THE AMERICAN SOCIETY OF INTERNAL MEDICINE

STATEMENT TO THE

PRACTICING PHYSICIAN ADVISORY COUNCIL

DECEMBER 16, 1996

The American Society of Internal Medicine (ASIM), representing the nation's largest medical specialty, is pleased to provide the following testimony to the Practicing Physicians Advisory Council (PPAC) on the implications of the Health Insurance Portability and Accountability Act of 1996 for the Medicare and Medicaid programs and on establishing a standard identifier for health care provider regulations.

IMPLICATIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 FOR THE MEDICARE AND MEDICAID PROGRAMS

The fraud and abuse and the administrative simplification provisions included in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 will have a significant impact on the Medicare and Medicaid programs. ASIM has concerns about how the implementation of these provisions will affect physicians and their patients. The Department of Health and Human Services (HHS), one of the agencies charged with implementing the fraud and abuse provisions of the HIPPA, must be careful not to create unintended problems for law-abiding physicians that are ably serving this nation's elderly.

Fraud and Abuse Provisions

ASIM has identified five provisions of the fraud and abuse section of the HIPPA that have the potential to unintentionally harm honest physicians and their patients. These provisions are: (1) preauthorization of certain high cost durable medical equipment; (2) sanctions for improper coding; (3) penalties for falsely authorizing home health services; (4) creation of "black box" coding edit systems; and (5) methods of investigation.

Preauthorization of certain high cost durable medical equipment

The HIPPA authorizes HHS to develop a list of durable medical equipment (DME) that must receive prior authorization from regional DME Medicare carriers. ASIM supports giving HHS authority to create such a list in order to target potential fraud and abuse in the utilization of high cost durable medical equipment, but only if this process does not result in delays in obtaining medically necessary services or an increase in the administrative burden placed upon physicians. Physicians should not be forced to provide more information than is required on the present forms and prescriptions. The DME supplier should have the responsibility of submitting certain record copies to the preauthorization entity since it is the DME supplier that provides the equipment and is reimbursed for it. It should be the supplier's responsibility to obtain copies of records from the hospital, or from the physician chart if necessary. The supplier should also be obligated to pay a reasonable fee if physician office records must be retrieved and copied for the supplier's records. DME preauthorization requirements that unduly burden physicians have the potential to discourage physicians from getting involved in DME prescription decisions.

HHS must also be careful not to create an unnecessary burden for patients waiting to receive DME equipment that requires preauthorization. A patient should not be unnecessarily detained in the hospital or a skilled nursing facility waiting for authorization of certain durable medical equipment needed to support the patient in the home setting. If preauthorization cannot be handled quickly and efficiently it is

likely that delays will increase costs to the Medicare program rather than reduce costs since hospital stays and inpatient stays at other facilities will be unnecessarily prolonged.

ASIM recommends that PPAC advise HHS to: (1) avoid forcing physicians to provide more information than is required on the present forms; (2) make the DME supplier responsible for submitting copies of records to the authorizing entity; (3) make the supplier responsible for obtaining records, if necessary, from hospitals and physicians; (4) make the supplier pay a reasonable fee to the physician's office if patient records need to be copied for the suppliers records; and (5) avoid unnecessarily confining patients in need of home health to inpatient settings while waiting for authorization of medically necessary DME.

Sanctions for improper coding

The HIPPA states that a physician can be sanctioned for improper coding only if he or she "acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of the information." Issues that involve one-level code discrepancies or minor differences of opinion between the physician billing for a service and the Medicare reviewer should not be the target of the sanctions under this provision of the law. ASIM has received many questions and calls of concern from law-abiding physicians that code for their services appropriately, but are concerned that a minor difference of opinion regarding the coding level of an evaluation and management (E/M) service could impose sanctions under this law.

ASIM reminds HHS that mechanisms are already in place to scrutinize claims for the appropriateness of the level of service billed. These mechanisms, such as claim-by-claim review and the post payment utilization review process, will continue to be used to identify aberrant billing patterns, to educate physicians on how to code correctly, and, if necessary, to recoup monies that result from what are determined to be overpayments. An Office of Inspector General (OIG) investigation of improper coding should only take place if an unexplainable aberrant billing pattern, which exceeds an acceptable standard deviation, persists after all other corrective actions have failed.

There are factors that the OIG should consider before initiating an investigation into a physician's coding practice. ASIM contends that true outliers can be identified only by comparing the billing patterns of physicians in the same specialty, after an adjustment for severity of illness based on patient case-mix is made. Because internists typically have a more complex mix of patients than family physicians and other primary care physicians, it can be expected that most internists will appropriately bill for more higher level visits than colleagues in other specialties. Also, simply because a physician is identified as an outlier does not mean that the physician is coding inappropriately. An internist who frequently treats elderly patients with multiple disorders may be justified in consistently billing for high level office visits. Aberrant billing patterns can also be attributed to a poor understanding of Current Procedural Terminology (CPT) codes and documentation requirements. An outlier physician should be contacted and given the opportunity to provide an explanation of his or her billing practices before an investigation actually takes place. Problems that occur because of misunderstanding of coding protocols and documentation requests are correctable and do not constitute deliberate ignorance or reckless disregard for the truth. Formal incorporation of all these factors into the process the OIG uses to determine who will be investigated for potential fraud and abuse violations will guarantee efficient use of the OIG's resources by ensuring that only physicians with a high probability of engaging in fraudulent activities--which is the intent of Congress--are investigated.

After considering the above factors, if the OIG decides that an investigation is necessary it must then prove that the physician acted with deliberate ignorance or reckless disregard for the truth. A review of patient records that demonstrates a lack of compliance with documentation requirements is not enough

to warrant sanctions. Evidence must show that a physician blatantly intended to defraud or abuse the program. Investigations should be conducted in a way that is least intrusive on a physician's practice and least disruptive to patient care.

ASIM reiterates that an OIG investigation into the billing practice of a physicians should not be initiated unless an unexplainable aberrant billing pattern persists after all corrective actions have failed. ASIM urges PPAC to advise HHS that there are several factors that the OIG should consider before beginning any investigation. These factors are that: (1) true outliers can only be determined by comparing billing patterns of physicians in the same specialty, after an adjustment for severity of patient illness is incorporated; (2) a physician identified as an outlier is not necessarily coding inappropriately; and (3) aberrant billing patterns can result from poor physician understanding of CPT codes and documentation requirements, problems that do not strictly translate into sanctionable offenses.

If the OIG decides to investigate, HHS should consider certain factors after the inquiry begins. These factors are that: (1) inadequate documentation, alone, does not warrant sanctions; (2) evidence must exist that the physician demonstrated deliberate intent to defraud or abuse the program; and (3) the physical investigation should be conducted with minimal disruption to the physician's practice.

Penalties for falsely authorizing home health services

One potential area of abuse in the provision of home health involves home health agencies that seek retrospective authorization. In such instances, the home health agency may have provided services without verbal or written authorization of the physician and then weeks or months later asks for the physician's authorization signature. The patient's family is aware that they will have to pay these costs out of pocket if the physician does not sign the authorization form so they encourage the physician to authorize the service. If it is the home health agency is abusing the system then the beneficiary should not be held responsible. If a physician signs a form which states "I only authorized an initial evaluation and 2 follow-ups" and the home health agency provided 12 visits by 4 different types of practitioners, then the agency should be held responsible for the additional costs. More importantly, the Health Care Financing Administration (HCFA) should look at the way home health agencies inform and document the approval of beneficiaries for non-covered home health services to avoid the common home health abuse that occurs when the home health agency indicates to patient or patient's family that a service will be covered, or the physician can authorize a services, and the service is provided before the physician is informed.

Internists are also concerned that the sanctions for "falsely" certifying home health claims could result in the OIG investigating physicians for authorizing the provision of home health services when there was no intent on the physician's behalf to defraud, abuse, or mislead the program. Physicians often receive multiple requests in a single day from home health agencies to authorize services for patients that have been under the physician's care, even though the physician often does not have the clinical information needed or the time required to personally evaluate the patient in order to determine if such services are needed. In such cases, the physician will often agree to authorizing the services, on the assumption that the information provided by the agency is proper and correct. Even if it is subsequently determined that the services that were authorized were not medically indicated, this would not constitute intentional falsification of the home health claim. Investigations into falsification of home health services should occur only if there is a compelling reason to believe that the physician has deliberately agreed to authorize home health services that he or she knows are not medically indicated. If the OIG adopts a lesser threshold for investigation of home health services, the result will be unjustified harassment of honest physicians. This would ultimately discourage physicians from authorizing any home health services, even those that are medically appropriate, leading to higher costs as patients are treated in more costly institutional settings.

Rather than threatening physicians with investigations into their home health authorizations, HHS--through HCFA--would be well advised to correct the factors that now discourage physicians from spending the time required to critically scrutinize the services provided by home health agencies. HCFA should consider ASIM's recommendation that Medicare should allow physicians to use their own nursing staff to treat homebound patients. This approach would be far more effective in reducing excessive home health services than intensified fraud and abuse investigations.

ASIM requests that PPAC advise HHS to: (1) hold the home health agency, not the physician or the patient, liable if the home health agency performs services beyond what the ordering physician authorizes; (2) shift its focus toward looking at how home health agencies document the approval of beneficiaries for non-covered home health services that are provided without knowledge of the physician in order to truly identify the source of home health fraud; and (3) recognize that the only feasible way for physicians to handle home health authorization requests--considering the volume of requests they receive--is to rely on the information that is provided by the home health agency. ASIM urges PPAC to advise HHS that the OIG must have compelling evidence to illustrate that the physician deliberately authorized unnecessary home health services before the physician is penalized.

Creation of "black box" coding edit systems

ASIM strongly opposes the creation of "black box" coding edit systems. It is our understanding that the HIPPA would allow HHS to implement coding edit systems without allowing physicians to review the edits. Such a closed system is totally inappropriate. The Medicare correct coding initiative demonstrates the problem of a closed system. ASIM and other medical organizations were able to identify numerous inappropriate coding edits in the Medicare correct coding system because it was available for public review. Many of these inappropriate proposed edits were later retracted or altered. The end result is that the system will be better because it had been appropriately peer reviewed. If the correct coding initiative was a closed system, then many inappropriate edits would have remained, which would have denied payment for appropriately provided services. HHS should use the maximum discretion allowed by the law to minimize the use of black box editing. Where this type of editing system is mandated by law, an arrangement should be worked out to allow practicing physicians the ability to review edits that are developed by commercial contractors, including those that are proprietary products.

ASIM urges PPAC to advise HHS to: (1) learn from, emulate, and improve the review process utilized in HCFA's correct coding initiative; (2) only incorporate black box edit systems to the extent that it is mandated by law; and (3) ensure that even when the law stipulates their use, that all edits--including proprietary products--be subjected to review by practicing physicians.

Methods of investigation

ASIM is also concerned with the potential methods of investigation that may occur based upon new fraud and abuse initiatives as a result of the HIPPA. The following investigative methods must be prohibited or restricted to cases where the apparent offense is so egregious or likely criminally fraudulent that "assault methods" are needed to capture evidence or put a quick stop to problems. The methods that HHS should restrict are: (1) unannounced entry to the medical office and disruption of work hours or unauthorized entry after hours; (2) wholesale removal of patient medical records and financial records, and seizures of computers and software; and (3) the imposition of costs on physicians for copying large numbers of records.

The OIG should not use the threat of civil monetary penalties to coerce law-abiding physicians who are unlikely to face actual sanctions into "negotiated" settlements. Physicians contacting ASIM express

concern that they will be threatened with choosing between paying the government $10,000 in a negotiated settlement so that HHS will drop the matter or risk further intrusive investigations, even though no sanctionable offense is likely to be found. Negotiated settlements should be available to physicians who wish to avoid further investigations and possible sanctions, but the OIG under no circumstances should pressure physicians into agreeing to a settlement.

Administrative Simplification Provisions

ASIM supports the goal of the administrative simplification provisions included in the HIPPA. ASIM is encouraged that the administrative simplification standards are intended to improve the efficiency of the health care delivery system in the both the public and private sectors. The provisions are expected to encourage the development of a health information system by establishing standards and requirements for the electronic exchange of certain health information, resulting in increased administrative efficiency for Medicare and all other federal health programs. However, ASIM does have several concerns with the implementation of this program that are discussed below.

The HIPPA creates a mandatory national framework for exchanging and storing patient data in a standardized format, by requiring the Secretary of HHS to publicize standards for processing medical information by February 21, 1998. The law also provides for a formal consultative role for the National Uniform Claims Committee (NUCC). The Secretary of HHS is to consult with the NUCC, which is chaired by the American Medical Association (AMA) to developed the electronic standards for financial and administrative transactions between physicians and health plans. Considering that the NUCC represents organized medicine in the development of these standards, HHS should strongly consider the recommendations of the NUCC and incorporate the NUCC's suggestions into the final standards. Since physicians are responsible for submitting claims on behalf of Medicare patients, while being required to shoulder an increasing portion of this responsibility for patients that are covered by private sector plans, the development of a standardized claim form for claims submission and encounter information (as well as other related data) should be done in close consultation with physicians.

HCFA already requires that physicians who submit Medicare claims electronically use one of two standard formats. HCFA currently provides the software that is necessary for physicians to convert their billing systems to these standard formats for little or no cost. After HHS decides and publicizes a standardized electronic format as mandated by the HIPPA, HHS should assist physicians in conforming to the new requirements. HCFA should continue to provide software and technical assistance to physicians for little or no cost. ASIM is concerned that the appearance of constant changes in the requirements for electronic claims submission in the Medicare program alone, as slight as those changes may be, will cause confusion among physicians and will hinder their efforts at compliance. HHS should provide sufficient education to physicians to assure that they are aware of the requirements and to guarantee that they are equipped to adhere to them.

Even though ASIM supports the current requirement that physicians who submit Medicare claims electronically use standard formats, ASIM policy states that physicians should maintain the option of submitting paper claims and that HCFA should eliminate the punitive reimbursement delay for nonelectronic claims submission. ASIM is pleased that the option of submitting paper claims to a claims processing clearinghouse was included in the HIPPA and encourages HHS to ensure that this right is not infringed upon in the future.

The HIPPA also requires that the transmission of health information maintain reasonable and appropriate, technical and physical safeguards to ensure the integrity and confidentiality of the information, and to protect against threats to security of the information. The issue of confidentiality and liability of medical information is of great concern to physicians. HHS should seek the input of practicing

physicians when developing the recommendations for protecting the privacy of individually identifiable health data that the Secretary of HHS is required by law to submit to Congress by August 21, 1997. If Congress fails to enact legislation by August 21, 1999, the Secretary of HHS is required to publicize final regulations containing these safeguards. Subsequently, the Secretary should also incorporate the concerns of physicians into a final rule if it becomes necessary for HHS to take such action.

ASIM policy on the electronic exchange of medical information, adopted by the 1996 House of Delegates, states that ASIM:

> *"support the adoption of measures to preserve confidentiality of individual medical information in the electronic collection, storage, retrieval and exchange of such information. Such steps could include identification of those with access to information, audits of persons with access to the data and specific clauses in contracts between health plans and third party electronic data management entities requiring the protection of medical record confidentiality.*

ASIM policy on confidentiality of medical records, adopted by the 1996 House of Delegates, is included at the end of this testimony under the heading **"ATTACHMENT A"**.

ASIM urges PPAC to advise HHS to: (1) appropriately consider the recommendations of the NUCC when determining a standardized electronic format; (2) assist physicians in converting to the newly defined requirements by continuing to provide software and technical assistance for little or no cost; (3) provide sufficient education to physicians to assure that they are aware of the requirements and to guarantee that they are equipped to adhere to them; and (4) solicit input from practicing physicians on the development of recommendations to Congress and/or the formation of the actual regulations concerning the protection of individually identifiable health data.

Full implementation of the administrative simplification provisions of the HIPPA will take years to accomplish. With much of the work yet to be done, it is imperative that physicians continue to be represented in the development of standards for electronic exchange of data, standards for a unique identifier for health care providers, and the development of physical and technical safeguards to ensure the integrity and confidentiality of information that is exchanged electronically.

ESTABLISHING A STANDARD IDENTIFIER FOR HEALTH CARE PROVIDERS REGULATION

ASIM commends HCFA for its decision to present the National Provider Identifier (NPI) project in the form of a notice of proposed rulemaking (NPRM). ASIM realizes that HCFA's plan to begin the assignment of NPIs to providers was delayed by the passage of the HIPPA. Outlining the specifications of the NPI project in a NPRM is important so that the comments from interested parties and the requirements imposed by the administrative simplification provisions of the HIPPA can be incorporated simultaneously into a final rule.

Although the NPRM has yet to be released, ASIM has been an active participant in the development of the NPI project and has an idea as to what will be included in the NPRM. ASIM is pleased that HCFA has moved from a "pay and chase" mentality to one that focuses its efforts on controlling provider entry into the Medicare program by ensuring that unqualified, fraudulent or excluded providers and/or suppliers do not bill the Medicare program.

ASIM supports the NPI project's goal to establish and maintain a comprehensive and unique number for health provider identification. Many of ASIM's concerns with HCFA's proposals for the development and

implementation of NPI have already been addressed by HCFA. ASIM commends HCFA's decision to streamline the Medicare Provider/Supplier Enrollment application. Shortening the length of the form--and making some of the more problematic sections optional--results in an application that is less burdensome for physicians to complete. ASIM is also pleased with HCFA's decision to eliminate the requirement that physicians have their applications notarized. ASIM remains concerned, however, that HCFA will utilize this application as a means of collecting redundant credentialing information. This new professional verification method is unnecessary since this physician information is currently available from other sources. The AMA's Masterfile provides the physician credentialing information sought in the proposed form. It should be noted that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently announced the acceptance of the AMA Masterfile as a primary source of verified physician information for its credentialing process.

ASIM advises HCFA to work with the AMA to develop a system through which physician credentialing information from its Masterfile would be accessible to HCFA, when appropriate. ASIM recommends that HCFA remain committed to allowing adequate time for provider education and training to ensure a smooth transition to the NPI system. ASIM agrees with HCFA that it is prudent to establish a link from old enumeration systems, such as the Unique Physician Identification Number (UPIN), to NPIs. Even though it is likely that providers will be afforded time to make the transition to NPIs, it is appropriate to equip payers with the means to link old UPINs to new NPIs for a specified period of time after the use of NPIs is mandated. ASIM asks that HCFA remain firm in its plans to establish "crosswalks" as a way to minimize disruptions associated with the processing of claims.

ASIM suggests that PPAC advise HCFA to ensure that the improvements made in the earlier stages of NPI development are retained and that ASIM's recommendations are included in the NPI NPRM. ASIM recommends that HCFA: (1) work with the AMA to obtain credentialing information through the AMA's Masterfile; (2) allow for adequate physician education and training during the implementation of the NPI project; and (3) remain firm in its plans to establish a "crosswalk" to link enumeration systems after the use of NPIs is mandatory.

ASIM thanks PPAC for the opportunity to comment on the implications for the Medicare and Medicaid programs of the Health Insurance Portability and Accountability Act of 1996 and the establishing a standard identifier for health care provider regulations.

ATTACHMENT A – ASIM POLICY ON CONFIDENTIALITY OF MEDICAL RECORDS (HoD 1996)

1. The House of Delegates expresses its support for adoption of uniform national standards to protect the confidentiality of patient medical records, for delineation of rules under which disclosures of protected health information should take place, for adoption of reasonable security measures by third parties that are granted access to patient health care information and for application of appropriate sanctions when confidentiality is breached.

2. The House of Delegates urges that any legislation to establish uniform standards to protect the confidentiality of medical records by consistent with the following principles:

   a. An exemption from the preemption of state confidentiality statutes should be provided for those state laws that preserve confidentiality of quality information garnered through the peer review process. Protection from discoverability must be maintained.

   b. Provisions governing correction or amendment of protected health information should require trustees only to inform patients who disagree with information in their records that they may submit a written statement of disagreement, clarification or rebuttal of that information for inclusion in their records. Such legislation should not impose detailed and burdensome requirements on trustees relating to subsequent notification of other parties who had received the uncorrected information; explanation of the reasons for not making a requested change in the record and; notification of procedures for further review of any refusal to modify a record.

   c. The law should provide a sufficient time frame -- e.g. two years -- for promulgation of implementing regulations with appropriate opportunities for public comment.

   d. The law should establish different levels of sanctions: a lower level that is applicable to inadvertent disclosures of information and a high level of sanctions applicable to willful, malicious disclosures.

   e. To the extent possible, the law should create distinct confidentiality standards that account for difference in responsibilities and resources of various entities that maintain protected health information.

3. The House of Delegates support the adoption of measures to preserve confidentiality of individual medical information in the electronic collection, storage, retrieval and exchange of such information. Such steps could include identification of those with access to information, audits of persons with access to the data and specific clauses in contracts between health plans and third party electronic data management entities requiring the protection of medical record confidentiality.

4. The House of Delegates encourages the AMA to examine issues related to electronic collection and transmission of patient medical information, the impact this has on confidentiality of patients' information and how such confidentiality can be protected.

5. The House of Delegates support adoption by medical and health research institutions of specific guidelines and rules for collection, use and dissemination of human genetic data. Such guidelines and rules should inform patients about how such information will be used, outline patient's rights to their genetic information and property and specify the steps that will be taken to obtain patients' consent to uses of that information and property.