AMERICAN HEALTH CONSULTANTS®

PHYSICIAN'S PAYMENT UPDATE™

INSIDE

APRIL 1999

VOL. 11, NO. 4 (pages 49-64)

American Health Consultants® is A Medical Economics Company

Physicians shed the kid gloves, come out swinging against HCFA

AMA pushes complaints to the forefront

Dropping the public niceties like a prizefighter shedding his robe, the American Medical Association has aimed a punch squarely at the jaw of the Health Care Financing Administration.

In written comments to the House Ways & Means health subcommittee, the AMA told Congress HCFA is so mismanaged and overloaded with work that it is the verge of a crisis — if not a total administrative meltdown. The problems already are "beginning to spill over into the actual delivery of health care to our nation's Medicare patients," the AMA said.

An "ill-advised" reorganization and a heavy workload caused by requirements of the Balanced Budget Act of 1997 have overwhelmed the agency, the AMA said. It called on Congress to intervene immediately and correct the "management problems" at the agency.

"We believe that HCFA's problems will only get worse as the number of Medicare patients, claims, and health care delivery systems increase. To say that HCFA's current problems could lead to a crisis is an understatement," the AMA wrote.

Drawing a connection between HCFA and the IRS, the AMA also wants Congress to take the agency to task for what it feels have been overbearing and intimidating tactics and attitudes towards providers.

"Just as the IRS is struggling to reinvent itself into a 'customer' friendly agency, HCFA must, with a push from Congress and the Administration, reassess its role and relationships with medical professionals who care for Medicare patients," the AMA said.

The AMA wants Congress to investigate these specific areas of HCFA's operations:

- the regulatory requirements HCFA places on physicians, hospitals, and other health care providers;
- the rule-making process;
- an alleged failure to distinguish inadvertent billing errors from intentional acts to defraud the government;
- ongoing implementation of the Medicare+Choice program;
- oversight of Medicare carriers and other contractors.

AMA has a laundry list of complaints about HCFA

Gripes range from policies to practices

The American Medical Association's scathing public criticism of the Health Care Financing Administration marked a calculated decision to go public with what has been an increasingly hostile and combative behind-the-scenes relationship between provider groups and the agency.

This tension is intensified by the massive volume of work assigned to HCFA by Congress over the past several years, the political pressure for the agency to get tough on fraud and abuse while finding a way to save Medicare from bankruptcy, and the general financial pressures and frustration all providers are feeling from having to deal with the changes brought on by managed care.

Feeling that relations with the agency are currently at an impasse, providers now are lobbying Congress to pressure the agency to tone down its attitude and make changes in some of its program decisions. **(For a list of complaints, see related story, p. 51.)**

HCFA, on the other hand, says it is simply giving some strong medicine to an independent provider-based system that still generates $20 billion a year in improper Medicare claims, while implementing a massive array of new programs designed to keep a sinking Medicare program afloat into the 21st century.

The AMA says the Sustainable Growth Rate (SGR) system is a good example of how is HCFA is mismanaging the Medicare fee-for-service program. The SGR is a target rate of spending growth. Cumulative actual spending is compared to cumulative target spending, and payment updates are determined by whether actual spending exceeds or falls short of the target amount. The target is based on annual changes in inflation, Medicare fee-for-service enrollment, real per capita gross domestic product (GDP), and spending due to law and regulation.

HCFA established a fiscal year 1999 SGR of -0.3%, which became effective Oct. 1, 1998. This negative growth target means that unless total physician fee-for-service spending is less in 1999 than it was in 1998, next year's physician payment update could bring a payment cut. A key HCFA assumption underlying the negative SGR is that the number of beneficiaries enrolling in Medicare+Choice plans will grow by 29% in fiscal 1999. "With the recent HMO withdrawals from Medicare, this assumption seems seriously overstated and obviously erroneous," the AMA says.

"In fact, the rate of increase in managed care enrollment has been declining since July, and the most recent monthly data show an actual decline in managed care enrollment," the AMA continues.

HCFA already has made one significant error in setting the first SGR for 1998. In October 1997, HCFA projected 1998 GDP growth of 1.1%, but 1998 GDP growth is now estimated to have been at least 2.8%. When combined with other, smaller projection errors in the 1998 SGR, HCFA made a net underestimate in the 1998 SGR of 1.5%. With Medicare spending on physician services currently at about $43 billion annually, the projection errors led HCFA to set the payment update for 1999 about $645 million lower than it should have been.

Because the SGR system is cumulative, the projection errors will be compounded with each year's payment update calculation if left uncorrected. If the cumulative SGR becomes merely an accumulation of erroneous HCFA estimates, this would defeat the whole purpose of the spending target system. The level of underfunding of Medicare physician services due to these errors could grow to the $1-2 billion range as early as next year, the AMA estimates. **(For another federal agency's views of the SGR system, see story, p. 59.)** ■

The General Accounting Office (GAO) also has criticized HCFA's operations. However, it placed most of the onus on the Y2K computer bug.

"Year 2000 computer compliance efforts have put a tremendous burden on HCFA that has affected the timing and quality of its work on many other projects," **William Scanlon**, director of health, education and human services studies at the GAO told a March 2 House Ways & Means health subcommittee hearing.

(Continued on page 52)

The AMA's complaints against HCFA

Here are some of the specific complaints the American Medical Association made against the Health Care Financing Administration in recent written comments to Congress

• **Program integrity.** The AMA is concerned about what it calls HCFA's "overly zealous implementation of its policies in addressing waste, fraud, and abuse." The AMA says HCFA continually fails to distinguish between knowing and willful fraud and legitimate differences of opinion regarding proper coding.

HCFA's sole response to a broad range of complex problems has been to address each one in an aggressive and punitive manner, the AMA says. In response to the current environment, carriers are forced to pursue aggressive tactics. In this "gotcha" atmosphere, both patients and physicians suffer, says the AMA.

In response, providers are asking HCFA to increase its education efforts and urge carriers to work with physicians to correct problems rather than nail physicians for honest mistakes.

• **Post-payment audits.** "These audit procedures lack fundamental fairness," the AMA said in its comments, presented to the health subcommittee of the House Ways and Means Committee. To avoid a total disruption of their practice, as well as expensive legal bills, physicians frequently are forced into civil settlements without the ability to appeal, the AMA says. In many cases, auditors extrapolate hefty fines from a small sample of claims, critics claim.

"We recommend that the Administration temper its rhetoric and refine its program initiatives so that those physicians honestly participating in the Medicare program are not subjected to the federal government's overly aggressive and punitive approach," the AMA told Congress.

• **Annual carrier performance reviews.** In determining whether the Secretary of Health and Human Services will contract with a carrier to administer the Medicare program, the Secretary should consider physician input in evaluating whether to contract with that carrier.

• **"Black box" edits.** The AMA says providers should have substantive input before HCFA implements the use of any commercial "black box" software for code editing / bundling. These "black box" methods do not draw on physicians' expertise and practical knowledge of the services billed. Their use distorts the billing process, discourages correct coding, creates inefficiencies, and often results in physicians being paid less than the physicians' cost of providing the service.

• **Carrier extrapolation techniques.** The practice of determining Medicare's estimated overpayment to a physician based on a statistical sampling of a small number of disallowable claims is inequitable. Provider groups are demanding that carriers identify a problem and provide the physician with an opportunity for a telephone discussion or a face-to-face meeting, in which the carrier must adequately explain how to correct the billing problem in the future. If a physician's future billing activities are found in error, HCFA should only recoup overcharges based on actual errors found.

• **Carrier assistance.** Medicare carriers should be required to give physicians, upon request and without charge, carrier-generated information needed to submit claims. This information includes the identifier number or other code of a referring physician, a list of maximum allowable charges, and coding protocols needed by physicians to submit a claim for payment or to respond to a carrier inquiry.

• **Fining carriers for violating regulations.** Carriers that violate Medicare policy should compensate aggrieved individuals. Any physician who is aggrieved by the failure of a carrier to carry out Medicare policy, and who can prove that he or she suffered damages of at least $500 as a result of the failure, should be permitted a hearing on compensating that physician.

• **Compliance manual.** HCFA should develop and provide a Medicare compliance manual to all participating physicians without charge.

• **Electronic claims.** Medicare should fund toll-free lines used for the submission of electronic claims to the program. Payment for use of a telephone line to submit electronic claims to Medicare is a de facto user fee. Medicare formerly provided this service at no charge.

• **Claim review parameters.** Carrier medical review screens or associated parameters should be released beforehand for providers to review before claims can be denied. ■

According to Scanlon, HCFA "has delayed needed systems modernization and computer changes that implement new payment systems intended to slow program cost growth. It has also slowed efforts to improve the oversight of ongoing operations, such as financial management and Medicare fee-for-service claims administration, which desperately need attention."

While noting that HCFA's attempt to manage the many new responsibilities given it in recent years has been "impressive," Scanlon said "measured against the magnitude of challenges it faces, HCFA's progress seems modest."

"Y2K presented an immediate problem with an inflexible endpoint, which has forced HCFA to shelve efforts to consolidate its Medicare claims processing systems and modernize other systems."

The GAO official also said HCFA's efforts to address Y2K problems are counterproductive because many of its computer systems will need to be replaced soon after the year 2000. "Y2K presented an immediate problem with an inflexible endpoint, which has forced HCFA to shelve efforts to consolidate its Medicare claims processing systems and modernize other systems," Scanlon says.

HCFA also suffers from a lack of "tactical" planning that could allow it to identify desired outcomes and assign deadlines and responsibilities for completing specific tasks. Instead, the agency often operates in "crisis mode," with staffers constantly being pulled from one hot project to another, according to the GAO.

Subcommittee member Rep. **Pete Stark** (D-CA) agreed with the GAO's assessment, saying recent reorganizations at HCFA have "demoralized the staff and largely failed to improve its operations."

Stark partly blames this on an administrative and staffing budget too anemic to support the duties HCFA has been assigned. "No business — no insurance company and no managed care plan — would even consider trying to operate with an administrative overhead of less than 2%," says Stark. "And no business would be required to operate under the management constraints that have been placed on HCFA" by Congress. ■

Steps you can take to get paid more quickly

Tips for faster, more accurate payments

It is not uncommon for as much as 25% to 30% of physician office insurance claims to be delayed, rejected, or simply vanish in the black hole of an insurer's payment office.

"Insurance companies are shafting us big time," says **Gary Gotthelf**, MD, a Pensacola, FL, internist. "It's a major problem." Then there are those patients who fail to pay their fee-for-service bills.

"While physicians on average eventually receive about 98% of what they bill in payment, it often takes a while for the money to arrive," says **David N. Gans**, director of survey operations at the Englewood, CO-based Medical Group Management Association (MGMA).

However, a few relatively minor changes in your billing and collection procedures can produce big results in how fast — and how much — you get paid. Here are some payment enhancement tips from the MGMA and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM):

• **Know and follow the procedures.**

It all starts with the basics. For instance, each payer has a different set of requirements for filing a claim. If you properly follow the set procedures, the claim gets paid. But if you overlook some seemingly minor items, the claim will be kicked back to you. Last October, for example, Medicare began requiring providers to note the full year — 1999 — instead of simply "99" in the claim date field.

One way to ensure your billing procedures are up-to-date is to keep separate notebooks of the latest guidelines from each payer that can be easily referenced and followed. Some experts recommend regular pop quizzes on recent procedural changes to ensure everyone is literally on the same page.

• **Develop specialists.**

Because it is impossible for one person to know all the rules, consider dividing claims among billing clerks by payer, says **Elizabeth Woodcock**, a Charlottesville, VA-based MGMA consultant.

For example, one clerk could be devoted full-time to Medicare, another to Medicaid and workers' compensation, and a third to the Blues and commercial insurers. By concentrating on just one

payer or payer type, a billing person can better understand that payer's rules and know how to work the system when problems occur. And by developing a relationship with the payer, billing clerks often can get to the right people more quickly and in some cases circumvent bureaucratic rules, such as restrictions on the number of claims that can be discussed per call, advises ACP-ASIM.

• **Update patient information regularly.**

Filling out the right fields in a claim is only half the battle. An invalid policy number or the wrong identification number may be enough to get the claim kicked back. Thus, insurance and employment information should be verified for each patient every time the patient comes in for a visit, with any changes immediately keyed into the system.

• **File early, file often.**

The faster you file a claim, the faster you get paid. Some experts advise setting a filing target of within three to four days after service has been rendered.

Get checks in the mail daily

Others prefer to file more frequently. Frederick (MD) Internal Medicine, a four-physician practice, files its claims daily. "If I wait until the end of the week, I'm looking at 200 claims," explains **Robin Laumann**, the practice's office manager. "If I file daily, there's not as much paperwork. Instead of getting a check once a week from an insurer, I get checks daily. Our accounts receivable stays low."

• **File claims electronically.**

If you're not already doing it, start filing as many claims as possible electronically. Moving to an electronic format can cut processing time from four to six weeks down to as little as two weeks. Some firms promoting electronic payment systems advertise the possibility of claims being paid before the patient leaves the office.

Even rejections are faster, generally letting you know within 24 to 48 hours if a claim has been turned down. This, in turn, permits you to correct the problem within days instead of having to wait for weeks to find out the paper claim was not considered kosher.

• **Make sure the EOB is A-OK.**

To increase cash flow, **Brian Kane**, CPA, president of HealthCare Advisors in Annandale, VA, suggests creating a tracking matrix with the main insurance companies you deal with across the top and the top 10 to 15 CPT codes on the left side. Fill in what insurers are required by their contracts to pay for these procedures; that way, billing personnel can check them against the EOBs.

You may be surprised to find many carriers are not fully honoring your previously negotiated fee schedule, notes Kane.

"Read your EOBs and make sure they're paying you correctly," advises **Sharon Pizzato**, office manager for a Pensacola, FL, internal medicine practice. "Go back and fight for that five or 10 dollars they're shorting you."

• **Track claim denials by payer.**

"See if you can spot a pattern," suggests **David L. Warren**, a CPA with Larson, Allen-Cherry Bekaert LLP in Richmond, VA. "A lot of times it could be the same mistake over and over again. If you don't investigate, you'll never know why you've been denied."

• **Collect patient payments up front.**

Insurance reimbursements are only part of the accounts receivable equation. Experts suggest that practices collect all copayments before the patient leaves the office. To avoid surprises, educate new patients about your policies as soon as they make an appointment.

• **Go beyond the copayment.**

Some practices collect the deductible and the 20% required by some fee-for-service plans. You can ask patients whether they have met their deductible; many know. To collect the 20%, create a grid of your top 10 CPT codes and the 10 most popular insurers so you know how much a patient will owe for a given procedure, suggests **Jeffrey E. Davis**, CPA, director of the Health Care Services Group of Glass, Jacobson & Associates in Owings Mills, MD. Keep the grid in sight at the front desk.

Pizzato's office uses a "cheat sheet" that outlines the deductible and copayments required by various insurance companies. In addition, the numbers come up on the office computer system, alerting employees that a particular insurer, for example, requires a $10 copay on office visits and obliges the patient to pay 5% of the allowable charge for blood work.

• **Multiple payment options.**

Providing a variety of options — including credit cards — helps ensure payment. Some doctors don't like credit cards because they charge a fee. "But for that 50 cents, you get the money up front," says Davis.

For those patients who regularly forget their wallet, give them a prestamped envelope to mail their payment in. ■

Wrong message delivered in bargaining effort

Misuse of 'messenger model' can bring trouble

Fed up with managed care's typical "take it or leave it" attitude regarding contract terms, 29 general and vascular surgeons in Tampa, FL, formed the Federation of Certified Surgeons and Specialists in August 1997.

The Federation's goal was to give the physicians more bargaining leverage when negotiating with health plans. At first the idea worked well. The group even got United HealthCare Plans of Florida to sweeten proposed fees on one contract by 30% over its original proposal.

But the group effort began to fall apart in January when the federal government charged the federation with violating antitrust regulations. Specifically, the U.S. Department of Justice alleged that the federation was involved in illegal collective bargaining and improper use of the "messenger model" method of setting fees and contract terms.

The problem: Collective bargaining by competing physicians who do not share some kind of risk sharing or common clinical integration is illegal, even when a third-party messenger is used. Plus, a messenger can only relay objective information about proposed terms and offers between the two parties, without making recommendations or influencing price and contract terms.

Messengers also are not allowed to actively bargain with payers on behalf of competing physicians and practice groups, and cannot strategize with providers about how to improve their negotiating positions. In the federation's case, for instance, its third-party messenger allegedly told local payers that if they did not improve their contract terms, the federation's affiliated surgeons were prepared to resign en masse from their plans.

"All we did was stop the bleeding," says **Joseph F. Diaco**, MD, one of the federation's original organizing members. "We didn't raise our prices; we said we are not going any lower." Despite the fact they feel they are not guilty of the charges, federation members decided to avoid possible lengthy litigation by signing a consent decree that bars them from further collective negotiations.

"We don't agree with the government's allegations, but their position was either spend a lot of time and money on an investigation or accept this. The doctors felt they couldn't afford it, so they accepted it," says **David Ettinger**, JD, a Detroit antitrust attorney who represented the group.

In the settlement, the group and its consultants, Pershing Yoakley and Associates, P.C., in Knoxville, TN, admit no wrongdoing. But they agree not to share competitively sensitive information, including contract terms that affect fees, duration of individual commitments to health plans, notice of termination, utilization review, and resolution of fee disputes.

Despite the settlement, many of the doctors involved in the federation still feel their collective-bargaining efforts were not improper.

"Everything [the antitrust enforcement agencies] do is by the book and for the insurance companies. They don't care about individual doctors and they don't care about patient care," says Diaco.

The cans and can'ts of messengers

As a general rule, federal antitrust rules prohibit competing physicians who are not already formally financially integrated from agreeing on what fees they will charge payers or otherwise acting in concert to affect reimbursement payer rates, notes **Daniel B. Vukmer**, an attorney with the Pittsburgh law firm of Houston Harbaugh.

The classic violation occurs when two or more physicians or practice groups meet to determine what fees they will charge. The law also prohibits two or more non-integrated competing practices from using a third party to negotiate payer contracts on their collective behalf.

However, under the messenger model, a third-party negotiator can be used by competing groups, provided the negotiator does not share financial information among the groups.

Under a messenger model, a third party collects price and other proposed contract terms from individual providers in a network. The third party then conveys this information to potential payers, who relay their counteroffers back to the providers through the messenger. Each provider member then makes an individual decision to accept or reject the proposed contract terms.

As long as members do not coordinate their actions in any way, antitrust problems should not arise, says Vukmer.

Messenger arrangements may take a number of forms. The most simple one is where the messenger, who may be an employee of the network

(Continued on page 59)

(Continued from page 54)

or an independent third party, merely receives offers from payers and communicates these to each network provider individually.

Messengers also are permitted to accept contract offers on behalf of a provider and explain the contents of the proposal to the physician.

A messenger also may obtain a schedule of fees from each provider and a fee schedule from the payer and compare the two. The messenger then may make a recommendation regarding whether each provider should accept or reject the contract offer based on guidelines each individual provider gives the messenger. For instance, a provider may say it is only interested in contracts in which at least 80% of the payer's CPT code fees are equal to or greater than its current corresponding fee schedule.

"Regardless of which model is used, the messenger is prohibited from providing an opinion on the terms of the offer, nor may the messenger make an independent determination regarding whether a contract offer should be presented for consideration," says Vukmer.

Also, if the messenger coordinates providers' responses, disseminates to network members the views or intentions of other providers, or expresses a personal opinion on the terms offered, government antitrust lawyers could see this as a per se illegal price-fixing agreement.

For instance, in the Federation of Certified Surgeons and Specialists settlement agreement, the Department of Justice said the messenger is allowed to:

• communicate accurate and objective information about a proposed contract, including comparisons with terms offered to that doctor by other payers;

• engage in activities to facilitate lawful activities by physician network joint ventures and multiprovider networks, as those terms are defined by the federal antitrust enforcers.

However, a messenger is precluded from:

• facilitating any agreement between competing physicians;

• encouraging any agreement among competing physicians to deal with any payer only through a messenger;

• negotiating, collectively or individually, with payers on behalf of competing physicians;

• making any recommendation about actual or proposed contract terms, including whether to accept or reject the terms. ■

MedPAC changes could aid practice bottom line

Medicare's growth rate formula could change

A powerful commission that advises Congress on physician payment matters has advocated a change that would benefit practices.

Reacting to complaints that the current method of adjusting Medicare's physician fee schedule for inflation could short-change providers by as much as $645 million this year alone, the Medicare Payment Advisory Commission (MedPAC) wants to change how annual fee updates are calculated.

MedPAC recommends several modifications to the sustainable growth rate (SGR) system. These include "revising the SGR to account for changes in the composition of Medicare fee-for-service enrollment, cost increases that reflect desirable improvements in medical capabilities and technology, and inaccuracies in the forecasts used in estimating the SGR each year," MedPAC Chairman **Gail Wilensky** said at a March 2 hearing before the House Ways & Means health subcommittee.

Ambulatory care payment concerns

MedPAC also is seeking technical changes that would make SGR changes more consistent to avoid large swings in yearly estimated payments while making updates for each upcoming year available earlier so providers will have more time to review them before they take effect. For instance, MedPAC wants HCFA to publish estimated conversion factor updates by March 31 of each year before they are implemented, rather than in the fall as it currently does for implementation on Jan. 1.

"I'm very encouraged and pleased the commission is correcting the problems with the sustainable growth rates," says **D. Ted Lewers**, MD, an American Medical Association trustee who also serves as a MedPAC commissioner.

The SGR is based on medical inflation, changes in Medicare fee-for-service enrollment, growth in the gross domestic product, and changes in spending due to revised laws and regulations. Authorized by the Balanced Budget Act of 1997, the new system took effect in 1998, replacing Medicare's volume performance standard.

Specific changes would include:

• **Allowing for more growth.** These proposed changes reflect the position among advocates

Date format changed for electronic claims

If you file Medicare claims electronically, circle April 5 on your calendar. As of that date, all electronic claims that fail to meet Medicare's new Y2K specifications will be kicked back as noncompliant.

The main thing to remember: All claims need an eight-digit date. For instance, May 1, 1999 would be 05/01/1999.

According to Medicare, some 95% of related electronic claims are Y2K-compliant. The main problem areas are rural providers and individual physician groups. ■

that some extra allowance should be added to the gross domestic product (GDP) part of the formula when estimating the projected growth rate for physician expenditures. The general feeling is that the GDP alone was too tight of a benchmark to permit Medicare payments to track ongoing improvements in medical treatment and advances in technology, Wilensky told the committee.

• **GDP change.** Noting MedPAC felt the SGR formula "ought to be GDP plus something," Wilensky wants HCFA to add at least one — possibly two — percentage points to the GDP formula.

• **Revised updates.** To avoid payment shortfalls, MedPAC also wants HCFA to revise the estimates it uses to calculate future SGRs when better data become available. For example, if fee-for-service enrollment actually declines by only 3.3% during fiscal year 1999, rather than the 4.3% decline HCFA has projected, the fiscal year 1999 growth rate would be revised upward.

• **Health status.** MedPAC urged Congress to require that changes, including health status in the Medicare population, be used in calculating the growth rate. The panel found that fee-for-service beneficiaries in 1997 were somewhat older and sicker than in 1993, and physician payments per beneficiary increased slightly when these data were taken into consideration.

• **Time period.** A mismatch between the dates used for the SGR target year and the actual time period measured for comparison also should be addressed, the panel said. It recommended that all data used in calculating the sustainable growth rate and the update adjustment factor be based on a calendar year to avoid "extreme oscillation in conversion factor updates."

Despite favorable changes made to the SGR, the AMA expressed concern over a MedPAC recommendation that all payments for ambulatory care — including physicians' payments — be moved under a combined volume control and update mechanism.

The lack of a single system for all settings creates an incentive for "site shopping" by physicians for the highest reimbursement rate, Wilensky told Congress.

The AMA urged the panel to take a closer look at the impact a single control mechanism would have on physicians, hospitals, and patients. The AMA said it doubted the accuracy of MedPAC's assumption that changes in costs and technology would occur at the same rate across all ambulatory care sites.

Site-of-service differences

MedPAC also made recommendations about HCFA's refinements in new practice expense values being phased in over a four-year period starting this year. As part of the new methodology, HCFA has expanded the number of services where separate practice expense values are calculated depending on whether the service is performed in the physician's office or another facility.

Several medical specialties have argued against the creation of separate and higher office practice expense values — even for services that are rarely done in the office — because they might create an incentive to move services into the office even when they cannot be safely performed there.

With respect to practice expense payments, MedPAC agreed that for some services it is appropriate to pay a lower practice expense amount when physicians perform the service in facility-based settings outside the office.

Wilensky, however, recommended using a service-by-service approach to decide which services are subject to this site-of-service differential, rather than applying the same decision to entire groups of services.

"Payments for services generally recognized as inappropriate to perform in a physician's office should also be reduced by the site-of-service differential," she said. ■

Change in Medicare billing rules starts in April

Itemized bills required on request

Starting April 1, Medicare providers must issue itemized statements to Medicare beneficiaries who request them. The new rule, mandated by the Balanced Budget Act of 1997, is another part of the federal government's campaign to actively involve Medicare seniors in fraud and abuse investigations by making it easier for them to identify incorrect or improper payments for services.

For Medicare Part A institutional providers in Alaska, Maine, New Hampshire, New Jersey, North Carolina, Vermont, and Washington state — and those served by fiscal intermediary Mutual of Omaha in any state — the new policy will take effect July 1, 1999.

Advisory statement to be printed on EOB

Pat Smith, a government affairs representative in the Medical Group Management Association's Washington, DC, office, cites these key provisions of the new rules:

• Medicare carriers and intermediaries on the Fiscal Intermediary Standard System will print a statement on the Explanation of Medicare Benefits and Medicare Summary Notices advising beneficiaries of their right to request an itemized statement from their providers.

• Providers and suppliers are required to furnish itemized statements within 30 days when requested in writing by Medicare beneficiaries.

• Providers may not charge beneficiaries for itemized statements.

• Itemized statements must include the beneficiary's name, the date of service, a description of the item or service furnished, the number of services provided, the provider / supplier charges, an internal reference or tracking number, and the name and telephone number of a person to contact for more information.

Medicare contractors have been directed to inform all providers and suppliers of this new requirement. The Health Care Financing Administration has notified Medicare contractors of the changes and asked them to reprint the information in their provider / supplier bulletins, plus post a notice on their electronic bulletin boards or Web sites as soon as possible. ■

HCFA issues changes to Medicare+Choice program

Rules now apply just to physicians

The Health Care Financing Administration (HCFA) has issued a final rule announcing limited changes to the Medicare+Choice regulations. The following changes were effective as of March 19, 1999:

• The provider participation rules now apply only to physicians. The Health Care Financing Administration (HCFA) originally had applied the Medicare+Choice regulatory requirements to health care professionals other than physicians.

• Plans must have provider appeals processes only for cases involving termination or suspension. This, however, does not include initial denials of applications for participation.

Solutions offered for Y2K problems

With the year 2000 fast approaching, physicians, hospitals, and other health care providers are scrambling to complete a process that in many cases was started too late.

To help health care providers deal with the Y2K problem, American Health Consultants has published the *Hospital Manager's Y2K Crisis Manual*, a compilation of resources for non-technical hospital managers. This 150-page reference manual provides answers to questions such as:

• Will your computers and software work in 2000?

• What does Y2K mean for patient care?

• What will happen to your medical devices?

• How can you make sure your vendors are Y2K-compliant?

• Are you at legal risk due to Y2K?

• Are you prepared if Y2K delays HCFA payments?

The *Hospital Manager's Y2K Crisis Manual* is available for $149. For more information, contact American Health Consultants customer service at 1-800-688-2421 or www.ahcpub.com. ■

• Plans must make their best effort to conduct an initial assessment of an enrollee's health status. Previously, HCFA had required an initial assessment of an enrollee's health status within 90 days.

• Plans are only required to offer enrollees an opportunity to use a source of primary care, and then provide that primary care source to enrollees who desire it. The original HCFA rule required health plans to provide each enrollee with a source of primary care.

• Plans now are required to develop policies that define under what circumstances and when care must be coordinated. This coordination of patient care is no longer limited to one provider.

• Plans are only required to notify providers in writing concerning the following terms of a policy: payment; credentialing; and, other rules directly related to participation decisions.

In addition to the HCFA action, the Medicare Payment Advisory Commission (MedPAC) has delivered several recommendations to Congress for the program.

• MedPAC endorsed a new risk adjuster that boosts payments to Medicare+Choice HMOs that enroll sicker beneficiaries. The panel said it was too soon to tell if recent departures of health plans from the Medicare+Choice program called for changes in payment rates. MedPAC said it remained hopeful that the program would provide beneficiaries with a variety of plan choices.

• MedPAC recommended that Congress move back the deadline to later in the year for health plans to submit proposals under Medicare+Choice. Plans now face a May 1 deadline for projecting payments and costs for six months in the future. That date "has appeared to create hardships for Medicare+Choice organizations," the panel concluded.

• MedPAC also recommended that Congress require independent assessments of need for beneficiaries who receive 60 or more home health visits and that a copayment, with an annual cap, be charged for each home visit. ■

Supreme Court affirms payment appeal limits

60-day limit on appeals stands

Medicare providers cannot challenge a refusal to reopen a decision to deny payment after the initial 60-day appeals period, according to a Feb. 24 decision by the U.S. Supreme Court.

Medicare providers' annual reimbursement is based on cost reports they submit to an intermediary, usually an insurance company, designated by the government to determine the appropriate reimbursement.

By law, Medicare providers have 180 days to appeal decisions to deny reimbursement claims to the Provider Reimbursement Review Board. The board's decision can then be appealed to a federal court within 60 days.

Health care providers also have three years to ask an intermediary to reopen a previous funding decision. But if the intermediary refuses, federal rules say that decision cannot be appealed.

In 1994, Your Home Visiting Nurse Services in Knoxville, TN, asked its designated Medicare intermediary to reopen a 1989 funding decision based on the allegation it was paid less than owners of a competing nursing home for the same services.

Blue Cross and Blue Shield of South Carolina, the designated intermediary, refused to reopen Your Home's 1989 case, and the Provider Reimbursement Review Board said it lacked the authority to hear the nursing service's appeal.

Your Home sued, asking a federal judge in Knoxville to either order Blue Cross to reopen the case or require the review board to hear its appeal. The judge ruled against Your Home, and the 6th U.S. Circuit Court of Appeals upheld that ruling. The Supreme Court, in turn, backed the lower courts' decisions. ■

COMING IN FUTURE MONTHS

- Coverage of fee-for-service alternatives to capitation
- Developments in a lawsuit to halt implementation of Medicare s practice expense formula
- What different levels of claim audits mean to you
- How to verify your medical devices are Y2K compliant
- An update on evaluation and management changes

Fraud probe caseload getting to be a burden

FBI investigating 2,800 cases

The Federal Bureau of Investigation is currently investigating approximately 2,800 cases of health care fraud nationwide, a top official reported recently.

Joseph Ways, chief of the FBI's healthcare fraud unit, told the Second Annual National Congress on Health Care Compliance in Washington, DC, on Feb. 12 that 420 of the FBI's 11,000 agents have been assigned to investigate health care fraud cases. Each of these agents is currently working an average of just under seven cases.

"That's a pretty heavy caseload for a paper-intensive, white-collar case," Ways said. The caseload "is one of the reasons [the FBI] is very strongly pushing for joint investigations where we can bring in the other agencies and outside entities to help us in continuing a good pace on these investigations."

Ways said the number of health fraud convictions has increased steadily since 1992, the year the FBI "really started to get involved in these cases."

Because the investigations usually take three or four years to reach trial, the number of convictions rose sharply in 1996 and 1997. The number dropped slightly in 1998, when many of the agents assigned to health fraud were "tied up in trial" and thus unable to pursue any other investigations, says Ways. "But I think in FY 1999 we're looking at . . . an upward spiral of convictions."

Meanwhile, Medicare audits show a dramatic decline in overpayments.

The FBI could see its future caseload drop, based on the results of a Feb. 9 Office of the Inspector General (OIG) report showing that improper Medicare payments to hospitals, doctors, and other health care providers declined dramatically last year to the lowest error rate since the government began performing such comprehensive audits three years ago.

The OIG estimates Medicare's payment error rate for fiscal year 1998 was 7.1%, representing $12.6 billion in improper payments. This compares with an error rate of 11% in FY 1997, representing an estimated $20.3 billion in overpayments, and 14% in FY 1996, accounting for an estimated $23.2 billion in improper payments. These improper payments ranged from inadvertent mistakes to outright fraud and abuse. However, the OIG could not identify how much of the error rate is attributable to actual fraud.

In contrast, a General Accounting Office study released just before the OIG's report credited the decline in improper Medicare billing by physicians and others to better documentation supplied by providers to auditors, rather than a reductions in improper payments.

The major problem areas with improper Medicare claims as identified by the GAO were:

- billing for services that were not medically necessary;
- upcoding services to secure a higher-than-justified reimbursement rate;
- poor and incorrect documentation;

Physician s Payment Update (ISSN# 1050-8791), including **Physician s Coding Strategist** , is published monthly by American Health Consultants® , 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Physician s Payment Update** , P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $319 per year; 10 or more additional copies, $239 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

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

Editorial Questions

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

• billing for services not covered by Medicare.

Hospitals, physicians, and home health agencies accounted for more than 77% of the improper payments. Of this, hospitals were responsible for 39% of erroneous claims, physicians accounted for 26%, and home health's share was almost 13%. The rest of the improper payments, in order of magnitude, were attributed to nursing facilities, non-prospective payment system hospitals, laboratories, end stage renal disease centers, ambulance companies, ambulatory surgical centers, durable medical equipment suppliers, and hospices.

In FY 1998, Medicare served some 39 million beneficiaries paying $210 billion in benefit claims, including about $33 billion in managed care expenditures. More than 860 million claims were processed during that time.

"The Inspector General's report is welcome proof that our zero tolerance policy against waste, fraud and abuse is paying off," HHS Secretary Donna E. Shalala said in a statement. "We still have a big job to do in eliminating improper Medicare payments, but with a 45% reduction in improper payments in just two years, we are making real progress." ■

NEWS BRIEFS

Coverage approved for prostate treatment

The Health Care Financing Administration has decided to approve national Medicare coverage for cryosurgical procedures for prostate cancer performed with Food and Drug Administration-approved devices.

This includes use of the Cryocare System from Endocare Inc., an Irvine, CA-based developer of prostate cancer technologies. Cryocare is used for minimally invasive targeted cryoablation prostate cancer procedures, and is the only temperature-monitored cryosurgical system specifically cleared by the FDA for the treatment of prostate cancer, the company says. ▼

HCFA may boost coverage for diabetes management

The Health Care Financing Administration has proposed a rule outlining expanded Medicare coverage for outpatient diabetes self-management training services.

The proposed rule provides "uniform coverage" of services including educational and training opportunities furnished by qualified entities to beneficiaries that would be paid under Medicare's physician fee schedule. Under the proposed rule, qualifying facilities can include clinics and end-stage renal disease facilities as well as regular hospitals.

A physician or qualified nonphysician practitioner (including clinical nurse specialists, clinical social workers, nurse practitioners, nurse midwives, and psychologists) must certify that the training is part of a comprehensive plan. ■