

## Chapter 2

# Getting the Team Paid: How Medicare Physician Payment Rules Impede Quality

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## § 2:1 Introduction

In 1998, the National Quality Roundtable proclaimed the pressing need to change the American health care system to deliver more reliable and better quality care.

[A]t its best, health care in the United States is superb. Unfortunately it is often not at its best. Problems in health care quality are serious and extensive; they occur in all delivery systems and financing mechanisms. Americans bear a great burden of harm because of these problems, a burden that is measured in lost lives, reduced functioning, and wasted resources. Collectively, these problems call for urgent action.<sup>1</sup>

Ten years later, there has unquestionably been some progress in some quarters. The Institute for Healthcare Improvement (IHI) declared that its “100,000 Lives Campaign” prevented 122,000 needless deaths in 2006.<sup>2</sup> Even as they touted the program’s success, the results were deemed insufficient by IHI itself. So they launched yet another campaign, “The 5 Million Lives Campaign,” to prevent avoidable harm.<sup>3</sup> Medicare’s Premier-Hospital quality demonstration was found to improve hospital care<sup>4</sup> for the participating institutions, and the Medicare Group Practice Demonstration project also improved care and saved Medicare money.<sup>5</sup>

On the other hand, in 2003, RAND researchers reported

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### [Section 2:1]

<sup>1</sup>Galvin, Chassin, et al., *The Urgent Need to Improve Healthcare Quality*, 280 *JAMA* 1000 (1998).

<sup>2</sup>McCannon, Hackbarth, Griffin, Miles To Go: An Introduction to Five Million Lives Campaign, *The Jt., Comm. J. on Qual. and Safety* (Aug. 2007), pp. 477–85, at <http://www.ihl.org/NR/rdonlyres/DA1D43DD-464A-46BC-9D1A-C290EE371DE0/0/MilestoGo.pdf>.

<sup>3</sup><http://www.ihl.org/IHI/Programs/Campaign/>.

<sup>4</sup>[http://www.cms.hhs.gov/HospitalQualityInits/35\\_\\_HospitalPremier.asp](http://www.cms.hhs.gov/HospitalQualityInits/35__HospitalPremier.asp).

<sup>5</sup>Press Release, August 14, 2008, <http://www.cms.hhs.gov/apps/meda/press/release.asp?Counter=3239&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordT>

that Americans are getting only 55% of the health care services that evidence says they should receive.<sup>6</sup> The Commonwealth Fund published a scorecard in 2006 and again in 2008 showing that the United States is far behind other countries in common measures of quality,<sup>7</sup> and the Agency for Healthcare Research and Quality (AHRQ) issued a report in 2008 showing that the overall rate of health care quality improvement is slowing.<sup>8</sup> For the Medicare population, the story is the same. In 2005, it was found that there had been some progress, but persistently lagging quality and large gaps in care there, too.<sup>9</sup> By 2008, the situation for the Medicare population was still nowhere near where it should be, with wide disparities in quality throughout the country.<sup>10</sup>

Clearly the pace of quality improvement is hardly commensurate with the scope of the problems identified by the National Quality Roundtable. Undoubtedly, many factors are at work. However, nowhere has there been an examination of the extent to which Medicare—in its own payment policies—explicitly impedes what is now understood to improve health care quality. With Medicare paying about 40% of the health care bills in this country, what Medicare requires drives much of the rest of the system, particularly for physicians. When they have to meet Medicare’s arcane, detailed, and counterproductive administrative demands in

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l=&pYear=&year=&desc=&cboOrder=date.](#)

<sup>6</sup>McGlynn, et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 *NEJM* 2635–2645 (June 26, 2003).

<sup>7</sup>Schoen, et al., *US Health System Performance: A National Scorecard* (Sept 20, 2006), at [http://www.commonwealthfund.org/publications/publications\\_\\_show.htm?doc\\_id=403925](http://www.commonwealthfund.org/publications/publications__show.htm?doc_id=403925); *Why Not The Best? Results from the National Scorecard on US Health System Performance, 2008* (July 17, 2008), at [http://www.commonwealthfund.org/publications/publications\\_\\_show.htm?doc\\_id=692682](http://www.commonwealthfund.org/publications/publications__show.htm?doc_id=692682).

<sup>8</sup>AHRQ, *2007 National Health Care Quality Report—At A Glance*, at <http://www.ahrq.gov/qual/nhqr07/Glance.htm>.

<sup>9</sup>Leatherman and McCarthy, *Quality of Healthcare for Medicare Beneficiaries: A Chartbook* (May 6, 2005) [http://www.commonwealthfund.org/publications/publications\\_\\_show.htm?doc\\_id=275195](http://www.commonwealthfund.org/publications/publications__show.htm?doc_id=275195).

<sup>10</sup>Arvantes, *New Studies Finds Wide Disparities in Medicare’s Quality of Care*, *AAFP News Now*, June 11, 2008, at <http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/20080611/medicare-dispar.html>.

delivering care, they naturally carry over the same behaviors to their other patients as well. This problem is big.

It is true that the Center for Medicare and Medicaid Services (CMS) has recently implemented a host of demonstration projects aimed at improving quality,<sup>11</sup> some instigated by congressional action and some on its own motion. Some are related to pay-for-performance.<sup>12</sup> In addition, with its comparison of data across providers, including hospitals, nursing homes, home health agencies, and dialysis facilities on the “Compare” Web sites,<sup>13</sup> CMS hopes that Medicare patients will choose better quality providers, and in response, those providers will improve their performance as a result of this comparative transparency. Physicians are not yet among compared providers.<sup>14</sup>

For physicians, Medicare thwarts their ability to deliver optimal quality. While the basic incentives of fee-for-service

<sup>11</sup>See Master Demonstration, Evaluation and Research Study for ORD System of Record 09-70-059, at [http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/Master\\_SOR\\_List.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/Master_SOR_List.pdf) and *Quality Initiatives General Information* at <http://www.cms.hhs.gov/QualityInitiativesGenInfo/>.

<sup>12</sup>Hospital reduced payment for failure to report quality performance ([http://www.cms.hhs.gov/HospitalQualityInits/20\\_HospitalRHQDAPU.asp#TopOfPage](http://www.cms.hhs.gov/HospitalQualityInits/20_HospitalRHQDAPU.asp#TopOfPage)); Premier Hospital Quality Demonstration ([http://www.cms.hhs.gov/HospitalQualityInits/35\\_HospitalPremier.asp#TopOfPage](http://www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp#TopOfPage)); Physician Quality Reporting Initiative (<http://www.cms.hhs.gov/PQRI/>); Physician Group Practice Demonstration ([http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MMA646\\_PGP\\_FactSheet.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MMA646_PGP_FactSheet.pdf)).

<sup>13</sup>Hospital Compare, at [http://www.cms.hhs.gov/HospitalQualityInits/25\\_HospitalCompare.asp](http://www.cms.hhs.gov/HospitalQualityInits/25_HospitalCompare.asp); Home Health Compare, at <http://www.cms.hhs.gov/HomeHealthQualityInits/downloads/HHQINavigationTips.pdf>; Nursing Home Compare, at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3060&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>; Dialysis Facility Compare at <http://www.cms.hhs.gov/ESRDQualityImproveInit/downloads/Measures.pdf>.

<sup>14</sup>As part of its “Value-driven Health Care Initiative” (<http://www.hhs.gov/valuedriven>), HHS is seeking to increase transparency to consumers. They have launched “Chartered Value Exchanges” (<http://www.ahrq.gov/qual/value/localnetworks.htm>) described as “community-based multi-shareholder collaborations on the forefront of implementing cutting edge ways to transform healthcare at the local level.” In connection with that, there are 12 measures, applied to subsets of physician group patients to calculate performance scores. These data are available by HHS Region (<http://www.cms.hhs.gov/GEM/>).

medicine have long been condemned as toxic to good-quality results,<sup>15</sup> the discontinuity between modern notions of quality and the details in Medicare reimbursement policy go far deeper. Some of the problems are created by the Congress in enactments with which CMS must comply, while others are created by regulators themselves.

This chapter begins with an elucidation of factors now known to enhance quality. Against that background, I highlight broadly relevant traditional Medicare policies, rules, and principles applicable within physician offices, across physician practices, and between physicians and their most significant others—hospitals—which just get in the way. These are contrasted with a new payment model outside of Medicare aimed in a different, better direction.

### § 2:2 What quality requires

The STEEEP values enunciated by the Institute of Medicine in *Crossing The Quality Chasm*<sup>1</sup> define the framework for the 21<sup>st</sup> century to drive, deliver, and assess quality of care. Care should be safe, timely, effective, efficient, equitable, and patient-centered (STEEEP). For those who would adhere to them, embedded in those values are wide-ranging changes in behavior, from the specific to the general: from preventing surgical site infections with glucose control and clipping, not shaving, hair at the surgical site to improving patient appointment availability; from consistent hand-washing to adhering to clinical practice guidelines and other evidence-based statements of appropriate care processes; from using full barrier protection to prevent central line infections to avoiding overutilization from defensive medicine while providing as much care as the patient needs; from raising the head of the bed 30 degrees to prevent ventilator-acquired pneumonia to facilitating transparency regarding quality performance . . . and much more.

To fulfill the potential in the STEEEP values, several

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<sup>15</sup>Pittsburgh Regional Healthcare Initiative, Reimbursement's Perverse Incentives, (June 2004), at [http://www.prhi.org/docs/Reimbursement%20perverse%20incentive\\_\\_6-2-2004.pdf](http://www.prhi.org/docs/Reimbursement%20perverse%20incentive__6-2-2004.pdf); Corrigan et al., *Crossing the Quality Chasm*, Institute of Medicine, Washington DC, 2002.

#### [Section 2:2]

<sup>1</sup>Corrigan, et al., National Academy Press, 2001 (hereafter "IOM").

principles in organizing care have been found to be important: (1) time and touch with patients; (2) teamwork; (3) clinical collaboration among otherwise independent practitioners; and (4) active patient engagement. Let us consider how and why they matter.

### § 2:3 What quality requires—Time and touch

The current context for American health care is one in which physicians are extremely dissatisfied with their quality of life as well as their increasing accountability for quality results, when the payment model which drives much of what they do values through-put and discounts more than the one-on-one doctor-patient relationship. They feel they have no time, for themselves or for their patient interactions. They are not wrong.

In a 2004 study in the *Annals of Family Medicine*, researchers applied clinical practice guidelines recommendations for 10 common chronic diseases to a panel of 2,500 primary care patients with an age-sex distribution and chronic disease prevalences similar to those of the general population. The researchers concluded there were real questions as to whether physicians could possibly spend the time required to deliver science-based care.<sup>1</sup> The loss of time with patients has been repeatedly cited by physicians as a problem in delivering care as well as a source of physician anxiety about delivering proper care.<sup>2</sup> So, when physicians are measured and scored in report cards and are excluded from networks on the basis of those scores, resentment and tensions exacerbate.<sup>3</sup>

The loss of time is not merely a problem of physician satisfaction. It is itself a quality problem. As stated in the

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#### [Section 2:3]

<sup>1</sup>Ostbye, et al., *Is There Time For Management of Patients With Chronic Diseases in Primary Care?*, 3 *Annals of Family Medicine*, 209–14 (2005).

<sup>2</sup>Zuger, *Dissatisfaction with Medical Practice*, 305 *NEJM* 69–75 (Jan. 1, 2004).

<sup>3</sup>Physicians Dispute Quality Rankings, *Pittsburgh-Tribune Review*, (Feb. 8, 2007). [http://www.pittsburghlive.com/x/pittsburghtrib/business/s\\_492216.html](http://www.pittsburghlive.com/x/pittsburghtrib/business/s_492216.html); see also Shay, *Transparency and The Law*, *Health Law Handbook*, pp. 77–122 (Gosfield, ed. 2008).

writings of James L. Reinertsen MD,<sup>4</sup> the Institute of Medicine observed that “the transfer of knowledge is care.”<sup>5</sup> High-quality care, therefore, is care which optimizes that transfer to the individual patient.

Effective transfer can only occur when the physician can bring to bear in his relationship with the patient two essential factors—time and touch. These factors are critical to a physician’s approach and treatment of a patient. Time and touch affect the physician’s ability to grasp the subtleties in each patient’s situation. These subtleties are significant when fashioning an effective approach to the patient. In addition, time and touch are essential to optimal communication which implements appropriate treatment. To customize the application of science, the physician must listen, explain, examine, comfort, teach, treat, perform procedures or surgery, and otherwise address the specific and variable needs of the individual patient. This “touch time” is what defines the art of medicine.<sup>6</sup>

Any administrative burdens, therefore, which steal from this “touch time” without adding clinical value, impede quality.

#### § 2:4 What quality requires—Teamwork

Time with patients to custom-craft the art of medicine is closely related to the benefits from teamwork—using every clinician at that professional’s highest and best use, together, in providing standardized, science-based, patient-responsive care. In the hospital, the critical role of nurses in improving quality and the tensions in demands on their time for work other than at the bedside has been noted.<sup>1</sup> Teamwork has improved quality and increased financial margins in office-

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<sup>4</sup>Reinertsen, *Health Care: Past, Present and Future*, Group Practice Journal, pp. 36–38 (Mar./Apr. 1997).

<sup>5</sup>IOM, at 72.

<sup>6</sup>Gosfield, after Reinertsen, in *The Doctor-Patient Relationship As The Business Case for Quality: Doing Well By Doing Right*, 37 J. Health Law 197–224 (Spring 2004).

#### [Section 2:4]

<sup>1</sup>Draper, et al., *The Role of Nurses in Quality Improvement*, Research Brief No 3, March 2008, Center for Health System Change, at <http://www.hschange.com/CONTENT/972/>.

based family practice.<sup>2</sup> The interaction of physicians with teams of other clinicians in delivering care has also been cited as critical to improve chronic care.<sup>3</sup> The Institute for Healthcare Improvement (IHI) gathers and reports a plethora of teamwork success stories in delivering care across a wide range of measures of quality explicitly by using multidisciplinary teams of professionals.<sup>4</sup> Patient safety advocates and researchers routinely report the value in teamwork across disciplines to create safe, effective care environments.<sup>5</sup>

### § 2:5 What quality requires—Clinical collaboration

“Teamwork” is observed within a care system, whether a physician office practice, hospital unit, or an integrated delivery system. The term generally refers to multidisciplinary interactions. Clinical collaboration among otherwise independent physicians has also been cited as essential to quality of care improvement. James L. Reinertsen, MD, has made the oxymoronic observation that for physicians to retain autonomy with plenary legal and clinical authority, they must give autonomy up to each other and work together for better, more standardized care.<sup>1</sup> He notes that clinical collaboration among physicians has produced spectacular quality and outcomes, particularly in pediatric oncology. Clinical collaboration across medical specialties has been

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<sup>2</sup>Okie, Innovation in Primary Care—Staying One Step Ahead of Burnout, 359 NEJM, 2305–2309 (Nov. 27, 2008), Anderson and Halley, A New Approach to Making your Doctor-Nurse Team More Productive, *Fam. Practice Mgt.* (July/Aug. 2008), pp. 35–40.

<sup>3</sup>Shortell, et al., The Role of Perceived Team Effectiveness in Improving Chronic Illness Care, 42 *Medical Care* 1040–1048 (Nov. 2004).

<sup>4</sup><http://www.ihl.org/ihl/search/searchresults.aspx?searchterm=teamwork&searchtype=basic>.

<sup>5</sup>For example, see Leonard, Graham, Bonacum The Human Factor: The Critical Importance of Effective Teamwork and Communication in Providing Safe Care, 13 *Quality and Safety in Health Care* (Suppl. 1) (2004); 13 (Suppl. 1): i85–i90; and McCarthy and Blumenthal, Committed to Safety: Ten Case Studies on Reducing Harm to Patients, The Commonwealth Fund (April 2006); Publication No. 923; [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=368995](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=368995).

#### [Section 2:5]

<sup>1</sup>Reinertsen, Zen and The Art of Physician Autonomy Maintenance, 138 *Ann. of Int. Med.* 992–95 (June 17, 2003).

noted as important to creating a culture of quality and safety within group practices and hospitals.<sup>2</sup> Marshalling the professionalism of the medical staff to take responsibility for the quality of care in the entire hospital is another form of clinical collaboration which has been cited as important to improving quality.<sup>3</sup> The high value placed on otherwise independent physicians, even competitors, collaborating to improve clinical quality can be seen in the antitrust regulators' acknowledgement that behavior which would otherwise be collusive and illegal is permitted to proceed without enforcement when the purpose and focus is to improve quality through "clinical integration."<sup>4</sup>

### § 2:6 What quality requires—Patient engagement

Finally, among the four quality improvement principles addressed here, patient engagement has long been cited as essential to achieving what science would recommend, since studies show that less than half of patients follow their prescribed regimens.<sup>1</sup> Variably characterized as patient engagement, "patient compliance,"<sup>2</sup> or "self-management,"<sup>3</sup> the active role of the patient in the care delivery process has become a bedrock of quality improvement, now promulgated

<sup>2</sup>Crosson, Weiland and Berenson, Physician Leadership "Group Responsibility" as Key to Accountability in Medicine, 8 *The Permanente Journal* (Summer 2004), at <http://xnet.kp.org/permanentejournal/sum04/ky.html>.

<sup>3</sup>Reinertsen, Gosfield, Rupp and Whittington, Engaging Physicians in A Shared Quality Agenda, Institute for Healthcare Improvement, (2007), at <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/Literature/EngagingPhysiciansinaSharedQualityAgenda.htm>.

<sup>4</sup>See Leibenluft and Weir, Clinical Integration: Assessing The Antitrust Issues, *Health Law Handbook*, pp. 1–47 (Gosfield, ed. 2004).

#### [Section 2:6]

<sup>1</sup>Defino, Getting The Straight A Patient, *Physicians Practice* (April 2006), at <http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/809.htm>.

<sup>2</sup>Pawar, Five Tips for Generating Patient Satisfaction and Compliance, *Family Practice Mgt.* (June 2005), at <http://www.aafp.org/fpm/20050600/44five.html>.

<sup>3</sup>Bodenheimer, Wagner and Grumbach, Improving Primary Care for Patients with Chronic Illness, 288 *JAMA* 1775 (Oct. 9, 2002), at <http://www.upt-a.com/PDF/JAMABodenheimer10-02.pdf>.

as a national measure by the National Quality Forum.<sup>4</sup> Patient satisfaction and measurement of the patient experience of care has a long history in managed care circles, going all the way back to the advent of NCQA measurement of health plan quality.<sup>5</sup>

Today, the sought-after engagement of the patient in the process of care delivery is far broader. No longer restricted to patient surveys, the activation of patients as true partners in improving care has produced excellent results in hospital settings,<sup>6</sup> too. Making care convenient, accessible, and proactive for patients is part of this movement. Bringing care to the patient and involving the patient in both decision-making around the care process as well as in responsibility for compliance with agreed upon care plans are examples of what these approaches entail.

So, if we know what techniques can enhance and propel quality and we also know that Medicare quality lags, what is it about “every system is perfectly designed to achieve the results it gets”<sup>7</sup> that is getting us today’s Medicare quality results?

### § 2:7 Where Medicare goes wrong: The overarching problems

While the fundamental financial incentive of fee-for-service is overuse—the more you do the more revenue you generate—that is not the only problem with physician reimbursement under Medicare. As we will see in more depth, there are two principal policy drivers which impede the four basic values considered here: (1) a vast array of administrative demands reflects the policy expectation that physicians will respond improperly to the incentives of the payment system

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<sup>4</sup><http://www.qualityforum.org/pdf/PtEngage%20Draft%20Goals%2006%2011%2008%20mtg.pdf>.

<sup>5</sup>See Gosfield, Guide To Key Legal Issues In Managed Care Quality, pp. 121–23, 189–91, 203–07 (1996).

<sup>6</sup>See Reinertsen and Schellekens, 10 Powerful Ideas For Improving Patient Care, (2005); and Goodman and Ward, Satisfied Patients Lower Risk and Improve The Bottom Line, Patient Safety and Quality Healthcare (March/April 2008), at <http://www.psqh.com/marapr08/satisfied.html>.

<sup>7</sup>Berwick, <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/ImprovementStories/ImprovementTipWantaNewLevelofPerformanceGetaNewSystem.htm>.

they suffer, so elaborate safeguards must be imposed on *all* physicians; and (2) fraud and abuse anxieties thwart a significant degree of professional collaboration because of concern about economic benefit flowing between otherwise independent parties who refer to each other.

Documentation merely to provide evidence that services were rendered at the scope they were claimed—the evaluation and management (E&M) code bullet points—is the beginning of the enormous amount of time Medicare forces physicians to waste doing things that are not clinically relevant. Although the creation of the visit codes came at the request of physicians that the payment system quantify and pay for the value of their cognitive services, the solution requires documentation which captures the intensity of the service. Differentiating the complexity of the visit—in the office, in the hospital, in the nursing home—distinguishing the level of consultation—in the office, in the hospital, in the nursing home—turns on characterization of the scope of the physical exam, the extent of the history, and, most burdensome, the complexity of the medical decision-making. This is less than science, and even certified coding professionals disagree almost half the time about what documentation supports what codes.<sup>1</sup> The documentation of the distinctions requires time spent toward no clinical purpose.

Medical necessity is an overarching requirement for payment for all Medicare services, like any other insurance program. However, in Medicare, because of the risk of postpayment audits, physicians must document the medical necessity of all services specifically. Diagnostic testing performed to rule out potential problems is not a reimbursable approach to documentation. This additional burden of writing, in addition to the order itself, the justification as to why the physician has ordered what the standard of care would require as appropriate treatment, adds to loss of time and touch with patients.

Still further, in the face of mounting expenditures, Congress has authorized an even more aggressive claims

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**[Section 2:7]**

<sup>1</sup>King, Lipsky, and Sharp, Expert Agreement in Current Procedural Terminology Evaluation and Management Coding, 162 Arch. Int. Med. 316 (2002).

review. The advent of “progressive corrective action,”<sup>2</sup> created by Congress to limit unduly burdensome extrapolation of documentation errors in a review sample to an entire physician practice, has not blunted the in terrorem effect of postpayment audits. Overpayments, false claims liability, and exclusion from the program lurk as potential outcomes. Recovery audit contractors, companies which are separate from both the carriers and the program safeguard contractors who also review care for overpayments, are being unleashed from the three pilot states where their work began as a demonstration, now to ply their trade throughout the country. Unlike the other administrative payment contractors, these organizations are paid a percentage of the dollars they recoup<sup>3</sup> from claims review. This army of reviewers with their weapons of enforcement looms over physician practices, imperiling their time with patients to assure that their documentation will withstand these many sources of potential scrutiny.

The real problem is that the entire claims review and audit process only looks at overuse and almost never at misuse or underuse. While most Medicare physician review is generated by data aberrancies,<sup>4</sup> the mere fact of comparatively high volume is not dispositive of the appropriateness of services rendered. Medicare claims review is fundamentally a cost-control mechanism with only a tangential connection to quality; yet its existence and potential impact steal time and touch from good physicians who could spend their precious time far more meaningfully.

Medicare offers no “quality corridor” of administrative burden reduction for those with demonstrably good performance. At best, Medicare regulates for the mediocre middle and, at worst, for those who would game the system or are just not very good doctors. More refined mechanisms to identify those at the bottom of the class and concentrate review efforts on them would be more consistent with the real concerns of quality in the new health care system. Today, good physicians lose time and touch with patients because they must document to no clinical purpose to the

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<sup>2</sup>Pub. L. No. 108-173, § 935; 42 U.S.C.A. § 1395ddd(f)(3).

<sup>3</sup>42 U.S.C.A. § 1395ddd(h).

<sup>4</sup>Program Integrity Manual 100-08, Ch. 2.

same extent that the overutilizers do. This is just the beginning of the trouble they face if they want to incorporate in their care the four principles of time and touch, teamwork, clinical collaboration, and patient engagement.

### § 2:8 Within the physician practice

Within a physician practice, Medicare reimbursement slices and dices the “team” with cost control-driven rules that verge on the metaphysical. Incident-to and shared visit rules undermine teamwork. Virtually all of the innovations proven to assure the viability of a high-quality primary care practice,<sup>1</sup> including nurses documenting care, group medical visits, e-mail, and more, are prohibited in Medicare. Diagnostic testing rules steal time and touch from patients, while they impose doctrinaire limits on teamwork, and the Stark rules undermine clinical collaboration while they increase administrative burden.

### § 2:9 Within the physician practice—Incident-to versus shared visits

One of the most confounding and longest standing reimbursement rules pertains to care rendered “incident-to” a physician’s personal professional service to a patient. This rule dates back to the inauguration of Medicare when the typical physician office consisted of a male physician and “the girl” who multitasked in ways few do today: she did reception, transcription, billing, vital signs, venipuncture, diagnostic services, and more. She was essentially inextricably entwined in the care the physician rendered. To have insisted that Medicare would only pay for the one-to-one interaction between physician and patient would have killed physician participation before the program even got started.

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#### [Section 2:8]

<sup>1</sup>Okie, Innovation in Primary Care—Staying One Step Ahead of Burnout, 359 NEJM, 2305–2309 (Nov. 27, 2008).

While there have been some changes over time in the details of the incident-to rules,<sup>1</sup> they have always required that there has to be a physician service to which the ancillary personnel's services are incidental.<sup>2</sup> The care has to be rendered in the course of physician treatment with interaction by the physician at such frequency that it is clear he is still involved in the care. The services of the personnel originally could only be rendered by W-2 employees, although that is no longer the case. The costs of the personnel may not be identified separately but must be included in the physician's charges to the program. The rules require, further, that a physician of the group, although not necessarily the treating physician, must be on premises in the office suite and immediately available to assist at all times that the ancillary personnel render services billable to Medicare. When care is provided "incident-to" the physician, the ancillary personnel are invisible on the claim form, and the claim is submitted as if the physician rendered the service. For many years, this was the only way that physician practices could be paid for anything not rendered by the physician himself.

As time went by, more types of practitioners sought to be recognized by Medicare. Nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), physical and occupational therapists (PTs and OTs), audiologists, psychologists, and clinical social workers are all now able to bill Medicare for their services on their own numbers.<sup>3</sup> NPs, PAs, and CNSs get paid at 85% of the physician fee schedule for everything they do. The others get paid the same rates a physician would. NPs, CNSs, PTs, and OTs can form their own groups, although PAs cannot. When their services meet

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**[Section 2:9]**

<sup>1</sup>See Gosfield, Highest and Best Use: Non-Physician Practitioners and Physicians Under Medicare, Health Law Handbook, pp. 99–103 (Gosfield, ed. 1999); Gosfield, The Ins and Outs of Incident-To Reimbursement, Fam. Practice.Mgt. (Nov./Dec. 2001), at <http://www.aafp.org/fpm/20011100/23thei.html>.

<sup>2</sup>For the current incident-to rules, see Medicare Benefit Policy Manual Pub. 100–02, Ch. 15, §§ 60, 60.1-4.

<sup>3</sup>Medicare Benefit Policy Manual Pub. 100–02, Chapter 15, §§ 120–210; see also Medicare Claims Processing Manual Pub. 100–04, Chapter 12, §§ 110–170.

the “incident-to” requirements, they can remain invisible on the claim form and be billed in the traditional manner where the physician group is paid 100% of the fee schedule.

When the E&M codes were introduced, it became possible to bill visits not only on complexity, but instead on the amount of time spent with the patient; but only if more than 50% of the visit entailed counseling or coordination of care.<sup>4</sup> However, the only time that counts is face time between the doctor and the patient. So an NP working incident-to a physician and meeting all those criteria cannot be billed incident-to when the service is mostly counseling or coordination of care. How does this make sense in an era where time between patients and doctors is at a premium? The NP might perform the education, comforting, and personalized interactions that would save the physician for her highest and best use, doing things which require a physician license. NPs, PAs, and CNSs can see the patient alone without a physician and still be billed incident-to, but not for counseling or coordination of care. Essentially, Medicare believes, although does not state, that counseling by NPs, PAs, and CNSs is worth 15% less than physician counseling.

So, taken together, we have rules which require the physician office to track whether there is a physician in the office suite when ancillary personnel are providing services, then to determine whether the ancillary personnel can be billed on their own numbers, for no articulated quality purpose of any kind. The rule is an attempt to ration Medicare dollars to be available only for a specified level of physician involvement in care. It certainly wastes time.

In 2008, in Transmittal 87, CMS published a major revamping of the incident-to rules which would have made them even more onerous. For example, when the patient presented with a new symptom, the physician would have to reauthorize a new treatment plan, so if a cardiac patient followed by the office staff for routine blood pressures and cholesterol checks reported a cold, the office visit services pertaining to the cold could not be billed unless the physician reintervened to authorize treating the cold. There was more which was even worse. The entire Transmittal was retracted. The bad news is that the bureaucratic thinking it

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<sup>4</sup>For general rules for billing E&M services, *see* Medicare Claims Processing Manual Pub. 100–04, Chapter 12 § 30.6.

demonstrated was a walk into the past, imposing even more restrictions, safeguards, and limitations on in-office interactions among the care team. The tone and implications of the Transmittal were surprising, since they would have been directly at variance with one rule which has been published which is unusual and fairly unique in its liberality—shared visits.

All from CMS has not been counterproductive. In an unprecedented move, a full 180 degree reversal from prior guidance, in Transmittal 1776,<sup>5</sup> CMS had promulgated a rule which recognizes that to function as a team, clinicians need not be in the same building at the same time; but this recognition extends only to hospital visits. Whether inpatient, outpatient, or in the emergency room, a nonphysician practitioner (NPP) may see the patient and perform virtually the entire visit. If the physician sees the patient later that day and performs any substantive portion of a visit in a face-to-face encounter with the patient, the services of both can be aggregated and billed as if rendered by the physician. The rule is more liberal than incident-to because the two clinicians don't have to be present in the building at the same time; and there are no boundaries as to how little the physician must do, as long as what he does is substantive and clinical, and not just a social visit with the patient. On the other hand, shared visits may not be used for consults.

Contrast that approach with CMS's refusal to acknowledge as reimbursable<sup>6</sup> any form of group medical visits—a well-recognized technique to bring together patients with common conditions, particularly chronic conditions, for education, self-help, and personal treatment.<sup>7</sup> These visits have been found effective to save time, improve care, and foster patient engagement.<sup>8</sup> Similarly, CMS has refused<sup>9</sup> to recognize a standardized form for a cardiovascular hospital stay which would track evidence-based medicine, save physi-

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<sup>5</sup>Medicare Benefit Policy Manual Pub. 100–02, Ch. 15 § 60.3.1.

<sup>6</sup>Personal communication, Terrence Kay, Director of Practitioner and Ambulatory Care, CMS, Jan. 30, 2002.

<sup>7</sup>Weinger, Group Medical Appointments in Diabetes Care: Is There A Future?, 16 *Diabetes Spectrum* 104 (Nov. 2, 2003), at <http://spectrum.diabetesjournals.org/cgi/reprint/16/2/104>.

<sup>8</sup>Jaber, Brocksmajer, and Trilling, *Group Visits: A Qualitative Review of Current Research*, 19 *J. Am. Bd. of Fam. Med.* 276–90 (2006). See Okie,

cians time on the day of discharge, as well as engage patients in a contract for their follow-up care. The completion of the form was to be customized for each patient, but the custom-crafting would require at least half an hour to complete. Asked to approve the document as qualifying for billing at the half-hour level for discharge day services,<sup>10</sup> CMS refused.

In terms of patient engagement in care, CMS allows the patients to complete only the review of systems and past family and social history to contribute to documentation of visits.<sup>11</sup> Everything else must be personally documented by the physician including the history of the present illness. Nurses may not do this either. Patients are not permitted to document their primary complaint, or their degree of pain, or anything else without the physician personally writing the information again; yet another time waster.

Distinct from commercial payors who increasingly recognize the value in paying for care which is convenient to patients,<sup>12</sup> CMS will not recognize e-mail interchanges or even telephone calls as billable services. Telephone calls are considered included as pre- and postwork of other visits or services already rendered or about to be provided.<sup>13</sup>

Recently, Medicare has recognized “telehealth” services, which involve a real-time face-to-face visit between a physician and a patient in disparate locations by means of video

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Innovation in Primary Care—Staying One Step Ahead of Burnout, 359 NEJM, 2305–2309 (Nov. 27, 2008).

<sup>9</sup>Personal communication from Stephen Philipps, Director, Division of Practitioner Services, CMS, April 13, 2004.

<sup>10</sup>CPT 99239.

<sup>11</sup>Documentation Guidelines for Evaluation and Management Services, 1995, <http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf> at p. 5 and 1997 edition <http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf> at p.6; *see also* Moore and Henry, Exam Documentation Just Got Worse, Fam. Practice Mgt. (Oct. 1995), at <http://www.aafp.org/online/en/home/publications/journals/fpm/collections/fpmmedicare/moreexam.doc.html>.

<sup>12</sup>“Insurers reimbursing physician email consultations,” [http://professional.cancerconsultants.com/reim\\_news.aspx?id=33470](http://professional.cancerconsultants.com/reim_news.aspx?id=33470); Trend: Health plans begin reimbursing for “virtual visits” “October 22, 2007, at <http://www.fiercehealthit.com/story/trend-health-plans-begin-reimbursing-virtual-visits/2007-10-22>.

<sup>13</sup>Medicare Benefit Policy Manual 100–02, Chapter 12 § 30B.

equipment.<sup>14</sup> That recognition, however, is consistent with the age-old Medicare requirement that a physician may only bill for either a face-to-face visit or an interpretation when he is able to visualize some aspect of the patient's condition without the interposition of a third party.<sup>15</sup> The only exception is for "care plan oversight services" rendered to patients in hospice or home health agency treatment<sup>16</sup> where the physician may bill for his interactions with others on behalf of the patient in coordinating care. Some have argued that even with the advent of five levels of visit codes, Medicare still does not support the full extent of the services patients with multiple comorbidities need when they are provided in a primary care office, while the system would support paying for separate visits to seven consultants.<sup>17</sup>

As a result of the interplay of these archaic rules and definitions, not only is redundant documentation from the physician required for physicians to be paid for their total time spent in patient care, but they must also require

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<sup>14</sup>Medicare Benefit Policy Manual 100–02, Chapter 12 § 270, and <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM4204.pdf>.

<sup>15</sup>Medicare Benefit Policy Manual 100–02, Chapter 12 § 30A.

<sup>16</sup>Medicare Claims Processing Manual 100–104, Chapter 15 § 180.

<sup>17</sup>"Consider this typical Medicare patient. She is a 72-year-old woman with diabetes, hypertension and coronary artery disease. Her blood pressure is controlled, but her cholesterol and blood sugars have been high since she abandoned her diet because of depression over her daughter's divorce and the unruly grandchildren who now live with her. She has occasional angina, which has been more frequent in recent weeks, has arthritis in her spine and knees, has recently developed vaginal itching, heartburn and a persistently stuffy nose, and she worries about changes in a spot on her skin. Her problems are common ones and could be readily managed by *one* primary care physician—or by visits to *seven* specialists (endocrinology, cardiology, psychiatry, gynecology, gastroenterology, otolaryngology and dermatology).

Medicare will pay for consults with each of the seven specialists, at \$117.70 or \$216.27 each, for an aggregate cost to Medicare of about \$1,200, plus any lab tests, imaging, allergy testing and mental health counseling. On the other hand, Medicare will pay the primary care physician at most \$80.18 to \$117.70 (and up to 30 percent less if he or she practices in a rural area) for the hour or more needed to evaluate her chronic problems and new concerns. That physician's overhead for the visit will be about \$125, based on conservatively estimated practice costs of \$300,000 per physician working 2,400 hour per year." Ness, A Multiple Service Rule for E/M Services, Family Practice Management (June 2008), at <http://www.aafp.org/fpm/20080600/9amul.html> (for subscribers).

patients to present at the office, a barrier to optimal patient engagement were other forms of clinical interaction recognized. Moreover, the rules regarding how the visit unfolds also further distance the physician from the patient in terms of their collaborating in the delivery of care and its documentation.

### § 2:10 Within the physician practice—Diagnostic testing

In 1999, after the relative scandal of independent physiology laboratories' (IPLs') lack of quality controls in the performance of diagnostic services, CMS issued rules for independent diagnostic testing facilities (IDTFs) to replace IPLs and articulated new supervision requirements.<sup>1</sup> In an effort to regulate the levels of supervision which would pertain to various types of diagnostic services, they published nine levels of supervision in final regulation. Three months later, those regulations were withdrawn. It took CMS another two years to issue new supervision rules for more than 750 CPT codes specifying degrees of supervision—whether there need not be a physician on premises (general), whether there had to be a physician in the office suite (direct), or the physician had to be in the room with the patient when the study was performed (personal).<sup>2</sup> Although they had confirmed in writing that the level of supervision that would pertain, even for services billed incident-to, was the level in the supervision Transmittal,<sup>3</sup> by 2007, in the Stark regulations, they took the position that diagnostic testing can *never* be billed “incident-to.”<sup>4</sup>

Nothing in the statutory authority for these services had

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#### [Section 2:10]

<sup>1</sup>64 Fed. Reg. 59415 (Nov. 2, 1999).

<sup>2</sup>Medicare Transmittal B-01-28 (April 19, 2001); [http://www.cms.hhs.gov/manuals/pm\\_trans/B0128.pdf](http://www.cms.hhs.gov/manuals/pm_trans/B0128.pdf).

<sup>3</sup>Personal communication from Robert Ulikowski, CMS, June 4, 2002, confirming personal communication from Terrence Kay, Director Division of Practitioner and Ambulatory Care, CMS, May 29, 2002.

<sup>4</sup>72 Fed. Reg. 51016 (Sept. 5, 2007) CMS stated that this prohibition had been made clear in the 2003 Medicare Fee Schedule that only services without their “own benefit” could be billed incident-to. So diagnostic testing no longer could be incident-to since it has its own benefit in 1861(s) of the Social Security Act. Mind you, not a word in the statute regarding

changed during this time. This instability in the rules of the game requires physicians to gear up for new administrative mandates only to have them change again. How can they standardize care delivery processes when the basic rules keep changing regarding how much supervision, by whom, and when pertains to billable services?<sup>5</sup>

Even less understandable, however, is the policy behind the directions to complete the claim forms for the diagnostic services. Traditionally, in a group practice, where all the physicians are in the group, they own the equipment and they employ the technicians, then they bill Medicare a global

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these matters had changed since Medicare was enacted. The proclaimed clarity of their position is dubious at best inasmuch as when challenged specifically to list which services, such as PT, they believed both had their own benefit and could be billed incident-to anyway, they advised the inquirer to “read the statute.” (Personal communication, Dorothy Shannon, June 22, 2004.)

<sup>5</sup>One of the worst examples of this regulatory whipsaw effect occurred in the 2009 MPFS where, in the Federal Register, CMS directly rejected an assertion regarding the requirement for anyone, including a physician practice, to enroll as a mobile IDTF if they lease equipment and personnel who render the services.

*Comment:* One commenter urges CMS to exclude from the definition of entities furnishing mobile diagnostic testing services those entities that do the following: lease equipment and provide technicians who conduct diagnostic tests in the office of the billing physician or physician organization; and furnish testing under the supervision of a physician who shares an office with the billing physician or physician organization.

*Response:* We disagree with the commenter. We maintain that a mobile entity providing diagnostic testing services must enroll for any diagnostic imaging services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location so that CMS knows which entity is providing these diagnostic testing services. (72 Fed. Reg. 69764, Nov 19, 2008)

Less than a month later they published the following directly contradictory colloquy on their Web site.

*Feedback:* My company leases/contracts diagnostic testing equipment and/or non-physician personnel described in 42 C.F.R. 410.33 to an enrolled Medicare provider/supplier (e.g., medical group practice). Do I need to enroll as an Independent Diagnostic Testing Facility (IDTF)?

*Answer:* Companies that lease or contract with a Medicare enrolled provider or supplier to provide . . . c) diagnostic testing equipment and non-physician personnel described in 42 C.F.R. 410.33(c) are not required to enroll as an IDTF. Medicare continues to evaluate arrangements where both diagnostic testing equipment and non-physician personnel are contracted to a Medicare enrolled provider or supplier and where the Medicare enrolled provider or supplier is billing for the diagnostic service. (ID 9511, 12/15/2008).

This approach to regulations is confusing, unmanageable, and just sloppy.

fee under the number of the treating physician. By the late 1990s, CMS parsed and sliced the delivery of the service to be reported on the 1500 claim form. Today, CMS requires that the physician who ordered the study must be identified on the claim. In addition, the form must identify the physician who supervised the study on the day the technical component was performed. This is separate still from the additional requirement to identify the physician who interpreted the study, even if all of them are in the same group practice!<sup>6</sup> Moreover, if the interpretation takes place on a different day from the technical component, two separate claims must be submitted, even when the services are performed by the same group or the same physician.<sup>7</sup> Someone has to keep records on all of this, stealing staff time and resources from clinically relevant services to patients.

Confounding the diagnostic testing rules are the new antimarkup prohibitions. These rules turn on whether the physician supervising the test or performing the interpretation spends 75% of his or her time with the group.<sup>8</sup> However, since the rules do not affect whether services may be covered<sup>9</sup> but only the amount the physician may charge, they will not be discussed further here. The rules do, though, significantly complicate clinical collaborations among physicians.

### **§ 2:11 Within the physician practice—Stark effects in general**

The Stark statute, originally focused on clinical laboratory services, was aimed at forestalling overutilization of “designated health services.” The fundamental concern of Rep. Pete Stark in the early 1990s was that physicians referred Medicare patients too often to certain types of

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<sup>6</sup>In particular, the instructions for completing items 17 and 24j demonstrate this approach. *See* Medicare Claims Processing Manual Chapter 26 § 10.4 for all of the various physician numbers requirements.

<sup>7</sup>Medicare Benefit Policy Manual Chapter 15 § 20.

<sup>8</sup>42 C.F.R. § 414.50.

<sup>9</sup>The Stark statute completely thwarts clinical collaboration around its designated health services diagnostic testing and is discussed further in the chapter.

providers with which they had a financial relationship.<sup>1</sup> His law was intended to blunt the conflict of interest. His anxieties, though, should have been aimed at three specific questions: (1) are we paying too much for this service because of the profit incentive in one supplier sharing profits with another?; (2) is the quality of the service appropriate?; (3) does this patient need this service for his condition? All of them are appropriate, legitimate policy issues. Unfortunately, the convoluted, disorganized piece of legislation which emerged substitutes abstruse, mysterious, and increasingly complex legal and organizational analyses for matters better addressed in a fee schedule, conditions of participation, and clinical practice guidelines. There is no question that there are enormous problems of overuse in Medicare. However, as we shall see, this law is completely ineffective in confronting them in any meaningful way. It is very effective at siphoning management time into compliance activities that serve no useful purpose, although they do thwart unfettered physician entrepreneurship, in some measure.

The drafters of the statute were not unduly burdened by any knowledge of Medicare reimbursement rules. They targeted a hit list of “designated health services,” leaving other similar services unaffected. For example, echocardiograms fall under Stark. EKGs do not. Radiation therapy is a Stark service; dialysis and lithotripsy are not. There are many more such contrasts.

They used well-defined terms—“incident-to,” “personal supervision,” and “direct supervision”—interchangeably, and then combined them with “member of the group” and “physician in the group” distinguishing further bona fide physician employment relationships from physician personal services relationships. They defined “designated health services” to include inpatient hospital services. Then, in a triumph of illogic, they defined a referral implicated by the statute as “a request for a service, item or good payable under Part B,”<sup>2</sup> when inpatient hospital services are only paid under Part A.

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**[Section 2:11]**

<sup>1</sup>See Gosfield, *Medicare and Medicaid Fraud and Abuse*, pp. 258–63 (2008 ed.).

<sup>2</sup>42 U.S.C.A. § 1395nn(h)(5).

The drafters were aware of the then-current “new-new thing” of groups without walls, which they apparently deemed yet another perverse attempt to bilk the Medicare program. So, they defined the qualifying characteristics of a group practice, and then, for the first time in Medicare’s history, reached directly into the personal pocketbooks of the physician group members by defining the permissible boundaries of compensation for the delivery of designated health services, within the confines of their own private practices.

The complexity of the regulatory scheme, which first was nonexistent and since has morphed into something approaching the Tax Code, is hard to believe and worse to apply, even in a regulatory world which includes the privacy and security regulations under HIPAA and the Anti-Kickback Statute and safe harbor regulations—none of them models of brevity or clarity. The full Stark statute was enacted in 1995 but there was not a word of regulation to interpret it until 2001, announced at the time as only Phase I.<sup>3</sup> That issuance didn’t even interpret all of the statute, leaving the industry waiting until 2004 and Phase II.<sup>4</sup> The Medicare Fee Schedule tinkered with small portions of the rules until September 2007 when Phase III was published.<sup>5</sup> Shortly thereafter, (at least in Stark historical terms), in both the Inpatient Prospective Payment System rules,<sup>6</sup> revisions of positions originally taken in Phase I were announced.<sup>7</sup> When they published the 2009 Medicare Physician Fee Schedule, instead of actually promulgating Stark exceptions for gainsharing (“shared savings programs”), which can reduce services to patients, or for payment for quality performance (“incentive payments”), they asked for comments on 55 separate questions admitting they are not familiar with quality measurement science or techniques.

In issuing regulations, the drafters are admittedly hampered by squeaky wheel problems—they can only respond to comments they get from the field, so that their view

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<sup>3</sup>66 Fed. Reg. 855 et seq. (Jan. 4, 2001).

<sup>4</sup>69 Fed. Reg. 16053 et seq. (Mar. 26, 2004).

<sup>5</sup>72 Fed. Reg. 51011 et seq. (Sept. 5, 2007).

<sup>6</sup>73 Fed. Reg. 48433 (Aug. 19, 2008), beginning at 48658 et seq.

<sup>7</sup>The change in the indirect compensation rules to no longer apply to “under arrangement” transactions was the most significant.

of health care is colored by that limited and skewed input. Even so, the rules are simply out of control. They manifest ever accreting layers of refinement and revision to address some perceived terrible ill which is actually a relatively small bore problem. For example, because urology-related concerns constituted the bulk of the comments on the IPPS provisions, the new interpretations are focused on how hospitals relate to physician-owned lithotripters, how urologists are incorporating IMRT into their practices, and the explosion of pathology-urology relationships as urologists become one-stop shopping centers for urological care. Somehow, this concentration of single-focused clinical care is perceived exclusively as a moneymaking proposition, which it undoubtedly is; but it also is a form of clinical collaboration under a single corporate umbrella. The same principle is applauded as an integrated delivery system in other contexts, far better able to deliver standardized, evidence-based, efficient, patient-centered care.<sup>8</sup> Here, it is decried as an improper inducement to use services and pay for referrals.

Compliance with this law now absorbs significant energy in ridiculous calculations and recordkeeping including for hospitals to avoid providing anything of value to their individual medical staff members of more than \$355 a year.<sup>9</sup> Additionally, physician groups must devise compensation formulas that isolate Medicare revenues from other payment. They must allocate their profits differently from their productivity bonuses,<sup>10</sup> making sure not to allocate to a physician any technical component revenues from those diagnostic services which are “designated,” even while they treat non-Medicare and nondesignated services entirely differently.

There are now 32 exceptions to the general Stark prohibitions, and all come with definitions, conditions, and qualifications. Rep. Stark himself has stated he regrets that

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<sup>8</sup>See Crosson, Weiland and Berenson, n. 28 and Cortese and Smoldt, Taking Steps Toward Integration, *Health Affairs* (Jan./Feb. 2007) w68–w71.

<sup>9</sup>The regulation says the limit is \$300 but there is a cost of living escalator so the amount goes up each year. 42 C.F.R. § 411.357(k).

<sup>10</sup>42 C.F.R. § 411.352(i).

the law was enacted.<sup>11</sup> The artificial organization of funds flow, required documentation of relationships, substantiation of fair market value, drafting of agreements, and reporting of misadventures has created its own industry of Stark compliance. None of it enhances quality of care in any way. All of it steals productive time from whomever is involved in compliance. It has given some lawyers the focus of their entire careers. Turning back to the specific ways, though, in which Stark impedes quality, the primary hindrances lie in impermissible clinical collaborations.

### § 2:12 Within the physician practice—Stark in-office services

Because the statute reaches directly into the boundaries of private practice, Stark defines the specifications for who may perform a service, where it may be performed, and how it may be billed, all in an effort to control utilization of designated health services. The first exception for permissible referrals is to a physician “in the practice,” which is not the same as being a “member” of a practice. Members of a practice are only shareholders, partners, or bona fide employees, including part-time employees. The statute sets forth that to meet the definition of a group, 75% of the services of the group must be rendered by members.<sup>1</sup> The regulators responded to comments on Phase I and determined that the drafters meant to differentiate between “members” of the group and physicians “in the group.” Therefore, only members count in the calculation of the 75% of service, so independent contractor physicians do not count there. They do count among physicians “in the group.”

This change was a liberalization in the idiotic proposed Phase I regulations, which not only required counting independent contractors in the group practice calculation, but also said that those nonmembers could not supervise ancillary personnel. Independent contractors are now a physician

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<sup>11</sup>Whelan, *Stark Regrets: I Shouldn't Have Written That Law*, The Science Business, Forbes.com, at <http://blogs.forbes.com/sciencebizblog/2007/11/stark-regrets-i.html>.

#### [Section 2:12]

<sup>1</sup>42 U.S.C.A. § 1395nn(h)(4)(A)(v).

“in the group.” However, such a physician only qualifies as such when he is on the premises of the group.<sup>2</sup>

*Physician in the group* means a member of the group as well as an independent contractor physician during the time the independent contractor is furnishing patient care services (as defined in this section) for the group practice under a contractual arrangement directly with the group practice to provide services to the group practice’s patients *in the group practice’s facilities*.<sup>3</sup>

It would be clear, then, that an independent contractor physician could not be referred to by any of the group’s physicians for designated health services billed by the group, if he renders those services at the hospital. Not so fast, though. In a bizarre feat of regulatory legerdemain, the regulators say that it is the definition of “entity” that trumps the definition of “in the group.” Because Stark only applies to a physician referral “to an entity” with which the physician has a financial relationship, does Stark even matter here? Apparently, not always. “For purposes of this subpart, ‘entity’ does not include a physician’s practice when it bills Medicare for a diagnostic test in accordance with § 414.50 of this chapter.”<sup>4</sup> So for diagnostic tests, the definition of “in the group” does not fully pertain. If, however, an independent contractor physiatrist goes to the hospital and performs a physical therapy evaluation (97001) on the group’s patient, or an independent contract or radiation therapist goes to a local cancer center to perform radiation therapy planning (77261) for the patients of the hematology-oncology group for which he works three days a week, neither group can bill these services. These razor-thin differentiations serve no quality purpose whatsoever and simply thwart professional clinical collaborations among physicians.

In a truly mystifying fix to a problem which is difficult to perceive, in the Phase III regulations, the rules went one step further. The independent contractor may not be leased from another entity. There must be a direct one-on-one relationship between him and the billing group.

In order to fit within the definition of “physician in the group

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<sup>2</sup>42 C.F.R. § 411.351 (72 Fed. Reg. 51082, Sept. 5, 2007).

<sup>3</sup>(Emphasis added, 72 Fed. Reg. 51082, Sept. 5, 2007).

<sup>4</sup>42 C.F.R. § 411.351 (“entity” definition at (3)).

practice,” an independent contractor must have “a contractual arrangement with the group practice.” We interpret this to require that the contractual arrangement be directly between the group practice and the independent contractor physician and not between the group practice and another entity, such as a staffing company . . .

Group practices receive favorable treatment under the physician self-referral law with respect to physician compensation. Accordingly, we believe that, in order to qualify as a group practice and receive such favorable treatment, the group practice’s physicians must have a strong and meaningful nexus to the group practice. An independent contractor in direct contractual privity with a group practice has such a nexus; employees leased from other entities do not.”<sup>5</sup>

This is a sweeping and patently absurd proposition. It has the effect of either preventing one physician group from collaborating with another by leasing one of its employees part-time to their neighbor or requiring that all three parties (the billing group, the leasing group, and the leased physician) sign the contract to create the requisite privity. A triumph of form over substance! There is no statement in the regulations as to how the money must flow, merely that there be privity of contract between the individual physician and the billing group.

So far, we have only navigated the shoals of which physician may be referred to. Then we have the issue of whether the services meet the definition of “in office ancillary services”—the second major exception in the statute. This rule turns on who does the service, where it is rendered, and how it is billed.

With respect to who renders the in-office service, the statutory language itself was a travesty, requiring that the person performing the service (e.g., diagnostic studies, physical therapy, occupational therapy, radiation therapy, etc) had to be the referring physician himself, another member of the group, or someone “directly supervised” by a physician in the group.<sup>6</sup> That term had 30 years of specific meaning in Medicare to require a physician within the office suite. From the inception of the Medicare program, though, skeletal films and abdominal films without the use of contrast media did not require physician in-office presence. Based on comments,

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<sup>5</sup>72 Fed. Reg. 51018 (Sept. 5, 2007).

<sup>6</sup>42 U.S.C.A. § 1395nn(b)(1).

the regulators finally did take the position that the level of supervision would be that level otherwise required in Medicare<sup>7</sup> which, as we have seen in the discussion of diagnostic testing generally, is still hardly a compliance romp in the park.

There are two options regarding where the service may be provided: (1) if the group has 24/7 control of the facilities, they may be centralized and independent of any other offices of the group; so a group may have a standalone laboratory or a standalone physical therapy or infusion center. If the facilities don't meet those standards, then (2) the designated services must be colocated with offices of the group where they perform nondesignated health services. If two groups want to share facilities, life becomes more complicated. If they are all in the same building and they all own the equipment together, they can share the equipment as needed (more or less by the entiresities) and bill separately with no difficulty.<sup>8</sup> However, if a group of radiologists or neurologists has equipment like MRI, CT, or PET, with unused capacity, other physicians—such as orthopedists or cardiologists—may not lease that equipment from them, even on a fixed block-time basis, for a fixed fair market value rate, unless the billing group has colocated offices where they actually see patients and render nondesignated health services between eight and 35 hours a week.<sup>9</sup>

This bright line was adopted to address complaints associated with an earlier iteration that required that the group render “substantially the full range” of its services at the shared location. Clinical collaboration which could potentially save money, by giving the tenant physicians access to equipment on a part-time basis (which they would not then be tempted to buy themselves), is seen as an improper opportunity to increase the volume of services billed. These structural, legal, and organizational minutiae underscore the very fallacy of the Stark statute—that any of these spec-

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<sup>7</sup>42 C.F.R. § 411.355(b)(1)(iii).

<sup>8</sup>42 C.F.R. § 411.355(b)(2)(i) and 66 Fed. Reg. 888 (Jan. 4, 2001).

<sup>9</sup>42 C.F.R. § 411.355(b)(2)(A) to (C) The antimarkup rules are even more restrictive, requiring that the services be colocated with offices where the ordering physician himself provides substantially the full range of services he provides, unless the supervising and interpreting physician spend 75% of their clinical time with the billing group. 42 C.F.R. § 414.50(a)(2)(ii).

ifications even work toward their intended control purposes. If these rules were effective, imaging expenses in Medicare would not be escalating as they are.<sup>10</sup> The rules don't even work to accomplish their goals.

Their preposterousness is further seen in the exclusion of most durable medical equipment (DME) from in-office ancillary services. Physicians are permitted to obtain numbers as Medicare DME suppliers. However, they may not use those numbers to provide DME to their own Medicare patients. Despite the statutory exclusion of DME from in-office ancillary services, the regulators have opened the door to permitting physicians to provide canes, walkers, and crutches to ambulate from the office;<sup>11</sup> so the patient who has been in a car accident and is found to have broken her ankle may be casted in the office and given a cane. However, if she has whiplash, the physician may not bill for the collar or brace because she does not need it to ambulate. Wheelchairs, even if needed to ambulate, may not be billed by the physician as Medicare DME. How is this convenient, patient-centric care for older people who have been injured? The maniacal focus on the financial opportunities that exist in clinical collaboration may be their most absurd in the rules regarding what may go on within group practices. The mania, however, does not stop at the group's doorway.

### § 2:13 Barriers to cross-group clinical collaborations

If clinical collaboration is an important approach to improving quality, then the ability for otherwise independent practitioners to work together, with recognition of the financial value of their interactions, would be important. Here, the Medicare rules, driven by cost-control concerns, thwart legitimate cross-group clinical collaborations.

### § 2:14 Barriers to cross-group clinical collaborations—Cross-specialty collaborations

One of the most significant challenges to clinical collabora-

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<sup>10</sup>GAO Report, "Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices" (June 2008), at <http://www.gao.gov/new.items/d08452.pdf>. Although some might argue things would be even worse without the statute.

<sup>11</sup>42 C.F.R. § 411.355(b)(4).

tion under Medicare rests on the quantification of each service under a fee designated by a CPT code—the essence of fee-for-service medicine. In general, the system takes the position that only one physician can do the work that generates the code. There are some distinctions within groups, so, for example, where a patient has a procedure which falls under the global surgery payment rules for the one code paid to the group, the follow-up visits postoperatively may be performed by anyone else in the group, there is no specific number of required visits, and they are not billed separately as E&M visits because they are all part of the global fee. The problems start where otherwise independent physicians seek to collaborate clinically and be paid for their portion of the service.

The anti-kickback safe harbors have taken on agreements among specialists to cross-refer. There is a safe harbor which excludes from the definition of prohibited remuneration among clinicians an “exchange of value” where one party agrees to refer a patient to the other party for the provision of a specialty service in return for an agreement by the other party to refer the patient back at a mutually agreed upon time.<sup>1</sup> The referral back has to be clinically appropriate; the referral may not be for something within the clinical expertise of the referring clinician; and unless the physicians are in the same group, they may not have any exchange of anything of value and may not share or split a global fee. There is a mechanism for physicians to use modifiers (-54 and -55) which indicate that they are not doing all of the service so that, as the regulators pointed out, an optometrist may refer to an ophthalmologist who agrees to send the patient back for postoperative care.<sup>2</sup> So, in terms of quality impediments, the safe harbor really addresses the financial relationships among the parties and requires that they bill separately, identifying the separate scope of work they have performed. While this mechanism is cumbersome, it is available. The same cannot be said when new technologies begin to disseminate across specialties.

The classic example of this dilemma is the move by

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**[Section 2:14]**

<sup>1</sup>42 C.F.R. § 1001.952(s).

<sup>2</sup>64 Fed. Reg. 63548 (Nov. 19, 1999).

cardiologists into cardiac tomographic angiography (CTA).<sup>3</sup> Today, cardiologists are trained to read these studies which formerly were performed only by radiologists. When the cardiologists do the interpretations, they often seek to obtain the participation of radiologists in the rendering of the services. The CPT code that is available requires a full review of the chest organs. Often, the cardiologists are most comfortable reviewing the coronary vessels and don't want to have liability exposure for missing something in the full chest. Although one might argue that if they can't do what the CPT code requires they shouldn't render the service, one might also argue that the service the cardiologist is performing does not have a code available and the codes have not kept up with the times. Regardless of whether they ought to be rendering services which don't conform with the full description of the code, the cardiologists may not, under Medicare rules of reassignment, purchase a portion of a professional component from the radiologists because they see the patient and order the study. Radiologists, on the other hand, could purchase the cardiac portion of the study from the cardiologists under the reassignment rule that permits an imaging center to purchase professional components.<sup>4</sup> This policy asymmetry has no clinical basis. While there is controversy over whether these studies should remain exclusively within the purview of radiologists, or whether cardiologists should perform studies that do not meet traditional descriptions and whether either position is actually supportive of quality, the point is that cross-group collaborations are made difficult by Medicare because of the anxieties about paying for referrals in the guise of fee-splitting.

As a result of the traditional Medicare emphasis on one fee for one service and no modifier available to describe what is happening, the ability for physicians to collaborate in service delivery is impeded. A far more obviously problematic context is not high technology imaging, but interdisciplinary

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<sup>3</sup>See, Gosfield, White Paper: Fraud and Abuse Issues in Billing 'Split Interpretations' Of CCT and CTA for the American College of Radiology (Aug. 23, 2006), at <http://www.gosfield.com/secure/pdf/ACR.White%20Paper.Final.082206.pdf>.

<sup>4</sup>Medicare Claims Processing Manual Pub. 100-104, Chapter 1 § 302.9.1. This section, however, may change in light of the anti-markup rules.

centers of excellence. For example, where breast centers bring together surgeons, radiologists, oncologists, physiatrists, nurse educators, and others, they cannot sit in team visits with the patient together and bill for that service unless each one fully performs and documents the entire scope of the visit. Then the issue becomes whether it is medically necessary for each of the full visits by each of the physicians. Still further, there is no way to share any of the fees among the collaborating physicians because the arrangement would not pass muster under the safe harbor for cross-specialty referrals. While there are CPT codes (99366–99368) for medical team conferences, with or without the patient and/or family members, Medicare explicitly will not pay separately for them, insisting they are already paid for.<sup>5</sup> This cannot be true since the CPT codes themselves acknowledge the time commitment to perform these specific, separate team services by requiring at least 30 minutes of time in interdisciplinary interaction for the code to be billed. Similar problems arise in cancer centers, spine centers, and many of the clinical contexts in which multidisciplinary skills can be marshaled to best serve the patient’s needs.

**§ 2:15 Barriers to cross-group clinical collaborations—Hospitalist/observation/community interactions**

Another recently created point of tension in the delivery system which Medicare just exacerbates comes in the interrelationships between community-based physicians and hospitalists and house physicians. Hospitalists are physicians who may work in independent groups or be employed by the hospital, but they work only in the hospital. Their patients are mostly referred by primary care physicians who no longer attend in the facility in the traditional sense. The rise of hospitalists has been cited as stemming from hospital desires to control costs by managing length of stay more effectively. Some believe that hospitalists do that better than physicians whose attention is diffused among practice venues. Where the hospital employs the hospitalists, their work generates another revenue stream for the facility. For

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<sup>5</sup>Medicare Claims Processing Manual, Chapter 15 § 30.6.16 “Payment for these is included in the payment for the services to which they relate.”

primary care physicians, the shift to a hospitalist model initially can be threatening because they give up income that comes from the inpatient visits, but the primary care physicians also often end up saving time and focusing on their principal activity which is outpatient and chronic care.

Studies have shown little difference in the quality of care with a slight decrease in length of stay where patients are treated by hospitalists.<sup>1</sup> Patients sometimes find it disconcerting to go to the hospital with an emergency admission only to be treated by a physician who is a stranger to them.<sup>2</sup> However, primary care physicians have in many instances embraced the phenomenon. Medicare pays for inpatient services by those who are dedicated to this work precisely the same way they do for those who otherwise see patients in their offices. While the handoffs from the community physician to the hospitalist and back again can raise some continuity of care issues, this is not where Medicare policies impede quality.

The more difficult issues lie in the changed role of “house physicians.” In community hospitals without residency programs, these physicians were typically moonlighting residents or employed physicians who were available at night to receive patients into the facility, get them stabilized and situated, and never bill for their services. They performed the functions that residents on-call do for teaching institutions. With the advent of hospitals billing for all the services they can, in more and more instances, hospitals or hospitalist groups have sought to bill for these formerly pro bono services, frequently provided in the middle of the night. If the house physicians bill for that admission, though, then the community physician cannot. This has increasingly led to tensions. The quality issue, however, lies in the implications for continuity of care in the hand-offs among the physicians.

There is no code in the Medicare Physician Fee Schedule

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**[Section 2:15]**

<sup>1</sup>Lindenauer, et al., Outcomes of Care by Hospitalists, General Internists, and Family Physicians, 357 NEJM 2589 (Dec. 20, 2007).

<sup>2</sup>Baker, The Hospitalist Is In, The Washington Post, Sept. 11, 2007, p. HE01, at <http://www.washingtonpost.com/wp-dyn/content/article/2007/09/10/AR2007091001113.html>.

which recognizes this limited “tuck in” service. Some house physician programs have billed consultations—which is usually wrong because Medicare policy requires a specific request from the referring physician and a written report back to that physician.<sup>3</sup> Patients admitted as an emergency often do not meet these criteria. If the house physician actually admits the patient, then the community physician who comes over the next morning to do the admission visit cannot bill for that visit, but only for a subsequent hospital visit, when the service he is rendering is more likely the full visit, taking into account the patient’s recent medical history and establishing the plan for the stay. Medicare considers only one physician to be the admitting physician to bill for initial hospital care codes; so any physician seeking to bill for this “tuck in” service has only the other option of the subsequent hospital visit.<sup>4</sup> However, if there is no formal admission yet, which the community physician will provide, to what is the house physician visit “subsequent”? Now we are into metaphysics, yet again. Medicare will not pay for two evaluation and management services on the same day unless the physicians are following two different clinical problems.<sup>5</sup> If the house physician does not formally “admit” the patient, then what is the status of the patient for reimbursement?

The Medicare program offers another option in the form of observation care codes. These codes are available to be billed when the patient is in limbo in terms of inpatient or outpatient status but is under evaluation as to whether he should be admitted. The patient is supposed to be under observation for less than 24 hours. To bill these codes, there must be a medical observation record for the patient, containing dated and timed physician orders regarding the care the patient receives from the physician attending the patient throughout the time the patient is in observation status, not a mere “tuck in” service. This permits the hospital to be paid for the facility resources. If the patient is then admitted as an inpatient, no observation care will be paid.<sup>6</sup>

The real point is that Medicare reimbursement policy does

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<sup>3</sup>Medicare Claims Processing Manual, Ch. 12 § 30.6.10(A).

<sup>4</sup>Medicare Claims Processing Manual, Ch. 12, § 30.6.9.1(G).

<sup>5</sup>Medicare Claims Processing Manual, Ch. 12 § 30.6.7(B).

<sup>6</sup>Medicare Claims Processing Manual Ch. 12 § 30.6.8(D).

not recognize the reality of medical practice in the 21<sup>st</sup> century. If it is medically appropriate for a physician to perform a limited, stabilizing visit for the patient as a quality safeguard, then there ought to be legitimate financial recognition of that service. If the community physician who has the full knowledge of the patient's medical history and needs is going to perform the admission visit, then he ought not have to repeat things the house physician has done in order to be paid. Medicare policy either forces artificial relationships to meet these rules,<sup>7</sup> denies payment for legitimate and valid services, or creates a disincentive for patients to receive the full panoply of services they clinically need. Physicians have to waste time doing repetitive work to get any economic value for these partial albeit very common visits by both types of physicians. This specific problem may be seen as too many pigs trying to feed from the same trough at the same time. However, payment drives behavior. The quality nexus is in the speed and thoroughness with which the patient is treated on the initial visit and how that is accommodated in the Medicare system.

Medicare payment policies steal time from the doctor-patient relationship, ignore team approaches to care, hinder clinical collaboration, barely recognize the value of patient engagement and impose daunting administrative burdens on physicians who would seek to deliver stellar care. The specific challenges noted here are merely highlights of a vast array of similar minute, time-stealing, burdensome hoops of fire through which Medicare fee-for-service physicians must hurl themselves on a daily basis. Every single specialty can cite other specific rules that make as little sense in an environment where quality lags. The absurdity of these dysfunctional policies can be appreciated even more when contrasted with a new payment reform model currently being tested in pilot sites in the private sector.

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<sup>7</sup>The community physician might pay some fair market value for the partial services of the house physician and then gross up what they both do. This is ridiculous.

**§ 2:16 The PROMETHEUS Payment® model<sup>1</sup>**

The PROMETHEUS Payment® model is a provider payment mechanism designed to counter the ill effects of fee-for-service, which rewards overuse by paying more with each service rendered to a patient even as the system generally fails to pay for valuable things that do not have CPT codes, such as teamwork, patient lifestyle improvement, and innovative communication techniques that improve patient engagement. The acronymic name articulates the values which are its underpinnings: **P**rovider payment **R**eform for **O**utcomes **M**argins **E**vidence **T**ransparency **H**assle-reduction **E**xcellence **U**nderstandability and **S**ustainability. The key difference between the model and fee for service payment, like Medicare, is that the PROMETHEUS Payment® model establishes a budget (Evidence-informed Case Rate® or ECR®) for all providers treating a patient for a clinical condition over a year or until the treatment ends. The budget is based on the cost of best care defined by risk-adjusted evidence-based guidelines. The amount paid to any provider turns on scores for outcomes, processes, and patient experience of care. Because 70% of the score reflects what that provider does, but 30% depends on what all the providers do, there is a real incentive for providers—physicians, hospitals, laboratories, everyone who treats the patient for that condition—to collaborate clinically.

**§ 2:17 The PROMETHEUS Payment® model—How the payment works**

The ECR® starts with a calculated cost of the services necessary to deliver basic care without complications to a patient with a condition as set forth in national, well-accepted clinical practice guidelines. Because the initial modeling of the rates was based on data in a very large national claims database from 2005–2006, the program had to come up with a way to establish a budget that would ac-

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**[Section 2:16]**

<sup>1</sup><http://www.prometheuspayout.org>. The author is the founding chairman of the board of PROMETHEUS Payment® Inc., the tax-exempt not-for-profit organization which stewards the development and implementation of the program. She has been a member of the design team since the inception of the working group which created the model.

commodate comorbidities, and therefore severity.<sup>1</sup> By isolating from the basic claims data, amounts associated with potentially avoidable complications (PACs), it became possible to determine a base rate, which could then be further adjusted as the complexity of the patient's clinical needs exacerbated. By beginning with guidelines, getting input from physicians as to the relevant services required to deliver those guidelines, and adding back additional dollars where the claims data demonstrated the physicians in the database had underserved their patients by comparison with what the guidelines called for, a rate could be constructed.

Most significantly, though, the amount of money which was found in the PAC pools was very high. For diabetes, for example, there was \$680 million which were paid for admissions for diabetes, strokes from diabetes, amputations, eye procedures, and the like—all deemed potentially avoidable (as opposed to “never events”). The PROMETHEUS model took half the money spent on potentially avoidable complications and distributed it in the ECR® budget to pay providers. For a non-insulin dependent, controlled diabetic in the database used for modeling, a primary care physician would be paid about \$311 for a year of care. Under the PROMETHEUS model, that same physician would be paid for the same period of time, for the same patient, \$2,329!!<sup>2</sup> This creates an enormously powerful incentive to avoid the complications in the first place and gives to providers money never before available in the system to pay for whatever techniques—more nurses, technology, better educational techniques, early interventions—will produce better care for

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**[Section 2:17]**

<sup>1</sup>For a description of how the modeling was done, *see* Gosfield, “Making PROMETHEUS Payment Rates Real: Ya’ Gotta’ Start Somewhere” (June 2008), at <http://www.prometheuspayment.org/publications/pdf/MakingItReal-Final.pdf>.

<sup>2</sup>As implemented, these numbers will vary regionally because complication rates vary across the country. Still further, the dramatic difference in payment is not quite as extreme on surgical services because doctors and physicians are already paid on case rates, it is just that they are disaggregated. On medical hospitalizations, like for acute myocardial infarction, similar significant changes can be seen. Hospitals also are paid more for their good care under the PROMETHEUS® model, but likely will see a decrease in admissions for complications which are, in fact, avoided. That is the point of what better care means, though.

patients and better scores for themselves. This approach also saves the system the other half of the money, in this example \$340 million, for one diagnosis in one claims database.

The starter conditions being piloted by the PROMETHEUS Payment® program include outpatient chronic conditions—diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease, hypertension, and coronary artery disease as well as inpatient medical treatment—acute myocardial infarction and inpatient procedures—hip and knee replacements, CABGs, bariatric surgery, cardiac catheterizations, and hernia repairs.

Providers come forward in whatever combinations they choose, or none—and contract to deliver that portion of the care that is within their licensure and expertise. There is no preference for any organizational model. The program is available to large integrated delivery systems, hospitals which employ some physicians, independent physicians in large groups and small, PHOs, and IPAs. The providers themselves determine in what configurations they will deliver care, and at what locus of delivery they will be scored. No provider holds the money of any other provider unless they choose to be paid together. The budget covers all the care by all providers for that condition; so, if a patient is treated for diabetes and over a year receives services from a primary care physician, an endocrinologist, a retina specialist, an independent clinical laboratory, a pharmacy, and is admitted to the hospital to restabilize after a transient ischemic attack which led her to neglect to take her insulin for several days, all of that care would come under one ECR® for diabetes.

During the year, the providers are paid on the same basis they currently are, fee for service for physicians, DRG payments typically for hospitals, as services are rendered. At the end of the year or the expiration of the case rate, a reconciliation is performed of the services provided within the budgeted ECR® and the provider's negotiated rate. Amounts remaining in the ECR® budget are paid out to the providers.

The payment of the amounts remaining in the budget turns on the application of the scorecard, which takes into account clinical measures of quality process, established

measures of outcomes, and patient experience of care. Seventy percent of a provider's score turns on what that provider does and 30% of the score turns on what every other provider treating the patient for that condition does. This creates a very explicit incentive to clinical collaboration.

**§ 2:18 The PROMETHEUS Payment® model—How the model enhances quality in contrast with Medicare**

Because of the effect of the science-based case rates, it is completely irrelevant to the payment model as to the level of visit that has been provided and when, which type of clinician rendered the care as long as they are licensed to do so, the documentation of the medical necessity of the service, the employment relationship of the personnel, who is on premises when the services were provided, or any of the incident-to, reassignment, E&M bullet point documentation, or supervision issues Medicare imposes. None of these need be provided or documented. This difference cannot help but save physicians time they are currently spending on needless administrative nonsense. They don't have to get prior authorizations for admissions or lengths of stay.

Physicians don't have to worry about postpayment auditors. They don't have to spend time either getting plan authorization for their services or authorizing services for which others will be paid, like durable medical equipment and ambulance suppliers.

The payment based on guidelines establishes the necessity of the services and the scorecard measures the results of the services. If those who voluntarily participate end up skimping on care, their scores will fall. If they overutilize, it will be financially disadvantageous to them. The mechanism is self-regulating and those who do not respond to its incentives will lose the ability to contract to be paid this way because plans won't tolerate their behavior. The plans have the same incentives as the providers; to deliver optimal care, as resourcefully as possible, to get good outcomes.

The model focuses on what science says should be provided to a patient for a condition and then makes money available to deliver that care. The scorecard measures whether the patient fared well from the services provided. If providers can produce proper quality scores within the budgets,

organizing their process delivery in any way they want, the payment model is completely agnostic to their approach. This means that using teamwork, deploying each clinician—whether physician, nurse, technician, physician assistant, or physical therapist, for example—at his or her highest and best use for the patient becomes possible. It also means that because the patient’s experience of the care is explicitly accounted for in the scores, good patient engagement will score well and will enhance compliance with science, by whatever techniques that might occur. Additionally, with the additional money paid to providers from the PAC pools, to avoid potentially avoidable complications paid for every day in the American health care system, there is funding to do new and innovative things to enhance the patient’s care.

The PROMETHEUS Payment® model scorecard gives physicians a strong incentive to collaborate clinically. Determining the optimal moment for referral to a specialist will contribute to provider success under the program. Taking referrals from primary care physicians who are providing science-based care will enhance the specialists’ scores. Communication among them will improve patient outcomes along with financial results. Admitting patients to hospitals which are working on the same ECR®s can only make life easier for the physicians, with better results for the patients, since *all* the providers treating the patient for the condition budgeted in the ECR® are being paid based on the same clinical practice guidelines. Unlike Medicare, which fragments care into CPT codes with modifiers as with the ophthalmologist-optometrist example and creates tensions between the house physician and the community physician for the tuck in service, none of those problems arises in the PROMETHEUS model because no one is paid for visits. They are paid to deliver a continuum of care which produces good clinical results, by whatever means they accomplish that.

If PROMETHEUS Payment® were to be used in Medicare, the army of audit and fraud enforcers would diminish, and the Stark statute would have no purpose whatsoever. The ECRs based on guidelines are a far better determinant of appropriate outlays for care than the legal, organizational, and structural Jesuitical/Talmudic inquiries driven by Stark. If providers can find a way to make money within the budgets, more power to them! Because there is no incentive in the system to deliver less care to patients, to cherry pick

healthier patients, and certainly none for overuse, the scores will tell the reality of what works.

The PROMETHEUS Payment® model has the potential to save money, by not paying, at a minimum, amounts currently associated with potentially avoidable complications. On the other hand, because it provides the remainder to providers far earlier on the care continuum, at least some of those complications ought to be avoided. Unlike the “never events” policies, though, money is available to pay for complications which do occur because what is potentially avoidable may not be avoided. The model is designed to enhance quality of care taking into account what science says patients need. It does not require any special legal structures, organizational relationships, or exotic contract models.

The complexity of the design is essentially transparent and invisible. In other words, providers need only understand the incentive to collaborate clinically, provide what science requires based on the applicable guideline, and help the patient have a positive experience of care. The plans continue with their current contracts with simple amendments that relieve the providers of unnecessary administrative burdens, like prior authorizations and other medical management programs. The engine which makes the program work, allocates dollars across the providers, and reports the scores to the plans for payments has been created to be as plug-and-play as possible for the plans themselves.

To perform well and score well under the PROMETHEUS Payment® approach, physicians will have to provide good, patient-centric, science-based, effectively resourceful care. The program was designed to make life easier for physicians and other providers who can do that. Whether the positive changes the PROMETHEUS model offers will lure those at the bottom of the quality class to perform better is yet to be told, but physicians and others who can respond to what it offers with better quality care should enjoy a far easier work environment than what Medicare provides.

The PROMETHEUS Payment® model is intended to enhance time and touch between doctor and patient, encourage teamwork and clinical collaboration, foster patient engagement, and explicitly lower administrative burdens. It is designed to be transparent to all—other providers, plans,

purchasers, and patients. Still further, it is not merely an idea whose time has come. It is a reality, launched for pilot testing in January 2009. There will be much to learn from its implementation, but it has to be better than what Medicare offers now.

### § 2:19 Conclusion

The Medicare approach to physician payment is not only one size fits all, it provides no benefit for physicians who perform better than others.<sup>1</sup> Recent initiatives claim to value quality,<sup>2</sup> but the program at its core squanders physician energies on requirements which do nothing to enhance quality or efficiency. While the fundamental problem rests on the perverse incentives of fee-for-service payment, CMS and Congress' concerns that physicians will abuse those incentives dominate payment policy. In today's world, the program simply is not keeping pace with measures now known to enhance quality.

The continuing drain on Medicare dollars from misuse, overuse, and underuse is, without question, a policy concern deserving of appropriate attention. Depletion of program resources from kickbacks is indefensible. However, the blind, sweeping impact of these detailed, complex regulatory laws and policies on all physicians equally is no longer defensible itself. Throughout the entire history of the Medicare program, there has been precious little attention paid to lifting administrative burden for those who can demonstrate

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#### [Section 2:19]

<sup>1</sup>The Physician Quality Reporting Initiative (PQRI) is the beginning of some distinctions, but it is purely about reporting itself and not about actual quality performance.

<sup>2</sup>In late 2008, CMS produced an issues paper in response to the congressional mandate in the Medicare Improvements for Patients and Providers Act at § 135(d) requiring CMS to develop a plan to move to value-based purchasing for physicians with a report due in May 2010. The issues paper does include a chart of Medicare's current efforts at value-based purchasing. USDHHS, "Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physicians and Other Professional Services," at <http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf>.

better quality performance.<sup>3</sup> Those who can perform at superb levels are swimming against the barriers that CMS erects to easy, seamless, team-based, patient-centric care, involving collaboration with other independent clinicians. Although those stellar physicians are doing the right thing against formidable odds, perhaps more physicians would be in a position to do better, if they knew that their quality performance might lead to administrative burden reduction. Those who would be willing to step up and try something new ought to be held accountable in scorecards or other measures of performance, but at least they ought to be given an opportunity to do so. The Medicare program should be more flexible to produce better quality results. Physicians and patients deserve better.

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<sup>3</sup>The new PQRI effort has only added to administrative burden with its requirements of reporting on 153 measures of quality. <http://www.cms.gov/pqri/>.

