



# OPHTHALMOLOGY COMPLIANCE & REIMBURSEMENT INSIDER

**JANUARY 2003**

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## Use OIG's 2003 Work Plan to Help Focus Your Ophthalmology Practice's Compliance Efforts

Overseeing the compliance efforts of a modern ophthalmology practice can seem overwhelming. With so many laws to obey and rules to follow, many things can go wrong.

Savvy compliance professionals stay on top of things by focusing their efforts on areas that represent a particular risk to their practice—that is, areas where the government is targeting its enforcement efforts.

One good way to do this is to take a careful look at the OIG's 2003 work plan. Every year the OIG—HHS's enforcement arm—publishes its work plan for the coming year. The work plan describes areas the OIG plans to focus on either because it suspects fraud in those areas or because it's interested in quantifying the potential for fraud.

Many areas in the OIG's 2003 work plan are particularly relevant to ophthalmology practices. The OIG will be looking into billing for procedures ophthalmologists perform in ASCs, private practice settings, and hospitals. We'll describe these areas so you can direct your compliance efforts accordingly.

### ASCs Come Under OIG Scrutiny

The 2003 work plan says that the OIG plans to devote some attention to ASCs in the coming year. Here are the specific issues the OIG is concerned about:

**Physician relationships with ASCs.** The OIG plans to study whether physician ownership of ASCs affects the cost and utilization of outpatient surgery. The OIG is concerned, says New York health care attorney Jay Silverman, that physicians who own ASCs may be performing more surgeries than they would otherwise—raising the possibility that Medicare is paying for unnecessary surgeries.

**IOL reimbursement to ASCs.** The OIG plans to look into whether the reimbursement Medicare pays ASCs for intraocular lenses (IOLs) is reasonable in comparison with the price ASCs pay for the IOLs. The 2003 work plan notes that Medicare paid ASCs \$120 million for IOLs in 2001.

### Physician Billing Issues on OIG Agenda

The OIG is always looking into physician billing patterns, says Silverman. Of course, every aspect of Medicare billing and compliance represents a potential risk factor for a physician practice. But certain billing problems or areas of practice seem to attract the most attention from the OIG in any one year.

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## OIG'S 2003 WORK PLAN (continued from p. 1)

Here are some of the issues the OIG says it will review in 2003. We've edited the list to include only those issues especially relevant to ophthalmology practices.

**Coding consults.** The 2003 work plan says that Medicare paid \$2 billion to physicians for consultations in 2000. The OIG plans to look into whether physicians are billing appropriately for consultations and to learn the reasons for any inappropriate billings.

**Coding E&M services.** As in past years, the OIG continues to focus on inappropriate coding of physicians' evaluation and management (E&M) services, Silverman says. The 2003 work plan mentions that the OIG will be looking for physicians with aberrant E&M coding patterns that result in higher than normal Medicare reimbursement.

**Cataract surgery comanagement.** The OIG plans to look at relationships between ophthalmologists and optometrists who comanage the pre- and post-operative courses of cataract patients. In particular, the OIG is interested in how often optometrists refer cataract patients to a particular ophthalmologist with the understanding that the patient will be referred back for post-surgical care, allowing the optometrist to share in the global surgical fee. Such an arrangement may violate the antikickback law, Silverman explains.

**"Incident to" services.** Physicians may bill for certain services provided by nonphysician health professionals on their staff as "incident to" the physician service. Medicare then pays 100 percent of the physician fee schedule amount for these services even though they've been provided by a nonphysician.

According to the 2003 work plan, the OIG suspects that some physicians are abusing the "incident to" billing rules, and has begun investigating the quality of the services provided and the appropriateness of claims for these services. This investigation will continue in the coming year.

## Billing for Procedures Performed in Hospitals

The 2003 work plan mentions several areas of hospital billing the OIG plans to study in the coming year. Ophthalmology practices that perform procedures in hospitals should be aware of these matters, says Silverman. That way, the ophthalmologists can be sensitive to OIG concerns that could affect the hospitals where they work.

Here are some of the areas the OIG plans to examine in 2003. Again, we've only listed those areas that are especially relevant to ophthalmology practices:

**Efforts to prevent clerical errors.** According to the 2003 work plan, clerical billing errors lead to significant overpayments to hospitals and other institutional providers. The OIG has been concerned with this problem for some time. In 2003 it plans to revisit the issue and analyze how successful fiscal intermediaries and hospitals have been in preventing and correcting it.

**OPPS.** The OIG plans to review hospital outpatient departments' imple-

mentation of the outpatient prospective payment system (OPPS). The 2003 work plan specifically mentions that the OIG will evaluate the effectiveness of controls designed to ensure that services are adequately documented, properly coded, and medically necessary.

Silverman says that the OIG also plans to look carefully at “pass-through” reimbursement, which allows hospital outpatient departments to bill separately for certain costly supplies and drugs.

**Procedure coding.** In the past, the OIG has looked into discrepancies between the way a physician and a hospital code the same procedure performed on a hospital patient. The OIG plans to revisit this issue in the coming year to determine and, if necessary, quantify any existing significant discrepancies.

The OIG also plans to analyze whether the OPPS system has helped alleviate the problem of coding discrepancies in procedures performed on hospital patients. If it hasn't, the OIG plans to examine how the OPPS system might be improved.

### Making OIG Work Plan Work for You

Obviously, many areas of compliance aren't mentioned in the 2003 work plan, and you must still consider them. By now every prudent physician practice will have adopted a voluntary compliance plan to provide structure and focus to its compliance efforts.

That compliance plan should include regular coding and billing audits, and periodic legal audits, to ensure that the practice's agreements with referral sources, vendors, independent contractors, and others are legally acceptable.

But you can and should use the work plan to help your practice concentrate its compliance efforts most effectively, Silverman says. It makes sense for an ophthalmology practice to get familiar with the areas the OIG intends to target and then make sure those areas of the practice are above reproach. Let your ophthalmologists and billing personnel know what issues mentioned in the work plan could affect your practice. For example:

- If you've got an ASC, make sure that the relationship between the ASC and its owner-physicians complies with the antikickback law, Silverman cautions. And tell your ophthalmologists about the OIG's concern that physician-

owners may be performing unnecessary surgeries at ASCs. That way, they can make any necessary adjustments in their practice, such as more carefully documenting medical necessity.

- If your practice often enters into comangement arrangements with optometrists, have your attorney review these arrangements to ensure that you aren't risking antikickback charges, Silverman suggests.

- Make sure all your ophthalmologists and coding staff are knowledgeable about coding consults and E&M services. You might even want to conduct an internal audit to be sure your practice is billing for these services correctly.

**Insider Says:** You can get the entire OIG 2003 work plan from the OIG's Web site at <http://oig.hhs.gov>. Click on “Publications,” then on “Workplan.” From there you can look at the table of contents and download the sections of the work plan that interest you. Or go to [www.brownstone.com](http://www.brownstone.com) and click on the “Free download” button, on the left side of the screen. ■

#### Insider Source

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## Recent Reg Changes Clarify When Incidental Uses and Disclosures Are Permitted

When the HIPAA privacy regulations first came out, there was a lot of confusion over whether protected health information (PHI) could be used or disclosed in emergency rooms, waiting rooms, and other semi-private areas, where it was likely to be overheard or seen by outsiders. Recent changes to the regulations have clarified that, subject to some conditions,

these uses and disclosures—called “incidental uses and disclosures”—of PHI are permitted.

The changes were published in the Aug. 14, 2002, *Federal Register*. According to the preamble to the changes, HHS added the clarification so that communications essential to providing quality health care would continue to be allowed. We'll explain

what incidental uses and disclosures are and tell you what the HIPAA privacy regulations now require.

### What's an Incidental Use or Disclosure?

According to the HIPAA privacy regulations, an incidental use or disclosure of PHI “would be a secondary

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**RECENT REG CHANGES** (continued from p. 3)

use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.” For example, emergency room physicians often treat patients in joint treatment rooms that are separated only by partitions or curtains. As a result, the PHI that’s discussed with one patient may unavoidably be overheard by another patient. The recent changes to the privacy regulations say that this disclosure would be a permissible incidental disclosure.

Here are some examples of situations in which an incidental disclosure may occur:

- Discussion of a patient, held at a nursing station, that might be overheard by personnel not involved in the patient’s care;
  - The use of joint treatment areas;
  - The use of sign-in sheets and the calling out of names in waiting areas; and
- Discussion of a patient’s condition, held during training rounds.

**When Are Incidental Uses and Disclosures Permitted?**

According to the HIPAA privacy regulations, an incidental use or disclosure is permissible when all three of the following conditions have been met:

**1) The use or disclosure is “incidental to” a permitted use or disclosure.** That is, the use or disclosure is made as a by-product of a use or disclosure that’s permitted or required by the HIPAA privacy regulations.

*Example:* A patient’s PHI is discussed for treatment purposes by two nurses at a nurses’ station. A snippet of that discussion is overheard by a passerby. Since the conversation itself is a permitted disclosure of PHI for

treatment purposes, this is an incidental disclosure.

**2) Reasonable safeguards have been applied.** The organization must have already taken reasonable steps to safeguard PHI from unnecessary disclosures.

*Example:* In the circumstance given in the example above, the hospital must have previously implemented adequate safeguards to protect PHI at the nurses’ station so that incidental disclosures would be minimized. For instance, it may have advised staff to speak softly in areas that may be accessible to visitors.

Other safeguards that could be implemented to prevent incidental disclosures might include adjusting computer monitors so that they’re out of view, requiring staff to keep documents containing PHI in covered folders or file cabinets, and locating fax machines and printers away from high-traffic areas.

**3) The minimum necessary standard has been implemented (where applicable).** The organization must make reasonable efforts to limit the use and disclosure of PHI to the minimum amount of information necessary to accomplish the purpose of the use or

disclosure. This is known as HIPAA’s “minimum necessary standard.”

*Example:* To comply with the minimum necessary standard, an ambulatory surgery center adopts a policy or policies granting its nontreating personnel (such as reception staff) very limited access to PHI (such as restricting access to a patient’s name, admission date, and physician’s name).

**Can an Incidental Use or Disclosure Violate HIPAA?**

Yes. Even if a use or disclosure is incidental, it isn’t permitted and may violate the privacy regulations if an organization fails to either adopt reasonable safeguards or implement the minimum necessary standard.

*Example:* A medical office has its computer screens facing the reception area, in plain view of its patients. A patient waiting in the reception area easily views the test results of another patient. Since the medical office failed to implement reasonable safeguards (such as relocating the computers or using screen covers or screen savers), the disclosure of the patient’s test results would very likely be a HIPAA privacy violation. ■

**► Must an Accounting to Patient Include Incidental Disclosures?**

The HIPAA privacy regulations give patients the right to request and get an accounting of the disclosures a health care organization has made of their PHI. The recent changes clarify that incidental disclosures of PHI don’t have to be included in a patient’s accounting of disclosures. Although this situation wasn’t addressed when the recent changes to the HIPAA privacy regulations were first proposed in March 2002, it was added to the final version of those changes that appeared on Aug. 14, 2002.

In the preamble to the recent changes, HHS explains that incidental disclosures are often unknown at the time they occur. So it’s impractical to require their inclusion in an accounting. HHS also points out that incidental disclosures are most often made as part of a permitted disclosure, and organizations don’t include permitted disclosures in an accounting.

## NEGOTIATING TIPS

### Use Customized Checklist to Negotiate Contracts

It's easy for practices to approach their negotiations with plans in a way that undermines their chances of getting a better contract. They may rely on memory and mental checklists to review the contract and so run the risk of forgetting to raise important issues. Or they may depend on a written checklist that doesn't give them the advantages it should. For instance, they use a cookie-cutter checklist they got at a seminar, which probably has items that don't apply and lacks others that are needed. The results are contract negotiations that are more difficult and less organized than they should be, and inconsistent contracts that aren't as favorable as they should be, warns Michigan consultant David Ruppert.

This doesn't have to happen to you, experts say. Invest a little time and develop a customized checklist that's tailored to the needs of your facility, practice, or provider organization. We'll tell you how to do it.

#### Cover All Points that Matter for You

Creating and using a customized checklist forces you to look at more than just the fees and helps to ensure that you won't overlook important negotiating points, explains Michigan attorney Kathrin E. Kudner. "Even experienced negotiators can miss things, especially at the end of negotiations, when everyone is tired," she points out. Using a customized checklist allows you to quickly decide whether to pursue an issue or suggest a fallback position. "It creates a discipline to contracting, which makes your negotiating as a whole more organized and your contracts more consistent," adds Debbie Welle-Powell, head of managed care for a Colorado health system.

"Once you've developed a customized checklist, it expedites your negotiating," says Kudner. "Even if you don't negotiate everything on the checklist, you'll still be more familiar with the contract than if you hadn't gone through the exercise of reviewing it against the checklist, and you can better assess whether you should sign the contract," notes Ruppert.

A customized checklist is also useful because it helps you address your individual contracting situation. "An urban practice has different needs and priorities from a rural practice," says Ruppert. For instance, if it's important for your contracts to require the plan to list you in its provider directory, make sure your checklist includes that. Different practices will have different "ideal" clauses, acceptable fallback positions, and deal-breakers.

#### Take Four Steps to Create Checklist

To develop a customized checklist from which to negotiate your plan contracts, start with whatever checklist you already use. If you don't have a written checklist, get a basic, commercial checklist from a managed care contracting handbook or seminar so that you're not starting from scratch, suggests Kudner. Then you (or one or more individuals from your staff, or an outside consultant you hire) can take the following four steps:

**Step #1: Assess your needs.** First, decide what's important for you to have or remove from plan contracts. For instance, if your practice has an ASC, you'll need to include contract provisions relating to that. Or you may feel strongly about deleting certain types of indemnification clauses

from contracts. One important part of your assessment should be a review of your existing contracts for clauses you've found helpful or troublesome.

Also, determine your ideal and fallback positions for all of these issues. "This will give you maximum flexibility and an ability to react quickly during negotiations," says Ruppert.

**Step #2: Remove unnecessary items from basic list.** Once you understand your needs, it's time to review the basic checklist. Begin by deleting items that don't apply or that you don't need. For example, if you don't have any capitation contracts, you don't need those checklist items. "Including irrelevant items only makes your checklist longer and gets you in the habit of skipping items," warns Ruppert. And if you later find that you need deleted items, you can always put them back.

**Step #3: Add items that meet your individualized needs.** Next, add items that the basic checklist doesn't cover but that you've decided you need. And note any ideal and fallback positions for these additional items, as well as for items already on the basic checklist.

Also, be sure to make any additions to the checklist to reflect state laws that may affect your contract but that the plan may not be aware of, says Ruppert. "For instance, if your state law limits the amount of insurance you need, you want to make sure you don't forget to point that out to the plan and get the contract's insurance requirement to be no greater than the state requirement," he notes.

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**NEGOTIATING TIPS** (continued from p. 5)

**Step #4: Anticipate preferences for contract renewals.** Make sure your customized checklist is usable whether you're negotiating a first-time contract with a plan, a renewal contract, or an amendment. For example, your provider organization may insist on a volume guarantee in a new contract but be willing to drop it for a renewal contract. When renewing, you already have a history with the plan and may prefer to trade the guarantee for higher overall rates. If so, make sure that this preference is in

your checklist so you don't forget about it, advises Kudner.

You can do this by creating a renewal section in your checklist, a separate renewal version of the checklist, or any other way that works for you. "With these changes to the basic checklist, "you'll end up with a practical tool that you'll appreciate using," notes Kudner.

**Insider Says:** Once you've developed a customized checklist, be prepared to update it as necessary. "It's a living document and may need to be refined occasionally," notes Ruppert.

So if your state passes a law that changes how to safeguard patient records, for example, you'll want to make sure that the change is covered in your checklist so it can be included in your contracts. ■

**Insider Sources**

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**Debbie Welle-Powell:** Senior Director, Managed Care and Network Operations, Exempla Healthcare, 600 Grant St., Ste. 700, Denver, CO 80203; (303) 425-8602.

## Take Four Steps to Deal with Bounced Checks

From time to time every practice gets a patient's check returned to it because of, say, insufficient or unavailable funds. In other words, the check bounces. If this happens a lot, it can lead to disruptions in your cash flow. But the more serious issue is the administrative burden of collecting the money the patient owes, without alienating him.

Dealing with bounced checks effectively but tactfully can be difficult, but it's easier if you take four simple steps. We'll tell you what those steps are and give you a Model Policy (see box, at right) that you can post to tell your patients what you'll charge them for a bad check. Plus we'll give you a Model Letter (see p. 7) that you can adapt and send to patients who pass you bad checks.

### Step #1: Learn Your State's Law

Your state law governs how you may handle bounced checks, says New York City health care attorney Matthew Kupferberg. Some states allow you to collect a certain amount more than the value of the check if it bounces. Some states require you to give the writer of the check a set

amount of time to make the check good before you can charge any penalty. But all states allow you to collect the face value of the check plus any fees your bank charged you, Kupferberg says. And many states allow you to charge an additional penalty for your inconvenience.

### Step #2: Set Policy and Post It

Establish a policy about how much you're going to charge patients who write you bad checks, Kupferberg advises. You definitely want to

recoup your costs, and you may also want to impose a penalty consistent with your state's law. But for the sake of good patient relations, it's probably a bad idea to charge the maximum penalty the law allows for bad checks—assuming that your state lets you charge a penalty. You want to discourage patients from writing bad checks, but you don't want to lose their business entirely.

Many practices redeposit a returned check once and will contact a patient only if the check bounces a second time. But since your bank may charge

#### MODEL POLICY

### Post Notice to Patients About Bad Check Policy

Collecting on a bad check is easier if the patient knows ahead of time what will happen to him if his check is returned to you unpaid. The simplest method of notifying patients about your policy is to post the policy in the reception area and print it on patient

receipts. But be sure to find out what your rights are under state law before you develop your policy, health care attorney Matthew Kupferberg suggests. Then make a sign, similar to the one below, stating your practice's policy regarding personal checks.

#### XYZ OPHTHALMOLOGY CHECK POLICY

We are happy to accept your payment by personal check, but please note that there will be a charge of \$30 for all returned checks.

you each time a check you deposited is returned unpaid, you may not want to do this. Patients may ask you to redeposit a returned check, so if you decide not to redeposit checks that bounced once, make this clear up front in your office policy.

Your policy needn't be a long, involved document. A simple one- or two-sentence statement like our Model Policy will do. Be sure to post it prominently in your reception area so that any patient who writes you a check can see it. You might also want to print your policy along the bottom of the receipts you give your patients, Kupferberg suggests. This lets patients know that your office has a method of dealing with bad checks. So they're less likely to feel that you're singling them out if you pursue them for extra fees and penalties. Plus letting patients know the consequences of writing a bad check may discourage them from doing it in the first place.

### Step #3: Send Letter

When your practice gets a check that bounces, deal with it immediately and in writing. This helps protect your rights, since you can prove that you tried to collect the check. Plus many patients will get defensive or embarrassed if confronted about a bounced check in person or on the phone, so a letter is also more tactful.

Send the patient a polite but firm letter letting him know that his check bounced and he needs to make it good immediately. Like our Model Letter (see box, at right), your letter should:

- Include information identifying the check—such as the date of the check, the check number, and the amount of the check;
- Inform your patient that the check he wrote your practice has been returned, and give the reason for its return (such as insufficient funds);

- Explain your practice's returned check policy;

- Demand the full amount that your practice's policy entitles you to demand;

- Set a reasonable amount of time for the patient to respond to the demand—say, 10 business days from the date of the letter;

- Ask for the payment in cash, money order, or certified check so that you don't just get another worthless check; and

- Explain the consequences if the patient doesn't respond within the time set. For example, in our Model Letter we let the patient know that we'll turn the matter over to a collection agency if we don't get full payment immediately. And we let the patient know that it will cost him more if he allows the check to be turned over to a collection agency.

### Step #4: Follow Up

Once you've sent the letter, someone on your office staff should keep track of the patient's account. After the time frame set in the letter has elapsed, follow up in accordance with the letter, Kupferberg says. Empty threats won't do you any good and won't relieve your staff of the administrative burden of dealing with bad checks. So if the letter says you'll send the check to a collection agency, do it, Kupferberg urges. And make a note in the patient's chart not to accept checks from him in the future. ■

#### Insider Source

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## MODEL LETTER

### Send Letter to Patient Who Bounces Check

Here's a Model Letter that you can adapt to reflect your office's bounced check policy and send to a patient whose check has bounced. Be sure to make a note of the date

you sent the letter so that you can follow up at the appropriate time. And you may want to make a note in the patient's file not to accept checks from him in the future.

[Insert date]

John Doe  
123 Fourth Ave.  
Megalopolis, USA 98765

Dear Mr. Doe:

Your check, number [insert #], dated [insert date], in the amount of \$[insert amount], was returned to us unpaid for [insert reason, e.g., insufficient funds].

In accordance with state law, and pursuant to our policy posted in our office, our practice charges a returned check fee of \$[insert amount] for each returned check.

Accordingly, kindly remit to this office \$[insert amount of check plus fee] by [insert date, e.g., within 10 days of the date of this letter]. Payment must be made in cash, by money order, or by certified check.

If we do not receive payment by [insert the date stated immediately above], we will forward your account to our collection agency. Please be advised that should your account be sent to collection, you will be charged an additional fee to cover our collection costs.

Thank you for your immediate attention to this matter.

Yours truly,  
Jane Roe  
Accounts Receivable Manager

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