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HCFA issues new 1999 RVU-based fee schedule, including 4-year transition

Medical societies sue to have rule declared illegal

Office-oriented practices come out winners while many surgical and hospital-intensive specialities stand to lose big under the final rule for the new relative value-based practice expense formula and 1999 physician fee schedule issued by HCFA in the Nov. 2 issue of the *Federal Register*.

But if you think this five-year battle is over, don't hold your breath. As part of this "final" rule, HCFA also declared that the formula for determining Medicare's new physician fee schedule — which will be based on relative value units (RVUs) — will officially only be considered an "interim" format while being phased in over the next four years.

Meanwhile, HCFA plans to form a new advisory group of physician specialty societies, providers, and other health care interests to help it

*(See **HCFA issues new fee schedule** on page 188)*

1999 RVU weights available to readers

As a reader service, the editors *of Physician's Payment Update* have compiled a complete listing of all 1999 RVU adjustments effective Jan. 1, 1999. We are making a printed version of this information available to all readers who renew their subscriptions. Even if your subscription does not expire for several months, if you renew now you will be sent a copy of our booklet containing all the new RVU values. Call (800) 688-2421 to renew and receive your copy.

In addition, readers may access this information on the Internet at: www.access.gpo.gov/su_docs/aces/aces140.html.

Once you access this Web page, select "1998 Federal Register" and type "Medicare" in the search terms section. Several options will appear on your screen; choose the selection for "Medicare Program: Revisions to Payment Policies and Adjustments," published in the Nov. 2, 1998, *Federal Register*. ■

New RVUs require new thinking for some groups

Best practices set operational benchmarks

The new practice expense reimbursement rules that take effect Jan. 1 deal a hard blow to particular specialties of medicine and practices that perform a large percentage of their services offsite. **(See story, p. 185, for more information.)**

"How hard you get hit by the changes in the physician fee schedule all depends on what specialty you are in and the mix of services your office typically provides," says **Carl Cunningham**, a former practice administrator and now internal managed care consultant for the American College of Physicians-Society of Internal Medicine in Washington, DC.

Groups taking a 15% to 20% cut in Medicare payments over four years, combined with pressure from commercial managed care plans, are definitely going to have to sit down and think hard about how they can run their practices more efficiently, Cunningham says.

He puts it this way: "Your strategic choices are really few. Do we continue in this specialty, and if so, how can we cut costs? Or do we move on and try to reengineer our practice and patient base?"

Cunningham says practices might want to consider these cost-cutting suggestions:

- **Cutting staff.** No one likes to fire someone, but surgeons, especially, might have to cut back on assistants they can do longer afford under the new practice expense rules.
- **Share expenses.** Situations where you share office space and staff may be worth looking at.
- **Buy more productive equipment.** You might have to spend some money to save money over the long run by investing in more productive medical equipment to lower per-patient costs. ■

Site-of-service element could hurt practices

Pay falls for procedures done outside practice

HCFA's new fee schedule changes will affect medical groups performing high volumes of work in such facility settings as hospital outpatient departments (HOPDs), ambulatory surgical centers, and skilled nursing facilities.

For those procedures currently subject to differential payment depending on where the procedure is performed, the fee schedule discounts all practice expense values by 50%. However, as of Jan. 1, the site-of-service differentials will be CPT code-specific, with some discounts less than 50% of the practice expense value—and others much greater.

When fully phased in, the ultimate financial impact on facility-based practices is likely to be substantial, contend organizations like the Medial Group Management Association in Englewood, CO. As such, depending on service mix, hospital-owned practices that have been structured to qualify as part of a HOPD could be vulnerable to big payment swings. ■

New fee schedule affects practices far beyond 1999

Phase-in, year 2000 concerns top list

Whether your practice expects to do better or worse under HCFA's new fee schedule, it looks like a good bet that no relative value units (RVUs) will undergo a routine update between Oct. 1, 1999, and April 1, 2000, according to HCFA officials. The problem: HCFA expects to still be tied up trying to correct any possible year 2000 computer bugs in its information and payment systems.

In turn, practices should start making contingency plans to handle financial problems this might create. And that's not the only long-range financial concern that the new fee schedule generates. In accordance with congressional directions, the changeover to a fully RVU-based practice expense formula will be phased in over a four-year period.

Beginning in 1999, HCFA will use a blend of 75% of the practice expense RVUs used for payment in 1998 and 25% of the relative practice expense resources involved in furnishing the service. In 2000, the blend will consist of 50% of the 1998 RVU and 50% of the relative practice expense resources involved in furnishing the service. For 2001, the blend will be 75%/25%, culminating in 100% implementation on Jan. 1, 2002. ■

Total Payment for Selected Procedures

Code	Mod	Description	Current Non-Facility	Resource Based Non-Facility	Non-Facility Percent Change	Current Facility	Resource Based Facility	Facility Percent Change
11721		Debride nail, 6 or more	$39.81	$37.16	-7	$29.91	$32.65	9
17000		Destroy benign/premal. lesion	36.69	46.89	28	28.99	30.56	5
27130		Total hip replacement	NA	NA	NA	1,656.80	1,360.78	-18
27236		Repair of thigh fracture	NA	NA	NA	1,244.62	1,060.70	-15
27244		Repare of thigh fracture	NA	NA	NA	1,230.38	1,074.59	-13
27447		Total knee replacement	NA	NA	NA	1,771.16	1,422.60	-20
33533		CABG, arterial, single	NA	NA	NA	2,107.91	1,839.38	-13
35301		Rechanneling of artery	NA	NA	NA	1,262.70	1,065.91	-16
43239		Upper GI endoscopy, biopsy	228.81	258.40	13	211.20	139.97	-34
45385		Colonoscopy, lesion removal	443.89	391.77	-12	414.17	277.50	-33
66821		After cataract laser surgery	187.65	191.37	2	187.65	181.65	-3
66984		Remove cataract, insert lens	NA	NA	NA	795.28	663.72	-17
67210		Treatment of retinal lesion	686.27	583.34	-18	520.81	516.80	-1
71010	26	Chest X-ray	9.36	8.34	-11	9.36	8.34	-11
71020		Chest X-ray	34.55	33.34	-3	34.55	33.34	-3
71020	26	Chest X-ray	11.44	10.07	-12	11.44	10.07	-12
77430		Weekly radiation therapy	188.62	170.88	-9	188.62	170.88	-9
78485		Heart image (3D) multiple	514.68	514.37	0	514.68	514.37	0
88305	26	Tissue exam by pathologist	65.95	58.35	-12	65.95	58.35	-12
88305		Tissue exam by pathologist	46.14	38.20	-17	46.14	38.20	-17
90801		Psy dx interview	122.08	136.15	12	122.08	135.45	11
90806		Psytx, office (45-50)	80.95	92.73	15	80.95	91.00	12
90807		Psytx, office (45-50) w/e&m	90.03	96.55	7	90.03	97.60	8
90862		Medication management	47.37	47.23	0	47.37	46.54	-2
90921		ESRD-related services, month	235.86	232.70	-1	235.86	232.70	-1
90935		Hemodialysis, one evaluation	NA	NA	NA	93.87	66.34	-29
92004		Eye exam, new patient	77.83	114.61	47	87.37	82.31	22
92012		Eye exam, established patient	39.42	71.89	82	31.35	34.38	10
92014		Eye exam & treatment	57.55	83.36	45	47.65	55.92	17
92980		Insert intracoronary stent	NA	NA	NA	1,142.75	899.89	-21
92982		Coronary artery dilation	NA	NA	NA	857.33	679.00	-21
93000		Electrocardiogram, complete	28.83	25.01	-13	28.83	25.01	-13
93010		Electrocardiogram report	11.96	8.34	-30	11.98	8.34	-30
93015		Cardiovascular stress test	116.95	101.07	-14	116.95	101.07	-14
93307		Echo exam of heart	215.85	193.80	-10	215.85	193.80	-10
93307	26	Echo exam of heart	70.94	47.23	-33	70.94	47.23	-33
93510	26	Left heart catheterization	266.37	219.16	-18	266.37	219.16	-18
98941		Chiropractic manipulation	32.87	32.99	0	27.55	28.83	5
99202		Office/outpatient visit, new	50.15	64.95	30	39.69	50.71	28
99203		Office/outpatient visit, new	68.93	92.04	34	56.82	73.98	30
99204		Office/outpatient visit, new	102.50	129.90	27	84.53	106.28	26
99205		Office/outpatient visit, new	128.35	161.15	26	108.72	137.88	27
99211		Office/outpatient visit, est.	14.16	21.88	55	9.94	13.55	36
99212		Office/outpatient visit, est.	27.61	34.73	26	21.01	26.74	27
99213		Office/outpatient visit, est.	39.42	45.85	16	30.61	36.47	19
99214		Office/outpatient visit, est.	59.39	72.24	22	47.65	59.04	24
99215		Office/outpatient visit, est.	93.67	105.24	12	76.06	91.69	21
99221		Initial hospital care	NA	NA	NA	69.84	68.77	-2

Source: 63 *Fed Reg* (Nov. 2, 1998).

Practice expense rule may require staff education

Historical background of practice expense rule

Translating the effects of HCFA's reimbursement changes to the day-to-day jobs of coders and billers reporting to you is no easy task. Here are some talking points for your use in explaining these reimbursement changes to staff members or physicians:

• Practice expenses are composed of direct and indirect expenses. Direct expenses include non-physician labor, medical equipment, and medical supplies needed for each procedure. Because indirect expenses such as the cost of general office supplies and utilities cannot be tied to individual procedures, HCFA will use accepted accounting techniques to allocate expenses to each medical procedure.

• Before implementation of the fee schedule in 1992, Medicare based payments on each physician's charges. The fee schedule system was created to relate future payments to the resources physicians use to provide a service rather than what physicians charge for a service.

• The three resources making up the new RVU-based fee schedule are practice expenses (41%), physician work (54%), and malpractice costs (5%). For the physician work and practice expense categories of resources each medical procedure will now be measured relative to all other procedures according to the amount of resources used. The third element, malpractice expenses, will be entirely resource-based starting in 2000.

The fee schedule for a specific procedure is determined by adding up the relative value units (RVUs), which are then adjusted for local cost differences and multiplied by a conversion factor that translates RVUs into dollars. ■

HCFA issues new fee schedule

(Continued from page 185)

continue ironing out bugs in the regulation while giving providers a forum to work out their disagreements over how to transfer several hundred million dollars a year in Medicare payments from surgical-based practices to primary care physicians in an attempt to more fairly equalize payments as mandated by Congress.

The final rules make only minor changes from HCFA's last preliminary June proposal. **(For more details on the original proposal, see *Physician's Payment Update*, July 1998, pp. 105-108.)**

As such, the agency also decided to stay with its so-called "top down" accounting approach that uses actual practice expense data collected by the American Medical Association's Socioeconomic Monitoring System to determine aggregate specialty practice costs and allocate practice costs to specific procedures.

This top-down approach is generally favored by surgical-based practices, plus such organizations as the Englewood, CO-based Medical Group Management Association, as a more accurate reflection of actual physician costs.

"Most of the physician specialty societies commenting on our proposed general methodology supported the top-down approach. This was echoed by comments by several non-physician organizations, the Association of the American Medical Colleges, and the Medical Group Management Association," HCFA noted in its final rule.

However, other groups, like the Washington, DC-based American College of Physicians-Society of Internal Medicine (ACP-ASIM), contend that this top-down methodology just "perpetuates the habit of basing practice expense payments on actual costs when they are mandated to move to a relative value-based system," says **Robert Doughtery**, ACP-ASIM's vice president for governmental affairs.

In determining practice expense costs under its top-down methodology, HCFA has used actual practice expense data by specialty, derived from 1995-97 SMS survey data, to create six cost pools: administrative labor; clinical labor; medical supplies; medical equipment; office supplies; and all other expenses. These data were used to allocate reimbursement to individual practice expense codes.

Maybe the most controversial part of the proposal is HCFA's decision to count the so-called 1998 fee schedule "down payment" when calculating future payment rates.

Basically, the down payment shifted about $39 million in payments from surgeons to primary care physicians in 1998 as a kind of "make-up"

Impact on Total Allowed Charges by Specialty of the Resource-Based Practice Expense Relative Value Units under the Practice Expense per Hour Method (percent change)

Specialty	Allowed Charges (in billions)	Impact per Year	Cumulative 4-Year Impact
MD/DO Physicians:			
Anesthesiology	$1.6	0	0
Cardiac Surgery	0.3	-3	-12
Cardiology	3.8	-2	-9
Clinics	1.6	-1	-3
Dermatology	1.0	5	20
Emergency Medicine	0.9	-3	-10
Family Practice	2.7	2	7
Gastroenterology	1.2	-4	-15
General Practice	1.0	1	4
General Surgery	2.0	-2	-7
Hematology/Oncology	0.5	2	6
Internal Medicine	6.0	0	2
Nephrology	0.9	-2	-7
Neurology	0.7	0	-1
Neurosurgery	0.3	-3	-11
Obstetrics/Gynecology	0.4	1	4
Ophthalmology	3.3	1	4
Orthopedic Surgery	2.0	0	-1
Other Physician	1.1	0	1
Otolaryngology	0.5	2	9
Pathology	0.5	-3	-13
Plastic Surgery	0.2	1	2
Psychiatry	1.1	0	1
Pulmonary	1.0	-1	-4
Radiation Oncology	0.6	-2	-6
Radiology	2.9	-3	-10
Rheumatology	0.2	4	16
Thoracic Surgery	0.6	-3	-12

Source: 63 *Fed Reg* (Nov. 2, 1998).

for what are now considered inadequate payments in previous years. Despite strong objections from mostly surgical specialties, HCFA has decided to include this down payment in the base used to figure future fee schedules.

"We consider this a very important issue to our membership," says **Randy Fenninger**, co-chair of the Practice Expense Coalition, an umbrella group of mostly surgical specialties.

A group of medical societies sued HCFA in U.S. District Court in Illinois to have the base year provision and the entire practice expense transition formula declared illegal. Plaintiffs claimed that including this down payment in the base for determining future physician payment could inflate the amount being transferred from from hospital-intensive practices to office-based physicians from $390 million to nearly $1 billion by 2002.

"HCFA's transition rule ignores the plain reading of the statute," says **Dunbar Hoskins**, MD, executive vice president of the Washington, DC-based American Academy of Ophthalmology. "What this action amounts to for ophthalmology is nearly $200 million in physician payments being transferred to primary care which we do not feel Congress intended."

The other plaintiff medical societies are: American Academy of Orthopedic Surgeons, American Association of Neurological Surgeons, American College of Cardiologists, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, American College of Gastroenterology, American Society of

Cataract and Refractive Surgery, Congress of Neurological Surgeons, Outpatient Ophthalmic Surgery Society, and Society for Excellence.

Overall, Medicare fees will rise an average 2.3% next year under the 1999 Medicare schedule.

As mandated by Congress, the practice expense rule must be budget-neutral, meaning it will not increase the amount of money Medicare would have otherwise spent. As such, under the new formula, physicians with office-based practices, such as family practice and internal medicine, will generally see their fees increase. Those with more hospital-intensive practices, like cardiac surgeons and neurosurgeons, will see their payments decrease.

Medicare will spend about $35 billion on physician services in 1999. By the time the RVU rule is fully implemented in 2002, some $390 million in annual payments will have been reallocated from mainly surgical to mostly primary care specialties.

According to HCFA, once the new resource-based system is fully phased in, general surgery will experience a 7% decrease in Medicare payments compared to the old system, while family practice will enjoy a 7% increase. The exact magnitude of the change for any practice will depend on the mix of services they provide and the sites where they are performed.

By the end of the four-year transition period, specialties like cardiac surgery, gastroenterology, neurosurgery, and thoracic surgery are projected to have their Medicare fees dramatically slashed. **(See chart on p. 189.)** Meanwhile, such practices as dermatology, rheumatology, otolaryngology, and oncology will see their fees rise substantially.

Congress rights a perceived wrong

Congress mandated these changes because it felt the old system unfairly favored physicians with hospital-oriented practices over those with patients making office visits.

Besides the practice expense rule, HCFA's Nov. 2 announcement also included final implementation of several other regulations contained in the Balanced Budget Act of 1997. According to an analysis by the Medical Group Management Association, these provisions include:

• **"Incident to" billing rules lifted for some outpatient rehabilitation services.** Orthopedic, rehabilitation, and other groups that make extensive use of therapists will benefit from changes to fee schedule rules for physical therapy and occupational therapy. The final rule allows medical groups to bill for services of their physical and occupational therapist employees without meeting the requirements of the "incident to" billing rules, including the direct supervision requirement.

• **Caps of $1,500 for physical therapy and occupational therapy will not be implemented by the carriers by Jan. 1, 1999, due to year 2000 computer technology issues.** Each supplier of therapy is expected to keep track of its own billings and payments. Suppliers are prohibited from billing if the cap is reached. Use of modifiers will be required to identify physical therapy, occupational therapy, and speech pathology services.

The final rule generally follows existing guidelines, with some minor clarifications. The incident-to provisions generally follow the current incident-to rules that apply to physicians. According to HCFA, "The various incident-to requirements are currently interpreted at Section 2050 of the Medicare Carriers Manual. [HCFA] will not amend any of the incident-to requirements at this time."

• **Payment for telemedicine in rural health professional shortage areas has improved slightly.** Groups involved in telemedicine will benefit modestly from implementation of a BBA provision authorizing payment for teleconsultations provided to patients in rural health professional shortage areas. The teleconsultation must be done "live" with the patient, the patient's physician, and the consulting physician all present (at different locations) at the same time for the examination. Payments for these consultations are split between the referring practitioner and the consultant. While the new benefit is quite limited and the payment rules restrictive, it is a "foot in the door" for telemedicine, says MGMA.

• **Payment for drugs & biologicals is more restricted.** The rule establishes payment guidelines for drugs not paid for on a cost or prospective payment basis. The BBA set payment at the lower of the actual billed amount or 95% of the Average Wholesale Price (AWP). Current regulations provide that for multiple-source drugs, the AWP equals the median AWP of the generic forms of the drug, ignoring the brand-name product on the assumption it is always priced higher. According to HCFA, this is not always the case. As such, under the final rule, "AWP" is now defined as equal to the lower of the median price of the generic AWPs or the lowest-priced brand-name AWP. ■

Belt-tightening doesn't have to mean lower profits

Here's how the best practices do it

With the prospect of having their practices crushed between the two-fisted grip of managed care and reduced Medicare practice expense payments, many physician groups will need to dramatically improve their financial performance to stay competitive, say many experts.

For those looking for both ideas and inspiration on how to operate a state-of-the-art practice, the Englewood, CO-based Medical Group Management Association's (MGMA) list of "best practice" multispecialty practices is a good place to start.

MGMA's annual best-practice survey culls key financial information from over 1,000 group practices across the country, then boils that down to the financials of 15 of the best-run practices.

"We define better practices as those that achieve above-median physician income with below-median per-procedure costs," says MGMA survey chief **David Gans**.

"Last year's survey, for instance, found that median operating cost as a percentage of total net medical revenue for all multispecialty practices polled was 56.02%, compared to 51.64% for the survey's better-run practices," says Gans. Additionally, these better practices have higher physician productivity, which is rewarded with higher compensation and benefits—$227,303 vs. $196,620 per full-time physician.

MGMA uses two basic criteria to identify these better-performing practices: above-median total physician compensation and below-median operating cost per nonsurgical encounter.

"These practices have characteristics that set them apart," says Gans. "They have higher net medical revenues, more support staff per physician, and lower costs per encounter, indicating that their higher staffing costs are more than offset by increased efficiency."

A common characteristic of MGMA's top groups is they all have a detailed blueprint, or strategic plan, they use to direct and build their practice over time. "A strategic plan is critical," says **Barbara Gunder**, administrator of 39-doctor Salem (OR) Clinic, which ranks among the top groups identified in the survey. "It acts as both a road map and a point of accountability."

Critical to the strategic planning process is how much of their earnings individual physicians will be willing to reinvest in building the practice. These retained earnings can give the practice the extra financial leverage it needs to do such things as shore up ancillary services, build satellite clinics, and buy computer information systems that eventually will generate more income and the muscle to negotiate better managed care rates.

Reinvesting 5% percent of its annual net earnings, for instance, has made it easier for Quincy, IL-based Quincy Medical Group to add new physicians and negotiate favorable financing on a $13 million loan to build a new main facility for the clinic. Also, the fact the group had the cash for a 25% down payment on construction financing meant the group's physicians did not have to sign individual notes guaranteeing the loan.

Best practices know an incentive program that encourages and rewards top production from each physician in the group is crucial to achieving the kind of financial success that generates profits that can be reinvested in the practice.

Profits come from volume

Administrators at the 80-doctor Springer Clinic in Tulsa, OK, say the best way to motivate its physicians is to pay them a higher percentage of revenue for the more patients they see. For instance, a primary care physician can receive 40% of collections for the first 25 patients seen in a day, 50% for the next 10, and 60% of collections for anything beyond 35 patients. The same concept can also apply to specialists.

While rewarding production, another purpose of this kind of formula is to constantly remind physicians that the clinic's profits come from volume. "The first 15 or 20 patients you see on any given day just covers your overhead," says Springer's practice administrator **Rick Callis**.

In fact, some of the most heated debates in many practices is how to fairly allocate overhead costs among the various specialists in the group.

Quincy Medical Group used to charge its doctors directly for their staff, liability insurance, and supplies. However, this approach also meant primary care physicians—who tend to have the highest overhead—ended up with a below-market paycheck once all these deductions were made. "We also found that this was making it harder for us to recruit top primary care physicians, which made the system counterproductive," notes **Diane Weber**, Quincy's chief financial officer.

The group's new policy now deducts overhead expenses from practice gross revenue, then divides the net among doctors according to their productivity. Management review panels also were created to keep overhead in check. "There's been no rush to add more staff since we eliminated the overhead charge-back, largely because our review committees take a hard look at the data to see if it's justified," Weber says.

Other best practices, however, have found direct overhead charge-backs to physicians work best for them. "We've found direct overhead charges mean a physician will think twice before hiring someone he doesn't need, or asks for an extra exam room," says **Bob Mann** Jr., president of the PAPP Clinic in Newnan, GA.

Financial incentives alone are not enough

Best practices know having the right financial incentives does not mean a practice will be financially successful. The other half of this equation is ensuring the practice has the right combination of physician personalities who share the same work ethic and buy into the practice's philosophy and culture.

When recruiting new physicians, Quincy Medical Group tells potential new hires up front what kind of performance will be expected from them, such as hours they are expected to work and productivity. Springer Clinic tries to cut the learning curve for new associates—and increase their productivity—by assigning each one a proctor or mentor from their department whose job is to teach them office operations and help refine their medical management skills.

This type of active oversight is not limited to first-year associates. Indeed, strong central management and constant monitoring of physician activities is a common best-practice characteristic. "The idea is to create a culture where you get everyone working for the common good of the group, and not just looking looking out for their own limited interests," says **Seth Garber**, a health care principal with consultants William Mercer in Washington, DC.

Administrators at Springer Clinic say tougher management oversight has helped the clinic improve its hospital utilization. "Over the years, we had tried everything we could think of to improve hospital days—educating the docs , installing nurse case managers, etc.," says **Riley Hill**, MD, Springer's director of managed care. However, utilization had gotten so out of control that the clinic faced losing up to $1 million on its managed care contracts if something was not done.

The answer, says Hill, is to do a daily review of every hospitalized patient to help identify those who can be appropriately discharged or moved to a less intensive form of care.

"The idea was both simple and successful," says Hill, who feels the main reason for its success is the fact he is a doctor. "A nurse case manager could have done the job, but the problem is, most doctors do not return the call when they are paged by a nurse manager," says Hill. Next, when a nurse asks why a patient is still in the hospital, "the typical physician's response is 'You don't understand,'" says Hill.

But because physicians were being called by a doctor—as well as a respected senior member of the practice—"the physician has to think a little harder when I suggest we move someone to outpatient management," says Hill. ■

Increase revenue through ambulatory care facility

Income can offset reduced Medicare dollars

There are two ways of dealing with budget cuts from outside sources: You can look for ways to keep your own costs down, and you can look for ways to bring more dollars in the door.

Practices facing cuts in their Medicare income can combat this situation by truly integrating and restructuring. While a physician network may look like or call itself an integrated delivery system (IDS), there's more to running an IDS than throwing the acronym around, argues Philadelphia health care consultant **Thomas W. Reinke**.

"The term 'integrated' is probably premature," says Reinke. "Generally, most mergers of physician practices into a larger group, or acquisitions by hospitals, have only taken half a step toward real integration."

According to Reinke, the most commonly found physician integration blueprint is the "as is, where is" model, where doctors remain in their offices and continue to function largely as they did in the past.

"There is no true integration here, as this type of organization operates more like a confederacy

than a single unified entity," he maintains. In turn, it is very difficult to make the financial, administrative, and clinical aspects of the as-is-where-is model work together. That's because the very idea of an integrated group is often in direct conflict with the reality of operating multiple small sites that separate doctors and require duplicated facilities, personnel, and overhead expenses, Reinke points out.

For these practices to succeed, they must find that medical niche where they have the most competitive advantage and where demand is projected to grow, he argues. "In health care, that means outpatient services," says Reinke. "This has been a successful area of expansion for providers in the past and still presents an opportunity."

Also, many studies are predicting an increased demand for specialist services. "The real opportunity for a health care organization to obtain a competitive advantage is to provide more specialist services in an ambulatory setting," says Reinke.

Some of the advantages of consolidating various physician practice groups into an ambulatory care center include: increased utilization of clinical space, elimination of duplicative personnel, reduced bureaucracy, and lower overhead and information technology costs along with a wider range of enhanced services.

"Instead of just acquiring physicians, ambulatory care centers offer the potential for true integration of health care services," maintains Reinke.

For example, once primary care physicians are capitated, they often see their responsibilities expanded to include treating simple low back pain. But in an ambulatory care center setting, a specific back pain treatment center can be created and staffed by both primary care physicians who screen and treat simple low back pain and orthopedists or neurosurgeons who are called in for difficult cases.

"Furthermore, by marketing the center to occupational health case management companies, you create an additional source of revenue," notes Reinke.

The key to making these ambulatory centers work is the proper integration of specialists into the operation. "True integration among providers must include specialists, since this allows you to better differentiate your products and services," says Reinke.

Contrary to recent common wisdom, Reinke says physician groups should not increase capital spending on expanding primary care services. Rather, "specialty services and unique programs are one key to differentiation and growth," argues Reinke. "Specialty services and unique programs require specialist physicians. Any provider organization intending to grow and become an integrated delivery system must plan to include more specialists." ■

Physician investors in ambulatory centers in luck

Physician-owned centers stand to profit

In its first opinion since establishing an advisory process for providers or family members who receive compensation from or have a financial stake in another provider, an Oct. 29 HCFA advisory opinion found that a proposed arrangement for a physician-owned ambulatory treatment surgical center (ATSC) "would qualify for the rural provider exception to the prohibition against physician referrals."

Referrals for designated ancillary health services such as outpatient prescription drugs, clinical laboratory services, and radiology services are "potentially appropriate" for the rural provider exception in this arrangement as well, according to the opinion.

The entity that requested the advisory opinion is a newly formed limited liability company proposing to build and operate an ambulatory surgical treatment center. "In order to finance the construction and operation of the ATSC, [the entity] will sell shares of the company to investors. The investors will be physicians who will refer patients to the ATSC. Further, some of these physicians will perform medical and surgical procedures at the ATSC. [The entity] expects that physician investors will refer Medicare beneficiaries to the ATSC," HCFA states in the advisory opinion.

The Social Security Act prohibits a physician from referring a Medicare patient to an entity for certain designated health services if the physician has a financial relationship with the entity, unless an exception applies. The statute specifies two categories of "financial relationship": (1) an ownership or investment interest in an entity, and (2) a compensation arrangement between a physician and an entity. An ownership or investment interest can be through debt, equity, or other means.

The rural provider exception "is available to parties that are involved in an ownership arrangement." The advisory opinion states that "the arrangement as described to us" between the company and its investors "fits within the definition of an ownership or investment interest" under the statute.

The entity had indicated to HCFA that in exchange for capital contributions, it proposes to offer investor physicians up to 49% of the company's interest in profits, losses, and cash flow. The remaining 51% of the equity will be owned and controlled by one physician. The company has not presented any issues regarding compensation relationships between the physicians and the company. "Therefore, this advisory opinion applies just to the ownership or investment interest," the document states.

The opinion states that the rural provider exception is "potentially appropriate" for designated health services furnished by the ATSC. The self-referral ban prohibits referrals for designated health services that include clinical laboratory services, radiology services, and outpatient prescription drugs. "[The entity] indicates that it anticipates providing some of these designated health services. Unless an exception applies, a physician investor in [the entity] who refers Medicare patients for a designated health service to the ATSC would be making a prohibited referral," the opinion states.

The rural provider exception for designated health services involves a two-part test. "In addition to the requirement that designated health services be furnished in a rural area, substantially all designated health services furnished by the provider must be furnished to individuals residing in a rural area," according to the advisory opinion. HCFA has interpreted "substantially all" to mean at least 75%.

"If, as [the entity] certifies, substantially all of the designated health services furnished by the ATSC are furnished to individuals residing in a rural area, the ATSC will meet the second element of the rural provider exception," the advisory opinion states. HCFA cautions, however, that the "substantially all" test is an "ongoing requirement."

Advisory opinions may be requested only by individuals or entities actually involved in a specific business arrangement, and an opinion "may be legally relied upon only by the requestors," under the rule. Advisory opinions issued by HCFA apply only to the specific arrangement described in the request for the advisory opinion and do not apply to other arrangements, even to those that appear to be similar. ■

New CPT codes contain over 600 changes

Coders must learn to use two new symbols

As of Jan. 1, there are some 600 changes in the newly released CPT codes that coders—and those dealing with codes in your practice—are going to have to incorporate into their operations.

Coding and billing staff take note: Odds are not all third-party payers are going to be geared up to immediately start using these new codes come New Year's Day. Therefore, the smart bet is to check with payers and carriers beforehand to see what their own internal timetable is for implementing the new codes.

The new CPT changes break down like this: 468 existing codes have been revised, 40 codes deleted, and 157 new codes added. Of the revisions, the majority (269) can be found in the Musculoskeletal System section.

Besides these code changes, practices are going to have to contend with a series of some 500 so-called "black box" commercial edits contained in the claims review software of Atlanta-based HBO & Company, (HBOC) an outside vendor selected by HCFA to check provider claims for accuracy and medical necessity.

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The plan had been to add these edits to a file maintained by the Correct Coding Initiative. However, HBOC objected, saying the edits are its private, proprietary property and cannot be released to the public. That's why they are called "black box" edits: The claims go in and the denials come back, but there is no explanation of why they were denied because the decision-making process is proprietary.

In turn, practices will need to keep an extra-close track on any denials so they can separate commercial edits from the regular HCFA edits.

Various medical and specialty groups are negotiating with HCFA to work out a compromise on this "black box" issue. Meanwhile, the best thing to do is stay in close contact with your Medicare carriers, who will handle any denials.

Black boxes aside, the most dramatic change in the CPT was the American Medical Association's addition of new symbols to the coding system. Specifically, a plus sign (+) now denotes an "add on" code, and a circle with a line across it (Ø) signifying that is a modifier -51 exempt code.

Coders should note many of the 1999 code descriptions also include the instruction "List separately in addition to code for primary procedure" to help denote a new or add-on code. "This helps clarify reporting requirements," says **Rita Scichilone**, a coding and reimbursement consultant with Professional Management Midwest in Omaha, NE, and *Physician Payment Update*'s resident coding columnist. For example, if more than one breast lesion is localized for biopsy, physician codes 19290 and 19291 would both be reported, and modifier -51 would not be added to the second procedure. Code 19290 is for the first lesion placement on the needle localization wire, and code 19291 is assigned for each subsequent placement during the same procedure episode.

For the new codes exempt from modifier -51 reporting, these codes may not have "each" or "each additional" within the CPT descriptions.

For example, code 17004 is one of the codes that caused confusion in reporting destruction of skin lesions. The previous issues of the CPT manual showed this code indented under the main code of 17000. Some coders would assign 17000 for the first lesion, code 17003 for the 2nd through 14th lesions, and then report code 17004 in addition for the lesions over 15 removed during a single episode. The revised terminology clarifies this as a separate code and provides these instructions: "Do not report 17004 in conjunction with 17000-17003." Some of the codes on this list will have terminology that reflects stages or other conditions that imply they would not qualify as multiple procedures subject to reduction in reimbursement policies by third-party payers.

Modifier listings have been moved to Appendix A at the back of the manual and do not appear in front of all individual sections of CPT, as they have previously, points out Scichilone.

"Physician coders will be pleased at the clarification provided in the 1999 book for modifier -25 dealing with 'Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service,'" says Scichilone.

The new clarifying language in the description reads as follows: "The E/M service may be prompted by the symptom or condition for which the procedure and/or the service was provided.

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Editor: **Larry Reynolds**, (202) 347-2147.
Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Glen Harris**, (404) 262-5461, (glen.harris@medec.com).
Managing Editor: **Francine Wilson**, (404) 262-5416, (francine.wilson@medec.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.

Editorial Questions

For questions or comments, call **Francine Wilson** at (404) 262-5416.

As such, different diagnoses are not required for reporting of the E/M services on the same date."

While third-party payers still will require documentation to support billing two service codes for the same encounter, this E/M change may help in obtaining reimbursement for an office visit and a procedure on the same day, particularly when the procedure has not been scheduled ahead of time, says Scichilone.

Other changes include additional language to preventive medicine service codes involving modifier -25 to report separate services provided during the same encounter. The 1999 version of CPT also explains that the comprehensive examination within the code range 99381-99397 is not the same as the "comprehensive" examination requirements for Evaluation and Management codes.

Also, a section has been added for hospital outpatient and ambulatory surgery center-designated modifiers to clarify reduced or discontinued procedure reporting, as required by the Health Care Financing Administration. "For the first time, CPT has also listed selected HCPCS modifiers for easy reference," says Scichilone. "These are only the HCPCS modifiers that apply to hospital reporting. For a complete set of HCPCS modifiers, a HCPCS manual must be consulted." ■

Complaints spur changes in Medicare+Choice rules

New regulations not as strict on providers

With the new Medicare+Choice program scheduled to go into effect Jan. 1, both congressional and health care groups are still working to revise the program's proposed regulations.

For instance, Rep. **Mike Bilirakis** (R-FL), chair of the House Commerce Health and Environment Subcommittee, says the interim Medicare+Choice rule is an "overly expansive interpretation of the Balanced Budget Act which runs counter to congressional intent. Thus far, HCFA has demonstrated a fundamental misunderstanding of the goal and spirit of the Medicare+Choice program."

In response, HCFA officials tell *Physician's Payment Update* they are not going to raise Medicare+Choice fees, but the agency is willing to make adjustments in other areas. Specifically, in contrast to the proposed rule, the final Medicare+Choice regulations will:

—phase in the new Medicare+Choice quality improvement requirements, rather than instantly institute them;

—reduce the number of performance improvement projects required of plans;

—increase flexibility in coordinating care and conducting site visits for provider credentialing;

—allow plans an additional year to implement compliance plans and execute contracts with current providers.

As of Sept. 28, HCFA had 48 pending applications for new Medicare+Choice contracts and 25 pending applications for service area expansions from existing contractors. Four of the applications are from provider-sponsored organizations, and two additional provider-sponsored organizations have waiver requests pending. The agency has only received one application from a preferred provider organization, but no applications from medical savings account or fee-for-service plans. ■