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Providers lobbying OIG for changes in small practice compliance guidelines

Final document expected to be formulated by the end of the year

Anticipating the Office of the Inspector General's (OIG) finalized compliance guidelines for small and solo physician practices by the end of the year, provider organizations have started a lobbying effort to make a number of changes in the original proposal.

Most physician-related societies have applauded the OIG for attempting to make its proposed guidelines more flexible, especially when compared to its previous guidances for other provider categories. For instance, most appreciate the fact the OIG did not insist small practices install a special hotline or 800 number for employees to report questionable activities. Instead, the guidelines state that an open-door policy would be sufficient.

However, while advocates like the Medical Group Management Association (MGMA) in Englewood, CO, believe the OIG is on the right path, "we still have several concerns regarding the draft guidance," says MGMA president **William F. Jessee**, MD.

Overall, the MGMA says the guidance is too complicated and should be scaled back. Specific changes MGMA and other organizations want the OIG to make include:

• **Voluntary nature.** There's a Catch-22 in the guidance. Specifically, the OIG says the guidelines are a voluntary document practitioners can choose to use or not when designing their compliance programs. However, in several places through the draft guidance, the OIG uses terms such as "mandatory" and "essential" when describing program elements.

For example, "written policies and procedures are essential to all physician practices, regardless of size and capability," says the OIG. Providers want the OIG to remove such references to underscore that the guidance is, in fact, voluntary.

• **Reference binder.** The OIG suggests that a practice create a "binder" containing relevant Health Care Financing Administration (HCFA) directives and carrier bulletins, and summaries of key OIG documents, such as special fraud alerts, advisory opinions, and inspection and audit reports,

to help stay current with regulatory requirements.

Provider groups say this may be too daunting a task for most small practices, and they are asking OIG and HCFA to create such a reference binder and distribute it for free to practices. Or, if that is too complicated, they suggest placing the material on a specified Internet site that could also be easily updated.

Standards for carriers

• **Reasonableness.** The MGMA wants the OIG to remove the "reasonableness standard" from its discussion regarding a practice's reliance on carriers. Under that standard, the OIG notes that when a physician practice requests advice from a Medicare fiscal intermediary or carrier, the practice should document the request and any response. This documentation may later become important when deciding if the practice's reliance on the carrier's advice was "reasonable," should compliance questions arise.

Rather than trying to determine if the practice's interpretation of a carrier's advice was reasonable, "carriers should be held to a certain standard to provide practices with reliable information so practices do not have to question whether they can reasonably rely on the information," argues Jessee.

Providers are also lobbying for a mechanism that will generate more uniform interpretation of Medicare regulations by different carriers. In turn, this could reduce the sometimes conflicting information physicians receive from those intermediaries. One suggestion is that carriers be forced to place any advice or interpretation they give a provider in writing.

• **Physician as compliance officer.** Besides the office manager or primary biller, the OIG should specify that a physician can also serve as a small group's compliance officer.

• **Training and education.** The draft guidance says simply providing individuals with compliance-related documents to read and learn on their own does not constitute a suitable training program. It also endorses the idea of using newsletters and bulletin boards as part of the compliance training and education process. To make training less complicated for smaller practices, providers want the OIG to declare that just utilizing a newsletter or bulletin board will satisfy the training and education provisions of the guidance.

• **Auditing and monitoring.** The MGMA does not like the OIG's recommendation that practices conduct a "baseline" compliance audit as part of the auditing and monitoring process. This decision should be left to each practice, it says. "It would be quite costly for many small practices to conduct a statistically valid baseline audit," says Jessee. "We believe practices can effectively monitor and review their bills and medical records without necessarily conducting a baseline audit."

• **Disciplinary guidelines.** The OIG stresses the importance of implementing enforcement and disciplinary guidelines in order to put teeth into a compliance program. MGMA believes, however, that the OIG goes too far when it states that a practice's enforcement and disciplinary procedures should "stipulate that individuals who fail to detect or report violations of the compliance program may be subject to discipline."

While it is reasonable to punish individuals who fail to report violations, "it is counterintuitive to discipline individuals for something they know nothing about," argues the MGMA. It wants the OIG to remove the word "detect" from the guidelines or at least modify the statement so just individuals who "reasonably should have detected violations" are subject to discipline.

• **Response to detected offenses.** The draft guidance states that "if a violation occurred and was not immediately detected, [the physician practice's] compliance program may require modification." The MGMA says the effectiveness of a practice's compliance program should not necessarily be measured based on how fast it detects a violation. As such, it wants the term "immediately" removed. ■

Changes being sought to simplify Medicare

Efforts would cut the bureaucracy

Besides pushing for changes in the proposed physician compliance guidelines, provider organizations are lobbying Congress and the Health Care Financing Administration (HCFA) to simplify current Medicare regulatory and administrative procedures.

Among the changes being sought:

• **Form 855.** Redesigning and simplifying the Form 855 used to enroll and re-enroll physicians in the Medicare program is a major priority. A recent draft of the revised form was still 48 pages

long. Private sector enrollment forms, meanwhile, average five to eight pages. Providers are also upset because when a form is not filled out correctly, physicians must resubmit their applications. The form then goes to the back of the line and often takes another eight to 12 weeks to process again.

• **Advance beneficiary notices.** Under current law, if a physician wants to bill a Medicare beneficiary for a service not covered by Medicare, the physician must request that the beneficiary sign an Advance Beneficiary Notice (ABN). The ABN states that the service may not be covered and that the beneficiary must pay for the service in full if Medicare does not cover it.

Many provider organizations say that creates a barrier in the physician-patient relationship, fostering an environment of mistrust.

• **The Health Insurance Portability and Accountability Act (HIPAA).** Providers say they appreciate HIPAA's goal of simplifying and standardizing electronic data interchange formats. They also recognize the need for upgrading security and privacy matters relating to practice software and hardware systems, plus any required training. But in turn, physicians want HCFA to provide some kind of training or financial assistance to help offset those costs. Additionally, medical organizations want to be relieved of potential liability for a breaches of security or patient privacy by a provider's electronic trading partner.

• **Post-payment audit/review.** HCFA contractors subject practices to post-payment audits intended to identify possible billing errors from a relatively small sample of claims, then use those possible errors to extrapolate any projected overpayments. Often, however, there is an error in those random samples, which means the estimated overpayment is incorrect.

Under current HCFA policy, the only practical alternative practices have for challenging the auditors' initial finding — and still retaining their appeal rights — is to ask the agency to perform what's known as a statistically valid random sample. However, since that can be highly disruptive, many practices simply decide to repay the alleged overpayment. Practice groups want to change that situation, plus give providers more options when it comes to retaining their right to appeal HCFA decisions.

• **Notification.** The process by which HCFA and Medicare carriers announce policy changes is too random, and physicians want a more standardized and formal process. For instance, policy information could be sent to Medicare providers free of charge. Now, providers now must pay to obtain the correct coding initiative edits.

• **HCFA reorganization.** Provider organizations want to consolidate the various managed care functions that reside in three different parts of the Center for Health Plans and Providers into a single unit under a single director. That, some say, would speed communications, make it easier to obtain policy interpretations, and streamline the management of Medicare intermediaries. ■

Will new APC system hinder some practices?

Finances could conflict with good medicine

Some reimbursement experts speculate that Medicare's new hospital outpatient prospective payment system (OPPS), which went into place in August, could have an unintended boomerang affect on office-based physicians as hospitals adjust how they manage both outpatients and inpatients.

This new payment methodology does not directly change Medicare payments to physicians. However, the Health Care Financing Administration (HCFA) says it wants to maintain consistent payments across both physicians' offices and hospital outpatient departments.

The system bundles some 8,000 outpatient services into 451 ambulatory payment classifications (APCs). Each APC has its own payment rate and contains services with similar clinical and resource uses. However, the actual cost incurred by hospitals for providing the various services included in each APC varies.

In the worst scenario, OPPS could be "catastrophic" to physician offices, the Chicago-based American Medical Association (AMA) has told HCFA.

"Physicians are even less likely than [hospital outpatient departments] to perform a mix of both high- and low-cost services within the payment group and, thus, many physicians would always be vastly underpaid," said the AMA.

Several physician specialties are especially concerned about how some outpatient services have been grouped under the APCs. The American Society for Therapeutic Radiology and Oncology

(ASTRO) in Fairfax, VA, for instance, is worried about how brachytherapy services have been bundled. One APC group, for example, contains five brachytherapy services. If there is a major difference between the actual cost of providing the most and the least complex services, that means the related APCs' set reimbursement rate will result in a $700 loss every time the high-end service is performed, and a $280 gain for the low-end service, ASTRO estimates.

Avoiding loss

Besides violating a congressional mandate that the APC system limit the difference between high- and low-cost services, such swings create worries among specialists that hospitals may start shifting resources away from some complex services to avoid financial losses under the APCs.

"The hospital could dictate and tell the physician that you can't do procedure X anymore because we lose money, so you need to do this other procedure," notes **Wendy Smith Fuss**, ASTRO's director of health care policy.

Physician organizations are also concerned about possible problems with the data and methods used to calculate payments for the individual payment groups. The American College of Radiology in Chicago, for instance, points to the $33.94 APC payment rate for a diagnostic mammogram. This rate is less than the congressionally set payment of $46.12 for a screening mammogram, even though the diagnostic procedure requires two to five more times the clinical labor, supplies, and equipment than a screening mammogram, says the college.

As a result of those differences, radiologists say payments for diagnostic mammograms have been set at a "dangerously low" level.

Emergency care

Under the OPPS, rather than reimbursing separately for observation care, payments for observation services in the emergency department are spread across all APCs for emergency services.

"This raises concerns that HCFA's policy removes any incentive for observation," notes emergency medicine physician **Peter Sawchuk**, MD, an AMA spokesman. This not only inhibits the best method for correctly making a difficult diagnosis — observation — but also increases the tendency for hospitals to simply admit more ER walk-ins as inpatients, some say. ■

Rising health care costs are changing the market

Drug price boosts spurring new trends

National health care expenditures increased 5.6% between 1997 and 1998, up from 4.7% between 1996 and 1997, reaching a record high of $1.1 trillion in 1998, reports the Washington, DC-based Employee Benefits Research Institute (EBRI).

Health care spending as a percentage of gross domestic product has stayed at a constant 13.5% between 1993 and 1998, paralleling the overall growth of the economy, says EBRI.

However, the Health Care Financing Administration (HCFA) predicts national health care spending could start rising rapidly, reaching 16.2% of the gross domestic product by 2008.

High prescription costs

A major driver behind that projected increase in spending is soaring prescription drug costs, which have been increasing 15% to 20% a year. Currently, "there is no end in sight" for those hefty drug price hikes, says **Randall Abbott**, a consultant with Watson Wyatt Worldwide in New York City.

Adding to the cost pressure is the fact many managed care plans are now demanding — and receiving — premium hikes in the 10%-12% range. As drug companies and HMOs dramatically increase their prices, providers are responding by raising their rates.

Doctors are bargaining harder because their recent pay raises have not been especially great, notes Abbott.

Another new trend is that providers and insurers alike are more focused on shoring-up profitability rather than lowering prices to increase market share, say experts.

Helping to support that move is the current tight labor market and strong economy that make employers more willing to absorb rate hikes rather than disrupt employee morale by reducing benefits or passing more of those cost increases onto workers.

Rates for other types of health plans also have been climbing recently. Point-of-service plans and preferred provider organizations (PPO), for instance, have averaged fee increases between 10% to 12% this year.

In another shift that providers would be smart

to pay attention to when considering which organizations to contract with, prompted by employee preferences, more employers are moving to open-ended products like PPOs and away from more restrictive HMOs.

"Right now, the HMO idea is just not selling. That market seems to be dead in the water," says **Bob Pures**, senior vice president at Horizon Blue Cross & Blue Shield of New Jersey in Newark. ■

Physicians feel fallout as hospitals nix HMO contracts

Get-tough policy can hurt practices

Increasingly aggressive in their contract negotiations with managed care plans, more hospitals are now opting to cancel their HMO agreements when they don't get the payment rates they want. Increasingly caught in the middle of this get-tough policy are the physicians affiliated with the hospital.

According to New York City-based Deloitte & Touche, poor financials have prompted about one-third of hospital chief executives to cancel managed care contracts. The statistics are significantly greater for larger hospitals — 60% of those facilities have terminated HMO deals this year.

California's St. Joseph Health System, for instance, Orange County's largest hospital-based system, plans to slash the number of its managed care contracts from 17 to three over the next 18 months to plug up the $45 million a year in loses those HMO deals are costing it.

"Right now, we're losing money on every patient," says **Joe Randolph**, St. Joseph's CFO. Given the recent trend where insurers are getting employers to accept major rate hikes, "there's no way physicians and hospitals are going to sit back and not insist a share of this be passed down to providers."

Lost referrals

In the short-run, however, canceling HMO contracts can cause a major disruption among providers as a key source of patient referrals and cash flow is lost.

Most often, specialists and surgeons are first affected when a hospital terminates its relationship with an HMO. The impact may even mean those hospital-based physicians will need to find another facility or organization to affiliate with, note experts. Meanwhile, physician groups working with a particular HMO might be forced to establish relationships with other facilities still working with the plan.

"When a hospital cancels a major managed care contract, there's an immediate downside for the physicians connected to that hospital," notes **Maria E. Minon**, MD, vice president of medical affairs at the Children's Hospital of Orange County. "The impact can be especially hard on younger providers just starting their practice who don't have a large number of long-time patients."

There's also an upside, she says. "If they are part of an IPA [independent practice association] that is not getting adequate compensation, it will cost money for the physicians to treat patients," notes Minon. "In the long run, I can see why the hospitals are doing this and how it will benefit the physicians. But in the short term, it's affecting the physicians by decreasing their referral sources."

Still, many insiders says those hardball tactics are necessary. "The bottom line is these HMOs have to start paying for the cost of care," stresses Randolph. ■

HMOs pushing specialists to sign up for capitation

Outcome will determine future roles in medicine

Nationwide, managed care plans are trying to shift more specialists from their customary fee-for-service reimbursement schedule to a capitated system based on a so-called episodes-of-care approach.

In Pittsburgh, for instance, Highmark Blue Cross / Blue Shield has been pushing for — and specialists fighting against — an episodic care-based payment plan for specialists. The HMO claims the system could reduce unneeded lab tests by as much as 20% without affecting the frequency of other vital therapeutic procedures performed by most covered specialists — while encouraging overutilizers to get in sync with other physicians.

Specialists, noting that episodic care is very different from primary care capitation, are skeptical about just how useful this system would be.

Also, they are upset because many HMOs are

Episodes-of-care capitation: The basics

• **What:** The idea behind episodic care came from the widely used practice of bundling obstetrical services, including prenatal care and delivery, into one rate.

• **Who:** Major specialists such as cardiologists, ophthalmologists, orthopedists, and their surgery counterparts are most often covered.

• **How:** Specialists are paid monthly over a set referral period, usually three to nine months.

• **Payments:** The payment process kicks in once the specialist receives a referral from a primary care physician. The cap rate is determined by the medical condition of each patient based on factors like their age, gender, any comorbidities, and whether care was performed in a doctor's office or an intensive care unit. A value is then assigned to each case, which is updated as the patient's condition changes.

The final capitation rate can also be affected by how much money is left in the funding pool used to pay specialists.

• **Specialty capitation on the rise:**

More than half of insurers now use some form of capitation for at least some specialists, reports the American Medical Association in Chicago. In 1999, the average percentage increase in capitation rates among providers was:

— primary care, 8.7%;
— all providers, 6.7%;
— specialists, 0.1% ■

including episodic care capitation under their "all-products" umbrella, meaning physicians must accept it if they want to participate in the plans' other products.

For some time, independent practice associations and multispecialty practice groups have had a kind of cap system to internally allocate payments among their specialists. However, rather than looking for a way to fairly distribute reimbursements, specialists are afraid HMOs are more interested in finding ways to force them to work more for less pay.

Under the episodes-of-care approach, selected specialties are paid fixed monthly rates for an entire episode of specialty care. The length of the episode is usually defined to last between three and nine months. At referral, the specialist provides the HMO with information about the patient, and the HMO uses that to develop and assign a monthly capitation rate.

In the past, it has been considered much more difficult to devise a specialty capitation system than one for primary care because specialists only see a small percentage of the overall patient population. Also, related costs for specialists tend to be higher and vary widely compared to primary care since the medical problems being treated tend to be more exotic and / or extreme.

Reasoning that specialty capitation is a fast-approaching reality, some specialists are offering up their own alternative payment proposals which they say rewards provider efficiency without having to resort to capitation. ■

Better financial controls put muscle into practice

Here are the key numbers to look at

A key component of any profitable practice is controlling expenses and making best use of staff and ancillary services, says **Rebecca Anwar**, a Philadelphia-based health consultant with the Sage Group. "The first step in maintaining financial control is to constantly analyze four areas of your practice financial operations: collection ratio, total accounts receivable, procedure production and revenue, and income and expense [reports]."

• **Collection ratio.** If your collection ratio for the past three months is below 90% after contractual adjustments, that is a good indicator your billing system is not working.

"The key to having an outstanding collections ratio is to hold your staff accountable and educate them about the importance of collecting accurate patient data and coding correctly," stresses Sage consultant **Judy Capko** of Philadelphia. For example, be sure to have your receptionist check to see that each patient's insurance status is up to date, and that the copay is collected upfront.

• **Total accounts receivable.** Ideally, this should be no more than two to three times your monthly charges. For example, if your group

(Continued on page 151)

Physician's Coding Strategist™

Coding method links electronic medical records

Process simplifies research, record sharing

As a pathologist, **John Neff**, MD, FCAP, is constantly asked to provide extensive and wide-ranging information on patients. For instance, a recent request was for all patients diagnosed with carcinoma of the lungs for the past four years. That's when Neff, chairman of the department of pathology at the University of Tennessee in Knoxville, puts SNOMED to use.

SNOMED, or 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 arm of the College of American Pathologists. Neff is chairman. "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 (HIPAA) 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 in 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," he says.

All physicians have a problem with records, Neff asserts. Even after 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 you are interested in 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, biopsy and calls up a database of all patients who received the biopsy. "Doctors are weighted down 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."

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

Watch for these red flags in your compliance work

Make sure your 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, a principal with Arista Associates, a health care consulting firm in Northbrook, IL.

Physician practices don't deliberately upcode, Williams adds. In most cases, it's due to a lack of education and training and the practice's failure to hire people who understand coding and can do a good job of coding properly.

Proper coding can help the bottom line

In addition to helping yourself 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 red flag 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," he says.

Poor documentation concerns OIG

Proper documentation is essential for being in compliance with government regulations, Williams says. "Realistically, the OIG's [Office of Inspector General] 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 he 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," he says. ■

Get some help for building E/M codes

Use this CodeBuilder form with 1997 guidelines

If seasoned coders find evaluation and management (E/M) codes difficult, students learning the system are probably even more confused. That's why a professor at Alfred (NY) State College of Technology worked with her students to develop the E/M CodeBuilder 1997.

Alfred State College's health information technology and medical assistant programs include coursework in CPT (common procedural terminology), which also includes instruction in the assignment of E/M codes.

The CodeBuilder form is to be used with the Health Care Financing Administration's (HCFA) 1997 E/M Documentation Guidelines when reviewing patient charts to identify the appropriate E/M code for a case, says **Michelle Green**, MPS, RHIA, CMA, CTR, a professor in the department of physical and life sciences. **(See E/M CodeBuilder 1997, pp. 149-150.)**

Draft may not be implemented until 2002

HCFA's draft version of the 2000 E/M Documentation Guidelines became available in June, but it might not be implemented until 2002. HCFA plans to conduct pilot tests of these guidelines beforehand.

Also prior to their implementation, Green will develop the E/M CodeBuilder 2000, which will incorporate the new documentation guidelines. Information about the availability of this free CodeBuilder tool will be posted onthe Part B-list, and it will also be available as an Microsoft Word e-mail attachment.

If you are looking for case studies using the form, consult the sixth edition of *Understanding Health Insurance: A Guide to Claims Processing* by JoAnn Rowell and Michelle Green (Delmar Publishers).

[For more information, visit Green's Web site at http://web.alfredstate.edu/greenma or contact her at greenma@ alfredstate.edu. Phone: (607) 587-3674.] ■

E/M CodeBuilder 1997

SELECTING THE LEVEL OF HISTORY

HISTORY OF PRESENT ILLNESS (HPI) (place a check mark next to each documented HPI elements)

___ **Location** (of pain/discomfort; is pain diffuse/localized, unilateral/bilateral, does it radiate or refer)
___ **Quality** (a description of the quality of the symptom; e.g., is pain described as sharp/dull/throbbing/stabbing/constant/intermittent/acute or chronic/stable/improving or worsening)
___ **Severity** (use of self-assessment scale to measure subjective levels, 1-10, or comparison of pain quantitatively with previously experienced pain)
___ **Timing** (establishing onset of pain and a rough chronology of pain development; e.g., migraine occurring mornings)
___ **Context** (where is the patient and what is he doing when pain begins; is patient at rest or involved in an activity; is pain aggravated or relieved, or does it recur with a specific activity; has situational stress or some other factor been present preceding or accompanying the pain)
___ **Modifying factors** (what has patient attempted to do to relieve pain - e.g., heat vs. cold - does it relieve or exacerbate pain; what makes the pain worse; have over-the-counter drugs been attempted - with what results)
___ **Associated signs/symptoms** (clinician's impressions formulated during the interview may lead to questioning about additional sensations or feelings; e.g., diaphoresis associated with indigestion or chest pain, blurred vision accompanying a headache, etc.)

___ **Total Score** (add the check marks and record the total; then, place a check mark next to the history type below)

___ BRIEF HISTORY (1-3 elements)
___ EXTENDED HISTORY (4 or more elements)

REVIEW OF SYSTEMS (ROS) (place a check mark next to each documented ROS elements)

___ Constitutional symptoms (e.g., fever, weight loss, etc.)
___ Eyes
___ Ears, nose, mouth, throat
___ Cardiovascular
___ Respiratory
___ Gastrointestinal
___ Integumentary (including skin and breast)
___ Genitourinary
___ Musculoskeletal
___ Allergic/Immunologic
___ Hematologic/Lymphatic
___ Neurological
___ Psychiatric
___ Endocrine

___ **Total Score** (add the check marks and record the total; then, place a check mark next to the ROS type below)

___ NONE
___ PROBLEM PERTINENT (1 body system documented)
___ EXTENDED (2-9 body systems documented)
___ COMPLETE (all body systems documented)

PAST, FAMILY AND/OR SOCIAL HISTORY (PFSH) (place a check mark next to each documented PFSH elements)

___ Past history (patient's past experience with illnesses, operations, injuries, and treatments)
___ Family history (review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
___ Social history (an age appropriate review of past and current activities)

___ **Total Score**(add the check marks and record the total; then, place a check mark next to the PFSH type below)

___ NONE
___ PERTINENT (1 history area documented)
___ COMPLETE (2 or all 3 history areas documented)

Circle the type of HPI, ROS and PFSH and then select the appropriate Level of History				
History of Present Illness	Brief	Brief	Extended	Extended
Review of Systems	None	Problem Pertinent	Extended	Complete
Past, Family, Social History	None	None	Pertinent	Complete
Select Level of History	**Problem focused**	**Expanded problem focused**	**Detailed**	**Comprehensive**

SELECTING THE LEVEL OF EXAMINATION

GENERAL MULTI-SYSTEM EXAM Refer to the General Multi-System Examination Requirements in the HCFA *Guidelines for Evaluation and Management Services.* Place a tally mark for each bulleted item documented for each organ system/body area (for up to the total number of allowed items; e.g., up to 2 marks can be made for the Neck exam)

_____ Constitutional (2)
_____ Eyes (3)
_____ Ears, Nose, Mouth and Throat (6)
_____ Neck (2)
_____ Respiratory (4)
_____ Cardiovascular (7)
_____ Chest (Breasts) (2)
_____ Gastrointestinal (5)
_____ Genitourinary (Male: 3; Female: 6)
_____ Lymphatic (4)
_____ Musculoskeletal (6)
_____ Skin (2)
_____ Neurological (3)
_____ Psychiatric (4)

_____ **Total Score** (add the tally marks and record the total; then, place a check mark next to the Exam type below)

___ PROBLEM FOCUSED EXAMINATION (1-5 elements identified by a bullet)
___ EXPANDED PROBLEM FOCUSED EXAMINATION (at least 6 elements identified by a bullet)
___ DETAILED EXAMINATION (at least 2 elements identified by a bullet from each of 6 organ systems/body areas OR at least 12 elements identified by a bullet in two or more areas/systems)
___ COMPREHENSIVE EXAMINATION (perform all elements identified by a bullet in at least 9 organ systems or body areas and document at least 2 elements identified by a bullet from each of 9 organ systems/body areas)

SINGLE ORGAN SYSTEM EXAMINATION Refer to the Single Organ System Examination Documentation Requirements in the HCFA *Guidelines for Evaluation and Management Services*; place a check next to the appropriate Exam type below

___ PROBLEM FOCUSED EXAMINATION (1-5 elements identified by a bullet)
___ EXPANDED PROBLEM FOCUSED EXAMINATION (at least 6 elements identified by a bullet)
___ DETAILED EXAMINATION (at least 12 elements identified by a bullet; NOTE: for eye and psychiatric examinations, at least 9 elements in each box with a shaded border and at least one element in each box with an shaded or unshaded border is documented)
___ COMPREHENSIVE EXAMINATION (all element identified by a bullet; document every element in each box with a shaded border and at least 1 element in each box with an unshaded box)

Select the appropriate level of medical decision making based upon the following criteria:			
Number of diagnoses or management options	*Amount/complexity of data to be reviewed*	*Risk of complications and/or morbidity/mortality*	**Medical Decision Making**
Minimal	Minimal or None	Minimal	**Straightforward**
Limited	Limited	Low	**Low Complexity**
Multiple	Moderate	Moderate	**Moderate Complexity**
Extensive	Extensive	High	**High Complexity**

Select the E/M code based on selection of level of history, examination and medical decision making:					
History	Problem focused	Expanded Problem focused	Expanded Problem Focused	Detailed	Comprehensive
Examination	Problem focused	Expanded problem focused	Expanded problem focused	Detailed	Comprehensive
Medical Decision Making	Straightforward	Low complexity	Moderate complexity	Moderate complexity	High complexity
Go to the appropriate E&M category and select the code based upon the information above					

Source: Michelle Green, MPS, RHIA, CMA, CTR, Alfred (NY) State College of Technology.

(Continued from page 146)

practice monthly charges amount to $200,000, your total accounts receivable should be no more than $600,000.

One reason practices sometimes see a sudden increase in outstanding charges or accounts receivable is that they send in a batch of incorrectly filled-out claims that payers refuse to honor. Or, a major payer may be having financial problems and just holding payments until pressed for the check.

Determining what's profitable

• **Procedure production and revenue.** By examining several months of charges by procedure you learn where most of your charges are being initiated. "You can also determine which third-party payers are accounting for most of your charges and which procedures are the most profitable this way," says Anwar.

Another important exercise is to analyze charges and services generated by individual physicians in the group to identify if the services performed by specific providers are consistent with practice standards, or if there any inequities in services or charges by different providers.

• **Income and expense reports.** These reports should be examined monthly to detect any unplanned changes in practice patterns. "If you spot a red flag, look at the itemization of expenses in that category. Then, when you find what's causing the increase, address it immediately," stresses Anwar.

For instance, when overhead is constantly rising, one of the first places to look is personnel expenses. Some questions to ask: Has there been an increase in staff overtime; have employees been added; too many raises been given out; or is the part-time staff increasing their hours?

"Before you make any drastic changes, find out if these higher personnel costs are being justified by increased production," Anwar advises.

A common problem area for practices with financial problems is they are not using their resources — staff and equipment — wisely. For example, a group buys a sophisticated computer system, but only uses 30% of its capabilities. One way to avoid overspending is to analyze whether such purchases will increase revenue or productivity — and by how much — and if any increases go beyond the break-even point justifying the expenditure.

Another common oversight is to either undercalculate the cost of training or fail to provide enough training for new computer programs and equipment. "Remember, proper training pays off in improved efficiency which permits staffers to be more productive which lowers costs," notes Capko.

Another way to increase efficiency is to compare what percentage of your patient base belongs to which payers and how much time your staff must spend on related paperwork and administrative issues with each insurer.

"If you discover only 10% of your patients belong to Insurer A, yet their paperwork and red tape eats up 40% of your staff time, you may want to re-evaluate if it is worth your time and effort to keep doing business with that plan," says Capko. ■

RVUs made simple, or at least understandable

Administrator tells how he does it

Been avoiding delving into the resource-based relative value unit scale (RBRVS)? That's probably not a good idea, says **Steve Dickson**, practice administrator for Village Surgical Associates in Fayetteville, NC.

With Medicare's RBRVS becoming the standard for determining provider reimbursement by both government and commercial payers, "it's imperative everyone from physicians to office managers develop a better understanding of how this system works and integrate it into their operations," he insists.

Dickson has developed a system for creating an in-house relative value unit (RVU) database he says is so easy to use that it only requires about 25 hours of a clerk's time, a personal computer, and a standard spreadsheet software to implement. "If I hired an outside consultant to produce a similar database for our group, it would cost about $10,000," estimates Dickson.

He now uses the system to price individual procedures, establish fee schedules, evaluate and negotiate outside contracts, and help determine physician bonuses. During one of his first projects, he found about 10% of the fee schedules for his group's most common procedures were priced too low. "I found we had priced some procedures as much as 70% to 80% below their actual cost,"

he recalls.

"I do not claim this system is perfect," he admits, "but, it does give you a realistic rough cut of that it costs a practice to perform various procedures. You also get a set of baseline RVUs that can be used for any number of purposes, ranging from pricing fee schedules to evaluating noncapitated discounted fee for service, percentage of Medicare, or single conversion factor-based proposals — as well as capitated contracts."

The basic steps in creating the RVU database are:

1. Gather data. Assemble a list of all the procedures by CPT code the practice performed over the past fiscal year, plus total practice expenses during the same period.

2. Update RVUs. Each December, the U.S. Department of Health and Human Services publishes an RBRVS update that is available on disk for about $20. This disk includes all CPTs, their associated RVUs, the geographical adjustment factors, and the *Federal Register* discussion of the Medicare changes for that federal fiscal year. The CPTs and RVUs are in spreadsheet format on the disk, making it easy to download onto a computer.

3. Load data. Once the RVU spreadsheet is loaded onto your computer:

A. Either type in or automatically download from your information system onto Column 1 of the spreadsheet all the CPT codes performed over the past fiscal year.

B. Enter the description of those procedures into Column 2.

C. Enter your current fee into Column 3.

D. Enter the RVU for each CPT code in Column 4.

E. Enter the volume per CPT — number of times providers administered this service over the past year — in Column 5.

F. Multiply the volume (Column 5) by the RVU (Column 4) to get the total RVUs for each procedure (Column 6).

G. Add the RVUs by procedure to get total practice RVUs (Column 6).

H. Determine the cost of providing all the services performed over the past year.

I. Divide expenses by total RVUs to obtain a conversion factor / cost per RVU. Enter this number in Column 7.

J. Multiply the conversion factor / cost per RVU by the RVU associated with each CPT to determine the cost per procedure. Enter the result in Column 8.

To determine your break-even fee, divide the cost per procedure by the practice's average collection percentage — minus Medicare and Medicaid payments. Now determine how much profit you want to tack onto each procedure and add that to your break-even cost. ■

Your Web site can bring trouble with fraud laws

Be cautious, lawyers advise

If you use the Internet to communicate with patients or market your practice, beware. Any computer links you provide to other sites — especially facilities you refer patients to — can get you in regulatory hot water with the fraud police. The same concern also applies when other providers and health care sites list you as a link on their Web pages.

Since the use of the Internet by providers is still relatively new, there is little case law and formal regulatory policy on the matter. However, the Office of the Inspector General (OIG) is looking into the issue, and hopes to issue an advisory on the topic sometime within the next year.

"This is a totally new area where no one has a definite take on the topic yet," notes **Eric S. Tower**, a lawyer with Mintz Levin in Washington, DC.

Until that happens, experts are advising physicians err on the side of caution when inserting links to hospitals and other providers they refer patients on their Web sites.

Under current case law, merely providing links to organizations outside the health care industry generally does not create liability risks. However, in the health care industry, creating financial relationships among health care providers through arrangements like computer links may trigger federal anti-kickback law and Stark investigations, advise legal eagles.

For instance, when a hospital-owned site provides a link to a physician at no cost to the doctor, some might argue this is compensation going to the physician in the form of free advertising, which violates anti-kickback rules.

Safe harbors

One way for doctors to avoid running afoul of the law is to pay fair-market value for any service they receive, including Web links.

"Any physician offered free Web sites needs

to consider the proposal in light of the fraud and abuse laws," advises **Bruce Fried**, chair of the health law group at Washington, DC's Shaw Pittman law firm.

"Is there a quid pro quo? Is there some sort of referral expectation? These — plus all the other thoughts that physicians go through when looking at their business relationships — need to apply to Internet relationships," says Fried.

For instance, besides links to other providers, physicians should also consider the potential impact of hyperlinks to pharmaceutical companies or other health care product makers.

The lines have not been clearly drawn, yet, but "distinctions are going to have to be made between sponsorship fees, advertising fees, and various forms of click-through arrangements," notes **Mark Lutes**, an attorney in the Washington, DC office of Epstein Becker.

Tip: If you have a Web site, make sure to include links to hospitals and other provider organizations you are not affiliated with to eliminate any potential allegations that the practice is not providing a full range of unbiased information. ■

HCFA adopts formats for electronic transactions

Implementation in two years

The new standard formats for data content and the formats for submitting electronic claims and other administrative health transactions have been released by the Health Care Financing Administration (HCFA).

This new national standard will replace the 400 formats for electronic health care claims now in use. Once the mandated congressional review period ends in October, the health care industry has 24 months to implement the regulation — 36 months for small health plans.

Under the new regulation, all electronic claims transactions must follow the single standardized format. Providers will still be allowed to use paper forms, but the simplified process is expected to encourage more electronic filing.

Under the new standard:

• Health plans will be able to pay providers, authorize services, certify referrals, and coordinate benefits using a standard electronic format for each transaction. Providers will also be able to use a standard format to determine eligibility for insurance coverage, ask the status of a claim, request authorizations for services or specialist referrals, and receive electronic remittance to post receivables.

• New standards for other common transactions and coding standards for reporting diagnoses and procedures in the transactions.

• Standard electronic formats to enroll or disenroll employees from plans and submit premium payments.

More rules expected soon

Other still-to-come related rules to look for from the Department of Health and Human Services (HHS) are: identifiers for providers and employers, standards for health data security, and standards protecting the privacy of patient health information. HHS also expects to release proposed regulations governing claims attachments (information requested by insurance plans from health care providers to justify submitted charges), the national health plan identifier, and First Report of Injury by the end of the year.

According to an analysis by the Washington, DC, office of the Medical Group Management Association, other key provisions of the regulation include:

• Uniform standards for the following: administrative and financial transactions, health claims or equivalent encounter information, health claims attachments, eligibility for a health plan, enrollment and disenrollment in a health plan, health plan premium payments, health care payment and remittance advice, health claim status, and referral certification and authorization.

• Transmission of nonstandard transactions between a provider and a health plan or a provider and a health care clearinghouse do not violate the law if part of a trading partner agreement.

• Local codes are eliminated, and a national process is established for reviewing and approving codes.

• Current Procedural Terminology codes will be used for procedure reporting.

• International Classification of Diseases, 9th Edition, Clinical Modification codes for diagnoses. Current Dental Terminology codes are to be used for dental services. American National Standards Institute Accredited Standards Committee X12N codes are to be used for most business applications. ■

Cyber signatures arrive, but are they a good idea?

Experts question safety features

Despite the new federal law that goes into effect Oct. 1 giving electronic signatures the same legal status as old-fashioned John Hancocks scratched out on paper, some experts question if a physician's cyber signature will meet the security requirements needed for health-related electronic claims and records.

"One of the problems with the law is that it has very low security standards making it relatively easy to challenge electronic signatures," says **Kepa Zubeldia**, MD, vice president of technology at Envoy Corporation, a Nashville, TN-based medical claims clearinghouse. "The new law makes electronic signatures legally valid nationwide. However, the related security standards are lower than generally required for health care transactions."

As a result of those concerns, many experts are advising physicians to wait until the Department of Health and Human Services (HHS) implements the complete set of final rules required by Health Insurance Portability and Accountability Act (HIPAA) governing the standardization and privacy of electronic health data and claim transmissions before using on-line electronic signatures **(see related story, p. 153)**.

However, if you do decide to start using electronic signatures in your practice, e-health experts point out that providers are required by law to adhere to the cryptographically based digital electronic signature standard set by HHS for any HIPAA-covered transaction.

Sacramento, CA-based Sutter Medical Group, for instance, hopes to start using digital signatures by the end of the year, allowing its doctors to electronically sign orders and X-ray readings, communicate with each other, and access patient data from home, says **John M. Whitelaw Jr.**, MD, CEO of the 175-physician multispecialty group. That should save time by reducing paperwork and eliminating the constant rounds of phone tag providers and other employees must endure before finally making contact with each other.

HHS's proposed standard

While the terms "digital signature" and "electronic signature" are often used interchangeably, they are different things, say e-health mavens. A digital signature is basically a document tightly bound to a "hash" mark, which is a unique number or fingerprint.

An electronic signature, however, can be an electronic sound, symbol, or process associated with a record and executed by a person with the intent of signing the record. It could be anything, including a digital signature, an X, or simply a name typed at the bottom of an e-mail.

Here's what HHS has proposed for its digital signature standard and the three mandatory technical features or technologies it says must be incorporated into it:

- **Nonrepudiation** — blocks a sender's false denial that he or she signed a particular message, allowing the recipient to easily prove that the sender actually did sign the document.
- **User authentication** — verifies the signer's identity at the time the electronic signature is generated.
- **Message integrity** — not only binds a signature to a document, but also shows the document had not been altered after the signature had been affixed. If the document is altered, then the signature is invalidated.

Despite the fact those technical features are not specifically required by the electronic signature law, physicians and their patients could face considerable risks if their electronic signatures for contracts, patient forms, and other electronic documents lack those features, says Zubeldia.

"If you and I agreed to enter into a contract by entering our names at the bottom of an electronic mail, and three months later I deny that I signed

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it, you have to prove that I signed it, which is also impossible," he notes.

Before you can digitally sign a document, both you and the other person involved in the electronic transactions need to acquire digital certificates issued by special Internet security firms known as certification authorities. Then, you must download them into your computer or special equipment attached to it.

Most of those certification authorities charge a fee for a digital certificate. However, the Chicago-based American Medical Association and the computer chip manufacturer Intel will provide certificates at no cost to physicians, says the North Carolina Healthcare Information and Communications Alliance, a Research Triangle Park, NC, nonprofit organization dedicated to advancing electronic communications in health care. ■

Mergers and acquisitions reverse trend and rise

Hospitals lead revitalized interest

During the second quarter, mergers and acquisitions (M&As) in the health care services sector rose for the first time in two years with 17% more deals than the previous quarter, according to New Canaan, CT-based health research firm of Irving Levin Associates.

"After two straight years of decline in health care services, M&A activity, the M&A market has finally pulled out of its nose dive," notes **Stephen M. Monroe**, a spokesman for the company.

Three sectors — physician medical groups, hospitals, and behavioral health care providers — accounted for 50% of the total mergers and acquisitions last quarter. For the third quarter in a row, the hospital sector led all others as the single most active sector in the industry.

The physician medical group sector "appears to have entered what we might call the post-physician practice management company phase following what amounted to a reckless trend of acquisition of practices for acquisition's sake, and the subsequent crash-and-burn of the PPMC [physician practice management company] industry," says Monroe.

For instance, PPMCs still exist, but now appear to be focusing on specialty practices or ancillary services instead of attempting to sign up as many physician groups as possible.

"Similar to the market of four years ago, the hospital sector appears to be re-establishing itself at the cornerstone of the health care services industry and attracting the lion's share of attention when to comes to mergers and acquisitions," says Monroe.

In the second quarter of 2000, the hospital sector led the activity, with 31 deals accounting for 23% of all health care mergers and acquisitions during the quarter.

"These 31 deals represent a total of 45 acute care facilities, which have a combined total of

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7,400 beds and generate more than $1.6 billion in annual revenue," observes Monroe. "Publicly traded corporations, privately held companies, and nonprofit organizations all took an active part in this market."

The behavioral health sector had 16 deals, representing a 167% gain. However, much of this activity can be attributed to the sell-off of 24 facilities by a bankrupt provider.

"The fact that buyers were found for these facilities at all suggests they feel confident that they can operate inpatient psychiatric facilities in the current reimbursement environment," notes Levin staffer **Sanford Steever**.

Meanwhile, the managed care sector experienced a 50% drop in activity during the second quarter. "The drop was the result of two concerns which diverted insurers' attention from their M&A programs: how the Supreme Court would rule on lawsuits against HMOs, and preparations to withdraw from many Medicare markets," he reports.

As payers and providers adapt to new reimbursement protocols and regulatory mandates, "we believe managed care players will pursue a prudent, but steady, stream of M&A deals," Steever predicts. ■

HCFA places updated training manuals on-line

Health care facilities searching for current information about the outpatient prospective payment system (OPPS) can now view updated training manuals used by fiscal intermediaries to train providers. The Health Care Financing Administration (HCFA) in Baltimore has placed them on its Web site.

A brief summary of the changes is included for each chapter of the manuals. This will allow those who already have the manuals to review the changed pages only.

The training manual is intended for use as a guide to facilitate training. Those affected by the outpatient PPS are advised to rely on the final rule and the implementing instructions for the outpatient PPS (PM-A-0036) and the Outpatient Code Editor (PM-A-0035) for official policy and instructions for the outpatient PPS. The final rule and instructions are also available via www.hcfa.gov.

In addition to the training manuals, HCFA has also placed the PRICER logic on the Web. The PRICER logic, which is technical in nature, will show how HCFA will price claims/services grouped by the Outpatient Code Editor under OPPS.

To view the training manuals or the PRICER logic:

1. Go to http://www.hcfa.gov/medlearn/refguide.htm.
2. Scroll down to Outpatient Prospective Payment System Training Session.
3. Look for the table of contents for the training manuals in this section and click on the chapters you want.
4. Find the PRICER logic by scrolling just beyond the training manual contents. ■

The high cost of Choice

Despite the fact it was created to cut costs, Medicare spent $5.2 billion more in 1998 on beneficiaries in Medicare+Choice plans than it would have if those beneficiaries had been enrolled in traditional fee-for-service, reports the General Accounting Office (GAO). That means, Medicare is spending 21% more on seniors in HMOs than those in traditional fee-for-service option, the GAO estimates. ■