

# PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

May 15, 2001

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## Collection Firms Help Boost Cash Flow

Given falling physician reimbursement and increasing overhead, physician practices are becoming more aggressive about collecting overdue bills from patients. In the past, physicians have used collection agencies selectively, says John W. McDaniel, president and CEO of Physician Management Group, management advisers in New Orleans. "But over the past five to 10 years, their use has been increasing," he says. "The time frame between a missed payment and submission of the claim to a collection agency is becoming shorter."

### A 90-Day Limit

At one time, physicians would let accounts remain unpaid for as much as six months. Today, they are likely to submit receivables to a collection agency after 90 days.

The greater use of collection agencies is a direct result of shrinking physician reimbursement. "Managed care has eroded physician incomes," McDaniel notes. "The average physician today might be reimbursed for only 60% to 80% of his or her gross charges. Given that significant upfront discount, physicians must make sure that they collect all the payments due to them."

Bernard Rineberg, MD, a practicing orthopedic surgeon in New Brunswick, N.J., and the president of BAR Health Strategies, medical practice consultants, agrees, saying, "Physicians are becoming more

aggressive with regard to collections. They feel the need to pursue strategies such as the use of collection agencies because their margins have become thinner."

When physicians face collection problems, their troubles are similar to those of other service providers. "A product like a car can be repossessed if a payment is missed," McDaniel observes. "Service providers in general tend to have more of a problem with collections because the threat of repossession is not there. In addition, very few physician practices charge interest on their accounts. As a result of these two factors, physician bills tend to be the last bills people pay."

But in some ways, collecting for health care can be more difficult than collecting for other services. "The doctor-patient relationship adds some complexity, because the physician is ethically responsible for the patient's care," observes Dorothy Sweeney, vice president of The Health Care Group, a health care law and consulting firm in Plymouth Meeting, Pa. "In addition, physicians participate in numerous plans, and the need to track and understand what each plan allows, and what must be written off can complicate or delay both billing and payment."

Of course, computer technology has enabled physicians and other providers to focus more closely on overdue accounts that might have otherwise "slipped through the cracks" in the past, Sweeney says.

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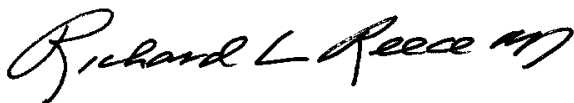
## Will Bush Administration Ease Up on Compliance?

The word "compliance" has many different meanings in health care. To practicing physicians, "compliance" means delayed payments for failing to code properly, Medicare audits, increased spending for a compliance plan, appointing a compliance officer, and the possibility of being fined or imprisoned for fraud and abuse under the False Claims Act and other laws.

But compliance also can represent an opportunity. Recently, we wrote about the value of compliance in an article, "Having a Compliance Plan May Help Prevent an Audit, Experts Say." In the article, experts reported that fraud investigators and U.S. attorneys usually avoid physicians who make a good faith effort to write and use compliance programs. These programs also usually increase physician-staff communication, yield more precise and accurate diagnostic and procedural information, and raise practice revenue.

Now that physicians are starting to recognize the value of coding accurately, it is ironic that the attitude about compliance among government officials may be easing somewhat, observers say. Congress has moved to limit aggressive investigations of physicians and other health care providers, and the Bush administration has nominated Michael Chertoff, an attorney who has represented HCA-The Healthcare Co. in Nashville in its fight with the government, to be assistant attorney general for the criminal division at the Department of Justice. Also, Bush has nominated Thomas A. Scully, the president and CEO of the Federation of American Hospitals, an organization in Washington, D.C., that represents 1,700 for-profit hospitals, health systems, and insurers, to run the federal Health Care Financing Administration, which oversees the Medicare and Medicaid programs. By nominating industry insiders, Bush has signaled that the federal Department of Health and Human Services (DHHS) may be kinder and gentler toward physicians.

Even if the government limits the aggressiveness that prevailed under the Clinton administration, physicians are wise to get and read a copy of the federal guidelines on compliance from the DHHS's Office of Inspector General and distribute them to all staff members. The document, *Compliance Program Guidance for Individual and Small Group Physician Practices*, is available on the Web (at [www.dhhs.gov/progorg/oig](http://www.dhhs.gov/progorg/oig)) under Compliance Tools. Simply reading the 47-page document provides physicians with a much-needed overview of the processes recommended for each practice, consultants say. Another resource for readers is an article published in our Feb. 15 issue, "Compliance Means Audits, Monitoring," in which John McDaniel, president and CEO of Physician Management Group Inc., physician advisers in New Orleans, discusses outside reviewers, self-audits, and what to do if an audit uncovers problems.



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# Office Practice Starts With Questions

By John W. McDaniel

**M**ore than at any time in the past, it seems that a great number of physicians are entering or reentering the private practice of medicine. While most of these situations involve physicians completing residency training, many doctors are making the transition into private practice after having been affiliated with a hospital, large group practice, managed care organization, physician practice management company, or other organization that is now jettisoning physician practices. These physicians are moving into a private practice in the same geographic area or establishing a new practice in a new location.

For physicians just entering or reentering private practice, there are several key considerations. First, physicians should determine if there is an adequate market need within the primary service area in their given specialty. When gathering this information from a local hospital or physician recruiting company, physicians will find market profiles include the necessary number of physicians by specialty for a given population.

## Market Considerations

National standards indicate, for example, that it takes a population of 3,500 persons in an area to support one internist or 696,000 persons to support one pediatric nephrologist. Any physician considering private practice should review this informa-

tion carefully before proceeding.

Another important consideration is the happiness of your spouse. Physician recruiters say one major reason physicians leave practice situations after they have been recruited is due to a spouse's dissatisfaction.

Interestingly, another major reason physicians leave a practice is that the practice was not established appropriately. In other words, after several

months in practice, the physicians may find that practice operations have not been well established, for example, or that the practice has poor billing and collection procedures, disorganized internal operations, or lower than expected reimbursement rates. Any of these or other factors may cause a physician or his or her spouse to want to relocate.

After obtaining baseline information regarding the primary market area, many physicians will engage the assistance of a consultant or experienced practice adviser about developing a medical practice business plan. This business plan outlines the basic service strategy the practice will use and involves a detailed market assessment including a SWOT analysis. In a SWOT analysis, a physician and his or her advisers will review the practice's strengths, weaknesses, opportunities, and threats. Such an analysis allows the practice to analyze its position in a market and determine areas of opportunity.

To perform a market analysis, physicians will need information about the market from a local hospital, chamber of commerce, or news-

paper. Typically, newspapers have one of the largest repositories of market data since publishers need this information to develop marketing activities for various advertisers. Once the service strategy and market analysis have been done, the physician should develop a financial plan with reasonable budget projections. These projections will include forecasts of expected patient volume

and revenue and budgeted operating expenses. Through the business planning process, the physician can best determine his or her likelihood for success.

After making the decision to enter private practice, the physician then faces myriad questions involving issues such as office location, legal structure, and practice equipment. To help simplify the processes involved in making decisions on these issues, we have compiled a physician practice start-up checklist. On this checklist, physicians will find the major areas of emphasis and some of the logistical requirements for entering private practice.

While this list is by no means complete, these areas are illustrative in terms of the coordination of dozens of logistical issues that account for the appropriate development and operation of a medical practice. It is easy to see why many start-up practice situations fail when physicians do not access professional assistance either through the local hospital or a physician consultant. The process for establishing a successful medical practice is virtually identical to the

*(Continued on page 4)*

**For physicians entering or reentering private practice, determining market needs is an important consideration.**

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(Continued from page 3)

process of establishing any successful small business and, in the business world, professional managers usually spend months developing a business plan before opening their doors to the public, whereas most physicians attempt to open their practice within

90 days of making a decision.

Our experience has shown that physicians in solo and small group practices not only enjoy increased professional satisfaction but usually also realize higher incomes than they experienced in their previous prac-

tice situations. These successes, however, begin with the establishment of a sound foundation with respect to the development of their practice in a very structured and formal way. In other words, "proper planning prevents poor performance." ■

## Physician Practice Start-Up Checklist

A physician opening a new practice may find the following list useful when opening a new office.

**Legal structure.** Decide whether the practice will be formed as a sole proprietorship, partnership, or corporation, such as a limited liability corporation. Also, choose an attorney with appropriate experience in corporate and health care matters such as physician contracting, office and equipment leasing, and bill collecting.

**Location.** Conduct a thorough analysis of competitors; locate the practice in an area that has the most appropriate demographic mix of patients, depending on your specialty; decide whether it's better, depending on specialty, to be on a hospital campus or in a free-standing location. Also, determine what type of lease is used for the office space and identify the process for developing architectural plans or construction documents that may be needed for expansion.

**Financial issues.** Conduct a thorough financial analysis regarding first-year operations, including cash-flow projections; gather information necessary to get a line of credit at the bank; outline your banking needs, such as personal and business accounts, loans, and letters of credit; have an accountant develop a chart of accounts and

accounts-payable procedures; and develop appropriate fee schedules for the primary market area to be served.

**Equipment.** Make a list of the major equipment you will need; secure bids on office equipment and examine lease-versus-purchase options.

**Licenses, permits, and registrations.** Consider all requirements for city and county licenses; inform the state medical licensing board of your new address, or get a new license if necessary; determine the requirements related to prescribing narcotics; review applicable CLIA requirements; and apply for a federal employer identification number (EIN).

**Provider numbers and credentialing applications.** Complete all requirements for medical staff applications for credentialing; submit all provider applications to Medicare and Medicaid as needed; determine the managed care organizations in which you will participate and submit the appropriate credentialing applications.

**Personnel.** Develop staffing salary projections; write appropriate job descriptions; advertise for job applicants and begin interviewing candidates; draft personnel policies and procedures; consider offering employee benefits.

**Patient information systems.**

Evaluate your management information needs; solicit ideas and bids from system vendors; and do a cost-benefit analysis of doing billing in-house versus contract billing.

**Medical records.** Get sample medical records from vendors; determine your dictation needs; and develop procedures about retaining records.

**Business office operations.** Write policies and procedures for billing and collections; select or develop appropriate business office forms.

**Clinical procedures.** Develop policies and procedures for patient care, laboratory, x-rays, prescription refills, infection control, employee safety and health, and other clinical areas.

**Insurance.** Evaluate your insurance needs and get quotes for professional and general liability and business insurance.

**Office services.** Evaluate the need for and receive bids for such services as medical waste removal, janitorial services, pest control, landscaping and maintenance, and telephone answering and transcriptions.

**Marketing.** Write a marketing plan; gather materials for a practice brochure, announcements, business and appointment cards, recall cards or letters, placards for the office, and newspaper announcements.

—JWM

# Systems Aim To Improve Work Flow

**M**any companies have developed Internet-based automated work-flow systems for medical practices. These systems are designed to meet physicians' increasing need to improve practice efficiency and to reduce overhead. Many physicians use the services offered by the largest and most visible companies in this field, but new, comprehensive, and user-friendly systems are being developed by lesser-known companies as well.

Many of the companies that offer work-flow automation systems provide billing and collection services for physicians. Of course, these services have been offered to physicians for years, and some of these companies started by offering services to hospital-based physicians, says Francis Rhie, MD, MBA, CEO of Alteer Corp. (at [www.alteer.com](http://www.alteer.com)), a company in Irvine, Calif., that provides automated work-flow systems to physicians. Today, both physicians and billing services are using programs that help improve work-flow, billing, collections, and other management functions.

## Training Needed

"As a physician in training, I never got a single day of education in accounts payable, human resources, or financial management," Rhie says. "I was like most doctors who handle these tasks by the seat of their pants."

To help physicians with these tasks, a number of companies have recognized that there is a market in helping physicians bring greater efficiency and profitability to their practices. In fact, many of the companies that offer office-automation software for physician practices claim they can reduce practice costs by 20% to 50%.

One company is Medscape/WebMD (at [www.webmd.com](http://www.webmd.com)), in Elmwood Park, N.J. WebMD offers

Medical Manager, one of the most popular Internet-based work-flow automation systems. About 185,000 physicians use WebMD's Medical Manager to help run their practices (at [www.medicalmanager.com](http://www.medicalmanager.com)). Independent physicians, physician groups, management services organizations, IPAs, managed care organizations, and other providers use this system to address financial, administrative, and clinical management needs.

Medical Manager includes an electronic medical record, appointment scheduler, a patient-flow tracking system, a form generator, and online availability of patients' histories,

**Many companies offer software to help improve practice efficiency by automating work flow.**

charts, and x-rays. To enhance cash flow, Medical Manager includes a collections system that tracks delinquent accounts, prints collection letters, and tracks payments. It also helps physicians administer managed care contracts by automating insurance eligibility checking, referral management, capitation payment posting, and profitability tracking.

## Making Improvements

While WebMD is the largest company in this field, other companies have had success developing automated work-flow systems that physicians find are user-friendly and effective. Alteer's automated systems, for example, allow physician practices to manage e-mail and patient faxes, reduce time to refill prescriptions, set priorities for certain clinical and management tasks, and reduce spending by 10% to 20%, Rhie says.

Executives at Alteer believe work-flow management software should be

integrated with other management programs in physicians' offices. "What we have noticed is that doctors do not want to interface with other products," Rhie explains. If a physician buys two software programs from two different vendors, the practice would need to integrate the programs. "And, if one of the companies decides to upgrade, you may need to go through the whole interface process of getting them to work together all over again," he says. "Once you interface one time, you don't want to do it again. That's why we have a work-flow program, electronic medical record (EMR), and

billing—all in one program. We believe it's best to have a completely integrated product in which all the parts—clinical, financial, and administrative functions—work together seamlessly."

When shopping for products in this category, Rhie believes it is best for physicians to seek programs that use the Web but that continue to work if the Web connection is disabled for any reason. "There will be a new breed of product that will use the Internet but will not be based on the Web exclusively," he says.

If a physician's high-speed access is disabled or if the Internet connection is cut for any reason, physicians who use Web-only programs may have no access to their software or other data, Rhie advises. The new breed of companies in this category will allow physicians to continue to work even if not connected to the Internet by using stored images and data, he says.

In addition to Alteer and WebMD,

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there are a number of other companies in this category. One of the oldest companies in this field is Medic Computer Systems, in Raleigh, N.C. (at [www.medcmp.com](http://www.medcmp.com)). The company is owned by the Misys Group in London and offers practice management and clinical systems to 70,000 physicians, including billing companies, home care providers, and IPAs.

### Filling a Niche

Two smaller companies providing practice management software are divisions of NDCHealth, a company in Atlanta that offers health information services to pharmacies, hospitals, physicians, pharmaceutical companies, and health care payers. One of these companies is Lytec Systems Inc. (at [www.lytec.com](http://www.lytec.com)) in Mesa, Ariz. Recently, Lytec released Lytec Medical 2001, Windows-based practice management software. In addition to helping physicians manage their practices, this version of the product allows inventory control and tracking of authorization referrals, among other features. The other division of NDCHealth is MediSoft (at [www.medisoft.com](http://www.medisoft.com)), also in Mesa. MediSoft patient accounting software is used for printing insurance claims, submitting electronic claims, tracking accounts receivable, and practice management reporting for physicians and billing services.

One fast-growing company in this category is Millbrook Corp. (at [www.millbrook.com](http://www.millbrook.com)) in Carrollton, Texas. Millbrook's practice management program is suited for physicians in solo practice or in groups of as many as 20 doctors, Rhie says. Physicians can use the program in a

client-server system and as a Web-based program. It is certified as being compatible with Microsoft BackOffice. Small and large physician groups, ambulatory surgery centers, single-site and multisite practices, and multispecialty organizations use the program, called Practice Manager 2001, Millbrook says.

Some companies in this category focus on a niche. IDX Systems Corp. (at [www.idx.com](http://www.idx.com)) in Burlington, Vt., offers practice management software for a number of settings, but in particular for university faculty practices at academic medical centers, an area in which the company has about 90% of the market, Rhie says. The IDX system offers integrated billing, managed care, scheduling, registration, and visit management processes designed to improve reimbursement, support regulatory compliance, and increase patient satisfaction.

The other 10% of the market for university practices is controlled by Epic Systems Corp., a company in Madison, Wis. (at [www.epicsys.com](http://www.epicsys.com)). Epic offers an EMR and a patient database that spans the entire continuum of care.

All of the companies developing practice automation software face a similar problem. Once a physician group has chosen a system, it is difficult to get the group to switch. Therefore, most of the sales efforts among these companies focus on those physicians who have not yet chosen a system.

James Weintrub, MD, a plastic surgeon and founder of Digital Physicians Network, a coding and compliance software company in Providence, R.I., says, "There are tremendous psycho-

logical barriers to switching to a new technology from an existing stand-alone legacy system. Once they have paid for something, physicians are very reluctant to switch to other systems. Their medical staffs are even more reluctant once they have learned to use an existing system. So the problem becomes how to pitch a new system and convince physicians to incur the switching costs."

### Increasing Reimbursement

While all of these companies aim to improve cash flow, Athenahealth.com, in Waltham, Mass., (at [www.athenahealth.com](http://www.athenahealth.com)) says its goal is to reduce repetitive administrative tasks and streamline claims handling to enhance physician practice efficiency and profitability. Athenahealth.com offers several automated work-flow services designed to determine eligibility and code claims accurately at the onset of the claims process. The company's goal is to reduce claims rejections to near zero and cut accounts receivable at least in half. Athenahealth.com hopes to free physicians and office staff members from paperwork and other management tasks so they can focus on patient care.

"Our mission is to provide intelligent infrastructure to practices so that health care can work the way it should work," says Jonathan S. Bush, founder and CEO of Athenahealth.com. "If the right infrastructure is in place, patient information will be clean, and the management information will be understandable and usable. This is a foundation from which to improve the efficiency of the health care system."

**"Products that automate work flow handle routine tasks so that more crucial activities remain the focus, both for the practice manager and for the physician."**

**—Jonathan S. Bush, Athenahealth.com**

Rather than having a physician investigate each rejected claim, some companies will research the claim with the payer.

The Athenahealth.com system was started in 1997 at the Athena Women's Health and Birthplace Center in San Diego, a large obstetrics-gynecology group practice. During its first year of operations, Athenahealth.com amassed contracts with some 750 physicians in Arizona, California, Florida, Georgia, Massachusetts, Ohio, Rhode Island, and Texas.

The system is available to users on a subscription basis; no hardware or software need be purchased. Subscribers to Athenahealth.com use a personal computer and a standard Internet browser to access the system. Athenahealth.com offers numerous services, including patient registration, scheduling, billing and collections, financial reporting, and payables, payroll, and cash management. Athenahealth.com provides Web-based links with payers and other organizations, allowing real-time checking of patient eligibility, claims verification, payroll tracking, and other practice functions. Access to Athenahealth.com's database allows physicians to view summary claims and billing information.

### Eliminating Denials

The system enhances cash flow by focusing on denied claims by verifying eligibility with the payer before a patient's visit and by flagging missing information before the patient leaves the office. In this way, any errors can be corrected before a claim is filed.

The Athenahealth.com site also includes what the company calls a Virtual Insurance Management Center, a team of revenue specialists who update payer rules and investigate the reasons behind claim denials. "Once new rules are added, all future claims are screened for that rule and, over time, the number of clean claims generated out of the practice will approach 100%," Bush says.

For the typical practice, the rate of denied claims is approximately one in three, Bush explains. Rather than having the physician spend the national average of about \$30 investigating each claim, Athenahealth.com will research the claim with the payer and gather the original documentation about why the claim was denied. "Then, we program rules into the system so that we can help prevent any doctor from encountering that denial again," Bush adds.

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

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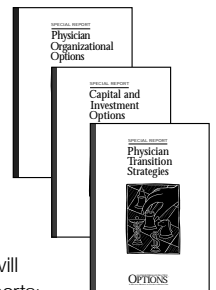
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"An office manager or billing coordinator can easily use computer software to track outstanding amounts by insurer and by patient," she notes.

### Collection Options

Usually, a practice's greater focus on collections first entails purchasing computer software and formalizing the collection processes internally, using the collection agency as a last resort. "Many practices have organized their systems so that they file claims with insurers in a timely fashion," McDaniel says. "Then, once the insurer pays its portion, the office will immediately follow up with the patient to collect the remainder."

A typical process might be to send three successive statements to a patient. If the payment is not received, the office then sends a demand letter, giving the patient 10 days to pay in full or make payment arrangements. "While uncommon in the past, many practices now offer patients the option of a payment plan, which gives patients a manageable way to settle bills," McDaniel notes. If the patient does not pay or request a payment plan, then the bill goes to the collection agency.

Some physicians use collection agencies to handle all bills, in effect, outsourcing their collections work completely.

Either way, physicians should separate the provision of care from the collections work. "The doctor should be removed from the collections process," Sweeney says. "Billing and collections should be an automatic process that is triggered by time frame. This process should be routinized, rather than influenced by a case-by-case judgment by the physician or the office staff."

These agencies obviously can increase a practice's cash flow, as patients may be more likely to respond to a collection agency notice than a bill from the practice. In addition, some physicians feel more comfortable when outsourcing patient billing problems to a third party.

"Reputable collection agencies handle their work very professionally, and have developed a standard process that has proven to be successful in collecting money," McDaniel says. "They can review this process with the practice so that the practice feels comfortable that their patients are being addressed in a professional, business-like manner."

Indeed, at a certain point, collection agencies may have better results than internal processes, Sweeney believes. "If a practice's attempts to collect on an account are unsuccessful after 120 days, the collection agency may have a better chance of receiving payment," she says.

What's more, collection agencies usually are more practical and effective than other collection alternatives that practices have used. In small communities, for example, where physicians are concerned about the heavy-handed approach that may be inherent in using a collection agency, physicians may report outstanding debts to the local credit bureau. "Typically, the credit bureau does not take any action," McDaniel says. "It simply reports the debt as being outstanding. Therefore, the physician might or might not receive payment. But if the patient attempts to obtain credit in order to purchase an automobile or another product, he or she will have to pay the debt to the physician before being given further credit. While some physicians find

the credit bureau option to be less onerous than collection agencies, this option should be used only for small dollar accounts because of its limited effect on cash flow."

Some practices have used small claims court to obtain payment, although this method often requires more time and emotional energy than using a collection agency

### Seeing the Downside

One disadvantage to using a collection agency is the fee the practice must pay. Effectively, the fee represents another discount on the original charge. Fees are structured either according to a set fee to pursue each claim—regardless of whether the collection efforts are fully successful—or based on the percentage of the total collected. This percentage usually depends on when the collection agency receives the accounts.

"The percentage fee is lower for 'fresh accounts' that have not been outstanding for long," McDaniel explains. "If a practice uses a collection agency to handle all of its bills, or sends bills to the agency after generating only one internal statement, the percentage will be lower than if the account is six months old." Percentages range from 15% to 20% for fresh accounts to 30% to 40% for accounts more than 90 days past due.

Another factor to consider may be a negative effect on the physician-patient relationship. "Some patients get angry when their bills have been turned over to a collection agency," McDaniel says. "Patient defection is always a concern. But aggressive collection of payment eventually becomes a business decision: The prospect of losing a patient may be outweighed by the burden of effective

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**"A rule of thumb is that more than 60 days of revenue in accounts receivable is too high."**

**—John McDaniel, Physician Management Group**

(Continued from page 8)

tively offering free care to the patient who is not paying. This may be the kind of decision a physician needs to make, particularly if he or she is running a busy practice.”

Rineberg believes some collection agencies can cast physician practices in a poor light. “If they are really aggressive, they may bring in the dollars, but they may anger patients to the point of defection or even lawsuit,” he says. “Collection agencies become an extension of the medical practice. So, physicians must be careful.”

A third disadvantage is loss of control. “When a physician hires a collection agency, he or she is subject to the agency’s practices,” Sweeney notes. “A physician can’t design the protocols, the letters, or the telephone scripts the way he or she wants.”

Using an agency also may be driven by a cost-benefit calculation: The potential revenue collected must outweigh the cost of collections. Therefore, practices tend to use collection agencies for claims of a high dollar value, or when they have a large volume of small claims.

A key benchmark for appropriate cash flow is to look at how many days of revenue a practice has in accounts receivable, McDaniel says. “A rule of thumb is that more than 60 days of revenue in accounts receivable is too high,” he says. “A practice with this much revenue in accounts receivable should consider refining its internal processes or possibly using a collection agency.”

### Minimizing Payment Delays

Collections as a practice management area represents a tremendous amount of work for a medical group. But McDaniel emphasizes that collections should be viewed, not as its own business function, but as the last step in the revenue generation process. “Poor collection activity can be the result of a dysfunction occur-

## Examine Processes Closely

Before contracting with a collection agency, a physician practice first should do some due diligence, experts advise. Physicians should determine, for example, if the agency handles other health care clients and other physician clients in particular, says Dorothy Sweeney, vice president of The Health Care Group, a health care law and consulting firm in Plymouth Meeting, Pa. These agencies are more likely to be sensitive to the physician-patient relationship when contacting patients.

“A practice should examine the processes of the collection agency, review the letters sent, and ask to see telephone scripts in order to feel confident that the process will not alienate patients,” Sweeney adds.

In addition, physicians interested in hiring a collection agency should contact references from other medical practices in a similar specialty that can address the agency’s reputation and performance over time, says John W. McDaniel, president and CEO of Physician Management Group, physician practice management advisers in New Orleans. Reputable agencies should be able to provide data on their success rates—including the number of accounts settled and dollar amounts collected—when doing collections for other similar practices, he says.

Finally, physicians should test the agency’s tone with patients by turning over a bogus bill with the name of a physician’s friend or family member, suggests Bernard Rineberg, MD, an orthopedic surgeon in New Brunswick, N.J., and the president of BAR Health Strategies, medical practice consultants. “In this way, a physician can learn how the agency’s staff members interact with patients,” he says. —DJN

ring much earlier in the stream of events leading to payment,” he says.

Confusion about what an insurer covers may delay patient payment, for example. Furthermore, insurers require clean claims before processing payment, or the claims will be denied. “The vast majority of denied claims are the result of poor information gathering at the beginning of the patient encounter, such as inaccurate insurance information, inadequate preauthorization, erroneous provider numbers,” McDaniel observes. “Many seemingly minor bits of data can hinder collections.”

To help prevent problems later, physicians should try to collect as much payment as possible before services are rendered.

Diligence is important when collecting co-payments, Rineberg agrees. “If a physician sees 40 patients a day and each is required to pay a \$10 co-pay, the physician will have

\$400 at the end of the day that he or she otherwise wouldn’t have had,” he says. “On the other hand, if the co-pay is not collected, it must be billed to the patient. And to bill for \$10 adds to practice expenses.”

To increase co-payment collections, physicians should consider reeducating office staff members about collections and focus on how to leverage their time, Sweeney says.

Overall, the entire process that begins with patient registration and includes receiving co-payments, filing claims, and following up on unpaid bills should be analyzed, McDaniel says. “Most practices will be able to make improvements to the process at the front end that will maximize the percentage of revenue that can be collected easily.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician strategies is available on our Web site (at [www.mdoptions.com](http://www.mdoptions.com)).

# Will New Rules Foster Success?

By Michael Alper

**H**ealth care provider groups are closing their doors in markets nationwide. From California to Massachusetts, an estimated 150 medical groups have gone bankrupt or closed for financial reasons in the past five years.

Virtually all physicians have contracts with managed care organizations, and these MCOs are seriously concerned about the factors affecting the volatility of medical groups and IPAs. Despite some claims that capitated payments for services are one of the main contributors to medical groups' financial problems, managed care agreements in the form of capitated-delegated contracts continue to be a popular means to keep premiums competitive and expenses controlled. Indeed, some 80% of health plans say they will continue to share with physician groups the financial risk of delivering care.

Concerned about the effects of risk sharing, many states are addressing the financial stability of physician organizations through regulation. At least a dozen states have adopted laws or are considering legislation regarding solvency and financial reserve requirements for physician organizations. Some of these laws are designed specifically to weed out weaker groups and to ensure success

for stronger organizations.

Whether regulation will help cure medical group woes is debatable, but it is, nonetheless, true that in a delegated-capitated model, physician groups take on some of the financial risk that HMOs had assumed originally and they do so without the attendant regulatory requirements

receiving referrals to specialists, and those scheduled for surgery are forced to wait until they can find a new surgeon affiliated with the health plan. Medical group insolvencies dislocated 2 million California patients from their physicians in 1998 and 1999, according to the California Medical Association.

## Physicians can reduce administrative costs and manage care more efficiently by using technology and the Internet.

that bind HMOs. There are, however, numerous opportunities for physicians to reduce administrative costs and manage the business of delivering care more efficiently through stronger management and the use of technology and the Internet.

### When Groups Fail

When medical groups close their doors, chaos ensues for patients, physicians, insurers, and regulators as all parties scramble to ensure that the delivery of care continues unabated. Largely at the mercy of failing medical groups, physician members can only hope to receive payment for services before the organization goes under. To receive payment, some physicians hurriedly sign up with other groups affiliated with their patients' health plans.

For patients, the delivery of care is severely interrupted. Some patients show up for appointments to find their physicians are no longer covered by their plan, and the physicians will therefore accept only cash payments. Other patients receive notification in the mail that they have been switched to a new group or a new physician. Delays result in

When a group fails, insurers move quickly to take back responsibilities formerly delegated to the medical group and to direct patients to new groups or physicians. Ideally, a health plan or medical group will have an early warning system to identify when they are at risk and take corrective actions prior to a group's demise. Recent failings have shown that such systems are not always implemented.

### New Solvency Requirements

Because so many people and lives are affected when medical groups go under, new solvency requirements are being legislated. Yet, each state is handling solvency requirements differently.

Given that its managed care enrollment rate is among the highest in the nation at 54% and that some 132 medical groups have failed in the last five years, California has passed the most dramatic legislation. Under the law, a new Department of Managed Health Care has adopted stringent regulations aimed at ensuring the financial viability of provider groups.

A few states are requiring that medical groups with substantial risks

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**Many provider organizations negotiate inadequate capitation payments because they base rates on last year's information. To determine capitation rates accurately, provider groups need analytical models to predict rates that will be appropriate for the future.**

hold an HMO license. Other states are placing limits on insurers' ability to delegate risk. Colorado and Maryland have passed controversial double-pay laws, requiring HMOs to pay physicians when medical groups fail. In this way, HMOs must pay twice, first to a medical group and again to the individual physicians if the group fails. Legislators in these states believe such legislation will encourage HMOs to pay adequate capitation rates the first time around.

Although regulations are aimed at improving the likelihood of medical group success, they may in fact increase administrative functions, technology needs, and costs, putting additional strain on resources. Some physician organizations may not be able to meet solvency requirements and may close or merge with others. There is also the potential that doing business with medical groups will become increasingly difficult.

Instead of regulations, medical groups need technology systems that can reduce costs and improve efficiencies. Information technology systems are an often overlooked, but central tool in improving business decisionmaking, tracking where money is spent, and improving a group's ability to operate within a budget. All of these factors can contribute to turning around the performance of a borderline medical group.

### The Capitated Model

Managing within the capitated model is a critical factor many medical groups face today and is frequently cited as a reason for the financial instability within this sector. In some markets, a large number of capitated-delegated

contracts are in place. The capitated model began primarily in the West, in such areas as Southern California, Oregon, and Washington state, before spreading to other markets, such as Colorado, Florida, Illinois, Texas, and Utah. In all of these states, health plans under pressure to cut premiums were looking for opportunities to reduce their business costs.

Under the capitated managed care system, health plans give physician organizations, such as IPAs or physician networks, a monthly per-member fee for providing care. Then, they delegate to these groups the responsibility of spending the money, deciding on care, and disbursing payments to physician members. If medical groups inadequately manage their resources or spend too much, they risk losing money and failing.

Despite the risk these organizations bear, these physician groups are not regulated as HMOs or insurers are. They are not required to keep reserves on hand, for example. Many believe these medical groups must be held accountable to the same legal, contractual, and quality standards as insurers.

Yet experts say the root of medical group failure is not legal and contractual standards but inadequate capitation payments paid by health plans. In some cases, these latter arguments are correct: The money that health plans have paid to some physician organizations has not been sufficient to allow the physicians to provide services adequately, let alone cover the cost of managing care. But other medical groups have succeeded when operating under these same difficult financial constraints.

As a result of this upheaval, health plans are beginning to realize that their success depends on the survival of well-run physician organizations. In the past, when health plans were pressured to cut premiums, many simply lowered physician reimbursement. Today, insurers are becoming more committed to paying actuarially sound rates that reflect the actual costs of care, including the higher costs of prescription drugs and technology needs.

### Medical Group Survival

Some industry experts believe that the failure rate of physician groups is not out of line with what would be expected in other industries or businesses. Medicine, after all, has become a commercial enterprise in which successes and failures are not uncommon, and it may be the group's management that is to blame, not capitation alone. These observers argue that while some physician organizations have gone bankrupt, others have done well.

Taken as a whole, medical groups are often undercapitalized and lack the management and administrative resources and infrastructure to handle the complexities of managing care and risk. Their systems cannot give them the timely information needed to make critical decisions. The costs of the information system that will do the job in the way it needs to be done may be too high for the group to afford.

Historically, the health care industry has underinvested in information technology. In the past, physician organizations implemented systems inappropriate for managing the intricacies of managed care. They tried to

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## Information systems are an often overlooked, but central tool in improving business decisionmaking, tracking where money is spent, and assisting groups in operating within a budget.

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incorporate practice management systems not designed for managing medical groups, for example.

Also, until recently, integrated solutions were not available. Organizations had to cobble together systems that addressed only one or two tasks in the management process. In addition, physician practices were already capital poor and could not afford to invest in the software, hardware, and information technology professionals needed to design, deploy, and maintain group management systems.

Today, medical groups need appropriate technology tools and Internet capabilities to help them negotiate, track, and manage capitated contracts successfully. The system should be built specifically for managing a network of physicians in managed care markets. Also, it should incorporate all administrative functions, including verification of member eligibility, processing referrals and authorizations, and submitting and processing claims.

When selecting a system, physicians should ensure that the company behind the system has a proven record of success. With so many health care entities using different applications, the system also must work flawlessly with different platforms and various levels of technology.

### Analyzing Data

The most critical function of an information system is its ability to interpret and analyze data. Many provider organizations negotiate inadequate capitation payments because they base rates on last year's information. To determine capitation rates accurately, provider groups need

analytical models to predict rates that will be appropriate for the future. The necessary data exist, of course, but they must be accessed and made readily available so that management can analyze the numbers and act accordingly. Therefore, reporting capabilities are equally important. With the option to use a variety of complex sorts and calculations, medical management will have the information needed to make cost-effective business decisions.

Several changes in today's technology environment have made systems more accessible to physician organizations. Application service providers (ASPs) allow groups to use state-of-the-art technology as a hosted application or over the Internet without having to buy, license, or install expensive software in-house. ASP technology is available at affordable monthly subscription rates, and deployment can take as little as one to three months.

The Internet and online connectivity have allowed physician organizations to connect providers to health plans and payers electronically. In this way, physician offices can submit claims and verify eligibility quickly and receive immediate feedback on referrals and claim status. These Web-enabled and online processes avoid long waiting times and follow-up calls for information. As a result, these systems go a long way toward improving the satisfaction of physicians in the group and patient members of the health plan.

Online systems also provide physicians with quick access to information, such as lists of specialists and providers, up-to-date member eligibility, and some benefit information.

Today's ASP solutions provide a whole host of services and tools that can make work flow much more streamlined on a routine, daily basis, resulting in efficient and cost-effective group management.

### Beyond Failures

The public press and general papers have reported on the failings of provider organizations, the rising costs of health care, and other issues that have alerted consumers to the turmoil in the industry.

It is important to realize, however, that in the midst of all the failures, there also have been many successful physician organizations with good medical management and information systems that analyze utilization against medical costs and revenue.

New state regulations are a modest step to solving the underlying problems, and as medical groups adjust to the new laws in their states, conditions may get worse before they get better. But experts agree that for those groups that can incorporate the benefits of new technology and Internet processing to operate more efficiently and profitably, the future looks bright. ■

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# Survey: Physicians Limit Access Due to Low Medicare Rates

*Kathy Lindquist-Kleissler is the executive director of the Denver Medical Society. Founded in 1871 and chartered by the Colorado Medical Society in 1952, the Denver organization has approximately 1,500 members in Colorado. Lindquist-Kleissler holds a masters degree in health administration and has taught health policy at the University of Denver for many years. Before being named executive director of the Denver Medical Society in 1990, Lindquist-Kleissler held a senior management position in hospital administration. Editor-in-chief Richard L. Reece, MD, conducted this interview.*

**Q.** Last summer, the Denver Medical Society coordinated a survey on physician acceptance of Medicare patients. Why?

**A.** The administrators of the county medical societies across Colorado had begun to hear that citizens covered by Medicare were having trouble finding physicians who would accept them as new patients. All of the medical societies were getting phone calls from citizens looking for physicians who would accept Medicare patients.

In addition, executives in the state Division of Insurance were getting a significant number of calls from Medicare patients. The issue was brought to the attention of the regional Health Care Finance Administration (HCFA) office. But the HCFA officials reported that the

information from patients was purely anecdotal, and that Medicare participation rate data showed that the vast majority of physicians across the country, including those in Colorado, were, in fact, participating in Medicare. So HCFA would not address the problem or examine reimbursement rates. Accordingly, we decided to collect data in an attempt to document that physician refusal to accept Medicare patients was a significant problem that existed across the state.

**Q.** Why did the HCFA Medicare participation rate data fail to reflect this access problem?

**A.** We were hearing from physicians that even if they participate in Medicare and are currently accepting Medicare patients, they are limiting the numbers or types of patients that they were accepting. That type of information would not be captured in any of the HCFA surveys or databases.

In contrast, our survey asked whether the physician has been participating in the Medicare program, and if so, if the physician was accepting Medicare patients, and—most important—for those who participate, if limits were placed on the number of Medicare patients accepted into the practice. That distinction is one of the most crucial aspects of the survey, because we were able to determine if Medicare patients were, in fact, facing an access problem, despite data indicating widespread

physician participation in Medicare.

**Q.** How do physicians limit Medicare patients in their practices?

**A.** Most physicians will treat Medicare patients only if the patient has some existing connection to their practice. Most physicians are choosing to keep their existing Medicare patients, for example, or they are retaining their aging patients in Medicare but they are not accepting any new patients who are covered by Medicare.

Some physicians may also accept elderly relatives of existing patients. For example, if my mother moves here from North Dakota, I might be able to go to my primary care doctor and ask him to accept my mother as a new patient. Other primary care physicians might take on a patient at the request of a specialist who treated a patient who needs primary care.

But if an older person moved to Denver and started calling practices, or if that person's HMO exited the Medicare market, he or she would have trouble finding a physician.

**Q.** How many doctors did you survey in your study?

**A.** We surveyed approximately 3,200 physicians across nine Colorado counties. We received responses back from 925 physicians, which is about a 30% response rate. One-third of the responses were from primary care physicians, and two-thirds came from specialists, which reflects the mix of U.S. physicians as a whole.

*(Continued on page 14)*

**“Most physicians are choosing to keep their existing Medicare patients or they are retaining their aging patients in Medicare but they are not accepting any new patients who are covered by Medicare.”**

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**Q.** What were the most salient findings of the survey?

**A.** The survey determined that, in fact, Medicare patients do face a problem accessing physicians. The biggest access problem lies in primary care. Approximately 54% of primary care physicians no longer accept new Medicare HMO patients, and more than 40% of primary care physicians no longer accept new Medicare Part B patients.

The data show a much different pattern among specialists. Only 20% of specialists are not accepting new Medicare HMO patients, and only 6% of specialists are not accepting Medicare Part B patients.

While the problem is larger in primary care, specialists too are affected by low reimbursement for treating Medicare patients. I have heard from a number of specialists that, while they are not closing their practices to new Medicare patients, they find it difficult to recruit new specialists to Colorado, especially the Denver-Colorado Springs metropolitan area, because they cannot pay new physicians or guarantee them the level of income that they can get in other parts of the country.

Our survey findings were supported by another survey, executed by the state's Division of Insurance and several patient advocacy groups. That survey determined that only about 35% of primary care physicians in the Denver metropolitan area are accepting new Medicare patients.

**Q.** Has the decline of Medicare HMOs in Colorado contributed to the access problem?

**A.** It has. The Denver market still has several Medicare HMO plans available, but we have

fewer than we had a couple of years ago. And, of course, these plans used to offer a zero deductible, while now more cost sharing is involved.

Outside of the Denver metropolitan area, the situation is more severe. Most of the HMOs have pulled out of the Medicare program in most rural communities. Colorado Springs has one Medicare HMO left. Some of the other counties that have larger cities have either one Medicare HMO or none. Accordingly, some of the Medicare patients left adrift because of the Medicare HMO closures are facing limited access to primary care.

**Q.** Is it true that the managed care enrollment rate in Denver, is high?

**A.** Yes, it is, and the payer mix drives part of the Medicare patient access problem. People have asked us, "Why is Medicare reimbursement a problem in Colorado when it's not that big of a problem in other parts of the country?" But the high managed care penetration rate in Denver means that there's less wiggle room for physicians. Denver's managed care enrollment rate is currently about 60%.

In the past, if physicians found that Medicare wasn't reimbursing them at an acceptable rate, they could recoup some of that loss someplace else. They could keep treating a high number of Medicare patients and increase their rates for commercial patients. But in Denver's current competitive managed care market, where the rates are nonnegotiable in many cases, physicians can't compensate for low Medicare reimbursement. So they are limiting the number of Medicare patients they treat.

Another factor may be higher overhead physicians incur due to the complexity of managed care, which

translates into lower margins.

**Q.** Are Medicare reimbursement rates more problematic in Colorado than they are in other states?

**A.** In some cases, yes. In Southern California, for example, and in other parts of the country, Medicare is still a good payer, and the commercial payers are paying a percentage below Medicare. Physicians in those areas may not like certain aspects of the Medicare system, but they still consider Medicare to be a desirable payer.

But that is not the experience in Colorado. Currently, most of our managed care plans are paying a percentage above Medicare. For example, Pacificare, one of Denver's largest payers, is paying from 118% to 140% of Medicare rates, depending on the contract. Here, Medicare is considered to be the second worst payer, second only to Medicaid.

**Q.** What issues surround geographic variation in rates?

**A.** The variation among geographic regions has shrunk over the years, due to a change in the statute that limits the variations to a 40% range. The national average is 1.0, while the higher payment areas can range as high as 1.2 and the lower payment can range as low as 0.8. The allowance for a variation of 20% below or 20% above the national average has limited the differential somewhat. But, obviously, that's still a significant differential.

The differential is supposed to be based on three factors: the professional work component, based on area wages; the cost of running an office; and the medical malpractice cost. Medicare rates are an ongoing area of contention, because the basic

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**"In Denver's current competitive managed care market, where the rates are nonnegotiable in many cases, physicians can't compensate for low Medicare reimbursement."**

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assumption is that the health care pie is not going to get bigger, so that if Colorado wants more money, it's going to come out of another state's slice. States like California, Florida, and New York have more representatives in Congress than Colorado does, and they are not particularly open to reallocating the pie. The result is that there is a significant difference between what a physician in Miami will get paid for a given code versus a physician in Denver. Whether that difference accurately reflects cost of living differences is constantly debated.

Geographic payment issues also arise within a state. Currently, as in many states, Colorado has a single geographic payment module. So a physician in Denver, where the cost of living and the cost of office space is high, will get paid the same amount for a procedure as a physician in Rifle, a rural town.

**Q.** *What are the Medicare-related complaints of Colorado physicians, besides low reimbursement rates?*

**A.** Physicians also complain about the onus of paperwork and the fear of Medicare audits, which carry the threat of heavy fines or even imprisonment. Both primary care and specialty physicians complain about these factors and low reimbursement rates.

Reimbursement is probably the top issue, because it has become difficult for practices to survive in the Denver market. But the whole experience with and perception of the Medicare program is very negative. Even if physicians were reimbursed at a higher rate, they might be more willing to see Medicare patients, but they would still be fairly frustrated.

Physicians feel that the Medicare program has evolved into an adversarial system over the last couple of years. They feel they are being criminalized through HCFA's emphasis on fraud and abuse investigation, and that, in general, the Medicare pro-

**"The officials in HCFA's regional office in Denver tell us there is a new wind at HCFA, and it's blowing more gently toward physicians' concerns."**

gram has taken every opportunity to put physicians in a bad light. So the real issue is not the actual number of physicians prosecuted—which is small—but it is physician perception of the Medicare system.

One problem, for example, is that, even with the best of intentions and the most diligent care with coding, physicians can't figure out how CPT codes and the HCFA guidelines mesh. Coding has become so complex that they just can't be sure that they are doing it correctly. There's such fear and confusion that even with coding technology tools, physicians are not totally comfortable. Frankly, if the program is so complex that we need to create an entire industry to help physicians code, then the system is not working.

Still, we may see a kinder, gentler HCFA evolve over time. There is a new HCFA committee that is examining the real concerns of practicing physicians through surveys, and it will be determining how Medicare officials can best respond. I also should add that the people at the regional HCFA office here in Denver have been very responsive to us. They tell us that there is a new wind at HCFA, and it's blowing more gently toward physicians' concerns.

**Q.** *What do you hope the effect of your study will be?*

**A.** In a society with so much concern about health care issues, the access of Medicare patients to physicians has the potential to be a major political issue that ranks right up there with prescription drug benefits. If a person can't get in to see a doctor, he or she is not going to get prescriptions, so prescription drug

benefits become secondary.

A year ago, when we started this study, the regional HCFA office indicated that our concerns about access were somewhat unique. But more HCFA offices are hearing similar stories elsewhere in the country. Now, the national office of HCFA is starting to take note of the problem. Our study started to get people to recognize the issue on a national level. I hope that we can trigger a trend of surveying physician access for the growing Medicare population.

**Q.** *What is your plan now, given the findings of your survey?*

**A.** We are doing everything that we can to get the results of the survey in front of policymakers locally and at the national level. We are examining the issue of geographic variance in reimbursement, so that we can determine whether variation in reimbursement is a major factor in access to care across the state. We are working with the local HCFA office to see if there are some strategies we can adopt to make interaction with HCFA more physician friendly. We are also working with several foundations and patient advocacy groups that have become interested in the access issue. We've been considering an education program for physicians, for example, that would focus on how to survive in the Medicare program. We hope this type of effort would encourage them to continue or increase their participation by helping them find ways to make participation pay off.

—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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