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PHYSICIAN'S PAYMENT UPDATE™

## INSIDE



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# Rise in downcoding and claim denials has AMA moving to bring changes

*Campaign will seek help from lawmakers and regulators*

Responding to a rapid rise in downcoding and retrospective denial of provider claims by payers, the American Medical Association is organizing a campaign to get lawmakers and regulators to crack down on the problem.

As part of this effort, the AMA plans to lobby health plans and utilization review organizations to give both providers and patients timely written notification explaining why claims are denied and the clinical rationale used in making the determination. The AMA also wants insurers to provide a description of the appeals process when claims are denied retrospectively or when a service is downcoded.

A Dec. 3 on-line survey by the AMA found one-half of responding physicians had had medical claims denied retrospectively by managed care plans over the previous 12 months.

Of these, one out of two respondents had had between 1% and 3% of their service claims denied retrospectively. Another 29% said 10% to 19% of their claims had been retrospectively denied, while 13% said 20% or more of their claims had been retrospectively turned down over the last year, the survey found.

The most common reasons given by the managed care plans for retrospectively denying payment was that the service was not covered (27%); prior authorization had not been obtained (22%); or the service had not been coded correctly (12%).

The problem of retrospective denial has become so troublesome in New Jersey that the state is considering legislation making insurers pay for services unfairly retrospectively denied, say AMA officials.

Meanwhile, downcoding continues to be a problem with payers, the survey also found.

Some 45% of physicians surveyed said that between 1% and 9% of their claims had been downcoded in the last 12 months; 19% indicated that between 10% and 19% of their service claims had been downcoded,

and 11% said that 20% or more of their claims had been downcoded.

The most frequent reasons given by managed care plans for downcoding was that the claim was coded incorrectly (43%), or the service was not medically necessary (20%), according to the report. ■

# Attitude, perseverance keys to the appeals route

*Place the burden on the MCO*

*(Editor's note: The following guest article was prepared by Appeal Solutions, a Texas consulting firm specializing in medical reimbursement and appeals management issues.)*

"Attitude is more important than facts." This quote is from noted psychiatrist Karl Menninger, who understood the vast importance about attacking a difficult situation with a strong mindset.

In appealing denied insurance claims, you need to have the mindset that it is the insurance carrier's burden to prove that the claim was not processed correctly and that any ambiguities in the coverage terms were construed in the insured's favor. A strong mindset will also give you the perseverance necessary to continue to appeal a claim the insurer strongly defends.

Attitude is more important than facts, because the right attitude will help you persuade the insurance carrier to look at the facts differently.

Many claims are overturned after a single appeal letter. If that's not the case, you want to persist with filing appeals until you get a satisfactory answer. When you do not receive an adequate response to your appeal from the appeals committee, it is imperative that you continue to appeal.

Persistence is often the key to overturning a denied claim. Many carriers overturn as many denials on the second and third appeals as on the first appeal. It is crucial to keep the appeal active, even after the initial denial.

In fact, statistics released from major insurance carriers indicate that about 25% of appeals are overturned on the first appeal and another 25% are overturned on the second appeal.

If you believe payment is indicated by the policy terms, continue to appeal the claim. See below for information on keeping your appeal alive.

### *Don't settle for 'denial upheld'*

It's not unusual to find that your carefully researched and strongly worded appeal is not being reviewed adequately by the claims department. In such instances, you can redirect your appeal to someone in a better position to review and respond to the information you have cited. Consider sending your appeal to one of the following:

- **Carrier's legal counsel.** If you have cited regulatory information, you can request a review and written response from the legal department.
- **Carrier's president. I**f your appeal involves a possible breach of claim processing procedures, ask the president or other senior management official to respond.
- **Department of Labor.** If the insurance is self-funded, file a complaint with the U.S. Department of Labor. Send a copy of the complaint to the insurer.
- **Employer.** The employer will have an appeals committee if the group is self-insured.
- **State department of insurance.** File a formal complaint with your state's department of insurance if you are unable to get a satisfactory response. Send a copy of the complaint to the insurer.
- **State medical association.** Many medical associations now have a complaint review process and will assist you with resolving denied insurance claims.

As you work your way up the appeals food chain you must make sure your request for intervention is clear and convincing. Letters to an insurance company president or legal counsel, for instance, should be specific as to where the appeal reviewer failed in the review of your claim.

Some common complaints providers have about the claims review process include:

- The appeal reviewer did not fully review a certain portion of the medical records. State which portions you wish to have reviewed and addressed.
- The appeal reviewer was not trained in your medical specialty.
- The appeal reviewer did not gather sufficient proof to justify the denial. Even though the carrier may have an official position on the treatment

## Here are ways you can fight downcoding

*Move up the complaint ladder quickly*

The first best way to stop payers from downcoding your claims is to make doubly sure they are correctly coded and documented when submitted, say experts. But if you believe you are being treated unfairly, don't be afraid to fight back. Here are some steps you can take:

1. If you believe your claims are correct and your bills are still getting downcoded and denied by claim reviewers, most experts advise that you not waste any more time with accounting clerks and instead take your complaint up the corporate ladder directly to the plan's medical director.

2. If you don't get any satisfaction from the medical director, then quickly file an internal appeal. To help navigate the appeals process, make sure you keep detailed notes of what you've done to resolve the disputed claim — and who you talked to at the plan.

3. It's also wise to report any suspected instances of downcoding to your local medical society or hospital association, which may track complaints to determine if it is an isolated incident or part of an emerging pattern.

*Tip:* If unhappy with how you're being treated by plan payers, you may want to add some political clout by asking your local or state medical society or hospital group to intervene on your behalf.

4. The next stop on the complaint chain is your state insurance department. State regulators are often reluctant to get involved in individual payment and contract disputes, but the fact that you're filing a complaint will give you added leverage by raising your case's visibility another notch. Plus, if enough providers file complaints, this puts more pressure on public officials to do something about the situation.

5. If all else fails, **James Wieland**, a Baltimore health care attorney, advises you to take the plan to court. "I have had good luck taking, or threatening to take, a carrier to arbitration or small claims court," he notes.

*Warning:* Only go down this road if you are sure your claim was properly coded and if you have the documentation to prove it.

Here are some other key factors to keep in mind:

- **Keep accurate and complete records.** Without this, you don't have a legal leg to stand on.
- **Have a good contract.** Review any contract before you sign it. Most contracts spell out reasons for downcoding and what the physician can expect during an appeal.
- **Follow procedures.** Make sure you've filled out the claim correctly. If a claim comes back, call the claims administration and check to see if more documentation is necessary. ■

course, the reviewer must still assess the appropriateness of this particular treatment for this particular patient.

- Case or statutory law was cited in your initial appeal letter, but the reviewer failed to cite any case or statutory law in the carrier's favor, or offer a different interpretation of the law you quoted.

*Tip: I*f the reviewer essentially ignored the law your letter cited, an additional review is justified.

When you follow up on the status of these letters, your call will likely be screened by the management party's assistant. Clearly state that the information you want to discuss is highly technical and you need to speak directly with Mr. President or Mr. Legal Counsel. If the company president fails to respond within a reasonable time, direct the letter to the legal counsel and vice versa.

If you are seeking reconsideration on a number of claims dealing with the same issue, seek a face-to-face meeting with top management officials. Ask that the meeting take place in your office. You can then assemble the many parties affected by the denials including professional staff, billers, and even patients.

### *Follow-up*

Follow up any phone and face-to-face conversations with a letter detailing what issues were resolved and your understanding of how future similar claims will be processed. If there are still unresolved details, you will need to restate your position on these issues and indicate that you would like a written response regarding the

## Some facts on denials

Having a claim denied is different from having it downcoded — it means you get no money as opposed to some payment. Here are the facts on denials:

• The Health Care Financing Administration rejects 26% of all claims processed, according to **Sara M. Larch**, chief operating officer of University Physicians Inc., the University of Maryland School of Medicine faculty practice in Baltimore. Of those claims, 40% are never resubmitted.

• In 1999, the Medical Group Management Association found the median denial rate among its medical practice members was nearly 14%. So-called "top performing practices," however, only had a 7% denial rate. ■

unresolved issues.

Bottom line: Tenacity may be your biggest asset when appealing claim denials. Do not give up until you are satisfied with the answer you receive.

You can contact Appeals Solutions at 1565 W. Main Street #208, Lewisville, TX 75067. Telephone: (888) 399-4925. Fax: (972) 420-7880. E-mail: sales@appealsolutions.com. ■

# Claims, benefits the focus for data interchange rules

*HCFA will stagger implementation*

The Health Care Financing Administration (HCFA) has issued the first of a series of program memoranda instructing its Medicare intermediaries about implementing the electronic data interchange standards recently issued by the Department of Health and Human Services (Transmittal A-00-89).

The memo says HCFA will "stagger implementation of these transactions beginning with the claim, coordination of benefits (COB), and remittance advice."

This decision was based on the fact that "these transactions are closely interrelated, since the outbound COB and remittance advice data content relies on the incoming claim, and they are grouped together to facilitate provider and trading partner testing," the memo notes.

Medicare intermediaries are to start analyzing such transactions by April, with final implementation by July.

The new electronic data interchange standards, mandated by the Health Insurance Portability and Accountability Act of 1996, took effect Oct. 16; and must be implemented by October 2002.

They require health care providers, plans, and clearinghouses use standard formats for eight data exchange transactions, and a standard set of medical codes when transmitting health care data electronically.

Medicare intermediaries are required to implement five of the standard transaction formats: health care claim and equivalent encounter, remittance advice, COB, eligibility query and response, and claim status query and response.

HCFA plans to send Medicare intermediaries quarterly memos instructing them how to implement the rest of these transactions. These upcoming memos will also include details on replacing the HCPCS (HCFA Common Procedure Coding System) "J" codes with the National Drug Codes and for eliminating the HCPCS local codes. ■

# Feds outline 2001 focus on regulatory issues

*Upper pay limit fight coming*

It's going to be a busy regulatory year for health care. Here are some of the regulatory items the Department of Health and Human Services plans to tackle, according to its regulatory calendar for 2001 published in the Nov. 30 *Federal Register*.

Medicaid Upper Payment Limit Rule. Perhaps the most controversial regulation to be published by the agency during 2001 will be a final rule on a Medicaid upper payment limit for hospitals, skilled nursing facilities, and other health care providers, which the Health Care Financing Administration (HCFA) hopes to publish in February.

• **Stark II.** HHS plans to finalize its long-awaited rule on physician self-referrals, or the

so-called Stark II regulations, within the next six months. Officially, the law prohibiting referrals for designated health services went into effect Jan. 1, 1995, but the regulations spelling out the details have just not been finalized. **(See story on this page.)**

Hospital and doctor groups have been lobbying to remove a ban on various compensation arrangements under Stark II, arguing that it inhibits business activities essential to integrated health care organizations. Instead of having regulators try to directly supervise financial arrangements banned by the law, Rep. Pete Stark (D-CA), the bill's namesake, has suggested a more effective enforcement mechanism may be to simply hold physicians legally and financial responsible for any services they provide in covered situations.

• **Risk-Sharing.** The HHS Inspector General plans to issue a final rule in March establishing an exception to the federal anti-kickback statute related to risk-sharing arrangements. According to the HHS regulatory agenda, the final rule will "set forth an exception from liability for remuneration between an eligible organization and an individual or entity providing items or services in accordance with a written agreement between these parties."

As such, remuneration would be permitted if a written agreement places the individual or entity at "substantial financial risk" for the cost or utilization of the items or services that the individual or entity is contracted to provide.

• **Ambulance Restocking.** The Inspector General also intends to issue a final rule in March creating a safe harbor to the anti-kickback law to address ambulance restocking arrangements between municipal and nonprofit ambulance companies and hospitals.

• **Durable Medical Equipment.** HCFA intends to issue a proposed rule requiring medical equipment suppliers to purchase surety bonds to do business with Medicare. This is intended to ensure that participating suppliers are legitimate and financially stable.

• **Medicare + Choice.** The inspector general intends to issue a proposed rule establishing civil monetary penalties for Medicare+Choice organizations and Medicaid managed care organizations. The rule would apply to organizations engaged in "certain abusive practices," including failure to provide medically necessary care and discriminatory enrollment practices (otherwise known as "cherry-picking").

HCFA's take on the topic is that some states are taking advantage of the flexibility of existing federal regulations used to set maximum rates that can be paid under Medicaid. In turn, that permits county- and city-owned hospitals to claim higher federally matched Medicaid reimbursement rates than should have been allowed.

• **End Stage Renal Disease.** In April, HCFA plans to release a proposed rule revising the conditions of participation for end-stage renal disease facilities.

• **Part B Changes.** A final rule establishing the criteria for determining the "inherent reasonableness" of Part B Medicare physician services is to be published in August. ■

# Incentive plans in danger if Stark II law adopted

*More exemptions needed*

The impact could be significant on hospital-physician risk sharing arrangements if the proposed Stark II regulations are adopted by federal regulators in their original form, says **Wendy Krasner**, a health care specialist in the Washington, DC, law office of McDermott, Will & Emery.

For instance, hospital incentive payments to physicians under a Medicare or Medicaid managed care plan would cause referrals to those physicians to be illegal unless a exception is created, Krasner says.

The current Stark prepaid plan exception only covers referrals of patients enrolled in a Medicare or Medicaid managed care organization (MCO) — or a federally qualified HMO — to a hospital, "but does not protect referrals of other Medicare beneficiaries or Medicaid recipients who are the physician's patients," she notes.

However, these other referrals would be protected under the proposed Stark II regulations provided they recognized that incentive payments could be made by either the MCO itself, or an intermediate provider like a hospital that subcontracts with the MCO.

The proposed Stark II regulations also incorporate statutory exception for physician incentive plans recognized under the Social Security Act, notes **Michael Blau**, a partner in McDermott, Will & Emery's Boston office.

According to Blau, in the preamble to the proposed Stark II rule, HCFA states that under the regulations ". . . the incentive plan qualification applies only when the entity paying the physician or physician group is the kind of entity that enrolls patients, such as a health maintenance organization."

"HCFA apparently considered and then dismissed the implications of this restriction for direct hospital-physician risk sharing arrangements, as evidenced by its commentary in the preamble to the proposed rules regarding 'evolving structures of integrated delivery and other health care delivery systems,'" notes Blau.

Bottom line: Unless changed in the final Stark II rule, any hospital-physician risk sharing arrangement must meet the narrow definition in the Stark II proposed regulations of a physician incentive plan, Blau says. To comply, the arrangement would have to be structured so the organization in which the patients are enrolled — the HMO or other MCO — is the source of payment to the physicians participating in the risk-sharing arrangement. ■

# Failures raising concerns about future of IPAs

*California groups staggering*

The recent rash of failures among independent practice associations (IPAs) has some providers wondering if these organizations are the right vehicle for physicians to use when assuming risk and contracting with managed care plans and hospitals.

Since 1996, more than 120 IPAs — 31 over the last year — have closed their doors in California, alone, reports the Oakland, CA-based IPA Association of America (IPAAA).

**Albert Holloway**, the IPAAA's CEO, says the IPA model is still viable. "We are going through a trend of adjustment, and this adjustment is good for the industry," he says. "Once we come out of it, we will have much stronger IPAs, as a result."

According to experts, key elements an IPA needs to succeed include:

• **Good cost and utilization data.** "Successful IPAs don't depend on managed care companies for data. They have their own data," observes **Michael Wood**, executive director of the Saint Louis (MO) Management Group, which manages 30 IPAs in five states.

Indeed, lack of data was a major reason behind the failure last April of Cascade Healthcare Alliance, a 200-physician IPA in Bellevue, WA, contends **Claude DeShazo**, MD, Cascade's president and CEO.

"We could never get accurate data from the health plans on our capitated contracts," says DeShazo. "It made it very difficult for us to analyze our activities."

• **Adequate capitalization.** A common mistake that IPAs make is starting without enough capital, says Wood, especially if it is not able to find a hospital partner.

• **Unnecessary risks.** Sound IPAs are selective about the contracts they accept. The Physicians Inc., an 1,800-doctor IPA in Louisville, KY, has 23 managed care contracts, but has avoided signing a fully capitated agreement because it believes that would be too financially risky for the organization.

• **Good information and sound management.** "You'd be amazed at what you can do once you have a good reporting, adequate utilization, and financial information and sound physician profiling in place," says **Michael Eberhard**, CEO of Medical Pathways, a Cerritos, CA, firm that specializes in turning around and managing faltering IPAs.

• **Empowered doctors.** " Physicians must feel like they have a stake in the situation to get them to support the changes that need to be made and to get them to work," Eberhard stresses. One tool to achieve this goal is to capitate the primary care physicians and at least some specialists.

• **Better contracts.** Marginal IPAs are often paid 10% to 20% less than their stronger counterparts, notes Eberhard.

• **Focus on quality care and accountability.** Successful IPAs always make quality care their first priority, says Holloway. University Affiliates, a non-profit 3,000-physician IPA in Alhambra, CA, for instance, operates more like a multispecialty group practice than an IPA, says **Sam Romeo**, MD, its president and CEO. "This, in turn, allows the physicians in the IPA to collaborate closely with one another on patient care," he notes. "While we are an IPA in a legal sense, we are much more like a group practice, which is the only way you can be accountable." ■

*(Continued on page 27)*

Physician's Coding Strategist™

# Medicare will pay some costs of preventive exam

*Be sure to use the right E/M code*

A ticklish question many providers and coders come across is whether Medicare will pay for a medically necessary service provided during the course of a comprehensive preventive examination.

"Medicare will pay for the evaluation and treatment of an acute illness or the ongoing treatment of a chronic condition provided during the course of a comprehensive preventive examination," says **Brett Baker**, a reimbursement expert with the American College of Physicians-American Society of Internal Medicine.

Medicare requires that you bill the appropriate outpatient evaluation and management (E/M) service code and the preventive medicine service code that corresponds with the beneficiary's age (in most instances, CPT 99387 or 99397).

Meanwhile, "the extent of the history, examination, and medical decision making involved in treating the symptoms and/or diagnosing conditions associated with the acute or chronic problem determines which office or outpatient E/M service code you select," notes Baker. For instance, the office or outpatient E/M service codes describe the portion of the visit that is covered and reimbursable by Medicare.

However, he also advises you to check with your Medicare carrier to see if it has any restrictions on which office or outpatient E/M service code you can bill in conjunction with a preventive medicine service code.

"Your carrier, for example, may prohibit you from using the highest office or outpatient E/M service code, CPT 99205 and 99215," he points out.

It's important to note that Medicare will deny payment for the preventive medicine service code because the law prohibits the program from paying for a comprehensive preventive examination.

Medicare requires you to use a formula to determine how much to bill the beneficiary for the non-covered preventive portion of the visit. Baker says you should bill the beneficiary your established charge for the comprehensive preventive examination — less the Medicare allowable for the Medicare-covered, medically necessary portion of the visit.

Here's a case study: You evaluate and treat a 70-year-old beneficiary's hypertension that you detect during a comprehensive preventive examination. You have been the beneficiary's physician for the past several years. The service you furnish relating to the patient's hypertension involves an expanded problem-focused history, an expanded problem-focused examination, and medical decision making of low complexity.

"This medically necessary service permits you to bill a mid-level established patient office visit, CPT 99213," says Baker.

In this case, you should report this code, along with the established patient preventive medicine service code for a patient 65 years and older, CPT 99397.

Medicare's average allowable for CPT 99213 is $47.23 (your payment may vary, depending on your geographic location). Assuming you submit an assigned claim and the beneficiary has met the deductible, your carrier will probably pay you $37.78 — or 80% of the allowable. Your established charge for a comprehensive preventive examination is $150, so you would bill the beneficiary $102.77, or $150 minus $47.23.

You would report the International

Classification of Diseases (ICD-9) code for benign hypertension, 401.1, to justify the 99213. You would likely report ICD-9 code V70, general medical examination, as the reason for the 99397, even though Medicare will never pay for the preventive medicine service code regardless of the diagnosis.

*Tip:* Ask your carrier about its policy on how to bill when you provide a Medicare covered, medically necessary service during the course of a comprehensive preventive examination. The formula your carrier uses to determine how much to bill the patient may differ slightly from what is described above, Baker suggests.

You should also explain to your patients that they will be billed for the preventive examination, the portion not covered by Medicare. "This will be especially helpful if you have not billed a medically necessary service in conjunction with a preventive service in the past," he notes. ■

# Coders needed! Work from home!

*They stayed home in droves, fully employed*

For three years, Inova Fairfax Hospital in Falls Church, VA, struggled with a 25% vacancy rate in coding positions. Then the facility began using application service provider (ASP) technology that allowed coders to work from home and receive their records over the Internet.

An advertisement boasted of these conveniences and a miracle occurred: Inova Fairfax was fully staffed within three weeks.

"You get inundated with coders by adding that one little line — 'work from home,'" says **Jennifer Shearer**, RHIA, director of Inova Fairfax's medical record department.

Inova Fairfax is using eWebCoding, an ASP based in Atlanta and a division of Intertech Information Management. "They provide the scanning hardware and the software and the storage of the chart. All the hospital and the coder need is an Internet connection," Shearer says.

Preliminary results show that with the new system, Inova Fairfax has gained one hour of productivity per coder, per day for outpatient charts. One of the inpatient coders who had met productivity requirements of 20 charts coded and abstracted per day has now exceeded 27 charts per day for six months. The quality of the coding has not decreased. Shearer attributes the increase to the coders having better concentration and fewer disruptions while working at home.

### *Setting up the system*

The installation process of the ASP model was minimal and took only a few weeks, Shearer explains. The main computer system is located and maintained at a remote site, and only workstation hardware was installed at the hospital and coders' homes. The users downloaded software from the Internet.

Inova Fairfax, which pays a per-chart fee, began its program by scanning and coding emergency room records first. The hospital has a scanner who is responsible for submitting records to each coder in a queue. The coders are then able to download the information from the Internet. Once they complete the record, they submit it back to the server.

For security reasons, the records undergo three levels of encryption. They are encrypted as soon as they are scanned and go across the Internet to the server. They are encrypted again when they go from the server to the coder's house, and once more when the coder opens the files.

Once the technology was implemented, all but one of Inova Fairfax's 18 coders wanted to work out of their homes, Shearer says. Inova Fairfax is located in a congested area, and the commute for clinical coder **Cheryl Shackleford**, CCS, can take 30 minutes to 2½ hours.

The hospital decided to only allow coders to work from home who were experienced and had been employed a minimum of six months. The coders remained hospital employees and were initially required to come into the office every other day to ensure that there were no glitches in the remote abstracting and bill dropping process. New coders remain on-site for three months until they establish their productivity and quality baselines.

The coders like the control they now have over their hours, Shearer says. "They regain so much time in the lives by not having to commute."

Each coder still comes into the office, usually two days a week, to code large bills or multivolume admissions. The hospital decided not to scan large volume (more than three-volume) records because of the fatigue factor. The coders don't complain, though, because a rotating schedule allows them flexibility in these days, too.

"We rotate so everyone has the opportunity to be home certain days," Shackleford says. She began working from home last July. The rotation also means that one coder is not responsible for coding the complicated bills all the time.

The work arrangement takes off the edge of having to work overtime, too, especially during the holidays. "We don't mind doing extra to help the backlog since we are working from home," she says.

Morale among the coders is great, Shackleford adds. "It is absolutely wonderful to be able to work from home."

### *Other services*

eWebCoding offers services for individual coders too. Coders, for example, can fill out a mini-resume, and that information is shared with the company's customers, says **Beth Friedman**, RHIT, director of marketing. "We have a coding pool."

The company is also introducing a free site with about 30 sample records for coders to use. "This site is for students in university programs or coding programs who are learning to code," she explains. "They can practice coding on an electronic image versus a paper chart."

*(Editor's note: A white-paper discussion of Inova Fairfax's switch to an ASP model for coding is available on the Web at www.ewebcoding.com/02_01_tech.asp.)* ■

# Feds offer answers to your questions

The Office of Inspector General (OIG) has posted on its Web site 23 new answers to frequently asked questions (FAQ) on corporate integrity agreement (CIA) billing reviews.

Most CIAs or settlement agreements with integrity provisions (agreements) require that a billing review be conducted, either by an independent review organization (IRO) or in some cases by the provider, with a verification review performed by the IRO. Over the past several years, the language used in these CIAs and agreements to describe the billing reviews has evolved from being general in nature to fairly specific.

For this reason, the OIG has updated its original list and has added a specific index of topics covered by these FAQs, as follows:

- reporting of overpayments;
- independence of an IRO;
- selecting an IRO;
- material violations;
- CIA billing reviews.

The access the FAQs, go to www.dhhs.gov/progorg/oig/cia/ciafaq1.htm. ■

# Coding assessment offered

The American Health Information Management Association (AHIMA) in Chicago has developed a Web-based program with the educational coding needs of health care organizations in mind.

"Coding Assessment and Training Solutions" provides an opportunity for organizations and coders to assess coding skills and knowledge and to keep abreast of the latest coding practices and policies. The program allows organizations to validate the coding skills of staff members, and to discover where improvement is needed.

The initial phase of the interactive program addresses the area of assessment. This portion provides resources to assess and validate individual coding skills and identify areas requiring improvement. The results of the testing allow organizations to assess their need for ongoing and future coding training.

After assessing knowledge in such areas as coding principles, coding guidelines, document analysis, problem solving, and data management skills, training needs may be outlined. The online training materials include instructional information, exercises, and actual case applications.

Training includes coursework in up to 19 specialty areas. On-line access and self-administration will allow users to learn at their own pace, dependent on initiatives and time available. All training allows users to accrue continuing education hours.

For more information about "Coding Assessment and Training Solutions," contact AHIMA at (312) 233-1158. ■

# Providers question process for E/M pilot test

The marathon process to create a new set evaluation and management (E/M) guidelines that pleases both providers and regulators hit another bump when the American Medical Association's House of Delegates recently voted to pressure Medicare to postpone the latest proposed pilot test until August 2001 — at least.

The AMA is also lobbying physicians to refuse to participate in any pilot study of E/M guidelines because of concerns about their potential legal exposure.

"The question is: Are the 2000 guidelines that problem-solving, simplistic, easy-to-use, and appropriate?' " says Pensacola, FL, neurological surgeon **Troy Tippett**. "The answer is, 'We have no idea,' although HCFA is asking us to acquiesce without having the prime component available to us — the vignettes."

**Paul Rudolf**, medical officer and senior technical advisor to HCFA's Center for Health Plans and Providers, hopes HCFA can gain the medical community's support for a set of E/M guidelines. "We certainly want to work with the specialty groups," says Rudolf. "We've heard [their] concerns."

Before this can happen, the question of immunity for providers that do choose to participate in any E/M pilot tests has to be settled.

Then there is the question of the vignettes that make up the core of the new E/M approach. "Physicians have some very grave concerns about the process of obtaining the vignettes," stresses Tippett.

HCFA originally promised specialty societies would develop the examples, but instead, the agency outsourced them to a contractor, Aspen Systems. HCFA then told specialists they would be given the vignettes for comment after they had been created.

The proposed vignettes are intended to encompass three levels of physical complexity: brief, detailed, and complex. They also would illustrate three levels of medical decision making: low, moderate, and high. The Aspen contract was written to cover 20 medical specialties, each receiving five clinical examples. A first-look progress review of the project is scheduled for early 2001 — with another during the summer, when the work is supposed to be finished.

To avoid the possibility of an audit some physicians downcode their service below what they might be able to charge. And since the guidelines will be the basis for determining the level of service they can bill, physicians want to make sure the vignettes accurately reflect the practice standards of their specialty.

Another problem has been HCFA's refusal to grant immunity as a condition of participation in a pilot study for the 2000 E/M guidelines.

Some providers also feel HCFA's refusal to consider outliers — and physician review of those outliers as part of its fraud fighting efforts — adds insult to the potential injury by inferring doctors can't be trusted. "We have peer reviews because we don't want bad actors in our profession. We are trying to run a clean house. If [HCFA] would let us work with them, we could get rid of fraud," argues **Elvyn L. Sterling**, an Orange, CA, internist.

"HCFA should focus on finding fraud. Instead, they are trying to smear our profession," Sterling says. ■

# HCFA creates new technology APCs

The Health Care Financing Administration (HCFA) has created 11 new technology ambulatory payment classifications (APCs) applicable only to new technology devices (0987-0997). With the new APCs, HCFA wants to differentiate between new technology services and devices, the agency says in its program memorandum, (PM) A-00-61.

The PM also contains a list of long descriptors for drugs, biologicals, devices eligible for transitional pass-through payments, and for all items classified in "new technology" APCs under the outpatient prospective payment system. In addition, the PM also corrects C codes that were listed in Transmittal A-00-42. Here are the corrected C codes:

- old code: C1108, C1600, C1601;
- new code: C1810, C1850, C1851.

The PM also states that code C1005 (Intraocular lens, Sensar Soft Acrylic Posterior Chamber IOL) could only be used to bill for pass-through payments for services beginning Aug. 1, 2000, through Sept. 30, 2000.

For a look at the entire PM, visit the Web site www.hcfa.gov/pubforms/transmit. ■

# More docs dumping IPAs for direct contracts

*Lower rates are the drawback*

Worried by the rash of failures among independent practice associations (IPAs), more physicians, especially in California, are dropping their IPA affiliation and opting to contract directly with HMOs.

Most physicians going the direct contracting route can expect to see their reimbursement rates fall. But many feel lower rates are better than taking the risk of not getting paid at all if their IPA goes belly-up.

"I would need an MRI of my head before I would join another IPA," says **Robert Feher**, MD, a family physician in Los Angeles' San Fernando Valley, who has been a member of several failed IPAs. Over the past four years, some 300 California IPAs and group practices have closed their doors, according to the California Medical Association.

A combination of static payments and poor management have hampered California IPAs in recent years, says **Chris Ohman**, CEO of CapMetrics, a Berkeley, CA, consulting firm.

This situation has been complicated by the fact many IPAs don't have adequate financial reserves — or warning systems which will alert then when the reserves they do have are being dangerously drained by high utilization, he says.

The Redwood Empire Medical Group Inc. (REMGI), in Santa Rosa, CA, had 350 physicians serving 50,000 enrollees and an annual budget of $30 million, when it went out of business last April.

REMGI's former president, **Don Van Giesen**, MD, says the combination of high utilization, inadequate reimbursement from HMOs, and the inability of member physicians to work together to control costs were the basic reasons the organization failed.

Founded in 1986, the REMGI was financially sound until the late 1990s, when HMO payments no longer were keeping up with rising utilization, especially for specialty services.

According to Van Giesen, because the specialists wanted "more control over their fate," in 1998, REMGI began capitating its 200 specialists through a new subcontracted specialty IPA. However, another consequence of placing the specialists in a separate organization meant was REMGI no longer had direct oversight of them. Also, because "we knew them personally," the parent IPA was uncomfortable "prying" into the group's business practices, he recalls.

By 1999, the specialty IPA had accumulated $3 million in debts from overutilization, which forced it to suddenly close — the fall out from this move then bought down the parent IPA, says Van Giesen. ■

# Budget relief bill contains many health care goodies

*Regulatory relief being studied*

Besides restoring $35 billion in previous cuts in federal health care spending, the massive budget bill approved during the final days of December's lame duck session of Congress also included a variety of provider and beneficiary provisions.

For instance:

• **Regulatory relief.** The bill directs the Government Accounting Office (GAO) to study the post-payment audit process for physician services. The study is to determine the proper level of resources the Health Care Financing Administration (HCFA) should devote to calculating overpayments, and to educate physicians about coding and billing documentation requirements.

The GAO is also required to study the aggregate effects of regulatory, audit, oversight, and paperwork burdens on physicians and other health care providers participating in Medicare.

• **Ambulatory surgical centers.** The bill delayed implementation of proposed regulatory changes to the ambulatory payment classification system until Jan.1, 2002. At that time, the changes would be phased in over four years. In the first year the payment amounts would be 25% of the revised rates and 75% of the prior system rates. In the second year, payments would be 50% of the revised rates and 50% of the prior system rates. The provision also requires that the revised system, based on 1999 (or later) cost data, be implemented Jan. 1, 2003. The phase-in of the revised system and 1994 data would end when the system with 1999 or later data was implemented.

• **Physician services.** A provision in the budget bill requires the GAO to study the appropriateness of furnishing physician offices specialist services

(such as gastrointestinal endoscopic physicians services) that ordinarily are furnished in hospital outpatient departments. The GAO also is required to study the refinements to the practice expense relative value units made during the transition to the resource-based system.

• **Medicare enrollment.** The bill requires the GAO to study the current Medicare enrollment process for groups that retain independent contractor physicians. Particular emphasis would be placed on hospital-based physicians, such as emergency department staffing groups.

• **Physical therapy.** The bill extends the moratorium on the physical therapy and occupational therapy caps through 2002, and extends the rule requiring focused reviews of therapy claims during that same period. The Department of Health and Human Services (HHS) must conduct a study on the implications of eliminating the "in the room" supervision requirement for Medicare payment for physical therapy assistants who are supervised by physical therapists, and the implications of this requirement on the physical therapy cap.

• **Skilled nursing facility staffing.** Skilled nursing facilities have to post nurse staffing information daily for each shift in the facility, effective Jan. 1, 2003.

• **EMTALA study.** The bill asks the GAO to evaluate the impact of the Emergency Medical Treatment and Active Labor Act on hospitals, emergency physicians, and physicians on-call to emergency departments, and report back its findings by May 1, 2001.

• **Alternative providers.** The law requires the Medicare Payment Advisory Council to study the appropriateness of current payment rates for services provided by a certified nurse midwives, physician assistants, nurse practitioners, and clinical nurse specialists, including specifically for orthopedic physician assistants.

• **Medicare+Choice.** The measure sets the minimum payment amount for aged enrollees within the 50 states and the District of Columbia in a Metropolitan Statistical Area with a population of more than 250,000 at $525 in 2001. For all other areas within the 50 states and the District of Columbia, the minimum would be $475. For any area outside the 50 states and the District of Columbia, the $525 and $475 minimum amounts would also be applied, except that the 2001 minimum payment amount could not exceed 120% of the 2000 minimum payment amount. This increase would go into effect March 1, 2001.

• **Advisory opinions.** The bill gives the Office of the Inspector General (OIG) authority to issue advisory opinions to outside parties who request guidance on the applicability of the anti-kickback statute, safe harbor provisions, and other OIG health care fraud and abuse sanctions.

The bill also addressed a number of fraud and abuse topics.

• **Drug costs.** The GAO is required to study reimbursement practices for drugs and biologicals under Medicare Part B and make recommendations for revised payment methodologies.

Until the report is presented, there will be a temporary freeze on the rates the federal government pays for drugs until HHS reviews the study. This provision is aimed at correcting complaints from Congress that drug companies have been taking advantage of loopholes in the current system to manipulate Medicare reimbursement rates for covered drugs, causing the government to overpay for these drugs compared to the private market.

• **Hospice certification.** Current law is changed to specify that the certification of terminal illness by a physician or hospice medical director should be based on his or her clinical judgment regarding the normal course of an individual's illness. This is intended to address complaints that overzealous auditors have threatened to prosecute providers and take away benefits if beneficiaries receiving hospice care live more than the maximum six-month life expectancy.

• **Physician audits.** The GAO is to study the post-payment audit process for physician services to determine the effect of regulatory burdens on physicians and the proper level of resources HCFA should devote to educating physicians about coding and billing. ■

# Key skills identified for surviving managed care

*Researchers offer protocol of competencies*

Have you got what it takes to survive managed care? Maybe it's hard to know if you were never really trained in managed care in general, or capitation in particular. With that in mind, three researchers have developed a protocol of specific clinical competencies for effective managed care practice.[1]

In addition to developing a useful protocol,

researchers surveyed four groups of physicians to determine what would be important in training physicians for capitation and its related hybrids. They surveyed 790 physicians — residency program directors, residents, managed care directors, and primary care residency program directors in areas of high managed care penetration. Response rates in each group ranged from 67% to 94%.

Ultimately, they learned that all four groups place a high priority on the emerging new skills of risk-based practice management and patient care, and that what counts most is making it all work. The most successful approach, researchers found, requires a balancing act of four main areas — patient care, performance monitoring, teamwork and coordination of care, and organizational issues.

These findings bode well for the future of capitation and other managed care systems approaches, say Michael J. Yedidia, PhD, and

## Core Competency Checklist

Below is a checklist extracted from Yedidia and team's accounting of core competencies of managed care, as identified by their surveys:

***Organizational issues***

☐ Economics — Evaluate managed care organization contracts and compensation plans on the basis of their incentives for particular practice behaviors.

☐ Ethics — (1) Act on ethical principles in resolving conflicts that may arise if it is decided that a patient needs procedures or services that are not covered by a managed care organization. (2) Explain the reasons for a decision to allocate resources to serve the needs of populations at the potential expense of individual needs.

☐ Managed care and health care delivery — (1) Predict the impact of different payment arrangements on consumer and practitioner behaviors within a specific health care environment. (2) Act as a resource on aspects of managed care practice for colleagues who have not had training in this area.

Managing multiple managed care organizations — (1) Reconcile your own treatment approaches with the potentially contradictory guidelines of multiple managed care organizations. (2) Adhere to the regulations of several managed care organizations in implementing referrals and ordering procedures.

☐ Practitioner morale and satisfaction — Develop a program updating the knowledge and skills of your colleagues and addressing practitioner morale and satisfaction.

***Patient care***

☐ Clinical epidemiology — Determine the effect of a positive or negative test result on the probability that a patient has a particular medical condition.

☐ Cost-effective clinical decision-making — Weigh the costs vs. the probable yield of a particular diagnostic procedure in managing a patient with a specific medical condition.

☐ Evidence-based medicine — Locate and critically evaluate research evidence and apply one's own conclusions to the care of an individual or patient group.

☐ Patient satisfaction — Interpret patient satisfaction data to make appropriate changes in practice operation.

☐ Population-based medicine — Use data on patients' communities and environments to design tailored strategies to reduce the incidence of undiagnosed conditions.

☐ Practice guidelines — Adapt clinical guidelines based on evaluation of evidence from relevant research.

☐ Prevention — Use data on patient population to design and evaluate a disease-specific prevention programs.

☐ Time management — Use time efficiently in the clinical encounter to maintain quality of care while sustaining an adequate flow of patients.

***Teamwork and coordination of care***

☐ Case management — For patients with complex disease processes, ensure access to necessary clinical services, coordination of care, and efficient use of resources.

☐ Collaboration — (1) Assess the roles of all practice personnel in regard to patient education and institute a plan for making better use of their expertise in this area. (2) Delegate responsibility and share authority with nurse practitioners and/or [physician assistants] to ensure productive teamwork.

☐ Gatekeeping — Perform the "gatekeeping" role for a panel of patients, maintaining quality and cost-effectiveness of care.

☐ Referral management — Evaluate referrals to specialists for appropriateness and quality and initiate strategies for improving their effectiveness.

***Performance monitoring***

☐ Clinical efficiency — Conduct time and work flow analysis to enhance productivity.

☐ Continuous quality improvement — Identify clinical conditions appropriate for quality improvement projects and participate in implementation.

☐ Practice profiling — Compare one's own practice profile to those of peers and make appropriate changes in one's practice behavior.

☐ Utilization management — Weigh the benefits of case-by-case concurrent review vs. practice profiling in addressing a particular clinical issue.

Based on their surveys, the researchers found that a majority of medical training program directors favor teaching mastery of these "essential tasks." Currently, the study's surveys show that about 40% of the programs surveyed are addressing two-thirds or more of the tasks.

Source: Yedidia M, Gillespie C, Moore G. Specific clinical competencies for managing care: Views of residency directors and managed care directors. *JAMA* 2000; 284.

Colleen C. Gillespie, PhD, both professors of health and public service at New York University in New York City, and Gordon T. Moore, MD, a physician at Harvard Pilgrim Health Care in Boston, who conducted the surveys.

"While recent surveys have documented considerable disaffection toward managed care among academic physicians, this negativism does not appear to have carried over to their views on the importance of teaching specific managed care tasks related to population health," the researchers write. "In spite of fundamental differences on other health care issues, our findings indicate that residency directors and MCO medical directors place high importance on specific clinical behaviors and that they share a similar vision of priorities for applications to future medical practice." ■

# Physicians need new skills for boomer demand

*DM, outcomes tracking add value to practices*

They're demanding, they're outspoken, they want hard, cold facts — and there are a lot of them. They're the baby boomers and as they age and need more medical care, they will likely create headaches for your practice.

The baby boom population represents an opportunity as well as a challenge for physician practices. They will be receptive to cutting edge technology and new treatment methods but they're going to want to know upfront what the outcome will be.

There are so many of them that practitioners are going to have to scramble to take care of their health care needs. At they same time they will be unwilling to wait weeks for an appointment or cool their heels in your waiting room.

This means that physicians are going to have to increase their efficiency and deal with the new patient loads effectively. They're going to have to keep track of their disease management and treatment outcomes to provide the information this new health care population wants.

### *Lean on nurse practitioners, PAs*

"Physician assistants and nurse practitioners are probably the physician's first line of defense against the future patient — the angry and demanding baby boomer with Internet access," says **William J. DeMarco**, president of DeMarco & Associates, a Rockford, IL, health care consulting firm

Nurse practitioners and physician assistants give physicians an opportunity to see the severely ill, most challenging patients but still accommodate patients with routine problems.

"To be successful in the future, physicians need to ask if every patient that walks through their office needs to be seen by a physician," adds **Randall Killian**, MS, MBA, executive vice president of the National Association of Managed Care Physicians in Glen Allen, VA.

Physicians are adding physician assistants, nurse practitioners, and even social workers to their practices to deal with patients who have psycho-social, in addition to medical needs.

"There are a lot of issues, particularly with the medically underserved and the elderly, that are not medical but social issues and should involve a patient education effort rather than a physician visit," Killian says. Among these are nutrition, preventive measures, and education on chronic disease, he says.

In addition to excellent customer service, the next generation of patients is going to want performance statistics, DeMarco says. That's why it's essential for physicians to look at performance measures, being able to track how many people with a particular problem had a good outcome with no recurrence, and with no extra costs.

"They are looking for a guaranteed outcome but they can accept performance statistics to assure them they'll have a good outcome," DeMarco says.

You also may need to show the patient of

## *COMING IN FUTURE MONTHS*

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tomorrow how you stack up against your peers in managing chronic diseases, says DeMarco.

In fact, from a business standpoint, disease management may be the best way to deal with the increasing health care needs of the next generation, Killian adds. Efficiency from a business perspective is the ratio of input to output, Killian points out. In medicine, efficiency means the best outcomes at the lowest cost, he says.

"Whether you call it disease management or health management, it is in essence combining the business and clinical piece of the practice to get the best outcome at the least cost," he adds.

With disease management, or more correctly, health management, physicians are focusing more on preventive care and maintaining wellness. Until recently, disease management has been a pie-in-the-sky approach to patient care, Killian adds.

"Health plans and pharmaceutical companies partnered together and developed great disease management models," Killian says. However, practicing physicians often didn't have the time to implement the models, he adds.

Killian tells of a panel discussion during which a family practitioner was asked what he thought of a particular disease management plan. "I don't have time to look at disease management models. I spend all my time treating patients," was the reply.

The National Association of Managed Care Physicians is concentrating on helping physicians implement disease management programs. "We have great models that have been approved by the medical directors of health plans but getting the physicians to implement them is where the rubber meets the road," he says.

The association has held seminars in 2000 on the subject and has others planned for 2001. ■

# Less controversy, a more fulfilling PPS

*Proposal contains few surprises*

Early November revealed another prospective payment system (PPS), this one much less controversial than the one for outpatient services.

On Nov. 2, the Health Care Financing Administration (HCFA) in Baltimore published on its Web site its proposed PPS for rehabilitation facilities. These facilities can be either freestanding or units of acute care hospitals. HCFA then posted the proposal on the *Federal Register* Web site on Nov. 3.[1]

Health care officials have found few surprises in the proposal, reports the *American Hospital Association News*. Here are some of the features of the system, which will be phased in over two years, as reviewed by the AHA.

- Rehab facilities will be paid on a per-discharge basis (for operational and capital costs).
- There will be comorbidity adjustments for varying degrees of patient needs.
- A transfer provision will determine payments

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for patients who are transferred to other facilities before treatment completion.

• Payments will be adjusted for geographic differences in wages and for disproportionate shares of low-income patents; rural facilities will receive special adjustments.

• Additional payment adjustments (coming from a set-aside fund made up of 3% of the overall rehab PPS budget) will be made for outlier cases.

• Facilities will use the Minimum Dataset Post-Acute Coding assessment tool to determine each patient's needs and appropriate payment categories.

The proposed rehab PPS is designed to pay 2% less than those under the existing cost-based system, but this percentage may change if Congress passes Balanced Budget Act relief legislation.

### *Reference*

1. 65 *Fed Reg* 66,303 (Nov. 3, 2000). ■



# E-health groups have a quorum

Three Internet health organizations announced in October that they were forming a coordinating committee to collaborate on ethical conduct codes. The committee has a goal of ensuring a system of e-health codes that is understandable to the public and that uses a common terminology. The organizations involved in this committee are:

• Hi-Ethics (Health Internet Ethics), a collation of 20 of the most widely used U.S.-based consumer health Internet sites and information providers.

• Health on the Net Foundation, a not-for-profit portal for medical and health-related information based in Geneva.

• Internet Healthcare Coalition's e-Health Ethics Initiative. The Internet Healthcare Coalition is a Washington, DC-based nonprofit organization. Its initiative aims to provide a forum for the development of a universal set of ethical principles for health-related Web sites.

The first step of the collaboration will be the development of a common glossary of definition and terms for verification and compliance efforts. E-health consumers should be able to easily compare security and privacy statements using universal descriptions. The common terminology will be used by the three organizations when communicating future developments. The groups hope their efforts may set domestic standards and may eventually led to cooperation on an international level. ■

# More providers qualify for small business loans

The U.S. Small Business Administration has increased the size standard for health care providers, meaning more can qualify as small businesses and be eligible for special government loans and set-aside programs.

Under the new standard, the following providers are considered a small business:

— hospitals and kidney dialysis centers with revenues up to $25 million;

— nursing care facilities, medical laboratories, and home health care services with revenues up to a $10 million; and

— outpatient care facilities and offices and clinics with revenues of up to $75 million. ■