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Quick steps you can take to stop managed care payers from stiffing you

Delays mean big bucks for insurers and less for you

Pressed by financial problems, many HMOs and other insurers are simply using any excuse possible not to pay legitimate claims, say reimbursement experts. The extent of the problem is hard to determine, but in Florida, where slow-paying payers seem to be epidemic, hospital providers that should be paid within 35 days report nearly 25% of their outstanding bills are at least six months old.

Even holding off on paying a small percentage of claims can generate big bucks for payers. Indeed, PriceWaterhouseCoopers estimates that insurance and managed care companies could earn up to $280 million in annual interest income simply by initially denying 1% of claims, then reversing the denials after a review process.

Here are some strategies providers are employing to help reduce claim denials, speed up claim turnover, and improve cash flow:

• **File frequently.** Most experts recommend that you have the bill prepared and out the door within three to four days after service has been rendered. If you wait any longer, you are just giving the payer what amounts to an interest-free loan.

Some offices prefer to file even more frequently. Frederick (MD) Internal Medicine files claims on a daily basis. Besides speeding cash flow, daily filing reduces paperwork by processing claims on a same-day schedule rather than waiting to do a week's worth of claims at once.

• **Know what you are due.** "It's been my experience that a great many carriers are failing to reimburse practices based on their negotiated fee schedule," says **Brian Kane**, CPA, president of HealthCare Advisors in Annandale, VA.

To help track what you are being paid vs. what you should receive, Kane suggests creating a simple grid with the insurance companies across the top and the main 10 to 15 CPT codes on the left side. Next, fill in what insurers are contractually required to pay for these procedures,

then check these amounts against the explanation of benefits (EOB) received from payers.

The EOB differences may seem small, maybe as little as $5 or $10 per patient. But this small change can add up to big bucks over the course of a year. Plus, the more aggressive you are in auditing and demanding full payment, the less likely it is payers will continue pulling the same tricks.

• **Track denied claims by payer and code.** The more information you have at your fingertips, the easier and faster it is for you to spot and correct a particular carrier's underpayment pattern.

• **Collect copayments and deductibles quickly.** Rather than bill, most reimbursement experts suggest you collect any copayment due before the patient leaves the office. When this is not possible, some practices have found that giving the patient a stamped, pre-addressed envelope to use when mailing in the payment improves collection rates.

The same attitude should apply when the patient is responsible for a deductible in his or her coverage. One way to easily track this is to create a chart listing your top CPT codes and your most-used insurers. The chart should give each insurer's deductible and co-pay policy for each code. ■

Collection ratios can show how much you're owed

Simple arithmetic doesn't work anymore

It used to be pretty straightforward and easy for practices to measure how well they were collecting on the monies owed them. The basic collection ratio of dividing payments by gross charges was good enough for most physicians' needs.

However, with the growth of managed care and complex payment agreements, the good old days of using simple arithmetic to determine how efficiently you are collecting on payments due are over, says **Jack Valancy**, a Cleveland Heights, OH-based reimbursement expert consultant to the American Association of Family Physicians.

To improve the accuracy of collection calculations, Valancy has developed a simple process for calculating individual plan collection ratios:

• **Create a separate plan code (also called payer category, financial class, or insurance type) for each plan covering many patients.** "I suggest giving the plan codes descriptive names so you can distinguish among different plans offered by the same company," says Valancy.

For the plans that include only a few of your patients, you may want to categorize these by a generic type of heading — Medicare HMOs, miscellaneous HMOs, capitated HMOs, and miscellaneous indemnity plans, for instance.

• **Attach payment codes corresponding to each plan.** For each plan category, list the appropriate payment codes reflecting how much you received from the patient, plan, or other sources for services covered by each plan.

• **Enter adjustments.** For each plan code, set up another code to reflect any contractual adjustments, voluntary adjustments (professional courtesy, discounts, and charity care), or bad debt write-offs.

• **Enter plan code for each patient record.** In each patient record, enter the code for the patient's insurance plan. For patients who have more than one plan, use the code representing the primary plan.

To ensure this information stays current, have your staff verify the patient's insurance information each time the patient comes in for a visit.

Tracking charges

Once this basic information has been gathered and entered into your computer system, you can start tracking charges, payments, and various types of adjustments by plan.

To track charges, post your usual charges (not your discounted charges) for all patients. For those in capitated plans, immediately post a counterbalancing adjustment. This way, you'll know the full value of the services you've provided to patients in each plan and you won't send bills to patients in capitated plans that don't owe you money, says Valancy.

Next, post payments according to the plan code the patient had at the time of the charge, not according to the source of the payment. This will permit you to find out how much you are receiving for patients covered by each plan, regardless of whether some of the payments come from patients or secondary insurers.

Capitation payments and other non-charge-related receipts from plans (such as withhold payments and bonuses) can present a special

Other ways to look at net collection percentages

Customizing your analysis

Like skinning the proverbial cat, there is also more than one way to calculate how much of your practice's expected revenue is actually collected, reports **Pamela L. Moore**, a communications specialist with the Medical Group Management Association (MGMA) in Englewood, CO.

According to **Elizabeth Woodcock**, a consultant with the MGMA Health Care Consulting Group, the most generally accepted net collection percentage calculation is: Net collection percentage = total fee for service revenue (cash collected) divided by adjusted fee for service charges, or gross charges minus contractual allowances.

While this may be the most common formula used to determine the efficiency of your collection process, others feel it is too limited for their needs. These reservations are based on the fact that the "standard calculation can't differentiate between collections lost to true bad debt and losses that could be controlled, and it doesn't work for practices doing accrual-based instead of cash-based accounting," notes Moore.

For instance, while accounting for losses due to managed care contracting adjustments, this formula does not account for collections lost to noncompliance with payer requirements, argues **Heather Bossin**, executive director of the shared billing and collection service at Washington University in St. Louis.

Under this method, claims that are not paid because a referral was improperly managed or filed late would simply appear as a bad debt, notes Bossin.

"That just hides the fact that some of those losses are, in fact, controllable. As such, the billing service is not responsible for 100% of the net collection percentage," she says.

Dave Gans, director of MGMA's Survey Operations Department, counters that "since calculations in the MGMA Cost Survey are based on a full year's amount of revenue, the amount of 'correctable' loss should be insignificant."

Another controversy in determining net collection percentage is whether the practice works on a cash or accrual basis, says Moore. Cash accounting records revenue when it is received and expenses when they are paid; accrual accounting records revenue when a service is performed and expenses when they are incurred.

Most experts estimate that 75% to 90% of all practices use the cash accounting method. The ones that use accrual are typically academic practices with large capital expenditures or practices linked through PhyCor or other publicly traded companies in which accrual accounting is the standard used, says MGMA.

Some other practices use a modified accrual method. For these, a typical series of calculations to determine net collection percentage would be: Net collectable charges = last month's charges minus this month's contractual adjustments minus this month's bad debt. Thus, collection ratio = net payments divided by net collectable charges.

The reason for using the one-month lag in calculating net collectable charges is to correct for variations in charges that won't affect you until about a month later, because this month's payments generally have more to do with last month's charges than this month's charges. ■

challenge. "Although some patient accounting programs have transactions for recording these properly, most don't," Valancy notes. "If your accounting system can't easily record these payments, keep track of them under separate payment codes in your general ledger system."

Valancy says the reports from your patient accounting system showing charges, payments, and adjustments by plan code, combined with your general ledger system's revenue reports of all other payments, should give you enough data to calculate how much each plan is really paying you.

Because the figures in these reports can fluctuate widely from month to month, he says combining data to produce three-month, six-month, or even 12-month profiles is the best way to use this information.

To perform the payment analysis:

1. Calculate total receipts. For each plan, add all payments you received from the insurer, patients, and any secondary insurance plans,

including capitation payments, refunded withholds, bonuses, and other payments.

2. Determine collection ratio. Divide the sum by your gross charges (i.e., the full value of your services) for patients in that plan to give you a collection ratio. An added advantage is that after comparing the collection ratios for all your plans, you can spot where you should focus your efforts when you renegotiate contracts with insurers.

3. Make adjustments. Determine the following three adjustment ratios for each plan code: contractual adjustments, voluntary adjustments (professional courtesy, discounts and charity care), and bad-debt write-offs.

4. Calculate ratios. For each plan, divide the sum of each of the three above adjustments by your gross charges for the period. Once this has been done, the contractual adjustment ratio will show how much the plan is discounting your fees; the voluntary adjustment ratio will show how much you're discounting your fees; and the bad-debt ratio will show how much of what patients and plans owe you is being written off as uncollectible. ■

Part B payments delayed until Jan. 17

While providers should file claims as usual after Jan. 1, Medicare plans to hold claims with service dates between Jan. 1 and Jan. 16 until Jan. 17 to ensure any changes in coinsurance or deductibles taking place on the first of January are accounted for. These claims will be released on Jan. 16. Meanwhile, this holding period will count toward the 30-day ceiling carriers have to pay clean claims before being charged interest.

HCFA also will make scheduled January 2000 payment updates on Jan. 17, then retroactively apply the updates to all services performed between then and Jan. 1.

The same retroactive rule applies to any coding changes previously scheduled to take effect on New Year's Day. ■

Y2K: Think you're ready? Surprises may await you

GAO raises red flag of warning

Besides concerns about how well federal and private payers will handle the Y2K problem come Jan. 1, the General Accounting Office has raised a red flag noting that many providers may not get paid because they have not corrected potential Y2K problems in their own systems.

Even groups that think they have done their Y2K homework may be in for a rude awakening when they learn that the Y2K-compliant guarantee they thought they received from their equipment or software vendor does not mean what they assumed it did. And they may find that by independently testing various software products, medical devices, and pieces of office equipment, they violated their contract, exposing the practice to possible liability. **(See related story, p. 157.)**

For instance, in one test, some 28% of providers had problems submitting electronic Medicare claims. The biggest reimbursement roadblock was the inability of providers to submit claims dated in the year 2000. In order to bill Medicare, claims must use 8-digit dates, with the year being 4 digits. For instance, Oct. 2, 2000, would appear as 10/02/2000.

If you have not already done so, practices are being urged to arrange a Y2K test submission with their Medicare intermediary, using future dates such as 01/01/2000, 02/29/2000, etc.

These problems, combined with the lackluster response to Medicare's free Y2K training sessions and low usage of its toll-free hotline, have Medicare officials worried that providers are not concerned enough about what could happen once the calendar rolls over to 2000.

For those that want it, Medicare carriers also have Y2K-ready software that is being offered to providers for free or at minimal cost.

Just because you are able to submit electronic data interchanges using a Y2K-compliant 8-digit date does not mean all of your systems are Y2K-ready, warn computer experts.

For instance, in another Y2K test series run by Nationwide Medicare, a subsidiary of Nationwide Insurance Co., in Columbus, OH, some 21% of the claims submitted failed to process on their first try, despite the fact they had been submitted on Nationwide's own Y2K-certified software. The most common reason for the snafu was that providers failed to follow instructions.

However, even after the procedural mistakes were corrected, a significant 3% of provider submissions still crashed, producing claims with dates of service in 1900, 1901, etc., when the dates should have reflected 2000, 2001, etc.

Nationwide's follow-up analysis found the practices had correctly followed instructions and nothing was wrong with the software, and the carrier concluded the problem had to be with the hardware and/or operating systems of the PCs being used by the providers. Specifically, these providers' computers were not able to generate dates later than 12/31/1999. ■

A last-minute triage plan for Y2K compliance

Internist group offers some solutions

Despite the fact that time is running very short, there are still things procrastinating practices can do to fix potential year 2000 problems, experts say.

According to the Philadelphia-based American College of Physicians-American Society for Internal Medicine (ACP-ASIM), smaller medical practices are the least prepared to cope with potential Y2K problems. In fact, studies show only about half of all internists are verified Y2K-compliant, while as many as 10% have done nothing to prepare for dealing with possible year 2000 computer glitches.

Y2K threatens scheduling, reimbursement

While most practice offices are not as dependent on medical device as hospitals or clinics, there are potential problems with different types of equipment ranging from X-rays to accounting systems to telephones and pagers.

But the biggest potential Y2K threat to most practices is a meltdown in their computer and billing systems, which could send their patient scheduling, medical files, and financial records into the ether of cyberspace, making it difficult or impossible to make appointments, process claims, and get paid.

To minimize the odds of this happening, ACP-ASIM has developed a six-point Y2K "triage" program to help practices that have not yet done their computer homework avoid Y2K shock come the millennium.

Here's how it works:

1. Inventory and assess. List everything in the office that could be affected because it contains a computer chip, including answering machines, automated lighting systems, smoke alarms, treatment equipment, and computer software and hardware.

2. Prioritize. Determine what absolutely must be checked and fixed and what you can let slide. A fast way to assess the Y2K readiness of your office equipment is to visit the various vendors' Web sites to see if they list the status of their equipment. Pay special attention to those everyday items you tend not to think about but that can put your business down for the count when they're not working.

Joel Nobel, MD, president of ECRI, a nonprofit health care research agency in Plymouth Meeting, PA, gives this example of prioritizing your Y2K issues: "If your building access card doesn't work, you can always break down the door," he says. "But if it's January in Maine, you are in deep stuff if your heat will not come on."

3. Check your hardware. Much of the concern surrounding Y2K issues has focused on what happens if your software crashes — medical record programs, billing software, etc. But this overlooks the fact all that software has to run on some kind of hardware.

"The typical practice has asked their vendor if its software is compliant, but failed to check out their hardware," says **Diana Parish**, Y2K project coordinator for Nationwide Medicare in Columbus, OH.

Tip: Most major computer makers have programs on their Web sites to test and update basic computer input/output systems and which can be downloaded free of charge.

4. Update software. When it comes to software, many large vendors have already supplied software upgrades or patches to physicians.

It is possible for a small practice to replace its old practice management software for as little as $300 to $700 if it is willing to settle for simple, off-the-shelf software that does a good basic job of patient scheduling and billing. The price starts to go up once you add data conversion, clinical support, or expanded features.

This off-the-shelf software can usually be bought by mail or on-line and delivered within a couple of

business days. Add another day for installation by an already tech-savvy office worker or physician.

Off-the-shelf packages also can be purchased for larger practices with starting prices between $1,000 to $3,000. For a system installed and supported by an outside vendor, the prices begin at about $5,000 to $10,000.

Most larger practices with a networked system should seriously consider hiring an outside consultant to help install any off-the-shelf software and provide staff training.

Tip: If you don't have enough time to complete a full data conversion, think about leaving your old system running while you're setting up a new, parallel system. For example, for practices on a typical 90-day billing cycle that install their parallel system in October, most new appointments and active patient information, along with new charges, can be entered into the new system before January. Previous records still must be entered into the new system manually, but that can be done after getting past the Jan. 1 drop-dead date.

5. Test your systems — carefully. While many experts say you should extensively test both hardware and software, others do not like the idea of nonprofessionals mucking around with these systems because they can create more problems than they solve.

Carolyn Albert of ACP-ASIM's Center for a Competitive Advantage recommends scheduling a thorough on-site testing and system review with your computer maintenance company. "Explain that you will require written confirmation of the results and an accurate survey of all hardware and software components, including model and serial numbers," she recommends.

Tip: Before anyone tests your system, print out and save a copy of critical schedules, accounting information, follow-up reports, and other needed documentation. Also, talk with the tester about what kinds of recovery procedures are available if the system should crash during the test.

Besides your main operating system, make sure the modem, backup software, laboratory interfaces, claims submission software, accounting and payroll programs, report generation software, diagnostic software, and electronic claims-submission data are tested.

Also, test-run all programs in the your office that exchange data, including laboratory interfaces, accounts receivable, payroll, accounting, and report generation software to ensure they are both individually compliant and compatible with each other.

6. Have a back-up plan. Everything in your office may be Y2K-compliant, but there is nothing you can do about what happens elsewhere. In turn, you need a contingency plan for such processes as scheduling, examining patients, billing, record-keeping, telephone service, access to bank accounts, and arrangements with vendors and hospitals.

Tip: Consider not scheduling any patients until Jan. 5 or 6 to give yourself some leeway should you blow a Y2K fuse despite all your efforts. ■

Simple ways to determine if you are Y2K-ready

Focus on key date changes

You may think your computer and data systems are Y2K-ready — but do you know for sure?

Here are some simple questions developed by the U.S. Small Business Administration to quickly evaluate if your office has been Y2K bug-proofed.

If you cannot answer yes or do not know the answers to all these questions, you may wake up with more than a headache to worry about next New Year's Day.

☐ Can the system perform projections through time? For example, can it calculate interest or payments or make inventory projections?

☐ Does the system allow for entering dates? If yes, is the year two digits or four? What happens if you enter "00" or "01?"

☐ Will the system operate differently depending on the day of the week? Will it operate differently at month-end, quarter-end, or year-end?

☐ Can the system put things in order by date?

☐ Does the system allow you to retrieve data by date?

☐ Can the system perform date-based calculations?

☐ Does the system have a security feature that includes date checking?

Here is a list of critical dates that you should take for a test-drive on your computer as soon as possible to see what happens when they appear

(Continued on page 155)

Physician's Coding Strategist™

Stimulation therapy has many faces

Question: Our clinic provides several types of stimulation therapy, including electrical nerve stimulation, osteogenic stimulation, and neuromuscular electrical stimulation. What CPT codes are used for these procedures, and are they covered by Medicare and other insurance plans?

Answer: The use of transcutaneous electrical nerve stimulation (TENS) units for pain management is coded 64550 in CPT. This technique involves attachment of the device to the surface of the skin over the peripheral nerve to be stimulated. The patient uses it on a trial basis for pain control under close monitoring of the physician and/or physical therapist. The patient's response should be carefully documented, because medical necessity will be required for Medicare coverage after the first month. The TENS unit usually is provided by the physician for the assessment period. Because this is equipment used by the patient at home, it is covered under durable medical equipment (DME) guidelines.

Percutaneous electrical nerve stimulation (PENS) units involve stimulation of peripheral nerves by needle electrodes inserted through the skin. Code selections in this range include the following:

64553 — percutaneous implantation of neurostimulator electrodes; cranial nerve
64555 — peripheral nerve
64560 — autonomic nerve
64565 — neuromuscular

Medicare covers a PENS procedure only when performed by a physician or when it is "incident to" a physician's service. If pain is effectively controlled by percutaneous stimulation, the implantation of electrodes would be warranted.

Treatments would not be covered in a physician's office for Medicare patients, as it would be expected that a patient would have a stimulator implanted for home use.

The CPT codes for this service for 1999 are:

64573 — Incision for implantation of neurostimulator electrodes; cranial nerve
64575 — peripheral nerve
64577 — autonomic nerve
64580 — neuromuscular

Code 64585 is used for revision or removal of peripheral neurostimulator devices. Two additional codes in this section are for subcutaneous placement, revision, or removal of a peripheral neurostimulator pulse generator or receiver.

The devices are covered by Medicare, when medically necessary for pain control, under durable medical equipment provisions.

Osteogenic stimulation

Electrical stimulation to enhance and augment bone repair can be invasive or noninvasive in nature. Invasive procedures provide electrical stimulation directly at the fracture site by percutaneously placed cathodes or by implantation of a coiled cathode wire in the site. The power pack required for the device is implanted into soft tissue near the fracture location and then subcutaneously connected to the cathode.

In a noninvasive procedure, opposing pads wired to an external power supply are placed over the patient's cast, creating an electromagnetic field between the pads at the fracture site.

The noninvasive procedure is covered by Medicare for the following conditions:

- nonunion of long bone fractures;
- failed fusion;

• congenital pseudoarthrosis;

• as an adjunct to spinal fusion surgery for patients at high risk for pseudoarthrosis due to failed spinal fusion at the same site or for those undergoing multiple-level fusion.

For all types of devices, nonunion is considered to exist only after six or more months have elapsed without healing of the fracture.

The invasive (implantable) stimulator is covered by Medicare for the following conditions:

• nonunion of long bone fractures;

• as an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple-level fusion.

The CPT codes for osteogenic stimulation are:

20974 — electrical stimulation to aid bone healing; noninvasive (nonoperative)

20975 — invasive (operative)

NMES Therapy

Neuromuscular electrical stimulation (NMES) is used to treat disuse atrophy. An NMES device transmits electrical impulses to the skin over selected muscle groups by way of electrodes. Medicare coverage of NMES is limited to treatment of disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord, and peripheral nerves, and other non-neurological reasons for disuse are causing atrophy.

Examples include casting of a limb, contracture due to scarring of soft tissue such as burn patients may suffer, and hip replacement surgery until orthotic training has begun.

The CPT codes for neuromuscular electrical stimulation are found in the neurostimulator section of CPT. Electrodes placed over motor nerves stimulate muscles to prevent atrophy. In code 64565, the electrodes are placed at the neuromuscular junction to stimulate a specific area of muscle tissue.

The analysis of neurostimulators is reported from the medicine section of CPT. Codes in the range of 95970-95971 are assigned for this service.

This section of codes is all new for 1999 in CPT. It involves simple or complex electronic analysis of implanted neurostimulator pulse generator systems. The stimulation affects the pulse (amplitude, duration, frequency) to treat specific disorders such as Parkinson's disease. These codes are only used with implanted devices.

A simple stimulator affects three or fewer variables to include the pulse, electrode contacts, electrode selectability, output modulation, and cycling. A complex stimulator affects more than three of the variables. For complex procedures, when more than one hour is provided, there are codes for the additional time that are reported in addition to the primary procedure. ■

Confidential exchanges in the electronic age

Docs, patients must know how, when to e-mail

Bob Jones needs a referral from his family doctor. Because he doesn't want to wait for the doctor to return his telephone call, he e-mails the request. The next day, he has a reply with the referral.

John Smith sends a message to his doctor complaining of chest pains. The physician is not able to check his e-mail for several days and is alarmed when he gets the message.

The above scenarios show the importance of establishing a policy about how and when to use e-mail communication between physicians and patients.

Whether to allow e-mail communication at all is no longer the question. More and more computer-savvy patients prefer e-mail for nonemergent requests because they can ask their doctors questions directly without having to wait by the telephone for a reply.

This trend will only increase, says **David Sanders**, MD, CEO and founder of Salu.net, a provider of Internet-based private networks for physician practices and health professionals in Portland, OR.

"Communication will migrate aggressively within the next five years to e-mail-based communication," he predicts. "[E-mail] will change the way doctors, staff, and patients communicate."

A medical practice is 90% communication, he explains. About half of that communication is face-to-face. The other half is communication by other means such as phone or fax. "The problem with the phone is that it requires the doctor and the patient to be available at the same time," Sanders says. "It's hard to do that when doctors are under such high time pressure. E-mail separates out the requirements for two folks being in the same place at the same time."

Encryption available through Medical E-mail

Providers who are trying to navigate the territory of e-mail but don't want to do it themselves might find help through a company named Salu.net. The company offers secure, encrypted messaging through its Medical E-mail; physician-customized Web sites; and permanent message archiving.

"Everything you do in a practice is a legal document," says **David Sanders**, MD, CEO and founder of Salu.net. "It is important you have a record means to track all of those [e-mail] communications. On a real-time basis, we extract all of the data points that go on, and we archive them in a compressed fashion. If a member wants to go back and retrieve documentation, it's there for them."

The messages are archived for 10 years. "Then we contact members and ask them if they want to receive data backups of their systems. At that point, we will begin to discard records."

The Web sites are used for patient education, practice promotion, and customer support. Patients can use them to retrieve educational materials the physicians have chosen to offer. Patients also can find out more about the practice and even get directions and office hours.

Physicians can access Salu.Net from any system that has Internet capabilities. Salu.net is also integrated, so physicians can access everything in the system by signing on and giving a password.

Salu.net has a training program for users, which urges them to talk to patients about using e-mail. "For example, make it clear to patients that if they are going to use e-mail with you, here is what is considered appropriate content and timeliness," Sanders says.

A newer version of the system will provide a guidance site for patients that tells them how to become an effective user of e-mail with their physicians.

Offering e-mail resources makes physicians seem more current with the times, Sanders says. "Doctors who are on-line are put back in the game. They are more in the partnering mode than an outsider who is not providing information."

[Editor's note: For more information about Salu.net, call (888) 288-SALU.] ■

"There is an increasing encroachment of electronic [communication] in the physician-patient relationship," adds **Faith McLellan**, PhD, faculty associate in the department of anesthesiology at the University of Texas Medical Branch at Galveston.

McLellan learned about e-mail communication while researching her dissertation about patients' illness experiences. Even though she found that physician / patient e-mail communication is becoming more common, many physicians are still uncomfortable using it.

"In a larger conceptual universe, it upsets the balance of power," she says. "Suddenly, there is information and information management tools in the hands of people who have usually been the recipients of physicians' power and knowledge."

Many physicians are computer-naive, too, she adds. "They haven't thought about some of the issues such as privacy and confidentiality, and how easy it is to disseminate information to other people through e-mail and how instantaneous it can be."

Many patients use e-mail so much that they see it as a natural way to communicate with their physicians, McLellan says. A recent article in the *Annals of Internal Medicine* found that patients think of e-mail as creating continuous access to the health care system, something they feel is lacking as physicians spend more time on administrative tasks and less time on personal interaction.[1]

E-mail works well when the patient requests general information or sends routine information about a chronic illness. A diabetic patient, for example, might send her physician information about her blood glucose levels. The physician doesn't need to respond right away unless the results are abnormal. "E-mail is the perfect medium for that," McLellan says.

E-mail also provides a way for physicians to filter medical information. Some managed care plans, for example, have a site where they recommend electronic resources on medical information.

In addition, e-mail can allow patients with similar conditions to meet in electronic discussion

groups. These groups can be a great relief to both the patient and the physician, McLellan says. "The patients are hooking into a source of support that they don't necessarily get from their personal physicians. It not only provides access — a route of communication between the patient and the physician — but it hooks other people up whose time is better served in discussion, answering questions, and support."

E-mail can be a barrier to patient care, however. Some questions to be considered include: What happens with e-mail communication between patients and their doctors when the doctor is on vacation, not in the office, or not on call? What happens if the physician's or patient's e-mail server goes down? When will the message be received? What kind of messages are appropriate for patients to send?

"Establishing a policy on using e-mail is a good idea," says **Victor S. Sierpina**, MD, an assistant professor of family medicine at the University of Texas Medical Branch in Galveston. For example, patients should be discouraged from sending emergency or urgent inquiries. They should be aware that their messages might not be answered right away.

Be aware of discrimination issues

Physicians should have an office e-mail account that is separate from their personal one. They should not use e-mail to communicate abnormal test results or to give bad news.

"You don't want to be discussing psychiatric history or HIV status — something that could be used to discriminate against the patient," McLellan says.

Physician e-mail users also should ensure that electronic communications do not widen the disparity between the haves and the have-nots. Patients without access to computers should receive the same health information, she explains. "You don't want to create a society where the patients who have e-mail are getting better care than the patients without."

Sierpina has one rule of thumb on the use of e-mail: "Don't put anything in e-mail that you wouldn't want to see on the front page of a daily newspaper."

In his experience communicating with patients, he has found that they usually write short messages and generally don't abuse the system, he says. They don't always think about the lag time between the sending and receiving of messages, however. One of his patients, the man with the chest pains mentioned earlier, luckily had a condition that did not require emergent care.

Reference

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Making histories unique avoids similarity problems

Question: A recent Medicare bulletin states that if visit documentation for a patient "looks similar" from visit to visit, Medicare will deny payment for the visits due to lack of medical necessity. What does "looks similar" mean?

Answer: Looking "similar" means the physician didn't dictate a new note for each visit. This can be a problem when an electronic medical record pulls all the information for each encounter into the next one.

It's not known if the physician actually looks at the information or if the system is simply printing out into the progress note. As a result, every visit looks alike.

The Health Care Financing Administration's concern is that the work isn't being done; the provider is just adding the information with a few clicks of a button, making the work look like a Level 5 service when the provider has not done the work associated with that level of service. The carrier is looking for something that indicates progression, or improvement, or at least what is really happening with the patient at the time of the most current visit.

Documentation guidelines for the progress note say the history should be based on the last encounter. Providers need to update that medical history from the last patient visit and not just repeat history information that is not relevant to today's visit. Some providers bring back complete patient histories every time the patient comes in.

Physicians, therefore, need to make sure their history is unique to that day's visit. They also need to reference anything that is key to treating the patient during the visit. ■

(Continued from page 150)

in the system. For simplicity's sake, use the ones that best match your business needs and ignore those that are not appropriate.

1. Test the changed system with dates before the year 2000 to ensure that it is working properly.

2. Test that the changed system rolls over from 12/31/1999 to 1/1/2000.

3. Validate the first business day of the year 2000 (1/1/2000, 1/2/2000, or 1/3/2000, depending on your business needs).

4. Validate that the system operates correctly at end-of-month (1/31/2000 and will roll over to 2/1/2000 properly).

5. Test that the system rolls over from 2/28/2000 to 2/29/2000 properly, operates correctly on 2/29/2000, and then rolls over and operates properly on 3/1/2000.

6. Test 3/31/2000 and 4/1/2000 to show that end-of-quarter processing operates correctly.

7. Test 1/7/2000 and 1/10/2000 to ensure that the system operates correctly on the first Friday of the new century, and on the Monday after the first Friday.

8. Validate year display fields, including data entry.

9. Validate the year in reports.

10. Test that the system sorts in correct order.

11. Validate correct calculation of dates.

12. Validate the correct acceptance of dates from the operating systems.

13. Validate calculated resultant values from dates.

14. Test that ages are calculated correctly.

15. Validate interest and other time-based financial calculations.

16. Verify that billing calculations are correct.

17. Validate cycle processing, including day-of-week and/or first business day of the month.

18. Test forward processing — process dates after the year 2000 (2001, 2002, etc.).

19. Validate backward processing — process dates prior to 2000.

20. Verify historical or archival date processing.

21. Validate that the system purges the correct records.

22. Validate date and data error handling routines.

23. Validate windowing, if used, both within the system and between interfacing systems.

24. Validate proper handling of special values in dates — 99/99/9999, 88/88/8888, 00/00/0000.

25. Validate that there are 366 days in the year 2000, and 365 days in the year 2001.

Some additional dates that could have an impact on your business operations:

- 10/01/1999 — start of federal government's fiscal year 2000.
- 02/15/2000 — W-2 forms due.
- 04/15/2000 — tax day.
- 04/30/2000 — first month ending on a weekend.
- 05/01/2000 — tax withholding report due, unemployment tax due.
- 09/30/2000 — federal government's end of fiscal year 2000.
- 10/10/2000 — first 6-digit date for systems storing date as MDDYY.
- 12/31/2000 (Sunday) — first year-end; check that the year contains 366 days.
- 01/01/2001 — test that the system has been instructed to roll over to 2001.
- 02/29/2001 — invalid date.
- 12/31/2001 — second year-end; check that the year had 365 days. ■

How to check your PC for year 2000 readiness

A step-by-step guide

The following steps are suggested by the U.S. Small Business Administration (SBA) to determine if a personal computer will roll over to the year 2000 correctly.

The SBA says using a DOS diskette is a safer method to test your PC's system clock because it leaves the data and programs on your PC's hard disk unaffected. If you boot to your C: drive, you may end up loading Windows or Windows 95 and other applications from your startup routine. Using a bootable diskette will ensure the integrity of the data and programs on your PC's hard disks.

Note: Do not perform the tests by changing your system's BIOS Setup screen.

1. Create a bootable test diskette. Insert a blank floppy diskette into the PC's A: drive. From a DOS prompt, type FORMAT A: /S. Or from Windows File Manager, click on DISK/FORMAT and check MAKE SYSTEM DISK.

SBA loan program helps providers afford changes

The federal government may have some help for smaller physician practices that might be less prepared for millennium bug problems.

Last April, President Clinton signed into law legislation that requires the Small Business Administration (SBA) to provide loan guarantees of up to $150,000 for Y2K-related equipment and software repairs, plus disruptions in normal business operations caused by such things as a breakdown in billing and accounts receivable functions.

To qualify for SBA's Y2K Action Loans program, health care providers must gross less than $5 million in annual receipts. The federal government will guarantee loans from commercial lenders to qualified small business providers, for which initial principal repayments can be postponed for as long as one year.

SBA will guarantee up to 90% of a Y2K loan of $100,000 or less and up to 85% on Y2K loans of over $100,000. If the application is processed through SBA Express, the maximum guarantee remains 50%.

For more information, contact your banker or local SBA office. If you have a specific question about the program, you can e-mail Greg Diercks at gregory.diercks@sba.gov. Or call the SBA Answer Desk at (800) U-ASK-SBA. ■

2. With the bootable diskette created in Step 1 still in your PC's floppy drive, shut down your system (close Windows) and turn off your PC. Don't just hit the reset button or warmboot (CTRL-ALT-DEL).

3. Turn the power on for your PC, and allow the PC to boot from the diskette. After bootup, DOS automatically shows the current date. Make sure that the correct date is displayed. Otherwise, you may have to set the correct date on your PC's BIOS.

4. At the "enter new date" prompt, type 12-31-1999.

5. After changing the date, the current time will be displayed. At the "enter new time" prompt, type 23:55:00.

6. Turn the power off on your PC and wait at least 10 minutes. If you don't, DOS will appear to transition correctly to the year 2000. However, once you reboot the PC, it will display the incorrect date if your system's RTC has the flaw described above.

7. Turn the power back on and wait for the boot process to complete.

8. Type in Date at the ready prompt. If Sat 01-01-2000 is displayed, your PC's BIOS passes the test.

9. At the "enter new date" prompt, type 02-28-2000. This will test your system's ability to recognize the year 2000 as a leap year.

10. After changing the date, the current time will be displayed. At the "enter new time" prompt, type 23:55:00.

11. Turn off your PC's power again and wait at least 10 minutes.

12. Turn the the PC on. Type in Date at the Ready prompt. If "Tue 02-29-2000" is displayed, your PC's BIOS passes the leap year test.

13. To conclude testing, at the "enter new date" prompt, enter the correct date, e.g., 10-04-1999.

14. After changing the date, the current time will be displayed. At the "enter new time" prompt, type the correct time, e.g., 06:00:00.

15. Remove the bootable diskette from the floppy drive and turn off your PC's power. ■

Legal audit determines your liability exposure

Know if your 'guarantees' are meaningless

Besides reviewing software, hardware, and other equipment for Y2K compliance, physician practices should do a legal audit of their Y2K exposure to related liability, warranty, and insurance concerns.

One problem is that many of these questions still have no answers. "The courts have not yet given guidance on the allocation of liability among health care providers, manufacturers, insurers, and others in the event of an injury or death caused by a Y2K failure of a biomedical device," notes **Jerald J. Oppel**, an attorney in Baltimore's Ober, Kaler, Grimes & Shriver's health care practice.

A question that's easier to answer: Are your Y2K preparations sufficient to prevent your insurance company from using that as a legal argument for not paying your claim?

One of the major Y2K legal questions is exactly who is responsible for testing and certifying that biomedical equipment is Y2K-compliant, notes Oppel.

Should you rely on manufacturer certification?

"Currently, there is no clear-cut answer as to whether a health care provider should rely on a manufacturer's certification of Y2K compliance or whether the health care provider also should perform independent tests to confirm Y2K compliance," says Oppel.

According to the General Accounting Office, some major private equipment testing and certification organizations have decided to rely on manufacturers' Y2K certifications because they have stated that manipulating the embedded software may void the manufacturers' certification to the Food and Drug Administration that the equipment is safe for patient use.

"This action, in turn, could expose the certification organization that performed tests on the equipment to legal liability should the equipment later malfunction and harm a patient," says Oppel.

Yet, other experts say each piece of equipment should be individually tested. The reason is that microchips in individual units of the same make and model of a device may have been manufactured by different suppliers or made at different times.

Some factors to take into consideration when deciding whether to independently test an item of medical or office equipment:

— Does the manufacturer certify the item as Y2K-compliant?

— What is the scope of that certification?

— What are the terms of any contract, license agreement, or maintenance agreement with each manufacturer, particularly warranty, intellectual property, and confidentiality provisions?

— What is the potential threat of harm posed by failure of the device?

— What will the cost and feasibility of replacing the device be?

Before testing any of your equipment, from telephones to medical devices, providers would be wise to first have their lawyer read the contract and guarantee terms for the equipment to ensure that testing does not place the practice at risk, Oppel advises.

For instance:

• **Warranties.** Tampering with a biomedical device to conduct Y2K testing can invalidate a manufacturer's warranty in some instances.

• **Intellectual property.** If a health care facility does not own the rights to a particular software product, tampering with it may infringe on the owner's proprietary rights or may constitute a breach of the license agreement.

• **Confidentiality.** Allowing a third party to access software may breach confidentiality obligations contained in the license agreement. It also may expose a provider to liability for misappropriation of trade secrets.

A sales or technical representative's statement to you that his company's equipment or service is Y2K-compliant does not always mean what you think it does.

"Even when a manufacturer certifies that its equipment is Y2K-compliant, there are varying levels of assurances — from the very general and

Don't forget to check your telephone system

Here's a Y2K checklist

As in most enterprises, the telephone is your practice's lifeline to patients, colleagues, suppliers, and the rest of the outside world. In turn, it should be a priority for ensuring Y2K compliance, along with related communication functions.

The first place to start will be to contact whoever is supplying your basic telephone equipment. If using a Private Branch Exchange (PBX) system, for instance, contact the vendor about its Y2K procedures and guarantees. Larger suppliers like Lucent Technologies, Nortel, and Mitel have prepared detailed Y2K information.

Then identify and contact the vendors responsible for the various communication functions that rely on your telephone, such as paging systems, voice mail, e-mail, Internet connections, computer telephony integration applications, automatic call distributors, interactive voice response systems, and networking hardware and software. ■

FDA site provides info on medical devices

For a central source of information on the Y2K compliance status of specific medical devices, you can turn to the Food and Drug Administration's biomedical equipment Web site at: www.fda.gov/cdrh/yr2000/year2000.html.

The site includes a searchable list of biomedical equipment and each piece's Y2K compliance status. "Compliance," in this case, means the device will function 100% as intended, in that the year change will not adversely affect the device's operation.

The database will allow you to search for specific items of biomedical equipment and determine each item's compliance status and the effect of noncompliance. ■

not so reassuring, to the very specific and much more reassuring," points out Oppel.

For instance, a certification may:

— refer only to general indications of Y2K compliance;

— refer to the general Y2K compliance of a manufacturer's entire product line;

— indicate that certain products have been tested and are compliant;

— indicate that a particular item has been tested in a certain way and is compliant.

There are also different definitions of the term "Y2K-compliant," notes Oppel.

The Food and Drug Administration, for example, defines year 2000 compliance to mean: "With respect to medical devices and scientific laboratory equipment, the product accurately processes and stores date/time data (including, but not limited to, calculating, comparing, displaying, recording, and sequencing operations involving date/time data) during, from, into, and between the twentieth and twenty-first centuries and the years 1999 and 2000, including correct processing of leap year data."

In short, products must function as intended or expected, regardless of the date, to be Y2K-compliant. However, each manufacturer is free to respond to a customer's Y2K compliance inquiry with any definition or interpretation of what it thinks Y2K compliance is. This lack of consistency should be taken into account when evaluating each certification. ■

Physician pay increasing at slower rate

Income growth for most doctors is slowing, with drops found in five specialties from last year, according to *Modern Healthcare* magazine's survey of eleven different physician compensation studies.

The bottom line: Primary care pay increases continue to slow, specialist pay is expected to climb, and more incentive pay is being offered to physicians.

Overall, physicians received cost-of-living increases of about 3% last year. Big winners, with raises ranging from 0.8% to 15.1%, were anesthesiology, noninvasive cardiology, emergency medicine, family practice, internal medicine, pathology, pediatrics, psychiatry, and urology.

Specialties singing the paycheck blues, with drops between 1.9% to 10.5%: general surgery, neurology, OB/GYN, oncology, and radiology.

Typical pay ranges reported last year for specific specialties included:

— anesthesiology: $184,000 to $270,462;

— cardiology (noninvasive): $175,000 to $345,849;

— emergency medicine: $161,857 to $187,000;

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— family practice: $126,800 to $164,069;
— general surgery: $166,000 to $261,749;
— hospitalists: $133,400 to $154,874;
— internal medicine: $135,000 to $159,906;
— neurology: $131,000 to $179,944;
— OB/GYN: $155,000 to $263,527;
— oncology: $175,000 to $337,603;
— pathology: $132,583 to $256,933;
— pediatrics: $120,000 to $151,396;
— psychiatry: $131,000 to $155,547;
— radiology: $145,000 to $292,278;
— urology: $147,000 to $360,153. ■

Providers want changes in new ambulatory rates

Current proposal would reduce some payments

If implemented next year as planned, Medicare will replace its current eight payment groups for ambulatory surgical centers (ASCs) with 105 categories based on the new Ambulatory Payment Classifications (APCs).

Unhappy with both the data used and the basic way in which rates would be calculated, physician and specialty groups are lobbying the Health Care Financing Administration to take this radical change in ASC payments back to the drawing board for more work.

"We have met with HCFA officials and let them know we feel delaying the final rule until our concerns are adequately addressed is reasonable and in everyone's best interest," says **Kathy Bryant**, executive director of the Federated Ambulatory Surgery Association in Alexandria, VA.

Basic provider complaints about the current proposed rule include the following:

• Providers say the new rule illegally shifts costs of Medicare treatment to private providers and payers. Providers challenge HCFA's claim that the proposed APC rates are budget-neutral as required by law. **Paul Rohlf**, MD, president of the American Association of Ambulatory Surgical Centers (AAASC) in Chicago, says the proposed payment rates would cut overall Medicare ASC outlays by closer to 10%.

Hardest hit would be single-specialty facilities specializing in ophthalmology, digestive G/I, and urology, which would probably see reductions in their Medicare reimbursement ranging from 15% to 25%, predicts Rohlf.

• Providers note that HCFA is legally required to use "actual costs" when setting payment rates for ASC codes. Yet HCFA's own original June 12, 1998, *Federal Register* notice admitted it had to extrapolate a large number of fees because it lacked sufficient cost data for 42% of all ambulatory surgical codes.

• The AAASC says the new rates are biased towards lower payments. The organization says a study by the Lewin Group, a Fairfax, VA, consultancy, found that there is a 65% greater chance of a reduction in the proposed payment for codes with extrapolated APCs than in those for which HCFA had actual data available. ■

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Reimbursement ROUNDUP

OIG expands fraud/abuse penalties

The Office of Inspector General (OIG) has released its final rule revising the exclusionary plus civil money penalties (CMP) for providers who commit fraud and abuse. The new rule:

— expands the OIG's power to exclude providers beyond Medicare and state health care programs, to include all public health care programs;

— establishes permanent exclusions for individuals convicted of three or more health care-related crimes and 10-year exclusions for individuals convicted of two health care-related crimes;

— assesses CMPs of up to $10,000 against institutional providers that knowingly employ or enter into contracts for medical services with excluded individuals;

— establishes a new CMP of up to $25,000 for health plans that fail to report information to the Healthcare Integrity and Protection Data Bank;

— creates CMPs for providers who violate the anti-kickback statute of up to a maximum of $50,000 per violation, including a maximum penalty of not more than three times the amount of remuneration offered, paid, solicited, or received in the kickback scheme.

HCFA wants self-policing reports

If you've been overpaid by Medicare, the government wants to hear about it. The Health Care Financing Administration wants to extend a proposal that providers submit a quarterly credit balance report identifying any improper payments they received from Medicare. These reports will then go to Medicare intermediaries, who will collect the overpayments.

While logical on the surface, many health care groups worry about such things as self-incrimination and what happens when there is an honest difference of opinion about a payment.

Specialties back Stark changes

Many different medical specialties are backing legislation to revamp Stark physician referral rules introduced by House Ways and Means Health Subcommittee Chairman Bill Thomas (R-CA). H.R. 2651, the "Physician Self-Referral Amendments of 1999," is a "critical first step to remove barriers to medical group practice integration and evolution," says a joint statement by the Medical Group Management Association and the American Medical Group Association.

While you can expect a lot of activity surrounding the issue, most insiders feel it will be at least two to three years before any substantive changes in physician referral rules make their way into law.

Double-check your modifiers

HCFA has directed Medicare carriers to pay special attention to possible improper use of modifiers by providers when reviewing claims. This extra oversight may result in delays in or denials of payment. You should check with your intermediary to ensure the two of you are on the same page when it comes to use of the most common modifiers in your practice. ■