the right to access personally identifiable health information. The rule covers all individually identifiable health information in the hands of covered entities, regardless of whether the information is or has been in electronic form.

The Privacy standards:

- Limit the non-consensual use and release of private health information.
- Give patients new rights to access their medical records and to know who else has accessed them.
- Restrict most disclosure of health information to the minimum needed for the intended purpose.
- Establish new criminal and civil sanctions for improper use or disclosure.
- Establish new requirements for access to records by researchers and others.

The new regulation reflects the five basic principles outlined at that time:

- Consumer Control: The regulation provides consumers with critical new rights to control the release of their medical information.
- Boundaries: With few exceptions, an individual's health care information should be used for health purposes only, including treatment and payment.
- Accountability: Under HIPAA, for the first time, there will be specific federal penalties if a patient's right to privacy is violated.
- Public Responsibility: The new standards reflect the need to balance privacy protections with the public responsibility to support such national priorities as protecting public health, conducting medical research, improving the quality of care, and fighting health care fraud and abuse.
- Security: It is the responsibility of organizations that are entrusted with health information to protect it against deliberate or inadvertent misuse or disclosure.