



Medical Market Analysts, INC.

Specialty Consulting for Physicians

Kaylen M. Silverberg, M.D.
Medical Director
Texas Fertility Center
Austin, Texas

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The health care industry represents one of the largest segments of the American economy. Most recent data suggest that health care costs may exceed one trillion dollars in 1999, accounting for almost 13% of our nation's gross national product. Managed care was proposed as a response to these escalating costs, and its evolution has changed the way that most American families obtain their health care, whether via health maintenance organizations (HMOs), preferred provider organizations (PPOs), or point of service (POS) plans, more and more employer groups are turning to an ever shrinking cadre of large insurers to obtain some form of managed care for their employees.

Usually these plans contain a set package of standard benefits providing coverage for most common medical and surgical illnesses. Insurers develop a network of physicians ("providers") with whom they negotiate fixed prices. The cost to the company depends on many factors. Typically, the larger the insured group, the lower the cost per employee ("plan member"). In addition, the more open the access, the higher the cost. For example, a highly restrictive HMO plan, in which members may only obtain care from a small group of contracted physicians will cost less per member than a less restrictive PPO plan. Participants in the HMO plan must select a primary care provider, and all referrals to specialists must come directly from this primary care "gatekeeper". The underlying theory is that the primary care physicians will only authorize necessary referrals, keeping specialist visits (and costs) down.

In a PPO plan, members may obtain care from any physician they choose. Care obtained from "in-network physicians", physicians who are contracted directly with the health plan, costs the member less than care obtained from "out of network physicians". Although the charge for services may actually be the same, members have lower co-payments ("co-pays") when they see in-network providers. For example, care obtained from a network provider may be covered at 80% (with the member paying the other 20% out of pocket). The same care obtained from an out of network provider may be covered at only 60% (with the member paying the other 40%).

Based on 1996 data, less than 30% of benefit plans nationwide currently include coverage for infertility. Thirteen states have passed some form of insurance mandate- a law requiring insurers to either offer coverage for infertility, or actually to include coverage in the standard benefits package. Many insurance plans, however, have been established under ERISHA (Employee Retirement Income Security Act) statute, which exempts them from certain state

laws- including in this case, mandates. In states where infertility coverage is not included in the standard package, companies may occasionally purchase a rider to their insurance contract, allowing for infertility coverage for an additional premium.

Occasionally, a large company may elect to expand their benefits package. They usually approach the insurer(s) that they are using to help them design such a package. Together, the company and the insurer specify the level of coverage sought, services provided, type of network (HMO, PPO, etc.), and restrictions on utilization. Based on this information, the insurer will actuarially determine a cost for the expanded benefit. This cost is then allocated among either the entire employee group or only those employees seeking the expanded services.

In the middle of 1998, I had the opportunity to become involved in the development on an infertility benefits package for Southwest Airlines. Started as a regional airline serving Dallas, Houston, and San Antonio in the early 1970's, Southwest has grown rapidly, becoming the nation's fourth largest airline with a work force of over 27,000 employees. Their original founder, Herb Kellcher, still runs the airline. Over the years, he has developed a reputation as in aggressive innovator who is very responsive to the needs of his employees. Southwest is a perennial favorite in Money Magazine's "Best Company to Work For" competition, and, as a result, has very loyal employees.

Although when we first spoke, Phyllis Adams, Southwest's Benefits Manager admittedly knew very little about Infertility, she was intent on developing one of the best infertility benefits packages in the country. One of our first steps was to arrange a conference call with Southwest's Human Resources team to discuss what items they wanted to consider including in their infertility benefit. My first job was to educate them about infertility, including its multiple causes and possible treatments. As a company with a high percentage of reproductive age employees, they were concerned about the potential for increased utilization of these services, and the accompanying high cost. We discussed data provided by William Mercer and Company suggesting that companies who do not technically cover infertility still frequently end up paying for fertility related services anyway. Specifically, we discussed how such companies might deny a laparoscopy if coded as infertility, yet unknowingly cover the same procedure when coded as endometriosis, pelvic adhesions, ovarian cyst, or pelvic pain.

Despite their profound desire to develop a comprehensive infertility benefits package, Ms. Adams and her team were intent on putting mechanisms in place to control costs. Much of our subsequent discussions therefore focused on establishing safeguards against over utilization. The first step in this procedure was to encourage Southwest to define the desired scope of their benefit. Rather than focus on specifics, we discussed such issues as whether they wanted to cover merely infertility diagnosis or appropriate treatment as well. We discussed placing limits on services, such as limiting the number of covered clomiphene or gonadotropin cycles. We also discussed whether they wanted to cover the assisted reproductive technologies. In order to limit the maximum amount of their potential liability, we suggested that they may want to consider establishing a lifetime cap on fertility related services. In addition, setting a co-pay at a significant percentage would encourage employees to take an active role in their treatment decisions. The more they had to pay out of pocket, the more likely they would be to focus on cost-effective diagnosis and treatment.

Following several internal meetings, Southwest arranged a meeting at their Dallas headquarters in order to sketch out specific plan guidelines. Fred Neaves, a managed care specialist with Serono Laboratories, accompanied me to provide data needed for the prescription drug portion of the benefit. The Southwest representatives had determined that they wanted to cover both the diagnosis and treatment of infertility. In addition, they wanted to separate the medical benefit from the prescription benefit, but wanted to establish lifetime caps on each to limit their potential liability. Although they did want to offer coverage for the assisted reproductive technologies, they did not want to cover donor gametes.

Perhaps one of the most difficult issues dealt with was who should provide these services. Specifically, Southwest did not want to prohibit their employees' from seeing their own gynecologists. Nonetheless, they believed that many gynecologists, whose potential array of fertility related services were limited, might be inclined to over use such service, continuously recommending the same treatments, rather than referring patients rapidly to the Reproductive Endocrinologist. In Southwest's experience, patients were able to obtain most cost-effective care when specialists provided it. They therefore asked me to develop a treatment algorithm that would specifically delineate the roles of the gynecologist and the RE. Although we initially discussed an algorithm that would allow the gynecologist to perform the majority of the basic evaluation as well as administer clomiphene citrate for 3-6 cycles, the Southwest representatives eventually decided on a plan that would only cover fertility related services when they were provided by a Reproductive Endocrinologist.

The final plan, which Southwest put into effect on January 1, 1999 allows for a \$10,000 lifetime cap on fertility-related services. In addition, there is a separate \$5,000 lifetime fertility prescription benefit. All fertility-related services require a 50% co-pay, and employees are only reimbursed when services are provided by a Reproductive Endocrinologist. Both the diagnostic and treatment algorithms that I developed are organized by CPT and ICD-9 codes. The diagnostic algorithm encourages the use of evidence based diagnostic tests, and the treatment algorithm recommends judicious use of surgery combined with intrauterine insemination, and the assisted reproductive technologies.

Overall, I found this an educational and thoroughly enjoyable process. I would strongly encourage you to seek out companies and offer them your assistance. I would be pleased to provide you with any assistance or recommendations that I learned as a result of this experience.



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FERTILITY@THE SPEED OF THOUGHT:
The Case for Electronic Medical Records
Richard Grazi MD

I'm no computer geek. For me, computers are like cars. I have a basic idea of how the engine works, and I can sure tell the difference between a ride in a VW and cruising in a Porsche.

When it comes to details, however, I'm lost. I couldn't tell an overhead cam engine from a muffler mount. When that hood needs to be opened, I'd sooner leave that job to the experts. Still, I can make just about any car take me from here to there. I didn't need to become a mechanic to appreciate the virtues of the automobile over the horse and buggy.

It's the same way with computers and me. I'm too busy practicing medicine and running my practice to become a computer whiz. I will never really know what's "under the hood" or, for that matter, how to make my own repairs. Still, I understand very well how to get my computer to take me from here to there, and I'll never go back to the way it was before it came around. Case in point? I haven't handwritten a note in a patient's chart in nearly five years. Nor have my nurses or secretaries. Paper records are, at least in our practice, the equivalent of the horse and buggy!

This article is about computerized patient charting, an idea whose time has come. In the short space I've been allotted, I will try to share with you how the electronic medical record (EMR) has improved our practice, and

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One of the most useful aspects of the system is that it allows patient phone calls to be routed through the internal computer network. All patient messages are typed by receptionists directly onto their computer screens and forwarded electronically to the appropriate receiver. Physicians receiving queries can find all pertinent information instantly, log in their responses and then forward them to nurses or other personnel for communication to the patient. This minimizes interruptions in the physician work schedule. All phone contacts with patients become an integral part of the chart, allowing every respondent to know what was previously told to the patient. The system supports consistency in patient management, especially in a multi-physician practice. The ability to access charts from anywhere off-site, including at home and at night, improves the quality of care for patients requiring attention during off-hours.

There is no system that will support every reproductive endocrinology practice, as physicians and practices vary in their individual needs. However, the strengths of using even a basic, first generation system are apparent:

- All patient information is available at the touch of the keyboard
- Charts are simultaneously accessible by multiple users
- Patient information is readily accessible from any location
- Notes written off-site are instantly available on-site
- Chart pulling, faxing, copying and ferrying is eliminated
- Flow of patient information e.g. phone queries and responses is simplified
- Quality and consistency of care are improved

More sophisticated systems will do more important things for the practice. A program that accurately codes diagnoses, procedures and outcomes allows the user to keep accurate statistics. When properly devised and maintained, the database should automatically provide the required statistics for reporting to SART. Beyond that, however, lay even more important data. The program should allow the user to compute statistics not only for

assisted reproduction, but also for every other therapeutic modality employed by the practice. Why focus on IVF patients only, when so many patients conceive in other ways as well?

Much has been written lately of the importance of evidence-based medicine. As a professional society, our goal is to strive not only for effectiveness, but also for efficiency. But few of us are able to account for the techniques we employ and the results we obtain on an ongoing basis. Electronic record keeping allows each individual practice to assess the effectiveness of its techniques. Networked practices can use such data to identify variations between practices; the basis of continued quality improvement. When this information is linked to financial data such as internal cost profiles, cost-effectiveness, or efficiency, can also be gauged. In the current practice environment, where the public has access to statistical outcomes and managed care keeps ratcheting down reimbursements, the only way to thrive is to have an efficient practice. Electronic medical records are the foundation of the efficiently run practice.

Michael Dell, the CEO of Dell computers, has stated that “process innovation is the fundamental source of competitive advantage.” We see this principle all around us, as businesses – especially big businesses – have reinvented their way of doing business. Investment in information systems – averaging 8-10% of revenues - has been the foundation of their success. Physicians, on the other hand, invest less than 1% of revenues on information systems. Nationwide, less than 5% of physician practices are maintained electronically. As a group, we are still trying to get from here to there by whipping horses!

The efficiencies inherent in electronic record keeping speak for themselves. Going forward, however, the main advantages of computerization may lie elsewhere. For further reading, I suggest *Business@The Speed of Thought*. In this book (which I am convinced was not written because the author needed extra money!), Bill Gates describes the ways in which the Internet has changed and will continue to change the nature of successful businesses, particularly in their outreach to consumers. Those who believe that medicine will not be similarly affected do so at their own peril. For the rest of us, it is time to acknowledge that the days of paper-based information systems are over. Adoption and continued improvement of the electronic medical record will be fundamental to our future success. *(END)*

Richard V. Grazi, M.D. is the Director of Reproductive Endocrinology and Infertility at Maimonides Medical Center and Brooklyn IVF.

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Practice Analyses

Practice analysis is one of the most important components of practice management. We have included examples of many different types of analyses at our Web site. The location, practice names, and numeric values are artificial to protect the confidentiality of our clients. Much information can be obtained by reviewing the process.

MMA has three specific focuses: 1) Practice Marketing, including specialty medical Web site developemnt. 2) Cost anlaysis. 3) Practice analysis including managed care initiatives.

No marketing, management, managed care, or personell decision should be made without the appropriate analytic information. In todays competitive and cost conscioius medical environment, there is rarely an argument for "paralysis by analysis". It is rare that a practice develops too much support information. In fact, it is amazing how many physicians and business managers negate analysis. Physicians don't have the time and business managers sometimes lack the necessary analytic tools and experience.

Cost analysis is the most most important component of assessing an planning profitability. This is especially true in managed care contractng where margins are very low. We have worked with physicians who have contracted below their costs. In every casee, analyses were inadequate, or missing entirely. We have devoted a special section to this subject with several articles related to costing and managed care.

Many practices decide to expand their patient base through markeing. This is another area where analsysss is critical. The demographic areas must be identified and the appropriated patint audince identified. No marketing program should ever be planned without the appropriate market research. To do so, leads to programs conducted in low potential areas with litte ROI. MMA conducts detailed demographic analysis based on the specific specialty. There are a myriad of demographic parameters that can be examined based upon the practice and patinet type. This is discussed furter in the marketing section.

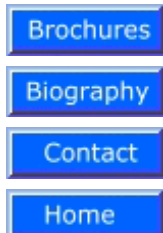
Other analysis included:

- Billing and CPT coding Audit
- Patient Volume and Profiles
- Patient Surveys
- Referral Physician Profies and Contribution
- Efficiency
- Staff Attitudinal Studies
- And Many More

We have included examples of basic analyses for your review. Realize that the data is artificial to protect our clients. Conclusions are eronous but demonstrate the type of information that can be obtaine. The documents are in html format.

Demographic Analysis

Laboratory Volume-Lost Revenue



[link](#)

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You will find much information relevant to practice management and marketing at our Web site. We have included several examples of market analyses and planning. All of these analysis are based upon fictitious data to protect the proprietary information of our customers. Our primary goal is to demonstrate the utility of these data.

Many documents are stored in the Adobe PDF format to facilitate cross platform utility. If you don't have Adobe Reader, a copy can be downloaded using the link below.

4915 Foxbriar Trail •Charlotte, NC 28269

Phone (704) 598-9309 • Fax (704) 596-0347

medmark@earthlink.net