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INSIDE

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Will your computers and software work in the year 2000?

Act now to make sure your records will stay intact

(Editor's note: As the clock ticks toward the millennium, physician practices should make sure their information systems and medical equipment will be working in the year 2000. In this issue, we examine the steps you should take to ensure your computer software and hardware will work in the year 2000. Next month, we'll take a look at medical equipment and supplies, and what other practices are doing to prepare for the millennium.)

If your practice hasn't started a year 2000 (Y2K) review of all its computer hardware and software applications, you should begin immediately. Otherwise, when Jan. 1, 2000, rolls around, your information systems may fail, leaving your practice unable to check patient records, schedule appointments, pay staff, or submit bills to third-party payers.

Donald J. Palmisano, MD, JD, a member of the American Medical Association Board of Trustees, addressed a U.S. Senate committee on the Y2K problem last year. "The year 2000 will affect virtually all aspects of physicians' practices," Palmisano said. "The medical profession and health care industry in general rely on information technology for a broad spectrum of services and products, from electronic data interchange for patient records, medical research, and billing, to medical devices in the surgical theater."

The Y2K problem arose because most computer hardware and software use a six-digit field for dates, with the "19" in the year being assumed, such as 12/25/99. When the year 2000 rolls around, it is possible that the computers will read "00" as "1900." A less common but also potentially distressing problem may arise because some programmers have used a string of nines to indicate a variety of conditions, such as "infinity" or "delete this record." Therefore, some computers may start having problems on Sept. 9, 1999 (9/9/99).

"No one should believe that they are immune from dealing with Y2K issues, or that there is a quick fix. It is taking a significant risk to try to correct the problems in the last six months of the year," advises **Malcolm Morrison**, PhD, president of Morrison Informatics, a health

Here's how to check for Y2K compliance

$50 software tells you what you need to know

Don't assume anything when determining if your computer hardware and software will work in the year 2000 (Y2K), advises **Joel Ackerman**, executive director of Rx2000 Solutions Institute in Minneapolis, a nonprofit clearinghouse of information about the Y2K problem. That means checking and rechecking every piece of equipment and software you have.

Here are some tips on how to make sure your practice won't be affected by Y2K problems:

Make a list of every piece of hardware and software you use, and note the compliance status of each item on the list. Many manufacturers will supply lists of compliant and noncompliant products. Check the serial numbers, not the model numbers. Identical products often have chips from different manufacturers or are made at different times.

Consider using an off-the-shelf software program, such as Norton 2000, to check out your software, hardware, and data. These products, generally available for around $50, tell you if your computer is compliant and what you need to do to make it compliant, says **Ed Cox** of Networked Financial Systems, a financial accounting system integration consulting firm in Houston.

It's possible to download a cheap "shareware" program from the Internet, Cox says, but he recommends buying commercial software to make sure you get something reliable.

Get written assurances

If you use a patient accounting software package or any other kind of specialty practice management software, it's advisable to check with the vendor about whether the software is compliant. Don't just settle for a verbal assurance that a product is compliant. Ask the company to mail or fax you a document that says their product complies, Cox advises.

Assume nothing; always check. The chance of a code being changed inside a computer is very small, but if it doesn't work correctly, everything on your computer could be lost.

If you purchase any kind of computer, computer equipment, or software from a vendor, make sure your contract specifies that your purchase is Y2K-compliant.

Test to ensure that corrections are in place and your computer system will function in 2000. First, copy all your software and data to a disk or another safe location. Then change the date on your computer to Dec. 31, 1999, Cox suggests. The next day, check the computer to see if it still works.

As the end of the year approaches, consider making paper backups of patient records and other vital data. ■

care information systems consulting firm in Mechanicsburg, PA.

Morrison advises looking at the Y2K problem as an opportunity to review all of your computer systems and products. You should make sure they are on the cutting edge and will be able to deal with the amounts of information health care providers will need to generate in the future, he suggests.

If you may need to update your computer systems in the future to deal with electronic data transmission to payers, now is the time to do it, he adds.

"In the future, virtually all reimbursement is going to be done electronically. Managed care will still accept pieces of paper today, but HCFA [the federal Health Care Financing Administration] has stated its intention to get away from paper entirely," Morrison says.

Most IBM-compatible PCs with 286, 386, and 486 microprocessors will have operating problems in the year 2000, Morrison says. Information technology personnel may be able to correct the problem on computers with 486 processors, but it may not be advisable to do so, he adds.

"You may be able to make your 486 computer Y2K-compliant and continue to use it. But the fact is that applications are now being developed that require more power to run than that computer can provide," Morrison adds.

Most Pentium-type systems are Y2K-compliant, but you should still check on them, advises **Ed Cox** of Networked Financial Systems, a Houston-based financial accounting systems consulting firm.

If your office uses just one or two PCs, Cox suggests checking them out yourself with an off-the-shelf software product. **(For details on how**

Y2K Resources

The following resources can give you more information on year 2000 (Y2K) compliance problems.

The American Medical Association's Web site provides regularly updated information about the Y2K problem and will help physicians solve their problems. Detailed information is available through their "members only" section. Web site address: **www.ama-assn.org/not-mo/y2k/index.htm.**

RX2000 Solutions Institute is a nonprofit organization that acts as an information clearinghouse on Y2K issues in the health care industry. The organization offers a variety of services, primarily through its Web site, which includes a checklist for Y2K compliance, how-to advice, and links to other Y2K Internet sites. Web site address: **www.rx2000.org.**

The federal Food and Drug Administration Web site maintains a list of manufacturers of medical devices and their Y2K compliance information. Web site: **www.fda.gov/cdrh/yr2000/year2000.html**

to check your own computers, see p. 34). If you have a network of personal computers connected together, it would be wise to consult a network engineer or whoever installed your network and have that person or firm check it out, Cox adds.

An information technology specialist should thoroughly correct any computers used as servers or servers that are part of a network system, Morrison adds.

"If the servers aren't correct, nothing will be correct. You can replace all your PCs, but if a server isn't compliant, it won't solve your problem," he says.

A significant amount of software for clinical, financial, scheduling, and other functions is not Y2K-compliant, Morrison says, adding that most Windows-based software designed in the mid-1990s should be compliant.

Most of the time, your software vendors will be able to tell you if your software is compliant, he notes. Many already have taken steps to notify purchasers of compliance.

In one of the first Y2K class action suits, Tampa, FL-based Medical Manager Corp. has agreed to provide a software patch to make its popular practice management software Y2K-compliant. **(See details in next story.)** ■

Popular software maker settles Y2K lawsuit

Software owners to receive free patch

Practices that bought versions 7 and 8 of The Medical Manager practice management software will receive a free upgrade to make the product compatible with year 2000 (Y2K) issues, under the terms of a settlement reached in a class action suit filed against the product's manufacturer.

The settlement was reached in December in a class-action lawsuit filed on behalf of Robert Courtney, DO, a New Jersey physician, and other purchasers of versions 7 and 8 of The Medical Manager. At the same time, the company settled five of seven similar cases filed in various judicial jurisdictions across the country.

Under the settlement, the company agreed to provide a software patch that will make its old software work after Jan. 1, 2000, and Medical Manager Corp. will be released from further Y2K claims about its products.

"Our settlement represents a landmark solution to the Y2K issue, and we consider it to be a win-win scenario for both our company and our clients. The settlement takes care of our customers, and at the same time protects our company from the unpredictable potential liability that could result from Y2K litigation," says **John Kang**, president of the Tampa, FL-based company.

The firm's Y2K-compliant product, Version 9, was released in 1997. It costs between $5,000 and $10,000 and must be run on a Pentium II processor, which means most physician practices would have to purchase new hardware along with the new software, says **Harris Pogust**, JD, of the Pennsauken, NJ, law firm of Sherman, Silverstein, Kohl, Rose and Podolsky, who represented the plaintiffs in the class action suit.

"With the patch, they can continue to use their old computers until they decide to upgrade, not when somebody else tells them it's time," Pogust says.

Courtney, who bought the product in late 1996 for about $20,000, got a form letter in 1998 saying the software wouldn't function in the year 2000.

About 2,000 to 4,000 practices who bought a Version 9 upgrade in response to the form letter will receive either a cash settlement or an additional Medical Manager module that will enhance their system, Pogust says.

The software product is used at approximately 25,000 physician offices throughout the country. About 75% of customers, or 10,000 physician practices, own the older versions of the software, according to Pogust.

The Medical Manager physician practice management system, the most widely installed physicians practice management system in the United States, provides financial, administrative, clinical, and practice management support for physician practices.

"Our goal is to take care of our customers in such as way as to ensure that they are happy with the product and the company they do business with. As our product is the most widely installed practice management software on the market today, a satisfied customer base is vital to our company's future," Kang says. ■

Capacity analysis can offer managed care insights

How many MDs do you really need?

In the increasingly data-driven environment of managed care, one consultant's message fits right in: Success in managed care boils down to capacity.

This analysis comes from **Theresa Raczak**, MBA, president of Linconlshire, IL-based MedComp. Raczak says capacity analysis lets a practice see if it is employing the right number of physicians doing the right things at the right time, with the appropriate number of support staff.

Put another way, is your practice employing too many physicians — or too few — given your managed care patient base?

Raczak recommends practices measure physician productivity in several ways and compare the data with national benchmarks. Areas of measurement might include number of patient visits per physician or gross production, defined as gross charges for professional work done by each physician, calculated on the basis of relative value units (RVUs) submitted by each physician.

If a group's patient base is at least 50% capitated, it can perform a utilization analysis per 100,000 members based on physician work components of the Resource-Based Relative Value Scale (RBRVS) measure used by Medicare.

Raczak recommends gathering one year's worth of data for an initial measurement. Then, generate reports on a monthly or quarterly basis to update this information.

Figure 1 **(see p. 37)** shows how a practice can track the number of patient visits for each physician and compare this against an average for the practice as a whole and against industry averages. Raczak says two good starting points for such benchmarks are cost and productivity surveys compiled by the Englewood, CO-based Medical Group Management Association (MGMA) and the Alexandria, VA-based American Medical Group Association.

You also can compare physician productivity based on gross charges. Again, numbers can be reported for each physician and measured against the average for a practice and against industry averages.

Raczak emphasizes that it is important to look for trends across several forms of measurement rather than using data from one category. This prevents a practice manager from making assumptions based on data from only one area. In addition to gross charges and patient encounters, other good measurement categories are RVUs, patient satisfaction, and collections (for practices that are not heavily capitated).

Does productivity match reimbursement?

Among the trends practice managers need to look for are whether a practice's reimbursement of a physician is in line with the productivity it is getting from that physician. "If you're paying physicians at the 75th percentile but you're getting only the 50th percentile in gross charges, you may be overpaying the physicians. Or if you have 14 physicians, this data may tell you the practice only needs 11 or 12," she says.

In the example given for Figure 1, the gastroenterology practice is measuring physician productivity in terms of patient visits compared to the 75th percentile based on a survey compiled by a national organization such as MGMA. The 75th percentile was chosen as a point of comparison because the practice has determined, again by comparing its data against MGMA's, that its physician salaries fall in the 75th percentile nationally for its category of specialists.

Figure 1 shows that when measured in terms of patient visits, physician productivity for a

Figure 1

XYZ Clinic — 1997 Visits — Capacity Analysis
Gastroenterology

Physician	1997 Visits	XYZ Average	Survey Mean	Average Mean	MD Capacity	Survey 75th	Average 75th	MD Capacity
A	2,136			115.4%			91.7%	
B	1,653			89.3%			70.9%	
C	1,229			66.4%			52.7%	
TOTAL								
3	5,018	1,673	1,851	90.4%	2.7	2,330	71.8%	2.2

Source: Medical Group Management Association, Englewood, CO.

specific practice only falls at 71.8% when looking at a national average of all practices in the 75th percentile.

Unless a practice is growing its business, it wants to look for productivity in the 95% to 100% range, Raczak says. If a practice is attempting to grow its business, productivity should be in the 85% range.

But the information presented in Figure 1 may not tell the whole story. In this case, a practice manager may decide to look at productivity based on gross charges in case the procedures performed by its physicians are more complex and thus take more of a physician's time.

Remember that while numbers don't lie, they still need to be taken in perspective and discussed with a physician leader, Raczak emphasizes. A physician's productivity numbers may be out of whack for several reasons:

- the physician could be undercoding;
- the physician's patient base may represent an older or sicker population;
- the physician could be referring to specialists too much;
- the physician's patients could represent what Raczak calls "the worried well" — patients who visit the doctor for every little ache or pain.

Regardless of the reason, a physician perspective on this information is vital, Raczak says. A fellow physician is in the best position to determine whether outliers exist because of the nature of the patient base. In addition, if there needs to be a discussion with the physician whose numbers are outside the norm, the information has more credibility coming from a fellow physician.

Physician buy-in also is important when setting up a measurement system, Raczak says. If physicians have a say in what data are being used to measure productivity, they are more likely to assign credibility to the data. For this reason, Raczak recommends forming a committee of physicians in your practice in order to put the measurement system in place.

But will physicians even see the need to measure productivity? Raczak admits it can be a hard sell.

"Yes, physicians may resist this kind of measurement," she says. "But the reality is, these groups are losing money. The average primary care physician practice loses $50,000 per doctor. And at the end of the day, the money has to come from somewhere."

The good utilizers may even embrace the concept of productivity measurement coupled with incentive pay — another must if productivity measurement is going to be effective, Raczak says.

There are as many models of incentive pay as there are physician groups, she says. It could be measured on straight productivity by RVUs, or a combination of productivity based on RVUs and patient encounters. "It really depends on the group's payer mix, the degree of risk they're willing to take, and if they're willing to pay just based on productivity or want to incorporate

Figure 2

Primary Care

Benchmark Productivity, Work RBRVS, All Payers

Family Practice	100%
Internal Medicine:	95%

Managed Care Utilization Analysis per FTE

Average (for XYZ Clinic) of total RBRVS	4,985
Managed Care Target RBRVS	5,600
Actual to Target	89%

Managed Care Utilization Analysis per 100,000 Members

Average (XYZ Clinic) of total RBRVS	314,858
Managed Care Target RBRVS	378,867
Actual to Target	83%

Source: Medical Group Management Association, Englewood, CO.

Figure 3

Gastroenterology

Benchmark Productivity, Work RBRVS, All Payers	
Gastroenterology	109%
Managed Care Utilization Analysis per FTE	
Average (for XYZ Clinic) of total RBRVS	10,499
Managed Care Target RBRVS	8,600
Actual to Target	122%
Managed Care Utilization Analysis per 100,000 Members	
Average (for XYZ Clinic) of total RBRVS	28,124
Managed Care Target RBRVS	23,193
Actual to Target	121%

Source: Medical Group Management Association, Englewood, CO.

patient satisfaction as part of the mix," Raczak says.

Practices that are more heavily capitated will obviously need to measure productivity a different way. Figure 3 **(see above)** represents data that can be used by practices that are majority capitated. The examples shown compare productivity among a group's primary care physicians with national benchmarks based on RBRVS. Benchmarking data like this are available from an actuarial firm such as Milliman & Robertson in Seattle.

Figure 2 shows that initial examination of productivity among a practice's primary care physician base looks pretty strong — family practice physicians have 100% productivity, while internal medicine physicians have 95% productivity.

However, when the total RBRVS values are compared against managed care targets, a practice may be operating at 89% capacity. On the other hand, based on the number of referrals to gastroenterologists, utilization as measured per full-time employees comes out to 122%. This information shows that the primary care physicians in a practice may be over-referring cases to gastroenterologists. A physician leader in the primary care practice may want to meet with the key gastroenterologists that the practice refers to in order to identify referral guidelines. There may be procedures — such as a flexible sigmoidoscopy — that primary care physicians can handle themselves.

If the process sounds like it can be a lot of work, you're right. Raczak admits it does take time to put a system in place — how much depends on a practice's current information management capabilities, the number of physicians in the practice, and how much information already is available.

But many managed care companies already are measuring productivity for the practices they contract with, and in some cases are using this information to reward or penalize physicians. Doesn't it make sense for your practice to measure these data internally to make sure you are being portrayed accurately? On the flip side, your practice could use this kind of data to show a payer that your physicians are effective utilizers capable of managing a capitation contract. ■

Durable goods becoming an unendurable headache

New federal probe targets physicians

If you routinely approve home health services or durable medical equipment (DME) and supplies for your Medicare patients without following federal guidelines for medical necessity certification, you could be facing charges of Medicare fraud.

Following an investigation of home health agencies and durable medical equipment suppliers, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has issued a Special Fraud Alert warning physicians that they share responsibility and potential liability for appropriate provision of home care, DME, and supplies.

While the incidence of physicians intentionally submitting false certifications of medical necessity is infrequent, laxity in reviewing and completing the certifications contributes to fraud and abuse by suppliers and home health providers, the report says.

"The potential liability discussed in the Fraud Alert has always been there. Publication of this Fraud Alert may signal the start of enforcement activities. It's a public warning to physicians that they are going to be held accountable for the items they prescribe," says **Elizabeth Carder**, JD, of Reed Smith Shaw &McClay, LLP, a Washington, DC, law firm.

She suggests that physicians be prepared in case their patients' files are audited by making

(Continued on page 43)

Physician's Capitation Trends™
• Capitation Data and Trend Analysis •

Use cost survey results to jump-start capitation review

Data show the picture better than Kodak

Walter Cronkite ended each news show with his now oft-quoted phrase: "And that's the way it is." He was reminding his audience that the string of news reports merely reflected reality.

If you are a practice administrator or a physician, you may have to deliver a similar message — and hope your audience doesn't shoot the messenger. If your job involves tracking financial trends in your practice, you may well have to tell your colleagues that the financial picture of capitation and other managed care activities isn't too good.

"I don't think it's any mystery that physician compensation isn't going anywhere fast, and in some areas it's going down — especially if you look at groups with over 50% of risk-based managed care," says **Jeffrey B. Milburn**, senior vice president of Colorado Springs (CO) Health Partners. Milburn speaks not only anecdotally from experience in his practice, but also as chairperson of an extensive annual cost survey of 1,334 group practices across the country. The practices are members of the Englewood, CO-based Medical Group Management Association (MGMA), which sponsors the 240-page cost survey each year.

What's an administrator to do? If you look purely at the numbers across practices, costs and capitation are not mixing too well. In short, looking at median measures, costs are going up, and physician incomes are going down. But before you consider dodging the bullet by keeping your mouth shut, remember that good data is the best start for knowing what you're working with, where you need to go, and how your practice stands in relationship to other practices.

Several key charts of data can help you present your case in numerical terms, even if your audience already has some idea of the overall theme. Milburn occasionally presents portions of the survey to his physicians and staff — even if the news isn't that good.

> "Comparing your performance to similar organizations doesn't necessarily result in improvement. You want to compare your group to superior organizations."

If your practice is struggling with costs and capitation, you're certainly not alone, survey data indicate. A good way to start tackling capitation and cost issues is to compare your practice to organizations that excel, suggests **Doug N. Futz**, MGMA's survey operations data system analyst and co-project manager.

"Comparing your performance to similar organizations doesn't necessarily result in improvement," Futz says. "You want to compare your group to superior organizations." The MGMA survey offers benchmarks for that kind of comparison. For example, the survey offers some useful benchmarks, such as:

Better-performing practices in the 90% percentile report 53.78% capitation revenue. They aren't dodging capitation. If you look at the median of all the better performers across the board, however, their share of capitation drops to a much lower level of 21.03%.

The study also identifies other key markers, such as operating cost compared to total cost. Even as practices become increasingly better performers, their operating costs as a percentage of total costs steadily increase — 52.02% for the overall median, and ranging from about 39% on up to 60% as performance standards improve.

The data also show actual revenues for "better performers" with comparisons of capitation and noncapitation revenue. Again, the median of the better performers showed less reliance on capitation than the top 90th percentile of better performers. The median group reports 22% ($115,256) of total net medical revenue derived from capitation, compared to practices in the 90th percentile, where capitation brings home 49% ($327,085) of total net medical revenues.

> "If the insurer is correctly and adequately using premium dollars, then there is a payoff for dealing with capitation in the long run."

Other information is useful if you want to look at the specific influence of capitation. The report offers some highlights of cost variations based on percent of capitation. For example, it shows that there is no question that as a practice's share of capitation increases, so do its costs. Total operating costs for practices with no capitation rests at 54.54% of total net medical revenue, compared with 56.8% for those with 10% or less; 60.3% for those in the 11%-50% range; and 62.14% for those in the 51%-100% range.

Also of importance is how data for the most current cost report compare to last year's data. **(See *Physician's Managed Care Report,* April 1998, pp. 55-58.)** In virtually every category, costs have increased from the 1997 report to the 1998 report. These indicators can give you an idea of benchmarks for how all practices — categorized by percent of capitation revenue — are managing their costs.

These cost trends are particularly troublesome, Milburn says. As your practice gets deeper into capitation, your costs are likely to go up, and you're likely going to need to invest in staff assistance to tackle them. "If you have 5% to 10% capitation, there's not that much impact," Milburn says. "If you're getting into the 20% to 40% range, you probably will need to either upgrade your own skills as a manager or bring on some additional talent to manage that book of business."

Is it all worth it? The jury is still out, say some experts. If insurers simply cut too much, all the expertise in the world won't make any difference, says Milburn. "If the insurer is correctly and adequately using premium dollars, then there is a payoff for dealing with capitation in the long run," he says. "If not, no matter how good you are, you can't make it. We were very close to dropping our participation in the Medicare senior risk product this year. We were right on the line. The HMO came back and increased the premium to help cover those expenses and made some concessions that helped. Overall, however, I'd say we're into capitation for the long-run."

Part of one's success depends on geography, notes **Laurie Foote**, MBA, medical practice engineering consultant for Healthcare Management in West Springfield, MA. "It's not as sweeping in some parts of the country as in others," Foote says. "It's cost over time that saves you money. It takes a lot of population to do that — and a lot of financial and intellectual capital." Practices not so skilled at it, she says, "have fallen into takeovers." Overall, it takes a step-by-step effort. "There's no silver bullet." ■

Are your PPO contracts capitation in disguise?

Discounted FFS cloaks actual budget limits

Whether you're aware of it or not, most physician groups participating in preferred provider organization (PPO) contracts with insurers are capitated — even though the contracts are presented as discounted fee for service.

That's the view of orthopedist **Thomas P. Schmalzried**, MD, president of California Orthopedic and Sports Medicine Associates in Los Angeles. The difference in how payment works out between a PPO and an HMO is really just a delay or lag time, he argues.

A physician group's PPO contract in a given year will reflect discounted fees on a per fee basis, but in actuality, there is a limit on a PPO budget allowed by the insurer for each PPO plan it offers, just as there is for an HMO plan. If that

PPO budget limit is exceeded by providers in a given budget year, the budget for the next year is reduced to make up for that loss.

Doctors see this reduction in the form of further discounted fees, and that is exactly what physicians have seen in recent years. This subtle form of capitation is simply retrospective rather than prospective, Schmalzried says. It also is a big reason for the heavy administrative costs in managed care.

"Those who are paying for health care are no longer in the 'insurance' business," Schmalzried says. "Insurance implies risk. Today there is no risk because there is a budget for spending. Whether this occurs up front, as with capitation, or retrospectively, as in discount [fee for service] PPO's, they are both a manifestation of budgets! This feature is here to stay, regardless of what it is called."

Discounted fee for service, with its tight but hidden overall budget target, requires tighter budget controls such as utilization analysis, case management, concurrent review, and claims adjudication — all of which require more staff and technical support.

"Physicians are keeping costs down and working hard, yet physician salaries are static."

These administrative costs consume resources that could be better spent on preventive care, or on keeping a lid on patient costs. The better option for everyone, Schmalzried says, is for physicians to take charge of capitated contracts, assume the risks, and be personally accountable for how resources are used.

Schmalzried's assertion that discounted fee-for-service contracts are cutting more and more each year is supported by two recent surveys conducted by the Englewood, CO-based Medical Group Management Association (MGMA).[1] In one survey, the MGMA salary review, most physician and administrative salaries are not growing, according to **Lisa E. Pieper**, MBA, MGMA project manager. "Physicians are keeping costs down and working hard, yet physician salaries are static. This is the squeeze that our members are in."

According to data in the survey, released in late 1998, group practices' fee for service gross collection percentage, which is the percentage of gross charges collected by group practices, continued its downward movement throughout 1997 to 69.2%, marking the first time it has dipped below the 70% mark. In addition, fee for service adjusted collection percentages — the amount of billed charges collected by medical groups — stayed level at 95.5% for multispecialty practices in 1997, continuing an 11-year flat or slightly declining trend.

A third key indicator comes from the cost factor, as reflected in MGMA's 1998 cost survey. Once costs are factored into the equation, actual revenues declined by 5.5%, according to the cost survey of 1,334 medical practices.

Reference

1. Schmalzried TP, Luck JV. Capitated reimbursement for medical services returns control of the patient to the surgeon. *Orthopedics* 1998; 21:620-631. ■

GUEST COLUMN

Checking behind MCOs can mean extra payments

By **Reed Tinsley**, CPA
The Horne CPA Group, Houston

How do practices and health care providers know they are receiving correct reimbursements from their managed care payers? According to an informal poll of practitioners at a recent health care conference, more than 50% of participants indicated that errors have been found regarding what the medical practice was contracted to receive as payment and what the managed care company actually paid for the service.

For example, one practice was contracted to receive $44 for visit code 99213 from ABC Managed Care Company, but the Explanation of Benefit (EOB) statement indicated only $38 was paid. Unfortunately, this type of situation seems to be occurring with increasing frequency. It affects not only physician medical practices but all other health care providers as well, including hospitals, health care facilities, and other health care service providers.

Managed care companies do make mistakes, and it is up to the health care provider to catch the errors and file an appeal for the additional reimbursement. Catching reimbursement errors can be extremely difficult for many providers, especially smaller service providers, including one- and two-physician practices.

Small practices or health care providers often have neither the time nor the personnel to pay attention to this type of activity, as important as it is. However, a good software system usually can catch these reimbursement errors. Unfortunately, most systems in the marketplace today are quite expensive, and many health care providers have not sought to acquire them.

"Managed care companies do make mistakes, and it is up to the health care provider to catch the errors and file an appeal for the additional reimbursement."

It is difficult to ask a provider to make a large capital investment in computer software (and hardware) when most payers are reducing their reimbursements. One reason we are seeing an increase in provider affiliations is that providers together can obtain the capital necessary to upgrade their informational systems.

At a minimum, a health care provider should have a manual system to spot-check managed care reimbursements. The easiest system is one whereby a weekly sample of managed care reimbursements is reviewed by a designated person.

Here is a typical process for a manual system. It works best for smaller providers but can be adapted to larger ones as well:

❑ Obtain reimbursement rates for the top 25 revenue-producing CPT codes (or utilized services) of the medical practice or health care provider. Place them in a spreadsheet for easy access. These should be obtained from the top 10 to 15 managed care plans from which the practice or provider generates revenues. Each week, take a sample of reimbursements from these plans (the provider can decide which ones) and compare the reimbursement per the EOB to the spreadsheet.

❑ If an error is found, file an appeal immediately. If errors continue to be consistent for a particular payer, meet with the payer to discuss why the mistakes are occurring and how they can be corrected.

A manual program of this type can be cumbersome, so each practice or health care provider will have to decide how to implement such a system. A provider could create a computer database in which the contracted reimbursements for a specific managed care payer are preloaded and EOB-approved amounts are entered into the system manually. The database could then make a comparison and detect payment errors.

Effective detection system needed

The main point to be made, and one you must keep in mind, is that managed care payers are making reimbursement mistakes, and health care providers everywhere must have a way to detect these errors to get paid correctly. If left undetected, significant revenues could be lost.

As mentioned, most systems in place today cannot compare managed care reimbursements and detect payment errors. Most cannot even tell a health care provider what a payer reimburses for a particular service. That is because most software systems used by medical practices and health care providers today were built for a fee-for-service environment.

Unfortunately, these software systems have not adapted themselves to a managed care environment. As managed care continues its growth throughout the country, the level of operational sophistication needed increases, and these systems just cannot provide the critical information needed to succeed in this type of environment.

The manual system, whether or not it can be computerized, will be insufficient over the long haul; the burdens often are too great. Therefore, health care providers everywhere should begin evaluating their current informational systems and define what they need both now and in the future as managed care continues to penetrate the marketplace.

Realize this process is an investment in the office, practice, or facility, and not just another piece of overhead. To be successful, health care providers and their managers must understand the long-term benefits of investing (i.e. spending money) in new informational systems.

Reed Tinsley, CPA, is shareholder in charge of Horne CPA Group's Houston office. He can be reached at (713) 975-1000. ■

(Continued from page 38)

sure each patient's chart contains information to support the need for the equipment or services prescribed. For instance, if a physician prescribes a wheelchair for the patient, the chart should note that the patient is not ambulatory.

According to the OIG, physicians may violate the law when:

• they sign a certification as a "courtesy" to a patient, service provider, or equipment supplier when they have not first made a determination of medical necessity;

• they knowingly or recklessly sign a false or misleading certification that causes a false claim to be submitted;

• they receive any financial benefit for signing the certification, including free or reduced rent, patient referrals, supplier, equipment, or free labor.

Physicians may be liable for making false or misleading certifications even if they don't receive any benefit from providers or suppliers, the OIG asserts.

While physicians are not personally liable for erroneous claims "due to mistakes, inadvertence, or simple negligence," they will face criminal, civil and administrative penalties for knowingly signing a false or misleading certification, the report says.

"We are issuing this Fraud Alert because physicians may not appreciate the legal and programmatic significance of certifications they make in connection with the ordering of certain items and services for their Medicare patients," the report says. ■

HCFA posts HMO ratings on its Internet site

Data are from survey of beneficiaries, NCQA

Medicare beneficiaries now have an opportunity to check out quality and satisfaction information about managed care plans before they sign up by examining information posted on the Internet by the Health Care Financing Administration (HCFA).

The Medicare Web site, www.medicare.gov, contains the results of a survey of more than 100,000 Medicare beneficiaries enrolled in managed care plans that participate in Medicare as well as selected performance data from the health plans' Health Plan Employer Data and Information Set (HEDIS) assessments. The *Medicare Compare* database contains information about Medicare managed care plans that serve about 6.5 million Medicare beneficiaries. The information will be updated on a quarterly basis.

The information is being provided to help Medicare beneficiaries make the best choices for themselves and their families, and is part of the Clinton administration's plan to strengthen patients' rights and emphasize quality of care, a HCFA spokesperson says.

In the spring of 1998, HCFA sent detailed surveys to about 136,000 Medicare beneficiaries asking them to assess the quality of their health plans. The survey was developed by HCFA and the Agency for Health Care Policy and Research.

Plan rankings high

In general, beneficiaries ranked their health plans highly. On a scale of 0 to10 with 10 being the best, almost half rated their plans a 10. Another 34% gave their plan an 8 or 9. About 70% of the respondents reported that their physicians always communicate well, and another 23% said their doctors usually communicate well.

The Web site also contains information from the first Medicare HEDIS assessment of health plan quality. HCFA required plans to report 30 HEDIS performance measures and then audited the seven measures deemed most important to Medicare beneficiaries. The National Committee for Quality Assurance developed HEDIS and collected the information from the health plans.

The data showed variability in the quality of care provided by Medicare managed plans:

• Approximately 75% of women between 52 and 69 who were enrolled in a managed care plan had at least one mammogram in 1996 and 1997.

• About 75% of heart attack survivors over the age of 35 received beta blocker prescriptions when they were discharged from the hospital.

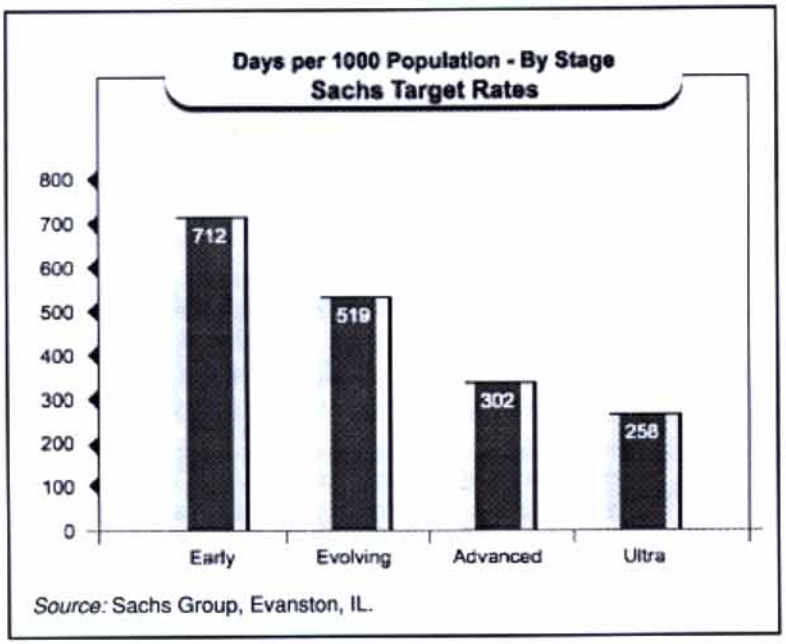
• Half of the beneficiaries with diabetes received an eye exam in 1996.

The Web site includes telephone numbers and Web site addresses for health plans, benefit and service packages offered by each plan, and helpful hints for navigating within the database. The information can be broken down by state or by zip code. ■

Tracking, reducing length of stay is vital for survival

Rates drop dramatically as managed care moves in

As managed care penetration increases, physician practices that reduce inpatient utilization are likely to do well, given managed care's insistence on cutting costs. Now a study has shown that the presence of managed care definitely affects inpatient lengths of stay in a given area.



Source: Sachs Group, Evanston, IL.

Research from the Sachs Group, a research organization in Evanston, IL, shows that markets with high managed care penetration have 58% fewer days in the hospital and 34% fewer discharges than markets with little or no managed care penetration. **(For details of the Sachs Group research, see charts, this page and p. 45.)**

"There is pressure from MCOs to get patients out faster and to avoid admissions altogether," says **Paul Presken**, product manager for research and development at the Sachs Group.

On the positive side, if physicians can document their length of stay for each diagnosis they treat and can prove they have a better length of stay than their colleagues, they often can use that information as justification for getting exclusive arrangements under managed care contracts, points out **Michael Fleischman**, CHC, of Gates Moore, an Atlanta-based health care consulting and accounting firm that specializes in medical practice management issues.

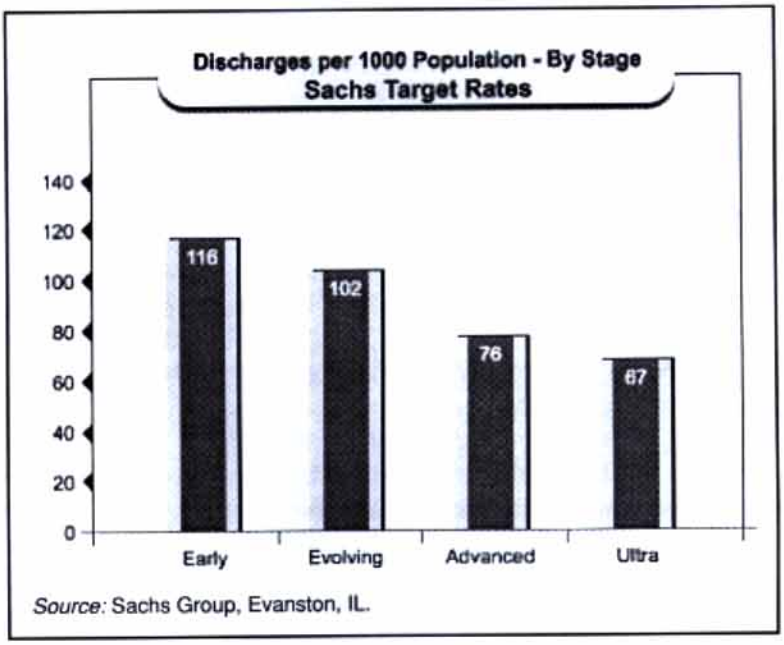
In addition, some managed care companies may offer additional compensation at the end of the year to practices that cut their average length of stay to below the norms for that diagnosis-related group, Fleischman adds. **(For tips on how you can shorten your lengths of stay, see related article on p. 45.)**

Managing cost and length of stay is becoming necessary to get any kind of insurance contract, says **Vance Chunn**, FACHE, executive director of Cardiology Associates in Mobile, AL, where managed care accounts for only about 10% health care reimbursement in the area.

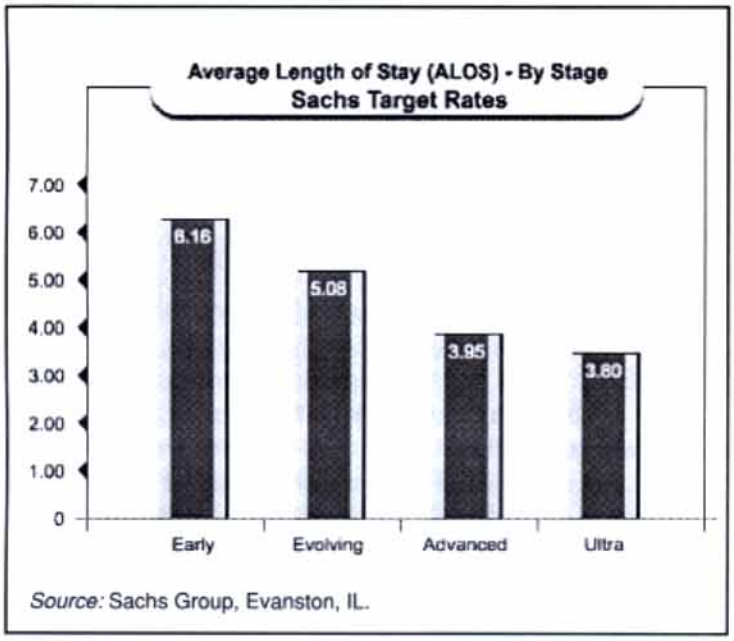
"We are taking steps to make sure we will benefit by making our profiles as attractive as possible. It's a hot topic for us right now," Chunn says.

For instance, Blue Cross, the largest insurer in Alabama, is looking at inclusion and exclusion of physicians in its Preferred Medical Doctor program based on the practice profile, including how well physicians manage cost and length of stay, he says.

"Length of stay is extremely important when you are in a risk contract. Even if you are paid under a per diem contract, if you exceed the average length of stay, it will be costly at some point," says **Barbara Gunder**, MA, practice administrator for the Salem (OR) Clinic, in an area with one of the highest managed care penetrations in the country. She adds that practices should monitor length



Source: Sachs Group, Evanston, IL.



Source: Sachs Group, Evanston, IL.

of stay not only from a monetary standpoint but also from a quality perspective.

"If we are an outlier in an area, it concerns us because we may not be providing the type of interventions we need to," she adds.

Unless your physician practice has a sophisticated relational database to manage its medical records, determining your length of stay for each diagnosis may be a matter of going through the medical records one at a time, Fleischman says.

However, information on national trends is available from national health care statistical tracking firms, published Medicare reports, and some professional organizations whose members participate in national outcomes studies. The hospital where you practice may have information available on average length of stay for its patients.

Cardiology Associates has begun monitoring length of stay using data from local hospitals and insurance companies, Chunn says.

"We can compare ourselves as far as cost and length of stay are concerned to each other in the group as well as to other cardiologists in the area. We can also compare our group to the other major cardiology group in the area," Chunn says.

The Sachs Group has created inpatient benchmarks to help physicians predict the effect of managed care on their market. These statistics can help you prepare for the future as managed care moves into your market.

Sachs statistics are based on 10 million actual discharge records from 1996 state databases in 45 markets in 15 states all over the United States. These records represent about 25% of all discharges in the United States, Presken says. ■

Proactive approaches can reduce length of stay

Protocols, preventive measures often help

There's no doubt about it: Managed care is not going away, and insurers are likely to put more and more pressure on physician practices to cut costly hospitalization days.

Practices with a few years of experience in dealing with managed care have come up with ways of cutting inpatient days without affecting quality of care. Here are some of their strategies:

• **Standardization of care.**

Cardiology Associates in Mobile, AL, is working on setting up practice protocols and guidelines for handing the major diagnoses that make up 80% of its caseload.

"Although each person is an individual, it's possible to standardize a lot of care. If all the doctors are doing the same thing and there is a plan for treating that diagnosis, it has the potential of shortening the length of stay," says **Vance Chunn**, FACHE, executive director.

For instance, if a physician is seeing another physician's patients, he or she loses continuity and efficiency if he or she doesn't know exactly what treatment the patient has been receiving, Chunn says.

"We're not looking at cookbook medicine, but we are putting in place guidelines to maximize patient flow," Chunn says.

The practice's physicians are using practice protocols from the American College of Cardiology and fine-tuning the protocols to meet the needs of their patients.

• **Utilization review measures.**

Many practices hire a nurse who acts as a case manager, reviewing inpatient charts and suggesting alternatives to inpatient care when appropriate.

"The physician may be aware of how patients are doing but may not know all of the alternatives available to them," says **Barbara Gunder**, MA, practice administrator at the Salem (OR) Clinic, where a registered nurse acts as inpatient reviewer.

At the Springer Clinic in Tulsa, OK, a nurse and the physician who heads the patient care committee make rounds on every patient in the hospital to make sure things are moving along and that the patient is discharged as soon as reasonably possible, says **Rick Callis**, administrator of the 75-physician group.

If the physician and nurse feel the admission may not be justified, they visit the attending physician, go over the details of care, and discuss options for shortening the length of stay.

Cardiology Associates is in the process of hiring a utilization management nurse to work with physicians on managed care contracts, particularly capitated ones, to help the practice get a handle on managing cost and length of stay. Job duties include making sure all the data the physicians will need are included in the patient chart, and getting copies of the results of tests and procedures performed by the referring physicians so the tests won't be duplicated.

• **Transferring patients to a less intensive part of the continuum of care, such as a skilled nursing facility (SNF), or discharging them to home with home health.**

The Springer Clinic makes extensive use of SNFs in lieu of hospitalization. For instance, total knee and total hip replacement patients may be transferred to the SNF when they are medically stable but not yet ready to function at home alone.

"We're starting to see more direct admissions to SNFs for patients whose care can be managed effectively in a less intensive setting," Callis says.

In another example, a pneumonia patient could be treated in a SNF at a cost per day that may be 30% of hospital costs because of lower overhead.

• **Taking a proactive approach to keeping patients out of the hospital.**

"The biggest factor that impacts length of stay is keeping patients out of the hospital. We identify diagnoses that are a significant cost factor and try various interventions to help keep those patients healthy," Gunder says.

For instance, hospitalization of chronic obstructive pulmonary disease patients dropped by 40% in a year after Salem Clinic provided patients with an eight-week course in managing their symptoms.

With chronic conditions such as asthma and diabetes, appropriate screening and blood sugar monitoring help patients avoid complications that could result in hospitalization, says **Michael Fleischman**, CHC, of Gates Moore, an Atlanta-based health care consulting and accounting company that specializes in medical practice management issues.

The Springer Clinic conducts a nursing assessment on all Medicare risk patients. If the nurse identifies any chronic condition that needs monitoring or significant health problems that should be addressed, the patient comes in for a physician visit.

• **Use of ambulatory settings instead of hospitalization.**

An increase in outpatient treatment is a major factor in declining inpatient lengths of stay, reports **Paul Presken**, product manager for research and development at the Sachs Group. Laparoscopic removal of gallbladders on an outpatient basis is one example Presken cites. In other instances, physicians are now scheduling cardiac catheterization on an outpatient basis a few days before surgery in some advanced managed care markets.

"Managed care has accelerated the move to ambulatory settings and adoption of newer technology," he adds. ■

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.

COMING IN FUTURE MONTHS

- How a case manager can increase efficiency and improve patient care in your practice
- Why some physicians are returning to school to get their MBA
- How to allay your patients fears about their care when the new year rolls around
- Should you be measuring patient satisfaction and outcomes?

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 in 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?"

Do spot checks

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 (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

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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.
Editor of **Physician s Capitation Trends: Reba Griffith**, MPH.

Editorial Questions

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

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?

What happened when

• **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 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% of your patient visits, you probably have a serious problem that needs to be immediately corrected," says Anwar. ■

New physicians shy away from managed care areas

Study shows HMO penetration affects location

New physicians are more likely to locate in metropolitan areas without heavy HMO penetration, a study by the Santa Monica, CA-based RAND Corporation shows.

A research team headed by **José Escarce**, MD, PhD, tracked 75,000 new physicians who finished their graduate medical education between 1989 and 1994 and who located in a metropolitan area with more than 500,000 in population.

During the first years of the study, primary care physicians tended to locate in areas with a high managed care penetration, while new specialists did not seem to be affected by the presence of HMOs. By the end of the study, the amount of HMO penetration in an area had a negative effect on practice location for all new physicians, the study says.

The HMO influence

The researchers concluded that primary care physicians are in high demand throughout the country and are choosing to avoid areas where they will be subjected to the pressures HMOs place on primary care physicians. Specialists find low demand for their services within a strong managed care market and are choosing other areas out of necessity, the study suggests.

"If our findings regarding HMO penetration are generalizable to other community sizes, continued HMO growth in large metropolitan areas may result in new physicians locating in smaller cities or non-metropolitan areas," the study says.

The RAND study is the first national study to examine the effect of HMOs on young physicians' practice opportunities, says **Jess Cook,** spokesman for RAND. The study was published in the November issue of the journal *Medical Care.* ■