AMERICAN HEALTH CONSULTANTS

Providing the highest-quality information for 13 years

PHYSICIAN'S PAYMENT UPDATE™

## INSIDE



**JUNE 2001**

**VOL. 13, NO. 6 (pages 81-96)**

American Health Consultants® is A Medical Economics Company

# Survey: Most physician pay flatlines, but some subspecialties may soar

*Physician employees face possible pay cuts*

Except for some subspecialists who can expect double-digit increases, most physician pay raises will hover around the inflation rate, experts predict.

One factor helping to hold the line on provider salary increases is the fact that more large not-for-profit institutions are tying compensation packages more closely to production incentives — while also raising the production bar.

With a median income in 1999 of $145,397, general internists remain among the best-paid generalists, but other primary specialties are fast gaining economic ground.

According to the Englewood, CO-based Medical Group Management Association's annual "Physician Compensation and Production Survey," the median income for primary care physicians such as non-obstetric family physicians and pediatric/adolescent medicine physicians rose 9.56% to $141,493 between 1995 and 1999. During the same period, pay for pediatric/adolescent primary care doctors rose 10.79% to $143,011.

### *Hematologists, oncologists see steep raises*

Several subspecialties, however, far outpaced these pay hikes. For instance, hematologist/oncologist compensation skyrocketed 35.32% to $255,167, while pay for gastroenterologists jumped 26% to $264,500.

For the 17 categories of subspecialists tracked by MGMA, five-year median pay rose 13.86% to $245,910. In contrast, primary care pay only rose 7.98% to $143,970.

The methods used to reimburse physicians have a major influence on how much they end up making. For instance, practitioners whose compensation is based solely on production tend to be higher paid than practitioners who work under a mixed productivity/salary compensation

## Physician Pay Comparison

| Type | Median Pay 1999 | % Change '95-'99 |
|---|---|---|
| All primary care | $143,970 | +7.98 |
| All specialties | $245,910 | +13.86 |
| Internal medicine | $145,397 | +4.36 |

*Source:* "Physician Compensation and Production Survey: 2000 Report Based on 1999 Data." Englewood, CO: Medical Group Management Association; 2000.

package or who are paid a straight salary, according to the MGMA. About 37% of group practices pay physicians just based on productivity, says the survey.

In 1999, for example, general internists made a median of:

- $151,188 when pay was just based on productivity;
- $145,610 when over half of their compensation was linked to production;
- $143,857 when salary made up more than half of their compensation package;
- $134,688 when on straight salary.

This connection is especially important because many experts say the trend is for more health care organizations, especially institutions employing physicians, to base a greater portion of their providers' paychecks on productivity.

Among the most popular productivity incentives and methods for calculating physician pay were gross and adjusted charges, net collections, patient encounters, patient panel size, and relative value units (RVUs).

### *Growth in production-based pay*

Besides medical groups, other health care organizations are turning to production-based pay packages. According to Detroit-based Sullivan, Cotter and Associates, the most popular tools for measuring physician production among not-for-profit hospitals and medical centers are: patient encounters (79%); direct patient care hours (78%); patient satisfaction (60%); cost-effectiveness (49%); total RVUs (33%); work RVUs (32%); net collections (29%); and gross revenues (23%).

These incentives account for about 15% of total provider pay for generalists at these institutions, with some marked differences between primary care and subspecialist comp packages.

For example, 69% of the organizations surveyed by Sullivan calculated primary care incentives only on individual performance, and only 3% used group performance to determine production pay. Patient satisfaction, net revenue, and patient encounters were the top three performance baselines used to reward individual physicians. In contrast, net revenue, patient satisfaction, and utilization are the leading performance compensation measures among primary care-driven groups.

### *Individual performance vs. group performance*

For subspecialists, however, 65% of not-for-profit health care organizations based incentives on individual performance, while 10% considered group performance. Subspecialists' incentives were most commonly based on gross revenue, net revenue, and patient satisfaction. This was also the same for subspecialty medical groups.

The Sullivan survey also found that about half of the health systems and hospitals that use physician performance standards planned to "raise the bar," making it potentially more difficult for their physicians to max out on their productivity-based bonuses. ■

## Median Physician Pay by Specialty

| Specialty | 1999 Average | % Change from '98 |
|---|---|---|
| Cardiology/invasive | $340,010 | -2.85 |
| Radiology/diagnostic | $315,048 | +15.90 |
| Cardiology/noninvasive | $278,712 | -0.07 |
| Gastroenterology | $264,500 | +10.08 |
| Hematology/oncology | $255,167 | +20.07 |
| Anesthesiology | $244,755 | - 2.18 |
| Surgery/general | $236,572 | +4.84 |
| Otorhinolaryngology | $235,945 | +2.84 |
| OB/GYN | $219,022 | +1.26 |
| Pulmonology | $199,221 | +4.82 |
| Internal medicine | $145,397 | +3.01 |
| Family practice | $141,493 | +2.33 |

*Source:* "Physician Compensation and Production Survey: 2000 Report Based on 1999 Data." Englewood, CO: Medical Group Management Association; 2000.

# Southern internists not just whistlin' Dixie

*Pay may depend on location*

Where a physician practices plays a major role in how much he or she is paid, according to information collected by the Englewood, CO-based Medical Group Management Association. For instance, internists in the South are generally better paid than their colleagues in other parts of the country. Median 1999 income for southern internists was $167,513, compared to $154,162 in the North, $148,182 in the West, and $138,506 in the East.

Median compensation levels for primary care physicians and specialists also tend to be higher in the South. In 1999, southern primary care physicians earned a median income of $153,096, compared to $142,708 for primary care physicians in the East, $144,006 for those in the Midwest, and $137,970 in the West.

Specialists practicing in the South earned a median of $326,144, compared to $233,356 in the East, $278,392 in the Midwest, and $215,879 in the West.

Why the big difference in regional pay? Most experts attribute it to the fact managed care penetration is not as extensive in Southern states, while there is relatively less competition among groups for patients. ■

# Inflating MD expertise could add to legal woes

*Court backs misrepresentation suit*

A recent New Jersey court decision means that physicians who overstate their qualifications place themselves and their personal assets at increased risk in medical malpractice cases, say legal experts.

In March, a Superior Court of New Jersey Appellate Division judge ruled it was proper for a patient to sue his doctor for fraudulent misrepresentation as part of his medical malpractice lawsuit.

The case stemmed from an operation that left a patient a quadriplegic. The plaintiff said his doctor told him before the operation that he was board-certified when, in fact, he was not. The plaintiff also said the doctor told him he had performed that particular operation hundreds of times when, in fact, he had only performed it 11 times.

"It's a significant breakthrough in the law, and it exposes physicians to claims that aren't covered by malpractice insurance," says New Jersey attorney **Bruce Nagel**, who represents Joseph Howard, the patient who filed the lawsuit. "Doctors must be extremely cautious about not overstating their qualifications."

### *Standard of care irrelevant to fraud*

One important ramification of the ruling is that the fraud claim holds doctors to a different legal threshold from a medical malpractice case. Unlike medical malpractice, patients don't have to show that a doctor deviated from the appropriate standard of care to prove fraudulent misrepresentation.

To prove that a doctor fraudulently convinced a patient to undergo surgery, the patient only has to prove that the doctor knowingly made a "material misrepresentation of a presently existing or past fact" with the intent that the patient would rely on it to his or her detriment, the court noted.

The New Jersey court said it was important to let patients bring a separate fraud claim because patients can't give fully informed consent if they don't even know whom they are hiring to perform the operation.

"Even more private than the decision who may touch one's body is the decision who may cut it open and invade it with hands and instruments," wrote New Jersey Appellate Division Judge **Jack Litner**. "If [the doctor] lied about his qualifications and experience, then a jury could find that he misled plaintiff as to the abilities and, hence, the true identity of the physicians who would perform the surgery," the court said.

Even in cases where no medical negligence is alleged, patients could be entitled to sue for and collect damages, because a "jury could award damages for mental anguish resulting from the belated knowledge that the operation was performed by a doctor to whom the patient had not given consent," the court said. ■

# Court: Financial incentive disclosure rests with HMO

*Ruling is a victory for Illinois physicians*

In a major win for physicians, the Illinois state Supreme Court ruled that patients suing physicians for negligence can't also sue them for not revealing payment arrangements with managed care companies.

In fact, the responsibility is on managed care companies to inform their members about any financial arrangements they've made with physicians for their services, the court decided.

The decision is especially important because it denies patients the ability to file lawsuits based solely on a physician's failure to disclose financial incentives. It also takes away a powerful financial incentive argument for awarding higher damages in malpractice cases, note experts.

"If the court had gone the other way, it would have been chaos for physicians," says **LeRoy Sprang**, MD, speaking for the Illinois State Medical Society. "Patients need to understand what the plan offers. But it's the responsibility of the plan to explain that before a patient signs up so they can make informed decisions when they are buying the plan."

### *The difference in this case*

The Illinois case — *Therese Neade v. Steven Portes, MD, and Primary Care Family Center* — was slightly different from other class action lawsuits that have been filed against managed care companies for failing to disclose financial incentives they offer physicians.

Prior HMO-related cases are based on the disclosure requirements in the Employee Retirement Income Security Act. The question at the heart of the Neade case was whether physicians have a fiduciary duty to disclose conflicts of interest, just like a lawyer, real estate agent, or judge.

Therese Neade filed the case after her husband, Anthony, died of a heart attack caused by coronary blockage. She alleged that after her husband complained of chest pain, her doctor ignored the recommendation of another physician who had examined him and recommended he have an angiogram. Another physician also had made that recommendation months earlier.

Instead, the doctor of record relied on hospital tests done about 10 months earlier, including a thallium stress test and an electrocardiogram that were normal.

After Neade died, his widow alleged her husband's doctor breached his fiduciary duty by not telling them his practice group received 60% of any money not used on referrals to specialists.

Had the Neades known that, she said, they would have questioned the doctor's refusal to approve an angiogram and would have sought a second opinion outside of the group.

The Illinois trial court originally threw out the fiduciary duty claim, but the appellate court reinstated it, saying there are times when a plaintiff could bring a negligence and breach of fiduciary duty claim.

The Illinois Supreme Court disagreed, arguing that the breach of fiduciary duty claim duplicates a medical negligence claim because, ultimately, a fiduciary duty claim "would boil down to a malpractice claim."

The court also said the Illinois Managed Care Reform and Patient Rights Act puts the burden of disclosing HMO incentive schemes on the HMO companies.

"Moreover," the court said, "the outcome that would result if we were to allow the creation of a new cause of action for breach of fiduciary duty against a physician in these circumstances may be impractical.

"For example, physicians often provide services for numerous patients, many of whom may be covered by different HMOs. In order to effectively disclose HMO incentives, physicians would have to remain cognizant at all times of every patient's particular HMO and that HMO's policies and procedures." ■

# Medicare reports drop in improper payments

The Health Care Financing Administration (HCFA) is touting the fact that improper Medicare payments to providers fell again last year, dropping to a 6.8% error rate in fiscal year 2000, down from nearly 8% the year before.

These figures are based on the most recent financial audit of HCFA claim payments by the Office of the Inspector General (OIG).

In FY 1996, Medicare's reimbursement error rate was an estimated 14%. The target goal for FY 2002 is 5%.

According to the OIG, virtually all the sampled claims examined in the review were paid correctly by Medicare based on the information that was submitted in the claims. The errors were identified by medical review staff members who researched a sample of claims in patient medical records and found problems with:

— documentation used to back up the claims;

— coding of the services provided;

— medical need for the services;

— the fact that Medicare did not cover the services provided. ■

# A GOP White House doesn't mean compliance breaks

*Bush administration steers a tricky course*

Just because the Medicare payment error rate is down and more provider-friendly Republicans are running the White House, that doesn't mean federal auditors will be going away.

Acknowledging that compliance efforts of the Office of Inspector General and Health Care Financing Administration (HCFA) have had a major impact on reducing payment errors, "problems remain in ensuring providers maintain adequate documentation, properly code claims, and bill only for services that are medically necessary," maintains Acting Inspector General **Michael F. Mangano**. "Continued vigilance is needed to allow HCFA to sustain and build on this progress."

"HCFA has made significant improvement toward assuring proper payment for medical services, but more must be done," adds Health and Human Services Secretary **Tommy Thompson**.

But there may be some good news from inside the Beltway. President Bush's proposed 2002 federal budget includes some $156 billion to reform Medicare and the Health Care Financing Administration.

As part of the GOP's more "provider friendly" approach to regulatory issues, this first Bush budget takes HCFA to task, calling for much-needed management reforms within the agency.

"The Medicare program, with ever-increasing pages of regulations, administrative guidelines and other endless directives issued on a monthly basis, leaves providers and beneficiaries often bewildered and frustrated," according to language in the proposed budget.

"We must not only modernize Medicare's accounting systems, but also make its rules and procedures more understandable and user-friendly," Secretary Thompson recently noted. "If we can make our programs and our coverage easier to understand, we'll be helping physicians and other providers to avoid unintended errors, and we'll help detect deliberate abuses as well."

That's the good news. The other news is that Bush wants to institute a $1.50 fee on all Medicare claims not submitted electronically and on claims that are duplicates or cannot be processed. This would help pay for HCFA's management makeover.

Because President Bush is a middle-of-the-road GOP politician who has cast himself as a "compassionate conservative," he may attempt to reform Medicare and how HCFA manages the program without being perceived as being soft on "waste, fraud and abuse." Therefore, it is just as much in his interest to keep lowering HCFA's reimbursement error rate as it was in the interest of his presidential predecessor.

One way the administration means to do this is by asking for $700 million in FY 2002 (a $20 million increase) to run HCFA's Medicare Integrity Program. This program is designed to pay particular attention to pre-payment claim reviews intended to stop improper payments before Medicare cuts a check, rather than trying to collect an overpayment afterward.

With the added emphasis on prepayment reviews, a good way to avoid getting your claim bumped back to you is to make sure each bill undergoes the same basic check for obvious errors that government computers look for in their first-level edits before your bill is sent to Medicare.

Items these initial pre-payment edits look for include:

— Is the provider or beneficiary ID number correct?

— Does the patient have other insurance that should pay?

— Do procedure codes match the place where the service was provided?

— Do procedure and diagnostic codes match?

— Are the diagnostic codes complete and fully documented?

— Have any services been unbundled and billed separately that should be part of a global fee?

Additionally, HCFA will employ these initiatives in an attempt to continue to cut Medicare's improper payment rate over the next year:

• **Target program vulnerabilities.** Since 1999, HCFA has used special contractors with program integrity experience to target problem areas, such as reviewing claims for therapy services and developing data analysis centers to identify and stop payment errors and possible fraud.

• **Develop contractor-specific error rates.** Last year, HCFA began developing error rates for each of the private insurance companies that pay Medicare claims to better target their education and program integrity efforts. These new measures are expected to prompt contractors to more closely scrutinize claims to avoid high erroneous payment profiles. The first contractor-specific rates are expected in 2002.

• **Improve customer service.** As part of the "kinder and gentler" HCFA, the agency is expanding efforts to improve the customer service provided by claims-processing contractors to ensure that they provide accurate, reliable, and relevant information about Medicare coverage and billing to physicians.

• **Expand education and outreach.** HCFA will continue to expand its education efforts to help doctors, hospitals, and other providers learn how to properly file and document claims. HCFA already provides free information, educational courses, and other services on the Web through the Medicare Learning Network at www.hcfa.gov/medlearn.

• **Clarify documentation guidelines.** This year, HCFA will test new guidelines for physicians who provide evaluation and management services to patients. The guidelines are designed to ensure Medicare pays claims appropriately while minimizing the paperwork burden for doctors.

• **Tighten provider enrollment review.** Look for HCFA to issue new procedures designed to help spot unqualified providers and prevent them from getting into the Medicare program in the first place, which in turn will reduce bogus billing schemes.

One new wrinkle to beware of was mentioned by **Gail Kursh**, head of the Justice Department's Health Law Section, at a recent meeting of the American Bar Association. Kursh told the meeting that the department is taking a closer look at antitrust issues inherent in "over-inclusive" groups of providers or individual physicians that are not clinically integrated in some manner but who work together to negotiate managed care contracts.

"This is conduct that raises serious concerns within the division, and we will continue to scrutinize it carefully," she said.

Another priority area of investigation at the Justice Department is the continuing consolidation among managed care plans and HMOs and the effect this has had on the power of a plan to suppress physician prices. ■

# Understand the basics in your employment contract

*Nail down the details*

In developing an employment contract, the first order of business is to get everything discussed and agreed upon in writing and make sure your lawyer reviews all documents before signing, advises Boston health care attorney **Lee Dunn**.

Whether a resident looking for a first-time job or a seasoned practitioner, here are some physician employment contract basics Dunn presented at the American College of Physicians-American Society of Internal Medicine conference, held March 29-April 1 in Atlanta:

• **Employment status.** Does your contract make you an independent contractor or an employee? That affects your tax planning and determines who pays legal fees and judgments if you are named in a malpractice suit. (If you're an independent contractor, you will be on the hook unless you have a clause guaranteeing the practice will pay such costs.)

• **Pay.** It may seem obvious, but what — and how — you are going to be paid needs to be spelled out. This means you'll need to analyze the group's compensation package carefully and determine what it means in terms of your specialty and career/personal needs. Another point to consider is determining when the regular salary paydays are as well as other payout dates for bonuses, risk pool distributions, etc.

*(Continued on page 91)*

Physician's Coding Strategist™

# Analysts begin making the case for APCs

*How will they compare to DRGs?*

Now that ambulatory payment classifications (APCs) have been in place for the outpatient prospective payment system, some analysts are comparing them favorably to the diagnosis-related groups (DRG) system for inpatient services. Others, however, aren't so sure about the way to go.

The real question is whether payers will follow the lead of the Health Care Financing Administration (HCFA) and use a system similar to APCs, says **Dean Farley**, PhD, vice president of health care policy and analysis for HSS, Hamden, CT. "Certainly we are seeing some of that now. A number of payers are looking at APCs and similar types of payment vehicles," Farley notes.

> Because outpatient hospital care is often only part of an entire episode of care, the technical and data issues of APCs are more daunting for HCFA.

Payers who are accustomed to the benefits of the DRG system may be disappointed if they put into place an outpatient prospective payment system similar to HCFA's. "The DRG system was pretty sophisticated, probably more than APCs at this point," he says. "I am interested in how private payers will respond once several of them get the payment system in place and realize that many of the benefits of inpatient payment systems don't carry over. I don't know whether they will continue to adopt that system or look at other strategies."

The DRG system created incentives for the hospitals by bundling services together in packages, but HCFA has not made an effort to revisit this issue with APCs, Farley says.

"DRGs gave a single payment for an entire hospital stay. They gave hospitals a great deal of latitude in terms of how they chose to treat that patient. That's where you get incentives to improve efficiencies," he says. "With APCs, the hospital is basically paid for each individual service — not bundled together in treatment categories."

### To bundle or not to bundle?

Because outpatient hospital care is often only part of an entire episode of care, the technical and data issues of APCs are more daunting for HCFA, Farley says. "I think HCFA will want to move in the direction [of bundling] even though MedPAC [the Medicare Payment Advisory Commission] has argued that HCFA shouldn't go with the straight fee-schedule type of arrangement for hospital outpatient services."

One analyst, however, says bundling services would not properly and adequately reimburse a hospital. "When you go to a bundled, single APC per encounter, then the reimbursement level has to reflect the average for all those types of cases that could be included in that bundle," says **Lamar Blount**, CPA, FHFMA, president of Healthcare Management Advisors in Alpharetta, GA.

The risk would be that providers would try to gain by doing fewer of the things that could have been included in that single encounter, he continues. The provider, for example, could have the

## Coders will be in increasing demand

*But can technology take over coding functions?*

Coders will be more in demand than ever in the future, says one industry analyst. New technology, however, threatens to turn that demand in the opposite direction.

"There are a couple of forces that are at work right now that have long-term implications on the role of coders," says **Lamar Blount**, CPA, FHFMA, president of Healthcare Management Advisors in Alpharetta, GA. First, with the conversion to ambulatory payment classification methodologies for outpatient hospital reimbursement and prospective conversions that Medicare has made for other providers, the demand for coders is higher than ever and still increasing.

"Hospitals that once felt that the majority of what they do could be controlled through coding, driven through the Chargemaster, are realizing that they still need a professional coder to be sure about many more of the types of services that previously were not affected at all by the accuracy of the codes," he says.

On a negative note, advancements in voice recognition technology and the increasing accessibility of computerized records and transcription may allow codes to be automatically determined by the system, as opposed to a human reading a record and developing a code, Blount says. He expects this kind of technology to be adopted first in larger institutions and medical schools and universities. As that technology becomes more affordable, then smaller, medium-sized providers might be next. "Over the long term, I expect in more than five years that the demand for coders will decline."

### *Technology will drive complexity*

Blount expects coding to also become more complex. "The continuing advances in medical technology means there are more tests and procedures than we have had available in the past. All of those require codes."

For example, coders who once knew every possible X-ray code have had to learn CT and MRI procedure codes, too, as those procedures have become more common. "That analogy will continue to work throughout the industry." ■

patient return at some other time for care that could have taken place in the first visit.

The current system is also beneficial and convenient for patients, Blount says. "They can take less time from work to be able to come in and have more than one thing done in an outpatient encounter."

In addition, there is too much diversity between hospitals and from patient to patient to make a single APC system for the entire outpatient encounter work well, Blount says. "[The current system] results in a more appropriate reimbursement that recognizes the differences between patients and between facilities in terms of the extent of services that could occur within a single patient encounter."

For example, some patients may see three or four different clinics within an organization, he says. "If that was not generating a single, distinct APC for each of those types of services, then that type of organization would likely be severely financially hurt by going to an all-inclusive bundle situation in which each patient encounter has one APC."

> "By law, we are seeing weights and categories changing every three months. That's a very fast pace for the providers to have to keep up with, just from a management perspective."

The frustration with APCs is that many providers were not prepared to cope with the system. HCFA acknowledged that it wasn't prepared to cope at that point either, Farley says.

Providers' ability to cope with the system will not improve if the outpatient prospective payment system continues to churn at the rate it is churning now, he adds. "By law, we are seeing weights and categories changing every three months. That's a very fast pace for the providers to have to keep up with, just from a management perspective."

Providers are also seeing changes in reimbursement policy that are being made on the fly, Farley says. "These changes are being made through program memoranda, not through regulations. In some cases, they are not being made explicit."

In addition, providers often find surprises in HCFA's Outpatient Code Editor. "The changes are not being well-articulated. The providers are trying to hit a moving target, and they don't necessarily even know what that target is," he says. **(For information on the increased demand for coders, see p. 88.)**

In a worst-case scenario, the outpatient prospective payment system will lose support if the pace of the changes and the lack of communication about them continue. "It will also be difficult for HCFA to figure out how to rationalize the system," Farley predicts. "They won't have a stable system that they can analyze and understand."

If the situation does change, however, providers might find a system they could embrace. "The providers could recognize the importance of the payment that they are creating and invest in their outpatient coding as they haven't in the past."

### A whole new system

Based on the history of DRGs, Blount says there is a reasonably good chance that the government will only tinker with APCs for at least 10 years. However, he does see the chance that the federal government could go to an all-capitated system. "Just as it pays HMOs on a capitated basis, it could do the same with the rest of the providers," Blount notes. He says such a change in reimbursement could reasonably occur sometime in the future, but he doesn't see that happening any time soon.

Farley says he expects a continued movement toward code-based reimbursement. The Balanced Budget Act (BBA) of 1997 put Medicare on the path to prospective payment — fee-schedule, code-based reimbursement, he says. This reimbursement is driven by diagnostic procedure codes on the bill for virtually all Medicare services. "Once the BBA is fully phased in, those payment systems will cover 99% of the Medicare dollar. I think is inevitable that Medicare will continue to move in that direction, although not as quickly as originally envisioned." ■

# New review medical criteria published

*19 items can be audited quarterly or annually*

Knowing what constitutes medical record completeness this year according to the Joint Commission on the Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, doesn't have to be a guessing game. The organization recently released its "2001 Medical Record Review Summary Sheet," which outlines 19 items that the Joint Commission requires to be included in an ongoing review of medical records. The sheet also includes ways to document any performance improvement initiatives that providers began to address their findings. **(See the "2001 Medical Record Review Summary Sheet" on p. 90.)**

### Process improvement must be shown

For a provider to be compliant with Joint Commission standards, the medical record review must be ongoing, with audits conducted on a quarterly or annual basis. If conducted on a quarterly basis, the quarterly results should be made available to the Joint Commission, and activities to address improvement should be evident. If the audits were conducted annually, the providers would need to report data from the previous two years to demonstrate process improvement.

Joint Commission surveyors will use the form to orient them to the scope of the medical record review activities of the provider for the 12 months prior to the survey. "We are using [the sheet] as a tool to help us evaluate the organization's activities and compliance with Joint Commission standards," says **Janet McIntyre**, spokeswoman for the Joint Commission. The form also lets providers know what the review process is going to be, she adds.

The completed form should be attached to the medical record review material supplied for the Document Review Session, which is a survey activity designed to prepare and orient the surveyors for subsequent survey activities. The medical record review material should include reports or minutes for the 12 months prior to the survey of the group responsible for the review of medical records. ■

## 2001 Medical Record Review Summary Sheet

The following items are required (IM.7.10-IM.7.10.1) to be included as part of the organization's ongoing review of medical records. The review must address the **completeness and timeliness of information** of the items listed. While the review is expected to be ongoing in nature, at least quarterly findings for the review process should be available and activities to address improvement evident. The 19 items can be reviewed each quarter or on an annual basis. If they are reviewed each quarter, quarterly findings need to be reported. If the 19 items are reviewed on an annual basis, then the data from the previous two years need to be reported to assure a performance improvement approach to ongoing record review. This form will be used by the surveyors to orient them to the scope of the medical record review activities of your organization for the twelve months prior to survey. The completed form should be attached to the medical record review material supplied for the Document Review Session (the document review session is a survey activity designed to prepare and orient the surveyors for subsequent survey activities). Such material should include reports or minutes for the twelve months prior to survey of the group responsible for the review of medical records.

| **Were the following items included in the review of medical records during the twelve months prior to survey?** | **Findings (Numerator/Denominator)** | | | | **Performance improvement initiative to address findings if appropriate.** |
|---|---|---|---|---|---|
| | **Q 1/D1** | **Q 2/D2** | **Q 3/D3** | **Q 4/D4** | |
| Identification data | | | | | |
| Medical history, including<br>- chief complaint<br>- details of present illness<br>- relevant past, social & family histories<br>- inventory by body system | | | | | |
| Summary of the patient's psychosocial needs as appropriate to the patients age | | | | | |
| Report of relevant physical examinations | | | | | |
| **Were the following items included in the review of medical records during the twelve months prior to survey?** | **Findings (Numerator/Denominator)** | | | | **Performance improvement initiative to address findings if appropriate.** |
| | **Q 1/D1** | **Q 2/D2** | **Q 3/D3** | **Q 4/D4** | |
| Statement on the conclusions or impressions drawn from the admission history and physical examination | | | | | |
| Statement on the course of action planned for this episode of care and its periodic review, as appropriate | | | | | |
| Diagnostic and therapeutic orders | | | | | |
| Evidence of appropriate informed consent | | | | | |
| Clinical observations, including the results of therapy | | | | | |
| Progress notes made by the medical staff and other authorized staff | | | | | |
| **Were the following items included in the review of medical records during the twelve months prior to survey** | **Findings (Numerator/Denominator)** | | | | **Performance improvement initiative to address findings if appropriate.** |
| | **Q 1/D1** | **Q 2/D2** | **Q 3/D3** | **Q 4/D4** | |
| Consultation reports if applicable | | | | | |
| Reports of operative and other invasive procedures, tests, and their results if appropriate | | | | | |

*Source:* Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

(Continued from page 86)

**Tip:** Before agreeing to a deal, have your lawyer or accountant examine the practice's billing-to-collection ratio to get an idea of its financial health. If the ratio is low, the group may be on the verge of a cash flow crisis.

- **Benefits.** Does your health policy cover pre-existing conditions? How are vacation days and times determined?
- **Work hours.** Does the contract specify the minimum and maximum number of hours you'll be expected to work in a week or month? What is the practice's policy on call duty and contingency plans for covering other physicians?
- **Restrictive covenants.** Can you live with any covenants in the contract designed to prevent you from competing head-on with the group should you leave?
- **Termination.** Does the practice want to retain the right to fire you without reason or cause, or do certain conditions have to be met first? Are you being asked to sign away your due process rights to examine evidence, confront witnesses, or examine charges against them during disputes?
- **Education.** Are continuing medical education classes taken on your time or the practice's time? Will you be paid for study and test time when have to renew your license?
- **Outside activities.** "If you want to continue to do something that's very important to you, get it in the contract," says Dunn. ■

# One size doesn't fit all in molding the right practice

*Research shows points of diminishing returns*

Size does matter when it comes to the particulars of your practice. At least that's the conclusion of recent research sponsored by the Englewood, CO-based Medical Group Management Association on the optimum number of doctors in a practice.

According to **Jonathan D. Ketcham**, a PhD candidate at the University of Pennsylvania's Wharton Business School in Philadelphia, once a medical group grows beyond 10 physicians, its operating efficiency drops dramatically.

Ketcham determines a practice's efficiency quotient by dividing the practice's total operating costs by the relative value units (RVU) it bills.

He concluded that for practices logging around 100,000 RVUs annually, optimum efficiency is reached once a group hits $23 in operating costs per RVU. These optimum practices tended to contain from three to 30 physicians, with an average size of approximately 10 doctors.

Despite the fact about two-thirds of self-employed physicians are in practices with one to three doctors, because of the inherent inefficiencies of these smaller practices, overall practice productivity is hard to improve by just adding another doctor, the study concludes.

To reach optimum economies of scale, the group must get big enough to free doctors to just see patients, while generating enough business to justify adding more nurses, front-office staff, and billing and collections experts.

On the flip side, the study argues these economies start diminishing once a practice expands beyond a certain size. This usually happens once it starts creating satellite offices that require more staff compared to patient volume at its main location.

However, while statistically less efficient, larger practices still tend to pay better. According other data from the MGMA, average physician compensation tends to be highest in practices with 50 or more doctors. ■

# Who does your billing? Key questions to ask

*Survey shows in-house billing may be best*

One of the questions you need to ask when looking for ways to manage your practice more efficiently is whether you should try to perform routine tasks like billing and collections, generating statements, and processing payroll by hiring extra office staff or outsourcing these tasks to vendors.

There are four basic factors to consider when deciding whether or not to outsource a function like billing, says **Elizabeth Woodcock**, FACMPE, an Atlanta-based health care consultant and a member of the American College of Medical Practice Executives. They are:

- **Control.** "Do the physicians have the ability to control the quality of the outsourcing product or service?" asks Woodcock. This is especially

important with billing, a process for which physicians are responsible whether it is managed in-house or at an outside billing service.

• **Performance.** Will the quality of the outsourcing service be equal to or better than what's being done in-house? For something like billing, one way to measure the performance of an outside service against in-house staff is to compare the two based on three critical indicators: accounts receivable over 120 days, days in accounts receivable, and adjusted collection rate. All other things being equal, if the vendor does better at these tasks than your current in-house staff, you may want to contract out your billing function.

• **Communication.** How well does the contractor understand your practice, anticipate problems, and respond to your questions? What has been the experience of other practices that have used the contractor's services?

• **Cost.** Is the cost of the product or service at least equal to — and preferably less than — the cost of managing the product or service in-house? Typically, billing costs range from an average of around 4% of revenue for surgery practices to 8% for primary care and most specialists.

According to the Medical Group Management Association (MGMA) in Englewood, CO, just 13% of all medical groups outsource their billing function. Of the groups with superior record of accounts receivable performance, only 3.23% use an outside billing service, notes the MGMA. ■

# Physician panel targets top regulation headaches

*Group will work with HCFA on relief*

After nearly three years of work, the Physicians' Regulatory Issues Team, an independent panel of doctors, has presented the Health Care Financing Administration (HCFA) with a list of 15 areas it says are ripe for regulatory reform and relief.

Top topics on the hit list include:

• **Advanced beneficiary notices.** The panel says these are often confusing to both patients and physicians and may be in direct conflict with the Emergency Medical Treatment and Active Labor Act.

• **Certificates of medical necessity.** A survey by the American Medical Association found that 39% of physicians say these pose the single greatest Medicare headache.

• **Coverage rules for follow-up visits for cancer patients.** The panel claims that Medicare often refuses payment for these visits because carriers classify them as "routine screenings."

• **Coverage of preoperative evaluations.** These evaluations are also frequently denied for falling under "routine screenings."

• **Laboratory services.** These are subject to differing local carrier medical review and coverage policies.

"These aren't the entire universe of potential issues a physician might have with Medicare regulations," notes **Barbara Paul**, MD, director of the physician panel. "But they are some of the most important day-to-day issues which, if properly addressed, can improve physicians' ability to care for their patients."

The next step in this regulatory relief exercise is for the panel to create working groups with HCFA staffers to start reviewing these top five topics. "Our goal is to take on these five topics right now then add other issues as we can," says Paul. ■

# New administration OKs HIPAA privacy rules

*New major changes added*

The Bush administration announced on April 12 that it will not make major changes to the delayed Health Insurance Portability and Accountability Act final privacy rule. Here are the basics:

• **Who's affected:** The regulation covers health plans, health care clearinghouses, and health care providers who conduct financial and administrative transactions like electronic billing and funds transfers.

• **What's protected:** All medical records and other individually identifiable health information held or disclosed by a covered entity in any form.

• **Disclosure:** Providers must give patients a clear written explanation of how they can use, keep, and disclose their health information. Patients must be able to see and get copies of

their records and request amendments. You must also give patients a history of disclosures.

• **Consent:** Providers must obtain patient consent before sharing their information for treatment, payment, or health care operations purposes. Patient consent also must be given for non-health care purposes such as releasing information to financial institutions or their employer or for selling names to mailing lists. Providers cannot condition treatment on a patient's agreeing to disclose health information for non-routine uses. However, this does not apply to the transfer of medical records for treatment purposes because primary care physicians, specialists, and other providers need access to the full record to provide the best quality care.

• **Security.** Providers must adopt written privacy procedures that include who has access to protected information, how it will be used within the entity, and when the information would or would not be disclosed to others. They must also take steps to ensure that their business associates protect the privacy of health information. ■

# Premium increases spur ways to cut costs

*Innovative plans being developed*

The fact that insurance premium prices jumped an average of 10.3% last year across all kinds of health plans — HMOs, preferred provider organizations, point-of-service, and indemnity — has encouraged both corporate and government policy-makers to search for ways to cut medical costs.

According to a recent survey by Watson Wyatt Worldwide, a Washington, DC-based consulting firm, the most popular reaction to skyrocketing plan payments has been to pass on part or all of these premium hikes to workers (71%).

On the policy front, a combination of business and medical groups is quietly working to build a political foundation to pitch so-called "defined contribution" health plans as a way to limit future corporate health care costs.

The basic idea behind the defined contribution approach is to shift the responsibility, payment, and related risk of selecting and maintaining health benefits from employers to employees.

For instance, a firm could agree to continue to contribute a certain amount of money in the form of a voucher that employees would use to negotiate for and buy their own health coverage, says a company report on the survey.

Some benefit experts also contend that a defined contribution health program could be modeled after Section 125 cafeteria plans that allow employers to allocate plan assets to a variety of services, including health care, dependent care, and life insurance.

"As managed care becomes more complex, health care costs continue to rise, and technical innovation in the medical area advances, some employers may find defined contribution-based benefits increasingly attractive," notes **Dallas Salisbury**, president of the Employee Benefits Research Institute in Washington, DC.

In recent months, Blue Cross of California and Myhealthbank Inc. in Portland, OR, have introduced modified versions of defined contribution health plans targeted to smaller businesses.

**Dave Sanders**, MD, CEO of Myhealthbank, calls his company's program a "first step toward moving the economic control from employer to employee."

Under the Blue Cross plan, small firms pay a fixed amount in health care premiums per month. Employers can pick any amount they want to contribute to employee health premiums above the minimum floor of $100 per employee per month.

Employees, in turn, are permitted to pick their care from any of Blue Cross of California's eight PPOs and two HMOs.

Premiums range from $65 per month for a bare-bones plan to $200 a month for the one with the most comprehensive benefits.

Employees pay the premium difference if they choose a plan that costs more than what the employer is paying each month, or they can pocket the difference if the plan costs less.

Myhealthbank has teamed up with Regence BlueCross BlueShield of Oregon to offer a similar plan to small businesses in Oregon.

As in Blue Cross of California's defined contribution product, employers who sign up for the Myhealthbank program pay a flat fee per employee, with employees picking up any difference between what their company pays and the cost of the plan they pick.

The big difference is that unlike Blue Cross of California, Regence limits the range of plans employees can select to join on the premise that this reduces confusion. ■

# Tips for taking the breath away from whistleblowers

*Learn the settlement process*

Here are 10 good tips from **Lynn Shapiro Snyder**, an attorney with Epstein, Becker & Green in Washington, DC, for you to follow if you're ever faced with a lawsuit by a False Claims Act whistleblower:

**1. Handle that knock at the door properly.** Educate employees about what to do should a federal or state government investigator literally show up at their home asking questions about the practice.

**2. Document contractor advice/contacts.** Document any advice you get from Medicare contractors. Make sure billing personnel keep a log of all contacts with government agencies and fiscal intermediaries/carriers, including a notation of whether the contact was oral or written.

**3. Contact former employees.** If the whistleblower is a former employee, contact other former employees who might have had contact with the whistleblower for any information about the potential allegations, and ask if they will agree to notify you should they be contacted by the government.

**4. Get human resources into the act.** Train your HR personnel or office manager to help identify disgruntled employees who leave the company and who might have a "compliance ax to grind," and teach HR to be sensitive to the idea that a "righteous indignation resignation" might be a sign of future trouble, says Snyder.

**5. Focus on the allegations.** Don't spend all your time trying discredit the whistleblower to the government (even if that may be justified). Instead, work to show the allegations have no merit.

**6. Get everyone on board.** Once the government intervenes, make sure they and the whistleblower have come to their own agreement about the relator's share of any settlement. This can speed up your negotiations with federal agents.

**7. There's no such thing as too much compliance training.** Make your office compliance training "frequent, fun, and informative," says Snyder. Also, strive to ensure that it covers the latest hot topics in compliance.

**8. Learn about the settlement process.** Read an entire set of settlement documents to familiarize yourself with the various options involved in the process. Ask yourself, "How would I have handled that situation?"

**9. Don't be myopic.** Pay attention to the types of settlements — or have your lawyer do it — to identify areas where your practice may be most vulnerable, then upgrade your compliance efforts accordingly.

**10. Use pre-employment agreements.** Have new providers and other employees who deal with sensitive financial and claims-related information sign a written employment agreement waiving their rights to a financial recovery if they file a whistleblower lawsuit. Warning: This kind of agreement may not be enforceable in some states. ■

## Reimbursement ROUNDUP

# Coverage extended to intestinal transplants

*Procedure available at three centers*

Medicare has approved coverage of intestinal transplants for beneficiaries with irreversible intestinal failure. These procedures will be available at three transplant centers recently approved by Medicare.

The transplant centers approved by Medicare to perform intestinal transplants are the University of Pittsburgh Medical Center, Jackson Memorial Hospital Transplant Center in Miami, and The Mt.

**COMING IN FUTURE MONTHS**

- Going through the process of determining your practice's value
- Tips for coding 'incident to' procedures
- Improving your practice's collections
- Clarifying preventive care coding
- Clean claim laws

Sinai Hospital in New York City. To qualify, centers must have performed 10 transplants per year with a one-year actuarial survival rate of 65%.

Patients who have total intestinal failure must receive their nutrients intravenously, a procedure called total parenteral nutrition (TPN). However, patients often are not able to tolerate long-term TPN because the process may cause liver failure, the patient's veins become clotted, the lines to deliver the nutrients become infected, or the process causes severe dehydration.

Intestinal and multi-visceral transplantation restores intestinal function in patients with irreversible intestinal failure who cannot tolerate TPN. The procedure can be performed on the small bowel alone or in combination with various parts of the digestive tract, such as the liver, stomach, pancreas, or colon.

Intestinal transplantation is a relatively new technology that has been pioneered in this country primarily at the University of Pittsburgh School of Medicine. Fewer than 1,000 transplants have been performed in the United States, with approximately two-thirds of the patients being children. ▼

# Medicare now covers carotid artery angioplasty

*Surgeons must follow FDA protocol*

The Health Care Financing Administration (HCFA) has added angioplasty of the carotid artery with stent insertion, a new treatment option for the prevention of stroke, to its Medicare coverage.

The treatment, however, is only covered when percutaneous transluminal angioplasty of the carotid artery is performed along with the placement of a carotid stent furnished in accordance with a Food and Drug Administration-approved protocol governing category B Investigational Device Exemption trials.

"It's important to make new technologies in health care available to Medicare beneficiaries," says Health and Human Services Secretary **Tommy Thompson**. "Older Americans are especially vulnerable to stroke, and we believe this may help prevent stroke in high-risk patients."

Stroke is the third-leading cause of death in the United States and the leading cause of serious, long-term disability. Approximately 70% of all strokes occur in people ages 65 and older.

The carotid artery is located in the neck and is the principal artery supplying the head and neck with blood. The accumulation of plaque in the carotid artery can lead to stroke either by decreasing the blood flow to the brain or when plaque breaks free and lodges in the brain or in other arteries to the head.

The new procedure involves inflating a balloon-like device in the narrowed section of the carotid artery to re-open the vessel. A carotid stent, a small, metal mesh-like device, is then placed in the artery to prevent it from closing and from allowing pieces of plaque to enter the bloodstream.

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

## Subscriber Information

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

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



Editor: **Larry Reynolds**, (202) 347-2147.
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcpub.com).
Managing Editor: **Robin Mason**, (404) 262-5517, (robin.mason@ahcpub.com).
Production Editor: **Brent Winter**.



**Editorial Questions**

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

AMERICAN HEALTH CONSULTANTS
THOMSON HEALTHCARE

"This is a promising new technology that may eventually be proven to prevent stroke in certain high-risk patients who would not be amenable to surgical removal of plaque from an obstructed carotid artery," says **Jeffrey Kang**, MD, director of HCFA's Office of Clinical Standards and Quality and the agency's chief clinical officer. "What we learn from this coverage decision also will help us consider this therapy as an alternative for other patients at risk for stroke."

The current standard of care for obstructed carotid arteries is carotid endarterectomy, a surgical procedure that involves opening the artery and manually removing the plaque. ▼

# Medicare reimburses for home health assessments

*Policy is new for 2001*

If you haven't done so already, now's the time to update your files to note that Medicare now pays physicians a separate fee for activities involved in certifying and recertifying a patient's home health care plan.

**Brett Baker**, a reimbursement expert with the American College of Physicians-American Society of Internal Medicine, says you must use the following HCFA Common Procedure Coding System codes to bill for these services:

• Use code G0180 when certifying physician services for Medicare-covered services provided by a participating home health agency (where the patient is not present). This includes reviewing patient responses to an Outcome and Assessment Information Set assessment, reviewing initial or subsequent reports of patient status, contacting the home health agency to ascertain the initial implementation of the care plan, and documentation in the patient's office record, per certification period.

• Use G0179 when recertifying home health agency patients. The initial certification code, G0180, must be used when patients have not received Medicare-covered home health services for at least 60 days. Recertification code G0179 must be used when patients have received covered home health services for at least 60 days and when the physician signs the certification after the initial certification.

To justify these services, you'll need to describe and document in the patient record what you did to decide if the home health care plan was appropriate — or if the proposed care plan needs to be modified to better meet the beneficiary's needs. "As a precaution, keep a copy of the approved care plan in the record," advises Baker.

Medicare does not require physicians to submit medical record documentation with the claim for these services. However, be prepared to provide supporting documentation if requested.

Medicare pays $73.08 for physician certification of a patient care plan (G0180) and $61.23 for recertification (G0179). These payment rates represent the national average. Payments vary slightly by geographic area.

Previously, Medicare did not reimburse separately for certifying or recertifying a patient's care plan. But "because these services were included in the 2001 Medicare physician fee schedule, physicians can be paid for services that they could not bill separately in the past," Baker notes.

As a result of these changes, you are no longer able to count time spent approving or revising a patient home health care plan as part of the 30-minute requirement of billing care plan oversight for a beneficiary's home health services if it relates to certification or recertification. If you do spend 30 minutes or more on care plan oversight of a home health patient, this time should be reported using G0181. ■