

PHYSICIAN PRACTICE OPTIONS™

September 15, 2000

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS

Features

New Technology
Firm Offers
Management
Data Online 3

Strategy
HIPAA Paves the
Way for E-Business 6

Interview
Practice Management
Expert Highlights
the Importance of
Coding Compliance 12

Departments

Editorial
Reform Aimed at
Prompt Payment Will
Require More Effort 2

Managed Care Theory
Administration of
Global Fee Plans 10

Questions from Readers
Specialist Interested in
Specialty Network 15

Physicians Urged To Act When Payments Slow

Slow payments from HMOs and other insurers are adding to the financial pressures physicians face. The delays are particularly frustrating because physician office overhead has increased significantly in recent years, in large part because more staff members are needed to process and track managed care claims.

"A large health plan can earn significant sums of money by delaying the payment of claims," says Tim Norbeck, executive director of the Connecticut State Medical Society in New Haven. "If they delay paying the claims, they get the interest on the money in the bank, called 'float' by economists. As this float becomes more significant, it becomes a true incentive to delay payment as long as possible." Norbeck notes that economists have calculated the value of delayed claim float to be worth up to \$400,000 per day for large health plans.

Steps To Take

Steven Larsen, commissioner of the State of Maryland Insurance Administration, in Baltimore, recognizes that delayed payment can have a significant effect on physician practices. "At a minimum, it's a frustration," he says. "But depending on the characteristics of an individual practice, such as practice size and percentage of patients covered by a payer that regularly delays payments, delayed payments can have a very large impact. We have heard complaints from physicians who said they have faced dire economic circumstances as a result of delayed payments."

But physicians are taking aggressive action in several states. In cases in which

payment has been delayed excessively, frustrated physicians are working with attorneys general and their state medical societies to force managed care organizations to pay providers more promptly.

In fact, officials in several states recommend that physicians take action if they believe payers are systematically delaying payment. Physicians need to be vocal about the problem to regulatory and elected officials in order to galvanize support and prompt real change, say Norbeck and Larsen.

First, physicians should report patterns of delayed payment behavior to their state medical societies, Norbeck says. "They should call their county medical associations as well," he adds. "These associations represent the interests of the physicians in their states, and they know who to contact and how to lobby the state government for change."

Norbeck strongly recommends reporting delays in payment to the state's attorney general as well. "In Connecticut, as in many states, the attorney general's office commands a tremendous amount of respect," he says. "If the attorney general takes an interest in an issue, the state legislature will tend to focus its attention on that issue as well."

Second, Larsen advises physicians to contact the office of their state's insurance commissioner if they are frustrated by delayed payment of claims. "Our consumer and provider complaint unit processes thousands of individual complaints each year," he says. "But insurance commissioners tend to act more quickly if groups of physicians can aggregate their experiences and document pat-

(Continued on page 8)

Reform Aimed at Prompt Payment Will Require More Effort

Understandably, physicians are frustrated when HMOs and other insurers stall or refuse to pay bills. The effect on the operations of any physician practice—large or small—can be staggering.

In a letter earlier this year, William Jesse, MD, the president and CEO of the Medical Group Management Association (MGMA), an organization in Englewood, Colo., that represents 7,100 health care organizations, 20,000 individuals, and 185,000 practicing physicians, says the problem with delayed payments is that “the administrative and financial burden is difficult for small group practices, which have to divert attention of limited staff away from patient care.” Solo physicians, who comprise 25% of American physicians, have little leverage when seeking to collect from large payers.

Consider this example: Lloyd White, MD, a 55-year-old solo otolaryngologist in Downey, Calif., says collections have dropped sharply over the past four years due to late, slow, or no payments from HMOs and other insurers. This spring, White submitted a bill of \$4,000 for sinus surgery. The HMO paid \$150 and said, “Take it or leave it.”

A surgical group in Texas employs 3.5 full time employees whose sole responsibility is collections, MGMA said. A women’s health group in Tulsa, Okla., spent 100 hours of staff time and more than \$10,000 to collect fees from one payer. At one point this year, a radiology group in Greenville, S.C., had \$6 million in accounts receivable over 60 days old. An anesthesiology group in Austin, Texas, has 45 physicians and employs 18 people who spend 80 to 120 hours a week prying money from insurers.

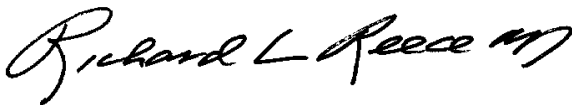
Physicians suspect HMOs and other insurers are making money by delaying payment because they collect interest on retained premiums.

One approach to the problem is for physicians to use the courts to force insurers to pay them. This approach is costly, however. Physicians in California and Georgia worked with the AMA earlier this year to sue health plans in their states, and these cases are pending.

Some physician groups have begun sending claims by certified mail. Others have brought in coding experts to develop protocols and maintain processes to expedite claims and to ensure that all claims are “clean,” meaning they will not be rejected on a technicality. More than 30 states have enacted prompt payment laws to force HMOs and other insurers to pay bills quickly, but as we report in our story, “Physicians Urged To Act When Payments Slow,” on page one, the insurers have found ways around some of these laws.

This year, the MGMA and other associations that represent physicians supported a prompt-payment provision in a bill in Congress that was designed to reform managed care. Unfortunately, the bill died, and it has almost no chance of being revived this year, says Tim Norbeck, executive director of the Connecticut State Medical Society in New Haven.

Norbeck and others encourage physicians to continue to collect data on how long and how many times they must wait for payment and they should report these numbers to their state medical societies. Moreover, physicians should let their congressional representatives know that managed care reform is necessary and, in particular, the prompt-payment provisions should become law.



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Firm Offers Management Data Online

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

The best managers of physician practices are often the physicians themselves. They are intimately aware of the nuances of their businesses and can make solid practice management decisions based on their own professional goals. In recent years, physicians have been forced to spend more time managing their practices because hospitals and management companies largely have failed in their attempts to bring greater efficiency and cost-effectiveness to physician groups.

Given these conditions, physicians need assistance in managing their practices and in gaining access to the business tools that will help them run their practices. One solution may be for physicians to get business support and practice information that allows them to benchmark their own practices against those of their peers. This type of information can reveal the need for strategies to correct, eliminate, or improve certain courses of action.

A number of new Internet-based companies can help physicians in their practice activities and lend them some support. One such venture is VPMManager.com, a company in Miami Lakes, Fla., that offers practice management assistance and comparative information to physicians over the Internet. "VPMManager.com offers simple, quick solutions to complex administrative problems that physicians face," says Michael Carbrey, president of VPMManager.com.

Previously a consultant, Carbrey has worked with primary care, cardiology, and orthopedics practices.

One of the most significant needs in each medical practice is the requirement to collect relatively discrete pieces of information, Carbrey observes. "While I

was a practice manager, it was never the big data needs that drove me crazy," he says. "It was always the relatively minor questions that were burdensome for me and the medical staff, such as, 'Are we a member of this plan or not? Do I have to call for a referral authorization on this

get a user name and password. At that point, they are eligible to use all of the services we provide."

Most of the services are automated. The site contains an e-mail service, however, in which questions can be posed to practice management experts. All accounting

Companies that provide practice management information on the Internet are helping physicians gather routine data on a daily basis.

particular plan? If so, whom do I call? What co-insurance do I need to collect? What are the latest regulations for the National Committee for Quality Assurance? What are the latest Office of Safety and Health Administration (OSHA) regulations?"

Carbrey believed that the Internet was a medium that could help physicians gather such routine data on a daily basis. "I also thought that the Internet could provide an opportunity for physicians to do some self-appraisals on their practices, enabling them to decrease their costs for consulting services," he says.

VPMManager.com may be particularly applicable for small groups. Approximately 80% of physicians are in independent practice, and most are in groups of 10 or fewer physicians. Many of these small groups cannot afford to employ an on-site practice manager. "VPMManager.com stands for 'virtual practice manager,'" Carbrey explains. "Our system was designed for the small practice because the information can be filled out by the physicians themselves, the practice's accountant, or a staff member. Simply by filling out these forms, the physicians can get a benchmark on how the practice is performing."

The services of VPMManager.com are free. "We have an online registration process," Carbrey says. "Physicians are asked to enter their name, address, telephone number, and specialty. Then, they

and general finance questions and data are handled by The PM Group, a consortium of independent accountants in 23 states. The PM Group provided the site with an accounting database. Physician Management Group Inc., in New Orleans, provides answers to general management and regulatory questions. Legal questions are handled by McDermott Will & Emery, a law firm in Boston.

VPM Services

VPMManager.com offers a variety of services in several categories, such as practice management, which includes a practice assessment, a coding assessment, human resources review, and medical records management; online services, including a question-and-answer service, and answers to common coding questions; group purchasing services; an HMO/PPO abstractor; and manuals and documents that address issues related to OSHA, the Clinical Laboratory Information Admendments (CLIA), an employee handbook, and human resources policies. Other services include coding compliance, a practice analysis, business plan writing, physician recruitment, relocation, financing, practice valuation, sales, purchases, transcription services, financial planning, investment advice, and retirement planning.

Practice assessment. One of the most

(Continued on page 4)

Editor's note: Since last month, Practice Options has carried a series of articles on information systems being developed for specific applications common in physician practices. This article is the second in the series.

(Continued from page 3)

important services VPManger.com offers is access to a database of physician practice performance statistics. "Most physicians want to know, at a basic level, how they are performing compared with their peers, and whether they are doing something wrong on a widespread basis that might get them in trouble," Carbrej explains. "So we developed VPManger.com with practice assessment as a major component. Practice assessment allows the physician to input his or her practice revenue and expenses and compare them against a national benchmark. This function enables physicians to know how much money they are spending and how much revenue they are collecting as compared with their peers." A three-physician cardiology group, for example, can compare the practice with a comparable group in the same region.

The data used for this benchmarking comparison are provided by The PM Group.

Coding assessment. VPManger.com also allows physicians to benchmark their own practices with others with regard to evaluation and management (E&M) coding. Many physicians are concerned about assigning the proper evaluation and management codes to their work, and they are concerned about complying with the coding guidelines issued by the federal Health Care Finance Administration, in Washington, D.C., Carbrej says. "VPManger.com includes a coding analysis based on HCFA data on submitted E&M codes. Physicians can put in the number of visits they coded by code number, and these data are compared with the distribution of codes assigned by other practices. This database allows physicians to see what the normal distribution curve is for assignment of codes, by specialty."

Such a comparison can be very revealing. "In fact, if a physician's E&M coding practices differ from the normal distribution curve, he or she could be eligible for an audit," Carbrej notes.

"Ask Vic." Many physicians are reluctant to use online practice management services because they often are impersonal and may provide only generic answers

to the most frequently asked questions. To address this failing, VPManger.com offers users the opportunity to get answers to specific questions from professional consultants. "Ask Vic allows a physician to type in a question that is then forwarded to someone on our staff," Carbrej says. "Then, our staff member can either

e-mail to a human resources consultant.

Personal financial consulting. VPManger.com also provides personal financial consulting services to physicians. "Suppose a physician has a concern, such as the need to plan for retirement," Carbrej explains. "We can put this physician in touch with a financial planner who

Approximately 80% of physicians are in independent practice, and most are in groups of 10 or fewer physicians. Many of these small groups cannot afford to employ an on-site practice manager.

call the physician on the phone or respond to the question by e-mail. Furthermore, after the physician completes his or her questionnaire, he or she may request that a consultant call and provide a consultation."

HMO/PPO abstractor. One source of frustration in the typical medical practice is knowing and complying with the different requirements of many various health plans. "Physicians can be on the panels of multiple plans, all of which have different utilization rules, review regulations, and other requirements," Carbrej notes.

To alleviate this administrative difficulty, VPManger.com provides a service called the HMO/PPO abstractor. "This function allows physicians to abstract the regulations of each of the plans with which they contract, enabling quick and easy reference," Carbrej explains.

OSHA regulation compliance. Many practices have difficulty tracking OSHA regulations. Busy physicians handling personnel policies and human resource problems want to ensure that they do so in a manner that complies with OSHA standards. VPManger.com publishes all OSHA regulations and answers to the 30 most frequently asked questions about regulation compliance. "VPManger.com also includes a full human resource package that provides physicians with guidelines for developing a human resources plan and an employee handbook with some hiring and firing tips they can use," Carbrej adds. For more detailed information, physicians can send a question via

can provide specialized services."

The one service VPManger.com does not offer is the design of strategies that can drive practice improvement. "What we do is show a practice whether it has a problem," Carbrej says. "The program is like a laboratory test: We point out the highs and lows of the normal range, and then the physicians either must call in a consultant to help fix the problems or they must come up with their own diagnostic solutions. But completely removing the physician from the administration of the practice will lead to problems in the business."

Identifying Problems

Still, some physician practices are going to be deeply troubled from a business standpoint, and no benchmarking service can solve that. "The first step in solving a problem is to figure out what the problem is," Carbrej says. "A lot of people spend a lot of time solving problems that, in reality, are nonexistent. By using VPManger.com, physicians can pinpoint the problem: Are revenues too low? Is the ratio of collections to receivables too low? Are contractual discounts too high? Determining problem areas allows physicians to spend time and money wisely by focusing on correcting the most significant problems in the practice."

Once it identifies a problem, VPManger.com can offer access to consultants who can help the practice improve. "We have partnerships with 123 consultants in 23 different states," Carbrej explains. "When a physician

The Internet allows physicians to do self-appraisals of their practices, cutting their costs for consulting services.

poses a question, we try to match that physician with a consultant located nearby who is very familiar with the physician's market environment."

Tapping the Internet
Many physicians are so busy treating patients that they may have little time left over to address management issues. As a result, they may operate in an information void. An Internet service such as VPManger.com helps to fill that void.

Physicians are also assured that the sensitive practice information they provide to VPManger.com will be kept private and confidential. "Our privacy policy states that we will not divulge any of the information that the physician has given us," Carbrey states.

The Internet offers physicians the potential to out-source administrative activities that they have done internally, thereby decreasing overhead, Carbrey says. Many companies handle practice billing and collections using the Internet, for example, he says. "The beauty of these systems is that physicians can get instantaneous feedback regarding what is an acceptable claim and what is an unacceptable claim," he states. "In the old days, physicians would mail a claim, the claims would be processed by the payer, and 30 days later they still might not know whether or not they've submitted a viable claim. With electronic payment such as through the Medicare system, claims were submitted faster but physicians were not necessarily paid faster. Now, with the Internet, in real time physicians can determine whether or not claims are valid."

While many companies provide services to physicians via the Internet, Carbrey believes VPManger.com is significantly different from those of other Web-based companies. "Product offerings on the Internet are generally categorized into three functional areas," he says. "The primary function can be connectivity, content, or commerce. A lot of the connectivity companies are simply trying to connect users and pass information along to affinity groups. The content companies promise great content, but a lot of them do not have that content yet. The characteristic that differentiates us is that we offer real-time, practical content applications that the physicians can use on an ongoing basis."

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

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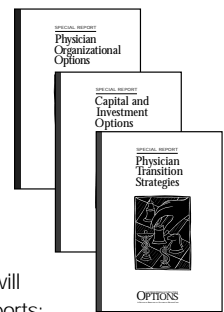
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HIPAA Paves the Way for E-Business

By Jon Zimmerman

Rarely does the federal government make it easy for physicians to improve their business practices and the quality of health care at the same time. In the case of the administrative simplification portion of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, however, the government aims to do so.

While HIPAA is the outside influence that may force many physicians to do business electronically, physicians should not seek to comply with HIPAA regula-

mandate standards for the use of electronic signatures, privacy, security, and unique identifiers in the near future. The law mandates a national standard for the electronic exchange of financial and administrative transactions in health care. In effect, all health care entities that use the transactions must adopt the standards to transmit information regarding enrollment and disenrollment in a health plan, health plan premium payments, eligibility for a health plan, referral certification and authorization, health claims or equivalent

be related to the complexity of each physician's information system, the current and intended use of electronic communication systems in the office, and how well they are running today.

Pervasive Standards

HIPAA affects all health care processes across the continuum of care, including how care is delivered, billed, and paid for. It will improve the efficiency and effectiveness of the health care system by standardizing common administrative and financial transactions for e-business. These transactions are the same ones in use today for interacting with payers, health systems, and peers. The differences are that instead of each party having its own specific methods, all parties will be required to use the same language.

By requiring all parties to meet HIPAA standards, the government hopes to cut administrative overhead, reduce fraud and abuse, and protect the privacy of health information.

The real value of HIPAA's transaction standards is the reduction of operational expenses. The U.S. General Accounting Office estimates that out of every dollar spent on health care, the government will save 26 cents on administrative overhead for Medicare and Medicaid and 11 cents on fraud and abuse. It also estimates that the use of electronic data interchange (EDI) will save physicians, hospitals, and other provider organizations \$9 billion, and will save the health care system \$26 billion.

The E-Business Value

In a broad sense, HIPAA paves the way for e-business by laying the groundwork for business-to-business e-commerce.

One of the benefits for physicians will be the application of transaction standards under HIPAA that will result in cleaner claims, faster payment, enhanced patient care, and the security of patient information. These benefits are in the general interest of all health care enter-

HIPAA mandates standard, secure, and private health care transactions.

tions just for the sake of complying. They should use the opportunity to advance their e-business initiatives as well. HIPAA lays the groundwork for e-business by mandating standard, secure, and private health care transactions. Physicians need to start planning for the implementation of rules under HIPAA now because the first provisions of the law must be implemented in 2002. While 2002 may seem like a long time from now, becoming HIPAA-compliant will take time and most physicians will need the time to develop the necessary systems. Moreover, if your implementation plan is executed properly, you will be HIPAA-compliant and be able to maximize your e-business efforts.

The first of HIPAA's rules regarding administrative simplification mandate standardized electronic transactions and code sets in health care. HIPAA also will

encounter information, coordination of benefits, health care payment and remittance advice, and health claim status.

Under the law, all health care transactions will require standardized code sets to simplify communications about diagnostic, therapeutic, and treatment plans. Privacy rules will set minimum standards regarding the disclosure of patient information and the sharing of information outside the facility, and will spell out patients' rights for viewing their own information and sharing such data with other provider organizations.

Security rules will mandate the use of technology, services, and processes to protect privacy and ensure the availability of patient information. The security standards will affect how physicians must safeguard their facilities, software, and network communications. The law also is designed to protect patient rights and business operations, and establishes processes for any exceptions to the law. It also calls for stiff penalties for noncompliance.

As a result of these requirements, HIPAA planning, implementation, and ongoing maintenance could become a substantial endeavor for solo practitioners, group practices, and integrated delivery systems alike. The size of the task will

Jon Zimmerman is the senior manager, HIPAA Initiatives, for Shared Medical Systems in Malvern, Pa., a Siemens AG company that provides health care information systems, and the general manager of Healthcare Data Exchange (HDX), a Siemens AG company that provides electronic health care transaction services.

prises and should be one of every physician's strategic goals regardless of HIPAA requirements. Integrating eligibility and other transactions into the patient scheduling or registration work flow reduces errors, saves time, and should help to reduce the number of full-time employees that payers, physicians, hospitals, and provider organizations need.

Consolidating several payers' points of access and using an electronic, integrated e-business system will make transactions more secure, accessible, and reliable. Standard transactions and networks will improve how physicians transact with labs, imaging centers, integrated delivery networks, pharmacies, and other provider organizations. Even purchasing, if it is done electronically, can be improved and would lend itself to better analysis and tracking.

Most health care entities are considering some form of e-business venture. Coupling e-business and HIPAA planning could help to eliminate redundant planning efforts and reduce costs.

Also, if the health care industry is to adopt e-business practices successfully and gain the highest value from e-business, effective security practices to protect patient privacy are mandatory. HIPAA recognizes and addresses this need. By establishing federal law that mandates effective security and definitions for ensuring privacy, HIPAA helps the industry come to a common and useful understanding of how to protect patients' rights and their data.

Daily Operations

For anyone working in an information systems department in a physician group, HIPAA has major implications. But it is much more than an issue for IS professionals. The HIPAA transaction standards are under the X12 classification developed by the Accredited Standards Committee, a group within the American National Standards Institute, a private, nonprofit standards-setting organization in Washington, D.C. All transactions, except those for retail pharmacies, must meet the X12 standard. The IS staff will need to implement the standard transactions and code sets and the privacy and security issues that require facility-wide compliance.

The federal Department of Health and Human Services (DHHS) may require changes in the physical layout of physician offices to ensure that computer printers and screens are not accessible to patients, where patient information is taken and viewed. DHHS offers more information on these issues on its site on the Internet (<http://aspe.os.dhhs.gov/admsimp>).

If they have been focused on security, privacy, and e-business in recent years, many health care enterprises may already have met a number of HIPAA requirements, such as developing disaster-recovery plans, procedures for granting access to patient information, and policies for personnel security, and internal audits. But the law also requires health care facilities to implement policies on incident reporting, termination procedures, and training staff on security and privacy procedures, and it is unlikely that many physicians have met these requirements yet.

Physicians seeking to develop privacy and security practices in the coming months might want to consider implementing systems that allow electronic signatures and data encryption. They may want to add new passwords or personal identification numbers to ensure that access to patient data is secure. Physicians also may need to start training programs to build awareness among staff members about HIPAA's privacy rules and to begin holding meetings with staff members to discuss the rules, their enforcement, and penalties for noncompliance.

Simply stated, HIPAA should help physicians reduce operational expenses and speed the transition to e-business but it is clearly a challenge for the entire organization, and particularly for the IS department. Those groups that begin making preparations for HIPAA compliance early may find that they can leverage existing policies, procedures, technologies, and business relationships to smooth the transition. ■

HIPAA Information on the Web

For physicians seeking more information on the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Internet offers several excellent resources including the following:

- The American National Standards Institute (<http://web.ansi.org>)
- ASC subcommittee and task group information on X12 (<http://www.x12.org>)
- American Society for Testing and Materials (<http://www.astm.org>)
- Electronic Healthcare Network Accreditation Commission (<http://www.ehnac.org>)
- Department of Health and Human Services (<http://aspe.os.dhhs.gov/admsimp>)
- Health Care Financing Administration (<http://www.hcfa.gov/regs/hipaacer.htm>)
- Health Level 7 (<http://www.hl7.org>)
- HHS Data Council (<http://aspe.os.dhhs.gov/datacncl/index.htm>)

- Joint Healthcare Information Technology Alliance (<http://www.jhita.org>)
- Medicare (<http://www.hcfa.gov/medicare/edi/edi.htm>)
- National Council for Prescription Drug Programs (<http://www.ncdp.org>)
- National Uniform Billing Committee (<http://www.nubc.org>)
- National Uniform Claims Committee (<http://www.nucc.org/nuccdaset>)
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- Workgroup for Electronic Data Interchange (<http://www.wedi.org>)
- WPC Healthcare Provider Taxonomy (<http://www.wpc-edi.com/taxonomy>)

(Continued from page 1)

terns of delayed payment that show, for example, what percentage of a given number of claims are not processed on time. Commissioners are encouraged by a level of evidence that gives them a concrete reason to initiate a full market-conduct examination of a payer.”

State medical associations often help by aggregating physician complaints, and may conduct surveys of physicians to use in their assessment of the problem. “Insurance commissioners often receive a lot of anecdotal evidence,” Larsen notes. “Medical associations help distill separate issues into a more credible level of evidence.”

Consolidation Hurts Physicians

For physicians in California, payment delays by health plans is an epidemic, says Reesa Wilkie, senior economic analyst for the 30,000-member California Medical Association (CMA) in San Francisco. “It has been increasing to the point where it now ranks as a fairly common experience among physicians,” she says. “For the last 18 months, the CMA has tracked physician complaints; over half involve delayed payments.”

Delayed payments are largely due to underfunding of the health care system, Wilkie explains. “We have tremendous consolidation in the health plan market: Five plans control 90% of the enrolled lives. California premiums are 40% lower than they are in states with similar costs of living, and our capitation payments are low. This underfunding makes it difficult to manage health care.”

Delayed payments have been so pervasive, that the CMA persuaded the state auditor general’s office to conduct an audit last year. “The audit found that 50% of physicians and 74% of medical groups experienced delayed payments,” Wilkie says.

State law, which requires timely payment, has largely not been enforced. “Our state law, Health and Safety

Third, Norbeck encourages physicians to make themselves heard, even if it seems as if they can make little difference on their own. “A lot of people forget that just one person can make a difference, by serving as yet another link in a chain,” he says. “The physicians in Connecticut contacted institutions that could effect change: the state medical societies, their representatives, senators, and the attorney general. Then, those offices put in motion a process to correct the problem. After an onslaught of complaints, the state legislature cannot fail to take notice.”

More than two dozen states have prompt-payment laws related to physi-

Code 1371, has a timely payment provision requiring health plans to make payment to providers within 30 working days of receipt of the claim, and HMOs are required to pay within 45 working days, or else pay interest at a rate of 10% per annum,” Wilkie explains. “The audit results demonstrate that many payers are in violation of the law, but enforcement has been problematic.”

In a positive development, the state created a new Department of Managed Care, which is scheduled to begin operations by the end of this summer. “We are hopeful that this will improve some of the regulatory problems we have been experiencing,” Wilkie says. In meetings with state officials, the CMA has been encouraging them to levy fines on payers who delay payment.

In May, the CMA filed a federal civil suit against the three largest for-profit health plans in California: the Blue Cross of California Inc. unit of WellPoint Health Networks Inc. in Thousand Oaks, Pacificare Health Systems Inc. in Santa Ana, and the HealthNet unit of Foundation Health Systems Inc. in Woodland Hills. The CMA charges that the health plans have delayed payments to physicians.

—DJN

cian payment by payers, and 12 of these laws were enacted last year, Norbeck says. “More states should be considering such laws, though,” he says. “HMO profits are down across the country, and many are reluctant to raise their premium or copayment rates because they want to remain competitive in the marketplace. By delaying payments, they can compensate for the red ink.”

New Rules

In Connecticut, the problem of delayed payments became obvious about two years ago, Norbeck says. “We always know what the ‘hot button’ issues are by the volume of calls we receive—and many of our 7,000 physician members were calling us to complain about payment delays,” he explains. “These delays were occurring with most of the insurance carriers operating in our state.” What’s more, the various Connecticut county medical associations also had received numerous complaints.

The delays were having serious repercussions for physician practices. “Some physicians were forced to take out loans simply to make payroll,” Norbeck says. “Furthermore, such excessive delays in payment are unethical and extremely unfair to physicians, a fact that spurred us to action.”

Although state legislators indicated that they did not want to pursue additional managed care reform activities after recently passing a comprehensive bill on the topic, they granted the Connecticut State Medical Society a hearing. “The state legislature listened to our evidence and recognized that payer delay in payments to physicians was a serious problem,” Norbeck explains.

As a result, in May 1998 the state legislature passed a bill, House Bill 5404 (An Act Concerning Health Provider Billing Practices), requiring health insurers to pay or reimburse providers on a timely basis. The bill, which was effective Jan. 1, 1999, required insurers to pay physician claims within 45 days; if they failed to do so, they would be required to pay an additional 15% interest on the owed amount as a penalty.

(Continued on page 9)

(Continued from page 8)

Unfortunately, several health plans found a way around this bill. "In the year following the passage of the legislation, some payers were imposing contractual clauses that were including longer payment periods, thereby superseding the 45-day period," Norbeck says. "In addition, some plans were waiting until the 44th day to tell the physicians that the claim wasn't 'clean,' so they needed another 45 days in which to assess and pay the claim," Norbeck says. "Clearly, these payers were circumventing the intent of the legislation."

To rectify the situation, the legislature passed a new bill in June 1999, which took effect on Oct. 1. House Bill 7032 (The Act Concerning Managed Care Accountability) gave insurers 45 days to reimburse physicians, and prohibited contractual language from overriding that time period. In addition, payers had 30 days to notify physicians of all deficiencies in a claim, and then another 30 days in which to pay, once information clarifying the deficiencies was received.

"It appears that most insurers are complying with the new legislation," Norbeck observes. "But it has not solved the problem entirely."

Seeking Clarification

In Maryland, the insurance commissioner was hearing similar complaints. "While our office had been hearing complaints for some time, we began to see a definable increase in complaints last year," says Larsen, who has served as Maryland's insurance commissioner since 1997. "In addition, in 1999 we instituted a new computer system in our complaints area. This system, which enhanced our ability to track complaints by subject matter, confirmed the problem with delayed payments."

Abuses occurred despite the existence of the state's prompt-payment law, which has existed since 1986. The law requires payers to process a claim within 30 days, and then either pay the claim, or deny the claim and provide reasons for denial. If the claim is paid later than 30 days, the payer is required to include an interest payment of 1.5% from the 31st day

"If claims are not paid promptly, then the payer must pay penalties in addition to interest."

— Steven Larsen, Maryland Insurance Administration

through the 60th day, 2% from the 61st day through the 120th day, and 2.5% after the 120th day.

"Like most prompt-payment laws, ours requires that payers pay interest when claims are delayed," Larsen says. "The administration before mine had taken the view that the prompt-payment law had not been violated if the payer included an interest payment when paying claims older than 30 days. But this interpretation of the law encouraged abuses. In my view, the intent of the law was not simply to require payers to include interest on late claims, but to require payment within 30 days; if claims are not paid promptly, then the payer must pay penalties in addition to interest."

As a result, the state adopted a regulation (COMAR 31.10.23, Penalties for Failure to Make Prompt Payment of Claims) in April 1999 that made insurers subject to penalties in addition to the payment of interest for failure to pay a claim within 30 days.

But when physician complaints continued, the insurance commission initiated a number of market-conduct examinations of four HMOs last fall. "We focused particularly on the claims-payment activity of some of the downstream contractors of the HMOs—the provider groups, like PSOs, that provide a range of services to HMOs and HMO members," Larsen explains. "Although the violations occurred as a result of the actions of these contractors, the HMOs are ultimately responsible."

The examinations revealed numerous violations of the prompt-payment law. Consent orders were negotiated with the health plans early this year. Administrative penalties totaled \$1.25 million. "The consent orders were relatively easy to negotiate, since the plans had no factual dispute about what we found," Larsen explains. "We ordered the payers to design corrective action

plans in which they would review all claims payments over the previous 12 months to ensure that interest was paid on delayed claims. They must also prove that they are monitoring their contractors for timely claims payment." All payers were required to submit these plans to the insurance commission this summer.

Taking Action

Physicians in other states are taking action as well. Last year, physicians in Georgia, working with the AMA, filed a class-action lawsuit against a large insurer. The suit, which is pending, charges the insurer with violating a state law that requires claims to be paid within 15 days.

Earlier this year, the Florida Insurance Commission in Tallahassee reported that it is considering levying a fine against two health plans for a total of \$175,000 for violating the state's prompt-payment law. Bill Nelson, the state treasurer and insurance commissioner, says the charges result from complaints from physicians.

Not surprisingly, frustration abounds among hospitals as well, some of which are taking action against payers. A group of 24 hospitals in the New York metropolitan area has sued one of the state's largest insurers, claiming the health plan has delayed payments and is in violation of New York's Managed Care and Prompt Payment Law.

A number of states—including Colorado, Florida, Georgia, Maryland, New Jersey, New York, North Carolina, Pennsylvania, and Washington—have levied fines for late payment when payers have violated states' timely payment statutes in addition to requiring interest payments on delayed funds.

—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).

Administration of Global Fee Plans

By Colleen E. Dowd, Michael R. Burcham, and Douglas W. Emery, MS

As managed care organizations struggle to lower health care costs, global pricing is becoming a common practice. Global pricing is the practice of setting a single fee to encompass an entire episode of care for a given set of diagnoses or conditions. Such pricing allows employers or health plans to make one payment for each case and transfers to providers the incentive to manage each patient throughout the episode continuum. This methodology ensures that the provider team will be accountable for the care delivered. Since the payer is purchasing an anticipated outcome, cost for the episode of care is fixed and predictable. Thus, a global fee is a fee-for-outcome method of reimbursement.

A Common Objective

The first and most important step in developing a global fee for an episode of care is establishing a common objective among the provider participants. Physicians may look to global fees as a method of avoiding aggressive fee schedules, for example, by shifting the majority of the financial risk to a hospital. Instead of developing a strategy to keep the relative reimbursement equitable, the physicians may plan among themselves to have their reimbursement under the global fee structure remain consistent with their current fee-for-service payment levels. The hospital, on the other hand, may wish to offer a competitive price to payers while shifting the risk of expensive implants and other physician-driven choices to the practitioner. Clearly, both of these examples illustrate

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a win-lose scenario and, as such, are certain to fail. In establishing the global fee, providers must be willing to share certain types of information with one another. All providers should be willing to supply the following data, for example:

- The amount each provider normally charges for the procedure
- The typical reimbursement amount per code, procedure, and day
- Their costs

If providers are not forthcoming about their current and anticipated reimbursement, discussions about a global fee and its effect on the participating providers can only be speculative.

The musculoskeletal segment of health care is an excellent diagnostic group within which to design global fees. The musculoskeletal segment is the largest component of medical services within the workers' compensation system and is

bundling, reporting, customer service, and provider payments

- Educating providers about clinical, service, and administrative processes
- Selling to payers and implementing services.

The physicians also would develop a professional services pool from which the costs for anesthesiology, pathology, radiology, consulting physicians, and implants would be paid. This pool should be funded at some level above its budgeted amount to provide the surgeons with some degree of surplus to accommodate services that may not need to be quantified in the clinical pathway but are necessary occasionally. The surgeon manages the dollars used by consulting physicians based upon a predetermined budget. Any surplus from this budget would be paid to the surgeon.

The physicians also would set aside funds for a postacute services pool to be

Since the payer is purchasing an anticipated outcome, a global fee is a fee-for-outcome method of reimbursement.

ranked as the second largest cost component of the group health insurance system. Using an orthopedic example, the development process to organize a global fee involves the following steps:

- Designing a product and initial clinical care maps
- Establishing criteria for provider selection and participation
- Conducting provider credentialing and annual recredentialing
- Developing diagnostic and procedure bundles for pricing models
- Validating clinical pathways with key physician leaders to determine use rates of services by diagnostic or procedure groups
- Designing network software and implementation plans to manage patient flow, provider communication, billing, medical management, claims

used to move patients as medically appropriate from costly inpatient rehabilitation facilities to home health and other outpatient services. The majority of these services should be contracted on a per-diem basis because the opportunity to manage the number of days or visits is significant. The surgeon will use pre-established protocols to establish the postacute process. Managing the postacute continuum can produce dramatic results. Not only does the patient regain functional independence more rapidly, but reducing the length of stay for acute and inpatient rehabilitation results in significant cost savings.

Physicians also will need to set aside a portion of the global fee to manage the cost of secondary infections, readmissions, and other patient complications that may arise within the time frame of the global fee. It is customary that complications

secondary to the surgery be covered within the global fee, but other medical conditions not associated with the procedure do not fit within the global fee structure.

For certain complex, polymorbid episodes, physicians will need to establish a consult pool to compensate consulting providers. If a cardiac patient is also a diabetic, for instance, the physicians may need an endocrinologist to consult on the case. Money for this consult would be paid from the global fee. Once patient claims are applied to the pool, the physicians should develop procedures relating to fund shortfalls. All physicians involved in the global fee should reach a consensus on the consult pool's initial funding, allocations for shortfalls, and reserve distributions, and the physicians should recognize that through experience, efficient projections and costs will emerge.

Diagnostic Groups

In most instances, global fees are actually clusters of procedures or services that share similar costs, risks, and clinical processes. Therefore, the concept of clinical homogeneity is critical to pricing episodes of care. These groups may be driven by any one of the following:

- Diagnosis-related group (DRGs)
- Administrative service code (ASCs)
- A specific set of disease or injury codes (ICD-9s)
- A set of surgical procedure codes (CPT-4s)

Using carpal tunnel release as an example, the diagnostic cluster for this orthopedic procedure would include: ICD-9 codes 04.43 (release of carpal tunnel), 83.42 and 83.43 (other tenectomy), 83.50 and 83.51 (bursectomy), 80.73 and 80.74 (synovetomy of wrist), and it would include the following surgical CPT-4 codes: 64719 (neuroplasty and/or transposition; ulnar nerve at wrist), 64721 (neuroplasty and/or transposition; median nerve at carpal tunnel), 25115 (radial excision of bursa, synovia of wrist, or forearm tendon sheaths; flexors), and 29848 (endoscopy, wrist, surgical; with release of transverse carpal ligament).

Once this group is established, the surgeon and surgical facility can be paid a single global fee for any combination of services provided from the above ICD-9

Through experience with global fees, efficient projections and costs will emerge.

and CPT-4 lists. The physicians then quantify the cost for each provider segment so that they can determine the total global fee amount.

The global fee is intended to be all-inclusive for the procedure. As such, the rate covers virtually all provider fees for services: facility, surgeon, consulting physician, anesthesiology, pathology, radiology, implant devices, ancillary services, and in many cases, the entire postacute or postsurgery follow-up, including durable medical equipment and physical therapy.

Time Sensitivity

In some cases, a length-of-stay threshold may be assigned to a DRG-driven global fee to shift some of the financial risk back to the payer. In these cases, the global fee is all-inclusive until the length of stay exceeds the threshold. At that point, a contractually defined outlier provision would apply and a per diem payment usually would be assessed for each day beyond the length-of-stay threshold. Cardiac global fees are almost always subject to such length-of-stay targets and rarely involve postdischarge services. In this way, technical risk can be clearly delineated from probability risk.

Orthopedic global fees are almost always established using time elements that begin the morning of surgery and extend for 90 to 120 days depending on the type of surgery. In these models, the payer has an advantage in that the single global fee covers all orthopedic services provided in this time. In addition, orthopedic global pricing structures usually include the posthospital services of inpatient rehabilitation, skilled nursing facility, home health, and outpatient rehabilitation services.

Administrative Costs

If an independent third-party administrator (TPA) is used, the TPA may charge a one-time development fee to administer the global fee. This fee could exceed

\$5,000 without being out of range. In addition, TPAs are typically reimbursed for each patient episode managed through the global process. A flat fee ranging from \$150 to \$500 may be charged to administer each case.

The rate charged should be based on the total global fee and the complexity of the administration. The administrative fee for a cardiac valve procedure, for example, might be \$400, while cardiac catheterization might cost only \$150 to administer. Another payment method would be based on a percentage of the total global fee, typically about 5%. This methodology can be costly for providers that deliver high-priced procedures.

Determining whether an external TPA will be paid using the accrual or cash accounting system is important. With accrual, the TPA would be paid when the payer is billed. If the cash accounting system is used, the TPA would be compensated when the payer remits the global payment.

Conclusion

As global pricing becomes more common, providers will seek administrators to manage and disburse global fees. When choosing an administrator, physicians should address the many important areas related to reimbursement in order to ensure that the relationship will be successful. Costs will be controlled, waste eliminated, administrative expense and time will be managed well, and all contracting parties will be satisfied.

On the other hand, if the administrative process does not work well, patients may receive inappropriate bills, payers will be dissatisfied, and provider payments may be affected adversely. By developing and administering globally priced services accurately and efficiently, providers can embrace an effective managed care alternative to capitation that is mutually beneficial to payers, physicians, and other provider organizations, and that simultaneously preserves patient choice at the point of service. ■

Practice Management Expert Highlights the Importance of Coding Compliance



John W. McDaniel is president and CEO of Physician Management Group Inc., a practice management company in New Orleans that manages and consults with

medical practices around the country. McDaniel has 15 years of experience in hospital administration and 11 years of experience in physician practice management. He earned a master's degree in health care administration from George Washington University. He has been published in *The Wall Street Journal*, and *The Harvard Business Review*, and has made numerous presentations to industry and professional associations. Richard L. Reece, MD, editor-in-chief, conducted this interview.

Q: Please tell us about your organization. What services do you offer?

A: Physician Management Group was founded in 1989. The organization is a full service practice management company. We manage and consult with medical practices and hospital-affiliated practices across the United States.

We also maintain two university affiliations. We are affiliated with the Tulane University Department of Health Systems Management in New Orleans as part of its administrative residency program. We are also affiliated with the University of New Orleans, where we sponsor an internship in medical coding. We have received endorsements from several state hospital associations and medical societies, including the Louisiana Hospital Association, Texas Hospital Association, Mississippi Hospital Association, and other organizations such as the Bexar County Medical Society in San Antonio, the eighth largest medical society in the United States.

In addition to the work we do on medical practice compliance and cod-

ing compliance, we offer a wide range of physician practice management and consulting services, ranging from the start-up of new medical practices to the ongoing management and consulting of existing medical practices to the valuation of medical practices for physicians who are retiring.

Q: One important aspect of practice management is coding compliance. How many practices does the federal Health Care Financing Administration (HCFA) audit for Medicare fraud and abuse and how do such audits work?

A: At least one-third to one-half of all medical practices will be subjected to a Medicare audit at some point in time. Most of these audits are routine. Medicare auditors visit the practice to validate the appropriateness of the diagnostic codes and the procedural (CPT-4) codes. In other words, the procedures performed for a patient should logically link to the diagnosis for that particular patient. For example, it would make sense to have a patient

charts, for example, and finds a 20% error rate because of insufficient documentation to support those codes, it will require the practice to reimburse 20% of all Medicare payments over a given time period. Needless to say, that's a significant shock to a medical practice.

Q: What percentage of physicians, in your experience, exhibit overcoding or undercoding patterns?

A: We work with hundreds of physician practices each year, and probably 80% of all the doctors with whom we work undercode. About 15% overcode, and about 5% code accurately. Even those that seem to overcode may not in fact be overcoding, because chart audits will reveal that the real underlying problem is inadequate documentation to support the appropriate code.

Q: Recent items in the news have highlighted the importance of coding compliance. HCFA just agreed to settle its Medicare fraud and abuse claim against Columbia HCA for \$745 million, for example, and recently settled another claim

"If HCFA audits 30 charts, and finds a 20% error rate, it will require the practice to reimburse 20% of all Medicare payments over a given period."

examination and x-rays for a patient with a broken arm but it may not make sense to have an x-ray of the arm for a patient whose primary diagnosis is gastroenteritis.

The frightening part for physicians, however, is that, while they may have coded the claims correctly, they may not have included enough documentation that would be sufficient to substantiate medical necessity in the patient's record. So, during an audit, the Medicare auditors will downcode some claims, then extrapolate their findings to the physician's entire practice. If HCFA audits 30

against a cardiology practice in Wichita, Kan., for \$1.3 million. How prevalent are these suits among physician groups around the country?

A: I'm not sure how many of these large-scale lawsuits are occurring. The important thing is that the routine audits that lead to a lot of these lawsuits are occurring every day.

Unfortunately, most medical practices do not have the internal processes that would allow ongoing monitoring of coding and documentation activities. Hospitals commonly have these processes. Since health care has become such a

large expenditure for the federal government, HCFA has enacted guidelines for hospital compliance plans to ensure that hospitals maintain internal monitoring and ongoing compliance with reimbursement rules and other government regulatory requirements.

Q: *When physicians receive a letter from HCFA informing them that they will be subject to a routine audit, what should they do? What outcomes can they expect?*

A: When HCFA requests an audit, it typically will request specific charts to be reviewed. Certainly the practice should pull those charts and the physicians should review the charts themselves, just to see if there are any weaknesses within those particular charts. Once they have reviewed their own internal charts, if they have not implemented a coding compliance program, they certainly need to make plans to do so.

When errors are found in the charts, the best the practice can hope for is low levels of repayments—maybe the difference between, for example, a Level 4 code versus a Level 3 code, which is only about \$20 on a particular claim. While the physicians will want to avoid paying penalties and interest, they will be most concerned about fines that can be as high as \$11,000 per claim where intentional fraud is determined. For the vast majority of practices, though, physicians are not intentionally overcoding. They are simply not paying attention to the criteria that are necessary to substantiate the different levels of service.

Q: *Do you think that practices should have their charts audited by an independent coding company?*

A: Depending on the resources of the practice, the physicians certainly can audit them internally, but only if they have the appropriate resources to devote to the effort and accurate criteria to evaluate the appropriate levels of service. But physicians may wish to outsource this auditing function to an independent company, simply to get an independent third-party evaluation.

Q: *When is an independent third-party evaluation more appropriate?*

A: Well, it would be appropriate for a large clinic with a lot at stake, given that the error rate is extrapolated

“If physicians have not implemented a coding compliance program, they certainly need to make plans to do so.”

to all of the practice's claims. If a practice is overcoding or has received a letter requesting a Medicare audit, an evaluation by an independent third party can decrease the practice's liability by showing that the physicians have good intentions in reviewing their coding patterns.

Q: *What is HCFA's stand on physician practice compliance plans?*

A: In June, HCFA's Office of the Inspector General (OIG) released guidelines regarding developing compliance plans for medical practices. The requirements are not quite as stringent as they are for hospitals, but I believe that the seven elements that the OIG considers necessary for a comprehensive compliance program will someday be in effect. These seven general areas include:

1. Written policies and standards of conduct
2. Designation of a compliance officer or contact
3. Development of training and education programs
4. Creation of accessible lines of communication to keep practice employees updated about compliance activities
5. Performance of internal audits to monitor compliance
6. Enforcement of standards through well-publicized disciplinary directives
7. Prompt corrective action to detect offenses.

The OIG further stated that the areas of greatest risk to physicians under a compliance plan are:

- Coding and billing
- Providing “reasonable and necessary” services
- Documentation
- Improper inducements, kickbacks, and self-referrals

We know that the biggest area of exposure for a medical practice involves inappropriate coding, whether it's the assignment of the incorrect code, insufficient documentation, or lack of medical neces-

sity to support the code.

Q: *You mentioned that many practices do not have the resources to deal with these coding compliance problems. What role can a hospital play in providing those resources to physicians?*

A: If hospitals own or manage medical practices, they should make those resources available to the practices for which they are responsible. When physician practices are independent, both the hospital and the physicians will be well served if the hospital sponsors seminars to educate the physicians on the importance of coding compliance, proper coding practices, and developing coding compliance plans. Coding compliance affects not only physician practices, but the hospital as well. In fact, the federal government is encouraging hospitals to establish such educational programs for physicians.

Q: *Why is the government taking that action?*

A: The government has acknowledged that inappropriate coding most often is a result of lack of knowledge, rather than intentional fraud and abuse. Let's face it: If a physician is treating 30 to 40 patients a day in the office, and visiting patients in the hospital as well, he or she is shouldering a great deal of responsibility each day. It is very, very difficult for doctors to keep all the coding requirements top of mind.

Q: *What tools are available to help physicians ensure proper coding behavior?*

A: One aspect of compliance is proper coding. Certain coding forms or patient encounter forms can help a doctor through that process. In addition, a number of coding software programs also help physicians code properly.

The second aspect of compliance is proper documentation. Documentation is crucial in order to substantiate medical necessity. Complete documentation can be influenced by a number of factors, such as whether physicians write their notes,

(Continued on page 14)

(Continued from page 13)

dictate them, or use electronic medical records. Certainly physicians can dictate a lot more information than they can write, so they tend to be more thorough when they dictate. Some of the new electronic medical record products help prompt physicians toward appropriate documentation. Physicians need to grasp some of the technological opportunities available to help them in their practices.

Q: *What is the systematic approach toward coding compliance for a physician practice? What are the steps inherent in a solid coding compliance program?*

A: The coding compliance program that we use and have used for years involves several steps. The first step is to analyze the levels of service utilization by each physician in order to ensure compliance with the HCFA-audit guidelines. This will help pinpoint any areas of potential undercoding or overcoding.

The second step after comparing coding patterns against the HCFA guidelines is to perform documentation chart audits for each physician to ensure that appropriate documentation supports the medical necessity for each of the procedural codes.

Chart documentation should always support the codes that are in the chart. Often, the initial assessment may indicate that doctors are overcoding. But in fact, when we do the chart audit, we find that the physicians are coding appropriately but need additional documentation to support those codes in the event of an audit. As mentioned, about 80% of doctors undercode. They have an important opportunity to improve their reimbursement by learning how to document appropriately.

The third step, following the analysis of the codes and the chart audits, is to conduct individual educational sessions with each physician to review the outcome of the assessment and then establish a framework within which each doctor may improve his or her coding proficiency to satisfy the compliance requirements. The educational component is imperative in any compliance plan.

The federal guidelines for compliance programs stipulate the use of audits and

evaluation techniques and the development and implementation of effective training and educational programs. Educational programs can make the physician and practice aware of the various professional resources that are available, such as various coding publications, newsletters, software, and coding hotlines. Our company has a toll-

sonnel how to develop coding compliance programs.

We also provide coding compliance programs for medical practices. First, we get the CPT-4 frequency information, which is the number of times each physician uses each specific code. We use this number to show them how they are coding against the HCFA audit standards.

“Improper coding is the number one most visible and correctable problem in any given practice. For most doctors, it is simple and quick, and it makes a big impact on their income.”

free coding hotline for all of our practices, for example. Any time a physician has a coding question, he or she may call for a consult.

Finally, we encourage practices to monitor their coding utilization internally at least twice a year, but preferably quarterly. This ongoing monitoring gives doctors some feedback in terms of how they're performing with regard to coding.

Once a practice has all of those steps in place, it is on the road to accurate coding practices. We are always encouraged because when we do follow-up reviews of our clients, we see marked improvement in coding practices. Probably 90% of the physicians demonstrate improvement each time we reevaluate the practice.

Q: *Can you explain, please, how your coding hotline works?*

A: We get coding questions every day by phone, fax, and e-mail. Our clients can call one of our reimbursement specialists and ask questions about coding, and we will provide an answer within 48 hours. Some questions are fairly simple and can be answered over the phone. Others require research. The reimbursement specialists will send back the answer along with the supporting documentation.

Q: *Do you provide any on-site services to hospitals and physician groups?*

A: Yes. We offer half-day seminars at hospitals, during which we teach physicians, hospital-based caregivers, and hospital administrative per-

sonnel how to develop coding compliance programs. Then our chart auditors go on site to the practices and perform a random sample chart audit of each physician. We also go on site and provide one-on-one education with each physician and office staff member to review the results of the program and to establish a framework for how follow-up resources can be referenced, if necessary.

Q: *What is the silver lining of coding compliance for physicians?*

A: Physicians have significant struggles in practice today. They have had their reimbursement cut by managed care companies, their overhead has increased, payers are taking longer to reimburse, and physicians' income has been adversely affected by all of these trends. Through appropriate coding, most doctors can improve their income because this is work they've already performed. These are dollars that have been "falling through the cracks" for years and will continue to do so until coding behaviors improve.

It's very rare for us to see a practice in which we cannot improve the bottom line by 10% to 20% or more, just through coding enhancements. Improper coding is the number one most visible and correctable problem in any given practice. For most doctors, it is simple and quick, and it makes a big impact on their income.

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

Specialist Interested in Specialty Network

Question: I am a 60-year-old otolaryngologist in a medium-sized city in the Midwest. I have formed a group with eight other ENT specialists and we are interested in expanding our group into a single-specialty network. How do we do so, what is the process, and what are the prospects for success?

Answer: One of the first places to start in assessing the value of single-specialty network development is to do a thorough assessment of your strategic goals, says Thomas M. Gorey, JD, president and CEO of Policy Planning Associates, a consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development, and a member of our editorial Advisory board. "The starting point would be to answer this question: Why do you want to set up a network?" he says. "The physicians must be clear on what they are trying to accomplish. Ask yourself: Can these goals be accomplished through the existing group, and can they be accomplished through some mechanism other than a network?"

A careful, detailed examination of the motivation for forming the network is crucial. "Some questions to consider are: What are the threats that they are responding to?" Gorey says. "What are the opportunities that they are hoping to take advantage of? What will happen if they don't form this network? Will it present any negative consequences?"

Physicians should carefully analyze their market before embarking on developing a network. "It's important for physicians to understand the market, how it's changing, and who the major players are," Gorey

says. Physicians should have a thorough understanding of all competitors and payers in the market. "Although strategic planning is sometimes a phrase that scares doctors away, it's important that they undertake some type of planning process," he explains. "It can be as formal or informal as they like, but they have to examine the characteristics of their market."

Understanding Payer Mix

The most important part of strategic planning, Gorey says, is examining the payer mix in the market and determining whether the different payers are interested in working with a single-specialty network. "Physicians must find out whether payers are willing to participate in facili-

or she was probably instrumental in forming the group," Gorey adds. "Assuming he or she is planning to continue in that leadership role, it's particularly important for that physician to assess where he or she wants to be. Is this physician interested in scaling back on clinical practice and getting more involved in administration?"

The co-author of a book on single-specialty networks, *Case Study Analysis of Single Specialty Physician Networks*, (published in 1997 by the AMA and seven organizations for specialists), Gorey examined seven specialty networks in various specialties and identified the key success factors. The importance of strategic planning and assessing payer interest in contracting with a network were two of the

Physicians considering a network should determine whether the different payers in the market are interested in working with a single-specialty network.

tating the formation of the network, and whether they will then take advantage of the network by contracting with it once it's in place," he says. "This step will serve as an important 'reality test' that should yield some good clues as to whether the network concept is viable."

In addition, it is important for physicians to consider the size and composition of the proposed specialty network carefully. "An attorney knowledgeable in the field of antitrust should be consulted to ensure that the organizers do not run afoul of antitrust laws," Gorey explains. "Besides determining how many otolaryngologists to include, the physicians will need to establish a process and criteria on which to base their decisions regarding network membership and for identifying compatible, like-minded physicians who will be committed to the network."

While professional and business goals are important, it is just as important for the physicians to analyze their personal issues involved in forming the network, Gorey says. "If the physician who posed this question is the leader of the group, he

most crucial success factors identified for the publication.

"Our research also brought into focus the issue of what physicians mean when they refer to a 'network' or a 'single-specialty network'," Gorey says. "Some physicians might view a network as simply a contracting mechanism in which the physicians can negotiate with managed care organizations through the network. But some of the entities we studied were moving beyond that, or the physicians had something else in mind when they formed their network. These physicians wanted their network to serve both as a contracting vehicle and also to handle some of the administrative aspects of providing specialty care."

"In fact, some networks are going far beyond their contracting role, providing services to their physician members such as information systems and billing services," Gorey continues.

The publication, *Case Study Analysis of Single-Specialty Physician Networks*, is available from the Michigan State Medical Society at 517/336-5769. ■

Editor's note: Readers of *Practice Options* are invited to call our toll-free line to speak with Richard L. Reece, MD, editor-in-chief. Often, Reece poses questions from readers to members of the newsletter's editorial Advisory Board. More information on practice strategies is available on our Web site (see page 16.)

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