January 2006

MEMORANDUM

TO: Participating Practitioners

FROM: Jim Walsh, Vice President
Provider Services

SUBJECT: Retrospective coding reviews for office visits

HMSA will be conducting retrospective coding reviews of 2004-2005 claims for established-patient office visits. The ongoing reviews are intended to identify providers whose billing patterns fall outside the norm for their specialty and peer group, and whose claims do not support the higher levels of coding when factoring in key characteristics such as age, gender and morbidity.

If a sample of your claims is selected for coding review, the review will be conducted by Certified Professional Coders. Those practitioners identified for follow-up are asked to provide supporting documentation for their claims. Retrospective reviews for primary care specialties are done using the 1995 CPT coding and documentation guidelines, which HMSA believes are easier to use. Reviews for other specialties are completed using the applicable 1997 single-system guidelines. If the documentation reviewed does not support the level of care billed, overpayment refunds may be requested by HMSA.

Enclosed is a personalized Physician Visit Procedure Progress Report for your review. This annual report analyzes your billing pattern for established-patient office visits and lets you know how your billing patterns compare with those of your peers.

- For purposes of this report, your peer group is determined by your specialty. If you practice at multiple locations, the report applies to all of your locations. This year, data from July 1, 2004 through June 30, 2005 is compared against corresponding data from 2002, the program’s base year. If you were not a participating practitioner in 2002 or if your patient volume that year was small, the base-year graph may be blank.

- The graphs show the relative distribution of established-patient office visit codes (99211 through 99215) for your patients in HMSA’s fee-for-service plans (i.e., Preferred Provider Plan, Federal Plan 87 and the EUTF Plan). The report also provides information on your patient mix when compared with your peers. Patient mix refers to the distribution of patients by age, gender and morbidity. Morbidity is defined and based on the ACG (adjusted clinical groups) Case Mix System developed by Johns Hopkins University.

- This report includes a cost summary which shows the average cost per established-patient office visit for your patients and those of your peers. The dollar amounts are based on what you would have been paid under the Medicare fee schedule. The Medicare schedule was selected for this comparison because it is a recognized standard that reflects the relative value for each type of visit. See the back of this report for information specific to the report and for analysis methodology.

HMSA appreciates your continued support and welcomes your comments regarding the enclosed report. If you have further questions about this report, please contact your Provider Services Field Representative or Coordinator directly. For assistance in contacting the Field staff, call 948-5190 on Oahu or 1 (800) 790-4672 from the Neighbor Islands.