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INSIDE

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Your next administrative headache: Complying with OIG compliance rules

Don't wait until the last minute and scramble for results

If your practice doesn't already have a formal program in the works to ensure that you comply with the regulations of federal health care programs, you should start to develop one now. The Office of the Inspector General (OIG) of the Department of Health and Human Services issued its "Draft Compliance Program for Individual and Small Group Physician Practices" in June.

Although the compliance program guidance is still in draft form, it is unlikely to change much when the final guidance is issued, says **John Knapp**, JD, a health care attorney with Cozen and O'Connor in Philadelphia. "What they have promoted as a draft is very consistent with the guidances for nursing homes, hospitals, and durable medical equipment companies," he adds.

The guidance calls for physician practices to establish a formal compliance program that includes internal controls and procedures to help prevent erroneous and fraudulent conduct by anyone in the practice and to ensure the accuracy of all claims submitted to federal health care programs.

"The OIG is serious. It has been giving notice of this for a long time, and it's not going to go away despite the fact that physician practices are already complaining that they are overly burdened by administrative requirements," Knapp says.

The compliance program should be part of each physician practice's efforts to make sure it complies with the law and to mitigate sanctions in the event that it doesn't, Knapp says.

"Adopting a voluntary compliance program is a lot like practicing preventative medicine. It helps identify and treat small problems before they become big problems," Inspector General June Gibbs Brown said in a press release accompanying the draft compliance program guidance.

The OIG calls the compliance guidance "voluntary," but it's advisable

7 Basic Compliance Elements

Here are steps the Office of the Inspector General suggests that physician practices take to establish a compliance program:

1. Establish compliance standards by developing a code of conduct with written policies and procedures.
2. Assign compliance monitoring efforts to a designated compliance officer.
3. Conduct comprehensive training and education for your staff on practice ethics and policies and procedures.
4. Conduct internal monitoring and audits, particularly in high risk billing and coding areas.
5. Develop lines of communication to keep your employees updated on compliance activities. These may include discussions at staff meetings about fraudulent or erroneous conduct issues or community bulletin boards.
6. Enforce disciplinary standards by making clear to your employees that compliance is treated seriously and that violations will be dealt with consistently and uniformly.
7. Respond promptly to any violations you detect. Investigate them and disclose them to the appropriate government entity. ■

to look at it as mandatory, the experts say. "When the OIG provides recommended guidelines, they are not technically required, but it is always a good idea to move toward compliance. These guidelines obviously represent an area of concern, and the OIG will concentrate on those issue in the future," says **Jay Williams**, principal of Arista Associates, a health care strategy consulting firm in Northbrook, IL.

Although the law doesn't say a practice must have a compliance program and there is no date for having it established, it's still advisable to start one, Knapp points out.

"What [the OIG] is saying is that if you don't have a compliance program and in the future you're subject to prosecution for violating the law, you won't have the defense of having a compliance program," he adds. **(To learn what areas are most frequently the targets of investigations, see p. 132.)**

Physician practices will have some time before the final guidelines come out, which will give them a chance to set priorities on the issues they need to tackle first, Williams says.

Although this is yet another administrative and bureaucratic burden on your practice, it can be blended into many things you are already doing, Knapp adds.

For instance, you probably already are training your staff in coding and producing documentation on how you keep records and how you code. You simply may have to expand the process to meet the federal guidance. **(For tips on developing your compliance program, see related article, p. 131.)**

The OIG regulations are just part of the changing nature of the practice of medicine that is making it increasingly difficulty for physicians to have small, independent practices, Knapp says. However, the same is true in many other professions, such as law, accounting, and architecture, he points out. "Look at any of the learned professions and you'll find that the administrative requirements of running the profession as a successful business are forcing groups to join together to share expenses, reduce overhead, and comply with regulations. Medicine is among them. It's not necessarily welcome news to medical practices, but it is reality."

The Medical Group Management Association (MGMA) in Englewood, CO, has recommended that the OIG amend the draft guidelines to improve the flexibility, clarity, and practicality of compliance programs for small group practices.

"These draft guidelines would be extremely difficult to implement for most small medical practices, or even many larger practices. Most of the medical practices affected by these guidelines are small and have scarce financial and human resources at their disposal," says **William F. Jessee**, MD, president and CEO of MGMA.

Relief from regulations

MGMA has asked the OIG to state more clearly that the draft guidance is voluntary and that medical practices are not required to include every one of the OIG's seven recommended basic elements of compliance in their compliance programs. **(See list of the seven recommended elements, above left.)**

In addition, the MGMA suggests that the OIG and the Health Care Financing Administration should assist practices in developing policies and procedures.

The criticism is a fair one but one that the OIG attempts to address in its guidance by offering some suggestions for making the process easier, Knapp asserts. The OIG makes suggestions to

How to begin your compliance program

The first point to remember when you tackle your compliance program is to not panic, says **John Knapp**, JD, a health care attorney with Cozen and O'Connor in Philadelphia.

Since the Office of the Inspector General (OIG) doesn't have specific guidelines for meeting the compliance program guidance, you have the leeway to move into a program gradually, he says.

The OIG will give practices time to comply. You should be safe, as long as you can show that you're making an ongoing effort to comply with the guidance.

"If all you do is have the start of a code of conduct and basic policies and procedures in 90 days, you'll be fine as long as the process continues and you have a more detailed compliance program down the road," Knapp says.

However, he warns, don't delay in starting the program. If you are audited, it will be to your benefit to have documentation to show that you have started the process.

Here are some other tips for complying with the OIG guidance:

- ✔ **Start reviewing the draft guidelines immediately and come up with a plan** rather than waiting for the final document to come out and scrambling to get everything done at the last minute, suggests **Jay Williams**, principal of Arista Associates, a health care strategy consulting firm in Northbrook, IL.
- ✔ **Develop a specific plan of action and have a time line for completing it.**
- ✔ **Include funds for meeting the guidance in your annual budget.** Expenditures may include extra training for you and your staff, outside consultants, and staff time to set up and implement the compliance documentation.
- ✔ **Don't go it alone.** Seek help from your professional society, your lawyers, and your consultants. Ask for low-cost advice to get you started.
- ✔ **Consider working together with your colleagues in other practices** to develop a joint compliance program that can be modified for each individual practice.
- ✔ **Conduct a compliance audit** to find out where your vulnerable spots are, Williams advises.
- ✔ **Develop checkpoints and reviews** to ensure that you remain in compliance.

"Most often if the OIG sees that you are taking a situation seriously and are moving toward compliance, they are much more willing to work with you," Williams says. ■

reduce the burden on small practices, such as sharing resources among physician practices and keeping one copy of the compliance manual in a central location rather than distributing it to all employees, he says.

"Throughout the draft compliance guidelines, the OIG attempts to say 'Here is what we'd really like you to do, but if it's too burdensome, here is another way,'" Knapp says.

In fact, the OIG cut physicians groups some slack in some areas, he says. For instance, in the guidances for other sectors of the health care industry, the OIG frowned upon using canned or standardized compliance programs, saying that each entity should develop its own unique program.

"With the physicians groups, the OIG seems to recognize that the cost and the amount of energy, time, and internal resources to develop customized compliance programs may not be consistent with the economic means of individual physician practices," Knapp says.

The physician guidance suggests that practices can use standardized compliance program developed by legal counsel, professional associations, or consultants, provided they make some effort to tailor the program to their particular practices, he says. ■

The buck stops with you: MDs responsible for errors

Make sure your staff are in compliance

It doesn't matter who made the billing error; if your practice is audited, the physicians will be held responsible.

"Historically, too many doctors have thrown up their hands at billing violations by saying that they don't do the billing. The federal government is saying that since doctors sign the claim form and they receive the money, they are being held responsible for any mistakes," says **John Knapp**, JD, a health care attorney with Cozen and O'Connor in Philadelphia.

Because the physician is the linchpin in the whole health care industry and nothing happens without a doctor's say-so, the government says that the doctor is responsible when something goes wrong, Knapp adds.

"The OIG [Office of the Inspector General] is attempting to hold physicians responsible for

knowing and complying with all elements of the law. It's saying that it wants you to go through a process of understanding the law so it can presume that any violations were intentional," Knapp says.

That's why Knapp advises physician groups to get started immediately on their compliance programs. The guidance the OIG issued in June — "Draft Compliance Program for Individual and Small Group Physician Practices" — makes it the responsibility of physicians to see that their employees get training and learn to code correctly.

The compliance guidance says that physicians have the obligation to get training for themselves and their staff, and that the training must be ongoing. This means that your practice must invest in training and education for all employees and keep your training up to date. And instead of throwing updates on billing developments from your Medicare carrier in a drawer, read them, put them in a manual, and make sure your staff know they have to pay attention to them, Knapp says.

The regulations deal with the difference in fraudulent and erroneous claims and state that nobody will be punished for honest mistakes. The OIG recognizes that "the majority of physician practices are run by well-meaning people who want to comply with the law," he explains.

However, the guidance goes on to say that the OIG will presume you did know the rules and that if there is a repeated pattern of violations, the OIG will presume that they are intentional and it will be up for you to prove you are innocent, Knapp says.

Currently, the government finds fraud and abuse in the following manner: Medicare carriers are required by the Health Care Financing Administration to conduct sampling and audits of physician practices. The agency typically conducts random and analytical samplings. For instance, it may examine evaluation and management codes in a region and conduct a more intensive audit of doctors who have a higher proportion of 4 and 5 codes than their peers in that specialty.

Other ways your errors might be caught include:

❒ **Whistle-blowers:** Unhappy employees may turn in physicians, particularly since they can make money.

❒ **Medicare recipients:** Statements from the Medicare carriers include a toll-free telephone number to register complaints about physician billing practices. This has the effect of encouraging millions of Medicare recipients who may be unhappy with or confused by their billing to turn in their doctors.

With more and more electronic billing and the requirements of the Health Insurance Portability and Accountability Act, it's going to be easier for the government computers to sort and sample items that are not in compliance, Knapp says.

Here are some ways to help your staff get training:

❒ Look for training sessions on compliance issues built into continuing medical education sessions.

❒ Bring a consultant into your practice to train your staff.

❒ Find out if your billing company will provide training for your staff.

❒ Subscribe to publications that keep you abreast of coding and billing developments. ■

Look for these areas of risk in your practice

OIG cites most frequent subjects of investigations

The Office of the Inspector General (OIG) cites the following areas that are most frequent subject of investigations of physician practices:

• **Billing and coding.** Areas you should look at include:

— billing for items or services not rendered or not provided as claimed;

— submitting claims for equipment, medical supplies, and services that are not reasonable and necessary;

— double billing and billing for noncovered services;

— knowing misuse of provident identification numbers, resulting in improper billing;

— billing for unbundled services;

— failure to properly use coding modifiers;

— upcoding the level of service provided.

• **Reasonable and necessary services.** The OIG reminds physicians that Medicare will pay only for services that meet the Medicare definition of reasonable and necessary. Practices should be able to provide documentation, such as patient medical records and physician's orders, to support the appropriateness of services, the OIG says.

Conduct a self-audit to identify problems

As part of its compliance program guidance for physician groups, the Office of the Inspector General (OIG) recommends conducting a baseline audit for compliance, followed by periodic audits at least once a year.

Self-audits should determine whether bills are coded accurately and reflect services provided, that services are reasonable and necessary, that no incentives for unnecessary services exist, and that your records contain sufficient documentation to support the charge.

If your practice already has a trained compliance officer, he or she may be able to perform the audit. If not, hire an attorney or consultant who is up to speed on the issues, advises **Jay Williams**, principal of Arista Associates, a health care strategy consulting firm in Northbrook, IL.

"There is danger in trying to evaluate your operations against regulations and missing a major area that needs improvement," he says. If you find any deficiency during your compliance audit, develop a specific plan of action to remedy it and document what you do, Williams adds.

There's no set formula as to how many medical records should be reviewed, but it stands to reason that the larger the sample, the more confidence you will have in your results.

The OIG offers a basic guideline of two to five medical records per payer or five to 10 records per physician.

Here are some more suggestions from the OIG as to what an audit should include:

- a valid sample of your top 10 denials or your top 10 services;
- confirmation that your physicians use specific codes, rather than general codes, to ensure that the treatment is reasonable and necessary;
- a check for data-entry errors;
- a confirmation that all orders are written and signed by a physician;
- a check for all reasonable and necessary services performed — for instance, confirmation that all tests ordered by the physician were actually performed and documented and that only those tests were included on your bill;
- a review of assignment codes and modifiers to the claims.

If you identify a problem during your internal audit, the OIG recommends that action be taken within 60 days. Your compliance activities should include creating a system to address how you will respond to and report potential problems. ■

- **Documentation.** Inappropriate documentation of diagnosis and treatment is the leading cause of inappropriate payments, the OIG says. The guidance cites two areas of concern: medical record documentation and proper completion of the Health Care Financing Administration (HCFA) 1500 Form. Current procedural terminology and ICD-9 codes on the claims form should be supported by the documentation of the medical record, and HCFA should be able to determine who provided the services.

- **Kickbacks, inducements, and self-referrals.** Your practice should have policies to ensure that you comply with the anti-kickback statutes and the physicians self-referral law, particularly in regard to your arrangements with hospitals, hospices, nursing facilities, home health agencies, durable medical equipment suppliers, and vendors. Improper inducement may include waiving co-insurance without ensuring that the patient is in financial need or failing to make an effort to collect the cost-sharing amount, the OIG says.

- **Retention of records.** Your practice should make it a priority to keep business and patient records as well as documentation of compliance-related activities. Keep all correspondence with Medicare carriers. This involves, at minimum, keeping an updated binder that contains information on compliance meetings, educational activities, and internal audit results. ■

Watch for these red flags in compliance activities

Make sure coding, documentation are in order

When **Jay Williams** works with physician practices on compliance issues, he inevitably finds problems with coding and documentation.

"Every time we look at a physician group, we find problems with coding. And, as often as not, they are directly related to downcoding as well as upcoding," says Williams, principal of Arista Associates, a health care consulting firm in Northbrook, IL.

Physicians practices don't deliberately upcode, he adds. In most cases, it's due to a lack of education and training and the practice's failure to hire

people who understanding coding and can do a good job of coding properly.

In addition to helping you avoid penalties from the government, proper coding can have a positive effect on your bottom line.

"My experience over the past few years is that it's very simple to find revenue on the downcoding side," Williams adds.

Documentation for coding is another item that has been a chronic problem for group practices, Williams adds. To ensure that you comply with government regulations, make sure that your charts are complete and that they support the coding for that patient. If you are coding appropriately, there must be enough information on the chart to support the coding.

"If a patient has a multisystemic illness, there's nothing wrong with coding appropriately, but you've got to prove it," Williams says.

Proper documentation is essential for being in compliance with government regulations, he adds. "Realistically, the OIG's concerns come from poor documentation and reporting than from any intent to defraud. However, an inadvertent practice of upcoding could give the semblance of fraud, and that's not a situation you want to be in."

One issue that Williams has found in many group practices is that supervising physicians fail to sign off on the chart notes of physician extenders. "I have found an unbelievable number of times it doesn't happen." ■

Productivity is the key to boosting profitability

Use efficiency to boost your bottom line

In a physician office, the doctor is the only element that actually generates revenue. Everything and everyone else is overhead, according to **Dick Haines**, president of Medical Design International in Tucker, GA.

That's why Haines asserts that the best way for a physician practice to increase its bottom line is to optimize the physician's ability to produce revenue. Medical Design International is a health care consulting firm that specializes in efficiency and productivity issues. If you're putting all your energy into reducing expenses, you may be taking the wrong tack, he says.

> *"If a doctor has the ability to see six patients an hour and he's seeing only three an hour, he is robbing the community of a scarce resource."*

When Haines conducts a patient-flow and productivity analysis, he encourages doctors to add staff so they can delegate the jobs that don't depend on the physicians' medical school training.

"Yes, a doctor could replace a nurse and hire an LPN and save $25,000 a year. But if she hires a physician assistant, she could increase productivity and increase revenue by $100,000 a year, or more," Haines says.

Haines gives an example of a physician/surgeon who increased her gross income by $300,000 a year by adding a physician assistant to whom she delegated many examinations.

To increase productivity and your bottom line, first look at what you can do to help the physicians in your practice optimize their time and effectiveness. "To generate revenue, a doctor needs to go from CPT [current procedural terminology] code to CPT code. The more time between the two, the less income he or she has," Haines points out.

Making optimal use of physicians' time is the best way to generate more revenue for your practice, but it also optimizes a scarce resource in your community by allowing doctors to use their skills on tasks for which they were trained.

"If a doctor has the ability to see six patients an hour and he's seeing only three an hour, he is robbing the community of a scarce resource," Haines says.

The types of activities on which a physician spends his time can be divided into three categories, Haines explains:

1. Essential tasks.

This is everything physicians went to medical school to learn, but it also may be talking to a young patient about an upcoming football game to establish rapport.

2. Tasks that can be delegated to other staff members.

An example is setting up an injection.

3. Tasks that are time-wasters.

One example is going to the waiting room to get a patient because the nurse is busy.

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Time is money when steps are wasted

Seek professional help for best results

If you are fundamentally frustrated with your productivity, it may be time to do a time-motion study to see if there is a problem and decide what the problem is.

It's too difficult for a doctor to conduct a productivity audit on himself or for a nurse to do it. "It's very difficult to be inside the organization and see how to change things," says **Dick Haines**, president of Medical Design International, a Tucker, GA-based health care consulting firm that specializes in efficiency and productivity.

He recalls trying to teach a nurse to do the time-motion studies for one group of doctors but finding the information she provided was practically useless. "Training orients you in different directions. The nurse was used to dealing with medical problems, and she saw things that way, rather than from an efficiency standpoint," Haines says.

For instance, a urologist insisted that his examination room was perfect until Haines pointed out that if the sink were moved to the other side of the room, it would save the doctor a lot of steps. "He was looking at the room from a medical standpoint, and I was looking at time-space orientation."

Three principles to follow

When Haines counsels doctors on how to increase their productivity, three principles are typically part of the advice he gives:

1. **It is far more important for the doctor to be fully busy than for the staff to be fully busy.**

"This is contrary to the way doctors typically think. Some do everything they can to make sure their staff are 100% busy," Haines says. For instance, if you have a doctor who can see six patients an hour, the assumption often is that the staff should be able to prepare six patients. However, every time there is a glitch in the system, the doctor's productivity suffers.

"If the doctor has the ability to see six patients, the staff should be able to produce more than six patients so if there is a glitch, the doctor's time is still optimized," Haines says. That means that there will be some time when staff have nothing to do, but it is important that doctors recognize that they should be busy and the staff periodically idle, rather than have the staff constantly busy, he adds.

2. **When you have the choice of saving the doctor two steps or the staff two steps, save the doctors two steps.**

That is a way to optimize incomes, since the doctor is the only income producer in the practice. For instance, in an orthopedic practice, it's more cost-effective for a cast tech making $20 an hour to walk to the physician than to have a physician who is making $200 an hour walk to a big cast room.

"Physicians get so concerned that they get $20-an-hour work out of the cast technician that they are squandering their own $200-an-hour time," Haines says.

3. **If you have the choice of saving the staff two steps and the patient two steps, save the staff two steps.**

"Staff make the trip 40 times a day. The patient does it only once a month," Haines points out.

However, Haines points out, don't sacrifice patient-flow characteristics in order to save your staff steps. "If patient continually need to be guided, that takes staff time which is noneffective. If a patient gets confused by an office layout, you're doing everybody a disservice and increasing patient apprehension," he adds.

In offices where patients bottlenecks occur and patients tend to bump into each other, physicians often try to solve the problem by having the patient enter through one door and exit through another. "It fundamentally doesn't work. Patients want to leave the way they came in, on a familiar route," Haines says. The solution is to make the corridors wide enough to support two-way traffic.

One size does not fit all

Haines also advises against a one-size-fits-all mentality.

He tells clients that in a group practice, particularly one that is the result of a merger, they will never be able to get every physician to do things the same way and to avoid making the mistake of comparing one doctor to others in the practice.

"When we do time-motion studies on doctors, we compare that doctor's ability to his potential. Some talk fast; some talk slowly. Some get right to the point, and others take more time. It's only fair to expect improvement in productivity in terms of what the doctor is capable of doing," he says.

When he does a productivity study with a large group practice, Haines looks at each physician as a production center and tries to optimize the production. "It's my job to help Dr. A do the best he can and Dr. B to do the best she can, and if we do it 53 times, we'll maximize the income stream." ■

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When time is wasted, there typically are three reasons: poor systems of communication, poor office layout, or inadequate staffing, he says. **(For details on how time-motion studies can identify your problem areas, see p. 139.)**

"A lot of doctors use the step-out-in-the-hall approach to communication, which doesn't get the job done very efficiently. If you need to communicate, you need to find another way," Haines says.

Rather than looking for the nurse in between seeing patients, or having the nurse wait for you, recognize that both of you have a job to do and find another way to communicate, Haines says.

This could be through a communication light-signal system, a check-off form for tests and studies, or use of a scribe who takes progress notes and tracks down other staff the physician needs to contact.

"When the systems are set up well, the doctor and staff can establish a rhythm," Haines says.

But interruptions break the rhythm and may throw the entire day out of kilter. For instance, a doctor may come out of an examination room and see several people lined up waiting to get an answer. This means the doctor hasn't delegated effectively, and the rhythm is about to be broken, he says.

Schedule the interruptions

Doctors should allow interruptions to take place on their schedule, not when it is convenient for their nurses.

Haines suggests having certain times allotted in the doctor's schedule when he or she can be interrupted for questions. Another way to avoid constant interruptions is to have a triage nurse who is authorized to refill certain prescriptions.

"One reason you have staff is so you can delegate things you don't need to do. [Delegating to] staff is good, not bad," he says.

Delegating tasks to your staff can increase your efficiency, increase your patient volume, and improve your bottom line.

Despite the fact that some of their peers disapprove, doctors who see a high volume of patients often are popular because they address the issues quickly and effectively. And since they are delegating the tasks they don't want to do to others, they get more satisfaction out of their practice, Haines says. "High volume doesn't have to do with money. It's what you are willing to delegate to others."

Recognize that if you increase the support staff, you're likely to increase the doctor's output because physicians won't have to do jobs that can be delegated effectively. Many of the published staffing ratios don't distinguish among physicians who see six patients an hour and those who see four. Therefore, the statistics can be misleading, Haines points out.

Coordinate use of space with schedules

For a more efficient operation, organize your space so that physicians and staff do a minimum amount of walking. No one gets anything done when he is walking from place to place.

Also, maximize the use of the space and staff. For instance, one physician may want to come in for 1½ hours twice a week. You'll make better use of the space if he works three hours one day a week, leaving the space available for other doctors the rest of the week.

Fine-tune the appointment scheduling to maximize output. The appointment schedule governs the doctor's output, and if it's in disarray, it can have a negative impact on the doctor's best use of her time. Avoid double and triple booking. Remember that doctors don't go faster because they are overbooked. ■

Stop, look, and listen to your patients' concerns

Good rapport is the key to better care

Julia Schopick speaks with an evangelist's zeal when she talks about doctors' lack of communication with their patients.

And there's a good reason for it. Schopick, an Oak Park, IL-based consultant who specializes in public relations for professionals, encountered numerous medical specialists and went to hundreds of physician appointments over the last 10 years as her husband, Tim, battled a brain tumor.

"I saw firsthand how physicians treat their patients. In some cases, we were pleased. But in most cases, I was appalled at the way we were treated," says Schopick, owner of Public Relations

for Professionals. She is the daughter of a doctor.

Simple human skills, such as listening and treating a patient like a person and not a body part, can make or break a practice today, explains Schopick.

Even if they must be treated within the boundaries of a managed care plan, patients are willing to change physicians if they feel they are being treated like objects and not humans, she says.

And, most lawsuits are prompted by hard feelings the patient or the family has toward the physician, she adds. "People don't sue someone who is a friend or who was with them at 3 a.m."

When physicians hire Schopick as a public-relations consultant, their initial motivation is to get their names before the public and increase their referrals. However, she maintains that those efforts are virtually useless unless physicians take the time to develop a good relationship with their patients.

That patient is more than an illness

"People know when a doctor thinks of them as a knee and not a person. If a doctor doesn't listen carefully and respond in a caring manner, the patients won't develop any loyalty to the doctor," she says.

Physicians' jobs will be easier if they listen and understand what is going on in the patient's life, Schopick says. That's why she cringes when she sees studies that show that the average physician listens for only 18 seconds before interrupting a patient.

"The irony is that with all the publicity these days about physician errors, this one easy-to-remedy problem is not routinely recognized for the culprit it is. When doctors not only spend more time with their patients but really listen to them, we will have truly satisfactory health care," Schopick says.

She says she is a firm believer that good communication is the only way that physicians are going to create a good partnership with their patients. "The more the patient is involved in the treatment, the better the result."

For doctors who feel constrained by managed care, Schopick has this advice: "You really don't have to see a patient every five minutes."

She advises doctors to talk to their providers and educate them about the necessity of spending more time with each patient. "When somebody takes a new job, they negotiate for all the things they need to do a job. One of the things the doctor needs in order to do his or her job is more time with each patient. The health care system is going to end up paying for it if the diseases aren't caught," she says.

For instance, if doctors listen and ask appropriate questions, they will know what medications their patients are taking and will avoid prescribing a drug that interacts with them.

Communication with patients can help avoid the myriad tests that are driving up the cost of health care, Schopick says. "In the year 2000, everybody is saying we've got to lower costs, but they don't realize that if they listen, they might be able to avoid some of the costs. Doctors are ordering more tests; patients are experiencing more drug reactions; and it's all the result of not taking the time with patients."

Schopick offers these tips for improving communication with your patients:

❒ Listen to your patients and to their family members.

❒ Try to be a little more passive than usual and let the patient talk.

"This is hard for doctors. I know some doctors advise patients to write down their three main concerns, but people don't know what is concerning them, and it is human nature not to mention the main concern until the end [of the visit]."

❒ When people are sick, be especially kind, particularly if they have a long-term illness. "These people have been run out, not only by their condition, but you can assume that they have not been treated well by the medical profession," she says.

Be a healer

❒ Be open to being a healer. A healer has to be sensitive and willing to take the time to explain, rather than just gruffly issuing a list of to-dos.

❒ Realize that patients are becoming more empowered and research-oriented. Look at that empowerment as an opportunity, not a roadblock to treatment.

"One of my friends who is a doctor says it sometimes makes his life easier when patients come in with research they have done on their condition," Schopick says.

❒ Respect the time of your patients and their family members. Make every effort to avoid keeping patients waiting for a long time.

❒ Remember that telephone etiquette is as important as face-to-face meetings. Don't be gruff or abrupt when a patient calls. ■

Automatic coding links electronic records

Process simplifies research, record-sharing

As a pathologist, **John Neff**, MD, FCAP, chairman of the department of pathology at the University of Tennessee in Knoxville, is constantly asked to provide extensive and wide-ranging information on patients.

For instance, he received a request for information on all patients diagnosed with carcinoma of the lungs for the past four years. That's when Neff puts SNOMED to use. SNOMED — Systematized Nomenclature of Medicine — is a method for coding electronic medical records to enable clinicians or researchers to share the information no matter what kind of medical record system they use. SNOMED can be encoded into whatever electronic medical records software physicians use.

The method was developed by SNOMED International, a not-for-profit division of the College of American Pathologists in Northfield, IL. Neff is chairman of SNOMED.

"If I didn't have the data coded, it would be an impossible task for me. As it is, I simply enter into my computer 'lung, carcinoma' and conduct a query," he says. "It's a great way to do research, and in the future, it will be a great way to link all the records together," he says.

The average patient today has 11.2 different medical records, and every provider has a different method of recording the information, Neff says. The Health Insurance Portability and Accessibility Act makes electronic medical records a necessity.

"We cannot continue this paper mess that we are dealing with now. We have to be able to get administrative information from one employer to another or one insurer to another or one state to another," Neff says.

However, he points out, electronic data aren't going to be much easier to handle than paper records unless the way the information is recorded is standardized. "Stop and think of any other large and complicated industry with which you come in contact. Whether it's a bank, a car dealer or a health club, the records are likely to be kept on a computer."

All physicians have a problem with records, Neff asserts. "One of the major problems is that records are on paper, but even after those paper records are reduced to an electronic format, you still have to review pages of papers to find one little fact."

SNOMED includes 190,000 synonyms, 121,000 concepts, and the relationship between them. Each is coded.

If a physician wants to research a particular topic, such as a group of patients with elevated blood pressure, what kind of insulin the majority of your patients are using, the results of all Pap smears, or whether there was improvement in activity status after using one kind of anti-inflammatory drug, you can find it with just a few keystrokes, Neff says.

The process works this way: If you use software in which SNOMED is encoded, the software automatically codes the data you enter as you document the patient's chart.

"At the user interface, things won't change that much except that the input will have to be structured," he says. For instance, if Neff wants to research left lung biopsies, he enters the SNOMED code for lung, left, and biopsy, and calls up a database of all patients who received the biopsy.

"Doctors are weighed down with the responsibilities for reporting information in their charts to one or another accreditation agencies, insurance companies, federal payers. You never know what someone will ask you. If it isn't coded, someone has to pull all the charts and find that information. SNOMED allows you to do this in any variation," he says.

(For more information on SNOMED, visit its Web site at www.snomed.org.) ■

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NEWS BRIEFS

Increase expected in prescription costs

The cost of prescription drug benefits offered by large employers is expected to increase an average of 22.5% for active employees and 23.4% for Medicare retirees during 2001, according to a new survey by Watson Wyatt Worldwide and the Washington Business Group on Health.

Responses from 61 companies covering 1.7 million employees indicate that overall medical costs are expected to increase an average of 12.2% for active employees and 13.3% for Medicare retirees. Those figures show a dramatic rise over the 8.1% increase for active employees and 9.6% increase for Medicare retirees this year. This marks the fourth year in a row that health care costs have accelerated, according to the report.

"While managed care was initially successful in bringing down health care costs and rates of increase, it appears that they have been less effective in containing the rate of increase," says **Rich Ostus**, global practice director of group and health care consulting at Watson Wyatt.

He cites the introduction of new medicines, the aging of the population, and the aggressive direct-to-consumer marketing by drug companies as reasons for the continuing escalation of prescription costs.

According to the survey, only 12% of employers plan to increase employee contributions to cover the increased costs. ▼

E-mail consults work best with careful questioning

Physicians can improve e-mail consults by carefully constructing the questions they want answered, according to a study at the University of Iowa in Iowa City. Researchers analyzed nearly 700 e-mail queries from and responses to 60 primary care physicians in eastern Iowa to specialty physicians and other health care professionals.

The study found a link between how primary care doctors structured their questions in the e-mails and whether the specialist consultants answered the questions with a formal consultation, according to **George Bergus**, MD, associate professor of family medicine at the University of Iowa and the study's lead investigator.

The researchers found that well-structured questions were those that clearly identified the treatment the primary doctor was proposing to use and the desired outcomes they hoped their patient would experience, Bergus says.

"When both components were present, primary care doctors had successful outcomes from their curbside consultations 90% of the time. However, when neither component was include

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Editor: **Mary Booth Thomas**, (770) 394-1440, (marybootht@aol.com).
Editor of **Physician's Capitation Trends: Reba Griffith**, MPH, (rocky.top@worldnet.att.net.)
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).
Production Editor: **Ann Duncan**.

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in the e-mailed question, only 70% of consultations were successful," Bergus says. A successful outcome occurred when the specialist consultants answered the question without requesting a formal consultation.

The University of Iowa offers a physician tutorial on formulating clinical questions at: http://fpinfo.medicine.uiowa.edu/tutorial/intro_questions.htm. ▼

Physician bargaining bill outlook turns bleak

Enthusiasm over the House of Representatives' recent passage of legislation permitting independent physicians and other providers to gather together to collectively bargain with health plans was dampened after Senate Majority Leader Trent Lott (R-MS) announced he opposes the measure. He said the bill would create more lawsuits while improving organized labor's health care hand. ▼

AMA seeks enforcement of nonphysician rules

The American Medical Association (AMA) is lobbying the Health Care Financing Administration (HCFA) to get more aggressive in making nurse practitioners and clinical nurse specialists stay within their designated scope of practice guidelines. In a petition filed with HCFA, the AMA alleges the agency has not made any serious attempts to enforce provisions in the Social Security Act requiring that advance practice nurses work only in collaboration with a physician — and in accordance with their state's practice requirements. The petition asks HCFA to:

• implement a system to ensure Medicare payments to advance practice nurses are made only in connection with services furnished in collaboration with a physician and within their state law's scope of practice requirements;

• conduct audits to ensure Medicare payments to advance practice nurses are limited to approved services;

• limit distribution and renewal of Medicare billing numbers to advance practice nurses who comply with these requirements;

• issue detailed instructions to Medicare carriers about implementing a system to ensure nurse compliance. ■

SourceKit

• **Jay Williams**, Principal, Arista Associates, Northbrook, IL. E-mail: jwwilliams@ix.netcom.com.

• **John Knapp**, JD, Attorney, Cozen and O'Connor, Philadelphia. Telephone: (215) 665-4660. E-mail:jknapp@cozen.com.

• **Office of the Inspector General**, U.S. Department of Health and Human Services, Washington, DC. Web site: http://www.hhs.gov/oig.

• **Health Care Financing Administration,** Medicare Training, Baltimore. Web site: http://www.medicaretraining.com.

• **Dick Haines**, Medical Design International, Tucker, GA. Telephone: (770) 939-7950. E-mail: haines@mdiatlanta.com.

• **Julia Schopick**, Public Relations for Professionals, Oak Park, IL. Telephone: (708) 848-4788. E-mail: JuliaS1573@aol.com. ■

Physician's Capitation Trends™

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Study shows capitation lessons learned from key markets

Where is Dr. Laura when we need her?

If there were a "Dr. Laura" for capitation, here is what she would advise: "What's the bottom line as to what makes capitation work? Relationships." And add "core competencies" of insurance, too.

Those two elements together — good relationships and competence — form the magic potion of success, according to an in-depth recent study of capitation.[1] **(See related story on core competencies, p. 136.)**

And if you thought capitation contracts can be as varied as the fish in the sea, that's pretty close to reality.

Four researchers, under the sponsorship of the Robert Wood Johnson Foundation in Princeton, NJ, recently set out to determine what's "real" or at least somewhat common in terms of contracting methods in different kinds of markets. Lead scientist **Gloria J. Bazzoli**, PhD, professor of health care policy at Northwestern University in Evanston, IL, and colleagues reported a wide variety of capitation hybrids.

Rather than relying only on a series of quantitative measures such as financial ratios or membership figures, researchers also used open-ended questions to gather a qualitative understanding of the capitation landscape.

Their database stemmed from market profiles developed by the Center for Studying Health System Change, a Washington, DC-based private research organization.

They selected these markets, or metropolitan statistical areas (MSAs):

• **Portland, OR** — high capitation market share; substantial medical practice development, including a large group-model HMO;

• **San Diego** — high capitation market share;

• **St. Louis** — lower capitation market penetration and less consolidation of physicians into practices.

Each of these areas had experienced significant declines in total hospital inpatient days between 1990 and 1995, and each had gone through a virtually complete consolidation of hospitals in their locality into health networks or systems.

In those three markets, these are the four most common types of capitation contracts, starting in order of highest volume:

• **"Professional service" or physician capitation.**

In each of the three markets, physicians led the way in capitation contracting — by either forming their own HMOs, by forming independent practice associations, or by affiliating with specific health networks or systems in their markets. Hospitals were typically paid on a negotiated per diem basis.

• **Global contracts.**

Portland and San Diego had significant levels of global capitation, and in those two areas that was well-received by physicians. Both systems are large and their leadership reported significant experience with physician capitation prior to entering any global arrangements. (In both MSAs, hospital and physician responsibilities are combined and covered by a single per-member per-month payment, with physicians controlling the contract.)

• **Separate but related professional and institutional contracts.**

Each of the areas reported that hybrid as well. HMOs owned and operated by health networks often had this type of contract, not only with their affiliated physicians but also with others outside their official physician panel.

What does it take? Core competencies for capitation

Beyond the ability to keep relationships in good standing, capitation requires the possession of several key competencies, according to researchers who recently reviewed the state of capitation in three intensely capitated market areas. **(See story, p. 135.)**

"Regardless of the type of capitated arrangements a health care provider holds, effective management of capitation requires the development of core business capabilities to deal with new responsibilities and accountabilities," wrote **Gloria Bazzoli**, PhD, professor of health policy at Northwestern University in Evanston, IL, and her team of three colleagues.[1]

To examine provider capabilities in capitation, they constructed the following list of core functions typically associated with the business of health insurance:

- Benefit plan design
- Actuarial estimated of rates*
- Actuarial evaluation of contract performance*
- Marketing to health plan purchasers and enrollees
- Negotiations with health plan purchasers
- Member enrollment / tracking*
- Provider contracting / relationships*
- Claims administration*
- Payment administration*
- Member relations
- Capital reserve management*
- Utilization management*
- Licensing / reporting to the state
- Management information systems (MIS) for administrative and financial functions*
- MIS for clinical management functions*
- MIS for patient management functions*

The items on the list with an asterisk show the competencies that the groups in the study reported they possessed. What is interesting, reports Bazzoli and team, are some of the ones that are missing — ability to negotiate with purchasers, member relations skills, and reporting abilities.

Also, the researchers found that the hospital-led groups tended to have more strength in the actuarial competencies, while both medical practices showed more strength in the areas of member relations than the hospital systems.

Neither hospital nor physician-led groups active in capitation reported any interest getting out of it, farming it out, or sharing the weight.

Instead, leaders from both camps reflected more interest in hiring staff internally to expand their capabilities than in sharing the development of competency with other entities in the community — either via outside vendors or other health systems.

Reference

1. Bazzoli GJ, et al. Capitated contracting roles and relationships in health care / practitioner application. *Journal of Healthcare Management* May / June 2000; 170-187. ■

That was especially prominent in Medicare managed care contracting. Typically, these involved hospital risk pools in which medical groups, hospitals, and, in some cases, HMOs shared efficiency gains in reductions of hospital expenditures.

• **Global capitation for hospital-led health networks or systems.**

Many experts have said that this would be the ultimate end point or evolution for the mature or sophisticated capitation market. But Bazzoli and her team found this not to be the case. "Instead, we observed global capitation arrangements only in instances where the physician market was too fragmented or physicians were previously ineffective at managing risk," they reported.

For example, in St. Louis, physicians were reluctant to enter into capitation at all due to poor experiences with it at the primary care level, the study said. "Capitation of the health care system was viewed as the only vehicle available for pooling these risk-averse physicians and buffering them from potential financial losses from capitation," Bazzoli and her team explained.

Given this wealth of experience, what were the lessons learned from all this effort? Key themes included the following:

• **Don't give up your core competencies and the accompanying name recognition.**

If your practice or health system already has a "centralized capacity" to managed capitated contracts, that's not an asset to take lightly, participants

advised. Centralization minimizes duplication of effort. It also offers something equally if not more valuable, they advised: visibility or branding. That is vital for member relations "because it provides enrollees with an identifiable focal point among affiliated health providers than spanned numerous practices and geographic locations," participants said in the survey.

• **If you can, steer clear of shared risk with health plans; instead, share the risk with other physician or hospital groups.**

"Shared risk arrangements, which involve withholds and risk pools, were often described as 'black boxes' over which health providers had limited control or ability to monitor," Bazzoli wrote. When health plans were holding these funds, any important information about them often was especially difficult to access, they warned. If the information was accessible, rarely was it made available in any timely enough fashion to make a difference.

• **Percent of premium capitation is working well.**

These types of contracts, in which per-member per-month payments vary based on the amount of premium paid by the enrollee are actually proving favorable and they are predictable and controllable.

• **Utilization management is the No. 1 critical competence to be successful.**

One participant expressed it this way: "Utilization management is the new business that we are in." Overall, capitation experts recommend nurses and physician-run review committees as the best ways to manage utilization — backed up information systems that can crank out well-prepared monthly reports, researchers said.

• **Continue to enhance your core business competencies.**

Organization officials in the study emphasized that "above all, development of utilization management capacity was most important to the successful management of capitation," researchers noted. Nurse and physician staff need to work together on that mission, they recommended.

"Fill remaining gaps by hiring talent from the health insurance industry," researchers said their participants advised. "This is especially important for developing capabilities outside the normal purview of health delivery organizations.

Also, they advised offering these competencies to other hospital or physician groups in your community to build possible new relationships down the road. By building skills, you're building bridges to form relationships that can carry you through capitation for the long term.

Reference

1. Bazzoli GJ, et al. Capitated contracting roles and relationships in health care / practitioner application. *Journal of Healthcare Management* May / June 2000; 170-187. ■

Will more insurers leave Medicare capitation?

HMOs seek more capitation funding

As the congressional budget season nears, managed care lobbies are threatening again to abandon the Medicare+Choice program if capitation payments aren't increased.

"What is needed is a $40 billion effort," said **Karen Ignagni**, president of the American Association of Health Plans in a press release. The $40 billion figure represents $15 billion above and beyond President Clinton's current budget recommendation of a $35 million increase for Medicare's capitation payments.

Another proposal is coming from Sen. Pete Domenici (R-NM), who recommends spending $3.7 billion over five years to boost the minimum payment received by Medicare capitation plans from a current average of $415 to $525, as well as an increase to $475 per member per month for beneficiaries in rural areas.

Current law allows for HMOs in capitated contracts to receive a 2% across the board each year, but HMO officials complain that 2% is less than the annual health inflation rate and inadequate to cover their costs.

In June, the Health Care Financing Administration tried to ease HMOs' complaints. The June 29, 2000, *Federal Register* included a long list of changes for Medicare+Choice. **(See related story, p. 135. Also, see *Physician's Managed Care Report*, August 2000, p. 119.)** In the *Federal Register* notice, the agency touted these improvements:

• Slowing the pace of the new risk adjustment payment system's phase-in. Originally, the phase-in called for 50% of payments to be based on principal inpatient diagnostic cost groups. But, Congress intervened and asked for a slow-down;

the new phase-in schedule will be determined in 2001.

• Increasing the flexibility in establishing a physician-based HMO, which would allow more physicians to serve capitated Medicare enrollees.

• Improving the freedom of choice by allowing plans to offer beneficiaries a point of service option that broadens access to health services from both in-network and out-of-network providers.

• Allowing MCOs that leave Medicare+Choice to return in two years, instead of five years.

• Easing compliance plan reporting burdens by completely deleting this part of the program requirements.

What patients should know

The tension mounts as the health care community observes whether Congress will make any more major changes during an election year; whether insurers are serious about dropping out more; and whether physician-based HMOs will enter more into the Medicare+Select market.

If more commercial insurers do drop their capitation patients, here are six key facts your patients need to know, advises **Kent Moore**, MD, manager of reimbursement issues for the American Academy of Family Practice (AAFP), based in Kansas City, MO:

• Medicare+Select patients can't be kicked out of Medicare all together. If a capitation insurer drops out, those patients will be enrolled in another Medicare plan — either by their same insurer, or they can opt for a new one. Capitation patients are automatically added to Medicare fee-for-service, effective Jan. 1, 2001, if they don't enroll into some other option by Nov. 30, 2000.

• If patients are interested in a Medigap policy, they should inquire with their insurer at least by the end of November to ensure a Jan. 1, 2001, effective date.

• Patients currently enrolled in Medicare capitation must be covered by that plan through Dec. 31, 2000.

• If capitated Medicare patients learn that their insurer is dropping out of the program, they have a choice about what they can do. They should have all their questions answered before they make up their minds.

By September, recipients should receive any notification of changes by their insurer, and they have three months to make a decision. Plans also are responsible for providing them information on any Medicare and Medigap options.

• Patients enrolled in traditional Medicare or in plans that are not changing their contracts with Medicare are not affected.

• If a Medicare patient receives Medicare coverage via a former employer, he or she should contact that employer before making a decision about any new form of Medicare coverage.

Three key facts physicians should know if an insurer drops out of the Medicare capitation program in their area:

• Your relationship with a capitated Medicare may or may not end by Dec. 31, 2000, if an insurer drops its Medicare+Select activities. If the patient chooses a plan with any insurer with which you contract, then you can keep the patient under your care.

• If the patient informs you of an insurer's plan to drop out, be sure to follow-up and determine what kind of impact the insurer's action will have on your practice.

• If your patient asks about the issue, physicians are permitted to describe other Medicare managed care plans with which they are involved. But HCFA discourages physicians from providing application forms for those plans or in any other way steering patients toward particular plans with which they participate.

Sources of information

Here are official sources you can refer patients to regarding the Medicare+Select program:

• Medicare+Choice Help Line: (800) 633-4227. This number has both English- and Spanish-speaking customer service staffing the telephones.

• For the hearing impaired using a telephone device for the deaf: (877) 486-2048.

• Both are toll-free numbers that are staffed Monday through Friday from 8 a.m. to 4:30 p.m. during the caller's time zone.

• The two government-based Web sites are www.medicare.gov, which is geared mainly for patients, and www.hcfa.gov, which contains more technical information and is geared more toward physicians, practice administrators, and other professionals involved in Medicare.

(Moore's points were summarized from several articles on Medicare and capitation by Kent Moore, MD, featured monthly in the AAFP's *journal,* Family Practice Management, *1999 and 2000, Kansas City, MO.)* ■