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PHYSICIAN'S PAYMENT UPDATE™

INSIDE

■ **Prompt pay:** States push for insurer sanctions 66

■ **Using the Internet:** Forget boosting revenues and look at cutting costs. 66

■ **A case study:** How the Internet saved money for one practice. 67

■ **The hassle factor:** Feds move to ease abusive auditing 68

■ **Verification headaches:** Steps you can take to stop the cash drain. 69

■ ***Physician's Coding Advisor:*** ABCs of the new APCs 71

■ **A myth debunked:** Data show employed doctors aren't slackers 75

■ **Concerns voiced:** MGMA outlines problems in 2001 federal budget. 76

■ **Data bank:** Opponents criticize opening of physician data bank to public 78

■ **Reimbursement Roundup**. 79

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Want your claims money faster? Take a ride on the electronic highway

Some insurers offering incentives to switch

Tired of your payers "losing" your claims and taking forever to cut and mail your checks? Some insurers are offering a promising solution to that quandary, provided you are willing to step into the electronic age.

The insurers, hoping to cut their own costs of dealing with paper claims, are promising faster payment if practices will process their claims over the Internet.

As provider groups lobby Congress and their state legislatures to force plans to pay their claims promptly **(see story, p. 66)**, some insurers and upstart Internet sites are joining forces to offer practitioners an array of incentives to use the World Wide Web to process medical claims electronically. Providers will get paid faster, the HMOs promise.

Plans such as Humana, Sierra Health Services, and Blue Cross/Blue Shield of South Carolina recently have struck deals with physician-oriented Web sites that permit doctors in their networks to submit claims, make referrals, and check claim status, patient eligibility, and deductibles over the Internet.

To get the physicians' attention, those HMOs promise to pay their related Internet claims transaction fees, which typically can amount to between 20 cents and 50 cents per claim. Some plans have even sweetened the deal by agreeing to electronically deposit the money from claims directly into the practice's bank account, eliminating the need to wait for a paper check.

"We're just trying to improve customer service for all our constituencies — providers, members, and employer groups," says **Peter O'Neill**, spokesman for Sierra Health, which operates in Arizona, Nevada, and Texas. "Over the long term, we think moving to Web-based transaction will reduce our costs significantly."

There is nothing particularly new about plans trying to wean providers from their attachment to paper claims. What's different this

Pressure builds for prompt-pay measures

State groups push for new laws

Fed up with what they consider an arrogant attitude among insurers toward late payments and intentional downcoding, physicians are organizing to change the situation.

Medical societies in more than 40 states have begun documenting reimbursement delays by HMOs, which they plan to use to lobby local lawmakers to put the pressure on payers to pay up. One sample of some 6,000 claims filed last July by Ohio physicians, for instance, found 42% of undisputed claims had not been paid within the state's statutory 24-day deadline. Meanwhile, 20% of claims remained unpaid 60 days after being filed.

Getting results

Florida providers scored a victory in March when Humana agreed to put a stop to its policy of automatically challenging bills for complicated patient office visits. The insurer also agreed to institute an expedited downcoding appeals process.

Humana says it will launch an automatic nationwide review of 5,000 of its physicians, including 1,500 in Florida, who file significantly more complicated medical claims than their peers.

Nationally, a coalition of medical specialties is pressing Congress to expand current Medicare prompt payment requirement to all plans. "Inclusion of a prompt payment provision is critical to providers, who must struggle daily to obtain payments legally owed them," coalition leaders testified on Capitol Hill.

"We understand some payers use a general payer denial code of $1.25 above contractual agreed-upon price by erroneously mispricing relative value units," explains **Robert Doughtery**, head of public affairs for the American College of Physicians-American Society of Internal Medicine.

Other payers "lose" claims — forcing practices to send them by certified mail or courier service — or habitually transfer claims from one department to another, he notes. That forces some providers to add administrative staff just to deal with the increased work caused by these slight-of-hand delay tactics. ■

time is that more reimbursement experts think it may work. The main reason is that the Internet has several major advantages over previous electronic systems. Namely, the Internet already exists, so offices don't have to buy and install a lot of new equipment. Start-up costs are low, and it is easier to use.

Of the physician claims processed by the Blues, 60% are still presented on paper, with the remaining 40% submitted electronically. The Blues' goal is to have nearly 100% of claims submitted to them electronically with the next five years. Doctors who are part of the Blue Cross Blue Shield network in South Carolina will be able to start processing claims over the Internet in July at the plan's own Web site. Meanwhile, they can check claim status, eligibility, and deductibles and make referrals on-line.

"We feel a lot of physicians are going to see that using Internet will be to their advantage," notes **Thomas G. Faulds**, president of the Blue Cross and Blue Shield Division of Blue Cross and Blue Shield of South Carolina. "The bottom line is that we hope to convince physicians it will save them money in processing costs while they get paid faster." ■

Best use of the Internet? Save time and money

The Web can streamline your back office

Many practices make a major error as they try to determine the best use of the Internet: They focus on the wrong end of the financial curve, experts say.

Instead of looking at the Internet as a way to dramatically increase billing and revenues, the typical practitioner's best bet is to think of it as more of a money- and time-saving tool, recommends **Douglas Goldstein**. Goldstein is a consultant in Columbia, SC, and author of *e-Healthcare: Harness the Power of Internet e-Commerce and e-Care.*

Unlike a retailer with a product to sell, the typical doctor's office sells a personalized service, says Goldstein. Unfortunately for physicians, it is usually easier to create and fill an increased demand for a product than a service — any service.

"My advice to health care providers is to look first to make money from the Internet by finding ways it can save them money," Goldstein suggests.

The easiest way is by transferring more administrative tasks from the office staff to the Internet.

For example, studies show the typical nonmedical office employee spends about 30% of total work time on the phone answering questions about office hours, doctors' credentials, and common ailments such as colds and fevers.

"But by posting answers to these frequently asked questions on a Web site, you are able to partially free up some of that time to concentrate on patient care," says Goldstein.

Being 'wired' helps

More insurers are encouraging doctors to submit claims and referral requests over the Internet, which also can save a practice time and money. "Some doctors are even starting to manage patients over the Net," says Goldstein. Patients with questions about noncritical ailments can e-mail the office and be guaranteed a response within an hour. Other providers have set up chat rooms for real-time consultations with patients.

"Every time a nurse picks up the phone, it's anywhere from $5 to $25 in time spent, depending on the length of the call, compared to 5 or 10 cents for e-mail," Goldstein says.

Practices are using Internet sites, or portals, that provide easy access to the different services and firms the practice does business with. Recently, two major Web players began offering provider services via the Web. ProxyMed in Fort Lauderdale, FL, has been selling transaction services using proprietary software for about seven years and is now testing a Web version of its service. Healtheon/WebMD in Atlanta, which started by creating Web-based transaction processing for large health care companies such as integrated health care and physician service organizations, is now offering the same service to individual doctors on its Web site.

Both Web sites provide a portal that gives doctors health care content, such as medical news and journal articles, along with transaction-related processing services. For a $30 monthly fee, doctors can use the Web site to send prescriptions to drugstores, authorize prescription refills, order lab tests, view lab test results, check patient eligibility, authorize referrals, submit claims to insurance companies, and check on the status of claims.

"Before turning to the Internet, the simple process of writing prescriptions and authorizing refills was seriously bogging our office operations down," says **Al Worchel**, MD, a general practitioner in Houston. Worchel, who uses ProxyMed, says the system makes it much easier to work with drugstores.

To create a prescription, he enters the patient's name and the first few letters of the drug he wants to prescribe. The system automatically completes the name of the drug, lists the dosages in a checklist, and indicates any potential conflicts with other drugs the patient is taking. Once the prescription is complete, he clicks a button that sends it to ProxyMed's server, which forwards it to the patient's pharmacy.

Previously, every time a patient wanted a refill, the pharmacist had to call Worchel's office for authorization, which took time out of the day for him and his staff to respond. Now, the pharmacist simply sends a query through the ProxyMed system. Every few hours, Worchel logs on to the system, checks the refill requests, clicks his approval or denial on each, and in about five minutes, he's finished. ■

Using the Internet cuts costs, boosts cash flow

Claims services can streamline

Using the Internet to outsource some financial functions has allowed a Portland, OR, pediatrics practice to eliminate one full-time staff position while slashing the time it takes to collect its accounts receivable by one-third.

A little more than a year ago, accounts receivable were averaging 60 to 90 days at Portland's Children's Clinic, says **Katherine Whitaker**, who supervises bookkeeping at the 20-physician practice.

Looking for ways to increase its cash flow, the clinic decided to experiment with an Internet claims service. After talking with a variety of services, it settled on the Dallas-based Claimsnet (www.claimsnet.com). The main attraction was that it offered a flat-rate service.

Since signing on, accounts receivable outstanding have dropped from nearly 90 days to nearly 30 days. One direct advantage of this speedier processing and cash flow is that even though the practice added four physicians during the same period, it only needed to hire one a part-time staffer to deal with the increased administrative workload.

"Without the Internet system, I would have had to hire at least a full-time person, and maybe one and a half people," estimates Whitaker.

For a flat fee of $25 a month, the clinic can process an unlimited number of commercial claims. Another selling point was that no new equipment was required because the system worked off the practice's Internet browser.

Reports available

Like many other Internet sites, Claimsnet, for an additional fee, also will produce a set of monthly reports that include diagnosis and procedure code by gender, all patients by procedure code and geography, all patients by diagnosis code and geography, all patients by payer and diagnosis code, all patients by payer and procedure code, and all patients by payer.

Claimsnet also is capable of producing individual patient billing statements and performing eligibility checks and referrals. ■

More providers catch Web fever

Physicians' use of the Internet has nearly doubled over the past two years, says the American Medical Association. According to the AMA, nearly 37% of physicians are using the Internet, up from 20% in 1997.

The main Internet functions doctors like to use include sending and receiving electronic mail; accessing medical, travel, and product information; and communicating with professional associations.

"Even physicians who are not now using the Net have accepted the inevitability that they will soon have to. In a few years, not using the Internet will be as unthinkable as not using the telephone for providers," says **Tom Ferguson**, MD, adjunct professor of health informatics at the University of Texas Health Science Center in Austin. ■

Feds ease hassle factor but not get-tough stance

Providers' complaints may be paying off

You might think Christmas came early this year. Over the past several weeks:

— The Health Care Financing Administration (HCFA) began spending $4 million on a crash program to install a toll-free number it wants up-and-running by summer. Physicians will be able to call with their questions about Medicare payment rules.

— HCFA Administrator Nancy-Ann DeParle has promised Capitol Hill she will "directly contact" all physicians, home care providers, and durable medical equipment suppliers participating in Medicare to address common documentation problems and billing errors. The agency also plans to help educate providers about satellite broadcasts and computer courses on proper claims filing and documentation, among other things.

— The Office of the Inspector General (OIG) has released an open letter saying providers who voluntarily step forward and disclose any billing errors and reimbursement problems before investigators find out about them can expect federal gumshoes to go easy on them.

— Medicare also says it soon will begin testing another set of possible revised guidelines for documenting evaluation and management services.

All those moves are a part of a renewed effort by HCFA to reach out to providers who feel increasingly abused and set up as cardboard bad guys by overzealous auditors who can't tell the difference between a simple billing error and outright fraud.

"They're wasting an awful lot of money harassing honest doctors," says **John A. Bennett**, MD, a Sequim, WA, family practitioner. "We've dedicated our lives to this profession, and we're being treated like common thieves." In frustration, Bennett recently dropped out of the Medicare program.

Many experts say the dropout trend will continue. "Medicare hassles and overly aggressive billing audits are souring physicians on the Medicare program, which will only make it more difficult to provide the best medical care for seniors," American Medical Association immediate past president **Nancy W. Dickey**, MD, told the Senate Appropriations Committee recently.

Last March, the OIG issued its annual audit of Medicare payments covering the 1999 fiscal year. It found that out of 5,223 claims reviewed, 1,034 did not comply with Medicare laws and regulations. According to the audit, improper Medicare

payments during fiscal year 1999 totaled $13.5 billion — $1 billion more than in fiscal year 1998, an increase the OIG admitted was statistically insignificant.

Although that was nearly half the $23.2 billion in improper payments estimated for 1996, the new figure is "unacceptable," says U.S. Sen. **Tom Harkin** (D-IA). "We've slipped. The steady progress has stopped."

Inspector General June Gibbs Brown's attitude is that federal officials "have resolved a lot of easier problems and now are at a point where it will take some intensive work."

What to focus on

Based on the kinds of errors identified in the OIG's audit, here are some areas where practices can expect more attention from claims inspectors:

- **Poor documentation.** Claims with no or insufficient documentation were the largest source of improper fiscal year 1999 Medicare payment payments ($5.5 billion) identified by the OIG.
- **No medically necessity.** $4.4 billion in claims were ruled not medically necessary by a carrier or peer review organization.
- **Incorrect coding.** $2.1 billion were spent on incorrectly coded Medicare claims.
- **Noncovered services.** $1.5 billion were paid for services not covered by Medicare.

"These improper payments range from inadvertent mistakes to outright fraud. The amount of fraud is likely very small, although the government has no way to actually measure it," notes Brown.

In fact, government officials do not know how many of the 900 million claims paid by Medicare annually are the products of outright fraud such as phony records, kickbacks, or billing for services that were never performed. "We cannot quantify what portion of the [improper payment] error rate is attributable to fraud," Brown told a House hearing on Medicare fraud.

According to American Osteopathic Association (AOA), the primary reason for the error rate is confusion over complex Medicare rules. "Frequently, what is being classified as fraud is actually billing errors that result from complicated regulations and burdensome paperwork," the AOA told the Senate.

HCFA's DeParle admits Medicare regulations can be complex, but she insists that providers are not being prosecuted for inadvertent errors. ■

Medicare's improper payment scorecard

Here are the sources and providers attributed to improper Medicare payments based on the Office of the Inspector General's fiscal year 1999 audit of the program:

- Documentation errors — $5.5 billion total (includes $1.1 billion to physicians, $1.6 billion to disposable medical equipment (DME) suppliers, $1.7 billion to home health agencies, and $1.1 billion to "other").
- Lack of medical necessity — $4.4 billion total (includes $2 billion to inpatient hospitals, $0.2 billion to DME suppliers, $0.1 to billion home health, $0.1 billion to physicians, and $2 billion to "other").
- Coding errors — $2.1 billion total (includes $1.5 billion to physicians, $0.5 billion to inpatient hospitals, and $0.1 billion to "other"). ■

Key holes to plug in the verification process

Steps you can take to avoid unpaid bills

Incorrect information about insurance eligibility is one of the most common reasons a practice does not get paid for properly treating a patient. Using incorrect information means the insurer will return your claims — or the HMO will refuse to include them under the cap payment — as unpayable because patients were not members at time of treatment or the services provided were not included in patients' coverage.

"Every time a payer rejects a claim for ineligibility, your practice is not only inconvenienced, but also shortchanged," says **Joan M. Roediger**, an attorney with Health Care Law Associates of Plymouth Meeting, PA. "When this happens, practices are forced to act as bill collectors and track down payments from their patients, provided their contract even permits them to do that."

When you think about it, insurance eligibility mistakes are relatively easy to make. "Before the practice is notified about a change in someone's eligibility status, the enrollee's employer must notify the HMO or health plan, which in turn must notify you," notes Roediger.

However, some employers may not notify their health plans of benefit status changes for weeks, then the plan may not notify your office until weeks after receiving the information. Plus, patients who change jobs or health plans may fail to tell your staff.

"During this time, your practice could be providing significant amounts of medical services to plan beneficiaries who are no longer eligible to receive health plan benefits but still appear to be eligible to your practice," she says, but you don't learn of that until the plan refuses to pay.

"The best way to deal with this type of situation is to deal with it before it becomes a problem," stresses Roediger. Here are some of the tips she recommends:

1. **Protect your contract.** Make sure your next health plan contract contains a clause stating that the HMO is responsible for absorbing — or at least sharing some part of — what it cost you to inadvertently treat an ineligible plan member.

"You should also be aware that it is possible to be contractually obligated to provide service to HMO patients for a period of time after an HMO declares bankruptcy," says Roediger. In fact, most states hold the physician responsible for patient care and might not even allow you to bill the patient in such circumstances.

Next, you want to make sure your office does everything it can to verify each patient's insurance eligibility and receive proper referral authorizations.

2. **Copy insurance cards.** Every time patients — and not just new patients — visit the office, make a copy of their insurance cards. "Always update enrollee insurance information. If yours is a primary care practice, check to see that your name is on the card as the enrollee's primary care physician," she advises.

3. **Talk with patients.** When patients call to make appointments or your practice calls to confirm their appointments, ask them about their insurance coverage. If there has been a change in health plan status, be sure you are aware of it in advance.

4. **Review lists.** Always check HMO capitation lists for enrollee names that have been added or removed. "It is important to impress upon your staff that it is vital they check the patient rosters as they receive these lists," Roediger says.

While checking capitation lists is a necessity, it is not the be-all and end-all of verification, she says. If you find useful information, such as the name of a new enrollee, use it, but remember that because many patient rosters are posted monthly or bimonthly, they are not always 100% percent reliable.

New members may not have been included, and disenrolled members' names sometimes stay on patient rosters for months. Therefore, when a patient's name does not appear on the patient roster, you must find some other way to verify coverage.

5. **Make internal updates.** Regularly checking health plan cards and capitation lists will provide you with a valuable source of information that needs to be integrated into your practice's billing and appointment scheduling systems. In addition, it is important to establish effective ways for your front desk personnel, billing staff, appointment schedulers, data input personnel, and other office staff to communicate that information with each other.

"You can also use these data to track patients who have selected you as their provider but whose names do not appear on the rosters, which means you are probably being shortchanged on your cap payment," notes Roediger. In such cases, notify the payer of the mistake and check on any retroactive capitation payments that are due you.

6. **Take advantage of technology.** Technology that makes patient eligibility verification easier is emerging constantly. Here is some of the technology your payers may be using:

— Automated voice response systems directly verify eligibility over the telephone. In the typical system, the practice keys in the patient's health plan identification number and receives the appropriate voice response. The system requires a touchtone telephone. The units also can be used to check referral authorizations or claims status.

— Swipe terminals for enrollee health plan cards provide your practice with a virtually instant response to an eligibility inquiry and work like credit card swipe terminals.

— Internet-based eligibility check systems connect providers' personal computers with the health plan's computers via the Internet. Internet inquiries provide real-time information about their patients' eligibility and benefit information. ■

Physician's Coding Strategist™

ABCs of APCs: Primer for the new system

Can you list the four types of APCs? Read on

(The information in this report is from IMRglobal-ORION. ***For details, see note at bottom of p. 74.****)*

Ambulatory payment classifications (APCs) make up a system for classifying outpatient services. Like diagnosis-related groups (DRGs), they cover the hospital fees but not the professional fees associated with a hospital outpatient visit or inpatient stay. APCs have 346 groups and use only ICD-9-CM diagnoses and CPT-4 procedures. Payments for both are based on a weight for each DRG / APC and a rate for the facility. The unit of classification for APCs is a visit, and the initial variable used in the classification process is the procedure. More than one APC may be assigned per visit. The payment calculation for each APC multiplies the facility rate by the APC weight by a discount factor (if multiple surgical APCs are performed during the same visit). Total payment for the visit is the sum of the payments for all APCs.

Medicare's outpatient prospective payment system (PPS) includes hospital outpatient services designated by the secretary of Health and Human Services. That includes most outpatient services, hospital outpatient department services not part of the consolidated billing for skilled nursing facility (SNF) residents, supplies also on the durable medical equipment point-of-service fee schedule, certain preventative services, Medicare Part B covered inpatient services if Part A coverage is exhausted, and partial hospitalization services in community mental health centers.

Medicare's PPS excludes services provided by critical access hospitals and prospectively paid services including ambulance; clinical laboratory; physical, occupational, and speech therapy; end-stage renal disease; and screening mammography services as well as durable medical equipment, orthotics, and prosthetics. Also excluded are outpatient services covered by the SNF prospective payment system and services that require inpatient hospitalization.

The APC classification system is designed to explain the amount and type of resources used in an outpatient visit. Each APC consists of patients with similar clinical characteristics and resource usage. APCs include only the facility component of the visit; medical professionals will continue to be paid from a fee schedule based on CPT-4 procedure codes and modifiers. The system encompasses all provider-based ambulatory settings including same-day surgery centers (ambulatory service centers, or ASCs), emergency departments (ED), and clinics, but it excludes home visits and nursing home or inpatient admissions. APCs were based on Version 2.0 of the Ambulatory Patient Groups (APGs). APCs added more groups for procedures performed in freestanding ASCs, which will utilize a subset of the APCs.

Types of APCs

The four types of APCS are:

- **Surgical procedure APCs.** These are surgical procedures for which payment is allowed under PPS. Only surgical APCs are subject to a payment reduction when multiple surgical procedures are performed during the same visit. Examples of surgical APCs include cataract removal, endoscopies, and biopsies.
- **Significant procedure APCs.** These are nonsurgical procedures that often are the main reason for the visit and account for the majority of the time and resources used during the visit.

Examples of significant procedure APCs are psychotherapy, CT and MRI scans, radiation therapy, chemotherapy administration, and partial hospitalization.

• **Medical APCs.** These consist of encounters with a health care professional for evaluation and management services. The medical APC is determined based on the site of service (clinic or ED) and the level of the evaluation and management service (low, middle, or high), as indicated by the evaluation and management CPT-4 code and the diagnosis. An E&M code with a fifth digit of 1 or 2 is considered a low-level visit, a 3 is a mid-level visit, and a 4 or 5 is a high-level visit. The diagnosis is assigned to one of twenty major diagnostic categories. Low-level clinic visit for respiratory diseases, high-level ED visit for cardiovascular diseases, and critical care are examples of medical APCs. A medical APC is assigned in conjunction with a surgical APC only if the surgical procedure is a direct result of the evaluation and management service.

• **Ancillary APCs.** These include diagnostic tests or treatments not considered to be significant procedure APCs. Examples are plain film X-rays, electrocardiograms, and cardiac rehabilitation. An ancillary APC may be performed in conjunction with a medical APC, a significant procedure APC, a surgical APC, or independently if the ancillary procedure is the only reason for the visit.

The 346 APCs consist of 134 surgical APCs, 46 significant APCs, 122 medical APCs, and 44 ancillary APCs. Surgical, significant and ancillary APCs are assigned using only the CPT-4 procedure codes, while medical APCs are based on the combination of the ICD-9-CM diagnosis code and the E&M CPT-4 code. HCFA also considered defining medical APCs based only on diagnosis code or only on E&M code.

Modifiers affect APC payments

Effective last January, providers are required to report modifiers, if appropriate, for outpatient services on the UB-92 billing form. This is a departure from past practice when only physicians were required to report modifiers on the HCFA-1500. Modifiers are being required for outpatient services in preparation for the introduction of Correct Coding Initiative (CCI) edits. Modifiers will be needed to prevent the CCI edits from rejecting pairs of CPT codes that would not normally be reported on the same UB-92. The 1999 American Medical Association CPT coding manual contains an explanation of the modifiers and those that can be used for hospital outpatient visits.

Two modifiers will be used to identify terminated procedures. Modifier 73 is used for procedures terminated prior to the administration of anesthesia and results in payment of 50% of the normal APC payment. Modifier 74 is used if the procedure is terminated after anesthesia is administered and is paid the full APC amount. Modifier 25 is applied to an E&M code to indicate that a surgical procedure performed during the visit was a direct result of the evaluation and management service. The presence of the 25 modifier will result in full APC payment for the medical APC as well as the surgical APC.

Another notable coding change includes the ability to bill for critical care (CPT 99291) for the evaluation and management of an unstable critically ill or injured patient who requires constant attendance of a physician. This code can be used in place of, but not in addition to, an E&M code for an ED visit. You will still be able to bill for any other services provided in conjunction with this visit. However, CPT 99292 cannot be used to bill for additional 30-minute increments.

Additionally, a new HCPCS code will be created for reporting screening services performed in the ED when no medical emergency exists and the patient is referred to a clinic or physician's office for treatment. This screening APC would be paid only if no other emergency services were rendered, and it includes any consults. If treatment is provided, bill for the appropriate ED visit code.

The claims submission process will change when APCs become effective. Claims spanning multiple dates of service will need to be itemized by service date. For example, if you currently bill a month's worth of radiation therapy treatments using the from / through dates on the UB-92 with the number of units indicating the number of treatments given during the period, you will now need a separate line item for each date of service. Multiple clinic visits on the same day for different diagnoses should be submitted on separate claims. There is also a proposal to modify the UB-92 to identify diagnoses by number and link them to the individual line item being billed, similar to the HCFA-1500. Claims will also be edited for "unbundling" prior to the assignment of an APC. The outpatient claims editor will be expanded to include a subset of the CCI edits. Unbundled codes will be eliminated from the claim before APC assignment and payment.

Packaging of services under the PPS will eliminate separate payment for operating room, recovery room, treatment room, and observation room charges. Anesthesia, medical, and surgical supplies, drugs (except chemotherapy), blood, intraocular lenses, casts, splints, and donor tissue also will be packaged into the APC. That doesn't mean you should stop billing for those services. The services should continue to be reported so that when the weights are recalculated, the data HCFA uses will include all of the appropriate costs.

Discounting of payments will occur under PPS for some services. Multiple surgical procedures performed during the same operative session will be discounted by 50%, just as they currently are under the ASC payment mechanism. Procedures terminated before anesthesia is administered will be paid at 50% of the APC payment, while procedures terminated after anesthesia is administered will be paid at 100% of the APC payment rate. However, significant procedure, medical, and ancillary APCs will not be subject to discounting.

Weights and rates for APCs

Weights and rates for APCs were based on 1996 Medicare claims and the most recent settled cost report for each facility. The departmental ratio of costs to charges was used to estimate operating and capital costs. APC weights were based on claims containing only a single APC. The median cost for each APC was calculated after standardizing costs for wage variations. A midlevel clinic visit for cardiology services was assigned a weight of one. The weight for all other APCs was calculated by dividing the median cost of the APC by the median cost of the midlevel clinic visit for cardiology services APC.

The national payment rate was based on projected fiscal year payments for 1999 under the current payment system with the elimination of the formula-driven overpayment and extension of the 5.8% operating cost limitation and a 10% capital cost reduction. The proposed national payment rate of $50.67 subsequently has been adjusted by HCFA to $50.89. The national APC payment rate is adjusted by the area wage index using a 60% labor component to determine a hospital's APC payment rate. However, the proposed system does not provide adjustments for outliers or teaching, rural, disproportionate share, TEFRA or specialty hospitals.

Beneficiary copayments will be determined for each APC. The copayment initially will be set at 20% of the 1996 national median APC charge after standardizing for wage variation, and then it will be updated to 1999. The copayments are frozen at the 1999 level until the Medicare payment percentage reaches 80% of the APC rate. Annual updates to the APC payment will increase the Medicare payment percentage. Once the Medicare payment for an APC reaches 80%, the copayment will be recalculated annually as 20% of the APC payment rate.

Hospitals will be allowed to discount their copayment amount in an effort to generate competition among providers. Hospitals can discount copayments for individual APCs and advertise those discounts. However, the decision must be made before the start of the year and cannot be changed during the year. Additionally, the discount cannot be less than 20% of the APC payment rate, and the copayment reduction cannot be written off or the deductibles waived.

A volume control method is mandated by the Balanced Budget Act to control unnecessary volume increases. HCFA expects hospitals to improve their coding for outpatient services, just as they did for inpatient services when DRGs were implemented. The calendar year (CY) 1999 update of the targeted expenditure for CY 2000 included factors for inflation (market basket: 1%), changes in volume and intensity of service, and changes in Part B fee for service enrollment. If the CY 2000 actual payments exceed the CY 2000 target, the CY 2002 update factor will be adjusted downward by the same percentage to compensate for that increase.

Payments can be determined as follows. First, calculate your hospital's payment rate:

Hospital payment rate = national payment rate × .6 × wage index + national payment rate × .4

To calculate the payment for each APC, use one of the following calculations:

- Payment for surgical APCs = hospital payment rate × APC weight × units × discount
- Payment for other APCs = hospital payment rate × APC weight × units

For visits with multiple surgical APCs, the APC with the highest weight is not discounted, but all additional procedures are paid at a 50% discount. Total payment for a visit equals the sum of the payments for the individual APC(s).

PPS will have a significant impact on hospital finances and operations. Hospitals will experience increased financial risk due to the lack of a phase-in, very limited payment adjustments, and volume-control-induced reductions to future

rates. PPS also will affect hospital operations, particularly the registration, coding, and billing processes and the information systems that support them.

Unfortunately, preparing for PPS will be hampered by several factors. Outpatient data access, availability, and quality are problematic for many hospitals due to the volume of visits and information systems limitations. Outpatient coding is more complex because a visit may contain codes assigned by clinic staff and the charge description master (CDM) as well as medical records staff. Information systems will need to be modified to support the operational requirements of PPS. Additionally, management and reporting processes based on APCs will need to be developed. Multiple APCs for a visit will complicate these processes.

The coding challenges will be many and complex. Ensuring that all visits are coded completely, accurately, and with specificity will be difficult. Outpatient documentation requirements will increase significantly. The assignment of E&M codes at an appropriate level will be a difficult task because the E&M coding guidelines are written for physicians, not hospitals. Most hospital billing and coding staffs are unfamiliar with modifiers and the CCI edits. Codes may be assigned via the CDM file, from super bills or via data entry. Some coding may be assigned by multiple departments plus the CDM and medical records abstractors. Compliance issues may result if monitoring and control procedures are not carefully implemented and followed.

The billing challenges include multiple visits on the same day, line item identification of recurring services, clarification of provider-based status, APC grouper errors, lack of pre-bill edit capability, handling of late charges, and reconciliation of billed vs. paid amounts, to name a few.

The operational challenges include the ability to distinguish whether multiple visits on the same date of service are related to the same diagnosis or different diagnoses. Documenting all procedures performed in the ED, clinics, and treatment / procedure rooms; identifying those that are the direct result of a medical visit; and selecting the appropriate modifier will require training. Documentation will become increasingly important as we rely on health information management staff to validate coding of CPT-4 and appropriate modifiers. Both hospital staff and physicians will require training and instruction. An APC management staff and process will need to be developed.

The systems challenges include retaining historical data in a readily available format, integrating the APC grouper, enhancing the pre-bill edit process, identifying multiple visits on the same date, splitting out recurring visits by date of service, establishing and maintaining data integrity across system interfaces, standardizing the hospital's CDM across departmental systems, and developing a management reporting capability.

The financial challenges include reduced payments resulting from incomplete coding of services (undercoding), multiple related visits on the same day, potential loss of provider-based status, elective copayment reduction analysis, and cost management for services where the cost of service exceeds payment.

How to succeed

There are several steps that hospitals will need to take to be successful under PPS:

- Hospitals will need to improve their coding and billing practices. They must determine and correct the causes for undercoding and grouper errors. They also will need to review the CDM, superbills, and data entry screens to ensure appropriate codes are assigned.
- Hospitals will need to ensure their claims will not raise compliance flags. Pre-billing edit procedures or software will be essential to minimizing compliance problems.
- Education of administrative, departmental, clinic, and medical staffs will be essential to complete the first two prerequisites.
- An APC management process must be developed to monitor both operational and financial performance under APCs. That will require improvements to data access and retention as well as reporting and analysis capabilities.

While hospitals have learned to survive and thrive under DRGs, success did not happen over night. If hospitals are to be successful under PPS, they must start making the transition now.

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Do hospital docs slack off? Latest data say no

How do your practice's charges stack up?

Conventional wisdom places most of the blame for the losses reported by system-owned medical practices on poor physician productivity. More to the point, the common assumption is that after selling their practice to a larger system, physicians just stop working as hard.

Elizabeth Woodcock, a consultant with the Medical Group Management Association (MGMA) in Englewood, CO, says that assumption is baloney. "While physician productivity does drop somewhat in the hospital setting, the drop isn't big enough to fully account for these kinds of losses," she says. For instance, other areas with even bigger losses than those attributed to reduced physician productivity come from the practice giving over its ancillary services to the hospital, plus comparatively poorer collections and a lack of support staff compared with the private practice, she says.

Consider the revenue

To create a more accurate picture of their practices' contribution, system administrators must look beyond expenses and consider the revenue, she stresses. MGMA studies, for instance, find the differences in productivity between private and hospital-owned practices is relatively small.

However, there is a much bigger and often overlooked difference between the kinds of activities physicians do in each setting and how much they charge for them. **The following two tables** compare overall charge activity based on procedures of the average private group and hospital-owned practice. All charts in this story are based on MGMA's *Cost Survey: 1999 Report Based on 1998 Data.*

Family Practice, Single-Specialty Activity Based on Charges

	Hospital-Owned	Private
Nonsurgical, inpatient	68.98%	59.80%
Nonsurgical, outpatient	—	7.37%
Surgical, inpatient	—	6.03%
Surgical, outpatient	—	4.85%
Other	26.23%	19.83%

Source: Tables on pp. 75-76 are from the Medical Group Management Association in Englewood, CO.

Family Practice, Single-Specialty Median Charge Per Procedure

	Hospital-Owned	Private
Nonsurgical, inpatient	$54.90	$48.12
Nonsurgical, outpatient	$98.12	$80.43
Surgical, inpatient	—	$54.43
Surgical, outpatient	—	$531.57
Lab	$20.49	$25.39
Radiology	$63.32	$80.94
Procedures per FTE physician	10,193	11,337
Gross charges per FTE physician	$514,964	$531,396

Based on a comparison of the number of procedures done per full-time physician, hospital-based physicians are about 10% less productive than their private counterparts — 10,193 procedures vs. 11,337 per physician, says the MGMA.

However, the impact of that difference is exaggerated by a major difference in gross charges by the two groups, notes Woodcock. "Private groups enjoy an 18.25% higher charge structure because they can provide ancillary services. That means private groups automatically have 20% more business you can charge higher rates for than most hospital-owned practices."

As a result, "private physician offices are generally more diversified, which permits them to devote more of their time to activities that pay more," she contends. In contrast, because of the way they are often organized, hospital-owned groups focus on lower-paying office visits while the higher-paying medical activities are redirected to the hospital and counted in its revenue stream.

"When you force your physicians to just perform routine $54 office visits, no wonder the practice has trouble making money," says Woodcock.

Billing and collections also sap a hospital-owned practice's bottom line, she says. **The table at the top of p. 76** compares typical private and hospital-owned practice revenue streams and payment patterns.

Family Practice, Single-Specialty Revenue and Collection Sources

Payer Mix	Hospital-Owned	Private
Medicare	21.60%	17.56%
Medicare and charity	7.10%	5.10%
Commercial/self-pay and capitation	63.70%	63.00%

Family Practice, Single-Specialty Collections and Receivables Management

	Hospital-Owned	Private
Gross fee-for-service collection rate	73.41%	74.82%
Adjusted FFS collection rate	95.44%	97.78%
Days in A/R	71.67	53.74
Net medical revenue	$360,541	$429,116
Difference in net medical revenue	+ $68,575	

Family Practice, Single-Specialty Nonprovider Costs

	Hospital-Owned	Private
Total FTE support staff per FTE physician	4.15	4.99
Total support staff cost per FTE physician	$117,667	$133,020
Total support staff cost (% of TMR)	31.06%	31.92%
Total operating cost	$108,307	$108,654
Total operating cost (% of TMR)	32.28%	25.55%
Total overhead	$226,414	$244,716
Total overhead (% of TMR)	62.90%	57.68%

This difference in net medical revenue has no direct relationship to productivity, Woodcock contends. The difference is due to the fact most hospital-based practices have a lower-paying payer mix than the typical private practices. The main reason for the difference is that private-group physicians have more discretion over how much Medicare and charity care they will provide than hospitals do.

Also, be sure to consider that the money owed to hospital-owned practices stays on the books as an outstanding receivable for an average of 17.93% longer than is the case with private practices **(see table, center left)**. "From a business perspective, there's nothing wrong with that. But it is not right to then say the reason the group is not making more money is because its physicians are not working hard enough," she says.

On the expense side, Woodcock says, penny-pinching by hospital health systems often cuts a practice's support staff, which often backfires by hampering physician productivity, which in turn reduces revenue. She says hospitals often do not see the consequences of such moves because they tend to focus just on the number of support staff or the total cost for staff.

Another way to go is to look at these costs as a percentage of total medical revenue (TMR). Data collected by the MGMA **(see table, bottom left)** showed that private practices are more efficient in their use of support staff.

Looking at the percentage of TMR, you see "even though private physicians pay more for support staff, they get more bang for their buck," she says. In short, investing in support staff helps you generate higher revenues because it permits physicians to spend more of their time on billable activities. ■

MGMA voices concerns about 2001 budget plan

Here are measures that could affect you

The battle over the 2001 federal budget is in full swing, and several new policies and program proposals have providers concerned. Many of the concerns were outlined in a recent letter from William F. Jessee, MD, to the Senate and House budget committees. Jessee is president and chief executive officer of the Medical Group Management Association (MGMA) in Englewood, CO. The MGMA is concerned because the budget:

• authorizes competitive pricing and price negotiations for Part B items and services (except for physician services). The provision could create a situation in which the Health Care Financing Administration (HCFA) could award in-office laboratory service contracts to the lowest bidder. That would eliminate a significant source of revenue for many practices and force

patients to drive to different offices to obtain necessary laboratory tests and X-rays.

• seeks to reduce payments for four tests (Hb A_{1c}, TSH, PSA, and urine culture) by 30% to help fund the new prescription drug plan.

Jessee argued that Congress should not consider reducing those payments until the Institute of Medicine releases its finding on Medicare Part B payment methodology for clinical laboratory services. "Providers must be compensated adequately for services they provide and should not have to shoulder the costs of Medicare reform," he wrote.

• attempts to create a Medicare PPO option and network that would give preference to physicians willing to provide certain services at reduced rates. The Clinton administration has failed to provide the details about how the program might work. For example, would Medicare force providers to enter new contracts with private PPO plans to participate in the Medicare PPO program?

"If it does, we fear that beneficiary access could suffer. The administrative hassles of entering into additional contracts could outweigh the benefits of serving Medicare beneficiaries selecting this option," wrote Jessee.

'Administrative advantages'

The budget proposal also suggests that Medicare providers would benefit from participation by being "given administrative advantages, such as faster claims payment and alternative administrative and related procedures." If the Clinton administration "is admitting that HCFA can adopt administrative efficiencies, why should it only be provided to PPO providers — in exchange for a discount? We urge Congress not to consider the PPO provision until all the details have been ironed out," Jessee wrote.

• permits bundling of payments only if savings are anticipated. Under the Clinton administration's proposal, Medicare would provide a single comprehensive payment for a group of related services regardless of whether the individual components typically are paid under Part A and Part B Medicare.

"While risk-sharing arrangements are evolving, there are currently no standards which allow for fair implementation of a bundled payment system across various entities," Jessee explained. And because the flat bundled rate is paid to the hospital and not to the physician, physicians are concerned that hospitals will begin to micromanage which services should be rendered.

• authorizes a demonstration of bonus payments for large physician group practices. MGMA says it supports compensating large physician group practices for efficiencies they provide to the Medicare program, but it wants to see more details.

• includes $220 million in new provider user fees. "User fees are nothing more than taxes imposed on providers who participate in the Medicare program, wrote Jessee. "Providers should not be charged fees to participate in the Medicare program."

What's included

These new user fees include:

— paper claim fee. The proposal says HCFA can charge providers $1 for any Medicare claim not submitted electronically.

— duplicate / unprocessable claim fee. HCFA could charge a $1 fee for each duplicate claim or claim with inaccurate or insufficient information.

— survey certification fee. Permits HCFA to impose a user fee for initial certification and recertification surveys.

• proposes elimination of the physician markup for outpatient drugs by limiting the Medicare payment to 83% of the average wholesale price. The MGMA says this proposal goes beyond fighting fraud and abuse and may harm group practices and patients.

"The administration's proposal to limit Medicare payment to 83% of the average wholesale price would create an uneven playing field in the group practice setting," Jessee wrote. "While many large practices buy drugs in bulk, small practices purchase drugs in small quantities. Limiting Medicare payment to 83% would disadvantage small practices."

Providers also worry the proposal could result in substandard patient care. Many physicians dispense drugs in their offices and provide extra services — such as discussing dosage and treatment of possible side effects — for which they are not directly reimbursed.

"The administration's proposal exacerbates this problem by limiting Medicare payment to 83% of the average wholesale price since some physicians may stop providing these services because of insufficient reimbursement," says MGMA Washington lobbyist **Pat Smith**. ■

Questions raised about open physician data bank

Public can access info on lawsuits, discipline

Capitol Hill lawmakers and officials from the Department of Health and Human Services (HSS) have joined with providers in questioning the usefulness of opening to the general public a federal data bank containing adverse regulatory and legal actions taken against physicians and dentists.

The National Practitioner Data Bank was created 10 years ago to help state licensing agents and hospitals make credentialing decisions. Since last March, its files have been open to public scrutiny. The data bank was never intended "as a tool for use by the general public in evaluating physician competence," says U.S. Rep. **Fred Upton** (R-MI), chairman of the House Commerce Committee's oversight and investigations subcommittee.

HHS, which operates the data bank, also has opposed giving the public free access to the files. There are "serious privacy concerns . . . raised by the specter of public disclosure of [this] information," notes **Richard J. Tarplin**, HHS assistant secretary for legislation. Moreover, "the information collected in the data bank was never intended to serve as a complete history but rather as an important supplement to comprehensive and careful professional peer review of a practitioner's credentials," he says.

However, Commerce Committee chairman **Thomas Bliley** (R-VA) favors keeping the data bank open to the public. "I want to empower patients by giving them the keys to this locked national database," he says.

The data bank contains information on more than 229,000 malpractice payments and adverse licensure, clinical privileges, and professional association actions taken against some 146,000 physicians and dentists.

Opponents of opening the database point out that much of the information it contains, especially malpractice information, may be more misleading than helpful to consumers trying to locate a qualified physician or check their current doctor's background. Those opponents argue that certain medical procedures are riskier and tend to attract more litigation. Plus, insurers often push physicians to settle claims rather than engage in expensive legal battles.

"Some of our country's best physicians are involved in settlements, yet this data bank contains nothing that also reflects their high level of competence," notes American Medical Association president **Thomas Reardon**, MD. ■

Data bank details

The Healthcare Integrity and Protection Data Bank, created by the Health Insurance Portability and Accountability Act of 1996, reports licensing actions, exclusions from the Medicare and Medicaid programs, criminal convictions, and civil judgments related to health care. The data are supplied by state and federal law enforcement organizations, licensing and certifying boards, and private health plans. Those agencies and entities are required to report all final adverse actions taken since Aug. 21, 1996.

The data bank does not contain information on settlements in which no admission of liability is made; nor does it contain malpractice findings or overpayment determinations by Health Care Financing Administration contractors.

This data bank is designed to complement the 10-year-old National Practitioner Data Bank (NPDB). The NPDB contains reports of medical malpractice and adverse licensing and professional society actions taken against some 146,000 physicians and dentists. Physicians can query the data bank for a $10 charge. Health plans and insurers pay $4 per query. State law enforcement agencies also pay $4. Federal agencies can request the information for free.

Physicians who wish to dispute information contained in the data bank must contact the agency or insurer that reported the violation.

COMING IN FUTURE MONTHS

- ■ 'Incident to' coding tips
- ■ Using a Web site to market your practice
- ■ The tricks for avoiding a Medicare audit
- ■ Is a practice management company still useful?
- ■ Reviewing your capitation contracts

If the reporting entity chooses not to change the report, the physician, practitioner, or supplier can add a statement to the report or request that the Department of Health and Human Services review the report.

For details on submitting a query, go to the Healthcare Integrity and Protection Data Bank's Web site at http://www.npdb-hipdb.com/. ■

OIG investigation targets practice buy-back legality

The Office of the Inspector General (OIG) has launched an investigation to determine if charging physicians low prices, or even no prices, to buy back their medical practices from current hospital owners constitutes an illegal kickback, say OIG sources.

The OIG is interested in determining if such practices have been used to encourage practitioners to continue referring their patients to the hospital. "Any time you have a business transaction between physicians and something like a hospital that stands to benefit from referrals from that physician, the potential for a kickback concern exists," says OIG spokesperson **Alwyn Cassil**. ■

Reimbursement ROUNDUP

Medicare+Choice payments announced

The majority of Medicare+Choice managed care plans will see their payment rates increase by 2% during fiscal year 2001, the minimum increase guaranteed by the Balanced Budget Act of 1997. Others will receive 3.3% hike, says the Health Care Financing Administration.

"Plans are getting paid more despite the fact that Medicare fee-for-service costs are coming down," said HCFA administrator **Nancy-Ann DeParle**. "If the Balanced Budget Act hadn't separated Medicare+Choice payments from fee-for-service costs, plans would be getting about $1.6 billion less." ▼

Physician compliance guidelines coming

Two sets of rules that will affect physician practices will be coming out in the near future, insiders say. The Office of the Inspector General (OIG) will release its long-awaited compliance guidelines for individual and group physician practices sometime in May. The new guidance is intended for use by practitioners as a model for their compliance efforts. Practices that make a good faith effort to follow the guidelines will be given a unofficial benefit of the doubt should there be questions about their billing methods, note OIG officials.

Also, Department of Health and Human

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Services (HHS) officials have set the end of June as their target date to publish final rule setting standards for electronic reimbursement transactions, say HHS sources. The original statutory deadline for those rules was February 1998. ▼

Feds loosen reins on nurse anesthetists

After a two-year debate, the Health Care Financing Administration has decided to remove the federal requirement that nurse anesthetists be supervised by physicians when administering anesthesia to Medicare patients. The final rule is expected to be published in the *Federal Register* in June.

Until now, for anesthesia cases involving Medicare patients, physicians had to supervise nurse anesthetists in order for hospitals and ambulatory surgical centers to be reimbursed for the nonanesthesia portion of a patient's care. However, for the nurse anesthetists themselves to be reimbursed, Medicare did not require supervision.

Nurse anesthetists provide 65% of the 26 million anesthetics administered in the United States each year and are the sole anesthesia providers in more than 65% of rural hospitals, according to the American Association of Nurse Anesthetists. ▼

Would they dare simplify Medicare?

One item buried in the proposed 2001 federal budget that physician practices are applauding would give the Health Care Financing Administration (HCFA) the internal administrative power to simplify the Medicare program.

Known as the Medicare Alternative Flexible Administrative Arrangements, the proposal would permit HCFA to negotiate administrative arrangements, including simplifying claims processing, reducing billing payment cycle time, and alternative claims and cost settlement processing.

"The use of these special administrative arrangements could be targeted to areas where there is market competition and discount arrangements are common," HCFA said in a statement.

However, there would be a price: In exchange, HCFA wants to tie simplification to reduced payments and price discounts from providers. ▼

Outpatient rehabilitation payments questioned

More than half the Medicare payments made to outpatient rehabilitation facilities during a one-year period were questioned by a recent Office of the Inspector General (OIG) study of pay practices in six states.

The OIG found $173 million out of $263 million outpatient rehabilitation claims for the year ending June 30, 1998, were either "unallowable or highly questionable." One claim even included the cost of a Caribbean vacation, say investigators.

The six states surveyed — Florida, Louisiana, Michigan, New Jersey, Pennsylvania, and Texas — represent nearly half the $572 million that Medicare spends for rehabilitation services nationwide.

In response, the Health Care Financing Administration plans to intensify its medical reviews of rehabilitation claims, say agency officials. ■