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PHYSICIAN'S PAYMENT UPDATE™

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Stark II rules give you some breaks if you follow tight pay guidelines

Incentive rules relaxed, but learn where pitfalls are

While there's still some confusion about when the newly published Stark II final rules will take effect, the fact is there's a new game in town that practices must learn if they are going to stay on the right side of the fraud and anti-kickback law.

One of the areas greatly affected by these new rules will be physician compensation, including the distribution of productivity bonuses and profit shares by physician practice groups to their individual practice physicians.

Here are some insights on Stark II's impact on physician compensation from **Steven M. Harris**, a partner in the Chicago law firm of Harris Kessler & Goldstein.

Generally, Stark II prohibits a group practice physician from being compensated directly or indirectly based on the volume or value of the physician's referrals for designated health services (DHS), says Harris. However, a doctor in a group practice may receive shares of overall profits of the group or a productivity bonus based on services the doctor personally performed.

Warning: In no way can any share or the bonus be determined in a manner directly related to the volume or value of the physician's referrals.

This version of the rule is a much more flexible interpretation of the Stark statute than the Health Care Financing Administration's (HCFA) earlier stance on the standard, experts note. Before, for instance, when it came to profit-sharing, HCFA required that overall profits be aggregated for the entire group and not by group components, such as separate offices or specialties.

Also, HCFA previously stated that productivity bonuses could relate only to work performed by the physician resulting from referrals from other physicians in the group, and not to work resulting from any DHS work ordered and performed by the physician or to the physician's DHS referrals to other group physicians.

"The effect of this interpretation was to severely limit the means and manner by which physician groups could compensate their individual physicians," maintains Harris.

However, in its final rules, HCFA clarified that allowing a physician to receive a "share of overall profits" means a share in the entire profits of the group or in any component of the group that consists of at least five physicians.

HCFA also said a group practice physician may receive shares of the overall profits of the group as long as the shares do not correlate directly to the volume or value of referrals generated by the physician for designated health services performed by someone else.

HCFA says group practices may pay productivity bonuses to member doctors based directly on their personal productivity, which could include work ordered and performed by the physician.

HCFA also has stated that the following indirect methods of distributing overall profit shares are allowable:

— a per capita (per physician) division of profits;

— a distribution of revenues derived from designated health services in accordance with the group's distribution of its revenue unrelated to those services;

— a distribution of designated health service revenue if such revenue represents less than 5% of a group's total revenues and provided that no single physician's allocation of that revenue exceeds 5% of that physician's total compensation.

HCFA also will allow the following indirect compensation methods by which a group practice may calculate physician productivity bonuses:

— based on the physician's total patient encounters;

— based on the allocation of the physician's compensation attributable to services unrelated to designated health services, including revenues related to designated health services if the group's total designated health service-related revenues make up less than 5% of the group's total revenues and if the physician's allocation of those revenues represents no more than 5% of the physician's total revenue from the group.

Group practices also can use other distribution methods, provided that they are "reasonable, verifiable and not directly related" to the volume or value of a physician's referrals.

Sticking to these distribution methods should ensure that your group's profit shares or productivity bonuses are not illegally directly related to either the volume or value of referrals. ■

Stark II more benign, but it still has a bite

In-office ancillary services are an example

While experts are calling the final Stark II rules released in January a more benign reading of the law than Stark I, they also warn that parts of the new rules will be more stringent than before.

One area in which the rules get more strict is in-office ancillary services, notes **John T. Brennan Jr.**, a lawyer with Crowell & Moring in Washington, DC. Specifically, part-time leases of space housing designated health services at a site away from the place of the physician group's main practice are not permitted under the final rule. This rule is intended to prevent practices from entering into bogus deals in which they "rent" useless off-site space to potential service providers to mask kickbacks.

On the plus side, Stark II gives health care providers more flexibility than many had expected, especially when it comes to things like indirect compensation arrangements.

When it came to indirect compensation, the original proposed rule focused on the so-called "first tier transaction" — the payment a designated health service (DHS) provider initially makes — and defined indirect compensation arrangements in a way that automatically placed most integrated health care systems in violation of the Stark statute, says **Mark R. Fitzgerald**, an attorney with Gardner, Carton & Douglas in Washington, DC.

The final rule, however, avoided this situation by focusing on final-tier transactions, or how a physician gets paid, notes Fitzgerald. In turn, such arrangements do not violate the new Stark provisions, provided the physician's compensation does not vary based on volume or value of referrals to the hospital or other DHS provider and is consistent with fair market pricing. "This was a very significant change," he stresses.

Here are some other changes:

• **Per use compensation.** Unlike the proposed rule, the final rule also allows "per-use" compensation to physicians — such as time-based and per-test payments — if the payment is set in advance, is not adjusted during the term of the arrangement as a reflection of the number of referrals generated for DHS, and is set at fair market value.

Time line is uncertain, but beware sleeping Stark

Tougher Stark I still in effect

When HCFA released Phase I of the Stark II final rule on Jan. 3, most of its provisions were scheduled to go into effect on Jan. 4, 2002, with regulations relating to referrals to home health agencies going into place Feb. 5, 2001.

However, on Jan. 20, the Bush administration released a memorandum postponing the effective date of regulations that have been published in the *Federal Register* — including the Stark II final rule — for 60 days. In turn, on Feb.1, the Health Care Financing Administration (HCFA) announced that the home health provision would take effect April 6 instead of Feb. 5.

Until final word comes down from HCFA, most observers now believe the final Stark II effective date will probably be March 5, 2002, 60 days after the originally stated effective date.

Meanwhile, there's also speculation that, to cut down on the confusion, Congress might intervene and implement the new rules sooner than the current year-plus waiting period

Until this implementation date is settled, providers must remember that their actions are still being judged by the stricter Stark I standards.

This distinction is especially important to physicians who make referrals to clinical laboratories with which they have financial relationships, notes **William H. Maruca**, an attorney with Kabala & Geeseman in Pittsburgh.

Under Stark I, it is illegal for physicians to refer Medicare patients to clinical laboratories in which the physicians have a financial or compensation interest. According to a statement released by HCFA: "Until the effective date of these new final regulations, the August 1995 final rule covering referrals for clinical laboratory services remains in full force and effect with respect to clinical laboratory services referrals and claims for services."

As such, a physician's office lab must technically satisfy the Stark I on-site supervision requirements and must meet the Stark definition of group practice, even though those standards have been loosened in Phase I of the Stark II final regulation, warns Maruca.

"In reality, it is highly unlikely that HCFA, the Justice Department, or the OIG would take any enforcement action against a physician or lab who was in compliance with the new regulations [Stark II final rule] but not the old ones [Stark I final rule] in 2001, but that does not prevent qui tam whistleblower plaintiffs from including Stark counts in false claims lawsuit," Maruca cautions. ■

• **Academic medical centers (AMCs).** Teaching hospitals and medical schools ordinarily give financial support to affiliated physician practices through funding for research / teaching activities as well as office space, administrative assistance, and other gifts.

In the proposed rule, HCFA wanted the separate legal entities of an academic medical center to demonstrate that their various financial transfers were based on fair market value — something most medical centers felt was not practical.

HCFA backed off in the final rule by acknowledging a "fundamental need" for a separate exception for services provided by academic medical centers.

Under Stark II, an academic medical center is in compliance with this exception if:

• the referring physician is a bona fide medical center employee and a bona fide faculty appointment at the affiliated medical school;

• the compensation paid to the referring physician is set in advance and does not exceed fair market value for the services provided and is not calculated based on the volume or value of referrals the physician makes;

• all cash transfers are in support of the AMC's missions (teaching, research, services for poor and / or uninsured patients);

• the different parts of the academic medical center have written agreements describing their relationship;

• all research funding directed to physicians is actually used for that purpose;

• the referring physician's compensation arrangement does not violate the federal anti-kickback statute.

Tip: Any arrangement that satisfies this medical center exception should also satisfy the indirect compensation exception, advises Fitzgerald. ■

Factors to consider when designing a pay plan

One size doesn't fit all

As practices review the new Stark II rules, it is also a good time to review the basics of compensation plans, especially when it comes to physician bonuses and incentives. Here are some tips from **Kent J. Moore**, a reimbursement expert with the American Academy of Family Physicians in Leawood, KS, on the basics of a properly designed physician pay plan.

What's right for you? Realize first that there is no universally accepted formula for incentives and physician compensation. However, several factors will determine which kinds of incentives are better suited for certain practices. For instance:

• **Market trends.** The amount of managed care penetration within a given market has a major influence on which incentives to use. Under fee for service, for instance, traditional incentive systems rewarded productivity and little else. The more patients doctors saw and the more services they performed, the more money they made.

"Managed care has changed all that," Moore observes. "Physicians still need to be productive, but they also need to pay close attention to issues such as utilization, efficiency, quality outcomes, and patient satisfaction."

As managed care penetration grows, these incentives become more crucial considerations in deciding what kind of behavior and results to reward and encourage.

• **Group characteristics.** Incentive plans will also vary depending on the kind of organization involved. For example, a small group practice is unlikely to have the same incentives as a large multispecialty group practice. Even among similar types of practices, incentives can vary according to the characteristics of that group or organization.

As such, incentive systems should be tailored to the personality of the group and its individual physicians. For example, is your group a "risk taker," or is it "risk-averse?" "If you are the former, a substantial incentive system may be more effective for you," Moore says.

• **Physician characteristics.** The career stages of specific physicians can also play a major role in deciding which incentives they find most attractive. Thus, you may want to consider offering slightly different incentives according to whether a doctor is younger and new to the practice, at the mid-stage of his or her career, or nearing the end of it.

Remember that physicians are not a homogenous group. They have different motivations, different specialties, different security needs. An effective incentive and bonus system takes these differences into consideration.

Here's a pop quiz on your incentive plan

Six questions to ask yourself

Here are some basic questions you should ask yourself to do a fast test of how effective and fair your group's compensation plan is, according to reimbursement expert **Kent J. Moore** from the American Academy of Family Physicians in Leawood, KS:

• **Does the system measure what it says it does?** For example, is it truly measuring quality or just processes? "There should at least be a strong correlation between what is actually measured and what is supposed to be," Moore stresses.

• **Do the measures account for outliers?** In other words, are the measures adjusted to account for confounding factors, such as patient mix? For example, if a particular provider's patient mix is largely Medicare clients, his or her utilization rates will naturally be higher than those of a colleague who cares for mostly younger patients.

• **Are the measures revised as new information becomes available?** Measures should not be set in stone, but should be changed as needed based on the finding of new clinical research or other data.

• **Is what's being measured within the doctor's control?**

• **Are physicians involved in defining the measures?** Physician input and buy-in are critical to developing an effective incentive plan because physicians best understand their work and what motivates them.

• **What's the baseline?** For example, is individual physician productivity judged against other members of your group, national data, or some arbitrary number? ■

• **Ethical limits.** The traditional ethical obligation of physicians includes a fiduciary responsibility to act in their patients' best interests. Unfortunately, some incentives may compromise this fiduciary responsibility, says Moore.

For example, an incentive plan that encourages physicians to consider costs when making individual treatment decisions may not appear to be in the patients' best interests. This raises the question of whether you can truly divorce financial and treatment decisions in a system that integrates finance and delivery. Regardless, the fiduciary duty to the patient should always come first.

• **Practical limits.** Beyond the legal and ethical issues, there are also practical limitations on what you can do in the way of incentives and bonuses. For example, the growing use of quality as a basis for incentives raises questions about the ability to identify consistent, objective measures of quality. Some quality measures are really process measures; they measure what or how care is provided, not the quality of the care itself. ■

HCFA opinion process held in abeyance

OIG still only alternative for help

In the Balanced Budget Act of 1997, Congress authorized the Health Care Financing Administration (HCFA) to issue written advisory opinions on whether a referral relating to a designated health service was prohibited by the Stark laws.

Under this system, health care providers would submit a request for an advisory opinion, outlining in detail their proposal for a particular arrangement. HCFA would then analyze the arrangement with regard to the physician self-referral laws and determine if it was legal.

This advisory opinion process, however, was placed on hold while HCFA concentrated its staff resources on crafting the final Stark rules, Phase I of which was issued last January.

Meanwhile, some 30 written requests for opinions on the Stark statute await a response from HCFA.

The question is, will HCFA resume its Stark advisory process or drop this service?

If HCFA stops providing advisory comments, then the Department of Health and Human Services' Office of Inspector General (OIG) becomes the only government agency providers can turn to for these kinds of advisory opinions. This option, however, sends a chill down the back of most physicians who believe the OIG errs on the side of regulatory rigidity when it comes to the Stark statute. ■

Physician extenders can extend your bottom line

Average income boost is 18%

Hiring nonphysician providers such as physician assistants, nurse practitioners, and other physician extenders will increase the cost of running a practice, finds a study by the Chicago-based American Medical Association's Center for Health Policy Research.

But, the increased productivity and efficiently these extender providers bring to the practice can also increase net practice income by an average 18%, estimates the AMA.

With an average salary of $55,000 to $60,000 for physician assistants, "employment of non-physician providers raises practice costs, but the resulting increased efficiency may reduce per unit costs or the price of services," found the study.

Another study by the Medical Group Management Association (MGMA) in Englewood, CO, found that the salary of a typical physician assistant only consumes about 30% of his or her related patient billings. In comparison, podiatrists' salaries consume 34% of their patient billings, OB/GYNs' salaries consume 35% of their billings, and internists' salaries suck up 43% of the practice revenue they generate.

The number of physician assistants is expected to grow 48% by 2008, according to the Bureau of Labor Statistics. As more practices expand their use of nurse practitioners and physician assistants to increase productivity, there's been a corresponding increase in confusion about how to bill Medicare and commercial insurers for their services.

Adding to this coding confusion is the fact that billing requirements for physician extenders

Impact of Employing Non-Physician Practitioners in a Solo Practice

	Number of Non-Physician Practitioners	
	None	One
Office visits per hour	2.8	3.1
Patient visits per week	116.4	127.2
Patient visits per year	5678.5	6040.9
Office visits — hours per week	32.7	33.9
Patient care — hours per week	48.6	47.7
Weeks worked per year	48.6	47.7
Fee — office current patient	$54.00	$52.80
Net income (thousands)	$186.9	$220.0

Source: American Medical Association, Chicago.

can — and often do — vary between payers. Also, a payer might have different instructions depending on the type of service a physician extender performs.

While you'll want to check with the Health Care Financing Administration and commercial plans when it comes to specific questions about their billing procedures for physician extenders, here are some general guidelines worth noting:

• **Medicare.** Medicare allows physician extender services to be billed in two ways, notes **Mary Stanfill**, coding and practice manager at the American Health Information Management Association in Chicago. "They can either be billed to the physician services or they can be billed independently," she says.

Direct billing is when the physician extender bills for his or her services using the extender's own provider number. Physician extenders can obtain a provider identification number by filling out HCFA form 855 for general enrollment **(see related story, p. 63)**, which is available on-line at the HCFA Web site (www.hcfa.gov/medicare/enrollment/forms/).

Any service a physician extender bills independently is reimbursed at 85% of the physician's fees.

• **"Incident to."** Medicare regulations also permit physician extender services to be billed as "incident to" physician services. These services are submitted to Medicare under the physician's provider number and are reimbursed at 100% of the Medicare fee schedule for physicians, according to the Texas Medical Association. For more information, the Texas Medical Association has a guide to physician extender billing available on-line at its Web site (www.texmed.org/pmt/prs/bgl.asp).

Also remember that services performed by physician extenders must meet several requirements to qualify for "incident to" billing, notes **Todd Welter**, a consultant with MGMA.

For instance, before you can bill a physician extender's services as "incident to," the extender must be employed by the physician, the physician must perform the initial examination of the patient, and the physician must directly supervise the physician extender who treats the patient, he notes.

• **Commercial carriers.** In regard to commercial plans, keep in mind that each insurer has its own policy for billing for physician extender services. This can mean some will require physician extender services to be billed using the physician extender's provider number, while others want them billed under the physician's provider number. If unsure about how to bill, call the insurer's director of provider relations. ■

Hard work, smart staffing keys to higher incomes

Texas practice is a top earner

When multispecialty practice Collom and Carney Clinic interviews new physicians, it always show the prospective employees the level of productivity the practice's doctors achieve.

"There's usually one of two responses: either euphoria or fear," says **Tom Simmons**, CMPE, chief executive officer of the Texarkana, TX-based physician practice.

Some physicians say the practice demands more work than they are willing to do. Others comment that the patient volume must mean good income, and that's the kind of practice they want to join.

"We are looking for physicians who want to perform at a high level. The process probably begins and ends at the recruitment stage. We believe that people with indications of high productivity are probably not made but are born," Simmons says.

(Continued on page 59)

Physician's Coding Strategist™

Fear of fraud police may be costing you

Uncertainty leads to underpayments

More physicians are being extra-cautious when billing Medicare, afraid of drawing the attention of the federal fraud police. Add to this the services that are often unknowingly undercharged by many practices, and you can end up missing out on a sizable amount of legitimate payments.

Being cautious in today's regulatory environment is prudent. However, there's no reason you should not be paid full freight for legitimate services. Next time you review your back-office practices, check to see if you are making any of the following common billing and coding mistakes that can leech the lifeblood out of your practice's cash flow:

• **Underbilling for office visits.**

Intimated by the idea of being red-flagged by government bean-counters, more physicians are taking the cautious approach and down-coding office visits for fear that claiming levels four and five visits will prompt an audit.

Sadly, there is some truth to that thinking. But the real smoking gun auditors look for is a constant billing of higher evaluation and management services across a wide array of patients in a manner that seems inconsistent with normal practice patterns.

In turn, if you do a properly documented (documentation is very important) multisystem exam of a moderately ill patient that requires multiple diagnoses and you only bill for a level three service instead of level four, you are just denying yourself appropriate payment, which in a busy practice can quickly run into the thousands of dollars.

On the flip side, billing a level four service for a hypertensive patient who comes in every month could get you into trouble.

• **Mismatching ICD-9 codes and procedure codes.**

Too many physicians simply mark ICD-9 and CPT codes on a superbill, assuming the billing office will take care of the rest.

The problem is that this can mean CPT and ICD-9 codes get mismatched or left off the bill altogether — a sure-fire way to get a claim denied or questioned.

Private codes can prevent mismatching

One way to avoid this problem is to have the physician place his or her own private code (a number or letter) matching each diagnosis with the corresponding CPT codes on the superbill to eliminate confusion about which ICD-9 goes with which CPT.

While many experts say it is easier for physicians to use a superbill or fee slip that already lists the practice's most frequently used CPT and ICD-9 diagnostic codes, others argue that offices should just do away with the superbills and have physicians write out their diagnoses while more experienced billers fill in the most appropriate diagnosis-related codes.

• **Not using the most specific and recent ICD-9 codes.**

Despite the fact many four-digit ICD-9 codes have been replaced with more specific five-digit codes, many physicians still use the older four-digit format without thinking.

Unfortunately, Medicare is now more likely to challenge these four-digit claims. Some examiners, for instance, will question why a simple code for abdominal pain was used instead of a code specifying the exact location of the pain.

Some key rules that must be followed

The best way to avoid payment and audit questions about your billing procedures is to make your claims are fully documented. Make sure, for instance, that:

- The medical record is complete and legible.
- Documentation of each patient encounter includes or references: the chief complaint and / or reason for the encounter and, as appropriate, relevant history, examination findings, and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and legible identity of the health care professional.
- If not specifically documented, the reason for the encounter and / or chief complaint and the reason for ordering diagnostic and other ancillary services can be easily inferred.
- Past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, are accessible to the treating and / or consulting physician.
- Appropriate health risk factors have been identified.
- The patient's progress, response to and changes in treatment, planned follow-up care, and instructions and diagnosis are properly documented.
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement are supported by the documentation. ■

• **Not using modifiers.**

At first glance, coding rules prohibit billing a patient for an office visit and a minor procedure on the same day. But it is allowed to bill for both an office visit and a minor procedure provided the physician does enough to justify both charges, the services are properly documented, and a modifier -25 is used to let the payer know more was done than just giving the patient an injection.

The catch: If the patient was only scheduled to receive a joint injection, for example, and that's the only service you provided, you cannot charge for both the procedure and the office visit.

Physicians often forget that they can bill for administration of an injection as well as for the drug or vaccine itself.

• **Not billing for injections.**

According to the ProStat Resource Group in Shawnee Mission, KS, physicians often forget that they can bill for administration of an injection as well as for the drug or vaccine itself.

Remember that charging for both an injection (a minor procedure) and an office visit on the same day without using a modifier is generally prohibited. But there are exceptions. For instance, when giving a vaccination for pneumonia, influenza, or hepatitis B, physicians can bill for the office visit, the injection, and the vaccine.

• **Confusing new patient visits with consultations.**

A patient consultation pays more than a new patient visit. To justify billing for a consult over a new patient visit, the patient must have been sent to you for a consult by another physician, and you must provide the referring physician with an opinion or advice — preferably in writing, which should then be included in the file.

• **Not billing for counseling.**

When a physician spends more than half of his or her face-to-face time counseling a patient or coordinating care — calling other physicians, making arrangements for diagnostic tests, etc. — he or she can bill for a higher level of service, even if the physician doesn't perform an exam or make a new diagnosis, says Orlando, FL-based practice consultant **Leslie Witkin**.

For instance, if during a visit a physician sees a patient recently diagnosed with cancer and does nothing but counsel the patient, talk to family members, and make arrangements for further treatment, the doctor is still entitled to code the visit as a level five, provided that more than half of the visit — 20 minutes minimum, because level-five visits must be least 40 minutes long — was spent counseling the patient and coordinating care.

• **Not billing for the nurse's time.**

A level one code can be used for office visits if nursing staff provide routine services when a physician is not present. However, it is best to bill only for when the nurse does those small extra things like showing a patient how to use insulin or giving the patient some other kind of detailed instructions. ■

Four steps to speed the reimbursement process

Fight back against slow payment

It's happening more and more: Payers are denying routine services and finding invisible clerical errors in claims, bills are being "lost," and it's taking longer and longer for bills to be paid in full.

Pressed by financial problems, many HMOs and other insurers are simply using any excuse possible to find ways not to pay legitimate claims, say reimbursement experts.

Here are some tips to help your practice reduce claim denials, speed turnaround time, and boost cash flow:

1. File frequently.

Most experts recommend you have the bill prepared and out the door within three to four days after service has been rendered. Anything less, and you are just making the payer what amounts to an interest-free loan.

Some offices prefer to file claims even more frequently. Frederick (MD) Internal Medicine makes a habit of filing claims daily. Besides speeding cash flow, daily filing reduces paperwork by processing claims on a same-day schedule rather than waiting to do a week's worth of claims at once.

2. Know what you are due.

"It's been my experience that a great many carriers are failing to reimburse practices based on their negotiated fee schedule," says **Brian Kane**, CPA, president of HealthCare Advisors in Annandale, VA.

To help track what you are being paid vs. what you should receive, Kane suggests creating a simple grid with the insurance companies across the top and the main 10 to 15 CPT codes on the left side. Next, fill in what insurers are contractually required to pay for these procedures, then check these amounts against explanations of benefits (EOBs) received from payers.

The EOB differences may seem small, maybe as little as five or ten dollars per patient. But this small change can add up to big bucks over the course of a year. Plus, the more aggressive you are in auditing and demanding full payment, the less likely it is payers will continue pulling the same tricks.

3. Track denied claims by payer and code.

The more information you have at your fingertips, the easier and faster it is for you to spot and correct underpayment patterns of particular carriers.

4. Collect copayments and deductibles quickly.

Rather than billing patients, most reimbursement experts suggest you collect any copayment due before the patient leaves the office. When this is not possible, some practices have found that giving the patient a pre-addressed envelope to use to mail in the payment improves collection rates. The same attitude should apply when the patient is responsible for a deductible in his or her coverage.

One way to easily track this is to create a chart of your top CPT codes and most frequently encountered insurers, listing their deductibles and co-pay policies for each code. Your front office staff can then easily refer to this chart to improve collection rates. ■

Savings mount up in 'real time' processing

Small slices from the cutting edge

Despite the introduction of various electronic and automated claims processing systems and techniques, the administrative burden and cost of processing medical claims continues to rise for many practices, according to an Indiana group practice.

"We're doing everything we can to automate everything we can," says **Mary Valdez**, manager of patient accounts for the Indianapolis Women's Health Partnership (WHP).

Yet, despite the fact that 80% of WHP's claims are processed electronically — compared to the 50-60% national average — it still costs this group practice an average of $7.42 to process each claim.

On the up side, the introduction of electronic data interchange (EDI) has cut two weeks off WHP's claim payment cycle. It now takes two months for the average claim to be paid instead of two and a half months.

Even with EDI, 30%-35% of claims are denied because of alleged errors or missing information, she says. "This claim rejection rate is compounded by the problems our various payers are having

with their EDI systems." For example, she says, "our EDI system may show a claim has been accepted by the payer when, in fact, it has been lost or just disappeared."

As an alternative, WHP has moved to a "real-time" claim resolution system distributed by RealMed Corporation of Indianapolis.

"With a real-time system, before the patient leaves our office, they are given an automated accounting of how much their insurance covers for that visit, and how much, if anything, the patient owes, without filing any paperwork," says Valdez. "By taking care of the transaction in one setting, with the patient present, and not having to re-open the claim file three or four times, we are starting to move our savings from processing claims into more quality care for the patient."

On a larger scale, Health First, a Melbourne, FL-based health network with specialties in cardiology and women's and children's services, has expanded its electronic medical records and claims management to make its use easier for the ambulatory physicians in its 29 clinics.

"This is an active managed care market with many patients who need both primary and specialty care," said Health First spokesman **Rich Rogers**. For instance, Health First wants any authorized caregiver in the system to have a patient's records available when the person arrives for a visit. "This assures them they're being cared for in a close-knit and efficient health care community, and they avoid the hassle of having each provider they see do a new chart work-up," says Rogers. ■

HMOs to use new funds to boost physician pay

Opposition may come from Congress

Health plans in the Medicare+Choice program are expected to use much of this year's $1 billion allocation of increased federal funding to boost payments to physicians and hospitals, say industry experts. However, this provider pay hike could be threatened by rumblings from legislators, according to Capitol Hill watchers.

Congress passed a Medicare "give-back" bill late last year that earmarked $11 billion over five years to strengthen Medicare+Choice, primarily by persuading health plans to remain in the four-year-old program. Of that amount, $6.2 billion was provided in direct payments to managed care plans, and just under $1 billion of that goes to plans in this calendar year.

"We are looking at shoring up our provider networks in certain markets," says **Dick Brown**, director of media relations at Humana Inc. in Louisville, KY. "We want to make certain we can keep providers in our Medicare+Choice networks and give our members the access that they want to the providers they need."

But there also is concern emerging from Congress about the give-backs. Rep. **Fortney "Pete" Stark** (D-CA), for instance, argues that not enough physicians were dropping out of Medicare+Choice to justify directing these extra dollars to them. Also, Rep. **William Thomas** (R-CA) likes the idea of using any extra funds to provide benefits directly to seniors. ■

Coding assessment offered by AHIMA

Program is Web-based

The American Health Information Management Association (AHIMA) in Chicago has developed a Web-based program to educate coders. "Coding Assessment and Training Solutions" provides an opportunity to assess coders' 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.

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

(Continued from page 54)

The process works. Physicians at Collom and Carney achieve far in excess of their peers.

For instance, the salaries of physicians in the internal medicine department are 180% of the median salary for similar physicians included in the Medical Group Management Association (MGMA) annual survey.

In 2000, 95% of the physicians in the practice had their highest income ever.

"A lot of them have worked harder to accomplish that, but we've had that trend for the past few years," Simmons says.

A whopping 90% of physician pay at Collom and Carney is based on productivity. "You can't drive the work ethic if you don't have the compensation," Simmons says.

Collom and Carney is a 68-physician multispecialty practice with 450 employees, including physicians. The practice owns a chain of dialysis facilities and 25% of an ambulatory surgery center.

The practice has always been in the 90th percentile for income and productivity in the MGMA survey.

When the members of the practice interview prospective physicians, they discuss professional and personal goals and show them the level of productivity the Collom and Carney doctors are expected to achieve.

For instance, in internal medicine, the average physician admits 10 patients when he or she is on call and does 10 history and physicals.

The practice also looks for the highest achievers among physician applicants. For instance, 30% to 35% of its physicians were in Alpha Omega Alpha honor society.

"We have found generally that those in the top of their medical class have a strong work ethic," Simmons says.

The practice is located in rural northeast Texas where there is only a small infiltration of managed care, but the practice still has a lot of insurance rules and precertification practices to follow.

Doctors at Collom and Carney spend less than 5% of their time on tasks that involve anything but treating the patients.

"When we recruit doctors, we tell them we want to minimize the paperwork hassles they have in practice. Anything we can accomplish for them — anything that does not need to be written and signed by a physician — we handle that for them," he says.

Collom and Carney keeps a close eye on the administrative structure and moves administrative tasks to nonphysician employees so doctors can concentrate on seeing patients.

When doctors arrive at the clinic from the hospital, they already have three to four patients in rooms, with the charts on the doors or pulled up on the computer screen. The nurse has already taken the initial information.

Collom and Carney's aggregate support cost is 15% to 20% higher than its peer groups in the MGMA survey, but the group's productivity is 70% to 80% higher.

"You don't want to have a doctor who is compensated at $200 an hour doing a $10 an hour job," Simmons says.

If there's an opportunity to use a signature stamp, rather than a doctor's signature, the practice takes it.

"The point is to alleviate the paperwork nightmare that today's doctors experience," Simmons says.

Making extensive use of nurses, clerks

The nurses call in all prescriptions, return all patient phone calls, and call patients with all the lab results. "The doctors do call patients back in some circumstances, but we are selective," Simmons says.

The practice employs clerks who handle precertification, set up patient examinations, and call the hospital to arrange admissions. "The doctors' involvement in all those things is just in writing the orders," Simmons says.

The clinic is located in a community of 56,000, with about 350,000 in the trade area. The physicians see more than 200,000 active patients, about 60% of the local market.

The practice works hard to stay on schedule, although emergencies do crop up from time to time. "If you don't stay with the schedule, you can't accomplish any of these goals," Simmons says.

On average, patients can get an appointment in one day to one week.

The practice hires part-time physicians only when it needs help complementing the work schedule. For instance, in a few locations, the practice may contract with someone to work only one or two days a week.

At present, only one physician is part-time. "We are looking for people with a full-time commitment to the practice of medicine," Simmons says.

The practice employs midlevel providers who are used selectively in some departments.

"Our use of midlevel providers is uniquely adapted to the needs of each department. They aren't just thrown into every department," he says.

For instance, in the internal medicine department, a nurse practitioner sees patients who can't get a regular appointment that day, as well as patients of a doctor who is on call and has to be at the hospital the entire day.

"In internal medicine, the midlevel providers are a release valve to take care of the overflow of patients. The family practice department doesn't have the same problem," Simmons says.

Each of the departments at Collom and Carney has a unique approach to management.

"You can't buy a book," Simmons says. "There is no cookie-cutter approach to increasing productivity. Every situation has its own set of problems you have to analyze. We can't draw a lot of parallels between the departments, other than going through the productivity analysis for each one." ■

10 reasons to stay up to date on capitation

Practices, insurers still use capitation skills

Like Dr. Jekyll and Mr. Hyde, capitation has a changing image that tends to morph from savior to pariah and back again. Once called a modern-day version of the California Gold Rush, capitation rocketed to the spotlight in the mid-1990s as a smart new way to contain costs and improve health. But in time, its reputation became tarnished as many physicians and patients found it to be too cost-conscious and simply too chintzy.

Amid capitation's checkered past, news accounts have featured stories of its demise, as well as accounts of its return to the spotlight. "Everyone is going back to fee for service," some headlines report. Yet a few days later, reverse predictions surface, asserting that "Capitation is here to stay." So what's reality?

The reality is that the best strategy for practice officials is to stay on top of capitation and its methodologies whether the practice is currently swamped in risk, or if it is shifting back toward more fee for service contracts, say consultants with Expert System Applications, Inc. (ESAI), a practice management software company in Solon, OH.

ESAI officials offer these 10 reasons to stay up-to-date on capitation:

1. The principles for calculating capitation rates can and should be used for projecting medical revenue and costs — regardless of the method of reimbursement. If you think about it, revenue and cost levels are not so much a function of your contracting methodology but rather how you run your practice overall. Capitation is one way to predict what you need to provide services, cover costs, and make some level of profit.

2. Capitation offers useful benchmarks for evaluating discounted fee for service as well as traditional fee-for-service contracts. It is common business practice to compare the profitability of one contract against another. Typically you compare how one fee-for-service contract compares to another or how a discounted fee for service is doing relative to other contracts. It is just as sensible to compare performance with capitation contracts as well, or with "shadow capitation" numbers — i.e., developing some "what if" scenarios as if the contract had been capitated. For example, evaluate how the practice would have fared had a particular fee-for-service contract actually been capitated with X,Y, and Z rates and coverage requirements.

3. Discerning the drivers of capitation enables you to understand what drives managed care overall. "To understand the core of the capitation concept, the focus should not be on the rates but rather on the driver of a capitation rate," ESAI officials say. The key drivers are:

- utilization rates (and what affects utilization rates);
- medical services covered under the plan and the fee-for-service equivalent fees per unit of service;
- required copayments.

4. If you understand the drivers of a capitation contract, you are equipped to analyze a health plan's cost components. Cost can be the toughest part of your analysis, and capitation expertise really homes in on cost analysis that you can apply across your practice.

5. Capitation places a significant emphasis on monitoring quality performance. This is an ever-evolving skill that can do nothing but improve

your bottom line and your patient care across the board.

6. Capitation's focus on efficiency also can benefit every patient and physician who walks in your doors each day. You can measure efficiency in all your contract arrangements on a per case or alternative basis.

7. Many fee-for-service arrangements still have additional partial risk-sharing arrangements that require capitation analysis. For example, many contracts have payment thresholds which, if they are exceeded, provide additional payments on a capitated basis.

8. "If a competitor is capitated, you might want to monitor their performance," ESAI officials note. For example, you may know that Practice X in your city entered a major capitation contract with a large insurer. In your professional networking circles, this competitor may be willing to share some of its experiences with you and others in the network. Or, the insurer may be willing to share some parts of the experience to entice your practice. Either way, you can't grasp the merits or demerits without up-to-date expertise in capitation itself.

9. "If a future [capitation] proposal is made to you, you might want to be able to adequately evaluate it," officials point out. If capitation is out of fashion in your market, that doesn't mean it always will be or that insurers won't take steps to make their proposals more palatable. Also, some practices have had huge success with capitation. Don't get too rigid in viewing your possibilities, ESAI consultants recommend.

10. "Health plans continue to use capitation principles to actuarially project medical costs so that a premium rate for those services can be determined, even when their reimbursement is on a fee-for-service basis," ESAI consultants say. Your practice may not be seeing much capitation, but that does not mean it's going away entirely. Throughout the indemnity profession, it is alive and well in the practice of health insurance methods. ■

How specialists can thrive under modified capitation

Brigham and Women's tackles global cap pitfalls

Just when women's health centers were hitting their stride and focusing on the value of comprehensive health care — POW! — capitation came along.

In women's health care and other areas of high medical specialization, capitation is stirring up huge issues of balancing quality of care with cost containment. Specialists, however, aren't giving up. Three concrete adjustments to capitation payment methodologies can go a long way toward mending some of the financial disrepair among these highly specialized centers, according to some experts who are fighting these issues every day. Their strategies can be useful not only to women's medicine, but to other areas of specialized medicine as well.

Brigham and Women's Hospital in Boston is just one example of a health care system that committed itself wholeheartedly to women's health starting 20 years ago. It became a Center of Excellence and now is absorbing some significant blows financially to survive capitation's grip on the Boston market. Brigham also is in a highly competitive market where capitation isn't likely to go away anytime soon.

Brigham's experience — and recommendations for capitation payment changes — are described in a recent study by **Andrew J. Sussman**, MD, MBA, **Robert Barbieri**, MD, and **Troyen A. Brennan**, MD, JD, MPH.[1] Each of these authors is a clinician in the Brigham system and an official in the physician-hospital organization (PHO) that oversees managed care contracts.

Brigham has over over 50,000 patients enrolled in these contracts, with 20,000 of them in global capitation (hospital services are capitated as well as physician services). About 100 primary care physicians and 900 specialists in the system participate in risk contracts. Brigham's is the largest birthing center in the state, and it averages 400 premature infant deliveries each year.

Global cap contracts need modifications

"Tertiary women's health centers are excellent resources for patients to receive coordinated care from obstetricians, gynecologists, medical and surgical specialists, and primary care physicians," Sussman and team point out. However, there is a drawback: "Many global risk capitation payment systems are not adapted appropriately to pay for the care," they argue. As a result, what often happens is that hospital costs exceed per-member-per-month payments. This means the key is to better adjust the hospital side of the payment picture, these officials suggest. Here are

their recommendations on how to do that, thus maintaining the superior care offered in highly specialized health systems and at the same time making global capitation work:

• **Develop case-mix adjusted length-of-stay (LOS) benchmarks.**

A PHO's global capitation performance can still be measured in part by how well the hospital meets LOS targets, but these targets need to be adjusted for case mix because LOS is bound to be higher in specialty centers than in nonspecialty hospitals. For example, the reason women choose Brigham's primary care physicians is to get access to the prestigious specialist care that would be available in the same health system if they become pregnant, seek fertility services, or seek other specialized services unique to women.

Once the specialist hospital meets or comes below case-mix adjusted LOS, then services that increase LOS based on clinical need should not charged against the agreed-upon capitation payment, Sussman and team suggest.

• **Carve out infertility and neonatal expenses, and then spread those costs across the entire health plan.**

For example, with infertility care, the carve-out should include pharmaceutical and procedural expenses. With neonatal care, carve-outs should extend to high-risk pregnancy patients and neonatal unit expenses. Development of clinical guidelines also would cultivate more cost-effective infertility and neonatal care, as well as the use of generic pharmaceuticals, to control costs.

• **Adjust capitation based on patient health status.**

Gender and age are far too limited to serve as reliable indicators for payment adjustments, particularly in a specialty setting as diverse as a large women's center like Brigham, Sussman says. The most promising health status adjuster may lie in Ambulatory Care Groups (ACGs), which assign each patient in a plan a score based upon one of 52 diagnosis groups. This is a system Medicare is phasing in and which may well work better in private sector contracting, these officials suggest.

Here is how ACG scoring or coding works: Each diagnostic group is ranked according to the intensity of resources needed for its medical problems. Upon assigning that score to each patient in the capitation plan, payments for the patient mix are adjusted accordingly.

"Then capitation budgets can be adjusted within an integrated delivery network and between integrated delivery networks," Sussman and team explain. "For example, a primary care physician group with less healthy patients can be paid appropriately a higher capitation budget than a group with relatively healthier patients."

Specialist care such as that in this case example — and those in other specialties and in other urban areas — provides a significant contribution to patient care, but specialist providers suffer selection biases under capitation that are threatening their financial solvency, Sussman says. These three payment adjustments to global capitation agreements would enable specialist providers to thrive even under the restraints of a fixed-payment environment.

Reference

1. Sussman A, Barbieri R, Brennan T. Global capitation at a women's health referral center: The challenge of patient selection. *Obstet Gynecol* 2000; 96:1018-1022. ■

Reimbursement ROUNDUP

HCFA experiments with coordinated care

A new demonstration project sponsored by the Health Care Financing Administration could lead to expanded coverage for coordinated care services for the chronically ill, say agency observers.

The idea for this pilot is to test the concept that coordinated care for a variety of chronic ailments can reduce the high costs associated with

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unnecessary utilization by teaching patients to understand triggers, in turn preventing acute episodes and complications that usually lead to emergency room visits.

Based in Maine, the four-year demonstration project is scheduled to be launched this fall and will involve between 700 and 800 Medicare beneficiaries.

"A shift in HCFA's reimbursement policy toward coordinated care could create an incentive for health care systems to provide additional services that can increase the quality of patient care while decreasing unnecessary costs," notes **Nancy Steele**, vice president of New York City-based Pfizer Health Solutions, which markets a disease management software program being used in the pilot by some of the providers in the project.

Under a cardio coordinated care program, for instance, a nurse could telephone beneficiaries several times a week to get a reading on their weight; any unusual sudden weight gain could mean excessive fluid build-up, signaling the onset of a possible medical problem.

General information about the demonstration program is available on HCFA's Web site at www.hcfa.gov/ord/coorcare.htm. ▼

HCFA releases Form 855 revised draft

The Health Care Financing Administration has released its most recent draft of the revised provider enrollment form, Form 855. Formal comments on the latest version are due by April 2, with a final form expected this summer.

The draft form is available on-line at www.hcfa.gov/regs/prdact95.htm. Scroll down to Information Collection Requirements in HCFA-0855 and click on HCFA0855.EXE. This will enable you to download the draft forms. ▼

HCFA sets procedures for advance benefit notice

As part of a recent crackdown on advance benefit notification procedures by providers, the Health Care Financing Administration has issued a program memorandum (Transmittal A-01-05) setting procedures home health agencies (HHAs) must follow when informing patients, prior to provision of health care services, that the proposed procedures may not be covered fully or partially by Medicare.

Under the memo, as of March 1, HHAs must start giving their patients an advance beneficiary notice to sign before providing a service that the agency believes might not be covered by Medicare or that might be covered at a reduced rate. The notice must inform beneficiaries that they would be responsible for the cost of any non-covered care. ▼

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Feds adding more common HIPAA questions

The Department of Health and Human Services (DHHS) has expanded the "frequently asked questions" (FAQs) section of its Health Insurance Portability and Accountability Act of 1996 Web site. The new site focuses on the final rule on Electronic Transactions and Code Sets. An added feature of this site allows users to submit specific questions that DHHS can choose to post and answer on the site if they are pertinent to the general readership.

To submit a question on the Transactions final rule, go to this address: http://aspe.hhs.gov/admnsimp/bannertx.htm. To read the FAQs, go to http://aspe. hhs.gov/admnsimp/qdate01.htm. ▼

Physician panel preparing top 10 bad rules

Provider insiders are hoping the Physicians' Regulatory Issues Team (PRIT) created by the Health Care Financing Administration can help reduce Medicare's regulatory burden on doctors.

Comprising 24 members, half of whom are physicians, the PRIT was organized as way to get give practitioners direct input into the way HCFA does business. PRIT is presently developing a "top 10" list of regulations or agency practices that it hopes to target for action over the next year, say sources close to the process.

Among the items to look for on this Top 10 regulatory hit list: reducing the time it takes new physicians to get Medicare billing numbers; creating a system to compile a list of "frequently asked questions" for public distribution; and refining HCFA's proposed evaluation and management documentation guidelines. ▼

Medicare may expand medical device coverage

Odds are looking very good that Medicare will expand its coverage of medical devices in the near future, say industry experts. One reason for the upbeat outlook is the strong support from U.S. Rep. **Richard M. Burr** (R-NC), the new vice chairman of the House Energy and Commerce Committee, which has jurisdiction over many heath care issues.

Burr has let it be known that he plans to be aggressive in his oversight of the Health Care Financing Administration, hoping to make the agency more responsive to both patients' and providers' needs.

Medical device hearings to be held

One of Burr's first official acts will be to hold a series of hearings on Medicare's treatment of medical devices, including how HCFA deals with coverage of drugs and devices, in response to complaints from device makers' complaints that Medicare is slow to pay for breakthrough medical technologies.

"We've gotten used to paying higher prices for drugs, but we haven't gotten used to paying incredibly high prices for devices," says Burr. In response, his office is pushing HCFA to alter its cost/benefit analyses to give more consideration to "savings per incident" from such things as the avoidance of invasive surgery and less need for medications when new technology is used. ■