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Persistence and a good system can boost your payment rates

Here are 10 ways to get the money that slow payers owe you

You have heard it all a thousand times before from payers:
— *"I'm sorry, we don't have any record of receiving that particular claim."*
— *"I'm glad you called. We have some problems with the way that claim was coded."*
— *"You say no one returned your previous calls? That's strange."*
— *"It looks like we're going to need more information before we can authorize payment."*

Health plans have always been good at finding ways not to pay providers. What's more, "based on reports from practices across the country, the situation seems to be getting even worse," says **Dave Gans** of the Medical Group Management Association (MGMA) in Englewood, CO.

"Many payers seem to be creating obstacles to cutting a check, hoping providers will just give up and write the bill off," says **Heather Bossin**, executive director of the Washington University School of Medicine, a St. Louis-based tertiary care faculty practice for more than 800 physicians at more than 60 sites.

One of Bossin's main jobs is to oversee the Washington University Shared Billing and Collection Service (WUSBCS), one of the country's largest centralized academic billing operations. WUSBCS's mission is simple: "Get our receivables in and out fast, preferably within 45 days," she says.

When it comes to administrative and coding hassles with payers, on average about 10% of the school's claims are denied, and another 20% end up in reimbursement limbo — neither rejected nor paid.

When confronted with a case of payer amnesia, "We don't just write off an account simply because we haven't gotten a response from the payer," Bossin stresses.

Here are 10 tactics these St. Louis providers and the MGMA recommend to get payers to respond when they put on the long stall hoping you will just give up and go away before receiving proper payment.

1. **Tag and route unpaid invoices.** WUSBCS routes its unpaid invoices through the IDX Paperless Collection System, which identifies target invoices and forwards them to the appropriate staff for action. Each receivable is sorted by major payer groups, allowing staffers to develop in-depth knowledge about each payer's payment habits and working relationships with their plan counterparts.

Starting with that approach allows you to quickly get on top of which accounts need attention and give responsibility for the follow-up to specific employees.

2. **Track your mistakes.** The billing software's rejection subsystem at Washington University tracks the volume of claims that are rejected or delayed due to departmental omissions or errors in registration and coding. That information is broken down by code and given to each department, which can use it to spot patterns by type of mistake and individual provider or coder.

"This kind of information helps us identify what and who needs training," Bossin notes.

3. **Know when to fold 'em.** If a rejected or denied claim requires action from the clinical department to be resubmitted, a request is sent to that department. If there is no internal response within 90 days, the charge is automatically written off to a special adjustment code.

Previously, billing would just keep resending such requests. Meanwhile, "the receivable would stay on the books. That's an inefficient way of working," says Bossin. "Now, claims we can't do anything about get written off."

4. **Use internal consultants.** Each clinical department is assigned an accounts receivable consultant. Smaller practices may want to use an in-house coder or biller to perform the same function.

Among the consultant's duties are these: Prepare the department's monthly claim reports, meet with staff to identify issues that delay reimbursement, identify specific late payers / types of services that are experiencing payment delays or denials, and help resolve accounts.

5. **Follow up aggressively.** Once a pattern of delays or denials has been established, WUSBCS follows a progressively more aggressive line of attempts to collect legitimate payment. A fundamental attitude to take in such situation is this: Don't be afraid to go over someone's head. For instance, Bossin's staff start by talking with the payer's line people. If the problem is not resolved, they move on to the director of billing operations. When contracting agents are needed to resolve the issue, they are contacted. If necessary, the provider's lawyer gets involved.

"A lot of people hesitate to take it to the next step with payers," notes Bossin. "They don't follow up with someone at the management level." It can be frustrating at times, but once payers know you're going to be persistent, they start to realize they might as well go ahead and deal with you, she adds.

6. **Categorize denials.** When claims are denied or returned for information, the charges are posted with a code noting the reason the claim was returned, then they are sorted, prioritized, and routed to the appropriate staff specialist for resolution. Denied or returned claims for medical reasons — such as medical necessity or current procedural terminology issues — are sent to a special appeals team for resolution.

When setting collection priorities, "why work first on aged accounts that you have to research the reason for the delay when you have the reason already at hand?" she asks.

7. **Set benchmarks.** Each clinical department at the medical school receives monthly reports on its claims accounts. In addition to accounts receivable performance, the reports include the volume and aging of fatal edits (missing information) and automated request forms (ARFs) pending. ARF reports summarize the volume and aging of accounts that are pending requests for information. Those volumes are compared to prior periods, other clinical departments, and schoolwide averages.

This information is compared among departments and discussed at regular management meetings. "No one likes to be the worst in the group," says Bossin.

8. **Monitor performance.** All claims that remain in third-party follow-up files for a certain period of time automatically are rerouted to the unit

supervisor to troubleshoot and to identify underperforming or undertrained staff.

9. **Act.** Employees are assigned a target number of invoices to act on each day. At WUSBCS, staff are expected to take action on 50 to 80 invoices daily. "If you follow up, you usually get your money after the first action," she says. "Accounts older than four months may have slipped through the cracks at first and possibly a second time, which is an indication of a different problem. You should hound payers; make it difficult for them to ignore you."

10. **Collect.** Those third-party collectors who collect from insurance companies are not assigned other duties, such as payment postings or refunds. They work exclusively in a specific payer grouping, such as Medicare, or government and commercial accounts. They learn the formal rules of their third-party payers, along with the unwritten rules and habits of specific departments.

"Some billing operations want each staff person to be a kind of jack-of-all-trades — post payments, appeal charges, and handle correspondence," says Bossin. In the process, however, collections can get pushed aside. "By placing a focus on our collectors, we can get them the training and mentoring they need" to do their best all the time. ■

Physician compensation: The carrot vs. the stick

Laying the foundation for a sound program

(This is the first of two articles on developing a sound physician compensation package. The second article will appear in the April issue.)

Private practices and other organizations that employ physicians tend to offer them compensation packages designed around a base salary plus bonuses or other incentives for meeting certain performance criteria.

While the packages' basic structures may seem similar, the details of these base pay plus incentive plans can be arranged in a variety of ways, says **Kent J. Moore**, an analyst with the American Academy of Family Physicians in Leawood, KS. Here are some of his insights on what should be taken into account when evaluating various physician incentive packages. Most incentive systems have either a positive or negative structure — a carrot or a stick, Moore says. A positive structure rewards you if you meet or exceed your goals but doesn't penalize you for not reaching them, as a negative structure does.

"The withhold is the most common negative incentive," he says. Part of physicians' compensation is withheld until the end of each accounting period. If the physicians achieve the goals, they receive the withheld pay. If not, they may receive only part of the withhold or none at all.

The withhold is a negative incentive because physicians generally consider it as part of their base pay. Thus, "getting your withhold is seen as receiving your due, while getting only part or none of it is seen as a penalty for poor performance," says Moore.

A subtle connotation

With a bonus, however, you receive extra compensation if you meet certain goals. Failure to receive a bonus doesn't carry the same negative connotation that failure to receive a withhold does because many physicians see it as extra income rather than part of their base pay.

"Of course, there can be a fine line between negative and positive compensation," he points out.

For example, if the practice sets productivity goals low enough so physicians can meet them with no difficulty, then the bonus (intended to be a positive incentive) may start to be regarded as a potential withhold (a negative incentive).

While the net result in terms of money paid out may be the same, the physician earning it doesn't see it that way. "The trend today is to use negatively structured incentives less frequently because doctors look more favorably on incentives based on positive reinforcement," Moore points out.

Another factor to consider when evaluating incentives is whether they are based on individual or group performance. "The trend is toward systems based on the performance of large pools of physicians rather than on individual or small-group performance," Moore says. That spreads the risk and lessens the financial impact on the individual physicians in the pool. It also means superior producers will not benefit as much from their efforts as under a system based on individual performance.

Here's a tip: Because of their nature, physicians in larger risk pools usually don't feel the financial impact of such things as poor clinical decisions or budget cuts as acutely as do physicians whose incentives are tied solely to individual performance. "That's one reason why incentive packages based on group performance are gaining popularity," Moore explains.

Yardsticks to use

Incentives can be based on almost anything that can be measured. Some of the most frequently used measures include:

• **Productivity.** Incentives tied to physician productivity are increasingly common. Moore notes. Different ways productivity is measured include charges, relative value units, panel size, hours worked, or patients seen per day. How an employer decides to measure productivity will depend on the nature of the organization and what type of productivity it's trying to reinforce.

• **Patient satisfaction.** Although not as easy to measure as productivity, patient satisfaction is an increasingly common basis for incentives. Practices are caring more about patient satisfaction, sometimes captured in scores known as service ratings, because employers and accreditation organizations such as the National Committee for Quality Assurance (NCQA) care about them. Patient satisfaction measures reflect patients' attitudes and perceptions of the health care they've received. The ratings may be based on waiting times, physician accessibility, patient retention rates, the thoroughness of exams, or patient education efforts.

• **Citizenship.** This measures how much time physicians devote to activities related to organizational goals and objectives such as participation in governance committees and peer review. "Traditionally, time spent on citizenship tasks has been included in a physician's base pay, but it's increasingly being rewarded with incentives to get doctors to play stronger leadership roles in their organizations," says Moore.

• **Quality of care.** With the increased emphasis on promoting quality in health care, more practices are tying incentive payments to quality measures. However, quality is difficult to measure, and indicators such as NCQA's Health Plan Employer Data and Information Set (HEDIS) tend to focus on processes rather than outcomes. "Despite this, HEDIS indicators are probably the quality measures most commonly used today," he notes. A good incentive system should be based on a broad variety of quality measures such as rates of immunization, mammography screening, and prenatal care.

• **Utilization.** Service utilization, sometimes called resource management, focuses on appropriate use of services by a particular physician or practice site. Ideally, appropriate utilization should be based on an actuarial analysis of your patient mix using such variables as sex, age, and illness severity.

"The point of using utilization as an incentive is to make you aware that you're practicing in an environment of finite resources and that your medical decisions should take into account effective use of those resources," Moore stresses. A manageable incentive system probably should include only four or five utilization measures and should align with your organization's values. Measures may include formulary compliance, avoidable emergency department use, hospital days, costs of referrals to other specialists, and use of ancillary services.

The overall package

Other factors Moore says comprise a good incentive system include:

• **Alignment.** "The incentive system must align with the organization's goals and your patients' best interests," he says. For example, if the organization's goal is to save money (as opposed to maximizing revenue), but its incentive plan rewards the physicians who bill the most, the practice's goal and its incentive plan are in conflict. "Aligning incentives is like ensuring that everyone in a boat is rowing in the same direction. If it happens, you get where you want to go. If not, you go in circles," he says.

• **Fairness.** The incentive system should be perceived as fair. For example, in a fair incentive system, groups or individuals would be rewarded in a way that corresponds to their contribution to the organization's goals.

• **Physician input.** A good incentive system should include physician input. For example, if incentive pay is based on performance, and physicians participate in setting the performance standards, they're likely to have a sense of ownership of the system. That fact makes it easier for physician employees to support it. Plus, their input may be useful in identifying other areas of the practice that can be targeted for improved performance.

• **Balanced risks and rewards.** "To the extent that the system transfers financial risk to the individual physician, it also should transfer opportunity to share in any realized rewards," says Moore. Incentive systems that transfer risk without transferring a proportionate chance for reward lack credibility and gain little sense of physician ownership, he adds. In turn, just as higher risk in the financial market yields potentially greater returns on investment, so should the amount of risk assumed determine potential gains.

• **Simplicity.** An incentive system should be simple in concept and easy to implement. Keep goals and other measures of success to a minimum so they can be understood and focused on.

Tip: "Any incentive system that can't be characterized in one or two sentences will probably implode over time," Moore predicts.

• **Control.** A good incentive system will focus on factors that can be controlled. For example, while it might make sense for performance to be based partially on referrals to other specialists (over whom you have some control), it makes little sense to base an incentive on facility administration costs (over which you have no control).

• **Attainability.** The basic goals of any good incentive system should be both realistic and attainable. ■

Medicare HMO rates in for a reshuffling

New formula could affect practice management

Physician practices may see another round of patient benefit cutbacks, withdrawals from the Medicare Plus Choice managed care program, and miserly rate adjustments in provider contracts.

The Health Care Financing Administration's recent announcement that next year's federal payments to Medicare HMOs will increase only an average 2% drew a pointed response from the top HMO lobbyist. **Karen Ignagni**, president of the American Association of Health Plans, commented in a press release that the small increase "amounts to a government-initiated benefit take-away."

With commercial health plans getting double-digit raises in their premiums from employers, Medicare managed care contractors feel as though HCFA is leaving them out in the cold.

The major reason for the proposed minuscule pay raise is that Medicare wants to change the way it establishes rates and pays HMOs. Instead of the basic age-, sex-, and location-based formula used to set risk rates, Medicare wants to make health factors the determining element in its payment policy. The basic idea behind HCFA's revised rate structure is simple: It will pay more to care for sicker patients and less for healthier ones.

For instance, under the health-based approach, HMOs could receive more than $26,000 per year for each member with a severe disease, according to estimates from the American Society of Internal Medicine-American College of Physicians. However, those same plans also could see current payments drop as much as 20% for healthy members.

That means practices could receive better reimbursements rates from plans for treating those sicker Medicare patients. However, doctors with a healthier clientele might face a pay cut.

Because HCFA intends to take the next four years to phase in the new managed care rates, look for several more twists and turns. ■

Pressure is building for more preventive care

Medicare urged to expand test coverage

Pressure is building on Congress to increase the number and scope of preventive care tests and services covered by Medicare. However, that effort is being complicated by competing cost considerations, such as Medicare paying for a drug prescriptions and catastrophic and long-term care measures, experts say.

The prestigious Institute of Medicine (IOM) in Washington, DC, for instance, has called for Congress to expand Medicare coverage to include such preventive services such as medically necessary dental care, skin cancer screening, nutrition therapy, routine care in clinical trials, and elimination of the three-year limit on immunosuppressive drugs for transplant recipients.

The IOM also is seeking the eight screening services recommended by the U.S. Preventive Services Task Force for people older than 64. Those services include blood pressure testing, height and weight checks, and screenings for vision and hearing impairments and problem drinking.

Currently, Medicare covers flu, pneumonia, and hepatitis B shots; mammograms; Pap smears; pelvic exams; colorectal screenings; diabetes self-management; bone mass measurements; and prostate screening tests.

The Health Care Financing Administration already funds a demonstration project for up to 1,800 Medicare beneficiaries with coronary heart disease to enroll in a program for reversing heart disease created by Dean Ornish, MD, who is founder and president of the nonprofit Preventive Medicine Research Institute in Sausalito, CA.

The project's goal is to determine whether a lifestyle modification program — a low-fat, low-cholesterol diet and moderate exercise — is a safe and effective alternative to bypass surgery and angioplasty.

Legislation sponsored by U.S. Sens. Bob Graham (D-FL) and James Jeffords (R-VT) adds eight new preventive screening and counseling benefits to Medicare's list. Those include hypertension, glaucoma, vision, hearing, cholesterol and osteoporosis, smoking cessation counseling, and hormone replacement therapy.

While it's hard to argue with the idea of preventive medicine, some critics say it is fiscally unsound to add more items to Medicare's coverage when many of the items on the current list of approved preventive services are being underutilized.

"The basic problem is that the Medicare benefit package, as it is now designed, does not distinguish between effective and ineffective services," says **John Wennberg**, MD, of Dartmouth College in Hanover, NH.

Before adding more preventive benefits, "the entire benefit package needs to be re-examined using the criteria of evidence-based medicine," Wennberg says. ■

HCFA focusing attention on benefit claim checks

Company gets $87 million contract

As part of its 2000 waste, fraud, and abuse program, the Health Care Financing Administration has awarded its first national contract to an outside vender to ensure Medicare does not pay health care claims that are the responsibility of private insurance companies. HCFA's new national coordination of benefits (COB) contractor will be Group Health Inc. in New York City.

"Medicare dollars must be spent on legitimate services for elderly and disabled Americans, not to pick up the tab for other insurance companies," HCFA administrator Nancy-Ann DeParle explained when announcing the contract.

Under the arrangement, Group Health will coordinate Medicare payments with other insurance companies by collecting, managing, and reporting claims information. The total cost of the contract will be $87 million over five years.

For those unfamiliar with the rules regarding coordination of benefit payments, here's a summary provided by HCFA:

• Patients age 65 or older covered under an employer's group plan based on their, or their spouse's, current employment must use those benefits. The same applies for people who have Medicare based on a disability and who are covered under the plan of an employer of 100 or more employees (or a multiple employer plan that includes an employer of 100 or more employees).

The ESRD exception

In such cases, Medicare only pays for benefits not covered by the employer's group plan. However, there is an exception for patients with end-stage renal disease (ESRD).

• Seniors who have or who develop ESRD and are covered under an employer group plan must use those benefits for the first 30 months after becoming eligible for Medicare based on ESRD. Medicare then becomes the primary payer. However, if the employer's coverage was secondary to Medicare when the patient developed ESRD, Medicare continues to be the primary payer.

If any no-fault liability insurance or payment from a liable third party is available, then the benefits under that plan (or from that liable third party) must be applied to the costs of health care covered by Medicare.

Where Medicare has provided benefits and a judgment or settlement is made with a no fault or liability insurer (or liable third party), it must be repaid. ■

Physician's Coding Strategist™

New rules apply to office visits, consultations

Avoid trouble: Know the difference

If you have not already, you need to update your reference manuals to account for Medicare's new clarifications of when it will pay for a consultation as compared to an office visit.

"Its vital to understand the changes since consultations tend to be reimbursed at a higher rate than comparable office visits," emphasizes **Kent J. Moore**, manager for reimbursement issues at the American Academy of Family Physicians in Leawood, KS.

According to Moore, Medicare now pays for a consultation only when all of the following criteria are met:

1. The service is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it's a patient-generated confirmatory consultation; i.e., a second opinion).

2. The request and need for the consultation are documented in the patient's medical record.

3. After the consultation, the consultant prepares a written report of his or her findings and provides it to the referring physician.

If the referring physician and consultant share the medical record, the request for a consult must be documented in one of three ways:

- as part of a plan in the referring physician's progress note;
- as an order in the record;
- as a specific written request for the consultation.

Likewise, the consultant's report may consist of an appropriate entry in the common medical record.

When the medical record is not shared, the request for a consultation may be documented in one of two ways. The consultant's record may include either a written request from the referring physician or a specific reference to the request. In either case, the consultation report should be a separate document supplied to the referring physician, says Moore.

When you consult

When you are the consultant, you could bill a consultation for performing a postoperative evaluation if you didn't already perform the preoperative consultation, he notes.

If another physician in your group asks you for a consultation or a surgeon asks you to perform a preoperative consultation, Medicare will reimburse you for a consultation as long as the previously mentioned criteria for use of the consultation codes are met.

It is also possible to bill a consultation code for performing a postoperative evaluation at a surgeon's request, but only if you did not already perform the preoperative consultation.

However, if you assume responsibility for management of a portion or all of a patient's condition during the postoperative period (such as the management of a local patient who receives surgery out of town), you may not bill a consultation code, regardless of whether you performed the preoperative consultation. Rather, you should use the appropriate subsequent hospital care code or office visit code to bill your services, Moore recommends.

Time can play a role in new guidelines

Legal guardians recognized

The American Medical Association (AMA) has clarified its evaluation and management instructions on how to use time as a way to select a level of service when counseling or coordination of care dominates the encounter — or accounts for more than 50% of the interaction.

Brett Baker, a reimbursement expert with the American College of Physicians-American Society of Internal Medicine in Philadelphia, notes that, specifically, the new counseling and/or coordination of care time guidelines now include "time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in locum parentis, legal guardians)."

"It is important to note that your third-party payer may accept or reject this clarifying language," reminds Baker. In turn, you should check to see which payers are accepting this revision and reimbursing time spent counseling or coordinating care with non-family members.

The AMA also has instituted revisions intended to help resolve some longtime questions about critical care coding. For instance, the word "unstable" and the phrase "requiring the constant attendance of a physician" are deleted from the descriptor for code 99291, Baker says. The time designations in the code descriptors also were revised to correlate with the instructions for reporting a critical care service of less than 30 minutes.

"The revised descriptor for code 99291 specifies that a critical care service must be at least 30 minutes long to be reported using a critical care code. The previous descriptor was less clear. It stated that code 99291 could be reported for the 'first hour' of critical care," Baker notes.

The code now reads: "99291 Critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes."

Code 99292 is an add-on code that describes each additional 30 minutes of a critical care service. It should be listed separately and in addition to code 99291. ■

If the criteria for a consultation are met, a consultant may bill an encounter as a consultation even if he or she initiates treatment, unless a transfer of care occurs.

A transfer of care occurs "when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance."

In such a case, the receiving physician should bill an established or new patient office visit code, whichever is appropriate, rather than a consultation code, Moore says.

Any subsequent visits to manage a portion or all of the patient's care should be reported using a visit code.

When it comes to consultations, **Brett Baker**, a reimbursement expert with the American College of Physicians-American Society of Internal Medicine in Philadelphia, also notes that physician consultants may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The phrase "at the same or subsequent visit" clarifies that physicians can report a consultation even if they initiate treatment (assuming that the criteria for billing a consultation are met).

However, if you assume responsibility for all or a portion of the patient's care, "do not use CPT consultation codes for subsequent visits," Baker warns. Instead, use the subsequent hospital care codes (99231-99233) in the inpatient setting and the established-patient office visit codes (99211-99215) in the outpatient setting, he advises.

Also, he says a physician request for an opinion from a consultant may be verbal or written. However, it must be documented in the patient's medical record.

Additionally, remember that physician consultants must now send a written report detailing their opinions and any diagnostic and/or therapeutic services to requesting physicians, says Baker. ■

New insurance offered for billing risks

Also protects against technology threats

Your risks against technology threats and billing mistakes are increasing. Have you thought about protecting your organization?

The American Hospital Association (AHA) in Chicago recently tackled the problem and endorsed two insurance products. The first, E-Comprehensive, offers a combination of insurance and embedded risk management and loss control. It was developed in collaboration with Underwriters at Lloyd's in London and Information Risk Group of Raleigh, NC.

"E-Comprehensive is the only product of its kind that we are aware of," says **Kathleen Stiens**, marketing communications supervisor for the AHA Insurance Resource. AHA Insurance Resource is the insurance and financial service subsidiary of the AHA; it evaluates the marketplace and collaborates with insurance companies to create products and services for health care companies.

Providers soon will have a lot more to lose through technology threats, with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 not only legislating strict guidelines on the privacy, security, and confidentiality of electronically transferred information, but also imposing strict penalties on providers who fail to protect it.

E-Comprehensive covers losses including those caused by fraudulent and malicious acts committed by employees or third parties against an insured's computer systems, electronic computer programs, or electronic information and records, as well as those caused by computer viruses that attack or close down the operations of the insured. Financial losses resulting from fraudulent input into computer systems also are covered, as are losses resulting from accidental alteration or destruction to electronic information and records.

Additional features include coverage for:

- loss of intellectual property when trade secrets are copied or recorded;
- extortion when someone threatens to introduce a computer virus into the computer system or threatens to divulge, disseminate, or use information held on the computer systems;
- business interruption and extra expense caused by a computer virus or accidental or malicious destruction of the electronic information inside the computer system;
- costs of loss control services rendered by information security experts to mitigate loss;
- multimedia liability such as libel, slander, invasion of privacy, infringement of copyright, plagiarism, and false advertising;
- computer systems liability such as prevention of authorized access, including denial of service, damage to a third party's computer system, breach of security, theft of information, hosting, or breach of duty;
- expenses for legal fees in defense of a claim;
- rehabilitation expenses to reestablish reputation and market share after loss or claim.

Limits are available up to $50 million, with a minimum deductible of $15,000 and minimum premium of $20,000. A satisfactory survey of an insured's computer systems is required within 45 days of the policy inception.

Guard against fraud investigations

The second insurance program, FFActs, protects providers that have made unintentional coding and billing mistakes in spite of their "good faith compliance efforts, " according to the AHA Insurance Resource. This program also helps buffer providers against the financial costs incurred through the defense of an investigation.

Other policies do exist in the marketplace, but most are considered too expensive for small- to medium-size hospitals, says **Kathleen Stiens**, marketing communications supervisor.

Anthony J. Burke, CEO of AHA Insurance Resource, says AHA chose the FFActs program because of its flexibility in pricing, deductibles, and limits. FFActs combines technical coverage, risk engineering, and legal expertise to create a risk management program. An upfront risk management assessment is conducted using risk profiling software to measure an insured's risk exposure. Based on the results of the risk assessment, limits and deductibles are determined.

Additional features include:

- limits up to $100 million;
- deductible options as low as $25,000;
- retroactive coverage for defense and indemnity;
- tailored risk profiling at no additional costs;
- discounts on shadow audit work and compliance software;

• access to specialized network of legal experts;

• automatic subscription to the AHA Health Care Compliance Service.

[Editor's note: For more information about either of these programs, contact John Stein, marketing manager of AHA Insurance Resource, at (800) 242-4677, ext. 2530.

Also another popular billing errors and omissions policy is offered to providers by Chubb Executive Risk in Simsbury, CT. The company can be reached by telephone at (860) 408-2000 or e-mail at info@execrisk.com.] ■

Feds open data bank to help boost quality

The public can't access the information

The Department of Health and Human Services' Office of the Inspector General has launched another tool to help ensure health care quality and fight health care fraud and abuse.

The Healthcare Integrity and Protection Data Bank (HIPDB), mandated by the Health Insurance Portability and Accountability Act of 1996, is expected to begin accepting requests for reports early this year. The final rule implementing the data bank was published in the Oct. 26 *Federal Register* and took effect upon publication.[1]

The new data bank contains the following types of information:

❑ civil judgments, with the exception of malpractice judgments, against health care providers, suppliers, and practitioners in federal or state courts related to the delivery of a health care item or service;

❑ federal or state criminal convictions against health care providers, suppliers, and practitioners related to the delivery of a health care item or service;

❑ actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, and practitioners;

❑ exclusion of health care providers, suppliers, and practitioners from participation in federal or state health care programs.

Overpayment determinations by Health Care Financing Administration contractors are not reportable, according to the final rule.

HIPDB will complement the 10-year-old National Practitioner Data Bank (NPDB). The NPDB contains reports of medical malpractice payments, adverse licensing actions, adverse clinical privileges actions, and adverse professional society membership actions against more than 133,000 physicians, dentists, and other health care practitioners.

Day-to-day operation of HIPDB will be managed by the Office of the Inspector General in the Department of Health and Human Services' Health Resources and Services Administration, which also operates the NPDB.

Because health organizations may find some overlap in the data banks, a single NPDB-HIPDB Integrated Querying and Reporting Service (IQRS) will be used to report to and query both of them over the World Wide Web. Based on the action being reported and the applicable laws, the IQRS will submit the report automatically to the NPDB, the HIPDB, or both.

Users first must register and certify eligibility to report or submit queries to the data banks before access will be authorized. Access to HIPDB reports is strictly limited by statute, and, as required by law, the general public will not have access to data bank information. The statute provides that only the government agencies and private health plans required to report to the data bank will be authorized to obtain data bank information. Subjects of reports may obtain access to their own reports.

Information reported to the data bank is confidential. HIPDB information may be requested for privileging and employment, professional review, licensing, certification or registration, fraud and abuse investigation, certification to participate in a government program, and civil and administrative sanctions.

As required by law, the operating cost of the data bank will be covered by a fee for each information search requested by a nonfederal entity authorized to use the data bank. It is estimated that the HIPDB will process in excess of 1 million requests during its inaugural year.

[Editor's note: The combined Web site can be accessed at http://www.npdb-hipdb.com, and additional information on the data banks can be obtained by calling (800) 767-6732.]

Reference

1. 99 *Fed Reg* 57,739 (Oct. 26, 1999). ■

Benchmarking role grows with move to RVUs

Get a handle on your expenses

Before the advent of managed care, maximizing revenue was the key to a financially successful practice. But in today's managed care environment, the economic dynamics have been reversed. Increasingly, the new paradigm for prosperity — or at least the avoidance of economic disaster — for most practices has become controlling expenses.

"The problem is, physician practices are characterized by a large portion of uncontrollable fixed costs, such as rent or malpractice insurance, and few variable expenses such as medical supplies. That makes reducing expenses difficult," says **David H. Glusman**, regional director of health care advisory services at BDO Seidman in Philadelphia.

The implementation of Medicare's new relative value unit (RVU) based system for determining physician practice expense payments makes it even more important that practices have an accurate picture of how well they are managing their expenses.

One of the most sophisticated and effective ways to control practice expenses is to organize an ongoing RVU-based benchmarking program, says Glusman. For instance, "a benchmarking system based on RVUs has the advantage of being able to link administrative and overhead expenses directly to the volume and complexity of services provided in the practice," he notes. As the volume of services increases, the benchmark expense will increase proportionately. Likewise, if the volume of services decreases, the benchmarking program will help identify line item costs that are getting out of control.

Fundamental to an RVU system for benchmarking Medicare practice expenses is the ability to identify the administrative and overhead costs of providing each medical service or procedure. In the following example, assume that during the month of March, your practice provides the following services:

- Office visit, CPT code 99213, volume 200;
- Office consult, CPT code 99244, volume 10;
- Lesion excision, CPT code 11401, volume 3.

Glusman says you can establish your practice expense benchmark by following these steps:

Establishing an RVU-based practice expense benchmarking program

- Determine the practice expense relative value units (RVUs) based upon the volume of services provided each month.
- Use the practice expense RVUs to calculate the benchmark work target expense for providing those services.
- Compare the actual expenses for the month to the benchmark.

HCFA to review work RVUs

Do you know of a work relative value unit (RVU) in Medicare's physical fee schedule you feel is incorrect and should be changed? If so, the Health Care Financing Administration wants to know about it as part of its just-launched five-year review of Medicare RVUs.

Comments must be received by March 1. Send an original and three copies of any suggestions to the following address: HCFA, Department of Health and Human Services, Attention: HCFA-1065-FC (Five-Year Refinement), P.O. Box 8013, Baltimore, MD 21244-8013. ■

1. **Establish the RVU allotted by Medicare for the practice expense component of the procedures normally performed at your practice.** Remember, practice expense RVUs do not include the physician compensation or the physician work component. (For purpose of this example, RVUs are based on 1999 values.)

That translates into:

- Office visit, CPT code 99213, expense RVUs 0.51;
- Office consult, CPT code 99244, expense RVUs 1.48;
- Lesion excision, CPT code 11401, expense RVUs 1.06.

2. **Apply a conversion factor to the expense RVUs.** The conversion factor is a dollar amount that translates the RVUs into a benchmark. Medicare's 1999 conversion factor was $34.73, the amount the Health Care Financing Administration established to determine that year's reimbursement levels.

Theoretically, the Medicare conversion factor has some factual relationship to the resources your office needs to provide a particular service, says Glusman. However, feel free to use a conversion factor that is different from the official Medicare number if your expenses are particularly higher or lower than the average practice. A historical average is one such option. For instance, if your practice averaged operating expenses of $15,000 per month and total practice expense RVUs of $500 per month, its conversion factor would be $30 per RVU. (For convenience, this example uses the 1999 Medicare conversion factor.)

3. Calculate the volume-related expense for each service provided in March.

- CPT code 99213, expense RVUs 0.51, April volume 200, conversion factor $34.73, benchmark $3,542.
- CPT code 99244, expense RVUs 1.48, April volume 10, conversion factor $34.73, benchmark $514.
- CPT code 11401, expense RVUs 1.06, April volume 3, conversion factor $34.73, benchmark $110.
- Total benchmark expense: $4,166.

For that month, the benchmark expense amount for this practice is $4,166. If the actual expenses for the month were below $4,166, the practice would receive a gold star for outperforming the benchmark. ■

Capitation audits check payers' accuracy, integrity

Focus on contract elements, performance patterns

What's good about tax season? Often it's a good time for a medical practice to audit its carriers' capitation performance. Another good time might be just prior to contract renewal season. If you have capitation contracts, which involve intermittent settlements, you may choose that as audit time.

Whatever time period you choose, a financial checkup is an excellent management tool that should be approached systematically and with some advance thought as to what level of detail you need.

Auditing can be especially valuable if you have a significant number of capitation contracts — for at least two reasons. One, auditing for capitation calls for quite a different process than auditing other areas of your practice, advises **Jonathan W. Pearce**, MBA, CPA, a principal at Dan Grauman Associates Inc., a Bala Cynwyd, PA-based health care consulting firm. The elements of analysis and the level of detail you need can significantly differ for the capitation portion of your practice than for more traditional areas.

Secondly, there's nothing like a track record to assess your contractors' performance in one year to prepare you for advantages and pitfalls in the coming year.

Don't let the sometimes onerous image of an audit turn you off, advises Pearce. "This is not a financial audit like a CPA firm would do. You're only doing this if you think it would be financially advantageous for you to do. There are no . . . regulatory requirements." Instead, this is an audit that amounts to a checkup or oversight of basic carrier practices.

Interestingly, another difference between capitation audits and internal audits you may have performed is that typically physicians serving capitated patients don't submit individual claims. That means the tried-and-true audit process of matching services with payment levels is much less applicable. So you need to look at other performance indicators.[1]

In capitation, the audit process is "testing the pieces of things," or checking patterns and elements of an insurer's payment methods, Pearce says. He recommends taking these steps when auditing capitated contract records:

- **Re-check payment rates per contract.**

Payments made to physicians need to be checked against what the contract had specified it would pay — both the per-member per-month amounts (PMPM) and any fee-for-service payments made for exempt services.

Also, often primary care physicians are paid incentive payments for remaining within certain budget targets. If that's the case, your audit should distinguish which payments are PMPM and which are for incentive agreements. If they don't, Pearce recommends extrapolating from a sample of reports and in the future having the insurer provide this information in a format you can use.

- **Review settlement calculations.**

Some capitation contracts pay a settlement at various intervals of the year — quarterly, twice a year, etc. If you have that arrangement, this series of payments also should be audited. For example,

in some cases, insurers will estimate payment levels, which may or may not benefit your practice. Key factors to check for are what you determine to be the total of stop-loss payments, incurred-but-not-reported adjustments, and any medical expenses charged against the practice.

• **Recalculate member counts.**

With physicians and plans swapping names and agreements so often, it can be tricky to determine which plan a patient is covered by within one year — or from one year to the next — and whether the patient's doctor is in the plan. **(See related story, p. 46.)**

Don't assume that because the insurer holds the contract that it has all the correct information. To obtain your member count, establish the actual date a primary care physician started or stopped participating in a particular plan. Pearce recommends doing that by checking the signature dates of each physician with each plan — both beginning and ending any contract. Check that against what the insurers use for their member counts to obtain your projection of the appropriate PMPM payments the practice as a whole and each physician should be receiving.

• **Check the insurer's use of countywide rates.**

Medicare HMOs always use a countywide factor in determining their payment rates; sometimes commercial insurers do, too. In either case, it can be beneficial to see whether the insurer is using the accurate county-specific number. Payers often use estimates based on the lowest paying county in the area, which isn't always a fair application to a specific physician practice or patient population.

• **Audit for accurate application of demographic factors.**

Demographic characteristics the Health Care Financing Administration applies in payment calculations include the age and gender of the enrollee, whether he or she has end-stage renal disease (ESRD), is institutionalized, and / or is eligible for Medicaid.

The presence of any of those factors is applied in the Medicare HMO payment formula along with geographic payment rates. You can check for institutional status by scanning for codes that reflect physician visits to nursing homes and other non-office settings. ESRD status can be checked by scanning for dialysis treatments. Sometimes payers fail to take those factors into account, or they estimate them even though individual patient bases may not be average for the nation.

Conversely, your audit may find your practice did not account for Medicare HMO enrollees who are younger than typical Medicare enrollees. If that's the case, you can make more accurate projections for your costs in the coming contract period. The same omission could be true for other patient factors. More accurate assessment of all of those factors can only make your financial projections for capitation more reliable.

• **Recalculate commercial capitation revenue.**

The level of difficulty for checking on insurer commercial HMO payments varies significantly based on how much latitude state insurance regulations allow insurers. In some states, insurers are limited to certain standard HMO rate formulas, and in other states, they aren't regulated that tightly.

Also, in some states, discounted services are not disclosed or regulated, making them difficult to audit. In those cases, about the best you can do is ask the payer to tell you how rates are calculated or make projections based on other state's published formulas.

Data you will need

To take on a capitation audit, you need to have certain data available. The following is a list of the minimum data requirements that Pearce recommends:

— Complete listing of all patients specifying whether the member is covered by Medicare, Medicaid, or a commercial plan. This list should at a minimum contain each member's health plan ID number, primary care physician identifier, and the date of enrollment with each primary care physician.

— All claims billed under the risk contract (when claims are used), including information for tracking their accuracy such as member and provider ID numbers, service dates, payment amounts, claim numbers, benefit codes, service or CPT codes, and the setting of care.

— Estimates of provider payment rates, the amounts actually paid to providers according to each capitation contract, and current payment rates for enrollees under Medicare HMO contracting.

Overall, this sort of financial checkup is a cost itself, notes Pearce, and there is no magic formula for how much should be devoted to any particular practice for audits. Cost benefit is the key guideline to consider.

"With one client, we decided that the things [the insurer] did as a normal course of business

they probably did right, and we wouldn't audit that," Pearce says. "Check how they [your contractors] generally are handling their business."

You may have an experience like this, says Pearce: "These guys are almost always paying us wrong — using 1998 fees instead of 1999 fees." If their daily practices suggest weaknesses, don't presume you are being paid at the right amount.

That's often the case with the smaller payers, he adds, and it may mean that investing time in an audit is worth it. On the other hand, in the case he described in which the payer seemed to be efficient and timely with payments, an $80,000 investment in staff time or consulting fees was not worth it. Overall, your practice's level of confidence in the payers' ability to administer contracts appropriately is the key factor in assessing just how comprehensive your audit needs to be.

Reference

1. Pearce JW. Annual audits of IDS risk contract settlements improve payment accuracy. *J Healthcare Fin Management Assoc* 1999; 53:31-34. ■

HCFA releases new member count rules

Effective dates make big pay difference

A seemingly simple matter of record — determining exactly when a beneficiary is enrolled in or disenrolled from a particular plan — has huge ramifications for capitation contracts. That's because monthly payments are based upon enrollment, and large capitation plans often involve thousands of bits of enrollment and disenrollment data. Multiply that by six to 10 capitation contracts you might have, and you have a major amount of money at question and a sizeable task.

You can't always depend on your insurer to have correct enrollment dates — sometimes because effective dates can differ from dates a patient actually signed on, and computer codes sometimes omit the information or report it incorrectly, notes **Jonathan W. Pearce**, MBA, CPA, principal of Dan Grauman Associates Inc. in Bala Cynwyd, PA. Because so much money can ride on effective dates of enrollment and disenrollment, it behooves practices to occasionally audit these data to make sure insurers are implementing the requirements correctly.

New enrollment rules

The Health Care Financing Administration (HCFA) recently announced that effective Jan. 1, 2000, new rules apply to Medicare HMO enrollment verification. Other payers may be revising their rules as well, making a review of other payers just as important.

Beginning Jan. 1, 2000, here are HCFA's guidelines:[1]

- Completed elections (i.e., enrollments and disenrollments) made on or before the 10th day of the month are effective the first day of the first calendar month following the date the election is made.
- Elections made after the 10th day of each month are effective the first day of the second calendar month after the election is made.
- An election is made only when it is received by the insurer and completed.

HCFA offers three examples to clarify those new provisions:

- If a completed enrollment form is received by the managed care insurer on May 10, 2000, the effective date is June 1, 2000. If that same completed enrollment form were to be received on May 11, 2000, it would be effective on July 1, 2000.
- If a completed written request to disenroll is received by the managed care insurer on July 10, 2000, the effective date is Aug. 1, 2000. If that same written request were to be received on July 11, 2000, the effective date would be Sept. 1, 2000.

HCFA's system processing cutoff rates are not affected by those changes, which were required

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by Congress' most recent budget. As has been in effect since the Balanced Budget Act, the date a completed election is received by an insurer determines the effective date. The system processing cutoff date does not determine the effective date.

• If an insurer receives a completed enrollment form on May 2, then the effective date of the enrollment is June 1. The insurer has up to 30 days from May 2 to submit the transaction. But submission of the transaction prior to the May systems cutoff date will ensure more timely payment for the June 1 effective date. Monthly cutoff schedules are provided to insurers.

Reference

1. Department of Health and Human Services. Operational Policy Letter #111, OPL2000.111. Washington, DC; Jan. 6, 2000. ■

OIG says Medicare is overpaying MCOs

HCFA resists making changes

The Office of the Inspector General (OIG) is pressing the Health Care Financing Administration (HCFA) to seek legislation to correct what it alleges was a 4.2% overstatement of 1997 standardized county rates.

Under the Balanced Budget Act of 1997, HCFA must use 1997 standardized county rates as the basis for all future capitation payments to Medicare managed care organizations. The 1997 rates were calculated in 1996 from actuarial estimates of per capita fee-for-service costs in each county.

The 1997 rates are updated each year by the national average per capita increase in Medicare expenditures minus a percentage specified by the Balanced Budget Act. The resulting capitation rate is the basis for Medicare payments to managed care organizations. However, studies found that the 1997 standardized county rates were overstated by 4.2% compared to actual costs incurred, says the OIG. If true and left uncorrected, that would mean Medicare managed care organizations could receive as much as $11.3 billion over the next five years — $34.3 billion over 10 years — in overpayments, argues OIG.

"We recommend that HCFA seek legislation to correct the overstated base year rates, or at a minimum, use this information to suppress or eliminate any future increases in managed care capitation rates until this wide discrepancy is corrected," concludes the OIG's report.

However, HCFA says new legislation is not needed. In a written reply to the OIG report, HCFA deputy administrator Michael Hash said that under President Clinton's proposed Medicare reform package, "the current administered pricing system would no longer be used to determine plan payments."

In addition, Hash wrote, the OIG recommendation "is not consistent with the current set of legislative proposals submitted by the Administration." ■

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Reimbursement ROUNDUP

Test project allows GMEs to form coalitions

The Health Care Financing Administration has announced a demonstration project permitting teaching hospitals to form coalitions and share Medicare graduate medical education (GME) payments among themselves. Under current law, GME payments are only paid directly to the teaching hospital.

To qualify, the consortium must contain at least one teaching hospital and at least one of the following: a school of allopathic or osteopathic medicine, another teaching hospital, a federally qualified health center, a medical group practice, a managed care plan, or an outpatient service provider. Applications are due to HCFA by April 4, 2000. For details, see the Jan. 5 *Federal Register* at http://www.access.gpo.gov/su_docs/fedreg/a000105c.html. ▼

NJ expands patients' rights to retain their physicians

New Jersey has enacted legislation preventing state HMOs from making patients with major illnesses switch physicians during the course of their treatment because their physician's contract with the HMO has expired or been canceled. The new rules give cancer and surgery patients one year to find a new plan-authorized physician. ▼

Facts to ponder

On-line health care business and insurance claims transactions will reach $348 billion by 2004, finds a survey by Forrester Research in Cambridge, MA. Within four years, 12% of private physician practices will do most of their practice-related purchasing on-line, from drugs to capital equipment, says the survey.

• About 20% of the nation's physician organizations now generate 100% of their revenues from managed care contracts, according to New Jersey's Managed Care Information Center. ▼

HCFA putting 'fraud cops' in insurer, contractor offices

As part of Medicare's 2001 budget to be officially released next month, Medicare wants to install teams of federal "fraud fighters" in the offices of health insurance companies and other contractors that process Medicare claims. The administration also wants authority to bring aboard more private sector companies to process claims and police payment activities.

In a related development, word from inside the Health Care Financing Administration is that the agency plans to expand its new hospital payment error prevention program to include nonhospital providers. HCFA auditors will do detailed carrier-by-carrier comprehensive error rate tests to determine what kinds of payment errors are being made and which providers are making them. ■