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THE PHYSICIAN'S COMPLIANCE ALERT™

PROVIDING PHYSICIANS WITH MEDICAL PRACTICE COMPLIANCE SOLUTIONS

Plan to Keep Your Practice Up and Running After a Disaster

The best time to get ready for a disaster is before it occurs. Whether the event involves fire, flood, earthquake, tornado, hurricane, theft, or any other threat, a small investment of time and money now can prevent major disruption to your practice later. The effort is particularly crucial for doctors, whose patients may need them the most in a national, regional, or local disaster.

The goal is to devise, test, and keep current a comprehensive disaster plan. Protecting valuable equipment and decreasing revenue loss are good reasons for investing in a disaster plan. Additionally, protection of patient records is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). "HIPAA applies mostly to protection of electronic records, but the rule does suggest that practices conduct impact analyses for different types of disaster," says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Peak Performance Physicians, LLC, based in New Orleans, La..

Despite its importance, many practices pay little or no heed to preparing for disaster recovery. The complexity of the issues and investment of time may deter some, but the investment is critical. "The average medium-size practice doesn't require a plan as extensive as a hospital's, but it does need a plan in writing that is given to all employees," says John W. McDaniel, president of Peak Performance Physicians, LLC.

Plan for the worst

Disasters fall into two categories. Local disasters generally affect a small area, such as a building and adjacent buildings. With these types, outside assistance is usually prompt. The second type is regional, which takes in a wide area. The Red Cross and the Federal Emergency Management Agency (FEMA) recommend that individuals prepare to be self-sufficient for the first 72 hours following a regional event, and it is this type of emergency that the plan should cover. Essentially, expect the worst; that is, prepare for a disaster that prevents returning to the work site for a prolonged period of time, if ever.

Specifically, a plan should include:

- A call list with all employees' phone numbers.
- A list of what equipment, records, and other items are to be protected.
- The specification of an off-site location to store the items.
- Lists of vendors, patients, insurance companies, and emergency phone numbers, such as the Red Cross, police, and fire departments.
- A plan for how records will be stored and moved. Determine the cutoff time that storage facilities require in advance and include this information in the plan. For example, some practices may decide to close a day or two before a hurricane is predicted to arrive.
- A list of assignments for each employee in the event of an emergency or disaster.
- An off-site location for back-up copies of electronic records, such as a bank deposit box. Medical records, patient lists, and accounts payable and receivable should be backed up often and stored off-site.
- A prearranged backup location for temporary office space, such as a hospital or another physician's office.
- Specific arrangements for calling patients if the office location will be closed or changed.

In addition to writing the plan, other

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EDITORIAL

A Designation Both Standard and Unique

With little fanfare, another facet of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) went into effect on May 23, 2005. On that day, the National Provider Identifier (NPI) became the official "standard unique health identifier" to be used by health care providers when submitting electronic claims to insurers or conducting other transactions covered by HIPAA. The NPI contains nine numbers that refer to the individual practitioner and a 10th "check digit," which makes it possible to use a simple mathematical formula to verify the series' authenticity. In some circumstances, the NPI will be preceded by the prefix "80840"; "80" specifies health applications; "840" denotes the United States.

An advantage is that you will no longer be required to maintain different identification numbers for various insurers; the NPI replaces all other identifiers you have been assigned. Created through a mathematical algorithm, the NPI does not expire and cannot be accidentally duplicated. In fact, an estimate from the Centers for Medicare and Medicaid Services (CMS) suggests that enough numerical combinations exist to provide health care providers with exclusive NPIs for the next 200 years. Although the compliance date—May 23, 2007—is nearly two years away, you can now begin the registration process online. For more information, go to: www.cms.hhs.gov/medlearn/npi/transcript_npi_viewlet.pdf.

Getting the information you need well before you truly need it helps to reduce the odds of an unpleasant discovery. Our cover article considers the importance of formulating a contingency plan in the event of a disaster. During the Fall 2004 hurricane season, medical practices along the Gulf Coast were moving their medical records in pickup trucks to protect them from impending storms. A written disaster plan allows you to avoid a panicked exodus. For example, companies that store records will relocate them for you, usually within 48 hours of a looming catastrophe. You must also have offsite copies of financial files and mechanisms in place for contacting patients if your office is seriously damaged.

In addition, take a look at the CMS's proposed rule for electronic prescribing. The agency is quite keen on the technology. Finally, brush up on Medicare's preventive physical examination benefit. Patients may not know that they have a limited opportunity to take advantage of this offering; it surely pays to know these things!

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Prescribing in the Electronic Age: A Look at the Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) is planning to implement a rule that puts into effect "foundation standards" for the practice of electronic prescribing, or e-prescribing, by September 1, 2005. Compliance with these standards is expected to become compulsory on January 1, 2006, to coincide with the launch of Medicare's Part D Voluntary Prescription Drug Benefit Program.

Like Part D coverage, the availability of an electronic prescription program is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The e-prescribing program will allow physicians, pharmacists, and prescription drug plans (PDPs) administering the drug benefit for the CMS—so-called Part D sponsors-—to correspond electronically in a real-time manner. For example, physicians and pharmacists will be able to confer by computer on new prescriptions, regimen changes, and refill requests and responses.

The MMA stipulates that the electronic prescribing program must also enable health care providers to transmit questions about patients' eligibility and benefits to PDPs. Other required elements include electronic access to a formulary; comprehensive drug information on the prescribed drug and other agents being used concurrently; information on less expensive therapeutic equivalents that could be substituted for a prescribed medication; and the procedure for obtaining prior authorization.

Mainly, the impending rule designates the materials that must be utilized to build the e-prescribing infrastructure; for example, the software technology to be used in encrypting, transferring, and interpreting each type of information sent from point to point. If everyone involved in e-prescribing uses a system that has been constructed according to a single set of standards, communication between all parties is guaranteed-and additional providers and PDPs can continue to enter the network once their systems meet the criteria.

Not for everyone

An essential point made in the proposed regulations is that physicians will not be obligated to take part in electronic prescribing. However, physicians who do use electronic media to dispatch prescription information or associated data for patients enrolled in a Part D PDP and receiving covered medications would have to abide by whatever standards go into effect in 2006.

That being said, what modes constitute electronic media? At present, the regulations employ the definition provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This pertains to electronic storage and transmission methods, encompassing the "Internet (wide-open), extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media." Using a fax machine to transmit prescriptions to your patient's pharmacy is not considered a mode of electronic prescribing, and neither is providing the patient with a computer-printed prescription.

PDPs serving as Part D sponsors, whether private or a Medicare Advantage PDP, are required to support electronic prescribing, and they must comply with e-prescribing standards, particularly because they are expected to serve as the repositories for most, if not all, of the pertinent information. Of course, protected health information will have to travel by routes that also meet HIPAA security and privacy standards.

Root of all e-bills?

The proposed e-prescribing regulation details potential clinical benefits of the program for patients—and temporal advantages for providers. Citing data from the Center for Information Technology Leadership (CITL), the rule states that "more than 8.8 million adverse drug events (ADEs) occur each year in ambulatory care, of which over three million are preventable. Medication errors account for one out of 131 ambulatory deaths." E-prescribing, if carried out on a national scale, would avert some 2.1 million ADEs, which in turn would

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put a halt to a related 1.3 million provider visits, 190,000-plus hospitalizations, and more than 136,000 life-threatening ADEs, according to the CITL. Providers would likely have more information than they have ever had in the past; the program is capable of uncovering a number of serious problems, such as drug-drug and drug-disease interactions; risk of hypersensitivity reactions, incorrect dosages, and duplicate prescriptions. It also eliminates mistakes traceable to illegible handwriting.

If time is money, as the saying goes, the CMS expects physicians to save in both areas. While the agency cannot yet make any definitive statements about how costs for hardware and software might stack up against the possible financial benefits connected with e-prescribing, it does point to a number of promising anecdotes. For example, the rule delves into a medical practice in Kokomo, Indiana, with 20 health care providers and 134,000 patient office visits per year. Before putting an e-prescribing system in place, the practice was handling some 370 daily phone calls, 203 of which involved requests for new prescriptions, renewal requests, or clarification of information contained in a prescription. Responding to these queries consumed an estimated 28 hours per day of nurse time and four hours per day of physician time. Use of e-prescribing has resulted in a "dramatic time savings that permitted reallocation of nursing and chart room staff."

A Kentucky practice credits e-prescribing with a savings of $48,000 per year—all attributed to a reduction in the time spent on renewal requests. Another reported 53% fewer calls from pharmacies as well as a 62% drop in calls to pharmacies. One other possible benefit noted in the proposed rule is the potential for lower malpractice insurance rates accompanying improved quality of care.

Perhaps not surprisingly, the CMS anticipates that e-prescribing could lead to reductions in its own costs. The rule points out that "e-prescribing shows promise for improving Medicare operations by creating efficiencies in the administration of the Part D drug benefit by decreasing costs in facilitating patient eligibility checks, promoting generic drug use, and creating timely interface with formularies."

Enhanced patient safety lowers expenditures as well. The agency maintains that by keeping physicians abreast of the latest scientific findings, e-prescribing can lead to more effective use of drugs, too. It mentions the PROSPER study as a noteworthy example: treatment with statin drugs lowered the incidence of deaths due to coronary disease by 24% among men and women aged 70 to 82 years.[1] In addition, the risk of nonfatal heart attacks was diminished, as was the risk of fatal or nonfatal stroke.

Creating a harbor

Clearly, the CMS is hoping that physicians will sign on to the electronic prescription drug program. At present, an estimated 5% to 18% of physicians are already using e-prescribing systems, according to the CMS. In contrast, 75% of pharmacies are equipped to take part in the electronic prescription program.

The proposed regulation notes that the cost of setting up an e-prescribing system is about $1,500 per prescriber for the necessary hardware and software. Of note: the estimate comes from health care plans that are offering to absorb some of the start-up expenses for physicians who begin using e-prescribing. Incentive packages might provide electronic prescription hardware, software, information technology, or training. According to the CMS, the motivation for this is the promise of fewer adverse events, better patient compliance, and reduced health care spending.

What's more, the CMS plans to publish a new Stark exception "in the near future," so that physicians can accept assistance without running into legal trouble. Similarly, the Office of the Inspector General for the US Department of Health and Human Services will put forward a new safe harbor under the anti-kickback statute.

"In the meantime, where relevant, arrangements involving nonmonetary remuneration" must comply with an existing Stark exception and must not breach the anti-kickback statute, the proposed regulation states. For example, an exception for community-wide health information systems was published in the March 26, 2004, issue of the Federal Register. Within certain limits, the exception allows physicians to accept "items or services of information technology" if these promote the sharing of medical information in a way that can "enhance the community's overall health."

A number of issues are yet to be resolved, some of which will be scrutinized in a pilot project slated for 2006. By law, final uniform standards for the electronic prescription program must be promulgated by April 1, 2008, and these must take effect within the following year. All of this is part of a larger effort to streamline the movement of health information. You can read the proposed e-prescribing regulation at: www.cms.hhs.gov/medicarereform/E-Prescribing.pdf.

Reported and written by Cynthia Starr, editor. For more information on the MMA, visit our Web site (see page 8).

1. Shepherd J, Blauw GW, Murphy MB, et al. Pravastatin in elderly individuals at risk of vascular disease (PROSPER): a randomized controlled trial. *Lancet*. 2002;360:1623-1630.

Billing for an Ounce of Prevention

Since January 1, 2005, newly enrolled Medicare beneficiaries have been entitled to what is described as a "once-in-a-lifetime" benefit: an initial preventive physical examination (IPPE). Also known as the "Welcome to Medicare Physical," the IPPE is one of three new preventive benefits put in place by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Screenings for cardiovascular disease and diabetes have been added to the Part B benefits package as well. These extras underscore Medicare's intent to turn more attention to disease prevention and management.

Possibly the most important thing to know about the IPPE is that it must take place within six months from the effective date of the patient's first Medicare Part B coverage period; otherwise, the opportunity is lost. The assessment is thorough, incorporating medical and social histories; measurement of height, weight, and blood pressure; a visual acuity screen; performance and interpretation of an EKG; screening for depression; and any additional elements that you believe are necessary. An appraisal of the patient's overall functional ability and level of safety are required—note any hearing impairment and evaluate the ability to carry out the activities of daily living, the risk of a fall, and the extent to which the patient is capable of being safe at home.

Physicians are also to provide education, counseling, and any necessary referral based on the findings of the IPPE. This includes a short, written plan or checklist describing any further covered screening or preventive services that should be obtained. The cost of the IPPE, which can be performed by a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist, can be applied to the patient's 2005 Medicare Part B deductible, which rose to $110 at the beginning of 2005. If the deductible has been met, a copayment should be charged.

A lipid panel or separate measurement of total cholesterol, high-density lipoprotein, and triglycerides can be performed once every five years to screen for cardiovascular disease in asymptomatic patients. Patients do not contribute to a deductible or provide a copayment. Testing should be performed after 12 hours of fasting. Several "V" codes are covered for the four lipid tests (see table).

Diabetes screening is reserved for patients who have risk factors for diabetes mellitus and for those who have been diagnosed as having pre-diabetes, including patients with impaired fasting glucose or impaired glucose tolerance. One test per 12-month period is covered for patients who have not been diagnosed with pre-diabetes. Patients with a diagnosis of pre-diabetes can be tested twice during a 12-month period, as long as the evaluations are at least six months apart. Again, patients pay no deductible or copay. Both the cardiovascular and diabetes screening tests can be ordered by a physician or by a qualified nonphysician practitioner.

Reported and written by Cynthia Starr, editor. For more information on coding, visit our Web site (see page 8).

Essential Codes

Service	HCPCS/ CPT Code	ICD-9-CM Code
Initial preventive physical examination(IPPE)	G0344	No specific diagnosis code needed
EKG for IPPE	G0366	No specific diagnosis code needed
EKG tracing for IPPE	G0367	Not applicable
EKG interpret and report	G0368	Not applicable
Lipid panel	80061	V81.0, V81.1, V81.2[1]
Cholesterol	82465	V81.0, V81.1, V81.2[1]
Lipoprotein	83718	V81.0, V81.1, V81.2[1]
Triglyceride	84478	V81.0, V81.1, V81.2[1]
Glucose, quantitative, blood (except reagent strip), fasting	82947	V77.1[2]
Post-glucose dose (includes glucose)	82950	V77.1[2]
Glucose tolerance test, three specimens (includes glucose)	82951	V77.1[2]

1. Report one or more of these "V" codes.

2. Report modifier "TS" (follow-up service) for diabetes screening where the beneficiary meets the definition of "pre-diabetes."

Source: The Centers for Medicare and Medicaid Services

steps are crucial, such as reviewing your insurance coverage. Will it cover the cost of replacing expensive and critical equipment? Will it cover all disasters? Most policies do not cover flood or earthquakes, and additional riders may be needed for this or other likely perils that are not covered.

Practices should also research any codes or regulations that apply to health care providers. Besides that, assign one individual or team the job of writing the plan, training the staff to use the plan, and testing the process. The team should identify a remote command center where recovery could be coordinated, and the center should be stocked with supplies ahead of time. An alternate information systems recovery site, which has or is ready to house computer hardware, must also be identified.

Phone services tend to become overloaded in emergencies, when communications are especially crucial. Practices should therefore have a backup phone plan. Some options are listed below:

- Cellular phones can contact other cellular phones in the cellular company's area, but may not be able to connect to overloaded landlines.
- Essential service provides the caller with a dial tone in advance of others. Public telephones are also given priority by the phone company in a disaster. Know the locations of all pay phones near you, and post their numbers in the office.
- Foreign exchange lines are expensive to maintain, but will not be jammed by a regional disaster.
- Satellite-based pagers are less subject to congestion.
- Amateur radios are unaffected by jammed phone lines.
- Fax machines are not exposed to network congestion if they are provided on a private line.

In an emergency, time is of the essence. "Write out a timeline that allows you to react early if there is enough warning," says McDaniel. "If you wait until the last day, you can expect that there will be gridlock on the roads, and storage locations and vendors may be closed," he says.

Finally, train the staff to use the plan, and test the system once it has been developed. First, talk through the exercises in a staff meeting, discussing different scenarios. Then, use a drill to test the plan. During both the talk-through and the drill, try to find errors, omissions, or details that need clarification. Finally, revisit the plan regularly and keep it up-to-date.

Lost data is a common calamity

"The biggest issue for physicians is lost data," says Johann F. Lee, consultant and owner of Decitech Services, a consulting firm located in Lawrenceville, NJ. Fire, theft, flood, weather disasters, and frozen pipes that break and leak represent just a few of the risks to data. "The loss is that a practice is unable to bill for patient visits included in the lost data, and would also need time to put back whatever data can be reentered," observes Lee. Therefore, the cardinal rule is to back up everything everyday and test the backups periodically, he says. "Ask yourself: How much data can I afford to lose? Even one day of patients is a lot of revenue," he suggests. Some companies, including Decitech Services, offer remote backup services in which data is backed up daily, encrypted, compressed, and then stored at a site other than the practice location.

"Another big problem is theft," says Picou. "People steal medications, computers, and equipment, so you need to have insurance that covers these," she warns. Also, change locks and passwords periodically, as well as after an employee leaves, she advises. Theft is almost always an inside job, so have a system of checks and balances in place for writing checks, then conduct regular audits. In addition, conduct background checks before hiring employees, including checking credit and criminal records, Picou recommends.

Another common danger is fire. When a complex of 40 health care offices was totally destroyed by arson in rural New York in 1990, virtually every patient's records were destroyed. Most of the practices were underinsured.

All practices should therefore review their insurance coverage for fire loss. "Does the policy only cover replacement value? If so, a computer that isn't new is not worth much," notes Picou. Special riders should be used to cover expensive-to-replace equipment. Also, use fireproof cabinets for anything that is important or expensive. "Overloaded circuits and space heaters are common causes of fire and should always be avoided," she adds.

Tools for survival

For those who need help writing a disaster plan, step-by-step guides and other excellent disaster recovery tools and advice can be found at numerous Web sites. The Emergency Management Guide for Business and Industry, a nearly 100-page guide to planning, can be found at www.fema.gov/library/bixindex/shtm. Other useful Web sites are the Disaster Recovery Journal, www.drj.com; the Small Business Administration, www.sba.gov; the Institute for Business & Home Safety, www.ibhs.org; and the Red Cross, www.redcross.org.

Planning software can also help in writing a good plan. The vendor section at www.drj.com offers information on software vendors as well as off-site data storage firms. Finally, some companies provide temporary computer and office space in the event of a disaster.

The perfect storm plan

Although the effort of preparing for a disaster sounds formidable, a good disaster plan is attainable even for solo practices. Brian Anthony, MD, a general surgeon with a solo practice in Bay St. Louis, Miss., acquired the military's passion for preparedness as a US Army doctor. "I was deployed eight to 10 times, and we were generally given 24 hours' notice. You had to be able to get your personal affairs in order quickly," he remembers.

He began making a disaster recovery plan for his practice after a number of close calls with hurricanes in the area. "I started by identifying what we would take and a means to evacuate the practice," he recalls. For patient charts, he purchased water-resistant plastic containers that could be labeled and relabeled. These are kept in a cargo trailer that can be attached to Dr. Anthony's truck. In a hurricane, the patient charts would be loaded 48 hours prior to when the storm is due. "As for equipment, we would leave the computers and take the lasers. Padding, boxes, and tape for packing these items are always kept in the cargo trailer."

Evacuation routes are well-marked and well-known in the area. "My policy is to go north and leave 12 hours before a storm is predicted to hit land." A relative's home is the meeting place. The office is closed two days before and two days after a storm. Before closing, the staff performs assigned tasks, such as shutting down the office, calling all patients who must be seen before the office is closed, and canceling those who have appointments. "I also see hospital patients and discharge those who can leave," Dr. Anthony notes. "Everybody has an assignment in the practice's written plan."

The last step before evacuating is to back up all computer files and place them in the water- and fireproof safe, along with the checkbooks. Windows, which have been outfitted with security film, are boarded up.

If the practice converts to electronic medical records, says Dr. Anthony, he will discuss with the server company whether the server is rugged enough to travel in the truck. "I also want the Internet connection to a second server off-site to be extremely secure. One company offers the use of their equipment as the off-site server." He has also made plans with a trailer company to acquire a two-bedroom trailer to temporarily replace his home or office. In addition, this physician has found a company that will rent and deliver a satellite phone if the cell towers are gone and/or phone-line congestion is high. "That will allow me to use my laptop to contact the backup server."

Dr. Anthony admits that most doctors have given far less attention to disaster recovery than he has. "This surprises me, particularly in the face of HIPAA regulations," he emphasizes. Overall, he keeps three objectives in mind when disaster planning: The first is to protect his family; the second, to continue providing care to his patients; and the third, to maintain his business. A good plan can help meet these potentially life-saving objectives.

Reported and written by Deborah Epstein, Contributing Editor in West Milford, NJ. For more information on HIPAA compliance, visit our Web site *(see page 8).*

More Tips for Distaster Planning

- Consider business interruption insurance. This is expensive, but will cover cash-flow losses and expenses in cases of an emergency.
- Make plans for temporary referrals to another physician.
- Make a list of alternate suppliers, in case disasters affect the ones you normally use.
- Keep a few days' supply of hard-to-replace items stored off-site.
- Consider buying a backup generator to keep computer systems, security systems, and other essentials up and running.
- Designate a remote telephone number on which you can leave recorded messages for your employees and, of course, give that number to all of your employees.
- Arrange for call-forwarding from your phone company so patients and suppliers and such will be able to contact the office.
- Install emergency lights that go on when the power is off. This type of lighting is inexpensive.
- Keep an off-site backup copy of your computer's operating system, boot files, and application software.
- Maintain off-site copies of computer invoices, shipping lists, and other documentation of the computer setup so that replacement components can be ordered quickly.
- Use a surge protector that has a back-up battery so the system continues to work through power blackouts.
- Develop an employee phone tree to quickly contact employees in an emergency.
- Always have emergency supplies available, including flashlights and batteries, a first aid kit, a tool kit, and a few days' supply of food and water.
- Don't forget to keep a copy of the disaster plan in a safe off-site location.

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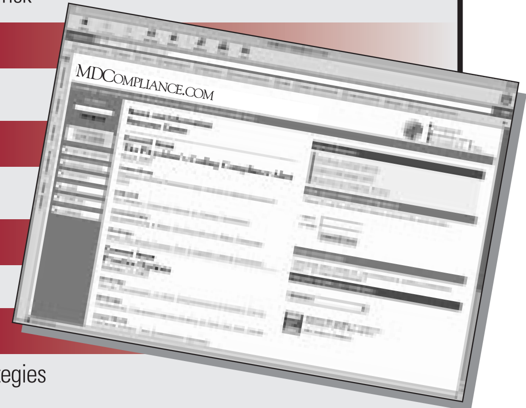

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