

# PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

August 15, 2001

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## 15 Ways to Enhance Practice Revenue

**F**or physicians seeking to increase practice revenue, consultants offer a wide variety of strategies. Colleen Grope, CEO of Medsys Consulting Inc., in Youngstown, Ohio, is one such consultant. A specialist in improving income, Grope believes in increasing the efficiency of practice operations for billing, coding, and collections. Her techniques, Grope says, can help physicians increase net revenue by 10%, and include retraining office staff and teaching physicians to identify revenue-boosting opportunities. Her clients include small groups, large-group practices, and hospital systems in Ohio and nearby states.

Based on 15 years of studying payers' denial of payments and other experience, Grope recommends that physicians implement the following strategies.

**1. Update ICD-9 codes.** When physicians receive a denial of payment from Medicare, the denial often lists "CO-11," a code that means Medicare staff has determined that the diagnosis was inappropriate for the procedure. Usually, the denial is because the physician used an incorrect 3- or 4-digit code instead of the newer 4- and 5-digit codes. In fact, it is common for a physician's staff to misread rejections on Medicare explanations of benefits (EOBs). "Don't assume your staff understands Medicare denials," Grope says.

William Fiala, president of ProMed

Analysis Inc., practice management consultants in Akron, Ohio, agrees. "I recommend that only a physician or a certified coder select the diagnosis code," says Fiala, who is certified as a coding specialist by the American Health Information Management Association, in Chicago ([www.AHIMA.org](http://www.AHIMA.org)). "Many lay staff pick up medical vernacular from working in the office, but using the vernacular and understanding it are two different things."

**2. Study all denials.** "When I ask physicians if they have studied their denials, I usually discover that the physicians are completely unaware of the denials and that their staff may be misinterpreting them," Grope says. "The problem results from a lack of training, staff turnover, and the fact that some explanations are hard to understand."

Studying denials helps physicians and staff learn from their mistakes, Grope says. To minimize the chances that future claims will be denied, she recommends that physicians and staff review at least one year of EOBs or payment vouchers, identifying all denied claims, evaluating the reasons for each denial, and addressing any patterns that are apparent in the denials. Also, if staff do not understand the denials or if they are billing more than once for the same claim, the practice has a problem that needs to be addressed by a consultant or through training in how to submit claims properly.

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## Developers Race To Build a Viable EMR

The health care industry is a tangled, complex, and fragmented giant that consumes \$1.5 trillion annually; that's 15% of the gross domestic product. What's more, it's an industry that is likely to be all that and more as the aging population demands access to new medical technology and new prescription medications, thereby further increasing the demand for services and raising the cost of care. One way to meet some of these demands is through the use of electronic medical records (EMRs).

"The race is on to standardize details of the physician-patient encounter at the point-of-care before the patient walks out of the doctor's office, out of a facility where a procedure was done, or out of a hospital," says Allen R. Wenner, MD, vice president of clinical applications design for Primetime Software, in Columbia, S.C. Primetime Software is one of many companies developing an EMR, which many believe is essential for physicians to practice more effectively under the constraints of managed care.

"Details of the patient-physician encounter must be complete within about 10 minutes, which is the length of time that most managed care companies allow primary care physicians to spend seeing a patient," Wenner says.

Only 2% of U.S. physicians use EMRs in their offices or in hospitals to document details of their encounters with patients. Physicians may be reluctant to adopt electronic systems perhaps because information systems companies have yet to develop a product that converts physician actions efficiently and effectively into useful patient-record entries. The ideal product would be easy to use, accurate, and inexpensive. It would also provide relevant information that is useful for clinical decisionmaking. It would optimize billing, help increase clinical quality, decrease the cost of care, and contribute in multiple ways to patient health.

In May, 10 companies competed in the clinical documentation challenge at a conference in Boston titled, *Toward an Electronic Patient Record*, sponsored by the Medical Records Institute, in Newton, Mass. Competitors needed to show their products could document a complete patient visit within 10 minutes. One, program, *Physicians' Workstation*, from Wang Healthcare Information Systems, in Billerica, Mass., did it in eight minutes.

But even that may be too long. John Bachman, MD, a family physician and professor of family medicine at the Mayo Clinic in Rochester, Minn., believes developers need to provide physicians with an electronic method of documenting patient encounter information that is faster, cheaper, and better than the paper charts that are currently used, and developers need to have products that can do so in less than five minutes.



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# N.C. Clinic Uses an Interdisciplinary Approach to Patient Management

**M**any health care experts say that pain is an epidemic. Because a primary function of medicine is to relieve pain, and patients who suffer from chronic pain are likely to define quality of care—at least in part—by how well their pain is managed, pain management should be incorporated within medical practice, experts advise.

Some physicians believe that the best pain management programs require an interdisciplinary approach. The Triangle Regional Interdisciplinary Pain Program, in Durham, N.C., uses this approach. TRIPP is a division of Triangle Orthopaedics, a group practice with nine offices throughout the Raleigh-Durham metropolitan area. Triangle Orthopaedics has 15 orthopedic surgeons, three physiatrists, 18 physical therapists, one behavioral psychologist, seven physician assistants, two nurse practitioners, and approximately 220 other ancillary personnel.

## Self-Management

TRIPP patients typically have four weeks of treatment, followed by brief aftercare as they return to work or to vocational rehabilitation. The emphasis of the first two weeks is on understanding chronic pain, developing pain management skills, and getting started in an exercise program. Activities in the second two weeks focus on return-to-work and productive activities, further developing physical activity tolerances, and gaining additional skill in the self-management of pain.

“Our patients typically view health and functionality improvement as their job,” says Les Phillips, PhD, program director of TRIPP. “All of them have suffered workplace injuries, have

not responded to previous treatments, and are in chronic pain. Their level of dysfunction is quite high. Most of them have been out of work for months, sometimes years. TRIPP helps them to create a structure through which they can regain functional capacity even though they still have pain, and even though we don’t anticipate that their pain is going to be completely ameliorated by the time they are discharged.”

**An orthopedics group uses surgeons, physiatrists, physical therapists, a psychologist, and others to manage patient care.**

Physiatrist Robert Wilson, MD, conceived the interdisciplinary pain management program. “Wilson’s experience at another pain management program led him to believe that interdisciplinary management of pain could help our patients who had not responded to interventional pain treatment and were still experiencing a significant amount of physical dysfunction,” says practice administrator Deborah Wilkins.

Orthopedic practices typically handle many workplace-related injuries and conditions, such as low back pain and those requiring knee or hip replacements. “Low back pain is among the most common diagnoses that we see in the pain center,” Wilkins says. “It is a complicated problem that, because it is not handled well in primary care, often results in a failure to return to work.”

Phillips, a behavioral psychologist who specializes in the treatment of chronic pain, was hired by Triangle Orthopedics last year, along with John Giusto, MD, a physiatrist, to

develop and implement the pain management program. Giusto provides medical direction for TRIPP and individual physiatry services in the orthopedics practice. “Physiatrists play an important role in pain management because they can do a comprehensive evaluation of patients before they enter the program,” Giusto explains. “We perform several interventional treatments, such as epidurals, electrodiagnostic studies,

acupuncture, and osteopathic manipulation. We also evaluate whether a treatment outside the scope of the pain program is indicated but has not yet been done.”

## Focusing on Rehabilitation

For Phillips, the focus of his career over the past 10 years has been in pain rehabilitation. “A psychologist’s role is crucial in an interdisciplinary pain management team,” Phillips says. “Psychologists address the patients’ beliefs about pain, which research suggests are probably the primary factors in how patients get on with their lives, even given chronic pain. Also, psychologists understand the complexities of personality and can help patients implement psychophysiological or mind-body techniques for dealing with pain, such as hypnosis and biofeedback. Finally, psychologists emphasize the need for behavioral change when such change can help patients avoid or alleviate pain.”

Such an interdisciplinary focus is  
(Continued on page 4)

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important in helping patients suffering from chronic pain, in part because the causes of pain can vary widely and because many patients cannot be given a precise anatomical diagnosis.

"Seeking a single anatomical cause of pain will not work once the whole chronic pain syndrome has started," Phillips adds.

Giusto says that TRIPP's staff addresses pain as a biopsychosocial experience, rather than looking for a

training. Giusto and the other physiatrists offer educational programs that attempt to explain the medical basis of chronic pain. The physical therapists provide specific skill training on posture, body mechanics, and functional movement, and play a primary role in getting the patients active again.

The final two weeks of the program include therapies that emphasize return-to-work and other productive activities. "We employ a vocational

program are either back at work, working with the vocational specialist to plan for returning to work, in vocational retraining, or in the process of closing their cases with their insurance adjusters," Phillips says. "According to those criteria, individuals are responding well to the program." Approximately 95% of participants complete the program. "Not everyone is motivated to participate at this level of treatment, but most are," he adds.

Another important criterion for success is the patient's emotional state. "A majority of individuals who begin the program are suffering from significant depression," Phillips says. "Most leave with an improvement of that depression, although it may not be fully resolved. Also, patients generally show improvements in pain coping skills and in their ability to assume the activities of daily living and social activities."

TRIPP uses various instruments to measure improvement. "We employ self-report scales to measure a patient's subjective progress, including measures of mood, self-perceived pain-related disability, and the use and effectiveness of pain coping strategies," Phillips says. "These are part of our methodology and data tracking, but our emphasis is on functionality rather than pain. We emphasize what people can do, not how much they hurt."

TRIPP uses the Oswestry Disability Index, a functionality scale commonly used in rehabilitation.

"The Oswestry Disability Index is a self-report measure of the extent to which one feels impaired in daily tasks, including activities of daily living; walking, sitting, and standing tolerances; sleep; sexual functioning; social and travel activities; and the extent of pain relief afforded by medication. We use it in part because of its proven ability to measure change, such that if a patient within the course of the program experiences

### The group uses a vocational specialist who helps patients return to work.

specific anatomical cause. "An injury that cannot be treated and causes chronic pain changes the nervous system, mostly in the spinal cord and the peripheral nerves, and that changes the way the pain or alarm system responds," he says.

The 15 orthopedic surgeons in the Triangle group refer many of TRIPP's patients. "The Triangle surgeons refer patients specifically for an interdisciplinary evaluation for participation in the TRIPP program, or just for psychological or physical medicine treatment," Wilkins explains. "We also receive a large number of referrals through our relationships with local insurers and employers, and through rehabilitation nurses in the workers' compensation system."

#### Boosting Productivity

Patients arrive at the TRIPP offices at 8 a.m. and stay until 4:30 p.m., each day, Monday through Friday. The duration of the program varies by patient, but typically lasts four weeks. Each patient's day is a mix of exercise-oriented physical therapy and group activities that include psychotherapy and education.

The program offers several specific pain management training skills, such as relaxation and self-hypnosis

specialist who works with patients to prepare them for reentering the working world," Phillips says. "Patients who are able to return to work first need to know the opportunities that exist for them if their original position is no longer available. The employers of many of our patients have positions that these individuals can fill, although those positions may have limited or restricted job duties. The vocational specialist helps patients work with their employers, determine what positions are available, identify transferable skills, and create a vocational plan for reentry to work."

The vocational specialist also helps patients become aware of their rights and obligations with regard to workers' compensation claims. "The vocational specialist offers patients a dose of reality," Giusto says. "They need to move on with their lives. Seeking endless payments under workers' compensation will be fruitless."

#### Program Results

Since TRIPP was initiated less than a year ago, fewer than 50 patients have completed the program, and early indications reveal remarkable success.

"As of today, all of the individuals who have completed the TRIPP pro-

**Medications and pain relief techniques can help many patients, but they may not be sufficient due to the psychosocial consequences of chronic pain.**

**—John Giusto, MD,  
Triangle Orthopaedics**

functional improvement, the index would reveal a measurable change,” Phillips says.

### Caregiver of Last Resort

Improvements are gratifying, given that most patients participate in the TRIPP program after failing to respond to other treatments. “We are the last stop for many of our patients,” Phillips says. “Most of them have been seen by several specialty or subspecialty physicians before coming to the pain program. Sometimes being the caregivers of last resort is tough to handle. Patients come in with emotional and physical ailments that have built up over time because they have not responded to past treatments. However, our work is rewarding because many of these patients do quite well and exceed their own expectations as well as the expectations of others in their lives.”

Too often, Giusto says, practitioners underappreciate and undertreat pain because they haven’t been trained to deal with the complexity of chronic pain. “Treating pain does not mean simply prescribing more drugs,” he says. “There are no such simple solutions. Furthermore, a fair number of our patients have experienced prejudice because of their pain or disbelief that it exists. Frankly, that environment tends to further entrench some dysfunctional behaviors that accompany the pain.”

TRIPP’s program seeks to help people address such dysfunctional behaviors and to improve their functionality and their lives, says Giusto.

“A large market exists for our services,” Wilkins says. “Millions of Americans suffer chronic pain each year, and hundreds of millions of work days are lost annually. Billions of dollars are spent on medical treatments, medications, and other attempts at pain relief. But we believe TRIPP is unique in the sense that our approach is interdisciplinary, emphasizes patient empowerment along with the restoration of functioning, and incorporates the talents and skills of exceptional practitioners in the pain management specialty.”

—Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

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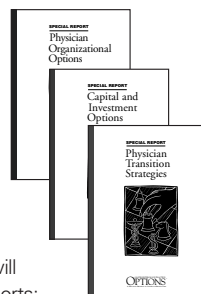
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# Risk Managers Question Consultations

By Toni Hendel, JD, RN

A physician asks a colleague: "What would you recommend for this patient?" The inquiry may come in a variety of settings, such as when the physician is making hospital rounds or responding to a telephone call from another physician. Known as "curbside consultations," such informal inquiries have been a long-standing practice among medical practitioners.

But today both physicians and risk managers are reexamining this practice. Physicians are concerned about the adequacy and quality of the information and recommendations being provided; risk managers have reservations about the potential professional liability exposure.

## Benefits of Consults

"Curbside consultation" usually refers to the informal process in which a physician obtains information or advice from another physician to assist in the diagnosis or care management of a specific patient. Generally, the physician being consulted has not reviewed the patient's chart or examined the patient, so the consultant's recommendations or comments are based exclusively on information provided by the physician seeking advice.

There are many potential benefits to a curbside consultation. For the

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requesting physician, it may be more time-efficient than it would be searching medical literature. Such consults also can encourage discussion among colleagues, as well as enhance a physician's ability to stay up-to-date on current medical knowledge. Further, neither the physician nor the patient incurs cost for such a consultation. The benefits for the physician being consulted include the intellectual stimulation inherent in conversing with a colleague about medical treatment, as well as the potential to enhance revenue through requests for formal consultations and the maintenance of an ongoing referral base.

On the other hand, the drawbacks to curbside consultations are considerable. Numerous studies have documented the concerns that the information being communicated in such

about how an insurer would respond to such an outcome.

## A Growing Trend?

Despite these drawbacks, the practice of obtaining curbside consults may increase as the way medical care is being delivered today continues to evolve. For example, physicians in solo practice moving to group practices, and patients moving from inpatient settings to outpatient clinics and from private pay to capitated contracts, are trends that foster curbside consults.

In two studies reported in JAMA, Sept. 9, 1998, researchers found that physicians in group practices requested more informal consultations and were more often asked to provide them than their counterparts in solo practice. Also, physicians with at least 30% of their income coming

**While legal precedents addressing liability for informal consultations have been few, physicians should recognize that such discussions place them at risk.**

informal exchanges is incomplete or inaccurate, thereby compromising the attendant quality of care. Another drawback is the possibility that information might be misheard or misunderstood, such as when a curbside consultation is conducted on a cellular phone and in a noisy environment.

Also, consulting physicians consider the lack of compensation for, and the time invested in, providing informal medical advice as drawbacks to curbside consultations. They are also concerned about the increased risk of professional liability in the event of an adverse outcome and uncertain

from a capitated payment system sought informal consultations more often and were more frequently asked to provide them than were their colleagues who had little or no capitated income.

The studies concluded that with growing numbers of physicians joining group practices, and with the penetration of managed care strategies emphasizing primary care gatekeepers, the use of curbside consultation would increase. Health care providers need to understand the potential risks involved in replacing specialty referrals with informal consultations, the researchers say.

## Despite some drawbacks, the practice of obtaining curbside consults may increase as the delivery of medical care continues to evolve.

### Legal Issues

To date, legal precedents specifically addressing liability for curbside consultations have been few. Nonetheless, physicians should be aware that this practice does place them at risk for being involved in litigation, either as a named defendant or as a witness.

Usually, a consulting physician becomes embroiled in such litigation when the physician who requested advice documents the consulting physician's name in the medical record or mentions it to the patient or the patient's family members. If that is not the case, it is likely that the defendant physician would state the consulting physician's name during a deposition, when the defendant physician, under oath, is routinely asked what he or she relied on in selecting the patient's treatment. Typically, the physician would respond, "I consulted with Dr. X, a specialist. I followed that advice." Such testimony, at the very least, leads to the consulting physician having a deposition taken and raises the possibility of being named as a defendant in the lawsuit.

In cases in which the consulting physician is a defendant, the court begins the inquiry by addressing whether a patient-physician relationship had been established. If not, no duty is owed to the patient; hence, there is no legal liability. This analysis is fact-based, and various jurisdictions are divided about which facts and circumstances are sufficient to form the relationship. Generally, merely answering a colleague's question does not give rise to a legal patient-physician relationship. Various contractual agreements or group affiliations, however, may be deemed sufficient for such a finding.

When making a determination,

courts ask the following questions: Has the doctor met or examined the patient? Has the doctor reviewed the patient's chart? Was the physician formally engaged to act as a consultant? Was the patient formally referred to the doctor? Was there a specific contractual relationship between providers? Was the physician engaged in conduct that can support the inference that he or she consented to treat the patient? (Was the patient billed for the services, for example, or was a follow-up visit contemplated?) An affirmative answer to one or more of these questions could result in a greater likelihood that a court would hold that a patient-physician relationship exists, and permit the action to proceed against the curbside consultant.

### Risk-Management Strategies

Given the often-blurred lines between curbside consultations and referrals, what should providers, medical groups, and health systems do to limit their risk? As an initial step, they should ask the following questions:

- Are informal consultations being used appropriately, or are they a substitute for a formal consultation?
- Do patients seen in formal referrals have better outcomes or shorter durations of illness than those treated based on informal consultations?
- Do fewer patients return to the clinic or is overall utilization improved for one group versus another?
- Are physicians aware that advice must be precise, objective, and include evidence-based medical support?

Also, all physicians might want to consider the following strategies:

- Implement an organized, informal consultation service. As part of the service, the group could institute guidelines for seeking infor-

mal and formal consultations, and consider compensating consultant physicians.

- Use principles of evidence-based medicine and view the consultant's recommendations with the same caution given to authoritative sources, such as textbooks and peer-reviewed literature.
- Have consultant physicians make clear that they are merely responding to a hypothetical case and that they have not examined the patient or reviewed any medical records.
- Have consulting physicians keep a record of the informal consultation.

### Coverage Issues

Not to be overlooked is professional liability insurance coverage. Depending on the insurance policy's language, there is a potential that the professional liability insurer may not provide coverage for resulting claims. Generally, medical malpractice insurance policies have triggers for coverage. The policy may state, for example, that the claim must be based on the rendering of, or failure to render, "professional services." This term may then be defined to exclude consultations for persons other than the physician's patients. The bottom line: Physicians who often provide curbside consultations should check with their insurers to confirm that this activity is covered under their policy's language.

Curbside consultations have been part of medical practice since the times of Hippocrates; today, however, physicians and other medical providers should be circumspect about this practice. Guidelines addressing the practice of informal consultations may require time and effort, which may be well rewarded by improved patient outcomes and reduced exposure to liability. ■

## Practices can lose as much as 25% of revenue through denials and may be writing off charges that could have been paid if physicians understood the reasons for the denials.

(Continued from page 1)

Practices can lose as much as 25% of revenue through denials, and they may be writing off charges that could have been paid if physicians or their staff understood the reasons for the denials, Grope says.

A diagnosis 600 code, for example, is likely to be rejected because as of Jan. 1, physicians should be using a 4- or 5-digit code, experts say. Also, many denials are the result of inconsistency in reporting the place of service. If the physician's staff bills a surgical procedure as being done on an inpatient basis, but the hospital bills it as observation or outpatient status, Medicare could view the claim as an unauthorized inpatient stay. This error is common, Grope explains.

**3. Don't wait for the patient to be discharged to bill the insurer.** Physicians can increase the speed at which they are reimbursed by billing Medicare or a private insurer as soon as a procedure is performed. Medicare accepts bills within the "global surgical period," defined as the postoperative days within which the physician must provide care and in which almost all charges are included and assigned to a given CPT code, Grope says. Since physicians are not paid for follow-up postoperative patient care for a full three months after the surgery, it is in physicians' best interests to bill for the procedure immediately following the surgery, she says. Doing so can affect 80% of a surgeon's revenue.

Marie Hayes, office manager for Berzon & Kaplan, MD Inc., a three-physician practice in Cleveland, agrees, saying, "For long-term hospital patients, we bill daily. We often secure payment prior to patient discharge, which boosts cash flow."

Fiala believes it is critical that

physicians submit claims for services rendered as soon as possible. "Insurers are constantly shrinking the submission time window," he says.

**4. Bill everything electronically.** Physician practices should submit all bills electronically, Grope says. "Reimbursement is significantly faster," she says. "I've seen checks cut in two days from insurance companies. Also, rejections are immediate, so you know right away if a claim has been denied, which can speed up cash flow by six weeks for denials."

Billing electronically requires computerization and billing software or a contract with a billing company. Practices that already have practice management software may be able to add a billing software module to it, possibly for little or no extra cost. Many physician practices are using electronic billing in some limited fashion, but Grope recommends that practices use electronic billing for every possible claim.

**5. Don't send attachments unless required.** Attaching a report or other information to a claim can delay payment because these attachments cannot be processed by the scanning software that handles most claims. Instead, such attachments must be reviewed by a claims reviewer in the insurer's office.

Stapling attachments to a claim also slows payment because the staples must be removed manually by payers that use automated scanners to read claims, and more insurers are using such technology to review claims, Grope explains. In fact, one attachment can delay payment by several weeks, Grope says. She estimates that about 15% of small practices regularly include attachments with their claims.

**6. Know the applicable Medicare policies.** Medicare has many pages of regulations, and the federal Centers for Medicare and Medicaid Services (CMS) can almost always explain why it issued a denial, Grope says. "Medicare staff can tell you exactly what they expect," she says. "So if you get a denial from Medicare stating that a particular service was not medically necessary, that simply means that there's a published policy and you didn't follow it."

CMS makes it possible for all physician practices to stay up to date, Fiala adds. Every practice should have a copy of the *Medicare Provider Manual*, which is available online (at [www.HCFA.gov](http://www.HCFA.gov)). "All billing and coding staff should read it," Fiala explains. "Also, reviewing the monthly *Medicare Newsletter* should be part of the monthly billing and coding compliance meetings."

**7. Understand CMS's correct coding initiative.** Under the correct coding initiative, procedure codes will be rebundled if a bill for two or three procedures or several CPT codes would better be described by one code. In this case, Medicare may rebundle the codes and pay them under the proper code, Grope says. During such rebundling, some codes are discarded, which often results in a lower payment.

CCI coding criteria are constantly being changed, which presents a problem for some practices. In some cases, physicians may charge too much for services included in some codes, increasing the risk of an audit. Given the current focus on compliance, coding accuracy is particularly important today, experts say.

**8. Understand the prompt-payment laws in your state and how**

(Continued on page 9)

**“With a paper denial, it takes four to six weeks to learn that the claim is being denied, whereas with electronic billing you know the next day if the claim will not be paid.”**

**—Colleen Grope, Medsys Consulting Inc.**

(Continued from page 8)

payers try to circumvent them. In Ohio, for example, insurers have 24 days to process a clean claim. “Some companies consistently fall outside the prompt-payment laws, and it would be advisable to work with your state medical association or the insurance commissioner to resolve any issues of slow pay,” Grope explains.

Moreover, many payers are wording contracts to circumvent laws on prompt payment, meaning physicians should be wary of any contract revisions. “Be sure to review your new contracts and eliminate any wording that gives the payers more time to pay,” Grope advises. “Edit the contract to fit your needs and negotiate it that way, if possible.”

**9. Understand insurers’ filing limits.** The length of time a payer allows physicians to submit a claim can range from 30 days to 2 years. Therefore, claims need to be filed on time. If they are not, the practice can lose a significant amount of money each year, Grope says. “This is another reason to file electronically because many insurers will send an electronic report showing they received the claim on time,” she explains.

**10. Follow the patient’s path of care.** Physicians should select a patient chart at random and see if the path of care is clear, and if the practice has billed for all care provided. “Many physicians would be surprised if they pretended to be a patient and went through their own system,” Grope says. In conducting such a review, she says, physicians are likely to find that charges have not been submitted quickly due to inefficien-

cies in office processes, as well as many missing charges, resulting in lost revenue.

“You may find that you saw 57 patients in your office, but billed for only 56,” Grope says. “We see this every day in practices.”

**11. Review all forms used in the office.** Once or twice each year, the practice should review all forms, particularly those related to finances, policies, and patient consent, Grope advises. When laws or practice patterns change, office forms may no longer provide the information needed to operate efficiently. Patient forms may not include spousal information or provide enough details to make contacting patients efficient, for example.

**12. Update patient information regularly.** In any group of patients, many are likely to change insurers regularly. “Practices are getting many denials because of invalid insurance information and mail being returned because of invalid addresses, a situation that creates extra work for the staff and delays reimbursement significantly,” Grope says.

Adds Fiala, “Many hospital systems require patients to re-register and to provide a copy of their insurance card at every encounter, yet many physician practices never ask patients to update their registration information. At the absolute minimum, every patient should be asked to complete a new registration form once a year.”

**13. Copy both sides of insurance cards and drivers’ licenses.** “Just because the front of the card lists Blue Cross Blue Shield, the back may list a third-party administrator, which is where the claim needs to be sent,”

Grope says. Also, staff should write down the date the card is copied. “A driver’s license can be used as a tool for recognizing a patient’s name and face, for collections, and also to prevent misuse of insurance cards,” Grope says.

**14. Audit charts for documentation and missing charges.** When Grope does a thorough chart audit, she says that she almost always finds charges that were never billed. In many cases, physicians have not billed for as much as 8% of revenue every year, she says.

Not only do these errors result in lost revenue, documentation errors can be problematic in federal compliance investigations, indicating at a minimum that a practice’s billing and documentation are sloppy and prone to errors.

**15. Adopt financial and collection policies, and follow them.** “Most of the practices I visit have signs saying that the co-pay is due at the time of service, or that payment in full is due in 30 days, but these rules are rarely enforced,” Grope says.

If a physician sends multiple statements to collect a \$5 co-payment, the cost of sending the statements can exceed the value of the co-payment itself.

“This situation results in negative cash flow,” Grope says. By having written collection policies, a practice empowers its staff to be able to explain the patient’s bill and to help to achieve prompt payment.

—Reported and written by David Kettlewell, in Akron, Ohio. Readers may contact Grope at 330/758-8832 and Fiala at 330/869-9596. More information on physician practice strategies is available on our Web site (see page 16).

# Despite Debate, HIPAA Moves Forward

By Ed Blonski

**R**ecent debate surrounding the privacy regulations in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 led many to believe that the regulations would be delayed and modified. So, many in the health care industry were surprised when the privacy regulations were released in April. With that release, two of the six mandated regulations are now in final form. Compliance with the regulations on transactions and code sets is required by Oct. 16, 2002, and compliance with the regulations on privacy is required by April 14, 2003.

The remaining regulations cover identifiers for providers, employers, health plans, and claims and are expected to be released by year end. The regulation for individual identifiers is on hold indefinitely, due to the many varying opinions and positions among members of Congress. One concern keeping this regulation on hold is a fear that health care organizations will be gathering and sharing too much private information about patients.

## What to Expect

Even as the health care industry awaits the remaining regulations, many physicians and health care administrators are concerned about the 24-month compliance period prescribed under HIPAA. Many organizations, such as Blue Cross

Blue Shield Association and the American Hospital Association, believe that two years is not enough time to change the systems and processes necessary for compliance.

Consensus is mounting in Washington that relief may be forthcoming regarding the compliance dates. Although the period for achieving compliance is mandated by law, the federal Department of Health and Human Services (HHS) may have the power to hold off on

enforcement, thereby effectively extending the compliance dates. Some pronouncements from HHS about this aspect of the law may come by the end of the summer.

In April, published reports said Health and Human Services Secretary Tommy G. Thompson used the term "common sense" to describe HHS's approach toward HIPAA regulations. This term has led some to believe that Thompson will refine the regulations in such a way that achieving compliance will be much simpler and less costly than many experts currently envision. In a recent statement about the new privacy regulations, Thompson said, "Certainly patients want their doctors to make the most informed decisions possible about their care and treatment. Patient care will be delivered in a timely and efficient manner and not unduly hampered by the confusing requirements surrounding consent forms."

Whether the compliance period is accepted as is or is extended, it is clear that HIPAA will be implemented. There is little evidence that the

Bush administration will repeal or soften the law in the foreseeable future. Therefore, all health organizations, which are legally bound to comply with HIPAA, need to become familiar with the proposed regulations as they are released and focus on achieving compliance. To comply, all organizations must have plans that address issues related to transactions and code sets, in-house software, billing services or clearinghouses, security, and privacy.

**Two of the six regulations have been released, and it is expected that the remainder will be available by year end.**

**Transactions and code sets.** Complying with the HIPAA-mandated transactions and code sets will require either using a billing service or clearinghouse, or upgrading existing practice management software. Currently, many practices are using a combination of a billing service, clearinghouse, and software.

**In-house software.** When reviewing new or upgraded software, it is best to look for systems that have fully integrated transactions for electronic data interchange (EDI), such as real-time eligibility verification, referral and status authorization, eligibility rosters, batch Medicare eligibility, patient statements, credit card verifications, check guarantees, laboratory interfaces, and electronic prescription authorizations and refills, and a guarantee that these transactions are or will be HIPAA compliant.

**Billing service or clearinghouse.** A health care transaction clearinghouse performs auditing services on insurance claims. If a claim is determined to be free of typographical, syntactical, and logistical errors, it is

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forwarded to the insurer for payment. If errors are detected, the claim is returned along with an explanation of what is wrong so that the errors can be corrected and the claim resubmitted for another pass. This process may be repeated until the claim passes inspection.

Under HIPAA, health care clearinghouses can accept nonstandard transactions for the sole purpose of translating them into standard transactions for sending customers and can accept standard transactions and translate them into nonstandard formats for receiving customers.

**Security.** The HIPAA draft security regulations are comprehensive, but the implementation of security in today's technological environment leaves open the possibility of security breaches. Both technological and process safeguards should be noted.

The infrastructure, networks, and other software employed in a practice must provide, at a minimum:

- Password security
- Firewalls to lock out intruders
- Limited access privileges
- Audit logs that record who has accessed patient records and with what intent, such as updating, viewing, and deleting
- Digital certificates so that management can guarantee the identity of anyone accessing the system

Minimal process safeguards to put in place include the following:

- Policies and procedures to define various levels of access to patient information
- An ongoing internal audit process to evaluate all procedures
- Policies and procedures to address the removal of passwords, identification cards, security codes, and other issues
- A security training program for employees, contractors, and agents
- A security officer assigned to review software and network operations periodically to ensure that security is not breached or misused

- A policy for issuing and updating passwords regularly, and that prohibits the sharing of passwords
- Hiring practices that ensure new hires and current staff have clear, ethical backgrounds in previous employment

where casual readers can see it

- Ensuring faxed material is always sent to the correct recipient

While there are many other areas of concern in the regulations, physician organizations will be well on their way to becoming HIPAA compliant if

## Taking no action means physicians would miss many of the opportunities associated with the HIPAA reforms.

- A policy against leaving terminals signed-on after workers leave their workstations
- A process for negotiating a "chain of trust" agreement with other organizations that will have access to patients' information

**Privacy.** The privacy regulations under HIPAA concern any clinical information about a patient that is transmitted electronically, on paper, or orally, and any information stored in any form, whether electronic, paper, or image. A practice's approach toward privacy should encompass, at a minimum:

- Establishing employee sanctions to be applied for any privacy procedure violations
- Posting public notices of each privacy procedure to assist patients in understanding what documentation is available
- Assigning a privacy officer to educate employees and review processes consistently to ensure privacy is not violated
- Negotiating agreements to allow other organizations access to patients' information
- Ensuring casual conversations about patients do not occur outside of the office or within earshot of other persons and ensuring that conversations about patients are limited to those directly involved with treatment or payment
- Ensuring any paperwork regarding patient clinical data is not left

they apply these basic guidelines.

### Implement a Plan

To take no action is, by default, to miss many of the opportunities associated with these reforms. At a minimum, every health care organization should become educated regarding HIPAA and how it will affect the organization. As a direct result of HIPAA and expanded use of electronic commerce, health care organizations can achieve significant cost savings through

- Reduced accounts receivable
- Improved quality of claims and associated reductions in the cost of processing claims
- Lower labor costs associated with enrollment verification, claims processing, medical records, and other areas
- Reduced opportunities for medical errors that often result from poor information
- Reduced fraudulent claims.

All signs from Washington indicate that HIPAA will steadily move forward. Given that two regulations are final and that experts expect the remainder will be released this year, focusing on compliance is essential. By following the guidelines outlined above, physician organizations will stay on track with HIPAA compliance no matter what action the government takes or how quickly the additional regulations are announced and finalized. ■

# Consultant Explains the Implications of HIPAA for Physician Organizations



**Peter Kongstvedt, MD**, is a leader in the managed care consulting practice of Cap Gemini Ernst & Young, in Washington, D.C.

Kongstvedt is an expert on the Health Insurance Portability and Accountability Act of 1996, and helps health care organizations assess and implement strategies to comply with HIPAA's regulations. Kongstvedt is well known for writing the reference book, *The Managed Health Care Handbook*, (Aspen Publishers, Gaithersburg, Md., 2000), which is currently in its fourth edition. He also conducts research and publishes monographs and position papers about health care issues. An internist by training, Kongstvedt has almost 20 years of professional management experience. Richard L. Reece, MD, editor-in-chief, conducted this interview.

**Q:** What is the Health Insurance Portability and Accountability Act of 1996?

**A:** HIPAA was originally designed to ensure that individuals who lost or switched jobs could continue their health care insurance coverage. The act also contains provisions on maternal health and mental health benefits, and medical savings accounts (MSAs). At issue today are many provisions in HIPAA that relate to simplifying health care administrative processes; standardizing medical transactions, data, and identifiers; and ensuring the privacy and security of medical information.

The first set of HIPAA provisions took effect in 1996 and 1997. These provisions, Titles I, III, IV, and V,

relate to the portability of insurance coverage, benefits, and MSAs. Title II, which will be coming into effect over the next few years, addresses administrative simplification and has four major components: transactions and code sets, privacy, identifiers, and security.

The final rules for the transactions and code sets have been issued and are scheduled to go into effect in October 2002. Final rules on privacy were issued and are scheduled to go into effect on April 14, 2003. Tommy Thompson, the Secretary of the federal Department of Health and Human Services, recently reopened those for comment, but subsequently issued a statement that the rules will go into effect as scheduled. The proposed rules on the other two components, identifiers and security, are supposed to be issued sometime this year, and it will be at least two years after that before they will become final. Each component of Title II will affect physician practice in a different way.

**Q:** What do the transactions and code sets mean for physicians?

**A:** The most positive effect of HIPAA on physician practice will stem from the regulations on transaction and code sets. Over 400 proprietary electronic formats for doing data exchange currently exist to deal with the business of medicine—functions such as claims filing

and eligibility determination. Through HIPAA, the government has taken one set of transaction standards, called the ANSI X12, and required that it be the only set of standards to be allowable after October 2002. Once this regulation takes effect, physicians will no longer be required to understand and use 400 different standards in managing the business end of their practices.

This standardization represents a huge benefit to practice management. One major barrier to electronic communication in physicians' offices has been the lack of data standardization. As a result, physicians must pay large fees to companies, such as clearinghouses, to transmit their data electronically to payers. Now that one set of standards has been mandated, the cost of transmitting this information will plummet. Physicians using practice management software that is based on ANSI standards and that meets security requirements can transmit data over the Internet directly to payers. The cost of data transmission for filing claims electronically, getting autho-

**“The regulations also should significantly reduce bad debt, because physicians will have the ability to electronically check eligibility.”**

rization, and determining eligibility and claims status will go way down.

In addition, HIPAA requires that ICD-9 and CPT-4 codes become the standard medical codes used by all providers and payers. All the local codes that have been developed will no longer be used. In other words, in

**“Physicians can maintain a paper system if they want to. But I don’t know why they would want to do that because the advantages of a computerized system will be significant.”**

most markets, payers and providers have created special codes to deal with unique payment or service items, such as bundled pricing for a specialized procedure, and these will be eliminated.

Such code standardization is both good and bad. On the positive side, codes will be standardized across the country, so that a code used in Schenectady, New York, can be billed to a payer in Hartford, Connecticut. The bad news is that many local codes have been created for special purposes—such as home health and ambulance services—and it is still not clear how those codes will be used. Some can be substituted for standard codes, but the government is considering how to replace codes that will become invalid.

**Q:** *Could these rules on transactions and code sets lead to speedier payments?*

**A:** Absolutely. Once the regulations go into effect, all the time required to create a paper claim, mail it, sort it in the mailroom, and log it in—with all the potential for errors in data entry—will disappear for electronic submissions. And if an error occurs, the staff in the physician’s office finds that out immediately and can fix it, so the claim is entered correctly into the system. Timelier submission of clean claims will speed payment to physicians.

The regulations also should significantly reduce bad debt, because physicians will have the ability to electronically check eligibility. Currently, physician practices may have practice management software that can check eligibility on the physician practice end when a patient comes in for treatment, but the payers do not necessarily have

the capability of responding to the query immediately. In other words, it is often difficult for a physician to find out if a patient is actually covered, and under what terms.

Under a standardized system connected through the Internet, when a patient makes an appointment or checks in, the staff can use the practice software to send an inquiry to a payer anywhere in the country and the payer’s software can link to its eligibility database and respond immediately. The payers will need to create this capability in many cases, and HIPAA requires them to do so.

**Q:** *Does HIPAA require a practice management system and Internet access?*

**A:** No, nothing in HIPAA requires physicians to do that. Physicians can maintain a paper system if they want to. But I don’t know why they would want to do that because the advantages of a computerized system will be significant.

**Q:** *How do small practices prepare for the October 2002 implementation of the final rules on transactions and code sets?*

**A:** Many small practices do not use computerized practice management software, and these practices will have to decide whether they will computerize their office. If they decide to do so, they should probably not purchase software unless they are guaranteed that it will be HIPAA compliant and be able to take advantage of all of the HIPAA-mandated transactions. If they cannot get such guarantees, they may be wise to wait until they can get a system that is compliant with the HIPAA requirements. One caution is that many vendors claim that they are currently HIPAA compliant, but

they are actually still working on it.

Physicians who do not want to buy software can use an application service provider (ASP), a software service available over the Internet by subscription. Physicians simply pay a monthly fee to log on and use the service. This is a much cheaper option than buying a practice management software system. More importantly, one of the great advantages of the ASP is that it continually updates any changes in the HIPAA rules and incorporates it in the software, meaning physicians do not need to purchase periodic upgrades as they do with stand-alone software systems.

The downside is that not all geographic locations have access to strong Internet connections over a DSL or dedicated line.

**Q:** *If simplifying transactions will generate positive financial results, why have so many physicians been anxious over HIPAA’s effects?*

**A:** Most anxiety has stemmed from Title II’s privacy component, the next major provision of HIPAA to be implemented. The privacy component includes both benefits and downsides for physicians. Privacy standards are being promulgated, and if the public feels safer about their private medical information, that’s good news because public confidence in the privacy of their confidential records is important.

The bad news is that the privacy standards extend to paper, electronics, and everything except the thoughts in the physician’s head. The actual regulations are only about 90 pages, but the commentary on them comes to almost 1,200 pages. In effect, the regulations micromanage the transmission of medical information, including highly detailed

*(Continued on page 14)*

(Continued from page 13)

requirements for tracking information, having a privacy officer, and creating audits of where information goes. However, certain major issues, such as faxing information, are not as easily interpreted as the drafters of the rule might have hoped.

The bulk of the responsibility for privacy falls on the providers. Frankly, that's perfectly logical because most protected health information exists in provider systems, such as medical and billing records, laboratory results, and X-rays.

**Q:** *Hasn't the passage of the privacy regulations been delayed for further consideration?*

**A:** Thompson reopened the regulations for further commentary, and the commentary period closed on March 31. The secretary has reiterated firmly that the Bush administration stands behind privacy rights, and he has not changed the date of implementation. However, the rules can be changed with the issuance of technical corrections and rule interpretations, which can be very lengthy. This may address many issues of concern. For example, one issue is that the way the rules are currently written, your spouse cannot pick up your prescription for you at the drug store, because the prescription contains protected health information. You would need to sign a special form for your spouse to present each time he or she got your prescription. The regulations include other complexities and inconveniences as well that may be addressed before the implementation date.

**Q:** *What are some other specific requirements of the privacy regulations that will affect providers?*

**A:** Currently, the regulations require the use of a consent

form, which is a special form that has to be clearly worded, identifiable, and not buried in any other paper work. The patient has to give written consent to allow a provider to bill for services and to transmit the necessary information in order to get paid in the normal course of business. Each provider has to get a signed consent form, although HIPAA does allow for groups of providers that normally work together—for example, hospital-based physicians such as radiologists, pathologists, doctors in a faculty practice plan, or a health clinic—to be grouped together under one consent form. In contrast, a specialist who comes in from the outside to do surgery may need to get a separate consent form.

That's just the requirement for the routine course of business. Providers who are involved in other activities, such as a quality study or sending information to a drug company, must get the patients involved to sign another form called an authorization form, which is even more explicit and has an expiration date.

**Q:** *What will be the effect of the security regulations?*

**A:** For the security component of HIPAA, the government is going to issue rules about what providers and payers must do to maintain secure systems. This is a big concern with regard to privacy. For example, all hospital data systems can be hacked. HIPAA will set forth regulations that specify what must be included in computer systems so that they cannot be breached. Examples include policies and procedures for login routines, password protection, restrictions on what may be accessed, automatic logoff procedures, and special access requirements.

**Q:** *The last of the four components is the identifier. What is it, and why is it important to providers?*

**A:** The identifier component stipulates that all ID numbers will be made uniform for providers, health plans, and employers.

Standardizing the provider identifier is a complex issue. The provider identifier will replace all other identifiers, including the Universal Provider Identifier Number (UPIN) used in Medicare, any Medicaid identifiers, and any and all commercial health plan identifiers. Each physician will be assigned one 10-digit identifier for use throughout his or her practice life. When he or she retires, that identifier will be retired as well. One reason behind setting a national provider ID is to catch fraud.

For many physicians, adopting their new identifier number will be simple and easy. But others who have been using different IDs for different purposes will face more complex situations, such as a physician who has one ID for HMO patients, and a different ID for PPO patients.

**Q:** *What do you think will be the broad implication of HIPAA?*

**A:** HIPAA will spur many physicians to computerize their systems and use applications that will facilitate the business of medical practice. I hope that the act will finally knock down the last major barrier to complete electronic communication in medicine, which has been the lack of computerization of private physician offices. Full electronic communication will enhance the quality and efficiency of the health care sector.

—Edited by Deborah J. Neveleff, in North Potomac, Md. More practice strategies are available on our Web site (see page 16).

**“I hope that HIPAA will finally knock down the last major barrier to complete electronic communication in medicine, which has been the lack of computerization of private physician offices.”**

# Steps To Starting a Group Practice

By John W. McDaniel

Physicians are seeking ways to have more control over their practices, time, and money, and many often find it difficult to achieve these goals when operating in practices that are owned by a hospital or health-system.

One model that physicians are using as a practice alternative is the medical group, which allows them to lower overhead expenses and to improve their quality of life. The typical group practices are either a single-specialty organization with three to 10 physicians or a multispecialty group of any size. For this discussion, a "group practice" could include a solo practitioner or a partnership of two physicians.

Any physician seeking to develop or expand a group practice needs to explore the process by which the model can be most effective. To do so, physicians need to understand the three stages of group practice development: feasibility, development, and implementation. (Implementation will be discussed in a future issue.)

**Feasibility.** The feasibility phase involves making a candid assessment of the financial projections of the group practice and doing a cost-benefit analysis of the lifestyle considerations. In this stage, physicians also should consider both the professional and personal interests and differences of each physician in the group in order to determine whether the group practice model is feasible.

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Interestingly, approximately one third of all potential group practice development projects do not go beyond the feasibility phase due to professional or personal differences and because of conflicts over the proposed physician compensation plan.

**Development.** Assuming the group practice idea survives the feasi-

bility phase, the next phase—development—is the most time consuming. This phase involves examining the legal and operational issues that the physicians must evaluate in order to help ensure that the resulting practice will succeed.

Among the legal issues the physicians should consider is the development of the articles of incorporation that address governance issues, buy-sell agreements, expense allocation, compensation formulas, and benefits. The physicians also must review any retirement plans and dispose of or revise existing plans, and arrange for new ones if necessary.

When developing a group, one of the most important issues to address involves the possibility of a merger and what effect a merger would have on physician compensation, governance, the pension plan and employee benefits, the name of the practice, support staff personnel, banking and lending relationships, appraisal of real estate, financial projections for the new group, employment agreements with physicians and administrators, licenses, and relationships with vendors.

The physicians also should draft a preliminary merger agreement that includes the group's articles of incorpo-

ration, bylaws, and the names of the directors and officers. It should address how to convert any securities to cash and should include all representations and warranties made by the medical group to its shareholders. It also should address the conditions required to close the deal, termination and abandonment, survival of representations

**Before starting a group practice, physicians should understand the steps required in feasibility and development.**

and warranties, and indemnification.

The preliminary agreement also should outline how the assets of the practice could be purchased, including a description of the facilities and definitions of terms. In addition, it should address issues related to the assumption of liabilities; purchase price and adjustments; representations, warranties, and covenants the selling physicians have to shareholders; the representations and warranties of the purchasing medical group; the conduct of the parties prior to closing; the conditions that must be met if purchasing a medical group or selling the medical group; and any restrictive covenants.

The physicians also should review and revise as needed any employment agreements. Such agreements address compensation and benefits, the duties and responsibilities of each physician, term and termination, restrictive covenants, and confidential information.

Finally, the physicians should write buy-sell agreements that outline what events would trigger a purchase, how the purchase price will be set, how the proceeds from a sale would be disbursed. Also, it would include any restrictive covenants and how to resolve any disputes. ■

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