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Feds shine investigative spotlight on relations with drug companies

'Marketing the spread' practice getting attention

Medical practices need to review their dealings with prescription drug manufacturers and marketers as federal investigators take a closer look at the relationship between pharmaceutical companies and providers for potential cases of fraud and abuse.

"Drug marketing is the next wave of health care fraud-related investigations and prosecutions," says **Michael D. Geldart**, an attorney in the St. Petersburg, FL, law office of Holland and Knight.

Federal law enforcement officials are ready to enter "a new and more aggressive phase" of fraud investigations and enforcement actions against pharmaceutical companies and physicians when it comes to drug marketing and pricing practices, agree **Michael E. Anderson** and **Keith D. Lind**, attorneys in the Washington, DC, office of Holland and Knight.

One focus is on gathering evidence about a specific pricing practice known as "marketing the spread." This is a business strategy that involves discounting prices to physicians to increase the manufacturer's market share.

"If these investigations grow into an all-out attack on this pricing practice, both manufacturers and physicians may have to overhaul their drug marketing and purchasing practices," warns Anderson.

While Medicare does not cover the cost of most outpatient drugs, it does cover the cost of drugs that cannot be self-administered and are furnished incident to a physician's services.

"Typically, these are drugs that require supervised intravenous administration in a physician's office or clinic," notes Lind.

Medicare pays for covered drugs at the lower of either the amount billed or 95% of the "average wholesale price" (AWP). AWP is typically a function of the manufacturer's suggested price, rather than an empirically derived statistical average of actual market prices.

Most manufacturers sell drug products to physicians at a discount

from AWP — sometimes a substantial discount. Meanwhile, current Medicare rules permit physicians to bill for these drugs at 95% of AWP, no matter what the drug costs the practice. Taking advantage of the difference between the physician's purchase price and the amount that a doctor is permitted to bill Medicare for is "marketing the spread."

While Congress, the Inspector General, and the Health Care Financing Administration have all investigated this practice and are considering moving against it, it is not currently illegal, say Anderson and Lind.

However, the Department of Justice appears to be taking the position that a deliberate manipulation of the price spread between AWP and the discounted price paid by physicians violates the laws and regulations governing billing for goods and services covered by federal programs, such as Medicare.

"It is not yet clear whether enforcement authorities are seeking to prosecute such activities under novel theories of civil or criminal liability or are investigating whether these practices amount to kickbacks based on existing enforcement theories," notes Lind.

However, the offering or providing of discounts, rebates, and free products for the purpose of inducing the referral of business, including the increase of business in an established relationship, could violate the Medicare and Medicaid anti-kickback rules, unless protected by a safe harbor, he warns.

Moreover, if such pricing arrangements are considered to be kickbacks, providers could face civil and criminal liability under the False Claims Act.

"With respect to marketing the spread, there are plenty of cases where drug manufacturers deliberately lowered the price of their drug so using it could be more profitable to a physician than a competitor's drug," observes Anderson.

Similarly, investigators are looking into allegations that manufacturers have artificially inflated the AWP to increase the profit physicians could pocket as a way to generate greater use of certain drugs.

Additionally, manufacturers have allegedly offered physicians free drug products that practices later resold for a profit. Some manufacturers have even linked receipt of these free drug samples to a physician's actual switching of patients from a competitor's drug to their drug. In at least one case, a physician has admitted to federal investigators that he demanded a free drug sample as a quid pro quo for each patient that he switched to the manufacturer's drug, says Anderson. ■

DOJ official spells out possible targets

Physician freebies to get scrutiny

Assistant U.S. Attorney **James Sheehan** recently told a gathering of the American Health Lawyers Association that his office is looking to prosecute cases involving such physician-pharmaceutical company arrangements as:

- drug "education" programs that are really nice lunches and dinners that drug representatives sponsor for physicians (and sometimes even for their staffs);
- free "gas and go" service station privileges for physicians;
- "educational" honoraria or "study" grants that place few or no requirements on the physician to get and / or keep them;
- gifts of professional sports tickets, golf rounds, and trips to vacation resorts;
- free drug samples that physicians then resell;
- "independent" speeches that a drug company writes and then pays the physician to present.

Sheehan also noted that under a 1994 special fraud alert from the Office of the Inspector General covering prescription drug schemes (59 *Fed Reg* 65,372), items such as frequent flyer programs, conversion payments, and "research grants" to physicians may violate federal anti-kickback laws.

"The federal government is also studying how to go after drug companies when Medicare does not pay" for the prescription, says **Michael D. Geldart**, an attorney in the St. Petersburg, FL, law office of Holland and Knight.

According to Geldart, some prosecutions might occur in instances where a prescription is paid for by private insurance. Investigators may use laws relating to the payment of anything of value to a physician if it constitutes interstate commercial bribery, a federal crime punishable under the Travel Act. Also, investigators could use the fact that paying anything of value to a doctor is an improper inducement "in furtherance of a health care fraud conspiracy," he notes.

The federal government is also focusing on drug manufacturer marketing programs, warns Geldart.

One specific area to watch is any approach by drug representatives to use or recommend any of their products for reasons other than those specified on the label.

In 1999, Genentech, a biotech firm in San Francisco, paid $30 million in criminal fines and $20 million in civil penalties for improperly promoting and marketing the off-label use of its products to doctors, hospitals, and other health care facilities. ■

Improper Medicare payments continue to drop

6.8% of payments now in error

Improper Medicare payments to doctors, hospitals, and other health care providers in fiscal year 2000 continued to fall, notes an Office of the Inspector General (OIG) report. Medicare's estimated error rate was 6.8% in fiscal year 2000, compared with nearly 8% the previous year, according to the OIG. The goal for FY 2002 is 5% or less.

The error rate has fallen to roughly half of the 14% rate estimated in fiscal year 1996, the first year that the OIG conducted an audit to estimate Medicare's overall error rate.

"HCFA has made significant improvement toward assuring proper payment for medical services, but more must be done," HHS Secretary **Tommy G. Thompson** said. "Our challenge now is to keep improving Medicare's management and to modernize and strengthen the program to ensure that we meet the long-term needs of our seniors and people with disabilities.

"We must not only modernize Medicare's accounting systems, but also make its rules and procedures more understandable and user-friendly. 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."

The fiscal year 2000 error rate represents an estimated $11.9 billion in improper payments out of the total $173.6 billion in fee-for-service Medicare payments, compared with $13.5 billion in fiscal year 1999 and $23.2 billion in fiscal year 1996.

The most common errors included:

— problems with insufficient or inappropriate back-up claim documentation;

— inaccurate coding of the services provided;

— no medical need for the services;

— Medicare did not cover the services provided under the claim. ■

HCFA increases attention on medical necessity

Practices could be liable for bills

As part of its crackdown on fraud and abuse, the Health Care Financing Administration (HCFA) and its local carriers are devoting more energy to determining if practices are following established guidelines regarding the medical necessity of the services they bill for and whether they provide the required documentation.

Medicare's policy says it will only pay for those services and procedures it determines are medically "reasonable and necessary" for diagnostic, treatment and therapeutic purposes.

According to the Medicare manual, if a provider knows or should have known that a specific service was not covered by Medicare, then the provider is financially liable for the cost the provider incurred delivering the service.

But, if it is determined the beneficiary knew or should have known the service he or she received was not covered by Medicare, then the beneficiary is ultimately liable.

Tip: Practices must remember to ask patients to sign an advance beneficiary notice (ABN) waiver informing them that a particular service is not covered by Medicare, which means they will be responsible for paying the bill. **(See related story, p. 100.)**

However, if neither the Medicare patient nor the provider knew or could have reasonably been expected to know that the service was not considered medically reasonable and necessary and would not be covered by Medicare, then HCFA is ultimately responsible for paying the claim.

Bottom line: Providers are responsible — and will be increasingly held accountable — for knowing what services are covered and considered medically necessary and which ones are not.

The first step toward protecting yourself from getting struck with denied claims is to stay on top of current Medicare payment policies.

When a new national payment policy is approved by HCFA, individual Medicare carriers are supposed to notify local providers of the change. Carriers are also charged with interpreting national coverage policy and applying these interpretations on a case-by-case basis to the providers they service.

In turn, if HCFA or a local carrier has published a policy, the policy is that the provider "should have known" about the standard before performing the service and submitting the claim, which will probably be denied. However, if it initially slips through the system and is paid, it may still be red-flagged for recovery in a post-payment audit.

If there is no national policy for a specific service or medical circumstance, Medicare carriers can form their own local medical review policy setting coverage criteria and clinical conditions under which they consider certain services reasonable and necessary.

The local carrier is also responsible for informing the appropriate providers of the new policy and its effective date. ■

HCFA unveils changes in advance notice form

New form more physician-friendly

The Health Care Financing Administration (HCFA) is promoting a new advance beneficiary notice (ABN) it says physicians will find easier to use.

The first unofficial reaction from the American Medical Association to the changes is that "HCFA needs to be complimented for the work they did on this," said AMA Trustee **J. Edward Hill**, MD.

The ABN form is used to notify patients that Medicare might not pay for a service recommended by their doctor. Many physicians have had problems with the current form, arguing that its language gives the impression that they recommend medically unnecessary care.

In contrast, the new, one-page ABN form removes existing language that Medicare only pays for medical items and services it feels are "reasonable and necessary."

Instead, the revised ABN says: "Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it."

The proposed form also asks beneficiaries to check a box indicating whether they still want to receive the item or service in question. It also states they can appeal Medicare's decision not to pay for it.

A sticking point still remains with the new form, say some physicians. Specifically, there are conflicts with the Emergency Medical Treatment and Active Labor Act (EMTALA). Under present regulations, physicians must give Medicare beneficiaries the ABN before treatment is provided. However, EMTALA says doctors and hospital staffs can not inquire about a patient's insurance status in an emergency situation before their condition is stabilized.

Besides coding and documentation mistakes, there are three basic reasons Medicare will deny payment:

• Medicare will not pay for non-covered services that have never been covered by Medicare under any conditions. These services include such items as routine checkups and certain immunizations or drugs. Because it is clear the beneficiary is responsible for payment, no ABN waiver is necessary.

• Medicare will not reimburse for services deemed not medically necessary by HCFA or local carriers. In this situation, the beneficiary should sign a waiver of liability in advance, expressly making himself or herself responsible for payment.

Tip: A modifier -GA added to the end of the CPT code indicates to the carrier that the patient has signed a waiver of liability.

• Unbundled services cannot be billed to a Medicare beneficiary. For instance, if a provider gives a patient an injection and performs an evaluation and management (E&M) service on the same day, the physician cannot separately bill Medicare for the E&M and the patient for the shot. HCFA considers the injection to be included in the E&M service payment. Billing the beneficiary separately for the shot would be classified as unbundling, and patients are not responsible for paying for unbundled services under Medicare. ■

Are your fees too low? Here's a way to find out

Using RBRVS to audit your fee schedule

Despite all the talk about fraud and abuse, the fact is that many practices consistently undercharge for services, note reimbursement experts.

To avoid payment hassles with insurers, some physicians knowingly charge less for a certain services than plans allow. More often than not, however, the practice simply has not audited its own fee schedules to ensure they accurately reflect the practice's costs and going market rates.

The current standard is to base your fees on Medicare's Resource-Based Relative Value Scale (RBRVS), which lists how many relative value units (RVUs) each procedure is worth. The advantage of using the RBRVS approach is that it gives you a consistent method for establishing fees that is in line with the approach used by most payers, while also creating a base for your internal management reports. Plus, this approach allows you to track payer compliance based on their permissible allowance.

Steve Dickson, administrator of Village Surgical Associates, a multispecialty group surgical practice in Fayetteville, NC, has developed a simple system to build an in-house RBRVS database to help develop fee schedules and evaluate outside contract proposals.

Spend 25 hours, not $10,000

Dickson says the system is so easy to use that implementation only requires about 25 hours of a clerk's time, a personal office computer, and standard spreadsheet software.

"If I hired an outside consultant to produce a similar database, it would cost about $10,000," he estimates.

With Medicare's RBRVS fast becoming the standard for determining provider reimbursement by both government and commercial payers, "it's imperative that physicians, practice administrators, and office managers develop a better understanding of relative value units and find ways to use them to better manage their operations," insists Dickson.

The first time he costed out the common CPT codes performed by his group using RBRVS, Dickson found fee schedules for about 10% of his practice's procedures where priced too low.

"Some of these procedures were priced as much as 70% to 80% below their actual cost," he recalls.

These underpriced fee schedules are now being slowly raised over a multiyear period to avoid giving patients a case of sudden sticker shock.

"I do not claim this system is perfect," admits Dickson, "but, for the money, I've found it gives you a realistic rough cut of what it costs a practice to perform various procedures." Other uses include pricing fee schedules to evaluate discounted fee for service, percentage of Medicare, or single conversion factor-based proposals, as well as capitated contracts.

How to do it

The basic steps in creating this RVU database are:

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

When it comes to expenses, Dickson likes to include everything, but permits practices the option of excluding physician bonuses or other items.

- **Update RVUs.** Each December, the Department of Health and Human Services publishes an RBRVS update that is available on disk. This disk includes all CPTs, their associated RVUs, the geographical adjustment factors, and the federal register discussion of the Medicare changes for that federal fiscal year. The CPTs and RVUs are in spreadsheet format on the disk, making it easy to download them onto a personal computer.
- **Load data.** Once the practice CPT codes the practice performed and the current geographically adjusted RVUs have been entered into a computer spreadsheet program, key in the number of times each procedure was performed over the one-year period in the cell next to the total RVUs.
- **Total the RVUs for each procedure.** Multiply the RVUs by the annual number of times each individual procedure was performed to obtain the total RVUs associated with each procedure.
- **Total all RVUs.** Sum the total RVUs for all procedures.

• **Determine cost per RBRVS.** Divide the annual expenses by the total RVUs to obtain a cost per RVU.

• **Determine cost per procedure.** Multiply the cost per RVU by the RVUs associated with each CPT to obtain a cost per procedure.

The practice administrator can now use the cost per procedure to evaluate the practice's current fee schedule and determine whether if its charges are in line with costs.

To compute a fee schedule, divide the cost of each procedure by the average reimbursement rate, says Dickson.

"This should result in a number that, when reimbursed at the average rate, will cover at least the practice cost," he notes. "At this point, practices must determine if they want or need to revise their fees, and how fast."

Evaluating managed care proposals

Once you have an accurate fee schedule in place, you can now use your RBRVS data to evaluate managed care contracts.

Here's one method Dickson uses to analyze managed care organization (MCO) contract offers:

• **Identify top procedures.** From the practice medical management system, identify the top 20 to 30 revenue-producing procedures performed within the practice. "I recommend loading the CPT code, description, volume of each procedure performed over a year, and the fee for each procedure into your computer spreadsheet," notes Dickson.

• **Factor in allowables.** Ask the managed care companies for a copy of their allowables as they relate to these top CPT codes. Enter this data into your spreadsheet program, multiplying the allowable by the volume of each CPT.

• **Sum the totals.** Divide the allowable totals by the sum of your practice fees. "The resulting RVU figure is the percentage of charge as it relates to the practice charge, adjusted for volume," notes Dickson.

If the practice's average reimbursement is 75% of charges (less Medicare / Medicaid) and the MCO's allowables result in a reimbursement rate equal to or greater than 75%, "then the contract is probably worth considering, provided other factors in the proposal are acceptable," says Dickson.

However, if average reimbursement is less than 75% of charges, odds are you will end up losing money on this specific proposal. ■

Fee schedule updated? It could cost you

Despite HMOs, it does matter

"Managed care has prompted some physicians to think their fee schedules are no longer relevant," says **David A. Hess**, director of contracting for PMSCO Healthcare Management and Consulting of Harrisburg, PA, a subsidiary of the Pennsylvania Medical Society. However, physician fee schedules remain a very important part of practice management, maintains Hess.

For instance, Medicare and Medicaid health maintenance organization (HMO) contracts and preferred provider organization (PPO) contracts commonly contain a provision to this effect: "Health Plan shall compensate Participating Physician for covered services provided to Members. Participating Physician agrees to accept the lesser of (i) the usual, customary and reasonable charge for the services provided, or (ii) Participating Physician's usual billed charges, as payment in full for the services provided to Member pursuant to this Agreement."

If you review Medicare's reimbursement rates between 1997 and 2000 for evaluation and management code 99213 (Outpatient office visit / established patient / expanded focus / 15 minutes), for instance, you'll find the fee for this code has increased nearly 31% during this time period: 1997 - $34.53; 1998 - $37.71; 1999 - $39.95; 2000 - $45.18.

A $5.18 difference

Based on this, practices that billed the 99213 code and charged $40 for this procedure would be reimbursed $40 instead of $45.18.

Multiply that by the number of times your practice uses this code, and you come up with a significant amount of undercharging for just one service over the course of a year.

What do you do if you discover your fee schedule is underpriced?

• **Don't dramatically raise fees overnight.** If you discover your fees have been too low, don't panic and try to immediately get back to market rates. Most experts recommend you gradually raise your affected rates by about 10% every six months.

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Physician's Coding Strategist™

New observation rules change coding practice

Same-day coding affected

The Health Care Financing Administration (HCFA) has changed its payment policy for situations in which observation care or a hospital admission takes place on the same date as a discharge, notes **Brett Baker**, a payment expert with the American College of Physicians-American Society of Internal Medicine in Philadelphia.

Previously, the CPT coding permitted physicians to use codes 99234-99236 to report hospital admission or observation care on the same date as the discharge, regardless of the total length of stay, notes Baker.

HCFA's new policy, however, allows physicians to use same-day admission and same-day discharge codes, CPT 99234-99236, only with patients who have been discharged at least eight hours after observation care or hospital admission on the same date.

Based on this concept, HCFA has also enacted the following policies:

— To appropriately report CPT codes 99234-99236, your patient must be an inpatient or an observation care patient for at least eight hours on the same calendar date.

— When admitting patients for observation for less than eight hours on the same date, use CPT codes 99218-99220 (initial observation care) and do not report a discharge code.

— When you admit patients for observation care and discharge them on a different calendar date, use CPT codes 99218-99220 (initial observation care) and CPT observation discharge code 99217.

— When you admit patients for inpatient hospital care and discharge them on a different calendar date, use CPT codes 99221-99223 (initial hospital care) and CPT hospital discharge day management codes 99238-99239.

— If you admit someone as an inpatient and discharge him or her less than eight hours later on the same calendar date, use CPT codes 99221-99223 (initial hospital care) for the admission service. Do not bill for the hospital discharge day management service.

— To bill CPT codes 99234-99236 (same-day admission and discharge), you must satisfy documentation requirements for admission to and discharge from inpatient or observation care. You also must document the duration of observation care or treatment status. ■

Five common types of coding mistakes

Expert outlines what to watch for

"Typically, it is newer coders who account for the majority of all coding errors, and usually these mistakes are concentrated in a few specific areas," observes **Hank Vanderbeek** of IRP Inc. (www.IRP.com), a medical coding and reimbursement consulting firm in Billerica, MA.

To reduce mistakes among newer coders, Vanderbeek recommends practices watch for these five common mistakes:

1. Confusing principal diagnosis (PDX) with admitting diagnosis (ADX). Is the condition established "after study" to be chiefly responsible for causing the admission of the patient to the hospital? "This can be the ADX but it is not always so.

The PDX is usually found after work-up or even surgery," he notes.

2. Coding past conditions that have no effect on the patient's current stay. Vanderbeek says coders should only report codes for diagnoses that require one or more of the following: clinical evaluation; therapeutic treatment; further evaluation by diagnostic studies, procedures, or consultation; extended length of hospital stay; or increased nursing care and/or monitoring.

Here's an example: A patient is admitted with a hip fracture. The medical record also mentions a hiatal hernia, which receives no attention or treatment. **Recommendation:** Do not code the hernia.

3. Coding symptoms that are an integral part of the disease process. When a patient is admitted with nausea and vomiting due to gastroenteritis, only the gastroenteritis is coded because nausea and vomiting are symptoms, he says.

4. Not coding from both the alphabetical index and the tabular list. To avoid inadvertent mistakes, first look to the index of the coding manual for the condition or procedures to be coded, then verify the code listed there in the tabular list.

5. Mistaking "not elsewhere classified" (NEC) with "not otherwise specified" (NOS). "NEC is used when the medical condition specifies a condition but no separate code is listed in the alpha index or tabular list," says Vanderbeek. In turn, NOS is used when the information provided does not warrant either a more specific or "other" code assignment. ■

New concerns arise over pneumonia coding

Upcoding initiative is returning

Hospitals hoping the government's pneumonia upcoding initiative had receded into the past should take no such solace. "There was a lull in the action for a good part of last year, but now we are seeing a reawakening in that area," asserts health care attorney **Greg Luce** of Jones Day in Washington, DC.

Luce says the current status of the government's overall pneumonia upcoding initiative, launched last year, is a mixed bag. "We have not seen very many coding investigations that we thought were particularly well-founded," he reports. But he adds that the sometimes "disproportionately large" settlements continue to roll in.

Earlier this year the Columbia Regional Hospital in Kansas City, MO, agreed to pay $359,254 to settle charges that it improperly coded Medicare and Medicaid claims for pneumonia patients who were treated at the hospital between 1993 and 1996.

According to Assistant U.S. Attorney **Andrew Lay**, who negotiated the agreement for the government, the hospital routinely used diagnosis codes for a more complex form of pneumonia than was actually warranted.

In January, Lankenau Hospital in Wynwood, PA, and Methodist Hospital in Philadelphia agreed to pay $303,000 and $103,000 respectively to settle charges that they improperly submitted claims for pneumonia due to "other specified bacteria" when medical records failed to support the diagnosis.

"The government's statistics tend to be less than reliable, and the changes in coding practices are not always attributable to a change in consultants or an effort to recoup reimbursement," Luce argues.

Instead, he says, those changes are often due to appropriate actions taken by hospitals such as a review of charge description masters or the purchase of coding software.

"The government's theory has been that sudden upcoding — such as changing DRG 89 to DRG 79 — can only be attributable to efforts at increased reimbursement without appropriate medical decision making, and that is just not true," argues Luce. The fact is that hospitals routinely downcoded to DRG 89, he maintains, and it was only in about 1992 with the advent of Medicare payment changes that hospitals started focusing on how they were coding.

In short, Luce argues that the incidence of DRG 89 vs. DRG 79 prior to that period is not evidence of anything. "It would not even be admissible as evidence in a lot of courts because the fact that there was a change is subject to too many variables," he asserts.

Luce also challenges the government's notion that the use of consultants renders the increase in coding intensity suspect. "It should be just the opposite," he asserts. "If a hospital had a responsible coding consultant who advised them that [the data] indicate that it should be nonspecified pneumonia, then they should do that.

"I would always challenge the government's

data and reviewers," Luce concludes. "We had a case where the government was relying on a reviewer that did not realize the difference in ICD-9 codes between bacterial and viral pneumonia — and that is pretty fundamental." ■

Trauma codes misused by home health agencies

Relevant medical diagnosis should be reported

A number of home health agencies are incorrectly using the diagnosis codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) when reporting the primary diagnosis for post-surgical admissions on the Outcome and Assessment Information Set (OASIS) and Uniform Billing Form-92 (UB-92), reports the Health Care Financing Administration (HCFA) in Baltimore. The agencies are using diagnosis codes for trauma instead of reporting the relevant medical diagnosis.

These trauma codes, which come from the ICD-9-CM chapter "Injury and Poisoning," are reserved for injuries from accidents and intentional violence. They include categories for fracture (800-829), dislocation, sprains and strains (830-849), internal injuries (860-869), open wounds (870-897), and other injuries and burns (900-999). This means surgeries and amputations performed for treating disease are not coded from the "Injury and Poisoning" section.

The only common condition in home health in which a trauma code is used is fracture due to a fall, other accident, or intentional injury, HCFA says. Therefore, in most cases, hip fracture and other fractures treated surgically or otherwise are correctly coded with a trauma code (using one of the codes for fracture, 860-869).

V-codes are not allowed on OASIS, even though they are the most appropriate code to use in many post-surgical wound cases, according to ICD-9-CM coding guidelines. Rather than using V-codes, the OASIS instructions indicate the agency should code the primary diagnosis from the condition responsible for the surgery. HCFA says this requirement raises a problem for diagnosis coding in many post-surgical wound care cases.

If the agency selects a code for the condition that led to the surgical wound, the result may be a diagnosis that the patient no longer has. Nevertheless, when a patient is admitted to home care mainly for surgical wound assessment and treatment, the condition responsible for the surgery must be used as the primary diagnosis. For example, on OASIS, it is correct to report spinal stenosis (724.0x) as the primary diagnosis in the case of a successful laminectomy performed to treat it, even if the patient is considered cured after surgery.

Agencies that have erroneously coded disease-related post-surgical cases with a trauma diagnosis should submit a corrected claim to ensure accurate payment.

Record V codes in item 21

Also, HCFA says to note the following guidance issued in Program Memorandum (PM) A-00-71 (www.hcfa.gov/pubforms/transmit/a0071.pdf). This PM stipulates that "the principal diagnosis must match on the physician-certified plan of care, the OASIS and the UB-92. In addition, V codes are not acceptable as principal or first secondary diagnoses but could be recorded in item 21 entitled Orders for Discipline and Treatments. The ICD-9-CM coding guidelines should be followed in assigning an appropriate V code." Possible appropriate V codes when the patient requires post surgical wound care include V54.x, V58.4x, and V58.3. ■

Technology will increase value of transcriptionists

Electronic record focuses attention on data capture

Transcriptionists may have worried about their jobs with the advent of speech recognition technology. But in the coming years, they may find their roles stronger than ever — increased by the same technology that once threatened to replace them.

The transcription profession is definitely going to change, says **Claudia Tessier**, CAE, chief executive officer of the American Association for Medical Transcription in Modesto, CA. "We anticipate the increased merging of new

technologies with the talent and knowledge of medical transcriptionists. The change has already started, but it is going to accelerate and be more dramatic."

Speech recognition technology is no longer viewed as the ultimate solution to replace transcription, she says. "Vendors now are increasingly aware that if they take the technology of speech recognition and combine it with the knowledge of the medical transcriptionist, they can be much more effective and can be bigger players in the market," Tessier says.

When working with medical transcriptionists, the speech recognition system would do the first pass for the record, but that record is recognized as a draft, she explains. The transcriptionist preferably would immediately edit the record, recognizing and clarifying any inconsistencies or redundancies.

The transcriptionist would be able to make the document clearer, more complete, and more consistent than direct speech recognition, because medical transcription is not a verbatim process, Tessier says. "It's an editorial process. Verbatim transcription can be a barrier to communication because people do not speak the way they communicate in writing."

Unfortunately, physicians who are happy about using speech recognition don't always review their work before they sign it, she adds. "Since they thought they said what they intended to say, they assume that the document is accurate as dictated." Tessier says she has seen multiple demonstrations of how it takes almost no effort to quickly identify errors, some of which are minor. "Some, however, are medical errors. The wrong term was used, or the procedure started on the left side and ended up on the right side. It takes that attention to reviewing the document for completeness, accuracy, clarity, and consistency to assure that the information is what you want documented."

Tessier says she doesn't think the person who dictated the record should also act as its editor. "Few people want to do that and can do that well for themselves."

Transcriptionists also can make contributions when data entry is structured, as with touch screens. "You often need the opportunity for free text," she says. "[The clinicians] may need to dictate information to the history or to add the reasoning behind a diagnosis, particularly with a differential diagnosis, and the transcriptionist would add this free text to the structured text."

Overall, Tessier says she sees an evolution of the transcription profession in which the editing skills, medical language, and content knowledge of the transcriptionist become more important. "The transcriptionists with the more sophisticated knowledge of medical care will have wonderful [career] opportunities."

Technology may aid clarification of content

The evolution of the transcriptionist role may not depend on direct relationships with physicians, though. Tessier expects that relationships between transcriptionists and physicians will continue to be as varied as they are now. "There will continue to be some direct relationships. There will also perhaps be an increase in the instances where transcriptionists and physicians will never see each other, because they might be on opposites sides of the country or the world."

Tessier says she hopes new technology will improve transcriptionists' opportunities to get clarification of confusing dictation or inconsistent content. For example, a physician may use a new term that is not familiar to the transcriptionist. The transcriptionist tries to research the term but cannot find it. He or she then leaves a blank in the document and asks the physician to fill it in as well as to provide feedback so the transcriptionist will know the term in the future.

"Unfortunately, the feedback too often never comes," Tessier says. "We hope there will be ways to reinforce the attention given to providing feedback about new technology and new techniques so the knowledge base of transcriptionists can increase faster than they could find the information on their own."

Transcriptionists may find that they are working on records dictated by staff other than physicians, too.

Physicians are doing more documentation with dictation and transcription, but so are health care professionals of other disciplines, Tessier says. "It's as though the development of the electronic patient record has stimulated a greater awareness and greater utilization of [dictation and transcription]."

The intense attention given to the electronic patient record has brought attention to dictation and transcription for data entry, especially because no alternative technologies have worked out to be the ultimate solution, Tessier says. "It has brought interest in it that all of our marketing efforts were not able to do." ■

(Continued from page 102)

• **Know your market.** If you know the going rate for a certain procedure is $75 and you've been charging $35, don't reset your fee schedule at $125 to make up the difference in the revenue you've lost over the years.

• **Have all doctors use the same schedule.** All physicians in your group, or at least within the same specialty, should charge the same price for the same services. It is all right, however, to charge self-pay patients less. Many practices offer discounts of up to 30% to self-pays who write a check before leaving the office. ■

Follow practice guidelines for better care, profits

Negotiate HMO payments based on guideline use

With the renewed interest in reducing medical errors and increasing quality of care, practices might want to consider negotiating a separate arrangement with managed care plans that increases their reimbursement for adhering to clinical guidelines.

That's the recommendation of **David A. Hess**, director of contracting for PMSCO Healthcare Management and Consulting of Harrisburg, PA, a subsidiary of the Pennsylvania Medical Society.

Choose most prevalent diseases

Hess says that kind of arrangement could work something like this:

— Propose using clinical guidelines that would cover the most prevalent and costly diseases within your practice as it relates to the health plan's members. If you have a smaller practice, ask the health plan's medical director what the most prevalent condition is that affects the health plan's membership, and choose a corresponding guideline.

— To simplify things, propose using two of the health plan's clinical guidelines. "It is not worth the time to enter into lengthy negotiations / meetings with the health plan over guidelines and measures," says Hess. However, it's wise to request that the physicians in your group have an opportunity to review the proposed guidelines for possible modifications. It is also reasonable to request literature references and background information used to support the clinical guidelines.

— Highlight the guidelines that can be easily convertible into economic performance measures. You will have to work with the health plan to determine how these measures will be defined to ensure they accurately reflect the clinical guidelines.

— Determine how this information will be standardized and entered into the plan database.

— Develop a description of the reports (including reporting time periods) that will be used to determine if the clinical guidelines are being met. One way you can do this is to use current medical record reviews the plan already performs as part of its HEDIS requirements.

—- Determine the price for your services on a per guideline basis. Remember, your goal is to "increase reimbursements, on the margin, to your practice," says Hess. Pick a price that is reasonable based on the size of your practice and the number of the health plans members affiliated with your practice.

Prorate payment based on performance

Hess suggests performance awards of 100% of the allotted monies for achieving 10% better than the national average. Prorated payments should also be considered. For example, should your group meet the national average, 70% of the allocated dollar amount for meeting the national average should be paid. A prorated schedule is also envisioned for adherence at a level between the national average and 10% above this level, as well as 10% below the benchmark.

Tip: Besides this price, also request a separate payment from the health plan to cover the cost of educating staff about these new clinical guidelines, updating internal documentation and procedures, and ongoing in-house audits to determine how well the practice is performing.

—- As to timing, consider establishing nine months as the adherence period. Guidelines and measures should be established prior to implementation. Adherence measurements would require one to two months to record and report, with payment made soon after.

— Try to structure the arrangement so it automatically renews on a yearly basis with an annual 3% to 4% increase in the per-clinical guideline rate identified above, Hess recommends. ■

New regulatory trend: Group solvency standards

Failing IPAs spark new legislation

Scared by a recent jump in medical practices going belly-up, states such as California, Colorado, and New York are on the forefront of a move to install solvency and other financial standards for independent practice associations and other physician organizations accepting insurance-like risk contracts.

Under the present guidelines scheduled to be phased in over the next year in California, nearly one-third of all medical groups would fail to meet the standards. The rules will apply to all capitated groups with claims-processing responsibilities, says the California Association of Physician Organizations (CAPO). California doctors, fearing that a poor solvency rating would make it harder to win future HMO contracts, are lobbying to have the state postpone the final implementation of its plan for at least three years to allow groups to build up their financial reserves.

Under the proposed new standards, California groups must ensure that their assets exceed liabilities by at least $1 at all times; they must pay subcontracted physicians on time; and they must keep track of what they will owe on bills that haven't been submitted.

New York, in contrast, wants to require large groups to place 12.5% of their total revenues into reserves to cover potential liabilities.

Some 20 states are now considering regulations affecting the "downstream risk" for which medical groups can contract, reports the National Conference of State Legislatures.

As with previous managed care issues, California seems to be the state to watch when it comes to the future of government-imposed solvency standards.

According to the California Medical Association, 125 California groups have closed their doors over the past five years. Meanwhile, 85% of the remaining medical groups are estimated to be at or near insolvency. Most physicians point to low capitation rates, which run as much as 40% lower than those in other parts of the country, as the main reason for their money problems.

On the HMO side, up to 60% of plans could be in financial trouble, according to studies.

California's Solvency Scorecard

Under California's proposed solvency standards, medical groups must need the following criteria:

- **Tangible net equity.** Assets such as cash, securities, and long-term receivables must be greater than liabilities.
- **Working capital.** Assets such as cash, marketable securities, and short-term receivables must exceed liabilities.
- **IBNR.** Track "incurred but not reported" claims — money owed for bills that have not yet been submitted.
- **Prompt payment.** Pay 95% of clean claims within 30 to 45 days.

While providers complain about many of the specifics of the California plan, many say these types of standards may be needed.

"I wouldn't say the new rules are a good or a bad thing. But they do seem be to a necessary thing," given the insurance risk being assumed and associated responsibility for paying physicians the group subcontracts with under the capitation arrangements, notes **Ira Davidoff**, MD, chairman and medical director of Oakland's Bay Valley Medical Group.

This, in turn, means practices must start to act more like insurers in their financial dealings by "accumulating reserves to weather the bad times," says Davidoff. ■

Use training to expand your in-house expertise

The basics of a billing training program

Most studies show it's newer billers and coders who make most claim-related mistakes. Even so, many practices fail to give their new billing staff adequate training in the fundamentals of their job, which includes an understanding of how their work contributes to the entire billing process, says **Donna Sherwin**, president of PBSI, a Wayne, PA, firm that provides staffing and training services to physician billing offices.

A lack of basic training and cross-training between billers, coders, posters, and schedulers

makes it easier to overlook mistakes or inconsistencies, because each function only knows its piece of the total reimbursement pie.

The first step to ensuring every biller and coder in the practice has a basic level of competency is to "start with a uniform and basic level of testing and training, then selectively add more training, as needed," says Sherman.

"The idea is that the practice benefits when everyone is working towards the same common goal: Maximization of reimbursement through timely and accurate billing while maintaining an optimal level of patient treatment and satisfaction," she notes.

"This not only ensures that all personnel are reading from the same page, but it will give your current employees knowledge that may help them move between jobs in the organization more easily," she says. "As a result, you will have created a much happier and more productive employee, from the front desk person to the accounts receivable management supervisor."

Before implementing any biller training program, Sherwin recommends practices determine exactly what it is they want each staff member to know. This could include such things as:

— patient flow from the initial call to the resolution of an account receivable, including a review of the basic functions and/or positions needed throughout the process;

— a minimum level of medical terminology;

— the importance of CPT 4 and ICD 9 codes;

— basic self-pay and third-party billing rules and procedures.

Once you've decided what you want your training program to concentrate on, Sherwin says you should test each staffer to establish their knowledge level in each area. That information will then be used to refine and focus the particulars of the training.

Based on her experience, this basic training should take between 15 and 20 hours. Depending on the size of the organization, it could take several core sessions before all staff have completed the introductory training activity.

To help facilitate the training process, Sherwin suggests dividing the program into several self-contained modules. For example, one module might be an introduction to medical terminology with a concentration on the terms most often used in your practice. Another might be on the importance of CPT codes, including a brief introduction to the CPT book and the most often used CPT codes in your practice. A similar module might be presented for ICD 9 codes.

Sherwin also says flowcharts are an excellent learning tool, particularly for visualizing how a patient moves through the system. The same applies for following a charge from initial data entry to resolution of the account.

"All trainees should be tested again to ensure that the training was effective and that your objectives have been met. I would suggest that you establish a minimum acceptable grade, and that anyone who does not meet the minimum be required to retake the basic training," says Sherwin.

Once the core conceptual training has taken place, you're then able to begin cross-training workers.

Sherwin says each person should immediately begin cross-training in functions other than the ones in which they normally work after completing their core conceptual training. Plus, "if you are organized along product lines in which one person is responsible for multiple functions within one product line, you will have to provide them with multiple function training," she says.

If done correctly, this training regimen will teach any entry-level employee to perform effectively as an appointment scheduler, a registrar, or a charge entry person, while also "providing an excellent base from which to build payment posters and junior-level collectors," says Sherwin. ■

Patient surveys: A good tool and a good investment

Keep them happy and keep them coming back

Thomas Engel, CMPE, administrator of the Heart and Vascular Clinic of Northern Colorado in Fort Collins, sees patient satisfaction surveys as a good investment, as do the clinic's physicians.

William Stewart, MD, medical director at Minor and James Medical PLLC, a 64-physician multispecialty group in downtown Seattle, says he thinks of patient satisfaction surveys as an education tool that keeps the staff aware that the practice depends on a high degree of patient satisfaction.

The patient satisfaction efforts of both practices were highlighted by the Medical Group Management Association (MGMA) in Englewood, CO,

in their report "Performances and Practices of Successful Medical Groups 2000."

"I look on the survey as an important teaching tool for physicians and employees as well as a measure of patient satisfaction," says Stewart. Instead of collecting patient satisfaction data once or twice a year, Stewart runs his survey all year long, alternating among departments.

"By running the survey throughout the year, my employees and my physicians are always aware that we are providing a service and that we are dependent on a high level of patient satisfaction," Stewart says.

Heart and Vascular Clinic of Northern Colorado, a group of 11 cardiologists with a patient base including parts of Colorado, Nebraska, and Wyoming, has used the data from its surveys to make the decision to move from a 10,000 square foot building with eight examining rooms to a 33,000 square foot building with 28 exam rooms.

When the practice installed its electronic medical record systems, it included a mechanism to measure the amount of time patients wait in the lobby and examination room, two trouble spots that frequently showed up on patient satisfaction data.

"We can track the elapsed time very precisely and can identify bottlenecks," Engel says.

Some of the bottlenecks occurred because medical assistants were on the phone handling prescription refills or other things were keeping patients in the lobby.

"If anybody is taking an inordinate amount of time, we can identify that. Generally, when the physicians and staff see the data, they are motivated to respond to it," Engel says.

The two practices handle their patient satisfaction surveys in different ways. Heart and Vascular Clinic of Northern Colorado uses a mailed survey sent out quarterly. One hundred patients per physician are surveyed. The patients are selected by an automated database, with the parameter that patients are surveyed only once every two years. People who are in collection are excluded because Engel assumes their responses would be biased.

Minor and James Medical targets 50 patients for each physician. Patients are chosen at random and are given the survey to fill out while they are in the office.

"The number of patient satisfaction surveys is the same as when we did it once a year; we just collect it over a longer period. This takes out seasonal variations and is less disruptive to our office," he says. Collecting data throughout the year has an additional benefit, Williams says: No longer do reception staff have to be trained once a year on how to greet patients, explain the survey to them, and make sure they fill it out before they leave.

The Heart and Vascular Clinic survey includes a comment section in which patients are asked what the practice can do to improve its service.

Frequently, the patients identify specific physicians for complaints. If the patient also fills out the optional name and phone number section, the physician calls the patient to try to make things right or at least make the patient feel his or her opinions are being heard.

The survey costs the practice around $5,000 a year for printing, mailing, and business reply costs, but Engel feels it's worth the cost.

"Our physicians never thought of it as an expense; they thought of it as an investment," he says. ■

OIG broadens ability of hospitals to recruit

A key: No referral requirements

A nonprofit hospital's recent proposal to recruit a head and neck surgeon might generate compensation that is technically illegal under the federal anti-kickback statute, but the Office of Inspector General (OIG) says it will not apply sanctions in that situation, according to a newly released OIG advisory opinion.

The rural hospital offered a recent medical school graduate either a loan or an undisclosed amount to pay for his five-year residency in otolaryngology and head and neck surgery. In

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return, the physician had to agree to establish and maintain a medical practice within three miles of the city in which the hospital is located for at least three years after completing his residency. In turn, the hospital would forgive one-third of the physician's payment obligation for every year the physician complied with the agreement.

The physician also was asked to accept patients referred by the hospital regardless of their ability to pay, to assist the hospital in its physician recruitment program, and to engage in other duties.

The OIG says it approved this proposal because it was not conditioned upon the physician making referrals to, or otherwise generating business for, the hospital. In addition, the OIG liked the fact that many of the physician's patients would be members of a medically underserved population.

The OIG's opinion noted that it considers the following factors when determining if a physician recruitment deal is appropriate under the anti-kickback law:

— documented evidence of an objective need for the practitioner's services;

— any indirect benefit from the deal to someone who might be in a position to refer patients to the hospital;

— whether the practitioner has an existing patient base within the designated area from which the hospital might benefit;

— whether the recruitment agreement is narrowly tailored and spells out how long incentives will remain in place. ■

Reimbursement ROUNDUP

Nurse anesthetist rule in trouble

The Bush administration says it will cancel a new rule that would allow nurse anesthetists to administer anesthesia without a physician's supervision.

Department of Health and Human Services Secretary **Tommy Thompson** said the department will issue a new rule that will require a physician's presence when nurse anesthetists administer anesthesia. Administration officials also said they would postpone the new rule for six months to give them time to revise it.

However, under the new rule, states will be able to avoid the requirement if they already allow nurse anesthetists to work alone and if local health experts feel this would benefit patients.

Supporters of nurse anesthetists argue that the rule was needed to ensure access to anesthesiology services in rural areas.

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Physician groups, including the American Society of Anesthesiologists and the American Medical Association, opposed the rule, arguing that nurses cannot provide the same level of care as physicians. ▼

Doctors retire earlier in HMO-heavy markets: Study

There is a 13% greater chance a generalist physician will retire by age 55 if he or she practices in markets where HMO penetration is greater than 45%, finds a study published by Health Services Research (www.hsr.org), a medical research group.

Female physicians were more likely to retire than male physicians, whereas international medical graduates had lower retirement rates.

For specialists, the chances of retirement were 17% greater than in markets with 5% or lower managed care penetration.

The "findings suggest that many older physicians have found it preferable to retire rather than adapt their practices to an environment with a high degree of managed care penetration," the study concluded.

"Because the number of physicians entering the older age categories will increase rapidly over the next 20 years, the growth of managed care and other influences on physician retirement will play an increasingly important role in determining the size of the physician work force," the study said. ▼

HCFA updates SNF rates

The Health Care Financing Administration has published a proposed rule updating Medicare payment rates for skilled nursing facilities (SNFs) for fiscal year 2002, plus moving so-called swing bed hospitals under the new prospective payment system (PPS).

Under the proposal, once SNF PPS rates rise 2.1%, swing bed hospitals would start their changeover to the SNF PPS system (except for critical access hospitals, which are exempt from the PPS). ▼

ESRD payments to rise

Medicare+Choice payment rates for end-stage renal disease (ESRD) beneficiaries will increase 1% beginning in 2002, say sources at the Health Care Financing Administration (HCFA).

The payment increase was mandated by Congress in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 as part of the give-back package for Medicare managed care plans.

Managed care plans are paid 95% of the fee for service rate under Medicare. The ESRD payment rate incorporates a new payment methodology for plans in which rates are adjusted for age and gender. Currently, payments are based on state-level rates without being risk-adjusted.

Beneficiaries with ESRD are the only group prevented from enrolling in Medicare risk health maintenance organizations and Medicare+Choice plans, although those developing the disease after enrolling may stay with their plan.

Health plans are required to submit their Adjusted Community Rate proposals to HCFA by July 1. ■