LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

# FOCUS

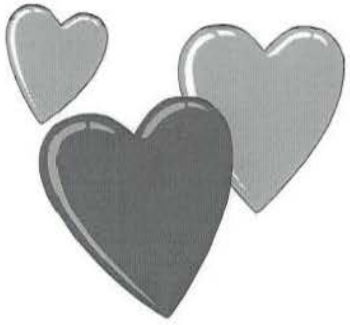
*The Quarterly Newsletter for Physician Office Staff*

**Route to:**

**Volume 8, Number 1**
**February, 1999**

**In This Issue . . .**





## LVH and MHC Medical Staffs Merge

At a history-making, combined meeting of the Medical Staffs of Lehigh Valley Hospital (LVH) and Muhlenberg Hospital Center (MHC) on December 17, both staffs overwhelmingly voted to approve the bylaws which will serve as the Bylaws of the merged Medical Staff. Additionally, the bylaws were approved by both hospital boards in early January. With these approvals now behind us, the reorganization of the Medical Staff has begun.

Assignments of physicians to their appropriate specialty have been made using LVH's Department, Division, and Section terminology. For those individuals who previously had privileges at both hospitals, they have been assigned to the highest medical staff category of the two. The official letters indicating these assignments have been mailed to each member of the Medical Staff.

In cases when there are no Medical Staff Development restrictions or when physicians are already approved to exercise privileges at the site with Staff Development restrictions, these individuals are approved to exercise privileges at both the Lehigh Valley Hospital and Muhlenberg Hospital Center campuses. However, before exercising privileges at a site where they formerly did not have privileges, physicians are asked to contact their Department Chairperson regarding any orientation that may be appropriate. Physicians are strongly urged to take advantage of this orientation process in order to facilitate access to services and to avoid being questioned by staff who do not recognize them.

If you have any questions regarding the Medical Staff merger, please contact Kathy Wise in Medical Staff Services at (610) 402-8900.

## Act 68 Implementation Moves Ahead

The signing of Act 68 by Governor Ridge last summer came with vigorous support from the Pennsylvania Medical Society as the law mandates new patient and physician protections under managed care plans. Also included are provisions for timely payment, disclosure of benefits, and credentialing of all utilization review organizations.

Following are the key provisions of Act 68, which went into effect on January 1, 1999, as prepared by the Pennsylvania Medical Society Government Affairs Division:

Establishes enrollee complaint process for coverage and plan policies disputes.

Defines "emergency service" using prudent layperson standard.

Establishes grievance process available to enrollee and health care provider for disputes arising from decisions concerning the medical necessity and appropriateness of a health care service.

Defines "health care service" as any covered treatment, etc., including behavioral health, prescribed or provided or proposed.

Defines "managed care plan" as a plan that:

- Uses a gatekeeper to manage utilization of services;
- Integrates the financing and delivery of services; and
- Provides financial incentives for enrollees to use participating providers.

Includes managed care plans operating under HMO Act, BC/BS enabling acts. Excludes plans which are primarily fee for service, including DPW fee for service, workers' compensation and auto insurance. Also excludes some ancillary service plans and CHAMPUS.

Defines "primary care provider" as one who supervises, coordinates, prescribes, or otherwise provides or proposes health care services, initiates referrals for specialist care, and maintains continuity of care, within their scope of practice.

Requires plans to:

- adopt and disclose a definition of "medical necessity."
- ensure the provision of emergency service.
- provide direct access to obstetrical and gynecological services.
- provide list of participating providers.

Prohibits financial incentives which compensate for less than appropriate care.

Prohibits "gag" clauses.

Requires provision of emergency services without prior authorization. Plan shall pay reasonable costs. Plans shall use presenting symptoms and services provided when determining payment.

Provides for 60 days continuity of care when entering or leaving plan, except for termination of provider for cause.

Directs Department of Health to establish provider credentialing standards.

Requires plan to disclose credentialing standards and procedures.

Requires protection of confidentiality of medical information.

Requires plan disclosure of:

- coverage benefits
- description of prior authorization requirements
- explanation of enrollee's financial responsibility (i.e., coinsurance, deductibles, annual limits, etc.)
- summary of utilization review procedures
- summary of complaint and grievance procedures
- description of procedures for selecting providers, including specialists
- a list, by specialty, of all network providers annually

Establishes requirement for certification of utilization review entities. Certification must be renewed every three years.

Requires toll-free telephone access to URO at least 40 hours/week. Also requires answering service for after hours with response within one business day.

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Requires the following timeframes for review:

- Prospective review - 2 business days
- Concurrent review - 1 business day
- Retrospective review - 30 days

Requires that utilization review resulting in a denial must be made by a licensed physician. Additional requirements are:

- Initial review denial - performed by a licensed physician.
- Internal appeal denial - performed by a licensed physician in the same or similar specialty as typically manages or consults on the service.
- External Grievance Denial - performed by one or more licensed physicians in active clinical practice (average of 20 hours/week) in the same or similar specialty that typically manages or recommends treatment for the service; or is currently certified by a board approved by the American Board of Medical Specialists or the American Board of Osteopathic Specialties in the same or similar specialty.

NOTE: licensed psychologists may be used to review behavioral health services within their scope of practice with sufficient clinical experience. Use of psychologist for review requires Department of Health approval. Psychologist shall not deny services involving inpatient care or prescription drugs.

Establishes external grievance process with following provisions:

- Enrollee or provider may request grievance process within 15 days of internal denial.
- Plan shall notify Department of Health of filed grievance within 5 business days.
- Department of Health has 2 business days to randomly select URO from its approved list. Otherwise plan may choose from URO list.
- External review shall consider all information from previous review and from provider.
- Decision with reasons shall be issued within 6 days of filing.
- External grievance is appealable to court. There shall be a rebuttable presumption in favor of URO decision.
- Fees related to external grievance shall be paid by non-prevailing party.
- Department of Health may remove URO from the list for failure to perform or for charging excessive fees.

Permits alternative dispute resolution process approved by the Department of Health.

Establishes requirement for prompt payment of clean claims by licensed insurers and managed care plans within 45 days. Interest at 10% per annum shall be added beginning the day after required payment date and ending the date claim is paid. Remedies and penalties are provided through complaint to appropriate Department.

Provides for providers and plans to refuse services on moral or ethical grounds.

Provides for preemption under ERISA.

For more information regarding this issue, please contact the Pennsylvania Medical Society at (717) 558-7750.

## Who's New

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## Pennsylvania Delegation Helps Pass E&M Amendments*

by C. Richard Schott, M.D., Delegate, Delaware County Medical Society

During the December AMA Interim Meeting, the preponderance of testimony surrounding Evaluation and Management (E&M) Documentation Guidelines opposed the present system and favored a system of peer review and one containing no numeric elements.

Following reference committee debate, representatives from key states -- including California, Florida, Georgia, New York, Ohio, Pennsylvania, and Texas -- quickly formed a coalition. Concerned that the reference committees proposed substitute resolution (802) did not go far enough, the coalition drafted six amendments, which were approved by the AMA House of Delegates.

The amendments are that the AMA express outrage that the practice of medicine is characterized as abusive and fraudulent, and vigorously oppose the harassment of honest physicians; reaffirm its strong rejection of a numeric counting system for documenting the medical record, and request that:

- the CPT editorial panel expand its evaluation to other alternatives for medical records documentation;
- the CPT panel urge the Health Care Financing Administration (HCFA) to eliminate random audits of all E&M services and instead use a focused review program that emphasizes identification of statistical outliers;
- use all possible means to ensure that no adverse determination regarding physician services be made without prior appropriate peer review, through procedures conforming to due process;
- use HCFA to revise the carriers' use of the extrapolation technique, using the following two-step process:

  1) Once a carrier identifies a problem, the carrier must provide the physician with an opportunity for a telephone discussion or a face-to-face meeting, in which the carrier must adequately explain how to correct the billing problem in the future.

  2) If the physician's future billing activities are found in error, HCFA may recoup overcharges based on actual errors found.

These amendments received strong support and were passed with a nearly unanimous voice vote. A final amendment requesting legislative action if negotiations with HCFA are unsuccessful in implementing all applicable AMA policies regarding E&M documentation issues received mixed testimony and was referred to the board for action.

The amended substitute resolution (802) passed with an overwhelmingly positive voice vote, to become policy of the AMA House of Delegates.

Readers must be cautioned that this does not translate into HCFA policy, and we are still subject to all existing policies, including compliance with the onerous 1995 and 1997 guidelines. But this policy does provide direction to ongoing AMA communications with HCFA and the CPT panel.

This action represents a great success for practicing physicians and demonstrates the role of grassroots activity of county medical societies, the Pennsylvania Medical Society, and the Pennsylvania Delegation to the AMA.

We have returned from the interim meeting with appropriate pride and sense of accomplishment. We have served our membership well, and have demonstrated value of membership in our societies.

**1999 PAHCOM Officers**

| | |
|---|---|
| President | Skie Kramp, CMM<br>Children's Healthcare |
| President-elect | Anita Bennett, CMM<br>Family Doctor, Inc. |
| Secretary | Pam Kametz, CMM<br>Sacred Heart OB/GYN<br>West & Bethlehem |
| Treasurer | Bev Haas, CMM<br>Alliance for Creative Development |
| Membership Coordinator | Nancy Edmiston<br>OB-GYN Care, Inc. |

## Medical Records -- Patient Access To/Ownership of Records*

### *Authorizations*

Requests for patients' medical records accompanied by authorizations come in various forms. Physicians may receive requests from insurance companies accompanied by a photocopy of the patient's authorization. Often such authorizations were signed long before the requested release. At other times, the requests may be presented by an attorney with an authorization which appears to be a preprinted form. Regardless of the form the authorization may take, physicians should exercise diligence to insure that the patient has, in fact, authorized the release of the records and/or the requested information. As a rule of thumb, if there is any doubt regarding the veracity of the signature, or whether the authorization is stale (i.e., signed long before receipt), physicians should request a more recent or a more legible authorization. If the requesting party refuses or is unable to provide additional documentation, physicians may request a specific authorization directly from the patient.

Not all record requests require the same substantive response. The request must be carefully scrutinized to determine whether it seeks any and all records or less than all. Depending on the scope of the request, the cost of copying the records may become an issue.

Record requests should be handled promptly. The American Medical Association has expressed the opinion that a physician should not refuse to make his complete records, including that of all prior treating physicians which may be in his possession, regarding a prior patient promptly available to another physician. The current regulations in Pennsylvania do not address the time within which one must respond to a record request.

Pennsylvania does regulate a physician's obligation to provide medical records, or copies of the records, to the patient, or to another provider, based upon a patient's written request. Failure to provide records in response to such a request may constitute "unprofessional conduct" and may subject the physician to disciplinary action by the State Board of Medicine.

* Information provided by Lehigh County Medical Society

## Workers' Comp Increase for 1999 is 4.8%**

Fees for workers' comp services performed on or after January 1, 1999 are calculated and paid in the following manner:

If you are using the 1994 Medicare Fee Schedule as your base multiplier, then use this formula:

**1999 WC FEE = 1994 Medicare Fee Schedule X 1.3458 (134.58%)**

If you are using the 1998 WC Fee Schedule as your base multiplier, then use this formula:

**1999 WC FEE = 1998 WC Fee Schedule X 1.048 (104.8%)**

(NOTE: Product is the same using either formula)

New or revised Medicare codes are frozen at 113% of the new rate for 1999 and will be updated for 2000.

The Bureau of Workers' Compensation has developed a Part B Fee Schedule for 1999 on diskette. The diskette contains data for all Medicare codes and geographic payment levels. You may contact the Bureau (Ms. Julie Knaby at (717) 787-3486) for information on the diskette. The cost of Part B diskette is $212.00.

**Obtained from www.pamedsoc.org/physicians/regsandrules/workers99rate.htm

### Upcoming PAHCOM Meetings

- February 16 - 5:30 p.m.
  PA Medical Society Current Happenings
- March 16 - 7:30 a.m.
  Open House
  Recognizing and Managing Stress
  Gail Staudt, RN, MSN, CS
- April 10 - TBA
  Certified Medical Manager Exam
  For information, contact Skie Kramp, CMM at 395-4444
- April 20 - 5:30 p.m.
  Planning for the Year 2000 (Tentative topic)

PAHCOM meetings are held at the Ambassador Restaurant, 3750 Hamilton Boulevard, Allentown.

## Advance Directives

In 1990, the Congress passed, and the President signed into law, the Patient Self-Determination Act. This law states that hospitals and other places providing health care must tell patients about advance directives.

In Pennsylvania, competent adults have the right to decide whether to accept, reject or discontinue medical care and treatment. If a person does not wish to undergo a certain procedure or to receive a certain type of treatment, they have the right to make his or her wishes known to his or her doctor or other health care provider and generally to have those wishes respected.

There may be times, however, when a person cannot make his or her wishes known to a health care provider. For example, a person may be unconscious or too badly injured to tell his or her doctor what kind of care or treatment he or she would like to receive or under what circumstances that doctor should withhold care or treatment.

To make these complex issues easier to understand, following is a series of questions and answers relating to Advance Directives.

***Q. What is an advance directive?***
A. Advance directives are a means for a person to tell his or her health care provider about the care he or she wishes to receive - or not receive - should he or she ever become unable to tell them of his or her wishes. There are two forms of advance directives. One is called a living will. The other is known as a "durable power of attorney for health care decisions" or may also be called "durable appointment of a surrogate for health care decisions." An organ donor card is another example of an advance directive.

***Q. What is a living will?***
A. In Pennsylvania, a "living will" is a written document that describes the kind of "life sustaining treatment" a person may or may not want if he or she is later unable to tell his or her doctor what kind of treatment he or she wishes to receive.

***Q. Are living wills legal in all states?***
A. Most states have laws that say living wills are legal. Most of these laws contain a form that a person can use. Many doctors will honor living wills even in a state without a living will law.

***Q. What is a "durable power of attorney for health care decisions?"***
A. "Durable power of attorney for health care decisions" allows a person to say who can make decisions about his or her health care if he or she is not able to make such decisions himself/herself. The person authorized to make these decisions is called a "surrogate" or "proxy."

***Q. Who is capable of making an advance directive?***
A. Competent individuals capable of making an advance directive include any individuals who are:
- 18 years of age or older;
- high school graduates; or
- married, or those individuals who have been married.

For more information regarding Advance Directives and other health care and legal issues of interest to the elderly, please contact one of the following organizations:

Lehigh County Area Agency on Aging
523 Hamilton Street
Allentown, PA 18101
(610) 820-3034

Northampton County Area Agency on Aging
Gracedale-Southwest Ground
Gracedale Avenue
Nazareth, PA 18064
(610) 746-1990

The Pennsylvania Medical Society
Division of Communication and Public Affairs
77 East Park Drive
Harrisburg, PA 17105-8820
(717) 558-7750

## Lehigh Valley Hospital Department Relocations

A number of hospital departments have recently moved to a new location. Please make a note of the new location and phone number changes for the following departments:

### Helwig Diabetes Center and LOVAR Research Office

On January 28, the Helwig Diabetes Center and the LOVAR (Lowering of Vascular Atherosclerotic Risk) Research Office relocated to the fourth floor of Lehigh Valley Hospital, 17th & Chew. In addition, Gregory Salem, Operations and Marketing Manager for the Center for Health Promotion and Disease Prevention (HPDP) will be located here. Other members of the HPDP staff have moved to the new Health Center at Trexlertown, one of many community sites for service delivery.

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New telephone numbers include:
Helwig Diabetes Center - (610) 402-4082
LOVAR Research Office - (610) 402-4088
Gregory Salem - (610) 402-4085
The fax number for these offices is (610) 402-4078.

Hours of operation for the Helwig Diabetes Center and LOVAR are 8 a.m. to 5:30 p.m., Monday through Friday. Courtesy valet parking is available for patients weekdays from 6 a.m. to 4:30 p.m. Parking is also available in the Visitor's Lot on the southwest corner of 17th & Chew and in the Fairgrounds Parking Lot. Entrances to both lots are on Chew Street.

### Marketing and Public Affairs

Effective January 18, the Marketing and Public Affairs staff, formerly located at 1243 S. Cedar Crest Blvd., Allentown, relocated to the First Floor of 1770 Bathgate Road, Bethlehem, PA 18017. The main Public Affairs phone number is (610) 317-4810; the fax number is (610) 317-4826.

### Physician Recruiting

On January 18, Physician Recruiting relocated to 2166 S. 12th Street, First Floor. The main phone number for Physician Recruiting is (610) 402-7008; the fax number is (610) 402-7014.

### Vitality Plus

On January 25, Vitality Plus, a program which promotes healthy living for people 50 and over, moved to a new office on the Second Floor of the School of Nursing at 17th & Chew. The main phone number for Vitality Plus is (610) 402-4678; the fax number is (610) 402-4690. Maria Kammetler, Program Manager, may be reached at (610) 402-4663.

## Upcoming Educational Opportunities

**The Administrator's Role in Coding** - Tuesday, February 16, 12:15 to 1:45 p.m., Lehigh Valley Hospital, Cedar Crest & I-78, Classroom 1. $25.00 per person including lunch.

This course is appropriate for Administrators and Office Managers. Class limit - 12 attendees.

**Compliance Programs for Private Practice** - Tuesday, March 2, 3 to 4:30 p.m., John and Dorothy Morgan Cancer Center, Computer Training Room, Suite 401, 4th Floor; OR Thursday, March 4, 3 to 4:30 p.m., Muhlenberg Hospital Center, 1770 Bathgate, 4th Floor, LVPG Computer Training Room. $25.00 per person.

This course is appropriate for Office Managers and Physicians from practices with fewer than five physicians. Class limit - 12 attendees.

**Incorporating Billing Audits into Your Compliance Program** - Thursday, March 18, 12:15 to 1:45 p.m., Muhlenberg Hospital Center, 2545 Schoenersville Road, First Floor Conference Room; OR Tuesday, March 23, 12:15 to 1:45 p.m., Lehigh Valley Hospital, Cedar Crest & I-78, Classroom 1. $25.00 per person including lunch.

This course is appropriate for Administrators, Office Managers and Physicians. Class limit - 12 attendees.

**Basic Billing - Part 1** - Thursday, April 8, 12 to 4 p.m., John and Dorothy Morgan Cancer Center, Conference Room 6; OR Thursday, April 15, 12 to 4 p.m., Muhlenberg Hospital Center, Bank Center Room 4. $50.00 per person.

This is an introductory course for new billing office employees or experienced receptionists who want to learn billing. Class limit - 12 attendees. Basic knowledge of medical terminology is required.

**Basic Billing - Part 2** - Tuesday, April 13, 12 to 4 p.m., John and Dorothy Morgan Cancer Center, Conference Room 6; OR Tuesday, April 20, 12 to 4 p.m., Muhlenberg Hospital Center, Bank Center Room 4. $75.00 per person for Parts 1 & 2.

This is the second in a series of introductory courses for new billing office employees or experienced receptionists who want to learn billing. Class limit - 12 attendees. Basic knowledge of medical terminology and completion of Basic Billing - Part 1 is required.

The programs listed above are sponsored by Lehigh Valley Physicians' Business Services in conjunction with the Physician Relations Department of Lehigh Valley Hospital.

For more information regarding any of these programs, please contact Pat Spacek, Lehigh Valley Physicians' Business Services, at (610) 317-4442.

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For more information, please call Janet at 402-8590.