PRACTICE MANAGEMENT

Putting Practices on the RAC

Kurt Ullman

Published: Monday, November 12th 2012

Recovery Audit Contractors (RAC) are yet another group of people dispatched by the Centers for Medicare and Medicaid Services (CMS) to look for, and most likely find, overpayments to physicians. Since they are paid a contingency fee for locating discrepancies, they are quickly becoming viewed as bounty hunters by many practices.

"RACs are tasked by CMS to go out and find overpayments and underpayments for Medicare services," said Abby Pendleton, Esq., from The Health Law Partners, PC, in Southfield, Mich. "The reality is that they are really out there looking for overpayments. Their percentage of any recovery runs between 9% and 12%."

There are currently four RACs working in the United States. RACs review claims on a post-payment basis. They are supposed to use the same Medicare policies as Carriers, Fiscal Intermediaries, and similar Medicare programs and follow the CMS manuals.

Unlike other types of auditing, these contractors can only look at specific issues approved by CMS prior to the review. Although many of these will probably be the same from contractor to contractor, others may be suggested by the RAC subject to CMS approval.

Currently, the look-back period is three years. CMS also limits the number of medical records that can be demanded, based on the number of physicians in a given practice.

If RACs find a concern, they can use statistics to extrapolate how much money should be returned to Medicare. This is not always based on chart audits.

"Contractors are not required to show everything you have done wrong," said Jeffery Ward, MD, Clinical Practice Committee chair for the American Society of Clinical Oncology. "For example, if they audit a sample of 10 charts out of 1,000 a practice submitted for a specific code and they think two of them are wrong, they will ask for repayment for 200 patients."

This means that all practices should take audits very seriously.

"I don't think there is any question that a RAC audit has the potential to destroy a practice financially," Ward noted. "These audits can very easily turn into big dollar losses and decimate a practice."

The next question becomes what can a practice do to avoid being audited? Apparently there is very little.

"We are often asked what can someone do to avoid audits," said Jessica Gustafson, Esq., also with Health Law Partners. "I believe that it isn't a matter of if, but rather when, an audit takes place."

For RAC audits, and most others, the best defense is a good charting. Since every RAC gets specific marching orders from CMS, it is also suggested that practices contact their contractor to see what they can review and concentrate on those issues.

"Physicians in particular have to pay special attention to enhancing their documentation knowing that at some time it will be reviewed by someone," Pendleton said. "Include information on medical necessity so when an auditor comes in it is very apparent to someone who doesn't know the patient why something was done."

Ward notes that having a good rationale for a treatment or intervention may not always be enough. He points to a controversy oncologists are having when RACs deny payment for using Neulasta (pefilgramstim).

"When the medication was approved 10 years ago, the label said it should not be given any time two weeks before chemotherapy or until 24 hours after chemotherapy," said Ward. "In the interim we have developed 'dose dense' regimens giving chemotherapy at two-week intervals. The literature shows Neulasta can safely be given on the day of chemotherapy, and many use it in that manner when next-day therapy is a hardship for the patient."

However, RACs are denying claims and asking for paybacks because this is outside of the parameters of the label.

"The money is not being demanded because the medication was inappropriate to give or it did not benefit the patient," Ward stressed. "Physicians did not follow the strict label that may have been approved years ago; so the RACs are denying claims simply because they can."

Medications can be very fertile ground for RACs. Many medicines are approved for one thing initially; however, as oncologists gain more experience with them, more uses become clinically acceptable and even part of standards of care. Unfortunately, RACs may not see things the physician's way without studies supporting the use.

If you are audited and claims are denied, all the experts agree there is very little to lose and quite a bit to gain by appealing. Pendleton notes that documentation from the CMS suggests that over 60% of all appeals are found in the provider's favor. These figures are probably conservative since CMS publishes figures on a fiscal year basis and it can take over a year to exhaust appeals.

"Our experience indicates the success rate could run to 90% or more," she said. "If you are confident the service you provided was appropriate, you should appeal because you have a reasonable likelihood of winning."

If a practice is audited and payments are denied, there is a very stringent protocol and timeline for appeal. Should one be missed, the appeal dies. Because of this, it is suggested that practices designate a person responsible for assembling records for the initial audit and keeping track of all deadlines for appeals.

"The reality of the situation is that the physician community is under a lot of pressure from auditors and it not just RACs," Gustafson said. "In addition to other players under

Medicare, we are seeing significant increases in audits by private payers. Practices need to acknowledge this and establish protocols for addressing these issues from initial documentation through to the last appeal."

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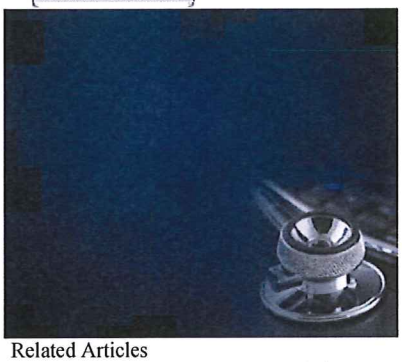

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PRACTICE MANAGEMENT

Docs Feel Lack of Control Over Practice Finances

Laura Joszt

Published: Wednesday, October 24th 2012

With all of the growth and regulatory changes in health care, physicians have their hands full with just doing their jobs of practicing medicine. Yet they still have to handle the business side of medicine. A new study revealed that three-quarters of doctors feel they do not have control over the financial aspects of their businesses.

The study, completed by ADP AdvancedMD and Sermo, surveyed 300 physicians in family medicine, internal medicine, obstetrics/gynecology and pediatrics specialties. The results showed that 74% felt they did not have financial control. According to ADP AdvancedMD, the results of this survey show that there is a need for stronger tracking and goal setting among medical practices.

"These findings validate what we've seen in the marketplace over the past few years — in particular, physicians are finding managing the finances of their practices increasingly challenging," Raul Villar, president of ADP AdvancedMD, said in a statement.

PMD's columnist Jeff Brown, MD, often hammers home the point that doctors don't receive enough (or any) business, organizational or financial training alongside their medical education.

The ADP AdvancedMD/Sermo study comes just months after one that revealed 26% of primary care physicians reported they were in poor financial health.

Only one-third of physicians are using cloud practice management and electronic health records (EHR), according to the report. Plus only 56% say their EHR is integrated with their management system, which would be more effective and efficient for claims processing.

"Technology has come a long way in providing physicians with more freedom and flexibility to balance their busy lives, as well as providing tools for improving the patient experience and financial health of their practices," Villar said in a statement. "Cloud practice software offering state-of-the-art revenue collection capabilities, accessible from anywhere, can play a significant role in helping to improve finances and saving private practices."

The study also found that half of physicians evaluate their financial performance and compare it with similar practices. More than half (across all specialties) see patient count increasing, which will at least partially be a result of the Affordable Care Act (ACA).

Other than ACA, more than half of respondents cited Medicare payment reductions and the impact of ICD-10 as concerns.

PRACTICE MANAGEMENT

Physicians Prepared to Leave Health Care

Laura Joszt

Published: Thursday, September 27th 2012

The physician shortage may be set to get worse, not better, regardless of how many new graduates medical schools send out into the world. Changing practice styles may limit patient access to physicians, according to a new survey.

Merritt Hawkins' Survey of America's Physicians: Practice Patterns and Perspectives revealed that physicians are working fewer hours, seeing fewer patients and limiting access to their practices. The research estimates 44,350 full-time-equivalent (FTE) physicians will be lost in the next four years if the current patterns continue.

By the Numbers

Physicians are seeing 16.6% fewer patients per day than in 2008

Over 60% would retire today if they had the means

Physicians spend over 22% of their time on non-clinical paperwork

Over 26% of practices have closed their doors to Medicaid patients

58% would not recommend medicine as a career to their children

Over one-third would not choose medicine if they had their careers to do over again

Some of the changes that half of all physicians will implement over the next three years include cutting back on number of patients seen, working part-time hours, switching to concierge medicine, retiring or taking steps to reduce patient access.

Plus, the exodus from private practice will continue as 100,000 physicians transition to hospital employment. According to Merritt Hawkins' research, this change over the next four years will mean 91 million fewer annual patient encounters.

According to Walker Ray, MD, vice president of The Physicians Foundation, which commissioned the study, the introduction of 30 million new patients as a result of the Affordable Care Act will have "profound implications."

"These practice changes amount to a silent exodus of physicians from the workforce," Ray said in a statement. "When these lost hours are added up, we get a much fuller and more ominous picture of the kind of access crisis that patients may soon face."

The 13,575 practicing physicians in the survey showed low morale with 77% pessimistic about the future of medicine and 82% believing they have little ability to change the health care system. Close to 92% admitted they are unsure where the health system will be or how they will fit into it in three to five years from now.

The open-ended responses were particularly telling from "I'm getting out ASAP" to "It has turned from a noble profession into a business where physicians are traded" and "We are in the process of ruining the profession."

There were some lone voices of optimism and pride among the respondents though, such as "It is still a very honorable profession that takes a lot of smarts, skills and patience to be truly good at, and it needs to be respected as such," and "America has the best medicine in the world. Leave it to doctors and the patients. You will see wonderful results."

However, it is clear that the vast majority of doctors are unhappy with the current state of the health care industry and they don't have high hopes for the future.

"The level of pessimism among America's physicians is very troubling," Lou Goodman, PhD, president of The Physicians Foundation, said in a statement.

Comment(s)

Your comments are valuable to us. Thank you.

Gerald Grim MD
October 1st, 2012 - 06:46:29 PM

At 62 I'm very busy but winding down as one in the opening cohort described. My satisfaction is great now that I just don't care about the paperwork, politics, and peripheral issues having shifted my focus back fuly onto patient care since my 9th mission trip overseas which totally rejuvenated me toward people. That's what is being left out of the equation. I still have patients that have followed me for over 30 years in priceless relationships that many forces have tried to break and in many instances have. I treasure the ones that remain and will for a few years yet.

Gary Blume MD PhD
October 1st, 2012 - 09:27:46 PM

In our clinic, we are practicing world class medicine, have great rapor with patients, have changed practice styles and we are still getting crushed financially. Any system such as this that has little relationship between true work done and reimbursement is bound to fail. This isn't about life style for us in primary care, this is about whether we can afford to own a home or even have enough money to eat after paying our employees. The US health care system is burdened by tremendous wasteful overhead of people doing no real work such as in the insurance industry and reimbursement among people actually doing real work that doesn't reflect actually work done. Until this is fixed there is no hope of it getting better. This is the most basic reason why there is a dramatic drop off in physician availability.

Frank Ashall
October 2nd, 2012 - 06:43:22 AM

The truth of the matter is that the US medical system is a huge complicated and shameful mess when it comes to the real reason why a medical system should exist- to provide people with the basic right of having access to decent medical care.

First, the 50 million or so uninsured people don't get that level of decent healthcare, unless it puts them into financial debt. Second, market forces dominate medical insurance companies, malpractice insurance companies, hospitals, doctors and patients alike. This leaves doctors with a system in which issues other than patient care can dominate and destroy or prevent three wonderful aspects of Medicine: patient-doctor relationships, compassionate care, and the intellectual beauty of Medicine.

We're hearing that $750,000,000,000 is wasted yearly by the US medical system; that the US spends more per person thn pretty much any country on medical care; that the US nevertheless ranks low amongst developed countries in life expectancy, prevention of heart disease, child mortality, and high in obesity incidence; and that a large proportion of US citizens are having their homes foreclosed partly because of medical bills they cannot afford to pay.

When you go into a doctors lounge in a hospital, you rarely hear enthusiastic and concerned talk about a patient's condition, or about an intellectually interesting disease. What you do hear is doctors discussing the system and how it affects them negatively.

An experienced surgeon in the hospital where I practiced medicine used to discuss the wonders of medicine and diagnosis with me in the doctors lounge. He once said to me, "You and I are among a very small group of doctors in this hospital who've managed to maintain our love of Medicine."

Hippocrates would not be happy, and probably would be an unsuccessful physician, if he practiced in the US system!

Keith
October 2nd, 2012 - 09:39:24 AM

This is an interesting article. However the biggest healthcare change in the near future is Obamacare. Please someone tell me how Obamacare will effect physicians and the physician shortage. Thank you.

Jon Schwartz
October 2nd, 2012 - 11:20:43 AM

All of this Healthcare 'mess' is a direct result of the distortion of the marketplace by the federal government. They distort the marketplace which causes abnormal winners and losers and choices leading to the need for further market distortions by the federal government. The 'consumer' is further isolated from the costs of their care which further distorts supply and demand. This must inevitable lead to a collapse of the system and or major rationing by unelected political appointees. Worst of all, Obamacare/governmental involvement takes the power out of the doctors office away from the patient and doctor and puts it in the hands of non elected political appointees. There are no Silver Men in Washington, D.C. They did this to our educational system years ago and look at the result....disaster and the inuring of the people it is intended to help. They cannot wait until older physicians leave as they have already indoctrinated the younger physicians with the Golden Calf of 'evidence based medicine'. If patents have to wait longer to see a physician what do they care. In the coming two tiered system of healthcare in the US (rich/privileged v the rest of us just like in any socialist country), members of congress will still have the best healthcare the world can offer.

Jon Schwartz
October 2nd, 2012 - 11:32:50 AM

Keith-Obamacare will insure 32 million more people, hire 16,000 new IRS agents to spy on us and not spend one red cent for any additional physicians or nurses, thus, you end up with shortages. It is already very difficult to find a decent primary care physician. It also tells you the motivations of our current administration. Most of the older physicians I know who know what it is like what medical care should be like , are just hanging on by their fingernails. As they continue to transfer power away from the physician under the guise of 'evidence based medicine' to unelected bureaucrats in Washington, DC, more physicians will get frustrated and leave. Also, as more patients transfer to government based care, physicians will find it more and more difficult to stay in business since no one can stay in business at medicare/medicaid rates. When you limit a human being's ability to make 'profit', you create shortages. The USSR et al proved that in the last century. Obama and his minions are hell bent on reinventing the same rusty wheel of Marxism.

John Campell, MD, MBA
October 5th, 2012 - 08:03:27 AM

There are certainly many problems in our system. We can work to change the healthcare in the US. Our current way of each physician doing things/treatments in his/her own unique way is one of the main problems in cost and poor quality. All successful businesses adapt best practices that are developed from other businesses and standardize them in there business plan and process. We must do this in medicine if we are to continue to provide quality at a reasonable cost. Clinical pathways and standard practices must be developed and followed if we are going to survive. This is the path to regaining control of our profession. It can be done, but we must "dance with the changes that are happening", not just complain about them.

dean langdon
October 5th, 2012 - 10:14:10 AM

Keith, me too would like Dr comments on ACA - Jon Schwartz are you an MD? The 16,000 spying IRS comment is not germain nor factual. I see at cernter of this issue is the Insurance industry. It is non-medical (in its staffing); it frankly is a leech on doctor care outcomes. Insurance companies make profits, they (they, not government stand between you and your doctor).

What/why do insurance companies have (logically) an understanding of you, the patient?

ACA is an attempt to increase doctor/patient (coverage) communication. It attempts to lower the rising...a smaller increase, in costs. ACA limits $ in premiums (money we pay in) that insurance companies can scrape off for overhead (not to health care of policy holders), and for salaries (which in effect steal from health care of policy holders).

Insurance companies are paper shifters...unqualified to assess medical issues and a clog in the system...exoensive one at that.

Jon Schwartz
October 5th, 2012 - 11:33:20 AM

I disagree with both of you..You have fallen for the Golden Calf of centralization...ACA's were tried in the late 1990's and were a miserable failure. Patients were unhappy and the truth is, the primaries were not trained to make these types of decisions(primary care training is even worse today).

ACA's are a statist utopian dream and like all of Obamacare, must ultimately fail as it further insulates the consumer, i.e. patient , from the cost and decision making of their care which is the ONLY way there can be any chance of cost containment. Taking the power from the doctor and patient and transferring it to a centralized organization(i.e. central planning) will only further increase costs which will necessitate major rationing as was suggested by Rattner in the NY Times last week. This is not the humane way to do this,especially in a country built upon the principles of championing the individual. Besides, it has already been tried in our educational system and look at the mess the central planners have wreaked upon our kids and our nation. You have fallen for the utopian promises of central planning but if you really critically look at the outcome of this aberant thinking, you will see destruction in it's path. Over 100,000 million human beings died in the last century to prove that it doesn't work. The point about the IRS agents is to demonstrate the sick punitive mentality of the Statist who developed Obamacare, i.e. 16,000 IRS agents/spys with nice government healthcare and pensions while not one red cent for more doctors or nurses. This is the Statist mind. Control of human behavior which always fails. Again, the only slight hope we have to have a cost effective humane system is to empower patients/consumers, not un-elected bureaucrats in Washington, D.C. You have both bought the Leftist narrative that the "Silver Men of Utopia' always know what is best for us and seem so willing to give away the sovereignty of you and your family. This failed philosophy has always lead to disaster....always!

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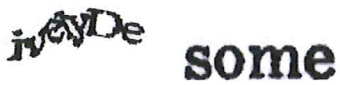

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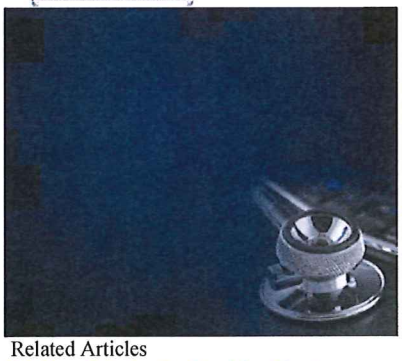

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PRACTICE MANAGEMENT

Nearly Half of Physicians Report Burnout

Laura Joszt

Published: Tuesday, August 21st 2012

Compared to other working adults, physicians are far more likely to be dissatisfied with their work-life balance or have symptoms of burnout, according to a national study in the Archives of Internal Medicine.

Almost half (46%) of U.S. physicians reported burnout symptoms, such as feelings of cynicism or "depersonalization" toward patients. In addition to causing medical errors, the high rate of burnout in the health care industry is one of the leading causes of the physician shortage as doctors leave the industry to find other jobs, according to a survey from November 2011.

In addition to evaluating burnout rates among physicians by specialty, it compared physicians to other employed adults. More than 7,200 physicians answered surveys and a modified version of their questionnaire was compared with a probability-based sample of nearly 3,500 working adults. Physicians were more likely to have symptoms of burnout with 38% of physicians compared to 28% of other working adults.

Individuals with an MD or DO degree had an increased risk for burnout, even compared to people with master's degrees, professional degrees or other doctoral degrees. The highest level of education completed related to burnout.

Physicians at the front line of care access were at the greatest risk of burnout: family medicine, general internal medicine and emergency medicine. Preventive care specialists are among the least affected.

In fact, preventive care specialists, along with those in occupational medicine and environmental medicine, reported being the most satisfied with the time they have for personal or family life. General surgeons are the least satisfied.

Here are the specialties reporting the largest and smallest percentages of burnout:

Most burnout
5. Otolaryngology
49%

4. Family medicine
51%

3. Neurology
52%

2. General internal medicine
55%

1. Emergency medicine
66%

Least burnout
5. Radiation oncology
39%

4. Pathology
38%

3. General pediatrics
36%

2. Dermatology
32%

1. Preventive medicine, occupational medicine or environmental medicine
30%

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PRACTICE MANAGEMENT

Government in Your Patient-Physician Relationship?

Laura Joszt

Published: Wednesday, August 8th 2012

The American College of Physicians (ACP) is concerned about the government's interference in the patient-physician relationship. The organization released a paper today offering a framework for evaluating laws that affect or could affect the patient-physician relationship.

The *Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship* was produced by the ACP's Health and Public Policy with input from ACP's Ethics, Professionalism and Human Rights Committee.

"The physician's first and primary duty is to put the patient first," David L. Bronson, MD, FACP, president of ACP, said in a statement. "To accomplish this duty, physicians and the medical profession have been granted by government a privileged position in society."

However, such principles are necessary as recent laws and proposed legislation seem to "intrude" into the medical profession and affect the relationships between patients and physicians, according to Bronson.

For instance, these laws limit the information a physician can disclose to a patient and yet others require that physicians discuss practices even if the physician doesn't believe they are individualized to the patient.

Another concern is that physicians are being prohibited from asking about risk factors that affect the health of the patient or his/her family.

"Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient, which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient," according to the paper.

The paper outlines seven questions to consider when a new law is proposed to restrict the patient-physician relationship. The first question is whether the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care.

"Laws and regulations should not mandate the content of what physicians may or may not say to patients or mandate the provision or withholding of information or care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are not necessary or appropriate for a particular patient at the time of a patient encounter," according to the paper.

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PRACTICE MANAGEMENT

Poor Financial Health of Primary Care Physicians

Laura Joszt

Published: Wednesday, August 1st 2012

The parts of the Affordable Care Act now set to be implemented over the next few years, the U.S. health system is really going to be relying on its primary care physicians. Unfortunately, a quarter of them are in financial trouble.

According to QuantiaMD's Physician Wellbeing Index, 26% of primary care physicians are reporting being in poor financial health, the main causes of which are financial instability, mounting professional challenges and a dearth of incentives, according to the survey.

"The financial struggles of a number of primary care physicians is disturbing news," Richard Roberts, MD, JD, president of the World Organization of Family Doctors and past president of the American Academy of Family Physicians, said in a statement. "Even more concerning is that health reform depends on having more primary care doctors playing an even more important role in health care, through new models such as the Patient-Centered Medical Home."

Profits are down for 81% of physician practice owners and 43% reported that they are actually having trouble covering their costs, according to the survey.

The financial trouble of these physicians is the result of a perfect storm in a way. The top negative financial impact to their practices is a decrease in reimbursement (80%), but the second most negative impact is a rise in operating costs (71%).

About half (49%) of employed primary care physicians reported not having a salary increase in one to two years, but even more alarming is that 18% have experienced salary cuts.

"If financial challenges dissuade young physicians from entering careers in primary care or cause established primary care physicians to leave their practices, will there be enough primary care doctors for the influx of patients expected to enter the system?" Roberts asked.

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Primary Care Pay Bump

Recession Still Colors Physicians' Reasons for Relocation

Death of the Solo Practitioner Almost Complete

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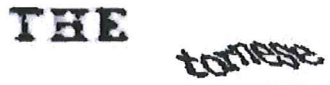

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PRACTICE MANAGEMENT

Recession Still Colors Physicians' Reasons for Relocation

Laura Joszt

Published: Tuesday, July 31st 2012

Email Print

A new trend has emerged for physicians choosing to relocate, according to a study on the top motivators for physician relocation. Changes resulting from the economic downturn are still partially dictating people's lives, the study revealed.

The American Medical Group Association and Ericksson Physician Search released its study on what factors play a role in a doctor's decision to move and the study showed something different.

"For years, we've seen physicians move for reasons that fall within a core group of categories including geographic preference, personal life balance, quality of practice setting, and income," said Rod Arnold, chief executive officer of Ericksson Physician Search, in a statement.

In other years, it made sense that physicians were moving to be closer to family or to a more desirable climate. However, now physicians are looking for places with financial security. More than half (57%) listed income as one of the top factors they consider when looking at new employment opportunities. The change, of course, can be linked to the economic downturn.

"In an uncertain economic climate, physicians are seeking the same thing you or I would: stability," says Arnold.

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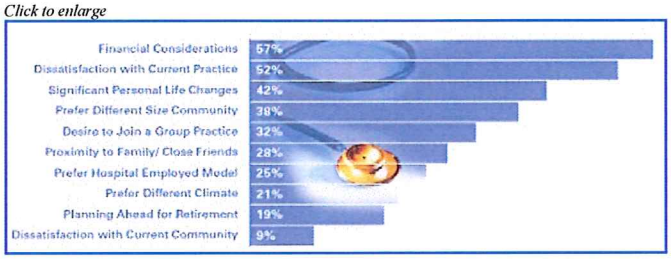

Also connected to the recent recession was another of the top factors. According to the study, 42% moved because of Significant Personal Life Changes. This category includes such changes as spousal job loss, divorce, and personal or family hardship. Many physicians said these situations were results of the recession, according to Arnold.

The economic downturn may have had an unintended good effect though, according to the study. With an uncertain economy and some still trying to pick up the pieces from four years ago, doctors are practicing longer. According to the study, one-third of America's physicians are 55 years old or older, and if they practice longer than expected, they could help out with the country's physician shortage.

"Many physicians we speak with who are nearing retirement age claim they're only still practicing because their retirement plans suffered during the recession," said Arnold. "They intend to embrace retirement once they rebuild their financial reserves."

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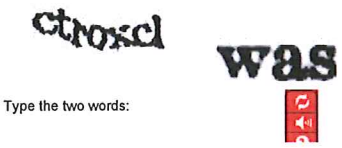

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PRACTICE MANAGEMENT

Death of the Solo Practitioner Almost Complete

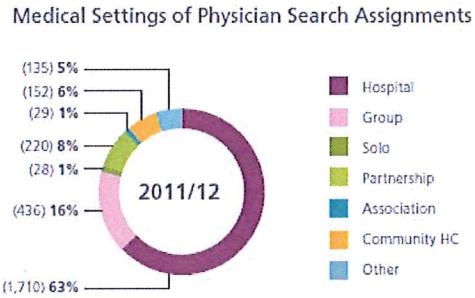
Laura Joszt

Published: Wednesday, July 11th 2012

The demise of the solo physician is official, according to Merritt Hawkins. A new survey revealed that only 1% of recruiting assignments was for solo practitioners.

The physician search and consulting firm tracked 2,710 physician recruiting assignments from April 1, 2011 to March 23, 2012. The small percentage of searches for solo physicians is a huge drop from less than a decade ago. In 2004, 22% of recruiting assignments were for solo practitioners.

"Nobody wants to be Marcus Welby anymore, practicing alone or with a partner, and fewer hospitals are seeking solo doctors for their communities," James Merritt, founder of Merritt Hawkins, said in a statement. "To incorporate required technology, comply with regulations and participate in new delivery models like Accountable Care Organizations, physicians today almost have to be part of larger practices or be employed by hospitals."



While employment of solo practitioners died a quick death since 2004, hospital employed physicians saw rapid growth during that time. The survey showed that 63% of assignments featured hospital employment of the physician, compared to only 11% in 2004. Merritt is forecasting that more than 75% of newly hired physicians will be hospital employees by 2014.

"The tide is turning, but increasing the volume of services they provide remains the most practical way for physicians to increase their incomes," Merritt observes.

And the most requested physicians were primary care, according to the survey. Family physicians and general internists were the two most requested physician search assignments by hospitals, medical groups and other health care organizations.

Demand for both radiologists and anesthesiologists decreased, however. This is a sharp drop for anesthesiology. In 2003, the specialty was among the top four most searched for and yet in the most recent survey, radiology wasn't even in the top 20.

According to Merritt Hawkins, there was only a slight increase in the number of recruiting assignment compared to the previous year. After the Affordable Care Act was made law in 2010, physician recruitment slowed as hospitals and other facilities evaluated the implications of health care reform.

"With the Supreme Court's recent decision on health care reform, the trajectory of the health care system seems clear," according to the review. "Physicians and hospitals are moving toward integrated models featuring care coordination and pay-for-performance. This market clarity should create forward momentum for a wide range of health facility initiatives, including physician recruitment, which can be a key part of the integration process."

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PRACTICE MANAGEMENT

Medicaid Audits Cost Far More than Discovered Fraud

Laura Joszt

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Although the Medicaid Integrity Group (MIG) was created to fight fraud in the health system, it may have been the biggest fraud of all. Over the past five years, MIG has spent at least $102 million while only finding $20 million in overpayments, according to investigators.

The Government Accountability Office (GAO) released a report on the program and found that part of the problem was that the database used. The Medicaid Statistical Information System (MSIS) is an extract of states' claims that misses key elements necessary for auditing.

"Since fiscal year 2008, 4% of the 1,550 MSIS audits identified $7.4 million in potential overpayments, 69% did not identify overpayments, and the remaining 27% were ongoing," according to the GAO report.

In comparison, test audits using the states' more robust Medicaid Management information System data identified more than $12 million in potential overpayments.

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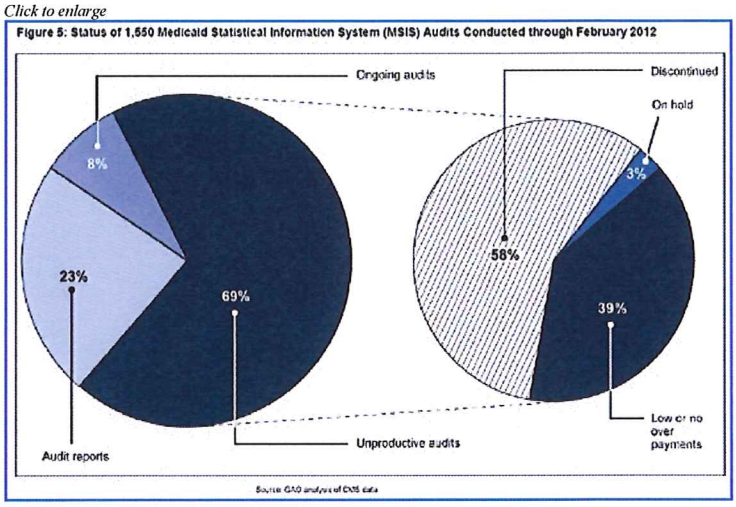

More than two-thirds (69%) of the audits assigned through contractors were discontinued, had "low or no findings" or were "put on hold."

Until 2005, Medicaid program integrity had been a state responsibility, primarily. However, the Deficit Reduction Act of 2005 made the Centers for Medicare & Medicaid Services responsible for oversight.

The Medicaid program consists of 56 distinct state-based programs. The sheer size and diversity makes the program vulnerable to improper payments. As a result, GAO has had the Medicaid program on its list of high-risk programs since 2003.

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$5.6 Billion in Suspicious Medicare Billing

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