On Your Behalf . . .

News and Notes from the Legislative and Practice Affairs Division

HIPAA: Time to Check Compliance

By David E. Willett, Esq., CSA Legal Counsel

Last April 14th, HIPAA "Privacy Rule" requirements became applicable to physicians and others providing patient care. While HIPAA requirements apply only to those providers who engage in "electronic transactions," it is rare that any anesthesiologist is exempt, particularly as a separate Medicare requirement mandates electronic billing effective October 16, 2003. Persons and facilities subject to Privacy Rule regulations are referred to as "covered entities."

A new industry, populated by consultants, in-house specialists, and lawyers, has blown HIPAA efforts beyond rational dimension. Nonetheless, anesthesiologists must observe HIPAA rules. HIPAA addresses "protected health information," oft referred to as "PHI." The basic rule is that PHI must be protected from disclosure without patient authorization, a concept certainly predating HIPAA. As was the case previously, the Privacy Rule permits use and disclosure of PHI without specific patient authorization for patient treatment, payment purposes, and for "health care operations." Health care operations are those things which must be done in order to maintain a practice, including management functions and activities such as quality assessment, audits, and securing legal advice or representation. Disclosure of PHI for most other purposes requires prescribed authorization forms.

With Privacy Rule requirements in place, it would be prudent for each anesthesiology practice to review compliance. Understanding the requirement is the first step. ASA has published *The HIPAA Privacy Rule in Anesthesia and Pain Management Practices*, a ten-step manual. CMA has published the *HIPAA Compliance Toolkit*, which addresses California as well as Federal requirements. By now, anesthesiology practices should have established formal procedures to ensure that HIPAA requirements for use and disclosure of patient PHI are being met. This requires adoption of a documented compliance program. The practice should have appointed a privacy officer.

Members of the practice should be trained with respect to privacy requirements and practice procedures.

The onset of HIPAA requirements as of last April came to the attention of patients as well as physicians because of the mandated "Notice of Privacy Practices." HIPAA regulations require each health care provider to provide each patient with a notice which tells the patient how PHI will be used, and describes certain patient rights. Each such notice must specify the date it was adopted, and must contain the following statement:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In addition, the notice must meet other specific Privacy Rule requirements. Providers must make a "good faith effort" to obtain written acknowledgement of receipt of the notice from the patient, or document why it was not obtained, except during emergencies.

Not all anesthesiologists are personally responsible for giving patients a notice of privacy practices. This is because anesthesiologists may participate in an "Organized Health Care Arrangement" (OHCA). When a number of separate covered entities integrate their activities in a clinical setting, sharing PHI, an OHCA is created. When an OHCA exists, responsibility for giving the requisite notice can be assigned to one entity. The most common example of an OHCA reflects the relationship between a hospital and its medical staff. OHCAs may come into being even when existence is not documented. However, prudence suggests that the OHCA's existence be documented, particularly in describing which entity has responsibility for providing notice to patients and securing acknowledgment of receipt. Patient care provided by a participant outside of the integrated setting, as in an outside medical office, requires a separate compliance arrangement.

While most OHCAs exist in hospitals, an OHCA can exist in an ambulatory surgery center (ASC), or even in a physician's office. Well-organized ASCs are implementing these arrangements. A plastic surgeon who arranges with an anesthesiologist to provide anesthesia in the office setting can do the same thing, and assume responsibility for giving the notice. Anesthesiologists should decide whether they are comfortable with allowing another entity or person to assume this responsibility, looking separately at each setting in which they practice. Ask these questions:

* Is the OHCA's existence documented?

* Is someone else providing the notice?

* Is the notice satisfactory, measured against Privacy Rule requirements?

* Can I depend on the entity or person assuming this responsibility to comply with HIPAA regulations on an ongoing basis?

If you are not comfortable assuming that the entity or individual arranging for your services will provide the necessary notice on an ongoing basis, documenting its delivery, then it is preferable that you yourself provide the notice directly to the patient. Practices which provide anesthesia in non-hospital settings should have their own form of notice available for use when compliance cannot be assumed. If you decide to rely on someone else to give the notice, review that decision annually to be sure that the decision remains appropriate.

By now, practices should have secured "business associate" agreements from entities utilized for business purposes which are routinely or occasionally given PHI, if that recipient is not a "covered entity." Because other health care providers, whether they are facilities or individuals who may arrange for your services, are usually "covered entities" which share patient information with you, business associate agreements are not required from them. However, organizations such as your billing service, your professional liability insurer and your accountants, to cite three examples, are not covered entities and should provide you with a business associate letter, agreeing to be bound by HIPAA privacy requirements to the same extent as you are bound. Forms are available from either ASA or CMA. Business associate letters must be signed by the business associate. You do not need to sign the business associate letter, although many business associates are requesting execution and return of their own business associate agreement. Before signing someone else's business associate form, be sure that it does not include objectionable or unnecessary provisions, such as indemnification agreements.

Summary. By last April 14, your practice should have prepared for HIPAA implementation, adopting a compliance program and securing a basic understanding of HIPAA requisites. The most visible change to past practices is the requirement that each patient receive a Notice of Privacy Practices, with documentation of such receipt. Responsibility for giving patients that notice

can be assumed by another participant in an organized health care arrangement, where PHI is shared during integrated clinical activities. Anesthesiologists should determine whether HIPAA requirements, including mandated notice, are being met in each setting where care is provided. Other HIPAA requirements also come into play occasionally, as when entities not involved in the patient's care, payment for care, or health care operations seek protected information. Each practice should be prepared to deal with these situations as well.

Recap of the 2003 Legislative Session

By William E. Barnaby Sr., CSA Legislative Counsel, and William E. Barnaby, Jr., Legislative Advocate

In our more than 50 collective years of working in and around the legislative process this has to have been the most difficult and trying year that we ever have experienced. The three main issues that have dominated this year's session have been (1) the budget crisis, (2) the workers' compensation crisis, and (3) the recall election.

Budget Crisis

In 1999 we were able to obtain a Medi-Cal reimbursement rate increase for OB anesthesia of 20%. In 2000, working with the CMA, we were able to obtain an additional physician Medi-Cal rate increase averaging 16.7%. Given the recent California budget crisis there have been many proposals to cut physician Medi- Cal reimbursement fees anywhere from the 16.7% average increase granted in 2000 to the 5% reduction ultimately enacted. This reduction was a last minute, behind-the-scenes insertion into the "compromise" budget deal. No Medi-Cal provider cuts had been approved during the lengthy budget hearings in both houses. It apparently was included in the final deal to reflect that the budget pain must be shared by all.

The current budget calls for an across-the-board 5% Medi-Cal provider reimbursement rate decrease effective January 1, 2004. We, as part of the CMA-led coalition, worked hard to restore this rate cut by means of subsequent legislation, much like was done last year via AB 3006, but with no success this year. However, other options are being explored, including a CMA-sponsored lawsuit based on access to care. Further developments on this issue will be reported.

Workers' Compensation Crisis

The Workers' Compensation Program is in a terrible mess. State law requires all employers to carry "workers' comp" insurance or be self-insured. Premiums skyrocketed over the past two years as many "comp" carriers became insolvent or left the market. Pressure from the business community was intense. Rapidly escalating medical costs were blamed as one of the main reasons for the situation. Businesses cited specific abuses such as unlimited chiropractic and physical therapy visits, and unrestrained fees charged by outpatient surgical facilities, such as $7,000 to $10,000 for an epidural injection.

After weeks of public hearings, private meetings and conference committee deliberations, it appeared that every compromise attempt had failed. Once again, a last minute, behind-the-scenes deal was cut. Two bills emerged. SB 228 (Alarcon) contained the provisions relative to medical services. AB 227 (Vargas) contained the insurance provisions. Rather than give a comprehensive run-down of the whole situation, the impact on anesthesiologists will be as follows if the current proposed package becomes law (Governor Davis has pledged to sign it).

1. A 5% physician reimbursement cut effective 1/1/04 through 12/31/05.

2. Thereafter, unless the law is changed, 120% of Medicare RBRVS.

Also included in the workers' compensation package of AB 227 (Vargas) and SB 228 (Alarcon) are:

1. An Outpatient Facility Fee Schedule based on 120% of Medicare RBRVS;

2. A 24 visit per life of the claim cap on chiropractor and/or physical therapy visits;

3. A Pharmaceutical Fee Schedule that will be the same as Medi-Cal.

4. Elimination of the vocational rehabilitation program.

Delaying a move to an RBRVS reimbursement system for treatment procedures to January 1, 2006 was intended to give physicians time to advance an alternative plan. All other parts of the "reform" will take effect on January 1, 2004.

Recall Election

The special election to recall Gov. Gray Davis appears to have the final court go ahead for Tuesday, October 7, 2003. Legislation passed during the final few days of the session must be signed or vetoed by October 12th. Governor Davis will remain in office at least until the results have been certified by the Secretary of State. Given the length of the ballot, the potential for complications in the counting of the ballots and the possibility of legal challenges, the results may not be certified until after October 12th. The recall proved to be a major distraction that contributed to a disjointed and dysfunctional 2003 legislative session. It is probably only fitting that the confusion will continue beyond the election date.

SB 2 Play or Pay Health Insurance Mandate

SB 2 authored by Senate President Pro Tem John Burton (D, San Francisco) is a mandate on employers to "play," to provide health insurance coverage to their employees, or "pay" into a state fund that would buy coverage. The measure was co-sponsored by the California Medical Association (CMA) and organized labor. It passed during the final hours of the session strictly on party line votes. The business community is working hard for a gubernatorial veto–and just might get it.

If the "play or pay" plan is signed into law, then more details on how it will be phased in will be reported in future communications. The 2003 legislative session gave new meaning to the old saying: "Those who appreciate legislation and sausage should watch neither being made."

As always, the CSA is indebted to "Team Barnaby" for their unrelenting advocacy for our specialty and its practitioners, and especially for their efforts during this most exasperating and maddening session.

–Stephen Jackson, M.D., Editor

The Americans will always do the right thing ... after they've exhausted all the alternatives.

–Winston Churchill