

PHYSICIAN PRACTICE OPTIONS™

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February 15, 2001

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Billing Inquiries by Private Payers Are Rising

For years, the federal government has been investigating physicians and other providers who deliver care to Medicare and Medicaid beneficiaries. Seeking to prevent fraud and abuse, the government has collected \$23 for every dollar it spends on these investigations.

In recent years, private payers have been doing their own investigations and have demanded repayment from physicians and other providers when they find a failure to comply with their rules and regulations. Having private insurers investigate and demand such repayments—called reimbursement adjustments—is a trend that will increase in the coming years, experts say.

"In today's environment, an HMO which doesn't perform some fraud investigation is rare," says Kirk Nahra, a health care attorney and partner with Wiley, Rein & Fielding, a law firm in Washington, D.C. Random audits are uncommon, however.

John McDaniel, a compliance expert who is president and CEO of Physician Management Group Inc., practice management advisers in New Orleans, says it is still unusual in the private sector for HMOs to investigate physicians randomly for possible billing errors, and then litigate to recover any losses. "But it may become more common as HMOs realize there's money to be made," he says. "Managed care organizations have been losing money for the last

few years. They can look at the fed's recovery rate and begin examining practice patterns more carefully, hoping to enhance their revenues."

About half of all states require HMOs to report fraud by physicians and other providers to the state agency that licenses health care insurers, and many of these states require HMOs to investigate the billing practices of physicians and other providers, Nahra says. "Those states that don't require fraud investigations soon will. HMOs have many reasons for conducting these audits, and those that don't conduct such investigations really aren't meeting their public responsibilities," he says. Nahra has written extensively about health care compliance issues.

Seeking Legal Protection

New Jersey and New York have the most detailed laws, requiring all licensed health care insurers to create special investigation units or hire fraud investigators, Nahra says.

Many HMOs conduct investigations to protect themselves from legal action by the federal government, state authorities, and their own customers, explains Leslie Moran, senior vice president of the New York Association of Health Plans, in Albany. "HMOs are increasingly being held accountable for the billing errors of their providers," Moran says.

Last fall, Univera Healthcare, an HMO in Buffalo, examined the records of physicians in western New

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Conference Shows Physicians' Role in E-Health

Over the past several months, we have introduced readers to developers of new technologies. In many cases, these physician-entrepreneurs have developed practical solutions to complex practice problems.

While we have done a number of articles and interviews with these entrepreneurs, we believe it is also useful for readers to meet these inventive and innovative entrepreneurs face to face. We believe evaluating the worth of new technologies is still best done through human interaction.

Therefore, we have helped to organize a conference titled, "The High Performance Physician: Technological Solutions To Ensure Compliance, Productivity, and Profitability," to introduce interested readers to physicians who have created new technological applications to help physicians practice more effectively and efficiently.

We have invited a number of physician-entrepreneurs to participate in the conference in April that will show off these applications. We believe physicians in practice will listen closely to physicians who have years of experience working in medical groups, hospitals, and clinics and who have developed useful applications to solve the problems physicians face every day.

The conference will address how physicians can automate workflow to make their practices more profitable, avoid external intrusions, increase patient satisfaction, and make practice more enjoyable again. It will be held April 20 to 21 at the Broyhill Inn & Conference Center in Boone, N.C.

We have found that entrepreneurial physicians share four characteristics. They have a desire to find practical solutions, know how doctors think, recognize what physicians need and want to succeed, and can raise capital to form a company. Each of these physicians also has what some experts describe as the soul of an entrepreneur, meaning a person who establishes and secures financing for new commercial enterprises.

Kent Bottles, MD, president of Genomics Repository, a company in Cambridge, Mass., that collects genetic information on material from biopsies, has described the characteristics of the new physician entrepreneur in an article, "The Ideal Physician Entrepreneur" in the November/December issue of *The Physician Executive*. Venture capitalists consider an ideal physician entrepreneur to be an expert in a field Wall Street investors consider to be trendy or hot, a public speaker who can communicate scientific and business plans enthusiastically to a variety of audiences, a team leader willing to share equity in the company with others, a recruiter, a motivator, an achiever who can help accomplish quickly the tasks needed to take a company public, and a realist who does not resent the terms of a typical deal.

For more information on this conference, readers may call or send me an e-mail. To register for the conference April 20 to 21, please call the Appalachian State University Conference Center at 828/262-3045.



Richard L. Reece, MD
Editor-in-Chief

Toll-free phone: 888/457-8800

E-mail: reece@premierhealthcare.com

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Publisher

Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054
888/457-8800
Fax: 973/316-5989
publisher@premierhealthcare.com

Neil Baum, MD

Urologist
New Orleans

Daniel Beckham

President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD

President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA

Executive Vice President,
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD

Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman

President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley

President and CEO
webEBM
Nashville, Tenn.

Peter R. Kongstvedt, MD

Partner
Ernst & Young
Washington

Richard Lilledahl, MD

Health Care Consultant
Milliman & Robertson Inc.
Seattle

Lee Newcomer, MD

Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

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Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD

Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

Jacque Sokolov, MD

Chairman
Sokolov Schwab Bennett
Los Angeles

W.L. Douglas Townsend Jr.

Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

Compliance Means Audits, Monitoring

By John W. McDaniel

When preparing its final compliance guidelines for physician practices recently, the Office of Inspector General (OIG) organized them in a step-by-step format, outlining the seven elements of a compliance program. In effect, the OIG recommended a roadmap for physicians seeking to implement a compliance program.

Unlike guidance issued by other organizations, the OIG of the federal Department of Health and Human Services said in its Final Physician Practice Guidance that it recognizes that most physician practices may not have the resources to implement all elements of a compliance program. Therefore, the OIG set priorities for the steps physician practices should follow when creating an effective compliance program. (Readers can find the guidance, *Compliance Program Guidance for Individual and Small Group Physician Practices*, at www.hhs.gov/oig/new.html).

Quality Control

Developing and implementing an effective compliance program begins with auditing and ongoing monitoring under a coding compliance program. The process of auditing and monitoring includes regular evaluations to determine whether the practice's standards and procedures are current and accurate and that the individuals responsible for discharging coding and compliance duties are

doing so accurately, thereby ensuring proper claims submissions. Each practice should adopt policies and procedures to ensure that it is complying with current reimbursement and billing processes and with all changes in CPT-4 codes and government regulations.

The OIG recognizes that it may be difficult for a physician practice with a single person supervising billing and coding to perform effective ongoing review. While some physicians have an understanding of basic coding principles, many do not have the detailed knowledge needed

perform a baseline audit for benchmarking to help the practice evaluate the progress it makes in reducing or eliminating potential areas of vulnerability.

The practice can use a self-audit to determine if bills are coded accurately and reflect the services provided, whether services or items provided are reasonable and necessary, and whether medical records contain sufficient documentation to support the charges. A self-audit also can determine whether any incentives for unnecessary services exist.

During the audit, physicians

The OIG suggests that physicians use outside reviewers to do baseline audits and an annual review, saying outside consultants bring a fresh perspective to auditing and monitoring.

to evaluate the accuracy of the specialized codes assigned to each procedure. Similarly, it may be difficult for a physician in a small practice to evaluate properly whether documentation of the professional care meets all payers' standards. For this reason, the OIG suggests that physicians use outside reviewers to do baseline audits and an annual review, saying outside consultants bring a fresh perspective to auditing and monitoring.

In addition to developing and implementing policies and procedures for coding and billing, physicians also should ensure that patients' bills and medical records are reviewed for compliance with applicable coding, billing, and documentation requirements. The OIG recommends that physicians

should establish a consistent methodology for selecting and examining records and develop the audit methodology to be used in the future. The audits should be conducted on claims submitted in the first three months after the practice has completed an education and training program on compliance issues. Using the first three months' of data will allow the group to establish a benchmark against which to measure future compliance effectiveness.

Following the baseline audit, the OIG recommends that physicians conduct audits at least once each year to ensure that the compliance program is being followed. Although there is no set formula as to how many medical records should be reviewed, the OIG recommends a basic guide of two to

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John W. McDaniel is the president and CEO of Physician Management Group Inc., physician practice improvement advisers, in New Orleans. Readers may contact McDaniel by phone at 800/764-2633 or by e-mail at pmg-code@eatel.net. More information on practice management is available on our Web site (see page 16).

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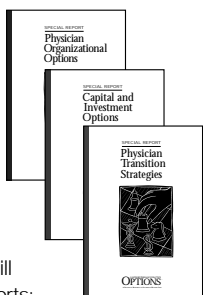
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Table 1: Family Practice E&M Coding Distribution
(CPT-4 Codes and Distribution Percentage)

New Patient Visits	
99201.....	7%
99202.....	29
99203.....	37
99204.....	19
99205.....	8
Established Patient Visits	
99211.....	4%
99212.....	19
99213.....	58
99214.....	15
99215.....	4
Consultations	
99241.....	7%
99242.....	18
99243.....	38
99244.....	26
99245.....	11
Hospital Visits	
99231.....	11%
99232.....	31
99233.....	58
Hospital Admissions	
99221.....	37%
99222.....	49
99223.....	14

Source: Health Care Financing Administration, Bethesda, Md., 2000.

five medical records per payer or five to 10 medical records per physician. Of course, physicians will have greater confidence in results from larger sample sizes.

If an audit uncovers problems, the group should conduct a focused review more frequently. When audit results reveal areas needing additional attention or reflecting the need for education of employees and physicians, these areas should be incorporated into the practice's training and education program.

Periodic audits should include the following:

- A valid sample of the practice's top-10 denials or the practice's top-10 services provided
- Confirmation that the practice has been using specific codes and not codes that are too general for payers' purposes
- A check for data-entry errors
- Confirmation that all orders are written and signed by a physician

- A check for reasonable and necessary services performed
- Confirmation that all tests ordered by physicians were actually performed and documented and bills were submitted only for those tests
- Review of assignment codes and modifiers to claims.

Taking Action

One of the most important elements of a successful compliance program is taking appropriate action when the practice identifies a problem in its internal audit. The action should be taken as soon as possible, but it is recommended that the action be taken within 60 days of the date the problem is identified. In some cases, the action can be as simple as generating a repayment to Medicare or the appropriate payer. In other cases, the practice may want to seek legal advice or consult with a coding and billing expert to determine the best course of action.

After a practice has conducted a baseline audit and corrected any deficiencies, it should establish an ongoing coding compliance program. Such a program would include the following components:

- An analysis of evaluation and management (E&M) coding for each physician and a comparison with

the federal Health Care Financing Administration's (HCFA) audit standards. This comparison will help physicians determine areas of potential undercoding and overcoding. Areas of undercoding indicate a reimbursement opportunity and any areas of overcoding indicate a potential liability for a practice.

- Quarterly reporting of E&M coding for each physician
- Chart audits for each physician
- Individual educational sessions with each physician to review the outcome of the coding assessment and to establish a framework to ensure that compliance requirements will be satisfied.

In addition to chart audits and physician education, each practice should profile each physician's utilization patterns of major E&M codes against HCFA's actual usage distribution. HCFA, which manages Medicare and Medicaid, has this information available by medical specialty and it may be obtained under the Freedom of Information Act. Or physicians may ask physician practice improvement advisers for this information. (See Table 1: Family Practice E&M Coding Distribution.)

Each practice should profile its utilization against the appropriate standards to determine the potential for

overcoding or undercoding. Upon review of this baseline information, physicians can use chart audits to determine whether they are overcoding or undercoding and to ensure the appropriate use of documentation and medical necessity to substantiate procedural coding. Table 2 shows utilization patterns for established office visits for two physicians in the same practice and the benchmark or target frequency for each physician.

While both physicians in Table 2 have approximately the same patient volume, Physician A is overcoding by approximately \$17,154 per year, and Physician B is undercoding by approximately \$8,669 per year on established office visits alone. A chart audit showed Physician A consistently failed to substantiate the need for higher levels of service, and Physician B had better documentation and proof of medical necessity but used lower-level codes.

Most physicians are like Physician B in that they have a tendency to undercode. Therefore, a coding compliance program can lead to increased reimbursement for most physicians. A program also can help those physicians who tend to overcode by setting a framework within which their coding proficiency can improve. ■

Table 2: Utilization Patterns for Two Physicians

CPT Code	Charge	Actual Frequency		Percentage Distribution		HCFA Standard	Benchmark Frequency	
		PHYSICIAN A	PHYSICIAN B	PHYSICIAN A	PHYSICIAN B		PHYSICIAN A	PHYSICIAN B
99211	\$22	16	105	0.5%	7.6%	4%	126	55
99212	38	319	312	10.2	22.7	19	596	261
99213	56	1,748	891	55.7	64.9	58	1,820	796
99214	84	968	64	30.8	4.7	15	471	206
99215	122	87	1	2.8	0.1	4	126	55

Source: Health Care Financing Administration, Bethesda, Md., 2000, and Physician Management Group Inc., New Orleans.
Note: Benchmark frequency is the goal frequency for each physician.

Lessons Learned From the Recent Past

By Thomas M. Gorey, JD

Over the two years that this column has appeared, the practice of medicine has changed considerably in many respects. We have seen five significant trends and at least 20 important lessons that could be called the enduring principles that have allowed physicians to adapt and succeed despite a turbulent practice environment. The five significant trends are:

1. The rise and fall of capitation. Perhaps the most significant change in the physician practice environment has been the realization that capitation may not be the solution to the problems the health care system faces. Throughout most of the 1990s, the mantra of managed care executives was that capitation was coming, fee-for-service medicine was dying, and physicians should prepare to practice in a system that offered radically different financial incentives. The theory was that the financial risk of delivering care would be shifted from payers to providers, who would be motivated to implement cost-effective practice patterns.

Although capitation made serious inroads among some specialties and in some markets, it never arrived in many parts of the country and failed in others. With the addition of safeguards to ensure cost-effectiveness and quality, fee-for-service medicine is making a return.

2. The failure of physician practice management companies. It was just over three years ago that large practice management companies

Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development. More information on organizational options is available on our Web site (see page 16).

were being touted as the latest strategy for solving what ailed the medical services sector of the health care market. It was difficult to counter many of the arguments being made in favor of PPMCs. Now, however, reversing the trend of the latter half of the 1990s, physician groups are negotiating with PPMCs to reacquire their practices.

3. The illusion that bigger is always better. Another widely held view was that the solo practitioner and the small-group practice was a vestige of the past. Part of the rationale for the trend toward larger group practices was that costs can be brought under control more effectively in a larger organization, and that large groups can negotiate favorable contracts. While in some cases

Once again, physicians are considering a solo or small-group practice as feasible.

these arguments may be true, larger entities often carried more extensive administrative structures that, in fact, resulted in higher overhead that was not offset by increased patient care revenue. As this realization has sunk in, physicians are once again considering a solo or small-group practice as a feasible option, particularly physicians in high-demand specialties.

4. The overselling of PHOs. Although the concept of the physician-hospital organization has considerable appeal, in practice it has proven more difficult to implement and sustain than many expected. Differences between primary care physicians and specialists and an inability to forge a common agenda between physicians and their hospital partners have thwarted the success of many PHOs. Nevertheless,

PHOs may yet serve a useful function in smaller communities where the physicians and the hospital can foster a collaborative approach.

5. The notion of the provider as payer. As the idea of physician-hospital integration has hit choppy waters, so too has the concept of vertical integration, involving systems of hospitals, health plans, and physician groups under common ownership and control. Many health systems that five years ago were in a bidding war for physician practices and were spending millions to launch or acquire their own HMOs are now spinning off those health plans and selling the practices back to physicians. These changes represent yet another step back to a more tradi-

tional health care market, which recognizes the unique and distinct roles and expertise of physicians, hospitals, and payers.

In addition to these five significant trends in the market, we have learned the following lessons through experience:

Know your market and tailor your strategy accordingly. The market for medical services always has been and always will be local. Therefore, practice development strategies must fit the unique characteristics of each market. Since there is no one-size-fits-all strategy, it can be dangerous to import a model from another market and expect it to succeed locally.

Respect key players in the local health care market. Before implementing a practice development initiative, physicians should consider

Perhaps the most significant lesson is that there is no one answer or right strategy for all physicians in all cases.

carefully the effect it will have, and the possible wrath of other, well heeled, competitive-minded health care organizations it could foster.

Find physician partners with similar goals, styles, and interests. Developing a practice strategy that involves physicians whose professional or personal styles are very different is doomed to fail.

Build a base of physician support for change. To get physicians to change, it is essential to identify and cultivate physician leaders willing to serve as champions throughout the process. Without strong physician leadership, it is difficult to generate the momentum needed to implement and follow through on any practice development initiative.

Get expert advice. Regardless of the organizational or practice development strategy you may be considering, it is almost inevitable that physicians will need consultants to assist them. It is important to have expert, objective advice from consultants who can transform the physicians' vision into a business plan.

Remember that forming a physician organization is just the first step in a long process. Whether physicians are forming a medical group, an IPA, or some other organization, the process of forming the entity is just the first step. The real work begins once the legal entity is created. Unless there is an ongoing commitment and a focus on long-term goals, disillusionment may set in.

Address operational issues first. Before implementing market enhancement initiatives, physicians should ensure that they have attended to any fundamental operational issues in their practices.

Keep support staff involved. Although physicians need to play the central role in the planning process,

it is important to keep employees informed and involved. Doing so helps to break down fear and distrust. It is best if office staff hear firsthand about possible changes.

Confront compensation issues directly. Whether physicians are forming a group practice, an IPA, or a specialty network, sooner or later physician compensation emerges as the make or break issue. It's best to confront this issue directly and as early as possible.

Remember that physicians will not be free from decisionmaking responsibilities after forming a physician organization. Contrary to popular belief, a physician organization increases the need for physician involvement in issues involving contracting, information systems, and quality management.

Don't overlook the importance of communication. Ongoing communication between the leadership of a physician organization and the group's members is critical.

Address issues involving group culture ongoingly. A new physician organization must develop a sense of team so that all physicians begin to think first about what's best for the group rather than acting as individual practitioners.

Recognize that ignoring threats and early warning signs of trouble usually leads to greater—and often insurmountable—challenges later. As tempting as it may be to avoid tackling the difficult issues an organization faces, over time such issues become even harder to resolve.

Know your mission. Without a strong, commonly shared sense of mission, groups may be tempted to pursue strategies that are inconsistent with their central purpose.

Allow adequate time for the gradual implementation of a physician

development strategy. There is a danger in implementing too much change too quickly. It is important to allow adequate time to ensure a smooth, comfortable transition.

Recognize that forming a physician organization does not allow physicians to reduce their workload. If anything, physician productivity must rise to compensate for the increased overhead and declining payment levels from health plans.

Commit capital willingly. Implementing a new organization or strategy is costly, and therefore physicians must be willing to make a meaningful financial commitment to it.

Remember that having a capital partner can be a double-edged sword. A capital partner can provide the funds needed to start a new physician organization, but it can lead to a loss of physician control. Also, a cash windfall can create a false sense of security and perpetuate the sense that there is no need for fundamental change.

Keep in mind that facing tough decisions can make a group stronger. Although most physician organizations have to face a number of difficult decisions—particularly in the early stages—facing such issues and surviving them often makes a group stronger and better prepared for the tougher challenges that lie ahead.

Be willing to change. Physicians cannot adapt successfully to a changing environment if unwilling to make fundamental changes.

Perhaps the most significant lesson is that there is no one answer or right strategy for all physicians in all cases. Each physician must make his or her own decision about the best practice option for his or her individual market situation and career goals. ■

(Continued from page 1)

York. Although it did not allege that any fraudulent behavior was involved, its examination led to a request for repayment of \$40,000 from one physician and \$100,000 from a second physician. Contesting the HMO's findings, the physicians asked that their names not be used.

Univera has been examining the billing practices of its physicians and other providers randomly for the past four years, Univera officials say. As a result of these examinations, it has sought reimbursement adjustments from hundreds of physicians and other providers, the officials say. "We are required by state law to conduct these investigations," explains Ronald White, director of Univera's special investigation unit. "It is part

of our responsibility under our state insurance license to protect our customer's premium dollars."

Investigations Required

Payments to physicians and other providers are generally set by all payers under the AMA's *Physicians' Current Procedural Terminology*, fourth edition, known as CPT-4 codes. Physicians are reimbursed by payers based on the diagnostic codes they list on their bills, and in private-payer contracts, specific codes are tied to negotiated rates. For Medicaid and Medicare patients, the federal Health Care Financing Administration sets billing rates.

A physician can be accused of upcoding if he or she submits a reim-

bursement code that reflects a more expensive service than was provided. If an investigation by a private payer or the federal Department of Health and Human Services Office of Inspector General determines that a purposeful pattern of upcoding has occurred, a physician or other provider can be charged with fraud and face criminal fines and possible imprisonment. There is no allegation of fraud if upcoding results only from error, but a provider still faces civil penalties, including fines for noncompliance with proper reimbursement procedures. The OIG and private payers also demand repayment.

In New York, insurers are required

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Audits Meant Trouble for N.Y. Physicians

For a physician in western New York, trouble started with a phone call from one of his HMOs, Univera Healthcare, in Buffalo. "They called a week or so before they came and said they'd picked me at random," says the physician who asked not to be named. "They said they were going to examine a number of patient charts, and they sent a list of the patients whose charts they were going to examine."

"I had no notice," the physician explains. "A doctor I know was hired by the HMO to come to my office to look at my x-rays to see if I had been diagnosing correctly and found nothing wrong. But he did find something wrong with my billing codes, and the HMO wanted me to pay \$40,000. I've hired a lawyer."

Univera did not say nor imply that the physician committed fraud. It simply demanded repayment through what it calls a reimbursement adjustment.

Univera was formed in December 1998 as the result of a merger of two HMOs, HealthCarePlan in Buffalo and PHP in Syracuse. It has about 225,000 covered lives in western and southwestern New York, 125,000 covered lives in central New York, and more than 22,000 covered lives in Jamestown, Olean, and Corning, N.Y. Univera has about 8,000 participating physicians.

A second physician providing care to Univera patients also was subjected to a review of patient charts. In this case, nurse practitioners examined charts in the

physician's office and determined that a percentage of the physician's coding had been in error. The NPs then extrapolated that percentage of errors to the number of Univera patients the physician has served, and determined that the physician owed Univera about \$100,000. It never said the physician committed fraud.

Again, the physician asked that his name not be used while he contests the findings. The second physician has hired an attorney and private auditors to examine all charts of Univera patients in his office. "The effort to fight this will cost me \$25,000 or more for an auditor, and \$10,000 or more for my attorney," the second physician says.

Univera's investigation unit randomly examines the records of about 100 physicians and other providers in Buffalo and about 50 physicians and other providers in Syracuse to determine whether recoverable billing errors have occurred, either fraudulently or inadvertently, says Ronald White, director of Univera's special investigation unit.

"Only a small percentage of providers commit fraud, nationally less than 2%, but we find a lot of errors, and it's our job to recover this money," White says.

White declined to say how much Univera collects in reimbursement adjustments or how many of its physicians and other providers are charged with adjustments, fines, or fraud. But "it's enough to make the effort worthwhile," he says. —MS

(Continued from page 8)

to create special investigation units to examine providers for fraud or overpayment periodically, says Terry Marchon, a spokeswoman for the New York State Insurance Department's Fraud Bureau. "Health insurers submit a plan to us for investigating fraud cases, and once we approve the plan, the HMO can conduct its investigations as it sees fit, as long as their procedures are laid out in the plan," Marchon says. "The investigation plans are confidential, and can't be examined by the public."

Univera examines physician records randomly, although a perceived overuse of a particular code or an anonymous call to its fraud hot line can trigger an investigation of a particular provider, Univera officials say.

Most HMO investigations of fraud or billing code noncompliance are not random, but are triggered by some form of physician profiling, says Nathan Kaufman, senior vice president of health care strategy in San Diego for Superior Consultant Co. Inc., physician and hospital consultants in Southfield, Mich. "An HMO may see a billing pattern it discerns as inappropriate, or it may see that a physician is performing too many procedures that fall outside of its established norms, such as too many C-sections in a given population."

Recovery and Deterrence

HMOs have many reasons to conduct investigations. Two of the chief reasons are to recover funds and to encourage compliance, says Nahra. When considering whether to investigate a physician for fraud or non-compliance, an HMO will first want to know the possibility of recovering any money, he explains. "They ask how much money is at stake, and whose money it is—the insurer's, a patient's, or a self-insured customer's," he says.

Deterrence is another reason

Steps Help Shield Physicians From Audits

Many HMOs investigate physicians and other providers to determine whether they are coding and billing accurately. To make sure the HMO's audit is accurate, a physician usually would need to hire an auditor to examine all the medical charts of the HMO's patients—not just those that the payer examined. The cost can be \$25,000 or more, says John McDaniel, President and CEO of Physician Management Group Inc., practice management advisers in New Orleans. "Once an HMO has completed an audit and a physician has been hit by an adjustment or fine, he or she has only two options: fight or pay," he says.

Since fighting an audit is expensive, physicians should know the compliance standards each payer uses. "Physicians should contact a payer and get as much benchmark profiling information as possible, such as how many of a specific procedure is considered a norm within a specific population," McDaniel says. A physician also can call three or four major payers, such as Aetna or United Healthcare, to determine their profiling standards, he says. Also, the federal Health Care Financing Administration publishes standards for specific billing codes.

It is also critical to keep accurate internal medical records, McDaniel says. "Staff has to be educated carefully about correct billing practices, and has to be familiar with the billing standards for specific procedures set by individual payers," he says. "The most important element is maintaining extensive, complete, and accurate records. What gets most doctors in trouble is keeping incomplete or sloppy records." Management consultants and medical record software can help a practice maintain accurate records, McDaniel says.

Another way physicians can protect themselves is to adopt a compliance audit and monitoring program, as explained in the *Compliance Program Guidance for Individual and Small Group Physician Practices*, published by the Office of Inspector General of the federal Department of Health and Human Services (www.hhs.gov/oig/new.html). —MS

HMOs will investigate. "They ask themselves whether a fraud investigation will lead to a high-profile case, and whether it is one likely to send a message to the provider community about a particular type of behavior or their company's position on fraud," Nahra explains.

Anti-fraud measures also are increasingly important to educated customers, Nahra says. Therefore, investigations make sense from a customer-service and marketing perspective, he adds.

HMOs also believe they have a civic and legal duty to protect their assets. Given the public nature of the

health care system, and the magnitude of losses that could result from fraud, many HMOs consider participation in fraud-fighting activities to be a public duty, Nahra says.

Another question HMOs ask themselves is how a case may fit into an overall claims handling program, and whether investigating a specific billing practice, such as the use of a specific code, can provide information useful in instructing or investigating other physicians.

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is available on our Web site (see page 16).

Building Physician and Patient Referrals

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

At one time, building a referral base was relatively easy. It was a personal process that involved being available, accessible, and amiable. Managed care has changed the process, however. To build and maintain referrals today, a physician still must be available, accessible, and amiable, but he or she must also be board-certified, be in the health plan referral panel, and have a physician profile demonstrating cost-consciousness.

Being selected or rejected for the referral panel may be based on inaccessible physician comparison data, such as cost per patient, average number of procedures and tests ordered, referral rate, average length of stay of patients, adherence to the requirements of the Health Plan Employer Data and Information Set, and patient satisfaction.

Cogs in the Machinery

In the eyes of patients and peers, being a so-called good doctor may no longer be enough to attract referrals. In the mid-1980s, Richard Frey, MD, a Minneapolis internist, commented on managed care growth in the Twin Cities, "It doesn't matter anymore if you are a good doctor. In fact, good doctors may be punished for being thorough and meticulous." Shortly after making that statement, Frey left practice in frustration, and accepted a management position.

Three years ago, *Harper's* magazine published an article critical of managed care, "The Doctor Is Not In: On the Managed Failure of Managed Care," by Ronald Glasser, MD, another Minneapolis physician. Glasser wrote that under managed care, physicians are merely interchangeable cogs in the managed care machinery.

While such attitudes may be com-

mon, there are, nevertheless, several techniques physicians can use to attract more referrals. Neil Baum, MD, a urologist in New Orleans, who writes a column on marketing for *Practice Options*, believes physicians need to focus on pleasing referring doctors. To obtain and maintain physician referrals, he says, takes patience, persistence, politeness, and prompt reporting. The main strategy for getting physician referrals is to have your name cross the minds of referring physicians and their staff frequently, and in a positive fashion.

In his book, *Marketing Your Clinical Practice: Ethically, Effectively, Economically*, 2nd ed. (Gaithersburg, Md.: Aspen Publishers, 2000), Baum

(particularly those for antibiotics) whenever possible, and keep tests and procedures at a minimum.

Exceeding Expectations

In her book, *Managing Practice Expectations: The Art of Finding and Keeping Loyal Patients* (San Francisco: Jossey-Bass Publishers, 1998), Susan Keane Baker, a practice consultant in New Canaan, Conn., says physicians can build referrals by exceeding patients' expectations. A pleased patient is likely to tell 12 other people, usually in the first 14 days after a physician visit, she says. Communicating with each patient during those two weeks increases the odds that he or she will tell others

When physicians build relationships with referral staffs in hospitals and HMOs and keep the staff of referring physicians happy, they can make staff and patients into a virtual sales team.

lists 25 ways to cultivate and keep an active referral base. He advises personally meeting every physician who refers a patient to you, showing interest in the referring physician's staff and family, keeping referring physicians abreast of changes in your specialty, and inviting them to support groups or seminars. He also suggests starting a journal club network, sending birthday cards, and keeping in touch with physicians who have moved.

To increase referrals from managed health plans, Baum suggests physicians review their managed care profile and find out how they compare with colleagues. He also says physicians should reduce prescription costs

about you, Baker adds. The best way to build patient referrals is to show what differentiates your practice from others, she says.

What's more, Baker agrees with Baum when she says physicians should build relationships with referral staffs in hospitals and HMOs and should keep the office staff happy by rewarding them often so the goodwill spreads. In doing so, physicians can make staff and patients into a virtual sales team, she says. Baker also recommends that physicians acknowledge all referrals.

To dispel the notion that you might skimp on the care of managed care patients to benefit your own income, Baker recommends being

A pleased patient is likely to tell 12 other people, usually in the first 14 days after a physician visit.

frank about financial conflicts relating to managed care. A physician in Colorado, for example, has posted a pledge on his office wall outlining what he will and will not do for each patient regardless of the patient's source of financing, she explains. The pledge also states, "I participate in managed care plans because many people have no other access to medical insurance. Whatever form your health coverage takes, I intend to deal honorably with you, your insurance company, and everyone else in the system."

The Best Physicians

Another way to build patient referrals is to be listed in the series of books titled, *How To Find the Best Doctors*. This series lists about 10% of physicians who are among the best in a given community and provides detailed information, such as the physicians' special expertise, insurance plans accepted, waiting times for appointments, and backgrounds. John Connolly, CEO of Castle Connolly Medical Ltd., publishers in New York, has developed these books. Connolly is a former president of New York Medical College and a fellow of the New York Academy of Medicine.

The book is currently published for Chicago and New York, and editions are planned for South Florida, Los Angeles, and San Francisco. Research also is under way to publish books on physicians in Baltimore, Boston, Philadelphia, and Washington, D.C. The books are based on anonymous surveys of physicians, nurses, and hospital administrators.

In New York, which was the first of the series (published in 1994), more than 70% of the consumers who bought the book used it to find a

physician, and more than half gave the book to a friend or relative seeking a physician, Connolly says.

The need for such guides will grow as consumers become more informed and assertive via the Internet and if employers move toward a defined-contribution approach to paying for health care. Under defined-contribution plans, an employer would give each worker a predetermined amount of money to spend on health coverage as the consumer sees fit.

Every physician wants to be the best doctor he or she can be, and under ideal circumstances, each of us would like to be recognized among peers and the public as excellent

physicians. This recognition should not come easily, however, and it should not rest solely on impersonal data created by managed care organizations to serve their own purposes. Recognition must come as a result of one's personal efforts and one's professional reputation. Managed care has added to the complexity of identifying the top physicians and thus may ignore the personal and professional characteristics that make a good doctor in the eyes of peers and patients. Fortunately, there are strategies available to physicians seeking to build patient referrals.

—More information on practice strategies is available on our Web site (see page 16).

Strategies for Building Referrals

The following list of strategies for building referrals comes from Neil Baum, MD, a urologist in New Orleans, who writes a column on marketing for *Practice Options*:

- Report to referring physicians promptly (by not allowing the patient to get to the referring physician's office before your report does, for example)
- Make referring physicians look good by treating their patients promptly and professionally
- Provide courtesies, such as gifts, to referring physicians and do not inconvenience them
- Recognize your referring physicians' accomplishments and those of his or her family members with cards or letters
- Send birthday cards
- Don't encroach upon your referring physicians' turf
- Show an interest in referring physicians as people by inviting them to professional seminars and other important events
- Do not forget your referring physician's staff
- Ensure that you are easy to contact
- Identify interests to share with your referring physicians
- Keep track of physicians who move or change positions
- Develop intraspecialty referrals
- Develop cooperative projects with referring physicians
- Meet every physician who refers a patient to you personally
- Develop relationships with physicians who are new to the area, especially those who are just starting their practices
- Keep your referring physicians abreast of changes in your specialty.

Internet Harnesses Group Buying Power

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

One way the Internet is helping physicians to practice more efficiently is by allowing them access to organizations that offer support services and give them some degree of group buying power. Organizations that assist physicians in managing their practices might help make the business of medicine more profitable, experts say.

A number of companies offer discounts and group purchasing for medical supplies over the Internet and some experts say these Internet-based supply purchasing organizations can help individual physicians get deals that are just as good as those obtained by physicians in larger groups. In a study last year, one researcher said less than 1% of products available in the medical supply and device market are currently purchased over the Internet.

Physicians and other health care providers spend \$83 billion annually on medical supplies. Eleven billion (or about 13%) of those costs could be eliminated by streamlining the supply chain using the Internet, according to a report by Daren Marhula, a senior analyst with U.S. Bancorp Piper Jaffray, financial analysts in Minneapolis. In fact, the Internet could shake up the distribution process for medical supplies, Marhula says in a report last year, *E-Health B2B Overview*. Medical supply distributors are using the Internet to offer new distribution channels, greater product selection, competitive pricing, and reduced transaction

costs, Marhula says in the report.

As with any product or service, it pays to shop for the best price and the best quality, expert says. In particular, physicians may want to find sites that allow purchasing supplies at a discount rate without any obligation to join an alliance or a network, experts say. Among the companies that offer medical supplies to physicians and other buyers on the Internet are Medsite.com, Everything4mds.com, and Esurg.com, and PhyBuy.com.

durable medical equipment, immunizations, injectables, janitorial supplies, x-ray film, reference materials, and office supplies. The company says its Web site serves as an electronic in-house office management system for more than 40,000 physicians and other providers of medical care.

Another company in this field has a similar approach. Esurg.com (www.esurg.com), a company in Seattle that was founded by a physician and other entrepreneurs, offers

Hospitals have long used group purchasing organizations to help keep costs down. Now, Web-based companies are making group purchasing available to physician practices.

Medsite (at www.medsite.com), is a company in New York that offered a discount of 15% on most items during a recent promotion and a discount of as much as 58% off on selected items in specialties such as family practice, urology, pediatrics, ob-gyn, cardiology, and orthopedics. What's more, Medsite has established a relationship with AuctionMart.com (www.auctionmart.com), a company that sells pre-owned and refurbished medical equipment from hospitals and clinics to physicians. In addition to offering supplies and equipment for sale, Medsite also sells software, books, journals, and services such as physician credentialing, medical news, a customizable finance channel, and continuing medical education.

Another company that offers discounted medical and office supplies over the Internet is Everything4MDs (www.e4mds.com), a company in Marina del Rey, Calif., which expected to have \$150 million in sales last year. E4MDs sells medical supplies,

medical, surgical, and pharmaceutical supplies to physicians and other health care providers over the Internet. Esurg has partnered with InSource, a division of MedAssets, which is a group purchasing organization in Atlanta. Previously InSource has focused on acute care and surgery centers, and now Esurg is serving as an agent for InSource, says Sean Browne, vice president of marketing and sales for Esurg. InSource has over \$2.5 billion in purchasing power through its 9,700 members, which are health care organizations such as hospitals and physician organizations. Esurg can offer InSource contracts to its physician marketplace at no obligation to the physician practice, Browne says.

"This significant book of business not only provides great pricing on everyday medical, surgical, and pharmaceutical products, but also provides leverage for many other specialty specific products as well," Browne explains. "As a result, we are able to

Editor's note: Earlier this year, Practice Options began publishing articles on companies and systems being developed for specific applications common in physician practices. This article is the third in the series.

take the leverage of the \$2.5 billion in purchasing power and the 9,700 members and bring this to the physician market, which means low costs and no long-term obligations for physicians."

All of these companies aim to increase practice efficiency and to cut costs by making it easy for physicians to buy medical supplies. One company that is trying to distinguish itself from the others is PhyBuy.com, a company in Encino, Calif., that provides medical supplies and support services to physicians. "PhyBuy.com—short for Physician Buying Group—is, in effect, a group purchasing organization for physicians," says Donald Cook, PhyBuy.com's CEO. "Our true goal encompasses an even broader mission: to support physicians in operating and making their businesses profitable."

Cutting Supply Costs

"Group purchasing organizations have been operating in the hospital environment for 20 or 25 years," Cook explains. "The concept encompassed by group purchasing is 'strength in numbers.' Hospitals become members of a group purchasing organization that negotiates the best prices on the products that hospitals use, based on committed purchase volume. Physicians cannot get these discounted prices on their own. PhyBuy.com makes the group purchasing concept, expertise, and price negotiation available to physician practices."

The Internet makes group purchasing for physician practices feasible since group purchasing involves complex record-keeping and data-processing that would not be possible without the Internet, Cook believes.

The PhyBuy.com site offers more than 20,000 commonly used medical, surgical, office, and pharmaceutical items that can be purchased at a cost below retail—sometimes reflecting a discount of as much as 85%, the company says. Items available for pur-

Report Evaluates B2B Market

The Internet has opened a new world of commerce called business to business (B2B), which has the power to shake up the distribution process for medical supplies as it is currently known today, says Daren Marhula, a senior analyst with U.S. Bancorp Piper Jaffray, financial analysts in Minneapolis.

In a report last year, *E-Health B2B Overview*, Marhula said about \$11 billion could be saved if physicians and other health care providers used the Internet to purchase medical supplies. "That's roughly the amount we spent on the hospitalization of Americans suffering from chronic heart failure in 1999," Marhula says.

A new breed of distributors is using the Internet to increase efficiency in moving medical products across the supply chain. "Acting as an electronic hub, these B2B Internet companies have a substantial opportunity to bring value to groups of motivated buyers and sellers by providing them with a liquid market, new distribution channels, greater product and service selection, competitive pricing environments and, most important of all in health care, reduced transaction costs," Marhula says.

The online medical supply companies that will survive into the future are those that are the largest, Marhula predicts. "The key to winning in this market is going to be critical mass—gathering together the largest number of buyers and sellers will create the greatest value," he explains. "We believe it will be a winner-take-all end game. Companies that already have relationships with hospitals and physicians' offices may be able to leverage those relationships into the online world, and have a head start from their native Internet competitors. Once an exchange can gather critical mass, the value of the exchange will increase exponentially with each additional customer and supplier." Although it is too early to predict the outcome of any shake-out among online medical suppliers, Marhula believes it will come within the next 12 months.

chase are listed within a series of catalogs, organized by category.

Manufacturers and distributors provide discounts because PhyBuy.com represents significant market share, Cook explains. "They know that we will be assembling a lot of market share for them," he adds. "Because of the purchasing power they can jointly deliver, physicians can drive the discounts on the products they use."

Physicians also can influence which products are available. "Approximately 300,000 products are available to health care professionals today," Cook says. "But about 5,000 of those products are used 95% of the time. By focusing on what products physicians need, we can get

prices down. Distributors and manufacturers can focus on stocking and producing the most needed products and be assured of high volume and market share."

Autonomous Operations

If physicians are to succeed in operating in solo and small-group practices, they need to keep costs down and harnessing the clout available to large buying groups allows them to do so, at least to some degree. In the future, physicians will function largely outside of hospitals, in part because of the trend toward outpatient care and a rising number of medical services that are delivered outside of acute-care settings, Cook says. Also, inte-

(Continued on page 14)

(Continued from page 13)

grated delivery networks are shedding the physician practices that they spent the previous 10 years buying and incorporating into larger organizations. "Those are only two examples that indicate the trend to move the focus of health care delivery outside of the hospital," he explains.

When operating in small groups, cost containment can be vital to success. "A physician office must be concerned with many expenditure categories, not just supply purchasing," Cook says. Other expenditure categories include pharmaceuticals, office supplies, medical malpractice insurance, billing and collection services, electronic claims processing, information technology, employee costs, and fringe benefits. Therefore, PhyBuy.com and other companies that provide physician services and medical supplies are also offering a wide variety of other service programs for physicians. Medsite, for example, offers news and CME.

In fact, PhyBuy.com and other online companies will move beyond their role of offering discount medical supplies. PhyBuy.com says it has two additional missions: increasing physician practice revenue and facilitating efficient operations. To help physicians increase revenue, PhyBuy.com offers an electronic billing and collection service to help maximize reimbursement and has partnered with a company that specializes in diagnostic testing to offer these services at a reduced cost. PhyBuy.com also is developing a way to facilitate physician participation in clinical trials. While clinical trials have proven to be a source of revenue for some physicians, fewer than 5% of patients and fewer than 5% of doctors participate in such trials.

More Efficient Operations

PhyBuy.com will also highlight market research opportunities in which physicians can participate to earn extra revenue. "For example, a phar-

Recognizing that physicians want access to information on how to improve business operations, some of these companies will screen sources of practice information to help save time and ensure that the information offered is useful.

maceutical company was interested in gaining input from 500 or 600 physicians over the course of a couple of days," Cook says. "The physicians had to answer about a dozen questions in order to participate. This is not clinical research. The physicians are simply answering market research questions based on their opinions and experiences. Information requested on such a survey might include how patients react to a certain drug, or have preferences for certain types of drugs. Pharmaceutical companies are typically willing to pay physician respondents about \$50 for their participation. By responding to a few different surveys, physicians can, over the course of a half an hour, earn an extra \$100 or \$150 during what might be spare time or nonproductive time from a billing standpoint."

Beyond decreasing costs and increasing revenue, PhyBuy.com also aims to help physicians operate their practices more efficiently. "To help practices increase efficiency, we are building a role for PhyBuy.com as an information provider," Cook says. "Physicians want access to sources of information on how to improve their business strategies, but, because of time constraints, they need those sources to be screened for appropriateness. We will screen sources of business practice information so that we can provide physicians with useful materials."

The company will provide news, for example, about information systems available to physician practices, options for billing and collections,

and examples of what works with other medical practices. The site provides reviews from publications for physicians and links to other practice management sites.

Currently, approximately 36,000 physicians use PhyBuy.com's services. Cook believes two factors differentiate PhyBuy.com from its competitors.

"First, by focusing on establishing contracts with existing group purchasing organizations in the hospital arena and extending that reach by working with manufacturers, we've created an intricate and hard-to-replicate web of relationships with manufacturers and distributors," Cook says.

The second factor that differentiates PhyBuy.com is its focus on practice operations as a whole, Cook says. "We are focusing on enhancing the business of medicine on numerous fronts: cost reduction, revenue enhancement, and the provision of information on practice management strategies," he says. "We don't see anybody else in our field focusing this broadly on the business of medicine."

The goal of each of these companies is to become a support organization that enables physicians to operate their practices as profitably as possible while still providing excellent medical care. If they can do as they plan and survive through the shake-out among all Internet companies, then physicians may have found a partner that offers substantial benefits.

—More information on practice strategies is available on our Web site (see page 16).

Government Issues More Privacy Rules

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

In one of his last acts before leaving office, President Clinton issued new rules to protect the privacy of medical records, requiring physicians and hospitals to get written consent from patients before disclosing health information.

Physicians already burdened with complying with rules on patient privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) now have new rules to meet. In developing a strategy for implementing the HIPAA transaction and code rules, physicians may find it wise to include methods for complying with the new rules Clinton issued in December. Both sets of rules require physicians to be in compliance by next year.

Physician groups and other health care providers should be alarmed by the new rules, says Lawrence A. Poleman, global leader of the privacy practice at PricewaterhouseCoopers, CPAs and health care consultants in New York. Most health care organizations are currently unable to comply with the new rules and few understand their magnitude, he says.

The most significant aspect of the new rules is that they allow patients to view, copy, and to request correction of potentially harmful errors in their health files. Privacy advocates argue that these records rightfully belong to patients and therefore they should control the content and use of the information.

Physicians argue that what they enter into records is not always suitable for patient viewing. Also, allowing patients to view and copy their records could simplify the screening

process lawyers use when seeking malpractice cases.

The new rules say patients must give special permission for nonroutine uses of information, such as employers seeking information on job applications or product marketers seeking lists of patients with specific conditions. Patients must be told how the information will be used and by whom. The penalty for selling information deemed to be private includes fines of as much as \$250,000 and prison terms of as long as 10 years.

Safeguards Required

The rules also restrict the amount of information used and disclosed to the minimum necessary. Currently, health care providers and plans often release a patient's entire health record even if an entity needs only a certain portion of it to process a claim, for example. The rules also require that health care organizations establish internal procedures to protect the privacy of health records, such as training employees about privacy, designating a privacy officer to assist patients with complaints, and ensuring that appropriate safeguards are in place for the protection of health information.

While the rules cover all medical records, physicians have broad discretion to determine what health information to include when patient records are sent to hospitals or to other doctors.

Organized medicine generally has been supportive of rules regarding confidentiality, and most physicians feel protective of their patients' privacy. In fact, this protective instinct

has had an influence on physicians who are reluctant to send patient data over the Internet.

Large health care institutions may not be as accepting as physicians of the need for new rules on patient privacy. Mary R. Grealy, the president of the Health Care Leadership Council in Washington, D.C. (at www.hlc.org), an association of 50 chief executives from large health care corporations, wants President Bush to modify the rules.

The government claims the rules are not directed so much at health institutions but towards medical companies using the Internet to get information on patients. The rules cover online pharmacies, for example, but they do not cover other Web sites that offer health information and collect data on the browsing habits of consumers.

Many health care organizations have been working on the privacy issue, and Health Internet Ethics Inc., a coalition of 18 health sites on the Internet, has reached an agreement with TRUSTe, an independent organization in San Jose, Calif., (at www.truste.org) dedicated to building consumer trust and confidence in the Internet.

TRUSTe has developed a so-called seal of approval aimed at helping consumers evaluate the avalanche of medical information available on the Internet. The group says the seal will ensure consumers that their private information will be protected and that the information they get is trustworthy.

—More information on information systems is available on our Web site (see page 16).

The new rules require training employees about privacy and designating a privacy officer to assist patients with complaints.

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