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PHYSICIAN'S PAYMENT UPDATE™

INSIDE

SEPTEMBER 2001

VOL. 13, NO. 9 (pages 129-144)

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New gold rush coming to California: HMO basing bonuses on quality of care

Is it a fad, or an indicator of true change in managed care pay?

In a dramatic change from the traditional managed care cost-cutting mindset, Blue Cross of California has announced it will begin using patient satisfaction measures instead of cost controls to calculate physician bonuses.

Under the Blue Cross plan, doctors who score well on patient satisfaction and preventive care surveys can receive up to a 10% bonus on top of their regular quarterly managed care payment, starting in 2003. Before, such bonuses were determined solely by how well physician groups controlled costs.

More HMOs are expected to follow this move as a way to quell employer complaints about recent hikes in insurance premiums of 10% to 20%, by improving outcomes. Other experts also see it as a response by the managed care industry to the patient rights legislation that has been moving through Congress and state legislatures.

While Capitol Hill debates a national patient rights bill, eight states have already passed new laws allowing patients to sue their HMOs for denying what they felt was necessary medical care.

"The decision to make this change was market-driven," says **Michael Belman**, MD, spokesman for Thousand Oaks, CA-based Blue Cross of California in "Employers want more value for their premium. From the provider side, we feel physicians who receive financial incentives to give quality care will be more satisfied."

San Francisco-based Blue Shield of California actually began its quality initiatives in January when it launched a separate quality incentive program. Under this plan, medical groups that meet established quality measures can increase their managed care payments by as much as 5%.

Other organizations affiliated with Blue Cross of California, such as Blue Cross Blue Shield of Georgia in Atlanta and UniCare Health and Life Insurance Company of Thousand Oaks, CA, are also considering

paying their doctors based on patient surveys.

PacifiCare Health Systems of Santa Ana, CA, has operated a quality reward system since 1998, based on about three dozen clinical measures. Under it, high-scoring groups are assigned more members, potentially resulting in higher revenues.

The first reaction from employers was a hearty thumbs up.

"With the significant increase in health care costs, purchasers are increasingly turning their attention to the quality of care being provided because they question the increased payments they're making," says **Peter Lee**, president of the San Francisco-based Pacific Business Group on Health.

"There's been more demand to improve health care quality as premiums have risen sharply in the past several years," he adds.

Despite the surface appeal of being paid when they keep patients healthier, some doctors are more weary of the messenger than the idea.

"You just cannot trust health plans to come up with an answer that's good for both patients and doctors. We're simply suspicious that this is more of a public relations ploy than real change," notes **Peter Warren** of the California Medical Association in San Francisco.

The idea of patient satisfaction-based pay schedules also has its skeptics in the HMO industry.

"Just because patients say they are happier because their access to a doctor has improved does not mean the technical quality of their health care has improved," says **Robert J. Forster**, MD, vice president of care for Florida Blue Cross and Blue Shield in Jacksonville. "Anyone who says different is just playing with smoke and mirrors." ■

Pay-for-quality movement expanding nationally

But a 'supreme cynicism' still pervades

Examples of the new emphasis on the quality of care are springing up around the country.

Last summer, Boston's Harvard Pilgrim Health Care signed a four-year contract with Partners HealthCare Systems, giving Partners' 1,000 primary care physicians and 3,000 specialists financial bonuses for taking preventive measures such as ensuring diabetes patients get regular eye and kidney check-ups.

In Indianapolis, Anthem, Inc., is reportedly creating a compensation system that pays physicians and hospitals based on meeting pre-set clinical and preventive health standards.

Jumping on the quality bandwagon, a major Florida managed care coalition now says it is willing to pay higher fees to physicians who achieve the best clinical outcomes. Under the Central Florida Health Care Coalition's proposal, physicians would be divided into platinum, gold, or silver categories based on their documented outcomes for 10 specified conditions. The Orlando-based coalition represents 145 employers covering more than 1 million people.

Risk-adjusted claims data on office visits would also be used to create a profile of treatment patterns and clinical results for some 5,000 physicians in five specialties.

To earn a top rating, doctors also must meet such additional requirements such as participating in annual mini-residencies to ensure they're up to date on the latest treatment techniques.

The decisions on how — and if — to proceed will depend on the results of a pilot program designed to test payment measures and an actuarial analysis.

Early indications are that reimbursement rates could vary from 70% of the current Medicare rate for silver physicians to 120% for platinum doctors willing to treat more patients with chronic illnesses, estimates the coalition's head, **Becky J. Cherney**.

Florida Coalition's Targeted Conditions

The Central Florida Health Care Coalition is considering adjusting physician fees based on clinical outcomes for 10 targeted conditions treated in doctors' offices that it says are the most costly and debilitating for its employees. These conditions are:

— Lower respiratory infection
— Sinusitis
— Hypertension
— Lipid/cholesterol disorder
— Abdominal pain
— Chest pain
— Lower back pain
— Diabetes
— Depression
— Ischemic heart disease/angina

To push more members to top-ranked physicians, their associated copayment would be reduced. "This is our way of saying we're willing to pay doctors more for being a good physician," says Cherney.

Not all doctors who work with managed care are buying this idea, however.

"The HMOs are still trying to nickel-and-dime doctors" when you compare what could be saved from more effective care that keeps people out of the hospital, maintains family physician **Joseph W. Gallagher**, MD, of Los Angeles.

There is a "supreme cynicism" among physicians across the country that no corporate purchaser really cares about medical quality, says **William F. Jessee**, MD, CEO of the Medical Group Management Association in Englewood, CO.

A major complaint is that many of these so-called quality compensation proposals don't really pay directly for better care. Instead, they attempt to drive more patients to top-performing physicians. However, there's no hard evidence that even this goal is being accomplished.

Others complain that what direct bonuses do exist are geared to patient satisfaction surveys rather than hard clinical data. There's also the question of whether mutually agreeable performance measures can be calibrated. Plus, a significant number of payers must switch to quality performance measures before the provider side of the equation starts to take the issue seriously, say experts.

"Experiments aimed at both holding providers accountable and encouraging them to practice quality medicine are happening across the country," notes benefits consultant **Helen Darling** of New London, CT. "Figuring out how to do this is going to be tough." ■

Tips for negotiating a quality-based contract

Base payments on guideline compliance

The renewed interest in reducing medical errors and improving quality of care may be a signal that it's time for practices to negotiate a separate arrangement with managed care plans that increases their reimbursement for adhering to clinical guidelines.

Here are the recommendations from **David A. Hess**, director of contracting for PMSCO Healthcare Management and Consulting, a subsidiary of the Pennsylvania Medical Society in Harrisburg:

• 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 is the most prevalent condition affecting 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.

Review for modifications

A smarter approach is to request that the physicians in your group be given an opportunity to review the proposed guidelines for possible modifications. It is also reasonable to request literature references and background information to support the clinical guidelines used to develop the measures.

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

• Determine how this information will be standardized and entered into the plan's 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 to do this is to use current medical record reviews the plan already performs as part of its Health Plan Employer Data and Information Set requirements.

• Determine prices for your services on a per guideline basis. Remember that your goal is to increase reimbursements to your practice, says Hess. In turn, pick a price that is reasonable based on the size of your practice and the number of the health plan's members.

Hess recommends 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 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 training staff about these new clinical guidelines, updating internal documentation forms and procedures, and ongoing in-house audits to determine how well the practice is performing

• Regarding timetables, Hess likes a nine-month adherence period. Guidelines and measures should be established prior to implementation.

• Finally, 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, he recommends. ■

Feds offer clarifications to medical privacy rules

Series of guidances promised

The Department of Health and Human Services (HHS) has released the first of what's expected to be a series of guidances on how the new rule governing privacy of patient medical records and information will work.

Stating that "we . . . understand that overheard communications are unavoidable," the HHS guidelines clarify that the new rules are not intended to stop physicians from talking with other health care professionals about a patient's treatment.

According to the guidance, when physicians and nurses talk to each other or with a patient about providing care, they should use privacy safeguards that are "reasonable" without getting in the way of rendering appropriate medical treatment.

For example, doctors are not prohibited from speaking loudly in a busy emergency area where they could be overheard talking about a patient's condition if that is necessary to provide appropriate care.

Also, physicians are not prevented from discussing lab test results with a patient or another health care professional in a joint treatment area.

These practices would be "permissible, if reasonable precautions are taken to minimize . . . inadvertent disclosures to others who may be nearby (such as using lowered voices, talking apart)," notes the guidance.

Scheduled to go into full effect in April 2003, various physician advocacy organizations are lobbying to extend the compliance deadline and change various provisions in the final rule.

HHS has already agreed to some changes. These include permitting pharmacists to fill prescriptions phoned in by a patient's doctor before getting the patient's written consent, and allowing "direct treatment providers" receiving first-time referrals to schedule appointments, surgery, or other procedures before obtaining the patient's signed consent.

To review the HHS guidance on medical records privacy regulations, go to: http://www.hhs.gov/ocr/hipaa/.

New Medicare chief pledges 'user-friendly' changes

More open discussions promised

The newly renamed Centers for Medicare and Medicaid Services (CMS) will implement three new programs designed to make the agency more responsive, efficient, and accessible, says administrator **Thomas Scully**, head of what formerly was the Health Care Financing Administration.

The new programs include:

• open door policy committees, chaired by senior level staff, including Scully, that will meet monthly with provider and beneficiary groups to give them a better understanding of, and access to, policy input;

• regional listening forums open to the public so they can hear about the daily effects of CMS regulations from physicians and HMOs;

• in-house expert teams across CMS' program areas to think about new ways of doing business to reduce administrative burdens and simplify regulations to make Medicare more "user-friendly."

"We have an enormous health care system with a lot of problems . . . I think we can improve [with] a list of things we can fix monthly," Scully says.

One area of long-time contention CMS has just acted on is a clarification of the duties of Medicare contractors in developing local payment policies that are included in changes to the Medicare Program Integrity Manual (Transmittal No. 8).

The manual update is intended to help providers understand why claims are paid or denied. It discusses circumstances under which Medicare contractors should issue new or revised local medical review policies (LMRPs). Changes required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 will be covered in a separate transmittal.

LMRPs are developed by contractors to make coverage decisions in their jurisdictions. According to the manual, LMRPs "are used to make local medical coverage decisions in the absence of specific statute, regulations, or national coverage policy, or as an adjunct to a national coverage policy."

Under these changes, contractors are to develop LMRPs when they have identified an item or service that is never covered and wish to establish automated review in instances where there is no national coverage decision.

Contractors are also encouraged to develop an LMRP when:

— a "validated widespread problem" threatens Medicare funds;

— a contractor has assumed the work of another contractor and is attempting to make policies uniform across jurisdictions;

— frequent denials are issued or anticipated involving certain issues.

Reviews and revisions

Contractors must review and revise LMRPs within 90 days of when a program instruction containing a new or revised national coverage decision is issued, when a new or revised coverage provision in an interpretive manual is published, and when a program instruction containing a change to national payment policy is issued.

As of Oct. 1, contractors must review all LMRPs annually to ensure consistency with national coverage decisions, changes in manuals, and other documents.

"If an LMRP has been rendered useless by a superseding national policy, it must be retired," according to the transmittal.

Other changes in the transmittal include requirements that contractors:

— name a medical review manager that will act as the primary contact between the contractor and CMS;

— attempt to develop uniform LMRPs across all their jurisdictions;

— use less stringent evidence when allowing for coverage of services that have lower risks of negative health effects on beneficiaries. ■

OIG wants more controls on nonphysician billing

Use of physician extenders soaring

The rapid rise in Medicare payments to nonphysician practitioners has the Office of Inspector General (OIG) worried that some of this increased spending may be the result of bogus billing. As a result, the antifraud shop is calling for added controls to determine which related services should be reimbursed.

In a recent report (OEI-02-00-00290), the OIG noted that nonphysician practitioners — nurse practitioners, clinical nurse specialists, and physician assistants — are paid through Medicare Part B.

According to the report, Medicare paid for 5.2 million nonphysician practitioner services, in 1999 compared to only 1.2 million in 1997.

One reason for this jump is that enactment of the Balanced Budget Act of 1997 allowed payments for nonphysician practitioners in all geographic areas. Before then, nonphysician practitioners were only allowed reimbursement in rural areas and selected health care settings. In addition, nurse practitioners and clinical nurse specialists are now allowed to bill Medicare directly, although physician assistant services must continue to be billed by an employer.

Scopes of practice vague

One problem the OIG zeroed in on is that while individual states are responsible for setting the scopes of practice for Medicare-recognized nonphysician practitioners, most jurisdictions have only a vague definition of any related responsibilities and educational requirements.

Many states also fail to clearly identify the duties beyond a nonphysician practitioner's scope. As a result, it is often unclear whether

these caregivers are prevented from performing certain services not specifically mentioned in a scope, the report noted.

Bottom line: Look for more limits to be placed on future scopes of practice for nonphysician practitioners, plus added guidance to carriers when determining which services are reimbursable. ■

Product-line billing could boost efficiency

Improves employee 'buy in' for work

Traditional medical billing systems are generally organized according to either function or payer, with each person who works in the billing office being responsible for performing a specific function.

An alternative — and potentially more efficient — way to organize the billing process is to appoint a product-line manager for each specialty. The product-line manager would be responsible for ensuring the various steps in the billing process are completed for their related claims, suggests **Heather Auld**, director of training and consulting services for Physician Billing Solutions, Inc., of Wayne, PA.

Under this product-line approach, one person essentially assumes responsibility for the major components of the billing and accounts receivable process for one of the specialties or "product lines" in a group practice.

The product line manager, for instance, completes the processing of charge entry claims, rejection posting, and resolution, along with any needed follow-up, notes Auld.

The major benefit of making a single person responsible for the complete billing process is that it increases accountability and sense of ownership in the job.

"When numerous individuals are responsible for completing the billing process, it is sometimes hard to pinpoint the source of a problem when individuals try to shift responsibility or blame around," notes Auld. "But, when one person is responsible for the specialty, they have to take ownership and final accountability."

Another advantage of the product-line approach is that because individual managers must immerse themselves in the details of their specialties, they develop a wider perspective. That helps them see and anticipate potential billing and claims processing problems unique to their specialty.

"Ideally, they learn something new each time they get a claim rejected in their area, which will help eliminate the problem and reduce the payment turnaround the next time that kind of claim is submitted," says Auld.

The product line approach can help improve morale among billers by creating new opportunities for career growth.

"The traditional data-entry position provides little opportunity for advancement. But, as a product-line manager, employees assume more responsibility and experience, which expands their long-term job possibilities, plus encourages the practice to employ higher-caliber personnel," she notes.

In a multispecialty practice, the best option is usually to organize a product-line billing system by specialty. If a specialty is large, you can appoint more than one individual to the task. This can be done by dividing the specialty according to provider, or by appointing different product-line managers within the billing office.

However, it may be wise to keep some duties traditionally segregated in the billing process separate. For instance, payment postings and collections can continue to be handled separately in the interest of volume and speed.

Ultimately, "each practice will divide duties and specialties based on the demands of its payer mix, number of doctors, patient base, accounts receivable, and how fast employees can successfully assume their new responsibilities," Auld says.

Other factors to be considered when making the shift to product-line billing include:

- **Training.** Physician Billing Solutions says it takes three to six months of training before employees are fully ready to assume their new duties as a product-line billing manager.
- **Equipment.** As your employees undertake their new duties, you may find that they need different equipment to perform their job (e.g., better computers, fax machine, etc.) All this new equipment requires space, which means you may need to physically reorganize the office, as well.

While patient scheduling and registration

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Physician's Coding Strategist™

Consultants' billing advice can attract fraud cops

Be skeptical about aggressive coding

A recent report from the General Accounting Office (GAO) waves a caution flag at providers about following the advice of reimbursement and coding consultants that seems to manipulate claims just to increase payment, without regard to medical necessity or standard billing procedures.

"This aggressive and unethical approach puts the [physician] client . . . at substantial risk," **Lewis Morris**, assistant inspector general for legal affairs with the Department of Health and Human Services, testified before Congress.

"Ultimately, providers need to recognize that hiring a consultant does not relieve them of the responsibility to ensure the integrity of all their dealings with Medicare and Medicaid," he warned.

As part of its investigation, the GAO sent a doctor and a criminal investigator undercover to two workshops and a seminar conducted over the past year by reimbursement consultants.

In its report, "Consultants' Billing Advice May Lead to Improperly Paid Insurance Claims," the GAO concluded the workshops offered advice that could open physicians to fraud investigations if they followed the billing suggestions.

According to the GAO, among the questionable advice given at the conferences was that physicians:

- not report or refund overpayments from insurance carriers;
- provide tests and procedures that were not medically necessary so they could bill at a higher level, while creating documentation to support the higher charge;
- give patients with low-paying insurance, such as Medicaid, appointments at inconvenient times during the day that are usually hard to fill.

In a related action, the Office of Inspector General (OIG) has issued a special advisory for physicians on the best way to spot consultants selling questionable advice.

It suggests you should be wary of any consultants who:

- claim they have a special relationship with or "inside" connection at Medicare or the OIG;
- claim their services or products are approved or recommended by Medicare, the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, or the OIG;
- guarantee specific results that are unreasonable or improbable through legal billing;
- encourage aggressive billing schemes or other unreasonable practices that are fraudulent and abusive;
- recommend you not cooperate when told some of your claims are going to be audited.

Bottom line: If what a consultant is promising you sounds too good to be true, it probably is. ■

Financial stability? It's in the coding

External audit of medical records is first step

Never before has coding has been so crucial to the financial stability of an organization. As the Office of the Inspector General in Washington, DC, focuses on certain coding practices, health information management professionals are feeling

the need to institute coding compliance and education programs.

Ray Pinder, MS, RHIA, has worked with several such programs in his 25 years of being a medical records director. Now, as director of medical records services at Holy Redeemer Hospital and Medical Center in Meadowbrook, PA, he has made it a priority to enhance the coding compliance and education program at his new facility.

"It's important that as a manager, I know the coding quality of my department in case I am questioned by my chief financial officer or chief executive officer on why our case mix index may be going up or down," he says. He needs to know, for example, if any changes in the case mix are significant or just due to a different patient volume that month.

Pinder began setting up the health information management program at Holy Redeemer with the blessing of Don Friel, Holy Redeemer's senior vice president and chief information officer, to whom Pinder reports. First of all, Pinder knew the program needed the assistance of a coding specialist. "I have a strong background in reimbursement methodologies, but coding is not my daily function," he says.

At the end of April, Pinder hired a coding manager to run and enhance the coding compliance and education program and to support the coding staff at Holy Redeemer. The manager, Margaret Giancaterino, RHIT, has more than 20 years of coding experience.

Baseline audit needed

As a new director coming into the facility, Pinder had already discussed with Friel the need to have a baseline study conducted by an external auditing company. "We needed to evaluate the quality of our coding in comparison with external regional and national data," Pinder explains.

Friel had wanted to do such an audit for some time, Pinder says. "Prior to my coming on board, we started talking about the vendors we would [consider]."

To decide among vendors for the baseline review, Pinder pulled from resources that he had used at his previous organization. He then asked for price quotes from the vendors, which he and Friel reviewed. "I made recommendations based on my knowledge of the companies," Pinder says.

The vendor chosen for the audit reviewed three months' data covering all inpatient admissions and outpatient visits. The data were provided by Holy Redeemer's information systems department. When the vendor ran the data through its system, it made a random selection of 100 records on each side. "We used that as our sample size, and it was above 5%. It was a good sample size for the study," Pinder says.

This first review took place within three months of Pinder's employment at Holy Redeemer. The final report, which was submitted to senior management as well as to Pinder, demonstrated that the coding at the facility was well within the national average, Pinder says. "We were informed that the ranges go anywhere from 92% to about 98% for accuracy in coding. We were in a 95% to 96% range."

Reviewing the recommendations

When Holy Redeemer received the results of the audit report, Pinder and Friel sat down with their coders — three full-time and three part-time employees — and reviewed the results with them. "We wanted them to know that they did well in the external review," Pinder says.

The report offered recommendations, because the audit looked at documentation as well as coding. The reviewers broke their comments about documentation into two categories of problems: The coders made errors because they missed documentation that was present, or the documentation was lacking in the first place.

"If the coders missed documentation that was present, we alerted them and put a reminder notice in each of their mailboxes, telling them to look for a certain report [in the record]," Pinder says. "Our coding staff reviewed the audited results and were given the opportunity to dispute cases based on coding guidelines."

If documentation was lacking, Pinder worked with Holy Redeemer's medical director to provide feedback to the medical staff. This feedback was provided either through a newsletter or by the medical director or Pinder going to the medical staff's monthly departmental meetings and giving a documentation update.

Pinder and his coding manager then developed their own coding quality review. On a monthly basis, Giancaterino will review a sample of each coder's work for accuracy and complete the chart review to determine whether all the codes were properly identified. "If any were not,

our work tool for both inpatient and outpatient [coding] would document the variances," Pinder says. These tools handle the different types of questions related to diagnosis-related groups and ambulatory classification payments.

Those worksheets are then tabulated, and the coders have an individual monthly review of their coding quality. If problems are found that seem to happen across the board, Pinder and Giancaterino have a general discussion during their monthly coders' meeting about how these patterns can be corrected.

Pinder presents a quarterly summary of this report to the hospital quality performance committee. He will also use the monthly and quarterly reports to supplement the department's annual evaluation for coding accuracy, quality, and productivity. Although the department does have a productivity standard, it is not the most important indicator, he says. "Quality is first and foremost over productivity."

(Editor's note: Next month, Pinder addresses the education component of his coding compliance and education program and how his program will affect the entire Holy Redeemer Health System.) ■

Electronic records simplify documentation, coding

'I don't go home at night and worry' about coding

Not long ago, **Mark Deis**, MD, got a letter from an insurance company refusing to pay a bill for a patient treated for abdominal pain without more documentation for a Level 4 patient visit.

Instead of spending time looking at patient records and dictating a letter as he did in the past, Deis merely called up the patient's electronic medical record, and in a matter of seconds had a six-page printout documenting everything he did during the patient visit.

The insurance representative was so impressed that she called Deis and pointed out that the documentation would have supported a Level 5 visit.

Deis is one of five pediatricians at the Cleveland Clinic's Independence (OH) Family Health Center who pioneered a new electronic medical records system beginning in October.

"The system has changed our lives in a lot of ways," he says.

About 60% to 80% of the center's 45 doctors have made the transition to the electronic medical records system. The practice includes physicians in internal medicine, surgery, family practice, OB/GYN, pediatrics, and 25 subspecialties.

"We wanted to start slow and eventually get the whole building on the system," he says.

Deis, a pediatrician with the Cleveland Clinic, estimates that he can see four to five more patients a day and stay on schedule better by using electronic medical records instead of the paper system.

He no longer worries about providing enough proper documentation for payers. The system prompts him through a series of templates and even records the "no" answers. It automatically records the ICD-9 code for the diagnosis and documents the level of patient visit.

"Coding is a big concern throughout medicine. With this system, it's so much easier to capture all of the information. I don't go home at night and worry, hoping I documented appropriately," he says.

Adjusting to the new system was easy, says Deis. He practiced using the system for two weeks on a laptop loaned to him by the software firm. When he went live on the morning of Oct. 26, he used the new system with about half of his patients.

"It was no problem to use. Since then, I've seen 100% of my patients on the system," he says.

Frustration with the paper chart system led the center to look at moving to an electronic medical records system. "We used to have a paper chart system, and we still do. But it was complicated because an internist or plastic surgeon might want the chart at the same time, and getting it from one place to another was complex," Deis says.

After studying products offered by several companies, the clinic chose Noteworthy, a Mayfield Heights, OH, technology firm. The firm developed the system for the Cleveland Clinic with the help of a single practitioner who used it for about a year before the Independence Family Center went on-line.

The five pediatricians at the center still sit down regularly with the medical information writer and walk through changes they would like to see in the system.

Here's how the system works: When a patient comes in for a visit, the nurse enters the reason for the visit on a template on the computer screen

and then answers a series of questions designed to find out more information about the patient's complaint.

"Some of the doctors' nurses ask all the questions. Some ask only a few and leave the rest for the doctor," Deis says.

Detailed questions automatically pop up on the screen if the answer to any question is "yes." For instance, if the patient reports having a fever, the computer will ask how long the patient has had the fever and how high the temperature has reached.

"The wonderful thing from the physician perspective if that it records the 'no' answers. You have a record of all those thing you never could adequately document in the past," Deis says.

There are multiple screens for every encounter. The face sheet contains ongoing data about a patient including past history, allergies, and problems. The history and physical screen has two different templates — one for a well-child visit and one for an ill-child visit.

The diagnosis and decision-making screen automatically enters the ICD-9 code. If there are several ICD-9 codes for a diagnosis, the doctor selects the right one.

Physicians can create a "problem list" for each patient, which comes up on the template each time the patient comes in for a visit. For instance, when a patient comes in with an ear infection, Deis can quickly see if it's a frequent complaint and decide whether to refer him or her to a specialist.

"I can write prescriptions in the computer, order lab work, or if I want to give specific instructions to the patient, I can type notes in there and print it out," Deis says.

With the new system, patients also received a printed prescription, which is easy for the pharmacist to read.

There is a computer in every examining room and at a workstation in the hallway in case the doctor wants to finish his notes after he leaves the patient. The clinic plans to eventually link the examining room computers to the billing system.

"The hardest thing about using the electronic medical record system is to make the patient feel that you're paying attention to them and not the computer," Deis says. He usually chats with his patients about school and sports activities while he finishes making notes on the chart.

The Cleveland Clinic made the decision not to re-enter all the old data on the new electronic medical record. Therefore, the physicians use both paper and electronic charts.

Deis' subspecialty is children with developmental disabilities, a group of patients who often have multiple medical problems and make frequent visits. For these patients, Deis has entered data from the paper chart showing each problem, the day it occurred, and a synopsis of the status. This gives him a quick history on the electronic medical chart.

Deis uses the old paper records only occasionally, such as when he wants to check whether he prescribed a particular medication for a patient in the past.

"Some of the doctors here are computer-phobic, and they are having a harder time," he adds. ■

Tips for setting up an electronic records system

Ensure you have a customer-friendly vendor

If you're considering setting up an electronic medical records system, **Mark Deis**, MD, has some advice: Do it sooner rather than later.

Deis was one of the pioneers of a new system at the Cleveland Clinic's Independence (OH) Family Practice Center. He offers the following tips for a good experience with your electronic medical records system:

- Shop around for a vendor that has the type of system you need. There are a lot of systems to choose from. Make sure you get a system that is compatible with the other computer systems your practice uses so you can interface easily.
- Make sure your system meets the requirements of the Health Insurance Portability and Accountability Act.
- Look for a vendor that will work with you to customize the system to meet the specific needs of your practice.
- Make sure your vendor will offer good support during the implementation process.

For instance, when the pediatricians at the Cleveland Clinic went live with the system, Noteworthy had a staff member assigned to every doctor and to the triage nurse.

"That's the kind of support you need. If you have a question, you don't want to have to spend five minutes looking for someone," he says.

- Make sure you have 24-hour telephone support when the system is up and running. ■

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remain the responsibility of workers on the so-called front end of the billing process, these employees are accountable to product-line managers for the accuracy of the information they give them.

For larger, multispecialty groups, each specialty can be a different product line. Depending on the group's size and number of specialties, the account lines can be divided among different designated product-line billing managers.

Some ways to divvy up the different product lines include by provider, location (inpatient vs. outpatient), or experience (senior vs. junior line managers).

Each line manager is responsible for charge entry claims processing, rejection posting, resolution, and follow-up of all claims in the specialties for which they are responsible.

To facilitate proper preparation of electronic claims, inpatient charge entry responsibilities should be transferred from data entry to a product-line manager.

"Because of the complexity of some modifiers, it's very helpful to have a more experienced person who's more conversant with the billing and bundling process to be in charge," notes Auld.

The product-line manager is also responsible for reviewing the monthly trial accounting balances for his or her specialty to prioritize accounts receivable. However, when it comes to individual self-pay patients, all these accounts should be assigned to one person to avoid having different product line managers from the various specialties calling on them.

Finally, a single supervisory product manager should be assigned primary responsibility for all main billing and accounts receivable functions. ■

Payer allows physicians to bill through Internet site

Payment cycle cut to 3.4 days

Physicians in South Carolina can now file health care claims directly through one of the biggest payers' Internet sites, saving time in payment turnaround and minimizing filing errors.

The physicians who are using this free service are finding that their claims are processed in just a few days. "The average number of days from the day we receive the claim to the day we actually cut the check is 3.4 days," says **David Boucher**, senior director of managed care services for Blue Cross and Blue Shield of South Carolina, based in Columbia. "That decreases [providers'] outstanding accounts receivable and increases their cash flow significantly."

Physicians can go to SouthCarolinaBlues.com, CompanionHealthcare.com, or HMOBlueSC.com to register a profile in the secure section, My Insurance Manager. Besides submitting claims on-line, they can use My Insurance Manager to submit referrals, check the status of a patient's claim, check eligibility, view benefit booklets, check authorizations and referral status, see how much patients have paid toward their deductible and out-of-pocket amounts, and confirm whether a patient has any other health insurance. They also can submit a question or comment on-line with secure messaging.

Growing steadily

The majority of the nearly 8,000 physicians in Blue Cross' networks in South Carolina still file claims through other electronic means. Many transmit their claims in batches through their practice management systems and then through a clearinghouse, Boucher says. About half of the physicians have registered to use My Insurance Manager. Only a few hundred have tried to use the claims function, but Blue Cross is encouraged that more are trying every day. "The number of providers who use this is growing on a weekly basis. We are averaging about 30 new providers a week. Our volume of claims is increasing about 13% a week."

Once physicians fill out claim information and submit them in My Insurance Manager, the claims are sent directly to the company's data processing center. The system does an immediate error check and informs the physicians if information is missing or incorrect. Physicians can check the next day on the Internet site to see if the claim has been processed, saving time traditionally spent on the phone.

One possible deterrent to filing claims over the Internet may be that the information has to be rekeyed into the Web site, Boucher explains. "On the surface, that appears to be a duplication of effort. The physicians who use this, though, see several advantages. When they hit the 'enter' key

and the claim is accepted, they get the claim number on-line. That gives them 100% confidence that we have the claim in-house on our mainframe computer. There are no clearinghouses and no buffering."

The system also edits the claim on-line. "[Physicians] don't have to look at a report later on telling them what they need to fix. They know right away."

So the minute and a half spent rekeying information into the web site is more than made up later, Boucher says. "It saves time at the other end if you don't have to have staff on the phone checking the claim status." ■

Rising costs charted in wide-ranging trend study

Report sizes up outlook for near future

Every two years, researchers from the nonprofit Center for Studying Health System Change in Washington, DC, interview health care leaders in 12 nationally representative communities to assess changes in local health care markets. The center then prepares an analysis that discusses recent developments it has identified in managed care, physician-hospital tensions, risk contracting, and health plan premiums.

Technological change and increased consumer demand are starting to drive health care costs up again, says the center's most recent analysis. "There is emerging evidence that changes in the organization and dynamics of local health care markets also may contribute to this phenomenon — and perhaps exacerbate it in the future," it concludes.

Managed care has been losing its power to control costs as health plans attempt to respond to consumer demand for less restrictive products and to restore profitability in the current stage of the insurance underwriting cycle.

Health maintenance organization (HMO) enrollment is stagnating or making only modest gains. In turn, plans are increasingly moving away from pure HMO products in favor of less restrictive, open-ended ones and preferred provider organizations (PPOs). "In fact, over the past two years, it appears that the benefits and features of HMOs and PPOs are converging and differences in premiums are diminishing," the researchers conclude. In a number of communities, plans are introducing direct access HMOs that do not require a gatekeeper and have broad provider networks that make them virtually indistinguishable from PPO products.

A leading plan in Seattle, for example, now uses the same utilization management processes across both its HMO and PPO products. Meanwhile, costs have increased more quickly under HMOs, eroding the price gap between the two products.

At the same time, health plans have shifted their emphasis from gaining market share to restoring profitability, reflecting the turn in the underwriting cycle. As a result, plans are no longer holding prices down to increase market share and are eliminating less profitable business, which for many now means exiting Medicaid and Medicare.

"These trends foreshadow premium increases that potentially will exceed already higher increases in underlying costs and threaten the viability of public sector managed care programs," says the center.

Providers gain clout

Hospitals in many communities have experienced extensive consolidation, enabling them to exert greater leverage in managed care contract negotiations. With more consolidated market power, hospitals are aggressively resisting health plans' attempts to control costs through reduced provider payment and utilization controls, the center says.

The changing balance of power between plans and hospitals has led to instances in many communities where hospitals or physician organizations could not come to terms with health plans, and, as a result, left the plans' networks.

Network instability often has significant effects on consumers, notes the center. Indeed, in Seattle, some large employers are pressuring plans to ensure network stability; this, in turn, has given providers added leverage with health plans, it notes.

Increased bargaining power comes at a critical time for hospitals, which have endured significant cuts in Medicare revenues as a result of the 1997 Balanced Budget Act and several years of intense pressure from health plans for discounts.

Hospitals have responded by reducing operating costs and have successfully held down

inpatient costs in recent years. However, unintended consequences of these efforts are beginning to surface, as some hospitals are now struggling with inpatient capacity constraints, the center's report says.

In other communities, hospitals have implemented diversion programs to accommodate overflow in the emergency room. Many attribute the current capacity problem not only to hospitals' cost-cutting strategies, but also to growing demand for inpatient services and a severe nursing shortage that has limited hospitals' ability to staff existing beds.

Hospitals in several communities are experiencing added conflict with physicians. For example, in Cleveland's highly concentrated hospital market, hospitals are exerting pressure on physicians to align more closely with one or the other system, spurring concerns among physicians about loss of autonomy, says the center.

In other communities, physician-hospital organizations formed to foster managed care contracting continue to decline in importance. Instead, physicians are focusing on independent strategies that emphasize opportunities for enhancing revenue rather than building capacity to engage in risk contracting.

This is seen most strikingly in Phoenix, where specialists are cutting back on affiliations with local hospitals and devoting more time to ambulatory surgery centers or specialty hospitals in which they have an equity interest, the study notes.

This trend threatens traditional hospitals with the loss of some of their most lucrative services and their ability to cross-subsidize less profitable services such as emergency care.

At the same time, "there are concerns that the proliferation of physician-owned facilities will induce greater utilization, particularly at a time when health plans' efforts to constrain utilization are weakening," notes the center. In turn, some experts feel this trend will lead to higher underlying health care costs, the study concludes.

As providers gain more clout and health plans move away from tightly managed products, there is a discernible shift away from capitation and other risk-based payment arrangements, says the center.

There is a strong trend among hospitals to revert to per-diem or diagnosis-related group payments, while physicians appear to be returning to fee-for-service payment. There is also experimentation with hybrid payment arrangements, such as withholds and utilization-adjusted fee schedules, but these developments are not widespread.

Although risk contracting was seen by some as a potential boon for providers, allowing them to share in the benefits of managing care, "most providers now view risk arrangements as automatically leading to losses," says the report.

But without some kind of risk arrangement, the center points out that some experts worry that providers will not have proper incentives to manage utilization, "setting the stage for higher costs and limited provider accountability." ■

Part One of Two

What to look for in writing a practice employment pact

Tips for an employment agreement that works

More physicians are opting for the security of employment rather than the adventure of entrepreneurship, in both large integrated organizations and small practices. One result has been to give added importance to employment agreements. The agreements spell out the details of the professional relationship, including mutual expectations, responsibilities, and financial arrangements.

Here are some tips on getting the most out of an employment agreement, offered by health care lawyers **Vasilios J. Kalogredis** and **Michael R. Burke** of Wayne, PA, and prepared for the American Academy of Family Physicians in Leawood, KS:

• **Get it in writing.** It sounds simple, but the first item of business is to always make sure you get the agreement in writing. "We are amazed at how often otherwise intelligent individuals enter into an arrangement based on just a handshake," notes Kalogredis. "Verbal agreements might be all right as long as everyone is happy, but a written contract becomes important when conflicts arise or when new owners or managers enter the picture."

• **Term and termination.** What are the terms for justifying termination? If there are provisions allowing termination for cause, are they reasonable and specifically defined?

Kalogredis and Burke say it is especially important in smaller practices to allow either

Here's a sampling of compensation methods

The relationship between salary and incentives

Many physician employment agreements call for a guaranteed salary combined with some sort of incentive. Following is a sampling of some basic compensation arrangements suggested by health care attorneys **Vasilios J. Kalogredis** and **Michael R. Burke** of Wayne, PA:

1. The employee is presented with a lesser guarantee because of the upside potential of income. One method of incentive compensation pays the employee a percentage of the gross revenues that he or she personally generates in excess of a certain threshold. The threshold is sometimes the amount of revenue the employee must generate for the practice to break even on the expenses incurred by the practice by employing the physician.

For example, the agreement may read thus: "You will receive a base salary of $80,000 with incentive compensation equal to an additional 25% of all gross revenue generated personally by you in excess of $200,000."

The advantage of such an incentive formula is that it would be directly tied to your work. The disadvantage may be increased competition for patients among the physicians in your group, they note.

2. The employee receives a percentage of the practice's gross revenues or net income over a clearly defined level. "This provides a group incentive. However, it can lead to problems if physicians perceive that not everyone is pulling his or her weight," says Burke.

3. Base salary increases each year the physician is employed by a practice. Where an employee's incentive formula is based on revenue generated by that employee, the threshold revenue will generally be increased to correspond to increases in the employee's base salary. Once an employee becomes a co-owner of a practice, compensation is generally divided among the co-owners according to a formula appropriate for the practice and its market. ■

party to terminate the relationship easily rather than have it come to a lengthy and contentious end.

In turn, you could insert a clause providing for termination without cause that might read: "Notwithstanding the foregoing, either party may terminate this agreement at any time for any reason or no reason by providing ____ days written notice to the other in accordance with the terms of this agreement."

The standard notice of termination tends to range from 30 days all the way up to 180 days.

• **Length.** This should include how long the contract will run and when you will be able to negotiate salary increases and other changes in the agreement. Most agreements run one or two years, say these experts.

• **Co-ownership.** Many newly hired physicians may want to know about the possibility of co-ownership down he road. From the employed physician's perspective, "co-ownership provisions may well be what distinguishes a decent employment opportunity from a great one," says Burke.

However, the reality is that "most employment agreements contain vague, non-legally-binding language as to the owner/employer's intentions regarding co-ownership by the employed physician that would allow you and your employer to change your minds about the terms of your deal," he notes. In some instances, the co-ownership terms are even removed from the employment agreement and instead laid out in a separate non-legally-binding letter that the employer sends to the employee.

Burke suggests that "when co-ownership terms aren't negotiated up front, the arrangements

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should be formalized and put in place within two to three years of the start of employment. The agreement should spell out the terms of purchase, including but not limited to the proposed purchase price and the period over which the purchase price will be paid. It must also establish the manner in which the physician will be compensated as a co-owner, including any income differential between junior and senior co-owners."

• **Involvement in management.** The contract also should address how much say the physician employee will have in the practice's operations, both now and in the future. In many situations, the employee may have little say in practice decisions until he or she has become a full partner.

• **Job description.** The agreement should clearly delineate job responsibilities. Is the position a full-time or part-time position? Will the doctor be required to provide administrative or teaching duties on behalf of the practice? What about evening office hours? How will call schedules be handled?

Many smaller practices prefer not to include specific contract language describing job duties or the hours required for a full-time position or call coverage, because specific responsibilities and schedules are subject to change.

Sample language covering this option might read: "You will perform such orders, directions and policies as stated by the employer from time to time. The employer will specifically have the power to determine the duties to be assigned to you and the days and hours of your duties for the employer."

• **Outside activities.** The employment agreement should also cover whether the physician will be able to work outside of the practice. It should address activities such as teaching, writing, giving expert testimony or legal consultation, and moonlighting. These activities would need to be carved out of any restrictive covenant included in the agreement.

• **Compensation.** "When negotiating total compensation, be sure to look at all pieces of the compensation puzzle, not just the base salary, and be sure you're comparing apples with apples," Kalogredis advises.

For instance, if opportunity A provides a guaranteed base annual salary of $100,000, and opportunity B provides a guaranteed base annual salary of $80,000, the first opportunity is not necessarily better than the second. Option A, for instance, might require the employee to pay expenses totaling $20,000 or more, or option B might include $20,000 or more in fringe benefits or business expense reimbursements.

And remember to consider the tax ramifications. A guaranteed salary of $100,000 with the practice paying no expenses does not leave as much in the physician's pocket as a guaranteed salary of $80,000 with the practice paying expenses that total $20,000 per year.

(Editor's note: Next month, we'll provide suggestions for handling expenses, benefits, malpractice insurance, and restrictive covenants.) ■

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.

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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), $457. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $366 per year; 10-20 additional copies, $274 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 $76 each. (GST registration number R128870672.)

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Primary care leads in academic pay hikes

All types of physicians in academic practices enjoyed steady pay hikes last year, with primary care physicians leading the way with median 11.9% pay bumps, according to a new study.

The figures come from the Medical Group Management Association of Englewood, CO, and its "Academic Practice Faculty Compensation & Production Survey Report" and "Academic Practice Management Compensation Survey."

Median compensation for all faculty members in academic practice increased during the 2000 fiscal year, according to the survey. Professors and associate professors enjoyed a 5% pay raise, and associate professors and professors in primary care saw their pay increase 3%.

The median pay for chief department administrators with clinical operations increased $1,000 to $83,000 during 2000, the survey found. Median compensation for associate/assistant administrators, however, dropped $510 to $49,960. ▼

Medicare must reveal physician errors

A New York Federal District Court judge ruled in July that Medicare must disclose the results of a consumer-initiated investigation that found a doctor provided inadequate quality care or committed errors that injured the patient.

The court found that the federal Medicare statute entitled a beneficiary who files a complaint to know whether medical services they received met professionally recognized standards of health care, regardless of whether the doctor in question consents to having the investigatory findings made public. The ruling overturns a federal policy that relied on a confidential physician peer review process to evaluate medical treatment complaints filed by Medicare patients. ▼

Medicare expands coverage

In recent months, Medicare has added several new services and procedures to its list of reimbursable benefits. If you have not already updated your files, these new coverages include:

• **Preventive.** Screenings for breast, cervical, and colorectal cancers are now covered. Beginning in January 2002, Medicare also will cover annual glaucoma screenings and medical nutrition therapy by registered dietitians for beneficiaries with diabetes and renal disease.

• **Sun-induced skin lesions.** Medicare now provides national coverage for treatment of common sun-induced skin lesions, which can develop into skin cancer. The decision to give uniform coverage for removal of actinic keratoses is intended to eliminate perceived inconsistencies in payment criteria among Medicare contractors.

• **Urinary tract.** Sacral nerve stimulation for the treatment of urinary incontinence is now covered. To qualify, patients with urge incontinence or urgency-frequency syndrome must also have failed more conservative treatments, such as behavior modification, drug therapy, or other surgical interventions. ■