

PHYSICIAN PRACTICE OPTIONS™

February 15, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Direct Marketing Physicians Find Success Building Niche Practices

Kathy Anderson longed to hang out her own shingle after finishing an ob-gyn residency at Loma Linda University Hospital in 1996. But Anderson knew it would be financial suicide to open a solo practice in California, a state mired in managed care. She feared managed care companies favored contracting with group practices.

While talking over options with her mother, Nasrin Farbaksh, MD, an ob-gyn associated with a group practice in Southern California, the two hatched a marketing idea they might not have considered years ago. Recently, other physicians have sought similar strategies to differentiate themselves in competitive markets.

Anderson and Farbaksh speculated that if they went into practice together and promoted themselves as a mother and a daughter who treat only mothers and daughters—which would include all women—they might set themselves apart enough to capture private-pay and PPO business. They hoped their gender and unique relationship would draw enough patients to sustain the practice.

"It was a gamble that paid off," says Anderson, 31. The Mothers and Daughters Center, in Santa Ana, Calif., is in its third year and by all measures, a success. "No one could have imagined we would have grown as fast," Anderson says. "Because of demand for our services, we're planning to expand this year." The two are hoping to open a second office this quarter.

Some physicians have always distinguished themselves as experts. They have developed reputations by informal physi-

cian-to-physician marketing at meetings, for example, says Peter Kongstvedt, MD, an internist and partner in the managed care division of Ernst & Young, CPAs and health care consultants in Washington, D.C. "What's changed now is the direct-to-consumer approach," he says. "Newsstand magazines are littered with ads for doctors. Advertising by physicians has gotten much more aggressive recently, and I expect it to get more aggressive." Kongstvedt also is a member of the editorial Advisory Board of *Physician Practice Options*.

Physicians who want to avoid direct competition with colleagues can define themselves in a different way, creating a niche. For that, many niche physicians enlist the services of public relations firms. "In the past eight years, there's been a big shift in how physicians view their practices; now they see them more as businesses," says Anthony Mora, owner of Anthony Mora Communications, a PR firm in Los Angeles. Mora represented only two physicians in 1990; now he represents more than 50, and they cross all specialties.

Ongoing promotion through hospital PR staff was crucial to Anderson and Farbaksh's success, Anderson says. In addition, mother and daughter regularly appear together in television news segments to talk about alternatives to hysterectomy, hormone replacement therapy, and fibroids, all the while promoting their gender and relationship. They also give community lectures in both English and their native Farci.

Bilingualism is another marketing tool for them. They place ads in Farci-language

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Suggestions for Physicians Who Want to Remain Independent

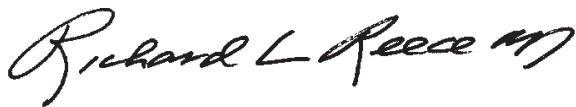
Physicians in managed-care-dominated markets are finding that to survive, they need to have substantial financial and management expertise or they need to affiliate with an organization that does. As a result, physicians can affiliate closely with an integrated delivery system, such as a hospital, HMO, or a combination of the two, and depend on that system for financial and management expertise.

Physicians also can consolidate into a large medical group or physician organization, and depend on that organization for financial and management resources. Physicians in an IPA or a large medical group can consider managing administrative costs by outsourcing them to another organization. An example of such a firm is Innovative Outsourcing. From its offices in Baltimore, Innovative Outsourcing uses computers to handle such services as claims administration, reporting of data for quality measurement, and providing medical information in order to help make physicians more competitive in managed care markets.

Most physicians, however, prefer to remain independent. For physicians in this group here are suggestions to help you acquire the business expertise necessary to deal with managed care:

- Consider practice leasing. Private medical practice today involves extremely complex administrative details, which include complying with federal and state regulations, marketing to patients and managed care plans, evaluating proposals from health plans, and managing the growing number of staff needed to bill payers. To concentrate on their clinical practice, some physicians have outsourced these functions. Under such an arrangement, a physician or small group pays a percentage of its current overhead to a management company and it retains the remaining percentage. The management company pays all practice expenses; the physician retains independence and ownership. This arrangement is attractive in that the management company has an incentive to help you enhance revenue and cut administrative costs.
- Consider a condominium office arrangement. In most major cities, office condominiums exist for lawyers, small businesses, consulting groups, architects, and other professionals. You can rent space in a central office building, and share front office, nursing, receptionist, laboratory, and x-ray services with other physicians. This arrangement allows you to retain your independence and control your time. What's more, if you're a specialist and want to visit the condominium site only once a week, you may be able to negotiate a once-a-week fee. Or, if you want to test out your practice in a new neighborhood, you can lease space for a limited time.
- Consider asking a consulting company to analyze which services you should outsource and which to keep in house. These consulting companies can also install systems and manage services for you, including systems for data collection, credentialing, billing, clinical laboratories, physical therapy, home care services, surgi-centers, and many diagnostic services, such as ultrasound, nuclear imaging, mammography, bone-density measurement, and endoscopic procedures, among others.

If you are interested in discussing the issue of having a professional analyze your practice and study the feasibility of outsourcing, please call me or send an e-mail with any questions you may have.



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Physician Practice Options is published by Premier Healthcare Resource, Inc., Parsippany, N.J.

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Subscription Price: \$299, 12 issues
Issue Price: \$25 each

Patient Surveys Produce Satisfying Results

Patients and purchasers expect physicians to deliver quality care, and patients' satisfaction with the care they receive determines whether they will remain with a practice and recommend it to others. Therefore, information gathered on whether patients are satisfied is invaluable to running a successful practice, regardless of how detailed or expensive the survey, say physicians who conduct patient satisfaction surveys.

"There are two ways physicians are successful," says Neil Baum, MD, a urologist in New Orleans, who has been conducting surveys in his office for 20 years. (See "A Simple Approach to Measuring Patient Satisfaction," Dec. 15.) "The first way is to give the patients what they want; the second is not to give them what they don't want." A solo practitioner since 1976, Baum hands out brief questionnaires to each patient at each visit. Getting results from his survey costs less than \$200 per month.

Many medical groups use more elaborate patient survey methods. For example, the 400-physician Dean Medical Center in Madison, Wis., collects data on 13 patient satisfaction questions in small, hand-held computers at its 35 treatment sites in Wisconsin. The 200-physician Palo Alto Medical Clinic, in Palo Alto, Calif., conducts telephone surveys of 40 patients per physician each year. Telephone surveys for a large group can cost more than \$30,000 annually, while mail surveys, although less costly, can still cost thousands of dollars a year.

Keep It Simple

Regardless of the method or the cost, patient satisfaction surveys collect data on patients' perceptions of care so that physicians can improve service and show patient satisfaction results to payers. In the future, more physicians will be asked to submit results regularly from patient satisfaction surveys and such results may be a prerequisite for continued contracting with many health plans, experts predict.

Even today, however, patient satisfaction survey results are worth the investment regardless of how much or how little is spent to produce them. "It isn't necessary to spend

a fortune on these types of surveys," says Donald Fisher, CEO of the American Medical Group Association, in Alexandria, Va. "A basic survey, conducted at a physician's office, can provide information for improving office practices," he says. The AMGA represents about 230 physician groups nationwide, and offers a rudimentary patient satisfaction survey for its members (see box).

For his survey, Baum pays less than a \$100 a month for printing costs and less than a \$100 a month in staff time and postage expenses. At the beginning of each visit, patients receive a small card that (on the front) asks them: "What three questions would you like answered today?" and (on the back) five questions about the ease of

phone call from Baum, who makes two or three such calls a month, a number that is about average for a solo practice, he says.

One drawback to Baum's simple method is that patient responses are not anonymous. "But no patient has ever complained about that, and most fill out the forms quite willingly," Baum says. His method has a significant advantage over telephone or mailed surveys. "Dissatisfied patients have the opportunity to vent their anger immediately, and we have the opportunity to respond almost immediately," he says. "That greatly reduces the bad word-of-mouth that can result from a negative experience and destroy a practice."

Baum finds that his survey method meets the needs of his small practice, but larger

"There are two ways physicians are successful. The first is to give the patients what they want; the second is not to give them what they don't want."

—Neil Baum, MD

getting an appointment, staff friendliness and level of concern, whether their questions were addressed adequately, their overall impression of the office, and whether they would recommend the practice to others. "The information we gather provides invaluable damage control, avoiding bad word-of-mouth that can result when a patient is dissatisfied," says Baum, who has written a book on patient satisfaction, *Take Charge of Your Practice* (\$66, Aspen Publications, Frederick, Md., 1996).

The card also contains a space for comments. Each patient who responds with a specific note of praise receives a letter signed by Baum, customized with the patient's name and information about the visit. If a patient is upset about the length of time spent waiting to see the doctor or a perceived lack of courtesy, Baum sends a hand-written note apologizing and expressing gratitude for the patient's comments. A patient who has been upset by a particularly egregious issue—such as hearing staff discuss a case in the hallway—receives a tele-

groups may seek assistance from professional survey firms. The cost of professional surveys is related to the frequency with which they are given, and cost estimates vary widely. A practice with five primary care physicians, each with about 2,500 patients, can spend \$1,250 for a survey of about 50 patients per physician twice a year, or \$10,000 for mailing a survey to all patients of all doctors four times a year, according to Kevin W. Sullivan, a partner in the survey firm of Sullivan/Luallin in San Diego. Telephone interviewing is the most expensive method, costing about \$30,000 for 500 completed interviews of 15 to 20 minutes each.

As for how often surveys should be conducted, Sullivan says twice a year is plenty. "We recommend quarterly surveys only if you're in trouble, if an HMO is breathing down your neck with negative results of surveys it has conducted about your practice, you're losing market share, or a competitor has just expanded," he says.

Surveys can also be useful in dealing with managed care plans. Many of these plans

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conduct patient satisfaction surveys as part of their physician profiling process. But if the HMO polls only the patients enrolled in its plan, the data it collects may not represent the quality of a group's total practice. The American College of Cardiology in Bethesda, Md., recommends that cardiologists conduct their own patient satisfaction surveys, especially if they want to question an HMO's evaluation of how well they are providing service, says Marie Michnich, ACC's senior vice president for health care policy. "We believe any tools physicians can use to bolster their claim that they are delivering quality service are useful, and HMOs can't always be counted on to provide accurate feedback," she says.

Jerry Seibert, of the medical survey firm, Parkside Associates in Park Ridge, Ill., agrees with the ACC. "If the group relies on the HMO's survey and the doctors get poor ratings, the HMO will drop the group," he says. "But if the group can counter with better ratings from its own survey, the doctors in the group have grounds for questioning the accuracy of the HMO's poll." Parkside Associates has more than 200 client groups.

Using Survey Information

Don Logan, MD, a cardiologist and medical director of Dean Medical Center, says patient-satisfaction surveys can play an important role in a competitive market. "In the Madison area, 60% of our patients are enrolled in managed care plans," says Logan. "We have plenty of competition from other groups for HMO contracts, and we have an active employers' coalition. Both the HMOs and the coalition are very interested in our survey results."

Managed care plans expect groups to use the plans' surveys to improve performance, Seibert says. And the key to effectively using survey information to improve performance is to view the results in the proper perspective, says Sheryl Thies, Dean's vice president for marketing. "We compare individual physicians to their peers in their own departments and sites, and to their peers in the entire center and throughout the country," Thies says. "And we do find differences among our sites. Some draw older or sicker patients, and their ratings tend to be lower, but not always."

Group size and setting can affect satisfac-

Basic Questions a Physician Should Ask Patients

The American Medical Group Association, in Alexandria, Va., has developed a survey that asks patients questions about their level of satisfaction with the care they have received in a physician's office. The survey asks each patient to rate the visit by responding to the following questions with "poor," "fair," "good," "very good," or "excellent."

- Length of time to get an appointment
- Convenience of the location of the office
- Getting through to the office by phone
- Length of time waiting in the office
- Length of time spent with the person you saw
- The quality of the explanation of what was done for you
- The technical skills (thoroughness, carefulness, competence) of the provider
- The personal manner (courtesy, respect, sensitivity, friendliness) of the person you saw
- The visit overall
- In general, your health is

Patients are asked to respond to the final question: "Would you recommend the person you saw to your family and friends?" with "definitely not," "probably not," "probably yes" or "yes."

tion ratings. In general, the larger the group, the lower the ratings, Seibert says. "That may be due to a loss of personal contact in the big groups," he says. Obviously, ratings will vary among physicians within a group. "It's not fair to compare all the doctors in a multispecialty group to each other," Seibert says. "The ratings can differ significantly from specialty to specialty." Surgeons, for example, rarely establish the kinds of relationships with their patients that lead to high satisfaction ratings, he says. Oncologists have more opportunities to build rapport with patients, and cardiologists generally have more time to build such rapport, so both specialists generally score higher than family practitioners, Seibert says. Patients visiting family practitioners often experience longer waiting times and may spend less time with their physicians, two factors that can build resentment and lower the physicians' scores, he says.

Moreover, some specialists, such as oncologists and cardiologists, do well on surveys because of the "halo effect." "They do their magic on patients with life-threatening illnesses, and when it works, they snatch them from death's door," Logan explains. "If things don't work out, the patients may not be around to complain on the next survey."

The Dean Medical Center staff meets

with each department at every site to review the ratings, says Thies. "Each physician gets his or her scores, plus the average scores for the department and the entire center," she says. Dean began conducting surveys in 1996. "This process is still relatively new, so it causes some trepidation among doctors," she says. "Those who do well are pleased; those who don't wonder why. At this point, we leave it up to them and their department heads to figure out how to improve the scores."

One Dean physician, for example, had high scores in all categories except one, the amount of time spent with each patient. The reason: His nurse was breaking in and cutting off visits whenever he was running more than five minutes late, so patients felt short-changed. After a brief discussion with the nurse, the physician fixed the problem.

"We use the ratings not just to attract new patients," Logan says, "but also to keep the ones we've got. It's our way of making sure patients are getting good value."

Regardless of frequency, method, or cost, patient satisfaction surveys can demonstrate the strength of the physician-patient relationship and provide evidence of the strength of that relationship to payers.

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

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publications and send letters and brochures to specific patient populations. Moreover, the name, Mothers and Daughters Center, is a subliminal play on the initials after the doctors' names.

Timing was a factor, too. Anecdotal reports reveal some women are deserting male ob-gyns for female ob-gyns, leading *The Wall Street Journal* to query in the 1996 headline: "The Male Gynecologist—Soon to Be Extinct?" The Mothers and Daughters practice remains 80% private pay and PPO.

"When I first started practicing, I hoped that skills and knowledge would expand my practice," says Farbaksh, 57. "Now even if you have skills and knowledge, they're not enough."

In tight managed care markets, traditional referral patterns have been upset by fixed panels, forcing physicians who cannot get on panels or who don't want to practice for cut-rate fees to seek alternative ways of attracting business. Many are seeking niches and marketing themselves to the public.

"Niche practices have always been around, but they're increasing more now because of economics," says Stephen Miller, MD, MPH, executive vice president of the American Board of Medical Specialties (ABMS), in Evanston, Ill.

"It can be a survival strategy," adds Charles Madden, PhD, chair of the American Marketing Association, in Chicago. "Every business finds that when a part of the market becomes well served, it can gain an advantage by differentiating itself from the majority. It's very good business sense."

Every boarded specialty today has physicians carving out niches to attract patients, some unwittingly, some deliberately. For those who create niche practices on purpose, it is an offensive and defensive business strategy, often devised by physicians who want to maintain a measure of independence.

To some extent, "niching" is a backlash against gatekeeper generalists. "A lot of health care today is everything for everybody," comments Regina Herzlinger, a professor of business administration at the Harvard Business School and author of *Market Driven Health Care* (Addison-Wesley, 1997). "Consumers don't want that because they understand everything

for everybody is not as good as somebody who specializes in meeting a need." Knowledgeable patients want to see physicians whom they perceive as having expert, up-to-the minute insight into their problems, Herzlinger says. (In an October 1997 interview in *Physician Practice Options*, "Harvard Professor Recommends 'Focused Factories' for Health Care," Herzlinger explained her theories about why medical providers need to be more focused on serving consumers in the future.)

While consumers are seeking experts, physicians are anxious to create new avenues of business. "I would maintain specialization is now more demand driven than supply driven," says Madden. "Patients are making more decisions about their health care."

Just as Anderson and Farbaksh attract patients by emphasizing their gender, male urologists have established men's health centers to attract male patients. In 1988,

1999), Goldberg is a nationally syndicated columnist.

In an era when patients are taking control of their medical care, marketing and advertising to patients appear to be working.

Creating New Markets

Physicians create a niche frequently by broadening treatments to many ailments or by narrowing services to the treatment of one malady. It was once thought impossible to make a living by treating a single problem. Marketing guru Madden says success in one arena sometimes rests in the numbers. "If you have a population base to support it, then you can build a very specialized practice," he says.

Besides narrowing their practices, some physicians have discovered a key to success lies in expanding their practices to define new markets. Some of these physicians offer a range of alternative, complementary, or preventive medicine services.

"Advertising by physicians has gotten much more aggressive recently, and I expect it to get more aggressive."

— Peter Kongstvedt, MD, Ernst & Young

urologist Ken Goldberg, MD, started a vasectomy clinic and a year later opened the Male Health Clinic in Dallas. Two years ago, Goldberg started the Male Health Institute as part of the Baylor Health Care System in Irving, Texas.

Goldberg aims his marketing efforts at trying to create an awareness of health issues among men. "We reach out to men because you have to draw them in," he says, explaining that the annual number of doctor visits among women is about 130 million more than that of men. The institute works with such employers as American Airlines and Texas Instruments and with other organizations to sponsor health screenings for men on a variety of conditions.

The author of two books, *How Men Can Live as Long as Women*, (Summit: 1995) and *When the Man You Love Won't Take Care of His Health*, (Golden Books:

Alan Mintz, MD, worked for 20 years (1970 to 1990) as a radiologist in Chicago. In 1990, he started a radiology management company, and in 1997, he founded the Cenegenics Anti-Aging Center, a name that is itself a marketing draw. In literature from his clinic in Las Vegas, Mintz tells patients their youthful lives can be extended by avoiding alcohol, tobacco, and recreational drugs, and by making lifestyle changes.

"Patients are not satisfied with what they are getting from disease-oriented, allopathic physicians," Mintz says. "People are tired of waiting to get cancer or have a heart attack. They're saying, 'I'm willing to pay dollars to optimize my health.'"

For an initial fee of \$1,300, patients can spend six hours with a board-certified internist or family practitioner, a nutritionist, and an exercise physiologist at Cenegenics, a Greek word meaning new beginnings. The fee includes myriad tests,

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such as certain cancer screens and readings of hormone levels, body fat, bone density, and cognitive skills.

Mintz advertises in *Esquire*, *Vanity Fair*, *Time*, and *Town and Country*, among others. He also appears on network news segments and daytime talk shows, attracting patients from 28 states and four countries. These patients are seeking a combination of herbs, minerals, and hormone and vitamin treatments coupled with diet and exercise regimens, Mintz says. As a result of these treatments, Mintz says, patients sleep better and see improvements in their skin quality, energy levels, memory, and mood.

A Niche of His Own

Mintz is capitalizing on a demographic trend: aging baby boomers. Another physician building a business on the strength of a trend is Steven Arkin, MD, an ob-gyn in Brandon, Fla. After five years of expanding his practice to specialize in teenage pregnancies, Arkin closed his office in 1997 to work full time for his company, Miracles Maternity Franchise Corp. Miracles teaches ob-gyns to draw in teenage patients and

helps them find government financing for prenatal care and deliveries. Many of these patients might seek abortions instead.

"I help ob-gyns get more patients in the door," Arkin says. "Then we train staff in how to get payment through social programs. We get paid over 90% of the time. We've taken ob-gyn practices that perform

The staff in affiliated physicians' offices are heavily supplied with promotional items, such as Miracles Maternity embellished t-shirts, pens, mugs, magnets, hats, pins, and stationery. After franchise approval, Miracles doctors may place a sign over the name on their doors announcing the practice is a Miracles Maternity center.

"We've taken ob-gyn practices that perform 15 to 30 deliveries a month and doubled their volume."

— Steven Arkin, MD, Miracles Maternity Franchise Corp.

15 to 30 deliveries a month and doubled their volume."

A pro-life advocate, Arkin says he provides Miracles consulting services to nine physicians in three states. The company snares young patients through radio talk shows, newspapers, and yellow pages ads, fliers posted in high schools, high school seminars on abstinence, and high school guidance counselors. "We figure out demographics and market strategically," Arkin says.

Using Television

Another method of promotion involves television. Steven Morganstern, MD, a urologist in Atlanta who directs Morganstern Urology Clinic and Men's Health Center, has appeared on television shows, such as "Good Morning America," nearly two dozen times. He chats about impotence, premature ejaculation, and vasectomy. That's not to mention radio segments and publications. "His practice was successful before his appearances," says Barbra Morganstern, the urologist's wife and office manager. "But it enhances credibility and to a small extent, it brings more people to the practice."

Credibility is important when convincing the public that the niche physician is indeed an expert in his or her field. Brochures for the Diagnostic Center for Men say that each of its physicians has completed special training in male sexual health and that all of them are members of the Impotence Institute of America. Cenegenics radiologist Mintz and his two primary care physicians are certified by the American Academy of Anti-Aging Medicine, in Chicago.

"When doctors look for a way to differentiate themselves, they use certificates as a measure of 'expertness,' if you will," says Philip Bashook, PhD, ABMS's director of evaluation and education. "So there's a greater need for these certificates. There are legal implications too. In many states, you can't advertise you are a physician unless you have a board certificate. That's where it becomes important."

ABMS's Miller says many of these orga-

Niche Becomes Crowded

In certain sectors, niching has become so popular that some niches have become saturated. Jaroslav Marik, MD, an ob-gyn in Los Angeles, started specializing in treating infertility in 1971 when few others were doing so. Today, he estimates, there are 10 times as many infertility clinics in his area as there were then. Moreover, traditional ob-gyns have taken back their infertility referrals.

"Ob-gyns used to be busy with hysterectomies and D&Cs," Marik says, "so they referred out cancer and infertility. Now, they're not as busy and managed care plans don't allow them to refer patients out." Also, fewer insurers pay for such treatments. "Infertility used to be a covered benefit. Ten years ago, about 80% of our fees were paid by insurers; now only 25% of our fees are," Marik says. The result is that his practice has suffered financially.

"In the last five to 10 years, many other infertility centers started appearing," Marik says. "I felt we should stay on top of the pack." In response, he hired Anthony Mora Communications, a PR firm in Los Angeles.

On news segments and television talk shows, such as "The Leeza Show," Marik touts his long experience, on-premises frozen sperm bank, and same-day hormone test results. In glossy magazines and daily newspapers, he is the expert quoted on gender selection and infertility. He also places ads in daily newspapers and infertility publications, such as *Resolve*.

Such advertising and public relations efforts are costly. Marik pays an estimated \$4,000 monthly for PR alone. And what does he get? "I have been on a number of shows, but the flow of patients has not increased significantly," he complains. "It tells me people are bound by their plans."

—M.G.

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Podiatrist Says Her Niche Is "Essence of Survival"

T amara Fishman, DPM, specializes in diabetic wound care and saving limbs from amputation. "I graduated at the peak of managed care," says Fishman, 31. "To find a niche was the essence of my survival. I wanted to separate myself from the masses of other podiatry graduates, from other physicians, and from nurses doing wound care."

She banks on her expertise to attract patients from family practitioners and internists who normally treat these problems. Eventually, she'd like to receive referrals from other podiatrists too. "Podiatrists treat wounds but they don't have as much knowledge or experience as I have," she says.

Such a strategy can be quite successful, says Charles Madden, PhD, chair of the American Marketing Association. "Many physicians who get to be very good at one thing can support a practice that is not in competition with former competitors," he says. "Some former competitors may actually refer patients."

One of Fishman's marketing moves was the creation of the nonprofit Wound Care Institute Inc., in North Miami Beach, an organization she touts on the Internet at www.wound-care.org. The institute produces newsletters, gives and receives educational grants, and conducts annual seminars. "Running the organization helps build my credibility," Fishman says, "Patients have come right from being on the Internet to see me."

"Initially, it wasn't enough to have a practice treating only wounds," says Fishman, "but over time, it's built up. I market myself. I'm aggressive. I'm obnoxious. I've fought with managed care carriers to get contracts."

To drum up business, the podiatrist calls directors of nursing homes and managed care plans. "I say, 'I'm Dr. Fishman and I specialize in diabetic foot wounds. My outcomes are very good and I want a chance to treat your patients,'" she says. —M.G.

nizations are trade associations not recognized by the 24 ABMS boards. ABMS boards are generally approved by managed care companies, physicians, Medicare, and Medicaid.

As knowledge and technology grows, some niches created today may one day become ABMS-approved specialties. "Many of the new boards arose from specialty societies," Miller says. "The criterion is that they must represent a distinct body of knowledge based on new concepts related to the advancement of medical science." Medical genetics and nuclear medicine, for example, grew to become board-certified specialties.

Harvard business professor Herzlinger believes these credibility-by-certification attempts are in vain. "Yesterday's news was credentialing," she says. "Tomorrow's news will be a system that focuses on accountability. I'm much more interested in whether the toaster I'm going to buy burns toast than whether the toaster maker was credentialed by a toaster organization."

—Reported and written by Maureen Glabman, in Miami

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System Helps Eliminate Coding Errors

By Laura Mulvey

For the past 10 years, the use of automated coding software for medical billing has been growing steadily among physician practices. Recently, this software has become even more important to physicians as a result of the passage by Congress of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The regulations for this act have resulted in intense scrutiny and severe fines for physicians and other providers involved in Medicare and Medicaid billing.

The federal Health Care Financing Administration (HCFA), the agency charged with ensuring compliance with HIPAA, has increased by tenfold its review of medical bills submitted to the government-sponsored Medicare and Medicaid programs. For HCFA, billing errors appear to be a sizeable problem. Recently released HCFA audit results show that Medicare billing errors cost the government \$20.3 billion in 1997. Of that total, 44% resulted from documentation problems; 37% resulted in payments to providers for services deemed medically unnecessary; 15% occurred because of coding mistakes, and 4% were attributed to "other" reasons, according to an article, "The \$20-billion Question" in *Modern Healthcare*, April 27, 1998.

While HIPAA requires that the frequency of audits be increased regardless of whether mistakes appear as errors or intentional fraud, providers should feel some relief from a communication from June Gibbs Brown, inspector general for the federal Department of Health and Human Services, which oversees HCFA. In a letter on June 3, 1998, to the American Health Lawyers Association, Brown wrote that the efforts of the Office of the Inspector

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General are targeted at improper claims made intentionally or with reckless disregard for the truth, not billing errors. The letter is posted on the association's Web site at www.healthlawyers.org.

"Health care providers, practitioners, and suppliers will not be subject to the civil monetary penalty laws or the False Claims Act for billing errors, honest mistakes, or negligence," Gibbs wrote. "Our law enforcement efforts are focused on improper claims that are made intentionally, or with reckless disregard for the truth, or with deliberate ignorance of the truth. Deliberate ignorance is the state of mind of an ostrich, who refuses to observe readily obtainable facts when submitting a claim ... significant penalties may be appropriate in such cases."

As probing into medical bills continues, physicians need to be aware of the extent of increased risk and the greater need to protect themselves from loss of revenue, costly

combinations and tremendous opportunities for errors.

When it audits medical bills, HCFA officials generally look for the following:

- Does the service rendered match the diagnosis?
- Does the fee charged fit within accepted cost parameters?
- Does the duration of care fall within accepted industry guidelines?
- Does the claim comply with the latest Medicare rules and regulations?
- Has the bill been "unbundled" for individual services provided when a contract clearly states that certain services are part of a global fee?

By levying fines, HCFA has demonstrated that intentional errors can be costly. For a miscoding error, a physician may be fined as much as \$10,000 per improper claim, plus three times the charge of the service item in question. At the same time, private insurers and health plans also have begun to seek

The Health Insurance Portability and Accountability Act of 1996 requires that HCFA increase the frequency of audits regardless of whether mistakes appear as errors or intentional fraud.

lawsuits for false claims, underpayment or, worse, potential removal from provider panels. This situation causes serious concern for physicians who are striving to provide quality health care and submit fair and accurate bills.

Opportunity for Errors

Yet even physicians striving to meet all federal requirements will find it a challenge to bill accurately when there are 8,000 International Classification of Disease-9 (ICD-9) or diagnosis codes that cover physician services and 11,000 Current Procedural Terminology (CPT) codes. Every bill submitted by a physician includes both ICD-9 and CPT codes, creating the opportunity for literally millions of coding

reimbursement from physicians who submit bills with errors.

Traditionally, medical offices have selected the appropriate ICD-9 or CPT codes by using coding system manuals. Anyone entering codes must analyze a variety of factors to determine which ICD-9 and CPT codes to use. To code a medical bill properly, for example, coders must have a variety of information at hand, including how many times the procedure has been performed in the past, if it exceeds accepted treatment duration parameters, and if the code matches the diagnosis for that particular patient.

Today, new knowledge-based software provides the necessary tools to help physicians become compliant and, if the software

To help its policing effort, HCFA will double its budget this year and is expected to purchase or lease new computers that will hunt for improper CPT coding.

is used properly, it can provide the corroboration needed if a physician ever faces an audit or suit by HCFA.

Coding Software

As the name implies, coding software helps physicians ensure that bills are properly coded, and it can limit liability by identifying that the billing complies with regulations from HCFA and requirements of private payers. Coding software incorporates all CPT, Medicare, and ICD-9 codes and allows notations on each. Practices also have the option of using linkage libraries to verify that a procedure correlates with an appropriate diagnosis. A linkage library would check, for example, that when a diagnosis code indicates a patient needs a tonsillectomy that the procedure does not get recorded as an appendectomy. The link between CPT and ICD-9 codes are cross-referenced by medical specialty in the linkage libraries, and some systems allow a practice to customize linkages by adding information that assists with code selection for Medicare and other payers.

To ensure optimal reimbursement from third-party payers, coding software modules also offer hundreds of Medicare rules, regulations, and fee schedules with Medicare fees by ZIP code. In addition to helping physicians achieve a higher rate of compliance with Medicare and other payers, this information can help lower a practice's risk of an audit and reduce claims denials. Also, it is useful when negotiating contracts with managed care organizations, PPOs, and IPAs.

Most coding software can be run as stand-alone systems or integrated with practice management systems. Most are offered in versions for DOS, Unix, AIX, and Windows.

Moving to an automated coding system

can be achieved in any one of three ways: Physicians' offices can use billing systems that come with physician practice management systems; they can buy separate software systems and develop in-house capabilities for the coding and editing of bills; or they can hire an outside billing service.

Shopping for Systems

If a separate software system is the option chosen, the physicians should set aside adequate time to evaluate all the benefits and features of the systems available. At a minimum, the buyer's checklist should include questions that identify each system's specific features and capabilities, including the following:

- Cross referencing codes. Can the basic system cross-reference CPT and ICD-9 codes through a linkage library function? Can it also identify procedure and diagnostic mismatches?
- Unbundling occurrences. Can the system automatically identify occurrences of unbundling?
- Artificial intelligence. Does the system have a level of artificial intelligence that allows an office to perform a code review function at the level of expertise of an expert coder without having such an expert on staff?
- Specialty linkage libraries. Does the system provide specialty linkage libraries containing appropriate procedures and diagnosis relationships?
- Codes, rules, and regulations updates. How often does the software company provide updates on codes, rules, and regulations? Note that Medicare updates are produced quarterly and CPT and ICD-9 codes are updated annually.
- Ease of use. Is the software user-friendly?

How quickly can staff be trained on it? Does the system let a user add personalized synonyms and a physician's notes to certain codes? Does the training include comprehensive support materials for additional tutorials once the initial training is over?

- Quality of customer support. What is the level of quality of the system's help-line and other customer support services? A buyer should test the service turn-around time by calling the customer support line to monitor the level of service and identify in advance if there are any costs associated with using a customer support line. Some vendors offer customer service at no cost.

The final but most important concern relates specifically to cost. Coding systems range in price from several hundred dollars for off-the-shelf products to millions of dollars for customized systems developed exclusively for large group practices.

Depending on the size of the practice and the coding system being considered, many excellent systems are available for well under \$1,000.

Summary

Physicians should remember that HCFA will continue to tighten its policing of medical practices while its software programs become more sophisticated. To assist in its latest policing efforts, the agency will double its budget this year and is expected to purchase or lease new computer systems that will hunt for improper CPT coding. Therefore, it will become even more important for physicians to step up their efforts to ensure that bills submitted for reimbursement are compliant. While the task is complicated and adds yet another layer of responsibility to already busy practices, it is one that shouldn't be overlooked. Using the appropriate software, coupled with staff who are knowledgeable and committed to ensuring that bills are submitted according to HCFA requirements, can help physicians ensure that they meet regulation requirements and minimize the chance of costly audits or fines. ■

Medical Director Finds Administration in Medicine Can Be Stimulating, Unsettling



Robert J. Hudson, MD, is medical director at ZymeTx, a viral diagnostic, therapeutic, and disease management company in Oklahoma City, Okla. Hudson received his undergraduate and

medical degrees from the University of Arkansas. This interview was conducted by Richard L. Reece, editor-in-chief.

Q. Dr. Hudson, since many of our readers are interested in moving from practice to administration, which you have done successfully, let's focus our discussion on your insights about how they might prepare for such a career move. Would you tell us about your background and how you got to where you are today?

A. In 1970, at age 30, I went into pediatric practice; and in 1989, at age 50, I left practice for other opportunities. Back in the 1970s, after I had been practicing for about five years, I realized that although I loved what I was doing I would need different challenges later in my career. So I started down two separate career paths to prepare for a new vocation when I reached age 50; one was in behavioral pediatrics, the other in health care administration. As it turned out, about 20% to 25% of my practice was in behavioral pediatrics when I left practice in 1989.

On the administrative side, I had been chief of pediatrics at St. John Medical Center, in Tulsa, Okla., as well as chairman of the hospital's bylaws committee and cost containment committee. At that time—the 1970s and 1980s—physicians in general weren't paying much attention to the administrative side of health care because we were all making a decent living. Increasing take-home pay by decreasing expenses was not something that most physicians thought much about. But as a pediatrician, I did and reorganized our busi-

ness office. In the two years after that reorganization, our overhead expenses decreased and we saved about \$100,000. What's more, our cash flow increased. That was the beginning of my interest in the economic side of medical care. Since I didn't take any business courses, my administrative managed care education could be characterized as on-the-job training.

As it turned out many years later, one month before I turned 50, I was interviewed for a managed care position as medical director of a utilization review center for Metropolitan Life Insurance Co. in Tulsa. I held that position until 1992, when I became the national director of MetLife's managed indemnity and PPO line of business.

At first, my work consisted primarily of telephoning doctors to get information

have about them. In fact, so much confusion exists that insurers are usually blamed for all the awful things happening in health care. But because most people get their insurance through their employers, it's the employers that decide which benefits they'll pay for and what the benefit structure will be.

Q. Were there signs back then that the indemnity business was in trouble?

A. No. That was the time when you could charge whatever you wanted to charge without being responsible for the cost, the quality, the customer service, or the outcome of medical care. And as the costs kept going up, the payers—primarily the employers—kept saying, "We have got to do something about these escalating health care costs." That's when utilization review and case management became more

"Most HMOs today are trying to shift as much risk as possible to physicians."

from them in order to approve or disapprove inpatient stays for payment purposes. But as our business increased and we started putting some real outcome numbers to what we were doing, we standardized the operational procedures and reduced the utilization management unit cost by 10%. We also consolidated some of the high-cost offices and service offices. At the same time that we were cutting our administrative cost and decreasing medical utilization for payers, we increased case management options for employees.

Q. How long were you at MetLife and what did you learn there?

A. I was at MetLife from 1989 until 1994, and the time I spent there laid the groundwork for my understanding of customer service. Because I worked with the benefits departments of about 60 of the Fortune 100 companies, I learned about company benefits and the confusion people

important in controlling cost. Of course, HMOs were attempting to control cost, but their strategy at that point was to carve out the young and healthy who didn't get sick much. That's how they kept costs down; not so much by managing costs but rather by selecting those who didn't cost much.

Q. In 1994, when MetLife and Travelers merged, you became the chief medical officer of the new company formed from that merger. What was that experience like?

A. I headed the transition team for the health care delivery system involved with the integration of MetLife and Travelers into the new company, MetraHealth. That involved leading the teams that designed the critical pathways and the time lines to accomplish this integration. Trying to integrate two different companies with two different cultures and two different information systems took a year, but it was absolutely fascinating. We

“Physicians can have a major impact in disease management. But one thing they have to do is operate as a team, and that team needs a coordinator who is probably not a physician because physicians have other things to do.”

created a company that was better than either had been singularly, and the systems that came out were an improvement over those of either MetLife or Travelers. We redesigned and streamlined the network referral process so that the administrative demands on the providers were fewer and required less of their staffs' time. We hired more than 60 medical directors for the company's HMO sites and, ultimately, the reorganization resulted in better economies of scale.

Q. *What criteria did you use when hiring medical directors for MetraHealth?*

A. We looked at the skills of the medical directors who had some understanding of utilization review and how it worked. Certainly, we were also looking for those who understood quality care and could talk to physicians without beating them up when attempting to get information from them to see if there were other ways to reduce the cost of care. Essentially, we were looking for people with good social skills and who could speak to physicians, who had some business sense and understood utilization review, and who could see other ways of doing things.

Q. *In other words, you were looking for physicians who were young enough to have a career but old enough to have experience?*

A. Yes. They had to have at least five years of practice experience, and we preferred physicians who did utilization review and were involved in those kinds of decisions in practice.

Q. *Then, as now, were major indemnity insurers under a significant amount of pressure because they were losing market share to managed care plans?*

A. Yes. At that point, the large companies started offering all the plans: point of service, HMOs, and PPOs. HMOs were selected for the young and healthy because of the cost structure differences among the plans. Older workers who had chronic illnesses, however, were hesitant to leave their physicians if their physicians

were not on the HMOs' panels. PPOs, of course, required a big, broad network. Therefore, the first step in moving to managed care involved gaining broad access to just about every physician who could meet minimal standards, and you wanted to get those physicians to offer a discount, which ran anywhere from 10% to 20%. That was the first step: discounting the price.

Next came the gatekeeper model, which allowed employees to go outside of the network if they paid a little more money. But that led to more restricted access and penalties for going outside the network. That was five years ago. Most HMOs today are trying to shift as much risk as possible to physicians.

Q. *After MetraHealth, what happened in your career?*

A. When United Health Care bought MetraHealth in late 1995, I took about three months to decide what to do. Although I had opportunities to move laterally, I was tired of what was becoming more of a business mentality in the sense that each quarter you had to save more money and ratchet down cost to get better medical ratios. Everything was geared toward money. If you had any drive to improve the quality of care but couldn't show that it also saved money, and you couldn't do it in three or four months, then no one was interested in hearing about it. I left MetraHealth and did several consulting projects over the next 18 months.

Q. *Based on that consulting experience, perhaps you can comment on the growing consensus in the industry that disease management is the niche in which physicians can excel. If it's true that 20% of consumers generate 80% of the cost, is it possible for physicians who concentrate on disease management to dramatically lower costs and improve care?*

A. Without question. Physicians can have a major impact in this area. But one thing they have to do is operate as a team, and that team needs a coordinator who is probably not a physician because

physicians have other things to do. Good RNs, for example, can't provide the care but they certainly know how to coordinate it. And incorporating a patient's social history should be part of that coordinated care. That's because often when you've got a patient with a chronic illness, you've also got social problems involving the patient's whole family. In those cases, the patient's care needs to be coordinated with all the providers involved.

The episodic health care delivery system that we have had works fine for about 80% of the people—especially the young and healthy. But for the other 20%, it is lousy, and that's where most of the money is being spent.

Therefore, many companies are interested in disease management systems. But sending a postcard reminder to chronic diabetics to get their eyes checked is not disease management, although that's how it got started three or four years ago.

Today, we have protocols, but critics are complaining that a national disease management program cannot work because the health care delivery system is regional and not national. That's bull! The diabetes disease process in Baltimore is the same as it is in Los Angeles, and good quality coordinated care would be the same in both places. Setting standards and baseline measures to compare against is imperative to improving the quality of care. Doing so requires a team consisting of the primary care physician, the specialist, and other providers, such as the social services people.

Q. *Do you believe physicians who go from being a practicing physician to an administrative position are motivated by the idea that they can make more of a contribution to medical organizations as an administrator than they can as an individual practitioner?*

A. Yes, I do. I was a busy pediatrician, but have now increased the quality of health care for more people by being a medical director than I ever could have in practice.

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Q. One challenge medical directors face today is the managed care backlash. In one recent example, a medical director was brought before a disciplinary board for “practicing medicine as a medical director.” Is this environment a problem for medical directors?

A. It hasn’t been, although Congress is addressing this issue and it could become a problem in some states. The issue stems from the frustration patients feel about decisions concerning their health

Q. In other words, the career path of corporate life in managed care is not a straight 30-year career march, but rather a wavy trajectory that involves a variety of learning experiences and dealing with possible setbacks?

A. Yes. That statement reflects what’s going on in business. Jobs as we used to know them no longer exist. Now, it’s much more cut and go, moving from one project to the next, where you are part of several different teams working on a num-

Essentially, you’re neither fish nor fowl as a physician in the business world. Although you may be respected as a physician, you’re constantly being questioned about your business sense. But the business sense is not what truly matters, because physicians can certainly learn what they need to know about business.

The big difference between the two is that in practicing medicine, physicians work hard at seeking the truth and don’t want to make any compromises in that search. In business, truth doesn’t matter as much as does the perception of truth. That’s a very big difference for someone who comes from a medical background.

Business has a lot to offer physicians and vice versa. The skills that physicians bring can increase the quality of care while decreasing the cost at the same time. But for this to happen, physicians will need to take control and start redesigning the system. Innovation generally doesn’t come from practicing physicians, but it’s going to have to come from them in order to improve the health care delivery crisis we are in.

Q. In other words, physicians are going to have to be responsible and accountable for improving the quality of care?

A. Yes. And at the same time, decreasing the cost and paying attention to customer service. Customer service will

“The episodic health care delivery system that we’ve had works fine for about 80% of the people—especially the young and healthy. But for the other 20%, it is lousy.”

care. Those decisions are being made not by their physician but rather by an administrator who wants to save money. And in some instances that does happen. But regardless of whether allowing individuals to sue managed care organizations is the proper recourse, there has to be some remedy involving a sharing of responsibility and risk on the part of both physicians and managed care companies.

Q. Based on your career experience, which has involved a number of different paths, some physicians view being a medical director as an unstable career path. Have you found it to be more stimulating or more frustrating?

A. Actually, both. I have learned that there’s a lot less stability in the business world than in the practice of medicine. In practice, if you go to work every day and you are competent, you have a job. That’s not necessarily true in business, especially if another company buys yours. For example, MetraHealth was huge, covering about 16 million lives. We thought if any company would be a buyer, it would be us. Well that wasn’t the case. In fact, it’s not uncommon for physicians in managed care to change careers and responsibilities fairly often, which is probably what most physicians find most bothersome. That aspect was the most frustrating for the physicians I hired. They didn’t want to move, and the insecurity of their position bothered them.

ber of different problems rather than being assigned to complete a set number of tasks. My job as medical director involved working on many different teams that were charged with redesigning, redeveloping, or otherwise improving some aspect of the system, and people with every type of expertise had to be represented on those teams. Giving teams of physicians the ability to control the restructuring of how health care is delivered in this country will result in better outcomes that can be

“A physician in the business world may be respected as a physician, but will constantly be questioned about his or her business sense.”

achieved more efficiently and with the patient more in mind than the current system allows.

These teams would have people from systems, marketing, and medical management. My experience since I left practice nine years ago can be compared to earning a couple of MBAs or doing a couple of different residencies. It’s been stimulating, and I’m a much broader person.

A physician once asked me, “What’s the difference between practicing medicine and being on the business side of medicine?”

become more important as the huge numbers of the baby boomers now approaching 50 start getting sick. When they entered the health care system, those baby boomers changed the way obstetrics was delivered. Now, they’re going to change how health care is delivered once again. They want more information and better customer service. The physicians who will succeed will be the ones who understand that the old way of delivering care is just not sufficient given the outcomes that everyone is now demanding. ■

Restrictive Covenants Require Caution

By Karla L. Kinderman, JD, LL.M.

Restrictive covenants are common in physician contracts, including employment, partnership, group practice, and practice acquisition agreements. Typically, such covenants (also referred to as “noncompete clauses” or “covenants-not-to-compete”) include a restriction on practicing within a certain geographic area during a specified period. When enforced, these provisions, in effect, force a departing physician to relocate so that he or she can neither compete for new patients nor retain patients the physician treated while under contract. The assumption behind the covenants is that patients would choose the departing physician’s replacement rather than follow the physician to an inconvenient location outside of the restricted area.

Although restrictive covenants can potentially disrupt patient care, they protect the economic interests of the party seeking their enforcement. Thus, a departing physician who doesn’t want to relocate may be able to compensate the party imposing the covenant monetarily. Occasionally, a restrictive covenant may include a liquidated damages provision under which a departing physician may be liable for a stipulated sum for violating the restriction. Such provisions often are referred to as “buy-out” or “compensation for competition” clauses.

There may be valid business reasons for incorporating restrictive covenants into physician practice agreements, but before signing contracts containing them, physicians should be aware of the potential consequences of being legally bound by such provisions, which could include having to relocate or pay damages. Otherwise, physicians may find themselves embroiled in legal battles that could affect their livelihood and their patients as well.

Consider the recent example in North Carolina in which physicians in a group medical practice, North Carolina Medical

Associates, argued about restrictive covenants with MedPartners, which owns NCMA. While the issues were in dispute, 65,000 patients were forced to find alternate care or delay medical treatment. The circumstances were as follows: NCMA filed for bankruptcy protection after it could no longer pay its physicians. Not being paid, the physicians sought to be freed from their employment contracts, which contained restrictive covenants forbidding them from practicing within ten miles of their offices if they left NCMA. MedPartners sought to enforce the restrictive covenants in NCMA’s physician contracts against the physicians. It conceded in

the patient-physician relationship and the effect enforcement may have on patient care. But there are exceptions.

State Statutes

Colorado (Col. Rev. Stat. Ann. Section 8-2-113(3)), Delaware (Del. Code Ann. tit. 6, Section 2707), and Massachusetts (Mass. Ann. Laws ch. 112, Section 12x) have expressly prohibited or limited enforcement of restrictive covenants against physicians. Although they prohibit enforcement by injunctions, both Colorado and Delaware law allow recovery of liquidated damages from a departing physician. Under Massachusetts law, however, such buyouts

While the issues behind restrictive covenants were in dispute, 65,000 patients were forced to find alternate care or delay medical treatment.

court that the physicians could continue to make house calls to housebound patients, but without pay.

Some of the physicians continued to see patients under these conditions, but a large majority of patients had to find other physicians, delay care, or seek care in the emergency departments of local hospitals. The state attorney general intervened on behalf of the patients to encourage a settlement. MedPartners dropped its claims against many of NCMA’s junior physicians, but it pressed its case against several senior physicians who were bound by shareholder agreements (which had decreased in value by 90%). Following an 18-hour mediation session, a settlement agreement was reached: Each of the senior physicians had to pay MedPartners \$50,000 to \$70,000 for a release from the restrictive covenants.

Despite patient concerns and potential hardship on physicians, restrictive covenants are generally enforceable against physicians as long as the covenants are reasonable. Typically, courts take a somewhat commercial view of physician contracts, and do not recognize the unique status of

apparently are not enforceable. The legislatures in several other states, including Alabama, California, Florida, Louisiana, Montana, and North Dakota, limit the enforceability of restrictive covenants for all professionals, including physicians. Generally, however, the statutes in these states allow enforcement of restrictive covenants executed in partnership agreements and contracts for the sale of a business, such as a medical practice.

Even if a covenant fits within the statutory criteria for enforcement, courts will review the restraint under “the rule of reason”; that is, courts will seek to strike a balance between the opposing objectives of upholding the freedom to contract and prohibiting unfair competition. A well-established body of case law sets forth the criteria for determining whether a restrictive covenant is reasonable. Although there are subtle differences among jurisdictions, a majority of courts will find a restraint to be reasonable if:

- The restraint is no broader than is necessary to protect the legitimate interests of the person for whom or entity for

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Once the patient-physician relationship begins, physicians generally are under both an ethical and a legal obligation to provide services as long as the patients need them, despite any contractual obligations—including restrictive covenants.

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which the restraint is to favor, and

- Enforcement does not impose an undue hardship on the public or person or entity upon which the restraint is imposed.

The term “legitimate interests” refers to those that merit protection against unfair competition and generally means patient contacts. Despite some early cases to the contrary, the prevailing view is that a patient base is indeed an asset that can be unfairly appropriated by a departing physician. Formalized training (meaning more than an opportunity to gain on-the-job experience) and confidential information, including referral sources and patients’ names and addresses, also are considered legitimate interests deserving protection.

A restrictive covenant cannot extend beyond the bounds necessary to protect legitimate interests. Typically, a covenant extends beyond legitimate bounds if the restraint:

- Encompasses more than a particular specialty
- Exceeds a duration longer than is needed to hire a replacement and demonstrate to patients the replacement’s competency
- Extends beyond the geographic area from which the imposing party attracts patients

Even if there is a legitimate interest that warrants protection and the restriction stays within the bounds to protect that interest, courts may consider whether enforcement imposes an undue hardship on the departing physician and the public. Generally, however, courts are not particularly sympathetic toward physicians who assert that a restrictive covenant would pose a personal hardship upon them, unless the hardship is severe. (Even if a physician needed to move his or her family, such a need would not typically persuade the court.) A more persuasive—but not always successful—argument against enforcement is that it would lead to a shortage of physicians in the area. Though

courts consider whether an area is medically underserved, they generally do not place value on the termination of patient-physician relationships.

In essence, using the rule of reason, courts will allow enforcement of restrictive covenants viewed as reasonable contracts in restraint of trade.

Federal Antitrust Law

Some commentators have suggested that, in effect, all restrictive covenants are unreasonable because they do indeed restrain trade and thus should violate federal antitrust laws. Section 1 of the Sherman Antitrust Act prohibits “[e]very contract, combination ... or conspiracy in restraint of trade or commerce among the several states, or with foreign nations” (15 U.S.C. Section 1). Read literally, Section 1 seems to preclude all restraint of trade, including restrictive covenants. But despite the broad language of Section 1, it is generally understood to prohibit only unreasonable restraint of trade.

Like state law, the federal antitrust law employs a rule of reason to determine the enforceability of contractual restraints. Unlike the state limitations on restrictive covenants, however, the federal rule is designed to preserve competition to benefit consumers, and a covenant valid under state law may be invalid under federal antitrust law. If the use of restrictive covenants gives rise to predatory and anti-competitive characteristics in the overall context of unfair monopolistic practices, a restrictive covenant may violate the federal antitrust law. Most restrictive covenants probably would not, however. Nevertheless, the Sherman Antitrust Act may be a viable and effective remedy in some situations.

The judicial interpretation on restrictive covenants is somewhat inconsistent with the law in other areas that accord the patient-physician relationship a unique status. An example of the latter is physician liability, under state tort law, for patient aban-

donment. Once the patient-physician relationship begins, physicians generally are under both an ethical and a legal obligation to provide services as long as the patients need them. Theoretically, this obligation continues despite any contractual obligations—including restrictive covenants—but the theory has not been tested in the courts.

Regardless of whether a physician is subject to a restrictive covenant, he or she should take steps to end the patient-physician relationship appropriately to avoid claims of “patient abandonment.” Otherwise, the physician may violate the law and run afoul of ethical requirements that physicians must give sufficient notice of withdrawal to their patients, relatives, or responsible friends and guardians to allow them to secure another physician.

Ideally, physicians should eschew contractual arrangements that make contacting their patients difficult. If confronted with such a situation, a physician should work with an attorney to ensure that appropriate steps are taken to avoid patient abandonment. Qualified attorneys also should review contracts to ensure that the provisions in them, if enforced, would not impose an undue burden on either the physician or patients. ■

Editor’s note: As a matter of policy, the AMA discourages the use of restrictive covenants in physician contracts, believing they restrict competition, disrupt the continuity of care, and potentially deprive the public of medical services. Readers seeking a referral to a qualified attorney may contact the AMA ConsultingLink/Doctors Advisory Network, a national network of prescreened health care consultants and attorneys. Physicians may visit <http://www.amasolutions.com> on the Web or call 800/366-6968. At the homepage, go to “PracticeLink,” then “ConsultingLink,” and then choose “Doctors Advisory Network Attorneys.”

Before Selling, Get Professional Advice

By W.L. Douglas Townsend Jr. and Jill S. Frew

The volatility in the health care market is forcing many physician groups to make choices that will affect the future of their organizations, and therefore, many physicians are faced with a serious decision: sell the entire organization to a strategic partner better positioned to endure the difficult times ahead or sell a portion of the business to raise capital and maintain control—at least for now.

Before taking any action, the owners of these groups must decide whether the company will evaluate and pursue such critical initiatives on its own or enlist the help of a financial adviser expert in analyzing similar situations and transactions.

Deciding to sell some or all of the business is a function of the shareholders' ability to understand market forces and the ability of the company to succeed now and in the future. Executing the decisions is challenging for shareholders who are unfamiliar with the territory of mergers and acquisitions. And those who buy or sell their business without seeking qualified, expert advice run the risk of getting too little or paying too much. Both buyers and sellers need specialized skills and a thorough knowledge of the market and of other similar transactions to complete a purchase or sale based on the most favorable prices, terms, and conditions.

Day-to-day Operations

Finding a willing partner and consummating a transaction is a time-consuming and complex process that may require many months of meetings, discussions, and research. During this period, we tell companies that have chosen to seek expert outside help to focus on the day-to-day operations of running the company. Rarely does the leadership of a company have the time—or the know-how—to manage and complete a purchase and sale successfully, while running the company. Moreover, a lack of experience often leads to costly mistakes and time-consuming delays.

Companies that have decided to do the deal themselves could limit the number of prospective partners or transaction alternatives considered because senior managers may not have enough time to commit to the process. An experienced financial professional can help the owners attract the largest number of potential offers while avoiding the appearance that the company has been “shopped” and turned down by other potential partners.

A physician group acting on its own may also appear to lack seriousness or credibility to potential buyers. While bargaining with the buyer or future partner, a group that attempts to pull the deal together on its own has no fallback intermediary to help move negotiations forward. On the other hand, an adviser can help a physician group that—on its own—risks being caught off guard by an unsolicited or surprising offer or may be unprepared to manage the many problems and details that arise during negotiations.

When entering into a purchase and sales agreement, many physician groups rely on their customary accountants and lawyers, who are certainly important contributors to

emotional and political forces that can inhibit effective decision-making.

Steps to Success

When seeking to retain a financial professional, physician groups should look for one that has at least the following qualifications:

- Industry expertise and focus. Does the adviser fully understand your business? Does it have relationships with key players in the market? The complex and dynamic nature of the health care industry make industry expertise a critical criterion.
- Past engagements. Who are the clients and what do they say about the adviser?
- Partnering process. What is the adviser's approach to representing an organization that is evaluating a variety of strategic alternatives? The physician group should ensure that it gets personal attention from the senior professionals at all times.

The process of assessing strategic and financial options, and ultimately executing such initiatives, may seem simple in theory: Options are considered; one is selected; potential partners are contacted; negotiations

Those who buy or sell a business without seeking qualified, expert advice run the risk of getting too little or paying too much.

the process. But their financial skills, experience, and knowledge of current merger and acquisition conditions are likely to fall far short of what is needed to consummate a strategic partnering transaction that ensures the most favorable results for their clients.

A particular advantage in working with a qualified financial adviser is that the intermediary is responsible for the entire process, including the coordination of a multitude of related activities. In addition, an unbiased third party armed with the proper analytical tools can minimize the

are initiated; proposals are evaluated; a single partner is selected; the details are ironed out; and the deal is closed. But taking this simplistic view is misleading. In reality, the process often involves many highly emotional decisions; protracted gut-wrenching; time-intensive negotiations over countless details; and numerous meetings and conversations with lawyers, accountants, and investment bankers before deciding on the prospective partner and the offer being considered.

What's more, many transactions never come to fruition or may drag on needlessly.

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CAPITAL IDEAS

A skilled financial adviser can help the owners attract the most potential offers.

(Continued from page 15)

Among the most common pitfalls to avoid are the following:

- The initial homework was not done properly. The original expectations of either or both parties were not established or were not realistic, or all potential options were not evaluated thoroughly.
- The organization was not presented properly in the marketplace. It should be presented in a positive and believable way to potential partners, and its representatives should anticipate concerns that potential partners are likely to have.
- All prospective partners were not contacted. Assuming they satisfy established criteria, both the obvious and the obscure partners should be contacted.
- Emotions got in the way of rational decision-making. It is difficult to be objective during a significant corporate transaction. When emotions run high, paralysis through indecision can result, thereby increasing the significant strategic and financial risks for organizations that operate in changing markets.
- Owners sought to control the process. The physician group should give the financial adviser control over the process to maximize the value of the transaction to the shareholders.

In the final analysis, whether to partner with a strategic or financial adviser may be the most important business decision the owners of a physician group will ever make. Deciding to engage a financial adviser, and then selecting the right one, is key to ensuring a partnering transaction will be completed on the best possible terms for the long-term benefit—and peace of mind—of the shareholders. ■

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Richard L. Reece, MD
Editor-in-Chief
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February 15, 1999



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