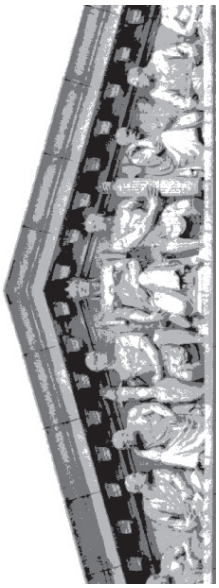

# G-2 Compliance Report

WASHINGTON G-2 REPORTS

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For Hospitals, Laboratories and Physician Practices


## OIG Proposal Could Limit Lab Discounts

### *Key Terms Defined, New Benchmark Set*

A new proposal from the HHS Office of Inspector General could potentially limit the ability of laboratories to negotiate discounted contracts with physicians or managed care plans for Medicare and Medicaid services, say industry experts. Alternatively, the proposal could force labs to charge these federal programs less than the rates established under government fee schedules.

The proposed rule, issued Sept. 15, would revise the OIG's policy regarding excessive billing practices. Currently, healthcare providers may be excluded from participation in Medicare and Medicaid for charging these programs "substantially in excess" of "usual charges" for a service. Those terms, however, have been subject to some interpretation over the years.

Historically, both the OIG and the Centers for Medicare & Medicaid Services have taken the position that "usual charges" are based on what laboratories and other providers charge their cash-paying patients and indemnity insurers with which they have no contractual arrangement, and do not include discounted rates to physicians, other providers or managed care plans. Thus, it generally has been permissible for labs

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## Inside this issue



## Tips On Meeting New Diagnosis Coding Rules

Effective Oct. 1, 2003, all Medicare Part B laboratory claims must contain valid ICD-9 codes to the highest degree of accuracy and completeness. For many labs, this means significant changes in how they handle coding.

Two industry experts recently explained the new requirement and discussed strategies for compliance during an audioconference sponsored by Washington G-2 Reports. Here are some of the major questions posed by audioconference participants to Christopher Young, president of Laboratory Management Support Services in Phoenix, AZ, and Hyde Frederickson, compliance officer for IHC Laboratory Services in Salt Lake City, UT.

*Q: Can labs receive verbal orders followed up by written codes?*

**Frederickson:** Yes, verbal orders and the diagnosis information that comes with them are acceptable, but we at IHC require follow-up with a written order. Also, if we have to call to get additional diagnosis information, we document that.

**Young:** Documentation is the key issue. The audit trail associated with how you obtain that information is very, very important. What you may find is that when you call to get more information, this may not be re-

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Chris Young

Hyde Frederickson

**New Diagnosis Coding Rules,** *from p. 1*

flected in the physician's medical records for that patient. So, it's very important that you document when you made the call, whom you talked to (first and last name) and his or her position in the physician office.

*Q: We do two basic kinds of tests—one is a slide prep that we send out that is diagnosed by the physician who did the biopsy, the other is a test where we prepare the slide and do the diagnosis with our pathologist here. Currently, our ICD-9 codes for the tests diagnosed in the lab come from our pathologist. Is that still okay?*

**Young:** The new requirement doesn't change that at all. The Medicare program memorandum AB-01-144 recognized a category called an interpreting physician, and a pathologist is an interpreting physician. You are allowed to use the diagnosis code generated by the pathologist on the claim. For the slides you send out, you will need the codes from the diagnosing physician.

*Q: Do you recommend that a lab have a certified coder to translate narrative diagnoses or can you use appropriate training in-house?*

**Frederickson:** We have required anyone who does any kind of coding to go through at least an internal coding class that our own coding people have developed to bring the staff up to a certain level.

**Young:** You don't really need a "certified" coder. What you're doing is translating a narrative description that you've received from a physician—you're not going through medical records and doing coding in the classic sense. I agree that you need some kind of a training program and some kind of written guidelines to explain when [staff] can and cannot take liberty with the narratives they've received in order to translate these into ICD-9 codes.

*Q: One of our common diagnoses is diabetes. Do we need to call the physician to get the fourth or fifth digit and not assume that it's diabetes unspecified?*

**Young:** I think you can get opinions both ways. Some coders would tell you to add the "00" to make it *unspecified*, but a strict compliance guy like myself would tell you to call the physician. If you're seeing this problem a lot, that needs to be a focus for your educational materials to your clients.

*Q: If we submit five claims together and only one is not coded up to the highest level, will the entire batch be denied or just the one that's the problem?*

**Young:** I suspect you'll get a rejection of the whole batch, but you might consider contacting your carrier to ask how it would handle this issue.

*Q: Do you think private payers will follow suit with this practice of requiring coding to the most specific level?*

**Frederickson:** We don't know if they will, but that's one of the reasons we have required the same standards for every claim we get and every order we get, so we don't have to deal with those differences.

*Q: What's the recourse for the lab if we don't get a diagnosis code, and we've requested it several times and still haven't received it?*

**Young:** One option is to quit doing business with that individual, but before you do that, I suggest having someone higher up in your organization, someone with leverage, try to get that individual to comply. Ultimately, you'll either end up writing it off or quit doing business with that customer.

**Frederickson:** We have from time to time applied a service fee [for non-compliance]. You can't charge physicians or somebody else other than Medicare for the same testing, but you apply a penalty on them each month. That's actually been quite effective in changing behavior.

*Note:* The ICD-9 coding requirement applies not just to lab claims, but to all Medicare Part B claims, electronic or paper. The sole exemption is for ambulance service claims.

*Audiotapes from the Sept. 9 session on ICD-9 coding may be ordered from Washington G-2 Reports. Go to* www.g2reports.com *and click on "G2 Products"*

## Resources

The official Medicare notices below are posted on the Web at *cms.hhs.gov/manuals*:

- CMS Program Memorandum-Carriers, Transmittal B-03-045 (June 6, 2003)
- Diagnosis coding changes to the laboratory national coverage decisions, effective Oct. 1, 2003: CMS Program Memorandum-Intermediaries/Carriers, Transmittal AB-03-104 (July 25, 2003)

# OIG To Focus On Pricing, Reimbursement & Quality

## *Healthcare Attorneys Get The Lowdown From Acting IG*

The HHS Office of Inspector General plans to focus on pricing and reimbursement policies in a number of areas in the coming year, including pharmaceuticals and enteral nutrition, acting principal deputy IG Dana Corrigan told healthcare attorneys Sept. 22.

Reimbursements that are not in sync with costs can lead to kickback schemes and can provide incentives to prescribe unnecessary drugs or provide unnecessary care, she said during the Fraud & Compliance Forum, sponsored by the American Health Lawyers Association and the Health Care Compliance Association and held in Washington, DC.

The OIG will also pay particular attention to pricing policies for power wheelchairs, Corrigan said, noting that Medicare has paid substantially more for power equipment in the past few years because of fraud and abuse by some fraudulent durable medical equipment providers (*see related article below*). "When we throw a lot of money in one direction, people will try to get it," she noted.

Quality of care in both nursing homes and hospitals will be on the OIG's radar screen too, said Corrigan, noting that she would use the Office's exclusion authority when warranted. For example, the OIG recently issued a notice of intent to exclude Tenet Healthcare's Redding Medical Center (Redding, CA) from participation in Medicare and Medicaid. Two doctors at the hospital have been charged with performing hundreds of unnecessary heart procedures (*G-2 Compliance Report, Sep 03, p. 3*).

Corrigan, who was named acting IG after Janet Rehnquist resigned earlier this year, said the OIG is trying hard to enforce Medicare and Medicaid program rules while at the same time working with healthcare providers. Balancing the two can often be difficult, she acknowledged. "The bottom line is, we want the system to work well."

Noting that healthcare attorneys often set the tone for the conduct of their clients' business, Corrigan cautioned them to follow the rules and avoid the temptation to "game" the system. "A lot of times, attorneys run the show. The message you send your clients—I wouldn't underestimate that."

# CMS Vows To Fight Abuse Of Wheelchair Benefit

*To address abuse in Harris County, TX, all payments for motorized wheelchairs will be personally and individually approved by CMS staff on a special task force based in the Dallas Regional Office*

The Centers for Medicare & Medicaid Services is launching a 10-point initiative it hopes will substantially curb abuse of Medicare's power wheelchair benefit, CMS administrator Thomas Scully said Sept. 9.

At the same time, the HHS Office of Inspector General said it is investigating the proliferation of durable medical equipment (DME) fraud cases involving inflated billings to Medicare, charges for equipment and supplies not delivered, and falsification of documents to qualify beneficiaries for wheelchairs and other equipment that they often do not need.

"Spending on power wheelchairs has increased nearly 450% over the past four years, an unprecedented growth in this benefit," Scully said. "While many of these wheelchairs are provided by ethical suppliers and go to beneficiaries in need, we know that a great number of unscrupulous suppliers are promising free wheelchairs to beneficiaries who don't need them. We are taking immediate action to stop these scams."

CMS plans to start its wheelchair campaign in Texas, where abuse seems to be a particular problem, he noted. In Harris County, Medicare paid for more than 31,000 power wheelchairs in 2002, compared with just over 3,000 power wheelchairs in 2001.

Nationally, total Medicare payments for motorized wheelchairs increased from $289 million in 1999 to $538 million in 2001 to more than $845 million in 2002. For 2003, the pro-

jected total is $1.2 billion. By contrast, overall Medicare benefit payments rose only 11% during that same period.

The number of Medicare beneficiaries with at least one claim for a motorized wheelchair rose from just over 55,000 in 1999 to almost 159,000 in 2002, an increase of 189%, while the Medicare population overall rose only 1% per year during the same period. "This abuse is an insult to all Americans who pay taxes," said Scully. "It's got to stop."

As part of the campaign, dubbed "Operation Wheeler Dealer," CMS will aggressively scrutinize all new applications for supplier numbers, publish regulations to enhance the ability to screen new supplier applications to identify and prevent inappropriate enrollment of suppliers, and finalize regulations revising coverage policy for motorized wheelchairs and scooters. The agency also will collaborate with law enforcement agencies to prosecute fraud cases and will develop inherent reasonableness review guidelines.

## Medicare Coverage Decision Process Revised

The Centers for Medicare & Medicaid Services (CMS) is updating it process for making Medicare coverage decision to incorporate what its says are "lessons learned" and to implement certain requirements of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

In a *Federal Register* notice published Sept. 26, CMS says it is taking the following steps to improve the process for making national coverage decisions:

- ❑ Establishing a separate process, with more rigid timeframes, for beneficiaries who qualify as aggrieved parties under section 522 of BIPA.
- ❑ Revising, formalizing and updating the elements that constitute a complete, formal request to reflect best practices.
- ❑ Updating and clarifying the conditions for acceptance of a complete, formal request.
- ❑ Making it clear that all evidence currently available must be adequate to conclude that the item or service is reasonable and necessary.

CMS also will pursue an ongoing effort to work with various sectors of the scientific and medical community to develop and publish on the CMS Web site documents that describe the agency's approach when analyzing scientific and clinical evidence to develop an NCD.

The Sept. 26 NCD notice is available online at *www.gpoaccess.gov/fr/index.html*

## CMS Posts Correct Coding Edits, Physician Fees

Physicians and other healthcare providers can now access online automated edits used to identify questionable claims and adjust payments to reflect what would have been paid if the claim had been filed correctly.

The edits, part of the National Correct Coding Initiative (NCCI), specify pairs of services, including laboratory services, which normally should not be billed by the same provider for the same patient on the same day. The edits are posted online at *cms.hhs.gov/physicians/cciedits/default.asp*.

Until today, the NCCI edits have been available to physicians and other providers on a paid subscription basis, but now they are available to anyone with a personal computer.

The edits will be posted as a spreadsheet that will allow users to sort by procedural code and by effective date. A "find" feature will allow users to look for a specific code, and the edit files are indexed by procedural code ranges.

CMS also has posted an online feature that allows physicians, including pathologists, to determine in advance what they will be paid for a particular service. The Medicare Physician Fee Schedule Lookup provides both the unadjusted payment rates as well as the payment rates by geographic location. The service at *cms.hhs.gov/physicians/default.asp*.

COMPLIANCE PERSPECTIVES

# How To Audit-Proof Your Medical Reports: Tips For Pathologists

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Medical review auditors seldom forgive physician reporting errors and omissions that raise questions about the propriety or necessity of procedures and services claimed for payment. Experience indicates that a high percentage of challenges for undocumented services, medical necessity and miscoding are avoidable. They arise merely because the pathologist failed to use a CPT keyword or ignored some other fundamental documentation principle. This article highlights several important "ounce of prevention" measures you should take to audit-proof your medical reports.

### How Auditors Audit

While the idea will offend some, pathologists must accept and be responsive to the fact that they are communicating via their medical reports with an audience much larger than surgeons. It includes third-party payer and insurance auditors. They are not physicians, and their interest in reading your reports extends well beyond the pathologic diagnosis.

Medical review auditors come from varying backgrounds. Their profession is dominated by registered nurses, medical record technologists and liberal arts or business administration majors with healthcare industry work experience. Very few have in-depth training in the laboratory sciences, and an even smaller number have had significant exposure to pathology.

### Lesson 1:

### "Everybody does not know…."

Why would you assume a liberal arts major knows that bone must be decalcified before it can be processed for microscopic exam? Is it reasonable to assume a medical records technologist knows that a reference to iron stores means the pathologist evaluated an iron stain? If you want to communicate effectively with the auditor who will one day pass judgment on your claims, *state the obvious*, because there's a 99% chance it's obvious only to you and your histology technician!

Medical review auditors audit from a stack of pathology reports and matching insurance claims, with their CPT text open to the pathology section. They look for keywords in your reports that correspond to those in the text. When keywords match and link to the same CPT code on your claim, the auditor is happy; when they don't, the auditor is not happy and will exact some type of retribution. The penalty depends on the nature of the mismatch: (a) if there is nothing in the report indicating the service was performed, the charge will be denied entirely; or (b) if the report keyword supports only a lesser service, the charge will be down-coded for payment.

### Lesson 2:

### "If it ain't documented, it weren't done!"

Want to get paid hassle-free for that fine needle surgical procedure; that FNA immediate study; that bowel margin you grossly examined and reported in the OR; all three pH levels of the ATPase staining you evaluated; or that PAS and PASd stain combination you considered for the diagnosis?

Make sure *your report* contains a *clear and complete description* of the service or procedure. Remember: work order and accession logs, requisitions, intraoperative consult worksheets and other internal documents *are not* part of the formal patient medical record an auditor will rely on when judging the validity of your claim, and they may not be accepted after-the-fact either.

**Lesson 3:**

### "Know and make ample use of CPT keywords."

Do you assume it's obvious from the gross description that the LEEP cervical specimen you examined was a *conization*, not a *biopsy*; that the piece of tibia you reported was a *biopsy*, not a *fragment*; that the "small bowel nodule" you received was a *segmental resection for tumor*, not a *biopsy*; that the breast mass you reported was an *excision of lesion, requiring the microscopic examination of surgical margins*, not a mere incisional *biopsy*?

Obvious to whom? To a medical review auditor whose résumé shows that he or she rose through the ranks to insurance billing manager of a large, multi-specialty physician clinic? Using *CPT keywords* at critical points in a pathology report *will not* interfere with the communication of vital diagnostic information, but it *will prevent* you from having to argue over the level of service you're entitled to bill.

The prime directive of a medical review auditor is: "Don't pay for services that aren't reasonable or medically necessary." A service is not "medically necessary" if it does not *contribute* to the diagnosis, care or treatment of the patient. Auditors carefully read physician reports to detect language indicating that a service or procedure may not have been necessary for the diagnosis. Because they are not physicians, auditors typically interpret words and phrases in their literal, denotative sense, not as the "words-of-art" that the pathologist intends. Practitioners can avoid "shooting themselves in the foot" by knowing and avoiding the expressions that cause auditors the most concern for medical necessity.

**Lesson 4:**

### "Avoid medical necessity *red-flag* words and phrases."

Why should an insurer pay for a special stain that was *non-contributory*? This guy's real gutsy—he billed a micro exam even though his report straight-out says *no pathologic diagnosis* was rendered! The patient's policy doesn't cover routine physicals, so I can't allow a charge for *normal* colonic mucosa. Tell me again, why should I pay for your examination of a thyroid FNA that was *non-diagnostic* (or *insufficient for diagnosis*)? All "word-of-art" terms and phrases that smack of absence of medical necessity have readily accepted substitutes and remedies, so there is no excuse for intentionally *red-flagging* services.

You should understand by now that a pathology report designed solely to communicate medical information to another physician will most likely fail your needs upon a claim audit. The pathologists who pass audit scrutiny time-after-time are those who have learned the four lessons cited above and who have adopted the preventive measures associated with each. They attend as well to the additional report format and content matters set forth below.

### Audit-Proofing Measures

Following is a potpourri of errors and omissions that have come to light via third-party payer or insurance audits of pathology reports. Each can be classified under one of the four "lessons" learned above, but the details are important in and of themselves. Please note that the controversy in each instance was entirely preventable.

❑ **Microscopic Description:** Many pathologists have abandoned the practice of dictating a detailed microscopic description of each specimen. While this is not a medical review issue *per se*, some pathologists have had their CPT 88302-88309 charges denied because their reports contained no evidence whatsoever that a *microscopic* exam was actually performed. Controversy can be avoided simply by including in each report a standard phrase such as: "Unless 'gross exam' is specified, the final diagnosis for each specimen is based on a microscopic examination of the tissue(s)."

❑ **Teaching Physician Attestation:** Medicare requires teaching physicians to attest in their medical reports that they performed or immediately supervised the "critical portion" of any billed procedure in which a resident or fellow actively participated. This coverage mandate can be fulfilled by incorporating in each report a standard phrase such as: "By my electronic signature I attest to having personally examined (gross or microscopic, as stated) each described specimen and to hav-

ing rendered or confirmed the diagnosis(es) related thereto." A separate attestation is needed for each adjunct procedure or service (*e.g.,* operative consult, electron microscopy, immunopathology study) reported by another teaching physician for the same case.

❑ **Report Section/Field Headings:** The title given to pathology report sections and fields must be judiciously selected, taking into account the broader audience that includes medical review auditors. In particular, remember that words-of-art may very well have an entirely different meaning when read literally by a non-physician or by someone not intimately familiar with the practice of pathology. Specific attention should be given to the following common pathology report section and field titles.

- ***Prepared vs. Examined*:** Non-gynecological cytology reports often have a "preparations" section to list the number and type of slides developed from the specimen (*e.g.*, "2 Pap stained cytospin, 2 Pap stained direct smear, cell block"). This information certainly supports the technical charges, but it provides no evidence in and of itself that the pathologist actually examined each preparation. The evidentiary loop can be closed with a section title such as "Prepared and Examined." However, the preferred method is for the diagnosis to conform to the following template: "[Specimen] (microscopic exam of specified preparations): [diagnosis]."
- ***Review vs. Interpret*:** Clinical pathology reports especially—but sometimes abnormal Pap smear reports as well—frequently describe the pathologist's interpretation as a "review." That term from the perspective of a medical review auditor most commonly points to a quality assurance function, not a physician diagnostic service; hence, the auditor may challenge the professional fee on grounds that the pathologist is billing for a "Part A" service. To preemptively avoid this issue, simply substitute the word "interpretation" for "review" in affected medical reports. Along the same lines, if some of your reports use the word "result" when "interpretation" is more accurate, make the same substitution.
- ***Consult vs. Interpretation*:** Pathologists in one jurisdiction are now engaged in a protracted fight with their Medicare carrier over the words "interpretation" and "consult." The carrier contends a "presumptive list" test such as protein electrophoresis cannot yield a professional fee (*e.g.,* CPT 84165-26) unless the patient's attending physician requests, and the pathologist reports, an "interpretation." The carrier also holds that a pathologist may not bill clinical consult code 80500 or 80502 unless the attending physician requests, and the pathologist reports, a "consultation." (The 18 tests on Medicare's "presumptive list" appear in §15020(E) of the *Medicare Carriers Manual*; see the Web site of the Centers for Medicare & Medicaid Services, *cms.hhs.gov*.) This "hair-splitting" would be laughable were it not for the tens of thousands of dollars of Medicare payments at stake! Pathologists who make regular use of the "presumptive list" test interpretation codes and clinical consult codes 80500 and 80502 are advised to revise their medical report and requisition terminology to correlate precisely with the Medicare language.
- ***Frozen Section vs. Intraoperative Consult*:** Medical review auditors always look for conflicting information in physician reports that may implicate the propriety of the service that was billed. Some pathologists still report their intraoperative work under a "frozen section diagnosis" heading. This is misleading or confusing, because the physician will have occasion to report a "gross only" intraoperative consultation (*i.e.,* CPT 88329) under that heading at times, as well as intraoperative diagnoses by touch imprint in lieu of or in addition to a frozen section. A somewhat generic section heading such as "intraoperative consultation" or "intraoperative diagnosis" is strongly encouraged to avoid information conflict.
- ***Specimen Adequacy vs. Immediate Study*:** The professional standard under which a statement on specimen adequacy is included in each cytology

specimen report creates the potential for conflict with acceptable documentation of pathologist fine needle aspirate immediate studies. In particular, while both are "specimen adequacy" statements, only the latter is separately billable (CPT 88172). To avoid any confusion, fine needle cytology reports should contain a distinct "intraoperative immediate study" or "immediate study" section, clearly separate from the "statement on specimen adequacy" field. The results of the immediate study should be phrased something like: "The specimen samples evaluated at the time of the procedure were reported by Dr. Pathologist as: pass #1—inadequate; pass #2—inadequate; and pass #3—adequate material present." This formatting supports both the immediate study and the number of billable units (CPT 88172 x 3 in the example).

❑ **Processing Steps**: Molecular diagnostics and cytogenetic tests, as well as conventional cytogenetic studies, most often are correctly reported for charge using multiple CPT codes, sometimes including multiple units of one or more of those codes. These tests are so highly specialized and the jargon in the typical report so technical that it's virtually impossible for anyone not thoroughly trained in genetics or cytogenetics to make "heads or tails" of the information, especially as it may translate into CPT coded services and units. Therefore, it is highly recommended that a "methodology" or "procedures" section appear in the report, where the test or study is described using CPT nomenclature. For example, it would be stated: "Methodology: this test was performed by molecular isolation; enzymatic digestion; and nucleic acid probe (x4)."

❑ **Miscellaneous**: No work product is complete without "other matters." So here they are:

- ***Frozen Block vs. Section*:** Recently, a dermatopathologist narrowly avoided a major overpayment claim by the carrier over additional frozen section block charges (CPT 88332). While both parties agreed that the accepted unit of service for pathologist frozen section work is the "block" (88331 for the first frozen section block per specimen, 88332 for each additional frozen section block per specimen), the carrier became concerned when it noted that the pathologist regularly used the words "block" and "section" interchangeably. The auditor suspected the pathologist might be billing 88332 per each additional *slide* instead of *block*. The matter was resolved without a formal complaint being filed by the carrier, but the pathologist learned the hard way about the importance of CPT keywords—he now faithfully refers to his frozen cassette labels (FSA1, FSA2, etc.) as "blocks" in his reports.
- ***The "Dangling" Touch Prep:*** Too often a specimen gross description will make reference to a touch imprint prepared by the pathologist, but the report will otherwise be silent on the vital matter of whether and how the smear was used. A medically necessary touch imprint is separately chargeable (CPT 88161), but the report must clearly demonstrate whether it was considered with the H&E sections or as part of an intraoperative consultation. A "dangling" touch preparation mentioned only in the gross description is not chargeable.

## Conclusion

Medical review auditors are not evil people. They are not "out to get" physicians. I would judge most to be of average—if not above average—intelligence. But they have a job to do, and that job unfortunately is defined in part by the fact that there are some "bad apple" physicians and other healthcare providers out there.

Pathologists are well advised to approach their medical reporting with the understanding that they will be audited somewhere along the line—it's just a matter of when and by whom. To a large and very real extent, the outcome of the audit—uneventful or highly contentious—is under the direct control of each practitioner. Adopting the audit-proofing suggestions herein will certainly move you in the "uneventful" direction.

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# CMS Modifies Emergency Treatment Obligations

A Sept. 9 final rule on the obligations of hospitals to provide emergency medical treatment revises key definitions of what constitutes a hospital emergency department and offers further guidance on the circumstances under which hospitals must ensure specialty physician on-call coverage.

The changes to requirements under the Emergency Treatment and Active Labor Act (EMTALA), takes effect Nov. 10, 2003. EMTALA provides that when an individual comes to the emergency department of a hospital and makes a request (or a request is made on the individual's behalf) for examination or treatment of a medical condition, the hospital must provide an appropriate medical screening exam within its capabilities.

The final rule modifies the criteria for determining under which conditions a hospital is obligated by EMTALA to screen and, if necessary, stabilize or transfer an individual who comes to the hospital, presenting at either its dedicated emergency department or elsewhere on hospital property.



CMS has revised its definition of "dedicated emergency department" to encompass any department located on or off the main hospital campus that is licensed by the state as an emergency room or is held out to the public as a place providing care for emergency medical conditions without requiring a previously scheduled appointment.

## On-Call Requirements

EMTALA currently requires hospitals to keep a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. No guidance is given in current regulations as to when such coverage must be available or what a hospital must do if there is no on-call physician available.

The final rule provides that each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients. The hospital must, however, have policies and procedures to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of situations beyond the physician's control.

## Other Changes

In other modifications, CMS:

- ❑ Changes the term "closest hospital" to "closest appropriate facility."
- ❑ Limits the application of EMTALA to individuals who are not patients, such as certain outpatients or those admitted for inpatient care.
- ❑ Allows a hospital to seek information from an insurer about a patient and to seek authorization for services as long as doing so does not delay the required screening and stabilization. This policy applies equally to hospital services, physician services and non physician practitioner services.
- ❑ Clarifies that a hospital only has to perform limited screening in cases where an individual comes to the emergency department and requests treatment but makes clear that the medical condition is not of an emergency nature. In this case, the hospital is only required to perform such screening as would be necessary to determine that the person does not have an emergency medical condition.

## Resource

- ❖ EMTALA revised final rule, *Federal Register* (Sept. 9 2003): *www.gpoaccess.gov/index.html*

Robert Mazer

Ron Wisor

*The burden of proof to show "good cause" is on the provider, and the OIG's decision wouldn't be subject to review. But providers wouldn't be excluded for isolated or unintentional mistakes, the OIG adds*

**OIG Proposal,** *from p. 1*

to offer below Medicare rate discounts to these clients on non-Medicare testing without risk of violating the "substantially in excess" provision.

In 1997 the OIG sought to modify its interpretation of "usual charges" to include charges for services and items provided to *any* customer, clients or patients. At the time, this move was widely viewed as an attempt to require that providers offer Medicare and Medicaid their best price. After numerous provider groups filed objections, the OIG withdrew the proposal.

### "Usual Charges"

In this latest attempt to restate its policy on discounts and discriminatory billing practices, the OIG again wants to modify how "usual charges" should be determined. Under the Sept. 15 proposal, "usual charges" would continue to include amounts billed to cash-paying patients and patients covered by indemnity insurers with which the provider has no contractual arrangement.

> ***"Volume discounts are a way of life in the non-Medicare market. All that could be turned on its head with this proposal."***
>
> ***—Ron Wisor***

But significantly, "usual charges" would also include any fee-for-service rates that a provider agrees to accept from any third party, including those with managed care plans. Because negotiated rates make up a large part of provider revenues, those discounts effectively are their charges, the OIG says. Among charges that would not be considered "usual" are free or reduced charges for uninsured patients, capitated payments, certain hybrid fee-for-service arrangements and fees from Medicare and state Medicaid programs.

To determine the "usual charge," the OIG is considering two alternative approaches:

- ❑ Average charge: List all the provider's charges for a particular item or service for the most recent one-year period, then divide the sum by the number of charges.
- ❑ Median charge: List the provider's charges for the most recent one-year period and calculate the point at which exactly half are above and half are below.

In either case, when providers calculate usual charges, they would need to consider charges billed directly to patients, discounted charges negotiated with physicians and other third-party payers, contractual rates offered directly or indirectly to managed care plans, rates offered to TriCare and charges of affiliated entities. The latter could require a hospital, for example, to determine whether a related clinical lab violated the excessive billing ban.

### "Substantially In Excess"

The OIG would define "substantially in excess" as any charge that is more than 120% of the usual charge for an item or service. Where the actual charge submitted exceeds an applicable fee schedule, the OIG would consider the fee schedule amount as the actual charge. For example, where Medicare pays the lower of the actual charge of $20 or the fee schedule amount of $10, the actual charge would be $10, explains attorney Robert Mazer, a shareholder with Ober/Kaler in Baltimore, MD.

In some cases, providers may charge Medicare or Medicaid substantially in excess of their usual costs or charges if there is "good cause," notes the OIG, which believes the term should be interpreted broadly, "given the myriad of healthcare payment and service arrangements." In general, "good cause" should apply when there is a "reasonable set of underlying facts and circumstances" justifying an excess charge.

One exception might be cases where the higher charge or cost submitted to Medicare or Medicaid is a result of increased costs associated with serving program beneficiaries, such as claims processing delays or denials of payment. The OIG says it is interested in hearing about other circumstances that may constitute "good cause."

### Impact On Labs

The proposed rule could have a major impact on labs, experts believe. Labs that typically offer discounted services to physicians or managed care plans could now be limited in just how deep a discount they can provide,

*Deadline for comments on the proposed rule: Nov. 14. Send to OIG, HHS, Attention: OIG-53-P, Rm. 5246, Cohen Bldg., 330 Independence Ave., SW, Washington, DC 20201*

Mazer notes. In some cases, labs might need to raise the costs to physicians to ensure that the difference in what they bill Medicare meets the 120% "substantially in excess" measure.

In cases where labs are locked into contracts with physicians and managed care payers and can't easily modify their charges, they might be forced to lower their charges to Medicare below the lab fee schedule amount to stay within the 120% ceiling, adds attorney Ron Wisor, a partner with Arent Fox Kintner Plotkin & Kahn in Washington, DC. "Volume discounts are a way of life in the non-Medicare market. All that could be turned on its head with this proposal."

Labs that perform only anatomic pathology procedures would not be subject to the excessive billing prohibition, says Mazer. This is because, according to the OIG, services reimbursed under Medicare's physician fee schedule are based on a review of the actual costs of delivering services.

The American Clinical Laboratory Association takes sharp issue with the OIG, contending it fails to take into account the fact that Medicare sets the price that labs are paid, says its president, Alan Mertz. Measuring Medicare charges against charges to the private sector "is like comparing apples and oranges," he tells *G-2 Compliance Report*. "Labs are already under a fee schedule."

What's more, exclusion from Medicare and Medicaid is such a "draconian solution," particularly in situations where just one test out of hundreds would fail the "substantially in excess" proposed standard, he adds.

"We already see a number of problems with this proposal. We'll be taking a couple of weeks to determine exactly what the impact will be."

**Resources**

- Robert Mazer: 410-347-7359
- Ron Wisor: 202-857-6067
- Alan Mertz: 202-637-9466
- OIG notice of proposed rulemaking on excessive charges, Federal Register (Sept. 15, 2003): *www.gpoaccess.gov/index.html*


## Providers Get Some Slack On HIPAA Transactions

The Centers for Medicare & Medicaid Services will implement a contingency plan to accept non-compliant electronic transactions after the Oct. 16, 2003, compliance deadline mandated under HIPAA (the Health Insurance Portability & Accountability Act), the agency said Sept. 23.

As of Oct. 16, covered entities—including healthcare providers, health plans and claims clearinghouses—are supposed to submit electronic claims that meet standards detailed in an August 2000 final HIPAA rule. Many entities, however, aren't prepared to meet the deadline.

CMS is allowing some leeway to ensure that thousands of providers that will not be able to meet the deadline will get their Medicare claims paid. The agency made the decision after reviewing statistics showing unacceptably low numbers of HIPAA-compliant claims being submitted, said CMS head Thomas Scully in a prepared statement.

"Implementing this contingency plan moves us toward the dual goals of achieving HIPAA compliance while not disrupting providers' cash flow and operations, so that beneficiaries can continue to get the healthcare services they need."

Under the contingency plan, CMS will continue to accept and process claims in the electronic formats now in use, giving providers additional time to complete their testing process for achieving HIPAA compliance. The agency will regularly reassess the readiness of its trading partners to determine how long the contingency plan will remain in effect, Scully said.

**Wider DRG Window?** The Centers for Medicare & Medicaid Services should ask Congress to expand the DRG (diagnosis-related group) payment window beyond three days, the HHS Office of Inspector General recommends in a new audit report. CMS concurred, but said it was concerned about the impact on medical practice and health risks to beneficiaries. Currently, hospital DRG payments include certain non-physician outpatient services provided up to three days prior to inpatient admission, such as laboratory, radiology and other diagnostic tests. Many of these tests, however, are provided four or more days before inpatient admission, notes the OIG, which estimates that in 2000 Medicare paid providers about $37 million for services rendered 4-14 days prior to admission. To view the report, go to *www.oig.hhs.gov/oas/reports/region1/10200503.pdf*.

**New Recordkeeping Rules:** Drug manufacturers must keep for three years data pertaining to average manufacture price and best price calculations, the Centers for Medicare & Medicaid Services says in a final rule published Aug. 29. The rule also sets a three-year limit for drug manufacturers to report changes to average manufacturer price and best price to CMS. The rule is effective Oct. 1, but allows a 60-day comment period. To view the rule, go to *www.access.gpo.gov/su_docs*.

**Privacy Complaints Abound**: Since the HIPAA privacy rule took effect Apr. 14, the HHS Office for Civil Rights has received more than 1,800 complaints, according to Susan McAndrew, OCR's senior advisory for HIPAA privacy policy. About 30% of the complaints have not been investigated because the office lacks jurisdiction over them, she explained Sept. 16 during the 7th National HIPAA Summit in Baltimore, MD. Many of the early complaints had to do with providers denying patients access to their medical records, which OCR was able to resolve by talking with providers. So far, the agency has not imposed any penalties for violations.

**More HealthSouth Pleas**: Three more officials of embattled HealthSouth Corp. (Birmingham, AL) have pled guilty to fraud charges related to the government's investigation of the company's accounting practices. The pleas by Richard Botts, Jason Brown and Will Hicks—HealthSouth's former senior vice president for tax, former vice president of finance and former vice president of investments, respectively—brings to 14 the total number of company personnel who have admitted wrongdoing. HealthSouth has been under investigation since March when the Securities & Exchange Commission alleged that it systematically overstated earnings since 1999 by at least $1.4 billion in order to meet Wall Street's expectations.





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