How to Resolve Common Documentation, Coding, and Billing Problems in a Private Practice

by Sonya Wade

Many practices do not keep adequate medical documentation as required by Medicare and private insurers. Problems with medical documentation can be as basic as inadequate historical information on the patient's medical condition or no provider signature or reference on the patient's initial history form. A patient's medical record may have instances of illegible documentation, misinterpreted abbreviations, and incomplete or missing documentation of tests, procedures, and/or follow-up orders from the physician. Other common omissions include:

- No patient identification on every page of the medical record
- Missing physician signatures
- No documentation of major patient complaints for each visit
- No documentation of counseling time, total face-to-face time in the office, and items discussed.

Another area where private practices experience problems is with coding and billing for services. While encounter forms, charge ticket/fee slips, and other documentation and charge forms are valuable tools used in every practice, their importance is often minimized. These tools should be maintained regularly and evaluated annually to foster accurate communication between the physician (who is providing the service) and the billing staff (who is coding the services and submitting the claims for payment).

Encounter and charge forms are frequently inaccurate and cause billing errors that affect the bottom line of the practice. If the information provided on the form is incorrect, the practice loses revenue for services it has provided to that patient. In order to fully capture revenue, the encounter form submitted to the insurer must reflect the services rendered with the correct ICD-9 codes.

All too often, submitted claims lack even the most basic information, such as correct documentation for services being billed, an authentication code or signature, and/or valid billing codes (usually caused by staff using outdated resources). Other common coding and billing errors include:

- Always assigning the same level of service
- Billing of consultation versus outpatient office visit
- Using inappropriate modifiers or no modifiers at all.

In addition to documentation, coding, and billing errors, many practices lack effective compliance plans. Some private practices have not even developed a compliance plan and do not perform quarterly progress reports of the practice's needs, functions, and progress. Even those practices that have an established compliance plan have problems defining a denial review process, establishing a system-wide auditing process, and fostering communication between key staff.

The first step to improving medical documentation, coding, and billing practices is to develop a comprehensive compliance plan that will educate staff on the proper policies and procedures. The compliance plan should also offer a mechanism for staff to report instances of improper documentation, coding, or billing without fear of reprisal.

Private practices should also establish an appeals or review process to deal with payment denials. If unchecked, denials accumulate and result in significant financial loss to the practice's bottom line. An efficient review process helps staff learn from documentation, coding, and billing errors and allows staff to correct problems or seek clarification from the fiscal intermediary or carrier.

Each month the practice should offer staff training on medical documentation and coding and billing issues, paying particular attention to changes and/or updates to coding and billing requirements.

The practice should also ensure a smooth continuum of communication between front- and back-end staff. The staff member who gathers patient information needs to communicate with staff providing patient services and performing medical documentation and staff processing and submitting claims. Knowing each other's jobs help staff understand the documentation, coding, and billing requirements for each service provided.

While quarterly screening of services will help identify any major deficiencies, private practices should also follow a few sound business principles. First, document and bill all services provided to patients in a timely manner. Second, perform random internal audits and have an independent auditor review your charges, forms, and office policies every 18 months. Third, ensure that staff is kept current on all of the changes with your insurance carriers, Medicare, and Medicaid. Finally, update your billing policy and procedure manual annually and have all staff sign off that they have read and understand every policy.

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Congress Acts to Restore Funding to Outpatient Cancer Programs

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In an effort to ensure that cancer patients have access to quality care, Senator Christopher "Kit" Bond (R-Mo.) has introduced the Beneficiary Access to Care Act of 2003 (S.1206). This legislation requires Medicare to reimburse appropriately for cancer treatment, thereby stabilizing outpatient cancer program payments. The legislation also calls for a study of the costs related to providing pharmacy services in hospitals—so vital for ensuring safe and effective care for cancer patients.

The need to protect patient access and adequate reimbursement for cancer care has never been more critical. In Senator Bond's state of Missouri alone, it is estimated that 29,500 new cases of cancer will be diagnosed in 2003. Many of these patients will turn to hospitals in their communities for life-saving treatment. However, the ability of hospital outpatient departments to provide such care is being jeopardized by the drastic reimbursement reductions proposed by the Centers for Medicare and Medicaid Services (CMS). In the future, these cuts are likely to disrupt and undermine the ability to deliver quality cancer care to Medicare beneficiaries in the community setting.

Historically, hospitals received two payments when they gave chemotherapy to a Medicare beneficiary—a payment for the drug and a payment to administer the drug. In 2003 CMS "bundled" these two payments together for all drugs costing less than $150 per use/encounter. With this move, CMS has drastically reduced the overall payment so that most of the new payment amounts do not even cover the cost of purchasing the drug, let alone administering it. For drugs that cost more than $150 per use/encounter, CMS implemented a new payment methodology that resulted in significant payment reductions. On the whole, CMS changed the payment methodology for 321 drugs in 2003 and reduced the payments for 95 percent of these drugs.

The drastic cuts affect *all* hospitals that provide hospital outpatient care but will be devastating to small, rural and community hospitals that often face cash flow problems that will disrupt their operations—in some instances permanently.

In the House of Representatives, Rep. Clay Shaw (R-Fla.) reintroduced the *Beneficiary Access to Care Act of 2003* (H.R. 1032), which now has a number of co-sponsors, including Representatives J.D. Hayworth (R-Ariz.) and Mark Foley (R-Fla.). Like S. 1206, this legislation addresses the January 1 cuts in Medicare drug reimbursement and is aimed at protecting patient access to cancer care in the hospital outpatient setting. Specifically, this legislation would ensure that sole-source and innovator multi-source drugs are reimbursed at 83 percent of AWP in the hospital outpatient setting and would require that CMS revise the data and methodology it uses to establish these reimbursement rates.

In the short term, both S. 1206 and H.R. 1032 provide immediate relief, so that in January 2004, these hospitals can start receiving increased payments that at least cover more of their costs as well as protect access to the newest and most effective drugs available on the market. As a part of the long-term solution to this problem H.R. 1032 would also require CMS to reexamine the data and methodology used to determine reimbursement levels so that in the future payment rates are more reflective of the hospital costs for cancer and other outpatient drugs. In addition, H.R. 1032 requires that the General Accounting Office (GAO) conduct a study of the costs of providing cancer drugs in an outpatient setting and report back to Congress with recommendations on the appropriate system to pay for these life-saving drugs.

The Association of Community Cancer Centers, US Oncology, the Oncology Nursing Society, the Association of Health System Pharmacists, the Association of Oncology Social Work, and the National Patient Advocate Foundation are among those organizations supporting the Beneficiary Access to Care Act of 2003.

Physician Office Reimbursement

The action on Capitol Hill remains fast and furious regarding which changes will be made this year to physician office reimbursement. In early June, two House Committees (Energy and Commerce, and Ways and Means) reached a compromise on physician office reimbursement. At press time, the following House proposal had not been voted on by the two committees or by the entire House of Representatives. In addition, the Senate proposal had *not* yet been released and could be substantially different.

House proposal: drug reimbursement changes. A competitive bidding model is being developed in the House, and the proposal would work as follows. Beginning in 2005, CMS will ask contractors/vendors to submit bids for oncology and

other drugs. Included in these bids will be important safeguard information such as the vendors' ability to furnish drugs quickly and in sufficient amounts. Also included in these bids will be the cost of delivery, shipping, and management fees…but not the cost of administration, wastage, spillage, or spoilage.

After reviewing the bids, CMS would set an average reimbursement rate for each drug—and could set different prices for different regions of the country. Contractors could be chosen to supply the drug nationwide or in certain regions. CMS would ensure that at least two contractors (national and/or regional) would be able to meet this price/reimbursement level so that physicians would have some choice in which contractor/vendor to use.

Physicians would then submit orders to the contractor and receive the drugs at the office. (Drugs would *not* be delivered to the patient directly.) CMS would reimburse the contractor directly for the costs of the drug, and the contractor would collect the co-pay from the beneficiary directly as well. This system would be implemented first for oncology drugs in 2005 and then other drugs in 2006. Blood clotting factor, end-stage renal disease (ESRD) drugs, and durable medical equipment (DME) drugs would be exempt from this system. Whether or not radiopharmaceuticals would be covered under this system is uncertain at this time.

For new drugs that have not been through the bidding process, CMS will have the authority to set a reimbursement rate based on "some other market-based methodology that [the agency] may choose to develop."

In the interim (2004 for oncology drugs; 2004-05 for non-oncology drugs), CMS Administrator Scully would have the authority to establish reimbursement rates that "take into account the costs at which such drugs and biologics are reasonably available in the market."

House proposal: practice expense changes. Much has been left to the discretion of CMS. The proposal directs CMS to use the ASCO supplemental practice expense survey conducted by Gallup in determining practice expense relative value units (RVUs). Furthermore, the proposal removes the budget neutrality adjustments required by current law. Thus, CMS will be precluded from reducing the payments for all services on the fee schedule to "pay" for the increased payments for chemotherapy administration that are likely to result from the use of ASCO's supplemental practice expense survey.

This proposal does not require CMS to shift the oncology codes out of the zero work pool to specific specialty pools (while protecting other codes such as radiation oncology services that remain in the pool). And neither proposal provides for any additional oncology codes for reporting services such as chemotherapy management or nutritional counseling. Nonetheless, under the CMS methodology for calculating practice expense RVUs, the higher practice expense per hour data in the Gallup survey should lead to increased RVUs for those codes used primarily by oncologists, e.g., chemotherapy administration services. The practice expense RVUs for those codes that are also used by other specialties, such as evaluation and management services, are unlikely to increase.

House committee staff has indicated that use of the Gallup data and removal of the budget neutrality feature would be implemented as early as 2004, so that CMS can make changes to the practice expense side as it sets interim drug payments for 2004.

Finally, the proposal includes a GAO study on the effects of these changes on patient access to care.

Progress on a Prescription Drug Benefit

The Senate Finance Committee held a hearing on June 6, 2003, to discuss providing a prescription drug benefit within the Medicare program. At the same time, Finance Committee Chairman Charles Grassley (R-Iowa) and Ranking Minority Member Max Baucus (D-Mont.) announced they had reached agreement on what such a benefit might look like.

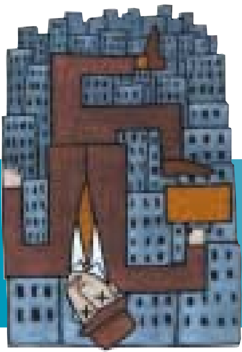
According to Senator Baucus, their plan would establish a voluntary drug benefit under a new Medicare Part D. The benefit would be available to seniors that choose to stay in Fee-for-Service (FFS) Medicare, as well as those that choose to join a new private plan option. To address the concerns of rural seniors, Baucus said that the proposal would ensure access to at least two private drug benefit plans. If no two plans enter a particular area, the government would take full-risk.

According to Senator John Breaux (D-La.), the Grassley-Baucus agreement is a "big step forward" in the prescription drug debate. He claimed that the agreement provides a rational approach to providing a drug benefit.

CMS Administrator Scully testified that Medicare must be reformed to offer beneficiaries prescription drug coverage and increased choices of health plans. According to Scully, CMS's current practice of micromanagement and "price-fixing" leads to inefficiency and improper payments, and the participation of innovative private plans is critical to the future health of the Medicare program. He claimed that more than 70 percent of Medicare beneficiaries currently obtain some form of coverage though private health insurers.

Chairman Grassley asked Administrator Scully if private health plans would be available in rural areas such as Iowa and spoke of his frustration with the lack of Medicare+Choice options in Iowa. Scully responded that preferred provider organizations (PPOs) are far more prevalent in rural areas than HMOs. He claimed that 92 percent of doctors participate in some type of PPO plan.

Senator Baucus asked why CMS actuaries estimate that private health plans would save money, whereas Congressional Budget Office actuaries argue that private plans will increase costs to the Medicare program. Scully responded that the matter represents a fundamental disagreement between the two bodies. He argued that private insurance practices such as care management could lead to modest program savings. Senator Baucus also asked if Scully would support some type of limit on private plan expenses to reduce the overall CBO score. Scully replied that such an approach would not be ideal, but may prove necessary.



Heads Up!

Private Insurers Are Revolutionizing Reimbursement

by Mary Lou Bowers, M.B.A.

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While the debate on Medicare reform continues, private insurers are initiating cost-saving efforts *now*. The national payer mix is about 50 percent Medicare/Medicaid and 50 percent private insurance, and physician practices cannot afford to ignore the second half of this equation.

The Pay Acquisition Model

Aetna is one national health insurer developing and using several new reimbursement models to contain health care costs and still ensure adequate patient care. The first approach—pay acquisition—is being piloted in Aetna's Northeast region.

Under its pay acquisition methodology, Aetna uses prices from pharmaceutical distributors to calculate an amount that it believes the physician paid for the drug. Aetna takes that number, adds a percentage for administration costs incurred by the physician (for inventory, handling, waste, etc.), and comes up with the total amount it will reimburse physicians for using the drug.

In Aetna's pilot program in New Jersey, physicians are being reimbursed at acquisition cost plus 7.5 percent. In Aetna's pilot program in Connecticut, plans call for physicians to be reimbursed at acquisition cost plus 12 percent, although physicians in that state have convinced Aetna to push back implementation of the new rates.

Under the pay acquisition model, physicians accustomed to drug reimbursement amounts equal to acquisition cost plus 60 to 80 percent are now being reimbursed at margins more closely aligned with drug costs. And, because these practices used the profit margin they made on drugs to offset the underpayment of their practice expenses, this new reimbursement model threatens the financial viability of providing cancer care in the physician setting.

The only recourse for physician practices is to take a hard look at their administration costs and negotiate with their insurers to come up with an adequate reimbursement percentage. This task may not be as difficult as it sounds, because private insurers and even the federal government have recognized that practice expenses are underpaid and have offered to increase these payments; they simply do not know what the increase should be.

In Aetna's pilot program, physicians are seeing an offer of 40 percent in additional payments for their practice expenses and thinking that percentage sounds good, but few physician practices have calculated the dollar equivalence to ensure that their costs are covered.

Physician practices cannot simply assume that the percentage or amount their insurer is offering for practice expenses is adequate, because the increased administration payment may *not* be enough to cover the reduction in drug payments. If a physician practice provides hard data about its practice expenses, insurers are more likely to negotiate a fair payment, even if the physician practice is asking for a higher percentage than the 40 percent currently being suggested by payers.

Purchase and Supply Methodology

Another methodology that Aetna is testing in its Southeast and Southwest regions is the purchase and supply methodology, in which the insurer purchases the drugs for the patient and supplies the drugs to the physician office. This methodology is popular with Aetna and other private insurers because it allows them to reimburse drugs at amounts closer to what it costs physicians and hospitals to purchase the drugs.

One version of the purchase and supply methodology is called the pharmacy benefit manager (PBM) model. Typically, the PBM model requires the physician to call and order the treatment, which is then reviewed and approved by the PBM. After approval, the PBM ships the patient-specific drug to the oncology practice for administration. The PBM bills the payer directly for the drugs; the oncology practice bills only for the administration of the drugs.

Blue Cross and Blue Shield is another national insurer that is using the purchase and supply methodology to pilot programs in Florida, New York, and Michigan.

In Michigan, Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN) are working hand-in-hand with pharmaceutical distributors to drive down their purchase cost of drugs. In a May 1, 2003, letter to oncologists, BCBSM and BCN announced "a way to acquire injectable drugs at reduced prices" by working directly with three national specialty pharmacy distributors: Curascript, McKesson, and Priority Healthcare.

Although the Blues call the program voluntary, they encourage physicians to establish "the most cost-effective process for acquiring injectable drugs" by purchasing their drugs through these suppliers. "By

lowering the prices physicians pay, BCBSM and BCN can adjust the fees they pay for injectable drugs typically billed by physicians... resulting in cost savings for physicians and insurers," according to the insurers' letter. The Blues asked physicians to review their prices, but they did not list any revised fees, which are scheduled to go into effect July 1, 2003.

While some insurers are easing into new reimbursement models slowly, others are not. One national insurer, UnitedHealth, has told its physicians in Minnesota that they have only two choices—buy their own drugs and accept a lower reimbursement rate or allow the insurance company to purchase the drugs for them. Oxford, a regional insurer in the Northeast, has given its physicians a similar choice to make.

When purchase and supply models were first developed, physicians revolted against the practice of "brown bagging" because of patient risk, and many insurance companies seemed to back down. The reality is that insurers went back to the drawing board, taking into account safety concerns voiced by physicians. Today, insurers have come up with a number of innovative ways to retain the savings of purchasing the drugs themselves while still meeting, they believe, the safety concerns of physicians.

What Does This Mean for Your Practice and What Can You Do?

Oncology practices in Connecticut, Florida, Michigan, New Jersey, New York, and other states using the pay acquisition or purchase and supply methodologies may be in a bind unless third-party payers and Medicare are willing to reimburse administration costs at an adequate level. Across the country, physicians are facing hard decisions and feeling as though they have little to no negotiating power under these new reimbursement models.

To deal successfully with private insurers, physician practices must assume control of the contract process. Every contract must be reviewed carefully, word by word, to ensure that practices are being adequately reimbursed for the cost of providing quality cancer care. Physician practices should disseminate insurer contracts widely among key staff. The Finance Department should review each contract and calculate if the terms will protect the bottom line of the practice.

Staff must familiarize themselves with the ins and outs of the contract. A checklist should be developed for each insurer contract, which documents all changes in the drug payments made by the insurer and whether an increased administration payment is offered to balance a decreased drug payment.

> **On average,** physician practices ***lose between 3 to 5 percent of their revenue annually*** merely because the practice is **unaware of or unfamiliar with the details** of the insurer contract.

Before entering into negotiations with an insurer, a physician practice should know its costs by service; understand its drug handling and inventory costs; and know where every non-reimbursed item is allocated. Most importantly, practices must identify an expected profit margin. No other business in this country is expected to operate at a loss or at break-even, and physician practices *can* expect a reasonable profit margin. Most insurers are willing to negotiate an increase in administration payments, and a physician practice that comes to the table with documentation of its cost of doing business and its expected profit margin will have an easier time with these negotiations.

A physician practice should also look at its patient payment history when evaluating an insurer contract and identify how much of its revenue comes from patient copayments or deductibles. Insurers have been steadily increasing the amount that the patient must pay the provider, making it more important than ever for physician practices to collect the full amount owed from patients.

Physicians should evaluate their insurance practices by major plan because prompt payers or more flexible ones can be treated differently than other payers.

Practices should also calculate their percentage of "non-contract" payers. Using non-contract payers makes it more difficult for a practice to identify covered services. A practice that sees a large number of patients under one or two non-contract insurers may benefit from negotiating and signing a contract with the insurers.

Coming to terms and entering into a contract with an insurer is just the beginning of the physician/insurer relationship. One of the most common problems for physician offices is that the ball gets dropped after the insurer contract is signed, with staff doing little to no follow-up to see if the insurer is actually adhering to the terms of the contract. How bad is this problem? On average, physician practices lose between 3 to 5 percent of their revenue annually merely because the practice is unaware of or unfamiliar with the details of the insurer contract. Remember, your practice is responsible for monitoring the terms of your contracts because your insurer is not going to come back and say, "We've made a mistake and paid you too little."

The last piece of the puzzle is to develop a practice reimbursement strategy for responding to insurers. If the insurer is deviating from the terms of the contract, physician practices should have a system in place for staff members to use when dealing with the insurer.

When all is said and done, physician practices must know when to fight and when to simply walk away from a contract that is going to put their practice at financial risk. During contract negotiations or re-negotiations, a physician practice must be prepared to present hard financial and patient data to back up its position and, if all else fails, to walk away from a nonlucrative contract.

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