LAW & MEDICINE

Concierge Concerns

As the debate about health care reform continues, one concept springing up from the private sector is concierge medicine. It is an innovative "product" created, as author Sandra Carnahan wrote 2 years ago, "to reclaim the heart and soul of medicine." Roberta Greenspan, the president of Specialdocs Consultants Inc., a company that organizes these practices, stated, "Physicians no longer wish to be known as 'service providers' but as physicians once more."

BY MILES J. ZAREMSKI, J.D.

Concierge medicine started a few years back, with about 500 physicians converting to concierge practices; today that number is about 5,000 nationwide. Most concierge practices require patients to pay an annual fee. This fee entitles the patient to receive "24/7" access to his or her physician by cell phone or pager, an annual physical examination, and perhaps other amenities. The fee also enables the provider to limit the number of patients he or she will see, and thus cut down on the enormous amount of paperwork required of a typical practice.

With the smaller practice, a concierge physician will provide as much time as necessary for each patient visit, rather than making sure he or she sees so many patients per hour in order to make ends meet.

Are there legal issues attendant to such practices? Absolutely.

The first question is how these arrangements affect payer-provider relationships. The answer depends on what a particular payer-provider contract covers. For example, does the contract cover an annual physical? If it does, and the physician's annual fee also includes a physical, the physician would be getting paid twice. Also, the premise upon which a concierge practice is based is 24/7 coverage; yet, the typical health care plan ensures that covered services will be made available 24/7. Is the annual fee reflective of this?

Additionally, a typical payer-provider agreement contains a hold-harmless clause. Such clauses generally obligate the provider to look to the managed care organization for payment of services rendered, and not plan enrollees, except for copays or deductibles. States such as Washington (through its insurance commissioner) have cautioned providers that charging mandatory access fees would subject them to legal liability. New York and New Jersey health commissioners have also made it clear that concierge physicians were engaging in impermissible practices, principally because services provided with the access fee were not readily distinguishable from care previously contracted through health plans.

Regardless of what the physician wishes to do, or what states may look at, an insurer that is reluctant to reimburse a concierge provider can always pressure the preferred provider organization or independent practice association to which the physician belongs for payment. There are instances of insurers doing this in places such as Texas, Illinois, and Arizona.

Then there is Medicare. Any concierge practice must ensure that what is being provided to a Medicare patient does not overlap with services deemed covered under the Medicare program, particularly with its recently enacted preventive care benefits. Among these are a one-time physical examination, supplies, self-management training, and diabetes screening. Another slippery slope is how consults are factored into the annual fee versus what is covered by the Medicare contract. Any overlap of services could result in expulsion from the program and having to pay monetary penalties.

On March 31, 2004, the Office of Inspector General issued a Medicare "Fraud Alert" that dealt with concierge practices. Its focus was on liability for billing Medicare patients for services already covered by Medicare, except for deductibles and coinsurance. Rarely do physicians who go into this new type of medical practice drop their Medicare participation; however, if the practice is not charging for Medicare-covered services, then staying in the program would not be problematic.

But to be absolutely certain that no rules are being violated, opting out of the Medicare program is the safest avenue to take—although in that situation, Medicare patients who wish to have the government pay for their services could no longer go to such a physician because they would have to pay an access fee, which may be a violation of Medicare rules depending upon whether any portion of the fee goes toward duplicating coverage already being provided by Medicare. A 2005 Government Accountability Office report indicated, however, that while concierge medicine had grown 10-fold since 2003, the number of concierge physicians was too insignificant, compared with the total number of physicians treating Medicare patients, to present any real worry or concern.

Another area of potential concern is whether concierge medicine is an insurance product that requires registration and insurance reserves. For example, Washington state's insurance commissioner believed that the concierge model in which there was a fixed fee for receipt of services was more akin to transferring risk from a patient to a provider. Regardless of the number of times medical services were rendered, the fee would remain the same—like a third-party payer who accepts a premium for coverage, no matter how many times in a year a patient visits his doctor for that care. Washington has rectified this through legislation.

Additionally, a physician looking to go into concierge medicine should consider whether his practice is sufficiently different from the practice he is leaving such that any restrictive covenant—also called a noncompete clause—he may have signed with his former practice is unenforceable. This has yet to be the subject of any published legal case; I would argue, though, that any such covenant is inapplicable because a concierge practice attracts a type of patient who no longer wishes to be seen by a typical internal medicine practice or family practice.

In the end, concierge medicine is a product of the private sector whose time has come. While it may not reduce overall costs, and may be really only for the well heeled, its creation reflects the notion that patients no longer wish to be treated like a number, and that physicians don't want to be known only as service providers where the measure of success is something other than patient satisfaction. As long as its various models abide by reimbursement guidelines, concierge medicine may be here to stay. ■

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Third Highest Occupational Fraud Rate Afflicts Health Care

BY DOUG BRUNK
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SAN DIEGO — Think your medical practice is immune from employees who commit occupational fraud? Think again.

Of 450 medium- and large-size organizations that participated in KPMG LLP's 2003 United States Fraud Survey, 75% had experienced an incidence of occupational fraud, which the Association of Certified Fraud Examiners (ACFE) defines as "the use of one's occupation for personal enrichment through the deliberate misuse or misapplication of the employing orgajnization's resources or assets."

What's more, the ACFE's 2008 "Report to the Nation on Occupational Fraud and Abuse" estimated that organizations lost 7% of revenues to fraud and abuse, up from 5% in 2006.

The ACFE report also found that the health care industry had the third highest number of frauds reported, at 8%, and businesses with fewer than 100 employees were more susceptible to occupational fraud, compared with larger businesses.

Motivations behind occupational fraud vary widely and include financial pressures, perceived opportunity, and rationalization. Financial pressures include "things like gambling, lack of money to repay debts, drugs, and seeking status beyond your financial means," Frederic R. Simmons Jr., certified public accountant, said at the annual conference of the Medical Group Management Association.

Perceived opportunity for fraud can occur when employees "have access to company information and systems and procedures, and knowledge about what the company does," he added. "Many have heard stories about others who have gotten away with fraud, and they think they can, too."

Employees may rationalize the fraud, intending to pay back what they steal, but if they aren't caught, the incentive to keep true to that intent fades away. "They get away with it, and the next time they have a need, they try it again and turn into a real dishonest employee," said Mr. Simmons, CEO of Clearwater (Fla.) Cardiovascular and Interventional Consultants.

In their book "Theft by Employees" (Lexington Books, 1983), sociologists Richard D. Hollinger, Ph.D., and John P. Clark, Ph.D., found that low job satisfaction was a primary cause of employee theft and concluded that the true cost of employee misconduct is grossly underestimated. The authors, who surveyed 10,000 employees, defined misconduct in two ways: property deviance, such as stealing money and office supplies, and production deviance, such as consistently leaving work early or conducting personal business on company time.

In a subset analysis of 4,111 employees who worked in the hospital sector, 27% reported taking hospital supplies, 8% took or used patient medication, and 6% were paid for more hours than they actually worked. In addition, 57% reported taking a long lunch or break without approval, 33% used sick time when they weren't actually sick, and 29% frequently arrived to work late or left early.

According to the ACFE report, more than half of all fraud is committed by employees in the accounting and finance departments or by upper executives. The amount of loss varies by age group, from a median of $25,000 for employees under the age of 26 to a median of $500,000 for those aged 51-60. The frequency of fraud is higher among men, compared with women (59% vs. 41%, respectively).

"People who have been with you a short period of time generally are not the ones who are going to commit the biggest fraud," Mr. Simmons noted. "It takes a while to understand how busi-

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nesses' systems and procedures work. It's really the people who have over 5 years experience with you that usually commit the biggest fraud."

Leading behavioral "red flags" correlated with occupational fraud in the ACFE report include living beyond one's financial means; having financial difficulties; having a "wheeler-dealer" attitude; displaying control issues and an unwillingness to share duties; having divorce or family problems; maintaining an unusually close association with a vendor or customer; displaying irritability, suspiciousness, or defensiveness; dealing with an addiction or with legal problems; having had past employment-related problems; complaining about inadequate pay; and refusing to take vacations.

Lee Ann H. Webster, certified public accountant and administrator of Pathology Associates of Alabama PC, noted that the revenue cycle is a popular target for fraud because "this is generally the largest item on a medical practice financial statement." The three main types of revenue cycle fraud include skimming unrecorded revenues, such as pocketing the payment from a self-pay patient and not recording the charge; skimming receivables, such as pocketing the payment for a previously recorded charge and covering it up with bogus adjustments or other methods; and lapping, or "robbing Peter to pay Paul."

Lapping occurs, she said, when patient A pays on account and the perpetrator pockets the payment. Patient B pays on account and the perpetrator records the payment by patient B on patient A's account. This goes on until the perpetrator is caught or covers up the fraud.

Practical ways to detect and prevent revenue cycle fraud, Ms. Webster said, include segregation of duties in the accounting department; using lock box; controlled access to billing system functions; review of accounts receivable aging and past due balances; review of patient accounts with a "hold" code; review of work areas and trash for evidence of secondary record keeping; mandatory vacations (with a substitute performing functions); rotation of duties (preferably without notice); follow-up on old deposits in transit or late deposits; electronic receipt of payments; and follow-up on patient complaints about billing.

Ms. Webster also warned about using facsimile signature stamps. "The person who has access to this has check-signing authority, even if they are not an official check signer," she said. "If you have one of these, seriously consider getting rid of it. If you have to keep it, make sure that the accounts payable clerks do not have access to it."

Other ways to prevent and detect occupational fraud include establishing a hotline for tips, conducting criminal background checks before hiring new employees, and providing some ethics training. ■