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New reason for doctor house calls: Feds tighten rules on physician role

OIG warns of durable goods crackdown

Turning up the anti-fraud heat a notch higher, the U.S. Department of Health and Human Services has issued a special fraud alert reminding physicians of their legal responsibility to authorize only necessary durable medical equipment and home health services for Medicare beneficiaries.

Given the fact that the Office of the Inspector General (OIG) has publicly red-flagged the issue, physicians and their billing offices should take extra care in ensuring they follow established procedures when filing home health and DME-related claims.

In a Jan. 7 alert, Inspector General June Gibbs Brown expressed concern that "some physicians are inappropriately ordering home health care and durable medical equipment and supplies for Medicare patients."

Under Medicare, a physician prescribing home health care or durable medical equipment, such as hospital beds, wheelchairs, and oxygen delivery systems, must certify that the services or items are medically necessary and that the beneficiary meets the requirements to qualify for the benefit.

Brown says she believes "the actual incidence of physicians intentionally submitting false or misleading certifications of medical necessity for durable medical equipment or home health care is relatively infrequent." However, recent OIG audits have uncovered a certain "physician laxity in reviewing and completing these certifications," which has aided "fraudulent and abusive practices by unscrupulous suppliers and home health providers," she says.

OIG audits, for instance, have revealed instances of physicians signing forms provided by home health agencies that falsely represent patients as needing skilled nursing services to qualify them for home health services, the OIG says.

In another case, a physician, at the urging of a durable medical equipment supplier, simply signed a stack of blank certificates of medical necessity that the supplier later completed with false information and submitted to Medicare along with fraudulent claims for

durable medical equipment. There also have been cases of physicians accepting kickbacks of $50 to $400 from medical equipment suppliers for each prescription the physician signed for certain equipment.

"A physician is not personally liable for erroneous claims due to mistakes, inadvertence, or simple negligence," Brown notes. "However," she adds, "knowingly signing a false or misleading certification or signing with reckless disregard for the truth can lead to serious criminal, civil, and administrative penalties." Moreover, offenders may be liable for making false or misleading certifications even if they did not receive any financial or other benefit from providers or suppliers.

The fraud alert specifically cautions physicians:

- not to prescribe services and items as a courtesy to a patient, service provider, or medical equipment supplier without first making a determination of medical necessity;
- not to sign false or misleading medical certifications knowingly or recklessly;
- not to accept kickbacks in return for their signature.

According to OIG spokesman **Ben St. John**, there are several key steps physicians must go through to properly document the need for home health care. "Before ordering home health care for a Medicare patient, physicians must certify that the patient is homebound, under physician care, and in need of intermittent skilled nursing care, physical therapy, or speech therapy. And they must also establish and periodically review a plan of care for the patient," says St. John.

When ordering durable medical equipment, physicians are required to give the supplier a written order or prescription that is dated and signed and lists the patient's name, address, diagnosis, the item needed, the length of time it is expected to be needed, and the start date, if appropriate.

Physician certification rules

According to rules established by the Health Care Financing Administration (HCFA), Medicare will pay a Medicare-certified home health agency for home health care provided under a physician's plan of care to a patient confined to the home. Covered services may include such services as skilled nursing services, home health aide services, physical and occupational therapy, speech-language pathology, medical social services, medical supplies (other than drugs and biologicals), and durable medical equipment.

As a condition for payment, Medicare requires a patient's treating physician to certify initially and recertify at least every 62 days that:

- The patient is confined to the home.
- The patient currently requires or has needed:

— intermittent skilled nursing care,

— speech or physical therapy or speech-language pathology services,

— occupational therapy or a continued need for occupational therapy.

- A plan of care has been established and periodically reviewed by the physician.
- The services are (were) furnished while the patient is (was) under the care of a physician.

The physician must order the home health services, either orally or in writing, prior to the services being furnished. The physician certification

Medicare increases pay to promote house calls

In an effort to promote more house calls by physicians, Medicare has increased by nearly half its reimbursement rates for home visits to patients with multiple chronic conditions.

As of January, Medicare fees for a physician visit to an established patient will range from $45 to over $145. House call payments to new patients will range from $58 to $173 per visit.

These higher payment rates "are HCFA's way to get more physicians back into the home care equations," which ought to reduce the instances of questionable home care billing practices by nonphysician providers, says **Melvin Britton**, MD, a member of the American Medical Association's Relative Value Scale Update Committee.

During 1997, some 4 million Medicare patients received some form of home care. However, physicians only billed for 1.5 million home visits, representing a scant 0.2% of Medicare's total 1996 physician service payments. At an average of six visits per year, internists make of the most house calls of all specialties, according to the American Academy of Home Care Physicians. ■

must be obtained when the plan of treatment is established or as soon thereafter as possible. This physician certification must be signed and dated prior to the submission of the claim to Medicare. If there are any questions about how these rules apply to specific situations, the physician should contact the appropriate Medicare fiscal intermediary or carrier. ■

Here are the key rules for home health compliance

The hows and wherefores of avoiding trouble

Medicare will only pay for durable medical equipment (DME) like hospital beds, wheelchairs, and oxygen delivery systems for home use — and the medical supplies that are necessary for the effective use of DME, like surgical dressings, catheters, and ostomy bags — if it has been first ordered or prescribed by a physician. To be official, the order or prescription must be personally signed and dated by the patient's treating physician.

DME suppliers that submit bills to Medicare are required to maintain the physician's original written order or prescription in their files. Physicians should not sign any order or prescription unless it contains:

- beneficiary's name and full address;
- date on which the physician signed the prescription or order;
- description of the items needed;
- start date of the order (if appropriate);
- diagnosis (if required by Medicare program policies) and a realistic estimate of the total length of time the equipment will be needed (in months or years).

For supplies provided on a periodic basis, appropriate information on the quantity used, the frequency of change, and the duration of need should be included. If drugs are included in the order, the dosage, frequency of administration, and the duration of infusion and concentration (if applicable) should be included.

Medicare further requires claims for payment for certain kinds of DME to be accompanied by a certificate of medical necessity (CMN) signed by a treating physician (unless the DME is prescribed as part of a plan of care for home health services). When a CMN is required, the provider or supplier must keep the certificate containing the treating physician's original signature and date on file.

A certificate of medical necessity generally has four sections:

- Section A contains general information on the patient, supplier, and physician. Section A may be completed by the supplier.
- Section B contains the medical necessity justification for DME. This cannot be filled out by the supplier. Section B must be completed by the physician, a nonphysician clinician involved in the care of the patient, or a physician employee. If the physician did not personally complete section B, the name of the person who did complete section B and his or her title and employer must be specified.
- Section C contains a description of the equipment and its cost. Section C is completed by the supplier.
- Section D is the treating physician's attestation and signature, which certifies that the physician has reviewed sections A, B, and C of the CMN and that the information in section B is true, accurate, and complete. Section D must be signed by the treating physician. Signature stamps and date stamps are not acceptable.

By signing the certificate of medical necessity, the physician represents that:

- he or she is the patient's treating physician and the information regarding the physician's address and unique physician identification number is correct;
- the entire CMN, including the sections filled out by the supplier, was completed prior to the physician's signature;
- the information in section B relating to medical necessity is true, accurate, and complete to the best of the physician's knowledge.

A physician is not personally liable for erroneous claims due to mistakes, inadvertence, or simple negligence. However, knowingly signing a false or misleading certification or signing with reckless disregard for the truth can lead to serious criminal, civil and administrative penalties, including:

- criminal prosecution;
- fines as high as $10,000 per false claim plus treble damages;
- administrative sanctions, including exclusion from participation in federal health care programs, withholding or recovery of payments, and loss of license or disciplinary actions by state regulatory agencies. ■

Documentation tops list of compliance bugaboos

Here are key tips on what auditors look for

When the Office of the Inspector General (OIG) issued its model compliance guidance program for third-party billing companies in December, poor documentation headed up the list of suspicious and questionable billing activities. Poor documentation also is one of the top reasons claims get kicked back in prepayment audits, according to billing experts.

"Many physicians simply don't see the reason for wasting time writing down all the details of a diagnosis they have already worked out in their head and which they feel is right and makes perfect sense," says **Catherine Fischer**, CPA, a reimbursement policy advisor at Marshfield (WI) Clinic.

Watch for these red flags

Indeed, Health Care Financing Administration auditors report that it is not unusual for them to find no documentation in a patient's file to support what seemed to be an otherwise proper diagnosis and action taken by the doctor. That's one of the key reasons claims get bounced back as "not medically necessary."

There are several red flags auditors automatically look for to determine if they should dig deeper into a provider's files and past claims for suspicious activity, experts say. These include:

• Patient records that look alike.

The fraud police want to be able to compare the records of different patients and find slight variations in how they are documented. Even allowing for whatever documentation procedures a practice uses, auditors expect documentation methods not to be exactly alike between any two (or more) records.

"Using the same wording and checking off the same problem levels are the kind of things that catch an auditor's attention," says OIG spokesman **Ben St. John**.

• Inconsistency between the chart and the evaluation and management guidelines.

When the information contained in a patient's chart is not consistent with the related evaluation and management guidelines, this sends up another flare that gets the auditors' attention.

HCFA stops using 'not medically necessary'

New nomenclature is more specific

The Health Care Financing Administration is retiring those three little words — "not medically necessary" — that often have been the only official justification many providers have received explaining why their claim for Medicare payment was denied.

The move to stop using the moniker came as a result of lobbying by provider groups such as the American Medical Association, which found the term insulting. They felt it insinuated that the medical service was not needed, when in actuality denial of the payment often was based on a determination that the particular service was simply not covered.

"We're tickled pink about this decision," says AMA Trustee **William H. Mahood**, MD. "The AMA for quite some time tried to get HCFA to make the change because a patient would receive a denial of coverage for a test or a service and see the words 'not medically necessary' and think that their doctor didn't know what he was doing or made a mistake," he says. "Physicians would face a long phone call or unnecessary visit to explain that it was a coverage decision."

In the future, HCFA will list more specific reasons for any claim denials, ranging from such phrases as "the information provided does not support the need for this service or item" to "Medicare does not pay for more than one assistant surgeon for this procedure."

The AMA also is pressing private insurers to follow Medicare's lead. "HCFA is not the only one sending those nasty letters and nasty comments on the explanation of benefit forms," says Washington, DC, physician **Carlos Silva**, MD.

All but eight of the 24 Medicare carriers currently use Medicare summary notices rather than explanation of benefits notices for each claim, according to HCFA records. Under the agreement with the AMA, the remaining eight will make the switch after they come into compliance with the government's year 2000 computer requirements. ■

• **Mismatch between procedure code and setting.**

Are you coding for procedures normally done in a hospital while claiming an office visit?

• **Discrepancy between procedure codes and the diagnostic codes.**

Does the prescribed treatment match the diagnosis?

• **Spiked billing patterns.**

Are your billings abnormally high compared to the average for a particular code or medical service, or compared to other physicians in your specialty?

• **Incomplete or truncated diagnostic codes.**

This is one of the most common reasons for issuing a medical necessity denial. If it seems like you have been receiving an unusually high percentage of rejections for certain procedures, make sure your codes and computer systems are up to date. Also, take a close look at your "5th digit" coding patterns to ensure they are both up-to-date and as specific as possible when it comes to completing the patient's diagnostic profile.

'Many physicians simply don't see the reason for wasting time writing down all the details of a diagnosis they have already worked out in their head and which they feel is right and makes perfect sense.'

The AMA's Office of General Counsel has developed model physician compliance guidelines outlining the minimum standard each file should meet to properly document medical services that have been provided. Each patient encounter documented in the medical record should include:

- the reason for the encounter;
- relevant medical history;
- findings of the physical exam;
- prior diagnostic test results;
- current assessment, clinical diagnosis, or impression;
- care plan;
- date;
- name and identity of any observers;
- rationale for ordering any additional diagnostic or ancillary services and tests that are inferred but not documented in the record;
- past and present diagnoses made accessible to treating and/or consulting physician;
- identification of appropriate health factors;
- patient's progress and response to treatment, any changes in treatment, and any revised diagnosis;
- CPT and ICD-9 codes reported along with appropriate documentation. ■

OIG deputizes billers as fraud police

Under the new compliance model for third-party billers issued by the Office of the Inspector General (OIG) last December, billing companies are directed not to submit for payment any claims they feel are dubious. Instead, they are instructed to notify the provider of their concerns in writing within 30 days.

If the provider "flagrantly" continues to submit questionable claims, the guidance suggests the billing company resign the contract and report any reliable suspicions to the OIG.

Included in the guidance are 17 specific kinds of abuses billers are instructed to watch for:

- billing for undocumented services or items;
- duplicate billing;
- upcoding;
- unbundling;
- improper use of modifiers;
- inappropriate balance billing;
- poor or no resolution of overpayments;
- lack of computer system integrity;
- computer systems with fields requiring information to be entered indicating services were rendered when they either were not properly rendered or were not completely documented;
- unsecured records/information;
- willful misuse of provider ID number;
- outpatient services rendered in connection with inpatient stays;
- improperly billing a transfer as a discharge;
- incentives from clients to violate anti-kickback or other compliance regulations;
- joint ventures;
- improper discounts on professional services;
- improper waiver of copayments. ■

Reimbursement analysis pays big dividends

How to determine if you're getting all you deserve

Poor billing practices can not only trigger a potential audit of your practice's past claims; they can cost you money if you base fee-for-service charges on improper or outdated codes. To ensure your fee-for-service business is being fully and fairly compensated, you need to analyze your coding practices regularly to find ways to improve them, as well as to update charges.

If you don't take these two tasks seriously, your practice may wind up short-changing itself. "I know of one physician who lost $800 in charges on one procedure alone because he didn't know what was acceptable to the insurance carrier," says **Ro B. Shattuck**, a Raleigh, NC, CPA specializing in health care.

"Doctors' offices often use improper or obsolete coding. Many of their staff members are not trained to set fees properly, to code correctly for the level of service performed, or to use coding to their advantage. He just didn't charge enough," Shattuck says.

Build your case before raising your rates

At the same time, you can't just arbitrarily raise charges across the board and expect to defend them to an insurer successfully. It takes a studied approach to both coding and fee analysis to make your case, notes **Don L. Oschwald**, MD, FACS, of Raleigh's Southeastern Plastic and Reconstructive Surgery Associates.

The first step in a reimbursement analysis is to review your CPT and ICD-9 codes from your computer printouts and charge tickets to ensure they are current, noting any rule changes and new codes to be included. This also is the first building block of a comprehensive compliance program. Many consider the period between December and February the best time to schedule this analysis.

Shattuck says the following coding errors are the most common ones he sees physicians make:

- invalid or deleted procedure codes;
- improper code for level of service;
- inaccurate code for services described;
- improper billing for surgical procedures;
- wrong code for particular site of service;
- improper use or no use of modifiers.

If these actions result in undercoding, the practice loses money. However, if Medicare computers detect what looks like a pattern of overbilling, then you could be flagged for an audit.

To avoid the headaches associated with improper coding, Shattuck suggests a two-pronged approach:

- **Review your charges.**
- **Make adjustments on a case-by-case basis.**

Once you know you are using the most appropriate codes, take a look at the rates you are charging. As you probably know, there is an unspoken rule among carriers to refuse to disclose the maximum rate they are allowed to pay physicians. But you can use that to your advantage.

Facing down an insurance company

"I know of a physician who challenged a managed care company whose official fee schedule stated that they would only pay a discounted $200 rate for what should be a $500 procedure," Shattuck says. "But when we confronted them with our in-house reimbursement analysis, they finally backed down, saying the low figure was simply a typo."

There are several ways to analyze your current fee schedule to determine if it is what it should be compared to costs. One method is to use the relative value scales provided by several sources, including the Washington, DC-based McGraw Hill Co., and Medicare's Resource-Based Relative Value Scale.

The second method, called "charge/cost analysis," factors in such considerations as type of specialty, physician location, time in practice, and patient load to establish the fair market value of the physician's services, Shattuck says.

An admittedly time-intensive but worthwhile task, the analysis studies current costs and charges based on current economic indices such as the Consumer Price Index, as well as urban and rural differentials.

The basic steps in performing a charge/cost analysis:

- **Obtain your practice's current fee schedule.**
- **Determine your most commonly used CPT codes and their frequency.** For best results, do a separate profile for each physician in the practice, and then a practicewide analysis.

(Continued on page 27)

(Continued from page 22)

• **Compare these data to an average collection of Explanations of Benefits (EOBs) for a given time, usually six months.**

"This gives you a complete picture of every reimbursed CPT code. By comparing your charges to the EOB, you find out exactly what the payer is paying by CPT code, and if there are variations, you can explore why," says Shattuck. "You may learn, for instance, that the payment rate has changed or a payer prefers a certain code sequence."

• **Review the pattern of reimbursement to determine how one payer compares to another by CPT code.**

To ensure accuracy, first compare your charges to what actually was paid by documenting payment from the EOBs. Once completed, these data will give you a more accurate picture of how your current charges and payments compare, which will give you a basis to negotiate increases in specific codes and procedures. ■

Incentive plan analysis can avoid problems

HCFA surveys due back in March

Managed care organizations are now completing the Health Care Financing Administration's third annual survey of the various financial incentive arrangements they have with their various outside physician providers. Completed surveys are due back to the office of Health Plan Purchasing and Administration by March 31.

"Where fraud enforcement in the fee-for-service days focused primarily on curbing the temptation for physicians to reap financial rewards by *overusing* medical services and generating excessive referrals, the growth of the commercial capitation and prospective pay system has forced regulators to also focus on preventing incentives to providers to *underuse* medically necessary services," says **Christopher Rolle**, JD, a lawyer in the Boca Raton, FL, offices of Broad and Cassel.

Accordingly, the purpose of HCFA 's physician incentive program (PIP) regulations is to determine if managed care organizations have instituted incentives for physicians or physician group to reduce or limit "medically necessary services" to individual Medicare beneficiaries or Medicaid recipients.

According to HCFA, "If these incentives place the physician or group at a substantial financial risk for referral services, the MCO must ensure that adequate stop-loss is provided and enrollee surveys conducted to monitor access to services and quality of care." Under HCFA guidelines, referral services include any specialty, inpatient, outpatient or laboratory services the physician or physician group does not directly furnish to a patient.

"Substantial financial risk occurs when the incentive arrangements place the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of referral services," says **Howard Robinson**, another Broad and Cassel attorney. "Amounts at risk based solely on factors other than a physician's or physician group's referral levels, however, do not contribute to the determination of substantial financial risk."

Where withholds (a percentage of payment or set dollar amount deducted from the physician's payment to be repaid to the physician depending on predetermined performance criteria) are used, a physician or group is deemed to be at substantial financial risk if withholds from physician payments exceed 25% of the maximum "potential payments" (as defined in the rules), or if the physician or physician group is liable for amounts exceeding 25% of the maximum payments.

Similarly, if potential bonuses in an incentive package are greater than 33% of potential payments (minus the bonus), then there is substantial financial risk. If incentives are based on a combination of withholds and bonuses, the risk threshold is surpassed if, according to a formula set out in the rule, the combination of incentives exceeds 25% of potential payments.

With capitation, the risk threshold is surpassed if the difference between the maximum potential payments and the minimum possible payments exceeds 25% of the maximum potential payments, or if the maximum potential and minimum possible payments are not clearly explained in the physician or physician group's contract. A contract also could have problems if it contains any other incentive arrangements that could leave a physician or physician group liable for more than 25% of potential payments.

Estimated Stop-Loss Levels

Patient Panel Size	Single Combined Limit	Separate Institutional Limit	Separate Provider Limit
1 - 1,000	$6,000*	$10,000*	$3,000
1,001 - 5,000	30,000	40,000	10,000
5,001 - 8,000	40,000	60,000	15,000
8,00I - 10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
>25,000	none	none	none

* The asterisks in this table indicate that, in these situations, stop-loss insurance would be impractical. Not only would the premiums be prohibitively expensive, but the protections for patients would likely not be adequate for panels of fewer than 500 patients. MCOs and physician groups clearly should not be putting physicians at financial risk for panel sizes this small. It is our understanding that doing so is not common. For completeness, however, we do show what the limits would be in these circumstances.
The institutional and professional stop loss limits above represent the actuarial equivalents of the single combined limits.The physician group or MCO may choose to purchase whatever type is best suited to cover the referral risk in the incentive arrangement.

Source: Health Care Financing Administration, Baltimore.

"There is one important exception to these rules where a physician or physician group will never be deemed to be at substantial financial risk for referral services," says Rolle. "That is when the patient panel size of a particular physician group is over 25,000 patients. Then that physician or physician group will never be at substantial financial risk for referral services."

The HCFA survey not only applies to MCOs' contracting arrangements with providers, but to subcontracting arrangements with "intermediate entities" as well. Intermediate entities include independent practice associations (IPAs) that contract with one or more physician groups, as well as physician-hospital organizations. IPAs that contract only with individual physicians and not with physician groups are considered physician groups under the rule.

According to the final rule, if a PIP puts a physician or physician group at "substantial financial risk" for referral services:

- The MCO must survey current and previously enrolled members to assess member access to and satisfaction with the quality of services.
- There must be adequate and appropriate stop-loss protection.

Substantial financial risk is set at greater than 25% of potential payments for covered services. The term "potential payments" means the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were low enough. If the cost of referrals exceeds the 25% level, the financial arrangement is considered to put the physician or group at substantial financial risk.

For example, a doctor contracts with an MCO that holds back a certain amount of his or her pay (e.g., $6 per member per month). The MCO will give the $6 per member per month back to the doctor only if the cost of referral services falls below a targeted level. That $6 is considered to be "at risk" for referral services. The amount is equal to the difference between the maximum potential referral payment and the minimum potential referral payment (but does not include any bonus payment unrelated to referral services). The six dollars is put into the numerator of the risk equation.

The denominator of the risk equation is equal to the maximum potential payment that the doctor could receive, which is the sum of the MCO payment for directly provided services, referral services, and administration. Therefore, if the same doctor receives $24 per member per month for the primary care services he or she provides and is subject to the $6 withhold, the risk equation is as follows:

Risk level: 6 / 24 = 25% — Not at substantial financial risk.

Note that if a physician group's patient panel is more than 25,000 patients, then that physician group and the group's physicians are not considered to be at substantial financial risk.

When it comes to determining significant financial risk for referrals, the formula is:

Referral risk: Amount at risk for referral services divided by Maximum potential payments.

The amount at risk for referral services is the difference between the maximum potential referral payments and the minimum potential referral payments, according to HCFA regulations.

Bonuses unrelated to utilization (e.g., quality bonuses such as those related to member satisfaction or open physician panels) should not be counted toward referral payments. Maximum potential payment is defined as the maximum *expected* total payments that the physician / group could receive.

But, if there is no specific dollar or percentage amount noted in the incentive arrangement, then the PIP should be considered as potentially putting 100% of the potential payments at risk for referral services.

According to HCFA, the following incentive arrangements should be considered a significant financial risk:

• withholds greater than 25% of potential payments;

• withholds less than 25% of potential payments if the physician or physician group is potentially liable for amounts exceeding 25% of potential payments;

• bonuses that are greater than 33% of potential payments minus the bonus;

• withholds plus bonuses that equal more than 25% of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula: Withhold % = *-0.75* (Bonus %) +25%;

• capitation arrangements, if the difference between the maximum potential payments and the minimum potential payments is more than 25% of the maximum potential payments, or the maximum and minimum potential payments are not clearly explained in the physician's or physician group's contract;

• any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25% of potential payments.

Under PIP rules, stop-loss protection must be in place to protect physicians and / or physician groups assuming substantial financial risk for the Medicare contract. The rule specifies that if aggregate stop loss is provided, it must cover 90% of the cost of referral services that exceed 25% of potential payments. Physicians and groups can be held liable for only 10%. If per patient stop-loss is acquired, it must be determined based on the physician or physician group's patient panel size and must cover 90% of the referral costs that exceed per patient limits. **(See chart, p. 28.)**

To determine the patient panel size in the chart, entities may pool risk in order to determine the amount of stop-loss required if they meet all of the following criteria:

— Pooling of patients is consistent with the relevant contracts governing compensation arrangements for the physician or group (i.e., no contracts can require risk be segmented by MCO or patient category).

— The physician or group is at risk for referral services with respect to each of the categories of patients being pooled.

— Terms of the compensation arrangements permit the physician or group to spread the risk across the categories of patients being pooled (i.e., payments must be held in a common risk pool).

— Distribution of payments to physicians from the risk pool is not calculated separately by patient category (either by MCO or by Medicaid, Medicare, or commercial).

Note: If a physician group's patient panel is more than 25,000 patients, then that physician group and the group's physicians are not considered to be at substantial financial risk. ■

Don't like your PPMC? Tips for voiding a contract

PPMC woes may create opportunities

When the formerly high-flying MedPartners decided last November to get out of the practice management business it marked the official end of the glory days for the physician practice management industry, says many experts.

This sudden reversal of fortune for many physician practice management companies (PPMCs) also could be the best thing that could happen to many of the 238 clinics and 13,000 doctors affiliated with MedPartners, says **Jeff Peters**, president of Harvey, IL-based Health Directions Inc., a physician practice management turnaround firm.

This reorganization in the PPMC industry gives physicians who are dissatisfied with the protocols and financial controls used by their PPMCs a unique opportunity to get out of their current arrangement and strike more agreeable deals with area hospitals, health systems, group practices, or even other PPMCs, according to Peters.

"Physicians who stay with PPMCs must accept the reality that they may be bought, sold, and managed by people over whom they have little or no control or influence, and that the situation could change at any moment," says Peters. "Physicians with an entrepreneurial bent and a need for autonomy are probably better off cutting their losses and seeking out other arrangements."

Peters recommends that physicians who want to leave their PPMC consider the following tactical options:

• Contract review.

"Simply put, review your contracts for clauses that would render them illegal," says Peters. For example, if a physician resides in a state such as Florida — which prohibits fee splitting and views management compensation on the basis of a percentage of collections — and the PPMC receives its fees based on a percentage of collections, the courts are likely to perceive the contract as invalid.

• PPMC service review.

Working with legal counsel, physicians should carefully review the scope and effectiveness of PPMC services as guaranteed within the contract. For example, did the PPMC provide management support as outlined in the contract? Did it help reduce overhead or secure new patients? If not, the PPMC could be in breach of contract and physicians may find it relatively easy to make a comfortable exit.

• Friendly persuasion.

Broach the subject of leaving with the on-site practice director or manager. At first contact, a non-threatening approach often works best, Peters says. Some suggested opening lines might be, "This situation just isn't working for me anymore. I'd like to leave the practice by early July and I need to talk with you about how I can make that happen and what it will cost me."

Once you start negotiating new contracts, avoid recreating old problems. Whether establishing a new relationship with other providers or another PPMC, physicians need to first develop a clear picture of what their priorities are, what they bring to the negotiating table, and what goals they have when it comes to such contract basics as income formulas, physician control, fee-based management services, malpractice insurance, and contract renewal periods, says Peters. Here are some of his suggestions:

• Contract length.

Peters advises physicians to negotiate for contracts of two years or less, but never more than five years. "Given the volatility of health care, few physicians can predict where they will be in five years, while others may want to redesign their personal lives," he says. "Long-term contracts preclude flexibility and change."

• Site-of-practice restrictions.

"Generally, when the business relationship goes south, you want to have a way established to exit the contract gracefully and still be able to practice within the same geographic area and specialty," Peters says. "One way to do that is being able to buy out for a relatively low fee." For example, he says, if a PPMC acquired the practice, the buy-out

Correction

A story in the January 1999 issue of *Physician's Payment Update* about Medicare intermediaries being authorized to pay for Food and Drug Administration-approved oral anti-cancer drugs contained an incorrect code for that treatment. The correct code is J8999. ■

COMING IN FUTURE MONTHS

- What are some of the fee-for-service alternatives to capitation?
- Latest developments in a lawsuit to halt Medicare s practice expense formula
- What different levels of claim audits mean to you
- Congress conducts oversight hearings on HCFA s activities

fee should be no more than 50% of the original cash payment.

• **Compensation goals.**

Physicians who desire some kind of income security should negotiate a relatively high base compensation in return for such trade-offs as working a pre-set minimum number of hours, advises Peters. However, those wanting to maximize their income can bargain for a productivity-based compensation formula.

• **Practice control.**

Peters says physicians should maintain as much control as possible over practice operations. This should include the ability to accept or reject managed care contracts, determine staffing levels, hire and terminate employees, and set practice fees. Other important considerations: final approval over addition of new physicians and limiting the total number of physicians in the practice and their specialties.

'If a PPMC, health system, or group fails to help a physician manage certain services, then I don't see why you should pay a management fee for them.'

• **Fee-based management services.**

Does the contract indicate which professional services are subject to management fees? "If a PPMC, health system, or group fails to help a physician manage certain services, then I don't see why you should pay a management fee for them, " says Peters. For instance, many physicians write papers and give lectures for a fee, for which they receive no assistance but which are still subject to a management fee. Or, sometimes PPMCs charge a percentage of the bonus physicians receive from their risk pool for effectively managing their capitation contracts, even though the PPMC contributed nothing tangible to managing these patients.

• **Malpractice insurance.**

The practice, hospital, health system, or PPMC should cover your malpractice fees should you decide to leave the practice, says Peters. "The optimum malpractice policy arrangement covers physicians for the time they work with a given practice as well as for any claims filed later for care provided during the same period," he says. ■

Diabetic eye exams get payment help

Following recommendations from the National Committee for Quality Assurance (NCQA) and the Diabetes Quality Improvement Project (DQIP), many of the nation's managed care organizations (MCOs) are encouraging direct access and offering copayment reimbursement for diabetic eye exams, says the American Optometric Association (AOA).

"MCOs are to be commended for implementing progressive initiatives that encourage direct access for diabetic eye exams by optometrists," states **John Mecca, Jr**., MD, president of the

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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).
Senior Production Editor: **Brent Winter**, (404) 262-5401.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

St. Louis-based AOA. "Oxford Health Plans, Prudential Healthcare, and Wisconsin-based Physicians Plus Insurance Corporation are a sampling of the health plans that have developed direct access programs and other diabetic eye care initiatives, such as co-pay reimbursement to patients. I believe many other MCOs will launch similar programs."

The Oxford, Prudential, and Physician Plus direct access programs allow diabetic patients to visit an optometrist for a dilated eye exam without a referral from a primary care physician. Additionally, Physicians Plus has implemented a co-pay reimbursement program in which the health plan disseminated co-pay coupons to its diabetic patients who had not already received a dilated eye exam in 1998. After receiving the exam, patients have the coupon signed by the eye care professional and then send it back to the HMO for a $10 reimbursement.

"In gatekeeper models, diabetics need a referral from a [primary care physician] for an eye exam. But the NCQA and DQIP reports are having a significant impact on this cumbersome process and are changing the ways that HMOs address diabetic eye care," says Mecca. "Direct access is a welcome change in diabetes management." ■

NEWS BRIEFS

New knee code at work

Synvisc (hylan G-F 20), treatment for osteoarthritis of the knee, is reimbursable under HCPCS code J-7320 effective Jan. 1.

According to **Endre A. Balazs**, MD, chief executive officer of Biomatrix Inc., the drug's maker, "Receipt of a unique HCPCS code for our patent-protected Synvisc is a very important achievement. It signifies that Synvisc is recognized as a unique viscosupplementation device with physical properties that distinguish it from other generic hyaluronan products." Synvisc is marketed by Wyeth-Ayerst Laboratories. ▼

Prostate procedure approved

VidaMed Inc. of Freemont, CA, has announced that, effective immediately, Los Angeles-based Medicare carrier Transamerica Occidental Life Insurance Company has begun reimbursing its TUNA (Transurethral Needle Ablation) procedure, a minimally invasive treatment of symptoms associated with enlarged prostate disease, or benign prostatic hyperplasia. The reimbursement policy approval covering TUNA, Final Local Medical Review Policy #98.5-6E, was published in Transamerica's December 1998 newsletter.

VidaMed says it hopes to be approved for Medicare reimbursement in northern California in the near future. ■