AMERICAN HEALTH CONSULTANTS®

PHYSICIAN'S PAYMENT UPDATE™

INSIDE

NOVEMBER 1999

VOL. 11, NO. 11 (pages 161-176)

American Health Consultants® is A Medical Economics Company

OIG fraud/abuse plan for next year will expand Stark 'safe harbors'

You should concentrate on areas targeted by OIG

The Health and Human Services Office of the Inspector General (OIG) has unveiled the list of the specific topics and projects it will be focusing on in its fraud and abuse efforts over the coming year.

Smart practices can use the OIG's work plan as a kind of laundry list of items to address in their own internal compliance efforts.

First, the good news: As *Physician's Payment Update* reported last summer, the OIG plans to publish soon final regulations establishing new safe harbor exemptions from the Stark anti-kickback statute. The OIG may consider adding more safe harbors later.

Besides the ongoing auditing of general coding and billing practices, OIG investigators will be paying closer attention over the next year to certain physician-related areas. You should be focusing on these areas:

• **Advance beneficiary notices.**

Examine the use of advance notices to Medicare beneficiaries, especially for non-covered laboratory services. By law, physicians must give seniors advance notice before they provide a service they know or believe Medicare does not consider medically necessary or for which Medicare will not reimburse. Beneficiaries who are not notified before they receive such services are not responsible for payment.

• **Automated billing.**

Determine what kind of billing errors can be commonly blamed on the use of automated coding software, and which cannot. OIG also will examine various billing processes to identify coding problems that occur when practices bill independently or use a third-party system.

• **Reassignment of physician benefits.**

Evaluate possible opportunities for fraud or abuse when, in exchange for a flat fee or salary, a physician agrees to reassign his or her billing number to clinics that handle all billing and keep all fees for services provided by the physician.

• Collection of Medicare secondary payer overpayments.

Evaluate Medicare contractors' track records in collecting Medicare Secondary Payer overpayments from providers.

• Medicare provider numbers and unique physician identification numbers.

Determine whether Medicare provider numbers and unique physician identification number information are accurate and up to date. This follows OIG reports showing problems with the issuance of provider numbers to such providers as durable medical equipment suppliers and independent physiological laboratories, and failure to quickly deactivate unused provider numbers.

• Routine nursing home visits by physicians.

Reacting to a five-state study that showed physicians sometimes billed for more services than they could physically perform in a normal workday, OIG will look at the need to establish controls over Medicare payments for routine nursing home visits.

• Podiatrists' billing practices.

Recent audits of individual podiatrists found a 99% billing error rate in some instances. In response, the OIG will launch a national review to determine the extent to which podiatrists improperly bill Medicare. Included in this review will be a study of podiatry claims for nail debridements, which increased 46% between 1992 and 1995.

• Myocardial perfusion imaging.

Assess the medical appropriateness of myocardial perfusion imaging to explain the recent rise in utilization since 1997. Myocardial perfusion imaging is a cardiac imaging procedure that is used to detect coronary artery disease and determine prognoses. This type of imaging procedure accounted for a large portion of the 23% increase in billing for all nuclear imaging services between 1997 and 1998.

• Clinical laboratory proficiency testing.

The Clinical Laboratory Improvement Amendments (CLIA) of 1988 established quality standards for all laboratory testing. This review will assess how well laboratories perform Medicare tests and adhere to CLIA standards.

• Medical appropriateness of end stage renal disease tests.

OIG will do a random medical review of end stage renal disease beneficiaries to determine if laboratory and other services they received were necessary and were provided in accordance with Medicare requirements.

• Questionable dialysis claims.

Examine claims for dialysis services to identify questionable billing patterns and aberrant providers. Dialysis treatments may be provided and billed either as single visits (common procedure codes 90935 and 90945), or, for patients with more complications, as multiple visits (codes 90937 and 90947), which are reimbursed by Medicare at a higher rate. On average, the ratio of services for the high to low codes is approximately 1 to 7.

A fraud alert has been issued to carriers to periodically determine if any nephrologist is extremely deviant from the norm.

• Duplicate payments for office visits to nephrologists.

Identify situations in which Medicare made separate payments to nephrologists for dialysis patients' office visits, but the services were already included in the monthly capitation payment for physician services during the same period.

• Physicians at teaching hospitals.

Continue investigations of inappropriate billing for physician services at teaching hospitals.

• Billing for resident services.

Assess extent of improper Medicare billing resulting from the issuance of provider billing numbers to resident physicians at teaching hospitals. In general, Medicare regulations do not allow residents to bill Medicare for their services. The exception is if the billable services are related to "moonlighting" activities unrelated to the resident's training program. However, OIG knows of instances where at least one hospital requested and received over 40 billing numbers for its residents over a six-year period. The residents were not involved in "moonlighting" activities, and the hospital used the numbers to improperly bill Medicare for services provided by the residents.

• OIG-excluded providers.

Examine how OIG exclusion data are used to protect federal health programs and their beneficiaries from fraudulent or poorly performing providers. Plus, identify the number of claims still being submitted by excluded providers.

• Improper Medicare fee-for-service payments.

For fiscal year 1998, the Health Care Financing Administration estimates improper fee-for-service payments totaled $12.6 billion, or 7.1% of the $176.1 billion spent on Medicare fee-for-service claims. OIG will perform another study to establish the extent of improper or inadequately documented Medicare payments. ■

Your Y2K to-do list should focus on carriers

Most providers haven't tested claims process

If you have yet to do so, contact your carrier and arrange a test of your ability to submit an electronic claim dated in the year 2000. Otherwise, you may be in for a rude wakening on New Year's Day.

As of late September, less than 2% of all providers had conducted Y2K claims readiness tests with their payers. Of these, 10%-30% of test claims flamed out because of improperly followed instructions, vendor billing software failures, or submitter hardware or software problems.

In turn, experts say group practices are more vulnerable than they realize to a Y2K meltdown — and resulting scheduling and cash flow problems.

Carriers, HMOs vulnerable too

On the flip side, the General Accounting Office (GAO) reports only about half of Medicare carriers have completed their own internal Y2K compliance testing. Additionally, only four of 424 HMOs were fully Y2K-compliant, and more than three-quarters of the contingency plans sent to Medicare by HMOs required significant changes. This revelation has prompted HCFA to demand managed care participants to recertify their Y2K readiness.

The GAO also says some areas were still unprepared to administer federal programs as of late September. According to the watchdog agency, Kentucky, Oregon, Nevada, South Carolina, Missouri, West Virginia, Oklahoma, Georgia, and the District of Columbia are all at "considerable risk" for Y2K failures in the area of administering Medicaid and children's health insurance.

HCFA's own internal computer systems seem to be on schedule to accept year 2000 claims and institute fee schedule changes. However, remember that even if nothing major goes wrong, HCFA still plans to place a two-week hold (Jan. 1-16) on initial year 2000-dated claims and fee schedule increases to allow for potential problems.

In turn, practices should figure on claim payments running from two to four weeks behind their normal processing cycle during this period and plan their cash and payroll needs accordingly.

Tip: Get all your 1999 claims in before the end of the year to avoid getting caught in the Jan. 1-16 holding pattern. ■

Putting more oomph into your billing practices

Here are key billing oversights

Afraid of drawing the attention of the federal fraud police, more physicians are being extra-cautious when billing Medicare. Add to this a series of services that are often unknowingly undercharged by many practices, and the result can be a costly evaporation of legitimate payments.

While it's wise to be prudent in today's regulatory environment, there's no reason you shouldn't be paid fully for legitimate services. Next time you review your back-office practices, check to see if you are making any of the following common billing and coding mistakes:

• **Underbilling for office visits.**

Afraid of being red-flagged by government bean counters, more physicians are taking the cautious approach and downcoding office visits out of fear that claiming levels four and five services will prompt an audit.

Sadly, recent physician office experiences nationwide do partially bear out those fears. But auditors say the real smoking gun they look for is a constant billing of higher evaluation and management (E/M) services across a wide array of patients in a manner that seems inconsistent with normal practice patterns.

Physician offices are caught on the horns of a dilemma. If you do a properly documented multisystem exam of a moderately ill patient that requires multiple diagnoses but you only bill for a level three service instead of level four, you are just denying yourself appropriate payment, which can quickly run into thousands of dollars in a busy practice. On the flip side, billing a level four service for a hypertensive patient who comes in every month could get you into trouble.

• **Mismatching ICD-9 codes and procedure codes.**

Too many physicians simply mark ICD-9 and CPT codes on a superbill and assume the billing office will take care of the rest. However, this habit often means CPT and ICD-9 codes get mismatched or left off the bill altogether. And that's a sure-fire way to get a claim questioned or denied.

One way to avoid this problem is to have the physician place a private code of his or her own (this could be a number or a letter) matching each diagnosis with the corresponding CPT codes on the superbill, to eliminate confusion about which ICD-9 goes with what CPT.

Some experts say it is easier for physicians to use a superbill or fee slip that already lists the practices' most frequently used CPT and ICD-9 codes. Others, however, argue that offices should just do away with superbills and have physicians write out their diagnoses, while more experienced billers fill in the most appropriate diagnosis-related codes. Billers and coders should check with the physician when there are questions.

Are you forgetting the five-digit format?

• **Not using the most specific and recent ICD-9 codes.**

Despite the fact many four-digit ICD-9 codes have been replaced with more specific five-digit codes, many physicians still use the older four-digit format without thinking.

The trouble with that is that Medicare is now prone to challenge these four-digit claims, reports Chicago's Karen Zupko & Associates. Some examiners, for instance, will question why a simple code for abdominal pain was used instead of a code specifying the exact location of the pain.

• **Not using modifiers.**

At first glance, coding rules prohibit billing a patient for an office visit and a minor procedure on the same day. But, it is OK to bill for both an office visit and a minor procedure, provided the physician justifies both charges, the services are properly documented, and a modifier "25" is used to let the payer know more was done than just giving the patient an injection.

The catch is this: if the patient was only scheduled to receive a joint injection, for example, and that's the only service you provided, you cannot charge for both the procedure and the office visit.

• **Not billing for injections.**

According to the ProStat Resource Group in Shawnee Mission, KS, physicians often forget that they can bill for administering injections as well as the drug or vaccine itself.

For instance, while charging for both an injection (a minor procedure) and an office visit on the same day without using a modifier is generally prohibited, there are exceptions. When giving a vaccination for pneumonia, influenza, or hepatitis B, physicians can bill for the office visit, the injection, and the vaccine.

• **Failing to distinguish between new patient visits and consultations.**

A patient consultation pays more than a new patient visit. To justify billing for a consult over a new patient visit, the patient must have been sent to you for a consult by another physician, and you must provide the referring physician with an opinion or advice — preferably in writing — which should be included in the file.

• **Overlooking payment for counseling patients.**

When a physician spends more than half of his or her face-to-face time counseling a patient or coordinating care — such as calling other physicians, making arrangements for diagnostic testing, etc. — they can bill for a higher level of service. That's true even if they don't perform an exam or make a new diagnosis, says practice consultant **Leslie Witkin** in Orlando, FL.

For instance, if a physician sees a patient recently diagnosed with cancer and does nothing during the visit but counsel the patient, talk to family members, and make arrangements for further treatment, the physician still is entitled to code the visit as a level five if more than half of the visit — 20 minutes minimum, because level-five visits must be least 40 minutes long — was spent counseling the patient and coordinating care.

• **Not charging for home care services.**

Each time a provider talks to a home health agency or nurse about changes in treatment or medication for a patient receiving home care, the physician should make a note of when each instance of this communication occurred and exactly how long it took. If, at the end of the month, the physician spent between 30 and 59 minutes overseeing or coordinating care for that patient, the physician is eligible to be paid by Medicare.

• **Forgetting to bill for the nurse's time.**

A level one code can be used for office visits if the nursing staff provide routine services when a physician is not present. However, it is best to only bill when the nurse does those small extra things like show a patient how to use insulin or gives some other kind of detailed instructions. ■

How to get paid when the physician is away

Tips for 'covering' arrangements

Did you know that Medicare permits physicians to bill for services performed by others when they are away from the office? **Brett Baker**, a third-party payment expert in the American College of Physicians-American Society of Internal Medicine's (ACP-ASIM) Washington, DC, office, explains how this is done.

PPU: How can providers bill Medicare for services provided to their patients by a physician who is covering while they are away from the office?

Baker: While Medicare typically only pays physicians who actually furnish a service, there is an exception for "covering physician" arrangements. Medicare will pay you for services provided by a covering physician under the following circumstances:

— You can enter into what's called a "reciprocal billing" arrangement with other physicians to cover each other's practice on an occasional, as-needed basis.

— You can also have a substitute physician cover your practice as an independent contractor when you are away from the office. This is known as a *locum tenens* arrangement.

PPU: What are the differences the fine print in the two kinds of arrangements?

Baker: The rules are similar, but there are some important differences. For instance, a reciprocal billing arrangement is typically an agreement among physicians that one will cover the other's practice when the regular physician is absent. Reciprocal billing arrangements are often informal, and Medicare does not require them to be in writing. No money changes hands, and the regular physician compensates the covering physician by reciprocating in the future under similar circumstances.

Physicians can develop reciprocal billing arrangements with more than one physician. For instance, such arrangements often include physicians who occasionally cover for their colleagues during extended office hours and who cover for colleagues who are on call on the weekend.

The coverage period for reciprocal arrangements is usually pretty short. However, Medicare says they last up to 60 days if certain criteria are met.

PPU: What about *locum tenens* arrangements?

Baker: *Locum tenens* is different in that the substitute physician generally does not maintain a practice, instead traveling from area to area as needed. The regular physician typically pays the substitute physician a fixed per diem amount, with the substitute physician working as an independent contractor, not an employee.

PPU: Are there any specific billing requirements for reciprocal billing arrangements?

Baker: Medicare will only honor reciprocal billing arrangements if the:

— regular physician is unavailable to provide the services;

— beneficiary has arranged or seeks to receive the services from the regular physician;

— substitute physician does not provide the services to the beneficiary over a continuous period of longer than 60 days;

— regular physician identifies the services as substitute physician services.

PPU: What about length of coverage?

Baker: Coverage starts the first day the substitute physician provides Medicare Part B services to the regular physician's patients and extends to the last day on which the substitute physician provides services before the regular physician returns to work, provided it is under the 60-day limit.

PPU: Can physicians in the same group practice have a reciprocal billing arrangement with each other?

Baker: Reciprocal billing arrangement rules do not apply to substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group.

As a result, physicians in medical practices that bill as groups do not need to maintain reciprocal billing arrangements with other members of their group.

PPU: What are the requirements for a *locum tenens* arrangement?

Baker: Medicare recognizes that physicians often retain a substitute physician to take over their professional practices while they are absent for such reasons as illness, vacation, continuing medical education, and pregnancy. Medicare also recognizes that *locum tenens* arrangements will pay the regular physician for services provided by the substitute provider if the:

— regular physician is unavailable to provide the services;

— beneficiary has arranged or seeks to receive the services from the regular physician;

— regular physician pays the *locum tenens* physician on a per diem or a fee-for-service basis;

— *locum tenens* physician does not provide services to beneficiaries over a continuous period of more than 60 days;

— regular physician identifies the *locum tenens* physician on claims submitted for the services provided by the locum tenens physician.

PPU: What about billing?

Baker: When billing under either a reciprocal or *locum tenens* arrangement, enter the substituting physician's unique physician identification number (UPIN) in field 23 of the HCFA 1500 form. If the billing physician is a solo practitioner, the physician needs to list his or her UPIN in field 33. But if the physician works in a group practice, list the UPIN in field 24k. ■

Role of deception grows in obtaining coverage

'Exaggeration' becoming more common

Almost 40% of physicians say they have exaggerated a patient's condition to an insurance company to make sure the patient has coverage for needed treatment or time in the hospital, according to a recent survey conducted by the American Medical Association (AMA) in Chicago.

"Physician deception of third-party payers is prevalent and may be rising," according to AMA investigators.

The most common forms of deception include:

• exaggeration of severity of the patient's condition in order to avoid early discharge from the hospital;

• changing the billing diagnosis to help secure services;

• reporting symptoms the patient did not have in order to obtain coverage and treatments.

Overall, 39% of physicians reported that they had "sometimes," "often," or "very often" used one of the three forms of deception, according to the 1998 survey of 724 doctors in primary care medicine.

Only 28% of physicians said they had never used any of these forms of deception within the last year, and 53% reported they "rarely" used them.

In addition, 37% of physicians reported that their patients asked them to deceive third-party payers, and this was the group of physicians that was most likely to have used deceptive strategies.

Some 31% of physicians had "sometimes" or more often refrained from offering useful or needed services to patients because of a lack of coverage by the patient's plan.

The data were collected by the AMA from its survey of physicians on "Meeting Patients' Needs in the Modern Era."

The report also found physicians who reported using deceptive strategies were:

— less satisfied with the practice of medicine;

— less financially secure themselves;

— less likely to try to talk patients out of unnecessary procedures;

— more dissatisfied with the amount of time available during patient visits;

— more likely to voice annoyance at intrusion of insurance companies into their practice.

Overall, 55% of physicians said they "would be more aggressive in cost control efforts if they knew that money saved would go towards serving more needy patients."

"While physicians' use of deception may benefit individual patients, using deception may also damage the patient-physician relationship, cause moral discomfort for physicians, subvert resource allocation systems, and risk prosecution for fraud," researchers concluded. ■

Study: Harder work needed to maintain pay

Charges outstripping pay increases

Last year, primary care physicians realized only a 2.54% increase in annual compensation, to $139,244, while specialist pay jumped 5.22%, according to the Englewood, CO-based Medical Group Management Association's (MGMA) recent *Physician Compensation and Production Survey: 1999 Report Based on 1998 Data*.

Meanwhile, gross charges increased 4.67% for primary care and 6.51% for specialists, says the MGMA.

(Continued on page 171)

Physician's Coding Strategist™

Same coders handle both physicians and hospital

Accuracy, consistency are achieved

If the pilot project of a Wisconsin research and teaching hospital catches on, the distinct division between hospital services coders and physician fee coders could soon begin to blur, leading to one coder handling both sides of the coding process.

The University of Wisconsin Hospital and Clinics (UWHC) in Madison is using coders who handle both the professional fee side and the hospital services side of coding patient encounters. The three coders at UWHC, who have the job titles of medical center coders, have started their hybrid coding in ambulatory services. Two of them code for the hospital emergency department (ED) and one codes for a dermatology clinic.

"This started out to provide consistent data so that what was coded for hospital services was consistent with what was coded for the physician services," says **Bill French**, MBA, RRA, director of health information services at UWHC, which includes 80 clinics. "As Medicare became more and more of an issue, [it ensured] accuracy on both sides."

When discussions about creating a new type of coder began about six years ago, health information professionals at the hospital and the University of Wisconsin Medical Foundation, an affiliated physician organization, saw changes in the wind. Not the least of these was the eventual spread of prospective payment systems from inpatient to outpatient settings.

"We knew that APGs [ambulatory payment groups] are down the road and wanted to make sure we had good-quality coding for the hospital side," French explains. "And we wanted to base the coding on the actual documentation, rather than on what somebody checked off a list or what the physician may have indicated verbally but did not document."

UWHC expects that coders who have access to both the physicians and their documentation will achieve greater accuracy. "Coders can't just discuss something in the hallway with the doctor. They have to complete the documentation so it accurately reflects what was done to the patient," French says.

Source documents are within easy reach

To bring them closer to patient encounters, UWHC medical center coders are located in the departments for which they code both the hospital and physician services. The two emergency department coders work near the ED, while the third coder is located at the dermatology clinic.

That way, the source documents — narrative, lab results, radiology results, or any diagnostic tests that are done — are within easy reach, French explains, and the coders are in close proximity to the physicians.

"You want them to have good contact with the care providers. You want good communication, and then they also have to have access to the documentation," French says.

The nearness to caregivers will be a key component of the medical center coders' success, predicts **Rita Scichilone**, MHSA, RRA, CCS, CCS-P, PMM, a practice manager in the coding products and services division with the American Health Information Management Association (AHIMA) in Chicago. Because medical center coders will be working closer to the care setting, they will be "more in tune than people in medical records. They'll get a lot more cooperation from physicians

for the information that you need to code for the facility."

In addition, "With one pass through the record, gathering all the information needed for hospital and professional fee coding, the big advantage is consistency of data; you would never have codes disagree. They're constantly in that chart reviewing and updating," she says.

AHIMA offers separate certifications for hospital and physician office coders: Certified Coding Specialist (CCS) for inpatient encounters and Certified Coding Specialist—Physician-based (CCS-P), a new certification that is about a year old.

Coding moves into 'hybrid world'

The idea of one coder handling both sets of coding systems gets a positive response from **Sue Prophet**, RRA, CCS, director of classification and coding for AHIMA. "It's a good idea because we're sort of moving into a hybrid world where the lines are getting blurred, and more and more you see people doing more duties and getting involved in coding in physicians' offices in integrated delivery systems."

"There could be a day where . . . it became one credential and everyone had to know coding in all areas. It's not like that in coding right now," she explains.

"There are still rather defined skill sets that are somewhat different on the two sides for physician services vs. billing for the DRGs [diagnosis-related groups] on the inpatient side. There is enough delineation to warrant two credentials, but if you're working in two areas, there is certainly nothing to preclude people from getting both credentials."

So far, the pilot program gets high marks, French says, though results haven't been quantified. "There are some efficiencies to be gained," he says. "You do find lost charges that may have been coded but not charged for and vice versa."

The pilot is working so well that UWHC plans to expand to 26 medical center coders, each coding both the hospital services and the physician fee sides of patient encounters — as many as 15,000 to 20,000 encounters annually.

The three medical center coders at UWHC are employed by the medical foundation, although they could just as well be employed by the hospital, French says.

The medical center coders are co-supervised by a manager from the physician organization and a manager from the hospital. As the number of medical center coders grows, UWHC plans to hire a separate supervisor to manage them. Under the expansion plan, the supervisor will handle training and education on compliance issues, including making sure the coders are aware of coding changes and the latest HCFA and carrier regulations.

"We're making sure they get all the material and that they understand it, and the supervisor will audit their coding to make sure they can demonstrate the coding," French explains. The supervisory tasks currently are handled by the two co-managers.

Although the medical center coders are expected to possess a larger body of knowledge than either hospital or physician services coders, their salaries are not initially higher than those of their colleagues, French says. "We are addressing pay issues," he adds.

Moving forward, medical center coders will be divided into three levels based on skill sets. "We're breaking it down the way we expect the APG system to break down," he explains.

Level one medical center coders will handle mainly medical visits where no procedures are performed. Level two coders will code roughly three to five medical specialties where procedures could be involved. Senior coders will have the knowledge to "code everything," French says. "Obviously, we'll have more people in the first two levels. The senior level is going to be someone who has been around for a long time and can basically go anywhere and code."

Coders will stay with same doctors

When more medical center coders come on board, they'll be assigned to handling hospital services and physician fee codes for a particular area. "We're not going to play musical coders," French says. "The plan is, the coders will basically stay with the same group of doctors until they are reclassified [to a higher level] and go on to [code] surgery." That way, they'll be able to develop a rapport with a particular group of doctors, he adds.

The plan sounds great to Scichilone, but she wonders where health care providers will find enough coders with the breadth and depth of coding knowledge to handle both the hospital coding guidelines and physician services guidelines. "Where are you going to find these wonderful

people? It's tough to find good qualified coders now," she says.

The answer lies in keeping lines of communication open with local education centers, French says. "We have improved our communications with local and regional associate's-level and bachelor's-level health information programs, as well as local community college programs."

Training current employees also will ensure a solid foundation of knowledge, French says. To master all the necessary information, "You do have to know about the two sets of coding guidelines. But you're going to start out with a small number of specialties, and then you're going to progress. You'll do medical [coding], then some medical and some surgery [coding], and so on. The trick is going to be training these people on how to code in both sets of codes. The two coding managers will develop the training."

UWHC is planning to use implementation teams to ensure that the expansion of the use of medical center coders progresses smoothly. The teams will consist of hospital medical records; coding management; and representatives from fiscal management, human resources, and information systems. Physicians, physician practice managers, and their administrative staff will round out the teams from the Medical Foundation side. The implementation teams also will monitor and audit the pilot project's growth, French says.

Next on the roster of hospital services to receive the benefits of medical center coders: oncology, neurology, transplant, surgery, ENT, orthopedics, and urology. ■

Unknown upcoding can put you at risk

Physicians' decision making is the weak link

One health system's health information services (HIS) department made a troubling discovery when it took over the billing for evaluation and management (E/M) codes for several of its hospitals from a third-party firm.

The company that had handled the coding functions had often "upcoded," or assigned higher levels of service — and higher reimbursement — than government guidelines permit.

Anita Orenstein, ART, CCS, CCS-P, HIS compliance coordinator, quickly made the decision to have the HIS department take over the coding functions, too. "We wanted to ensure the quality and compliance since we were taking the risk for liability," she says.

Orenstein's employer, Intermountain Health Care in Salt Lake City, is a corporation comprising more than 20 hospitals. The HIS department now takes care of the E/M coding and billing functions for six of those facilities.

"Sometimes there is an incentive for outsourcing services to upcode," Orenstein says. "They either get a percentage, or they just want to maintain their contract. If they keep their physicians happy with good reimbursement, the physicians are not going to let them go. But if you follow the guidelines the way they are meant to be used, then you don't have all those higher levels of service. We wanted to ensure that ours were by the book."

E/M codes are used to report physician visits, consultations, and similar services. The level of service assigned is intended to reflect the work involved in providing the service.

Two out of the three primary components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service for the following established or follow-up patient categories or subcategories:

- ❒ office;
- ❒ established patient;
- ❒ subsequent hospital care;
- ❒ follow-up inpatient consultations;
- ❒ subsequent nursing facility care;
- ❒ domiciliary care, established patient;
- ❒ home, established patient.

In June, the current procedural terminology editorial panel of the American Medical Association (AMA) in Chicago submitted its recommendations to the Health Care Financing Administration for revising its documentation for the E/M codes.

The proposed guidelines are said to be less rigid for physicians to use. But the guidelines also may make it easier for physicians to justify a higher level of service.

E/M upcoding is always going to be a problem, says **Caren Reney**, RN, CCS, owner and technical consultant for HealthCare Quality Consultants in Avon, CT. "It's never going to go away."

Several issues contribute to the upcoding problem, she says. One factor is the push toward increased physician productivity. "We have the

government saying physicians have to comply with these guidelines and it's going to pay them X amount [for the services]. Then we have organizations and physician practices saying physicians have to bill X amount of dollars to receive a particular salary in a year."

Both sides are working against each other.

"[Productivity standards] are counterproductive to the physician, but the system is now set up that way," she continues. "I work with academic institutions and private institutions, large groups, hospitals. Everyone has the physician on some sort of productivity standard. The physicians as a general group aren't happy. They are hoping that the new guidelines will give them more flexibility to reach those higher levels of codes."

Another issue pertains to the number of people, such as accountants, who present themselves as coders.

"It's frightening," Reney says. "Some of them don't have the knowledge. When you are hiring accountants with a little bit of coding background, they are going to figure out that the higher codes bring higher dollars. They are trying to meet their customers' requests, which has a tendency to be a problem." Some "true" outside coders refuse to misrepresent the physician services, but Reney calls them "few and far between."

> "The majority of physicians I speak to about medical necessity don't have a clue as to what it means."
> ***Caren Reney**, RN, CCS*

The primary problem that leads to E/M upcoding is a lack of physician knowledge, she says. "Medical necessity is the key to E/M services; a lot of physicians are not being educated to that level. The majority of physicians I speak to about medical necessity don't have a clue as to what it means.

"They are just being educated on meeting the key components, the documentation requirements — such as doing a history, including family and social history — and so many reviews of systems and so many elements for an examination," she continues. "They are not being educated on medical decision making, which is [contrary to their job as a physician]."

When coders or auditors review physician E/M service levels, they often find that the physician meets the history and examination requirements. The medical decision-making aspect, however, is "usually down at a low level, in around one and two," Reney says. "That is usually the weakest area."

For example, one doctor documented a visit with an elderly patient who had anemia. "The doctor wrote in the chart that the patient had anemia, but the doctor gave no parameters for the anemia. There were no blood levels [in the report], even though a lab sheet was in the medical record." The doctor also never said what he was going to do to treat the anemia. "That's medical decision making." The medical director who reviewed the documentation decided it was not sufficient to justify the service.

Physicians should learn more about coding

The "bell curve" for E/M coding is at the third level, Reney says, but many physicians feel that their time is worth more than just that third level. "They are not understanding that time isn't playing a role anymore."

To address the coding problem at the outset, physicians should be taught E/M coding and documentation in medical school, Reney suggests. "The rare school in the United States teaches it at that level."

Physicians with an established practice can teach themselves about E/M coding, too. According to Reney, physicians should use these resources:

❒ They can access the AMA Web site (www.ama-assn.org) to review the guidelines.

❒ They can purchase pocket guides that spell out the guidelines. "The guides are multipurpose and can go anywhere," she says.

❒ They can implement E/M documentation templates for what they see most in their practice.

In recent months, Reney has been providing E/M coding training to residents who have recently graduated from medical school.

"It's been a constant complaint that they have not received any of this training and they are thrown out on the streets to make a living. Then they find out that they can't," she explains. ■

(Continued from page 166)

The gap between the charges different physicians generate and related pay increases illustrates the fact that more providers must work harder and longer hours to maintain their present level of take-home pay after factoring in inflation, says **David F. Thomas**, CEO of Midwest Physician Group in Olympia Fields, IL.

Over the five-year period tracked by MGMA, compensation rose more than 9% for both primary care and specialty physicians. In contrast, gross charges jumped 11.59% and 29.33% respectively.

Pediatric / adolescent medicine — with a pay gain last year of 2.43%, to $135,000 — leads the primary care pack. However, internal medicine still tops the field, with an annual salary of $141,147. Pulling up on the outside was family practice (without OB) at $138,277.

Among the specialties, dermatology had the biggest one-year jump in compensation, rising 9.23% to $193,215. The next biggest gainers were hematology / oncology (8.95% to $212,516), noninvasive cardiology (7.29% to $278,900), and invasive cardiology (7.19% to $350,000).

The 5.22% pay boost among all specialists

Tips on structuring a smart physician pay plan

Throw out the cookie cutter

With physicians having to work harder to maintain their paychecks, compensation questions can lead to serious conflicts among colleagues.

Robert C. Bohlmann, a principal in the Medical Group Management Association (MGMA) Health Care Consulting Group in Englewood, CO, offers some tips on the fundamentals that make a compensation plan successful:

• **Cookie-cutter approaches don't work.**

No one "canned" approach works for everyone. "I know of a heavily capitated group that implemented a cookie-cutter plan which lasted until the administrator blew the whistle, saying, 'If we keep on like this, we'll go broke because nobody is working,'" Bohlmann says.

• **No plan will satisfy everyone.**

The best you can hope for in an "optimum compensation plan" is a consensus of acceptability, not necessarily an overwhelming endorsement by each and every physician.

• **The plan must support practice and organizational goals**.

If it doesn't, you are just driving with the brakes on.

• **It must include adequate work or production incentives.**

Remember, you want to encourage and reward hard work, not make the goals so high or low you stifle the practice's overall work ethic.

• **The plan must peg compensation to the market.**

"If a compensation plan doesn't pay each specialist a reasonable comparative income consistent with productivity, it's doubtful that the plan — or the group — will survive," he says.

• **It must reflect the dynamics of the practice.**

To develop a workable plan, first answer these questions: What are the unique features of practice and market? Where does most of our revenue come from? Who are our main payers? What is our patient mix? How important is managed care to overall reimbursement?

• **The plan must take governance into account.**

Poor governance is the Achilles' Heel of any physician organization. Most groups have moved away from an environment where everybody is boss, but some of this philosophy remains in many groups. "As medical organizations expand in size, a control body is necessary to facilitate success," says Bohlmann.

• **It must deal with the issue of part-time physicians.**

Frequently, part-timers don't fit well into a compensation plan, he says. When part-timers are present in a practice, Bohlmann prefers a negotiated pay arrangement for them. "In the final analysis, successful organizations require that the bulk of their physicians be full-time and producing at a level that exceeds median effort," he stresses.

• **The plan must comply with Stark rules.**

You can create big problems if you don't adhere to this set of restrictions, especially when it comes to ancillary services. ■

represents a "re-emergence of the specialists," says **Susan A. Cejka**, president of Cejka & Co., a St. Louis-based physician recruiting firm that helped fund the report.

Cejka says the recent focus on primary care, especially by hospitals buying up and creating their own primary care practices, dampened the market for many specialists. However, the red ink thus far generated by this primary care strategy is now giving specialists more leverage when it comes to pay talks.

While demand for primary care physicians will remain strong, **Laurie Foote** of Healthcare Management, a health care consulting company in West Springfield, MA, says primary care compensation will experience a "right-sizing."

When you analyze the MGMA study, two major capitation-related trends emerge: Specialists are undergoing pay cuts in heavily capitated markets, and there is a growing disparity in compensation between different areas of the country.

MGMA predicts that as managed care makes up a larger percentage of overall practice revenues, physicians can expect their compensation patterns to follow the following model:

— Once 51%-100% of a specialist practice's total revenue comes from capitation, specialist compensation drops to about $100,000 less than for colleagues with no capitation.

— Primary care practitioners' capitation compensation follows a similar path as specialists, until group capitated revenue reaches 50% capitation. Then, primary care pay starts to increase.

Southern docs make more money

Specialists in the South made $305,800 last year, while those in the West earned $210,073. Primary care physicians in the South outpaced the rest of the country, making $150,000 vs. about $135,000.

Why the big regional pay difference? "The western part of the country is heavily capitated, and the reimbursement rates there are lower," says Cejka. ■

Groups want $3 billion for Medicare underpayments

Sustainable growth rate at issue

Representatives from 40 different physician specialties say problems in Medicare's fee schedule formula have short-changed physicians some $3 billion in legitimate payments over the past two years. They have have formed a coalition to press Congress to correct these alleged mistakes.

Many Capitol Hill insiders say recovering the entire $3 billion is a long shot. However, any money the coalition is able to squeeze out of Congress will be like found money for affected physicians.

At issue is the so-called sustainable growth rate system. Enacted as part of the 1997 Balanced Budget Act (BBA), the sustainable growth rate establishes a target growth rate for Medicare spending on physician services that annually adjusts payments up or down depending upon whether actual spending is below or above the target.

"Despite the fact that Medicare spending on physician services has been growing more slowly than all other Medicare benefits, physicians are the only group subject to this target," notes **Robert Doughtery**, vice president for governmental affairs with the American College of Physicians-American Society of Internal Medicine in Washington, DC.

Provider groups argue that fundamental flaws in the sustainable growth rate formula have caused major errors in its spending projections.

As the Chicago-based American Medical Association (AMA) recently testified on Capitol Hill, last year the Health Care Financing Administration underestimated the gross domestic product by a whopping one-third. This year, the agency estimated Medicare+Choice enrollment would grow by a third, when the actual growth rate only reached 11%.

Combined, these two gaffes cost physicians some $3 billion in otherwise deserved Medicare payments, contend providers.

Bad estimates pegged as culprit

In testimony before the House Commerce subcommittee on health and environment, **Richard F. Corlin**, MD, said: "Physicians — regardless of specialty — are unanimous in our concern that payment cuts due to flaws in the sustainable growth rate, on top of more than a decade of previous cuts, could threaten our ability to continue to offer Medicare patients the finest medical care in the world."

Growth rate announced

Medicare's FY 2000 sustainable growth rate covering expenditures for physicians' Part B services has been set at 2.1%, says the Health Care Financing Administration. The new rate went into effect in October. ■

Providers want Congress to cough up so-called give-backs, erasing some of the funding cut by the BBA for hospitals, skilled nursing facilities, home health, and other Part A providers. Physicians are pressing an equity argument to get the sustainable growth rate shortfall included in any budget revision bill.

One congressional champion of the campaign to revise the sustainable growth rate is Rep. **Greg Ganske**, MD (R-IA), who took HCFA to task at the September House hearing for not correcting the problems with the formula faster and failing to respond to provider complaints.

Changes in fee schedule sought

Providers want Congress to authorize payment of the $3 billion they say was mistakenly not included in Medicare's physician fee schedule payments over the past two years, then implement changes in the formula already recommend by the Medicare Payment Advisory Committee (MedPAC). MedPAC's suggested changes would:

1. Create an add-on to the sustainable growth rate formula allowing for technological changes in medicine that increase the demand for physician services.

2. Create an add-on to the formula to account for the rising cost of ambulatory care practice, brought on by the shift in care from hospital inpatient settings to outpatient sites.

3. Instruct HCFA to periodically adjust the formula to allow for changes over time in the characteristics of patients enrolling in Medicare+Choice plans compared to those remaining in the fee-for-service program.

4. Raise the lower limit on formula updates to provide a more acceptable floor on payment updates.

5. End formula projection errors by giving the administration the authority to change projections as new Gross Domestic Product (GDP) data become available or by requiring the administration to update the formula using actual GDP data. ■

Part B claim challenges may be handled by phone

HCFA proposal would speed appeals

The Health Care Financing Administration (HCFA) has released a proposed rule change that would permit providers, patients, suppliers, and carriers to challenge Medicare Part B initial claim determinations by telephone.

Currently, claim appeals and responses must be submitted in writing and filed with HCFA and the carrier. After its initial decision, the carrier must give the provider (or another party) six months to request a review of the action. Upon the provider's request, this initial review period can be extended an additional six months.

Under HCFA's new rule, the current review time frames still stand. However, both providers and carriers would have the option of asking to have a decision reviewed by telephone.

Formalizing an informal process

HCFA notes that the current paper review process can be time-consuming. The agency also says both physicians and beneficiaries already frequently call the carrier to dispute a determination, to ask for clarification, or to protest a denial. HCFA wants to be able to turn these informal inquiries into a formal appeals pleading.

Besides saving time, HCFA hopes the process will provide more opportunity for an exchange of questions, answers, and explanations between the agency and providers, resulting in better give-and-take during the appeals process.

HCFA also considered the idea of letting providers file electronic or e-mail appeals, but decided to table that option for now.

The proposed rule is scheduled to go into effect Feb. 1, 2000. HCFA is accepting comments on the rule until Nov. 29. To submit comments, mail an original and three copies of written comments to:

Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA-4121-FC
P.O. Box 9013
Baltimore, MD 21244-9013

To view the full text of the final rule on the Internet, go to: www.access.gpo.gov/su_docs/aces/aces140.html, and search under the date 09/30/99, with the search term "telephone." ■

Feds taking closer look at hospital-owned practices

Billing habits will be surveyed more closely

Integrated systems can expect closer scrutiny of hospital-owned physician practices as a result of a recent Department of Health and Services Office of Inspector General (OIG) report alleging many of these groups are overcharging Medicare.

Inspector General **June Gibbs Brown** contends that half of the hospitals investigated improperly labeled their physician practices as outpatient departments, even when the doctor's office was located nowhere near the hospital. That allowed them to take advantage of differences in Medicare outpatient payment schedules between hospital-based claims, which receive higher reimbursement, and physician office-originated claims.

All practices to be treated as freestanding

Brown's Sept. 20 OIG report recommended the Health Care Financing Administration:

- treat all physician practices as freestanding to eliminate hospital overcharge of Medicare;
- only pay hospital-owned practices according to its physician fee schedule;
- have hospitals report all purchases of physician practices and clinics;
- require hospitals to declare how the costs of such facilities are represented on cost reports;
- require hospitals to treat all physician practices they own as separate entities for billing purposes, except for such special situations as where a clinic has for a long time been located in a hospital building.

Medicare's Deputy Administrator **Michael Hash,** however, disagrees with Brown's position, saying the complicated nature of a hospital's relationship with its physician practices makes the IG's proposal impractical.

Hash, instead, wants to clarify Medicare rules governing when physician practices may be treated as integrated with a hospital and seek new legislative authority to punish any attempt to evade the rules. ■

New accounting rule takes effect in November

As of Nov. 26, the accrual basis accounting rules according to which employers declare payroll taxes as a Medicare allowable cost would be changed, under a regulation being proposed by the Health Care Financing Administration.

According to an analysis by the Washington, DC, office of the Medical Group Management Association, the payroll taxes that providers currently pay to the government are included as allowable costs only in the cost report period in which the payroll is paid. For example, if payroll is accrued in the first year and not paid until the second year, employers may not designate the taxes as a Medicare allowable cost until the second year, when the payroll actually is paid.

Taxes to be paid in year of accrual

HCFA's new rule would allow an exception when the payroll is accrued in one year and paid in the second year — provided the payment day is regularly scheduled in the second year. As a result, employer-providers could declare the accrued taxes on payroll for the same year in which the payroll was accrued, rather than the year in which it was actually paid.

The bottom line is that practices can now deduct these accrued Medicare payroll tax payments a year earlier. ■

COMING IN FUTURE MONTHS

- What the new physician fee schedule means for you
- Solutions to problems with advance beneficiary notices
- Is an MSO right for you?

Reimbursement ROUNDUP

ASCs get pay hike

Ambulatory surgical center (ASC) facilities received a small pay hike as of Oct. 1. These new rates are in effect until the new ambulatory payment classification pay system goes into effect next year.

The new ASC rates are: Group 1/$317; Group 2/$425; Group 3/$486; Group 4/$699; Group 5/$683; Group 6/$794; Group 7/$949; Group 8/$934.

Medicare covers insulin pumps

HCFA now covers insulin infusion pumps for seniors with Type I diabetes, which affects about 5%-10% of the estimated 16 million Americans with diabetes.

The agency, however, declined to also cover insulin pumps for Type II diabetic seniors, saying the devices had yet to be shown effective for these patients.

"Making the insulin pump available to Medicare beneficiaries will improve the quality of their lives. The infusion pump offers them a choice to better control their condition so that they are more active and productive," said HCFA Deputy Administrator **Michael Hash.**

Medicare to garnish some payments

As part of its get-tough program, HCFA on Sept. 21 published a proposed rule giving it power to "offset" Medicare payments to providers whom it says have been overpaid by Medicaid and have not yet refunded the money.

Crackdown on home oxygen therapies

HCFA has launched a crackdown on improperly documented certificates of medical necessity (CMN) for home oxygen equipment.

A recent Office of Inspector General audit of medical records and billing documentation for home oxygen therapy found one-quarter of oxygen CMNs were either inaccurate or incomplete. Indeed, 27% of the claims reviewed lacked proper documentation, confirming test results recorded on the CMN. Even more suspicious, 13% of beneficiaries reported they never used their portable oxygen systems.

In response, HCFA has agreed to target oxygen claims for focused medical review.

Magistrate nixes 'down payment' challenge

A lawsuit by 11 provider specialty organizations challenging the propriety of HCFA's decision to use 1998 rather than 1992 as the base year for calculating the so-called "down payment" — which kicks off a four-year transition to Medicare's new relative value unit-based physician fee schedule — recently took a blow when a federal magistrate reviewing the case recommended to the U.S. District Court in Chicago that the agency's action was reasonable.

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), $419. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $335 per year; 10 or more additional copies, $251 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 $70 each. (GST registration number R128870672.)

Editorial Questions

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

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Physician's Payment Update	1 0 5 0 - 8 7 9 1	9/24/99
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$419.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta,
Fulton County, GA 30305

Contact Person: Willie Redmond
Telephone: 404/262-5448

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Larry Reynolds, same as above

Managing Editor *(Name and Complete Mailing Address)*
Glen Harris, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Medical Economics Data, Inc.	Five Paragon Drive
	Montvale, NJ 07645

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Physician's Payment Update
14. Issue Date for Circulation Data Below: November 1999

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			668	575
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	530	450
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	0	0
	(4)	Other Classes Mailed Through the USPS	0	0
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			530	450
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	0	0
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			10	10
f. Total Free Distribution *(Sum of 15d and 15e)*			10	10
g. Total Distribution *(Sum of 15c and 15f)*			540	460
h. Copies Not Distributed			128	115
i. Total *(Sum of 15g, and h.*			668	575
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			98	98

16. Publication of Statement of Ownership
Publication required. Will be printed in the November issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher — Date: 9/24/99

Brenda L. Mooney

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
6. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
7. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

The hospital-intensive specialties backing the lawsuit argue that HCFA did not have the authority to take the action it did and that the law required the earlier 1992 time frame be used as the base year.

The difference between the two dates translates into nearly $500 million in additional payments to primary care-oriented doctors during base year transition, which mainly came out of the pockets of surgical specialties. Also, the later date acts as a multiplier, increasing future payments to office-based practices at a faster rate than if 1992 was used.

While awaiting the U.S. District Court's final decision, specialty groups are also waging what some consider to be an uphill battle to convince Congress to delay implementation of the practice expense transition process. ■