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INSIDE

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Pilgrimage to a patient-centered medical home

by Carrie Vaughan

For the past two years, Southeast Texas Medical Associates (SETMA) has been on a journey to be recognized as a patient-centered medical home (PCMH)—although, in truth, the journey began more than a decade ago.

The Beaumont, TX–based multispecialty practice began aggressively working with managed care in 1997, says CEO **James L. Holly, MD.** "This was an effective way to address many of the needs of our patients, especially the cost, quality, and access to care by our medically most vulnerable friends and neighbors."

SETMA then became involved in Medicare Advantage, which enabled the practice to extend care to many patients who previously could not afford or obtain it.

In 1998, SETMA adopted electronic health records, but soon realized that they were too expensive and difficult to manage if the only benefit was an electronic method of documenting a patient encounter. So the following year, SETMA redirected its efforts to electronic patient management and began developing disease and data management tools.

In 2000, SETMA determined that to provide excellent care, it needed to track the quality of care, audit the care given to populations of patients, and statistically analyze its outcomes. "We began tracking and auditing various quality metrics, including diabetes, hypertension, care transitions, congestive heart failure [CHF], and chronic stable angina—most of which were published by Physician Consortium for Performance Improvement. In time, we expanded that to include other nationally recognized metrics," says Holly.

Finally in 2009, SETMA embarked on its journey to be recognized as a PCMH.

Recently, Holly discussed with HealthLeaders his views on SETMA's care model, healthcare reform, and the lessons learned along the way:

HealthLeaders: What were driving forces behind your decision to adopt a PCMH model of care?

Holly: The features of medical home which intrigued, attracted, and challenged us were:

> "The key to 21st century healthcare is thinking about our **patients when they're not in our presence."**
>
> —*James L. Holly, MD*

- The process of coordination of care and the outcome of coordinated care.
- The further development of our team approach to healthcare, including a truly collegial relationship between nurses, medical assistants, administration, information technology, nurse practitioners, and physicians.
- The realization that the "patient-centered" element of medical home was the ultimate reality of the principle we have stated to our patients for the past fifteen years.
- We have long given our patients report cards telling them what they should expect from

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Medical home

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their healthcare provider. Now, we have added outcomes transparency to those expectations with our decision to publicly report process and outcomes metrics.

- Our COGNOS Project (using business intelligence software to build a data mart and auditing tools) enables us to do real-time auditing on our care processes and outcomes.
- Believing the key to 21st century healthcare is thinking about our patients when they're not in our presence and using technology to fulfill the requirements of excellent care.

This process led us to seek medical home recognition from the National Committee for Quality Assurance [NCQA] and accreditation from the Accreditation Association for Ambulatory Healthcare [AAAHC], the two bodies offering evaluation of medical groups as medical homes.

HL: How does your model of care work?

Holly: At the core of SETMA's practice is that one or two quality metrics will have little impact upon the outcomes of healthcare delivery. SETMA employs two definitions: A "cluster" is seven or more quality metrics for a single condition (i.e., diabetes or hypertension), and a "galaxy" is multiple clusters for the same patient (i.e., diabetes, hypertension, lipids, and CHF). SETMA believes that fulfilling clusters and galaxies of metrics at the point of care will change outcomes. The following are the key elements of our model of care:

- The **tracking** by each provider on each patient of their performance on preventive, screening, and quality standards for acute and chronic care. Tracking occurs simultaneously with the performing of these services by the entire healthcare team, including the provider, nurse, and clerk.
- The **auditing** of performance on the same standards either of the entire practice, each individual clinic, and each provider on a population or panel of patients.
- The **statistical analyzing** of the above audit performance to measure improvement by practice, by clinic, or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, socioeconomic groupings, education, and frequency of visit.
- The **public reporting** of performance on hundreds of quality measures by provider. This places pressure on all providers to improve, and it allows patients to know what is expected of them. The disease management tool plans and medical home coordination document summarizes a patient's state of care and encourages them to ask their provider for any preventive care that has not been provided. We believe this is the best way to overcome provider and patient treatment inertia.
- The design of **Quality Assessment and Permanence Improvement initiatives.** This year, SETMA's initiatives involve the elimination of all ethnic diversities of care in diabetes, hypertension, and dyslipidemia. Also, we have designed a program for reducing preventable readmissions to the hospital.

HL: How easy was it to transition to this model of care?

Holly: It is one of the most difficult things we have done. I use the word "is" because I believe that all of us who already have medical home recognition or accreditation or both are still in the process of transforming the practice of medicine by the principles, ideals, and goals of medical home. The formal process took SETMA from February 16, 2009, to the date we first submitted our NCQA application on April 12, 2010.

The transition is a true transformation rather than a reformation. Reformation comes from pressure from the outside, while transformation comes from an essential change of motivation and dynamic from the inside. Anything can be reformed if enough pressure is brought to bear. Unfortunately, reshaping under pressure can permanently alter the structural integrity of that which is being reformed. Also, once the external pressure is eliminated, the object often returns to its previous shape as nothing has fundamentally changed in its nature. Transformation is not dependent upon external pressure, but is sustained by an internal drive, which is energized by the evolving nature of the organization.

The currently proposed reformation of the healthcare system does nothing to address the fact that the structure of our healthcare system is built upon a patient coming to a healthcare provider who is expected to do something for the patient. There is little personal responsibility on the part of the patient for their own healthcare, whether as to content, cost, or appropriateness.

Transformation of healthcare would result in a radical change in the patient-provider relationship. The patient would no longer be a passive recipient of care. The collaboration between the patient and the provider would be based on the rational accessing of care based on need, not desire.

HL: How is the patient experience different today under this model?

Holly: The patient experience has dramatically changed. For instance, the patient's care is evaluated on the basis of more than 200 quality metrics; the patient receives a summary of these quality metrics with a recommendation to contact his or her healthcare provider to request that any metrics not completed be done and care transition points are attended to; and a "plan of care" and "treatment plan" baton is handed off to the patient so that they can participate effectively as the head of their healthcare team.

Because of SETMA's department of care coordination, every patient who leaves the hospital receives a follow-up call the day after discharge. This is not a 15-second administrative call to fulfill a metric, but it is a 12–30 minute call, which has substance. Selected patients seen in the clinic receive follow-up calls at any interval determined by the healthcare provider related to vulnerabilities or complexities of their care.

In addition, both during the visit and in the treatment plan, a section is included which is entitled, "What If?" This section shows the patient how his or her risk will change if a number of individual elements or a combination of multiple elements used to calculate the risk is changed.

HL: What steps did you take to ensure your providers and support staff were on board?

Holly: The first step we took in transforming our practice was an in-depth evaluation of our practice by the medical home standards published by CMS and NCQA. All of our executive management staff and providers were involved in this evaluation, which resulted in a 400-page review of our practice. The evaluation allowed all of our providers to see where we were, where we needed to go, and be part of the transformative process.

We looked at the requirements for medical home and designed tools that made it easier to fulfill the requirements than not to fulfill them. We were able to transform our disease management tool follow-up documents into plans of care and treatment plans.

We close the clinic one-half day each month and have a seminar to discuss the ideal of medical home and how we are performing or not performing. We have illustrations of where we are doing it well, and we share that by e-mail daily; and when we do not do it well, we share that as well.

We welcome and seek ideas from all members of our team to improve our processes and outcomes. We post on our website by provider name performance on more than 200 quality metrics.

HL: What advice do you have for practices seeking to undergo a similar transition?

Holly: Look into your own organization for the creativity and energy to change. There are many consultants and agencies who would like to charge you hundreds of thousands of dollars to transform you. At best that will be reformation. Transformation can only come from within, and it can only be sustained by your own passion, resolve, and relentless pursuit of excellence. Get counsel from those who have succeeded, evaluate their ideas, and modify them to your situation. Often the best help is free. Excellence and expensive are not synonyms.

HL: For practices seeking recognition as a medical home, what should they know about the application process?

Holly: It is tedious and complex, particularly NCQA. But that may just reflect my prejudice about forms; others may find them simple and straightforward. Currently, less than 1% of medical practices have any form of medical home recognition, so the process is in its infancy. It is SETMA's judgment that an ideal process would be a combination of AAAHC and NCQA.

HL: What lessons have you learned along this journey?

Holly: It is worth the process, the price, and the pain. This is the future of healthcare, and it is possible to be part of that future now. It is not easy, but it is not impossible. Measure your success by your own advancement and not by whether someone else is ahead or behind you. In the same way, share your success with others. The following steps will help:

- Determine where you are and where you want to be.
- Select the template or model you will follow.
- Outline the steps you will take.
- Develop a timeline for completing each task.
- Be innovative. Emulate the best of others, but expand upon their work and make it yours.
- Be patient but eager.
- Enjoy what you are doing and celebrate where you are.

'Doc fix' provides more questions than answers

by Jeff Elliott

With a stroke of a pen, President Obama signed the so-called "Doc-Fix" bill in December 2010. The law delays by one year implementation of the sustainable growth rate (SGR) formula, which sets the rates of Medicare reimbursements to physicians.

Healthcare groups have publicly applauded the postponement, saying that it is vital to ensuring the availability of healthcare coverage for seniors. Privately, however, many remain frustrated that a permanent solution to the SGR formula for Medicare funding, which has called for cuts in Medicare reimbursement over the past decade (including a 25% reduction in Medicare reimbursements that would have taken effect January 1, 2011), remains so elusive.

Among others, President Obama recognizes the need for this issue to be dealt with. "It's time for a permanent solution that seniors and their doctors can depend on, and I look forward to working with Congress to address this matter once and for all in the coming year," he said after the U.S. House voted overwhelmingly to delay the cuts. For its part, Congress voted in favor of delaying the nearly $20 billion in reductions to physician pay five times in 2010 alone.

Perhaps the easiest question to answer in regard to the seemingly perpetual delays to Medicare reimbursement cuts is, "How did we get into this mess?"

"It's the insane rules of the budget game in Washington," says **Bruce Vladeck,** former administrator of the Health Care Financing Administration. "It often boils down to selective insistence by some members of Congress relative to what is allowed to enter the deficit and what isn't."

More often than not, SGR has fallen into the latter category, with lawmakers believing that a true physician compensation solution should have funding before it's approved.

According to Senate Majority Leader Harry Reid (D-NV), the legislation would be paid for by modifying the policy regarding overpayments of the healthcare affordability tax credit.

But the irony is that the longer Congress avoids a permanent solution, the greater toll the SGR formula extracts on the federal budget. "There is the underlying deficit that is something akin to $300 billion that needs to be dealt with first," says **Anders Gilberg,** vice president of public and private economic affairs for the Medical Group Management Association. "This is the biggest impediment to long-term reform."

So can we expect more of the same waffling next year when this temporary fix ends? Experts say it's likely, although there are avenues that could serve as a permanent solution, such as implementing a system that tracks some level of medical inflation to pay physicians for the real cost of delivering care.

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Sometimes you just have to end it: How to terminate a contract that's not working

When you're scrambling for revenue anywhere you can find it, terminating a managed care contract may sound like the last thing you should do. But in fact, getting rid of a contract that is not working for you can actually make your practice more profitable.

Physician practices often hold on to contracts that are not profitable because they have had a relationship with that managed care provider for years and losing it would seem like a financial loss, says **John Schmitt**, a managed care expert with EthosPartners Healthcare Management Group, based in Suwanee, GA. However, a close analysis of the numbers may show that the contract is not producing any revenue for your practice—in fact, it may actually be costing you money, says Schmitt.

"We can be reluctant to let go. People often think anything is better than nothing, but with managed care contracts that's not always true," he explains. "If you have a bad contract or a bad business partner, it can be very resource-consuming for the practice because it will take a lot of time and require a lot of hassle."

A practice also may be reluctant to terminate a contract because a personal relationship has been established, Schmitt says.

"Often the payer is represented by a very cordial, nice person and you don't want to tell them no," he says. "So you renew the contract, and then months later you ask yourself why you ever signed this contract in the first place. You have to not make it personal and just say you don't want contracts that don't work for you."

> "If you have a bad contract or a bad business partner, it can be very resource-consuming for the practice **because it will take a lot of time and require a lot of hassle."**
>
> —*John Schmitt*

Broken promises often the cause

Termination frequently is prompted by payers who have unreasonable fees or aren't responsive to problems such as claim denial rates and pre-authorization rates that are difficult to work with. Another common reason for terminating a contract is the payer not fulfilling promises it made when trying to get you on board, Schmitt says.

"It can be like a divorce: too many irreconcilable differences and you just can't work it out," he says. "Breaking up is not something you want to do, but you just can't go on like that."

Managed care contracting is becoming more complicated than in years past, Schmitt says, particularly with the growing popularity of incentive-based payer programs. These arrangements can hinge on promises that, if unfulfilled,

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Terminate a contract that's not working

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may form a reasonable basis for terminating the relationship, he says.

The incentive arrangements require a great deal of trust between the two parties, Schmitt says. If the managed care provider is not transparent, cooperative, and willing to resolve problems, the arrangement can fall apart.

Detecting a lack of trust should put you on the alert that this may not be a contract that is worth keeping, Schmitt says. Warning signs can be a pattern of delayed or denied claims that seem unreasonable, a failure to respond in good faith when the practice reports concerns about transactions, or overly burdensome requirements from the payer, he says.

"When there's no trust, the negotiations are slow, and because they're slow, you lose revenue you could have made in the meantime, and it's more costly in terms of the time it consumes," Schmitt says. "So it actually results in a trust tax, so to speak."

Not the time for emotion

So when it comes time to say good-bye, how do you do it? The first rule is to make the termination strictly factual and not emotional, Schmitt says. All communication should be respectful, and you should document why you have decided to end the relationship, he says.

"You should present it to them in a very clear way, saying, 'These were our expectations and these are what the results were. We expected these things and you did not deliver. You didn't keep your commitment to what you said you were going to do.' They deserve to know why you're terminating the contract, but this is not the time to get angry or tell them how frustrated you are. Simply state the facts calmly and leave it at that," Schmitt says.

Although terminating a contract can be the right business decision, do not take the decision lightly, he says. Remember that terminating a contract will cause some headaches for you.

Not likely to come back

For starters, you must give notice to patients covered by that payer, and the patients will not be happy about the news, Schmitt says. Patients should be notified individually, and a notice should be posted in the lobby stating that you no longer accept the payer's coverage, but you will still see the patients if they wish to self-pay.

"The front office should be prepared to convey this information and discuss it in a caring way because this is a difficult issue for patients. They take it personally," he says. "You can't just say, 'Oh, we don't take that anymore.' "

Don't terminate or threaten to terminate a contract in hopes of getting a better offer from the payer, Schmitt says. If the payer were going to make you a better offer or provide better service, it already would have before you got to the point of termination. Likewise, don't expect the payer to court you in the future. The relationship will be strained at best, he says.

"Will they come back later and try to make it all better, change their ways and give you better rates?" Schmitt says. "Well, some divorced couples get back together. But don't count on it. Usually it takes a new era of management to come in at the payer and change things around, then they try to show you they don't have the same problems as before."

Source

Adapted from **Managed Care Contracting & Reimbursement Advisor,** January 2011.

How lifestyle management coaches can improve physician practices' bottom line

by Joe Cantlupe

In one of my favorite sections of David McCullough's biography of John Adams, the author relates a vivid scene of Adams and Benjamin Franklin about to share a room in Newark, NJ, and not being very happy about the prospect. They argued over whether to keep the window open. Adams, saddled with a head cold, didn't want any part of the chilly night air, whereas Franklin enthusiastically sought out the fresh air. In the end, Franklin won; the window was left open through the night.

Adams may have been reluctant about the window because he had a history of colds. He was also into a bit of self-diagnosis. "You know I cannot pass a spring or fall without an ill turn and I have one of these for four or five weeks—a cold as usual," Adams wrote to his wife, Abigail, according to historians. "Warm weather and a little exercise with a little medicine, I suppose, will cure me as usual."

Franklin, meanwhile, had his own ailments. He may have had diseases linked to his diet, with biographer Walter Isaacson noting he had gout and kidney stones.

What if Adams and Franklin had been under the care of a lifestyle management coach and physician? Adams would have certainly been encouraged to keep exercising, and he might also have been helped with a strategy to combat his perpetual colds, such as washing his hands more often. Additionally, a coach might have introduced the idea that fresh air is beneficial. As for Franklin, a lifestyle management coach might have led him toward cutting back on certain foods and preventing the gout to begin with.

The business case

Today, there is increasing debate about physicians entering into lifestyle management for patients—serious debate that goes beyond whether rooming house windows should be left open or closed. There are other areas of greater consequence that have come into play, including stress and especially eating habits.

Gout is still an issue in this country, which it was in Franklin's day, as it is often linked to diet. But unlike colonial times, obesity and the spread of diabetes are areas of far more concern in modern-day America.

In contrast to Adams, who often tried to figure out his own health plan, more patients are turning to physicians for their long-term maladies linked to diet. And the physicians, trapped by time and in some cases uncertainty involving nutrition, are finding that adding a lifestyle coach to a practice is both good business and beneficial for patients. Others, however, say that lifestyle coaching generally may not be long-lasting enough to truly help patients over the long haul.

> "I didn't have the time to do it myself. I know I don't have an hour to spend on an initial visit **unless I stop seeing other patients."**
>
> —*John W. Wilson, MD*

John W. Wilson, MD, a family practitioner in Daly City, CA, uses a lifestyle educator to help with his practice because he doesn't have the time to handle the nutrition issues faced by his patients. He uses the FirstLine Therapy® program, developed by Metagenics of San Clemente, CA, in which a lifestyle educator is appointed as a patient coach to perform health assessments. This can help patients lose weight, lower blood pressure, and deal with metabolic syndrome, diabetes, cardiovascular disease, and other chronic conditions. Medical food supplements that can be added to shakes or water and nutrition bars are also included under the plan to augment diet and exercise and help manage specific health conditions such as hypercholesterolemia and chronic fatigue syndrome.

Wilson says he sees an increasing number of patients with comorbidities in his practice.

"We've got a terrible obesity problem in this country, and diabetes issues aren't far behind," he says.

Although he was traditionally trained, Wilson says he has always been interested in alternative approaches, including

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Boost a physician's practice

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holistic methods, to help patients, "but never found evidence to support it."

As he cared for more patients with chronic conditions, he says he was "prescribing more and more medications, and there were more unknowns and I wasn't seeing great results." He says he would suggest patients "eat better, but I didn't have a structured way of dealing with nutrition."

"I had to intervene in a different way," Wilson says. Metagenics states that clinical trials have shown that it developed a medical food that enhances the effects of a Mediterranean-style low-glycemic-load diet, which can help reduce the risk of cardiovascular disease.

Wilson hired a lifestyle educator because "I didn't have the time to do it myself. I know I don't have an hour to spend on an initial visit unless I stop seeing other patients."

Generally, Wilson says his patients are seeing better results. "They feel better and are getting lower medication in the process," he says. "They are seeing themselves gaining lean mass and losing fat."

While he works on the "decision-making and treatment plans," the lifestyle educator he hired is handling nutrition education for his patients. "The patients have been excited about it," Wilson says. "They come in with low expectations and they start seeing how quickly they start feeling better on the eating plan."

Wilson notes that data from his program have shown fiscal success for his practice. About 250 patients have enrolled in the program over the past two years, he says. Without providing exact numbers on return on investment, Wilson says his income increasedby an amount between $50,000 to $70,000 with a lifestyle educator working twice per week, which he says is a good return given the minimal overhead involved.

Long-term solution?

Nationwide, there has been much discussion over the value of intensive lifestyle intervention versus drugs for certain illnesses. During the Endocrine Society annual meeting this past year, it was stated that at least one physician-reported intervention was a better frontline intervention than drug therapy for prediabetic conditions. There were also reports indicating that the efficacy of lifestyle intervention can reduce the incidence of type 2 diabetes.

But Sunder Mudaliar, MD, an associate professor of clinical medicine at the University of California, San Diego School of Medicine, said "lifestyle intervention is effective, but its efficacy wanes over time; it is durable, but its durability goes down over time," according to *Endocrine Today.*

Alas, we are all human, and we all struggle with consistently maintaining wellness over a long period of time. John Adams walked up to several miles per day, but he still had stress to deal with. In 1781, a doctor who had been with Adams spoke of the "strain bore down upon his appearance every bit as much as it did his personality," according to John E. Ferling in his *John Adams: A Life.*

Benjamin Franklin, who often partied in Paris, did not always live in moderation, but as a writer he could advise otherwise. "Be temperate in Wine, in eating, Girls and Sloth, or the Gout will [seize] you and plague you both," he wrote in *Poor Richard's Almanack,* published in 1734.

Even without life management coaching, both men lived long lives. Franklin died at 84, and Adams lived to be 90. In colonial times, there wasn't a life management coach in sight. But neither were there office cubicles, massive hamburgers, or sugar-laden soft drinks the size of farm silos.

Mitigate revenue impact brought by denied claims

With about 10% of claims denied on average, a physician practice must have a specific plan in place to respond to denials. Otherwise, you are forfeiting a significant amount of revenue that is rightly yours, says **Brian Sanderson, JD,** a partner with Crowe Horwath, LLP, in Oakbrook, IL.

That 10% is the first-level denial rate, but then the second and final denial rate—after you have worked the claim but still have not received payment and now must write off the loss—is about 1%–3% of those initial denials, Sanderson says.

"Some organizations are proud of the fact that their initial denial rate is less than 1%, but if their second denial rate is 13% or 14%—and I've seen multiples of that—then the expense that is required to recapture that money also is a significant expense," explains Sanderson. "It puts a lot of pressure on the business office."

A physician practice must have a plan that dictates how a denied claim is addressed, Sanderson says. Rather than the business office simply taking a look at the claim and trying to figure out what the problem is, each denied claim should be routed through a process that captures the data and enables those employees most appropriate to that particular claim to study the reason for nonpayment, he says.

Reducing the denial rate should be a top priority. That starts with analyzing your denials, Sanderson says. Understand what types of denials you're getting. The denials can be broken down into broad categories such as administrative, which might include denials for incorrect insurance and not a covered patient, which are more related to registration and patient access.

> "It's tempting to pile on the work so that people are always working near their limits, but that can be one reason you get inaccurate or incomplete patient registration. **You can be saving yourself pennies in the short run but costing yourself thousands of dollars later."**
>
> *—Brian Sanderson, JD*

Technical issues require digging

Another category might include problems that are more technical in nature, such as when a claim is denied for lack of medical necessity, lack of proper modifiers, or a CPT code not matching the demographics of the patient. An example would be the submittal of a CPT code for a prostate exam on a female patient.

"Those will vary by physician, by group, by specialty, because they are dependent on the performance of each organization," Sanderson says.

With claims related to technical issues, denials usually can be tied to the following three problems:

- **Quality issues in the charge capture process.** This can be a disconnect within the charging process of how a service gets put onto the charge ticket and then onto the bill. Sometimes there is a mix-up in that process and the resulting bill will have incorrect information. For instance, in surgery, the sequencing of CPT codes is very important.
- **Not following a payer's specific rules.** Some payers have specific rules regarding what can be charged or what can be bundled, for example, and not following those rules will result in a denied claim. Understanding the details of each managed care contract is key to avoiding this problem.

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Upcoming events

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Denied claims

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» **Breaking an unknown "rule" with the payer.** In some cases the denial seems arbitrary, when in fact the managed care payer is denying claims for a reason not clearly stated to providers. The denial code may seem unjustified. The true reason may be that the payer has deemed the procedure unnecessary but doesn't come right out and say so. Claims in which the reason for denial is unclear must be fought vigorously, Sanderson says.

Staff must have time to do the job right

With administrative denials, the first thing to consider is whether your staff has the time and resources necessary to produce quality patient data, Sanderson says. "Some practices are extremely diligent with patient access and registration, but with others the front office person is responsible for that task and four or five others. Then it becomes just a matter of throughput, getting the patient data through the system, rather than ensuring the quality of that data."

This means that reducing your denial rate sometimes requires assessing your staffing and task assignments for the front office, Sanderson says. The first question is whether you have enough staff. Then ask yourself whether those staff members have enough time to register patients efficiently and accurately.

This assessment can be a challenge, Sanderson says, because the practice needs staff to work at full capacity. You don't want to have too many staff members on the roster such that you're paying people to sit around with little to do. At the same time, you must not burden those staff members with so much work that they cannot properly perform their jobs.

"You have to find a balance. If you have coordination of benefits issues, it's largely a matter of whether those people have time to focus," he says. "It's tempting to pile on the work so that people are always working near their limits, but that can be one reason you get inaccurate or incomplete patient registration. You can be saving yourself pennies in the short run but costing yourself thousands of dollars later if that hurried work results in denied claims."

Discuss data with staff

Although education of staff also can be an issue, Sanderson says that generally takes a backseat to the administrative processes in place and the time staff have to work with patient data.

Tracking the reason for denials is the best way to discover where your shortcomings are, Sanderson says. Monthly data on denials should be posted in the office for all staff to see, and they should be discussed in staff meetings, he says.

"Sometimes simply giving them that information and discussing it openly can have a significant effect, even without making any process changes," Sanderson says. "Once they're aware of the rate of denials and the reasons, and they know that you're monitoring it, they pay more attention to what they're doing."

Source

Adapted from **Managed Care Contracting & Reimbursement Advisor,** January 2011.

Physician RAC vulnerabilities detailed in CMS release

by James Carroll

Continuing its efforts to publicize valuable information derived from the Recovery Audit Contractor (RAC) demonstration, CMS released the fourth in a series of *MLN Matters* articles in December 2010.

The latest, Special Edition article SE1036, provides education on two high-risk vulnerabilities for physician claims. According to CMS, these claims were denied because the demonstration RACs determined that either a duplicate claim was billed and paid, or the involved physician reported an incorrect number of units for the CPT code billed based on the CPT code descriptor, the reporting instructions in the CPT book, and/or other CMS local or national policy.

> **"Physician offices need to be proactively self-auditing their billing process and actively monitoring the RAC websites** for medically unlikely edits such as IV hydration, fulvestrant—dose vs. billed units."
>
> —*Elizabeth Lamkin, MHA*

Examples include:

- **Other services with excessive units**—Units billed exceeded the number of units per day based on the CPT code descriptor, reporting instructions in the CPT book, and/or other CMS local or national policy. (Pre-appeal improper payment amount: $6,635,558)
- **Duplicate claims**—Physician billed and was paid for two claims for the same beneficiary, same date of service, same CPT code, and same physician. (Pre-appeal improper payment amount: $1,094,751)

Although CMS is not directly stating it, these issues in actuality are medically unlikely edits (MUE), which should come as no surprise, according to **Elizabeth Lamkin, MHA,** president of Dalzell Consulting Group, Inc., in Hilton Head, SC. "During the demonstration project RACs were very sensitive to physician providers and other small providers, and RAC auditors at this time were also very clear about medically unlikely edits, which is what we see here," Lamkin says.

In the case of MUEs, physician offices, as well as any other type of provider organization, should be able to take notice of these issues prior to receiving a demand letter.

"Physician offices need to be proactively self-auditing their billing process and actively monitoring the RAC websites for medically unlikely edits such as IV hydration, fulvestrant—dose vs. billed units, and so on," says Lamkin. "Issues involving MUEs are oftentimes clerical errors, though, so this is an issue that can be avoided with comprehensive review."

Although the two vulnerabilities described in SE1036 apply to duplicate payments and services with excessive units, it's clear that RACs and MACs may eventually choose to target physicians for other vulnerabilities as well, according to **Michael Taylor, MD,** vice president of clinical operations at Executive Health Resources in Newtown Square, PA.

"A clear vulnerability, although not listed in SE1036, involves cases where the physician billing does not match the hospital's billing status—for instance, when the physician's billing is for an inpatient level of care but the hospital bills for an outpatient observation service," Taylor says. "This would be a simple, clear-cut reason for a RAC or MAC to audit and potentially deny cases when the billing is incongruent."

While physicians have not been a primary audit target to date, anything can change in the ever-shifting world of RACs, according to Lamkin.

"Physicians are going to be the next big target for the RACs," she says. "When they do automated reviews, there's no differentiation between provider types, so this is something that physicians are going to have to get their arms around."

The Breakroom

AMA urges providers to take action on inaccurate payments, says one in five are wrong

The AMA is urging physicians to take action against inaccurate payments from private health insurers. As part of the launch of its "Heal That Claim" campaign, the AMA is supplying physicians with tools to fight flawed and inefficient claims processing by health insurers.

One out of five medical claims is processed inaccurately by commercial health insurers, according to the AMA's National Health Insurer Report Card.

A 20% error rate represents an intolerable level of inefficiency that wastes an estimated $15.5 billion annually.

The administrative costs of ensuring proper insurance payments takes a heavy financial toll on physicians and can consume up to 14% of their earned revenue, says AMA President **Cecil Wilson, MD.**

"The AMA's goal is to significantly reduce the administrative costs of processing claims from 14% to 1% and allow doctors to focus on caring for patients instead of battling health insurers over delayed, denied, or shortchanged medical claims," Wilson says.

Because health insurers often increase their rate of claim denials during the last quarter of the year, many more physicians may have just experienced such activity and will appreciate the reason for the campaign, Wilson points out.

He urges physician practices to take the initiative in improving the accuracy of claims, rather than waiting for insurers to do it.

The AMA is helping physicians overcome claims obstacles by offering online resources to help prepare, track, and appeal claims. These resources include template appeal letters, printable checklists, and logs that can help physicians simplify their claims management systems.

To learn more about how the AMA is helping physicians get paid accurately by health insurers, please visit the "Heal That Claim" campaign site at *www.ama-assn.org/ama1/pub/upload/mm/368/htc_general_flier.pdf.*

At the site, physicians can pledge support for the campaign, report unfair health insurer practices, share successes, or sign up for the AMA's free e-mail alerts to help stay up to date on unfair payer practices.

Source

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