"Building a Healthy, Independent Practice"

Presented by Association of American Physicians & Surgeons &
Montgomery County Medical Society

May 30, 2008
1 – 5:30 pm

AGENDA

1:00 – 1:10 Welcome & Introductions

1:10 – 1:45 Patient-Doctor Direct Models, Impact of Policy & Regulations

Kathryn Serkes
Director, AAPS Policy & Public Affairs

1:45 – 2:30 Legal Wellness & Defending Your Practice; Legal issues & case studies in Patient-Doctor-Direct Practices™

Andrew Schlafly, Esq
General Counsel, AAPS

2:15- 2:45 Hospital Contracts & the Dark Side of Peer Review
Lawrence Huntoon, M.D., PhD
Editor, *Journal of American Physicians & Surgeons*

3:00 – 3:15 BREAK

3:15 – 5:00 Case Studies in Patient-Doctor-Direct Practices™: Specific Steps to Setting up or Converting Your Practice

Mark Schiller, M.D.
Past President, AAPS
Assistant Clinical Professor at UCSF
Adult Neuropsychiatry
San Francisco & Marin County, CA
www.DrMarkSchiller.com

George Watson, M.D.
Director, AAPS
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OBJECTIVES
Upon completion of this workshop, the attendees:

1. Will know risk-management policies and procedures to:

   A. Identify and implement policies and procedures to improve compliance with government regulations, reduce administrative errors, and prepare for audits.

   B Identify and implement policies to minimize third-party disruptions of patient care and interference with the patient-physician relationship.

   C. . Identify and implement procedures to minimize exposure to licensure actions and criminal prosecutions and to protect personal and professional assets through applied risk management; and

2. To maintain the focus of their medical practice on improved patient care rather than malpractice or compliance defense.

FOR CATEGORY II CME INFORMATION, PLEASE SEE THE AAPS WEBSITE.

SAMPLE START-UP COSTS & REQUIREMENTS

Patient-Doctor-Direct™ Practice Solo Practice

General Practice

	Low end	High end
Advertising		
Newspaper	500	1500
Mailing to small businesses	400	500
Letter to some interested patients	100	500
Office sign	1000	5000
Cable	500	2000
Billboard	500	2000
Website	500	2000
Yellow pages	1000	2000
Total advertising expense	4500	15500
Deposit on rental	1500	2000
1st month rent	1500	2000
Utility deposit	200	200
Business license	100	100
Insurance		
Liability	400	400
Building	350	350
Medicines	200	1000
Medical equipment		
exam tables	300	2500
procedure light	700	1500
Gloves	100	100
vaginal exam supplies	200	200
Splints	200	200
Bandages	100	100
clia waived lab supplies	200	1000
AED	1500	1500
resuscitation equipment	200	1000
Nebulizer	100	200
disposable suture kits / scalpels	300	300
fine needle holders, scissors, etc	0	1500
kick buckets	100	100
view box	400	400
blood pressure pulse ox	1000	3000
tympanic thermometer	100	100
EKG machine	0	3500
Autoclave	0	2000
Spirometer	0	700
Total medical equipment	5500	19900

Office equipment		
Phone	200	500
Credit card machine	1000	1000
Merchant account contract	500	500
Desk	1000	2000
Copier / fax	500	5000
Stapler, etc	200	200
Ledger	500	1000
Filing cabinets	500	2000
Charts	500	1000
Waiting room furniture	200	5000
Refrigerator for meds	100	300
OSHA manual	300	300
Chairs	100	2000
Computer	0	5000
Book cases	200	1000
Pictures and other décor	200	2000
Total office equipment	6000	28800
Living expenses for 30 days	6000	15000
TOTAL START UP COSTS	**42,250**	**149,050**

SUGGESTED MINIMUM PHYSICAL LAYOUT & SPACE REQUIREMENTS

Waiting room and reception area:	**200 SQ. FT.**
The medicine room:	**50 SQ. FT**
Exam rooms:	**100 SQ. FT.**
A coffee /supply room:	**70 SQ. FT.**
Procedure room:	**100 SQ. FT.**
Personal office:	**100 SQ.FT.**

Additional offices/storage for colleagues, ancillary practitioners: **100 SQ. FT. each**

SUGGESTED MINIMUM OFFICE SUPPLIES

- ❑ **Paper shredder**
- ❑ **Cash register**
- ❑ **Credit card machine which doubles as a check securing machine**
- ❑ **All-in-one printer/copier/fax/scanner**
- ❑ **File cabinets for charts**
- ❑ **Waiting room furniture**
- ❑ **Water dispenser**
- ❑ **Desktop computer**
- ❑ **Desk**

Besides the usual pens, paper clips:

- ❑ **Laptop/pda in examine room**
- ❑ **Histaccount peg board / receipts / daily transaction sheets**
- ❑ **Histaccount chart files / dividers / letters**
- ❑ **Hole puncher**
- ❑ **Regular file folders**
- ❑ **Clip boards for intake and sign-in sheets**
- ❑ **Name printer for charts**
- ❑ **Notebook of plastic sleeves for important information and templates**
- ❑ **Rolodex**
- ❑ **Yearly planner for appointments if not computerized**
- ❑ **Containers with mints / lollipops / and stickers**
- ❑ **Brochure and business card holders**
- ❑ **Business cards / clinic brochures / stationery / envelopes / appointment cards**
- ❑ **Notebooks to store daily transactions sheets**

SUGGESTED MEDICAL EQUIPMENT

- ❑ Adult and pediatric eye charts
- ❑ Ophthalmoscopes and otoscopes
- ❑ Blood pressure cuffs
- ❑ Ishihara's Tests For Colour Deficiency
- ❑ Automatic external defibrillator
- ❑ Automatic BP, pulse, and pulse ox machine
- ❑ Overbed tables
- ❑ Stryker ER stretcher
- ❑ Two Ritter exam tables
- ❑ X-ray view box
- ❑ IV poles
- ❑ Oxygen tank
- ❑ Centrifuge
- ❑ Autoclave
- ❑ Wheelchair
- ❑ Electronic scale
- ❑ Clinteck urine analyzer
- ❑ Fiberoptic vaginal light
- ❑ Reflex hammers
- ❑ Fraser suction
- ❑ Alligator forceps
- ❑ Woods lamp
- ❑ Welch Allen 12 lead EKG machine
- ❑ Corneal burr

OTHERS:

SUGGESTED MEDICATIONS

- ❑ Lidocaine 1% and Lidocaine 1% with epi
- ❑ Marcaine 0.5%
- ❑ Solumedrol
- ❑ Depomedrol
- ❑ Nalbuphine
- ❑ Promethazine
- ❑ Ketorolac
- ❑ Ancef
- ❑ Bicillin
- ❑ Rocephin
- ❑ Amps of epinephrine
- ❑ Narcan
- ❑ Benadryl injectable and capsules
- ❑ Dextrose 50%
- ❑ Lovenox
- ❑ Heparin flush
- ❑ Acetaminophen
- ❑ Ibuprofen
- ❑ Amps of albuterol solution
- ❑ Gentamicin injectable and ophthalmic ointment
- ❑ Tetracaine ophthalmic soln 0.5%
- ❑ Pneumovax 23
- ❑ Influenza vaccine
- ❑ Tuberculin, purified protein derivative (ppd)
- ❑ Humulin 70/30
- ❑ Tetanus and diphtheria toxoids
- ❑ Vitamin B12
- ❑ Ampicillin injectable

OTHERS:

SUGGESTED MEDICAL SUPPLIES

- ❑ 4X4 & 2X2 sterile and non-sterile gauze sponges
- ❑ 2", 3", 4" sterile and non-sterile stretch gauze bandages
- ❑ Steri-strips
- ❑ Adaptic non-stick dressing
- ❑ Petrolatum dressing
- ❑ Tube gauze dressing and cylinders
- ❑ Fiberglass 2", 3", 4" pre-padded splints
- ❑ Slings, wrist, metacarpal, and finger splints
- ❑ 2", 3", 4" ace wraps
- ❑ Surgical tape 1", 2", 3"
- ❑ Sterile and non-sterile gloves
- ❑ Eye pads
- ❑ Fluorescein strips
- ❑ 5X9" ABD pads
- ❑ Bandaids
- ❑ Sterile saline eye wash
- ❑ Blairex
- ❑ Disposable suture sets
- ❑ Disposable suture removal and staple removal sets
- ❑ Vicryl, chromic, nylon suture
- ❑ Disposable I & D sets
- ❑ Surgical masks
- ❑ Ear irrigation equipment
- ❑ Scalpels
- ❑ Silver nitrate sticks
- ❑ ¼" and ½" packing gauze
- ❑ Ear specula
- ❑ Razors and clippers
- ❑ Paper rolls to cover exam tables
- ❑ Nebulizer and tubing
- ❑ Vasoline nasal packing
- ❑ Penrose drains
- ❑ IV bags, tubing, and catheters
- ❑ Thin prep pap vials and papettes
- ❑ Oral and ear thermometers and covers
- ❑ Chucks (diaper pads)
- ❑ Pillow cases
- ❑ Cotton balls
- ❑ Saline irrigation solution
- ❑ Betadine
- ❑ Foley catheters
- ❑ Cotton tip applicators sterile and non-sterile
- ❑ Benzoin tincture
- ❑ Iodine swaps
- ❑ Tennis elbow brace
- ❑ Lab draw equipment
- ❑ Tongue depressors
- ❑ Drapes (sterile) - fenestrated and non-fenestrated
- ❑ Triple antibiotic ointment and bacitracin
- ❑ "Kick bucket"
- ❑ Hhydrogen peroxide
- ❑ Alcohol prep pads
- ❑ Needles 18g, 21g, 22g, 23g, 25g, 27g
- ❑ 3cc, 5cc, 10cc, 20cc, 60cc luer lock syringes
- ❑ Insulin and tuberculin syringes
- ❑ Biohazard disposal containers
- ❑ Emesis basins
- ❑ Plastic vaginal specula
- ❑ Histofreezer portable cryosurgical system
- ❑ Bionix ear curettes
- ❑ Ethyl chloride fine pinpoint spray
- ❑ Hurricane topical anesthetic spray
- ❑ Sterile saline in 10cc vials
- ❑ Sterile water
- ❑ Medicine dispensers 30cc
- ❑ Urine collectors
- ❑ Urine strainers
- ❑ Word catheters
- ❑ K-Y jelly
- ❑ Hemoccult cards and developers
- ❑ Pill cutter
- ❑ Pill crusher
- ❑ Kenalog
- ❑ Decadron

The AAPS Hassle Coefficient Factor Analysis[1] (rev. 2004)

To do the HCFA, and assess your practice liabilities, follow these steps. You may wish to do a separate analysis for Medicare and for managed care.

Preliminary investigations:
For several days, have each staff member and physician use a stopwatch to time every activity related to third-party payment, including telephone calls, correspondence, and study of carrier manuals.

Accounting assessments:
Consult your balance sheet, bank statements, tax forms, payroll records, etc., to make the estimates required to fill in the table.

Overhead Costs for Claims Submissions

1.	Salaries, taxes, benefits for employees: Full-time third-party-related work:	$
	Part-time insurance-related work (multiply by percentage of time spent on such work)	$
2.	Excess computer equipment required for claims processing, EHRs, other mandates:	
	Purchase of hardware and software, leasing, maintenance, required software upgrades	$
	Personnel costs (training, consultation, need for more highly skilled workers)	$
3.	Additional telephone lines	$
4.	Forms, manuals, and other supplies	$
5.	Training and compliance costs (seminar fees, time off for personnel to attend, consultants, voluntary audits)	$
6.	Additional credentialing expense	$
7.	Excess liability coverage	$
8.	(Physician time spent in excess third-party-required work) x (hourly earning potential)	$
9.	Rental of space needed solely for employees or supplies related to third-party relations	$
10.	Other (psychotherapy or medical treatment for stress-related disorders, etc.)	$

Total the amounts to arrive at a monthly or annual estimate of office overhead for claims submissions: $_____

Liabilities

If you have managed-care contracts, estimate the expected income loss due to withholds or possible penalties for overutilization: $_____

Liability due to "anti-fraud" initiatives:

Method 1 (shortcut): Multiply the functional equivalent of infinity by any nonzero probability.

Method 2: Fill in the table on page 2.

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[1] Title plagiarized from the American Society of Dermatology, and from the Health Care Financing Administration, now called the Center for Medicare and Medicaid Services or CMS.

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Association of American Physicians and Surgeons, Inc.
A Voice for Private Physicians Since 1943
Omnia pro aegroto

HOW TO OPT OUT OF MEDICARE

It is simple to opt out of Medicare - far simpler than staying in the Medicare program. Hundreds of physicians have already opted out, and we not heard a single regret by any of these physicians. Once CMS unleashes its dreaded new program of "private auditors" to shake down physicians in the Medicare program, far more physicians will likely opt out - and even more will wish they had.

We have prepared this "How To" guide for your benefit. These suggestions do not constitute legal advice - please consult an attorney for any legal issues or questions.

IF YOU ARE A NON-PARTICIPATING PHYSICIAN, then opting out is as follows:

Step One: Notify your patients that you are opting out of Medicare.

Step Two: File a copy of the following affidavit with "each carrier that has jurisdiction over the claims that the physician or practitioner would otherwise file with Medicare." (quoting CMS Qs and As on Private Contracts, #10). The addresses will vary depending on the region of the country in which you practice. Click here for a list of Medicare carriers by state. The affidavit should be equivalent to the following:

> I, _____, declare under penalty of perjury that the following is true and correct to the best of my knowledge, information, and belief:
>
> 1. I am a physician licensed to practice medicine in the state of _____. My address is at _____, my telephone number is _____, and my [national provider identifier (NPI) or billing number, if one has been assigned, uniform provider identification number (UPIN) if one has been assigned, or, if neither an NPI nor a UPIN has been assigned, my tax identification number (TIN)] is _____. I promise that, for a period of two years beginning on the date that this affidavit is signed (the "Opt-Out Period"), I will be bound by the terms of both this affidavit and the private contracts that I enter into pursuant to this affidavit. [NOTE: Your personal UPIN number must be used, not a corporate UPIN number. Persons opt out, not corporations.]
>
> 2. I have entered or intend to enter into a private contract with a patient who is a beneficiary of Medicare ("Medicare Beneficiary") pursuant to Section 4507 of the Balanced Budget Act of 1997 for the provision of medical services covered by Medicare Part B. Regardless of any payment arrangements I may make, this affidavit applies to all Medicare-covered items and services that I furnish to Medicare Beneficiaries during the Opt-Out period, except for emergency or urgent care services furnished to Beneficiaries with whom I had not previously privately contracted. I will not ask a Medicare Beneficiary who has not entered into a private contract and who requires emergency or urgent care services to enter into a private contract with respect to receiving such services, and I will comply with 42 C.F.R. § 405.440 for such services.
>
> 3. I hereby confirm that I will not submit, nor permit any entity acting on my behalf to submit, a claim to Medicare for any Medicare Part B item or service provided to any Medicare Beneficiary during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation for which I am required to submit a claim under Medicare on behalf of a Medicare Beneficiary, and I will provide Medicare-covered services to Medicare Beneficiaries only through private contracts that satisfy 42 C.F.R. § 405.415 for such services.
>
> 4. I hereby confirm that I will not receive any direct or indirect Medicare payment for Medicare Part B items or services that I furnish to Medicare Beneficiaries with whom I have privately contracted, whether as an individual, an employee

of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare Beneficiary under a Medicare+Choice plan, during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation. I acknowledge that, during the Opt-Out Period, my services are not covered under Medicare Part B and that no Medicare Part B payment may be made to any entity for my services, directly or on a capitated basis, except for items or services provided in an emergency or urgent care situation.

5. A copy of this affidavit is being filed with [the name of each local Medicare carrier], the designated agent of the Secretary of the Department of Health and Human Services, no later than 10 days after the first contract to which this affidavit applies is entered into. [FOR PARTICIPATING PHYSICIANS ONLY: My Medicare Part B Participation agreement terminates on the effective date of this affidavit.]

Executed on [date] by [Physician name]
[Physician signature]

Step Three: Enter into a private contract for, and prior to, rendering any covered services to a Medicare Part B Beneficiary. Such private contract should include the following:

This agreement is between Dr. _____ ("Physician"), whose principal place of business is _____, and patient _____ ("Patient"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on _____ for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):

[LIST ALL THE SERVICES HERE]

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.

[Optional:

- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

Executed on [date] by [Patient name] and [Physician name]

[Patient signature] [Physician signature]

[NOTE to physicians: keep a copy of all of these contracts in case CMS demands them! CMS requires that this contract be re-executed each period.]

Step Four: Install procedures to ensure that your office never files a Medicare claim, and never provides information to a patient that enables him to file a Medicare claim. The two exceptions - for emergency or urgent care and for covered services that Medicare would deem unnecessary - should be used with caution.

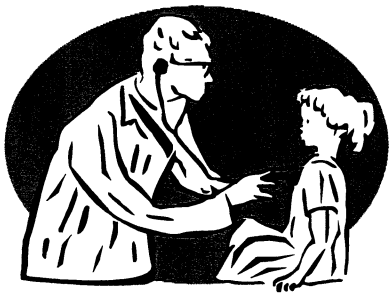
Step Five: Reduce the substantial overhead costs resultant from participating in the Medicare program and being subjected to the Medicare-inspired audits and threats. Then celebrate: you can now spend your time serving patients rather than catering to and being controlled by the government.

Step Six: Mark your calendar to send in a new "opt out" affidavit every two years to maintain your status.

IF YOU ARE A PARTICIPATING PHYSICIAN, then opting out is as follows:

Step One: In the words of CMS: "To opt out of Medicare, a participating physician must first terminate his or her Medicare Part B participation agreement." (CMS Qs and As on Private Contracts, #5). At the beginning of 1998, CMS only allowed termination of participation on an annual basis. More recently, however, CMS has allowed termination on the following quarterly basis: Jan. 1, Apr. 1, July 1, and Oct. 1. Note, however, that a participating physician must give his or her carrier 30-days' prior notice by sending in the opt-out affidavit with an effective date of the beginning of the next quarter.

Subsequent Steps: Follow the above Steps One through Five for a non-participating physician, except that the physician may not provide private contracting services until the first date of the next quarter that is at least 30 days after receipt of the notice by the carrier. For example, the carrier must receive the notice from the physician by Sept. 1 if the physician seeks to provide private contracting services beginning on Oct. 1. Mark your calendar to send in a new "opt out" affidavit every two years to maintain your status.



PATIENT'S REQUEST FOR CARE
Personal Services Agreement

Several members recently consulted the AAPS General Counsel on use of a "Patient Request for Care" that would address the issue of liability and arbitration.

Many of you may be interested in using a similar request, so as a service to our members, we are providing this example of one "Patient's Request for Care" currently in use by a member.

The "waiver" may not only protect you and your patient from protracted litigation, but it may also help to educate patients about the dire consequences of the medical liability crisis and the role one individual may play in solving it or exacerbating it.

There is no single solution to this problem, and AAPS is developing and supporting a menu of solutions to the malpractice premium problem, including caps on non-economic damages and other legislative remedies, as well as support for physicians who want to go bare, such as tax-deductible defense-fund savings accounts. ***(See our "Primer on Medical Malpractice," www.AAPSonline.org)***

But doctors and patients can't sit on their hands waiting out the battle between the politicians and the trial lawyers. Personal service agreements may make some dent in the problem.

One AAPS-member physician reports that patients are gladly signing this agreement – which even includes a statement that he has stopped carrying malpractice insurance coverage. Out of hundreds of patients, only one has refused his request.

We emphasize that this example is offered only for informational purposes. It is not offered as and does not constitute legal advice. If you are considering using a personal services agreement, please consult your own attorney to write the best agreement for your particular practice.

- If you have any questions, please contact the AAPS Limited Legal Consultation Service at the office.
- Send your suggestions or other examples of letters to: AAPS@AAPSonline.org
- Check the FORUM at www.AAPSonline.org for postings of these suggestions.

AAPS
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www.aapsonline.org

EXAMPLE OF "PATIENT WAIVER"

[This is one example of a "Patient Request for Care" currently used by a physician. His name has been deleted.]

[This example is offered only for informational purposes. It is not offered as and does not constitute legal advice. Do not rely on this example without either verifying its suitability independently or seeking appropriate legal advice.]

PATIENT'S REQUEST FOR CARE

Dr. [JOHN DOE] feels there is a "malpractice crisis" that threatens medical care. Lawsuits can be costly and time-consuming, and often interfere with care for sick patients.

Dr. [JOHN DOE] asks patients to complete this form. You may decline to do so and may see a different doctor. You may also use our phones to call anyone for advice in filling out this form.

☑ **I'm not having an emergency at this time:**
Yes: _____ **No:** _____ **Patient's initials:** _____

☑ I'm having an emergency at this time:
Yes: _____ **No:** _____ **Patient's initials:** _____

☑ I agree to submit any and all claims against Dr. [JOHN DOE] to arbitration by the American Arbitration Association rather than to a judge or jury:
Yes: _____ **No:** _____ **Patient's initials:** _____

☑ I agree that Dr. [JOHN DOE] may submit any claim asserted by me to binding arbitration before the American Arbitration Association, and agree to be bound by that arbitration even if I decline to participate:
Yes: _____ **No:** _____ **Patient's initials:** _____

☑ I agree to limit any claim relating to any diagnosis, treatment or care by Dr. [JOHN DOE] to $250,000 for all non-economic damages, including pain and suffering or inconvenience: **Yes:** _____ **No:** _____ **Patient's initials:** _____

☑ In the event I assert a claim against Dr. [JOHN DOE] and it is denied, then I agree to pay for the reasonable attorney and expert fees of the defense:
Yes: _____ **No:** _____ **Patient's initials:** _____

I request to be a patient of Dr. [JOHN DOE] in full agreement with and understanding of the above.

I do not rely on any oral representations by anyone on staff in completing this form.

This waiver form applies to all past and future services rendered by Dr. [JOHN DOE].

Patient's signature: _____ **Date:**__ _____

Patient's name: _____

A COPY OF THIS SIGNED FORM WAS RECEIVED FROM THE PATIENT BY:

Staff member's signature: _____ Date:_____

Staff member's name: _____

Jane M. Orient, M.D., F.A.C.P.
Internal Medicine
1601 N. Tucson Blvd. Suite 9
Tucson, AZ 85716
(520) 325-2689

Request for medical service

This is a request for a medical service from Jane M. Orient, M.D., based on the following understandings:

___ The code of ethics and standard of care in this office is the Oath of Hippocrates.

___ Dr. Orient works only for patients, not for insurers or health plans. Obtaining any third-party reimbursement is the responsibility of the patient.

___ Dr. Orient has chosen not to be a Medicare, AHCCCS, or TriCare provider. She provides only services that are not covered by any government program. I promise never to submit a claim to any government program, or to permit any claim to be submitted on my behalf.

___ Only limited services can be offered in this office, as agreed between Dr. Orient and each individual patient. Dr. Orient does not offer comprehensive care, primary care, emergency treatment, chronic pain management, vaccines, or disability evaluations.

___ ***I do not have an emergent problem at this time.***

___ Medical records kept by Dr. Orient are confidential and are released only upon signed written consent of the patient or legal guardian, except as required by law. Because of concerns about confidentiality, Dr. Orient does not engage in the electronic transactions that would make her a "HIPAA-covered entity."

___ I agree to allow Dr. Orient to contact me at intervals to find out how I am doing, in order that she may improve her diagnostic accuracy and inform other patients about how others have responded to treatment for similar conditions. I have no objection to the compilation of outcomes data, with the understanding that no individual patients will be identifiable in any data released outside the office. The preferred method of contacting me is:

___ If I have a question, a concern, or a complaint about anything related to Dr. Orient, I will bring it to her attention immediately, so that she may try to resolve the matter.

___ I understand that all doctors are fallible, and all medical treatments, or lack of treatment, are associated with risks, known and unknown, including death or serious disability. I freely assume all risks incurred in connection with my consulting Dr. Orient and waive any claim to indemnification by Dr. Orient for bad medical outcomes.

___ I recognize that at a future time, when I might decide to file a claim, Dr. Orient may not be covered by professional liability ("malpractice") insurance.

___ If I should file a complaint against Dr. Orient that is determined to be nonmeritorious or "frivolous," I agree to reimburse her for all reasonable costs of her defense, including but not limited to attorney fees, expert witness fees, printing costs, and court costs.

___ I request services from Dr. Orient in full agreement with and understanding of the above. I do not rely on any oral representations by Dr. Orient or her staff in completing this form and am not under any pressure to sign. I am free to seek legal advice about this form, to decline to sign it, and to decide to see a different physician.

___ This form applies to all past and future services rendered by Dr. Orient and shall bind me and my heirs, legal representatives, and assigns. Each provision shall be severable from the remainder and enforceable to the fullest extent of the law.

Patient's signature: _____ Date: _____

Patient's name: _____

A copy of this signed form was received from the patient by:

Staff member's signature: _____ Date: ____

Staff member's name: _____

Oath of Hippocrates

I swear by Apollo, the Physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgment, I will keep this oath and stipulation:

To reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required: to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

With Purity and with Holiness I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this oath unviolated may it be granted to me to enjoy life and the practice of the art, respected by all men at all times but should I trespass and violate this oath, may the reverse be my lot.

Principles of Medical Ethics

of the Association of American Physicians and Surgeons

Preamble:

Being aware that a physician's religious and moral principles are the source of his ethical behavior, this Association adopts the following statement of principles of professional conduct. The principal objective of the ethical physician in his practice is to treat human illness while maintaining the highest respect for the dignity of his patient.

Section 1

The physician's first professional obligation is to his patient, then to his profession. His ethical obligation to his community is the same as that of any other citizen.

Section 2

The physician should conduct himself at all times with dignity, integrity, honesty and diligence in the practice of his profession so that he will engender the confidence of his patients and respect of his colleagues.

Section 3

The physician should not condone the taking of human life in the practice of his profession, but at all times respect the sanctity of human life and seek to preserve or improve the quality of life.

Section 4

The physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 5

The physician may choose whom he will treat, but having undertaken the care of a patient, he should not discontinue his care without adequate notice.

Section 6

The physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. He should neither pay nor receive a commission for referral of patients. The value of professional services should be determined only by mutual agreement between physician and patient, and in no other way.

Section 7

The physician should personally counsel another practitioner who behaves incompetently or unethically and report persistence of that conduct to the proper authority.

Section 8

The physician should seek advice and consultation with ethical colleagues whenever the quality of medical care may be enhanced or whenever consultation is requested by the patient.

Section 9

The special importance of the patient's privacy in medical matters requires that the physician never reveal either the confidences entrusted to him in the course of medical attendance, or deficiencies he may observe in the character of the patient, releasing information only with the consent of the patient and with due consideration of the mandate of law.

Section 10

The physician should constantly seek factual and reliable information that will assist him in the treatment of illness.

Section 11

The physician should not solicit patients. Professional reputation is the major source of patient referral. The physician should be circumspect and restrained in dealing with the communication media, always avoiding self-aggrandizement.

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THE DOCTOR IS IN, SHOULD INSURANCE BE OUT?

Paying for Medical Care

By Jane M. Orient, M.D. & Kathryn A. Serkes

There are two ways to obtain medical care: (1) use your own resources to buy it or (2) get someone else to buy it for you. There is prepayment through insurance or postpayment through cash or credit. There is direct payment or "assigned" payment through an insurer. One can request charity, or use force, the latter most often through government, the largest third party.

Though it may be dismissed as irrelevant, *the method of payment is critical.* It affects almost everything else in some way: the patient-physician relationship, the type and quality of service, the availability and promptness of service, the conditions for delivery of service, the documentation, the morale of medical professionals and the cost.

Almost all the complexities that have ensnarled medical offices during the past 50 years and distracted physicians from attending patients and expanding their medical knowledge are the consequence of third-party payment. Physicians are forced to game the system and bill $200 if they have any hope of getting reimbursed $43.

Without the third party there is *no need* for coding, claims forms, authorizations, eligibility checks, documentation of medical necessity, postpayment audits, payment delays for "re-pricing," compliance plans, or expensive consultants.

Some patients believe that medicals goods can only be purchased with an insurance card, not cash. But third-party payment is a recent phenomenon, rare and unimportant when many doctors started practice in the 60's. Maybe it's time we started to take a look at the "good old days."

In response to escalating regulatory costs and threats of prosecution for "non-compliance," thousands of doctors across the country have chosen to go back to "patient-doctor direct" cash-based practices. In doing so, they have reduced administrative and compliance costs, and passed those savings along to patients.

Dr. Robert Berry of Tennessee estimates that he saves $200,000 annually as a result of opting out of Medicare and forgoing all third-party payments. "If all primary care physicians went insurance free, the country would save approximately $60 billion in physician overhead alone."

Without all those extra costs, Dr. Berry is able to charge his patients about the same rates as does Jiffy Lube for their cars -- $35 office visits and $15 laboratory fees. All prices are plainly posted in his office.

When patients buck at the concept of foregoing their insurance and $10 co-pay, Dr. Berry uses a simple analogy. "If you don't have insurance for routine car maintenance, then why have it for routine medical care since fees at our clinic run anywhere between an oil change and a brake job."

Dr. Todd Coulter of Mississippi is proof that critics are wrong that cash-based practices can't survive and serve indigent or low-income communities. His walk-in clinic has provided him with a livable income and caters to his uninsured patients. "I'm practicing medicine again."

But the hidden "sick tax" is most evident in hospital bills. Self-paying patients are increasingly irate about the inflated prices they are billed, compared with what hospitals collect from lowball Medicare and insurance contracts. But until the cash-strapped hospitals get some relief, they will continue to cost-shift and charge the highest prices to those who can least afford it.

Inflated retail prices help to scare people into paying too much for insurance. Indoctrination in the concept of a "right to health care" tends to make people unwilling even to consider postpayment, say by incurring a debt of $10,000 to $20,000 to cover a deductible even though the interest on the debt might well be less than the higher premiums for lower-deductible insurance.

As more patients set up Health Savings Accounts (HSAs) and pay out of their own pocket for routine medical services, realistic pricing will become even more important.

You can negotiate medical costs. Start with your doctor. You'll be surprised how receptive he'll be to direct payment. And try laboratories as well. It's amazing how $1200 MRIs suddenly cost only a few hundred when payment is made at time of service.

Honesty is an essential part of good medicine. And honest pricing is indispensable for restoring both trust and accurate economic calculations in the medical marketplace. Patients need to start demanding transparency and fairness in medical prices.

Dr. Orient, an internist in Tucson, is Executive Director of the Association of American Physicians and Surgeons, and author of "Your Doctor is NOT In." Kathryn Serkes is co-author of "Patient Power: The Patient Handbook. See www.AAPSonline.org for more information.

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THE NEWSPAPER FOR AMERICA'S PHYSICIANS

GOVERNMENT & MEDICINE

Panel studies retainer care, practice trends

Physicians who have opted out of health insurance can offer new solutions, lawmakers say.

By Joel B. Finkelstein, *AMNews* staff. May 17, 2004.

Washington --"What will it take to get physicians excited about practicing medicine again?"

That was the question Sen. Robert F. Bennett (R, Utah) asked a panel of physicians testifying recently before the Joint Economic Committee. Their answer: Opting out of the mainstream, health insurance-oriented system of reimbursement.

With this article
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Like these physician panelists, a seemingly growing number of physicians are eschewing insurers and Medicare in favor of cash payment and retainer practices, also called boutique practices.

The American Medical Association's Council on Ethical and Judicial Affairs last year determined that the trend is not necessarily a bad thing.

"Retainer practices provide an opportunity for patients to develop a more personalized relationship with their physician," said Council Chair Leonard Morse, MD, in an earlier statement. "But physicians should also make sure that all patients, including those who ... do not pay retainer fees, continue to receive the same quality of care."

The panel of doctors told lawmakers that retainer care allows them the freedom to practice the type of medicine they think most appropriate.

"If a practice is limited to 600 patients, such as in my current practice, then 12 hours a week, or even 18 hours, can be devoted to annual preventive exams, with adequate time still available for routine and urgent care," said Bernard Kaminetsky, MD, a Boca Raton, Fla., internist. By contrast, in a typical practice with 2,500 patients, just doing one-hour annual preventive exams would take 50 hours a week, 50 weeks a year, he said.

The physicians testified that they chose retainer care to avoid spending too much time with paperwork and too little with patients. Conventional practices end up charging uninsured patients more to cross-subsidize the high cost of administration for low-paying patients with private coverage and Medicare, the doctors said.

"The move to cash-based practices is concrete evidence of the atmosphere of fear and frustration in which doctors practice today," said Kathryn Serkes, policy and public affairs counsel for the **Assn. of American Physicians and Surgeons.** The group says thousands of doctors across the country are choosing this approach.

"Money is not the issue -- control is. More doctors would rather treat uninsured patients, possibly for free, than jump through insurance and government regulatory hoops," she said.

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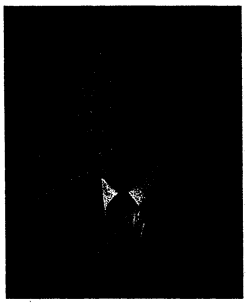

CONCIERGE MEDICAL PRACTICES EXPANDING ACROSS THE NATION

By

John R. Marquis

Quietly emerging across the country are a handful of unique medical practices. Some call them revolutionary and long overdue; others brand them as unethical or, at the least, not in the general public's best interest. But one fact remains: Concierge medical practices are steadily growing in numbers and captivating the public's attention in the process.

The topic of so-called "boutique," "retainer" or "concierge" medical practices is being picked up by the national media, discussed by physicians in hospital corridors, and debated in the halls of Congress and the Harvard Medical School. Letters to the editor concerning concierge practices are cropping up across the country, from the *New York Times* to Delaware's modest *Cape Gazette*. Even the new law overhauling the Medicare system, the Medicare Prescription Drug Improvement and Modernization Act of 2003, addresses concierge medicine. The law requires the Government Accounting Office to study concierge medicine and then issue a report to Congress.

The History. Concierge medical practices were the brainchild of a former team doctor for the NBA's Seattle Supersonics. After seeing firsthand the remarkable level of service provided to professional athletes, the doctor founded MD2 (pronounced "MD Squared") in 1996 in Seattle, Washington, to provide the same kind of services to nonathletes. The idea underlying MD2 resonated with overworked, understaffed physicians who found themselves being stretched to the breaking point by the rigors, quotas and financial limitations of managed care.

What began as a solitary, platinum-plated, Ritz-Carlton-like medical practice in Seattle has now moved into the limelight—and, increasingly, more into the mainstream. Following on the heels of MD2, a small number of doctors began concierge practices. Today concierge practices are operating in nearly half of America's 50 states.*

How Do Concierge Practices Work? Physicians charge patients a fee in exchange for more personalized and convenient health services. Such services often include guaranteed same-day or next-day appointments, no waiting time at office visits, in-depth medical evaluations, customized health care and lifestyle plans, around-the-clock access to physicians via cell phones, pagers, and e-mail, coordination of care with specialists, and even house calls.

While all concierge practices share similarities, they vary widely in their structure, payment requirements, and form of operation. In particular, they differ in the level of service provided and the amount of the concierge fee charged. While some concierge physicians (including MD2) charge well over $10,000 per patient per year, others charge considerably less. Some practices provide service for both concierge and non-concierge patients, while others see only concierge patients. Some accept Medicare and traditional insurance coverage, while others do not. Several concierge practices have begun "franchising" their operations.

*States that have existing concierge practices include: Alabama, Alaska, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Virginia and Washington.

So What's All the Noise About? While at first blush they may seem to be little more than a medical novelty, concierge practices raise a host of ethical, legal, and medical issues that have stirred controversy.

Arguments in Favor. Among the most common reasons cited by physicians for making the switch to a concierge practice is their desire to spend more time educating and treating their patients. To them, concierge medicine represents a return to old-fashioned medicine. They cite as examples the opportunity a concierge doctor has to accompany a nervous patient to meet with a specialist, or to spend time with a terminally ill patient and her family in the waning hours of life. By reducing their patient load, concierge physicians are freed up to practice medicine in a more personal and caring fashion.

Some concierge doctors also argue that they are able to provide not only more personalized treatment to their patients, but also truly ***superior*** treatment. Concierge doctors indicate that they are able to spend more quality time listening to and treating patients, and less time worrying about paperwork, red tape, and coverage restrictions. Moreover, the physicians are able to focus on wellness and prevention instead of treating health problems after it is too late.

Another common thread that emerges from the collective experience of concierge doctors is that their new practice has enabled them to regain control of their health care practices—and their lives. More time at home with family. Increased salaries. More time for research and perhaps recertifying in specialty fields. Less harrowing and grinding daily routines. Fewer burned-out family practitioners.

On a more pragmatic note, physicians say that another reason they made the jump to concierge medicine is because of patient demand. Simply put, many patients are clamoring for a more personal, convenient, and effective form of health care. The numbers seem to bear this out. Physicians who make the switch seem to be filling up their patient rosters with patients who are happy to pay the concierge fee. Defenders of the idea argue that concierge medicine provides a desirable option for many who seek a different type of health care.

Arguments Against. Notwithstanding the benefits many attribute to them, concierge practices have vocal detractors. Charges of "country club" elitism and favoring the rich at the expense of the poor are routinely made. Some believe physicians should be obligated to provide the same health care services to every patient—regardless of one's ability to pay. Perhaps more stinging is the claim that with between 40 and 50 million uninsured Americans, a physician's decision to drop his or her patient load from 4,000 to 800 is almost unconscionable. Rather than helping the system, critics argue, concierge practices merely increase the burden shouldered by other physicians who remain behind in the trenches.

Some critics have denounced concierge medicine as injurious to America's system of health care. "Change is inevitable, but a change toward elitism in the delivery of health care is pernicious," Professor John Goodson of the Harvard Medical School observed in a letter to the *Boston Globe*. "It undermines the most fundamental commitments of our profession."

AMA Guidance. In June of 2003 the American Medical Association (AMA) issued ethical standards to guide physicians who operate or are contemplating concierge medical practices. The AMA largely endorsed these practices so long as physicians communicate clearly with patients and insurers about their fee arrangements and do not tout their practices as providing better diagnostic and therapeutic services.

Regulatory and Legislative Criticism. Criticism of concierge practices has not been limited to academic circles and media outlets. Insurance regulators in a handful of states have scrutinized concierge practices. Proposed legislation seeking to limit these practices has surfaced in a few states. A small cadre of Congressmen in Washington, D.C., has also cast a skeptical and wary eye on these types of arrangements.

Among other claims, the Congressmen have asserted that certain concierge arrangements may violate Medicare billing laws and the federal False Claims Act. To address these perceived abuses, they have introduced federal legislation aimed at preventing certain concierge doctors from receiving

Medicare payments. Although all these bills have fizzled thus far, it remains to be seen whether a similar bill in the future will eventually become law.

In addition to proposing legislation, several Congressmen petitioned the Department of Health and Human Services ("HHS") to clarify the law regarding concierge practices. In May of 2002, HHS responded that concierge practices, if properly structured, do not conflict with Medicare's requirements. HHS further indicated that physicians may proceed with concierge arrangements, but "they are responsible for complying with Medicare requirements. [HHS] will advise physicians contemplating use of such agreements to seek legal counsel ensuring that the agreements comply with the law."

Concierge medicine implicates a number of complex state and federal issues. Before physicians throw their hats into the medicine concierge ring, they should carefully evaluate the legal and regulatory issues underlying the decision.

Conclusion. Notwithstanding the controversy that has encircled concierge medicine, an increasing number of physicians across the country are deciding that such practices make sense for them. Patients with their pocketbooks open appear to be following them. In the view of many, concierge medicine is no different than choosing to fly first class, buy a luxury vehicle, or order a satellite dish TV package with hundreds of channels. Certainly the debate will go on. In the meantime, watch for an increasing number of physicians to give concierge medicine a try. If you have questions about, or would like additional information concerning, concierge medical practices, contact the Concierge Medicine Team at Warner Norcross & Judd.

* * *

John R. Marquis is a partner in the Holland office of Warner Norcross & Judd specializing in concierge medical practices, business and tax law, health care law and closely held businesses. He may be reached at 616.396.3054 or jmarquis@wnj.com.

Editorial:
Abuse of the "Disruptive Physician" Clause

Lawrence R. Huntoon, M.D., Ph.D.

Buried deep in the "Corrective Action" section of most medical staff bylaws is a provision known as the "Disruptive Physician" clause. It is arguably the most dangerous and, in recent years, the most abused provision in medical staff bylaws.

The term "disruptive physician" is purposely general, vague, subjective, and undefined so that hospital administrators can interpret it to mean whatever they wish.

How this treacherous trap got into medical staff bylaws is no mystery in most instances. It was added at the urging of hospital administrators, often with help from a medical staff president who was duped into believing that the clause would only be used in those extreme cases where a physician was found running drunk or naked through the halls of the hospital.

Lack of vigilance by physicians, and failure of medical staffs to obtain independent legal advice on changes to the bylaws, allowed most hospital administrations to insert this clause without difficulty or any meaningful opposition.

Why this clause was strategically placed in medical staff bylaws is also no mystery. It is part of the strategic plan developed in 1990 by the hospital industry. The stated goal was to gain more control over physicians in hospitals. Abuse of the disruptive-physician clause and increasing use of sham peer review has allowed hospital administrations to make great strides in achieving that goal.

Attorneys who specialize in representing hospitals have definite recommendations on how "disruptive physician" can be defined by a hospital, in order to remove a targeted physician from staff. In fact, some law firms offer seminars for hospital officials and their legal representatives that teach optimal methods for eliminating certain physicians that the hospital dislikes. Here are a few of the criteria for identifying a "disruptive physician":

1. **Political:** Expressing political views that are disagreeable to the hospital administration.
2. **Economic:** Refusing to join a physician-hospital venture, or to participate in an HMO offered to hospital employees, or offering a service that competes with the hospital.
3. **Concern for quality care:** Speaking out about deficiencies in quality of care or patient safety in the hospital, or simply bringing such concerns to the attention of the hospital administration.
4. **Personality:** Engaging in independent thought or resisting a hospital administration's "authority."
5. **Competence:** Striving for a high level of competence, or considering oneself to be right most of the time in clinical judgment.
6. **Timing:** Making rounds at times different than those of the "herd."

Although the disruptive-physician clause and sham peer review are current weapons of choice used by hospital administrations across the country, more weapons of physician destruction loom on the horizon.

Physicians should be aware of the "Code of Conduct" and "Exclusion from the Hospital Premises" clauses currently being promoted by the hospital bar.

AAPS has posted a letter dated January 31, 2003, to the General Counsel of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which was drafted by the leaders of the credentialing and peer review practice group of the American Health Lawyers Association, in the Hall of Shame on our website (see www.aapsonline.org). The letter is rated "R" for stark Reality. Physicians need to wake up quickly and take notice because this is what hospitals really have in mind for medical staffs across the nation. Interested readers can also learn more about the hospital industry's strategic plan, developed in 1990: see "Hospital Industry Reveals Its Strategic Plan: Control Over Physicians" in the AAPS Hall of Shame.

Physician vigilance, and advice from knowledgeable, independent counsel, are key to preventing further abuse of medical staff bylaws by hospital administrations.

Lawrence R. Huntoon, M.D., Ph.D., is a practicing neurologist and editor-in-chief of the *Journal of American Physicians and Surgeons.*

Memo to the Disruptive Physician

Oh how we strive
For quality high,
For health
And most of all safety.

But a word to the wise:
Reproof we despise
And outspoken physicians:
We hate thee.

Feel free to opine,
But note we define
All critics
As never constructive.

And, thus shall ensue
A sham peer review
And henceforth
You're labeled "disruptive."

Dr. Berry Receives Cup Of Kindness Award

On May 17th at the Healthcare Hero Awards Banquet at Meadowview Conference Center, King Pharmaceuticals recognized the efforts of Dr. Robert Berry with its 2002 Cup of Kindness Award for Innovation.

By re-introducing point-of-care payment for routine medical care, Dr. Berry has created an alternative to bureaucratic medicine while caring for persons falling through the cracks of a broken healthcare system.

"[He] has made high quality outpatient medical care affordable to the uninsured of northeast Tennessee while establishing a more rational and humane model of primary healthcare delivery ..."

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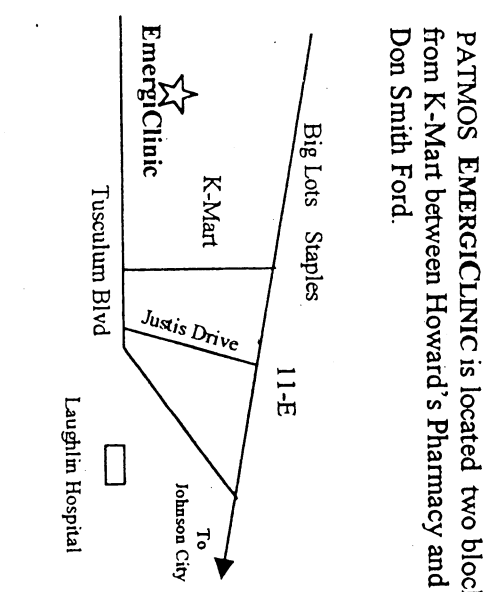
For uninsured Christians who prefer the Biblical concept of "bearing one another's burdens", Christian medical cost sharing programs are available.

PATMOS supports patient-driven healthcare and provides information about these options.



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October 2002 version

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PATMOS literally stands for "payment at time of service." It was the island to which political prisoners of Rome were exiled during Biblical times. As a little play on words, **PATMOS** was established to care primarily for the politically exiled within our healthcare system – the uninsured.

PATMOS EmergiClinic makes no apologies for not accepting insurance. In order to keep costs down for those who have no other choice, we cannot assume the massive overhead involved in billing third party payers. This has the added benefit of eliminating bureaucratic hassles and intrusions into the doctor-patient relationship as well insuring strict confidentiality of patient information. Besides, our typical charges are usually less than those of most local veterinarians.

Although you might associate low cost with low quality, **Dr. Berry** has considerable expertise in **Emergency and Internal Medicine.** He is able to provide many ER-level services such as suturing complex lacerations, splinting fractures, and treating asthma attacks. He has kept many patients from being hospitalized by giving IV therapy in his clinic over the course of their illnesses.

His credentials? **Diplomate of the American Board of Internal Medicine** (scoring at the 99th percentile on the core component of the board exam) and **Board Eligible in Emergency Medicine** (with over 8 years ER experience).

Even insured patients who can't see their doctors in a timely fashion come to **PATMOS.** They have found that **quick, competent care** for simple, acute illnesses such as sore throats and bronchitis is worth shelling out a few extra bucks over their regular co-pay. For those desiring reimbursement from their insurers, **PATMOS** forwards the claim to a billing service for a small surcharge.

But healthcare is changing today even for the insured. Just to afford their skyrocketing premiums, many are choosing higher deductibles and co-pays. Forced now to pay more out of pocket for routine medical care, they are demanding more for their money. Like the uninsured, they have found **PATMOS EmergiClinic's excellent care at reasonable rates** to be a **Godsend.** They are thankful that **PATMOS** has made high-quality, comprehensive primary medical care more affordable and have joined us in the new movement of **patient-driven healthcare.**

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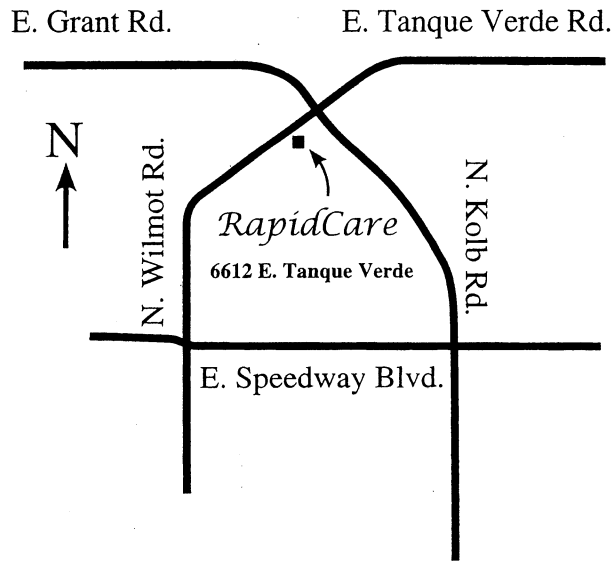

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Lipid panel / PT (protime)	20
Comp chem. / Hgb A1C	25
PSA / TSH	25
Quant serum preg / FSH	30
Urine Culture	40
Other_____	

Clinic Medications

Albuterol-nebs 1st	20
Albuterol additional	10
Ampicillin / Ancef	10
B-12 inj./ Benadryl	10
Bicillin CR- 600,000	25
Bicillin LA-1.2 mil units	40
Celestone	10
Decadron / Solumedrol	10
Depomedrol	15
Diptheria Tetanus tox	25
Humulin 70/30 & Insulin R	5
Ketorolac	10
Nubain	10
Promethazine	10
Rocephin 0.25/0.5/1gm	15/20/25
Other _____	

Discharge Medications

Amoxicillin 500mg #30	5
Atenolol 50mg #30	5
Auroto otic drops 10cc	5
Carisoprodol 300mg #10	5
Carisoprodol 300mg #30	10
Cephalexin 250mg #15	5
Cephalexin 500mg #30	10
Ciprofloxacin 500mg #10	5
Citalopram 20mg #30	5
Clobetasol 0.05% 30gm	10
Doxycycline 100mg	5
Enalapril 5/10/20mg	5
Fluocinonide 0.05% 30gm	5
Fluoxetine 20mg #30	5

Discharge Meds (cont)

Gentamicin eye drops 5cc	5
Glipizide 5mg #30	5
Glipizide 10mg #30	10
HCTZ 25mg #30	5
Ibuprofen 600mg #30	3
Indomethacin 50mg #20	5
Loratadine 10mg #15	2
Meclizine 25mg #30	5
Meloxicam 15mg #30	5
Penicillin VK 500mg #20	10
Phenergan gel syringe	5
Prednisone 20mg #13	5
Promethazine 25m #8	6
Phenazopyridine 200mg #10	3
Ranitidine 300mg #30	5
Tetracaine lollipop	5
Triamcinalone 0.5% 15gm	5
Triam/HCTZ 37.5/25mg #30	5
Trimeth/sulfa DS #10 / #20	5 / 7
Other _____	

Procedures

I & D simple / intermed	95 / 145
I & D complex	175
Skin FB rem sim / com	95 / 145
Burn care sim / inter	95 / 145
Ingrown toe nail rem	125
Drainage subung hema	50
Skin tag removal	50
Simple cut < 1 in	95
Additional inch	25
Intermed cut < 1 in	135
Additional inch	35
Complex cut < 1in	175
Additional inch	50
Wart removal 1,2 / 3-5	95 / 135
Lesion destruction	50
Trigger point inj 4 / 8	25 / 40
Trigger point inj 12 / 16	50 / 60
Excision lesion – simple	125
Excision lesion – intermed	175
Eye FB removal simple	50
Corneal FB removal	125
Corneal abrasion care	75
Foreign body removal ear	75
Earwax removal – one	30
Earwax removal – both	45
Joint injection	50
IV one bag	50
IV additional bag	25
EKG & reading	40
Fiberglass splint	40
Elbow Brace	15
Bath wrist splint	15
Metacarpal splint	15
Finger splint	5
Other _____	

Diagnoses

_____

_____

_____

_____

_____

Discharge Medicines

- See prescriptions provided

_____

_____

_____

_____

_____

_____

_____

Discharge Instructions

_____

_____

_____

_____

If not improving by _____, return here or see your regular physician.

In signing this, I agree that I understand the above instructions. Also, if I am a Medicare beneficiary, I realize that this clinic does not accept Medicare, and I agree ***not*** to bill Medicare for reimbursement.

Sign _____

Witness _____ **Date** _____

Version 05/29/08

No Health Insurance?

Money Tight?

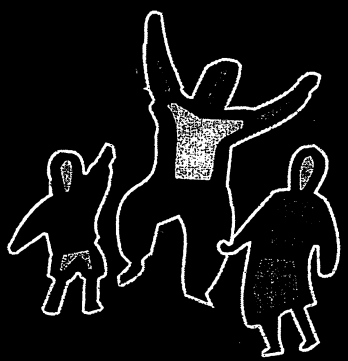
Family Member Needing Medical Care?

No Health Assistance Program to Help You?

Then you need to know about the

Midway Family Care Bridge Account

We have adjusted our rates without compromising service to help our patients with their primary medical care needs. The Bridge Account enables you to feel comfortable with the cost of health care.



H.Todd Coulter, M.D.

MIDWAY FAMILY CARE
Walk-In Clinic

is a primary care medical facility offering an Affordable Alternative

to high cost emergency room treatment, the constant rise of insurance premium costs and rising co-pays. Through our Bridge Account you don't need insurance to see the doctor. You don't need an appointment. We offer primary medical care at an affordable price.

$40 Office Visits
$40 X-rays
$20 EKG

Discount prices on lab test studies
We are Available Accessible and Affordable

2693 Hwy. 90, Ocean Springs, MS

875-7474

Open Daily: Mon-Fri 8am - 7pm

OS doctor big on low-cost medical treatment

■ Dr. Todd Coulter operates Midway Family Care

By LICI BEVERIDGE
Mississippi Press Staff

OCEAN SPRINGS — An Ocean Springs doctor has come up with an innovative way of helping people get low-cost medical treatment.

Dr. Todd Coulter has set up a program at his clinic to offer office visits for $40. Other testing and X-rays are available at lower costs, too. For example, X-rays are $40.

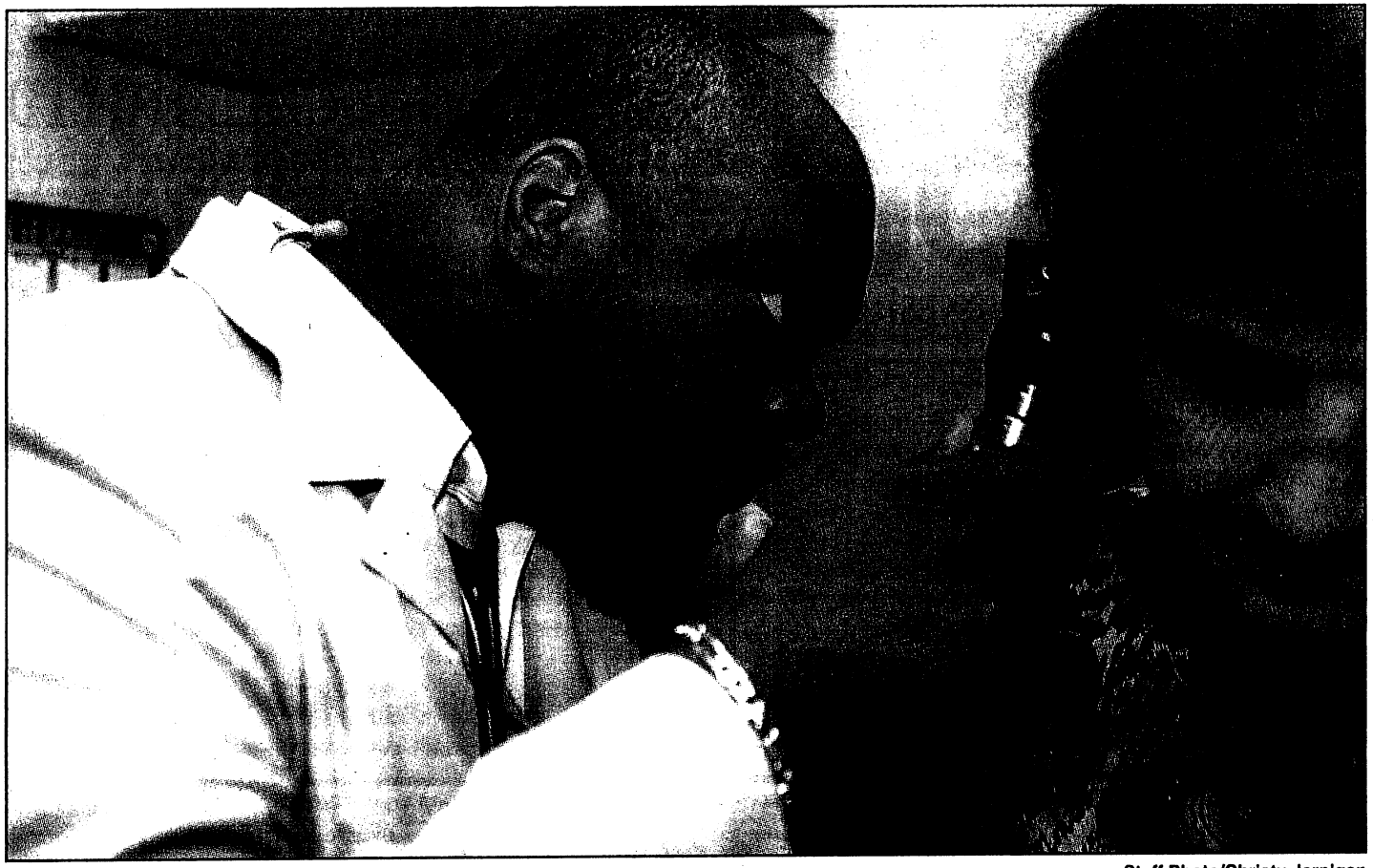
"Our goal has been to increase the number of people who can afford medical care," Coulter said.

"There are a lot of people who do not have medical insurance."

Coulter said he is able to lower his prices because he no longer files insurance claims, thus saving money on administrative costs. The clinic, Midway Family Care, also operates on a cash-only basis, eliminating losses from unpaid checks.

People with medical insurance can benefit from the program. They can receive the same low-cost treatment and later file a claim for reimbursement with their insurance company.

Coulter said insurance companies often dictate what doctors can or cannot do for their patients.



Staff Photo/Christy Jernigan

HELPING — Dr. Todd Coulter has started a new medical program offering low-cost treatment at Midway Family Care in Ocean Springs.

The name of the program is the Bridge Account. There is no cost to sign up for the account. Patients may register when they arrive for treatment or fill out the form in advance.

With the Bridge Account, Coulter said, his patients get predictable service, too.

"You know what you're getting," Coulter said.

Insurance costs are on the rise, so many more people may be without medical insurance in the coming years.

Coulter does not require his patients to make appointments, so seeking a doctor's help also is more accessible.

"Everybody's taken care of as we go along," Coulter said.

Coulter's Bridge Account has drawn national attention. He will be in the spotlight on Friday's edition of CBS Evening News.

The program will feature a number of new medical models around the country in which doctors are trying to keep their practices up and running, said Linda Karis, a CBS Evening News producer.

"Throughout the country doctors are struggling with their private practices," Karis said.

"Overhead is going up and reimbursements are coming down. Believe it or not, doctors are having a difficult time making ends meet."

ACCOUNTS PAYABLE FOR SEPTEMBER 2002

September 13, 2002
1st - 30th

th DUE DATE	PAYEE	AMOUNT DUE	PAY	DO NOT PAY
	BEGINNING BALANCE : $2,818.17			
	PAYROLL = approximately Helen-76hrs/798 Nikki-91.5hrs/869.25 Dr. C.-12K Taxes – 700.00	14,367.25		
	Debits: AMEX – 5.35pd ck protect – 33.17pd Visa/mc –41.51pd Paychex – 105.10pd UP mazda – 446.89 UP x-ray 1115.65 Golden Rule – 499.72	185.13pd 2062.26 due on 17th		
	PAYROLL & DEBITS	16,429.51		
	MISC- Total = 219.25	0		
	Dr. Gollott - rent sept	3000.00pd		
	Union Planters Bank – ford van	402.79pd		
	Union Planters Bank – LOC	177.10pd		
	Rotary Club of Ocean Springs – Total 568.00	60.00pd		
	J C Chamber of Commerce – dues	108.00		
	City of Ocean Springs – privilege license	30.00		
	Goodyear – mazda tire	81.25		
	Utilities = 460.72	**0**		
	MS Power –	135.64pd		
	Access Integrated -	279.73		
	Voice Stream - *estimated*	60.00		
	Cingular - *estimated*	80.00		
	Rainbow Spring Water –	17.23		
	Datasync –	13.95		
	AT&T -	9.81		
	MEDICAL EXPENSES = 1340.00	**0**		
	jan/640.00 feb/506.00 mar/902.75 apr/759.25 may/682 jun/682.25 july/542.75 Dynacare – total bill = 4715.00	640.00		
	SRH lab work bal 13092.12	300.00		
	Gulf Coast Radiology – overreads	440.00		
	Jefferson Medical – no bill/ cleaning is 63.13	0		
	Environmental Medical – red bag disposal – 22.00	0		

	BILING OFFICE, ETC. - 1545.52			
	Todd & Dionne Coulter - sign & rent	1300.00		
	City of Ocean Springs	25.25		
	MS Power -	108.26		
	Bell South	67.01		
	NDC Health Info – electronic billing	45.00		
	OFFICE SUPPLIES = 100.00	**0**		
	Office Depot - total 344.08	100.00		
	ADVERTISING = 1505.42	**0**		
	The Sunshine Pages–june/574.52 july/291.38 aug/295.99 sept/300.32 total bill (1062.21)	574.52		
	Seacoast Hospitality – sept/ no bill 50.00	0		
	Graphics House –postcards/930.90	930.90		
	TOTAL BILLS	**5170.91**		
	GRAND TOTAL	**21,600.42**		
	Blue Bag			

Ruden McClosky

FIGHTING BACK HEALTHCARE PROSECUTIONS AND AUDITS

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I. INTRODUCTION

Resources dedicated to the detection, investigation and prosecution of health care fraud and abuse are at unprecedented levels. The Health Insurance Portability and Accountability Act of 1996 provided additional funding for health care enforcement activities. Moreover, the use of criminal and civil statutes traditionally used to combat organized crime (e.g., RICO, Money Laundering, Mail and Wire Fraud) are now being used against persons and organizations who allegedly submit false, fraudulent and abusive claims for services rendered. Finally, the number of whistleblower ("***qui tam***") lawsuits filed under the civil false claims laws continues to increase, placing health care providers at great risk given the heavy monetary penalty provisions contained in these statutes.

II. DEFINITIONS

A. Fraud

An ***intentional*** deception or misrepresentation made by a person with the knowledge that the deception results in an unauthorized benefit to himself/herself or another person.

B. Abuse

Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to publicly-funded healthcare programs or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

C. Medical Necessity

Any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.

III. REGULATORY, INVESTIGATIVE AND PROSECUTING ENTITIES

A. Federal

1. Medicare Intermediaries (Part A) and Carriers (Part B).

2. Office of the Inspector General, U.S. Department of Health & Human Services.

3. Federal Bureau of Investigation.

4. Drug Enforcement Administration.

5. Criminal Investigation Division, Internal Revenue Service.

6. United States Department of Justice.

B. State

1. Medicaid Program Integrity Units

- Housed in state Medicaid agencies

- Essentially perform medical record audits and claims review to determine whether claims meet "payment criteria."

2. Medicaid Fraud Control Units (MFCU)

- Normally housed in state Attorney General's Office or state police agency.

- MFCU responsibilities include: (a) investigate allegations of billing fraud occurring in state Medicaid program; and (b) investigate alleged abuse or neglect of patients in health care facilities (i.e., nursing homes) receiving Medicaid payments.

3. Local Prosecuting Attorneys

- Particular titles differ depending on state (e.g., District Attorney, State Attorney, District Attorney General, County Solicitor).

- Primarily interested in "slam dunk" cases (i.e., cases involving "phantom" billing operations").

IV. THE CHALLENGES FACING PROVIDERS

A. The "Bureacratization" of Medicine

B. Criminalization of Coding, Billing and Coding Standards

1. "If it's not documented, it didn't happen."

2. Coding and documentation errors commonly used as basis for criminal prosecutions and civil fraud actions.

C. Government's "Scorekeeper" Mentality

1. Need to maintain publicity regarding large monetary recoveries.

2. Scorekeeper mentality clouds investigative objectivity.

D. Government lawyers and agents who do not understand the healthcare system.

E. Government Intimidation Tactics

1. Execution of search warrants by government agents.

2. Use of criminal statutes (e.g., RICO, Mail Fraud and Money Laundering) designed to combat organized crime against healthcare providers.

F. "Clubby" relationship between defense counsel and prosecutors?

V. CIVIL FALSE CLAIMS LAWS: A BRIEF PRIMER

The Federal Civil False Claims Act and several state false claims laws allow the government to bring civil lawsuits against persons who submit false claims for payment to government-funded programs. Moreover, these laws provides that private whistleblowers, also known as *qui tam relators,* may file such suits on behalf of the government and share in any proceeds obtained through settlement or judgment. Finally, the federal and virtually every state false claims law contains severe damage and monetary penalty provisions which effectively punish persons found liable under either statute.

A. What is a ***claim***?

1. Any request or demand, under a contract or otherwise, for money, property, or services made to any employee or agent of the government. 31 U.S.C. § 3729(c).

2. An actual "claim" is the Health Insurance Claim Form (HCFA Form 1500), not each payment code contained on the claim form. *United States v. Krizek,* 111 F.3d 934 (D.C. Cir. 1997).

B. What is meant by *False?*

1. Question of "Falsity" may be based on the interpretation of a regulation, contract, or agreement, or state or federal law. Most courts hold these are questions of law to be decided by the court. See *United States ex rel. Berge v. University of Alabama,* 104 F.3d 1453 (4th Cir. 1997).

2. A statement, to be actionable, must be false under any reasonable interpretation. *United States v. Adler,* 623 F.2d, 1287 (8th Cir. 1980).

3. Whether claims are false must be viewed from the common-sense reasonableness of a defendant's interpretation of requirements or regulations. *See United States v. Data Translation, Inc.,* 984 F.2d 1256 (1st Cir. 1992).

C. Intent Standard under the False Claims Laws

1. Standard of "Knowing" or "Knowingly" defined as:

   a. Actual knowledge of the falsity of the claim;

   b. Deliberate Ignorance; or

   c. Reckless Disregard.

2. Though the false claims laws make clear that the government does not have to prove that the defendant *intended* to commit fraud, the government must prove ***more than a mere mistake or negligence.*** *United States ex rel. Anderson v. Northern Telecom, Inc.,* 52 F.3d 810 (9th Cir. *1995), cert. denied, 516* U.S. 1043 *(1996); Hindo v. University of Health Sciences,* 65 F.3d 608 (7th Cir. *1995).*

D. Penalties under the Federal Civil False Claims Act (31 U.S.C. § 3729).

1. Treble Damages (i.e., three times the amount of improper bills)

   - Multiplier is automatic and non-discretionary.

   - Damages *can be reduced* upon voluntary disclosure of false claims violations.

2. Monetary Penalties

   - $5000 to $10,000 per false claim.

- Debt Collection Improvement Act of 1996 allowed U.S. Department of Justice to make "inflationary adjustment" to the monetary penalty provisions of the Federal Civil False Claims Act. As a result, the DOJ adjusted civil false claims monetary penalties to $5500 to $11,000 per false claim. *See* 64 Federal Register 47099-47104 (August 30, 1999).

3. Disproportionate fines and penalties may violate the Excessive Fines Clause found in the Eight Amendment of the U.S. Constitution. *See United States v. Mackby,* 243 F.3d 1159 (9th Cir. 2001); *United States ex rel. Smith v. Gilbert Realty,* 840 F. Supp. 71 (E.D. Mich. 1993).

E. False Claims Pleading Requirements

1. Federal Rule of Civil Procedure 9(b) and virtually all state procedural rules ***mandate*** that allegations of fraud must be plead with particularity (i.e., the who, what, where, when, and how of the alleged fraud must be spelled out in specific detail).

2. Federal Rule 9(b) pleading requirements apply to civil false claims actions. *See U.S. ex rel. Clausen v. Laboratory Corp. of America*, 290 F.3d 1301 (11th Cir. 2002).

3. Government must spell out allegations of alleged false, fraudulent or otherwise improper billing in specific detail (e.g., identify each improper claim and explain why it is false or fraudulent). Failure to do so subjects the suit to a motion to dismiss.

VI. WHAT YOU CAN DO TO FIGHT BACK

A. Preventive Measures

1. Get questions to government answered ***IN WRITING***.

2. For answers given verbally (i.e., over the phone), write down the name, job title and contact information for the person who provided the answer.

3. Consider some moderate compliance or auditing activity.

B. Ask for all audit documentation utilized by government.

1. Government auditors usually prepare set of audit "worksheets" which should be provided upon request.

2. Request copy of all regulations, guidelines, policies and internal memos used to provide "guidance" during the audit process.

C. Challenge institutional assumptions.

1. "That's the way we've always done it."

- Institutional "groupthink" seldom supported by law, regulation or agency policy.

- Usually signals attempt by payer or agency to discourage further inquiry or difficult questions.

- Demand copy of ***SPECIFIC*** law, regulation or payer policy supporting decision to deny or adjust claim.

2. "If it's not documented, it didn't happen."

- Relieves auditors and investigators of performing a more complete, even competent, inquiry of billed claims.

- External evidence of patient care (e.g., what does the patient say about the care provided) is powerful evidence mitigating against finding that deficient documentation equates to service never being provided.

D. If under investigation, ***DO NOT*** engage government auditors, investigators or attorneys without speaking to your lawyer or without your lawyer present.

1. Must determine what "type" of investigation or audit is occurring (i.e., routine licensure or quality audit, billing integrity audit, or civil/criminal fraud audit).

2. Government agents will frequently attempt to take words or statements out of context, or leave out exculpatory details.

E. Disgruntled Employees

1. Today's disgruntled employee is tomorrow's government witness.

2. Should deploy "exit interview" strategies which include having the employee sign a statement indicating no knowledge of false or otherwise improper billing, or to detail instances of illegal or otherwise improper activity.

3. Contact legal counsel when separating "problem" employees.

VI. WHAT SHOULD YOUR LAWYER BE DOING?

A. Aggressive Motion Practice

1. At the start of case, avoid repeated "preliminary" meetings or ongoing "settlement" discussions with government lawyers and investigators. After an initial meeting, these follow-up meetings rarely produce any benefits.

2. Avoid submission of "thought pieces" to government counsel explaining why they are wrong. Government counsel will not read these papers in their entirety and will probably ignore them altogether. All initial attacks on government's case should be in the form of a motion to dismiss.

3. Initial arguments attacking the legal sufficiency of the government's case (e.g., the government fails to plead fraud, false claims or other improper billing allegations with the requisite degree of specificity required by the law) should be made in a motion to dismiss and argued to the court.

B. Retain a ***QUALIFIED*** Expert to Evaluate Government's Findings

1. Initial engagement should be limited to a sample review of claims denied by government for payment.

2. Expert should focus on:

   - Whether government was too aggressive in audit or review;
   - Was government following its own payment policies; and
   - Did the government ***underpay*** for services rendered.

C. Thorough Case Investigation

1. In cases involving allegations of criminal and/or civil fraud or false billing, consider retaining an experienced professional investigator to handle investigate duties. Professional investigators are generally less expensive than law firm associates, and are usually more skilled at conducting interviews and gathering background information on potential witnesses.

2. Avoid using law firm associates (typically younger lawyers) to perform investigative duties. This is not an efficient use of resources and will generally not yield the best results.

3. There is no substitute for a thorough investigation of the facts. Generally speaking, the facts, not the law, win cases.

D. Aggressive Discovery Practice

1. Counsel should immediately initiate discovery against government with a view toward identifying:

   - The ***specific*** claims that are improperly billed;

   - The ***exact*** law, regulations or policies which dictate that the claims are wrong;

   - All individuals (including expert witnesses) who will testify on behalf of the government and the content of their testimony; and

   - All ***relevant*** documents in government's possession.

2. Counsel must also carefully evaluate government discovery requests and seek court protection when government lawyers engage in oppressive or abusive discovery practices.

F. Prepare with a view toward trial.

1. Best way to achieve favorable settlement options is to prepare as if case is going to trial. This will force government to take a hard look at the merits of their case, and possibly cause them to reevaluate any initial settlement demands.

2. Throughout the course of discovery and case preparation, counsel should keep you apprised of any new developments, and continually reassess the relative strengths and weaknesses of the case.

VII. HANDLING HIPAA INVESTIGATIONS

Step 1: Don't Panic. Really. It's important to keep calm when the investigators are at your door. The reason for this is simple-prosecutors "like" nervous interviewees. They like them so much that they oftentimes invite them back to the home office for a more in-depth discussion. Each covered entity should choose a liaison for investigations; that liaison should be someone that has a cool demeanor under pressure. If a covered entity's key executive does not possess this trait, they should recognize that fact and select another manager or employee to serve in this key position. The investigation liaison serves as the covered entity's "face" during the investigation; make sure it is a good one.

Step 2: Expect the Unexpected. Remember-anyone may file a complaint with OCR; the complainant need not notify the CE before filing a complaint. Technically, complaints must be filed within 180 days of when complainant knew or should have known of the violation. Beware, however, that DHHS can extend this time period for "good cause shown." While OCR

"will generally" give notice before requesting access to a CE's compliance staff should be ready to respond to an investigation "out of the blue." It might be prudent to hold an "investigation" drill periodically, to ensure readiness.

Step 3: Phone Home. Each covered entity should have a "phone tree" that should be activated whenever an investigation occurs. The designated communicator should call:

- Your Attorneys (HIPAA counsel AND local counsel, if they aren't the same)
- Your Executive Management
- Your Privacy Officer
- Your Security Officer
- Your Health Information Management Department/Custodian of Records

Everyone on this list needs to know that "the wolf is at the door." Everyone also needs to hear it from the horse's mouth; the only thing worse than not notifying these individuals in a timely manner is letting them hear it from the "grapevine." It would probably go something like this: Original Communication: "OCR is here to ask questions about our NPP acknowledgement." Grapevine Gossip: "OJ came by and acknowledged that we don't know anything about HIPAA." It's best if you immediately assign someone to make these calls (as part of a well-crafted "responding to investigations" policy that should apply to ALL official inquiries, not just HIPAA) OUT of sight (and hearing) of the investigators; you'll likely be too busy doing other things, and you really don't want to make the calls in front of them.

Step 4: Know What's in Store. Forewarned is Forearmed. HIPAA's privacy requirements that can be the source of civil monetary penalties are enforced by OCR. We know that enforcement activities will include:

- working with covered entities to secure *voluntary compliance* through the provision of technical assistance and other means;
- responding to questions regarding the regulation and providing interpretations and guidance;
- responding to state requests for exception determinations;
- investigating complaints and conducting compliance reviews;
- where voluntary compliance cannot be achieved, **seeking civil monetary penalties and making referrals for criminal prosecution**.

How do we know this? Because the government published these comments in the Federal Register.

It's also important to know where enforcement initiatives will originate from. OCR noted that "[t]he [investigation] process will be complaint-drive and consist of progressive steps that will provide opportunities to demonstrate compliance or submit a corrective action plan." 68 FR 18897. "Complaint-drive" means that unhappy patients, disgruntled employees, former employees, competitors and others with an ax to grind will likely initiate HIPAA investigations.

Step 5: What to do when OCR arrives at your door. Here are some of the things that I recommend:

- Cooperate (but cautiously!) Ask for the official government agency issued identification of the investigators (TIP #1-Business cards are NOT official identification); write down their names, office addresses, telephone numbers, fax numbers and e-mail addresses. (TIP #2-if they can't produce acceptable I.D., call your attorney immediately and defer the provision of any PHI until after you confer with counsel or until the investigators produce acceptable I.D.-but BE SURE that you've made appropriate requests for I.D. and that they've been unreasonably refused before you do.) (TIP #3-I would have at least one, if not two witnesses available to testify as to your requests and their response if you are going to go down this route.)

- Ask for the name and telephone number of the lead investigator's supervisor, but only if, in your judgment, his/her demeanor indicates that you can ask such a question without engendering "hard feelings." Under NO circumstances should you take any action to escalate tensions, except if you genuinely doubt the identity or authority of the investigators. If you can obtain this information, your attorney will thank you for it, because it will prove an invaluable "short-cut" to obtaining information about the investigation, and may potentially clear the way to a settlement in short order, if advisable (thus, reducing your legal fees).

- Be sure to determine if there are any law enforcement personnel present (i.e., FBI, US Attorney investigators, State Prosecutor investigators, etc.). Again, this is information that will be invaluable to your attorney (to help him/her make a determination as to the gravity of the investigation; if law enforcement personnel are present, then the investigation is likely a criminal one, with much more severe penalties than may result from a civil investigation). Generally, guns strapped to hips are a good indicator of the presence of law enforcement personnel; but, if in doubt, ask.

- DO permit the investigators to have access to protected health information ("PHI"), in accordance with your notice of privacy practices ("NPP"), and Federal and State law. Once investigators have verified their identities and have also verified their authority to access PHI, it is a violation of HIPAA to withhold PHI from them, if the PHI sought is the subject matter of the investigation, or reasonably related to the investigation. Again, ask them to verify that they are seeking access to the information because it is directly related to their legitimate investigatory purposes; and document their responses in your own written records (TIP #4-Have a witness

with you when you ask about their authority to access PHI, and the use that they will make of the PHI they are seeking access to, who can later testify as to what they told you. Two witnesses are even better! All witnesses should also prepare a written summary of the conduct and communications they observed as soon as possible after the incident; these summaries should be annotated with the time and date of the event, the time and date that the summaries were completed, and the witnesses signature.)

- Send your staff employees elsewhere, if possible. There is absolutely no requirement that you provide witnesses to be questioned by the government during the initial phases of the investigation; likewise, there is no need for you to connect the investigators with any disgruntled employees. If necessary, give your employees the rest of the day off; but do whatever you have to do to send them away and keep them away. Definitely consider it a game of "keep away" that you need to win. Unless the investigators subpoena your employees (which they probably won't do until after the initial visit) you likely have no Federal duty to line up your employees for questioning at this point (although, State laws may vary on this one; check with your local counsel for more information). Do NOT instruct your employees to hide or conceal facts, or otherwise mislead investigators, though, once they are face to face with OCR-that's called obstruction of justice, and its is a crime in and of itself.

- Ask the investigators for documents to the investigation; for example, request –

    - copies of any search warrants and/or entry and inspection orders
    - copies of any complaints
    - a list of patients they are interested in
    - a list of documents/items seized

    DO NOT expect that they will give you any of the above, except for the search warrant, and a list of documents/items seized (if any).

- Don't leave the investigators alone, if possible. Assign someone to "assist" each investigator present.

- Don't be TOO solicitous –

    - Don't offer food (coffee, if already prepared, and water, if already available, if probably ok; don't do anything that could be construed as a "bribe" or a "kickback" to induce favorable treatment, such as offering to buy the investigators lunch).

    - Don't get "chatty." Although OCR has indicated they are here to help, these people aren't your friends; only tell them what you are required by law to tell them; always defer to the advise of counsel if you are unsure. Don't be

uncooperative; don't exhibit a poor attitude; do answer direct questions fully and to the best of your ability. Don't offer opinions; don't talk about your competitors; especially don't complain about the burdens associated with HIPAA compliance OR the government.

- Notify your State Practice Association, if you feel comfortable, under the "Golden Rule" theory, to help "spread the word" about local enforcement activity, as well as to obtain their assistance. Most State Associations have a government relations coordinator who has contacts that may be valuable to a covered entity under investigation; the only way to access those contacts is to make the call.

Step 6: What CAN they do to you? It's important to know the potential consequences of a HIPAA investigation, before deciding what your response will be. If OCR determines that a CE has committed a HIPAA civil violation, they will:

- Inform the CE (in writing)
- Inform the complainant (if any, in writing)
- Per the enforcement rule, OCR SHOULD attempt to resolve the matter by informal means "whenever possible."
- If the issue cannot be informally resolved, DHHS has the authority to issue a written noncompliance finding.

If the violation is egregious enough to constitute a crime, DHHS "shall impose"

- Criminal Fines: up to $50,000 and/or 1 year in jail
- If the crime involves obtaining, using and/or disclosing PHI under false pretenses, the penalty can include a fine of up to $100,000 and/or 5 years in jail
- If the crime involves the intent to sell, transfer, or use IIHI for commercial advantage, personal gain, or malicious harm, the penalty can include a find of up to $250,000, and/or 10 years in jail

Remember that OCR enforces civil violations of the Privacy Rule; criminal issues are referred to OIG and the Department of Justice.

If no violation is found, OCR will inform the CE and the complainant, if any (nothing says this notification must be in writing).

Can a CE be excluded from Federal Healthcare programs based on a HIPAA violation? Is a HIPAA violation also a violation of the Medicare Conditions of Participation? DHHS has "not yet addressed" it; however, DHHS did "note that Medicare conditions of participation

require participating providers to have procedures for ensuring the confidentiality of patient records." 65 FR 82605.

Step 7: Know DHHS' Limitations. Every CE should be aware that:

- Civil Monetary Penalties ("CMPs") cannot be imposed in respect of acts that constitute a "HIPAA Crime." 42 USC 132d-5(b)(1).

- A CMP may not be imposed if "it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision." 42 USC 132d-5(b)(2).

- A CMP may not be imposed if the failure to comply was due to "reasonable cause and not to willful neglect." 42 USC 132d-5(b)(3).

- A CMP may be *reduced* or *waived* "to the extent that the payment of such penalty would be excessive relative to the compliance failure involved." 42 USC 132d-5(b)(4).

- Secretary may NOT initiate a CMP action "later than six years after the date" of the occurrence that forms the basis for the CMP. 68 FR 18896.

- CMP actins are NOT summary; the person upon whom DHHS seeks to impose CMPs MUST be given the written notice and an opportunity for a hearing on the record, where the person may be represented by counsel, may present witnesses, and may cross-examine witnesses. 42 USC 1320a-7a(c)(2).

- DHHS CANNOT impose a HIPAA CMP on any person that is NOT a CE! 68 FR 18898.

Step 8: Know When to Hold 'em, and Know When to Fold 'em. Sometimes, discretion is the better part of valor, and it makes sense to settle charges of a HIPAA violations. There is a specific process to settle a case, though, and it is important to follow the procedures to the letter.

- DHHS can "settle any case or ... compromise any penalty during the process" 68 FR 18898, referencing 45 CFR Part 160.510.

- Factors to be taken into account by OCR when making a settlement determination will be "addressed in the notice-and-comment rulemaking" planned for the remainder of the Enforcement Rule. 68 CFR 18899.

- Timely Requests: If DHHS notifies a CE of a proposed penalty, the respondent MUST timely request a hearing IN WRITING or the penalty becomes final, and the respondent has "no right to appeal." 68 FR 18899, referencing 45 CFR Part 160.516.

- Time Period: Sixty (60) days after notice of the proposed penalty determination is received by the respondent. 45 CFR Part 160.516(b).

    - Receipt date is "presumed" to be 5 days after the date of the notice. This is a rebuttable presumption. Id.

- Hearings are on the record. 45 CFR Part 160.530(a); 560.

- The HHS party will be "OCR and/or CMS." 68 FR 18899.

- Discovery is "limited." 45 CFR Part 160.538 (Document production, essentially) Depositions/Interrogatories are specifically prohibited. 45 CFR Part 160.538(c).

- Decision of the ALJ is the decision of DHHS. 45 CFR Part 160.564(d). (This is contrary to many state administrative law systems, where an ALJ's decision can be adopted, modified or rejected by the head of the administrative agency.)

- Judicial Review of final penalty decisions is authorized. 42 USC 1320a-7(e); 45 CFR Part 160.568.

- Respondent may request a stay pending judicial review. 160570(a) (file federal appeal papers with ALJ; the stay is automatically granted until ALJ rules on the request).

Step 9: What to do BEFORE the investigation. Two words-Be Prepared!

- Implement your HIPAA Compliance Plan to the greatest extent; if you take reasonable and scalable steps to comply, you can make all of your "incidental disclosures" permissible pursuant to the Final Privacy Rule, and thus, they will not constitute HIPAA violations.

- Document the steps that you took to implement your plan; HIPAA committee minutes (if you have a HIPAA compliance committee) should be maintained in writing.

- Document the monies you spent in implementing the plan; save budgets and receipts.

- If you made any cost/benefit "reasonableness" determinations regarding specific plan elements, document them and have that documentation available for inspection.

- Periodically examine reports to your Privacy Office/HIPAA Hotline (suggest semi-annually or more).

    - Investigate ALL reports and conclude ALL investigations with WRITTEN documentation.

- Trend all your reports; if there are discernible trends, conclude them with written documentation.

- Revisit the trends over time to see if your solution is effective; if not, revise the solution and try again!

- Keep your disclosure logs in good order (especially with respect to inappropriate disclosures-this is where complaints are VERY LIKELY to originate; you don't want it to appear that you "covered-up" anything!)

- Train, educate, explain, and then train some more.

- Maintain employee time records, training funds expended, and training materials used. (TIP #5-Make sure each employee takes and passes a HIPAA training post-test. If they fail, re-train them and test them again.)

- Create a "Culture of Privacy" (which probably already exists at most healthcare facilities).

- Read the latest OCR HIPAA implementation and enforcement guidance at: http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/

- Watch the online enforcement video from OCR, at http://www.ehcca.com/streaming/index.html. This is great guidance from Robinsue Froboese, J.D., Ph.D., Deputy Director, Office of Civil Rights.

- Include HIPAA in your policy for responding to official investigations. (Don't have a policy for responding to investigations? Now's the time to get one!)

- DON'T include the OCR address in your NPP (you don't have to; you just have to tell the patient how to get it. If they have to contact you to get it, then you may have the opportunity to resolve the complaint; at the very least, you'll be on notice of a potential complaint!)

- GET AND RELY ON THE WRITTEN ADVICE OF COUNSEL/QUALIFIED CONSULTANTS!!!!!!!!!! (at best, they'll be right; at worst, you can be indemnified by their professional liability policies!). Due diligence is important in developing an effective HIPAA compliance plan.

It is important to remember that OCR is a relatively "new animal" to those of us in the healthcare field. We have some experience with OIG investigations, but we're just not sure how OCR will treat us. A strong, effective compliance plan, and a well-crafted response to investigations policy will be your best tools to survive a HIPAA investigation and not get trampled by the HIPAA HIPPOs (Health Information Protection Police Officers).

MEDICARE OPT-OUT AFFIDAVIT

TWO COPIES OF THIS AFFIDAVIT SHOULD BE COMPLETED—ONE MUST BE FILED WITH YOUR MEDICARE CARRIER (SENT BY REGISTERED MAIL, RETURN RECEIPT REQUESTED) AND THE OTHER SHOULD BE KEPT ON FILE IN YOUR OFFICE.

I, _____, being duly sworn,

Full Name of Physician

depose and say:

1. I promise that, except for emergency or urgent care services (as specified in 42 C.F.R. §405.440), during the opt-out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of 42 C.F.R. §405.415 for services that, but for their provision under a private contract, would have been Medicare-covered services.

2. I promise that I will not submit any claim to Medicare for any item or service provided to any Medicare beneficiary during the 2-year period beginning on the following effective date: _____; nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in 42 C.F.R. §405.440.

3. I understand that, during the opt-out period, I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare + Choice plan.

4. I acknowledge that, during the opt-out period, my services are not covered under Medicare and no Medicare payment may be made to any entity for my services, directly or on a capitated basis.

5. I promise that during the opt-out period I will be bound by the terms of both this affidavit and the private contracts that I enter into with Medicare beneficiaries.

6. I acknowledge that the terms of this affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by me during the opt-out period (except for emergency or urgent care services furnished to

the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.

7. I understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of 42 C.F.R. §405.440 apply if I furnish such services.

8. *[Section 8 should be used only for those physicians who have signed a Part B participation agreement.]* I acknowledge that my Part B participation agreement terminates on the effective date of the affidavit.

_____

Signature of Physician

_____

Principal Office Address

_____

Telephone Number

_____

National Provider Identifier (NPI) or Billing Number, if one has been assigned

_____

Uniform Provider Identification Number (UPIN), if one has been assigned

_____

Physician's Tax Identification Number (TIN), if neither NPI or UPIN has been assigned

Sworn to and subscribed before me

this _____ day of _____

_____

Notary Public

MY GOALS AT PARK CITY MEDICAL CENTER

GLORIFY GOD EACH DAY

FOLLOW THE LEADING OF THE HOLY SPIRIT

DOCUMENT SIGNS AND WONDERS, MIRACLES OF GOD

PROVIDE 20 IV THERAPIES PER DAY

PROVIDE 20 OMT TREATMENTS PER DAY

PROVIDE 10 DOT EXAMS PER DAY

FAMILY PRACTICE FOR THE WHOLE PERSON—SPIRIT, MIND AND BODY.

HELP OTHER BUSINESSES CONTROL THEIR MEDICAL COSTS WHILE IMPROVING THE HEALTH AND MORALE OF THEIR EMPLOYEES

EMPLOY ONE OR TWO PART TIME PA'S OR NP'S

BE AN INCUBATOR FOR OTHER MEDICAL ENTREPRENEURS. EVERYONE WORKING HERE EXCITED ABOUT ACHIEVING THEIR INDIVIDUAL GOALS.

DEBT FREE IN TWO YEARS

BUILD NEW CLINIC WITH ROOM FOR FIVE OR SIX OTHER BUSINESSES IN 2 AND ½ YEARS WITH ROOM TO BUILD 32-PLEXES ONE AT A TIME

PARK CITY MEDICAL CENTER
425 E 61ST STREET N. STE 2
PARK CITY, KANSAS 67219
744-3400

HOW MAY WE SERVE YOU?

KTE MEMBERS/BUSINESS OWNERS: You know how much insurance premiums have jumped the past several years. You also know how much it costs to send your employees to the emergency room. Dr George Watson, at Park City Medical Center is here to serve you and your employees. While our regular business hours are **8:00 AM to 5:00 PM Monday to Friday**, we understand that your business may have two or three operating shifts. So, for **afterhours and weekend** medical needs, you may still call **744-3400** and it will forward to Dr Watson or one of his associates. You can then explain what type medical problem you have, and Dr Watson will tell you if it is something that can be handled at the Park City Medical Center or if it does require more extensive intervention. Dr Watson will meet your employee and supervisor at Park City Medical Center, if it is something that can be handled here. As a former emergency room physician and Air Force Flight Surgeon, responsible for the health of the pilots, their families, and the ground crews working in very sophisticated shops, he can handle a very wide array of problems.

OSTEOPATHIC MEDICINE: Dr Watson is a D.O., doctor of osteopathy. That is valuable to you, the owner/manager, because he can provide you and your employees all the services that an M.D. and Chiropracter **combined** could offer---at much less cost and not having three appointments per week. So you don't have to wonder who to call if you or your employee has a musculoskeletal problem (HEADACHES, NECK AND BACK PAINS AND STRAINS). Call **744-3400.**

COSTS: Park City Medical Center does not participate with any insurance companies. You pay a reasonable fee for the time that the doctor spends in your care. And, of course, it is KTE TRADE!

I ALREADY HAVE A DOCTOR/INSURANCE PLAN: Can you afford to receive only what the insurance company allows? You might be surprised at how much better your health could be (heart disease, diabetes, infections)---find out by getting a **SECOND OPINION** at Park City Medical Center.

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
744-3400

DID YOUR HEALTH INSURANCE COSTS GO UP?
HIGHER DEDUCTIBLES AND CO-PAYS?

FOR YOUR EMPLOYEES---Please post copies of the enclosed flyer, to help them control their health costs. Our "insurance-free" fees for doctor visits are often equal to or less than the insurance plan co-pays. See the example on the flyer.

FOR YOUR BOTTOM LINE---Most businesses find that it costs far less to pay directly for non-hospital expenses than to have your Work Comp insurance get involved. We can save you TIME and MONEY compared to a visit to the ER.

Please call me, at your convenience, so we can discuss your needs.

Also, please let me know if you would want to attend a brief meeting to discuss how to dramatically reduce your health insurance costs. (You might think, "I already made my decisions for this year." But it is never too late to reduce your costs. You can change your coverage any time YOU choose. Insurance companies try to make us think we a LOCKED in for a year, but see how strong the lock is if you miss one or two premiums.)

George R Watson, D.O.
PARK CITY MEDICAL CENTER

UNINSURED IN KANSAS—CRISIS OR OPPORTUNITY?

More than 300,000 Kansans, nearly a fourth of them children, have no health insurance

Is health insurance/health care a right?

Is car insurance/car ownership a right?

55% of the insured are worried about being able to afford it in the future.

59% of employers think it is important to provide health insurance, but many are increasing employee costs or cutting back on benefits.

National Institute of Medicine—leading advocate for universal health coverage (government control of medicine)

Small business seminar—informational session on providing health coverage to employees.

Example: Business with 41 employees. HMO contract costs $332,000 per year or about $675 per employee per month. MAJOR MEDICAL policy would cost about $300 per month (with wellness benefit included). The savings of $375 per month per employee equals $184,000 per year. Should that be in the business' account or the HMO's account? The $184,000 could be placed in HSA's and the employees could use that for out of hospital services. They would pay cash, then go to the HSA for reimbursement. Insurance companies should only be involved in MAJOR MEDICAL coverage, as their overhead currently DEVOURS from 40 to 68% of each premium dollar, leaving only 32 to 60% of the money to provide the actual medical care to the subscriber/patient.

HIPAA—Health insurance portability act. True portability would be each employee owning THEIR OWN policy. HIPAA added OVER 1000 pages of new rules and regulations and made your CONFIDENTIAL medical records ACCESSIBLE to more insurance companies and bureaucrats!

COVERED/APPROVED services—these words give patients the impression that, since the insurance company doesn't cover certain procedures, that there is something wrong with them. EXAMPLE: Insurance does not cover intravenous hydrogen peroxide therapy, but, in just 6 IV's each, one man has gone from chest pain at one and one half minutes on the treadmill to NO PAIN at 45 minutes at 4 mph, and the other diabetic male has not had his infected toe amputated, because it is now pink. Total cost to each has been under $600 vs the $2500 work ups for high cholesterol and the $15,000 costs for angioplasties and stents, and the several thousand dollars to amputate the middle toe.

Solutions: www.aapsonline.org for information on SAVING free market medical care

www.simplecare.com for information on a nation-wide network of doctors who contract with their patients, not insurance companies.

WORST SOLUTION—universal health care run by Ted Kennedy and Hillary Clinton. This will lead to rationing of care, so the real question is, "DO WE WORK THIS OUT ON THE STATE LEVEL, OR DO WE PRESUME THAT FEDERAL BUREAUCRATS WILL KNOW WHAT IS BEST FOR OUR OWN CITIZENS?"

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
316-744-3400

SCENARIO 1: (You've seen this one!)

Employee is injured and goes to the clinic designated by the insurance company. "It's covered, so cost is no object," mindset leads to unnecessary tests, x-rays, and services. Employee isn't concerned—it's covered. Doctor isn't concerned—this is guaranteed income. Employer isn't concerned—our insurance covers it. Then you get the next premium increase.

SCENARIO 2:

Employer has high deductible Work Comp policy (aware of $500 limit on unauthorized medical that employee may obtain, and employer must pay). Employer (not the insurance company) sends employee to a doctor who provides quality care at reasonable prices for payment in full at time of service. The employee knows that the company (not the insurance company) is paying for his care. The doctor knows that he is working for the employer AND employee (not the insurance company). And the employer knows that the doctor is working for them.
THE RESULT: Direct communication between the doctor and the company allows for timely, appropriate care without unnecessary expenses.
Example: The employee presents with a back injury. A doctor with wide experience in occupational injuries does NOT need an x-ray or CT scan to begin treatment.
The employer pays the doctor, turns in the report to the insurance company, and premiums do not go up ("Losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification.").

If one assumes that insurance company overhead is 50% (reported ranges of 40-68%), a $500 deductible would save $250 in EXTRA cost if the insurance company handles it. In other words, would you rather pay $500 to the doctor, or pay the insurance company $750 to pay the doctor $500 MINUS "write-offs" that their reviewers have determined were not appropriate (even though the reviewers never examined the patient).

ROUTINE MEDICAL CARE—the high deductible plan paired with a Health Savings Account keeps the money in YOUR account, not the insurance company's account.

Medical 2nd Opinions---Who needs them?

We are bombarded with messages "Do this, do that, ask your doctor." All are carefully crafted marketing strategies. **Pharmaceutical companies** brainwash doctors with "standard of care" promotions---the drug companies' perceived standards that **promote their drugs. Insurance companies** and the Golden Rule--he who has the money makes the rules. We give them our money, and they tell us what they will pay. They even tell us who we can see. **Doctors** learn to "play the game" that gets them the best reimbursement, and frequently **the patient's health suffers** for it.

Examples of **people who need second opinions**:

*Lady needing referral for **carpal tunnel** surgery on both wrists and a bilateral release surgery at the left elbow. Stretching exercises had her pain free in 4 weeks without surgery.
*Lion's club member who had had 34 **angiograms**! Six angiograms were too many!
*Angiogram by cardiologist announcing 80% and 60% blockages read by a different cardiologist (a second opinion)---40% blockages at most! **Angioplasty** NOT NEEDED.
*Man who was told he needed another **stent** and was well enough informed to graciously decline. Angina free after 5 days of conservative care for less than $500.
*Eighty year old man had had **bypass and angioplasties of coronaries AND legs**; after cadaver graft in his leg, he was told, "there is nothing else we surgeons can do for you." He had pain relief with his first treatment with Dr Watson.

Back pain patients—horror stories:

*Young slender male with **discectomy** two years prior to seeing Dr Watson was relieved of the pain in one treatment (except for his painful scar from surgery).
*Fighter pilot had symptoms of **ruptured disc** when he sat in the ejection seat of the plane. Second opinion prior to discectomy revealed painful nodule; removal relieved pain.
*Business man who travels out of town had seen "over 50 chiropracters in the past 2 years" for **low back pain**; "FEELS FINE" after two treatments by Dr Watson.
*Lady called and still had the **same pain** she had before her back surgery 2 and ½ years ago.

WHO DO YOU BELIEVE?

The surgeon who charges you $3-5,000 for the procedure (oh, it's covered by insurance); the lawyer who gets 30% of all your medical bills (the more surgery on you, the better for him); or do you get a second opinion—at YOUR EXPENSE---and make up your own mind what is in YOUR BEST INTEREST?

At **PARK CITY MEDICAL CENTER**, you pay for the time that Dr Watson spends reviewing your medical condition and records, examining you, and then discussing YOUR options. He may suggest some reading for you to better understand your options. **Don't you or your loved one deserve a second opinion?** If so, call **744-3400** to schedule your appointment to get YOUR SECOND OPINION.

PARK CITY MEDICAL CENTER
425 E 61ST ST N STE 2
PARK CITY, KS 67219 PHONE 744-3400

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
316-744-3400
October 24, 2005

CHELATION STUDY Park City Medical Center has been accepted as a study site for the NIH (National Institute of Health) funded Trial to Assess Chelation Therapy. This study is FREE to those who volunteer to participate. See the **enclosed flyer** for details regarding criteria for selection of participants. This might be of huge benefit to **YOU, SOMEONE YOU LOVE, OR YOUR EMPLOYEES** (we have many patients who pay $4,000 for similar services). Please, tell everyone you know that has had a heart attack about this study, and have them call 744-3400 for information to see if they qualify. Thank you.

THERMOGRAPHY Beginning November 15th, 2005, Park City Medical Center will offer **infrared thermography imaging.** Women can have breast imaging without the crushing pain of mammography. NOTE: Thermography does not replace mammography, it complements it by showing thermal changes that can direct mammography to find cancers at the earliest stages. Some other benefits of thermography, other than the very affordable cost, are: non-invasive evaluation of lumbar pain, carotid artery blockages, kidney infections, trigger points of fibromyalgia, varicose veins, reflex sympathetic dystrophy, chronic fatigue syndrome. These studies will be done by Kathy or Kim, and a written report by an experienced thermologist will be provided to the patient. Call 744-3400 and ask for Kathy or Kim for further information.

IV THERAPIES We do many different IV therapies at Park City Medical Center. Some typical patients are **angina** patients that are exercise limited by chest pain. After two to six IV's, they are able to go 45 minutes on the treadmill with NO chest pain. Or the patient scheduled for amputation of a **diabetic** toe who, after ten IV's, no longer needed amputation. Or patients who have had bypass surgeries and angioplasties, and have been told "there is nothing more we can do", and, after ten IV's, they have less chest pain, and are able to walk without leg pain. And we have many patients who have read *Bypassing Bypass Surgery* by Elmer Cranton, M.D., and have made the decision to PREVENT the need for surgery by taking IV therapies. VIRUSES and BACTERIAL infections respond dramatically to our IV therapies.

OSTEOPATHIC MANIPULATION Dr Watson is a D.O., Doctor of Osteopathy. He doesn't have you come back three times a week for a month. He FINDS it, FIXES it, then shows you how to help yourself with daily exercises. You may come back if you NEED to come back. Some people find that a good manipulation once a month helps them to be more efficient on their jobs.

OCCUPATIONAL MEDICINE Dr Watson is a honors graduate of the U.S. Air Force Flight Surgeons Course. He kept the F-16 fighter pilots fit to fly at McConnell AFB. He was team physician for a semi-pro football team. And he has helped many local businesses control their workplace medical expenses with the wide range of services offered at Park City Medical Center. He is also a certified MRO for drug testing. He has been certified in Occupational Medicine since 1986, one of the first doctors in Wichita to become certified.

ANTI-AGING MEDICINE/FAMILY PRACTICE Dr Watson is the first doctor in Kansas to be a diplomate of the American Board of Anti-Aging Medicine. The paradigm of anti-aging medicine is to help the individual function at a level ten to fifteen years less than their chronological age. Dr Watson's biological age has been measured at 21 years LESS than his chronological age.
And, at Park City Medical Center we provide the usual family care for sore throats, lacerations, foreign bodies in the eye, asthma, pneumonia, and elevated cholesterol levels are treated with the more natural approach recommended in the National Cholesterol Education Guidelines.

HOW MAY WE SERVE YOU? Please call Park City Medical Center to schedule your appointment. 744-3400
Note: We do not participate with Medicare or any insurance company. That way, we can charge fair prices to everyone. Also, if you have a HIGH DEDUCTIBLE health plan, such as the new HSA's require, your deductible dollars buy you MORE services here than at a clinic that charges insurance-based fees, which are generally 30-60% higher. And many patients tell us that "they run a lot of extra tests", because "the insurance will cover it." AND, what does that do to YOUR insurance premiums?

Best regards,

Dr Watson and Staff

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
316-744-3400
May 12, 2004

Sandy Praeger
State Insurance Commissioner

RE: Out of network medical care

Dear Mrs. Praeger,

I fully understand the value of insurance companies having preferred provider networks, which help the company control health care expenditures. But there is a serious flaw that penalizes subscribers when they go out of network, SAVE MONEY, and GET RESULTS that they had not previously received in the network.

When there are measurable outcomes, demonstrating definite improvement, the subscribers should be REWARDED (not punished) for finding cost effective care, by receiving full reimbursement by their insurance company. The ultimate question is, "Do we care about results for the subscribers, or do we care more about people following our rules and procedures?" Too many insurance companies prefer the latter. That must change in order to meet the NEEDS of the SUBSCRIBERS.

Two examples from this week: The first is a diabetic male with retinopathy leading to blindness. He was to have the right middle toe amputated, due to a chronic infected ulcer that had not responded to antibiotics for at least six weeks. After just three IV treatments (non-covered and by a non-participating physician), it is obvious that he will not need the amputation. Cost for 11 treatments is $850. That is less than one day in the hospital, and far less than all the costs associated with amputation. What is the result? He will be penalized (not REWARDED) for his good sense to seek out a measurable medical outcome. The second is another diabetic male with chest pain after only one and one half minutes on his treadmill. He was told he

needed angioplasty and stent. Instead, he sought alternative care, and after just six treatments, was able to go 45 minutes on the treadmill at 4 miles per hour with NO CHEST PAIN. This is a much more accurate measure of improvement than an angiogram. (I have had patients told by one cardiologist that they had an 80% blockage. When they took the SAME films to another cardiologist, it was read as 40% at the most.) What will be the result with this patient? That's right, he will be PUNISHED for seeking cost effective care outside the insurance company's network (web). Rather, he should not only be REWARDED for saving them thousands of dollars, but encouraged to help other subscribers to similar savings.

Please look at the www.Simplecare.com website. We do not participate with any insurance companies. We have lower overhead, because we don't have to fight with the insurance companies for the reduced payments for our labor and expertise. So we also have lower charges than "participating providers" of the insurance company lists.

TO COVER THE NEEDS OF THE UNINSURED, we need more physicians that provide services at affordable rates using the Simplecare concept. AND INSURED patients who chose to use "out of network" physicians, AND obtain measurable improvements at a savings to the insurance company, should be REWARDED by PROMPT reimbursement IN FULL for their medical expenses.

Your strong influence as Insurance Commissioner to stop the NON-COMPETITIVE, PUNISHING practices of the insurance companies would benefit BOTH the UNINSURED and the INSURED.

Thank you for serving the great State of Kansas.

George R Watson, D.O.

Consumer protection from abuse in access to medical care. Reason for this bill—non-competitive clauses in insurance company contracts that allow monopoly pressure in the medical marketplace.

Example: BCBS penalizes its own subscribers who choose to go to a private physician (BCBS calls them non-contracting) to obtain cost effective medical care. Even if the physician charges are equal to or less than what BCBS would pay one of their "contracting providers" (they don't even call them doctors), BCBS PENALIZES their subscriber by DELAYING payment with unnecessary requests "for additional information" (which they DO NOT need), and then pays a reduced reimbursement, because the patient/subscriber went to a doctor who has not surrendered to BCBS policies and procedures.

This is non-competitive, typical of a monopoly like system, and should be made an unlawful practice. This bill should give the State Insurance Commissioner power to fine insurance companies who abuse their subscribers with unnecessary reimbursement delays and reimbursements that are LESS than what they would pay for the SAME services, if provided by one of their contracting doctors.

Example 2: A patient with back pain goes to her "contracting provider" who gives her a prescription. She gets worse and goes to a private physician who does Osteopathic manipulation, with significant improvement, but she needs one more treatment. She goes back to her "contracting provider" who sends her to physical therapy for two weeks. When she returns to her private physician, they calculate that insurance has paid physical therapy about $1600. She is back where she started, and pays her private physician "out of pocket" $50 for another treatment with significant improvement. SHE SHOULD BE FULLY REIMBURSED for obtaining cost-effective care. But she is NOT.

Let's look at a few pertinent questions.

What does the health care premium dollar buy? Documented studies show that 40-68% of the premium dollar goes to insurance company overhead—these dollars do not provide any medical service to the subscriber. ONLY 32-60% of the premium dollar actually benefits the patient.

What does it cost a physician to file a reimbursement claim with an insurance company? Studies show that it is $20 per claim filed. And, when the insurance company sends their "we need more information" letter, it costs another $20 to refile the claim.

Why are doctors retiring early? A combination of high malpractice premiums and increasing stresses and costs CAUSED by insurance companies is driving many good doctors to early retirement.

Why would doctors choose to be private physicians and refuse to contract with any insurance company, including Medicare? If you could be fined and sent to prison for an honest clerical error that a reviewer thinks is willful and deliberate, would you contract

with such a company? A murderer is innocent until proven guilty. In the insurance system, a doctor is guilty UNLESS he can prove himself innocent.

How will the new HSA's (Health Savings Accounts) fit in with the existing and proposed systems? First of all, the insurance companies don't like HSA's, because the health savings account belongs to the subscriber, and the subscriber chooses how to spend HIS/HER money up to the deductible. (Previously this money went to the insurance company for them to dole out as THEY saw fit.) These individuals want to get the BEST VALUE for their money. So, when they go to a private physician (who DOES NOT charge the inflated fees necessary to cover all the paperwork to get paid by the insurance company), they get PERSONAL CARE (the doctor works for them, not the insurance company), they pay fair fees, and they should have 100% qualification of those fees toward their deductible. Currently that would not happen, because the insurance company would call those charges "out of network" and allow only a portion of the fees to apply toward the deductible. This MUST BE CHANGED, so the patient is not DEFRAUDED by a monopolistic system.

Who will fight this legislation? The insurance companies will be first in line. Medical societies may fight this, too. They have many members who have been led to believe (coerced or frightened) that they can not succeed unless they "accept assignment" of the insurance companies. Fearful of change, they will fight to maintain the status quo. Large medical groups will probably fight this. They have learned to "play the game" and have purchased expensive equipment to do tests that are handsomely reimbursed by the insurance companies. High priced specialists will likely fight this. If they charge $2,000 to $5,000 for a procedure, they accept

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
316-744-3400
January 6, 2005

Jim Stevens
Stevens Enterprises
2400 N Woodlawn Ste 140
Wichita, Ks. 67220

Dear Mr. Stevens,

You have to be a sharp businessman to have achieved your success. So, I will present the details, and you can decide what is in your best interests.

My office is in Park City, near your Applebee's restaurant. My wife and I eat out at least twice a week, and I always tip the server at least 15%.

Your Park City Applebee's sent your employee, Christina , in for an on the job injury 4-14-04. We made it clear to her supervisor that we charge reasonable fees (30-50% less), because we don't have the overhead of dealing with insurance companies. When the bill was not paid by 10-18-04, I spoke with Sara Tyler, manager, who referred me to Bill Gray, district manager. I offered to accept a gift certificate in the amount of $110 to be used at your restaurant. Bill referred me to Cynda, who, when I tried to explain that I had made a fair charge by not dealing with insurance companies, took issue with my raised voice when she told me how I had to run my business in relation to Applebee's.

So, I sent the bill to Liberty. As expected, they "needed more information", so we refiled the same bill with them. December 21, 2004, they issued a check, allowing ONLY $82.50 of the $110 bill (see enclosure). This is typical for insurance companies (and why I do not participate with any of them). It costs any doctor's office $20 every time they file, and then the insurance companies "review" the bill, and discount it.

From my perspective, I provided prompt, effective care that *protected your interests* at a very reasonable cost. I charged $110. It cost me $20 each time

I filed with your insurance company x 2 = $40. That totals $150 in charge plus costs of filing. Liberty paid $82.50, so I lost $67.50 providing care for your employee.

Let's be clear. Insurance companies are not the doctor's or employer's friends. Doctors who DO participate with insurance companies "play the game" and charge much more than I do, because they know that the insurance company will pay less than what is billed. That way, the insurance companies *appear* to be saving YOU money. But, when the next year rolls around, they raise YOUR premium. It happens year after year.

Do you want to save money? Use a high deductible on your work comp policy and deal directly with an efficient physician, and pay him directly. That physician is then working for you, not playing the "work comp insurance game." Turn in only the claims for injuries that require hospitalization or expensive tests. The savings might astound you.

The bottom line. I believe I gave you good service. I offered to make a trade for services. Your insurance company robbed me in your name.

Maybe you have all the customers you can handle at the Park City Applebee's. If you would like me to spend any of my money ($35x52 = $1820 minimum per year spent eating out) in your restaurant, send me a gift certificate for $67.50, and we can put this behind us. (2007 update—more like $60x52=$3120 plus at least 20% tip to the servers that I have NOT spent in your restaurant since you did not respond to my reasonable offer.)

I would be happy to care for your injured employees. I am the first physician in Wichita to be certified in Occupational Medicine. But, I will only work for you, not the insurance company. You would pay me for my services to your employees, and I would pay your restaurant and employees when my wife and I eat there more often.

Best regards,

George R Watson, D.O.

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
316-744-3400

Filing for reimbursement from your insurance company.

Most insurance companies believe that every doctor should contract with them for your care. That makes the doctor equally obligated to the insurance company's contract as well as you for your care. Is that really a good triangle?

Because I have chosen to be totally obligated to YOU in your health condition, I do NOT contract with insurance companies. That bugs them.

When you file for reimbursement, they will use their knee-jerk excuses to delay payment, such as "we need more information". That is a LIE. We charge based on time with you. Our PLAIN ENGLISH diagnoses are sufficient for YOUR insurance company to use whatever code THEY want on THEIR form. They will insist that we have to do that. We don't, because we have no contract with them. THEIR obligation is to YOU, to HELP YOU obtain coverage (reimbursement) for appropriate charges. Ask to speak with a supervisor, and INSIST that they work WITH you, their subscriber, and stop their silly game of delaying reimbursement to you.

When you submit your receipt from Park City Medical Center, they will penalize you for not going to one of THEIR "providers"—EVEN though you are probably saving them money. That is one of their coercive ways to try to get you to talk me into contracting with them. Do you want me working for you or for them? This is where you should send a letter of complaint to the State Insurance Commissioner (Sandy Praeger), telling her that YOU should not be penalized for your good sense to find an efficient doctor who saves you AND the insurance company money. They SHOULD REWARD YOU.

Next, they want me to sign a form for your services and include MY tax ID number. I inform them that you already paid me, they are to PAY YOU in reimbursement, because they have a contract to provide **your** coverage. BUT, they frequently send the check to me anyway. If that happens, we call you and give the check to you to trade for a check written to you.

We are here to serve YOU. And your medical records are afforded far more privacy here than they would be if we contracted with insurance companies.

INSURANCE COMPANY RESPONSE

GEORGE R WATSON, D.O.
425 E 61ST ST N STE 2
PARK CITY, KS 67219

Dear Insurance Company:

We have NO CONTRACT with you. We don't play your GAME. So, you don't need my tax ID number.

You don't need "more information" to process the claim to reimburse your subscriber. We charge by time WITH THE PATIENT, not a set of numbers that change yearly to provide revenue for the AMA. We tell you, IN PLAIN ENGLISH, what the diagnosis or procedure is. If we were to give you a code, and you thought it was the wrong code, you would tell us. So, just put down the code, including the 4th and 5th digit, that you think fits the PLAIN ENGLISH that we have provided you. Then you know it will be correct.

Then, process the claim without further delays. Your subscriber deserves prompt handling of their request for reimbursement.

NOTE: Because we don't add extra charges for filing, re-filing, and insurance company write-offs, you probably noticed our charges are LESS than your contracted physicians charge. That costs YOU LESS (saves you money). So, maybe it would make sense to REWARD your subscriber for saving you money and for you to remember not to hassle your subscriber with this silly "more information" game in the future.

Sincerely,

George R Watson, D.O.

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
316-744-3400

Claims Department
Blue Cross Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Re: ID#
Patient:
Control #:
Our office received your request for further information before processing a claim submitted by YOUR SUBSCRIBER for services provided by HER PHYSICIAN.

RESPONSIBILITIES: As her independent physician, I am responsible only to her for the care that she requests. As her insurance provider, you are responsible to reimburse her for her medical expenses. If it is your policy to PENALIZE your subscribers who choose independent physicians who choose not to surrender their independent thinking to your controlling contracts, you are obligated to notify your subscriber.

I provided the services for which your subscriber is requesting reimbursement.

You do NOT need my tax identification number, because you do not have me under your contract, and you will be paying YOUR SUBSCRIBER, not me. DO NOT send any checks to me.

Your records are correct! I do not have a provider number with you. But that does not prohibit you from PROCESSING the claim and REIMBURSING your subscriber.

Please process the above claim and fulfill your RESPONSIBILITY TO YOUR SUBSCRIBER.

Thank you,

DR WATSON

Cc:

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
316-744-3400

Cardiovascular risk reduction per NCEP guidelines:

The National Cholesterol Education Guidelines for cardiovascular risk reduction recommend Total Lifestyle Change—dietary change, exercise, and, if those fail, prescription drugs to lower cholesterol. If the dietary change does not result in cholesterol reduction, the next step in the NCEP guidelines is to add viscous soluble fiber and stanols and sterols for more aggressive intervention.

_____ consulted regarding his dyslipidemia, with elevated LDL (bad) cholesterol. Since general dietary change was not effective, I prescribed Bios Life Complete, which contains viscous soluble fiber and stanols and sterols. Like medication for high cholesterol, this is a lifetime intervention. Since I prescribed these as a specific medical intervention, they should be covered under his flexible spending plan.

Thank you.

George R Watson, D.O.
Diplomate, American Board of Anti-Aging Medicine

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PARK CITY, KANSAS 67219
316-744-3400

THIS CLINIC AND PHYSICIAN DO NOT CONTRACT WITH ANY INSURANCE COMPANIES. WE CONTRACT ONLY WITH OUR PATIENTS. THE FOLLOWING INFORMATION IS PROVIDED FOR THE BENEFIT OF THE PATIENT TO OBTAIN REIMBURSEMENT FROM THE CARRIER THAT HAS CONTRACTED TO PAY FOR THE SUBSCRIBER'S MEDICAL EXPENSES.

PATIENT NAME_____
SSN_____

SERVICES RENDERED BY GEORGE R WATSON, D.O.

DIAGNOSIS CODE AND DESCRIPTION
1._____
2._____
3._____

DATE	CPT-4	DESCRIPTION	CHARGES

TOTAL PAID BY PATIENT _____
THANK YOU FOR REIMBURSING YOUR SUBSCRIBER PROMPTLY. SEND THE CHECK TO THE SUBSCRIBER.

GEORGE R WATSON, D.O.

Fee Ticket for Services Rendered:

We are so glad that you came to the Good Samaritan Mobile Medical Clinic. Our first priority is to meet your health need. We are also interested in your spiritual needs.

You will receive your care in the Good Samaritan Mobile Medical Clinic **FREE** of charge. Because some people have asked if they could pay for their services or make a donation, the following charges are for information only. If you would like to make a donation, please take it to the registration table, and help Good Samaritan help those who are unable to pay.

Physician services:	up to ten minutes	$30
	11-15 minutes	$40
	16-20 minutes	$50
	30 minutes	$75
	OMT (manipulation)	$30
	2 areas	$40
	neck, thorax, lumbar	$50
Medicine	$10 per medicine	$_____
Procedures	by description and individual fee	
	Ex. Incise and drain cyst	$95
	Procedure_____	$_____

THE ABOVE FEES ARE FOR INFORMATION ONLY. NO DONATION IS REQUIRED.

MOST IMPORTANT----WHAT ARE YOUR SPIRITUAL NEEDS? WHAT DO YOU NEED PRAYER FOR? Please take this with you to the prayer room.

PRAYER
NEEDS:_____
_____
_____
_____

PARK CITY MEDICAL CENTER
425 E 61ST ST NORTH, STE 2
PARK CITY, KANSAS 67219
316-744-3400
January 1, 2008

Notice to Patients:

Effective immediately, we will have to raise some of our fees. This is primarily related to fuel surcharges being applied to all of our supply orders. But, you can check a couple of websites of other doctors providing the services that we provide and see that our prices are still VERY fair and competitive. In particular, check www.caringmedical.com and look at their prices for prolotherapy of the knee, shoulder, back---$250 to $500. Their IV charge for chelation is $150. And they DON'T take insurance.

New charges are:

New patient hormone replacement consultation	$150
Follow up visits	$ 50
New patient chelation (or other IV) consultation	$150
IV's (H2O2, EDTA, GLUTATHIONE)	$115
Extra Vitamin C, DMSO	$ 10
Second IV of glutathione, antibiotic	$ 35
High dose Vitamin C, Plaquex	$125
Prolotherapy (knee, shoulder, back with 6cc's)	$ 75
1cc multiple injections $15 each with minimum	$ 75
Triggerpoint injection	$ 75

TO SOFTEN THE BLOW—for those of you getting IV's regularly, we will extend the PACKAGE PRICES through January 18, 2008. Through that date, you can buy ten IV's for $1,000 and get ELEVEN (1 free), or buy 20 IV's for $2,000 and get 23 (3 free). **After** January 18, 2008, ten IV's will cost $1150, and you will get ELEVEN (1 free), and 20 IV's will cost $2300, and you get 23 IV's (3 free).

Thank you for the privilege of serving you.

George R Watson, D.O. and Staff

Building a Healthy, Independent Practice

ssociation of American Physicians & Surgeons

May 30, 2008

Introduction

- Getting the Government Off Your Back: NPI, HIT, HER, P4P
- Consumer Directed Healthcare: Picking the best, leaving the rest

- Kathryn Serkes
- AAPS Director, Policy & Public Affairs
- Kaserkes@att.net

Topics of Discussion

- Examine government & insurance regulatory initiatives & impact on your practice
- Analyze business models for patient-doctor-direct practices
- Incorporate consumer-directed-healthcare (CDHC) into practice

Health Information Technology (HIT)

- TODAY'S DISCUSSION

- Rationale
- Definitions/acronyms/roles
- Status of adoption, integration
- Government v. private sector
- Business models

Change is Underway: Drivers of Health IT Adoption

HIT, EHR, PHR,NPI, P4P, CDHC 5

Key Health IT Components

A Robust, Interoperable, Health IT Environment that brings together:

- Electronic Health Records (EHR)
- Personal Health Records (PHR)
- Public Health Information

- Standards (Data, Technical and Security)
- Interoperable Health Information Exchange Network
  (Nationwide Health Information Network - NHIN)

The Ultimate Reason for Health IT

PERSPECTIVE YOU SHOULD TAKE:

- What quality of **health** do *you* want and deserve?
- What quality and value of **health care services** do *you* demand?

HIT, EHR, PHR,NPI, P4P, CDHC 7

Office of the National Coordinator (ONC)

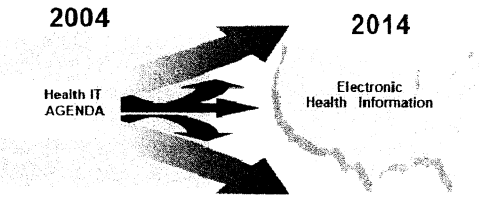
Executive Order, April 2004:
The President created the National Coordinator position
- To advance the vision of developing a nationwide interoperable health information technology infrastructure
- To achieve the President's goal of widespread adoption of interoperable electronic **health records** (EHR) by 2014

Key Role for ONC:
Provide **leadership** for the development and nationwide implementation of an **interoperable health information technology infrastructure** to improve
- The quality and efficiency of health care and
- The ability of consumers to manage their health

National Health IT Agenda

HIT, EHR, PHR,NPI, P4P, CDHC 8

The Framework for Transformation



Widespread adoption of interoperable electronic health records by 2014
- Improve quality and efficiency of health care
- Improve individual and population health

EHRs PHRs Public Health
Home Telehealth

Standards ... Interoperability

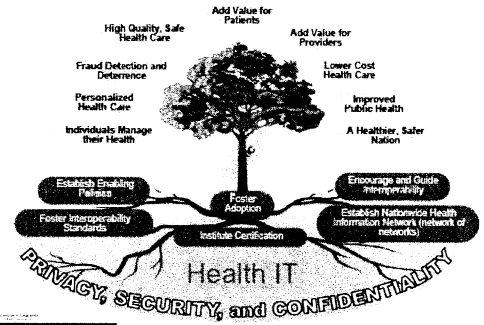
Nationwide Health Information Network

Organizational Framework to Facilitate Transformation: AHIC

American Health Information Community (AHIC – "The Community")

- A federal advisory committee (FACA), funded & staffed by ONC
- Chaired by Secretary Leavitt
- 17 members; public – private collaboration
- Provides input and recommendations to HHS
  - How to make health records digital and interoperable
  - Assure that the privacy and security of those records are protected, in a smooth, market-led way
- Detailed work performed in work groups and brought back to The Community for deliberation and decisions

Health IT Support for Transforming Health and Care



HIT business models:

-Utility

-Subscriber

-Value Added Services

- "NHIN is likely to be highly sensitive to the appetite for date by secondary users."

  Scott Cullen, MD of Accenture, at AHIC meeting January 2007

Evidence-Based Medicine & P4P

- Carrot vs. Stick?
- Government
- Private Sector

HIT, EHR, PHR,NPI, P4P, CDHC 13

National Provider ID

- May 2008 deadline/extension
- HIPAA-covered transactions
- Hospital squeeze is on
- This may a Catch-22 GOTCHA!

HIT, EHR, PHR,NPI, P4P, CDHC 14

WATCH OUT FOR:

- National licensure
- Punitive P4P
- Third-party administrators
- Insurance companies acting like managed care again

HIT, EHR, PHR,NPI, P4P, CDHC 15

CONSUMER-DIRECTED-HEALTHCARE (CDHC)

- All under guise of "Patient Empowerment"
- Patients do like:
  - information/decision support websites
  - Electronic Rx
  - Electronic Medical Records
    - 63% support/ Mar. '07 Harris poll

HIT, EHR, PHR,NPI, P4P, CDHC 16

The Marketplace

- Clinical delivery
  - Concierge
  - Retail
    - Minute Clinic
    - Wal-Mart, Target
    - RediClinic
  - Walk-in
  - Traditional, with PATMOS

HIT, EHR, PHR,NPI, P4P, CDHC 17

Consultants & other "help"

- Fee-based
- Percentage of revenues
- CAUTIONS:
  - Mine current pt lists
  - Open-ended contracts
  - "Associations" started by consultants

HIT, EHR, PHR,NPI, P4P, CDHC 18

- The system is designed for you to be a compliant, insurance-seeking doctor
- You have to break through the system and let patients know that you offer something special
- Internet, Cable TV, Radio, whatever it takes
- Give talks to patient groups and physicians
- Nurture professional referral sources

HIT, EHR, PHR,NPI, P4P, CDHC 19

TAKE THE BEST, LEAVE THE REST

- Laboratory services
- Negotiate with hospitals
- Offer information services
- Personal health records
- Consult with successful doctors!

HIT, EHR, PHR,NPI, P4P, CDHC 20