

Visit www.CardiologyOptions.com

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

August 2005

EDITORIAL

Electronic Records Offer Raises Questions 2

CARDIOLOGY STRATEGY

Benchmarks Show Health of Practice 3

HEALTH POLICY

Book Says Experts Support Reform 6

Electronic Records Offer Raises Questions

The theory behind offering an electronic health records system to all physicians is solid. In practice, however, having every physician adopt an EHR may prove to be complicated.

Early this month, the federal government announced that VistA-Office EHR, a high-quality, low-cost electronic health record (EHR) system for use in physician offices with one to eight practitioners, will be made available to any physician interested in using the system. The EHR has been developed through a collaborative effort of the federal Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration (VHA). The system works on an open, standards-based foundation that will allow vendors to develop value-added enhancements, such as installation, training, and support for physicians. The chief concern for physicians is that the high cost of implementing an electronic record system can be a significant impediment.

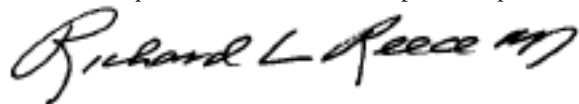
Medicare officials say the lack of electronic records is one of the biggest impediments to improving health care, according to *The New York Times*. By using the give-away software, an office of five physicians could save more than \$100,000, Medicare officials say.

This prediction sounds too good to be true. The American Academy of Family Physicians Center for Health Information Technology (www.centerforhit.org) says the give-away system lacks several important components included in other EHRs, including pharmacy, radiology, and laboratory results reporting and modules for scheduling visits, billing, and practice management functions. Also, the database that is part of the system must be licensed at a cost of about \$2,700, according to some estimates.

The Vista system does not include the CPT codes necessary to generate claims. These must be purchased from the American Medical Association at \$89.95 per year. The cost of integrating the system with other office software may total hundreds to thousands of dollars.

By some estimates, the cost of installing and maintaining the Vista system may be higher than installing and maintaining other EHR programs. It is likely that the system will cost \$10,000 per doctor in the first year, not including hardware, training, or other software needed to make the system work in a small office.

Allen Wenner, MD, a family physician in Columbia, S.C., and information technology expert, says making the Vista system work with other programs could be expensive. Also, the Vista system doesn't address the expensive problem of how physicians can enter patient data. Furthermore, the system does not include methods for handling task analyses and workflow changes. While the Vista system seems quite attractive, these important questions remain unanswered.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

This newsletter is published by Premier Healthcare Resource, Inc., Morristown, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

Neil Baum, MD
Urologist
New Orleans

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, PA
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley, PhD
Executive Director
Vanderbilt Center for
Evidence-based Medicine
Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
Cap Gemini Ernst & Young
Vienna, Va.

John W. McDaniel
President and CEO
Peak Performance Physicians, LLC
New Orleans

Lee Newcomer, MD
Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

James G. Nuckolls, MD
Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

James M. Schibanoff, MD
Editor in chief
Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD
Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

Benchmarks Show Health of Practice

Many cardiology practices analyze their coding methods to ensure that they are assigning codes properly. The goal of such analyses is to prevent downcoding, which results in loss of reimbursement, and over-coding, which can result in a Medicare fraud and abuse investigation. The importance of proper coding cannot be underestimated.

A rising number of cardiologists are finding that evaluation and management (E&M) coding software tools can help them validate the proper assignment of codes and audit their practices for proper coding. Now, sophisticated groups are realizing the value of coding benchmarking: the comparison of a group's own coding patterns with those of other similar groups.

Comparing Patterns

"A comparison of coding patterns reveals important information about the health of a practice," asserts Phyllis Ann Brown, chief executive officer of Arkansas Cardiology, PA, a 10-physician cardiology group in Little Rock. "It also enables cardiologists to confirm that their coding patterns are valid given the needs of their patient population. Benchmarking helps cardiologists identify outliers and asks why these outliers exist. The cardiologists can consider whether they are over-utilizing or under-utilizing services, or whether some reasonable variable is making the numbers appear skewed."

One tool available for cardiologists who want to benchmark their coding

practices is the *2004 Coding Profile Sourcebook: Medical Specialties*, published by the Medical Group Management Association in Englewood, Colo. The sourcebook includes data for three categories of cardiology practices: noninvasive, invasive, and invasive/interventional. In each category, data are presented for the top 40 procedure codes and the top 40 diagnosis codes. Coding data also are broken down into categories including evaluation and management, anesthesia and surgery, radiology, pathology and laboratory, and medicine.

"The breakdown of data in the coding sourcebook allows cardiologists to analyze a smaller portion of their business or a distinct revenue center," says Brown, who served as a reviewer.

Breakdowns by common diagnosis codes (such as 786, symptoms involving the respiratory system; 414, other forms of chronic ischemic heart disease; and 427, cardiac dysrhythmias) are provided. These were singled out because they are the most common diagnoses in cardiology practices.

Finally, coding data are broken down by age and gender. Brown notes that it is quite helpful to review the coding data by age or gender. "For example, a practice's utilization code patterns will be different if its population is elderly," she observes. "And considering patient gender can help cardiologists identify potential patterns of insufficient treatment."

Coding benchmarking can reveal whether a practice is downcoding its services, thereby foregoing earned

revenue. "Cardiology and other specialties that treat very ill individuals tend to downcode, because severe illness is routine for us," Brown believes. "A patient may be very ill with a lot of complications; however, if he is stable, his acuity relative to the other patients we see may not seem as high. Cardiology practices should be aware of the tendency to downcode and ensure that they are evaluating their services accurately. Such an evaluation should be based on a realistic assessment of patient acuity and the level of service needed to treat those patients."

Improved Coding

Using coding benchmarks not only prompt practices to adopt new processes to ensure proper reimbursement if down-coding is identified, but can also help practices identify and fix over-coding well in advance of an audit. "The last thing a practice wants to receive is a letter from a payer asking for reimbursement of overpayments generated from incorrect use of a CPT code," Brown says.

For example, according to the sourcebook, a vast majority of the codes billed by noninvasive cardiology groups are level three and level four codes. The two most common diagnosis codes for noninvasive cardiology are 786, symptoms involving the respiratory system, and 414, other forms of chronic ischemic heart disease. For diagnosis code 786, 49.1% of the codes are level-three codes and 36.8% of the codes for this diagnosis are level-four codes. For diagnosis code 414, a similar trend exists: 53.5% are

(Continued on page 4)

By reviewing coding patterns, cardiologists can see how well they are managing their patients and the effectiveness of their practice patterns, says Phyllis Ann Brown, CEO of Arkansas Cardiology, PA.

Expert Emphasizes Risks of Inaccuracy

Like other physicians, cardiologists will negatively affect their practices if they either downcode or overcode.

In some cases, physicians code incorrectly because they are detached from the operations of their practices, says Curtis J. Udell, CPAR, CPC, senior adviser with Health Care Advisors, Inc., consultants in Annandale, Va. “Coding drives the revenue cycle, supports practice expansion, and enables fulfillment of the practice’s mission, which is to serve patient needs,” he says. “Physicians who are not intimate with the numbers at the level of the encounter are putting their practices at risk. A cardiologist can have an excellent reputation, but if accurate coding and timely billing are not emphasized, then the practice will suffer and may even fail.”

In other cases, physicians can cheat themselves by habitually downcoding their services, Udell continues. “In contrast, physicians who code accurately obtain accurate reimbursement for the level of service they provide.”

Downcoding has implications beyond lost reimbursement. “Poor coding data will result in an inaccurate representation of a group’s operations,” Udell cautions. “Cardiologists that focus on accuracy in coding can use that coding data for a number of important purposes, including cost accounting, modeling for managed care contract analysis, and determining the viability of potential strategic relationships.”

Over-coding is also a risk. Udell recommends that cardiology practices review the U.S. Office of the Inspector General’s annual Work Plan (available at www.oig.hhs.gov), which outlines the important coding issues for each year. “While improper coding is a general risk, there may be cardiology-specific services that will be under particular scrutiny,” Udell says. “As technology changes and inpatient services move to the outpatient setting, the OIG will focus on whether practices are abusing new opportunities for reimbursement.”

Udell emphasizes the importance of having monthly or quarterly consensus meetings and education sessions for practitioners. “Physicians, clinical support staff, and billing staff should formally discuss coding problems and patterns in claim denials,” he says. “Furthermore, they should standardize coding practices for the 20 conditions that account for 80% of the practice. A group’s physicians may have individual methods of coding, and some physicians may realize that their practices have been costing the group a lot of money in terms of foregone reimbursement.”

In an analysis of coding practices, Udell emphasizes that cardiologists should focus on the adequacy of documentation, the codes that are entered on the claim, and whether full payment is received. “Most practices tend to catch only the more obvious coding errors, but they need to examine every possibility for error to capture full reimbursement.”

—DJN

(Continued from page 3)

level-three codes and 36.2% for this diagnosis are level-four codes.

“If a practice bills more level-one

or level-two codes for these diagnoses, then the practice might have a downcoding problem,” Brown says.

“On the other hand, if level-five codes comprise the majority of procedures billed, then the practice should be careful about over-coding and make sure that each level-five code is truly justified with documentation.”

Beyond ensuring proper coding, benchmarking of coding practices against those of similar groups could be useful, says Curtis J. Udell, CPAR, CPC, senior adviser with Health Care Advisors, Inc., practice management consultants in Annandale, Va. “After all, public and private payers compare each physician’s practice patterns to those of a designated peer group on an ongoing basis,” he notes. “Physicians may even receive reports from payers regarding their coding and utilization.” Therefore, physicians who can perform such benchmarking have the opportunity to examine their practices and make adjustments proactively.”

New Revenue Sources

Coding benchmarking also offers revenue enhancement opportunities. For example, benchmarking may identify services that a practice is performing but neglecting to bill. “Every year I download the Medicare utilization database and identify all the services performed by specialty,” Udell says. “Then, when I review a client’s procedure code list, I may find that certain services should be added.” Examining a practice’s use of visit codes, consult codes, procedure codes, and modifiers can reveal potential billing opportunities, he adds.

The sourcebook also allows an examination of coding for each service. “Cardiology practice managers reviewing the data should ask, ‘Given the coding patterns of other practices, is there a CPT code I am not using that I should be using to maximize the practice’s revenue?’” Brown poses. “Practices may be billing a service globally but missing some aspect of that service, such as a separate CPT code for an injection.”

Software Serves Several Functions

Coding software serves a number of important functions, says Curtis J. Udell, CPAR, CPC, senior adviser with Health Care Advisors, Inc., consultants in Annandale, Va.

The first function is validation, in which the medical record is examined to determine if the documentation supports the code. "Validation can be handled by some electronic medical records that both prompt physicians to ensure their documentation is complete and suggest appropriate codes based on the documentation entered," he says. "Validation can occur either before or after a claim is sent; sometimes validation is part of an auditing function."

A second function is benchmarking. Udell explains that the E&M service levels are reported, on average, along a bell shaped curve, which varies by specialty. "Benchmarking software allows physicians to see how their coding practices compare with that of their peers in the same specialty," he says. "Each specialty has a specialty-specific E&M utilization distribution. Payers benchmark to determine which physicians are outliers. Medicare is mandated to examine the data submitted by every physician at least twice a year, and those who seem to be overcoding significantly relative to their peer group in a certain level of service may be identified for focused audits." Benchmarking could also help a physician determine if he or she is downcoding.

Physician and staff education is a third function. Over time, users can see how different patient conditions are coded and become more proficient at providing adequate documentation to generate the proper code.

Reimbursement-related software that is linked to the practice's billing system can be a particularly useful practice enhancement, Udell adds. "As the claim is being generated, this software ensures that the diagnosis code supports the CPT codes, thereby optimizing claims," he states.

—DJN

Furthermore, benchmarking can highlight potential new revenue streams. If a group falls below the benchmark for use of a particular CPT code, then that group might consider whether to expand the use of that service for its own patients.

"A cardiologist might note that similar practices are frequently billing for interpretation, but he or she refers all that business out," Udell offers. "Similarly, codes indi-

cating that other practices provide nuclear medicine services may prompt a cardiologist to investigate the possibility of bringing those services in-house."

Medicare offers data on the number of times a particular code was denied. "This is good information for physicians, who then know they must thoroughly understand how to code a particular service because it has a high denial rate," Udell says.

While Udell is a supporter of coding benchmarking, he emphasizes that practices should not automatically code to the benchmark. "If a practice falls outside the curve or is an outlier, that doesn't necessarily mean that its coding practices are incorrect. Benchmarks are not a gold standard," he says.

Rather, benchmarking gives the practice a reason to examine outliers and determine if there is a valid reason for them. "Cardiologists should consider the environment in which they operate as well as the needs of their patient population," Udell comments. "They may even have to go back to the level of the individual encounter to confirm the validity of their coding practices."

Looking Forward

In the future, physicians will be reimbursed according to some form of pay for performance mechanism, Brown believes. "Coding patterns can reveal the extent of a practice's adherence to the principles of evidence-based medicine, and therefore may be examined to identify the better performers in a pay for performance system," she says. "Reimbursement will also be tied to outcomes. Did one cardiologist manage heart failure patients with an office visit and follow-up phone calls, while another cardiologist managed heart failure patients with hospital admissions every three months? Through diagnosis creep, coding patterns will reflect how well cardiologists are managing their patients and how cost effective their practice patterns are."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 8).

Benchmarking can help identify new revenue sources, particularly if a practice is below the benchmark for a certain code.

Book Says Experts Support Reform

For a new book published this year, some 40 health care experts were interviewed about what ails the health care system. Their answers are illuminating about what needs to be done to reform the system.

Written by Richard L. Reece, MD, editor-in-chief of the *Practice Options* newsletters, the book shows that consensus exists among the 40 health care experts he interviewed for the book. The experts cite the rising cost of health and the growing number of uninsured Americans as two factors that are intensifying the need to reform the system.

Reaching Consensus

The experts agree that if reform measures are going to succeed, then those who are organizing those efforts need to foster collaboration among all parties on such issues as basic insurance coverage for all Americans. The experts also agree that management processes must be developed to monitor the performance of major health care organizations. While these two needs seem self evident, the 40 experts in the book also agree on a more controversial topic: the need for medical liability reform.

Reece is a physician and editor who over the past nine years has interviewed hundreds of health care experts in his role as editor-in-chief of *Practice Options*. For this book, he conducted interviews separate from those he has done for the newsletter with 40 prominent leaders who are engaged in health care and represent a range of industry segments and points of view.

The interviews are organized into six parts:

1. Private-public consensus as a solution
2. Government-assured coverage
3. Consumer-driven solutions

4. Vested interests of physicians and hospitals

5. Vested interests of health plans

6. Support and supply chain interests

Following the interviews, Reece gives 11 conclusions that one would reach from the interviews.

A Range of Opinions

Among the health care leaders Reece interviews are hospital administrators, practicing physicians, consultants, heads of reform think tanks, advocates of a single-payer system, consumer-driven care enthusiasts, health plan executives, academics, disease management experts, physician innovators, medical directors of large multispecialty clinics, government insiders, and leaders of some large organizations. Among the organizations that are represented are the American Medical Association, American Academy of Family Physicians, the Medical Group

engage in straight talk about what these leaders thought. I waited until the end of the book before I developed the conclusions."

Indeed, the conclusions are compelling. "In general, the health care leaders interviewed thought the system was hurtling toward an economic abyss," Reece comments. "They agree that we cannot continue to spend two to eight times the general inflation rate on health care. The typical premium has risen by a total of 60% over the last five years. That's unsustainable. The system is pricing itself out of business. Health insurance now covers fewer than 50% of private American employees and private coverage is eroding at 2.5% per year. The numbers of uninsured and underinsured are rising."

Those suffering the most include consumers, hospitals, and general-practice physicians such as family physicians, general internists, pedia-

Health plan leaders say consumer-driven health plans will have a more significant effect on health care than managed care has had.

Management Association, and the Blue Cross Blue Shield Association.

Reece conducted the interviews over the telephone and allowed each interviewee to edit the final transcript. Since he is a physician and practiced for many years as a pathologist, Reece says he is sympathetic to physicians but still attempts to maintain his objectivity and professes to have remained neutral during the process. "These interviews reflect the true views of each of the experts," he says. "In other words, I ground no ideological ax. Instead, I sought to

tricians, and those in emergency medicine, Reece says. Safety-net hospitals also are suffering. In July, for example, the St. Vincent's Health System in New York City, one of that city's largest health systems, filed for bankruptcy. Over the past 10 years, more than 65 emergency rooms in California have closed.

Consumer-Driven Care

One of the trends discussed in the book is consumer-driven health care. Reece says some industry experts, such as George Halvorson, president

At a Glance

Voices of Health Reform: Interviews with Health Care Stakeholders at Work was published this year by Practice Support Resources, Inc., a publisher and book store in Independence, Mo.

For more information visit Practice Support Resources on the Web (at www.practicesupport.com). The book contains 210 pages and costs \$49.

and CEO of Kaiser Permanente, is profoundly skeptical about the commercial viability, social desirability, and ultimate sustainability of consumer-drive care. Some of the CEOs of the nation's major national health plans, however, such as UnitedHealthCare, Cigna, and Aetna, say consumer-driven health plans will have a more significant effect on health care than managed care has had. Also, they say, consumer-driven care may replace HMOs and PPOs. "To these CEOs, consumer-driven care is the next big thing," Reece comments.

When speaking with industry experts, Reece was surprised how positive employers, insurance brokers, bankers, and other financial professionals are about consumer-driven care. "The banks see these plans as a golden opportunity to serve as repositories of health savings accounts (HSA), to use their information infrastructure to process claims, and to introduce debit and smart cards at the point of care," Reece says. "One health plan executive says HSA plans will capture most of the market in two years. For physicians, the positive aspect of these developments is that they will be paid at the point of care with the swipe of a card."

Medicare Questions

On the issue of Medicare, the experts are not as positive. Reece says the Medicare system is not sustainable in its present form. "It's already costing \$300 billion, and it will jump to \$400 billion next year when the Medicare drug bill kicks in," he comments. "Medicare now has 42 million bene-

ficiaries and takes 15% of the federal budget. By 2020, it will have 60 million beneficiaries and be responsible for 25% of the federal budget.

"The consensus is that Medicare can't keep rewarding all providers in the same way, whether the care is good or bad, regardless of patient outcomes," Reece continues. Therefore, Medicare needs to develop pay-for-performance, quality measurement, and quality-reward systems. Despite the need for such systems, most interviewees thought pay-for-performance for hospitals and doctors based on meeting quality indicators is a strategy aimed primarily at containing federal costs. "There's considerable skepticism among physicians about the fairness of such systems," Reece says. "They don't believe government can separate the good doctors from the bad on quality indicators or patient satisfaction surveys alone." Therefore, it may be necessary to introduce consumer-driven programs into Medicare. "In that way, we can let the consumers decide," Reece concludes.

Industry leaders were particularly pessimistic that Congress would reverse the 26% cuts in reimbursement scheduled to take effect in Medicare over the next five years.

Despite the problems of Medicare, Reece said he was surprised to learn what a powerful influence Medicare has on the health care system. "It sets the rules for the rest of the system, and other payers and all providers must follow its lead," he comments. "One person I interviewed called Medicare the sheriff of the system, and said nobody bucks the man with the badge. Any reform, therefore,

will depend on interactions between Medicare and the private sector."

A Few Surprises

Reece also was surprised about the significant role American culture plays in shaping the health system. "Since our founding, Americans have believed in a relatively weak centralized federal government, in choices and freedom of action, and in equal opportunity, rather than equal results, for its citizens," he says. "Americans, for example, want choice and equal opportunities for access to the marvels of high medical technology. These cultural characteristics will dictate the direction and pace of health reform."

He was also surprised to learn about the tremendous strides being made in disease management. "When patients with chronic diseases are monitored closely and educated about their diseases, they respond intelligently and their health, and outcomes improve significantly," Reece says. "Readmission rates to hospitals for chronic heart failure, for example, often drop to near zero when patients are enrolled in effective disease management programs. Without disease management, we would not come close these results."

In conclusion, Reece is pessimistic about the future of the health care system because so many health care leaders are narrowly focused on solving their own problems and are not interested in addressing the problems that plague the health care system itself. But he also is optimistic because Americans tend to be entrepreneurial, innovative, and adaptable and can solve even the most difficult problems. "As a result, I think we'll end up with a uniquely American public-private collaborative with lots of innovation and multiple payers," he says.

—Written by editor Joseph Burns. More information on physician practice strategies is available on our Web site (see page 8).

CARDIOLOGY OPTIONS.com



Our FREE online resource includes:

- ▼ Strategies and tactics to build your practice
- ▼ A complete database searchable by keyword, subject, or issue
- ▼ Interaction with experts on all aspects of the Business of Medicine™
- ▼ Links to business resources, such as practice management, marketing, and CME
- ▼ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let CardiologyOptions.com come to you! CardiologyOptions.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at CardiologyOptions.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.

Name: _____

E-mail: _____

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

August 2005



Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

PSRST STD
U.S. POSTAGE
PAID
Permit No. 664
S.HACKENSACK,NJ