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Worsening economic outlook will bring lower Medicare reimbursement rates

Economic slowdown affecting payment formula changes

If the economy continues weakening as expected, this will activate automatic changes in Medicare's physician fee schedule that would cut projected pay raises for next year by as much as two to three percent, say reimbursement experts.

Each year, Medicare updates its physician fee schedule to account for changes in the cost of providing health care services. Last March, the Centers for Medicare and Medicaid Services (CMS) issued an initial estimate that predicted the 2002 update would be -0.1%. Now CMS officials are saying the fee schedule update could be several percentage points lower, based on the most recent economic data.

"I am very concerned about what kind of impact that would have on physicians who are already accepting discounted payments for Medicare patients in many parts of the country," notes **Alan Nelson**, MD, an internist and a member of the Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment issues.

Others note that over the past two years, Medicare's physician payments have jumped a total of 10% — a significant amount that will help cushion next year's shortfall.

Sustainable growth rate targeted for change

These events have spurred physicians to put increased pressure on CMS to revamp the formula used to calculate changes in Medicare's fee structure, especially when it comes to setting the sustainable growth rate (SGR) used to establish a spending target for physician services.

The SGR takes into account four factors: gross domestic product (GDP) growth, changes in Medicare fee-for-service enrollment, increases in fees for physician services, and changes in physician spending due to law or

regulation. Accurately calculated, the SGR should expand per-beneficiary spending at the rate of increase in the gross domestic product.

After the SGR is established, CMS calculates the payment update with a congressionally mandated formula based on the change in costs for physician services as measured by the Medicare Economic Index, as well as expected changes in physician behavior due to payment modifications. If physician spending exceeds the target rate in a given year, Medicare cuts spending for the next year. If the GDP does not grow as much as predicted — or the volume of doctor services grows more rapidly than expected — physician spending by Medicare is likely to exceed the SGR.

It seems both of these possible scenarios are coming true this year, notes **Yank Coble**, MD, speaking for the American Medical Association (AMA). For instance, the GDP for 2000 is being revised downward by economists, while the 2001 GDP is not expected to meet projections. Meanwhile, initial estimates from CMS show that Medicare spending for physician services is rising faster than in previous years.

Part of the problem is that the CMS does not accurately account for all costs when it calculates the cost of physician services, especially the costs of new Medicare regulations, quality improvement projects, and large one-time costs, such as Y2K conversions, contends the AMA.

Type of beneficiary should be accounted for

To soften this projected shortfall, the AMA and other groups have suggested that if the CMS uses the current formula, it should then adjust the numbers to calculate the SGR and the update. Specifically, physician groups want Medicare to account not only for an increase in enrollment but also for the type of beneficiary it enrolls in its fee-for-service program to provide additional funding for the growing percentage of high-cost patients, such as those with disabilities or end-stage renal disease.

Meanwhile, various medical societies are also lobbying Congress and CMS to make other regulatory and legislative changes to push up payments, such as increasing spending for physical therapy and nonphysician practitioners. However, with the nation's capital focused on the war on terrorists, Beltway insiders are saying any other "nonessential" legislation will probably be on hold for the foreseeable future. ■

A healthy bottom line means plugging the leaks

Here are key flaws to look for

Even if you think your practice is doing well financially, it could still be leaking cash. What can you do to identify and plug possible holes in your cash flow? According to the St. Louis-based accounting and management consulting firm of Stone Carlie & Co., important areas to investigate include:

1. Cash controls. Compare your monthly patient revenues posted in the billing system to the amount posted in the general ledger. The totals should be the same. If not, any differences will have to be reconciled.

If the amount in the general ledger is less than that on the billing report, it could mean there are posting errors in the billing system or that deposits are not being posted to the general ledger, which would affect cash flow.

Next, examine your daily activity to determine whether the total payments per superbills, receipts, and check copies equal the amount posted to the billing system and the amounts listed on the bank deposit slip and on the related bank deposit receipt.

For even more detail, compare your billing system end-of-month numbers with the reconciled bank statement. If you notice a series of discrepancies, this could mean you have "leakage" problems requiring more formal cash management controls.

2. Billing. To ensure proper cash flow, office visit and procedure charges should be submitted to the insurance company within one working day. Hospital and surgery charges should take no longer than five days to submit.

Remember: Some insurers include clauses in their contracts that say they can deny payment if a claim is not is not submitted within a certain amount of time, usually 90 days.

3. Collections. Review collections by payer and type of claim to determine how long it takes to get paid — and how long it takes before your staff start following up on unpaid claims. Make a chart of excuses given by payers for delays or denials so you can review your procedures and install proper countermeasures.

4. Accounts receivable. How do your key accounts receivable indicators such as gross

collection rate, net collection rate, accounts receivable ratio, and adjustment rate compare to similar practices of your size and specialty? The Medical Group Management Association in Englewood, CO, is a good source for this type of information.

Here are some critical ratios you should be constantly tracking:

• Gross collection rate: This figure, which is receipts divided by charges, indicates the amount of money coming into the practice in comparison with charges. For most specialties, this rate should be between 70% and 80%.

• Net collection rate: This figure, which is receipts divided by the difference of charges minus adjustments, shows the relationship between receipts and charges once the anticipated adjustments are removed. A rate of more than 90% generally indicates a healthy collection rate.

• Accounts receivable ratio shows how fast charges are being paid. Depending on the specialty, this can range from 1.2 to 2.5 months, meaning it takes an average of 36 to 75 days to receive payment. Ideally, you want no more than 20% to 25% of your accounts receivable to be greater than 90 days old.

• Adjustment ratio indicates what percent of the charges are being adjusted. The lower the percentage, the better. If the ratio is greater than 30%, it would be prudent to look at the amounts in the individual adjustment accounts to determine whether there are any accounts that seem unusually large.

Higher-than-normal adjustment ratios, along with low collection rates, could be caused by inappropriate fees or unnecessary write-offs. Unnecessary write-offs could be caused by a lack of staff knowledge about what the insurance companies should be paying for certain procedures and/or the lack of denial appeal activities. ■

Talking time will cost you, practice tells drug reps

Salespeople must pay for appointments

In a controversial move, earlier this year Cincinnati's Queen City Physicians group told drug company representatives calling on the practice that it would no longer be accepting traditional company-sponsored gifts.

Instead, if a pharmaceutical firm wants to pitch its products to anyone in the 56-physician multispecialty practice, it would have to pay $65 for a 10-minute visit.

"Some doctors would like to have that information but don't have two hours to go to a dinner meeting," explains Queen City internist **G. Stephen Cleves**, MD. "Rather than getting a free gift from a pharmaceutical rep, I'd personally rather see that money put to use to directly benefit the patient."

Under the group's plan, drug representatives or their companies sign up for appointments through a for-profit company, Physician Access Management Ltd. It was set up by the practice, with the doctors wanting to participate in the pay-to-pitch program.

None of this money goes directly to individual physicians. Rather, Queen City plans to use this money to help finance a new $1 million computerized medical records system for the practice.

Under the American Medical Association's guidelines on gifts to physicians, individual gifts "of minimal value" are permitted provided they are related to the physician's work.

As such, modest meals and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted.

However, a fee-based system like Queen City's strips the physician-drug representative meetings of any pretense, argues **Frank A. Reddick**, MD, chairman of the AMA's Council on Ethical and Judicial Affairs.

'It might prove a refreshing approach'

"This is setting up a commercial relationship, and it might prove a refreshing approach in that it's a straightforward transaction," says Reddick, an endocrinologist in New Orleans. "Whatever the pharmaceutical reps would have you say about their role, they have to admit it is a fundamentally a commercial one."

Leonard Nelson, a lawyer in the AMA's health law division, is more cautious. While not saying the arrangement is illegal, he says this is a radical new approach that could tread on the border of the law. His worry is that once hard cash starts changing hands, some physicians might start wanting more money in exchange for their business.

Others note that drug companies spend an average of $1,500 on marketing per physician per

year. That's not chicken feed, but it's certainly not enough to corrupt most providers.

"You're not talking about astronomical amounts of money," observes **Neil Carrey**, a health care attorney with the Jenkens & Gilchrist law firm in Los Angeles. "But if innovative, it could make this whole marketing thing more upfront, not less, so that everyone — doctors, patients and the reps — end up winning." ■

You may walk the walk, but do you talk the talk?

Documentation critical to accurate billing

Here are five strategies for addressing areas of practice billing that are often riddled with errors, as well as ways to improve your billing processes and keep federal fraud investigators off your back:

1. Document all findings. Many physicians, especially surgeons, frequently fail to document the number of a patient's bodily systems they review, which could lift an office visit out of a level one exam. This is the case despite the fact that Medicare's evaluation and management (E/M) documentation guidelines require a history of present illness, a review of systems, and medical, social, and family histories.

"You find the docs often forget to note that the results of a review of a particular system were negative, even though they'd get credit for reviewing that system if they did," says **Lisa Warren**, of Warren, Averett, Kimbrough & Marino, a consulting firm located in Birmingham, AL.

For instance, if you find the cardiovascular system was negative, you can get credit for reviewing that system if you write "regular rate and rhythm."

2. Verify consults. Many physicians don't adequately document consults in the medical records, notes Warren. For example, coding rules say the consulting physician must explicitly state that "this is a consult for Dr. X" to qualify as a consult. The lesson is that it is not enough to use a consult code without also documenting in the dictation who the consultation was for. As such, physicians need to get in the habit of saying, "This patient was referred to me by Dr. X and we are looking at Y."

It is also important for consulting physicians to stay in communication by copying the ordering physician in the dictation. "Part of the definition of a consult is that you communicate with the referring doctor what you did with this patient," says Warren.

3. Note the little things. Physicians frequently fail to document routine parts of an exam, such as taking the patient's temperature, blood pressure, weight, and height. "This is all part of the exam," Warren says. "Some physicians don't realize this counts toward the bullets for the exam" in the Medicare E/M documentation guidelines.

Tip: Even if the nurse checks vital signs and writes the results in the chart, the doctor still gets credit, because a physician still has to sign off on the exam and dictate what happened for transcription.

4. Report lab results. Failing to report lab results reduces the complexity of medical decision-making, which lowers the level of service that can be billed. "When you order lab tests or review the results of an X-ray, for example, be sure to dictate

Here's how to improve documentation

When it comes proper documentation, here's what the Bethlehem, PA-based consulting firm of HP3 says are fundamental rules every practice should follow:

— Medical documentation should be complete, clear, and specific.

— The attending physician is the ultimate authority for determining what kind of clinical documentation goes in a patient's records.

— Physicians should document the rationales behind their treatment decisions. For example, when a test or drug is ordered for a patient, the physician should document the diagnosis or differential diagnoses he or she is treating, confirming, or ruling out.

— Improved documentation is an ongoing process, not a one-time or occasional effort. It must embrace every person involved in the coding and documentation chain, including physicians, case managers, nurse managers, coding professionals, other clinicians, and compliance officers. ■

that you looked at the data and took whatever action was appropriate," says Warren.

If you have an in-house lab in your office, reporting lab results in your notes or transcription and recording how it affected your treatment plan is a particularly important part of the documentation process.

5. Look for what's missing. One cause of undercoding is that physicians often fail to give their coders the full story about the procedures they perform each day. For example, a surgeon may tell his clerk he performed an appendectomy that morning, but he may forget to report that he performed another procedure, so the clerk submits a bill for less than what could legitimately be billed.

Tip: Many experts recommend waiting until you've received a copy of the hospital's operation notes before billing a surgery, because the surgeon may have misstated something or the clerk may have misunderstood the type and number of procedures performed, which could lead to either underbilling or overbilling. ■

Medicare offers data for comparing billing patterns

Track CPT coding trends

A relatively fast way to compare how the codes you most frequently use compare to the national average for other practices is to access Medicare's Part B billing data. These data on physicians' services and specialty-specific procedure code utilization are available for free on the Internet.

"This will permit you to view the number of times your specialty billed each Current Procedural Terminology [CPT] code. Using this information and a few simple calculations, you can determine the frequency with which your specialty billed Medicare for a particular CPT code within its family of codes," notes **Brent Baker**, a reimbursement specialist with the American College of Physicians-American Society of Internal Medicine (ACP-ASIM).

Follow these instructions from Baker, and you'll be able to use Medicare's on-line database to find out the frequency and distribution of your specialty's billing of specific CPT codes. For instance, you can find the frequency and distribution of internists' billing of established patient office visit codes. You can also use these figures, which represent national billing patterns, as a general guide when assessing your own billing patterns. Medicare carriers, for instance, use these physician billing profiles to find billing patterns outside the norm so they can flag practices for possible investigation.

Here's how to get started with your computer search:

- Create a folder on your C: drive, name it "Specialty Utilization," and note the folder's location.
- Go to the Centers for Medicare and Medicaid Services (CMS) Internet home page at www.cms.gov.
- Click on the "Stats and Data" box in the left-hand column of the site's main page, which contains the "Welcome to" heading.
- Click on "Resource Based Practice Expense Data Files" under the "Information Clearinghouse" heading.
- Click on "Procedure Code Utilization by Specialty" under the "Interim Resource Based Practice Expense Data Files" heading.
- You will be prompted to save the database file to your hard drive; click on the "yes" button and save the file in the "Specialty Utilization" folder you created on your C: drive. Once the file has been saved, exit your Internet browser.
- Go to your C: drive and open the "Specialty Utilization" folder. You will find a file named "Specutil.exe"; double-click on this file. A window will appear telling you that three files are being decompressed and deposited into your "Specialty Utilization" folder. The window will disappear once the files have been decompressed.
- Go to your "Specialty Utilization" folder. In addition to the Specutil.exe file (which you can now discard), there should be four other files. Look for the file named "Specutil.mdb" and open it in Microsoft Access or another database program. If you have a recent version of Access, you will be prompted to convert or open the file; choose to convert the file. You will then be prompted to save the file; save it in your "Specialty Utilization" folder and assign it a new file name.
- A box will appear asking you to acknowledge the AMA's copyright; click on the "OK" button.
- In Microsoft Access, you will see three tables:

Where do you fall on the coding curve?

Besides government investigators, commercial payers also track your coding practices to see if they fall within the normal bell curve for your specialty.

All insurers, including Medicare, benchmark physician evaluation and management (E/M) coding to develop benchmark claim patterns that they then use to help flag practices that fall outside the norm. You can do the same thing to see how your practice compares.

Performing your own in-house comparison helps you learn where you fall on the curve — and why — which can be helpful in evaluating your patient mix and coding habits. It also can help you explain any suspicious-looking patterns to auditors.

Here are some of the common elements investigators use when creating the coding benchmarks they choose to track:

- amount of physician documentation;
- specialty (and sub-specialization within a specialty);
- diagnostic focus (i.e., the type of conditions treated);
- diagnostic severity;
- patient mix;
- practice style;
- place of service. ■

Table 1 provides a note on non-facility PE-RVU; disregard this information.

Table 2 is a specialty code description table that lists all the specialty designation codes. For example, the specialty designation code for internal medicine is "11" and the code for rheumatology is "66." You will use the two-digit number for your specialty to locate the relevant data in the utilization database.

Table 3 is a utilization table that contains utilization data per code for each specialty. The table, which contains a massive amount of information, has headings of: CPT (HCPCS) code; modifier, HCFA specialty code; facility indicator; and allowed service.

Follow these steps to determine the frequency and distribution of billings for a family of codes:

1. Select a family of codes.

2. Find the appropriate specialty code and total the "allowed service" column for each individual CPT code. Note: A single specialty may have more than one allowed service number for a single CPT code because of modifiers.

3. Add the allowed services for each CPT code to arrive at the total for the specialty for a family of codes.

4. Divide the total allowed services for each individual CPT code by the total allowed services for the family of codes to arrive at a percentage for each individual code. The percentage for each code signifies the frequency with which it is billed compared to the other levels of service within its family of codes. ■

A blueprint for monitoring managed care contracts

Give yourself a competitive advantage

The first step toward monitoring your managed care financials is making sure you have a contract specifying that the HMO you are doing business with must provide specific information in a timely fashion — and what will happen if it fails to perform.

The Westchester, IL-based Healthcare Financial Management Association (HFMA) advises that certain financial data related to practice contracts, such as capitation reports, are compiled by all managed care organizations (MCOs) and should be shared with your practice. Each of these reports — along with their formats, frequencies, and age of the data included — should be specified in your contract

Make sure you can audit data

Tip: To guarantee the accuracy of the data you are receiving, include a provision in the agreement giving you the right to audit and inspect any related information.

Your contract also needs to specify any consequences should the plan fail to provide the agreed-upon data. Consequences could include provisions allowing you to terminate the deal, making the

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Physician's Coding Strategist™

Understanding modifiers a key to better coding

How does modifier -25 differ from -26?

Normally, Medicare only pays physicians once for a specific service provided to a specific patient per day. However, there are exceptions that are usually noted by placing a modifier on a code.

Here's a primer on how to use these modifiers correctly:

• **Modifier -25 (new patient visit).**

Modifier -25 is primarily designed for use with a new patient visit or a consultation, which is usually for a new patient. The usual justification for using this modifier is when a physician does the entire work-up of the patient, and a procedure is performed as a result of the work-up.

Tip: Most practices get into coding trouble for using modifier -25 with an established patient.

• **Modifier -26 (professional component).**

If not correctly used, modifier-26, professional component, can produce both undercoding and overcoding. For instance, the global package for certain radiological procedures includes the technical and professional component. If a physician performs a fluoroscopy, and you include modifier -26, this indicates the physician both owns the equipment and interpreted the fluoroscopy data.

Because Medicare pays more for the owning or leasing of equipment than for interpretation, you would be overcoding if you used modifier -26 and your facility did not really own the equipment. However, if you own the equipment and use modifier -26, you would be undercoding.

• **Modifier -50 (bilateral procedure).**

Superbills make this one of the most misused modifiers in anesthesia, say experts. Many physicians, for example, think each time they perform a separate injection it is counted as an additional procedure. But superbills are designed to have a first level and then subsequent levels of service.

For example, say a physician does a bilateral injection at two levels, meaning she gives four injections. The doctor then writes on the superbill the primary procedure times one and additional levels times three. However, this really should have been coded as the primary procedure times one plus modifier -50, and a subsequent level times one plus modifier -50.

• **Modifier -59 (services not usually performed together).**

This modifier is used to identify services not usually performed together except in certain circumstances. Reasons why two procedures or services that are not normally reported together might be included on the same UB-92 form include:

— separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician;
— different session or patient encounter;
— different procedure or surgery;
— different site or organ system;
— separate incision.

After an extensive surgery, for instance, you can use modifier -59 to inform the Medicare fiscal intermediary that the additional procedure codes are not being inadvertently duplicated on the UB-92.

The two biggest misuses of modifier -59 are using it to report a CPT/HCPCS code that is mutually exclusive when reported with another code and using it to report a CPT/HCPCS code that is a component of another code.

Here are some questions you should ask yourself to determine if the -59 modifier should be used in specific situations:

1. Do any of the codes violate the correct coding initiative edits?

2. If yes, is modifier -59 appropriate to explain the violation?

3. Are any of the codes being repeated for this case?

4. If yes, would modifier -59 be appropriate to explain the duplication?

5. Do any of the codes have "separate procedure" in their narrative description?

6. If yes, would modifier -59 be appropriate to explain that in this case, the "separate procedure" is not an integral component of some larger procedure? ■

Coding intrapartum care: A case study

How would you code the following case?

The following case study from the American Academy of Family Physicians *American Family Physician* magazine illustrates how various coding strategies can work with regard to intrapartum care:

Mary, a 22-year-old white female, goes to her family physician's office for maternity care at six weeks gestation by dates and size. Prenatal care is routine, and the family physician provides one "new OB H&P" and 10 routine prenatal visits. Mary goes into spontaneous labor at 40 weeks and has mid-labor severe fetal distress requiring one hour of face-to-face and 30 minutes of non-face-to-face prolonged physician attendance by the family physician before a consultant performs a cesarean section. The family physician assists at surgery and then provides uncomplicated postpartum care for the mother and baby for three days.

Based upon these facts, coding options include:

— 59426 Antepartum care; 7 or more visits (plus Pap and lab)

— 99223 Initial hospital care, level 3

— 99354 Prolonged (face-to-face) services; first hour

— 99358 Prolonged (non-face-to-face) services; first hour

— 59514-80 Assist at cesarean section

— 59430 Postpartum care (plus Pap and lab)

— 99433 Subsequent hospital care, normal newborn

— 99238 Hospital discharge day management

— 99431 Normal newborn H&P

To show you how different carriers might interpret this scenario, here are some of the instructions from insurance companies instructing family physicians on how to bill for the evaluation and management of a maternity care patient who ultimately undergoes a cesarean, as described above.

• **Blue Cross/Blue Shield of Oregon:** According to this carrier, the scenario indicates that the family physician should bill for only antepartum care using the appropriate evaluation and management codes and, if performed, the assist at the cesarean section (59515-80). If the family physician will be following the patient for postpartum care, the physician should also code 59430.

• **Lincoln National Life Insurance Company of Indiana:** This company also suggests that the family physician bill for antepartum care using the appropriate evaluation and management codes for initial hospital care such as 99221 or 99222. Of course, if the family physician assists in the cesarean section, the family physician could also bill 59515-80.

• **Oregon Office of Medical Assistance Programs:** The family physician should code 59899 for unlisted procedure, maternity care, and delivery, as well as 59515-80 if the family physician assists in the cesarean section.

Note: If you compare the instructions of the insurance companies with the coding options discussed earlier, you would be undercoding the actual work performed. That's another reason why it is vital that additional documentation such as a copy of the hospital admission note, intrapartum progress notes, or a written summary outlining the nature of services delivered be included with the claim.

A sample letter

Many practices find it effective to attach a face letter to the claim, acknowledging that the claim is unusual and asking claim processors to pay special attention to the claim. Here's a sample letter prepared by *American Family Physician* magazine that you could use when corresponding with your insurer in situations such as this.

XYZ Insurance Company
Anywhere, USA
12345-6789

Patient Name:
Patient Number:

To Whom It May Concern:

I am submitting a hard copy claim with this cover letter to inform you of the unusual circumstances associated with this patient.

I was the primary physician for [patient's name], who had a normal pregnancy until she was admitted to the hospital. Up until that time, I followed and took care of all of her antepartum needs. Because of fetal distress, I was obligated to spend a prolonged time with the patient. A decision was made to perform a cesarean section, and a specialist was consulted. I assisted at the cesarean and performed all of the newborn and postpartum care.

This claim contains those codes that describe all of my antepartum, intrapartum, newborn care, and postpartum work-up. Appropriate documentation is also enclosed.

I would appreciate careful review of this claim. Should you have any questions, please do not hesitate to contact this office.

Sincerely,

Signature

Note: Any claim submitted for unusual circumstances or services should always be submitted on hard copy and not electronically. ■

How one practice conducts its own coding audits

Process is built into the office routine

Rather than thinking of coding audits as just another administrative hassle, Inlet Medical Associates of Murrells Inlet, SC, considers coding audits to be part of its total quality management approach to running the medical practice.

Courtesy of the American Academy of Family Physicians' Family Practice Management bulletin, the practice's principals, **William Jackson Epperson**, MD, **Karl S. Hubach**, MD, **Karen E. Menn**, DO, and **Sharon Oates**, FNP, explain their philosophy and approach to coding audits:

"We believe that the way we do business affects the way we take care of patients, and that all issues that affect patients merit our attention. Our patients deserve the best care and the best service we can offer.

"With this objective in mind, we've developed a coding audit process based on the principles of total quality management that has significantly reduced patient billing problems, saved personnel time, improved our collections and, best of all, improved our documentation and quality of care.

'Delegating coding can lead to bad business'

"One of the fundamentals of this process is that the clinician is primarily responsible for all coding. We believe that delegating coding can lead to bad business and bad service. We train each member of our office staff to review our coding with the mindset of an outside auditor. They catch errors, ask questions, and make suggestions regarding accuracy. Diagnosis and procedure coding manuals are readily available in the patient care, checkout, and insurance billing areas of our office.

"Here's how our system works: When patients check out of the office, they are given a copy of their superbill. Another copy is printed and returned to the providers' dictation area. We review these at lunch or at the end of the day, while the patient visit is still fresh in our minds. We check for accuracy and to make sure no charges were omitted. This review also helps to guard against embezzlement.

"We then hold a weekly 30-minute meeting over lunch, involving our physicians, nurse practitioners, physician assistants, front-office staff, and office manager. We choose two or three charts at random from each provider's patient contacts for the previous week. We review each chart as a group, paying attention to the quality of the documentation and the quality of the care that was documented; then each provider proposes a code for the visit. Finally, the provider whose chart we're discussing reveals the code that was submitted and defends it.

"It's important to try to make these discussions positive rather than an exercise in finger-pointing. A negative environment will discourage participation. We frequently refer to the CPT manual and coding tools during these meetings.

"Before instituting a system like this and at regular intervals thereafter, it's important to

review each provider's coding distribution and collection per encounter. A software program like Excel that allows you to graph the data facilitates this process. In fact, with such programs, these simple graphs are a snap. You should expect your individual physicians' coding patterns and collections per encounter to differ; individual practice styles, patient mix, and payer mix will affect these measurements.

Coding may change over time

"The purpose of this comparison is to examine how individual physicians' information may change over time as a result of the regular audits. If the popular conception that family physicians tend to downcode is true of your practice, you'll probably see a shift in your bell curve.

"Relatively simple graphs of each provider's code distribution can provide helpful feedback for any practice seeking to improve its coding. Physicians' patterns may not be identical because of individual practice styles and patient and payer mixes, but you can track each individual's coding patterns over time. This will help you judge whether coding practices are improving.

"For a physician with typical monthly collections of $30,000, a 3% improvement brought about by the audit process would amount to $900 a month. That increase, divided by the four hours of time it took one physician to produce it, comes to $225 per hour. We believe this to be a conservative estimate of the value of regular audits for most fee-for-service practices.

"Physicians who are already overburdened by paperwork and meetings may resist, but we believe the economic outcomes make the time investment worthwhile. We also know that because we've been proactive, we would probably perform well in an outside audit and avoid the fines and other penalties that might otherwise result." ■

How well do you know rules for E/M coding?

Here's a quick quiz

Just how well do you know the basics of evaluation and management (E/M) coding? Take this quick quiz developed by the justcoding.com web site to test your knowledge. The answers are at the end of the test.

1. When assigning E/M codes, which of the seven components are considered to be key components?
   A. Counseling, Medical Decision Making, and History
   B. History, Examination, and Coordination of Care
   C. History, Examination, and Medical Decision Making
   D. History, Medical Decision Making, and Coordination of Care

2. A new patient is defined as:
   A. A patient who has received professional services from a physician within the past three years
   B. A patient who has not been treated by a physician within the past three years
   C. A patient who has never sought medical care
   D. A patient who has not been seen by the physician within the past three months

3. Time is not considered a descriptive component in which of the following settings?
   A. Hospital observation services
   B. Office consultations
   C. Critical care services
   D. Emergency department services

4. Which area of service does not rely on the distinction of new vs. established patient?
   A. Inpatient consultation services
   B. Office or outpatient services
   C. Emergency department services
   D. Initial hospital care services

5. The time component is significant in assigning E/M codes because:
   A. It can substitute for one of the key elements in any situation
   B. It can substitute for the key components when it accounts for 50% of the encounter
   C. It can be inferred from the text of the encounter
   D. It is only a substitute for the history component

Answers: 1-C, 2-B, 3-D, 4-C, 5-B ■

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plan pay fines, or having it assume more of the financial risk.

Note: The law generally requires the provider to notify the plan when the MCO has breached the contract and give the plan an opportunity to "cure" the problem before the termination clause can be activated.

To dissuade the plan from entering into a constant breach/cure cycle, the HFMA recommends providers also include language stating that the "notice-and-cure" provision only applies to the first breach. If the plan commits the same or a substantially similar breach within a specified period from the date the breach is cured (e.g., six months), the provider may terminate the agreement immediately upon written notice.

Keep track of key dates

Other key elements of a successful managed care contract monitoring program include:

• **Reviewing the contract for key dates and performing appropriate follow-up.** The Centers for Medicare and Medicaid Services (CMS) recommends drawing up a comprehensive list of key dates, such as deadlines for submitting certain reports, or dates that indicate an opportunity to terminate the contract or renegotiate rates. These should be kept in a separate binder or software-driven reminder system to alert whoever is charged with tracking this information that a critical date is approaching.

• **Reviewing the contract for key performance obligations and rights.** Create a comprehensive summary of your contractual obligations and rights, including timetables and/or events associated with those rights.

• **Establishing benchmarks.** Monitor both the plan and the practice's performance against key "best practice" benchmarks produced by relevant trade associations or consulting studies.

• **Assigning responsibility.** Assign responsibility for contract monitoring/information gathering to a specific person in the practice, and designate someone to back that person up. The HFMA says these duties should include: monitoring key dates; performing administrative duties; reviewing and analyzing plan reports; performing routine audits of plan information (preferably in monthly or quarterly increments); comparing plan performance (e.g., timeliness or amount of payment) against contractual obligations; and comparing performance of plan and provider against adopted benchmarks.

Besides monitoring how well the MCO is complying with its managed care contract obligations, it is just as important that you monitor your own compliance performance.

For instance, administrative requirements or new government regulations sometimes are passed onto providers by health plans as part of their contract, notes the HFMA. A provider's contract with a Medicare risk plan may require the provider to supply the plan with certain encounter data that the plan is required to give to regulators. The contract also may include a clause that requires the provider to indemnify the plan against penalties and sanctions imposed by Medicare if the plan fails to provide the requested data. That, in turn, exposes the practice to potentially painful financial penalties should it fail to comply with the contract.

Facilitating performance improvement

Other benefits of self monitoring include:

• **Improving performance.** Self-monitoring specific performance indicators provided in the contract gives the practice a source of new data to improve its operations. For example, having the MCO provide a list of why it denied or reduced payments over a certain time period is a great way for the practice to spot trends and potential weaknesses in its coding and claims processes. It also can pinpoint flaws in the MCO's reasoning and can be used to improve clinical outcomes such as reducing lengths of stay.

• **Financial analysis and management.** A key reason to monitor a contract is to assess and manage the organization's financial performance. For example, unless a provider knows that it receives $100 for a service costing $125 to provide, it cannot take the steps necessary to reduce costs or renegotiate the contract.

This kind of ongoing review can also help distinguish whether a performance problem is a matter of poor utilization, high costs, or a combination of the two.

• **Contract negotiation and renegotiating.** Maybe the best argument for a contract monitoring program is that it gives you the information you will need to determine if you need to renegotiate your current contract before you find yourself awash in red ink. It also can pinpoint what changes you need to make when renewing an agreement. ■

Society 'hassle logs' are measuring MCO gripes

Red tape reform is the goal

Spurred by the frustration of their physician members, nearly two-thirds of state medical societies are now keeping detailed databases, or "hassle logs," tracking the specific problems providers are having with managed care organizations, says the American Medical Association (AMA). As the logs grow larger, providers hope to use this information to push managed care organizations (MCOs) and state insurance regulators to introduce reforms.

In Texas, for instance, the state medical association is using information gleaned from its members to lobby insurers to negotiate changes involving slow payments, bundling, downcoded claims, and administrative hassles on both a broad policy and individual case basis.

The Illinois State Medical Association launched a managed care hassle log last year, notes **Ronald L. Ruecker**, MD, the state society's president and an internist in Decatur, IL. "We weren't sure what to expect, but we've had a very positive response," says Ruecker.

The Colorado Medical Association uses its hassle log to set the agenda for regular bimonthly meetings with representatives from managed care companies, notes spokesperson **Edie Register**.

Its approach is to have doctors fill out a hassle form detailing their problems. The form is submitted along with documentation that the society's staff use to determine if the problem lies with the provider or the plan — or both.

The results are then complied into a quarterly report that is sent to managed care plans and the state insurance department. The idea is to pressure the plans — without taking a directly confrontational approach — to look into the problems being presented and resolve them on their own. If that does not work, the association will turn up the heat by formally requesting the state insurance department to investigate its findings.

The top managed care issues for physicians, as reported by state medical societies, are:

— prompt payment (82%);
— administrative hassles (62%);
— downcoding (62%);
— lack of bargaining power (62%);
— all other reimbursement issues (38%). ■

The secrets to outsourcing your compliance program

The pros and cons of contracting these duties

Faced with the constant need to control costs, many providers are turning to outside contractors to manage their regulatory compliance efforts. Rather than sacrificing quality, many practices have found that leaving this function to an expert can also actually improve their compliance activities.

But there are still risks associated with contracting out your compliance management, and you need to factor these risks into the cost-benefit equation. The biggest risk is that you are still legally liable for anything that goes wrong.

According to a report by the Health Care Compliance Association (HCCA) in Washington, DC, the main benefit of outsourcing compliance is that it permits providers to "supplement scarce internal resources, verify internal compliance processes, and gain access to compliance 'best practices' through the consultant's broader exposure to the industry," says the HCCA.

On the downside, relying on outside vendors for compliance functions can mean you are not able to develop the kind of internal expertise that creates long-term cost and operational efficiencies.

You also run the risk of exposing yourself to fraud and abuse charges. The most likely problem area is creating "a compensation or risk-sharing mechanism that results in an illegal kickback violation under the federal anti-kickback statute" or similar state law, says **Frank P. Fedor**, an attorney with Murphy Austin Adams Schoenfeld in Sacramento, CA.

Kickback concerns

According to Fedor, the federal fraud and abuse cops are giving extra scrutiny to such items as physicians' contractual relationships with hospitals that outsource their clinical services for possible kickbacks.

Another potential kickback problem area is marketing agreements in which providers compensate nonphysicians based on the volume of Medicare beneficiaries they refer for Medicare goods or services.

The advantage of an aggressive compliance

program is that if the feds ever do have reason to question certain practice activities, the presence of a good-faith compliance effort on your part can minimize any legal fallout.

"But if you're relying on advice from an outside source, you'd better know what advice was given and what you did to implement it if you hope to get any slack from regulators," says **Stephen L. Hill Jr.**, a Kansas City, MO, lawyer and former U.S. attorney.

If a practice that outsources its compliance functions is questioned by compliance investigators, the worst-case scenario would be if all the practice has to point to is an off-the-shelf CD-ROM tutorial for compliance-related programs. "That just tells the government they're dealing with someone who doesn't want to meet their responsibilities," Hill says.

Use an outside auditor

When it comes to things like performing your own internal audits, government gumshoes tend to feel that the fox is guarding the hen house unless the practice is also periodically audited by outside professionals.

Tip: If you use an outside auditor, have him or her report the findings to your practice's attorney, who then should pass the findings along to the group's compliance officer, thus keeping the results under the umbrella of attorney-client privilege.

Practices that outsource their compliance officer function should maintain constant contact with the person or organization they contract with, the Office of the Inspector General (OIG) advised in its compliance guidance to small physician practices, issued Oct. 5, 2000.

To do this, the OIG suggested designating someone to serve as a liaison to help ensure a strong tie between the compliance officer and the group's day-to-day operations.

The guidance also warned against outsourcing to a compliance officer who spends most of his or her time off-site, because this makes it hard for the compliance officer to know the inner workings of the practice due to reduced accessibility. The OIG also notes that possible conflicts of interest can arise when one compliance officer serves several different practices.

Providers who outsource must also be particularly careful about fulfilling their responsibility to protect patient confidentiality under the Health Insurance Portability and Accountability Act of 1996, notes the OIG.

Using confidentiality agreements and outsourcing only to reputable firms are ways to avoid such problems, recommend experts. Tip: Many compliance consultants warn against hiring compliance contractors who suggest they can increase your revenues by eliminating or reducing undercoding. This type of sales pitch can indicate an attitude that may create compliance problems rather than avoid them.

Also, once a compliance contractor gets on the radar of regulators because of questionable advice to one client, that firm's other clients tend to be investigated as well.

Whether your compliance officer is an inside staffer or an outside contractor, "the buck stops at the top," says **L. Stephan Vincze**, president of Atlanta's Vincze & Frazer consulting firm. "You may decide to delegate, but whether you outsource or keep it in-house, in the end, people report to somebody inside, and that is where the ultimate responsibility lies."

Whoever does the job, "you're relying on that individual's integrity and professionalism, because if the person doesn't have that, your system will ultimately break down," Vincze points out.

Bottom line: "Get a true professional and an honest person, because that is really the most important credential of all."

Consider outsourcing hotline

Outsourcing a compliance telephone hotline is a good way to avoid many of the pitfalls associated with the compliance function, says **William Tillett Jr.**, director of corporate compliance for Ernst & Young's health care advisory services in Atlanta. "Basically, there are just a lot of things you can do wrong when you answer a hotline call that an outside professional will probably avoid," he notes.

According to Tillett, advantages to outsourcing this function include that you don't have to worry about what hours the hotline will operate or what the protocols will be. You also don't have to build a tracking system that gives you reports on the kinds of calls you receive.

Outsourcing also is a way of getting around the fear some workers will have of their voice being identified if they leave a voice-mail message. Plus, "You really need a two-way conversation to get the kind of information that will lead to effective compliance," Tillett notes. ■

NEWS BRIEFS

Medicare to cover home blood tests

The Centers for Medicare and Medicaid Services (CMS) will now cover home testing that enables patients with mechanical heart valves to measure how well their blood is thinned.

Previously, there had been no national coverage policy for self-testing prothrombin levels (also called INR testing) in the home for patients with mechanical heart valves, and the insurance companies that process and pay Medicare claims had been denying claims for home prothrombin self-testing.

"This simple home test can help Medicare beneficiaries reduce their risks of strokes and bleeding," Health and Human Services Secretary **Tommy G. Thompson** said in a release. "The decision reflects our commitment to expanding Medicare coverage to include effective preventive care and services."

Noted CMS administrator **Thomas A. Scully**, "This decision will give a new option to Medicare beneficiaries who need to get frequent prothrombin tests. The scientific data we reviewed showed that when patients with mechanical heart valves used these devices at home, they may suffer fewer strokes and bleedings."

Under existing local carrier coverage policies, patients receiving home health care could have their prothrombin level measured by home health personnel, and phlebotomists could come to patients' homes to draw samples to be processed in laboratories. The new national coverage policy allows beneficiaries to perform the test themselves and could permit more frequent monitoring of a patient's response to blood-thinning medication. ▼

Doctors providing less charity care: Study

The percentage of physicians donating charity care dropped from 76% to 72% between 1997 and 1999, says a study by the Washington, DC-based Center for Studying Health System Change (HSC).

The types of physicians most likely not to perform charity work were those working in a staff-model or group-model HMO and doctors who do not own their own practices, says the study.

"Policy-makers should take note that an important part of the health care safety net — physician charity care — is in danger of fraying," observes HSC president **Paul B. Ginsburg**. "If insurance costs continue to rise rapidly and the number of physicians providing charity care declines, access to care for the poor and uninsured will be in jeopardy."

Most indigent people are still getting medical care, the report found. However, with the supply of practicing physicians only growing at a 1% rate — compared to 3% in the 1990s — some experts wonder if there will be enough physicians available and willing to provide charity medicine.

"The proportion of physicians willing to provide charity care is shrinking, while demand for charity care is likely to increase if rising health care costs add to the ranks of the uninsured," says Reed.

The report cited these reasons for the trend:

- an increase in managed care and a trend away from physician-owned practices, which tend to donate more of their time to charity work;
- financial pressure on physicians from lower payment rates following efforts by health plans and employers to cut costs;
- administrative burdens from multiple payers and managed care, leaving doctors with less free time to devote to charity care;
- pressures on hospital emergency departments and academic medical centers to save money. ▼

COMING IN FUTURE MONTHS

- The feds are looking at suspicious drug company-physician arrangements
- Tips for getting paid faster
- The new HIPAA rules are on hold, but for how long?
- What is your practice worth?
- Cultivating cash-only clients

Doctor UPIN data often wrong: OIG

Nearly one-third of the addresses for physician and practices listed in Medicare's Unique Physician / Practitioner Identification Number (UPIN) Registry are wrong, according to a study by the Office of the Inspector General (OIG).

"Even the Medicare carriers did not have correct addresses for all of these providers," the OIG's report noted, opening up the possibility that many of the wrong addresses are being used by scam artists to bilk Medicare.

To get a UPIN, a doctor or group practice must submit a Medicare enrollment application, including relevant addresses, to the appropriate carrier. Once the registry assigns a UPIN, the carrier is responsible for maintaining physician enrollment data and promptly notifying the registry of address and other changes.

In 1999, the OIG reported that 39% of UPINs were listed as active in the registry, even though those practice settings had no Medicare claims activity for 12 consecutive months, which is grounds for deactivation of the UPIN. ▼

Medicare will now pay for pre-op screenings

Medicare will now pay for preoperative screening and evaluation, provided it is medically necessary, the Centers for Medicare and Medicaid Services (CMS) recently told its carriers.

In its transmittal, CMS clarified that medical preoperative examinations performed by or at the request of the attending surgeon are neither routine screening nor part of the global surgical practice and, with proper documentation, should be paid. CMS left it to physician discretion to determine at which level to code the service and the types of tests that are medically necessary.

"Preoperative medical evaluation is a critical evaluation for Medicare patients, particularly if they have significant illnesses or a multiplicity of medical illnesses," says **William G. Plested III**, MD, an American Medical Association spokesman. "To improve the safety of operations that can be offered to patients, careful preoperative evaluation with appropriate tests is essential."

Surgeons and anesthesiologists often ask patients to obtain preoperative evaluations from their primary care or other physician to determine whether the patient has additional medical problems that could affect the procedure. However, some Medicare carriers have regularly denied payment for these services by calling them routine screenings. Other carriers denied payment for preoperative screenings, saying it was already included in the payment for the global surgical package. Some carriers also have said Medicare does not permit physicians to run tests on asymptomatic patients to screen for potential problems. ▼

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Matrix helps turn denials into cash

Information is power when it comes to tracking the reason — correct or not — given by specific payers for why they turned down your claim.

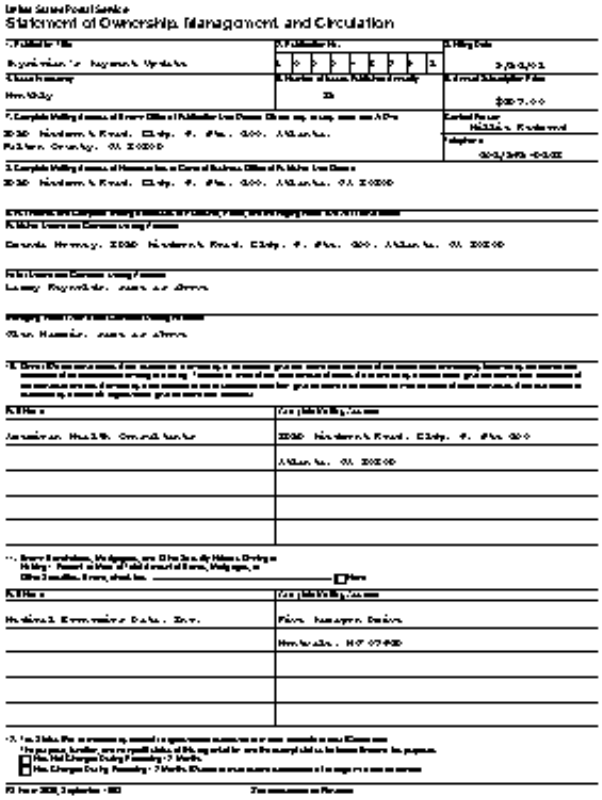
But building a simple matrix can be an easy way to gather intelligence about denial patterns that you can then use to prevent future claim denials.

On the left side of a piece of paper, list all the different kinds of denials your practice receives. At the top of the chart, list all the payers you work with.

Where a type of denial and payer name coincide, write down a set of initials for the action that needs to be taken. For instance, write CAR (correct and resubmit) for denials due to miscoding, incomplete information, and other mistakes that affect just one claim. You can also color-code this section.

With this information, you can now track what types of denials each payer tends to make and why — and then act to correct these problems.

Tip: Consider setting up a separate column for denials that were turned into approvals. ■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