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New provider user fees would finance HCFA fraud and abuse probes

Agency to shift audit focus to prepayment reviews

Tucked away in President Clinton's 2,600-page federal budget proposal for fiscal year 2000 are some $200 million in new annual user fees that would be charged to providers participating in the Medicare program. The money would finance a Health Care Financing Administration (HCFA) effort to double the number of audits and medical reviews it conducts of provider claims. The overall goal is to reduce inappropriate payments, as well as underwriting the launch of the new Medicare+Choice program.

This marks a new focus that HCFA sources say will focus more attention on prepayment audits than on post-payment reviews.

Last year, HCFA tried to inaugurate a similar set of user fees, only to see Congress cut them out of its final budget in response to intense opposition from provider groups. "Like last year, we'll fight the institution of these user fees," says **Dennis Barnhardt**, communications director for the Englewood, CO-based Medical Group Management Association.

Under the proposed user fees:

— Physicians, other providers, and suppliers would be charged a registration fee to participate in the Medicare program. That would produce $20 million.

— Providers would be charged $1 for each claim submitted on paper rather than electronically, raising $55 million.

— Providers would be charged $1 for each duplicate and unprocessable claim submitted, producing $17.8 million.

— Medicare+Choice plans would be charged a fee to underwrite beneficiary education programs, raising $5 million.

— Medicare managed care organizations would be charged a fee when submitting initial applications and renewing annual contracts, producing $36.7 million.

— Home health agencies and skilled nursing facilities would be charged initial certification and recertification fees, raising $65 million.

The budget asks for an additional $11.5 billion in overall Medicare funding to increase Medicare payouts to $216.4 billion. Out of this,

the White House wants to cut provider payments by some $9 billion — the bulk of which would come from freezing FY 2000 hospital payment updates.

The President's proposed budget also projects saving $2.9 billion over five years through implementation of various measures to cut waste, fraud, and abuse in federal health programs **(see *Physician's Payment Update*, January 1999, p. 1)**. Under these antifraud initiatives, HCFA will:

— limit Medicare payments to providers for outpatient drugs to 83% of the average wholesale price;

— reduce the lab fee schedule ceiling from 74% to 72%;

— pay market prices for Epogen, a drug used to treat anemia in chronic renal failure;

— expand Medicare's authority to contract with "Centers of Excellence";

— require that insurers report to HCFA all Medicare beneficiaries they insure;

— grant HCFA authority to fine private insurers twice the amount owed if they intentionally allow the government to pay claims for which the private insurer is responsible;

— impose stricter controls on Medicare's partial hospitalization benefit to ensure the government pays for therapy actually provided to beneficiaries. ■

HCFA will change some claim review procedures

AMA wins partial victory

The Health Care Financing Administration (HCFA) has agreed to institute several long-sought changes in its claim review and auditing procedures. The changes, worked out after negotiations with the American Medical Association (AMA), were spelled out in a letter from HCFA administrator **Nancy-Ann DeParle** to the AMA.

These changes are the first victories in what AMA executive vice president **E. Ratcliffe Andersen Jr.**, MD, called a new "intensive campaign to refocus fraud and abuse enforcement efforts so that honest, law-abiding physicians are not coerced into paying huge financial penalties for inadvertent billing errors."

In a Nov. 2, 1998, letter to DeParle, and in meetings with staff from HCFA's Office of Program Integrity, the AMA said it was worried that "the federal government and Medicare carriers are beginning to focus their enforcement efforts on unintentional billing errors, and that many of the government's current efforts to address fraud and abuse are heavy-handed."

While saying the AMA has "zero tolerance for true fraud," the AMA letter said "federal officials and Medicare carriers are, in fact, focusing on unintentional billing errors" and many of their related antifraud enforcement actions "are unnecessarily heavy-handed."

Prepayment screens delay payments

Of special concern to the AMA are HCFA policies dealing with prepayment reviews and screens and post-payment audits. The AMA is concerned about prepayment screens because after a carrier conducts a post-payment audit and determines there has been an overpayment, it often instructs its computer to pull and screen any future claims submitted by that provider that involve the codes in question.

The AMA argued this practice places a hardship on many physicians by holding up their payments while these claims are being reviewed. Adding to the problem is the fact there is no time limit on how long carriers can take to review the claim. The AMA has lobbied to require carriers to immediately discontinue prepayment screens once physicians show they are making a good-faith effort to file correctly.

"We agree that carriers should discontinue pre-payment screens / edits when billing patterns change and physicians come into compliance," DeParle wrote the AMA. She said HCFA will instruct carriers to change prepayment screening policies accordingly.

The AMA said letters from carriers requesting additional documentation often fail to clearly communicate the necessity of responding to these letters if physicians are to get paid. HCFA said it will work with the AMA to develop a model sample letter for use in such circumstances. HCFA also said it will work on developing a program to educate physicians about the purpose and importance of these prepayment review letters.

The AMA also voiced concerns about post-payment refund demand letters. The AMA said the 30-day time limit physicians currently have to respond to letters from HCFA demanding it be reimbursed for an overpayment is "woefully

insufficient" for a provider to seek counsel and decide how to respond. HCFA agreed, and is preparing new instructions telling contractors to give physicians 60 days to respond to consent settlements.

Despite these changes, there remain several outstanding areas of conflict where HCFA and the AMA could not reach agreement.

The AMA, for instance, questioned the benefit of conducting prepayment reviews of evaluation and management (E/M) services. Instead, the AMA wants HCFA to focus its attention on those "outliers" it already has been able to document rather than conducting random prepayment claim reviews.

"HCFA has assured the AMA time and time again that the agency is focused on substantive disputes and not on coding differences of one level," wrote the AMA. "This is not what we are seeing from Medicare carriers and physicians across the country. Frequently, the carriers are focusing on coding differences of only one level. Reasonable people can certainly disagree regarding such nuances. A more prudent use of HCFA's resources would be for the agency to concentrate on the outlier."

Contributing to the AMA's concern are situations where physician E/M claims have been rejected and downcoded on a prepayment review basis for not having enough documentation to support the higher levels. However, when some physicians have challenged the decision, also sending along a copy of the 1997 E/M guidelines, the carrier has changed its mind and approved the original claims.

Citing the fact a 1997 audit of Medicare payments found physician services accounted for 29% of an estimated $23.2 billion in improper payments, DeParle told the AMA: "HCFA must take strong, aggressive actions to reduce inappropriate payments. Such actions include increasing the proportion and effectiveness of medical reviews, including reviews conducted on a random basis."

According to DeParle, HCFA must retain random claim reviews because:

— Payment errors are spread throughout the system and cannot be attributed solely to outlier providers.

— Random review provides a more general picture of where errors are occurring, permitting HCFA to formulate and target its education efforts and guidance, as well as to point its review resources in new directions.

— Random medical review is the only way HCFA can guarantee that any individual claim submitted to Medicare has a chance of being scrutinized. That lets providers know it is possible that any claim could be reviewed by agency auditors. "Random review creates broad awareness of the need for accurate claims submission and imposes an overall discipline on the system," said DeParle. ■

Commercial carriers doing more audits

Florida carrier garners $458 million

Many Medicare carriers and contractors, still smarting from a recent Office of the Inspector General report criticizing them for not being "proactive" enough in investigating fraud and abuse, are gearing up to increase their audit activity.

For instance, Blue Cross and Blue Shield of Florida (BCBSF) — the parent company of Florida's primary Medicare administrator, First Coast Service Options (FCSO) — recently reported it prevented or recovered over $458 million in Medicare fraud, waste, and abuse during the fiscal year ending Sept. 30, 1998. This is nearly a 15% increase over the $400 million in questionable payments it either identified or recovered the year before.

The $458 million in potential inappropriate payments included:

- $192 million identified through prepayment medical reviews;
- $99 million in unallowable provider costs recovered through retrospective financial audits;
- $44 million collected from retrospective medical audits of physicians and suppliers.

The biggest single source of questionable problem payments identified by Blue Cross and Blue Shield of Florida last year: $107 million in claims where Medicare was inappropriately billed or paid as the primary insurer.

These audits also produced some 50 cases of outright fraudulent or abusive billing activity, which BCBSF turned over to law enforcement officials for further investigation.

"We are feel we're making significant progress in eliminating much of the blatant fraud, waste,

and abuse in Florida's Medicare program," says **Patricia A. Williams**, FCSO's senior vice president and chief operating officer. "For every dollar we spent in safeguard efforts, we recovered $18."

Williams credits much of FCSO's success in increasing its inappropriate payment recovery ratio to the installation of powerful computer programs capable of more precisely pinpointing both outright fraud and "wasteful activities" by identifying provider billing trends that seem inconsistent with bona fide Medicare claim profiles.

This new technology is needed because professional Medicare con artists have improved their own techniques beyond the old, less subtle method of simply billing for services that were never rendered or falsifying the Medicare provider's and / or beneficiary's identity, Williams notes.

Increased scrutiny on medical necessity

"These days, we find more activity — and, in turn, focus more attention — on what seem to be suspicious instances of claims submitted for services that don't meet Medicare guidelines or do not appear to be medically necessary," says Williams.

According to **Karen Monson**, director of benefits integrity for BCBSF and FCSO, both organizations use a claims review strategy that stresses closer scrutiny of claims before they are paid to identify potential instances of Medicare fraud, waste, and abuse.

FCSO's prepayment review strategy focuses on the following areas:

- **Paying for the right service.** This is done by paying closer attention to medical necessity to ensure payments are only issued for the medical care a beneficiary actually needed and received.
- **Paying for services on behalf of the right beneficiary.** This ensures payments are only made to eligible beneficiaries.
- **Paying the right provider**. This ensures that payments are going to entities that are legitimate, act in a reasonable manner, and render quality care.
- **Paying the right amount.** This ensures accuracy of reimbursements by using correct fee schedule prices and properly applying deductible and coinsurance amounts.

Focusing on these four areas should allow the companies to keep ahead of anyone intending to challenge the integrity of the Medicare program, says Monson. ■

Thinking like an auditor can speed your payments

Peek inside an auditor's head

All health care claims, whether commercial or government, undergo the same basic reviews as they move through the payment cycle. Knowing what these steps are and what they involve can help your office avoid snags that could mean delays in payment — or worse, having your future claims automatically red-flagged for closer examination and possible audit. Here are the key steps in the process:

- **Automated edits**. As the first step in the audit process, carriers use automated methods to edit or quickly check claims for obvious inaccuracies or incomplete information that will kick the bill back to the provider to be cleaned up.

Warning: A pronounced pattern of extensive or similar "mistakes" can result in the computer automatically red-flagging claims from that provider for a more extensive audit. Depending on the kind of pattern identified, investigators might decide to look at all the claims submitted by the provider, focus on a certain kind of claim filed by that physician, or tag all the claims a provider has submitted for an individual beneficiary.

Here are some of the common technicalities that can result in your claim being denied in these first-level edits:

— provider or beneficiary identification number is wrong;

— patient has other insurance;

— procedure and the place of service do not match, i.e., hospital code is used for an office visit;

— procedure codes and diagnosis codes do not match;

— incomplete diagnosis codes;

— unbundling and billing separately for medical services that should be included as part of a global fee.

Carriers often compile this kind of automated edit information on each provider they deal with for periods from 18 months to four years long to see if the computers spot a particular pattern of questionable denials or a billing profile out of sync with other providers.

If a red light does go off, then auditors may pull your file to take a closer look at your billing history for questionable patterns or unusual claims that would justify an audit.

High on the list of suspicious activities investigators will want more information on are seemingly high claim volumes for a specific CPT code or kind of service. What looks to be a superhuman level of billing for one person during a given 24-hour period or work week for certain services and an individual patient also raise questions for claim examiners.

• **Prepayment review**. The next step in the audit food chain is the prepayment review, where the carrier sets aside certain types of claims by a particular provider for closer examination before payment. This also can involve a written request for the provider to produce more information about specific claims.

The good news here is that if you do not receive any further communications from the carrier fairly quickly, this probably means the carrier has found nothing and the claim is being paid. But if reviewers find what they feel is an intentional pattern of abuse, the case could be under consideration for a more detailed fraud and abuse investigation.

Develop your own provider profile

Commercial and Medicare payers keep detailed profiles of questionable claims submitted by each provider, so it makes sense that practices can use this same information to spot patterns and weaknesses in their own coding and billing operations.

One of the easiest and best ways to start accumulating this information is by tracking the reasons for denial cited on the Remittance Advice Notice from your Medicare contractor.

Based on data from the Health Care Financing Administration (HCFA), some of the leading reasons for denying claims are:

• **Poorly documented and/or outdated diagnosis codes.**

To avoid unintentional mistakes, make sure your diagnosis codes have been updated. Physicians and staff, and even computers, should be tested on the use of codes, specifically on making them as complete and specific as possible.

The more details and documentation you have, the easier it is to avoid the classic denial of payment based on a conclusion that procedures do not appear to be medically justified based on the information presented to the claims examiner. If you have had problems with frequent denials based on questions of medical necessity, check with the carrier on its policies regarding coding for that particular set of problems. Also, check on what protocols the carrier considers appropriate regarding how often a service should be performed over a specific time period and alternate ways to treat that particular medical condition.

• **Medicare is this beneficiary's secondary payer**.

One of HCFA's new policing priorities when it comes to processing claims is to ensure it does not get stuck paying the bill for patients who also covered by private insurance. However, Medicare's information about a beneficiary's employment and third-party insurance status often is outdated. This makes it even more important that patient files be kept updated with patients' most recent employment/retirement status and alternative coverage before submitting a claim. To avoid possible denials, you might consider asking patients to call Medicare and update their files on their own.

• **Duplicative claims.**

If you are receive a number of denials because these claims were duplicates of claims already being processed, first check your computer software and billing system for a glitch. Second, remember that it takes time for a claim to move through the system. It is best to wait at least 14 business days to resubmit an electronic claim, or 28 days for paper bills.

Coding miscues for services performed several times on the same date also can produce a duplicative claim denial. One way to avoid having your claim rejected is to log the procedure code only once, then enter the number of units provided in block 24G of the HCFA 1500.

• **Incomplete or inaccurate physician ID and referral numbers.**

A simple cross-check of your claims processing software will determine whether the various physician identification and referral numbers (PIN, UPIN) required by Medicare have been correctly logged for every physician in the practice. Also, remember that after hiring a new physician, you must submit the new physician's group PIN before filing claims in the physician's name.

Well-designed forms and office procedures will help eliminate the referral problem. For instance, patient registration forms should have a space to list the physician who referred the patient to the practice. Likewise, a similar line should be included on charge slips so the treating physician can note to whom the patient was referred. This information should automatically be logged into the patient's computer file with a cross-check to ensure the data are complete and included on the claim. ■

Random billing audits help ensure full payment

Go back to the fundamentals

Commercial and Medicare payers are becoming even more picky about the appropriateness of claim coding. In this atmosphere, "it is even more important that practices implement processes to ensure that physicians are getting paid in full for what they do," says **Rebecca Anwar**, a senior health care consultant in the Philadelphia office of the Sage Group.

Like many things in life, this means paying more attention to the fundamentals. And with billing, this translates into making sure the steps in the claims process are done correctly, from posting charges to final explanation of benefits.

"One way to do this is to perform regular random audits of your entire billing process to ensure your systems and controls are in place and working properly," says Anwar. "I recommend random audits be done quarterly and include at least 20 to 25 patients for each provider which are tracked from the date of service through the entire process."

Steps in these random audits include:

• **Appointment system.**

Do you know if all your patients are being properly entered on the appointment system, including walk-ins, add-ons, and nurse visits? "This can be verified by matching your charge documents or superbills used the previous day with the appointment schedule for that day," says **Judy Capko**, another senior Sage consultant. "For instance, is there a charge document for each patient on the appointment calendar? What about the patients who were not in the appointment system?"

Once all appointments have been documented for a given week, create a hard copy of that week. Then pull the patient charts for every fourth or fifth appointment on the schedule.

• **Chart notes to charge slip.**

Examine the chart notes for each patient to determine if the documentation matches the description of the service on the charge document. For example, the charge document may show the patient had a problem-focused exam, but the chart documentation could reveal a detailed examination with lab and X-ray done. If this is the case, are there results in the chart to substantiate that the ordered diagnostics have been completed? Are the diagnoses listed on the charge document also listed in the patient's record?

• **Charge slip to patient ledger.**

Take the charge slip with a copy of the patient's ledger from either your computer or your billing system and determine if all the charges were transferred from the charge slip into the accounts receivable system. Have all CPT and ICD-9 codes been entered correctly? Do the ICD-9 codes match the corresponding CPT codes? "You also will want to make sure any payments made at the time of service were entered into the system on the correct date, and verify that the services were submitted, either electronically or by paper claim, to the appropriate third-party payer," says Anwar.

• **Explanation of benefits (or remittance advice).**

Finally, review the explanation of benefits (EOB) for third-party payment on the date of service being audited. "The important thing here is to not assume the insurance company did not make an error in processing the claim," says Anwar. "Therefore, you want to check to see that all the services submitted for payment were considered by the insurer and any adjustments made by the payer were indeed appropriate. Finally, verify that an attempt was or is being made to collect any remaining monies due from either a secondary carrier or the patient."

• **Analyze the findings.**

Add up the number and kinds of discrepancies uncovered, along with their total dollar value. Then project these findings over the next year. For example, if you audited 20 out of 200 total patient visits for the week, the findings represent 10% of total visits. If the audit revealed just $90 in lost revenue, you would multiply this by 10 for a potential loss of $900 a week, $3600 a month, or $43,200 a year. "Even this relatively small amount of missed revenue can quickly add up to pay the salary of another full-time employee," says Capko.

• **Pinpoint patterns.**

Is there a common type of error being made, such as in diagnosis, service code, or date of service? Does one physician or one small group of physicians account for the bulk of the mistakes, or are errors evenly distributed among all providers?

• **Timing.**

How long did it take between the time the data were originally entered and the claim was submitted? What kind and percentage of claims were

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returned for correction and had to be resubmitted? Are your insurance plans paying you in a reasonable length of time and in agreement with your contract? Are the payments posted promptly and correctly? After the insurance payment is posted, is the patient (or secondary insurance company, when appropriate) balance-billed promptly?

• **Action plan**.

"Naturally, you want the process to be perfect," says Anwar. "However, if the audit uncovers errors in more than 10 percent of your patient visits, you probably have a serious problem that needs to be immediately corrected," says Anwar. ■

Top-performing practices garner more cash up front

View billing and collection as one process

One of the key factors distinguishing top-performing group practices from their peers is that they pay closer attention to — and get better results from — their accounts receivable and cash collection activities, reports a recent study by the Englewood, CO-based Medical Group Management Association.

"Although the bulk of patient care is now paid by third parties, the prompt collection of cash, especially copayments, remains an important element of practice performance," says **Sara M. Larch**, chief operating officer of Baltimore's University Physicians.

Even seemingly small amounts of co-pay-related cash can soon turn into big bucks, notes Larch. For instance, if half of all your patient visits are covered by insurance requiring a $10 co-pay per visit, this translates into $10,000 for every 1,000 patient visits.

Rather than thinking of billing and collections as separate functions, "it may be more advantageous to think of the collection process as a continuum of duties beginning with front-desk functions and ending with the final resolution of an account receivable," says **Donna M. Sherwin**, president of Physician Billing Solutions in Wayne, PA.

Larch agrees that staffers handling traditional "front office" duties like patient registration can have a major impact on improving the practice's billing, cash flow, and collections process.

"We're always reluctant to hire more front-office staff, yet we keep adding people in billing and collections," says Larch. "Maybe we should move some of the billing staff to the front office. After all, who knows better about what happens to a claim when those pre-visit duties are either not done or not done right?"

For example, when the front desk person fails to inform patients about their co-pay or to ask an HMO patient to bring their referral to the appointment, this creates a potential collection problem for the practice.

"When the registrar collects incomplete data or enters the data incorrectly, a collection issue is created. When charges are entered incorrectly, when payments are posted incorrectly, when balances are not 'moved' to the appropriate payer, or when inaccurate or incomplete claim forms are submitted, collection problems are created," says Sherwin.

Setting collection goals

To speed up cash flow, practices need to install procedures that "ensure each of these kinds of billing-related functions are performed with the objective of collecting on the account in the least possible amount of time," recommends Sherwin.

For instance, you could set the goal of collecting 100% of co-pays at the time of service. To implement this standard, you might develop a script to be read to all patients when making an appointment and when checking out after their visit, says Sherwin.

The pre-appointment script should include information about what to expect at the time of service relative to the patient's financial obligation, referral information, etc. A post-visit response might be as simple as, "How would you like to pay today?" or, "The bill today is $x. Will you be paying by check or credit card?"

"You want to be polite and tactful without devaluing the value of your service," says Larch.

According to Sherwin, up to 65% of the reasons why claims are rejected or for which payment is delayed can be traced to errors in the patient's enrollment information. To avoid the problems associated with patient enrollment, consider setting a standard of a maximum 2% error rate for registrars.

Larger practices can buy management software that will automatically track registrar error rates. "Smaller groups could just have the registrar initial

the system or the registration sheet from which he or she took the information," says Sherwin.

"Further, you will need to develop a procedure for identifying errors. That is, you might create a change form to be used by individuals when they identify inaccurate data. The change form would be reviewed by the supervisor and the appropriate registrar would be counseled," she says.

By applying these concepts to each function in the billing process, "you could minimize, or even eliminate, the need for someone to collect bad debts," says Sherwin. ■

Consensus getting closer on provider ID rules

Final rule due by end of year

Final agreement on a new standard for assigning new provider numbers to all providers (physicians, hospitals, nursing homes, etc.) has come closer after a meeting of the Workgroup for Electronic Data Interchange (WEDI) in Washington, DC.

The group is attempting to develop a consensus for use of a single provider identification number to be used when processing electronic claims, plus a universal standard format for these electronic claims.

As called for in the Health Insurance Portability and Accountability Act of 1996, the Department of Health and Human Services has issued a proposed set of regulations for implementing the new system of provider ID numbers and the national provider system (NPS) of standardized electronic claims. WEDI was created as a forum for industry and government officials to informally hash out differences and come to consensus on the best way to implement the new electronic payment system.

"The aim of these efforts is to help move more providers from paper to electronic claims submission," says **Nancy-Ann DeParle**, administrator of the Health Care Financing Administration (HCFA). HCFA estimates the electronic-based claims system will save the agency some $1.5 billion in processing costs over five years once the system is fully implemented. As part of a goal of pushing more providers to convert to electronic processing, HCFA also is asking permission from Congress to start charging a $1 processing fee on every paper claim submitted by physicians.

Stewart Streimer, the HCFA official charged with coordinating the installation of the agency's new provider ID and electronic payment system, told a January WEDI meeting that the agency has completed a draft of its proposed rule-making on electronic claims attachments, which the agency hopes to release this spring. However, additional proposed rules covering such topics as standards for electronic medical records, health data confidentiality, and the national patient identifier are not likely to be published before the year 2000.

Three sets of proposed rules directly affecting providers already have been released: Standards for Electronic Transactions, National Provider Identifier (NPI), and Security and Electronic Signature Standards. Streimer hopes to have these rules in final form by the end of the year.

"Once a final rule is published, Congress has 60 days to comment, extend the effective date, or even repeal the proposal entirely," says **Pat Smith**, a government affairs representative with the Washington, DC, office of the Medical Group Management Association. Official implementation would take place 24 months after the final rule's effective date.

Under the January working group's recommendations:

- Every provider will receive an NPI.
- Providers who bill Medicare will automatically be enumerated first; others will have to apply for an NPI.
- Organizations will receive separate NPIs.
- There would be no fines for noncompliance until the system is fully implemented and tested.
- All entities billing Medicare would be enumerated, not just physicians.

Under the three levels of clearance to NPS information constructed by the working group, enumerators would have access to all NPS-related information. Meanwhile, providers, payers, and clearinghouses would be given restricted access to information for which they can justify a "legitimate business use." The general public, however, would only have very restricted access to limited data elements.

Other recommendations include:

- **Funding.**

— No fees will be charged to place providers or update their information in the NPS.

— Federal funds should be used to create the NPS, with user fees charged to those accessing the data to cover ongoing maintenance costs.

Electronic claims filing 'is the way to go'

More are using it, but progress slow

The Davenport, IA-based ophthalmology practice of R.C. Bedell, MD, handles certain patients with an absolute minimum of hassle. When these patients go in for an exam and give the receptionist their insurance card, the receptionist then enters the patient's ID number into an electronic data interchange (EDI) system. In seconds, the receptionist knows if the patient is eligible for insurance and the amount of copayment required.

By the time the appointment is finished, the insurer has paid the bill, leaving Dr. Bedell's staff with one less claim to worry about.

"It costs a health care provider up to four dollars to process a claim by paper," says **Ron Glassner**, executive vice president of VHx, the Cedar Rapids, IA-based electronic claims processing system that administers Bedell's system. "With EDI technology, it costs less than a dollar. It is truly an amazing cost savings. It's even more amazing that providers and payers aren't yet demanding EDI in their offices."

Despite the appeal of EDI, practices have been slow in adopting it, relying instead on labor-intensive paper claims. In fact, some small doctors' offices still do not have the computer capacity to make converting from paper possible.

"Going to a technology-driven system is an adjustment," says Glassner, "but that short-term adjustment pays off very quickly in productivity and financial savings. Some doctors write off 50% of uncollected copayments as bad debts. That number will drop dramatically when they can determine if a patient is indeed covered by insurance, what procedures are covered, and the co-pay amount. Claims can now be adjudicated on-line and payments can be collected on the spot."

One reason for the slow embrace of EDI is the fact that many payers are still not technologically equipped to handle it. This creates a Catch-22: Payers are not interested in upgrading until more providers have EDI capability, but providers are reluctant to make the switch until payers can accept electronic claims.

A good example of a comprehensive, well-functioning EDI relationship can be found between the Eye Associates Network (EAN) managed care plan in Davenport, IA, and third-party administrator Comprehensive Healthcare Administration. EAN requires all its network providers to install EDI equipment, even if they see only as few as 10 EAN members per month.

"To be able to determine a patient's benefit without making a phone call is tremendous," says **Annette Tomlinson**, systems director for Eye Surgeons Associates P.C. in Davenport. "The benefit of not having your staff making phone calls to check on eligibility is probably one of the system's biggest strengths."

Patients who come to Eye Surgeons Associates give the receptionist a card to swipe through a card reader. Alternatively, the receptionist types in the patient's social security number to access the patient's insurance eligibility data. The cost of a transaction between the provider and payer can be as low as 48 cents.

"You figure 33 cents for postage if you mail a claim, and certainly EDI is faster, so there's definitely an advantage," says Tomlinson. "Electronics is the way to go." ■

— Contrary to HCFA's proposed rule, the meeting recommended that providers be enumerated through a single federal registry, not a combination of federal and state registries.

• **Data.**

Concerned that HCFA's proposed NPS would capture much more information about providers than is necessary for regular business purposes, the meeting recommended that several data elements — such as educational information and race — be deleted.

To protect provider confidentiality, WEDI members also recommended that no fraud and abuse or other legal-related information be included in the NPS. "This is a politically sensitive subject which is going to require more discussions between HCFA and provider groups over the need for — and type of — provider-related fraud and abuse information contained in the final rule," says a lobbyist for one health care group.

WEDI will meet again in March to vote officially on these recommendations. ■

HMO enrollment grows, national study finds

Growth, profitability vary by market

The number of geographic markets with relatively high managed care penetration is growing, a new study from Minneapolis-based InterStudy Publications finds. However, HMOs had have limited success in reducing their medical expense ratios, and per-member-per-month (PMPM) medical costs are continuing to increase, the study finds.

As of January 1998, there were 149 markets with managed care penetration rates of 25% or greater, according to InterStudy's report, *Regional Market Analysis 8.2*. This represents a substantial increase from the comparable 1996 period, when only 71 metro areas had managed care penetration above 25%.

Heavy penetration

The data show managed care penetration building in Pittsburgh **(see chart, below)**, one of the most heavily penetrated large markets, with a penetration rate of 53.5%. Pittsburgh's penetration rate is well above the 75th percentile compared to other large markets (cities with a population of 1 million or more).

The three most highly penetrated large markets measured in the InterStudy report are

Metro Markets Accounting for One-Third of HMO Enrollment Growth

Rank	Metropolitan Area	Enrollees Added '97 to '98	Plans with Largest Enrollment Gains	Growth Products
1	New York, NY	958,088	Physicians Health Services, Oxford Health Plans, CIGNA	POS
2	Philadelphia, PA-NJ	648,843	Physicians Health Services, Keystone Health Plan East, Aetna/US Healthcare	Medicaid, Group, POS
3	Nassau-Sulffolk, NY	515,756	Physicians Health Services, Oxford Health Plans, CIGNA	POS
4	Boston, MA-NH	453,361	Tufts Health Plan, HMO Blue	Group and POS
5	Los Angeles-Long Beach, CA	391,877	Pacificare, HealthNet, Kaiser of So. CA, CaliforniaCare, Blue Shield of CA	Medicare, Medicaid, Group
6	Pittsburgh, PA	378,458	Keystone Health Plan West	POS
7	Chicago, IL	337,299	HMO Illinois, United Health Care of IL, Principal Health Care of IL	Group and POS
8	San Francisco, CA	283,388	Pacificare, HealthNet, Kaiser of No. CA CaliforniaCare, Blue Shield of CA	Medicare, Medicaid, Group

Source: InterStudy Publications, Bloomington, MN.

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- Update on evaluation and management changes

Rochester, NY (71.4%), Sacramento, CA (66.1%), and Buffalo-Niagara Falls, NY (64.8%), the study finds. The three most highly penetrated medium markets are Santa Rosa, CA (74.3%), Boulder-Longmont, CO (71.5%), and Worcester, MA (70%). The three most highly penetrated small markets are Burlington, VT (79.7%), Springfield, IL (72.8%), and Pittsfield, MA (63.2%).

Total PMPM revenue received by health plans grew slightly for year-end 1997 compared to year-end 1996, the report says.

Another InterStudy report, *The InterStudy Competitive Edge*, found that medical expense ratios among health plans across the country continue to average around 89% to 90%, while average medical expenses for all metro areas totaled $124 per member per month. Why are these expenses still so high? "Managed care has been around a while [in many markets], and a lot of the fat has been cut out," says **Tammy Lauer**, research manager for InterStudy's Competitive Edge series. "Plans got to a place where they couldn't cut anymore. Even though premiums have finally been raised in the last year, this is basically making up for years of losses."

For a copy of the InterStudy reports, contact the company at (800) 844-3351. ■

Tensions grow between Texas physicians and MCO

After years of escalating tension, two large Dallas-area physician practice organizations have canceled their HMO contracts with mega-insurer Aetna US Healthcare.

In retaliation, Aetna invoked its "all products policy," requiring physicians to participate in all of Aetna's products in order to participate in any of them. Additionally, Aetna has brought anti-trust charges against the largest of the two physician organizations, the 560-physician Genesis Physicians Practice Association.

In a countermove, the Dallas County Medical Society, the Texas Medical Association, and the American Medical Association (AMA) have filed comments with the Justice Department opposing Aetna's proposed purchase of Prudential HealthCare, which would make it the nation's largest health care insurer.

"This is the first time the AMA has publicly opposed a health insurance consolidation," says **Randolph Smoak**, MD, chairman of the AMA's Board of Trustees. However, the AMA was forced to act because of a number of issues, such as the market share the new consolidated Aetna would have and the history of difficulties physicians have had with Aetna US Healthcare, says Smoak. "These problems are particularly acute not only in Texas, but six to eight other states, as well, " he says.

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"While this may be the first time the AMA has opposed a health insurance consolidation, it almost certainly will not be the last," says **Todd Vande Hey**, the AMA's vice president for private-sector advocacy. "The AMA will challenge anti-competitive consolidation in health care and help physicians to collectively bargain with consolidated insurance and hospital entities." ▼

Medicare will cover EECP coronary therapy

Vasomedical Inc. of Westbury, NY, says the Health Care Financing Administration has extended Medicare coverage to enhanced external counterpulsation (EECP), Vasomedical's noninvasive outpatient treatment for coronary artery disease. Medicare coverage of the EECP procedure includes patients with disabling angina who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical interventions such as percutaneous transluminal coronary angioplasty or cardiac bypass.

EECP is a noninvasive, atraumatic procedure involving a series of compressive air cuffs placed on the lower extremities, with inflation and deflation modulated by events in the cardiac cycle via microprocessor-interpreted electrocardiogram signals. The beneficial effects of the procedure on perfusion of the ischemic myocardium in patients with coronary artery disease are sustained between treatments, and may persist long after completion of a course of therapy, say company officials. ▼

Heart laser procedure recommended for coverage

A Health Care Financing Administration advisory group has recommended that Medicare approve payment for transmyocardial revascularization (TMR) procedures performed with Food and Drug Administration-approved devices.

The recommendation was made by staff in HCFA's Coverage and Analysis Group following its review of scientific evidence on the medical effectiveness of TMR. The coverage staff recommended the rescision of the current Medicare national noncoverage instruction and the adoption of a new coverage policy to allow payment for TMR consistent with FDA-approved uses of the devices to perform TMR.

The memorandum recommends coverage of TMR "as a late or last resort for patients with severe . . . angina . . . which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages. In addition, the angina symptoms must be caused by areas of the heart not amenable to surgical therapies such as PTCA, stenting, coronary atherectomy or coronary bypass."

The HCFA staff recommendation is being forwarded internally for final agency approval and the issuance of a formal instruction requiring coverage for TMR. ■