

Provider Guide

Introduction

In this Subsite a closer examination will be given to the characteristics of the major provider of health care services to the plan participants. These are:

- Physicians
- Physician Extenders
- Non-Physician Professionals
- Hospitals
- Home Health Care
- Convalescent Health Care
- Hospice Care
- Birthing Centers
- Miscellaneous
 - Corporate Medicine
 - Alternate Site Providers.

Physicians

In General

Physician includes these licensed professionals:

- Medical doctor or surgeon
- Dentist or dental doctor
- Chiropractor
- Podiatrist
- Osteopath
- Optometrist
- Psychologist.

Such person must not be related to the covered person.

Physician Defined

The term *physician* means a licensed doctor of medicine, osteopathy (including an osteopathic practitioner), dental surgery or dental medicine, podiatric medicine, chiropractic services, and optometry. However, only certain services of dentists, podiatrist, chiropractors and optometrists are covered and these are discussed below. The term *physician* does not include a Christian Science practitioner or naturopath.

In order for services to be covered as services of a *physician*, the doctor performing them must have *legal authority*; that is, such physician must be licensed to practice by the state. Coverage will not extend to services which the practitioner is not legally authorized to perform. For example, if state licensing law limits the scope of practice of osteopaths and osteopathic practitioners to the manipulation of bones and muscles, only these authorized osteopathic services are covered.

A doctor of dental surgery or dental medicine having state authorization to practice is also defined, as stated above, as a *physician*, but only with respect to (1) surgery related to the jaw or any structure contiguous to the jaw, which includes structures of the facial area below the eyes, e.g., mandible, teeth, gums, tongue, palate, salivary glands, sinuses, etc.; (2) the reduction of any fracture of the jaw or any facial bone; and (3) treatment of an oral infection. Furthermore, a dentist is a physician for purposes of providing the physician's certification required for inpatient hospital services connected with a dental procedure when the patient requires hospitalization.

Podiatrist

A doctor of podiatric medicine is included within the definition of *physician*, but only with respect to functions he is legally authorized to perform as such by the state in which such podiatrist performs them. Certain types of foot treatment or foot care are excluded, whether performed by a doctor of medicine or a doctor of podiatric medicine. A doctor of podiatric medicine is also considered a *physician* with respect to the physician certification and recertification of the medical necessity for provider services, for establishing and reviewing a home health plan of treatment, for utilization review, and for outpatient ambulatory surgical services.

Chiropractor

Chiropractic medicine is defined as the diagnosis and analysis and the manipulation and adjustment of the spine and adjacent tissues by locating and correcting interference with nerve transmission and function.

Controversy

Chiropractic medicine has always been and undoubtedly will continue to be controversial. Those helped sing its praises; those who pay their money with no help are opposed to it. Several alarms sounded by conservative and traditional medicine are these:

- The appointment *a month* club scheduling of manipulations, etc. is overtreating or perhaps nontreating on a regular basis for a fee.
- There is the hazard of the chiropractor *missing* an important diagnosis because it doesn't fit into the chiropractor's treatment ability. Nineteen X-rays were paid for by the plan and read by the Chiropractor; the twentieth was taken and read by a medical doctor with the diagnosis of terminal cancer, as an example.

Traditional medicine does ignore causes and cures claimed by chiropractic medicine which explains why it continues to flourish.

Because of the extent of chiropractic medicine and its attendant controversy, it is given special treatment herein. Also, many examiners may be familiar with traditional medicine but quite unfamiliar with chiropractic medicine.

Plan Benefits for Chiropractic Care

The typical self-funded plan document will either have full benefits for chiropractic care or reduced benefits. It is not unusual to find a self-funded plan to pay no benefits at all for chiropractic care. This contrasts with fully insured plans which are mandated by most state laws to fully cover chiropractic care.

Scope of Practice

Licensing requirements of the states are varied but similar. States may differ on the various types of treatment that would be within a provider's scope of practice. See the current Licensure and Practice Statistics published by the Federation of Chiropractic Licensing Boards. For information regarding specific modalities of treatment, contact the State Licensing Board.

Extent of Chiropractic Practice

The chiropractor is authorized by law, if properly licensed, to perform certain services. When such services are performed, the plan will cover them as set forth therein.

Medical History

History of complaints and symptoms may be elicited along with the patient's general health.

Examinations

The examination may be limited to the area of complaint which is symptomatic or may be extended to the entire body as deemed appropriate. Minimum vital signs of pulse, blood pressure, e.g., should be included in the examination.

X-Ray

Chiropractors may take and interpret X-rays. Where clinically indicated, a two-view study is appropriate. Comprehensive studies may also be made.

Laboratory

Chiropractors may obtain and interpret urinalysis tests. Most states do not permit the chiropractor to obtain and interpret blood tests, however. In these instances, an independent laboratory is used for such testing.

Diagnosis

The chiropractor is permitted to complete the examination, make diagnosis and prescribe appropriate treatment.

Progress Examination

The chiropractor is permitted periodic evaluation and reexamination based upon objective findings of changes in the patient. Adequate daily records of symptoms, treatments, changes as well as monthly progress reports should be routinely available on request.

Treatment

Necessary chiropractic services rendered must be appropriate to the diagnosis and consistent with state and federal law.

Manipulation. Chiropractors are permitted to make manual manipulations to the musculoskeletal system. Any fees for manual traction, neuromuscular reduction and intersegmental immobilization would be classified as manipulation.

Drugs. Chiropractors are specifically not licensed to dispense or prescribe any medication which, by law, can be purchased only on a doctor's written prescription.

Vitamins. A chiropractor may dispense food supplements, non-prescription vitamins or minerals and simple pain pills (such as aspirin). Such medications would not be payable as a prescription.

Surgery. Surgical procedures are outside of the chiropractic scope of licensing with the following exception:

Oregon - Minor surgery meaning *the use of electrical or other methods for the surgical repair and incident thereto of superficial lacerations and abrasions, benign superficial lesions and the removal of foreign bodies located in the superficial structures and the use of antiseptics and local anesthetic in connection herewith.*

Obstetrics. The scope of practice for chiropractic medicine excludes obstetrics in most states. Exception: Oregon - obstetrics requires registration to Board of Chiropractic Examiners.

Fractures. Chiropractors may not set fractures or treat fractures in any way. Casts are sometimes applied which would require an investigation as to the reason for casting. Chiropractors are licensed to apply plaster casts and remove same.

Proctology. Some chiropractors and naturopath still perform colonic irrigation or lavage. These two services are not considered generally accepted medical practice under chiropractic or any other circumstance.

Infections. Chiropractors are not allowed to give injections.

Oklahoma - may use vitamins, minerals and nutritional supplements administered by injection or orally.

Needles. A chiropractor may not use needles, electric or otherwise unless he is performing acupuncture and has extended his practice to include a special certificate to cover this form of treatment.

Adjunctive Therapy. Those physical, mechanical or thermal devices used in treatment as an adjunct or in conjunction with physical therapy such as adjustments (manipulation).

- Heat (infrared, microwave, diathermy, electric heating pad, ultraviolet and whirlpool)
- Cryotherapy (ice)
- Ultrasound (mechanical, chemical, thermal)
- High volt galvanic
- Low volt galvanic
- Traction
- Cervical collars and limbo sacral supports
- Combination of the above.

Limitations on Practice of Chiropractor

Based on the medical evidence available, the following items are not reimbursable:

Foot Levelers. These are used to insure weight distribution through lower extremity by correcting arch and pronated foot disorders; not normally medically necessary.

Contour Topography. This procedure is not recognized as scientifically accepted and further, is not taught in any accredited college.

Percussion Therapy. This is not an approved procedure. It is not taught by any accredited college and is of no therapeutic value.

Spinal Column Stressology. This does not necessarily involve subluxation or a nerve impingement, but merely a position that creates an accelerated stress factor that is a stress fixation, a condition where the structure has become sprung away from its normal position. This procedure is not recognized as scientifically accepted nor is it taught in any accredited college.

Thermoscribe- Nerve Graph. Procedure of this nature should be included in the over-all office visit fee.

Vibratory Therapy. This is not a viable modality and is a form of soft tissue manipulation and should be given no consideration.

Weight Reduction Programs. Not covered unless resultant from a verifiable metabolic disease; hypothyroidism, etc.

Colonic Irrigation. This is not considered generally accepted medical practice under chiropractic or other circumstances.

Doppler Studies and Plethysmography. These may have worthwhile diagnostic value to cardiologist or vascular surgeon in patient with clinical signs or symptoms of peripheral arterial insufficiency. This type of disease seldom renders itself to treatment by chiropractic manipulation and therefore is unlikely to be medically necessary in chiropractic examinations.

Thermography. This is to show sensory nerve irritation (pain) and soft tissue injuries by recording heat emissions from the body. Objective diagnostic efficacy has not been established in musculoskeletal disorders. (This is not to be confused with the exam of breast tissue to detect the presence of tumors.

Osteopath

In General

One of the fastest growing segments of the health industry is Osteopathic Medicine. Though only 10-15 percent of the U.S. population knows anything about it, many people still relate osteopathic physicians with chiropractors.

M.D. and Osteopaths are similar in many ways. The true difference in the training is in the Osteopath's extra studies of Dr. Andrew Taylor Stills philosophy.

Osteopathic Beliefs

Osteopathic medicine looks at the human body as a whole organism, that has many parts but must always work together smoothly. A disease is considered not just an illness, but a breakdown of one of the body's systems. A D.O. (Doctor of Osteopath) will treat the body and the disease as whole rather than two separate parts.

Special emphasis is placed on the musculoskeletal systems. It is believed that improper functioning can effect other parts of the body. A D.O.'s first priority is to realign the skeletal system in hopes that drugs and/or surgery will not be necessary. Preventive medicine also plays a big part in the osteopathic medicine. They stress exercise, proper diet and healthy living as a maintenance program.

Training

Education of a D.O. is similar to a M.D.'s. A minimum of a three year degree at an accredited college or university is required. A preparatory course of study in physics, biology, inorganic and organic chemistry is required plus the passing of the MCAT (Medical College Admission Test). To obtain the Doctor of Osteopathic the student must then take four years of basic science, including anatomy, physiology,

biochemistry, pathology, microbiology and pharmacology. There is also special instruction in Osteopathic techniques.

He or she must then complete a twelve month rotating internship at one of 200 nationally approved Osteopathic hospitals. To become a specialist the D.O. will have another 2-6 years residency in their chosen field. In order to retain a license each D.O. must complete 150 hours or more of approved continuing education every three years.

Practice of Osteopathy

A practicing D.O. will use all standard and accepted diagnostic and therapeutic techniques. However, the difference will be that a D.O. will use manipulation as a form of treatment, using his or her hands as tools for the exploration and correction of body problems.

Nearly 90% of all practicing D.O.'s are involved with primary care as compared with 45-50% of M.D.'s; also half of all D.O.'s practice in rural areas. This is in accordance to the belief that medical care should be given in the area of greatest need.

Osteopathic doctors participate in Medicare and Medicaid and are licensed in all fifty states including the District of Columbia.

Optometrist

A doctor of optometry who is legally authorized to practice optometry by the state in which he performs these services is included in the definition of *physician*, but only for limited purposes. An optometrist is a physician with respect to all services related to the treatment of aphakia.

Psychologist

A licensed psychologist (Ph.D) is covered under the terms of the physician definition.

Special Consideration

Hospital and Residents

Provider-based physicians often engage in a variety of activities, including teaching, research, administration, supervision of professional or technical personnel, service or provider committees, and other provider-wide activities, as well as direct personal health services to individual patients. Those services rendered directly to, or for the benefit of, individual patients, the professional component of physicians' services, are covered as physician charges and not hospital charges.

Interns and Residents

Services of interns or residents-in-training under teaching programs are specifically excluded from the definition of *physicians' services* and, thus, are covered as hospital services, even when they are professional services rendered directly to a patient by a licensed practitioner. Services of interns and resident-in-training, regardless of whether they are under an approved teaching program, performed in hospital outpatient departments are covered not as physicians' services

but as outpatient services. Also covered are services performed for skilled nursing facility and home health agency patients by interns and residents.

Teaching Physicians

Physicians teaching or supervising in an approved teaching program are normally regarded as provider services, reimbursable to the hospital. However, if the teaching or supervising physician is the patient's attending physician, such services will usually be covered by physicians' services.

Specialists

The major areas of medical specialists are as follows:

<u>Physician</u>	<u>Specialty</u>
General Surgeon (GS)	General surgery
Allergist (A)	Allergic origin
Cardiologist (CD)	Heart
Gastroenterologist (GE)	Stomach, intestinal tract
Internist (IM)	Internal medicine, diagnosis of medical diseases
Otologist (OT)	Ear
Laryngologist (LAR)	Vocal cords and larynx
Rhinologist (RH)	Nose
Ophthalmologist (OPH)	Eye
Dermatologist (D)	Skin
Gynecologist (GYN)	Female reproductive organs
Neurologist (N)	Nervous system
Psychiatrist (P)	Mind
Orthopedist (OR)	Bones, joints, muscles, tendons, etc.
Physiatrist (PM)	Physical medicine and rehabilitation techniques

Proctologist (CRS)	Anus, rectum and colon
Urologist (U)	Urogenital system

Physician Extenders

Background

Within the last decade or so, several specialty professionals have emerged in health care basically known as physician extenders, named because such professionals are *extensions of* the physician as regards to care provided. Such extenders dominate primary care but also assist in specialty type practice (surgery, e.g.). Such extenders are classified as follows:

- Physician Assistant (PA)
- Advance practice Nurse
 - CRNA – Certified Registered Nurse Anesthetist
 - NP – Nurse Practitioner
 - CNM – Certified Nurse Mid-Wife

Extend of Such Extenders

The authority to practice as physician extenders must begin with enabling state statutes or regulations. A brief summary of such enabling legislation or regulations is as follows:

- Advanced Practice Nurse

There are 16 states with advanced practice nurse title protection, sole Board of Nursing authority to practice, and APN scope of practice with no requirements for physician collaboration or supervision. There are 24 states with advanced practice nurse title protection and sole Board of Nursing authorized scope of practice, but advanced practice nurse scope of practice has a requirement for physician collaboration or supervision. There are 4 states with advanced practice nurse title protection but the scope of practice is authorized by both the Board of Nursing and the Board of Medicine.
- Physician Assistant

Begun in 1965, there are now 52 physician assistant schools. Such practioners are regulated in 45 states:

 - Require licensure: 3
 - Require certification: 28

- Require registrations: 3

Other Advanced Practice Nurses

This analysis is restricted to anesthesiologists, clinical mid-wifery and practitioners. There are other specialties of advanced practice nursing with more being expected. They include: pediatric, nurse specialist, psychiatric, e.g.

General Discussion of Physician Extenders

While there has been much progress, many observers yet believe that the recognition of the physician extender has been too slow. Particularly irksome to the physician extender lobbyists is the reluctance of states to empower such extenders to:

- Prescribe medication
- Be directly reimbursed by third party payers
- Practice as autonomous providers of care.

The lobbyists for the extender industry believe that for many reasons they should be further honored:

- Runaway health care costs
- Decreasing access to health care by many
- Overemphasis by present system in high-tech and specialist
- Ability of extenders to be better communicators.

The power struggle between the physician industry and the extender industry is intense. The extenders are offended by the entrenched attitudes of the physicians which are believed to be incorrect:

- Physicians are omnipotent.
- Physicians have a good success rate.
- Physicians should *head up* the medical team.

The lobbyists for the extender industry believe that economics and the consumers will eventually force a better division of authority between the physician and the extender. Especially critical to the outcome is the need for more primary care providers.

Lobbying Activities of the Extenders

The lobbyists are promoting the extenders as a critical piece of the health reform puzzle. The extender is available, cost-effective and probably satisfactory. To aid the reform, statutory barriers must be removed. Specifically needed are the following:

- National extender standards
- Direct reimbursement to the extender.

The goal of the lobbyists for the extender industry is that the extenders be *special physicians*.

The lobbyists for the extender industry find opposition from these groups:

- Physicians
There is the fear of loss of money and control. Extenders are viewed as acceptable so long as they are not autonomous, cannot prescribe and cannot directly bill.
- Pharmacists
Pharmacist distrust extenders' ability to understand medications; also the division of power between physicians and pharmacists would be upset.

Then too, lobbyists find division within the extender family:

- Physician assistants conflict with advance conflict with advance practice nurses.
- Many extenders are *nonbelievers* in the rapid advances being thrust upon them.

Peripheral Issues

There are numerous side issues which arise with extenders:

- Care for the uninsured
- Shortage of primary care providers
- Geographic restrictions
- Confusion of titles
- Proper regulation (state board of nursing, e.g.).

Terms Defined

Typical definitions are as follows:

Nurse Practitioner. Nurse practitioner means a registered nurse authorized to practice in the state who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription of medical, therapeutic, or corrective measures under regulations adopted by the board; board means the Board of Nursing.

Physician Assistant

Background

States statutes vary widely. Some states allow the physician assistant to perform surgical procedures that require local anesthesia without the presence of the

supervising physician. Some states have rigid direct supervision requirements only and no treatment authority whatsoever. However, there has been a gradual evolution in many states to expand, for physician assistants, both prescriptive powers and the practice of medicine through indirect supervision. The American Medical Society has steadfastly opposed the right to prescribe for these reasons:

- Absence of peer reviewing ambulatory setting
- Loss of control by physician
- Evidence of abuses in practice of the physician assistant.

For the most part, physician assistants practice only under the supervision of a physician.

What is Responsible Supervision

Most states demand that the physician assistant be responsibly supervised. Adequacy of supervision is a function of these factors:

- Complexity of the task
- Risk to the patient
- Background, training and skill of the physician assistant
- Adequacy of the direction in terms of its form
- Setting in which the tests are performed
- Availability of the supervising physician
- Necessity for immediate attention
- Number of other persons whom the supervising physician must supervise.

There are several specific supervisory rules which are commonly followed:

- One physician cannot supervise more than two assistants.
- Supervising physician must be specialty-qualified in the field in which the assistant is practicing.
- Physician is legally liable for acts of assistant.
- Physician assistant may not imply the role of physician; must caveat any prescription with the suggestion of confirming such with a physician.

General and Typical Activities

The usual activities of the physician assistant include these: A sole practitioner, performance of histories and physicals; family counseling; record pertinent data on patient charts for signature by M.D.; facilitate referral of patients; dictate progress notes and discharge summaries; administer medication upon request of supervising physician; initiate emergency measures; order medication upon request of supervising physician; draw venous and arterial blood; perform routine immunizations; and similar activities and duties within the scope of inpatient care provided by the supervision physician.

As support to physician: assist in surgery; administer local infiltrative anesthetics; incise and drain superficial skin infections; perform cardiac stress

testing only under direct supervision; perform endometrial biopsies; apply cast and remove cast; evaluate common orthopedic injuries; remove and/or adjust tongs or halo traction; perform bone marrow biopsy; and administer chemotherapy. Duties once forbidden, but not often permitted, (a) prescribing, dispensing, or compounding medicinal drugs; (b) determining a final diagnosis; (c) and avoidance of performing a variety of procedures and tests under indirect supervision, e.g., insertion of chest tubes; performance of cardiac stress testing; injection of intrathecal medication; excision of skin lesions unless previously seen and approved by physician; administration of general, spinal and epidural anesthetics.

Certified Registered Nurse Anesthetist (CRNA)

Nurse anesthesia became a specialty in the United States many years ago as a result of poor results of the *occasional* anesthetist. Surgeons turned to the professional nurse to provide a stable, qualified, and experienced anesthesia provider. There are now approximately 20,000 active, practicing CRNAs in the United States who administer more than 60 percent of the twenty-four million anesthetics administered annually.

Unlike many other areas of health care delivery in the United States, anesthesia care is provided by both physicians and nonphysicians, primarily CRNAs. Although licensure and certification laws require CRNAs work under the supervision of a physician, direction by an anesthesiologist generally is not required. In many hospitals, CRNAs are the primary anesthesia providers and are supervised by surgeons in the absence of anesthesiologists.

Indications are that conflicts over practice areas exists between the CRNA and the physiciananesthesiologist. Recent Medicare revisions honor the CRNA as a provider for which a separate reimbursement is possible.

The CRNAs have their own professional organization which publishes a professional periodical: *Journal of the American Association of Nurse Anesthetists*.

Nurse Practitioner

The nurse practitioner is a term which includes those registered nurses who have successfully completed advanced training as proscribed by the state's Board of Nursing. Further, the state statute will establish the framework in which the nurse practitioner may operate. This framework deals primarily with the tasks which may be performed and the degree of supervision needed.

The nurse practitioners have their own professional organization which publishes a professional periodical: *Nurse Practitioner: The American Journal of Primary Health Care*.

Certified Nurse Mid-Wife

All of the states in one way or the other regulate mid-wifery to some extent; some do so by statute; some by regulation.

Typical Mid-Wife State Statute

Most states make mid-wifery a special class of advanced nursing. The statute often states that a person attending women in childbirth must be one of the following: a qualified physician, a registered nurse certified by the state's Board of Nursing as a qualified nurse mid-wife, a person acting *under the personal direction and supervision of a qualified physician*, a licensed mid-wife, or a parent of his or her own baby.

In order to be certified as a nurse mid-wife such person must have completed an American Certified Nurse Mid-wife accredited educational program and pass an examination stipulated by the Board of Nursing.

A nurse mid-wife may perform in collaboration with and under the direction of a licensed physician. They include history-taking and physical examinations, ordering laboratory procedures, and the management of labor and delivery, including the performance of amniotomy, episiotomy and repair, and paracervical, local and pudendal anesthesia. Newborn evaluation and the assessment of the growth and development of the infant are also included.

Powers of the Nurse Mid-Wife

Typically, the nurse mid-wife may do the following:

- Prescribe medication
- Sign birth certificate
- Bill and be paid in own name
- Be recognized by Medicaid.

Organization of Nurse Mid-Wives

The American College of Nurse Mid-Wives is the national professional organization. This organization publishes a quarterly called, *Journal of Mid-Wifery*.

Regulations of Birthing Centers

These states specifically have statutes governing birth centers:

Alaska	Iowa	Oklahoma
Arizona	Kansas	Oregon
California	Kentucky	Pennsylvania
Colorado	Massachusetts	Tennessee
Delaware	Mississippi	Utah
District of Columbia	New Hampshire	Washington

Florida
Georgia
Indiana

New Mexico
New Jersey
New York

West Virginia

Non-Physician Professionals

Physical Therapists

Qualifications. 4 ½ to 8 years of training including physical therapists educational program.

Job Description. Test and measure certain functions of the musculoskeletal, neurological, pulmonary and cardiovascular systems and treat physical problems caused by illness, injury of birth defect.

Hospitals

Registration with the American Hospital Association

There are the four ways by which an institution may be registered with the association:

1. Accredited
Such accreditation is given by the Joint Commission on Accreditation of Healthcare Organizations, a body of the association.
2. Acute Service Provider
The provider must given the Association the verifying documents as required by Title 18 of the Social Security Act.
3. State-Accredited Institution
To gain the right registration, the institution must be state-accredited and also show evidence of the following:
 - At least six beds for 24-hour care
 - Uncrowded and sanitary conditions
 - Morally responsible government in control
 - Responsible chief executive
 - Organized licensed medical staff
 - Admitting privileges to approved physicians
 - Full-time supervision of registered nurses
 - Appropriate and legal medical records
 - Registered pharmacy available
 - Nutritional and special diets.

Types of Hospitals

There are four types of hospitals.

1. General
 - Diagnostic and therapeutic care
 - Radiology, laboratory and pathology services
 - Equipped operating rooms.
2. Special
 - Specified medical conditions
 - These are *not* required: radiology, laboratory, pathology and operating room, except as needed for the specified medical condition.
 - Example: abortion clinic.
3. Rehabilitation and Chronic Disease
 - a. Care for handicapped or disabled.
 - b. Where appropriately needed, these facilities are needed:
 - Radiology
 - Laboratory
 - Operating room
 - Physical therapy
 - Occupational therapy
 - Psychological and social work
 - Educational and vocational
 - Transfer arrangements.
4. Psychiatric

This is care for the mental/nervous disorders.

 - As may be needed, laboratory, radiology, psychological support (group therapy, e.g.) and social work
 - Electroencephalograph services as needed
 - Transfer arrangements.

There are special authorities which have approval authorities over certain hospitals:

 - American Osteopathic Hospital Association
 - Commission on Accreditation of Rehabilitation Facilities.

Types of Services Offered

Each institution may offer a wide variety of services. Examples are as follows:

- AIDS Care

General care – no special facilities

Special unit – inpatient

Special unit – outpatient.

- Substance Abuse
Inhospital diagnostic and therapeutic
Primarily rehabilitative.
- Arthritis
Special staff and equipment.
- Obstetrics
Birthing rooms – home environment
Full maternity care – regular, cesarean, e.g.
- Burn Care Unit
Major trauma center.
- Cardiac Catheterization Laboratory
Primarily for insertion of catheter into heart.
- Open Heart Surgery Facilities
Blood must be recirculated and oxygenated.
- Cardiac Intensive Care
Specialized support – team for heart attacks.
- Angioplasty
Either by balloon dilation or by laser.
- Chronic Obstructive Pulmonary Disease Services
These include asthma, chronic bronchitis and emphysema.
- Emergency Room
Unscheduled 24-hour, outpatient emergency conditions, fully staffed.
- Trauma Center
Intensive care to critically hurt.
- Lithotripter
Non-invasive treatment of kidney stones by acoustic shock waves.
- Fitness Center
Testing and evaluation as well as exercise.
- Genetic Counseling and Screening
Possible tests include prenatal diagnosis, MRI imaging and ultrasound as well as DNA blood sampling.
- Adult Day Care Program
Medical, social and psychological supervision of the elderly.
- Alzheimer Diagnostic and Assessment
Includes assessment, treatment program and handling social and psychological problems.
- Comprehensive Geriatric Testing
Includes family and financial aspects.
- Elderly Emergency Care
Hot line care for elderly.
- Geriatric Acute Care

Multi-disciplinary team care.

- Geriatric Clinic
Special care to elderly, such as for arthritis, podiatry, e.g.
- Respite Care
Short term placement for family emergencies, planned absences, etc.
- Senior Membership Program
Information, claims-filing assistance, senior wellness are examples.
- Health Promotion Services
Education and supportive services, self-help, managing minor ailments, etc.
- Patient Education
Therapeutic regimens, medical procedures, and self-care.
- Community Health Promotion
Similar to patient education except the activities are in a community setting.
- Worksite Health Promotion
Similar to patient education except the activities are in a employment setting.
- Hemodialysis
Treatment of renal insufficiency.
- Home Health Services
Approved by a home health agency.
- Medical-Surgical Intensive Care
Special operating recovery rooms with specialized staff and equipment.
- Histopathology Laboratory
Must be staffed by a qualified pathologist.
- Blood Bank
Must have procurement, drawing, processing and distribution facilities.
- Neonatal Intensive Care Unit
Must be able to handle low birth weight (infants under 1500 grams).
- Occupational Health Services
Services must protect workers from occupational dangers.
- Organized Outpatient Services
Care must be walk-in with diagnostic and laboratory facilities.
- Pediatric Acute Inpatient Unit
Staffing and facilities for children.
- Psychologic Child and Adolescent Services
Diagnosis and treatment of the emotionally disturbed.

- Psychiatric Consultation-Liaison Services
Tie-in between psychiatric and general care facilities.
- Psychiatric Emergency Service
Primarily crisis intervention.
- Psychiatric Geriatric Services
Emotionally disturbed elderly.
- Psychiatric Inpatient
Acute care to mental nervous patient.
- Psychiatric Outpatient
General care on outpatient basis.
- Megavoltage Radiation Therapy
Deep treatment of cancer; includes cobalt units, linear accelerators, betatrons and Van de Griff machines.
- Radioactive Implants
Cancer treatment by radium, cobalt-60/cesium-137 or iridium-192 implants.
- Therapeutic Radioisotope Facilities
Cancer treatment by radiopharmaceuticals.
- X-Ray Radiation
Roentgen rays or other radiant energy.
- CT Scanner
Computer tomography.
- Diagnostic Radioisotope
Where isotopes are used as tracers or indicators to detect disease.
- Magnetic Resonance Imaging
Magnetic fields are radio frequency study of tissue.
- Ultrasound
Acoustic waves over 20,000 cycles per second.
- Rehabilitation Inpatient Unit
Restorative services to help patient attain maximum functional capacity.
- Reproductive Health Services
These include counseling, in vitro fertilization and sterilization.
- Skilled Nursing or Long Term Care Unit
Convalescent, rehabilitative and/or restorative care.
- Single Photon Emission Computerized Tomography
A nuclear medicine imaging technology which combines existing technology of gamma camera imaging with computed topographic imaging technology provide a more precise and clear image.
- Organized Social Work Services
Social, emotional financial and environmental problems are dealt with. This may be for either inpatient or outpatient persons.
- Sports Medicare Clinic

Provisions of diagnostic screening and assessment, clinical and rehabilitation services for the prevention and treatment of sports related injuries.

- Hospital Auxiliary
Volunteer community organization.
- Outpatient Surgery Unit
The surgery may be performed in operating suites also used for inpatient surgery, specially designated surgical suites for outpatient surgery, or procedure rooms within an outpatient care facility.
- Organ-Tissue Transplant
Tissue-organ removal in connection with transplant surgery.
- Orthopedic Surgery
Treatment of the skeletal systems.
- Occupational Therapy Services
Must be a qualified occupational therapist.
- Physical Therapy Facilities
Services prescribed by physicians and administered by, or under the direction of, a qualified physical therapist.
- Recreational Therapy services
Supervised by a qualified recreational therapist.
- Respiratory Therapy Services
Equipment and staff necessary for the administration of oxygen and certain potent drugs through inhalation or positive pressure.
- Speech therapy
Evaluation and treatment to inpatient or outpatient with speech and language disorders.
- Women's health-Fitness Center
Coordinated education and treatment services specifically for and promoted to women.
- Cardiac Rehabilitation program
Restorative services whereby a patient is reconditioned from a state or cardiac injury or high risk, to resume daily activities of living at an optimum level.

Other Ways to Classify Hospitals

There are several additional ways by which hospitals may be classified:

1. Control
 - a. Nonfederal Government
 - State
 - County
 - City
 - City-County

- Hospital district or authority.
 - b. Nongovernment Not-For-Profit
 - Church
 - Other.
 - c. For-Profit
 - Individual
 - Partnership
 - Corporation.
 - d. Federal Government
 - Armed Forces
 - VA
 - Public Health Services
 - Indian Services.
2. Stay
- a. Short-term (primarily under 30 days)
 - b. Long-term (primarily over 30 days).
3. Special Services
- Special purpose (prison, e.g.)
 - Tuberculosis
 - OB/GYN
 - Eye, ear, nose, throat
 - Rehabilitation
 - Orthopedic
 - Chronic disease
 - Children's
 - Substance abuse.

Home Health Care

Background Considerations

Forty-four percent of all patients discharged from the hospital by primary care physicians require post-hospital medical or nursing care that cannot be provided by family or friends alone (nursing home or home care). Between 5-10% of all patients in a medical practice receive home care services. For every patient in a nursing home, there are three more severely impaired patients cared for in their own homes. An estimated 20% of patients over 65 have functional impairments with related home care needs. Their physicians may be unaware of these needs during the typical office visit.

Home health care involves self-care, professional care and family/friends assistance. A team approach around the physician and home care agency is needed.

Physician-Patient Checklist

These items should be discussed and resolved:

- Disease process and treatment options
- Effect of disease and treatment on the patient's daily functioning and life-style
- Expected course of illness, both short-term and long-term
- Tasks that the patient and/or caregiver will be expected to perform
- Stress and burdens arising from chronic illness and methods to relieve such stress for both the patient and caregiver(s)
- Potential for rehabilitation
- Importance of monitoring the conditions(s) by the patient and/or caregiver
- Early signs of instability or deterioration which should be reported to the physician
- Improvements in function or condition which should be reported to the physician
- The need for outside assistance, roles of home care staff
- Patient and caregiver participation in treatment decisions including discussion and documentation of the patient's advanced directives and wishes concerning rehospitalization, resuscitation and use of various medical technologies.

Evaluations

A distinction between medical management in the home and medical management in the hospital, clinic or office, is the emphasis which should be placed on the abilities of the various *players* on the team to perform their requisite tasks.

Patient Assessment

- Functional (activities of daily living)
- Mental/Cognitive (understanding)
- Nutritional (problem of malnutrition)
- Medication (not accidentally overdosing).

Professional Assessment

- Home Health Care Agency (accreditation/nurses)
- Pharmacy
- Durable Medical Equipment
- Laboratory.

Caregiver Assessment

- Extent (hours, schedule)
- Quality (reliability).

Environment Assessment

- Factors (safety, space, telephone).

Community Assessment

- Factors (fire, police, emergency services).

Financial Assessment

- Medical, Medicaid, etc.
- Family resources
- Ability to manage.

Primary Duties of Physician

- Establish and maintain communication with the other physicians involved in the patient's care, and become familiar with the details of their treatment plans.
- Provide/arrange for 24-hour physician coverage for all homebound patients (including coverage when the physician will be out of town).
- Maintain organized records on home care patients.
- Communicate promptly with the home health care staff and all other who are providing services.

Selecting a Home Health Agency

General

- Agency reputation
- Management/direction of the agency; background of board of directors, key personnel, director of nursing, medical director
- Composition of the Professional Advisory Board
- Annual evaluation/report
- Evaluation process for policies and procedures/protocol
- Accreditation: Medicare certified or JCAHO accreditation
- Quality assurance activities: clinical record review, audits, supervisory capacity (number of nurses per nursing supervisor)
- Professionalism of care as illustrated by review of a complete chart of a patient referred from the physician's practice
- Availability of on call coverage by nurses and other staff 7 days/week, 24 hours/day
- Agency policies for coverage of underinsured or uninsured patients
- Response time for newly defined home care need
- Capacity to provide full range of services, depth of experience.

Services Offered

- Skilled Nursing
- Physical and occupational therapy
- Speech therapy
- Medical Social Services

- Nutritional Guidance
- Home Health Aide.

Terminating a Home Health Care Plan

- Goals of treatment have been reached and the patient and/or caregiver is independent.
- Changes in the course of illness make the home an inappropriate site for care.
- Patient/caregiver refuse to continue home care.
- Patient is non-responsive to home care interventions.
- There is caregiver burnout or loss of caregiver with inability to obtain alternate caregiver.
- There is evidence of patient abuse or neglect that has not responded to home care interventions.
- There is gross noncompliance.
- Safety of patient or provider is threatened.
- Irresolvable problems persist between patient/caregiver and home care team.

If Not Home Care, Then What?

- Acute or chronic care hospital
- Outpatient services/clinic programs
- Nursing homes
- Continuing care facility (board and care, life care community, licensed adult home)
- Day care
- Other family care options
- Group home with shared services
- Foster homes
- Respite care
- Hospice care.

Patients' Rights and Responsibilities

Rights

- Be treated with dignity and consideration, respect, and with timely attention to needs.
- Have the patient's property treated with respect.
- Confidentiality of all information related to care within required regulations.

- Be fully informed of the care and treatment which will be provided by the physician and others, how much it will cost, how payment will be handled and whether the patient is responsible for any payments.
- Discuss benefits, risks and costs of appropriate treatment alternatives.
- Receive guidance from his/her physicians as to their recommended course of treatment.
- Be advised of potential conflicts of interest which physicians may have, and of the right to receive independent professional opinions.
- Freedom of choice in care providers, to receive care from professionally competent personnel, and to know the names and responsibilities of people giving the care.
- Accept or refuse treatment or other forms of health care recommended by the physicians, and to be informed of the consequences of this action.
- Participate actively in the design of the care plan, and to help update it as needs change.
- Experience continuity in the health care that is provided.
- Be informed by a home health agency of anticipated termination of agency service and to be referred elsewhere.
- Have the freedom to make a complaint or recommend changes in services, or in agency policy, and know how to do so.

Responsibilities

- Remain under a physician's care while receiving home care services.
- Inform the home care team of any changes in physicians involved in the patient's care.
- Provide the physician and the agency with a complete and accurate health history.
- Provide the physician and the agency with all requested insurance and financial information.
- Sign the required consents and releases for insurance billing.
- Participate in the care by asking questions and expressing concern.
- Provide a safe home environment in which care can be given; allow necessary changes in the home environment.
- Cooperate with the physician, the agency staff, and with other caregivers by compliance with the therapy agreed upon.
- Accept responsibility for any refusal of treatment.
- Treat the physician and other health professional with respect and consideration.
- Advise the physician or agency administrator of any dissatisfaction or concerns about the care provided.

Community Services

- Adult Day Care
- Congregate Nutritional Programs
- Respite Services
- Employment Services
- Rehabilitation Services, including Vocational Rehabilitation and Special Education
- Foster Grandparents
- Self-Help/Support groups
- Crime Prevention/Victim Assistance
- Transportation
- Senior Centers
- Elder Abuse/Protective Service
- Legal Assistance
- Housing Services
- Volunteer Programs
- Energy Assistance
- Counseling
- Senior Companions
- Outreach

Convalescent Health Care

In General

Convalescent care benefits are an extension of inpatient hospital care, at a lower level of care than provided in a hospital, but still requiring *skilled* nursing or rehabilitation services.

Patients using coverage are entitled to have payment made on their behalf for covered extended care services furnished by the facility, or by a hospital with which the facility has a transfer agreement, or by others under arrangements with the facility. Generally, only the kinds of services that would be covered if furnished to a hospital inpatient are covered during a stay in a skilled nursing facility.

Qualifying For Benefit

The Schedule of Benefits sets forth the required hospital stay (usually three days), the time between discharge and admission to a convalescent care facility (usually fourteen) and the maximum number of days in such facility for Benefit Year (usually thirty).

Provided Services

Provided services include the following:

- Nursing care, provided by or under the supervision of a registered professional nurse
- Accommodations provided in connection with the furnishing of nursing care
- Physical, occupational, or speech therapy furnished by the facility or by others under arrangements with the facility

- Medical social services
- Drugs and biologicals including whole blood and packed red blood cells and supplies, appliances, and equipment for use in the facility, ordinarily furnished by the facility for the care and treatment of inpatients
- Medical services of interns and residents-in-training under an approved teaching program of a hospital with which the facility has in effect a transfer agreement and other diagnostic or therapeutic items or services provided by a hospital with which the facility has in effect a transfer agreement
- Such other services necessary to the health of the patients as are generally provided by skilled nursing facilities.

Accommodations

The coverage of ward or semi-private accommodations in a convalescent care facility is now treated in the same manner accorded coverage of these types of accommodations in a hospital.

Nursing Care

Nursing care provided by a convalescent care facility is covered if it is furnished by, or under the supervision of, a registered professional nurse. However, the services of a private-duty nurse or other private-duty attendant are excluded from this coverage.

A private-duty nurse or attendant is a registered professional nurse, licensed practical nurse, or any other trained attendant whose services are rendered to and restricted to a particular patient by arrangement between patient and the private-duty nurse or attendant. Such persons are generally engaged or paid by an individual patient or by someone acting on his behalf, including a skilled nursing facility that initially incurs the cost and looks to the patient for reimbursement for such noncovered services.

Where the convalescent care facility acts on behalf of a patient, the services of the private duty nurse or other attendant under such an arrangement are not extended care services regardless of the control which the convalescent care facility may exercise with respect the services rendered by the private-duty nurse or attendant.

Therapy

Physical, speech, and occupational therapy furnished by a convalescent care facility are covered when provided in accordance with a physician's orders and by or under the supervision of a qualified therapist.

Drugs and Biologicals

The coverage of drugs and biologicals as an inpatient convalescent care service and as an inpatient hospital service is basically the same.

Blood

The covered convalescent care services for which payment may be made include the amount of unreplaced whole blood or packed red blood cells and the administration of the blood to inpatients of convalescent care facilities. However, blood transfusions are ordinarily performed by hospitals and not by care's facilities. Thus, in the usual care, when a convalescent facility inpatient needs blood, a participating hospital will provide the blood and the laboratory services and perform the transfusion, under arrangements with the facility. In such a case, the facility pays the hospital's charge for these services, and this amount becomes the facility's cost.

Supplies and Equipment

Supplies, appliances, and equipment are covered as post-hospital convalescent care services only if they are ordinarily furnished by the convalescent care facility for the care and treatment of inpatients, and if furnished to an inpatient for use in the convalescent care facility. The following are examples of covered supplies: oxygen, surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.

Under certain circumstances, supplies, appliances, and equipment used during the beneficiary's stay are covered even though they leave the facility with the patient when he is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. An example of a covered item which may leave the facility with the patient is a brace temporarily attached to the patient's body while he is receiving treatment as an inpatient and which is also necessary to permit or facilitate the patient's release from the facility.

Supplies, appliances, and equipment furnished to a patient for use only outside the facility would not, in general, be covered as convalescent care services. However, a temporary or disposable item provided to a patient which is medically necessary to permit or facilitate his departure from the facility and is required until such time as he can obtain a continuing supply would be covered as a convalescent service.

Other Diagnostic and Therapeutic Services

Convalescent care services also include other diagnostic and therapeutic services provided by a hospital with which the facility has an agreement for the transfer of patients and the exchange of records, or by a hospital that has a swing-bed approval. While a convalescent care facility is permitted to secure diagnostic and

therapeutic services for its inpatients from the transfer hospital, the hospital must have the capacity to provide the services directly. If the transfer hospital does not have the capacity to provide the services directly, but provides them through an arrangement with an outside source, these services would not constitute covered convalescent care services.

Interns and Residents-in-Training

The medical services of an intern or resident-in-training under an approved teaching program of a hospital are covered convalescent care services. If the intern or resident is in a participating hospital with which the convalescent care facility has in effect an agreement for the transfer of patients and exchange of medical records, or in a hospital that has a swing-bed approval.

Inpatient Ancillary Services

The services of the ancillary type which are covered under the convalescent care provision include the following:

- Diagnostic x-ray tests (including portable x-ray services), diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Surgical dressings; and splints, casts, and other devices used for reduction of fractures and dislocations
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices
- Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition
- *Outpatient* physical therapy services furnished by a skilled nursing facility to its own inpatients
- *Outpatient* speech pathology services furnished by a skilled nursing facility to its own inpatients
- Pneumococcal vaccine and its administration.

Hospice Care

In General

Hospice care is a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes

supportive services, such as home care and pain control, rather than the cure-oriented services provided in institutions.

Covered persons who are terminally ill are eligible to receive hospice benefits in lieu of most other plan benefits.

Hospice Benefits

Hospice benefits include:

- Services of an physician and a registered nurse
- Physical and speech therapy
- Home health aide by a registered nurse
- Medically necessary short term hospital care.

Hospice services that are not reasonable and necessary for the palliation or management of terminal illness are excluded from coverage.

Eligibility

Hospice care is covered only for those beneficiaries who are terminally ill. A participant will be considered to be terminally ill if there is a medical prognosis that his life expectancy is six months or less. There must be certification by the participant's attending physician and the medical director (or staff physician) of the hospice program providing the care that the beneficiary is terminally ill.

In addition to the physician certification requirements, a written plan for providing hospice care must be established before such care may be provided by, or under arrangements made by, a hospice program. The written plan of care must be established by the attending physician, medical doctor, or physician degree and interdisciplinary group (this group must have at least one physician, one registered profession nurse, one social worker, and one pastoral or other counselor) and periodically reviewed by the beneficiary's attending physician (as well as by the medical director and the staff). The care provided by the hospice must be provided pursuant to this established plan of care.

A physician is an attending physician for certification purposes (who may be employed by a hospice program) and whom the patient identifies as having the most significant role in the determination and delivery of medical care to the patient at the time the patient makes an election to receive hospice care. A patient need not have an attending physician; in such a case the medical director of the hospice or a staff physician can perform as attending physician's certification functions.

Benefits

The Schedule of Benefits shows two expense limits:

- The maximum payable for hospice room and board benefits
- The maximum payable for ancillary benefits.

Only expenses which are reasonable and customary are payable.

Excluded Services

Certain services are not covered.

- Counseling and bereavement services rendered to family members are not covered.
- Charges for pastoral and dietary services are not covered unless legislation takes precedence.
- Charges for psychological counseling or social services provided to covered person are not covered.

Birthing Centers

Background

There are some 26 states which regulate birthing centers by means of state statutes. Most of such statutes are *pattern in nature*. A summary of the typical statute is summarized. The purpose of the statute is, of course, to enforce high standards of care.

Definitions

The statute requires a few basic definitions:

Birthing Center. Means any facility, institution, or place, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

Clinical Staff. Means individuals employed full time or part time by a birth center who are licensed or certified to provide care at childbirth.

Consultant. Means a licensed physician who agrees to provide advice and services to a birth enter and who either is certified or eligible for certification by the American Board of Obstetrics and Gynecology, or has hospital obstetrical privileges.

Law-Risk Pregnancy. Means a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.

Premises. Means those buildings, beds, and facilities located at the main address of the licensee and all other buildings, beds, and facilities for the provision of

maternity care located in such reasonable proximity to the main address of the licensee as to appear to the public to be under the dominion of the licensee.

Licensure

All birthing centers must be licensed; such licenses are for a limited time period (one year, e.g.) and must then be removed. Such license must be posted; such licenses may be revoked.

Regulation of Birthing Centers

The birthing center must be adequately staffed, and governed by qualified persons. Their activities must be supervised by a consultant-physician. The birthing center must be correctly equipped, sanitary and met all health/safety standards. A plan for emergencies must be in place. The state shall oversee such standards.

Informed Consent

Only persons expecting normal deliveries may be admitted. The patient must sign an informed consent statement with the risks explained and understood.

Prenatal Care

The birthing center must provide prenatal care, including serological tests: records of such prenatal care shall be retained.

Ancillary and Support Services

The birthing center is authorized to do these services:

- Laboratory
Tests must be pregnancy-related.
- Surgical
Limited to episiotomies and repairs; excludes C-sections or other operative obstetric surgery.
- Anesthesia
Excludes general and conduction anesthesia; includes systemic analgesia and local anesthesiology.
- Intrapartal Use of Chemical Agents
Labor may not be inhibited, induced or augmented with chemical agents. There must be a current signed consultant agreement with a physician.

There must be transportation facilities ready for emergency transfer to a regular hospital.

Postpartum Care

Discharge is generally anticipated within 24 hours. Certain minimum care to the infant is required:

- A prophylactic to be instilled in the eyes of each newborn
- Physical examination of the infant
- Metabolic screening tests
- Referral to sources for pediatric care
- Maternal postpartum assessment
- Instruction in child care, including immunization.
- Family planning services
- Referral to secondary or tertiary care, as indicated.

Miscellaneous

Appropriate clinical records shall be kept. The state regulations shall periodically audit and inspect. Infractions shall be punished.

Miscellaneous

Corporate Medicine

Benefits of Corporate Medicine

The usual motivations are lower cost to the employer and better quality of care to the employees.

Because the cost of delivering primary care in the corporate medical facility can be well below that of the *open market*, employee cost sharing can be entirely eliminated. Also, since the clinic operates much like an HMO, there are no claim forms or other paper work for participants.

Liability to the Employer

There is an undoubted employer liability:

- Patient's choice of providers
- Access to specialty and inpatient care
- The setting and timing of services
- The services and procedures covered under the plans
- The differential in reimbursement amounts for procedures and services performed in and out of the managed-care plan.

Reaction of Employers

A primary employer concern relates to confidentiality and privacy.

Employer Looks at the Corporate Medicine

The employer is usually reluctant to get into the provider business because it does not mesh with the corporate skills. Yet, like it or not, the employer is in the provider business one way or the other. To assess the feasibility of having an employer medical center, the employer should do four things.

1. Determine current primary care service utilization and cost. This information should be available in the claims data from the carrier or third-party administrator, and needs to be reviewed to determine the type and volume of services that can be provided in the medical center.
2. Estimate the cost of establishing a medical center. This will depend on staffing requirements and equipment and facility needs, determined by the size and characteristics of the patient base.
3. Evaluate the financial effect of incentives that can be used to encourage employee use of the medical center. The cost of establishing the medical center, the potential savings to the employer, and the level of care available can vary significantly under different levels of employee participation.
4. Compare the cost of directly providing primary care services with the cost of contracting with an outside vendor.

Vendors or Subcontractors

By using a vendor, the employer has most of the advantages but shifts the liability burden to the contract firm. Picking a vendor requires certain positive steps by the employer.

- Knowing the vendor's standards for licensure and accreditation
- Making sure that a formal, documented quality assurance review process exists and is in accord with accepted criteria and standards
- Using experts to conduct an on-site quality assurance review
- Requiring the vendor to warrant its compliance with all government laws and regulations
- Providing in its contract with the vendor that nothing in the agreement shall be construed to require any provider to take (or fail to take) any action inconsistent with its professional judgement concerning the medical care and treatment of covered persons.
- Requiring the vendor to indemnify and hold both employer and employees harmless from any liability in connection with the vendors' activities under the agreement.

- Requiring the vendor to provide evidence of adequate professional and comprehensive general liability insurance (and future notice of any cancellation of coverage); a warranty that all physicians and other medical providers on the vendor's staff or under contract with the vendor carry adequate insurance for professional liability; and notice of any malpractice actions.

Provider Credentials

As with HMOs the sponsor must be sure that the physicians are properly credentialed. To do that, these steps are needed.

- Require the physician to warrant and provide evidence of the maintenance of certification, licensing and staff privileges.
- Provide that nothing in the contractual agreement between the employer and the physician shall be construed to require the physician to take or fail to take any action inconsistent with his professional judgement concerning the medical care and treatment of covered persons.
- Require the physician to identify and hold the employer harmless from and against any and all liability in connection with the physician's activities under the agreement.
- Require evidence of adequate professional liability insurance and future notice of any cancellation of coverage, as well as notice of any malpractice actions.
- Include an organized method of ongoing, regular recredentialing of all participating physicians.

Making It Work with Employees

Communicating the program to the employees is essential.

- Describe the process undertaken in provider selection, quality review and credentialing.
- State that the patient (with family and physician) is ultimately responsible for determining the appropriate course of medical treatment in any given case, regardless of the benefits payable under the plan.
- Clearly allocate responsibility for medical diagnosis, treatment and provisions of medical services to the contracted and noncontracted facilities and providers.

Alternate Site Providers

Provider	Definition	Ownership	Savings
Freestanding Ambulatory Surgery centers	Provide outpatient surgical Services in facilities physically separate from a hospital.	Physicians Hospitals Corporate Chains	Cost savings associated With reduced length of stay.
Alcohol and Drug Abuse Centers	Inpatient, residential, emergency, intermediate and outpatient facilities, treating alcohol and substance abuse.	Hospitals Public and Private Organizations Physicians	Cost savings associated with ambulatory setting.
Mental Health Care Facilities	Psychiatric and other hospitals, community mental health centers, residential treatment centers and freestanding psychiatric outpatient clinics that provide inpatient and outpatient health services.	State and Federal Government Hospitals Physicians Public and Private Organizations	
Nursing Home	Provide a level of care less intensive than a hospital but more sophisticated than home care. Two types: skilled nursing care and intermediate care facilities.	75.3% Proprietary, 19.6% Non-Profit, 5.1% Government Owned in 1985	Often less than inpatient hospital care.
Independent Clinical Laboratories	Provide laboratory services for physicians, hospitals and other smaller laboratories.	Pathologists and other Physicians Corporations	
Physician Solo Practices	Two or fewer physicians in a single practice.	Physicians	
Diagnostic Imaging Centers	Provide a range of diagnostic services such as MRI, breast cancer diagnosis. Provide services for independent physicians and hospitals.	Physicians Hospitals Corporate Entities	Lower costs due to ability to stay open less than 24 hours/day; offers only profitable services; maintains lower overhead costs.
Birth Centers	Any health facility, place or institution that is not a hospital and where births are planned to occur away from the mother's usual residence following normal, uncomplicated pregnancy.	Physicians Certified Nurse-Midwives Business Groups Hospitals	Average birth center charge of \$643 compared to \$1,024 for hospital stay lasting less than 24 hours.
Hospice Care	An approach to treatment emphasizing palliative and supportive care to meet the needs of patients and family during final stages of	Independent Investors Hospitals Home Health Agencies Nursing Homes	Lower costs associated with emphasis on home care. Cost savings ranging up to 40% over traditional care.

terminal illness.

Home Health Care	Services and products to test patients at home for existing medical problems. Can require physician prescription and professional assistance.	Proprietary Chains Home Health Agencies Hospitals Visiting Nurses Association Skilled Nursing Facilities	Less costly than extended hospital inpatient care. Role as substitute for hospital admission is less clear.
Rehabilitation Centers	Designed to approach the whole process of restoring a disabled person to fullest mental, physical, economic and social well being.	For-Profit and Non-Profit Companies Religious Groups Hospitals	Existing statistics suggest savings often achieved.
Ambulatory Care Centers	Provide episodic and primary care; are physically separate from hospitals; extended office hours; no appointment needed; generally do not provide emergency care.	Non-Physician Corporations Physician Groups Single Physicians Hospitals	Costs slightly higher than physician office charges.
Physician Group Practices	Three or more physicians in one practice. Typically they are single specialty and have an average of 9.1 MDs.	Shared-Physician Ownership	