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Medicare intermediaries in spotlight of new federal effort to cut fraud, abuse

White House unveils new package of proposals

The federal fraud and abuse program has heated up on two fronts. The White House has announced a new investigative initiative directed at Medicare intermediaries, and the Chicago-based American Medical Association (AMA) has asked for an investigation of "petty harassment" of physicians by the government.

Just days after the White House's early December announcement of a major new initiative designed to continue ferreting out fraud in the Medicare and Medicaid programs, delegates at the AMA's interim meeting in Honolulu weighed in with a report calling for Congress to investigate the Department of Health and Human Services for alleged misuses of its regulatory power in fraud investigations.

The AMA's Dec. 7 report maintains that the Health Care Financing Administration's "misuse" of regulatory authority includes its evaluation and management documentation guidelines and Correct Coding Initiative. The AMA also is asking Capitol Hill to hold hearings to "ensure that the federal government focuses its law enforcement efforts on truly fraudulent behavior, not inadvertent billing errors."

"Honest physicians of America have had enough and will no longer stand for petty harassment by auditors or for being falsely accused of abusive and fraudulent behavior," stated one AMA-approved report.

Given the bluntness of the AMA's language, Capitol Hill insiders expect fireworks when the first round of HCFA oversight hearings is held by the Senate Finance Committee in early 1999. "We felt we had to do this because of the unrest we've been hearing from some providers," says **Ted Lewers**, vice chairman of the AMA Board of Trustees.

The AMA's complaints came on the heels of the White House's Dec. 7 announcement of a legislative and regulatory package of anti-fraud proposals intended to save $2 billion, including a new crackdown on Medicare contractors to make them more effective and accountable.

The President's proposal is a combination of something old, something new, and something borrowed from previous anti-fraud recommendations and reports that the administration plans to implement over the next year. According to the plan, the administration will:

AMA supports HCFA changes

Besides calling for congressional hearings into how the Health Care Financing Administration manages its anti-fraud programs, delegates to the American Medical Association's Dec. 2 interim meeting also approved reports:

• demanding major changes in Medicare prepayment and post-payment review programs that would require physicians to receive due process and accurate and clinically informed review of their services;

• calling for well-designed pilot tests to assess any new E/M guidelines before implementation by HCFA;

• reaffirming the AMA's efforts to advance other alternatives to numerical guidelines as a basis for coding review, including peer review of statistical outliers. ■

• Grant HCFA more authority to enhance contractor performance.

HCFA would get new authority allowing it to more quickly fire contractors who don't perform well. The proposal would give HCFA the power to contract with a wider range of carriers to administer the program, and then to terminate them if they fail to perform effectively. The proposal would give HCFA greater authority to oversee contractor performance of such functions as enrolling providers, investigating fraud, and collecting overpayments.

• Contract with special fraud surveillance units to ensure detection of fraudulent activities.

Office of Inspector General (OIG) reports have shown that many Medicare contractors do a poor job of investigating fraud. That is partially because they have a wide variety of other functions, and partially because they have multifaceted relationships with providers that may create conflicts of interest. As a solution, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave HCFA new authority to contract with specialized fraud, waste, and abuse surveillance units, or "fraud fighters," which HCFA says are better equipped to audit cost reports and conduct activities vital to the detection of fraud, waste, and abuse. The first fraud surveillance units will begin their efforts this spring.

• Require contractors to report fraud complaints to the Inspector General right away.

Many contractors now defer reporting cases of suspected fraud to the OIG when the dollar amounts are low, even though these reports could show significant patterns of fraud. In response, HCFA has sent program memorandums to all contractors requiring them to refer suspected fraud to OIG immediately, regardless of the amount involved.

• Announce a new comprehensive plan to fight fraud and abuse.

HCFA officials say they will very soon announce a new Comprehensive Plan for Program Integrity that relies heavily on increased audits and better internal data management.

• Eliminate excessive Medicare reimbursement for drugs.

A recent report by the OIG confirmed that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than it would if it paid market prices. For more than one-third of these drugs, Medicare paid more than double the average wholesale price, and in one case paid 10 times the amount. This proposal would base Medicare payments on the actual acquisition cost of these drugs to the provider, eliminating current mark-ups, and, in turn, substantially reducing Medicare costs.

• End overpayments for Epogen, a drug used to treat anemia related to chronic renal failure.

An OIG report found that the current reimbursement rate of $10 per 1,000 units of Epogen exceeds the current market cost of the drug by approximately 10%. The administration's proposal would reduce Medicare reimbursement to reflect current market prices.

• Prevent abuse of Medicare's partial hospitalization benefit.

A recent OIG report found providers abusing Medicare by billing for partial hospitalization services that were never given or provided to many fewer patients than were billed for. This proposal would ensure that Medicare reimburses only for services actually given.

• Ensure Medicare does not pay for claims owed by private insurers.

Private insurers of working Medicare beneficiaries are required under law to be the primary payers of health claims. These insurers, however, do not always pay the claims for which they are responsible. This proposal prevents this abuse by requiring private insurers to report all Medicare beneficiaries they insure to HCFA. This proposal

also would give HCFA greater authority to fine private insurers, including the authority to recoup twice the amount owed if insurers intentionally allow Medicare to pay claims for which they are responsible.

• Empower Medicare to purchase cost-effective high-quality health care.

Medicare now has limited demonstration authority to contract out with institutions — called centers of excellence — that have a track record of providing exceptionally high-quality care at a reasonable price. This proposal would expand this authority to urban areas that have multiple providers, thereby enabling the Medicare program to provide higher-quality health care at less cost.

• Implement competitive bidding demonstration for durable medical equipment.

The OIG recently found that Medicare rates for hospital beds are substantially higher than rates paid by other payers. HCFA will begin a demonstration this spring that will use competitive bidding to decrease Medicare payment for hospital beds and other durable medical equipment, thereby lowering program costs. ■

HCFA emphasizes proactive abuse probes

'National objectives' to come for intermediaries

The Health Care Financing Administration says it plans to develop "specific national objectives" for the internal fraud squads of Medicare fiscal intermediaries.

The announcement came in response to a scalding report from the Office of Inspector General (OIG) criticizing the fraud units of the private fiscal intermediaries used to process Medicare payments for not initiating efforts to identify holes in the system that could leave the claims processing system open to fraud.

While HCFA says it "emphasizes the importance of doing proactive work," half of all the fraud units at Medicare's fiscal intermediaries failed to open any new fraud investigations during 1996, the OIG said in its Dec. 2 report.

Of the 4,008 cases being investigated by Medicare intermediaries, only 5% (184) were opened as a result of "proactive case development," the OIG reported. "Furthermore, the fraud unit opening the largest number of proactive cases (97) was responsible for more than half the national total," notes the report.

"Rarely did the size of the fiscal intermediary, or the resources of the fraud control unit, correlate to the number of cases opened proactively," found the OIG. For example, "half the large, medium and small fraud units had no such cases, and one small fraud unit had seven" such cases.

Key congressional figures are reported to be outraged at the OIG's findings. Sen. **Charles Grassley** (R-IA), chairman of the Senate Special Committee on Aging, for instance, calls this lack of investigative initiative "unacceptable. It especially disturbs me that half of the fraud units didn't proactively identify fraud and simply took complaints as they came in," says Grassley. "If some of [the fraud units] aren't doing their job, the taxpayers have little assurance of a fraud-free Medicare system."

Indeed, while identification of program vulnerabilities is the first item on the official list of fraud unit responsibilities in the Medicare Intermediary Manual, "39% of fraud units [16 of 41] did not identify any [vulnerabilities]," the OIG said in its report. In addition, while "fraud units are required to keep track of identified program vulnerabilities . . . at least one fraud unit that [did] identify vulnerabilities had to rely on memory to describe them."

Bottom line: This lack of action and follow-through probably means most of these fraud investigation units are not doing the job they were designed to do, sums up the OIG report.

Even through HCFA currently conducts performance evaluations of its various fraud units, the OIG is recommending the agency shore up its monitoring and oversight of these contractors' efforts to identify fraud and abuse. HCFA officials, in turn, say the agency plans to develop a specific set of national objectives intermediaries must implement and then to design a new management information system to help track and achieve these objectives.

Of the 61 program vulnerabilities the fraud units did identify, 52% "seemed to be systematic problems that make the Medicare program vulnerable to abuse, such as loose guidelines that promote inappropriate billing for a service," the OIG said.

Another 41% were described as "instances of wrongdoing," such as billing a noncovered service as a covered service. The report also notes that "key words and terms related to fraud unit

work vary in meaning . . . hindering HCFA's ability to interpret fraud data and measure fraud unit performance."

The report is based on a fiscal year 1996 survey of the 41 fiscal intermediaries contracted by HCFA to process Medicare payments. These intermediaries process 75% of Medicare payments. Since 1993, HCFA has required all intermediaries and carriers to have distinct units to detect and deter Medicare fraud.

But before HCFA's initiatives get off the ground, they apparently will face aggressive questioning in the U.S. Senate.

Sen. **William Roth** (R-DE), chairman of the Senate Finance Committee, is not happy with the way the agency is doing its job, and he says he plans to hold "vigorous" oversight hearings of the agency in the coming months.

Roth is particularly upset with what he calls "serious setbacks" in implementation of the Medicare+Choice program, saying he believes "HCFA is undermining our efforts to create this new program."

Specially, Roth is concerned that HCFA is making the Medicare+Choice rules so difficult to follow that managed care plans are reluctant to participate. "It has become clear that there may be a conflict of interest that creates some bias at HCFA against reforming the Medicare program to permit private managed care plans to compete with the traditional fee-for-service program," says Roth. ■

OIG work plan outlines its investigatory priorities

Coding, PATH, billing on its list

The best indication of what are the Office of the Inspector General's (OIG) priorities are — and how it plans to allocate its resources over the next year — is its annual work plan. According to the OIG's FY 99 work plan, the office will focus on several specific areas when it comes to investigating possible physician fraud and abuse. These are:

1. Accuracy and carrier monitoring of physician visit coding.

The OIG will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding.

2. Physicians at Teaching Hospitals (PATH).

OIG plans to continue the PATH initiative to verify compliance with Medicare rules governing payment for physician services provided in the teaching setting, and to ensure that claims accurately reflect the level of service provided to the patient.

3. Billing service companies.

OIG will conduct reviews to determine:

— whether Medicare claims prepared and submitted by billing companies are properly coded in accordance with the physician services provided to beneficiaries;

— whether the agreements between providers and billing service companies meet Medicare criteria.

OIG says fraud changes saved billions

Implementation of fraud-related program changes saved the federal government $10.96 billion in FY 1998, according to the Office of the Inspector General's Dec. 1 semiannual report. The bulk of these savings came from implementation of the OIG's recommendation to extend congressionally mandated cuts in hospital costs and a reduction in the fee schedule amounts for Medicare laboratory reimbursements.

Physicians at Teaching Hospitals (PATH) audits conducted by the OIG produced settlements totaling $67 million from four hospitals during 1998. The multiyear initiative is intended to verify compliance with Medicare rules governing payment for physician services provided by residents and interns, and to ensure that all claims for services accurately reflect the level of service provided to the patient.

The Health Care Financing Administration also recovered $63.8 million from its Diagnosis-Related Group Payment Window Project. The DRG project is designed to recover overpayments made to hospitals as a result of claims submitted for nonphysician outpatient services that were already included in the hospitals' initial prospective payment. The agency has entered into settlements with 2,483 hospitals to date under the DRG project, the report says. ■

OIG investigators are especially interested in finding instances where billing service companies may have upcoded and/or unbundled procedure codes to maximize Medicare payments to physicians.

4. Patient billing records.

OIG will examine a sample of one state's physicians' patient billing records to identify and obtain refunds for Medicare and Medicaid overpayments. The review will be expanded to other states if significant problems are discovered.

5. Other physician reviews.

Studies will be made of the following issues:

— billing records of physicians with extensive visits to Medicare patients in SNFs;

— whether podiatry services were medically necessary and met Medicare coverage policy;

— improper billing of Medicare for psychiatric services;

— practice of allowing physicians to reassign their billing numbers to clinics;

— whether errors found in Medicare billing for physician services are associated with providers' use of automated encoding software.

6. Medical equipment and supplies.

The OIG will conduct seven reviews regarding durable medical equipment (DME) in FY 1999, including medical necessity of oxygen. The OIG will compare Medicare beneficiaries' self-reported use of home oxygen therapy with documentation supporting the medical need for such therapy. The OIG will assess the prescribing practices of physicians who order the service and how Medicare monitors utilization and medical necessity for the systems. ■

Feds offering new break to wrongdoers who confess

New self-disclosure policy now in effect

The Office of the Inspector General's (OIG) voluntary disclosure program has engendered a lukewarm response from providers since its launch in 1995. The OIG has decided to scrap the program and replace it with a new self-disclosure protocol, effective immediately.

The new protocol gives health care providers who uncover past or current billing problems an opportunity to essentially turn themselves in to the OIG. The understanding is that in return, the provider will avoid a lengthy investigation and prosecution in exchange for repaying any overpayments plus applicable fines, unless involved in overt and ongoing criminal activity.

"Although the protocol eliminates some of the problems with [the voluntary disclosure program], it is not a risk-free procedure for disclosing noncompliance," says **Joan Dailey**, an attorney in the Washington, DC, office of Reed Smith Shaw & McClay. "Health care providers should carefully consider the risks and benefits of voluntary disclosure under the protocol."

The good news is that "the OIG has created an expanded — and, in some ways, more flexible — successor to the program," says Dailey. All health care providers nationwide, regardless of industry, specialty, or type of service, are eligible to participate. In addition, the program is open to both corporate entities and individuals, and participants will not be automatically rejected if they are already the subject of an investigation.

"This protocol should prove more appealing to providers, because, according to the OIG, it contains no predisclosure requirements, applications for admission, or qualifying criteria," notes Dailey. "Moreover, there is no requirement that providers sign a written agreement with respect to their participation in the program, but the government expects good-faith disclosure and cooperation."

While the new disclosure protocol has its place, it may not be right for every situation, advise experts. For instance, "if a provider has received an overpayment through no fraud or fault of its own, a refund in the normal course of business may be more appropriate than using the protocol process," says Dailey.

For providers who are at fault in any way, "the protocol process may prove to be a viable mechanism for notifying the government and arriving at a palatable resolution," she says.

However, the OIG's outline also advises that the protocol should not be invoked by a provider who discovers an "ongoing fraud scheme" within its organization. In such a case, "there is a substantial risk that the government's subsequent investigation will be compromised." How the OIG defines "ongoing fraud scheme," however, is uncertain.

Another downside is that providers cannot expect confidential treatment of any of the information they disclose or other information gained by the OIG through its verification process.

Like many things in life, timing plays a critical role in determining whether or not a provider will receive favorable treatment by the OIG. For instance, based on the guidelines for the OIG's compliance program, providers who report any possible wrongdoing within 60 days of discovery have the best chance to avoid being subject to a full-court legal press for being perceived to have acted in "bad faith."

To qualify for assessment of double damages instead of triple damages under the False Claims Act, a provider must report the noncompliance within 30 days of its discovery.

Full cooperation, however, does not mean you get a get-out-of-jail-free card for all activities.

"Even after good-faith disclosure and cooperation with the OIG, this does not guarantee that you can't be excluded from the Medicare or Medicaid program, investigated for unrelated noncompliance discovered during disclosure, or prosecuted by another state or federal agency regarding the disclosed matter or disclosure of sensitive information," says Dailey.

If approved by the OIG's assistant inspector general for investigative operations, the protocol says the OIG will generally agree, for a reasonable period of time, not to investigate the matter if the provider agrees to perform an internal investigation to determine the extent of the problem and how much money is involved.

The results of the internal review must be summarized in a written report certified by the provider to be truthful and made in good faith. In general, the report must set forth the nature and extent of the noncompliance, as well as the circumstances under which the disclosed practice was discovered and the provider's response to the matter. More specifically, the report must include such information as:

— potential causes of the practice;

— divisions, departments, and related entities involved or affected;

— the impact on and risks to the health and safety of patients and their quality of care;

— names of corporate officials, employees, or agents who knew of, should have known of, encouraged, or participated in the practice, and the names of individuals who detected the practice.

The amount of any related monetary damages over and above any improper payment will be based on the results of a self-assessment of how the provider says it responded once it discovered there was a problem. This information must include the chronology of investigative steps taken in connection with the internal investigation, including a list of the individuals interviewed and interview summaries, a description of the records reviewed, and a summary of audit activity. It also must include actions taken to stop the practice and prevent its recurrence, as well as a description of any disciplinary actions taken against the provider's employees, officials, and agents.

Following protocol-provided guidelines, providers calculate the monetary impact of their noncompliance on the affected federal health care programs. While it does not have to accept this calculation, the OIG says it will give "substantial credibility" to those providers that faithfully followed its guidelines. ■

Prompt-pay law in effect, but the problem continues

New York providers raise ruckus over slow pay

Despite a prompt-payment law that took effect a year ago in New York, managed care plans have been paying their providers bills even later than usual, alleges the Healthcare Association of New York State (HANYS).

New York's prompt-pay law requires payment of clean provider claims within 45 days. However, a study released in November by HANYS found the average number of days it took managed care plans to pay their claims grew by 37%, from 47 days during the first half of 1997 to 64 days during the first half of 1998. The study is based on reports filed with the State Insurance Department by 24 managed care plans.

"Apparently, the definition of 'clean' is somewhat muddy to the plans," says HANYS' president **Daniel Sisto**. "The increase in unpaid claims demonstrates that New York's prompt-payment law requires prompt attention from the legislature when it reconvenes in 1999 so doctors and hospitals aren't left hurting when they heal plan enrollees," he says.

"This situation is not unique to New York," says Sisto. "Nationally, the managed care industry has been been having a very difficult time financially. What it looks like is many HMOs are

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trying to finance some of their operating losses with the cash flow that should be used to pay claims."

But **Nicole Reilly**, a spokeswoman for Oxford Health Plans of New York, disagrees. "These allegations show a complete lack of understanding of HMO claims-payment practices," she claims. Reilly says the information filed with the insurance department on which the HANYS study was based has little to do with calculating days of unpaid claims.

"The health care association is relying on data about financial reserves, the amount held to pay claims. This money has nothing to do with how long it takes to pay claims," she says. "In fact, reserves are mostly for claims yet to be received. They're looking at money that hasn't even been claimed yet."

HANYS officials acknowledge that while their calculations are not exact, they represent an accurate picture of the overall situation: Despite the enactment of a prompt-pay statute, there has been a recent increase in the percentage of providers not being being paid within the 45-day time limit, causing providers' level of accounts receivable to increase.

The situation has gotten so bad that many plans are withholding payment for preauthorized care, claims HANYS. "We think that if a plan preauthorizes a patient to receive medical services, it should pay for that service," says Sisto.

According to HANYS, 14 of the 24 plans operating in New York state saw their unpaid claims rate increase last year. Eleven of these plans had 60 or more days of unpaid claims during the first half of 1998. The largest percentage increase was by Kaiser Foundation Health Plan of New York in White Plains, with a 105% rise to 64 days. Other plans with 60 or more days of unpaid claims during the first half of 1998 included:

— Oxford Health Plans, with 72 days' worth of unpaid claims, up 74%;

— Aetna U.S. HealthCare, with 76 days of unpaid claims, up 53%;

— MVP Health Plan, with 80 days of unpaid claims, up 40%.

Despite this overall poor showing, 10 plans still managed to reduce their unpaid claim days. The plan with the biggest reported percentage decline was MetroPlus Health Plan of New York City, which trimmed its payment delays by 30%, from 195 days to 137 days. ■

Faster payments promised with new system

Aetna U.S. Healthcare plans on-line claims

Feeling both market and political pressures, Aetna U.S. Healthcare in Blue Bell, PA, has begun building its own in-house on-line electronic claims payment system, which it hopes will be up and running by the end of 1999. Once completed, company officials say, the system will mean faster, paper-free claim transactions and payments for providers.

Aetna is not the first carrier to create its own on-line billing service, but it promises to be the most prompt when it comes to making payment. The insurer estimates some 38% of physicians currently submit bills electronically.

Called "E-Pay," the system's goal is to pay physicians within 15 days on average for clean, problem-free claims submitted electronically. The carrier has also built in a fudge factor, saying reimbursement for any unusual claims requiring some kind of intervention could take longer.

According to Aetna, the national average is 40 to 45 days from initial billing to when a provider gets paid by a commercial plan. Meanwhile, Aetna says it averages 30 to 32 days to pay its participating doctors. Many physicians, however, say it takes them much longer to get paid. In fact, focus groups of physicians organized by Aetna often complained of bills running 90 to 120 days past due.

While doctors stand to benefit greatly from E-Pay, Aetna and other carriers completing similar systems are merely responding to competitive pressures while trying to curtail lobbying efforts by provider groups to have state and national lawmakers enact even stricter prompt payment rules.

After all, most plans feel "having a private business tailor its approach [to paying claims] is certainly preferable to having the legislature craft its own approach," says former New Jersey Insurance and Banking Commissioner **Elizabeth Randall**.

Slashing administrative costs is another potential payoff from installing such systems.

"I like to spend 95% of my time taking care of patients," says **Bernard Schayes**, MD, a New York City-based primary care physician. "Anything that gets in the way, like filing claims, takes away from that time. "

Neil E. de Crescenzo, IBM's director of global marketing and business development, estimates

The cost of processing medical claims

• Insurance and health care providers processed 3.76 billion paper claims last year.

• Nearly half of total health claims — 1.6 billion — are still processed manually.

• Consumers wait an average of six weeks for insurance companies to process their claims for payment; errors can add more weeks of waiting; and 20% to 30% of current claims need to be refiled.

• Average claim for physicians' services stood at $130.20 by year-end 1995.

• Average cost for a physician to file a claim was $7.92.

• For insurers, the cost of processing and paying a claim ranges from $8.50 to $18, the average cost being $10.95.

Source: Milliman & Robertson, Seattle; Coopers & Lybrand, Chicago.

that the U.S. health care system spends $200 billion per year in administrative costs.

"We've seen the tremendous benefits derived by the banking industry in cost reductions on electronic transactions on an ATM vs. going to a teller," de Crescenzo says. "Those same efficiencies are sorely needed in health care. In some ways, this is simply about bringing to health care many of the tools that have been used in the banking and retail sectors for some time."

The basic design of the system calls for it to:

— match claims with referrals, which will require both sides of the paperwork to be in the system;

— screen for duplicate payments or fraud;

— watch for mistakes and keying errors. Aetna officials estimate that in about two-fifths of enrollment forms, either a mistake is made or an error is keyed in. However, a directly submitted electronic product can reduce errors to 1% of forms.

Physicians can choose from among three options for entering the system: via their office computer, through a card-based machine that is similar to a credit-card reader, or by phoning their claims into voice-response units.

Once participating doctors submit their electronic bill, they will be "flagged" by the system as it searches for a corresponding electronic referral. If found, it matches the two and routes the claim for processing. ■

The rush isn't on for PSO licensing

10 questions to answer

Despite early fanfare, interest in the new Medicare+Choice provider-sponsored organization (PSO) option has been cooler than predicted.

The Health Care Financing Administration has predicted up to 1,800 PSOs could be created over the next five years. However, as of early last December, only three organizations had applied for a PSO license. One of these — Central Oregon Independent Health Services — was already state-licensed, thus permitting it to skip the complicated federal waiver process. It has been approved by HCFA and began enrolling members on Jan. 1.

"One explanation for this situation is since the process of PSO market research, business plan development, and formal application is complicated and time-consuming, many groups are still evaluating their options and watching what's happening in the market," says consultant **Abe Schneiner** of McKevitt & Schneiner in Washington, DC.

For providers still considering Medicare risk contracting, the following checklist outlines 10 questions you need to answer before getting into the PSO business:

• What competitive advantage do you have over existing area HMOs?

• Will you have access to a large enough provider network to make the PSO viable?

• Can you afford to provide care at less cost than competing HMOs?

• Can you offer better care than other plans?

• Will you be forced out of existing provider contracts with local HMOs if you become part of a competing PSO?

• Does it make more sense to partner rather than compete with other area plans?

• Will your current patients follow you to the PSO?

• Will you have the capacity to deliver or contract for different types of services, rather than being limited to a single category of care?

• Can you realistically reduce current Medicare utilization levels, particularly inpatient hospital, enough to earn a profit?

• How will you raise the money needed to start and underwrite the operation until it begins making a profit? ■

Midwest alliance focuses on quicker claim payments

Company mounts effort to seek solutions

As conflicts between physician groups and payers intensify over how speedily claims are being paid, one electronic claims processing firm says it has a new product to solve the problem. And it says it has devised a unique way to promote the system: Form an alliance of physicians and practice administrators to lobby insurers and plans to install its system.

The Indianapolis-based RealMed Physician and Practice Manager Alliance was organized in October "to address what we believe is the single most important issue facing the provider community: making the current claim processing and payment process faster, less time-consuming, less costly, more secure, and more convenient for patients, physicians, and their staff," says RealMed spokesman **Dan Perrin**.

The purpose of RealMed's Alliance is simple: lobby plans to install faster, more accurate electronic claim processing and payment systems — which the company hopes will be RealMed's system. Membership in the Alliance is open to any provider, not just RealMed customers. "We wanted to provide a forum for providers to organize around the idea of having plans install faster electronic payment systems, then communicate this desire to payers," says Perrin. Meanwhile, RealMed hopes to develop a loyal customer base — something like Saturn has done with car buyers — which will prompt more plans to use its product.

"According to a Booz-Allen study and the *Journal of American Medical Association*, 84% of a nurse's time is spent on administrative duties. According to the same study, almost 40% of a physician's time is spent performing administrative duties," says Perrin. "Our system can greatly reduce this time and cost by resolving claims before the patient leaves the physician's office."

"We have identified the most vexing problem in our industry, and are working to fix it," says **Kevin McCallum**, MD, an Indianapolis internist and member of the Alliance. "It is my diagnosis that claim processing and payment issues are at the heart of most of the physician-payer acrimony.

"Obtaining timely and correct payment from third-party payers has become the major problem for medical practices. Lost claims, delayed claims, and dirty claims mean that physicians wait months for payment for services rendered," says another Alliance member, **Paula Y. Sowers**, office manager for Associated Vitreoretinal and Uveitis Consultants in Indianapolis.

The goals of the RealMed Network represent the ideal of claims processing: The patient's eligibility status is verified when he or she checks in at the office, the amount of the patient's deductible and / or co-pay is produced, and an explanation of benefits (EOB) is printed out and the claim is processed before the patient leaves.

"We have designed the process to be much like buying groceries at the supermarket. Normally, when a consumer purchases a product or a service, the consumer knows how much it costs," says **Robert B. Peterson**, chairman and CEO of RealMed.

Besides processing claims, the system also collects and sends the payer clean encounter data in real time, allowing better case management and analysis of the claim or encounter data by actuaries and plan administrators.

Two months vs. 69 seconds

Last November, RealMed concluded six weeks of pilot tests involving some 500 physicians, mostly in Indiana and the Midwest. Pilot participants ranged in size from single physician practices to 50 physician groups with eight satellite offices.

"The current claim resolution process at most pilot practices — electronic or paper — presently takes about two months," says Perrin. According to Seattle-based actuaries Milliman & Robertson, it costs the average payer $11 to receive a claim, review it, print and send two EOBs (one to the patient and one to the physician), and print and mail the check to either the physician or the patient.

According to RealMed, the average elapsed time from claim transmission to completion of repricing, claim adjudication, and acceptance of the claim by the physician's staff during the pilot was 69 seconds.

Before the pilot test, the practices had an average of 30% to 35% of their claims rejected for errors. With RealMed, 99.96% of their claims were error-free, according to company officials.

"Many offices are stuck doing billing the old-fashioned way where you print a claim form, seal it in an envelope, and wait several weeks or

months for a response. In our office, it takes six full-time employees to enter charges, file claims, and follow up with insurance companies," says **Sherry A. Coleman**, operations manager for Indianapolis Gastroenterology & Hepatology, which participated in the pilot test.

"We think these private networks could have a tremendous impact in re-establishing a positive relationship between physicians and insurance carriers across the country." ■

OIG OKs plan to help financially needy patients

Dialysis patients would benefit

A dialysis company may contribute to a Medicare Part B premium assistance program for financially needy end-stage renal disease patients, according to an advisory opinion issued Nov. 6 by the Office of the Inspector General.

The advisory opinion concludes that donations to a Medicare premium assistance program administered by a charitable organization "would not constitute grounds for the imposition of civil monetary penalties" under the Social Security Act "because the contributions are not made to, or on behalf of, an individual eligible for Medicare or state health care program benefits."

Under the proposed arrangement, the charitable organization "will have absolute discretion" regarding the use of provider contributions made to the organization, according to the opinion.

The opinion was in response to a proposed arrangement under which a dialysis company ("Company X") would make donations to a charitable organization ("Organization A") to fund a program to pay for Medicare Part B or Medigap premiums for financially needy Medicare beneficiaries with end-stage renal disease (ESRD). Under the plan, some or all of the beneficiaries might receive treatment from Company X.

The company in question owns 12 renal dialysis facilities in "State Z" and is a wholly owned subsidiary of another company ("Company Y"), OIG notes. Organization A is an independent 501(c)(3) charitable organization "providing financial support to needy persons in State Z with ESRD for items such as transportation, medication and other living expenses," according to the document.

OIG notes that the board of the charitable organization "is not directly or indirectly controlled by Company X, Company Y or any of its subsidiaries or affiliates."

The organization provides financial support to low-income ESRD patients through a general fund and an emergency fund. Eligibility for the general fund is based on a measure of monthly income and family size and proof that the applicant is unable to pay his or her monthly expenses.

The organization is seeking to extend the general fund assistance program to include financial assistance for this patient group for health insurance premiums, including Medicare Part B and Medigap premiums, OIG states. The advisory opinion notes that eligibility for the premium assistance program is available to "any financially needy ESRD patient regardless of the provider; it is not limited to patients of Company X."

OIG found that Organization A's status as an independent charitable entity and its administration of the proposed arrangement "provides sufficient insulation so that the premium payments should not be attributed to Company X.

"While the premium payments by Organization A may constitute remuneration to beneficiaries, they are not likely to influence patients to order or receive services from particular providers," OIG comments. "To the contrary, the insurance coverage purchased by Organization A will follow a patient regardless of which provider the patient selects, thereby enhancing patient freedom of

COMING IN FUTURE MONTHS

- HCFA unveils new claims processing objectives
- Improving collection processes
- E/M coding update
- Progress on implementing HCFAs new practice expense formula
- Blending fee-for-service and capitation income streams

choice in health care providers." Medicare Part B payments generally cover 80% of the composite rate for Medicare-covered maintenance dialysis services, physician services, and certain ancillary services. ■

New knee pain injection code

On Nov. 12, the Health Care Financing Administration announced assignment of a new unique code to facilitate Medicare billing for Hyalgan (sodium hyaluronate) for intra-articular injection for the relief of pain in osteoarthritis of the knee.

The new code for Hyalgan, J7315, went into effect Jan. 1, and should be used for all Hyalgan injections on or after that date. In the United States, Hyalgan is marketed to non-orthopedic physicians by Sanofi, and to orthopedic surgeons by Sanofi's marketing partner, OrthoLogic.

Hyalgan is used to relieve the pain of osteoarthritis of the knee in patients who have failed to respond adequately to conservative nonpharmacologic therapy and to simple analgesics such as acetaminophen. ▼

Physician pay raises remain flat

Compensation for both primary care and specialty physicians has remained flat for two years in a row, says a recent survey by the Medical Group Management Association in Englewood, CO.

The MGMA's *Physician Compensation and Production Survey* says 1997 pay for primary care physicians rose just 0.86% to $135,791, while specialist pay fell 0.48% to $220,476. The year before, primary care compensation rose only 1.42%, while specialists' income increased 2.58%.

Susan A. Cejka, president of consultants Cejka & Company in St. Louis, attributes much of this stagnation to cross-currents in today's health care economy. "We're seeing overhead take a larger share of practice income as it becomes more expensive to administer practices," she says. "Costs are going up, fees are coming down, and physicians are getting squeezed in the middle."

Midlevel providers, however, came out winners. Their compensation jumped 4.41% to $57,907, reflecting an increased demand for their services. "In many managed care markets, you are seeing one midlevel provider being recruited for every two physicians," says Cejka.

Among selected specialities, income for noninvasive cardiology rose by 5.19%, much more than the average, to $259,961. Meanwhile, income for invasive cardiologists dropped the most, by 7.7 % to $326,537. ▼

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AMA wants dietary rules

The American Medical Association's House of Delegates voted at its December meeting in Honolulu to develop ethical guidelines covering the sale of dietary supplements sold in physician offices.

According to the resolution, the AMA will "develop ethical guidelines that will discriminate between the legitimate provision of medically necessary goods and services in physicians' offices and physicians' marketing activities that exploit the patient-physician trust." The new guidelines are to be ready by the association's June annual meeting.

The resolution further states that "physicians are being heavily marketed by health and fitness companies to recommend, sell and distribute nutritional fitness and weight management products, such as vitamins and dietary supplements, to their patients. . . . Some companies encourage physicians to recruit other members of the profession, offering financial rewards such as a percentage of the sales made by the recruited physician."

Whether physicians should even be allowed to sell nonmedical items in their office has been an ongoing issue for the AMA. In 1997, the AMA Council on Ethical and Judicial Affairs recommended against the sale of nonmedical items because some doctors might take advantage of the physician-patient relationship, pressuring patients to buy products that are not medically necessary. ▼

Oral cancer drug coverage OK'd

Authorized Medicare intermediaries can now pay for Food and Drug Administration-approved oral anti-cancer pro-drugs on claims dated on or after Jan. 1, 1999. The Health Care Financing Administration approved the change based on recent advances in the drug's metabolic make-up. Payment is under Part B on a reasonable cost basis with deductibles and coinsurance.

Providers must report the pro-drugs under revenue code 636 using existing HCPCS code 18999, prescription drug, oral, chemotherapeutic, not otherwise specified.The name of the drug, number of units, and a diagnosis of cancer also must be reported.

According to Medicare, no payment will be paid unless a cancer diagnosis appears on record type 70 when either the UB-92 flat file or FLs 67-75 for the hard copy UB-92 is used. ▼

Digital cardiac device covered

The Health Care Financing Administration has approved the noninvasive BioZ digital cardiac output monitoring device for full Medicare coverage. The BioZ, manufactured by CardioDynamics International in San Diego, will provide continuous data on a wide range of measurements of the heart's ability to deliver oxygen-rich blood throughout the body.

Patients suffering from hypertension and congestive heart failure, as well as those wearing pacemakers and requiring fluid management, are expected to benefit from the technology. ■