E-mail your way to better communication with patients

The risk that private information could end up in the wrong hands often discourages physicians from using e-mail to communicate with patients. But e-mail can save time, allow for more physician-patient interactions, and preserve confidentiality as long as physicians know the limitations and set up proper safeguards to protect the information.

Advantages to e-communication

E-mail offers physicians more freedom than other types of communication, says Daniel Z. Sands, MD, MPH, assistant professor of medicine at Harvard Medical School in Cambridge, MA. “I think the number one advantage to e-mail is that it’s asynchronous, meaning that the two people communicating don’t need to be doing so at the same time.”

By its nature, e-mail provides proof of conversations between physicians and patients—ready-made documentation that can go into a medical record without creating more work for the physician, adds Sands.

“The advantage from my standpoint as a doctor is that I don’t have to write a separate note, says Sands. The advantage from a patient standpoint is that often when the patient walks out of the office, he forgets more than half of what the doctor said. Well, if he can walk away with a transcript, he can think about what was said and write a response if necessary.”

Communication via e-mail also gives the physician and patient extra time to ask and answer questions. “When we’re in the office or on the phone, we’re often rushed and we don’t have a lot of time,” says Sands. “[E-mail] allows us a little bit more breathing room.”

If a patient has a follow-up question or concern, he or she can get an answer quickly through e-mail, says Jennifer Schuder, project coordinator for HealthyE-mail, a nonprofit organization that provides physicians with a secure e-mail communication network. “Say you were just at the doctor’s a week ago and you have a question. We all know how long it takes to get back to the doctor. If you can send an e-mail, it saves everyone time.”

—INSIDE—

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Find out the proper precautions to take before using this mode of communication at your practice.

HIPAA 4
Learn how you can prepare for the transactions and code sets deadline.

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Columnist Barbara Eberly provides tips on making decisions that will bolster your practice’s financial outlook.
What is HealthyEmail?
A tool physicians can use to promote the appropriate use of secure e-mail messaging. Physicians send e-mails to their patients via the HealthyEmail message center.

How does it work?
Go to the Web site, register for the program, and download the software, which works through almost any e-mail program. With software such as Microsoft Outlook, a red “Z” will appear in the tool bar. Instead of hitting the send button, hit the “Z,” and the program automatically encrypts the message.

The patient then receives an e-mail saying he or she has a message from the physician waiting on the HealthyEmail Web site. When the patient clicks on the link, he or she is automatically sent to the message Web page and must sign in with a username and password to read the message. It makes little difference what e-mail software the patient uses because HealthyEmail can send to any software.

How much does it cost?
HealthyEmail is free. When the nonprofit organization started the program, Zix Corporation donated two million licenses—enough to cover every physician in the United States and two staff members.

How many people use HealthyEmail now?
Since the launch in February, 700 physicians representing more than 400 have offices registered.

Where can I find more information?
Go to www.healthyemail.org for more information or to register for the secure e-mail program.
to use e-mail in the past,” says Schuder. “But they’re becoming more open to it and they’re starting to understand that it’s a productivity tool.”

“As physicians grow more comfortable with technology in their offices and more patients want to communicate online, physicians will start to use it more,” says Sands, “Many physicians are now dipping their toes in the water and giving it a try.”

Physicians shouldn’t worry about the number of e-mails they’ll receive because the volume is often modest, he adds. “Doctors are worried they’re going to be overloaded with messages, but in practice that generally doesn’t occur.”

“Nowadays, it’s pretty inexpensive or free to use secure communication. So unless there’s some compelling reason not to, they should register for a tool like HealthyEmail or one of the secure communication portals such as RelayHealth, Medem, or My DocOnline,” says Sands. “Doctors need to decide that they’re going to use e-mail or a secure communication tool and just do it.” (See the box on p. 2 for more information about the HealthyEmail program.)

Editor’s Note: Go to www.e-pcc.org for articles and guidelines on e-mail communication between physicians and patients, and for information on other companies that provide secure e-mail message services.

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**Five considerations for safe e-mailing**

**Daniel Z. Sands, MD, MPH**, assistant professor of medicine at Harvard Medical School in Cambridge, MA, suggests several areas you should consider before using e-mail at your practice.

1. **Patient preferences.** Talk to your patients to find out their communication preferences before using e-mail, says Sands. Patients should have a say in whether you use e-mail to communicate, particularly if you’re planning to send lab results or other personal information.

2. **Limitations of the technology.** E-mail contact should not replace regularly scheduled face-to-face visits. Although e-mail can make your life easier, it does not suffice for every interaction, says Sands.

   If you and a patient go back and forth without finding a solution, or if you repeatedly receive long, detailed e-mails describing patient ailments, ask those patients to come in, says Sands. “If something requires too many back-and-forth messages, it’s time for a visit or a phone conversation.”

3. **Types of information.** Use your judgment when sending e-mails. Don’t send e-mails containing lab results that indicate problems or other information about serious situations. Also, don’t use e-mail to communicate bad news. Warn your patients not to contact you via e-mail in an emergency.

   “I think we have to understand the limitations,” says Sands. “If I want to contact a patient about a panic lab value, it would be wrong to send this through e-mail. It shouldn’t be used for anything time-sensitive or urgent.”

4. **Policies and guidelines for your practice.** Make sure you spell out clear guidelines for anyone who might use or see e-mails to and from patients. If you have precise guidelines, you’ll know how to handle most situations, according to Sands.

5. **Learning curve.** “You have to recognize that you’re learning how to use this [system] and your patients are learning how to use it too,” he says. Sands suggests starting this method of communication with only a few patients at first.

   “Then gradually expand the circle of patients to which you offer e-mail communication, as you become more comfortable with it.”
HIPAA, take two: Transactions and code sets deadline follows privacy rule

The HIPAA transactions and code sets deadline has arrived and many facilities aren’t prepared. As of October 16, payers will deny incorrectly formatted claims and facilities won’t be reimbursed. Make sure you understand the HIPAA requirement and talk to your billing department, system, or service about its compliance activities. The faster you comply, the less likely your facility will incur costly last-minute problems or lose revenue.

The transactions and code sets regulation requires providers to use a standardized format for all electronic claims submitted for reimbursement. Whether you use a clearinghouse or have your own billing department, you are responsible for making sure those claims contain the necessary data in the correct format.

“The transactions regulations deal with the electronic transmission of claims,” says H. Spencer Wilcox, managing director of HealthCare Information Solutions in Kalamazoo, MI. “If you don’t submit the transactions in the right format, you won’t be compliant.”

Noncompliance with the requirements means practices will lose a good deal of money—significantly more than if they weren’t compliant with the privacy regulations, says Margret Amatayakul, president of Margret&A Consulting in Schaumburg, IL. “If their claims are denied, no money will come in. It’s the difference between a slap-on-the-wrist fine and [having] claims rejected altogether.”

Know what you’re up against
Before you can ensure compliance at your practice, understand the information and requirements of the transactions and code sets regulations. If you don’t know the requirements, you won’t know whether your billing department or clearinghouse made the necessary adjustments.

Use resources such as guidance from the Centers for Medicare & Medicaid Services (CMS) to help you understand the final transactions regulations. Go to www.hipaapro.com and look under “Rules, Regulations, and Government Documents” to download the final rule and to find compliance guidance from CMS.

“Physician practices need to be informed,” Amatayakul says. “They need to understand what [the transactions regulations] are all about. They should verify that what needs to be done is getting done.” You shouldn’t sit back and assume your vendors are supplying the right tools for you to comply, she adds.

Communicate with your vendors
Once you understand the regulation, get in touch with your vendor or billing service. Ensure that your billing department and other staff are kept up to date. Keep the lines of communication open with your payers as well. The best way to make sure you’ll get paid is to test your billing entity on its compliance with the new regulations, says Wilcox.

“[Practices] need to validate that the vendor who performs billing for them is in fact compliant,” he says. “They need to emphasize the testing, validation, and vendor compliance with the transaction requirements regardless of the type of vendor they’re using.”

Physician practices can test their billing services by “submitting a letter to the service asking for the steps it has taken to comply and getting a documented response back, or by having direct participation with the service, balancing and validating that the transactions being submitted for the billing process are indeed compliant,” says Wilcox.

Simply validating the compliance of your clearinghouse’s procedures and claims is not enough, Amatayakul warns. Test them with information specific to your practice. “You need to send some sample transactions to find out if the transactions get accepted,” she says.

However your claims are submitted, make sure they include all necessary information, says Amatayakul. “Get in touch with the billing service or vendor and find out what they’re doing for you. Somehow, you have to capture the additional data.”
Choose a proper transmission method to comply with HIPAA’s transactions rule

Any health care provider who transmits health information in electronic format in connection with a transaction under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is considered a “covered provider” and must comply with the transactions and code sets rule. Providers who send paper claims to a clearinghouse to be processed into electronic format are also included.

The Administrative Simplification Compliance Act of 2001 allowed providers to request a one-year extension from the original October 16, 2002, compliance deadline. Providers granted the extension must submit all claims to Medicare electronically by October 16, 2003. Providers with fewer than 10 full-time equivalents (FTEs) and suppliers with fewer than 25 FTEs can send paper claims or use electronic transactions.

Covered providers have the following options for adopting transactions:

- **Direct transmission.** In this approach, providers and payers exchange transactions directly. To accomplish this, providers and payers need the necessary information systems, including a translator and communications technology, to conduct electronic data interchange.

- **Use of a clearinghouse with the standard transactions.** This option might include a mix of direct transmission and a clearinghouse. Typically, if providers use a mix, they send claims directly to Medicare Blue Cross/Blue Shield and/or other major commercial payers and use a clearinghouse to send claims to other payers.

Some providers use a clearinghouse for editing services. In the past, these services were critical if a provider had many payers because each one had its own set of rules for what data to submit. Under HIPAA, a standard set of data content exists, making services that help manage the various data requirements unnecessary.

Editing may still be necessary to make sure all required fields are filled, valid codes are used, etc. Providers may find they can submit claims and other transactions more quickly by bringing this editing capability in-house, especially if it can be done in real time.

- **Use of a clearinghouse to format standard content.** Providers whose vendors do not supply translation software must use a clearinghouse to put the data into standard format.

Clearinghouses cannot create or modify data content, so the provider must send all necessary information to the clearinghouses. Payers who do not acquire translation software before the compliance deadline can also use this method. However, if they use a clearinghouse in this manner, they cannot pass the cost onto the provider.

- **Direct data entry, if offered by the payer.** Direct data entry refers to the use of a Web-based service into which employees key the standard data elements required by HIPAA for claims submission, eligibility inquiry, etc. Although the data elements must meet the HIPAA requirements, they do not have to be formatted into an X12N transaction for transmission.

- **Paper.** With the exception of Medicare—which will accept paper claims only from small providers after October 16, 2003—payers must accept current paper transactions.

This is not a desirable option from many standpoints. For most providers it is not an option for Medicare, so they must capture the necessary data elements for Medicare claims and have a system that will continue to generate UB-92s or HCFA 1500s. Since they cannot drop the X12N transactions to paper, they need to continue running an older version of their billing system to drop other claims to paper.

Editor’s note: This article was adapted from an excerpt from the new book HIPAA Transactions Made Simple. Go to www.hcmarketplace.com or call 800/650-6787 for more information or to order.
‘Separate procedures’ the key phrase for modifier -59

If you’re not sure when to use modifier -59, you’re not alone. Many physician practices have difficulty interpreting the guidelines for its use. Modifier -59 is known as the “last resort” modifier, but you’ll probably run into situations where you’ll need it to get paid. Understanding the meaning of the term “separate procedures” can help you use the modifier appropriately and be paid properly.

According to the Current Procedural Terminology (CPT) manual, physician practices should use modifier -59 in situations where “the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.”

The procedures must be differentiated by one of the following: session or patient encounter, procedure or surgery, site or organ system, incision or excision, lesion, or injury.

In other words, if a physician performs two separate procedures on one patient in the same day, the practice can bill separately for them using modifier -59, as long as the procedures were separate and distinct, and the practice can prove that the two procedures were performed separately.

**Two separate procedures, same session, different sites**

Consider the removal of a lesion, says Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS, owner, consultant, and instructor at A+ Medical Management and Education. You can’t use modifier -59 to get paid for both the lesion removal and the repair. “When you remove a lesion, it includes doing a simple repair, like stitching it up. So if the payer sees two codes on the claim form, one for the lesion removal and one for the repair, they’re going to assume you’re trying to unbundle and that you’re trying to get paid for the closure, which is included in the procedure.”

However, many times during one session, a physician will remove a lesion on one site and perform a simple repair in a different area. “You need to put -59 on the simple repair to tell the payer that although this code looks like it should be bundled, it’s not the same procedure. It’s a separate procedure,” she says.

**Two separate procedures, same session, same site**

Modifier -59 can occasionally be used for two services in the same location, as long as they are clearly two separate procedures, says Jo Ann Stiegerwald, RHIT, senior consultant for the Wellington Group in Cleveland.

For example, while removing skin lesions from a patient, the physician sees one that looks malignant and decides to perform a biopsy rather than remove the entire lesion. Bill separately for the removal of the lesions and the biopsy. In this case, it’s appropriate to use modifier -59 for the biopsy because without it, the biopsy will end up bundled with the skin lesion removal procedure, says Stiegerwald. 

“Because the biopsy is on a separate lesion than those you are removing and you’re really only taking a sample of it and not the whole lesion, it’s appropriate to bill the whole biopsy separately with -59. Otherwise you’re not going to get paid for the
tissue sample,” Stiegerwald says.

“It’s a different procedure from excising the entire lesion. If you’re excising the entire lesion and sending it to pathology, the biopsy is already in there. But this would be a biopsy on something different.”

**Two procedures, same site, different sessions on one day**

Billers can also use modifier -59 when a physician performs two different procedures in one location at different times on the same day, says Jandroep. For example, in the morning, the physician opens the patient's abdomen, performs exploratory labs, looks around, and removes nothing.

Later that day, the doctor finds a problem and goes back into the abdomen to remove the patient's appendix. Once the doctor removes the appendix, you can’t bill for the exploratory labs unless you use modifier -59, she says.

“Any steps you take before removing something are included in the procedure, just like work on your car;” Jandroep says.

“If you have the engine worked on, you don’t expect to see on the bill that they charged you for opening the hood. They have to do that to fix the engine. It's already part of the price. That's the concept with modifier -59.”

But if you perform one procedure in the morning and then go back in the afternoon and do another, you can use the modifier, “not because it’s a different area, but because it’s done during a different session. If it’s on the same day of service, without -59, it would’ve been bundled. The second procedure wouldn’t have been paid for;” she adds.

**The last resort**

Many circumstances seem to call for modifier -59, but it should only be used when no other modifier is applicable.

“When another already established modifier is appropriate, it should be used rather than modifier -59. Only if a more descriptive modifier is not available, and the use of modifier -59 best explains the circumstances, should it be used,” according to the CPT manual.

“Modifier -59 is always the modifier of last resort,” says Stiegerwald. “It should never be used if there’s another modifier that says it better.”

Look closely at what you’re trying to convey, agrees Jandroep. “If there’s any other modifier that tells the story the provider is trying to tell, use that modifier instead. But if there’s no better way to explain that it was truly a separate procedure, then use -59.”

Know the NCCI edits

When you’re trying to decide whether to use modifier -59, ask yourself the following questions:

- Is the procedure at a separate site, injury, or lesion?
- Was the procedure performed in a separate session?

If you believe the procedures are separate, can justify your responses, and have clear documentation proving this, use modifier -59. You should be paid for separate procedures.

Keep an updated copy of the National Correct Coding Initiative (NCCI) edits handy, Stiegerwald says. The NCCI edits provide information on what procedures are bundled together and under what circumstances bundled procedures can be billed separately.

“[Billers] have to know the bundling edits and they have to know the circumstances of the surgery,” she says.

“If all the surgery was done in the same encounter, the bundling edits themselves will tell them whether this procedure can be billed out separately.”

“Most practices have NCCI edits built right into their computer billing software. The software will check [the codes] for them and give them an alert before they actually send the claim out the door;” says Jandroep.

Practices should refer to the NCCI edits before sending their claims to make sure that everything that needs to be bundled is, and that all procedures billed separately are truly separate procedures.”
Medicare hotline

AAFP survey shows more physicians declining new Medicare patients
A survey from the American Academy of Family Physicians (AAFP) revealed that almost 24% of physicians participating in the Medicare program are not accepting new fee-for-service Medicare patients. Nearly 57% percent of those not accepting the patients said the reason they stopped taking new Medicare patients was because of the small payments provided by Medicare.

Other reasons physicians gave for turning away new Medicare patients: They aren’t accepting any new patients at all or they don’t agree with or understand Medicare rules and regulations.

The number of physicians declining new Medicare patients increased 2% from 2002, a difference small enough that it could be a result of the survey’s margin of error, according to an AAFP spokesperson. Go to www.aafp.org for more information about the organization and the survey.

RAND research reveals physicians ignoring Medicare bonus offer
The Medicare bonus program, which is designed to entice physicians to practice in rural or underdeveloped areas, has not lived up to government expectations, according to a study conducted in July by RAND, a nonprofit research organization. The program allows physicians in rural areas to collect 10% more than doctors in other areas for services provided under Medicare.

Researchers have yet to determine why so few physicians have taken advantage of the opportunity for extra money. “We found that a lot of physicians who could be collecting the payments aren’t asking for them,” said researcher Lisa Shugarman. “We don’t know why. They may not be aware they qualify, the paperwork may be onerous, or they may be concerned about being audited.”

The bonus program only costs Medicare one dollar per beneficiary per month. Medicare hopes to raise the bonus to 20%, although previous attempts to do so have failed to pass through Congress. Go to www.rand.org/hot/press.03/07.08.html for more information.

AAFP offers access to benchmarking data
Physicians who belong to the American Academy of Family Physicians (AAFP) can now gain access to national benchmarking data online through their AAFP memberships. The new data will help them gauge their performance compared with physician practices of similar size, payer type, and patient mix across the country. It will also provide benchmarking data about coding.

Go to www.aafp.org/x21959.xml for more information.

Share your bright ideas
Send your “First Class Mail,” practice management, documentation, or coding ideas to TDO Associate Editor Michele Wilson.

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Back up your computer system to protect your data

The push toward paperless recordkeeping and data filing at physician practices has made backing up data more important than ever. Backing up data may seem like an obvious step, but the majority of practices don't have systems in place to do so, and most of those that do haven't tested them.

Creating backup and recovery systems—even simple ones—for your computer systems can save your data and your practice from disaster.

“A lot of outside forces are in a position to take [your data] away from you,” says Ken Nicholson, president of Systems Live, Ltd, an Illinois-based computer consulting company. It’s not just when a virus comes in and eats your hard drive or your operating system fails. Those are the two most common problems, but there are a lot of other factors that can destroy your data.”

“Unusual circumstances, such as a disgruntled employee wiping away data, can happen—even if they do occur rarely,” says Nicholson. “If you fire someone and he has access to sensitive information, it would only take him a second to make all the [data] go away, along with any backups stored in the office.”

Why haven’t physicians backed up their systems? Despite the potential consequences, many facilities don’t have a backup system in place, have one that has not been tested, or have one that staff don’t know how to use. Of five physician practices Nicholson surveyed, three had no backup or recovery systems in place, one had a system that had not been tested, and one was properly protected.

“Three were doing nothing in the sense that they didn’t have a tested system. They’d be running backup but they never ran a single restore test. They didn’t know if it worked and they didn’t know how to fix any problems,” he says.

Physicians also may not understand how vulnerable their data are. Since physicians access computer files on rare occasions, they take for granted the files will always be there, says Nicholson. “Most people have a blind spot for how vulnerable they are. It’s always something that happens to the other guy.”

What can physicians do?
Nicholson suggests the following steps to protect your important data and records:

Create and implement back-up and recovery plans. "If you don’t have a backup procedure in place, get one immediately, even if it’s the simplest kind," he says. “Some backup is better than no backup.” Start by copying critical files onto CDs or an external hard drive at regular intervals. Keep a copy outside the office, he suggests.

“The best way is often an external hard drive, which has the benefit that you can use it with more than one computer, even if the computers aren’t networked.” These simple backup methods work because almost everyone knows how to use them and those that do not can be easily trained, he adds.

Test your systems. Your systems will be useless if they don’t work or if you don’t know how to use them. Test your systems at least once a month to make sure they correctly back up and recover the data. It seems that more than half of the physician practices that employ backup systems have not tested them, according to Nicholson.

Save the original software in case of an emergency. “You need to keep the disks you originally installed software from so you can reinstall from scratch if necessary,” says Nicholson. “You’ve got to have everything you’d need to redo the installation. Good backups enable you to grow, not just recover.”

Editor’s note: Systems Live, Ltd. is a computer consulting firm based in Chicago. For information on the company and to learn about alternative backup strategies, go to www.systemslive.com.

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Manage software decisions to bolster financial outlook

By Barbara Eberly

If you want to strengthen your practice’s financial outlook, you’ll need to find solutions that will do the following:

• Eliminate labor expenses that add no value to service
• Reduce accounts receivable days and improve collections
• Improve communications
• Increase revenue

Consider the following tips to improve the business end of your practice:

Use the query and reporting power of your practice software

Author Francis Bacon once said, “Knowledge is power.” Powerful software can provide knowledge. To capture the information you need for analysis, learn everything you can about the analysis reports and queries available from your practice management software. Participate in training sessions, and share ideas, processes, and reports with other users. Let the software analyze key indicators about your practice, including the following:

• Number of no-shows you have each day
• No-show rate by provider
• Average time patients wait for an appointment
• Average time patients spend in the waiting room
• Quality of the patient demographics
• Quality of information you download from other systems
• Number of charges entered per day
• Number of copays missed
• Process for reviewing data prior to dropping claims/statements
• Number of errors
• Nature of the errors
• Rate at which errors are fixed
• Collections percentage
• Days in accounts receivable overall and by major payer

Develop additional query and reporting resources

Add key indicators specific to your practice. Check off the information you can easily obtain from your practice management software. Evaluate how you will obtain the data for the questions you didn’t check. Determine a way to capture that information because you will need to report on it.

Find the best software for your practice

Software tools such as Crystal or Cognos can greatly improve your reporting capabilities on relational databases. Monarch is an excellent tool for converting large, flat reports into useful analyses. You may have to explore several different software options before finding the one that’s right for you.
Review your needs with your software vendor
Look for software that has programs with reporting mechanisms that you do not already use. Ask vendors whether they have enhancements or custom products available.

Act on big-ticket items first
Your data analysis should tell you the areas that need the most improvement. Find creative and imaginative ways to continuously improve your practice. Don’t let the volume of work overwhelm you. Prioritize your focus by starting with the items that will pay big returns.

Create a list of no-value-added expenses
Identify areas of your practice that create additional expenses—costs that provide no value to your patients or practice, such as the following:

- Uncollected copays that cost billing staff time, postage, and forms, and reduce cash flow
- No-show patients who cost cost practices in the form of reception staff time, forms, and revenue
- Inaccurate demographics and billing errors that create duplication of work or loss of staff time and delayed cash flow

Focus on physician questions
Physicians often want information about charges and collections. Be ready to answer the following physician queries:

- How can we improve days in accounts receivable?
- How do we know whether everything is being billed?
- Why are collections so much lower than charges?
- What is being written off?

After you identify and resolve problem areas at your practice, regularly monitor the new procedures you’ve created to make sure your solutions continue to work.

Editor’s note: Eberly is the Information Technology Manager for the Central Penn Management Group in Lancaster, PA, where she helps practice managers and physicians improve their efficiency.

Factors to track
Keep the following information in check to know where your practice stands and to determine areas that need improvement:

- No-shows each day
- No-show rate by physician
- Copays missed each day/each month
- Quality of patient demographics
- Quality of charge entry information
- Nature of mistakes made at charge entry
- Person making the mistakes
- Percentage of errors caught prior to dropping claims

Source: Barbara Eberly, Central Penn Management Group. Reprinted with permission.

Illustration by Dave Harbaugh

“He’s allergic to medical records.”