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PHYSICIAN'S PAYMENT UPDATE™

## INSIDE



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# HCFA looks at standardizing rules among local carrier networks

*One goal: Eliminate differences in reimbursements*

There is movement within the Health Care Financing Administration (HCFA) to address two issues that have been causing providers payment heartaches for some time: inconsistent definitions of what are "reasonable and necessary" medical services, and differences between national Medicare and local carrier reimbursement rules.

In fact, agency officials say HCFA probably will publish a notice of intent to create a proposed rule clarifying "reasonable and necessary" this summer. Meanwhile, HCFA is holding internal talks to see if — and how — it could limit the discretion local carriers now have when making coverage decisions. Instead, that local discretion would be replaced with stronger national reimbursement standards. Local carriers now make about 80% to 90% of all Medicare coverage decisions, according to HCFA.

By law, carriers can only approve Medicare payments for services that are medically "reasonable and necessary" for treatment or diagnosis. Carriers are not supposed to make decisions that would expand coverage beyond Medicare's current benefits or interfere with national coverage decisions.

Local carriers do "pretty good" when making payment calls, says **Jeffrey Kang,** MD, MPH, HCFA's chief clinical officer. Even so, he admits it might be "desirable to have criteria that apply at the national and local levels. The trick is to make them have enough flexibility so that legitimate and desirable variations in practice can be recognized."

Before any action is taken to change the present system, the possible consequences must be evaluated carefully, says **Gail Wilensky,** PhD, chairwoman of the Medicare Payment Advisory Commission.

For instance, because local carriers often approve new procedures and technologies more quickly than the federal government, strict national standards might slow down this process, she says. Plus, she adds, "You have to make sure you don't just create more bureaucracy," which can create even more problems.

The American Medical Association (AMA), however, complains that carriers sometimes use their authority to deny payments arbitrarily while secretly developing coverage policy without explaining the reasoning behind their actions.

Even though carriers use advisory panels comprising physicians and consumers, many providers feel they are not independent enough. "We want a more public process, not a bunch of people using a dartboard to make decisions," says AMA trustee **William G. Plested**, MD.

The AMA is pushing for something like the open national coverage decision-making process HCFA established last year with the Medicare Coverage Advisory Committee. It comprises six medical specialty panels organized roughly parallel to Medicare's benefit categories.

The Medicare Rights Center, a New York City-based beneficiary advocacy group, also supports a more uniform carrier decision-making policy. "The process should be transparent, with carrier guidelines available to consumers and physicians and published on the Internet," says **Joe Baker**, the center's executive vice president. ■

# Supervision may increase for third-party billers

*New national database coming next year*

Providers using outside billing companies to prepare and process their Medicare claims should be prepared for increased scrutiny by federal investigators.

The caution is spurred by an Office of the Inspector General (OIG) report that concludes the Health Care Financing Administration (HCFA) encourages fraud because it cannot identify and track the third-party billers used by providers. Federal policy-makers have put HCFA on notice that they are becoming frustrated with the agency's efforts in this area. "A scam artist can hide behind the billing number of a legitimate health care provider and evade detection," argues **Lew Morris**, counsel to the inspector general.

Adds House Commerce Committee Chairman Rep. **Tom Bliley** (R-VA), "HCFA is failing to adequately protect Medicare from potential fraud and abuse by third-party billers."

The issue should be of more than passing interest to medical practices because physicians can be held liable for misdeeds done in their names. **(See story, p. 83.)**

In response to the criticism, HCFA agreed to a May minisummit with billers and Congress to come up with ways to implement new third-party billing safeguards. Among the ideas to be considered at the summit are for HCFA to:

- register all claims clearinghouses and third-party billers to identify billers participating in Medicare and other federal heath programs. This step also would require billers to place their ID on all claims they prepare.

"The Internal Revenue Service requires all preparers of tax returns to identify themselves. Medicare should require claim preparers to do the same," the OIG report states. "This would provide an audit trail and ensure that claims enter the Medicare system from authorized sources."

- require providers to periodically verify enrollment data and report who does their third-party billing. HCFA is expected to unveil a proposed rule by October implementing these ideas.

Other measures that could be included are to:

- develop a new national database, the Provider Enrollment, Chain, and Ownership System (PECOS), to provide information on provider billing arrangements. HCFA hopes to implement PECOS as early as August 2001, say agency officials.
- outlaw commissions paid to billers based on the number of claims they process or the amount of money they collect.

In 1996, HCFA updated enrollment forms for new health care providers to require identification of outside billing companies. Under the rules HCFA wants in place by October, providers would have to update their Medicare enrollment forms every three years.

Admitting that "our overall ability to monitor third-party billing companies is quite limited," Medicare's director of program integrity, **Penny Thompson**, says HCFA also will ask providers to be more careful about the billing companies they hire and review their work.

Billing companies, however, don't like the idea of additional regulations, arguing adequate rules are already on the books. However, there are indications the billing industry would accept a ban on collections-based commissions. Industry representatives also are pushing for safe harbors and amnesty from prosecution for billing firms that voluntarily disclose possible payment problems they know about. ■

# OIG: Third-party billing procedures rife with holes

*One company worked a $362,000 scam*

An Office of the Inspector General (OIG) report on third-party billing problems scorches Medicare administrators for a lack of safeguards.

For instance, the April report said a Texas billing company collected some $362,000 in false Medicare claims over a 20-month period without its provider-client's knowledge.

Medicare "cannot identify most of the clearinghouses and billing agencies submitting claims" to the program, OIG found. When third parties submit claims to Medicare, they use the physician's or medical supplier's billing number and submitter number, according to the report. "Medicare cannot determine whether claims enter their system from an authorized biller's site and computer or from unauthorized sites and computers."

Because both the provider and billing company employees have access to patient and provider information necessary to access the Medicare system, those data "can be misused [without the medical provider's knowledge] by clearinghouses or their employees to generate false claims," the OIG noted.

As a safeguard, the OIG wants HCFA to:

- use passwords and new technologies, such as caller identification, to ensure claims are received and processed only from known terminals;
- put more pressure on providers to review and verify the remittance notices they receive for any erroneous claims submitted to Medicare using their provider ID numbers.

Currently, HCFA simply asks that providers review remittance notices for any possible misuse of provider numbers. However, under the present system, these notices can be rerouted to a billing company or another address so authorized providers may never get to see them.

"An unknown number of providers allow billing companies to use their submitter number. The potential for misuse of submitter numbers is a vulnerability not adequately addressed by Medicare," according to the report.

When it comes to the billing software used to produce claims, OIG said proprietary software presents the greatest fraud risk. Proprietary software can be a problem "because it is created for, and used by, a select few," according to the report. Because hidden programs can add or modify claim information, this "poses the greatest risk of being intentionally designed to produce improper or inaccurate claims."

Commercial software that produces inaccurate claims, however, "has a greater chance of detection and of being reported by honest medical providers," the report said.

The OIG previously has expressed problems with arrangements in which providers pay third-party billers based on a percentage of the claims they collect.

Despite that, "there is nothing inherently wrong — or illegal — with a percentage of collections arrangement," says **Bob Burleigh**, CHBME, of Brandywine Healthcare in Malvern, PA. "Properly structured, a percentage of collections can work just fine."

However, a percentage of claims or charges deal "would be problematic, since the only incentive would be to submit claims, not get them paid," he says. ■

# Bogus billers can leave physicians on the hook

*Liability for fraud can fall on doctors*

Besides the headaches that come from getting unknowingly entangled in a criminal investigation, otherwise innocent providers can be held liable for repaying any fraudulent Medicare overpayments obtained by unscrupulous outside billers in their names.

While physicians feel this is unfair, many lawmakers think it is the best way to police the program. "It's a simple solution: Look to the health care provider with the deep pockets" to repay Medicare, says Rep. **Ed Bryant** (R-TN). "Doctors are smart people. They have to get the message that they will be held responsible."

That means it's crucial for providers to check the credentials and track records of the firms they hire to process claims and to do regular audits of the bills submitted in your practice's name. Even then, there's no foolproof assurance you won't be hoodwinked because con artists still can arrange to have remittances and other paperwork sent to a dummy address.

Some 5,000 third-party billing companies prepare and submit claims for physicians and providers to Medicare, Medicaid, and private health insurers. Medicare, alone, processed more than 700 million Part B claims last year.

To improve oversight, the Health Care Financing Administration (HCFA) hopes to release new rules in a few months requiring regular verification of information of any third-party billing arrangements involving physicians in Medicare and other government health programs.

Even after the agency's new enforcement efforts go into place, there is "nothing we do that can take the place of, or be as effective as, physicians asking questions of billing companies and monitoring their account activity," says **Penny Thompson**, HCFA's director of program integrity.

For instance, if your billing company codes claims, Thompson suggests you verify that the firm is certified, examine its quality control program, and determine whether it has a compliance program.

Contracts between you and the billing company also should be scrutinized, advise health care lawyers. Of particular interest is language outlining each party's responsibility when it comes to claim documentation and code selection. ■

# HCFA may get tougher in disputed payment talks

*Did three agencies get special treatment?*

Providers involved in negotiations about alleged Medicare overpayments should be prepared to receive an extra icy reception from government lawyers.

The reason: a General Accounting Office (GAO) report saying the Health Care Financing Administration (HCFA) circumvented the law by giving special treatment to three major providers when it agreed to accept only $120 million — or about 36% — of $332 million in alleged overpayments.

As a result, HCFA officials are extremely careful to avoid any appearance of playing favorites when it comes to the recovery of possible overpayments.

"I am alarmed that these overpayments were never reviewed by HCFA's own lawyers or the Department of Justice. The evidence suggests that HCFA staff short-circuited the routine process because of pressure applied by then-HCFA administrator Bruce Vladeck," says Sen. **Susan Collins** (R-MA), chairwoman of the Senate Governmental Affairs Permanent Subcommittee on Investigations. Vladeck, who now handles health care issues for a major Washington law firm, was HCFA's top official from 1993 to 1997.

The GAO found HCFA circumvented the standard process for settling overpayment claims against Medicare providers in cases involving New York City Health and Hospitals Corporation, Los Angeles County Department of Health Services, and Visiting Nurses of New York.

Testifying before the Senate, Vladeck denied any wrongdoing. "I do not believe the providers think they received sweetheart deals,'' he said.

Even the GAO admitted it found nothing illegal about those settlements. However, its investigators did ask why those settlements were never reviewed by HCFA or Justice Department lawyers. Also, the settlements contained a confidentiality clause preventing public discussion of the details of the agreement.

Indeed, the "evidence suggests that . . . [Medicare] would have prevailed for the entire amount had the matter been litigated,'' the GAO concludes. The three overpayment claims found by GAO constituted 66% of all Medicare overpayments over $100,000 since 1991, according to government records.

HCFA settled the claim against Visiting Nurses Services of New York in 1995 by accepting $67 million of the approximately $98 million owed by the home health agency. In 1996, HCFA accepted $25 million in payment of the $155 million owed by New York City Health and Hospital Corporation. HCFA made the settlement before a hearing could be held by HCFA's Provider Reimbursement Review Board (PRRB), the administrative appeals panel that normally reviews such disputes.

In 1997, HCFA also agreed to accept $28 million of the $79 million in overpayments owed by Los Angeles County before a PRRB hearing was held, according to the GAO.

As a result of the questions and allegations raised in the GAO report, HCFA administrator Nancy-Ann DeParle has issued new guidelines clarifying procedures for processing disputed provider payments. Under the new rules:

- Only Medicare's chief and deputy financial officers are authorized to approve any compromise on or termination of debt collections.
- Medicare no longer will agree to keep settlements with providers confidential. ■

# Raising needed capital through a 'tithing' system

*Orthopedic practice shows how it can work*

Access to readily available and reasonably priced capital is key to a medical group's ability to compete and grow in today's managed care-driven marketplace. However, many groups are finding it harder to raise the increasing amounts of money needed to finance a leading-edge practice without having to accept onerous contract terms and escalating interest rates.

"The rise in power of managed care eroded physicians' autonomy over their fee schedules, driving their practice overhead up and their incomes down," says **Michael J. Pulaski**, FACMPE, chief executive officer of Atlanta's Peachtree Orthopedic Clinic. "The pressure on practicing physicians to keep their medical businesses viable in this environment became unbearable for most, driving many into the hands of practice consolidators or physician practice management companies."

The physicians at Peachtree, however, have been able to avoid this situation by taking a leaf from the physician practice management company (PPMC) playbook and creating an alternative source of low-cost self-financing to underwrite the group's growth. "Historically, medical groups have run their businesses by the 'eat what you kill' or 'Darwinian' method. That is, the physicians take home whatever money is left after income is received and expenses are paid, leaving no corporate earnings," notes Pulaski.

In turn, capital acquisitions by the practice normally have been financed using either debt or lease agreements. "These capital acquisitions, along with satellite office expansion and the addition of contracted physician employees, sometimes mean that the pool of money available for distribution to the group is diminished by the added expense," he points out. That often forces a group to take out loans to maintain physician compensation at current levels.

Complicating this situation, consolidation in the health care marketplace has driven up the amount of capital most groups need to operate, a cost that is starting to become "more than the average group with a Darwinian compensation scheme and tax strategy is willing to pay," says Pulaski.

PPMCs have taken advantage of this situation by marketing their ability to finance medical projects. Rather than perform some kind of financing magic, "all the PPMCs really do is leverage the management fees they collect from their physician clients," he says.

A typical PPMC's management fee, for instance, is 15% of the client's practice income. Ordinarily, the physician practice agrees to pay this management fee for 40 years. The fees the PPMC collects from its client practices are then consolidated into a single revenue stream — a stream that can be pledged, in part, to finance cash loans to the PPMC. The PPMC, in turn, agrees to pay back the loan principal with interest using a portion of its income stream received from its physician practice clients.

## *Trying a different approach*

Peachtree Orthopedic Clinic has developed its own variation of this PPMC financing model, which it calls a "tithe," to finance its capital needs. Under this mechanism, each practitioner in the group agrees in writing to have 10% of his or her compensation withheld for five years. The money is accounted for separately and only used to underwrite group-ratified strategic projects.

Money going into the tithe account creates an income stream that can be used to leverage outside lines of credit to finance the group's operations and acquisitions. "Like the PPMCs, the group pledges its tithe revenue stream as payment of principal and interest for any use of credit facilities," Pulaski notes.

For participating providers, the system works something like a "second buy-in" through an income-deferral program, he explains. In turn, "when a tithing physician leaves the group, [his or her] stock is re-purchased and the tithe amount is repaid as compensation, and the group takes the tax deduction," he says. If they choose, groups also can include the time/value of the tithe in its re-purchase agreement with program participants.

Another advantage of this tithe approach to financing is that it can enhance a group's attractiveness to local lenders compared with other practices, the Peachtree physicians say. Similarly, "your tithing group will be perceived as more formidable by your local hospital administration, medical product companies, and insurers, making them more likely to strike favorable joint venture

deals with your group," predicts Pulaski. Practices with money or profits still on the books at the end of their tax year — which a tithe will do — are subject to corporate tax. "However, there are reasons why showing profit may be better than many practices commonly think," he says.

In most cases, the marginal tax rate for individuals is about 5% greater than for professional corporations. In turn, if a physician leaves money in the professional corporation, the tax is 5% less than if it had been paid out, Pulaski calculates.

Also, there is the potential value of such things as better insurance contracts, added ancillaries, more satellite offices, more providers sharing call, access to sophisticated information systems, more autonomy, and greater stability the tithed money would bring.

"It is entirely possible for the tithing group to plan its use of tithe money so well that the only amounts subjected to corporate tax would be depreciable capital items or investments in outside businesses," Pulaski says. ■

# HCFA: Medicare+Choice enrollment is dropping

*Lobbying to raise rates increases*

The pipeline of new Medicare+Choice members "is essentially drying up," a Health Care Financing Administration (HCFA) official told a recent meeting of the Washington Health Care Forum.

"Two years ago, the M+C program seemed pretty vibrant," noted **Robert Berenson**, MD, director of HCFA's Center for Health Plans and Providers. However, since then, there has been a dramatic reduction in net enrollment growth.

The total number of beneficiaries in Medicare+Choice actually declined by 126,000 between December 1999 and April 2000. Most of the decline occurred in January when health plan withdrawals from the Medicare+Choice program were announced. About 320,000 enrollees were affected by the January withdrawals, according to HCFA data. Of those, about 80,000 did not have the option to enroll in another Medicare+Choice plan.

After the January drop, Medicare+Choice projects a net increase of about 10,000 beneficiaries each month this year, according to Berenson. That would bring total enrollment at the end of this year to where it was at the end of 1999. In previous years, Medicare+Choice enrollment averaged 40,000 new enrollees each month in 1999 and about 90,000 enrollees per month in 1998.

About 16% of Medicare beneficiaries are now enrolled in risk plans, compared with 4% in 1993.

That has led to increased lobbying by health plans and state governments to raise Medicare+Choice rates to attract more HMOs into the program. However, Capitol Hill watchers like **Ira Loss** of the consulting firm Washington Analysis in Washington, DC, conclude that lawmakers are not in a mood to hike Medicare risk reimbursement this year.

On a separate track, Wisconsin and Minnesota have sued the federal government, claiming the reimbursement rates paid Medicare-risk HMOs are so low they are unconstitutional. They claim the low reimbursement rates effectively deny their senior citizens access to local providers who refuse to participate in the program, says **Jim Haney**, a spokesman for Wisconsin attorney general's office. "Our intention is not to take away anyone's benefit," he says. "We want equal benefits for seniors in all states."

In 1999, 43 Medicare-risk HMOs left the program nationally, while 52 reduced their service areas. Many of the remaining HMOs since have raised their premiums or cut benefits. Besides Minnesota and Wisconsin, states especially affected by these HMO dropouts include Arkansas, Missouri, Montana, North Dakota, South Dakota, South Carolina, Utah, Vermont, and Wyoming.

Like other managed care plans, Medicare HMOs make money when they negotiate contracts with providers that cost them less than the HMO is paid. How much Medicare pays these HMOs varies widely depending on their location.

Nationally, the average Medicare+Choice reimbursement per member per month (PMPM) nationally was $488.45 in 1999. But specific payments ranged from $676.64 PMPM in Broward County, FL, to $394.42 for Dakota County, MN.

In Broward County, a member of a Medicare HMO pays no annual premium, no fee for doctor visits, prescription drugs, outpatient mental-health treatments, or emergency medical services.

However, a senior in Dakota County must pay an average annual premium of $1,137 plus additional fees, including a $10 co-pay for a doctor's visit, out-of-pocket expenses for almost all prescription drugs, $15 to $30 for each mental health session, and $30 for emergency room treatment. ■

Physician's Coding Strategist™

# Outpatient payments rise under final PPS rule

*A drop in payments had been expected*

Rather than dropping by 5.7% as previously predicted, Medicare payments for hospital outpatient services will increase 4.6% under the new outpatient prospective payment system (PPS) when the new system becomes official July 1, estimates the Health Care Financing Administration (HCFA). Medicare outpatient payments are estimated to total some $11 billion this year.

"This is a significant swing," says **Robert Berenson**, director of HCFA's Center for Health Plans and Providers. The new hospital transitional corridor payments Congress decided to include in the Balanced Budget Refinement Act of 1999 (BBRA) are credited with creating most of the swing.

## *Some hospitals omitted*

The budget bill also permanently exempts certain cancer hospitals from any reduced Medicare payments resulting from the PPS and provides for outlier payments for high-cost cases. **(For information about what's in the final rule, see story, p. 88.)**

The BBRA also mandates that Medicare pay hospitals part of any losses they incur as a result of lowered payments under PPS during a transition period lasting until 2004. For rural hospitals with up to 100 beds, the losses will be fully replaced by Medicare.

As a result of these legislative changes:

- Payments to rural hospitals will increase 4.4% annually, rather than decreasing 1.8%.
- Payments to large urban hospitals will increase 4.3% rather than decreasing 0.3%.
- Major teaching hospitals will see a 0.2% payment gain rather than a 3.7% decline.

To implement the new PPS, the final rule divides all outpatient services included in the new payment schedule into 451 groups, or ambulatory payment classifications (APC). The APC payment rate for each group applies to all services within the group and is wage-adjusted to account for geographic differences.

## *Blood products separate*

HCFA also developed separate APCs to pay for blood and blood products. However, the new regulation does not apply to services paid for under existing fee schedules, such as durable medical equipment and orthotic and prosthetic devices. Ambulance services also will be included under another fee schedule HCFA is now developing.

Currently, Medicare beneficiaries pay half or more of their total hospital bills for outpatient services, according to HCFA. One of the primary objectives of the new regulation is to reduce beneficiary copayments for hospital outpatient services to 20% of Medicare payment rates.

To accomplish that, under the final rule, coinsurance will be frozen until the coinsurance payment for an APC becomes 20% of the total payment.

It could take as long as 20 years for the coinsurance payment for some APCs to come down to 20%, estimates HCFA. But when that does happen, the Medicare payment and co-insurance amount will be updated annually to keep the copay at 20% of the total payment. In addition, the copayment amounts for an APC will be capped at the Medicare hospital inpatient deductible. In 2000, that deductible is set at $776. ■

## Details of the changes for the final APC rule

Here are more details of the changes lawmakers included in last year's budget bill affecting the final rule implementing the new Medicare prospective payment system (PPS) using ambulatory payment classifications to reimburse hospital-based outpatient services, which goes into effect July 1.

According to Program Memorandum Transmittal A-00-09 from the Health Care Financing Administration to its fiscal intermediaries, the changes:

1. extend the 5.8% reduction in operating costs and 10% reduction in capital costs due to expire December 31, 1999, to July 1, 2000. The bottom line is that this will permit hospitals to continue billing that this part of their capital costs for six months longer than expected;
2. require PPS payment weights, rates, payment adjustments, and groups be updated annually;
3. establish budget-neutral outlier adjustments based on the cost-adjusted charges for all services included on the submitted outpatient bill for services furnished before Jan. 1, 2002, and thereafter, based on the individual services billed using the appropriate department-specific cost-charge ratio for each service;
4. provide transitional passthroughs for the additional costs of new and current medical services, drugs, and biologicals for at least two but no more than three years;
5. require several types of drugs and services not reimbursed under the Medicare program to be covered under PPS during the transition process. Those could include experimental drugs the U.S. Food and Drug Administration has not approved that have been clinically shown to significantly reduce problems with diseases;
6. include implantable devices, durable medical equipment, prosthetics, and items used in diagnostic testing under the PPS;
7. limit beneficiary copays for services paid under PPS to the inpatient hospital deductible;
8. pays for acute dialysis, such as for poisoning, under the PPS. ■

## Does your coding pose a compliance problem?

*Electronic records make it easier to get caught*

As the government and payers institute stricter reimbursement policies and electronic medical records make it easier to check for compliance, it's more important than ever for your practice to improve its coding performance. If you're not coding correctly, you could face a government review and stiff fines — even if it's an honest mistake.

Proper coding is important because it's how you communicate what you've done, points out **Todd Welter**, MSM, CPC, coding consultant for the Medical Group Management Association in Englewood, CO. It's getting easier to get caught if your coding isn't correct. The federal Office of the Inspector General and local Medicare carriers are conducting pre-payment and post-payment reviews comparing you with others in your specialty, he says.

"In the government's eyes, if you bill for a 99213 and all you documented was for a 99212, it's the same thing as saying you did four bypass graphs when you did only two. The government looks down on that," he says. "If you do more of a particular code than your peers, they may randomly ask you to send in documentation of some patients. Such a letter is the beginning of an audit."

If you do get a letter requesting more documentation, take it seriously, he adds. "A lot of those letters requesting documentation look benign but they can get doctors in a lot of trouble."

Welter cites three reasons for coding correctly:

- **Compliance.** Your practice can prove it provided the services it billed for.
- **Reimbursement.** Each code has a dollar figure applied to it. If you code correctly, you'll get the correct amount of reimbursement.
- **Statistical analysis.** Coding shows the acuity of your patients. This is important in a lot of managed care situations. You'll need that information if you are going to enter into any kind of capitation arrangement.

Most health plans, including government programs, use the CPT code as a method to determine the payment you'll receive. If you're going to get paid correctly, you have to submit the correct code.

"Although there are a number of software products and tools that can help, there's really no substitute for a good background in coding principles," says **Rita A. Scichilone**, of Woodbine, IA, practice manager of coding products and services for the American Health Information Management Association in Chicago.

Coding software sometimes gets physician practices in trouble, particularly if it suggests certain code combinations or tends to maximize billing, Scichilone says. However, other software may have useful segments, such as showing if the CPT code is correct for Medicare coverage or if you have to add additional codes, she adds.

If, in your practice, the physicians check off codes on the encounter form, they should be aware of the rules and guidelines that affect code choices, she points out. "The best situation is to have the physician select the code and the billing and coding specialist validate the code choices to make sure the codes are complete, accurately represent what was performed and what was documented, and [contain no] conflicts with health plan reporting requirements."

She suggests having anyone in your practice who deals with coding attend an educational seminar to make sure his or her skills are up to snuff. Or your practice can hire a consulting firm to review your records and provide one-on-one instruction on coding principles, coding guidelines, and improvement of documentation.

Your practice may decide to conduct its own audit. A good coding review includes checking to see if the documentation meets the criteria laid out for the particular code. Welter suggests compiling a year's worth of utilization data by doctor, broken down by code. Then ask for 10 randomly selected evaluation and management (E&M) notes and accompanying billing forms for each physician. Break the E&M notes into subpieces and compare them with the coding criteria. Look at coding per practice and per physician. If physicians' coding varies from the norm, see whether they have sicker patients or aren't coding correctly.

When Platte Medical Clinic in Platte City, MO, conducted a coding audit, the staff took the physicians' office notes and compared them with what was billed to see if the level of services the physician billed matched the documentation.

In addition to beefing up the practice's coding compliance, the audit discovered the practice was losing revenue because some physicians were undercoding, says **Lori Norris**, FACMPE, former practice manager at Platte Medical and current physician recruiting and marketing director for North Kansas City (MO) Hospital, which owns the practice.

"I encourage every practice to have it even if it has to outsource. Not only do you need a coding audit for compliance, but you can find a lot of missed revenue," she says. ■

# Should your facility move your coding department?

*Coders benefit from reimbursement knowledge*

Many coders know the stress that can occur while they are working in the medical records department. They feel pressure to improve the quality of their coding, while noncoding personnel grumble that the coders also should help with the phones and filing. That leads some coders to wonder — would the grass be greener under the direction of the billing department?

Having coding personnel in the financial department rather than in medical records is logical, says **Colleen Albert**, RHIT, CCS, a contract coder from California. "It is always useful to expand your knowledge [and career potential] and familiarity with insurance/reimbursement issues. And the role coding plays may best be accomplished by more direct exposure to such. Medical record offices are often noisy and cramped, and coding requires a high level of concentration to work not only accurately but quickly."

Some billing and financial managers also may see a good match, thinking that if they had control of coding, accounts receivable (A/R) would decrease, says **Allan P. DeKaye**, MBA, FHFMA, president and CEO of DeKaye Consulting in Oceanside, NY. Because medical records coding is both an art and a science, though, placing it in the financial department could have the opposite effect. "Billing, and for that matter, the A/R functions, certainly have enough open accounts of their own to devote their attention to lowering their investment in A/R, without the added worry of all the clinical and physician interaction that would likely occur with coding in the billing department," he says.

DeKaye says the coding function appropriately belongs in the medical records department but should be staffed with qualified credentialed staff. "The biggest challenge is, of course, overcoming

the inadequate numbers of available skilled personnel. This becomes especially difficult with increasing outpatient volumes."

Most medical records departments will, of necessity, use their most qualified coders for inpatient accounts, he says. That often leaves less experienced personnel taking on the most voluminous activity. "Private ambulatory services have increased vulnerability given Medicare's requirement that a relevant diagnosis be provided when ordering laboratory and X-ray services.

"With APCs [ambulatory payment classifications] looming on the horizon, coding will take on even more significance," he says. "If hospitals are prepared to invest in coding infrastructure, therefore, let the investment be in medical records."

*(DeKaye also offers the Patient Accounts Management Listserver. For more information, visit the Web: www.dekaye.com.)* ■

# AHIMA issues standards of ethical coding

*Are you doing it right?*

Because of the continuing federal campaign against health care fraud and abuse, the American Health Information Management Association (AHIMA) in Chicago recently revised its ethics policy for coding practices.

AHIMA initially developed its "Standards of Ethical Coding" in 1991. The association says it revised the standards because of the increasingly important role quality coding plays in complying with regulations governing payment for health care services and in curbing fraud and abuse. The newly developed standards are:

1. Coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality health care data.

2. Coding professionals in all health care settings should adhere to the ICD-9-CM coding conventions, official coding guidelines approved by the cooperating parties **(see editor's note)**, the CPT rules established by the American Medical Association in Chicago, and any other official coding rules and guidelines established for use with mandated standard code sets. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable health care settings.

3. Coding professionals should use their skills, knowledge of the currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.

4. Coding professionals should only assign and report codes that are clearly and consistently supported by physician documentation in the health record.

5. Coding professionals should consult physicians for clarification and additional documentation prior to code assignment when there are conflicting or ambiguous data in the health record.

6. Coding professionals should not change codes or the narratives of codes on the billing abstract so that the meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because the payment or insurance policy coverage requirements will be affected. When individual payer policies conflict with official coding rules and guidelines, those policies should be obtained in writing whenever possible. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer's policy.

7. Coding professionals, as members of the health care team, should assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, resequencing, or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and occurrence of events.

8. Coding professionals should participate in the development of institutional coding policies and should ensure that coding policies complement, not conflict with, official coding rules and guidelines.

9. Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of any changes in codes, coding guidelines, and regulations.

10. Coding professionals should strive for the optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines.

*(Editor's note: The cooperating parties are AHIMA, the American Hospital Association in Washington, DC, the Health Care Financing Administration in Baltimore, and the National Center for Health Statistics in Hyattsville, MD.)* ■

# When capitation gets raw, try CHF 'best practices'

*Pharmacists offer optimism, tested strategies*

One of the more promising ways to supercede the challenges of capitated pharmacy contracting lies in first going after the "biggie" — congestive heart failure (CHF) — and managing the nation's most prevalent disease with an eye toward avoiding all too common negative drug interactions among elderly patients.[1]

That's the recommendation of **William J. Waugh**, PharmD, director of disease state management and outcomes research at Wellpoint Pharmacy Management, a part of Wellpoint HMO, both based in Calabasas Hills, CA.

Waugh has tested with success a three-part approach to making a start toward taming the beast of pharmacy capitation. His research team's common-sense, pharmacy-driven approach offers hope for a healthier quality of life for CHF patients at significantly lower costs. In brief, the three main steps he and his team recommend are:

• Identify Medicare risk enrollees who have a CHF diagnosis.

• Screen (at minimum) for the top 20 most commonly contraindicated drugs in the elderly. **(See chart, p. 92.)**

• Follow the Agency for Healthcare Research and Quality's (AHRQ) clinical guidelines for CHF — particularly the drug recommendations.

Waugh's overall message to insurers is this: "Managed care organizations should be willing to pay for medications if they are going to take on Medicare risk, because that is the most cost-effective." He stops short of recommending physician groups accept pharmacy capitation.

His key worry is that patient medications will be shortchanged. When that happens, overall costs will shoot up, he says. To guard against that threat, a physician group is advised to determine whether a capitated drug plan under consideration is set up to pay adequately for drugs.

The assertion that lowering drug therapies results in higher long-term costs is confirmed in a 1999 study by Robert Popovian, PharmD, senior medical liaison for Pfizer Inc., and his team at the University of Southern California in Los Angeles. In Popovian's study, primary care patients in the capitated drug plan incurred 14% higher overall costs than patients in noncapitated drug plans.

But his theme rings true for physician practices engaged in Medicare risk contracting, too. One of the best places to start when looking to managed cost issues in a Medicare risk contract is coronary heart disease (CHD), Waugh suggests.

CHD is the nation's biggest killer. This year, an estimated 1.1 million Americans will have a new or recurrent coronary attack, says the Centers for Disease Control and Prevention in Atlanta. About 650,000 of those will be first attacks, and 450,000 will be recurrent attacks. The patient survival rate is about 60%, and after age 50, the prevalence of CHF doubles with each decade of life.

Given such high rates of heart disease, expenditures for CHF treatment also are high, but they are not uncontrollable, Waugh asserts. Of the $10 billion spent nationally each year on CHF treatment, hospitalization consumes $7 billion, and rehospitalization is a big part of that high price tag. Drugs account for $230 million overall, or about 2.3% of total expenditures.

But improved drug treatment — even if drug costs go up — can significantly reduce hospital admission and readmission costs, Waugh argues. Otherwise, without prevention and optimal drug therapy, CHF cases will only increase as the whopping numbers of baby boomers turn gray.

## *A three-step approach*

Waugh recommends this three-step approach, which he and his team tested among a sample of the HMO's Medicare risk beneficiaries:

1. Identify Medicare risk enrollees who have a CHF diagnosis. This is done by flagging patients based on prescription records and the ICD-9-CM codes for CHF if hospitalization has occurred. This is where the urgency for insurance coverage starts. Many elderly patients cannot afford to comply with all the drug therapies they need if the drugs are not adequately covered in their plans, he notes. Therefore, their risk for heart failure may not show up in medications records.

2. **Screen for the top 20 (at minimum) most commonly contraindicated drugs in the elderly.** Even though the threat of drug side effects is well known, patients often are not screened for drugs they are taking to prevent interactions with other new prescriptions, Waugh says.

At one plan he and his team researched, 15% of Medicare risk patients were taking a contraindicated drug. After intervention, drug therapy

## Contraindicated Drugs in the Elderly

| Drug Name | Reason | Suggested Alternative(s) |
|---|---|---|
| diazepam | daytime sedation, risk of falls | temazepam, estazolam |
| chlordiazepoxide | daytime sedation, risk of falls | temazepam, estazolam |
| flurazepam | daytime sedation, risk of falls | temazepam, estazolam |
| meprobamate | daytime sedation, risk of falls | temazepam, estazolam |
| pentobarbital | daytime sedation, risk of falls | temazepam, estazolam |
| secobarbital | daytime sedation, risk of falls | temazepam, estazolam |
| amitriptyline | anticholinergic effects, risk of orthostatic hypotension | nortriptyline, desipramine |
| indomethacin | risk of CNS toxicity | other NSAIDs |
| chlorpropamide | risk of SIADH syndrome | other hypoglycemics |
| propoxyphene | risk of CNS & cardiac toxicity | acetaminophen |
| pentazocine | risk of CNS & cardiac toxicity | acetaminophen |
| isoxsuprine | no demonstrated efficacy | |
| cyclandelate | no demonstrated efficacy | |
| dipyridamole | headaches and dizziness | aspirin |
| cyclobenzaprine | risk of CNS toxicity | acetaminophen |
| methocarbamol | risk of CNS toxicity | acetaminophen |
| carisoprodol | risk of CNS toxicity | |
| orphenadrine | risk of CNS toxicity | |
| trimethobenzamide | no demonstrated efficacy, risk of drowsiness, diarrhea | other antiemetics |
| propranolol | risk of CNS toxicity | atenolol, nadolol |
| methyldopa | risk of CNS toxicity | atenolol, nadolol |
| reserpine | risk of CNS toxicity | atenolol, nadolol |
| guanethidine | risk of hypotensive episodes | atenolol, nadolol |
| guanadrel | risk of hypotensive episodes | atenolol, nadolol |

*Source:* Waugh WJ. Managing congestive heart failure in the Medicare risk population. *J Man Care Pharm* 1999; 5:16.

changes were prescribed for some 70% of the patients in that plan. While end results are not yet available, Waugh expects hospitalizations to be lowered in that plan while quality of life for beneficiaries improves.

**3. Follow the AHRQ's clinical guidelines for CHF — particularly the drug recommendations.** The guidelines emphasize appropriate drug use. They recommend use of angiotensin converting enzyme (ACE) inhibitors in all CHF patients and the use of low-intensity warfarin in most atrial fibrillation patients to reduce the incidence of stroke, Waugh explains.

While "firm research" supports the use of ACE inhibitors and warfarin in CHF patients, use has not greatly increased, he says. In Waugh's study, both drugs were used by less than 40% of the patients in plans managed by Wellpoint's pharmacy benefits management company, and 20% of patients were not appropriately monitored for warfarin effectiveness. Other research cited by Waugh shows that of patients who need ACE inhibitors, only 40% under primary care physician supervision are prescribed them, and only 70% under the care of specialists are receiving the prescription.

This overall three-step approach for CHF was applied recently to one of Waugh's assigned plans. While his research is not yet complete, he estimates that hospitalizations will decrease up to 40% within the first year. He also expects that overall patient outcomes will improve and be reflected in the Health Plan Employer Data and Information Set as well as other key performance measures.

### *Reference*

1. Waugh WJ. Managing congestive heart failure in the Medicare risk population. *J Man Care Pharm* 1999; 5:14-17. ■

# Diabetic test could aid telemedicine payments

*Providers hope HCFA will pay for remote care*

An 11-member consortium of health care groups and providers hopes a pilot project using Internet-based telemedicine to deliver home care to low-income diabetics will convince federal officials to reimburse doctors for electronic delivery of health care. If Medicare and Medicaid endorse the idea, commercial payers are sure to soon follow.

> If the project works in contrasting neighborhoods such as Harlem and rural upstate New York, it "will work anywhere in the United States."
> ***Steven Shea**, MD, Project Director*

Lead by Columbia University, the consortium is financed by a $28 million grant from the Health Care Financing Administration (HCFA) to install Internet technology in the homes of hundreds of low-income diabetic patients living in medically underserved areas of New York state.

HCFA has funded other telemedicine projects. However, this effort, known as Informatics for Diabetes Education and Telemedicine (IDET), is HCFA's biggest investment to date in a single demonstration project.

"Presently, HCFA doesn't reimburse for the electronic delivery of health care services except for very limited circumstances and demonstration projects it funds across rural America," notes the project's director, **Steven Shea**, MD.

If IDET shows that low-income Medicare recipients in contrasting neighborhoods such as New York City's Harlem and rural upstate New York can use and accept the technology, "then this will work anywhere in the United States," Shea says.

"If we can improve outcomes and show telemedicine is effective and cost-effective," the project could serve as a model for treating a wide range of conditions such as asthma, congestive heart failure, obesity, smoking cessation, and depression, he says.

Unlike other federally funded telemedicine projects, the New York project is designed as a randomized trial. Organizers will recruit 1,500 patients, starting in September. Half of them will receive telemedicine services, while the other half receive routine diabetes care. Patients will be enrolled in the study for two years.

The consortium will contract with a home care provider and a technology firm to install the telemedicine units in patients' homes, teach patients how to use them, and provide technical support. Patients will receive computers equipped with a two-way video camera to take pictures of their skin and feet for signs of infection and a glucometer and blood pressure devices to check their blood sugar and blood pressure levels.

The devices will automatically capture patient data, which will be securely transmitted over the Internet to a clinical information system at Columbia Presbyterian Medical Center. ■

# Lenders reject practices as good loan prospect

*Health care apparently is risky business*

Health care now ranks as one of the most unappealing sectors for banks and other lenders to do business with, reports the Phoenix Lending Survey in Philadelphia. In fact, 85% of commercial lenders say they do not want to lend to a health care provider, finds the latest Phoenix survey. This is the fourth consecutive quarter that health care has led the list of least-attractive industries for lenders.

When it comes to making loans to physician practices, only 45% of commercial lenders said they considered practitioners to be attractive candidates.

"The loan prognosis for health care is grim," says **E. Talbot Briddell**, president of Phoenix Management Services. "There are very few signs of life among the various sectors that comprise the health care industry."

### *Providers are out, suppliers in*

Besides medical practices, lenders also are disenchanted with managed care companies (named by 55% of respondents as unattractive), not-for-profit hospitals (48%), and for-profit hospitals (45%).

When asked which parts of health care were appealing to their lending institutions, 41% of lenders preferred pharmaceutical companies, followed by durable medical equipment suppliers at 39%.

"The fact that no single sector of the health care industry scored above the 50% level is indicative of the low esteem in which the industry overall is held," notes Briddell.

When asked when they think the current economic boom will quit, 75% predicted it would end before the end of 2001. One-quarter of lenders expect it to halt this year, while half think the bubble will burst during 2001.

An overwhelming 98% of lenders also predicted interest rates would rise again soon.

"What we're seeing is a restrained optimism about the economy among lenders balanced against an expectation of rising rates, loan losses, and bankruptcies," Briddell says. ■

# Liability questions arise over home care referrals

*Certification of need at center of issue*

The home care industry has launched a national education campaign to bring providers up to speed on the Health Insurance Portability and Accountability Act (HIPPA) because of physician concerns about potential liability. The focal point of this effort is a memo on potential physician liability when certifying a Medicare home health care patient plan of care prepared by the National Association for Home Care (NAHC).

The NAHC memo acknowledges that, under HIPPA, physicians are now subject to civil and financial penalties if they certify in a plan of care that a patient meets Medicare coverage qualifications when, in fact, they know the patient does not qualify.

According to NAHC, physicians only face problems if they know a patient does not meet Medicare benefit qualifications for home care but still certify that those qualifications are met.

Any "unintentional error in the physician certification or a matter where there is a possibility of professional disagreement does not constitute a circumstance, which meets the test of 'knowing,'" says NAHC.

"The Medicare program would be required to establish that not only does the patient fail to meet Medicare coverage qualifications, but also that the physician knew that the patient's needs

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did not meet those qualifications and still certified the care as necessary for a patient confined to the home," maintains the memo.

In short, physicians are not subject to sanctions if, in good faith, they certify that a Medicare patient needs home health services, says the association. ■

# Feds continue probe of selling free drug samples

As many as 100 urologists have been subpoenaed by the Justice Department as part of an ongoing national investigation into questionable billing practices involving two prostate cancer drugs, Lupron and Zoladex.

Specifically, the government wants to determine if physicians charged Medicare for free samples given to them by drug makers. Billing for free samples is a felony under the federal Prescription Drug Marketing Act. It also may be a violation of the federal anti-kickback statute.

The American Urological Association recommends separating sample drugs and purchased medications and keeping accurate records.

According to sources, investigators are looking at the billing practices of physicians in Connecticut, Indiana, Kentucky, Maine, Massachusetts, and South Carolina.

Other states also may be targeted. One Indiana urologist already has been charged with billing Medicare and other payers between $400 and $550 for each of the free cancer drug samples he received. If convicted, the physician faces maximum sentence of five years in prison and a $250,000 fine.

"Physicians who bill Medicare carriers or Medicare patients for sample or 'starter' medications given them gratis by pharmaceutical companies seriously risk running afoul of the law," according to a statement by the American Urological Association. It recommends that providers keep any sample drugs separate from purchased medications, maintain records on the samples, and keep accurate records on those medications in case of a Medicare audit. ■

# Malpractice judgments jump by almost half

The median medical malpractice jury award in 1998 was $755,530, up from $515,738 in 1997, says a study by Jury Verdict Research in Palm Beach Gardens, FL. The national ratio of plaintiff victories to pro-defense verdicts dropped one point to 36%, which means plaintiffs won 36 of every 100 suits. The largest awards went to plaintiffs suing for medical negligence in childbirth, with a median award averaging $2 million. The median award for medication cases was $636,844; $625,000 for misdiagnosis; $400,000 for nonsurgical treatment; $300,000 for surgical negligence; and $230,000 for physician-patient relations. ■

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# Reimbursement ROUNDUP

## SGR for 2000 higher than expected

*An expected minus becomes a plus*

The sustainable growth rate (SGR) for Medicare physician payments in calendar year 2000 has been placed at 5.8%, reports the Health Care Financing Administration (HCFA). Last fall, HCFA was predicting a 2.1% SGR for 2000. The 1999 SGR was -0.3%.

The SGR is used to set a yearly target for payment increases in Medicare spending on physician services. If the target is exceeded, HCFA reduces the next year's physician reimbursement rate update to compensate.

This year's 5.8% rate increase reflects estimated changes in physician fees (2.1%), number of Medicare beneficiaries (-0.6%), growth in per capita gross domestic product (2.5%), and impact from changes in laws and regulations (1.7%), according to HCFA. ▼

## HMOs expanding into administrative field

*Internet project coming*

Six of the country largest health maintenance organizations are developing a joint Internet that will process provider claims, patient referrals, and prescriptions, say industry sources.

The consortium is being formed in reaction to HMOs' fears that unless they act quickly, they will be locked out of the potentially lucrative market for Internet-based health care administrative services by such fast-growing portals as Healtheon / WebMD in Atlanta.

The managed care plans working on the online project, tentatively named MedUnited, are Aetna, Cigna, Wellpoint Health Networks, Oxford Health Plans, Foundation Health Systems, and Pacificare Health Systems.

"These HMOs are saying they want to participate in this emerging market offering Internet-based alternatives for providers looking for ways to reduce their practice management hassles," notes **Claudine Singer**, an analyst with Internet research firm Jupiter Communications in New York City.

However, many experts wonder if such consortia can get off the ground given the hotly competitive nature of the HMO industry and possible reluctance of doctors to do business with a plan they feel is already working overtime to cut their income.

Another potential pitfall is that submitting a claim over the Internet is not as simple as insurers and Internet health companies would lead you to think.

"One challenge for doctors is that they have to figure out how to take the claim from their practice management system and put it on the Internet," notes **Michael Mytych**, a principal with Health Information Consulting in Menomonee Falls, WI.

"The same challenge applies to doctors whose offices aren't automated because they still have to produce a claim file from somewhere," he explains. ■