AMERICAN HEALTH CONSULTANTS®

Providing the highest-quality information for 12 years

PHYSICIAN'S PAYMENT UPDATE™

INSIDE

■ **'Fess up:** Admitting your mistakes carries a lot of weight with the feds 158

■ **Doctor dumping:** Bad communication is costing doctors money 160

■ **No more phone tag:** E-mail more efficient, docs say . . 161

■ **Trouble in HMOland:** Half of all commercial HMOs lost money last year 161

■ **Healthy incentives:** Employers base physician pay on health of employees. . . 162

■ ***Physician's Coding Strategist*** 163

■ **Telemedicine:** Technological advances are improving usefulness 167

■ **What a racket:** Physicians using racketeering law to fight HMOs 168

NOVEMBER 2000

VOL. 12, NO. 11 (pages 157-172)

American Health Consultants® is A Medical Economics Company

OIG gives physician groups a reprieve by modifying final compliance plan

Guidance builds in more flexibility for practices

Officially, they were polite and "pleased" by the news, but off the record, executives at physician-related societies and organizations let out a collective whoop of satisfaction in late September after the Office of Inspector General (OIG) released its final compliance guidance for solo practitioners and small group practices.

They were elated because the changes incorporated by the OIG contained most of the alterations physician lobbying groups had been asking for.

In an understated official statement, the Medical Group Management Association (MGMA) of Englewood, CO, for instance, said it was "pleased that the final compliance guidance reflects several suggestions that [were] made in formal comments, as well as during . . . discussions with the OIG regarding the draft guidance."

As with previous guides, the OIG outlines the seven standard components of a full-scale compliance program. While the agency underscored that that guidance, like its guidelines for other providers, is voluntary, the fraud police backed off its "suggestion" in earlier provider compliance guidelines that all seven of those components be implemented by physician practices.

Bottom line: Letting physicians off the hook when it comes to adhering to all seven points gives practices more flexibility — and less built-in costs when implementing and managing their internal compliance programs.

"The intent of the guidance is to provide a road map to develop a voluntary compliance program that best fits the needs of that individual practice," said Inspector General **June Gibbs Brown**.

"The guidance itself provides great flexibility as to how a physician practice could implement compliance efforts in a manner that fits with the practice's existing operations and resources, " Brown continued. "Our goal in issuing this final guidance was to show physician practices

that compliance can become a part of the practice culture without the practice having to expend substantial monetary or time resources."

In another key point providers had been seeking, the OIG included a statement in the materials accompanying the guidance that "physicians are not subject to civil, administrative, or criminal penalties for innocent errors, or even negligence."

It stated that "the government's primary enforcement tool, the civil False Claims Act, covers only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard or deliberate ignorance of the truth, or falsity of a claim. The False Claims Act does not cover mistakes, errors, or negligence."

As Brown pointed out, "The OIG is very mindful of the difference between innocent errors [erroneous claims] and reckless or intentional conduct [fraudulent claims]."

In a major victory for physicians, unlike other provider guidelines already issued by the OIG, the final physician guidance does not suggest that physician practices implement all seven standard components of a full-scale compliance program.

Noting that it would be great if a practice did build a solid compliance program based on those seven components, the OIG also acknowledged that "full implementation of all components may not be feasible for smaller physician practices."

A step-by-step approach

Instead of having to adhere to the so-called seven pillars of compliance, the guidance emphasizes what it calls "a step-by-step approach" for smaller practices to follow in developing and implementing a voluntary compliance program.

The first step the OIG suggests is for physician practices to identify risk areas which, based their history with billing problems and other compliance issues, might benefit from closer scrutiny and corrective / educational measures.

The next steps are to:

1. conduct internal monitoring and auditing through the periodic audits;
2. implement compliance and practice standards through the development of written standards and procedures;
3. designate a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards;
4. conduct appropriate training and education on practice standards and procedures;
5. respond appropriately to detected violations through the investigation of allegations, and the disclosure of incidents to appropriate government entities;
6. develop open lines of communication — such as community bulletin boards and discussions at staff meetings — regarding erroneous or fraudulent conduct issues, as well as compliance issues;
7. enforce disciplinary standards through well-publicized guidelines.

Risky business

The final guidance also identifies four specific areas it feels present higher than normal risk when it comes to compliance for physician practices:

- proper coding and billing;
- ensuring that services are reasonable and necessary;
- proper documentation;
- avoiding improper inducements, kickbacks, and self-referrals.

While it might sound like a broken record, those are also the areas you can expect government auditors and inspectors to take an extra hard look at when reviewing your claims.

To increase flexibility and lower costs, the OIG also is encouraging physician practices to participate in the compliance programs of other providers, such as hospitals or venues where they practice.

Larger practices are being asked to use both this guidance and previously-issued guidelines, like the Third-Party Medical Billing Company Compliance Program Guidance or the Clinical Laboratory Compliance Program Guidance, to create a compliance program that meets their special needs. ■

Admitting your failures can avoid federal snares

Self-disclosure can make it easier on you

It's more vital than ever that practices conduct their own internal investigations when they suspect something is out of kilter rather than risk having federal gumshoes get wind of the problem, **Michael Kendall** of McDermott, Will & Emery's Boston office recently told the Health Care Compliance Association's annual conference in New Orleans.

OIG's criteria for reduced penalties

According to the OIG, what course of action it takes when dealing with compliance problems depends on:

- the scope and seriousness of the misconduct;
- the risk of it recurring;
- whether the disclosed matter was identified and reported as a result of the provider's compliance measures;
- the degree of the provider's cooperation during the disclosure verification process. ■

The main advantage of this aggressive approach is that you're able to get a handle on what's happening — and why. Then, if it's a real compliance issue, you will be able to self-disclose the problem to government officials — which generally earns you brownie points — before they become suspicious and start demanding answers.

"Being the first one to knock on the door places you on a certain moral high ground and gives you some creditability," says Kendall.

Here are his rules for conducting an in-house investigation:

- Gather all the relevant facts before the government does.
- Uncover and research potential problems before the government comes to the door.

This way, you already have your defense worked out before any official investigation gets under way.

- Know the relevant laws and regulations thoroughly so that you are will be able to help "educate" investigators and prosecutors about the real issues they should be considering.
- Immediately stop doing whatever it is that could get you into legal trouble.
- Tell the government what you did wrong before it finds out on its own.
- Don't do something stupid, especially anything that could be construed as an obstruction of justice, such as changing or destroying documents. Make it clear to employees they are to tell the truth if interviewed as part of an investigation.

Remember that when it comes to compliance, it's not always what you do that gets you into trouble. Sometimes it is what you don't do — like closely supervise your outside billing service, for instance.

Four emergency physician groups recently learned this lesson the hard way when they were forced to repay Medicare $2.6 million because they allegedly cashed overpayments generated from the regular upcoding of claims by their billing company.

Self-disclosure

If, after talking with your lawyer, you decide to self-disclose possible compliance problems to the government, cases that involve an accidental overpayment or other billing errors that have nothing with breaking the law should go "directly to the attention of the entity responsible for claims processing and payment," advises **Jillian Wilson**, a health care attorney in the Baltimore offices of Ober Kaler.

However, if you believe an intentional violation of the law has occurred, report that to the OIG, or some other enforcement agency.

This distinction is part of an October 1998 protocol on self-disclosure published by the OIG for all health care providers doing business with Medicare, Medicaid, and other federal health care programs.

In another March 9, 2000, open letter to the health care community, Inspector General June Gibbs Brown announced that providers that self-disclosed improper conduct can receive an expedited review of their disclosures "and, where appropriate, favorable treatment in the resolution of their cases," notes Wilson.

In this open letter, the OIG said it "may forego" exempting providers who step forth and reveal criminal activities from being barred from federal health programs if they demonstrate "sufficient trustworthiness."

Additionally, if the provider can show its compliance program is functioning effectively, the OIG might not require a corporate integrity agreement outlining the terms under which the provider agrees to operate in the future.

For instance, if a practice's own audit detects a problem that it then discloses, the OIG may permit the practice to perform some or all of the billing audits through its internal auditors rather than requiring the retention of an independent review organization, says Wilson.

Additionally, the OIG might even narrow the

scope and focus of the claim review to just the areas reported to be out of compliance — or agree to the use of less burdensome, alternate audit methods than the statistical sampling techniques usually used in such instances. ■

Patients dumping doctors in record numbers

Poor communication cited

Half of America's 100 million households changed, added, or selected a physician in the past two years, according to a recent study by VHA Inc., an Orlando, FL-headquartered network of community-owned hospitals.

Contrary to popular assumptions, health plans are not the top reason for this record change, the study concludes. The main reason for physician-hopping cited by patients was dissatisfaction with the quality of care and doctor-patient communications they had with their present provider.

According to VHA's findings, 52% of health care consumers say poor communication was the primary reason for being dissatisfied with their present physician.

In contrast, slightly more than one-quarter of consumers said quality of care was the most important factor in determining how satisfied they were with their doctor.

"In the information age, there shouldn't be barriers to quality communication," says **Kelly W. Breazeale**, VHA senior vice president. "We learned from the study that patients want access to credible, current information, and they want to be able to communicate easily with their doctor about treatment options."

Connecting with patients

According to the research, a startling 71% of health care consumers say they were given no health information during their last physician visit. Yet 85% of those who did found it extremely helpful. The study also found that of all the ways to obtain health information, getting information from their physician is most consumers' first choice.

"The roles played by quality communication and shared information in improving health cannot be underestimated," says **Roxy Marrese**, MD, of Daytona, FL. "My ability to help my patients, and their satisfaction with me, is directly determined by how well we connect with each other."

In another study, if only 5% of the patient base of the average internal medicine practice decides to switch to another physician over the course of the year, this turnover costs the practice $23,000, annually. The study, by Bayer, the pharmaceutical company, found a $18,000 in net revenue loss plus $5,000 in services related to terminating and replacing the lost patients.

And a poll conducted by an Internet enterprise found that over one-third of consumers say they would be "more likely" to choose a doctor who offered electronic communication options than one who does not.

"These results lead us to believe providing an e-mail option for patients to communicate with you may be one of the biggest changes for physicians when it comes to attracting and keeping patients in the future," says **Peter J. Plantes**, MD, medical director of LaurusHealth.com, a health care Web site that conducted the poll.

The poll found also that only 3% of patients currently e-mail their physicians — some 35% don't even know if their physician offers e-mail communication.

However, of those who exchange e-mail with their physicians, 90% find it valuable and convenient, and 3% say it is necessary in maintaining a strong patient / doctor relationship.

"Consumers in this survey make it clear how important it is to them to be able to communicate electronically with their doctors," observes Plantes. "This survey should challenge physicians to consider adding new technologies such as e-mail to strengthen relationships with their patients."

Among the top e-mail and Internet options, the survey found patients want:

- electronic access to appointment scheduling (49%);
- ability to e-mail their doctor (46%);
- access to their test results (37%);
- electronic access to their patient records (28%).

"It is fair to say that today, e-mail communication is increasingly viewed by patients as an added convenience," notes Plantes. "Offering the convenience of on-line services that consumers are looking for could be a great way for physicians to build and maintain patient loyalty. This strategy has been used successfully in financial and other service industries." ■

Use of e-mail grows as a patient satisfier

Reductions cited in administrative hassles

When it comes to improving communicating with patients, "the telephone is no longer adequate," says **Daniel Hoch**, MD, assistant in neurology and director of neurology operations improvement at Massachusetts General Hospital in Boston.

"There are too many calls, and people are dissatisfied with a quick answer. The Web-based approach is more convenient, and more information can be given," says Hoch, who heads a pilot e-mail program at the hospital.

The neurology department has a service that allows patients to post a message to Hoch on a bulletin board. He answers directly to the bulletin board, and the postings are saved to provide a record of the interaction that is easy to review. The site is password-protected, and more secure than standard e- mail, he says.

He uses e-mail for such purposes as answering patient questions, leaving instructions for medication changes, and directing patients to Internet sites that might supply more information. Hoch hopes that adding e-mail will cut the time he has to spend on the phone by 25%-50%.

"We've found e-mail is generally more efficient than telephone calls since it can eliminate constant rounds of phone tag. Then there is the ability to take care of business from remote sites, to work at odd hours without worrying about waking someone up," he says.

Another benefit is since e-mail messages can be printed out, there is a written record for both the patient and the physician.

Small, but growing

Hoch is on the cutting edge of using a technological tool that could transform the day-to-day practice of medicine. Only about 5%-10% of physicians currently correspond with their patients by e-mail. This is up from less than 2% just a few years ago.

"The small group of clinicians who routinely use provider-patient e-mail say that it has revolutionized their practice in very positive ways," notes **Tom Ferguson**, MD, an Austin,TX-based consultant.

"In many cases, they can avoid the need for a clinic visit by an on-line exchange. And there is always a full record of the on-line conversation, so it can automatically become a part of the patient's medical record."

Ferguson says 25%-30% of doctor-patient e-mails deal with follow-up questions after an office visit. "It's wonderful when a doctor can say, 'Send me an e-mail in 10 days to let me know how you're doing.'"

Internist **Paul M. Ford**, MD, an assistant professor of medicine at Stanford University in Palo Alto, CA, has been using e-mail with his patients for about five years.

"E-mail gets you take care of a lot of the administrative stuff you have to do in medicine," he says. "I really believe if we had more patients using e-mail, it would decrease our overall practice costs. We wouldn't need so many people to answer the telephone [and] in the file room moving charts around. Also, patients would feel more connected to the practice, which could help financially in the long run."

Ford's practice of 10 physicians has a central e-mail address and a software filtering program that helps automatically route messages to the appropriate people. An automatic reply is sent to tell patients their message was received and who will take care of their request.

Sometimes, the practice adds standardized reminders to the automatic message such as information about flu shots. Many of the messages involve prescription refills, appointments, and specialist referrals that can be handled by someone other than a doctor.

Physicians only give out their private e-mail addresses when they feel it's appropriate. The American Medical Informatics Association Internet Working Group has developed "Guidelines for the Clinical Use of E-mail with Patients." The guidelines are available at www.amia.org. ■

Half of all HMOs lost money last year

Is one of your payers on the problem list?

Half of the nation's HMOs lost money last year, according to Weiss Ratings, an insurance rating firm based in Palm Beach Gardens, FL.

Despite total profits of $753.5 million by

nation's 34 largest HMOs, the overall industry reported losses of $186.6 million in 1999, according to Weiss.

"There is a very large and disturbing disparity between the profits of the few large HMOs and the continuing red ink in the rest of the industry,'' said Weiss Ratings chairman **Martin D. Weiss**.

The smaller the HMO, the more likely it is to lose money, according to the firm. For instance, over 56% of HMOs with fewer than 100,000 members reported losses, vs. about 37% of HMOs with 250,000 to 500,000 members.

Among states with 10 or more HMOs reviewed, California HMOs collectively posted the largest overall profit, at $789.4 million. Other states in which HMOs reported overall profits include New York ($91.8 million) and New Jersey ($41.3 million).

States with the largest losses included Texas ($463 million), Massachusetts ($217.1 million), and North Carolina ($87.2 million).

Of the 540 HMOs that Weiss rated based on year-end 1999 data, 50 received rating upgrades, while 56 were downgraded.

Notable upgrades included Parker Benefits in West Virginia (from D to C), Alameda Alliance for Health in California (from C- to C+), and Amerigroup New Jersey Inc. (from D to C-).

Notable downgrades included Carelink Community Health Partners in Delaware (from D to E-), Omnicare Health Plan in Michigan (from D- to E-), and HMO of Northeastern Pennsylvania Inc. (from B- to C-). ■

Alliance bases incentives on health, not savings

Employers bet quality will win out

Unhappy with their managed health care programs, a coalition of Ohio employers are betting that by concentrating on quality preventive care instead of short-term cost control, they can better contain their employee medical expenses over the long term.

Many managed care plans are now demanding — and receiving — premium hikes in the 10%-12% range. Prompted by a combination of skyrocketing prices and employee preference, more firms are dropping the old HMO in favor of a physician-led health product such as a preferred provider organization.

"Right now, the HMO idea is just not selling, " says **Bob Pures**, senior vice president at Horizon Blue Cross & Blue Shield of New Jersey.

The Tri-River Valley Healthcare Initiative, an alliance of major, self-insured employers in the Dayton area, has taken this trend one step further by creating its own physician-driven managed care alternative.

Unlike the typical HMO, the alliance gives physicians the first and final authority over what they feel is the best treatment for a particular patient. Another major difference is that instead of basing financial incentives on how much less money they spend to treat patients, the alliance bases incentives for participating doctors on how healthy they're able to keep employees.

Conflicting financial interests

The incentives that typically drive the financial and patient care portions of most managed care plans often work at cross purposes, maintains **John Tonkin**, executive director of the Tri-River Healthcare Initiative.

When that happens, it can create a dynamic that forces employers, insurers, and health care providers into an almost adversarial situation to protect their financial interests, while what is best for the patient can get lost in the process.

In an effort to break this cycle, the coalition has made a bold bet that putting physicians back in control of health care decision making, combined with an emphasis on preventive care and consumer satisfaction, will produce lower medical bills over the long term.

Since preventive care is the focal point of the program, physicians' financial packages are geared towards diagnosing and resolving potential medical problems early on.

Bottom line: The healthier employees are, the less these companies will have to spend on medical benefits — leaving more money on the table for their docs to pocket.

As part of this approach, an Internet-based system is being put in place making it easy for patients to e-mail health-related questions to their doctors while also giving them fast access to medical information on the Web.

Another major change is that instead of acting as a gatekeeper who tells participating doctors what they can or cannot do, the Tri-Cities insurance plan's main function will be to collect and share information providers can use to

(Continued on page 167)

Physician's Coding Strategist™

Confused about modifiers? Don't fret, you're not alone

Have they moved too far from the original intent?

Confusion reigns as providers try to decipher portions of the outpatient prospective payment system (PPS). The Health Care Financing Administration (HCFA) has tried to clarify the use of modifiers, but some analysts say the effort to explain modifier –25 has only made it more controversial.

On July 20, HCFA issued a program memorandum (Transmittal A-00-40) to fiscal intermediaries detailing the correct use of modifier –25. The memo was helpful, says **Rita Scichilone**, MHSA, RHIA, CCS, CCS-P, coding practice manager at the American Health Information Management Association in Chicago.

"It seemed to tell us that you can attach modifier –25 to just about any E/M [evaluation and management] service that has a procedure connected with it," she says. "The definition of procedure in it is fairly broad. Their examples include EKGs and X-rays."

Previously, Scichilone had thought the modifier could be used only if the medical visit and a surgical procedure for the same session were unrelated and significant and separately identifiable. "That doesn't seem to be the case," she says.

Time for a rethink?

Others are more critical in their assessment.

"HCFA's instructions on how to use modifier –25 are very troublesome," says **Deborah Williams**, senior associate director of policy development for the American Hospital Association in Washington, DC. "About 85% of ER [emergency room] claims have modifier –25 on them, which is not useful. That's the modifier we believe needs significant rethinking."

The program memorandum leaves people guessing, says **Laura Frazier**, RHIT, manager of APC Solutions for QuadraMed Corp., San Rafael, CA, a health care information systems company. "The most problematic thing about it is that you are supposed to use it for all diagnostic or therapeutic medical or surgical services except for lab services. Why isn't modifier –25 appended to lab services, too, if they are going to apply the modifier across the board?"

A conflict with the AMA?

The memo moved the modifier away from original intent of the American Medical Association (AMA) when it created Current Procedural Terminology (CPT) codes, say Williams and Frazier.

"The AMA is not happy because it feels that HCFA is giving instructions on how to use HCPCS [HCFA Common Procedure Coding System] codes and modifiers in ways that were not intended," Williams says.

"HCFA is losing some consistency," Frazier adds. Modifier –25 now has a completely different application for what it was created for — physician services, she explains. "When [providers] do their billing, it means that they did something besides evaluating the patient, and there is significant documentation to substantiate that.

"HCFA's will-nilly application of [the modifier] is causing a discrepancy between the CPT guidelines for how you use that modifier and the billing guidelines for being compliant with the federal government," Frazier says.

Even though the transmittal does not always agree with the instructions written about the

modifier in AMA's publication *CPT Assistant*, providers should follow HCFA's billing instructions, Frazier says.

As a written document, the transmittal is a superceding authority, she says. "[Providers] have a written document [in the memo]. That protection in writing will keep them from any rift of a fraudulent action taken against them." Frazier says she always instructs her clients to retain access to any written instructions from their fiscal intermediaries.

Providers also need to remember that the rules for using modifier –25 are different for hospitals vs. physicians, Scichilone says. "On the physician side, it is still very restricted. You can only report it when you have separately identifiable services."

For the hospitals, however, HCFA says that any time you make a decision to do a procedure, you can use modifier –25 and be paid for both, she explains. But always remember to include the modifier, she advises. "Otherwise, I think the system is set up to not pay for the E/M."

Modifier –25 . . . in HCFA's words

Here is a summary for use of modifier –25 in association with hospital outpatient services, as published in HCFA's transmittal A-00-40:

• Modifier –25 applies only to E/M service codes and then only when an E/M service was provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s). In other words, modifier –25 does not apply when no diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) is performed.

• It is not necessary that the procedure and the E/M service be provided by the same physician/practitioner for the modifier –25 to apply in the facility setting. It is appropriate to append modifier –25 to the qualifying E/M service code whether the E/M and procedure were provided by the same professional.

• The diagnosis associated with the E/M service does not need to be different than that for which the diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) was provided.

• It is appropriate to append modifier –25 to emergency department codes 99281-99285 when those services lead to a decision to perform diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).

(Editor's note: All of HCFA's transmittals are available on its Web site, www.hcfa.gov.) ■

New Web site offers access to database

Claims status, eligibility available in real time

Submitting claims and checking eligibility status through a dial-up connection to payers is nothing new. Now, one major payer is offering providers this service through a secure Web site — and giving its members access, too.

In essence, Blue Cross and Blue Shield of South Carolina in Columbia has Web-enabled its mainframe transactions, explains **Terry Povey**, chairman of the Internet steering committee for the company. Blue Cross wanted to allow its members and providers the opportunity to conduct their business transactions with the company at any time, and in real time.

"We were trying to accomplish another means of superior customer service," he says.

Users of the system are able to access account updates immediately.

To access the database, users must visit Blue Cross' Web site, www.SouthCarolinaBlues.com, and then select "My Insurance Manager." A demo is available on the site for guests to view the technology. Through "My Insurance Manager," members can check:

• personal claim status;
• amount paid toward deductible;
• out-of-pocket amounts;
• hospital inpatient and outpatient authorization status;
• eligibility status;
• explanation of benefits (EOB) statements;
• other health insurance such as coverage through a spouse.

Depending upon their health plan and product, members can also:

• change primary care physicians;
• order ID cards;
• view benefit booklets;
• check bill status.

By signing on to "My Insurance Manager," providers can:

• check a patient's claim and/or eligibility;
• view benefit booklets;
• check hospital inpatient and outpatient authorizations;
• see how much a patient has paid toward the deductible;
• check a patient's out-of-pocket amounts;

• confirm whether a patient has any other health insurance.

Providers can also go on-line to check one function for numerous patients or check all functions for one patient. Multiple staff members within a provider's organization can be authorized to perform these tasks on-line.

Blue Cross maintains the security of the site through socket layer encryption. This means that all personal information is encrypted. Users must create a profile and receive a password before accessing the system.

The information in the profile, such as member ID number and birthdate, also enables Blue Cross to know how to route an e-mail message in case the information the user needs cannot be located on the Web site. "[Users] can select 'Ask Customer Service,' and the system will route the question to the appropriate customer service area," Povey says.

After research and design, the site was unveiled to the company's 10,000 employees in November 1999. Blue Cross tested the system for a month, and then publicly announced the site in December.

The company decided to take a low-key marketing approach to the system. "The market for 'My Insurance Manager' was so focused on our own membership base and our providers that were part of our network," Povey explains. "All [of] the communication, training, promotion and marketing, therefore, has been directed to those audiences. We have had growing utilization as individuals find out about it."

Blue Cross inserted information about "My Insurance Manager" in EOB statements to policyholders and in remittances to providers beginning last February. Company representatives also demonstrated the site to providers, and placed a message about the technology on the company's voice response unit (VRU), which providers and patients often call to receive more information about accounts. In addition, all of the payer's advertising and brochures referenced the Web site.

The system is still too new for Blue Cross to see if the Web access has reduced the number of calls into the VRU. By monitoring the utilization of the site or its hits to various functionalities, though, the company does have indications that "My Insurance Manager" is doing its job.

"We are finding on a weekly basis that when providers or members sign onto 'My Insurance Manager,' they submit an additional question only 3% of the time," Povey says. That indicates that 97% of the time users can find the information they seek on the site.

Blue Cross sees a much higher opt-out rate with its VRU, she adds. "Sometimes, [users] get on the VRU and then have to opt out [of the system] and talk to a customer service representative almost 50% of the time."

Povey says Blue Cross has received a great deal of attention from "My Insurance Manager." If providers would like more information about the site, they can call Elizabeth Hammond at (803) 788-0222, ext. 44626. ■

Carriers told to focus on two CPT codes

The Health Care Financing Administration is telling Medicare carriers to pay extra attention when reviewing claims to the documentation used by physicians who bill two particular Current Procedural Terminology (CPT) codes.

The codes in question are: 99233, used for subsequent evaluation and management (E/M) of hospital patients, and 99214, for high-level subsequent physician office visits.

HCFA wants to see a direct connection between the code and the documentation used to justify it, say reimbursement experts.

Translation: Don't just assume because your patient is very sick, Medicare is going to accept your word that he or she required the highest level of service.

Judgment aside, auditors are going to want an itemized bill and documentation showing something like three for hospital visits — or one to five physician office visits — to justify a 99233 code.

Solid documentation is also going to be needed when billing a CPT 99214 level office visit. For instance, it's recommended that you show at least two of those three components: detailed history and/or detailed exam and/or medical decision making of moderate complexity. ■

It's time to update your internal coding guides

The emphasis by Medicare and commercial payers on proper documentation of items such as medical necessity means practices must

keep their inhouse code books, billing procedures, and staff current on the latest codes to avoid problems getting paid — or even potential audits.

New codes could take longer to implement

Here's a list of the new ICD-9-CM diagnosis codes used by most physician practices that have been approved for use in FY 2001. These codes became effective Oct.1, 2000. But, it could be several months before they are implemented by most payers.

If you have not already, your office should be keying these codes into its information system plus briefing both billers and providers about the changes.

New diagnosis codes include:

Infectious and parasitic diseases

- 007.5 Cyclosporiasis
- 082.40 Ehrlichiosis, unspecified
- 082.41 Ehrlichiosis chaffiensis (E. chaffiensis)
- 082.49 Other ehrlichiosis

Diseases of the blood and blood-forming organs:

- 285.21 Anemia in end-stage renal disease
- 285.22 Anemia in neoplastic disease
- 285.29 Anemia of other chronic illness

Mental disorders:

- 294.10 Dementia in conditions classified elsewhere without behavioral disturbance
- 294.11 Dementia in conditions classified elsewhere with behavioral disturbance

Diseases of the nervous system and sensory organs:

- 372.81 Conjunctivochalasis
- 372.89 Other disorders of conjunctiva

Diseases of the respiratory system:

- 477.1 Allergic rhinitis, due to food
- 493.02 Extrinsic asthma, with acute exacerbation
- 493.12 Intrinsic asthma, with acute exacerbation
- 493.22 Chronic obstructive asthma, with acute exacerbation
- 493.92 Unspecified asthma, with acute exacerbation
- 494.0 Bronchiectasis without acute exacerbation
- 494.1 Bronchiectasis with acute exacerbation

Diseases of digestive system:

- 558.3 Allergic gastroenteritis and colitis

Diseases of the genitourinary system:

- 600.0 Hypertrophy (benign) of prostate
- 600.1 Nodular prostate
- 600.2 Benign localized hyperplasia of prostate
- 600.3 Cyst of prostate
- 600.9 Hyperplasia of prostate, unspecified

Complications of pregnancy, childbirth, and the puerperium:

- 645.10 Post-term pregnancy, unspecified as to episode of care or not applicable
- 645.11 Post-term pregnancy, delivered, with or without mention of antepartum condition
- 645.13 Post-term pregnancy, antepartum condition or complication
- 645.20 Prolonged pregnancy, unspecified as to episode of care or not applicable
- 645.11 Prolonged pregnancy, delivered, with or without mention of antepartum condition
- 645.13 Prolonged pregnancy, antepartum condition or complication

Diseases of the skin and subcutaneous tissue:

- 692.75 Disseminated superficial actinic porokeratosis (DSAP)
- 707.10 Ulcer of lower limb, unspecified
- 707.11 Ulcer of thigh
- 707.12 Ulcer of calf
- 707.13 Ulcer of ankle
- 707.14 Ulcer of heel and midfoot
- 707.15 Ulcer of other part of foot
- 707.19 Ulcer of other part of lower limb

Diseases of the musculoskeletal system and connective tissue:

- 727.83 Plica syndrome

Symptoms, signs, and ill-defined conditions:

- 781.91 Loss of height
- 781.92 Abnormal posture
- 781.99 Other symptoms involving nervous and musculoskeletal systems
- 783.21 Loss of weight
- 783.22 Underweight
- 783.40 Lack of normal physiological development, unspecified
- 783.41 Failure to thrive
- 783.42 Delayed milestones
- 783.43 Short stature
- 783.7 Adult failure to thrive
- 790.01 Precipitous drop in hematocrit
- 790.09 Other abnormality of red blood cells
- 792.5 Cloudy (hemodialysis) (peritoneal) dialysis affluent

Injury and poisoning:

- 995.7 Other adverse food reactions not elsewhere classified
- 996.87 Complications of transplanted organ, intestine ■

(Continued from page 162)

improve the quality of their care.

Like a traditional managed care plan, employees can pick their primary care providers from the list of participating physicians — or opt to use an out-of-network physician, if their employer offers this alternative. Should a claim be denied, patients can appeal the decision to a panel of outside doctors for review. ■

Telemedicine payments are gaining ground

Technological advancements spur new interest

Despite the fact that 25% of elderly Americans live in medically underserved areas, current regulatory restrictions prevent Medicare from reimbursing for telemedicine treatments related to over 90% of outpatient services.

Seeing the potential in terms of both improving patient well-being and cutting health care costs, the Health Care Financing Administration is underwriting a major telemedicine field research project it hopes will prove the concept's viability.

Meanwhile, look for new rules next year increasing telemedicine reimbursement rates.

In Congress, House Commerce Committee chairman Tom Bliley (R- VA) also is pushing lawmakers to expand Medicare's telemedicine coverage to include health services provided through video conferencing and long-distance phone line transmission of digital photographs, X-rays, and other patient data.

While the Washington policy-makers do their thing, private sector engineers and entrepreneurs have been pushing telemedicine's technological envelope forward. As such, smart practices will make a place for telemedicine on their long-range strategy agenda, advise experts.

The current state of the telemedicine market shows that the fastest-growing segment of the technological market is end-user devices for home care.

Meanwhile, efficiency improving virtual teleconferencing systems, once only available to major hospitals, are now within the reach of individual practitioners.

Apollo Telemedicine, in Falls Church, VA, for instance, recently announced a new program that permits individual physicians joining its eHealthStat network to consult physician-to-specialist, potentially reducing the time it takes to put a diagnosis and treatment plan together.

"The idea is to create a virtual hospital environment where physicians can interact with other specialists over the Internet so they can get on with their primary business of diagnosis and treatment more easily," says Apollo spokesman **Mark Newburger**.

Major advances are also being made in the remote controlled instruments and medical sensing devices for patients.

Miami's American Medical Supplies (AMS), for instance, has various specialized medical devices operating in over 1,700 telemedicine-related sites in 41 countries. Notes AMS president **Mark VanderWerf**, "Right now we can give patients a dedicated device to remotely read out each of the normal diagnostic measures such as blood pressure, pulse rate, temperature, etc. The patients now have to buy these devices themselves. But, once Medicare starts paying, the device will just come as a free part of the service of monitoring you at home."

E-mailing sounds

Among the items in its catalog, AMS currently sells four types of remote-control stethoscopes, including its Phone-Steth, which the company says passes high-quality heart and lung sounds over telephone lines for real-time assessment of patients.

One stethoscope, the e-Steth, connects to the sound card of a patient's personal computer to digitize heart and lung sounds as well, creating a simultaneous multimedia phonocardiogram, which is automatically e-mailed to the physician.

Like other vendors, AMS is developing remote-controlled versions of all the various diagnostic instruments often used by providers. It, for instance, has a remote-controlled scope that a nurse can insert in a patient's ear, nose, or mouth while a doctor at a remote site views the resulting image on a computer screen.

Those images and data also can be stored so the reviewing physician can look at the procedure at his or her convenience.

Government and private researchers also are perfecting the ultimate telemedicine specialty — remote-controlled surgery.

In fact, remote-controlled surgery has been successfully performed by SRI International of

Menlo Park, CA, operating under a contract with the U.S. Armed Forces. And the prototype system, Telepresence Surgery System, is being perfected as a teaching tool at the Uniformed Services University of the Health Sciences in Bethesda, MD.

Initially intended for combat situations, physicians located away from the fighting use robotic surgical instruments equipped that mimic their movements equipped with 3-D vision monitors to operate on wounded soldiers still on the battlefield.

One private firm, Computer Motion of Goleta, CA, has used this research to develop what it calls a "smart" operating room where surgeons never touch the patients. Instead, they use a voice-controlled robot to make surgical incisions.

"You never have to worry about your hand shaking or slipping, while the enhanced dexterity and precision reduces patient pain, trauma, and recovery time. These new minimally invasive procedures just are not possible without robotic assistance," maintains **Robert Duggan**, Computer Motion's CEO.

Last July, Computer Motion announced the first successful robot-assisted surgery on a major organ — the removal of a gall bladder by a surgeon at the University Hospital of Gasthuisberg in Leuven, Belgium. Since then, surgeons have also used its robots in over 500 endoscopic radical prostate removal procedures.

"If you can operate the robot from 10 feet away, then you can operate it from 10 miles or 10,000 miles away with the proper data connections," says VanderWerf. ■

Racketeering lawsuits become way to fight HMOs

Lawsuits use strategy of Big Tobacco fight

Disgruntled with managed care practices, more physicians are turning to the federal Racketeer Influenced and Corrupt Organizations Act (RICO) to sue HMOs when they feel they have been treated unfairly.

This trend toward physician-driven RICO lawsuits against managed care organizations has occurred even though "physicians are more conservative and less likely to jump into litigation" than beneficiaries, according to plaintiff's lawyer **Archie C. Lamb Jr.**, of the law offices of Archie C. Lamb Jr. in Birmingham, AL. Lamb is involved in physician-originated RICO lawsuits against insurers Cigna, Aetna, and Humana in the U.S. District Court for the Northern District of Alabama, and Blue Cross of California, PacifiCare Health Systems, and Foundation Health Systems in the U.S. District Court for the Northern District of California.

"There are a lot more cases around the country than ours," he notes.

Some providers don't like the idea of using the RICO statues against health plans, preferring more traditional lawsuits.

"There's a real split among medical society attorneys and lobbyists, with some supporting this type of litigation, feeling it might make the HMOs behave better, and some of us more skeptical," says **Gordon H. Smith**, executive vice president of the Maine Medical Association.

RICO complaints

According to the Alabama complaint filed by Lamb, "cost considerations and profits are routinely given priority over patient care" as health plans allegedly misrepresent their business practices to physicians and violate their promises of noninterference in medical care.

"This is an old HMO scheme," Lamb argues.

Mirroring what happened when private lawyers and state attorney generals went after Big Tobacco last May, the Judicial Panel on Multidistrict Litigation issued a conditional transfer order moving the Alabama case to the Southern District of Florida for consolidated pretrial proceedings.

Humana opposed the transfer, arguing it could "lead to the potential and undesirable result of a consolidated proceeding involving all managed care litigation in the country, potentially involving some 150 million managed care patients and 83% of the nation's physicians."

The Florida case tracks the Alabama complaint in that it maintains health plans provided inadequate payments, withheld payments, and threatened to withhold payments due for services provided.

Florida doctors say they turned to the RICO law as a last resort. "We've tried to work with the for-profit HMOs in the marketplace, and have attempted to curb the abuses through the legislative process — all to no avail," says Florida physician **Marie Kuffner**, MD. "We simply felt we could not continue to allow our patients' health to be jeopardized by corporate greed."

Many legal experts say it is very hard for plaintiffs to win a RICO case in court. However, some of lawyers representing physicians in those cases admit the courtroom is not where they plan to win their case.

Instead, they intend to try the managed care industry in the court of public opinion, inundate it with lawsuits while putting pressure on Wall Street to force health plans to the bargaining table.

Points out **Saul J. Morse**, vice president and general counsel for the Illinois State Medical Society, "the benefit of litigation is that it makes people think about costs: Do we want to keep doing what we're doing, or do we want to compromise?" ■

Is capitation regaining its lost momentum?

Workplace changes may bring a revival

Is the downward cycle of capitation's viability finally shifting back up? Is the capitation slump over?

Some experts answer "yes" to those two questions, pointing to the erratic life cycle of the sometimes scary risk-driven system that undergirds so much of managed care.

If you graphically visualize capitation over the past 10 years, you see a bell-shaped curve — starting low in the early 1990s, booming in the mid-1990s, then falling and slowing down well into the late 1990s until now. What's next? Another move upward, experts suggest, based on two current factors that are making the upcoming year unique:

• Employers are willing to pay for health insurance with less complaints than in recent years because they need to recruit and keep their work force.

• Capitation's clinical goal of emphasizing preventive care and keeping patients healthy has a strong appeal to some clinicians despite the sometimes unresolved financial issues.

One trend may be shorter term, the economic climate for employers, compared to the less volatile clinical promise of capitation and physician interest in shifting the focus of medical care.

Early on with the rise of capitation, employers had a big say in capitation's momentum. In the early years of health care reform, employers were protesting high health care costs amid a climate of overall economic slowdown. Now employers are working from different position. Employers have enjoyed some savings in medical expenditures because of capitation, and employers are competing for good workers. Capitation, and various hybrids of it, has shown them some success, and the employee market is much different.

"Organizations have been willing to cover these rising costs as a value-add to employees," says **Lorraine Lyle**, senior manager with Arthur Andersen, a New York City-based accounting firm. Lyle was project leader for a recent Andersen survey of some 400 companies nationwide. Here are some key findings:

• The average cost of covering medical benefits for employees rose 10.5% between 1999 and 2000. This was the third consecutive year that employer costs have risen.

• Few employers say they are willing to reduce the level of benefits they are offering employees.

• Nine out of 10 employers now offer the same health care package at the same contribution level by employees to part-time workers as they do full-time workers.

• 43% of employers surveyed say they are willing to defray an employee's out-of-pocket expenses for medical care to keep them on board.

Even with the hard times in capitation, however, some physicians say they plan to stick with it. "I believe in risk as the right way to practice medicine," says **Andrew P. Siskind**, MD, medical director at Bristol Park Medical Group in Orange County, CA. Siskind describes his position in detail in a recent journal published jointly by the American College of Physicians (ACP) of Kansas

(Continued on page 171)

COMING IN FUTURE MONTHS

- What's working in physician compensation strategies
- How new Medicare rules will affect your practice
- Changing your front office procedures can boost the bottom line
- An update on the continuing evaluation and management debate
- What you need to know before selling your practice

Comparison of Fee-for-Service, Partial Capitation, and Fully Capitated Payment Methodologies

	Fee for Service	Partial Capitation	Full Capitation
A. Ensuring sufficient plan and provider participation	Payers assume all risk	Shared risk	Plans and/order providers assume all risk
1. Adequacy of rates	Many important services not covered or rates may be too low	Reduces financial risk of low capitation rates	Capitation rates may be set too low
2. Low enrollment/outliers	N/A	Reduces financial risk of low enrollment/outliers	Plans face large financial risk associated with low enrollment (e.g., outliers)
B. Care coordination and cost-effectiveness	Little incentive to improve care coordination or to maximize cost-effectiveness	Medium incentives	Strong financial incentives to improve care coordination and to maximize the cost-effectiveness of care
C. Service utilization	Incentives for overutilization	Balanced	Incentives to stint on appropriate care
D. Cost shifting between Medicare and Medicaid*	Strong incentives to cost shift	Depends on design	No incentive to cost shift
E. Risk selection	N/A	Balanced	Strong incentives for favorable risk selection
F. Administrative burden**	Need to submit claims imposes large burden on providers	Need to submit claims imposes large burden on providers	Burden depends on how providers are paid by health plans, and whether encounter data are required

- This analysis was designed to compare advantages and disadvantages of partial and full capitation and fee-for-service structures for a specific population: dually eligible Medicare and Medicaid patients. The issue of cost shifting among various programs, however, clearly can exist among contracts that are not specific to Medicare and Medicaid as well. The comparisons are valid for virtually any medical insurance program.
- Administrative costs associated with submitting claims or cost information for all (or most) enrollees.

Source: New England States Consortium Finance and Payment Work Group. *An Introduction to Partial Capitation of Medicare and Medicaid Payments for Dually Eligible Persons.* Portland: University of Southern Maine; 1999.

City, MO, and the American Society for Internal Medicine (ASIM) in Washington, DC.[1] Just because capitation has been underfunded, it doesn't mean it is a poor concept, says Siskind. The incentive of making more money based on keeping the patient healthy is a valid one, he says.

Siskind and other ACP and ASIM colleagues across the country cite several methods they've used for averting the hardships of capitation:[1]

• Forming their own medical services organization (MSO). Bristol Park formed an MSO with three other medical groups to give them more negotiating clout. The MSO represented some 450,000 patients.

• Changing subcapitation back to Medicare's Resource-Based Relative Value Scale (RBRVS). In Denver, cardiologists and oncologists banded together to convince the city's United HealthCare of Colorado to change its subspecialty capitation methods. Instead of an episode-of-care approach, they persuaded the insurer to adopt a form of RBRVS. They also negotiated a way for the insurer to establish a risk pool for physicians.

• Forcing themselves to create a "rainy-day account." In 1994, when the Lakewood, CO-based New West Physicians Group started into capitation, each of the physicians set aside 10% of their bonus dollars. When capitation times were tough, the savings carried them through. Now with rates climbing back up, the group has almost replaced the reserves it had lost. In some states, lawmakers are now requiring those kinds of set-asides to ensure solvency.

• Blending capitation. Some experts contend taking this route will ensure capitation's longevity. The aim of partial capitation is to keep the best aspects of fee-for-service and capitation to drop the worst aspects of both.[2] **(See chart, p. 170.)** For example, New Century Health Quality Alliance, a multispecialty IPA in Kansas City, MO, uses blended capitation. In their arrangement, professional services are at full risk and pharmacy and hospital services are at partial risk (part capitation, part fee-for-service). Also, the group's primary care physicians receive fee-for-service payments for excluded procedures such as immunizations, colonoscopies, and echocardiograms.

Partial capitation is getting serious consideration at the federal level. Last year, a special consortium of 25 experts met to develop a position paper describing strengths and weaknesses of partial capitation.

Here is how the group defines partial capitation: "Under such a system, plans or providers would receive a specified percentage of the full capitation rate for each enrollee, plus a specified percentage of the fee-for-service rates for services that are provided. For example, a health plan might contract with Medicare or Medicaid to receive 60% of their regular full capitation rates and 40% of the Medicare or Medicaid fee schedule for each service provided."

If designed correctly, partial capitation could perhaps achieve the best of all possible worlds, says consortium leader **Stuart Bratesman Jr.**, professor of public health at the University of Southern Maine in Portland. Partial capitation has the potential of reducing selection of healthier

Physician's Payment Update™ (ISSN# 1050-8791), including **Physician's Coding Strategist**™, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Physician's Payment Update**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $437. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $350 per year; 10-20 additional copies, $262 per year. For more than 20, call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $73 each. (GST registration number R128870672.)

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

Editorial Questions

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

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Physician's Payment Update	1 0 5 0 - 8 7 9 1	9/28/00
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$437.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Willie Redmond
Telephone: 404/262-5448

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Don Johnson, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Larry Reynolds, same as above

Managing Editor *(Name and Complete Mailing Address)*
Glen Harris, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Medical Economics Data, Inc.	Five Paragon Drive
	Montvale, NJ 07645

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Physician's Payment Update

14. Issue Date for Circulation Data Below: November 2000

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			531	500
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	377	291
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	0	0
	(4)	Other Classes Mailed Through the USPS	0	0
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			377	291
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	0	0
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			7	7
f. Total Free Distribution *(Sum of 15d and 15e)*			7	7
g. Total Distribution *(Sum of 15c and 15f)*			384	298
h. Copies Not Distributed			147	202
i. Total *(Sum of 15g, and h.*			531	500
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			98	98

16. Publication of Statement of Ownership
Publication required. Will be printed in the November issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher — Date: 9/28/00

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

patients, reducing risks of lower levels of enrollment and low capitation payment levels, and encourages better coordination of health care.

References

1. Maguire P. Amid tough times with capitation, doctors struggle to balance risk. *ACP-ASIM Observer* May 2000; 1-9.
2. New England States Consortium Finance and Payment Work Group. *An Introduction to Partial Capitation of Medicare and Medicaid Payments for Dually Eligible Persons.* Portland: University of Southern Maine; 1999. ■

Consolidated billing coming soon

The Health Care Financing Administration is expected to release a program memorandum around the first of November outlining how it plans for skilled nursing facilities (SNFs) to implement Part B consolidated billing.

Under the new system, SNFs will submit bills on behalf of their vendors. SNFs are to start phasing in Part B consolidated billing on a voluntary basis April 1, 2001 — while the system is scheduled to become mandatory Jan. 1, 2002. ■