

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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CONTENTS

Features

Commentary
Expert Offers Five
Steps for Developing
Clinical Systems 3

Strategy
Data Management
Can Address Cost,
Access Issues,
Expert Says 8

Interview
Washington Physician
Advocates Billable
Electronic Medical
Services 13

Departments

Editorial
New System
May Help Offset
Medicare Cuts 2

Practice Management
Innovations Can
Improve Efficiency 6

Are Cash-only or Concierge Practices Viable Options?

Frustrated with today's practice environment, some physicians are leaving traditionally organized groups to practice in unconventional ways that they hope will allow them to alleviate one of the most common complaints about office practice: the pressure to see too many patients in too little time.

Two alternative economic models of practice have recently received media attention as examples of how physicians are trying to break out of the current system while retaining the traditional rewards of practice. Frustrated by shrinking reimbursement levels and rising costs, some physicians are opting out of the insurance-sponsored, third-party payer system and practicing on a strictly cash basis. Others are charging patients an annual fee for extra services in so-called boutique (or concierge) practices.

Risk and Reward

While neither of these practice options is thought to portend a significant trend—at least not yet—the attention they have garnered has reignited debate and discussion about the rewards and pitfalls of today's practice environment, as well as the obligation of physicians to their patients and their community.

Relatively few physicians opt out of the insurance system to do business

with patients on a cash basis, according to some industry estimates. The AMA, for example, says that about 90% of practicing physicians have at least one contract with a managed care or private insurance plan. Coincidentally, this is almost the same percentage of physicians—87%—who believe that overall morale has decreased among physicians in the past five years, according to the National Survey of Physicians released by the Kaiser Foundation in April 2002. More than half of the responding physicians said they felt less satisfied during the previous year, laying the blame primarily on administrative headaches and loss of autonomy.

More than three quarters of doctors surveyed said managed care has had a negative effect on the way they practice, citing increased paperwork, decreased time with patients, and more restricted patient access to specialists as their chief complaints.

These are the complaints most often cited by doctors who set up cash-only practices, which serve both insured and uninsured patients. Not simply for the wealthy, these practices attract uninsured patients searching for care at a fair price because some physicians offer cash-paying patients a discount that reflects the practice's lower overhead costs. These practices also attract many insured patients who submit claims to their insurers.

(Continued on page 10)

New System May Help Offset Medicare Cuts

Earlier this year, the Centers for Medicare and Medicaid Services cut physician fees by 4.9%, under a law passed by Congress. Deeper reductions are scheduled to go into effect over the next three years, affecting the revenue of the 550,000 physicians and other providers who supply services to the program's 39 million disabled or elderly recipients.

Many physicians have reacted to the cuts by refusing to take on new Medicare patients. The American Academy of Family Practice says that 17% of its members have made this choice. In Colorado and Washington state, as many as 50% of physicians no longer accept new Medicare patients.

CMS says that the denial of access to Medicare is not systemic and that it sees no reason to change its physician reimbursement policies. Faced with declining reimbursements from the fee-for-service and the Medicare sectors, what are doctors to do?

One response has been political. In May, the AMA and others argued that CMS can revise fee projections and restore \$62 billion in Medicare payments to physicians over the next 10 years. But CMS Administrator Thomas Scully has said that he doesn't have the power to do so. Nevertheless, the AMA and other medical societies continue to make the case that such deep cuts will result in limiting access to care for those who need it most: older Americans and the disabled.

Another response would be for physicians to use new technologies to reach more patients more efficiently. Medem Inc., sponsored by the AMA and seven professional medical societies, has created an online consultation service that permits patients to pay \$20 to \$30 for consulting advice without visiting a physician's office. Such consultations allow physicians to communicate online with patients via a secure Web server and to receive payment for their work, according to Medem (at www.medem.com).

Medem CEO Edward Fotsch, MD, says that 1,000 doctors have used its online consultation service; and the service may generate as much as \$5,000 to \$10,000 in new revenue per year for the physicians who participate, experts predict. In addition, the service could increase savings and convenience for patients, give physicians more access to insured patients, and increase patient satisfaction.

Online consultation is a new source of revenue for physicians, and Medem offers a promising system that gives physicians a potential opportunity to offset cuts in Medicare payments.



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Expert Offers Five Steps for Developing Clinical Systems

Clinical computer systems can improve the efficiency of a medical practice and increase the quality of care being delivered. Despite these benefits, technical difficulties and physician resistance have resulted in slow adoption of these systems.

A step-by-step approach to introducing computers into medical practice can ease the burdens of such a task, says Brent C. James, MD, vice president for medical research and continuing medical education, and executive director of the Institute for Health Care Delivery Research at Intermountain Health Care (IHC), an integrated delivery system in Salt Lake City.

Integrated Efficiency

"To be widely accepted by practicing clinicians, computerized support systems for decisionmaking must be integrated into the clinical work flow," says James, a co-author of the Institute of Medicine's report, *To Err Is Human: Building a Safer Health System*. "They must present the right information, in the right format, at the right time, without requiring special effort. In other words, these systems cannot reduce clinical productivity. They cannot require physicians to learn to use a series of disconnected computer systems, and they must not be at odds with the physicians' concept of the medical record or their sense of auton-

omy in day-to-day decisionmaking."

To integrate a clinical support system into a physician's workflow, the system must be built up through a series of incremental steps. "Each step should be natural and straightforward, justify itself on its own accomplishments, and generate a return on investment," James explains. "Once physicians accept a low level of technology, such as voice activation, their ability to get to the next level of technology becomes easier."

Through incremental implementation, an organization can develop a staff of physicians who have moved from a paper-based system to an entirely electronic one, James says. "At IHC, we have changed physicians' concept of the medical record, but we have done this incrementally—a simple step at a time so that physicians do not have to learn a whole new way of thinking about practicing medicine," he explains.

First Steps

The first step is easy: automated scheduling and billing. "This function performs so well in its own right that even small physician practices have adopted it," James observes. "Now, we are at the point where Medicare is requiring electronic billing from providers." This step increases the efficiency of office operations, and it does not require physicians to change their practice

patterns significantly, he notes.

The second step is to automate clinical support services, such as pharmacy, laboratory (including microbiology and surgical laboratory), and radiology, James says. "Such systems, properly implemented, increase the efficiency and smooth the operation of the support services in question," he explains. "Plus they can speed access to critical patient management information for physicians and nurses.

"For example, back when I was a resident, one of our teaching hospitals implemented a computerized laboratory system," James continues. "All of the house staff and attending physicians routinely used the computer to retrieve lab values simply because it was so fast and easy, as compared to calling the lab or waiting around for a paper report."

The third step involves what James refers to as the electronic filing cabinet. Implementation of an electronic filing cabinet is perhaps the key step in the implementation process, he believes. "The concept is to allow physicians to document all care electronically, but without changing how they think about or format the medical record," James explains. "To do that, the electronic filing cabinet accepts encoded data where such data are easily available (for example, patient demographics from the scheduling and billing system and lab results from the laboratory system)

(Continued on page 4)

An electronic filing cabinet is a key to implementation because it allows physicians to document all care electronically, but without changing how they think about or format the medical record.

—Brent C. James, MD, Intermountain Health Care

(Continued from page 3)

and it allows physicians to enter dictated or boilerplate text easily, in the same format as a written record.

"The only change such a system requires is that physicians record to the EMR, rather than to a piece of paper," James says.

Cutting Costs

Physicians can reap numerous benefits by using an electronic filing cabinet. "IHC physicians have realized that, with the right technology, they can complete their documentation during patient visits without damaging their ability to interact with their patients," James notes. "In addition, enormous quality and cost benefits accrue. For instance, one physician reports that, by using such a boilerplate system, he reduced his office transcription costs from about \$1,600 a month to zero. His patient wait time dropped from about 30 minutes to 14 minutes, enabling him to increase his patient volume by about 10%, all because he is not stopping between cases to dictate."

Other physicians believe that their clinical quality has improved because they can always access the information on each patient's chart, even from home when on call and dealing with patients who their partners saw in the clinic that day. "Across our whole physician division, physicians are reporting lower costs and higher quality by using the EMR as compared with traditional dictation and transcription," James says. "From the physicians' perspective, the electronic filing cabinet is just the practice of medicine as they've always known it, but with a better tool for documentation."

What's more, an institution that does a good job at implementing an

electronic filing cabinet system can pay for it simply from the efficiencies that the system generates, James says.

The fourth step is the introduction of coded patient data that a physician enters and maintains. "Coded data are entered into computerized fields, which enables the computer to translate and process the data, as opposed to free text, which a computer cannot easily analyze," James explains. "This is Level I encoding, with encoded focused problem lists (which double as patient registries for chronic diseases), encoded medication lists, and encoded medication allergy lists. With those three components, physicians can do a surprising amount of disease management using a computer. The hurdle for disease management then becomes the development of a registry system. It is now becoming evident that to manage chronic disease, an institution must have registries that can track patients continuously over time."

Increased Efficiency

Using such a system can significantly enhance efficiency and quality of care. "The medication lists can solve a lot of the adverse drug event problems," notes James. "In fact, much of patient safety can be addressed simply with good computerized medication lists. These lists save physicians time as well. It is faster for physicians to pull down the pick list of the common drugs they use, click on a drug, pop it onto a medication list, and print a prescription than it is for them to write a prescription by hand. Our outpatient system does not yet have the full decision support to check for drug interactions and known allergies and to calculate ideal dosing, but those capabilities are

coming. We do have such capability in our inpatient system, where it is very popular with our physicians."

In another example of possible efficiencies, James considers a physician group that treats patients covered by the Federal Employee Health Benefits Plan. "FEHBP requires providers to rewrite all prescriptions every six months," he says. "If a practice includes many geriatric patients, some of whom may have as many as 15 prescriptions, or perhaps even more, the system can pay for itself in physicians' minds simply because of the time it saves when managing complex medical patients."

The fifth step is Level II encoding. In this step, the system adds specific codes that describe clinical factors associated with the common chronic diseases that account for most care. "IHC has such decision support for diabetes, congestive heart failure, and asthma, as well as chronic anticoagulation, with more conditions under development," says James. "Such coding systems add a few critical factors for a specific disease, while leaving most of the note to be dictated or added as boilerplate free text. The aim is to get the few encoded data necessary to allow the computer to produce useful patient management reports (for example, a list of all patients with diabetes who are late for recommended testing) while not significantly burdening physicians and nurses."

The single most important step any health care organization can take is to have a good long-term strategic plan for implementing these or similar incremental steps, James says. "Physicians and health care administrators should not think of computer systems as a big buy," he explains.

"Across our whole physician division, physicians are reporting lower costs and higher quality by using the electronic medical record as compared with traditional dictation and transcription," James says.

“We can always find the electronic medical record, regardless of when or where the patient was seen,” James says. “This feature has been among the most popular with our physicians.”

“They are something to be built over decades. Computer systems are dynamic; they grow over time, with bug fixes, individual module upgrades, and subsystem replacements. I sometimes think of big computer systems as topiary: You grow them in a particular direction, into a final desired form. But to do that there must be a vision of what the final form will look like in 10 years.”

Overall, if computers make it easy to practice high-quality medicine and to do it profitably, then it will be in the physicians’ best interest to use these systems, James adds. “But institutions should not try to do this all at once, with some single massive investment,” he says. “In fact, trying to implement a massive system in one step is probably a serious mistake that can drive the organization to its knees.”

Practice Benefits

The goal of the incremental steps is to achieve a state in which all record keeping is in electronic formats. The benefits of such a state can be enormous, James notes. “To date, by reducing our paper handling, we have been able to reduce our staff for finding, storing, and managing medical records,” he says. “Furthermore, electronic record management is clearly more accurate. We do not lose lab slips or radiology reports; in fact, we do not lose any medical information. What’s more, we can always find the medical record, regardless of when or where the patient was seen. This feature has been among the most popular with our physicians. Finally, physicians can access the record easily. We even have a secure Web interface so they can access their patient records from home.”

Recently, James visited a large academic medical center and was reminded of the significant problems with paper record management. “The colleague I was visiting was covering the internal medical outpatient clinic service at the time,” James relates. “As we were chatting about patient safety, residents were coming in to present cases. If a patient came in and the office staff could not find the regular chart—a frequent occurrence—a temporary chart had to be generated. (A temporary chart is a completely new chart, which includes a new history and physical

About 15% of nursing time is devoted to entering data into our transaction system for billing purposes. That’s just a rough estimate, but it is a massive expense for a completely redundant data system. The nurses collect the data in the clinical chart, and subsequently must make the same entries into a transaction file for the purposes of generating a bill.”

The redundancy doesn’t stop there. “We take the completed chart and send it over to the medical records department, where the staff extracts the codes, again for billing

James believes that noncompatible electronic data systems represent a huge unrecognized problem in health care.

examination information.) The staff also had to find and pull all the lab results and include them in the temporary chart so that the physician had access to that information as well. This is an expensive and totally redundant process. What’s more, the institution is required to maintain a whole group of people whose only job is to take the temporary charts and merge them into the real chart. One reason some of these charts were not available in the first place was that the records were in the merge process after the patient’s last clinic visit.”

Still, despite the efficiency benefits of electronic record keeping, data collection is often slowed because electronic data systems are not compatible. “Noncompatible systems represent a huge unrecognized problem in health care,” James says. “For example, at IHC, the single biggest expense for a hospital is nursing time.

purposes,” James explains. “This is not only redundant, but significantly inaccurate. This is the foundation for the whole federal fraud and abuse program—billing systems that don’t link well to clinical care. It also leads to arguments with insurance companies about what really occurred during a patient visit and whether the coded diagnoses and treatments are accurate and appropriate.”

The ideal system would collect data once, at its point of origin, and then use that one record for all subsequent purposes, James says. “Health care organizations will eventually be forced to move to point-of-origin data capture in order to achieve complete and accurate data while avoiding redundancy,” he predicts.

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

Innovations Can Improve Efficiency

By Neil Baum, MD

Today, the challenges for physicians and other health care providers are to improve clinical outcomes, increase access to the health care system, and reduce the rising cost of delivering services. Implementing changes also can be one of the biggest challenges they face.

Most physicians, health care providers, and technology companies are working diligently to improve the practice of medicine by seeking ways to provide better service using some of the same technologies (such as the telephone and computers), medications, or devices that have been in use for many years. Other physicians, providers, and companies are taking radically different approaches to improving the delivery of care, through what some experts call disruptive innovations. A disruptive innovation is usually a solution to a problem that is less costly than other solutions that have been tried and solves the problem to the benefit of patients, physicians, or others.

Positive Disruptions

There are numerous examples of disruptive innovations in medicine, especially in urology. These include extracorporeal shockwave lithotripsy and percutaneous nephrolithotomy, which are relatively new approaches

to the treatment of kidney stones. Laparoscopy is a disruptive innovation used in the management of many urologic conditions and is slowly replacing the scalpel as a treatment option for many procedures from adrenalectomy to radical prostatectomy. Also, a new technology called bladder tumor antigen is being introduced to replace cystoscopy as a method of monitoring bladder tumors.

In an interview in this newsletter last year, John Kenagy, MD, a visiting scholar at Harvard Business School who has written extensively about dis-

ruptive innovations, said there are hundreds of them in daily life. Personal computers are but one example in that they have helped individuals work more effectively, and they were instrumental in eliminating their forerunners, minicomputers and mainframe computers, just as desktop copiers disrupted the large copier business.

As new technologies change the way physicians work in their offices and interact with patients, they are also improving efficiency and cash flow, and disrupting long-held practices.

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Focused retailers, such as Home Depot and the large consumer electronics chains represent a disruptive innovation in that they have taken market share away from many large department stores, Kenagy explained. In turn, focused retailers and the large chains were disrupted by discount retailers and warehouse clubs. Many of the world's great companies started with a poorly functioning, disruptive idea, and improved on it over time until it became widely accepted, he added.

Typically, a disruptive innovation

will enter the system at the low-profit end of the market, an area in which market leaders are disinterested. For example, Dell Inc. began selling computers directly to consumers, taking sales away from larger companies that sold through computer dealers. Today, Dell is a market leader. Initially, such innovations usually have poor functionality, but they improve over time by continuing to meet the needs of consumers so that they eventually replace technologies that have been used at the high-profit end of the market, Kenagy explained. In this

way, cheaper, simpler, more convenient innovations replace those that are more complex, he said.

Today, new technologies are changing the way physicians work in their offices and interact with patients. Examples of these changes—many of which involve e-health care systems—include those that allow physicians to interact with patients over the Internet. Physicians can now answer patients' questions, refill prescriptions, and allow patients to schedule appointments by using e-mail. Such systems give patients access to physician practices 24 hours a day, seven days a week.

The paperless office, which was once only a dream, is slowly becoming a reality. Many believers hope this reality will extend to the patient's chart, and that the paper chart will soon go the way of the ledger card. Using hand-held person-

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al digital assistants, a physician can send a patient's prescription to the pharmacy when he or she is at the point of care with the patient.

Another disruptive innovation involves the use of computers to replace the operative note. Currently, a urologist must use his or her time during a patient visit or afterward to dictate an operative note. It then takes seven to 14 days for a transcriptionist to type the note and place it in the physician's box among other medical records, causing a delay of as long as two weeks before a bill can be processed and sent to the insurance company. This type of system can result in slowing payments for physicians and hospitals.

Faster Payments

Since few medical records departments can get a copy of the operative notes to the referring physician in a reliable, timely manner, the specialist or his or her office staff must provide the patient with postoperative instructions and then create a letter to let the referring physician know the outcome of the surgery.

Images taken during endoscopy or laparoscopy, or while using the ultrasound machine, often do not get into the doctor's office chart and are seldom attached to the operative note even in the patient's hospital record. Also, delays often occur and mistakes are often made in applying the proper diagnosis code to the procedure code. These errors result in a loss of time for the medical records department or office staff because the physician must be contacted in order to revise any inaccurate codes.

Failure to code properly or accurately can represent a loss of revenue for the physician or hospital when bills are rejected for improper coding. What's more, because the insurer will withhold payment while the physician's staff corrects the codes and resubmits the bill, receiving rightful revenue is delayed.

Simply calculating the savings on reducing transcription costs can more than make up for the cost of such computer systems.

Today, computers can replace the Dictaphone, the transcriptionist, and the coder who provides an operative note; a letter to the referring physician; and instructions to patients. What's more, computer systems can send images from fluoroscopy, endoscopy, or ultrasound machines, in seconds at the point of care, so that the steps required for documentation can be taken in the procedure or examination room.

These computer systems can also print notes for the chart, the patient, the referring physician, the physician's staff, and the business office of the hospital even before the patient reaches the recovery room. These notes contain an electronic signature, meaning additional reading and signing is not needed before the notes can be submitted to the insurer or before the hospital can process the bill.

Operative notes provide accurate documentation of the appropriate diagnosis and procedure codes and can go immediately to the billing office so that a clean claim can be submitted the same day the procedure is performed. Simply calculating the savings on reducing transcription costs, which are approximately \$15,000 per year for a busy urologist, can more than make up for the cost of such computer systems.

Innovative Developers

Many companies are developing disruptive innovations for computerized operative notes, such as Provation Medical in Minneapolis (at www.provationmedical.com) and Greenway Medical in Carrollton, Ga. (at www.greenwaymedical.com). Greenway provides an electronic medical records program that also contains a

practice management system, so double entry is not needed to create a record from the practice management system to the EMR. Data Strategies Inc., in San Diego (at www.e-dsi.com), offers its CompuMedic product, which provides an electronic billing program that cleans the claims submitted to Medicare and Medicaid.

MD Logic Inc. in Duluth, Ga. (at www.mdlogic.com) offers an electronic coding adviser and documentation program to assist physicians in recommending the proper evaluation and management code for each patient visit. MedicWare in Irwindale, Calif. (at www.medicware.com) offers an EMR for a hand-held computer.

Dialog Medical in Snellville, Ga. (at www.dialogmedical.com) provides educational materials and consent forms for every urologic procedure in the diagnosis and procedure code books. Doctor Goodwell, in Bellevue, Wash. (at www.doctorgoodwell.com), lets physicians use the Internet for real-time, virtual office visits between doctors and patients, improving office efficiency and helping to reduce overhead.

These are a few examples of disruptive innovations and how they can improve the practice of medicine. When introducing these systems, the flow of work in a physician's office is disrupted until all staff members become accustomed to the new methods and begin to see improvements in practice efficiency, cash flow, and patient care. The simple fact that physicians are using these systems to improve workflow and increase their efficiency means disruptive innovations are likely to become part of how doctors practice medicine and conduct the business of their practices. ■

Data Management Can Address Cost, Access Issues, Expert Says

By Richard L. Reece, MD, editor in chief

As health care purchasers brace themselves for the return of double-digit cost increases, they are also looking for ways to squeeze the inefficiencies out of the health care system that managed care could not eliminate, while at the same time seeking to improve the quality of care. Many industry experts argue that new technology, including data management, is an area that holds promise on both counts.

Norbert I. Goldfield, MD, medical director for 3M Health Information Systems, in Wallingford, Conn., believes that most aspects of quality and medicine are quantifiable, and that improving quality would reduce costs. Goldfield is well suited to speak on this topic, since he is responsible for developing the clinical logic for software used worldwide for payment and quality management purposes.

"To me, developing clinical logic for payment and quality management is as much an art as it is a science," Goldfield says. "But what distresses me is that quality issues play second fiddle to money issues, and understandably so because of the current rapidly rising health care costs."

Quantifying Quality

Quality is quantifiable, and improving it reduces costs, Goldfield believes. Unfortunately, he adds, "most of the

talk about quality improvement and measurement occurs in academic circles, when the real action in the real world involves cutting costs, not improving quality." In fact, rising health care costs—not improving quality—are currently driving the health care system, he argues.

To illustrate this assertion, Goldfield offers the following example: "If I look at diagnosis-related groups adjusted for risk and mortality, and I compare hospital A to hospital B, I can make a significant case for cost savings and quality improvement for one hospital versus the other." These efforts to cut costs, Goldfield says, are not in response to reports such as *To Err Is Human: Building a Safer Health System* or *Crossing the Quality Chasm: A New Health System for the 21st Century*, which were both issued by the Institute for Medicine and have received much media attention. Rather, Goldfield asserts, "the responses are directly related to the fiscal exigencies required of these hospitals to stay afloat financially."

Nonetheless, Goldfield believes that quality and cost control can both be improved through information technology. As a staff physician at Brightwood-Riverview Health Center, in Springfield, Mass., Goldfield is not only an expert on data management,

but also a practicing clinician; in other words he can see whether, and how, the theories and strategies that he and others who embrace the cost/quality paradigm actually work in practice.

To illustrate, he says: "Our medical group of 35 providers assumes capitation, which I encourage because if we are fairly paid to take on risks, we can become known as the best provider in our area of, for example, AIDS care. If we get fair payment, we are happy to take on those patients and not depend on fee for service. This strategy allows us to hire nurse practitioners and physician assistants who can provide home care for the complex patients who can be best medically managed in their home."

Challenges Ahead

One of the biggest challenges the nation faces and one that is exacerbating the issue of rapidly rising health care costs, is the increasing number of Americans who have no medical insurance. Goldfield is acutely aware of the problem of the uninsured because he confronts it in his practice and is addressing it through the clinical logic embedded in the software he develops.

"One of our challenges is taking care of the uninsured, and we have enrolled more than 1,000 uninsured people who receive a means-tested

(Continued on page 9)

"Most of the talk about quality improvement and measurement occurs in academic circles, when the real action in the real world involves cutting costs, not improving quality."

—Norbert I. Goldfield, MD, Brightwood-Riverview Health Center

“Many inexpensive and effective information technology products are available that can provide data capture and analysis for disease management,” says Goldfield.

(Continued from page 8)

card to receive care at private physician offices for significantly reduced fees or at no charge. Also, as part of the screening process, the program determines that almost half of the uninsured are, in fact, eligible for some type of program,” Goldfield says. “We also take care of underinsured patients—that is, those who have no prescription drug coverage or who have huge copayments—and we develop capitated programs for them. Participating in these programs provides me with clinical and organizational ideas for the software that I help to develop. The hospital participates in this program partly as a community service, but ultimately some of these patients become ‘paying’ patients as a significant percentage of them become eligible for Medicaid or other insurance.”

But software cannot solve the nation’s problem of health care for the uninsured. Goldfield tackles that issue in his book *National Health Reform American Style: Lessons From the Past, A Twentieth Century Journey* (published in 2000 by the American College of Physician Executives). In it, Goldfield argues that the nation’s health reform depends on the willingness of U.S. presidents to put their prestige on the line.

“I believe that significant national health care reform, which I define as universal coverage, depends on the president being passionately involved,” Goldfield says. That involvement, he believes, is more crucial now than ever before because of the huge amounts of money involved. “The president has to use the implicit and explicit powers of the presidency to make anything happen in the area of health care reform,” he asserts.

“I emphasize in my book that foreign policy crises can easily derail national health reform,” he continues. “Before Sept. 11, for example, prescription drug coverage was a prominent reform issue.” The events of Sept. 11 caused a delay in any immediate action being taken regarding health care reform, Goldfield says, but he believes that as circumstances improve in foreign policy, health reform will return to being a pressing national concern.

“I have no reason to doubt that President Bush will once again be interested in health care reform, at a minimum in prescription drug coverage,” Goldfield says. “What’s more, in the current economy, with hundreds of thousands of people being laid off from their jobs, the middle class may well be impelled to take a more active interest in universal coverage, especially if current foreign policy concerns recede. This in turn will lead to pressure on Congress and the president, especially Congress, since the president appears uninterested at the present time.”

The Only Solution?

At some point, universal coverage will be embraced as the inevitable and the only solution to the nation’s health care crisis, Goldfield believes. Yet it will not be a precipitous change, but rather a part of the political process, and as this process evolves, the efforts of certain reform-minded organizations will come into play, he notes. “Such groups can focus concerns on preserving the best and shedding the worst of the system we now have,” he says.

To illustrate his point, Goldfield cites the efforts of the Center for Practical Health Reform, in Orange

Park, Fla. CPHR brings together representatives of various health care organizations to improve the existing health care system by making recommendations designed to improve health care policy. The center’s mission—to “create broad-based, grassroots support for practical health care change that can improve quality, lower cost, and create greater satisfaction for all stakeholders”—is a recognition, Goldfield says, that the private health care system has benefits that are rapidly being challenged by those who believe a market-driven system tends to ignore the uninsured.

“If we continue with the current private health care system, we will need significant reform that includes universal coverage or else the private system will be in serious jeopardy,” Goldfield explains. “There are other important factors to be considered as well—such as tort reform, quality, outcomes, and disease management—but universal coverage is key. If, for example, the percentage of uninsured in California becomes prevalent in the rest of the country, I believe the voting public will demand that the government take over the payment of the entire health care system.”

IT and Health Reform

While health care reform is secondary to other national issues, information technology is evolving to provide the tools that can improve the quality and lower the costs of health care, Goldfield believes. “Many inexpensive and effective information technology products are available that can provide data capture and analysis for disease management, for example,” he says.

“In looking at risk adjustment,
(Continued on page 12)

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With the cost of insurance-related paperwork in most practices estimated at 20% to 30% of overhead expenses, it's not surprising that some physicians are frustrated, says Donald Berwick, MD, MPP, president of the Institute for Healthcare Improvement, in Boston. "It's really clear that the current insurance system burdens effective productivity of care with non-value-added work," Berwick said in an interview in the *Chicago Tribune*. "Doctors will tell you, and I believe them, that an increasing percentage of their day is going to record-keeping, filling out forms, justification, and review. That takes them away from the bedside."

Improving Cash Flow

At one time, Vern Cherewatenko, MD, a family physician in Renton, Wash., billed \$79 for a 10-minute visit at one of his five bustling family medicine clinics outside Seattle. But since insurers had negotiated reduced rates, they paid him an average of only \$43 for those visits. Moreover, it cost him between \$5 and \$20 in staff time to collect payment.

He and a colleague from another clinic system with similar problems considered overhead costs and determined that they were losing about \$7 on every patient visit, or thousands of dollars a month between the two systems. Under these arrangements, they believed they were only six months away from bankruptcy. Therefore, they joined forces to embrace a radical—some would say a thoroughly old-fashioned—economic model of practice: cash only, paid in full at the time of the visit. Cherewatenko cut his fees in half last

January when he began his new practice, charging \$35 for 10 minutes of his time. Now, both his practice and his income are thriving, he says.

Rejuvenated by his new freedom, Cherewatenko co-founded the American Association of Patients and Providers in Renton (at www.aapp.net) to help patients, physicians, and other health care providers implement patient-focused solutions to problems in the current health care system. Under AAPP, he and a partner created SimpleCare, a Web-based network (at www.simplecare.com) of about 1,000 physicians in 46 states who have agreed to offer rates reduced by 30% to 50% for patients who pay cash.

Patients can join SimpleCare for \$20 (\$35 for families) and use the directory of physicians in the network. Physicians, who pay \$50 to join, are promised access to cash-paying patients and an escape from the approximately 7,500 procedural codes they use to code most patient visits for insurance purposes.

"With SimpleCare, you are not performing all the billing and administrative services included in your CPT-insurance bills," says SimpleCare, which promises doctors they will need only three codes when dealing with it. "To distinguish SimpleCare from other services, we use short, medium, and long to describe most visits." SimpleCare doesn't dictate to its member physicians what to charge, but does expect them to abide by the organization's pledge: "I will give my patients, that pay in full at time of service, my best price." Currently, SimpleCare says it has about 3,000 patient members.

Critics of direct-pay practices concede that these practices offer America's more than 40 million uninsured citizens a health care option that, for at least some, may be affordable. Boutique, or concierge, practices, on the other hand, have drawn fire because of their exclusive nature: They are available only to those willing to pay an extra fee, sometimes a very high one.

Boutique Medicine

The subject of recent articles in both medical literature and the general media, boutique practices are a lightning rod for debates about the profession's obligation to provide access to care for all citizens. There are no figures on the prevalence of these practices; neither the AMA nor the American Medical Group Association in Alexandria, Va., can quantify the presence or growth of boutique medicine and spokespersons for both organizations speculate that it is a minor phenomenon isolated to certain geographic areas, most notably Arizona, Florida, New York, and Seattle.

While the numbers may be small, the issues raised by luxury medicine are not. The AMA has not taken a formal position on this practice model, but there is growing pressure within the organization to do so, says an AMA official who asked not to be named. Two committees studying the issue plan to report their findings to the AMA later this year.

"Physicians have an obligation to meet the needs of a community," Frank A. Riddick, Jr., MD, chairman of the AMA's council on ethical and judicial affairs, told *The New York Times*. "You could do that with 10%

After physicians from two practices determined that they were losing about \$7 on every patient visit, or thousands of dollars a month, they embraced an old-fashioned model of practice: cash only, paid in full at the time of the visit.

For physicians, the potential rewards of practicing luxury medicine are clear. “We want to be able to spend more time with patients,” explains Steven Flier, MD, of Personal Physicians HealthCare. “We’re desperately struggling to create a system that lets us do that within the limitations of managed care.”

of physicians in an area practicing boutique medicine, but if it gets much more than that then I think you really have to question the process.”

The fees charged and the services offered by luxury care practices vary. At the high end is a Seattle clinic run by MD2. It charges \$20,000 annually for round-the-clock access and amenities, which include heated towel racks, marble showers, plush terry cloth robes, gourmet food, and house calls to vacation villas. MD2 is planning to open additional practices in New York and Los Angeles.

Most practices, however, charge annual fees in the low- to mid-thousands. Practices affiliated with MDVIP, a company in Boca Raton, Fla. (at www.mdvip.com), charge \$1,500 per patient; the Dare Center in Seattle charges \$3,000; Personal Physicians HealthCare, a new three-person physician group in Boston (at www.personalphysicians.net), charges \$4,000 per patient and \$7,500 for families.

“I couldn’t stand it anymore. The day was an absolute treadmill,” said Bernard Kaminetsky, MD, in an interview with *The New York Times*. An internist in Boca Raton, Fla., Kaminetsky formed a boutique practice through MDVIP. “I wanted to devote more time to patients, and I wanted to enjoy practicing,” he said.

Getting Attention

In return for their annual fee, patients get access to their physicians via e-mail and their doctors’ cell phone numbers if necessary; same-day appointments that are long enough to

satisfy both the patient and the doctor; and the option of having their primary care physician accompany them to visits with specialists.

What is not known, but may be worth studying, is whether the care delivered in boutique practices is of higher quality and produces better health outcomes. “There’s no question that the Flier-Busch patients get more attention,” says a long-time nurse at the Beth Israel Deaconess Medical Center in Boston, referring to patients of Steven Flier, MD, and Jordan Busch, MD, two internists who left the medical center’s practice to start Personal Physicians HealthCare last winter. “The doctors are in here all the time checking on their patients,” she says. And, says the nurse, who did not want to give her name, “the patients make it very clear to us when they are admitted that they are Flier-Busch patients. They’ve paid extra for extra-special care, and they want to make sure we know that.”

Improving Satisfaction

For physicians, the potential rewards of practicing luxury medicine are clear. “We want to be able to spend more time with patients,” says Flier. “We’re desperately struggling to create a system that lets us do that within the limitations of managed care.” Now, instead of a panel of more than 4,000 patients each, Busch and Flier expect to care for about 300 patients each.

The transition for Flier and Bush is nearly complete, though the new practice is not quite full. Because they practice in a metropolitan area and can retain or attract patients

who can pay their fee, the risk of failure is not as great as it might be in another market.

Still, just because patients can afford the fee, doesn’t mean they will pay it. “We were surprised that some of the patients we felt sure would stay with the practice objected to the idea philosophically,” says a physician in another boutique practice who did not wish to be named. “But we were equally surprised by the passion of some patients who said they would never consider leaving the practice, and that the investment was well worth the peace of mind and extra attention.” The practice waived the fee for long-time patients with critical needs, who currently constitute about 10% of the practice’s patients.

For Flier and Busch, having fewer patients has meant recapturing some of the satisfaction that they had lost for the practice of medicine, says a spokesperson for the practice. “Both physicians are much happier with the quality of care they are delivering,” she says. “They are able to spend the time with patients that they need to, they can be proactive rather than simply reactive, and they have accompanied patients to specialist appointments and have made many house calls.”

Perhaps to balance the ethical scale, both physicians are also working as volunteers at a local health clinic, delivering care to the uninsured and underinsured free of charge.

—Reported and written by Ann B. Gordon, in Wayland, Mass. More information on physician practice strategies is available on our Web site (see page 16).

“Currently, health plans are simply passing on increased cost to payers without demanding that providers improve care.”

—Norbert I. Goldfield, MD, Brightwood-Riverview Health Center

(Continued from page 9)

there's a perception that health plans have been managing risk rather than care, which means they have been selecting healthy people who cost less than sick people," Goldfield continues. "These plans have no incentive to select sicker people. Software tools for risk-adjustment can automatically quantify the future level of risk posed by each individual in a population based on that person's medical history and treatment patterns. It can then help correlate appropriate payment levels with the predicted level of future medical services required by the population. So, I believe that tools like this could be profitably used to manage sick patients."

There are currently no economic incentives for either employers or the federal government to use these tools, Goldfield notes. "Which is a big reason Medicare and Medicare HMOs are in such deep trouble," he says. "Medicare HMOs, for example, have already abandoned more than 500,000 recipients because they have no incentive to serve them."

What's more, Goldfield points out that health plans, even if they do practice some disease management, still get most of their profits from avoiding risks by insuring mostly the young and healthy, not from using risk-adjusted tools to manage risk among older and sicker people. "Another factor is that so much disenrollment is going on, between 15% and 20% a year, that disease management firms cannot fulfill their promises," he says. "Their members aren't around long enough for the plans to recover disease management costs and to document results."

For risk adjustment to be used as a statistical tool so that capitation can be extended to cover more of the old,

the poor, and the uncovered or poorly covered populations, financial incentives are needed for payers to cover those in need, Goldfield explains. First, physicians and other health care providers should be paid enough to cover those in need, and second, health care payers should demand results from physicians and other health care providers.

"Large corporations, health plans, Medicare, and Medicaid need to be encouraged to take on these sicker individuals using risk-adjusted tools so that we can document illness in those who are covered," Goldfield says. "And then the health plans need to document how much they have improved care. This documentation can be easily demonstrated using risk-adjustment software technology that's available today."

Overcoming Inertia

Part of the problem of implementing health care reform that addresses the issues of cost, quality, and access is overcoming the inertia that dominates the system. Today, health plans are simply responding to the incentives that are built into the current system, and the incentives are not there for them to accept sicker individuals, Goldfield believes. Managed care companies need to have incentives before they will take care of sick individuals in a risk-adjusted and coordinated fashion, he asserts.

Moreover, Goldfield says, physicians are immobilized in the current system. "Physicians, unless they are capitated or are provided with a care-coordinated profile, have no idea how well or how badly they are performing; they cannot improve care until they get accurate feedback," he

explains. "Currently, health plans are simply passing on increased cost to payers without demanding that providers improve care."

Only capitation will allow managed care companies to provide doctors with information based on their performance that will enable them to improve the care they provide, Goldfield says. "But the capitation rate must be fair so that groups have enough money to give coordinated care," he says. "Contrast this to fee for service, whereby more services provided to more patients mean more fees. As an interim step toward capitation or episode of illness payment, we should do away with the unworkable CPT E&M codes for PCPs and pay them on the basis of diagnosis and time spent with the patient."

In Goldfield's vision, the ideal health care system would preserve the best of what is present in the private sector, and add on universal coverage and accurate outcomes reporting to doctors so they can gauge whether they are providing the best care at an appropriate price.

"We have the tools to make this happen, but we still need the will to do so," Goldfield explains. "It would be easy to use existing technology tools to dramatically narrow that variation by providing risk adjustment for different kinds of health care encounters. But with a lack of universal coverage, we can't do that. Recently, I saw two patients with diabetes who had no coverage. The way things are now, these patients would be excluded from the database; and a database without the sick is meaningless."

—Edited by Paula Grant, in Lincoln, Va. More information on physician practice strategies is available on our Web site (see page 16). he

Washington Physician Advocates Billable Electronic Medical Services



Tom Gumprecht, MD, is an otolaryngologist in a five-physician single-specialty practice in Redmond, Wash. After graduating from the University of Washington

Medical School in 1975, he completed his internal medicine training at the University of Washington and at the University of California, San Diego; and his otolaryngology residency at the University of Colorado. He was twice elected chief of staff at his local hospitals. Gumprecht is the author of "Are We All Just Stupid?" an article published in the September 2000 issue of ENT Journal. This interview is one in an occasional series of interviews with physicians in practice. Richard L. Reece, MD, editor in chief conducted this interview.

Q: You feel strongly that patients who do not show up for an appointment or who cancel an appointment at the last moment should be charged a fee. Why do you hold that opinion?

A: This is an ethical issue. The American Medical Association's Code of Medical Ethics states that patients generally have a responsibility to meet their financial obligations with regard to medical care and that patients are to be cognizant of the costs associated with limited

resources, such as medical care, and use those resources judiciously. The AMA's ethics code also states that it is both ethical and appropriate for the doctor to charge a patient for a missed appointment or for an appointment that was not canceled with at least 24-hours of advance notice.

Patients who make appointments and then either do not show up or cancel at the last minute are not acting ethically with regard to the limited resource of patient appointments and because the appointment that was missed or canceled could have been used by another person with a medical problem who was waiting for help. In my community, which is an upper-middle-class community, patients can wait up to eight weeks to get an appointment to see their primary care doctor and up to three months to see a specialist. Nationwide, there is a large shortage of specialists, and this shortage is increasing every day, partly because of the growing population and partly because of the number of physicians who are retiring early or are choosing to limit their practices.

Furthermore, no shows and late cancellations constitute disrespectful behavior toward the physician and the physician's office personnel, who usually exert a considerable amount of effort to get patients their appointments in the first place. For every

patient who calls for an appointment, the telephone receptionist must gather information about the patient—including the nature of the medical problem, the patient's insurance status and information, and the need for a referral—and then juggle the schedule to get the patient in to see the doctor in a timely manner.

Finally, as we all know, physicians' offices around the country are in financial distress. And when patients do not show up for their appointments, that represents lost revenue. Despite the fact that a physician's staff makes every effort to call the patients a day or two ahead of time to confirm their appointments, the burden of no-shows continues.

Physicians should learn a lesson from other businesses. Take the travel industry, for example: People who reserve a room at a motel and then fail to show up bear some financial burden for the fact that they have not used the limited resource judiciously. Likewise, patients need to act courteously and respectfully with regard to medical appointments as a limited resource.

Q: How do you address this problem in your practice?

A: About five years ago, I posted signs at the checkout desk and on the door of my office for patients to see as they leave. The signs say: "There will be a charge for no-shows

(Continued on page 14)

"When patients do not show up for their appointments, that represents lost revenue. Despite the fact that the physician's staff makes every effort to call the patients a day or two ahead of time to confirm their appointments, the burden of no-shows continues."

(Continued from page 13)

and appointments broken without 24-hour notice.” Since that time, when a patient makes a late cancellation or is a no-show, I review the patient’s chart and note whether the patient called and offered a reason for canceling the appointment.

Because we have a small practice, I know which patients are the abusers and therefore can decide whether a patient who has cancelled late should be assessed a \$25 charge. I do not try to recoup the entire cost of the missed appointment—that is, all of the revenue I have lost—but I do charge a nominal fee so that patients get the message that such behavior is unacceptable. When they make another appointment and show up at the office, they know they will have to pay \$25 above and beyond their office appointment charge in order to access me as their doctor.

Merely putting up the signs has helped to reduce the number of no-shows and late cancellations and has helped my practice to run more efficiently and productively. In addition, it has helped to improve the morale of my office staff.

Q: *What have you found has been the response from your patients to this strategy?*

A: Occasionally, patients will call the office and complain about this policy. But we remind them that it is clearly posted in the office. If these patients want to see me again, they will have to pay the \$25 no-show fee. Alternatively, they can seek another provider.

Q: *Have you ever estimated the financial consequences of a patient who does not show?*

A: I have not specifically calculated how many no-shows or late cancellations I have had in a month and multiplied it by an office charge. That calculation would be fairly easy to do, especially in a large practice where scheduling data are often computerized. But the amount, I am sure, is not inconsequential. I estimate a 5% to 10% loss of revenue as a result of no-shows.

Q: *You also feel strongly that physicians should charge for the electronic services that they offer, including fax, e-mail, and telephone services. Why is that?*

A: Whatever professional services doctors provide to their patients, they are medically and legally liable for those services. In that case, we should be reimbursed for the professional services that we provide. Many other service professionals—such as attorneys and accountants—bill their clients for communications, which they regard as constituting a professional service.

In time, technology will evolve such that the electronic links between doctors and their patients will become more sophisticated and will facilitate access to physicians. What’s more, physicians will be able to provide medical care and information in new ways, not strictly by making the patient come in to the office for a face-to-face consultation. In fact, certain elements of care will be handled electronically in an appropriate manner. The doctor and the patient will choose the manner of and the setting for the care that is most appropriate, and physicians will be providing medical services regardless of how the care is provided.

Take, for example, a patient who comes to the office for an initial visit and some laboratory test work. Rather than coming in for another office visit a week later to review the findings of the lab tests, the physician and the patient can communicate by e-mail, fax, or telephone—or, very soon, tele-video conference. In the future, physicians will require patients to return to the office only when that visit is truly medically necessary.

In many circumstances, these types of communication will be better and more convenient for the patients. Speaking from my experience, I can offer an illustration: Early in my career, I practiced in Idaho, where I would treat patients who came from, literally, a hundred miles away. In such places, there could be times when the burden of a 100-mile trip is not necessary for the patient, but that is currently the only way doctors can be paid for their services.

Surprisingly, few doctors interact with patients by e-mail or by other electronic means; this is because these types of interactions simply represent another nonreimbursable activity for the physicians. The delivery of medical care would be much more rational if electronic services were billable.

While in some locations reimbursable e-mail consultations have been attempted, the idea is far from widespread. For example, I suggested to the medical director of the insurance company for a large employer in our area that a small pilot program to pay for employees’ electronic communication with their doctors be tested. The company refused, saying that its contracts do not permit payment for

“Surprisingly, few doctors interact with patients by e-mail or by electronic means; this is because such interactions simply represent another nonreimbursable activity. The delivery of medical care would be much more rational if electronic services were billable.”

“Electronic communication between physicians and patients is a logical, more efficient way to practice medicine, not an add-on. It would contribute to the efficiency of the system and enhance patient satisfaction over time. Unfortunately, as long as we are not paid for telephone, e-mail, or fax communications, physicians will resist communicating with patients via those means.”

electronic services. This is just an old-fashioned way of thinking.

Q: *What steps can physicians take to promote payment for the electronic services they provide?*

A: First, doctors should start charging for electronic services—especially in those instances when the patient insists on a medical communication by telephone, fax, or e-mail that could have been handled by an office visit. Doctors should send patients a bill for services provided electronically. For example, physicians might start to selectively send bills to patients who are trying to schedule after-hours telephone service for something that could be handled during the daytime office hours. If a patient insists that a matter be handled by the physician on the telephone when the physician has recommended an office visit, the patient should receive a bill.

Second, doctors need to write to their local, state, and national medical associations requesting that their societies explicitly develop a policy statement to remind members and others—both within the medical membership and members of the public—that it is proper, fair, and ethical to bill for services that physicians have rendered electronically.

Third, physicians should request that our medical organizations communicate to insurers and Medicare that we need to eliminate any contractual language that disallows electronic services. I served on an advisory

committee several years ago with one of our insurers in this area, Premera-Blue Cross, in Spokane, and I was able to get the insurance company to eliminate contractual language stating that electronic services were disallowable. As a result, if a doctor chooses to charge any Blue Cross patient for a telephone call, that is a matter for the doctor and the patient to resolve.

It would be quite a leap to expect Medicare or our private insurers to suddenly pay for electronic services, but at least they could eliminate contractual language that prohibits payment for electronic services or that makes electronic services contractually disallowable.

Q: *Are there any steps that medical organizations can take?*

A: Yes, medical organizations need to pursue a policy stating that physicians should be paid for their services, however those services are provided, and that physicians should negotiate for such language to be incorporated into their third-party contracts. Perhaps organizations could suggest a copayment on electronic services in which 50% of the cost of electronic services would be paid by insurance, 50% would be paid out of pocket by the patient, and the amount paid by the insurer would be capped at \$1,000 per year.

Also, we need to talk among ourselves as physicians, building acknowledgement and agreement that it is fair, reasonable, and appropriate

to charge for electronic services. Currently, doctors are handling this issue by saying to their patients, “Do not bother me by telephone, fax, or e-mail.” They want patients to come to the office so that the service will be billable. But if doctors start agitating about this issue, patients will start agitating to get coverage.

Q: *In summary, what do you see as the role of electronic communications in physicians’ medical practice in the days ahead?*

A: Electronic communication between physicians and patients is a logical, more efficient way to practice medicine; it’s not an add-on. Endorsing such communications would not only lead to a more logical progression in the development of related technology, it would also facilitate the interaction between doctors and patients.

What’s more, electronic communication would contribute to the efficiency of the system and enhance patient satisfaction over time. Unfortunately, as long as we are not paid for telephone, e-mail, or fax communications, physicians will resist communicating with their patients using these means.

This will be a long up-hill political battle between medical organizations and insurers. But we have to take the first steps.

—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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