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INSIDE

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American Health Consultants® is A Medical Economics Company

Looking for more profits and less hassle? Consider firing your HMOs

Cash-only reimbursement becomes more popular

Fed up with managed care's high costs, low reimbursement rates, and administrative hassles, **Dean Peyton**, MD, has eliminated HMOs from his practice.

Since making the switch last year, the Arlington, TX, family practitioner admits he sees fewer patients, but he also says he makes more money and provides better medical care than he did when most of his practice was managed care-based.

"We came to the realization that we couldn't provide the level of health care that our patients deserved if we were dealing with HMOs," says Peyton, a co-founder of Arlington Family Practice.

Today, some 40% of the six-physician practice's 1,200 patients pay cash. The rest are covered by traditional indemnity insurance or preferred provider organizations.

Like many other trends, this HMO-free concept started on the West Coast and is starting to spread across the country.

"Doctors have just become so frustrated with all the hassles that go with managed care," notes **Vern Cherewatenko**, MD, a family practitioner in Renton, WA. He is active in promoting the idea that doctors should drop their managed care plans in favor of patients who pay cash or are covered by plans that do less second-guessing of medical decisions.

"I've nuked about 80% of the insurance companies from my own practice," says Cherewatenko.

He argues that HMO reimbursement has gotten so low that physicians must sign up as many patients as possible just to make ends meet. That creates a situation in which a trip to the doctor is less pleasant for patients, and doctors are left with less time to spend with them.

"We're forced to juggle patients in two, three, or four examination rooms at once, spending no more than 10 or 15 minutes with each one," Peyton says. "It's incredibly distracting, and it just isn't the level of care that patients deserve."

Besides fostering better patient care, Cherewatenko claims that because he does not have to adhere to HMO-mandated administrative requirements, he can charge a cash-paying patient much less, yet make more money than what his managed care contracts generated. Consider these two theoretical patients provided by Cherewatenko from his practice's experience:

Case 1. Patient A has managed care insurance. The doctor normally charges $80 for a 10-minute office visit. But the insurance company's contract specifies it will only pay $43 for the visit, for which the practice must incur $20 in administrative expenses and $30 in overhead charges related to the examination.

Bottom line: The practice loses $7 on the visit.

Case 2. Patient B pays cash. Because no claims have to be billed to an HMO, there are no additional administrative expenses. Given existing office overhead, the practice can charge that patient $35 for the visit and still make a $5 profit.

Outcome: "You can charge a reasonable fee and still make money when you're dealing with cash," he says.

Cash-paying patients get discounts

Based on his experience with running a cash-oriented practice, Cherewatenko has created a payment program called SimpleCare, which he says is now being used by some 800 physicians nationwide.

The basic idea: Doctors charge cash-paying patients less, based on their actual costs, than they do managed care patients.

A similar program was also recently launched by Jefferson Physician Group, a Dallas-based practice. That program, called Liberty Care, gives cash-paying patients discounts of up to 50% on health services. It costs $120 annually per family. The program's primary market is uninsured families, says **Tim Paquette**, Jefferson's chief operating officer.

"There is a huge segment of our population that has to pay for medical services out of their own pocket," he says. "This enables them to get the same kinds of discounts that everyone gives to the HMOs."

"It's so much simpler, cleaner, and straightforward to deal with the cash-paying patient than dealing with the managed care company," he says.

The big obstacle to a cash-only practice, of course, is that most consumers are insured. However, Cherewatenko estimates that 90% of people willing to pay cash at the doctor's office don't have managed care coverage.

Peyton admits he lost patients when he dropped HMOs. "But it hasn't harmed us in any way. We're thriving," he says. "Plus, my quality of life is much better." ■

Fee for service gains, with modified capitation

Rising popularity of PPOs is a factor

In recent months, major health plans like Aetna Inc., UnitedHealthcare, Cigna HealthCare, PacifiCare Health Systems, and Coventry Health Care have announced they are converting some of their capitation agreements to fee-for-service (FFS) contracts. Also giving FFS a boost is the boom in popularity being enjoyed by preferred provider organizations (PPOs).

The percentage of multispecialty practices with capitated contracts has dropped from 68% in 1996 to 58% in 2000, reports the Medical Group Management Association (MGMA) of Englewood, CO. Based on this trend, MGMA's survey guru, **Dave Gans**, predicts the overall cap rate among multispecialty groups could fall to 40% within the next two years.

Rather than going straight to FFS, some plans are modifying their cap arrangements. In Denver, for instance, Anthem Blue Cross and Blue Shield has changed its money-losing capitated global risk contracts — covering physician, hospital, and pharmacy services —to less risky payment pools for hospital and pharmacy charges. Physicians in the pools share savings with Anthem but are not responsible for losses.

Experts note that California doctors are also dropping their pharmacy and hospital risk provisions, but not professional risk. At PacificCare, for instance, the proportion of members under a global risk contract dropped from 91% in 1998 to 66% in 2001. Meanwhile, members under professional risk only fell from 99% to 98% during the same period.

Because the costs of one sick patient can exceed the capitation income from several healthy patients, a primary care physician needs at least 100 to 150 capitated patients to make the payments worthwhile. This is a major reason

larger groups have traditionally done better under capitation. However, this also is changing.

According to the MGMA, groups generating from half to all their income from capitation had a median revenue of $533,211 per physician in 1999 — less than the median revenue of $562,673 per physician earned by groups that accepted no capitation. Groups earning 11% to 50% of their income from capitation only generated a median of $507,043 per physician.

Rate raises

Flush from double-digit premium rate hikes, many insurers say they plan to raise both their capitation and FFS rates more than usual. Because of the fundamental differences in the two payment systems, however, it is difficult to determine how any increase in reimbursement compares.

Because PPOs cannot cannot guarantee patient volume, they have to pay primary care physicians FFS fees 10% to 15% higher than an HMO pays for the same capitated services, estimates the Chicago-based consulting firm of Milliman USA.

But don't get your hopes up too much. With the economy cooling, many predict that employers will start to tighten their purse strings by restricting their more generous PPO and FFS arrangements.

In fact, "if employers continue to see the kind of premium increases they've seen this year, capitation may make a very big comeback as cost control becomes top priority again," predicts the Managed Care Information Center of Manasquan, NJ. ■

Feds get first settlement in self-referral suit

ACP-ASIM pushing for law amendments

In a precedent-setting move, a Massachusetts group practice recently entered into one of the first known settlements involving alleged violations of the Stark self-referral law. Many experts say the settlement could foreshadow more aggressive enforcement of the Stark II law, once its final Phase I regulations become effective on Jan. 4, 2002.

The civil suit settlement involves an allegation that B.J. Carlen, Inc., formerly known as Pastor Medical Associates ("Pastor"), improperly submitted claims to Medicare seeking reimbursement for clinical laboratory services performed at Pastor's on-site lab.

The government claimed that Pastor's physicians received compensation that was directly linked to the monetary value of the patient referrals made to the lab. According to the government, this direct financial link between compensation and referrals violated the Stark law. The practice agreed to a $230,000 settlement.

New regulations much improved

Many medical experts say the new Stark self-referral regulations are a major improvement over the earlier government proposals.

In a letter to the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration), **C. Anderson Hedberg**, MD, chair of the Medical Services Committee of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), noted the following improvements in the new regulations:

— excluding services personally performed by the referring physician from the definition of "referral";

— no longer requiring a referring physician's presence to meet the supervision requirement needed to qualify for the in-office ancillary exception;

— making it easier to qualify as a group practice;

— allowing physicians to refer to entities with which they have a compensation relationship (as long as the compensation paid to the physician is no more than would be paid to someone who provided the same services but was not in a position to refer to the entity);

— allowing physicians to receive fair market value payment (on a time or unit-of-service basis) for referrals for designated health services, and permitting physicians to supply patients with certain durable medical equipment required for ambulation.

Even so, many physician organizations are still lobbying CMS to make additional changes in the Stark II self-referral rules before they are scheduled to go into final form next year.

One change being sought by ACP-ASIM involves the in-office ancillary services exception governing supervision. The current exception

requires a physician to personally perform or "directly supervise" laboratory tests ordered under Medicare Part B. The direct supervision requirement was interpreted in the Stark I final rule to mean that the physician must be ". . . present in the office suite and immediately available to provide assistance and direction throughout the time services are being performed."

ACP-ASIM likes the final rule because it more liberally redefines the supervision requirement "as the same level of supervision that would already apply under all other Medicare payment and coverage rules for the specific service." Also, it notes the final rule provides practices with further flexibility in furnishing designated health services by allowing independent contractor physicians in a group practice to supervise in-office ancillary tests — something that was prohibited in the proposed rule. **(For tips on running your own lab tests, see story, above.)**

However, it does not like a requirement in the final rule stating that, in order to qualify for the in-office ancillary services exception, physicians must furnish in the same building "substantial physician services that are unrelated to the furnishing of DHS [designated health services] payable by Medicare."

"This standard is undefined and thus would leave physicians guessing as to what 'substantial physician services' meant," Hedberg wrote to CMS. "It could also force physicians into providing services that are not vital to high quality patient care, or for which the physician has lesser expertise, just to meet a vague and somewhat arbitrary standard."

The ACP-ASIM also would like changes in the prohibition on paying a physician group member a share of profits or productivity bonus in a manner related directly to the volume or value of DHS referrals generated by that member. The final rule does not eliminate this requirement (which the ACP-ASIM would prefer). However, it does say the regulations contains several useful clarifications.

For instance, it makes clear that productivity bonuses can be based directly on a physician's personal productivity. For instance, a physician may be paid a share of overall profits of the group or for services the physician has personally performed (including services "incident to" those personally performed), provided that the share or bonus is not determined in a manner directly related to volume or value of the physician's referrals.

However, physicians may not be paid any bonus based directly on their referrals that are performed by someone else within the group, unless those services are provided "incident to" the physician's personally performed services. In addition, the "incident to" services must be directly supervised by the physician.

ACP-ASIM also says the final rule is helpful in providing a definition of "overall profits" as "either the group's entire profits from Medicare payable DHS or the profits derived from the Medicare payable DHS of any component of the group practice that consists of at least five physicians."

It says the final rule "offers useful guidance" to group practices in setting out a number of distribution methods for overall profit shares and productivity bonuses that "will be deemed not to relate directly to the volume or value of referrals."

It also says the final rule also offers groups the flexibility to utilize any other distribution method as long as the methodology is reasonable and verifiable and not directly related to the volume or value of the physician's referrals.

How is 'group practice' defined?

ACP-ASIM also would like a revision in the definition of group practice. It is generally pleased with the final rule's less restrictive definition of group practice, which it says should provide opportunities for sheltering group practice / in-office ancillary arrangements from the Stark law's purview.

Features it especially likes are that independent contractors can supervise the provision of health services under the in-office ancillary services exception and that independent contractors are not counted as true members of the group. The latter provision helps groups meet the requirement that "substantially all" group practice members' services be provided through the group.

The final rule gives a new physician practice 12 months' lead time to qualify as a group practice before the regulations take effect, when practices must meet the requirement that "at least

75% of the total patient care services of the group practice members . . . must be furnished through the group and billed under a billing number . . ."

However, this exception would not apply to an "existing group practice [that] admits a new member."

The ACP-ASIM says it fears that applying this 75% rule to new physicians joining an existing practice could result in many group practices losing their group practice designation for the period of time when a new physician joins the practice. In turn, this could create a "substantial disincentive for physicians wishing to bring younger physicians into their practice," ACP-ASIM says.

It also argues that many physicians are not able to obtain Medicare billing numbers for up to their first nine months of practice, because the carriers have not been able to process their Medicare enrollment applications to permit submission of claims.

For these reasons, ACP-ASIM is recommending new physicians' services not be included in the group practice pool for purposes of the 75% rule calculation. It is also asking that the requirement that a solo practitioner employ at least one other full-time physician to qualify as a group practice be dropped, so that a physician employing a part-time physician would also be able to qualify as a group practice.

Another change the organization seeks concerns not including prescription drugs administered in the physician's office as "outpatient prescription drugs." The final rule provides an in-office ancillary exception for chemotherapeutic agents and drugs administered or dispensed by a physician; creates a "new limited exception" for Erythropoietin and other specific dialysis drugs furnished in end stage renal disease facilities; and establishes a new exception for certain vaccines and immunizations.

However, many physicians would still like all prescription drugs administered in the physician's office not to be classified as "outpatient prescription drugs" to avoid self-referral prohibitions. ■

The basics of operating an in-office laboratory

Get good advice at the outset

The prospect of running into regulatory or reimbursement hassles sours some practices on the idea of establishing their own in-office lab operation. Others, however, says the idea is a relatively low-risk and high-profit connivance for both physicians and patients — as well as good medicine.

Some experts estimate an efficient lab could produce a profit margin of 40% or more by doing tests in-house. Depending on patient mix and how many lab tests you typically run, this could amount to big bucks for practices with as few as four or five doctors. Smaller practices could also benefit by limiting the cost of their most common tests, while still being able to send out less popular ones to cheaper outside labs.

When considering creating an office-based lab, one of the first things you'll want to think about is hiring a certified medical technologist to consult on setting up a Clinical Laboratory Improvement Amendments (CLIA) compliance manual and related procedures for you. This person can also help get the lab going and help train your laboratory staff.

Getting a good handle on CLIA is critical because CLIA sets the standards for quality control, personnel requirements, test management procedures, proficiency testing, and inspections you must follow. For a list of consultants who specialize in lab issues, you can call American Medical Technologists of Corpus Christi, TX, at (847) 823-5169, ext. 226.

Of course you'll need equipment, and what you need varies from practice to practice. But three types of machines common to most office labs are a chemistry analyzer, a hematology analyzer, and an immunoassay machine.

Competition among vendors and improved technology have driven equipment costs down in recent years, putting this equipment within reach of more practices. Also, consider the options of leasing equipment or purchasing used machines. If you go the used route, make sure you get at least a one-year written warranty.

You also should think about downstream operating costs as differentiated from the up-front purchase price. For example, if your test machine operates on a closed system that uses individual cartridges that contain reagent, it will have a higher operating cost per test than machines that

use batch reagents that carry a higher initial sticker price.

Once you have the proper equipment, you'll need someone to work either part-time or full-time running the lab. This could be an existing staff member such as a nurse or medical assistant. A baseline consideration when deciding how qualified — and costly — a person to hire to manage your lab is how complicated the typical test will be.

Many experts say it is a better investment to hire an experienced person to minimize the possibility of future regulatory and testing problems.

Believe it or not, most HMOs will reimburse you for your in-house lab services.

"True, HMOs have national contracts with big labs to do their tests," notes **Charles B. Root**, PhD, of Venture Resources, a Chicago-based firm specializing in laboratory economics. "But, I've found if you simply write and tell them you have the ability to perform these tests in-house and ask to be reimbursed at the standard Medicare rate, typically there's no problem." ■

CMS answers questions about the CLIA program

CLIA covers all lab testing

If you are interested in or already operate an in-house laboratory, it will be subject to the Clinical Laboratory Improvement Amendments (CLIA). Here are answers to the most common questions the Centers for Medicare and Medicaid Services receives from practices about CLIA:

Q: If I don't bill Medicare or Medicaid, do I still need CLIA certification?

A: The CLIA law requires any laboratory performing testing on specimens derived from a human being for purposes of providing diagnosis, treatment, etc., to enroll with the CLIA program, regardless of whether or not the laboratory receives payment from Medicare, Medicaid, or any other third-party payer.

Q: If I'm only doing blood draws, do I need a CLIA number?

A: No. You do not require a CLIA number if the facility only collects specimens and performs no testing.

Q: I'm only doing waived tests. Why do I need a CLIA number?

A: The law requires that all laboratories performing testing, no matter what type of testing they are performing, must have a certificate and obtain a CLIA number.

Q: What about inspections?

A: Many labs are exempt from routine CLIA inspections, including those that perform only waived tests or certain microscopic tests as part of a patient exam. Accredited labs are inspected by their accrediting organization, and labs in CLIA-exempt states (with standards at least as stringent as CLIA) are inspected by the state. These labs pay their inspection fees to the accrediting organization or exempt state, respectively.

Q: My certificate is still current. Why am I getting a bill?

A: The bill you have received is most likely for your next certificate. The CLIA program bills laboratories 6-12 months in advance for the appropriate fees for that particular certificate. This is because CLIA is a user-fee funded program and fees must be collected prior to the laboratory's survey being performed and / or the certificate being issued.

Q: Is CLIA a self-funded program?

A: Yes. Congress mandated that the program be entirely supported by fees. All laboratories must register with the Department of Health and Human Services, obtain a certificate, and pay a certificate fee. Labs performing moderate- or high-complexity tests are inspected every two years . . . with fees assessed to cover inspection costs. ■

Lott says AMA's CPT use is anti-consumer

Taking aim at AMA's 'financial windfall'

The American Medical Association (AMA) has been forced to defend its proprietary Current Procedural Terminology (CPT) coding system for medical services in recent months after coming under criticism from Senate Minority Leader **Trent Lott** (R-MS).

Lott accused the AMA of running a monopoly that guarantees it an annual multimillion-dollar "financial windfall" while preventing consumers

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Physician's Coding Strategist™

Tips for coding new Medicare benefits

Coverage has expanded

Medicare has expanded coverage for several preventive health services in recent months, including the following:

• **Colonoscopies.** In July, Medicare started covering screening colonoscopies every 10 years for beneficiaries not considered at high risk for colorectal cancer, provided they had not already had a screening flexible sigmoidoscopy within the last 48 months. Medicare also covers a screening colonoscopy for high-risk beneficiaries every two years. High-risk individuals are defined as those with a family history of colorectal cancer, prior experience with cancer or precursor neoplastic polyps, a history of chronic digestive disease conditions (including inflammatory bowel disease, Crohn's disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors.

According to **Brett Baker**, a third-party payment specialist with the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in Philadelphia, if you want to bill for a screening colonoscopy for a beneficiary who is not considered high risk for colorectal cancer, you must use HCFA Common Procedure Coding System (HCPCS) code G0121. The code applies to colorectal cancer screening for individuals who do not meet the criteria for high risk.

The 2001 Medicare payment for a screening colonoscopy performed in a hospital or other facility on a patient who is not high risk for colorectal cancer (G0121) is $239.51. (This rate will vary slightly by geographic area.) Medicare gives the same payment for a screening colonoscopy on a high-risk beneficiary, G0105, and for a diagnostic colonoscopy, CPT 45378.

Coding Pap smears/pelvic exams

• **Pap smears/pelvic exams.** In July, Medicare began paying for screening Pap smears and pelvic exams, which include clinical breast exams, every two years for women who are postmenopausal and/or not at high risk for cervical or vaginal cancer. Before July 1, Medicare only covered these screening services every three years.

Meanwhile, Medicare still covers an annual screening Pap smear and pelvic exam for women of childbearing age who have had an abnormal Pap smear within three years or are considered at high risk for cervical or vaginal cancer, notes Baker.

"Medicare considers a woman at high risk if she has a prior history of cancer or sexually transmitted disease; began having sexual intercourse before age 16; has had more than five sexual partners; has not had a Pap smear within seven years; or has a mother who used diethylstilbestrol during pregnancy," he says.

For a screening Pap smear, use HCPCS code Q0091 to report the process of obtaining and preparing the specimen and conveying it to the laboratory. Medicare will pay $38.26 for this code, which will vary somewhat by region, when the specimen is obtained in your office or other outpatient setting.

Medicare pays you separately for obtaining a specimen for a screening Pap smear during a patient office visit or other evaluation and management (E/M) service.

Baker advises you append CPT modifier -25 to the E/M service to indicate that it is a significant,

separately identifiable service performed on the same date as a specimen collection service.

For example, if a beneficiary visits your office for ongoing treatment of her chronic hypertension — a service consistent with a midlevel established patient office visit (CPT 99213) — and you obtain a specimen for a screening Pap smear during that visit, bill 99213-25 in addition to HCPCS Q0091, he says.

Use HCPCS G0101 to report a pelvic exam, Baker advises. The Medicare 2001 payment rate for G0101 is $39.41, which also will vary a little by region.

Medicare will pay separately for a screening pelvic and clinical breast exam (G0101) and for obtaining a specimen for a Pap smear (Q0091) when the two services are billed together for the same patient on the same date. In turn, Medicare will pay for both G0101 and Q0091 when they are billed with an E/M service, as long as the E/M service is appended with modifier -25.

Medicare still pays separately for a pelvic and clinical breast exam performed during a medically necessary office visit, even if you do not obtain a specimen for a screening Pap smear. Append the E/M service with modifier -25 and also bill G0101 for the pelvic and clinical breast exam. ■

Here's how to avoid the top 10 coding mistakes

The Top 10 coding goofs, according to **Ruthann Russo**, executive director of HP3 Healthcare Concepts, a reimbursement and coding consulting firm in Bethlehem, PA, are:

— Failure to document services billed

— Failure to provide signatures

— Consistent assignment to the same level of service

— Billing as a consult rather than an office visit

— Use of invalid codes (e.g., codes taken from an outdated resource)

— Unbundling of procedure codes

— Misinterpreted abbreviations

— Failure to list chief complaint

— Billing as a separate professional fee those services included in a global fee

— Use of an inappropriate modifier or no modifier for accurate payment of a claim

Besides setting off compliance bells with federal auditors, miscoding can also cost you money. Even small mistakes can add up to big bucks. At one 200-physician multispecialty group, Russo's firm found improper coding practices of evaluation and management-level assignments resulting in an estimated $10 million in unbilled services. And that is "a figure that we felt was conservative," she notes.

Nearly nine of 10 coding errors result from mistakes in processing claim forms, says Russo.

A doctor working in the emergency department may fail to write down the chief complaint, thinking the coding staff will use documentation from the registration form. However, this won't happen, because the coding can only be based on physician documentation.

When it comes to reducing physician-related coding errors, "the most important thing you can do is educate physicians on what is important, what they must do to correctly code and to make sure that their coders get their certified professional coder designation," advises **Jim Gibson**, vice president of Comforce, an Addison, TX, health care staffing and recruiting company.

To help reduce the incidence of coding mistakes, the 23-physician Texas Gulf Coast Medical Group in Houston holds regular coding workshops for its physicians and billing staff, notes **Susan R. Waldron**, the group's executive director.

This practice also conducts periodic revenue team meetings in which a physician, a nurse, a front desk representative, a scheduling department representative, and a business office supervisor discuss current claims documentation and billing issues.

One surprising fact these meetings have uncovered is that the group's doctors tend to undercode rather than overcode, contrary what recent government reports might lead many to believe.

One reason for this is that many physicians are unsure of exactly what the latest rules are and are afraid of having the coding cops sweep down if they overcode. Most physicians prefer to take the conservative approach and undercode, according to many coding consultants.

An easy way to address your practice's coding problems is to perform an internal audit to determine the most common reasons that claims are denied or sent back for additional documentation. From this audit's results, you can create a priority list of in-house coding and documentation practices that need to be examined more closely. ■

Are you cheating yourself by undercoding?

Here are some of the top underbilling mistakes

Afraid of drawing the attention of the federal fraud police, more physicians are being extra-cautious when billing Medicare. Add to this the fact that many practices often unknowingly undercharge for many services, and your practice may be leaving a significant amount of legitimate payments on the table.

Being cautious in today's regulatory climate is prudent. However, there's no reason you should not be fully paid for legitimate services. Next time you review your back-office practices, check to see if you are committing any of these common billing and coding oversights, which can choke off your practice's cash flow.

Intimidated by the idea of being red-flagged by government bean-counters, more physicians are taking the cautious approach and downcoding office visits.

Sadly, there is a grain of truth at the center of the widespread physician fear of overzealous fraud cops. But the real smoking gun that auditors look for is a constant billing of higher evaluation and management-level services across a wide array of patients that seems inconsistent with normal practice patterns.

Are you losing legitimate income?

If you do a properly documented multisystem exam of a moderately ill patient that requires multiple diagnoses but you only bill for a level three service instead of level four, you are just denying yourself appropriate payment. In a busy practice, that unbilled legitimate income can add up much faster than you'd think.

On the other hand, billing a level four service for a hypersensitive patient who comes in every month could get you into trouble.

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

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

Also remember not to bill for injections. For instance, charging for both an injection (a minor procedure) and an office visit on the same day without using a modifier is generally prohibited. But, there are exceptions. According to the ProStat Resource Group in Shawnee Mission, KS, physicians often forget that when they can bill for injections, they can bill for both administering the injection and for the drug or vaccine itself. For instance, when giving a vaccination for pneumonia, influenza, or hepatitis B, physicians can bill for the office visit, the injection, and the vaccine.

It's important not to confuse new patient visits with consultations. A patient consultation pays more than a new patient visit. To justify billing for a consult over a new patient visit, the patient must have been sent to you for a consult by another physician, and you must provide the referring physician with an opinion or advice — preferably in writing, and preferably included in the file.

Counseling can increase level of service

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

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

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

Bill for consultations, office visits correctly

Many practices are not clear on when they can bill Medicare for a consultation rather than a typical office visit. Because "consultations tend to be reimbursed at a higher rate than comparable office visits, understanding the differences can be to your advantage," notes **Kent J. Moore**, manager for reimbursement issues at the American Academy of Family Physicians (AAFP) in Leawood, KS.

Moore notes that Medicare only pays for a consultation when all of the following criteria are met:

• A service is provided by a physician whose opinion or advice regarding evaluation and / or management of a specific problem is requested by another physician or other appropriate source — unless it's a patient-generated second opinion.

• A request and need for the consultation are documented in the patient's medical record.

• After the consultation, the consultant prepares a written report of his or her findings and provides it to the referring physician.

If the referring physician and consultant share the medical record, the request for a consult must be documented in one of three ways:

— as part of a plan in the referring physician's progress note;

— as an order in the record;

— as a specific written request for the consultation.

Likewise, the consultant's report may consist of an appropriate entry in the common medical record.

"In situations where the medical record is not shared, the request for a consultation may be documented in one of two ways," says Moore:

— The consultant's record may include either a written request from the referring physician.

— The consulting physician can refer to the request in his or her documentation notes.

In either case, the consultation report should be a separate document supplied to the referring physician.

"When you're the consultant, you could bill a consultation for performing a postoperative evaluation if you didn't already perform the preoperative consultation," Moore advises.

If another physician in your group asks you for a consultation or a surgeon asks you to perform a preoperative consultation, Medicare will reimburse you for a consultation as long as the previously mentioned criteria for use of the consultation codes are met.

"It is also possible to bill a consultation code for performing a postoperative evaluation at a surgeon's request, but only if you did not already perform the preoperative consultation," says Moore.

However, if you assume responsibility for management of a portion or all of a patient's condition during the postoperative period — such as for a local patient who receives surgery out of town — you cannot bill a consultation code, regardless of whether you performed the preoperative consultation. Instead, use the appropriate subsequent hospital care code or office visit code to bill your services, he says.

"If the criteria for a consultation are met, a consultant may bill an encounter as a consultation, even if he or she initiates treatment, unless a transfer of care occurs," Moore says. A transfer of care occurs "when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance," according to Medicare.

The receiving physician should bill an established or new patient office visit code, whichever is appropriate, rather than a consultation code. Any subsequent visits to manage a portion or all of the patient's care are then reported using a visit code, he notes.

Other experts note that physician consultants can initiate diagnostic and / or therapeutic service as the same or a subsequent consultation visit.

"The phrase 'at the same or subsequent visit' clarifies that physicians can report a consultation even if they initiate treatment — assuming the criteria for billing a consultation have been met," says **Brett Baker**, a reimbursement expert with the American College of Physicians - American Society of Internal Medicine (ACP-ASIM) in Philadelphia.

If you assume responsibility for any or all of a patient's care, however, you should not use CPT consultation codes for any other visits, says Baker. Instead, use the subsequent hospital care codes in an inpatient setting and established-patient office visit codes in an outpatient venue. Also, be sure to document the request for a consult in the patient's medical record.

Physician consultants also should send the requesting doctor a written report detailing their observations and any resulting suggested or rendered diagnostic and / or therapeutic services. ■

(Continued from page 150)

from comparison-shopping for outpatient medical care.

In what some say is a related event, these accusations came shortly after the Department of Health and Human Services (HHS) ordered Aspen Systems of Germantown, MD, to stop work on its contract to help develop a new set of evaluation and management (E/M) guidelines used to bill Medicare and other insurers. Medicare has been trying to devise an alternative to the current (1995 and 1997) guidelines for six years.

Many coding insiders took this action to mean any new E/M codes, along with new guidelines for billing them, would be developed and incorporated into the CPT system.

As part of the Senate finance committee's investigation into reforming and modernizing Medicare's bureaucracy, Lott has asked HHS Secretary Tommy G. Thompson to provide a detailed accounting of Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) efforts to update inpatient codes and the impact of the AMA's coding system upon that effort.

Lott and other critics are especially interested in HHS' attempt to develop, through a contractor, its own coding system for inpatient services, and in the relationship between any HHS system and the AMA's outpatient coding system.

Investigators are also looking into the terms of the agreement between the federal government and the AMA concerning the use of the AMA's CPT system.

Lott said in his letter to HHS that it "is my understanding that HCFA [CMS' predecessor] in 1983 granted the AMA what has been characterized as a 'statutory monopoly' by agreeing to exclusively use and promote the AMA's copyrighted CPT code for the purposes of reimbursing Medicare and Medicaid bills from doctors for outpatient services."

As a result, other entities, including private insurance companies, had to adopt CPT as their primary billing standard, Lott said.

"This predictably led to a financial windfall for the AMA in the form of CPT-related book sales and royalties approaching $71 million a year, according to a report by the *Wall Street Journal*," Lott commented. The AMA says the figure is really closer to $18 million annually.

Lott also claimed that the existence of the AMA coding system prevents consumers from comparison-shopping for medical services. By suing web sites and others to block them from posting comparisons of doctor and other medical fees on the Internet, the AMA has made such comparisons impossible, he said.

The AMA has responded by saying it lets the federal government use the CPT system without charge and only charges licensing fees when the codes are used for profit-making purposes.

As far as the widespread use of the codes is concerned, private concerns, like insurers, have voluntarily adopted it "because the AMA code set is comprehensive, reflects expert physician input, and most accurately describes the full range of services that physicians provide for a given procedure," says AMA Chairman **Timothy Flaherty**, MD. CPT is the "gold standard" of medical coding, he maintains.

Not all physicians feel this way, said **Kathryn Serkes**, spokeswoman for the Tucson, AZ -based Association of American Physicians and Surgeons: "Senator Lott deserves everyone's support in his effort to pull the rug out from under the AMA's secret monopoly on these codes. Elimination of this AMA cartel will do more to protect patients than any patient's bill of rights law." ■

CA practices flounder; how sound is your group?

Key questions to ask yourself

Nearly one-fourth of California's medical groups don't meet the state's financial solvency requirements, finds a recent report by the state's Department of Managed Health Care.

"This demonstrates the grave instability in the for-profit HMO system that threatens to affect patients," said **Daniel Zingale**, director of the California Department of Managed Health Care. "Those in the hole are deep in the hole."

Some 25% of California's groups have assets worth less than 70% of what they owe others, according to the agency. Also, 20% of groups have a negative net worth and little to no tangible assets.

In response, the state is considering actions ranging from publishing the names of troubled groups in the newspaper to forcing HMOs to

drop contracts or stop enrolling members in practices with severe financial problems.

Just how financially sound is your practice? Here are some key questions to help you size up your practice:

• **How busy are you?** Seeing about 28 or more patients per physician each day is baseline for a full practice. If each physician sees fewer than 22 patients a day, you are probably looking at a cash flow problem, depending on the economics of the practice.

• **Are you growing?** Are you busy enough to justify adding a new physician? For a family practice, a general rule of thumb is that you need 2,000 lives or active charts to support each full-time physician (3,000 for a team composed of one family physician and one midlevel provider).

Patients added vs. patients lost

• **Are you generating new patients?** A four-physician group that adds an average of 20 new patients a month is probably growing fast enough to add another physician. Or, looking at it another way, if you are turning away 20 new appointments a month because your schedule is too full, you may be able to justify a new hire. Finally, are more of your established patients leaving for another practice than new patients being added?

• **What is your percentage of revenue and patient visits from capitated systems?** Does this mirror your local market mix? The more capitation you carry, the more efficient you'll need to be when it comes to primary care, hospitalizations, and specialist referrals.

• **Is the practice making the same or more from capitation than it would from providing the same care under a fee-for-service arrangement?**

• **If more than 15% to 20% of the practice revenue comes from a single HMO contract, what would happen if you lost that business?**

The right physician compensation package will depend on the dynamics of your group. However, one rule of thumb is that after revenues from capitation exceed 30% to 40% of your practice, it no longer makes sense to reward physicians purely on a fee-for-service-based productivity formula. At this point, it is better to start looking at pay packages that reward increased utilization or other measurable factors like productivity as a percent of billings, quality, or patient satisfaction.

Generally, a thriving family practice generates over $300,000 in billings per full-time physician. A collection ratio of 80% or more from both fee for service and capitation is considered good.

Typical total overhead as a percent of revenues for an average family practice office is about 60%. Anything lower either means you are running a very efficient office or don't have enough support staff, which may cost you in the long run in the form of overworked doctors and lost ancillary income. ■

Physician fee schedule shifts to RVU payments

A look at what's ahead

Medicare's proposed 2002 payment schedule for physicians will complete the four-year transition from paying doctors based on the fees they charge to paying them according to the resources they use in providing services.

In 2002, for instance, all components of the fee schedule — physician work, malpractice expenses, and practice expenses — will reflect the relative costs of resources used in providing physician services. Physician fees in 2002 also will be affected by a statutorily required five-year review of the work component of the schedule.

Among the specialties, general surgery and pathology are slated for increases of 4% and 3% respectively, while ophthalmology can look for a 1% payment cut.

The Centers for Medicare and Medicaid Services (CMS) estimates it will spend some $45 billion in 2002 on physician fee payments. New physician services that Medicare will pay for in 2002 include an annual glaucoma screening for persons at high risk for glaucoma, for those with a family history of the disease, and for individuals with diabetes.

Medical nutrition therapy is also covered for the first time for individuals with diabetes or renal disease. Medicare also wants to increase payment for screening mammography services from $69 to approximately $88, as well as to provide payment for certain new mammography services.

Also included in Medicare's 2002 physician fee schedule is a proposal permitting "auxiliary personnel to provide services incident to the

services of physicians or practitioners who supervise them, regardless of the employment relationship."

Reimbursement experts say this will create greater flexibility for group practices to bill Medicare for services performed by physician assistants (PAs) and nurse practitioners operating as independent contractors when these contractors perform follow-up and other services on behalf of physicians in the practice.

Under current Medicare rules, PAs are free to perform any Medicare-eligible services in any setting that's been approved by the program, provided they conform to local state guidelines.

In exchange for this increased flexibility, Medicare lowered its PA payment rate from 100% to 85% of the fee schedule in effect if the same service had been provided by a physician.

While Medicare still pays PAs through their practice employer, Congress also made it easier for them to enter into an independent contractor relationship with practices. ■

Physician extenders boost profits: Study

Hiring non-physician providers (NPP) such as physician assistants, nurse practitioners, and other so-called physician extenders does increase the cost of running a practice, found a study by the American Medial Association's Center for Health Policy Research.

But because of the increased productivity and efficiency NPPs can bring to the practice, physicians in solo and group practices employing NPPs increase their net income by an average of 18%, estimates the AMA.

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

Indeed, another study by the Medical Group Management Association of Englewood, CO, found that the salary of a typical physician assistant only consumes about 30% of his or her related patient billings. In comparison, salaries of podiatrists consume 34%, OB/GYNs 35%, and internists 43% of the practice revenue they generate. ■

More practices pressing for arbitration clauses

Here's the language to help you

Rather than suing each other, a growing number of providers and payers are opting to use alternative dispute resolution (ADR) mechanisms such as arbitration and mediation to settle their differences.

Organizations such as the New York City-based American Arbitration Association (AAA) and the American Health Lawyers Association (AHLA) in Washington, DC, say they have seen a major surge in health care-related dispute resolution agreements over the past five years.

"There has been a real boom in alternative dispute resolution between providers and health plans," maintains AAA vice president **Robert Meade**.

During the first 11 months of 2000, the AAA was involved in 368 non-patient-related health care disputes. Of those disputes, 337 cases involved conflicts between providers and managed care companies, Meade says. Those cases settled for a total of $374 million, or more than $1 million each.

The AHLA handled 67 such cases in 1999-2000, a 29% increase over 1998-1999.

"Recently, we've been seeing a significant increase in the number of cases that come to us," notes the AHLA's **Peter Leibold**.

One reason for this increase is that more providers are demanding arbitration provisions be written into their contracts with insurers. **(For suggested contract language, see story, p. 158.)**

"I'd say this idea is growing tremendously among practices," says **David Florin** of law firm Crowell and Moring of Washington, DC.

Another ADR growth area involves practice-physician employment contracts. "I've noticed what seems to be a jump in employment contract-related disputes in the health care area, especially among physicians and their former medical groups over things like unfair termination of their contract or disagreements over non-compete agreements," Leibold says.

Many experts say these kinds of employment disputes are especially well-suited for ADR because this is typically a less expensive and faster way to settle differences than going to court. ■

Dispute language suggested for contracts

Here's some arbitration/mediation wording

Here are several examples of language developed by the American Arbitration Association (AAA) of New York City for inclusion in contracts that provide for the arbitration of future disputes.

• **Example 1:** This language can be used in contracts.

"Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by the American Arbitration Association under its National Rules for the Resolution of Employment Disputes, and judgment upon the award rendered by the arbitrator(s) may be entered by any court having jurisdiction thereof."

• **Example 2:** Arbitration of existing disputes can be accomplished by use of the following clause.

"We, the undersigned parties, hereby agree to submit to arbitration, administered by the American Arbitration Association under its National Rules for the Resolution of Employment Disputes, the following controversy: (describe briefly). We further agree that the above controversy be submitted to (one) (three) arbitrator(s) selected from the roster of arbitrators of the American Arbitration Association, and that a judgment of any court having jurisdiction may be entered on the award."

• **Example 3:** Parties may agree to use mediation on an informal basis for selected disputes, or mediation can be designated in a personnel manual as a step prior to arbitration, litigation, or some other dispute resolution technique. If the parties want to adopt mediation as part of their contractual dispute-settlement procedure, they can add the following mediation clause to their contract.

"If a dispute arises out of or relates to this contract, or the breach thereof, and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its Employment Mediation Rules before resorting to arbitration, litigation or some other dispute resolution process."

• **Example 4:** If the parties want to use a mediator to resolve an existing dispute, they can enter into the following submission:

"The parties hereby submit the following dispute to mediation administered by the American Arbitration Association under its Employment Mediation Rules (the clause may also provide for the qualifications of the mediator(s), method of payment, locale of meetings, and any other item of concern to the parties)."

Employee disputes

If you decide to set up an arbitration or other alternative dispute resolution mechanism in your practice, here are some suggestions from the AAA's Task Force on Alternative Dispute Resolution in Employment:

• **Due process protocol.** Employees should not be permitted to waive their right to judicial relief of statutory claims arising out of the employment relationship for any reason.

• **Choice of representative.** Employees considering the use of or now utilizing mediation and/or arbitration procedures should have the right to be represented by a spokesperson of their own choosing. The mediation and arbitration procedure should also specify and include reference to institutions that might offer assistance, such as bar associations, legal service associations, civil rights organizations, trade unions, etc.

• **Fees for representation.** The amount and method of payment for representation should

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be determined between the claimant and the representative. The AAA, however, recommends employers reimburse at least a portion of the employee's attorney fees, especially for lower-paid employees. The arbitrator should also have the authority to provide for fee reimbursement, in whole or in part, as part of the remedy.

• **Access to information.** Adequate but limited pre-trial discovery is to be encouraged and employees should have access to all information reasonably relevant to mediation and/or arbitration of their claims. The employees' representative should also have reasonable pre-hearing and hearing access to all such information and documentation.

"Necessary pre-hearing depositions consistent with the expedited nature of arbitration should also be available," says the AAA. ■

Feds expand treatment for breast and cervical cancer

Nine states added to Medicaid program

The Department of Health and Human Services (HHS) has approved nine state plan amendments allowing expanded Medicaid coverage to women diagnosed with breast or cervical cancer through a federal screening program.

Alabama, Georgia, Iowa, Mississippi, Missouri, North Dakota, South Carolina, Virginia, and Washington are the latest states to be given a green light to amend their Medicaid programs to expand coverage under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000.

So far, HHS has approved state plan amendments allowing 19 states to expand Medicaid coverage to this new eligibility category.

In addition to the nine most recent approvals, Utah, Idaho, South Dakota, Illinois, Indiana, Montana, Rhode Island, New Hampshire, West Virginia, and Maryland have been given permission by the Centers for Medicare and Medicaid Services to take advantage of the new option, according to HHS.

An October 2000 law (Pub. L. No. 106-354) created the optional Medicaid eligibility category for low-income women diagnosed with breast or cervical cancer through the Centers for Disease Control Prevention's National Breast and Cervical Cancer Early Detection Program.

States that decide to expand coverage under this new option will receive an enhanced federal match of up to 85% of the costs, according to HHS. Women qualifying for coverage under Medicaid must be under 65 and without "creditable" health care coverage. These women may be eligible for Medicaid coverage for the duration of their cancer treatment. ■

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News Briefs

Failure to ease pain brings large jury award

A San Francisco jury awarded $1.5 million to a family of a deceased cancer patient who died while experiencing severe pain. The jurors agree that Wing Chin, MD, failed to address the patient's pain adequately, but it did not rule that he acted with malice or had intentionally caused emotional distress, so there were no punitive damages.

In a trial that became a forum for the debate over how pain is treated in American medicine, an Alameda County jury on June 14 found that the internist committed elder abuse and reckless negligence by not giving enough pain medication to William Bergman, who died in 1998.

The suit was brought by Beverly Bergman, 45, the daughter of the retired railroad detective. The verdict is a major victory for patients' rights advocates who argue that many doctors don't treat pain adequately. ▼

Certified palliative medicine docs on the rise

The American Board of Hospice and Palliative Medicine (ABHPM) granted certification to an additional 56 physicians as of July 1, bringing the number of physicians certified in the specialty of hospice and palliative medicine to 835 worldwide.

The medical specialty of palliative medicine is devoted to achieving the best possible quality of life for patients and their families faced with a life-threatening or terminal illness. Physicians who achieve ABHPM certification are recognized as experts in the practice of palliative medicine.

"The art and science of care for patients who are not likely to be cured has always been an important part of the physician's role," says **Ronald Schonwetter**, MD, ABHPM chairman. "Unfortunately, for the last generation of physicians, training in palliative care was not considered important. Physicians had to keep up with all of the technological advances in curative medicine. But all patients die eventually. Unless the physician is skilled in providing pain control, symptom relief, and working with a palliative care or hospice team, patients generally will not have the opportunities for comfort, dignity, and closure that they deserve. ABHPM diplomates are the physicians helping medicine realize the importance of high quality end-of-life care."

Eligibility requirements for certification from ABHPM are significant. Applicants for certification must have received prior major specialty certification, have practiced at least two years following residency, have worked as a member of an interdisciplinary team for at least two years, and have directly participated in the active care of at least 50 terminally ill patients in the preceding three years. Applicants who meet these requirements are then permitted to sit for the annual certifying examination.

A handbook for examination applicants as well as other information on the American Board of Hospice and Palliative Medicine may be obtained from the ABHPM web site at www.ABHPM.org or by calling (301) 439-8001. ■