

# PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

April 15, 2001

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## Having a Compliance Plan May Help Prevent an Audit, Experts Say

Many physicians are reluctant to put a coding and reimbursement compliance plan into place, experts say. These physicians believe they already comply fully with federal laws and that the government has unfairly targeted all physicians simply because a few have committed fraud in the past.

All physicians who accept payment from Medicare, Medicaid, or private payers should overcome their reluctance, however, and adopt a compliance program that focuses on coding, documentation, and medical necessity, lawyers and consultants say. Simply having a compliance plan is an effective form of insurance against an audit or fraud investigation, they say.

When federal investigators find a practice that has adopted a thorough compliance program designed to address the government's concerns about fraud, they go elsewhere to investigate, says consultant Charlie E. Colitre. Last year, Colitre founded Med-Management Group Inc., in Akron, Ohio, to advise physicians on compliance issues. Previously, he had spent 14 years leading Medicare fraud investigations for the FBI.

The U.S. Justice Department's guidelines for determination of wrongdoing weigh heavily on

whether a medical practice has a compliance plan in place, says James Bickett, an assistant U.S. attorney in Akron. A litigator who works on fraud cases, Bickett says federal investigators want to know if a group has made a good-faith effort to adopt a compliance plan.

### A Different Perspective

Despite such warnings, the current rate of physicians adopting compliance plans is low, says Amy Woodhall, an attorney with Walter Haverfield, a law firm in Cleveland. "People are talking about compliance but not doing it on an aggressive level," adds Woodhall, who represents physicians in compliance cases. "They believe they already comply with the law and that it's not warranted because they delegate tasks or don't understand the regulatory environment. They have a false sense of security about their level of compliance."

Government enforcement agencies view physicians' obligations quite differently from the way physicians do, however, Woodhall continues. "They have suspicious minds," she says. "That's their job. What physicians might think is a legitimate and reasonable interpretation of their regulatory duties might not be viewed the same way by enforcement agencies."

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## Pain Needs To Be Addressed Realistically

**P**ain looms in our health care system almost like the proverbial elephant in the corner. Few of us want to talk about or acknowledge it, yet it's there in the physician's exam room, the lawyer's courtroom, and the patient's home.

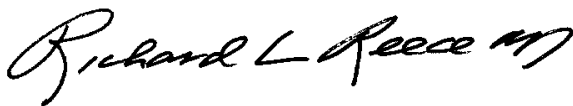
Two-thirds of Americans suffer from back pain at some time, and low back pain is second only to upper respiratory infections as the reason patients see their physicians. About 70 million Americans suffer from chronic pain, and we spend \$100 billion annually to treat pain, including \$51 billion in lost workplace productivity, according to the Equal Employment Opportunities Commission. Each year, chronic pain patients spend \$4.5 billion at pain clinics, \$3 billion for over-the-counter analgesics, and more than \$1 billion for narcotics. Each day, 23% of Americans say they suffer from joint pain; 22% from back pain, 20% have muscle pain, and 18% have arthritis, according to a Gallup Poll.

In the courtroom, pain is also significant. Les Phillips, PhD, a psychologist who specializes in behavioral medicine, and John Giusto, MD, a physiatrist who heads an interdisciplinary pain program for Triangle Orthopaedic Associates, in Durham, N.C., say their typical patients are workers who have been injured on the job. Many of these patients are suing their insurers, Phillips says. Since the Americans with Disabilities Act became law in 1991, back injury claims have become the single largest impairment alleged by workers who have filed on-the-job discrimination cases, the employment commission says.

But the pain problem may be greatest among patients with diseases not involving injuries. In a recent survey of 233 HMO patients in Connecticut who have cancer, arthritis, or nerve pain, 67.8% said they had suffered pain for more than a year and only 21% said medical treatment had relieved the pain.

To help ensure that patients get adequate treatment for pain, the Joint Commission on Accreditation of Healthcare Organizations, in Oak Brook Terrace, Ill., requires physicians and other providers to score the level and characteristics of pain in each patient. The new standard went into effect in January. It requires protocols for pain treatment and calling in a pain specialist if the pain consistently rises above a certain score. The protocol also requires physicians to treat pain until it is relieved and for mandatory pain education of physicians, nurses, and other health care workers.

Perhaps the most positive approach physicians can take is to ask each patient about his or her degree of pain and to record a pain score as if it were a vital sign such as blood pressure and weight. Such a record can help ensure that pain is no longer overlooked, serve as concrete evidence that a narcotic was indicated, and provide evidence against sanctions for overuse of narcotics.



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# Carve-Outs Offer Advantages

As reimbursement declines and payer contract terms become more stringent, physicians in a variety of specialties are seeking strategies to ensure financial success under managed care. Many are considering alignments with colleagues, either in single-specialty or multispecialty group practices or in looser contracting alliances such as multispecialty IPAs.

One potential strategy available to physicians in a variety of specialties is carve-out contracting. A carve-out is simply a direct contract between a payer and a group of specialists who agree to provide specialty services to the payer's enrollees. Carve-out contracting is not limited to specialists in single-specialty groups, as many believe. A group of specialists might come from multispecialty practices to address a specific carve-out contracting opportunity.

## Clinical Autonomy

"If several groups each include a few cardiologists, the cardiologists can join together for a separate, specific carve-out contract for cardiology services," explains Charles Peck, MD, a specialist in internal medicine by training and director of physician and managed care services in Arthur Andersen's Atlanta office.

Carve-out contracting offers numerous benefits, including the ability to make clinical decisions with others in the same specialty and the possibility of retaining a greater portion of health care premiums.

"After a managed care payer withholds funds for administrative expenses and profit, the premium dollar is divided among three entities—primary care, specialty care, and hospital care," Peck explains. "Primary care receives a very small percentage of the premium dollar—about 13%. Specialty care is allocat-

ed about one-quarter of the dollars. The remainder of clinical care dollars is paid to hospitals."

If a group agrees to manage the financial risk of caring for the payer's enrollees, the payer will allocate additional money to the group, because the payer does not have to perform functions such as case management, utilization review, and disease management. Instead, these responsibilities fall to the group. But

often cannot agree on what portion of the money each specialty will be allocated," Peck says. "Inefficient behaviors can result. If the PCPs are allocated their own portion of the premium payments, they might refer patients with minor symptoms to a specialist, whether or not those patients need to see a specialist." Such referrals can reduce primary care expenses and leave a greater pool of unspent primary care funds to

**Benefits of carve-outs include increased income and an ability to make clinical decisions with others in the same specialty.**

in exchange for the additional funds, the specialists must assume the financial risk of delivering care. As a result, specialists need to manage risk and analyze contracts carefully to ensure that they can cover the costs of care for each patient population—or they will have to finance the excess costs on their own.

Specialists find carve-out contracts attractive because they afford more control over patient care than when they have to share risk under contracts negotiated with colleagues in other specialties, particularly primary care. Much of specialist frustration with multispecialty risk contracts centers on inappropriate referral behavior, experts say.

First, primary care physicians (PCPs) may refer to specialists some patients who do not necessarily require specialty care. Sometimes these inappropriate referrals result from a lack of knowledge among PCPs about certain diseases and indications; other times, these decisions are based on inefficient financial incentives.

"When a multispecialty group signs a risk contract, the physicians

be divided among the PCPs at the end of the year.

"In contrast, a group of cardiologists, for example, can sign a carve-out contract, receive more money directly from the payer, and won't be concerned with how to share funds," Peck continues. "If patients are inappropriately referred to the practice, the cardiologists can refuse to see them. Specialists pursue carve-out contracts because it allows them to be somewhat independent of PCPs, other specialists, and payers."

## Countering Inefficiencies

Specialists are also frustrated by the opposite referral inefficiency: PCPs who continue to treat patients indefinitely rather than sending them to specialists for necessary care. Once again, such actions may be driven financially.

"PCPs may believe they are doing the best thing for the patient and for the group by attempting to treat a patient cost-effectively," Peck says. But if referrals are not made when they should be, care costs to the group can increase substantially, leaving less money in the pool for

*(Continued on page 4)*

## For payers, carve-outs may be easier to administer than managing primary, specialty, and hospital care separately.

(Continued from page 3)

year-end distribution to physicians.

"When a cardiologist is referred a patient with a serious heart problem, he or she may not prolong the process of care by trying interventions that seemingly use fewer resources," says Peck. "Rather, he or she might decide that it's more cost-effective to perform a cardiac catheterization or an angioplasty right away—in the end, the patient will get better faster and will not require numerous interventions and hospitalizations. If doctors are reimbursed out of professional funds based on patient visits, the incentive for the PCP might be to keep the patient as long as possible."

Typically, specialists emphasize clinical autonomy as a major benefit of carve-out contracting. "Carve-outs allow physicians network autonomy in determining appropriate services," says Michael Weinstein, MD, president of Metropolitan Gastroenterology Group in Washington, D.C., and founder of the 140-physician Mid-Atlantic Gastroenterology Network, which has negotiated carve-out capitation contracts since 1993. "While this does not mean individual physician autonomy, at least our physicians as a network are determining appropriate care instead of being subject to guideline interpretation by executives, secretaries, or others."

It is not unusual for specialists to believe they can do a better job of managing financial risks when they are making patient care decisions, Peck says. "In a carve-out contract, the specialists have control and can make the most cost-effective decisions resulting in higher care quality and potentially a greater amount of money left for the physicians or for new clinical programs at year-end," he explains.

Recognizing that they can receive a greater portion of the premium dollar if they deal directly with payers drives many specialists to pursue carve-out contracts. "We've been involved with various loose affiliations of physicians in numerous specialties that joined together for contracting purposes," says Steven Montgomery, MD, president of the Raleigh Orthopaedic Clinic in Raleigh, N.C., an 18-physician orthopedic surgery group. "But over the last few years, our practice has tried to get closer to the premium dollar by dealing directly with payers. Contracting directly with plans is preferable because we can negotiate a better relationship than if that relationship is filtered through an IPA."

### Marketing Advantages

While there are advantages for specialists involved in carve-outs, benefits accrue to payers as well. "Payers will try to sign carve-out contracts with the best specialists in the area," Peck says. "The payers can then leverage this marketing benefit, emphasizing the reputation, prestige, and quality of its physicians."

But a more significant benefit might be financial. "Since payers have been experiencing financial difficulties, the prevailing trend over the last five years has been for payers to try to off-load as much risk as possible," Peck explains. "Instead of simply paying the physicians for treating enrollees, payers will offer a little more money to physicians who will assume responsibility for managing risk and utilization. This limits the payers' financial risk. Furthermore, payers prefer to sign carve-out contracts as opposed to multispecialty contracts when designating risk, because carve-outs are easier to administer than a contract in which

a group of providers must manage primary, specialty, and hospital care."

Despite the benefits, some health plans remain reluctant to negotiate carve-out contracts, Weinstein warns. "Some health plans are hesitant to begin carve-outs because they feel that additional discounts can be achieved by playing specialists against each other," he says. "They also are reluctant to disrupt the referral patterns of primary care providers."

### High-Tech Care

Theoretically, physicians in any specialty can negotiate carve-out contracts. In reality, however, carve-out contracts are most common in high-revenue, surgical specialties such as orthopedics, neurosurgery, interventional cardiology, and cardiovascular surgery. What's more, the prevalence of carve-out contracts varies significantly by market.

"Managed care penetration is especially important," Peck observes. "Obviously, if a market is not significantly penetrated by managed care, there's no reason to have a carve-out contract."

Also, in markets that have experienced much consolidation among payers, carve-outs may be rare, Weinstein says. The size of the market, however, may not be an important factor, especially if the physicians are creative. In Springfield, Ill., a relatively small city, Prairie Cardiology, a large group, has enjoyed significant success in carve-out contracting by incorporating cardiologists across a broad geographic area.

Competition is a significant factor, of course. Competitive markets lend themselves to carve-out contracting. "If a market is overpenetrated with physicians in a particular specialty, specialists who can organize themselves into a group for contracting

purposes will then have more leverage,” Peck notes.

The number of physicians in a carve-out group is an additional factor. “A group must be large enough to be able to manage risks associated with the carve-out,” Peck explains. There is no rule of thumb based on group size, although a risk contract usually requires a minimum of 7,500 to 10,000 patients if the physicians hope to spread the risk adequately and be successful financially. “If the contract includes a smaller number of patients and a few become seriously ill, the group will suffer financially,” he says.

Similarly, there is no rule for whether the physicians or the payers pursue the relationship. Either single-specialty groups can pursue carve-out contracts, or physicians of a given specialty from several multispecialty groups can seek a specialty-specific contract. Sometimes the specialists form an alliance and approach a payer, while other times the payer might contact the specialists.

### Mitigating Factors

“Payers may notice that they are losing money in a particular specialty, or believe that costs are too high as a result of an excessive number of specialists, or that quality of care is not satisfactory,” Peck says. “In such instances, payers might contact the leading specialists in the market and encourage or assist them in organizing a group of colleagues into a carve-out contract. On the other hand, specialists might be unhappy with the amount of money they’re allocated within their own multispecialty group or they might believe they can obtain greater market power. If so, then they can initiate carve-out contract negotiations.”

Although carve-outs may be attractive for many reasons, physicians in a particular group may not be able to agree on contracting philosophy and terms, Weinstein cautions.

“For the most part, the network of physicians is still a group of independent physicians,” he says. “Not everyone agrees what is appropriate for a given contracting situation.”

Furthermore, capitation requires strict management. “Under capitation, the network’s incentive is to provide the appropriate level of services to achieve the highest quality of care,” Weinstein says. “As a whole, the network will receive the highest per-service reimbursement when

instances a costly service may be so infrequently performed that it is impossible to determine the risk for a given population,” he adds. “In this circumstance the code—for instance, ‘endoscopic ultrasound’—is ‘carved-out’ of the capitation and an alternative fee-for-service agreement is included to cover the specific service. In general, the network should be willing to take the risk on any service it can control, meaning any service for which it can predict the utiliza-

**In some markets, specialists may be able to organize themselves into a group for contracting purposes to gain more leverage.**

unnecessary services (those that do not contribute to better health) are denied and when health-improving services are provided quickly. Individual physicians may still have the financial incentive to provide more services regardless of need or outcome. In a capitation contract the network must police its own. And no one likes to confront colleagues.”

The biggest disadvantage for the physicians involved in carve-out contracting is the financial risk. “If they accept the risk, they have to be able to cover it,” Peck says. Nonetheless, physicians can mitigate this risk.

“Specialists considering a carve-out contract should invest money upfront in an actuarial analysis of the market,” Peck advises. “Actuaries will analyze the population in terms of age, sex, and severity mix of hospitalized patients, and make a determination as to whether the contracted fees are likely to cover the costs of care based on the population’s health risks.”

When negotiating a capitation contract, it is beneficial to be extremely specific, Weinstein offers, saying physicians should determine by CPT code which services will be included in the contract. “In some

tion. In a small population, it is not possible to determine the need for rare, high-cost services.”

Also, specialists should not sign any contract without stop-loss insurance coverage for catastrophic claims. “If physicians assume the risk for all care and a few catastrophic cases occur, they may have to assume huge financial losses,” Peck explains. “It’s crucial to have protection against this possibility.”

Finally, Peck highlights the value of cultural congruence among physicians who enter into carve-out contracting arrangements. “Especially when specialists join with colleagues with whom they may not have personally practiced, the issue of cultural compatibility arises,” he cautions. “All the physicians must share the same vision for what they want to accomplish. Specialists should not simply focus on the financials of contracting activity. They should also ensure that they are joining with people with whom they want to work and who share their goals.”

—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 16).

# Managing Cycles Can Boost Revenue

By John W. McDaniel

One of the most common reasons for poor financial performance in a medical practice is inattention to revenue cycle management, specifically reimbursement systems, billing and collection processes, and accounts receivable. When inattention to revenue management is coupled with declines in income from other factors, it can be disastrous for any physician group. As a result, physicians who manage revenue processes diligently will see improvements in financial performance.

Over the past few years, many physicians have experienced a decline in cash flow for a variety of reasons. Within each practice setting, the increase and complexity of reimbursement regulations requires a different level of expertise among physicians and office staff members. Also, increased employee turnover and more payer scrutiny of claims have resulted in delays of payments by almost all third-party payers. Furthermore, in the past few years physicians have spent more time and money on oversight control, in areas such as medical practice and coding compliance, the federal Health Insurance Portability and Accountability Act requirements, charge validation studies, utilization and referral management, and follow-up on denied claims. While physicians can do little about these factors except apply the necessary management expertise, there are other areas of revenue cycle management that,

when managed properly, can help boost income.

## Signs of Weakness

If revenue cycle management is weak, for example, physicians will see the following symptoms:

- Aged accounts receivable reports not being managed consistently
- Decreased number of telephone calls being placed to delinquent payers
- Many duplicate claim rejections
- Secondary payers not being billed promptly or payment denials not being followed

and a reduced chance of facing civil or criminal penalties.

Another issue related to reimbursement involves physician fee schedules, which typically are inadequate to meet the rising costs associated with practicing medicine today. In particular, fees often are inadequate under managed care contracts since most practices do not know the true cost of delivering patient care and yet try to cover expenses under fee schedules that may not have changed for several years. Therefore, when negotiating managed care rates,

**Coding, contracts, and fee schedules all require continuous monitoring if physicians want to see a steady increase in income.**

- Rising numbers of unanswered letters or other communications from payers seeking more information.

In any medical practice, there are only five areas to address when seeking to improve profitability:

1. Reimbursement systems
2. Billing and collection processes
3. Accounts receivable management
4. Operations improvement
5. Practice growth.

On this list, three of the five areas for practice improvement focus on revenue cycle management. Under the area of reimbursement systems, appropriate coding has been determined to be the single most important area for practice improvement, given that approximately 60% of all physicians undercode. Therefore, implementing a coding compliance program usually leads to revenue enhancement. For physicians who tend to overcode, the implementation of coding appropriateness reviews may lead to decreased audits

physicians should insist on timely payment of claims and get a clear definition of the term "clean claims." Payers often will use this term to delay payment. What's more, practices must fully understand risk contract management in terms of global fees and capitation rates in order to ensure that they are not underpricing their services.

While improving reimbursement systems usually results in a quick and positive effect on profitability, the areas of coding, fee schedule analysis, and managed care contracting require continuous monitoring and management if physicians want to see a steady increase in practice revenue.

## Billing and Collections

A second area of importance involves the processes used for billing and collections. Physicians should think of this area as being akin to an assembly line that begins with patient scheduling and registration

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and continues through insurance verification and eligibility, over-the-counter collections of copayments and deductibles, referral management, charge entry, initial billing and follow-up, electronic claims submission, payment posting, self-pay account management, claims denial monitoring and management, and adherence to prompt-payment laws.

Clearly, these processes are critical for any medical practice seeking to generate and maintain consistent cash flow. To shorten the time from bill to payment, physicians may want to send payment notices to patients and copies to the third-party insurer. The notices should tell the patients that the insurance company has not responded and the claim may be billed to the patient if there is no response. Most practices also attempt to contact the insurer's provider representative when payments are slow. When these efforts fail, however, the practice should report the problem to state authorities.

Facilitating cash flow also requires daily reconciliation of charges and cash receipts through various activity reports. Tools such as online eligibility verification systems and claims scrubbers can help physicians improve the effectiveness of billing and collection systems. Therefore, physicians may want to ask a consultant or accountant to suggest some tools that may help them meet their particular practice needs.

### Managing Receivables

The next area for improving the revenue cycle is accounts receivable management. We recommend that each practice segregate its aged trial balance by major third-party payer to determine the number of delinquent accounts over 30 days old. It is easier to contact one insurer regarding 20 accounts, for example, than it would be to make 20 separate inquiries.

Also, when seeking to collect a balance from a patient, if there has

## Take Steps To Improve Cash Flow

Many physician office practices could increase cash flow by making changes in five specific areas as follows:

**1. Business office operations.** Encourage the use of information systems for appointment scheduling, implement formal training programs for front end clinic personnel, and develop performance monitoring benchmarks and claims denial follow-up procedures.

**2. Patient registration.** Develop a patient financial screening reference manual to outline major aspects of contracts from each insurer or health plan. Set monthly targets for over-the-counter collections. Establish a patient-recall system and monitor no-show patients and cancellations.

**3. Billing and collections.** Monitor collection agency performance each quarter, develop systems for tracking compliance with patient payment plans, and monitor credit balances monthly.

**4. Accounts receivable.** Segregate aged trial balances by major payers, audit accounts receivable and claims denial follow-up performance each month. Use a credit bureau, small claims court, and prompt-payment laws.

**5. Internal controls.** Perform sample audits to help ensure compliance and capture all charges. Develop a coding compliance program that focuses on coding, documentation, and medical necessity. —JWM

been no activity at the end of 90 days, the group should send a final demand letter offering the option of payment in full or letting the patient contact the office to make arrangements for payment. If the physician gets no response within 10 days, these accounts should be referred to a collection agency. Many practices have not developed formal processes for arranging and monitoring patient payment plans.

Since most insurers now require deductibles and copayments at time of service, it is critical that practice office staff make every effort to improve over-the-counter collections. In the average primary care practice, 25% to 35% of income comes from such collections and these small balances can be difficult to collect after the patient visit.

For any business, the expression, "Cash is king," is unassailable. Therefore, after a practice has addressed the five areas related to improving profitability, it can develop a system to predict cash flow accurately. Cash flow management is

extremely important when planning to make large payments during the year, such as those for professional liability insurance, employee bonuses, quarterly taxes, and equipment purchases. To do so, physicians will need to review the appropriate management reports daily, weekly, and monthly in order to preempt any errors that have been occurring and to develop corrective action plans as soon as possible.

Improving revenue cycle management is the single most important business task any physician can undertake. When done properly, it will require physicians to review trending reports for each area of emphasis, set priorities by function and individual for improvement, take specific action steps for each priority, set specific goals and due dates, and possibly establish an incentive system for practice employees who help improve the practice's financial performance. Once these steps are completed, the physicians can move on to the last step: deciding how to spend or invest the extra cash. ■

(Continued from page 1)

As a result, all physicians would be wise to put a compliance plan into place, if only to help prevent the kinds of problems physicians confront when they face a federal or state fraud investigation, Woodhall explains. "Investigations are not being opened against just bad doctors," she says. "If physicians saw the types of allegations the government is making and understood that no one is immune from the government's suspicions, they would adopt a compliance plan."

In addition to protecting physicians in case of an investigation, a compliance plan is important simply because it is the law, says Mike Coyne, a principal with Waldheger Coyne, a law practice in Cleveland. "When physicians say, 'I'm not going to worry about this,' I remind them they do have an obligation for billing the government accurately for professional services," he adds. "If they are so inattentive toward billing practices that it amounts to recklessness, they have criminal exposure."

Having a compliance plan also may help to raise practice revenue, experts say. Total practice income often increases when billing and coding are done at maximum efficiency, consultants advise.

There is still another good reason to have a compliance plan, says L. Stephan Vincze, an attorney with Vincze & Frazer, in Montgomery, Ala. "Compliance is about the procedure and diagnosis involved in treating each patient, and how accurately you record what you did and how you did it," he says. "Can you name one example where more accurate and precise information

caused greater harm than good? In almost all cases in business, the more information we have, the greater the accuracy and precision, the better armed we are to make good decisions."

#### Detecting Illegalities

In fact, Vincze recommends that physicians think of a compliance plan as a multidimensional management process. "It is a process that depends on the exchange of accurate and precise information for the purpose of preventing and detecting improper or illegal conduct, while promoting ethical and quality medical care," he explains. "In their day-to-day practice and in their training prior to becoming doctors, precision and accuracy come first. That is exactly what a compliance program amounts to, precision and accuracy."

Yet before they accept the fact that a compliance plan is needed, many physicians may be angry that one is required at all, Vincze says. "This is not something addressed in medical school, and they hear the bad news when government agencies recommend compliance plans," he adds.

Last fall, the Office of Inspector General (OIG) of the federal Department of Health and Human Services released compliance guidelines that explain how small and medium-sized practices should proceed. They also define the key elements that the government recommends be included in any compliance program.

Physicians who remain reluctant to begin the process of adopting a plan should at least become famil-

iar with the regulations, experts say. "The first step is for the physicians in a practice to educate themselves about compliance by reading through the guidelines, and they have to make a commitment to be personally involved," Colitre says.

One problem with achieving compliance is that it cannot be delegated in full to an employee or to an outside firm to the point where physicians are not involved. Much of the compliance in a physician practice involves modifying staff and physician behavior, Colitre says. Without full physician support, changes in behavior will not be made, he adds.

What's more, the full legal responsibility for compliance rests with physicians. Therefore, they need to have some level of ongoing involvement in the process. Practices that try to implement a plan without full physician support and involvement may find that the plans never become operational, Woodhall says.

#### Improved Communication

While some physicians are reluctant to begin the process, those who have adopted compliance plans found benefits beyond the simple act of achieving conformity. Installing simple reporting mechanisms, for example, can help improve internal reporting.

Mike Dobrovich, MD, whose group, Westshore Primary Care Associates, recently completed a compliance plan, found that many of the comments brought to the physicians' attention under the plan's new reporting mechanisms

(Continued on page 9)

**"If physicians saw the types of allegations the government is making and understood that no one is immune from the government's suspicions, they would adopt a compliance plan."**

**—Attorney Amy Woodhall**

(Continued from page 8)

had little to do with violations of reimbursement law. Instead, the members of the 18-physician primary care group in Cleveland found the new compliance mechanisms resulted in an increase in physician-employee communication, which helped to improve staff morale.

"At times, we learned that our people have been unclear about practice policy," Dobrovich explains. The compliance plan helped to eliminate confusion.

### Monitoring Compliance

Sally Rintoul, executive director of University Anesthesiologists, a 45-physician group affiliated with University Hospitals Health System in Cleveland, agrees that increased internal reporting helps to strengthen a practice. But doing so is not necessarily easy, in part because compliance addresses sensitive areas involving employee and physician performance.

"Definitely, the sensitive areas are those that deal with discipline, internal reporting, and performance evaluations," Rintoul says. "They all center around monitoring: who will monitor, who is responsible, and the disciplinary actions you take when someone is repeatedly not in compliance."

To help University Anesthesiologists determine if a violation has been made, the group performs quarterly audits. Staff members conduct most of these audits, and outside experts conduct others. The group uses report cards to keep physicians apprised of progress on compliance issues.

"Once we find a problem through an auditing process, we will approach the individual having inappropriate documentation," Rintoul says. "If the problem is repeated, we may propose disciplinary action."

For most groups, the time needed

## Seven Steps To Comply

Experts recommend physicians take the following steps to comply with the reimbursement guidelines from the Office of Inspector General of the federal Department of Health and Human Services.

**1. Distribute the guidelines to staff members.** All physicians and management personnel should obtain and read a copy of the guidelines. The document, *Compliance Program Guidance for Individual and Small Group Physician Practices*, is available on the Web at [www.dhhs.gov/progorg/oig](http://www.dhhs.gov/progorg/oig) under Compliance Guidance.

**2. Organize the effort and select a compliance officer.** The group will need to choose a senior physician, administrator, office manager, attorney, or outside consultant to head the compliance program. The officer must be credible within the organization. When starting the effort, many groups name a compliance committee to implement the appropriate checks and balances needed to ensure that the practice effectively deters illegal conduct under the federal False Claims Act and other laws related to reimbursement.

**3. Consult with a health care attorney.** For reasons related to attorney-client privilege, physicians should have an attorney assign an audit to a consulting firm, says Mike Coyne, an attorney with Waldheger Coyne in Cleveland. A retrospective audit could uncover wrongdoing or fraudulent acts, raising issues best left to an attorney to sort out, he adds.

**4. Consider using a consultant.** In many group practices, an administrator or office manager may undertake the requisite self-education to develop a compliance plan. But in other practices, the administrator or office manager may be overwhelmed by the task. In this case, it may be best to hire an outside adviser, says Amy Woodhall, an attorney with the law firm of Walter Haverfield in Cleveland.

**5. Write a compliance plan.** The committee or others drafting a plan should outline key areas of concern, and explain how each will be addressed. The plan should include timelines and should assign responsibilities to committee and staff members.

**6. Review all areas of risk.** Identifying all areas of risk provides the practice with advance knowledge of problem areas and would be the same approach the FBI would take in an investigation, says Colitre.

**7. Distribute the plan.** Once the procedures are written, the committee should distribute the plan and explain the main elements. The committee also should plan to send staff for training. —DK

to write and adopt a compliance plan is directly related to the size and complexity of the practice. A solo practitioner may need three months to draft a plan, Colitre says, and he adds an extra month for each additional physician.

The cost for a group of two to three physicians would be about \$5,000, Coyne says. These funds would be used to hire a consultant

to review the program and the group's coding procedures, he adds. Larger groups can spend \$40,000 or more, he says. To keep costs down, physicians can get copies of plans from other physician groups and should send out requests for proposals before hiring any consultants.

—Written by David Kettlewell in Cleveland. More information on practice strategies is available on our Web site (see page 16).

# Systems Help Solve Problems

By Richard L. Reece, MD, Editor-in-chief

Physicians today continually face complex clinical and business problems. Luckily, an increasing array of technological solutions—from low-cost CD-ROMs for use on personal computers to cost-per-transaction services on the Internet—is available to help them address these problems and to guide them in ways that help enhance revenue, reduce overhead, improve documentation of their work, and boost productivity. The difficulty physicians face is determining which technological solutions will work best for them.

In the past year, *Practice Options* has discussed some of the practical office-based technologies currently available to help physicians in solo practice and in large provider groups solve the complex clinical and business problems they confront. In this article, we look at how solo practitioners or those in small groups can use one or all of these approaches to meet their practice needs.

## Building Success

One concept that may be useful in finding practical solutions to problems today is called “chunking.” The term refers to the principle that all information should be presented in small, digestible units. George A. Miller, a psychologist at Harvard University who was doing research on short-term memory, introduced the concept in the 1950s. Since then, the term has been used in a variety of settings, including those involving cognitive theory and Web site development. The term is appropriate in a physician practice context when referring to how a system for solving clinical and business problems can be developed from a series of small, incremental building blocks.

The key to this approach is that the building blocks can be used

either independent of each other or integrated into a comprehensive system. The approach allows physicians to test various ways to address a problem and to link the ones that work into a system specifically tailored to their own practice styles.

## Boosting Productivity

David Bright, MD, a solo family practitioner, in Stuart, Fla., has “chunked together” an integrated clinical and business management system using Dragon 4.0 speech recognition soft-

saving \$12,000 annually. Also, his net income rose by 20%, and the hardware and software paid for themselves in the first year, he says.

## Improving Data Entry

Another example of chunking can be found among physicians who use a hand-held computer to collect and track clinical, administrative, and outcomes information at the point of care. This solution gives them more control over the quality of patient data while reducing costs. What's

**E&M services can account for as much as 75% of the total revenue of primary care physicians, 55% for internal medicine specialists, and 30% for surgical specialties.**

ware linked to clinical, referral, dictation, patient education, and prescription templates. Bright and a physician assistant see 40 patients a day. As they examine each patient, they speak naturally to voice recognition software and call up the appropriate templates to dictate, prescribe, and refer. By taking two existing information technologies—an electronic medical records program and a voice recognition program—and integrating them into his practice, Bright has changed how he and his staff enter data and compile medical records.

Bright's system also helps him to encourage patients to participate in their care since the system includes drug reference and patient education software. Prescriptions, medication information, patient handouts, laboratory orders, and disease management algorithms can be printed on a networked printer at the checkout station for patients. The system has helped Bright cut transcription costs,

more, improving the accuracy and completeness of the data collected helps to reduce the likelihood that claims will be denied or challenged for payment. MDeverywhere is a company in Durham, N.C. (at [www.mdeverywhere.com](http://www.mdeverywhere.com)), that provides software for hand-held computers to help physicians collect data on diagnosis and treatment while they are seeing patients. Lloyd Hey, MD, chairman and founder of the company, says that the company's software can help to integrate the administration, clinical care, and outcomes areas of health care. Accurately tracking the diagnosis is important clinically for patients, of course, but also for medical record documentation, for bill paying, and for recording why patients needed treatment and what conditions they had that might affect outcomes, he says.

Computerized record keeping at the point of care also can help to improve and control costs, Hey

explains. Using a hand-held computer while examining a patient helps to ensure that all of the physician's charges are captured, while reducing costs because the need for rework or double data entry is eliminated. Because billing time is reduced, physicians can be reimbursed more quickly. What's more, the software can be incorporated easily into a practice to help physicians collect information for clinical research, for example, or to help meet compliance guidelines from accrediting organizations and payers.

### Coding Compliance

Software applications are also available to meet the specific and complex evaluation and management (E&M) coding requirements. For the many physicians who treat Medicare patients, using such software helps them to validate the proper assignment of codes. It also helps to ensure that they are not overbilling for their services, thereby reducing the anxiety they may feel over the chances they will face an audit or charges of fraud or abuse. Such systems also help to prevent underbilling.

Curt Udell, president of Emphysys, a physician reimbursement compliance firm in Cumming, Ga., says that because E&M services account for more than 70% of all Part B claims and over 35% of all Part B payments, the federal Health Care Financing Administration (HCFA) targets all physician E&M coding for audits. E&M services can account for as much as 75% of the total revenue of primary care physicians, 55% for internal medicine specialists, and 30% for surgical specialties, he says. Therefore, as HCFA puts increasing emphasis on preventing Medicare fraud and abuse, collecting data accurately becomes even more critical. By not documenting their charges accurately or thoroughly, physicians could see their claims denied or they could be hit with steep fines.

## Before "Chunking," Ask the Right Questions

When adopting a chunking solution to address clinical and business problems, physicians should be sure to ask the right questions of the vendors and developers of the software and equipment being considered. Among those questions are the following:

- How long has your company been in existence?
- How does the application (or equipment) benefit users?
- How many physicians or physician groups are using the system?
- Can the company provide a list of users to contact?
- For every dollar invested, what is the bottom-line return of the application (or equipment)?
- Has the system increased revenue or cut overhead? If so, how?
- How long does it take to learn and master the application?
- How does the application speed workflow? Will it interrupt normal practice procedures?
- Can the application (or equipment) be used in multiple locations?
- Is the application useful, useable, and user-friendly for physicians, or is it geared toward office staff only?
- Does the application help physicians see more patients each day?
- How does the application affect physician-patient interactions?
- Does the application enhance physicians' ability to document their work completely?
- Does it help to minimize chances of being audited? Does it help physicians prepare for an audit?

—RLR

When physicians see as many as 60 patients a day, meeting the E&M documentation requirements can become a significant administrative burden. Many physicians are learning how E&M coding software can help them validate that their codes have been assigned properly. It can also show where the doctors seem to be overbilling because of underdocumentation, and where they could be underbilling because they are not providing enough documentation to bill appropriately.

In fact, E&M coding software performs a number of functions. One is validation, whereby a medical record is examined to determine whether the documentation supports the code and to suggest appropriate codes. Validation can occur either before or after a claim is sent, and sometimes validation is part of auditing.

Another function is benchmarking, which allows physicians to see how their coding practices compare with those of their peers in the same specialty. A third function is physician and staff education. Over time, users of the software begin to see how different patient conditions are coded and they become more proficient at providing adequate documentation to generate the proper code.

As more physician-related systems are developed, physicians will become more adept at using technology in a variety of ways. Also, they will find an increasing array of options to improve productivity, decrease costs, complete legal and administrative tasks, and, most important, deliver better patient care.

—Edited by Paula Grant, in Lincoln, Va.  
More information on practice strategies is available on our Web site (see page 16).

# Marketing Expert Explains Keys to Successful Practice Building



Neil Baum, MD, is a practicing physician in New Orleans who is an author and expert on how physicians can improve communication with patients. For 10 years he wrote a monthly column, "Marketing Dynamics," for American Medical News and is a contributor to numerous medical journals and publications. He is on the clinical faculty at Tulane University and the Louisiana State University School of Medicine in New Orleans. His book, *Marketing Your Clinical Practice Ethically, Effectively and Economically*, was published last year by Aspen Publishers, in Gaithersburg, Md. Aspen published his first book, *Take Charge of Your Medical Practice Before Someone Else Does It For You*, in 1996.

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**Q.** What has been the response among physicians to your suggestions that they actively pursue practice marketing activities?

**A.** Initially, I was worried that there would be some backlash, because many physicians think marketing is unseemly in our profession. But I realized that the types of activities I propose are ethical marketing—not advertising—and primarily fall under the auspices of patient education. Physicians seem to be much more amenable to marketing as a secondary benefit of patient education and community

service activities. As a result, I have had colleagues ask me how to get media recognition, how to get a television appearance, how to enhance their communication with colleagues, and how to enhance relationships and obtain loyalty with existing patients.

**Q.** In your book, *Marketing Your Clinical Practice Ethically, Effectively and Economically*, you note that there are four pillars to a successful practice. What are they?

**A.** The four pillars to a successful practice are: relationships with existing patients, the ability to attract new patients, relationships with colleagues, and a highly motivated staff.

**Q.** You suggest calling patients at home as a means of building relationships with existing patients. Why is this strategy effective?

**A.** Whenever physicians ask me for advice on the best thing to do to market and promote a practice, I always say, start with your existing patients and make certain that each patient has a positive experience with you and your practice. There is no better way for physicians to enhance relationships with existing patients than to call a patient at home to check on his or her condition.

We've identified in our practice what we call key patients. Those key patients fall into one of two categories: first, those who have recently been discharged from the

hospital who have questions regarding their discharge instructions, their medications, when they need to make their next appointment, and under what conditions they should contact the doctor; and second, those with a new diagnosis or who have a significant medical problem and who will almost certainly have some questions after they leave the office. Very often, a key patient is one whom physicians are treating as an outpatient today who, just a few years ago, they would have admitted to the hospital, or one who has had a procedure that required sedation and couldn't remember the information that was given before they went home.

We found that by calling these patients at home and checking on their conditions, we could create a "wow" experience for the patient. Patients absolutely cannot believe that their doctor has called them at home. In fact, I have introduced myself to people at community functions and they've said, 'Oh, I've heard of you. You're the doctor who calls his patients at home.' That's not a bad image to have in this day and age, when doctors are taking such a beating in the media.

The patients who receive a personal phone call from their physician will almost certainly tell dozens of other people about it, generating word-of-mouth referrals. This strategy is easy, costs nothing, and is extremely effective.

**"There is no better way for physicians to enhance their relationship with their existing patients than to call a patient at home to check on his or her condition."**

**Q.** *Second, how can physicians get their names across their referring doctors' desks as often as possible?*

**A.** Whenever physicians have an opportunity to communicate with referring physicians, they should communicate in a positive fashion, whether that be writing a referral letter or sending a congratulations note on something that the physician did in the community or even something the physician's children accomplished. This creates positive name recognition and will encourage the referring physician to continue the referral relationship.

My goal is that every time I have a chance to interact with a referring doctor, I take that opportunity. Every time I treat a patient, I communicate with the referring doctor, even if it's one sentence that indicates that the patient is doing well or that I put the patient on a certain medication. If I see an article that I believe is pertinent to the physician's area of medical interest, I send it. If I know the physician has an area of interest outside of medicine and I see a relevant article, I send it. This says, 'I'm thinking of you even when we are not discussing professional activities.'

This type of communication is far more important than the wine and cheese basket given at Christmas time, because the referring doctor gets two dozen of these kinds of gifts and can't remember who gave which present. It is far more important to maintain an ongoing dialogue with referring physicians and keep them informed about their patients, so that you allow them to be the captain of their patients' health care ship.

Physicians should look at referring relationships broadly and take all opportunities to communicate positively with all the colleagues who refer or have the potential to refer patients. Physicians should make an effort, for example, to

communicate positively with emergency room doctors. Also, physicians should cultivate good relationships with alternative health care providers.

Finally, physicians should promote solid relationships with referring physicians' staffs. I want my name to cross the minds of the staff members and the physicians in a positive light. Once every quarter, for example, we invite another office's staff over for a lunch-and-learn program. We provide food, give them a tour of the office, tell them how our practice interacts with theirs, and then have an informal discussion. We receive incredi-

ble compliments on that program. Such interactions make it more likely that these staff members will comment favorably to their patients about our services and ultimately send their patients to our practice for their urological care.

**Q.** *Third, you suggest that physicians identify and pursue niche activities. How can they do so?*

**A.** Physicians must identify the areas of unmet needs in their communities and try to pinpoint needs that they are interested in satisfying. For example, if none of the physicians in a community has a weight-loss program, then one physician can become visible on that topic by writing articles and getting recognized by the media. When there are new techniques, new medications, new approaches to weight loss, that physician can let the community know that he or she includes these new approaches as part of his or her practice, and

has state-of-the-art information on the subject. Other possible niche topics include allergies, alternative or complementary medicine, cancer prevention, nutrition, headache, and sports injuries.

Physicians can also create a niche by setting themselves up as experts in certain areas of their specialties. For example, as a urologist, I go out into the community and explain to people that they need to obtain an annual prostate-specific antigen (PSA) test as a screen for prostate cancer. I also contact primary care doctors and tell them which patients need to be tested—all men over 50 and all men over the age of

**"An annual survey where action is taken on the information obtained from the survey is one of the best ways to make a continuous effort to improve your practice."**

40 who have a blood relative with prostate cancer—and that those who have an abnormal PSA or an abnormal digital rectal exam should see a urologist. Although all urologists are experts on PSA testing, I have become visible on the subject.

**Q.** *Fourth, you suggest that physicians motivate their staffs to present the practice in a positive light. Why is this important?*

**A.** Staff-patient interactions are crucial because the reality is that the staff spends more time with the physician's patients than the physician does. An average patient spends 45 minutes to one hour in the office and only five to 10 minutes with the doctor. So the staff must ensure that the patient has a positive experience even when the doctor is not eyeball to eyeball with the patient. Every interaction that patients have with the practice has to be managed and made positive, and this is what the staff does.

*(Continued on page 14)*

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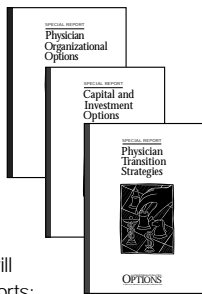
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**“Doctors have to act as if they want a staff that is highly motivated to exceed patient expectations.”**

(Continued from page 13)

Everyone in my office wears a lapel pin as a reminder to have a positive attitude toward each patient.

Positive interaction begins with answering the telephone. In my office, we have a script in front of every phone telling the staff member how he or she should answer the phone. This facilitates consistently positive phone manner. We also tell the staff to smile and be enthusiastic while on the telephone. In fact, there is a mirror in front of every telephone because I believe the smile can be heard on the other end of the line.

**Q.** How can physicians go the extra mile with patients, as you suggest?

**A.** It's so important to exceed patient expectations. Every doctor can make a diagnosis and prescribe medication. But physicians should go the extra mile by giving their patients more than they expect. Find out what interests them and give them educational material. Call in their prescription to the pharmacy so that it is ready when they arrive. Notify them when there's going to be a delay in service. Don't charge them when the schedule is delayed excessively. Make an effort to be an on-time physician. These are just simple things, but they have to begin at the top. The doctors themselves have to act as if they want to have a staff that is highly motivated to focus on exceeding patient expectations.

In addition, physicians should survey patients on a regular basis. Find out what they want and give them more of it, and find out what they don't want and avoid it. An annual survey where action is taken on the information obtained from the survey is one of the best ways to make a continuous effort to improve your practice.

**Q.** For physicians, the Internet has become a significant factor. Do you use the Web to market your practice?

**A.** Yes, my Web site address is [www.neilbaum.com](http://www.neilbaum.com). However, I have rarely gotten new patients from the Internet. Rather, I use the Internet to help me exceed patient expectations, mostly by using the Internet as an educational tool. My patients can get a vast array of educational material over the Internet. For example, if they want to see information about impotence medication, they can view a video on the subject on the Internet. The idea is to leverage the Internet to educate existing patients.

—Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

# Doctors Need Security-Planning Role

By Brian McCardel, MD, and Joel French

When physicians and office staff members begin using Internet technology to improve administrative tasks, the issue of patient confidentiality becomes increasingly important. Clearly, ease of access to information can lead to ease of abuse. For the promise of technology to become a reality, security and access must not be mutually exclusive. One without the other is useless. As a result, physicians must be involved at every stage of the development process.

## Information Sharing

The federal Health Insurance Portability and Accountability Act (HIPAA) contains wide-ranging mandates that all physicians need to understand regarding privacy and security for insurance claims. Understanding HIPAA is particularly important for physician practices that are considering new systems designed to increase efficiency by using the Internet to share records, test results, and insurance claims. It is also important that physicians working with new computerized physician order-entry (CPOE) systems understand the requirements. Some observers believe CPOE will help eliminate errors in health care, but any electronic order entry system also must comply with HIPAA requirements for privacy and security.

It goes without saying that medical records have always been shared

among health professionals. And the adoption of technology for information sharing—such as photocopiers and fax machines—is not foreign to medical offices. But unlike photocopiers and fax machines, the Internet allows data to be transmitted across public networks, making security a much more critical issue.

As a result, physicians need to evaluate all office practices and make a variety of decisions about who will have access to which documents. Then, they need to draft policies explaining their decisions so that office staff can comply. Decisions

show that the practice is vulnerable, it would be wise for physicians to develop a plan to increase security and protect the confidentiality of all patients' records. It is insufficient to leave these decisions to information systems professionals.

## Collaborative Planning

At Sparrow Hospital in Lansing, Mich., a team of physicians, administrators, and information systems personnel is working collaboratively on this issue. So far, the hospital has adopted an open access strategy for physicians, meaning physicians will

**When drafting plans to protect patient confidentiality, physicians need to be involved.**

need to be made, for example, on whether only physicians with permission can view patient records (which would be a closed system) or if all doctors can view any record (an open system).

Physicians and office managers in small private practices can start the process of evaluating the risk of breaching the confidentiality of patient records by answering the following questions:

- Does the office have a policy addressing confidentiality?
- Has it been updated to include e-mail and the Internet?
- Does the office have a policy regarding faxing information?
- Are claims transmitted over a private network or over the Web?
- Does the office have Web access?
- If so, do you use high-speed, always-on connections that should be protected with firewall software?
- Does the office have dial-up access to patient records?

If the answers to any of these ques-

have access to all records as needed. The hospital also is exploring the use of badges and biometrics to help ensure easy and secure access for those personnel who must be allowed access, particularly in high traffic areas such as the emergency department. The system will deny access to those individuals who should not be present in sensitive areas.

What's more, the hospital will use a system that allows selected access so that physicians can see certain records while nurses and patient care technicians will get only what they need and nothing more.

Someday, making decisions about what level of security to use in an information system will be unnecessary because sophisticated security measures will be built in. For the time being, however, it is critical that physicians get involved in as many decisions as possible. If physicians do not get involved, we will have security without access, which will not serve patients or physicians. ■

*Brian McCardel, MD, is a board-certified orthopedic surgeon and the head of orthopedics at Sparrow Health System, in Lansing, Mich. Joel French is president and CEO of ComTrust, LLC, a wholly owned subsidiary of Superior Consultant Holdings Corp., in Southfield, Mich.*

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