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Proposed Labor Department rules would speed insurers' UM response times

Some MCOs deny there's a problem in this area

Slow reimbursement by many managed care organizations is a common complaint among physician practices across the country. But relief may be on the way, thanks to a newly proposed rule from the U.S. Department of Labor. The new rule gives health plans stricter deadlines for telling members and providers whether urgent and experimental medical procedures are covered by the patient's benefit plan.

Under the rule, managed care organizations would have 72 hours to tell a beneficiary involved in an "urgent care" case whether the plan will cover a specific procedure or service that requires precertification before payment is approved. For non-urgent care, the notification deadline is 15 days. Current rules give health plans up to 90 days to notify patients and their physicians of the coverage decision. If coverage is denied, a beneficiary has 180 days to appeal the decision.

If the medical service already has been performed, MCOs have 15 days to tell patients and providers whether the claim is approved or denied, partially or totally, or if it needs more information before making a payment decision.

Plans claim good response time

When it comes to initial benefit determinations, many plans say they already are more responsive than the proposed standard. For instance, Blue Cross & Blue Shield of the National Capital Area, which serves the Washington, DC, metropolitan area, claims it typically decides requests for urgent care coverage within 24 hours of receipt. Meanwhile, requests for non-urgent care generally take two working days to decide.

The new rule could have a major impact on those difficult requests to cover experimental procedures that, in the opinion of the patient's physician, may be the only chance to save the patient's life

"Decisions for this kind of treatment often take longer to make since the HMO or insurer generally wants to perform a thorough review of the patient's past treatments and their response," says **Tracy Cassidy**, a consultant in William M. Mercer's Washington, DC, office.

Many experts also expect a fight over the Labor Department's requirement that health care plans notify participants within 15 days whether they will cover a claim for a service that already has been performed.

"That time frame may be unrealistic, especially during certain times of the year when the number of claims to be processed tends to be particularly heavy," says **Jane Galvin**, director of managed care for the Health Insurance Association of America in Washington, DC. "These are pretty tight deadlines," agrees **John Piro**, a consultant with Hewitt Associates in Rowayton, CT.

Another area of potential controversy involves the extended set of patient appeal rights when it comes to plans' medical decisions. Under this provision, the parties reviewing the appeal cannot be affiliated with same party that made the original decision or a subordinate.

The regulations, however, are not clear on who the "party" is that made the initial coverage decision. It could, for example, mean the actual individual who made the decision, or possibly the unit that person is in.

"This will be an area of some controversy," said **Henry Saveth**, JD, a Mercer attorney in Washington, DC.

What is meant by 'pertinent documents'?

Another problem area, benefit experts say, is a provision giving participants access to "pertinent documents." Participants would be entitled to review all documents, records, and information relevant to their claims for benefits. That information would include internal rules, guidelines, protocols, and criteria under which the plan is operated.

In situations where a patient is suing because coverage for a procedure was denied, the Labor Department is considering amending the final regulation to require participants to be entitled to receive "reasonable access and copies of all documents relating to previous claims involving the same diagnosis and treatment that were decided within five years of the previous adverse benefit determination."

This provision has some employer and patient groups worried that requiring plans to disclose information on how prior claims with a similar diagnosis were handled could violate the privacy of those other beneficiaries.

For instance, even if the names of other beneficiaries were blacked out, their identities could be determined in some cases, especially at smaller firms. "The question is, how you do you provide information without violating an employee's right to privacy?" asks **Paul Dennett**, vice president for health policy at the Association of Private Pension & Welfare Plans in Washington, DC.

After reviewing provider and plan comments on the proposed rule, the Labor Department will issue a revised final rule, which is expected to go into effect as early as next summer. ■

Debate continues on new E/M guidelines

Late 1999 is the likely effective date

After intense behind-the-scenes negotiations, the Health Care Financing Administration (HCFA) and the American Medical Association (AMA) have agreed to agreed to continue working on a set of new official guidelines physicians will use to document the provision of medical evaluation and management services (E/M) for Medicare reimbursement.

While an official date for implementing the new E/M guidelines has not yet been set, most insiders say it will be late 1999 before they go into effect. Meanwhile, HCFA policy permits physicians to use either the 1995 or the 1997 documentation guidelines as they see fit.

One area of contention between the AMA and HCFA is the future use of numerical formulas in evaluation and management documentation procedures. HCFA claims these techniques are necessary to ensure consistent interpretation of results by Medicare carriers.

Most provider groups disagree, however. "The AMA strongly regrets HCFA's insistence on retaining some quantitative formulas," said **Randolph D. Smoak**, Jr., MD, chair of the AMA Board of Trustees, in a prepared statement. Signaling a willingness to compromise, HCFA has indicated it will consider minimizing the use of such formulas in any future evaluation and management guidelines.

"After intensive discussions with the Health Care Financing Administration, the AMA feels HCFA is responding to physician concerns and has agreed to work with the AMA and its CPT Editorial Panel on new evaluation and management documentation guidelines that are simpler

and less burdensome than current guidelines or earlier proposed revisions," said Smoak.

"This issue is of critical importance to practicing physicians," he continued, "since these guidelines indicate the medical record documentation needed by physicians and claim reviewers to determine the level of evaluation and management service provided to patients in Medicare." ■

Study questions future of academic medical centers

High expenses hurt market competitiveness

Market pressures imposed by managed care are magnifying various factors that make teaching hospitals look like an endangered species, says a study released Sept. 14 by the Fairfax, VA-based Lewin Group.

The report, titled *Teaching Hospital Costs: Implications for Academic Missions in a Competitive Market*, concludes that teaching hospitals associated with academic medical centers — hospitals designed to train medical students, conduct research, and provide specialized medical services to some of the nation's sickest patients — may be in particular trouble. The study was funded by the Commonwealth Fund, the U.S. Public Health Service, and the Association of American Medical Colleges.

The study reached the following conclusions:

• In 1993, unadjusted costs per patient for academic medical centers — which combine medical schools, teaching hospitals, and physician groups — were 83% more per patient ($9,900) than for the average urban non-teaching community hospital ($5,412).

• Unadjusted costs per case for other teaching hospitals (those without medical schools but with residency programs) were 22% more than those of non-teaching institutions.

• After adjusting for case mix, wage levels, and direct graduate medical education costs, academic medical centers still were 44% more expensive than non-teaching hospitals, and other teaching hospitals were 14% more expensive.

These higher costs are mainly related to the teaching hospital's social missions, such as instruction, biomedical research, highly specialized services, and indigent care, says the study.

"These higher costs put academic medical centers at a disadvantage in the competition for managed care contracts and patients," which can spell disaster for their cash flow, says **Allen Dobson**, a Lewin senior vice president who co-wrote the study.

Having documented the cost disadvantage facing academic medical centers, Dobson expects to release future studies outlining a variety of new funding formulas that will take the specialized mission of academic teaching hospitals into consideration when negotiating future compensation agreements with managed care organizations and other payers.

"It is our feeling these initial findings will serve an important purpose in providing a starting point for developing new payment solutions that go beyond historic methods, " he adds. ■

Groups call for shift in employee benefit financing

Proposed changes could increase provider leverage

While public and congressional attention has been focused on the controversial battle over patients' rights and managed care reforms, power brokers from both medical and business groups have been quietly laying the foundation for a fundamental shift in the way health care is financed in this country.

Specifically, plans are being developed to make a major move next year to shift the basic financing of the average family's health insurance away from the current employer-based system to one in which coverage is purchased and owned by individual employees. The long-term goal: to effectively get companies out of the business of providing and paying for their workers' personal medical plans and turning them into central information clearinghouses to help employees with their health care coverage.

The American Medical Association (AMA) is a major backer of this concept. "The AMA's goal is to convert the current tax treatment of insurance coverage away from an employer-based tax deduction to an individually owned and individually purchased system of health insurance," says **William H. Mahood**, MD, a member of the AMA's board of trustees.

"We see this as simply as a natural outgrowth of the trend where employees take more responsibility for the cost and quality of their health care coverage," notes **Pat Cleary**, director of human resource issues for the National Association of Manufacturers in Washington, DC.

Medical providers also see this as a way to break managed care's growing grip on the health care marketplace. According to Mahood, studies show cost-conscious employers are increasingly shifting their employees' medical programs from indemnity coverage to managed care, and then from one managed care plan to another, based almost exclusively on which plan is the cheapest.

Two companies control 85% of lives

"As competing plans have consolidated in competitive managed care markets, this process has given them tremendous leverage in negotiating payment rates with local providers," argues Mahood. "In Philadelphia, for instance, just two companies control something like 85% of all the lives covered by managed care."

As a result, groups like the AMA contend that providers don't have the ability to bargain when it comes to determining the terms of a managed care contract. "They are afraid they will be dropped by the plan, and that could be economic suicide," says Mahood.

"We feel many of these problems would go away if the individual patient had an opportunity to choose a health plan from a wide variety of health plans based on quality and costs, rather than have an employer shift 5,000 people here or there based on premium cost alone," argues Mahood. "The idea of having choice at the patient level could eliminate an awful lot of the distortion in today's marketplace."

Under the proposal floated by the AMA, employers still could contribute toward employees' coverage in the form of a voucher or defined contribution, which could be set at a fixed amount with no need for annual increases. However, individual employees would be responsible for buying their own medical coverage, which would be partly underwritten by the federal government via a refundable tax credit capped and indexed by income. To lower costs and increase access, individual employees also could join joint purchasing cooperatives to purchase coverage.

A system quite similar to the one suggested by the AMA already is being used in Minneapolis. The Buyers Health Care Action Group, an employer coalition, sponsors a health benefits program for its members in which employees of participating companies choose their health plan by provider rather than by insurance carrier. One carrier provides administrative services for all employees covered under the program. The program currently is in its second year.

The AMA's Maher says his organization's proposed system would allow employers to effectively tell employees, "We will continue to give you the same amount of money for your health insurance coverage as we did when we purchased your managed care policy last year in the form of a voucher or in the form of a defined contribution."

Meanwhile, companies continue to keep their tax deduction for whatever funding they provide. Over time, proponents of this idea expect the employer's contribution to gradually drop as the employee's tax credit increases. "We see the employer and employee tax credits as a kind of safeguard to discourage firms from just suddenly cutting out whatever contributions they have been making to their workers' health coverage," says Mahood.

The ultimate benefit of putting health benefit choices in the hands of consumers rather than employers is a much more competitive marketplace, Maher contends. If consumers governed choice, this would lead to both lower costs and higher quality in health care.

The AMA, which has just recently begun promoting the idea, hopes to build a foundation of support for a more intensive lobbying campaign starting next year. ■

Groups flood HCFA with Medicare+Choice input

Many say program needs modifications

Ever since HCFA published its interim final rule establishing the Medicare+Choice Program on June 26, various provider organizations have been preparing and filing their comments and recommended changes in anticipation of the program's official Jan. 1 launch.

Provider groups such as the Washington, DC-based American College of Physicians - American Society of Internal Medicine (ACP-ASIM), while

generally supportive of the rules implementing the Medicare+Choice program, also are wary of the potential "hassle factor of too much paperwork and bureaucratic red tape the rules could inflict on physicians, other health care professionals, and managed care organizations," says the group's president, **Harold C. Sox**, MD.

Key areas of concern include:

1. Beneficiary information. One ACP-ASIM member recently complained to the organization that a plan was consistently providing inaccurate physician panel information to patients seeking to enroll with the plan. "When patients asked if the doctor in question was in the plan, the plan responded that they had a doctor with the same last name," says **John Moulin**, director of managed care and regulatory affairs for ACP-ASIM. After looking into the situation, ACP-ASIM discovered that not only was there a different physician with the same last name, but the physician was located in a different city as well.

"Physician directories are out of date almost from the instant they are printed; for this reason, patients must be able to access more current physician directory information though telephone contact with the managed care plan and through the Medicare Compare Internet Web site," says Moulin.

Physicians: Tell us when patients switch plans

To avoid problems, ACP-ASIM recommends that HCFA make sure each patient knows that his or her current physician may not participate with a Medicare+Choice plan before the patient makes a change to a new Medicare+Choice plan. In addition, ACP-ASIM contends, the primary care physician treating the patient must be notified of the patient's decision to switch to a new plan when the patient informs the plan. Whenever possible, the specialty care physicians currently treating the same patient also should be informed of the change.

"Often, the physician is not informed or is informed only after the patient has been seen several times after changing to a different plan of which the physician is not a member," says Sox. "At this point, the patient is liable for the cost of care, and it is often very difficult to collect for services provided once that happens."

2. Beneficiary protections. ACP-ASIM supports the requirements for Medicare+Choice organizations to assume financial liability for emergency services; urgently needed services; renal dialysis services; post-stabilization care services; and services denied by the Medicare+Choice organization for which enrollees are found upon appeal to have been temporarily eligible while outside the plan's service area.

ACP-ASIM also supports the requirement that upon enrollment, Medicare+Choice organizations must disclose to each enrollee clear, accurate, and standardized information on various procedures and coverage including information about the plan's service area, benefits, access, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, grievance and appeals procedures, disenrollment rights and responsibilities, and information about the organization's quality assurance program. Also, ACP-ASIM supports the requirement that upon request, Medicare+Choice organizations must provide additional information on utilization control procedures, the financial condition of the organization, and a summary of physician compensation arrangements. Medicare+Choice organizations also should be required to disclose their plan procedures for the termination of physicians and other plan health care professionals, ACP-ASIM stated in its response to HCFA.

However, the group says the termination notification requirement for physicians is inconsistent and needs to be standardized. For instance, under the proposed rule, when a contracted primary care physician is terminated, Medicare+Choice organizations must make a good-faith effort to give all enrollees who regularly see the physician written notice of that physician's termination within 15 days of that provider's receipt or issuance of a termination notice.

The requirement for specialty physicians is stronger. Under ACP-ASIM's preferred approach, Medicare+Choice organizations must inform beneficiaries at the time of termination of their right to maintain access to specialists, and provide the names of other Medicare+Choice plans in the area that contract with specialists of the beneficiary's choice, as well as an explanation of the process the beneficiary would need to follow should he or she decide to return to regular Medicare.

3. Quality. ACP-ASIM is concerned that because Medicare+Choice's Quality Improvement System for Managed Care (QISMC) regulations have not yet been issued, this will make it especially difficult to achieve the program's quality goals. "We also understand that managed care

organizations are concerned that the implementation rate of two new performance improvement projects each year is overwhelming." says Sox. "We are concerned that the rapid rate of implementation will overrun physician offices with data collection requests for information that is not central to patient care." As such, ACP-ASIM does not feel it is right for HCFA to institute a quality process that has unrealistic expectations, which could lead to faulty implementation and create new hassles for physicians and other health care professionals, Sox says.

The group also says the provision requiring plans to maintain a health information system that collects, analyzes, and reports data also is unrealistic, especially for non-network Medicare+ Choice Medical Spending Account plans and Medicare+ Choice private fee-for-service plans. "This requirement will create an inordinate burden for plans and their associated physicians, who will be responsible for data collection and reporting to plans," says Moulin. "Furthermore, Medicare+ Choice plans are unprepared to deal with the potential volume of data they would be required to collect, analyze, and report."

4. Limitations on provider indemnification. ACP-ASIM supports HCFA's proposal prohibiting Medicare+Choice organizations from requiring physicians and other health care professionals to indemnify the Medicare+Choice plan against any civil liability for damage caused to an enrollee as a result of "denial of medically necessary care."

"This prohibition recognizes that a managed care plan's refusal to authorize treatment sometimes results in harm to patients," says Sox. Also, provider groups want HCFA to expand this provision to recognize that harm to a patient can sometimes result from a physician simply following the Medicare+Choice plan utilization protocol, which can look like failure to deliver medically necessary care after the fact.

In its comments to HCFA, the Health Insurance Association of America (HIAA) said that scheduled 1998 payment increases to providers could "disappear" because the funding will be diverted to pay for the beneficiary education program in the form of "user fees" on participating health plans. Instead, the Administration should seek the authority to finance this program from the Medicare trust fund, says HIAA.

HIAA also opposes the 2% limit on payment increases to plans. "Simply stated, organizations cannot sustain such arbitrary limits on capitation rate increases," the association says.

The capitated rate was set in the Balanced Budget Act of 1997 and implemented in the interim final rule. "HIAA is urging Congress to reconsider these artificial and arbitrary limits on capitation rate increases," the organization says. Without reconsideration, Medicare+Choice organizations may withdraw from the program or increase health plan premiums, leaving the program "only a shadow of what it has the potential to become," the association remarks.

Addressing concerns that HMOs would choose not to participate in Medicare+Choice, HIAA President-elect **Chip Kahn** said at a Sept. 17 press briefing that it will take three or four years to judge whether the program has been successful in attracting providers. He explained that the program would evolve, and noted he had spoken to "a number of companies" looking at various kinds of Medicare+Choice products.

Addressing a separate provision requiring plans to use encounter data for purposes of risk adjustment, HIAA requests that the agency seek a "less burdensome basis for [formulating] risk adjustment data," such as a survey-based approach. "Such requirements would create a significant hurdle for new entrants wishing to serve as Medicare contractors and might well deter participation," the association asserts. "We encourage HCFA to continue exploring alternative methodologies for risk adjustment."

After considering these and other comments, HCFA hopes to unveil any changes it feels are appropriate around the end of the year. ■

HCFA study estimates health care spending jump

A recent study by the Health Care Financing Administration, titled *National Healthcare Expenditures*, predicted national spending for health care will increase from $1.0 trillion in 1996 to $2.1 trillion in 2007, averaging annual increases of 6.8% over this period. Health spending as a share of gross domestic product is estimated to increase from 13.6% to 16.6%.

National health spending growth is expected to accelerate beginning in 1998, growing at an average annual rate of 6.5% between 1998 and

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2001. This compares to 5.0% average annual growth from 1993-1996. The slower growth over the past few years was due mostly to slow spending growth in the private sector (2.9%), while public-sector spending grew more quickly (7.5%).

Between 1998 and 2001, private-sector health expenditures are predicted to grow at a faster average annual rate (7.2%) than public-sector spending (5.7%).

According to the report, real per capita private-sector health spending growth is projected to accelerate as "recent stronger growth in real per capita income is expected to boost underlying demand for medical services, and higher medical inflation is expected to fuel increasing health spending growth. An anticipated slowdown in the growth of private-sector managed care enrollment and a pause in the downward trend for private health insurance coverage also are expected to contribute to the acceleration in health spending growth." ■

Surviving in today's Medicare risk climate

Follow these 10 steps to better results

Over the past several months, some of the country's largest health plans have chosen to opt out of certain Medicare markets, citing prospective losses as the reason.

Despite these unprecedented actions by some of the biggest players in the Medicare risk market, HCFA maintains that it has no plans to cut benefits or raise fees to erase the projected red ink of these Medicare risk HMOs.

This situation, in turn, has raised questions from many physician groups about the viability of creating provider-sponsored organizations (PSOs) or other entities to vie for the newly authorized Medicare+Choice business, which becomes available this January.

Charles A. Peck, MD, of Arthur Andersen's Atlanta-based health care consulting group, says it is still possible to make a profit in many Medicare markets. "While there are select markets with unreasonably low adjusted average per capita costs or average per patient benefits Medicare will pay in a particular county, most markets' rates are high enough for a plan to be viable, " says Peck.

"Many believe that medical costs are the problem, but management of these costs is the issue. The real root of these losses lies with medical management processes and the need for investment in the systems of care necessary to support these patients," says Peck.

According to Peck, there is adequate reimbursement for providers or health plans to operate profitably today, provided they properly structure their products and invest in programs that maximize preventive and intervention services.

> "Physician groups that want to share upside bonuses must expect to also share downside risk."

Based on these concepts, Peck has developed this 10-step method for ensuring Medicare risk viability:

1. Improved risk assessment methodology. Remember the 80-20 rule: 20% of the current Medicare population generates 80% of the costs. "That makes it vital in the Medicare arena to identify the most vulnerable seniors in an HMO prior to their accretion into the program," says Peck.

2. Better-trained geriatric care managers, along with the institution of a geriatric assessment team. Seniors require specialized services and increased attention during their seventies and beyond. When they require hospitalization, it is common for their functional status to decline, which then increases their risk status upon discharge. A specialized geriatric team comprising a geriatrician, geriatric care manager, social worker, and pharmacist can help prevent functional decline by aggressively managing the inpatient stay.

3. More disease management programs. "Providers can benefit greatly by developing their own programs. Most providers need a program for congestive heart failure, diabetes, and oncology. Determining which programs to develop can be done by an assessment of the system's high-volume and -cost diagnoses," says Peck.

4. More risk sharing. Financial incentives must be properly aligned across all providers for any risk program to be financially successful. "Physician groups that want to share upside bonuses must expect to also share downside risk," says Peck. However, risk should be balanced to achieve the desired outcome, and have enough upside potential to encourage behavior change as needed. Hospitals also must expect to share risk in Medicare risk arrangements with physicians.

5. Strong physician leadership. Simply put, "physician leaders must be capable of making the tough decisions that arise in regards to performance measurement and accountability, "says Peck.

6. Strong hospital leadership. Many hospitals have recently appointed physician chief operating officers to help their managed care organizations improve physician relationships. This process must continue because "a transformation of values from hard assets to relationships must occur for hospital-driven systems to be successful in the risk environment," contends Peck.

7. Physician- and administrator-friendly reporting tools. Both patient and financial information generated within the practice must be accessible, available, understandable, flexible, and relevant. "Real-time information transfer to the people running the business is critical to enable behavior change and make rapid course corrections when needed," says Peck.

8. Physician accountability for controllable outcomes and cost. Consistency of medical practice remains a challenge for all physician groups. Clearly agreed-upon practice benchmarks must be followed by everyone with clinical care responsibilities, and key performance measures for physicians must be clearly articulated and followed.

9. Openness to change. "Change causes fear, and fear leads to poor decision making," says Peck. Networks launching a new Medicare risk program should seriously consider providing change management training for their physicians and their other clinical and nonclinical employees.

10. A clearly communicated vision and mission. Once change has been confronted, new programs have been put in place, and systems of care have been made consistent across all specialties, the vision and mission of the organization must be clearly and repeatedly articulated by its leaders, says Peck. ■

EDI saves Indiana practice time, money

But function still labor-intensive

Although various electronic and automated claims processing systems have been introduced into the health care industry, the administrative burden and cost of processing medical claims continues to rise for many practices, according to one Indiana-based group practice that has converted to electronic claims processing.

"We're doing everything we can to automate everything we can," says **Mary Valdez**, manager of patient accounts for the Indianapolis Women's Health Partnership (WHP).

Yet, despite the fact 80% of WHP's claims are processed electronically (compared to the 50% to 60% national average), it still costs this group practice an average of $7.42 to process each claim, which the practice still considers expensive.

"I was alarmed at the lack of sophistication of the computer systems and the lack of industry benchmarks in health care compared to banking," says Valdez, who worked in the banking industry before coming to health care. "In banking, I could move hundreds of millions of dollars in a matter of minutes. But once I started in patient accounts, I was amazed to find myself having to send a $10 claim to an insurance company three times before it would get paid."

The introduction of electronic data interchange (EDI) has cut two weeks off WHP's claim payment cycle. Instead of two and a half months for the average claim to be paid, it now takes two months.

Even with EDI, 30% to 35% of all WHP's claims are denied because of alleged errors or missing information, she says. "This claim rejection rate is compounded by the problems WHP's various prime payers are having with their EDI systems. Our EDI system may show a claim has been accepted by the payer, when in fact it has been lost or has just disappeared," says Valdez.

Because electronic claims often make multiple stops among three or four entities before reaching the end of their processing ride, this makes it "hard to figure out who is at fault, who didn't get it, and where it was lost," says Valdez. Backtracking is supposed to be a key element of an EDI system, but in reality, it takes a lot of work to find the claim. Historically, researching this problem with payers often takes a couple of weeks.

As an alternative, WHP has moved to a "real-time" claim resolution system distributed by RealMed Corporation of Indianapolis.

"With a real-time system, before the patient leaves our office, they are given an automated accounting of how much their insurance covers for that visit, and how much, if anything, the patient owes, without filing any paperwork," says Valdez. "By taking care of the transaction in one setting, with the patient present, and not having to reopen the claim file three or four times, we are starting to move our savings from processing claims into more quality care for the patient."

On a larger scale, Health First, a Melbourne, FL-based health practice with specialties in cardiology and women's and children's services, has expanded its electronic medical records and claims management to make them easier for the ambulatory physicians in its 29 clinics to use.

"This is an active managed care market with many patients who need both primary and specialty care," says **Rich Rogers**, Health First's vice president of information technology and chief information officer. "We know that to capture and retain patients, we have to make their experience with us satisfying. Electronic records are key to reaching this objective."

For instance, Health First wants any authorized caregiver in the system to have a patient's records available to them whenever a patient arrives for a visit. "This assures them they're being cared for in a close-knit and efficient health care community, and they avoid the hassle of a new chart work-up by each provider they see," says Rogers.

Look for built-in coding prompts

Significant improvement in coding by physicians is one of the key benefits Rogers expects the new system to produce. "One of the keys when evaluating new software is whether it has built-in prompts and lists that cover practically every procedure. This really simplifies the process and all but eliminates under- and overcoding. In turn, we bill and receive a reimbursement rate that reflects the care we're providing," he says.

The evaluation process for picking the new system took about six months. Health First picked software named Logician, produced by MediaLogic of Hillsboro, OR. Logician easily fits into the organization's current information technology infrastructure. "Logician scored well given that it runs in Windows 95, Windows NT, and Novell environments, and is HL-7 compliant. Also, being based on Oracle, it meshes well with our financial and human resources systems," Rogers said.

Another important element in the software evaluation process is the ability to accommodate the different needs of the various practice disciplines in Health First's 29 clinics. This meant finding a product whose screen icons flowed according to the way most physicians practice, or that could be easily customized to meet specific needs.

Other items Rogers found important in making the final choice included the ability to track immunizations, the ability to add a module that automates the prescription process, and the ability to print patient handout materials. "These are the kinds of features that really boost practice efficiency, " he adds.

Health First also is integrating the software into its new after-hours call center, which is designed to serve out-of-town visitors needing a primary care physician. Nurses will field calls from patients, enter their medical information in Logician, forward it to the nearest Health First clinic, and schedule the next available visit. "When the patient arrives, the record will already be there. It's a way for us to build our business base and deliver exceptional patient service," Rogers said. ■

Use these guidelines when training billers

Many practices complain about the accuracy of the bills sent from their office, but how many are doing something about it by investing in a training program?

The rudimentary training most physician organizations give their billers does not teach employees how their job contributes to the entire billing process, says **Donna Sherwin**, president of PBSI, a Wayne, PA, firm that provides temporary and permanent staffing as well as testing and training to physician billing offices.

In addition, the lack of cross-training between billers and other staff members, such as coders and schedulers, makes it easier to overlook mistakes or inconsistencies because each person only knows his or her piece of the total reimbursement pie.

The first step to ensuring every employee in the practice has a basic level of competency and is working to maximize appropriate reimbursement while minimizing coding and claim errors

is to start with a uniform and basic level of testing and training for every staff member. Then you should provide additional layers of selective cross-training, says Sherwin.

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

Sherwin has developed her basic approach to billing training over the past six years.

Provide care to all employees

"It is based on the belief that the organization will benefit from everyone striving toward the common goal: maximization of reimbursement through timely and accurate billing while maintaining an optimal level of patient satisfaction," says Sherwin. Because each office is different, she recommends it be customized wherever possible to meet each practice's specific needs. "However, if a basic core is not provided to all employees, the success of the training program may be jeopardized," warns Sherwin.

Basic elements in Sherwin's core training program include:

- core conceptual training for all staff members;
- basic system training;
- selective training based on positions;
- testing to determine whether objectives have been met.

Before implementing the program, you first need to determine exactly what it is you want every member of your staff to know, Sherwin says. One basic outline she suggests would be a patient flowchart starting with the initial call for an appointment and ending at the resolution of an account receivable item, including a review of the basic functions and positions needed throughout the process.

She also suggests a course including more technical information, such as key medical terminology a biller needs to be familiar with, the importance of CPT-4 and ICD-9 codes, and an introduction to self-pay and third-party billing.

Once the detailed elements of the training have been outlined, a document should be developed that clearly tests for the fundamental knowledge each staffer should know.

"Your core training schedule should then be based on the results you have determined you want to achieve," says Sherwin. "You also need to make a decision as to whether or not you will allow individuals to opt out of the training based on test scores."

Based on Sherwin's experience, this basic training should take between 15 and 20 hours. Depending on the size of the organization, it could take several core sessions before all staff are trained.

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

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

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

Once the core conceptual training has taken place, you will be able to review and apply the concepts taught through system training, and then begin cross-training.

Offices that are organized along functional lines, such as appointment scheduling, the registration function, and other duties can elect to have those individuals who are responsible for the function receive training in that function only.

However, Sherwin says each person should immediately begin cross-training in other staff functions after completing his or her core conceptual training. "If you are organized along product lines in which one person is responsible for multiple functions within one product line [physician, specialty, etc.], you will necessarily have to provide them with multiple function training," she points out.

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At this point, participants need only learn how the system captures and processes the information they received during the core conceptual training. Knowing that all participants have a basic understanding of physician billing concepts will allow the system training to take place in a relatively short time. "Again, I would suggest testing at the end of system training to ensure that your minimum level of competency standards have been met," says Sherwin.

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

NEWS BRIEF

Philadelphia physicians join union

A move by Philadelphia-based Independence Blue Cross Blue Shield to lower reimbursement rates has spurred a group of Philadelphia-area surgeons to join a union in hopes of gaining better bargaining leverage when it comes to plan payment rates.

Since this summer, some 300 Philadelphia-area orthopedic surgeons, urologists, and ear, nose, and throat doctors have joined the Federation of Physicians and Dentists (FPD) union.

Physicians in Independence Blue Cross Blue Shield's network keep an average of only 40% of each dollar they make, says FPD spokesman **Michael Connair**. On top of this, last July, the plan instituted a 2.5% across-the-board fee cut intended to dampen a recent rise in health care costs averaging 5% to 8% annually.

Surgical specialists were hardest hit by these cuts, who had to eat a 16% reduction in their reimbursement, says **John Zamzow**, vice president for contracting at Independence.

Because they are considered independent contractors, surgeons are restricted from collective bargaining by the Sherman Antitrust Act. However, they have agreed to pay the Fort Lauderdale, FL-based FPD annual dues in exchange for its consulting services relating to reimbursement and bargaining issues.

One such service being provided by the union is review and consultation on insurance company contracts, along with assistance in drafting counterproposals. FPD also will gather information on customary charges for key medical procedures and reimbursement rates of other insurers in the Philadelphia area.

"We're now being paid about one-third of what we got paid five years ago for the same procedure," says **Michael Okin**, MD, an orthopedic surgeon in Philadelphia. Affiliating as a group with a union like FPD to help give physicians more leverage in contract negotiations is "the only venue we have left to save our profession," says Okin. ■