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New evaluation guidelines draw praise for minimizing 'counting' methods

New system won't be tested until 2002

At a June 22 "town hall" meeting at its Baltimore headquarters, the Health Care Financing Administration (HCFA) finally unveiled the latest version of its much-contested evaluation and management (E/M) documentation guidelines. The E/M protocols are used to document the level of service physicians provide individual Medicare patients.

Because it will be at least January 2002 before this latest E/M proposal is pilot-tested and vetted, practices are free to continue using the 1995/1997 guidelines for documentation purposes. Meanwhile, the June 1999 draft guidelines have been ditched permanently. The June 2000 guidelines, which are based on HCFA's 1995/1997 documentation guidance, represent the agency's latest attempt to clarify the requirements for the E/M's history-taking component. They attempt to minimize — but not entirely eliminate — the often criticized "counting" method used for the E/M's exam and medical decision making sections.

> "We want to make it as easy as possible for physicians to do their jobs and provide appropriate, quality care to their patients."
> ***Nancy-Ann DeParle**, HCFA*

Compared to the consternation caused by the 1997 proposed protocol, the first-blush reaction to this edition of E/M changes is generally positive. The highest praise from physicians goes to HCFA's decision to eliminate most of the so-called counting methodology.

As part of the June proposal, HCFA says it will develop specialty-specific vignettes for multisystem exams, single-system exams, and medical decision making that physicians can use as a guide for designing their

own personal documentation to go with exam findings, assessments, and the plan of treatment parts of the E/M process.

HCFA is planing two pilot studies of the June 2000 guidelines before making them official."We want to make it as easy as possible for physicians to do their jobs and provide appropriate, quality care to their patients,'' said HCFA administrator **Nancy-Ann DeParle**. "These simpler guidelines should make it easier for physicians to focus on patient care while ensuring that Medicare pays them appropriately for their services."

In 1995, HCFA and the American Medical Association issued the first set of documentation guidelines. These were updated in 1997 in a response to requests from specialists wanting more detailed E/Ms that recognized the narrower focus of the clinical services they provide. However, many physicians rebelled against the 1997 rewrite, calling them too cumbersome and hard to understand. "Physicians helped develop these guidelines, and we want physicians to tell us whether the revisions being tested are, in fact, better for them in the real world of day-to-day clinical practice," DeParle said.

A shorter format

Last June's version of the suggested E/M coding guidelines is similar to the earlier 1995/1997 proposals, except it tries to minimize the use of counting when it comes to exam and medical decision making.

The exam section is collapsed into three levels: brief, detailed, and comprehensive. A brief exam consists of one to two areas or organ systems; a detailed exam has three to eight areas, and a comprehensive one includes nine or more areas. Single-specialty exams will be determined by vignettes that are still being written.

Medical decision-making protocols also contain three levels: low, moderate, and high and will be based upon a series of future vignettes.

The history section contains clarifications relating to inclusion of medication lists and the review of stable chronic illnesses. Instead of the two to nine systems previously used for a detailed history of present illness, the review of systems section has been revised to include three to eight systems.

In another change, medical histories are only measured by the actual information obtained from the patient. No allowances, such as considering a history to be complete even if unable to obtain any data, will be granted. ■

Compliance plan helps, but other risk areas lurk

These key areas also need a practice's attention

The Office of the Inspector General's (OIG) guidelines for small and solo practices cover considerable ground. But OIG officials also are pointing to other risk areas that physician practices must focus on to avoid problems with investigators. Those include:

❑ **Advance beneficiary notices (ABNs).** The OIG reminds practices that before providing services a patient's local carrier does not consider reasonable and necessary, the practice first must tell the patient that Medicare may not pay for the treatment. The ABN acknowledges that coverage is either uncertain or yet to be determined and stipulates that the patient promises to pay the bill if Medicare does not. Patients who are not given an ABN before receiving medical treatment do not have to pay for those services.

To ensure patients make an informed decision about paying for potentially uncovered services, HCFA says an ABN must:

1. be in writing;
2. identify the specific service that may be denied (procedure name and CPT/HCPC code are recommended);
3. state the specific reason the physician believes the service may be denied;
4. be signed by the patient acknowledging that the required information was provided and that the patient assumes responsibility to pay for the service.

According to the *Medicare Carrier's Manual,* an ABN is unacceptable if the:

- patient is asked to sign a blank ABN form;
- ABN is used routinely without regard to a particular need. In other words, "the ABN must state the specific reason the physician anticipates that the specific service will not be covered," stresses the OIG.

Diagnostic tests and related services are areas in which practices often run afoul of ABN rules. Here are the steps the OIG suggests physicians take to help ensure they stay in compliance with proper ABN protocols:

1. Determine which tests are not covered under national coverage rules.

2. Determine which tests are not covered under local coverage rules such as local medical review

policies. The OIG recommends providers contact the carrier to see if such a list exists.

3. Determine which tests are only covered for certain diagnoses.

❑ **Certification of medical equipment and home health services.** The OIG reminds doctors they can be hit with criminal, civil, or administrative penalties for signing a certificate of medical necessity (CMN) for durable medical equipment or home health services when they know the information is false, or if they exhibit a "reckless disregard as to the truth of the information."

To avoid possible problems, before signing any CMN, you should:

- be the patient's treating physician;
- ensure any information regarding your address and unique physician identification number is correct;
- make sure the entire CMN, including the sections filled out by the supplier, is completed before you sign;
- ensure the information in section B relating to whether the item or service is reasonable and necessary is true, accurate, and complete to your best knowledge.

Actions such as signing a blank CMN, signing CMNs without seeing the patient to verify the item or service is reasonable and necessary, or signing a CMN for a service you know is not reasonable and necessary are considered violations by the OIG.

❑ **Teaching physicians.** The OIG says that in teaching programs, a teaching physician must be present during the key portion of any service or procedure for which payment is sought. To ensure that happens, the guidance recommends the following points be followed when services are provided in a teaching physician setting:

- Only bill for services actually provided.
- Every physician who provides or supervises the provision of services to a patient must be held responsible for the correct documentation of the services rendered.
- Every physician must be responsible for assuring that in cases where the physician provides evaluation and management (E/M) services, the patient's medical record includes appropriate documentation of the applicable key components of the E/M services provided or supervised by the physician (e.g., patient history, physician examination, and medical decision making), as well as documentation to adequately reflect the procedure or portion of the services provided by the physician.
- Every physician must document his or her presence during the key portion of any service or procedure for which payment is sought.

❑ **Third-party billing services.** The OIG's guidance reminds physicians that they are responsible for all claims in their names or containing their signatures, even if they were not aware of any billing improprieties. In other words, you're still on the hook even if your billing service screwed up.

When it comes to third-party billing arrangements, it's OK to contract with a billing service on a percentage basis. However, the billing service cannot directly receive Medicare payments made to the physician. Medicare payments can be made only to either the beneficiary or a party (such as a physician) who furnished the services and accepted assignment of the beneficiary's claim, says the OIG.

According to the *Medicare Carriers Manual*, a payment is considered to be made directly to the billing service if the service can convert the payment to its own use and control without the payment first passing through the control of the physician. For example, a billing service cannot bill claims under its own name or tax identification number. The billing service must bill claims under the physician's name and tax number. Nor can a billing service have Medicare payments sent directly to its office or bank account. Payments must be sent to the physician's office or bank account, says the OIG.

❑ **Billing by nonparticipating physicians.** Nonparticipating physicians can't knowingly and willfully bill or collect on a repeated basis an actual charge for a service that is in excess of the Medicare limiting charge. For example, a nonparticipating physician may not bill a Medicare beneficiary $50 for an office visit when the Medicare limiting charge for the visit is $25.

Also, nonparticipating physicians can't charge more than the statutory limit for such procedures as cataract surgery, mammography screening, and coronary artery bypass surgery. Nonparticipating physicians who collect more than the legal limit for a service must refund the excess to the patient within 30 days of the violation. For example, if a physician collects $50 from a Medicare beneficiary for an office visit, but the limiting charge for the visit was $25, the physician must refund $25 to the beneficiary. Physicians failing to comply can be fined up to $10,000 per violation or excluded from federal health care programs for five years.

❑ **Professional courtesy.** A "professional courtesy" is traditionally defined as the practice

of waiving all or a part of the fee for services provided to the physician's office staff, other physicians, and/or their families. It also can mean waiving the coinsurance obligations or other out-of-pocket expenses for physicians or their families (i.e., "insurance only" billing). Similar payment arrangements can be made by hospitals or other institutions for services provided to their medical staffs or employees.

That's fine except in cases where recipients of the care "are selected in a manner that directly or indirectly takes into account their ability to affect past or future referrals," said the OIG. In those cases, federal anti-kickback statutes can come into play.

If the professional courtesy involves waiving a copayment — or "insurance only" billing — that also can raise fraud and kickback questions.

The OIG's viewpoint

Here's the OIG's general take on professional courtesy issues: The "regular and consistent" practice of extending professional courtesy by waiving the entire fee to a group of persons (including employees, physicians, and/or their family members) is OK as long as there are no questions about a group member's ability to directly or indirectly refer federal health care business to the physician.

Tip: Even though sharp discounting of fees is legal, OIG sources say fraud investigators consider deep discounts to be suspect. That means the OIG is putting providers on notice that such arrangements are automatically open to scrutiny.

Medicare says charge differentials are OK, if for a "good cause." You have to be careful when a discount is substantially below the establish federal payment level. If a generous discount involves someone who is not indigent, the OIG will want to take a closer look to see if it is being used to generate illegal referrals.

❑ **Unlawful advertising.** The guidelines remind practices it's illegal to run advertisements using the names, abbreviations, symbols, or emblems of the Social Security Administration, Health Care Financing Administration, Department of Health and Human Services, Medicare, or Medicaid. You can't, for instance, place an ad that says something like, "Dr. X is a cardiologist approved by both the Medicare and Medicaid programs." Fines can reach $5,000 for print ads and $25,000 for radio or TV. ■

The compliance guidelines at a glance

Here are the basics of what has to be done

Following are the basics of the Office of the Inspector General's (OIG) proposed guidelines defining what constitutes an acceptable physician compliance program. **(For more information, see *Physician's Payment Update,* July 2000.)**

❑ **Written policies and codes of conduct.** It's not a compliance program if your policies and procedures are not written down. Specific areas for which the OIG wants written policies and protocols are coding and billing; reasonable and necessary services; documentation; kickbacks, financial inducements, and self-referrals; and record retention.

❑ **Compliance officer.** Practices must designate one person from the staff to be responsible for overseeing the compliance program. More than one staffer or physician can be appointed to do compliance monitoring. You also can outsource part of all of the compliance officer's responsibilities to a third party, such as a consultant, physician practice management company, management services organization, independent practice association, billing company, or professional association. Finally, you can place your practice under the compliance program of another institution, such as a hospital.

❑ **Training and education.** All employees must at least be familiar with the key risk areas identified in this guidance and the annual OIG Work Plan, which highlights the agency's enforcement priorities for the coming year. The OIG wants to see new hires in compliance training within 60 days of coming aboard. It also wants practices to perform annual training that emphasizes that compliance is a condition of continued employment.

❑ **Communication.** There needs to be evidence of a clear open-door policy when it comes to registering concerns. That includes emphasizing employees can report any concerns without fear of retribution.

❑ **Internal audits and monitoring.** The OIG will be looking for regular self-audits of claims based on the practice's top 10 denials — or top 10 services provided.

❑ **Disciplinary actions.** The program needs to have consistent and appropriate sanctions

Sending money back? Prepare to be questioned

The Health Care Financing Administration (HCFA) has told Medicare contractors any time they receive an unsolicited, voluntary refund check from a provider or supplier they must contact HCFA. Specifically, the carrier must find out why the refund check was cut, how the payment problem was identified by the provider, and why the incorrect bill was originally submitted. Then the carrier must take corrective steps to prevent similar errors from happening.

On top of that, if the refund is at least 20% of the total annual Medicare payments to that provider, the carrier must perform an analysis to determine if there is a pattern of inappropriate payments requiring closer investigation. ■

ranging from oral warnings to termination for anyone violating compliance rules.

❑ **Responsiveness.** Practices must quickly investigate and correct any possible compliance questions and take decisive steps to correct the problems. That includes returning any overpayments you uncover. Providers have a 90-day grace period from day of discovery to report possible problems to appropriate officials before the feds start wondering why you have not been more forthcoming. ■

Five key questions auditors likely will ask

The right answers can avoid headaches

Here are five key questions federal inspectors often ask when looking at a provider's reimbursement profile. These are questions your compliance officers also should be asking, suggests **Sanford V. Teplitski**, head of the health law practice at the law firm of Ober, Kaler, Grimes and Shriver in Baltimore.

1. **Do your medical services cost the federal government more than they should?** Remember, things like joint ventures designed to capture a noncompetitive market can have the effect of driving up charges to a point where they are higher than those in more competitive, nearby markets. That, in turn, may raise a red flag among government auditors, says Teplitski. To protect yourself, he recommends establishing a set of controls and objective audits to justify your claims.

2. **Are you appropriately providing services to patients?** Do you give the appearance of overutilizing services for patients you can bill for such procedures? Do you appear to be underutilizing services in cases were reimbursement is fixed? Either can get you into compliance trouble.

3. **Is the quality of the care you provide up to community standards?** Look for different standards for different payers and whether your physicians and nonphysician providers meet or exceed officially recognized medical quality standards.

4. **Is there adequate access to medical care?** Check to see if patient access is uniform, regardless of how patients pay, especially when it comes to emergency services. Anything you can do to improve access will be considered a compliance plus. However, any actions that appear to restrict patient access could create a problem.

5. **Do your patients have freedom of choice?** Be prepared to show that there is informed consent and that patients are free to choose their provider, home health company, radiotherapy institution, etc., regardless of any relationship you have have with those entities.

Also, be prepared to show that patients participate in the decision making when it comes to choosing alternatives between expensive and less expensive treatments or tests. You should be able to demonstrate that patients participate in deciding whether they should go home, be transferred to another kind of facility, or remain for an extended inpatient hospital stay.

Some final considerations when reviewing your compliance efforts include how aggressive you are in repaying overcharges to intermediaries and whether your compliance program ensures disclosure of prior contractual arrangements that may result in inadvertent overpayment by Medicare or duplicate payment by other funding sources. ■

Advice on structuring small-group pay plans

Here are models to choose from

Medical groups with 10 or fewer physicians face unique challenges in designing a workable compensation plan, says **Bruce Johnson**, JD, MPA, a consultant with the Medical Group Management Association's in Englewood, CO.

For one thing, "a smaller group's administrative staff may not have the time or resources necessary to properly administer a plan based on multiple and complex measurements of physician production and behavior," notes Johnson.

Overinvolvement of all the physicians in a small group is another common factor that creates its own set of concerns. Particularly because "the defection of just one physician from the group can mean a big hit in income to the rest, each physician in a small group — even a nonshareholder — can give that doc effective veto power," he observes.

The fact that group members often are asked to make subjective judgments about each other's performance also complicates compensation planning.

Two approaches

Most groups deal with those issues by taking one of two different routes — either the individualistic or team approach — toward their physician payment programs, he says.

Groups taking the individualistic approach act more like a cost-sharing alliance with each physician responsible for his or her own costs and revenues. The downside to that can be internal squabbling over cost allocation, micromanagement of expenses, and a lack of group identity.

Johnson calls the other strategy the "single economic unit" or team approach, in which each physician receives base salary and they all share business costs. "This approach promotes the group concept but does not impose direct responsibility for costs," he notes. Another potential problem is that it fails to account for large variations in production and work level among physicians.

For most groups, a middle-ground approach that combines features of the individualistic and team models is probably best, Johnson says. "Compensation under these models can be based on production, equal share, a base salary plus incentives, or a combination of approaches," says Johnson. Warning: Practices taking this approach must ensure that the method of allocating revenues they use complies with physician self-referral laws.

Other details he feels should be part of your physician compensation plan include:

- **Buy-in.** "There must be physician buy-in as to what data the plan will be based on, how it will work, and what goals and values it will promote," he stresses.
- **Education and assessment.** "Physicians should understand exactly how the plan works and which benchmarks or comparisons will be used; otherwise, it's a dictatorship," he says.
- **A time frame.** To keep everyone focused on the task at hand, set a date to complete and present the proposal for approval or disapproval before starting to design a plan.
- **Goals and values.** Do you know exactly what you want? Is the goal to promote the individualistic approach, or are you after better teamwork?
- **Modeling.** Physicians will want to see how the plan will affect them, so make sure the proposal contains a model that uses recent financials to show how everyone's pay would be affected. ■

Will payers in the future be individual patients?

Some believe a radical shift is coming

More businesses are actively discussing the idea of dropping their employee health insurance benefits and instead giving workers a lump sum of money — or defined contribution — to buy their own medical care directly, note a growing number of health care experts.

A recent survey of *Fortune* magazine's "100 Best Companies to Work For" by Booz Allen & Hamilton, for instance, found most of those top employers plan to shift to a defined-contribution health care plan over the next decade as a way to manage rising employee medical costs and ease their way out of the business of directly buying and providing health care benefits.

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Physician's Coding Strategist™

Consultation vs. office visit: Know the difference

Knowledge can pay off

Many practices are not clear about when they can bill Medicare for a consultation rather than a typical office visit. Since "consultations tend to be reimbursed at a higher rate than comparable office visits, understanding the differences can be to your advantage," notes **Kent J. Moore**, manager for reimbursement issues at the American Academy of Family Physicians (AAFP).

Moore says Medicare only pays for a consultation when all of the following criteria are met:

• The service is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source — unless it's a patient-generated second opinion.

• The request and need for the consultation are documented in the patient's medical record.

• After the consultation, the consultant prepares a written report of his or her findings and provides it to the referring physician.

If the referring physician and consultant share the medical record, the request for a consult must be documented in one of three ways: as part of a plan in the referring physician's progress note, an order in the record, or a specific written request for the consultation.

Likewise, the consultant's report may consist of an appropriate entry in the common medical record. "In situations where the medical record is not shared, the request for a consultation may be documented in one of two ways," says Moore. The consultant's record may include either a written request from the referring physician or a specific reference to the request. In either case, the consultation report should be a separate document supplied to the referring physician. "When you're the consultant, you could bill a consultation for performing a postoperative evaluation if you didn't already perform the preoperative consultation," he advises.

If another physician in your group asks you for a consultation, or if a surgeon asks you to perform a preoperative consultation, Medicare will reimburse you for a consultation as long as the previously mentioned criteria for use of the consultation codes are met.

"It is also possible to bill a consultation code for performing a postoperative evaluation at a surgeon's request, but only if you did not already perform the preoperative consultation," says Moore.

However, if you assume responsibility for management of a portion or all of a patient's condition during the postoperative period — such as for a local patient who receives surgery out of town — you cannot bill a consultation code, regardless of whether you performed the preoperative consultation. Instead, use the appropriate subsequent hospital care code or office visit code to bill your services, he says.

When a consultation turns into treatment

"If the criteria for a consultation are met, a consultant may bill an encounter as a consultation, even if he or she initiates treatment, unless a transfer of care occurs," says Moore.

According to Medicare, a transfer of care occurs "when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance."

In turn, the receiving physician should bill an established or new patient office visit code, whichever is appropriate, rather than a consultation code. Any subsequent visits to manage a portion or all of the patient's care are then reported using a visit code, he notes. ■

New CPT codes took effect July 1

-27 modifier approved for early use

Make sure you and your payers have updated your code books with these new American Medical Association codes, which went into effect July 2000. The new codes are:

- **90378.** Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg each.
- **90669.** Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use.
- **90702.** Diphtheria and tetanus toxoids (DT) adsorbed for use in individuals younger than 7 years, for intramuscular use.
- **90718.** Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals 7 years or older, for intramuscular or jet injection.
- **90723.** Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use.
- **90732.** Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use.
- **90740**. Hepatitis B vaccine, dialysis, or immunosuppressed patient dosage (three-dose schedule), for intramuscular use.
- **90743.** Hepatitis B vaccine, adolescent (two-dose schedule), for intramuscular use.
- **90744.** Hepatitis B vaccine, pediatric/adolescent dosage (three-dose schedule), for intramuscular use.
- **90747.** Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (four-dose schedule), for intramuscular use.
- **Modifier -27: Multiple Outpatient Hospital Evaluation and Management (E/M) Encounters on the Same Date.** This CPT modifier has been approved for early electronic release to help facilitate hospital CPT outpatient reporting. The new CPT modifier will be used to delineate when a patient receives multiple E/M services performed by the same or differing physicians(s) in multiple outpatient hospital settings. This modifier will be used in reporting utilization of hospital resources related to separate and distinct E/M encounters performed on the same patient and provided by the same or different physician(s) in more than one (different, multiple) outpatient hospital setting(s) — such as a hospital emergency department or clinic — on the same date. ■

E/M coding still confusing under final outpatient PPS

By **JoAnn Pata**, MS, RHIA, CCS
Health Information Management Consultant
HIM Professional Resources
Philadelphia

Q. The final rule of the outpatient prospective payment system (PPS) states: "Therefore, each facility should develop a system for mapping the provided services or combination of services furnished to the different levels of effort represented by the codes. . . . We will hold each facility accountable for following its own system for assigning the different levels of HCPCS [HCFA common procedure coding system] codes.

"As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill. Therefore, we would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility."

Does that mean coders would not use the HCFA/AMA (Health Care Financing Administration and American Medical Association) documentation guidelines that were developed to aid physicians in evaluation and management (E/M) code assignment?

A. According to this *Federal Register* reference, the HCFA/AMA documentation guidelines don't even come into play, in my opinion.

What system or methodology for E/M code assignment does HCFA expect hospitals to use? HCFA and the AMA developed documentation guidelines for E/M code assignment in 1994 because providers and carriers had trouble assigning and auditing the E/M services codes revised in 1992. If each facility will be held accountable for following its own system for assigning the different levels of HCPCS codes, who will determine whether a facility's own system reasonably relates the intensity of hospital resources to the E/M outpatient and emergency codes?

I urge coders to go to the beginning of this section, which deals with visit codes, to get the whole picture. It begins on p. 18,450, item 3, "Treatment of Clinic and Emergency Department Visits." In the discussion, HCFA states it had been concerned that certain hospitals' use of the lowest-level code, CPT code 99201, to bill for all clinic visits would distort the data.

That, however, was HCFA's required reporting per the *Medicare Hospital Manual*. A facility could report codes 99201 or 99211 as an indicator or "flag" for a medical visit, or it had the option of reporting visits according to the specific E/M levels. Reporting a code from the five visit levels was not a requirement.

The discussion continues on p. 118,451: "We have developed the weights for clinic visits by using claims data only from a subset of hospitals that billed a wider range of visits rather than relying solely on claims with CPT code 99201. We chose to use this subset of hospitals (for this purpose only) because we do not know what CPT code 99201 indicates when hospitals use it exclusively to bill all visits."

Q. HCFA has developed the weights for visit codes found in this final rule from a subset of hospitals that used a wider range of visit codes. How did hospitals assign E/M codes in 1996, the year used for analysis?

A. From my consulting experience, some hospitals applied the HCFA/AMA documentation guidelines to determine the visit level. Other hospitals used the code for the E/M level found on the emergency department physician's encounter form used for billing professional services, and some hospitals applied a nursing classification system that was mapped to the existing E/M levels. I don't believe there has ever been a consistent approach.

The final rule continues, "We emphasize the importance of hospitals assessing from the outset the intensity of their clinic visits and reporting codes properly based on internal assessment of the charges for those codes, rather than failing to distinguish between low- and mid-level visits because the payment is the same. The billing information that hospitals report during the first years of implementation of the hospital outpatient PPS will be vitally important to our revision of weights and other adjustments that affect payment in future years.

"We realize that while these HCPCS codes appropriately represent different levels of physician effort, they do not adequately describe nonphysician resources. However, in the same way that each HCPCS code represents a different degree of physician effort, the same concept can be applied to each code in terms of the differences in resource utilization," the rule states.

Consistency a problem

To an HIM professional, that statement about assigning visit codes is most disturbing because it suggests a system that is not standardized across the board and has the potential for abuse. HCFA is asking that codes be reported properly, "based on internal assessment of the charges for those codes. . . ."

Given the variation in charges from hospital to hospital, it could be possible that an emergency department record, for example, would be assigned to a higher E/M level at another hospital, even though the documentation is the same. The billing information hospitals report during the first years of implementation of the hospital outpatient PPS are vitally important to HCFA's revision of weights and other adjustments that affect payment in future years. But can it be meaningful when there is the possibility for broad variations in E/M level assignment, as the final rule suggests?

Finally, HCFA states, "In the same way that each HCPCS code represents a different degree of physician effort, the same concept can be applied to each code in terms of the differences in resource utilization." I agree that the same concept applied to the different levels of physician effort can be applied to differences in resource utilization. But how can a valid, proven method of doing this be developed by the implementation date? In my opinion, leaving each facility responsible for developing its own system can only lead to chaos.

Q. With this confusion, what would you recommend to hospitals?

A. According to the final rule on p. 18,451, coders will have to learn the mapping system their hospital decides to use, "which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes."

I suggest looking to the American Health Information Management Association, the American Hospital Association, and the state hospital associations for direction in this area.

[HIM Professional Resources can be reached at (215) 389-6777.] ■

OIG to review claims software

Problems with proprietary software

Although Medicare claims software written for commercial distribution to a large audience poses little risk of producing erroneous or false claims, proprietary software appears more likely to pose some risk of misuse or fraudulent use, according to a report released by the Office of the Inspector General (OIG) in Washington, DC.

The OIG had decided to review software literature and claim preparation processes because of the vast numbers of claims that were being electronically submitted to Medicare.

Here's what the report found

The report, "Medical Billing Software and Processes Used to Prepare Claims," found many potential problems with the submission of the claims, including:

- Medicare cannot identify most of the clearinghouses and billing agencies submitting claims into the Medicare systems because most use the physician's or medical supplier's billing number and submitter number.
- Medicare can't determine whether claims enter its system from an authorized biller's site and computer or from unauthorized sites and computers.
- Billing companies, their employees, and employees of providers have access to patient and provider information needed to gain entry into the Medicare system.

The Health Care Financing Administration in Baltimore has taken a "step in the right direction" by creating a new computer system, called the Provider Enrollment, Chain and Ownership System. The OIG made these further recommendations in its report:

- Identify and register all clearinghouses and third-party billers. This would provide an audit trail.
- Improve safeguards to ensure that electronic claims are accepted only from authorized sites and terminals.
- Educate the provider community about its liability for erroneous claims submitted to Medicare using its provider number(s). ■

(Continued from page 114)

"A quiet revolution in health care benefits is coming, as employees are placed in the driver's seat for selecting their own health plans in an open market," notes **Gary Ahlquist**, a Booz Allen & Hamilton consultant. "Over the next 10 years, employer-sponsored health plans will evolve en masse into defined-contribution formats, finally and irrevocably creating a consumer-driven health care system in the United States," he says.

The next revolution?

If enough employers decide to get out of the business of directly buying health coverage for their workers, that decision would represent a revolution in the way health care benefits are delivered and how the current managed care system operates. The change would radically affect finances and the way providers promote their practices, say many observers. For instance, rather than competing for contracts covering large numbers of lives from employers and managed care companies, providers may have to rely more on retail marketing, gathering patients one at a time through affiliations with cyberspace-based marketing intermediaries.

A defined contribution health care plan mirrors the well-known 401K pension concept in that employers give employee participants a certain amount of money to purchase health benefits that suit their individual needs, often using on-line services to obtain information about costs and benefits.

Under this new approach, employees create their own customized network of providers who set their own fees from a Web-based menu supplied by an outside vendor.

Meanwhile, how much an employer contributes to each worker's health account is based on accrual calculations using age and number of dependents, not unlike the way most firms currently determine their projected health care costs. The difference is that the employers' total financial liability is set at a fixed annual amount.

Many employers like the concept because it has the potential to control costs while easing them out of the business of directly managing health care benefits. Providers, in general, are responding to the idea because it permits them to set their own reimbursement rates, be paid directly by patients, and avoid dealing with managed care paperwork and contracts.

One big issue supporters don't like to acknowledge is that most polls show consumers prefer the current employer-based health system over a defined contribution one. Experts like Ahlquist acknowledge that consumer resistance will slow the transition to defined-contribution health plans, but he insists the shift will occur.

Oddly, one factor most likely to give defined contribution health accounts a boost will be a slowdown in the economy, which would cool the currently overheated job market, making firms less worried about alienating top talent.

"The transition to defined-contribution plans will become a tidal wave within three to five years, and eventually, employer-managed, defined-benefit health plans will be largely a memory," Ahlquist predicts. ■

Two 'virtual HMOs' prepare for launch

Pros and cons still being debated

Two Minneapolis start-up companies based on the defined-contribution, virtual HMO philosophy already are planning to sell health services on-line to employer-based groups. Vivius (www.vivius.com) plans to pilot-test its concept in Kansas City, MO, starting this fall. HealtheCare (www.healthecare.com) is aiming for a pilot launch by year's end.

Vivius divides providers into 20 categories, including primary care physicians, doctors in 14 specialties, hospitals, labs, and pharmacies, according to an analysis by the American Medical Association (AMA). Each specialty sets its own fees, which are translated into a flat monthly rate paid by consumers, much like capitated per member per month fees. "Under this system, doctors in a new practice might charge less to draw patients while those in established practices with a solid reputation might charge more," notes the AMA. Vivius also permits physicians to raise or lower their rates for new customers and, after one year, alter rates for existing customers.

HealtheCare, on the other hand, plans to create an instant network by offering the services of independent practice associations to its customer base. However, individual doctors also can join the system, says **Tom Valdivia**, MD, HealthCare's chief medical officer.

Under both approaches, employees pay out of their own pockets if the benefits they select, and the providers, cost more than defined contribution set-asides by their employers. However, workers choosing lower-charging providers can use any leftover funds to buy other health-related services.

Both of those dot.coms make their money by charging providers an administrative fee or a fee for any the business they generate.

On the downside, some experts worry that without a traditional carrier to cover the related insurance risk associated with unexpected costs of care for some patients, providers will end up having to pay monthly risk payments to the dot.com to cover that contingency.

Vivius counters that it is less risky than traditional capitation because physicians can raise charges whenever they like for new patients. The company also says it is spreading the risk by charging higher rates to certain demographic groups that generally have higher medical bills, such as women in their childbearing years and men ages 55 and older.

While the approach is financially sound, some benefit experts wonder if companies would be willing to segment employees that way because of the morale problems it could create. ■

New Medicare+Choice rules aim to end exodus

Will it be a kinder, gentler program?

The Health Care Financing Administration (HCFA) has released final rules for its beleaguered Medicare+Choice program intended to sooth concerns that have led to a mass exodus of HMOs from the program.

The rule changes are aimed at quieting criticism that regulations for the risk-based program regulations were too harsh and reimbursement rates too low. The regulations released June 19 will "allow the agency to continue to ensure that Medicare beneficiaries enrolled in Medicare+Choice plans will receive quality health care without imposing new, unnecessary costs on the organizations that provide the care," claimed HCFA administrator **Nancy-Ann DeParle**.

HCFA plans to extend the transition period for adjusting risk rates in response to health plan complaints that a more gradual phase-in of risk adjustment to would ease the transition to the new system.

The Medicare +Choice program was created in 1997. About 6.2 million, or 16% of all Medicare beneficiaries, are currently enrolled in a Medicare HMO. According to HCFA, the proposal will help streamline the Medicare+Choice program by:

- increasing flexibility in establishing a provider network, which will allow more health care providers to serve plan enrollees;
- improving freedom of choice by allowing plans to offer beneficiaries a point-of-service option that broadens access to health care services from both in-network and out-of-network providers;
- allowing organizations that left Medicare+Choice to return in two years, instead of five;
- easing compliance plan reporting by eliminating the self-reporting component of the Medicare+Choice program.

The regulations also include a number of key elements that were part of earlier Medicare+Choice regulations. Those measures:

- speed the appeals process to ensure that beneficiaries' appeals are heard based on their health needs;
- simplify the certification of payment data and adjusted community rate submissions by Medicare+Choice organizations that establish a good-faith standard for the certification of data. Medicare+Choice organizations now will certify the accuracy of payment information to their "best knowledge, information, and belief";
- clarify provider anti-discrimination rules that state Medicare+Choice organizations can no longer discriminate against providers based solely on their licensure and certification. However, this requirement does not preclude organizations from contracting with the providers they choose and setting their payment rates, consistent with their quality and cost control responsibilities under the statute;
- allow out-of-area Medicare beneficiaries to convert to a Medicare+Choice plan. This will expand the opportunity for a seamless conversion to Medicare+Choice for beneficiaries who wish to continue receiving health care services through their managed care organization when they become eligible for Medicare;
- implement a bonus payment program to encourage Medicare+Choice plans to serve beneficiaries in areas that currently do not have Medicare+Choice options. ■

Oklahoma doctors building their own 42-bed hospital

Special focus may be key to success

Twenty Oklahoma physicians will take the idea of integrated medical services to the extreme when they break ground sometime this fall on construction to build their own 42-bed $24 million hospital. The project was announced last May.

The group hopes to have the Moore, OK, facility, about 10 miles from Oklahoma City, open by summer 2001. The 106,000-square-foot, for-profit hospital is being built next to the existing Moore Medical Office Building, where some of the physicians already have offices.

Despite the poor record of similar ventures, the Oklahoma doctors say the combination of local demographics and a focus on certain specialties and patient populations give them the edge they will need to succeed.

Matching the population

For instance, Moore is a relatively young, growing community with many families, notes **John Resneder**, MD, a spokesman for the physician group. With the highest rate of private health insurance in the state and a $50,000 per capita family income, Moore also has a very small percentage of Medicare-eligible residents.

With those facts in mind, the facility has been organized to focus on such things as obstetrics and gynecology, pediatrics, and routine surgeries. The hospital will offer emergency and diagnostic services, a women's center with 12 specialty birthing suites, three surgical suites, and 30 inpatient beds.

Patients needing the services of specialists such as cardiologists, oncologists, or neurosurgeons will be referred to local tertiary care facilities for treatment.

Often, the odds of financial success for this kind of primary-care-focused hospital depend on the makeup of its payer mix, says **Dean Coddington**, a principal in the Denver office of health care consultants McManis Associates.

"If they stay away from a lot of the Medicare and Medicaid population and don't have to discount or provide a lot of care for free, they may they have a shot, he says.

The Schuster Group, an Oklahoma City health care development company, is helping finance the start-up with cash and by providing the land and equipment for the facility. In exchange, the doctors are investing an undisclosed amount to cover start-up operating costs and construction. ■

HMOs using a combo of physician pay plans

RVS and capitation used together

During the last two years, HMOs have shifted toward paying physicians via two payment systems — capitation and a relative value scale (RVS), according to InterStudy, one of the nation's leading trend analysis firms of HMO activities, based in Minneapolis.

"The latest trend between 1997 and 1999 shows that relative value scale and capitation have both become increasingly important to HMOs," says **Tammy Lauer**, lead author of InterStudy's most recent trend report.

"Increasingly, HMOs are applying both systems simultaneously. The RVS reimbursement method is used to reinforce the importance of front-end (preventative) patient care by improving the payment doctors receive for working with patients to prevent, detect, and treat health care conditions earlier and more efficiently," Lauer and colleagues report.

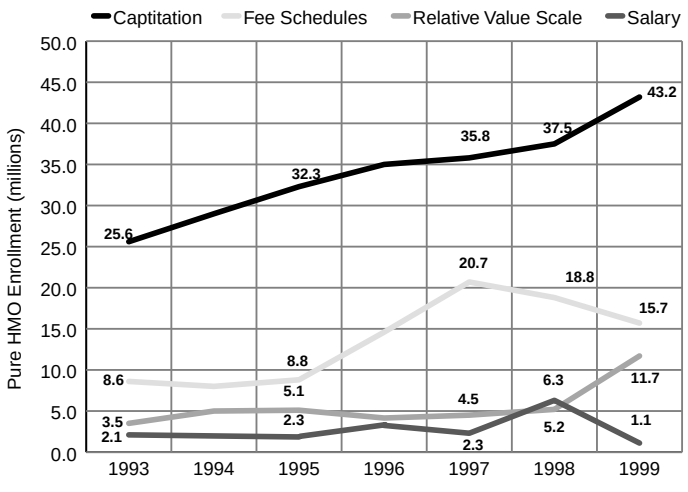
In HMOs using only one type of reimbursement for primary care physicians, RVS is the most popular method, utilized by 38.8% of HMOs.

Trends to watch

The following are other trends regarding capitation vs. fee-for-service payment in HMOs, based on InterStudy's survey of 338 responders (figures in this article do not add up to 100% in all cases because other payment methods such as non-RVS fee schedules and salaries were measured in the study but not highlighted in the report):

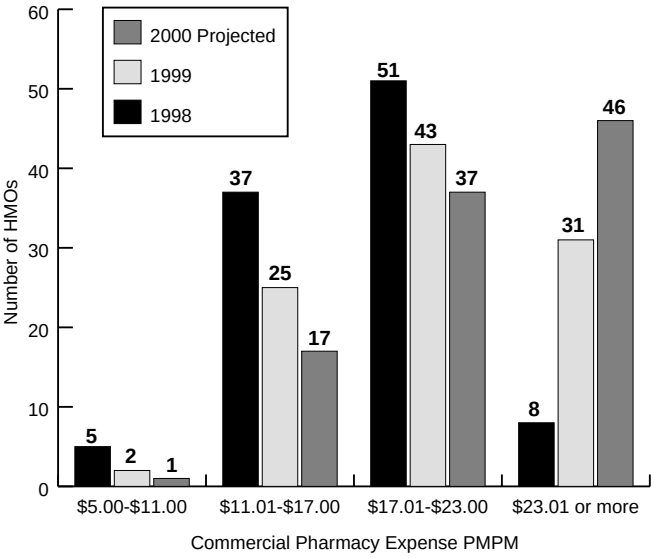
• Primary care physicians are reimbursed by HMOs almost as often through fee for service (30.6%) as capitation (27.2%).

HMO Growth by Primary Care Physician Reimbursement Type: July '93-July '99



Source: Interstudy, Minneapolis.

HMO Commercial Pharmacy Expense PMPM



Source: Interstudy, Minneapolis.

• The majority of HMOs that use only one type of reimbursement for specialty care physicians are relying on a fee-for-service structure, which is used by 58.6% of HMOs.

• 34% of HMOs use RVS exclusively to pay specialty care physicians, while only 7.4% report using capitation.

• Approximately 46% of HMOs reimburse primary care physicians through a combination of two reimbursement methods. Of that group, 107 HMOs use both fee for service and capitation for primary care services, while 31 HMOs reimburse primary care doctors through a combination of capitation and RVS.

Membership dropping

Overall, HMOs' previous skyrocketing growth rates have entered a clear reversal. For the first time in their history, the semiannual growth rate of HMOs has dropped, decreasing 0.6% from Jan. 1, 1999, to July 1, 1999, for a net total enrollment loss of 508,000 members, InterStudy reports.

At the same time, the annual growth rate continues to decline, dropping to 2.6% from July 1, 1998, to July 1, 1999.

In every domain of HMO business, graphs of growth rates bear the bell-shaped curve effect. For example, the growth peaked in the mid-1990s and then steeply declined in late 1999. Overall, the highest growth hit 18.5% in 1996 and trickled down to 2.6% in 1999.

Jagged growth

Looking at Medicare HMO exclusively, the bell curve for growth is more jagged but also more extreme: 6.7% growth in 1991, 25% in 1992, 35% in 1996, and 4% in 1999.

Medicaid HMOs reflect more ups and downs: 27.3% growth in 1992, a spike to 42.1% in 1994, a drop to 22.2% in 1995, back up to 57% in 1996, and down to 14.3% in 1999. ■

COMING IN FUTURE MONTHS

- The dos and don'ts of nonphysician billing
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- Exploring the latest trends in physician compensation
- Learning to use — and love — the Internet

Reimbursement ROUNDUP

Medicare may cut payments for some drugs

Medicare wants to cut reimbursement for about 50 drugs typically administered in physicians' offices to control drug-related costs.

Under current policy, Medicare pays physicians 95% of the average wholesale price of drugs administered to patients incident to other professional services.

However, because many physicians can purchase drugs at below wholesale prices used by Medicare carriers to calculate payments, some are reaping profits anywhere from 11% to 900% over official reimbursement levels, says the Office of the Inspector General. In turn, Medicare is asking carriers to use newer, more accurate average wholesale prices for these 50 popular drugs starting Oct. 1.

As part of the policy review, the House Commerce Committee is investigating allegations that drug companies have artificially inflated the average wholesale prices for certain prescriptions to give physicians a financial incentive to use particular drugs. ▼

Got a gripe about Medicare? MGMA wants to know

Got a pet peeve about a regulation or administrative requirement? How about a suggestion for reducing the hassle when dealing with Medicare? If so, the Medical Group Management Association (MGMA) wants to hear from you.

MGMA is asking providers to help identify Medicare compliance and reimbursement problems they feel present the greatest barriers for medical group practices. That information, along with recommended solutions, will be presented to Congress, the Medicare Payment Advisory Committee, and the Health Care Financing Administration.

If you have a suggestion, contact the Medical Group Management Association by e-mail at govaff@mgma.com or call (202) 293-3450. ▼

Medicare+Choice providers must have physician ID

Beginning Oct. 1, 2000, Medicare will start collecting physician encounter data from Medicare+Choice organizations as part of its programs to devise more accurate risk adjustment payments. To identify participating providers, the agency plans to use the Unique Physician Identification Number (UPIN). In turn, Medicare+Choice contracted physicians and nonphysician practitioners — physician assistants, nurse practitioners, physical therapists, etc. — who don't already have an ID number need to get UPINed ASAP. ▼

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Editor: **Larry Reynolds**, (202) 347-2147.
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcpub.com).
Senior Production Editor: **Terri McIntosh**, (404) 262-5446.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

Pharmacy capitation offers edge downward

The hottest thing going with marketing capitation to seniors has been the addition of prescription drug coverage — in some cases, fully covered drugs. Add the rich drug benefit and the much-lowered basic price of an office visit — as opposed to the fee-for-service approach — and you see major cost shifting. The hottest feature in marketing becomes the coldest disaster of physicians straining under drug-included capitation arrangements.

But the "freebie" drug benefit that had been so characteristic of Medicare+Choice (M+C), which is Medicare's capitated system, is declining. The question is whether this decline will continue, or if it's a blip on the radar screen, according to a recent report by the Medicare Payment Advisory Committee (MedPAC). MedPAC is Congress' chief research and advisory group for Medicare and Medicaid policy decisions. In 1999, 65% of Medicare beneficiaries had access to a plan with drug coverage. In 2000, that percentage dropped to 64%. In 1999, about 54% had access to a zero-premium drug plan with drug coverage, and in 2000, the proportion dropped to 45%.

Drug benefits dropping?

Medicare beneficiaries have access to a M+C plan with rather extensive drug benefits. For example, the typical Medicare capitation plan offered an annual cap of $500, generic copayments of no more than $15, and brand copayments of no more than $20.

Managed care plans may be cutting back their generosity in drug coverage to seniors, given the intense rise in expenditures in that area. But at the same time, public pressure is building for lawmakers to broaden Medicare's coverage of drugs. The demand is huge. In 1968, seniors spent an average of $64 annually on drugs, compared to $848 in 1998. At the same time, out-of-pocket expenditures have reversed. In 1968, seniors paid about 87% of their drug costs themselves, compared with 28% in 1998.

"This decline in patient liability for prescription drug costs has been one of several factors that have contributed to a 200% increase in total real drug spending per person in the same year," MedPAC stated.

According to MedPAC's analysis, Congress has a long way to go before deciding on the vast array of options for beefing up Medicare's pharmacy benefits. Here are a few options they care considering:

- voluntary vs. mandatory pharmacy benefits;
- subsidies;
- changing deductibles, out-of-pocket maximums, and benefit limits;
- adding an extensive benefits management component to Medicare's administration;
- tax credits, vouchers, and deductions.

Congress will address those mammoth tasks again this summer. ▼

Pap coverage may be expanded

Medicare would cover annual pelvic exams and Pap smears for all women under legislation being promoted by Reps. Clay Shaw and Karen Thurman, both Republicans from Florida.

Currently, Medicare will pay for annual cervical cancer screening for women who meet high-risk criteria or are of childbearing age and have had an abnormal Pap test during the past three years. ■