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SUMMIT

DPC Legal 101: Medicare, Medicaid, Tricare, IHS, PPOs, & HMOs – Addressing Each “Opt Out” Type Decision


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- ▶ Navigate to <https://aafp1.cnf.io/> and tap the session titled "DPC Legal 101: Medicare, Medicaid, Tricare, IHS, PPOs, & HMOs – Addressing Each DPC “Opt Out” Type Decision"
- ▶ OR just point your phone’s camera at the QR code to join directly



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Learning Objectives

1. Describe options for participation in Medicare and Medicaid, including when and how to opt out of Medicare Part B and considerations for determining an appropriate Medicaid approach at the state level.
2. Analyze payer and HMO agreements to identify provisions that may be unlawful or overly restrictive and assess their impact on physician independence, credentialing, and practice operations.
3. Compare strategies for navigating prior authorization and utilization management requirements to reduce administrative burden and support timely, patient-centered care.



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Abstract

- This review of all types of third party payors will go into detail about how a DPC practice can adjust to best serve patients covered by each of these third party payors in the DPC model. We will review how and when/if to opt out of Medicare. We will cover ordering, referring and prescribing status in Medicaid. We will cover less common questions about default Tricare and Indian Health Service contracts. We will review example Preferred Provider Organization and Health Maintenance Organization agreements for common pitfalls. We will review how to be acknowledged but not constrained by these organizations and how to most efficiently fight utilization management and nonform battles should you choose to engage in these administrative approval debates.



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Medicare in Parts

- Eligibility mostly = Age 65+, Disabled, ESRD
- Medicare Part A = Inpatient
 - Mostly automatic without the need for patient to pay a premium
- Medicare Part B = Outpatient
 - Patient must elect to pay for it with a premium (usually > \$200 per month)
 - Often declined by those that are still employed with other coverage
- Medicare Part C = Medicare Advantage (HMO)
 - Theoretically this private insurance company could pay a DPC fee
 - Example = Iora Health
 - Commonly you wind up with HMO-ish prior auth problems
- Medicare Part D = Prescription Drug Benefit
 - Offered by private insurance companies
 - Often capped at \$2,100 out of pocket drug spending per year

<https://www.cms.gov/medicare/enrollment-renewal/original-part-a-b>



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Medicare Provider Status Options

- Participating = accept Medicare and always take assignment
 - Patient pays 20% coinsurance
 - Default physician status as resident trainees, automatic PECOS #
- Non-Participating = accept Medicare, but take assignment on a case-by-case basis and must still bill in the regular manner but may charge up to 15% more than the Medicare approved amount.
 - Patient pays 20% coinsurance + 15% limiting charge (NY limited to 5%)
- Opted Out = Do not accept Medicare
 - Patient pays the entire cost under a private contract for covered services
 - Physicians remain credentialed with Medicare and orders for labs, DME followed
- Disenrolled = Unofficial status, not credentialed, not legally tested

<https://www.medicareinteractive.org/understanding-medicare/medicare-covered-services/outpatient-provider-services/participating-non-participating-and-opt-out-providers>



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Why should a DPC Dr opt out of Medicare?

- The ONLY reason to opt out of Medicare is if you want to
 - 1) see a Medicare patient,
 - 2) under a private contract,
 - 3) for covered services.
- All three of these must be true, or it is not worth your trouble to opt out.
- Most DPC physicians build a wait list of Medicare patients that want to join the practice prior to taking the step of opting out.
 - As the waitlist grows...
 - As the appetite for outside moonlighting work decreases....

<https://www.dpcfrontier.com/opting-out-of-medicare>



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Do the following **need** to opt out of Medicare?

- Pediatrician?
 - No, except for the rare child with ESRD they NEVER had Medicare patients
- “Concierge” Physician?
 - No, they are charging a membership exclusively for “noncovered” services
 - This comes with a burden to justify bundles of services as covered and other bundles as noncovered, and thus an obligation to bill Medicare for those services that are covered
- Physician seeing a 67-year-old “Medicare” patient for an office visit that is still employed and declined Medicare Part B?
 - No, this patient is “not a Medicare patient” for outpatient services
- Physician seeing a “Medicare” patient pursuant to a Part C patient pursuant to a Medicare Advantage arrangement?
 - No, private insurers can contract with a physician in front of regular Medicare



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Do the following **need** to opt out of Medicare?

- Physician that is collaborating with an NP or PA that opted out and is seeing a Medicare Part B patient under a private agreement for covered services?
 - Yes, everyone in the collaborative/documentation chain must opt out
- Physician that wants to allow Medicare Part B patients to join her DPC practice as regular members?
 - Yes, this is the most common reason to opt out as a DPC physician
- Physician that is merely cross covering for another DPC physician to see her panel while she is on vacation?
 - Yes, if the panel includes Medicare Part B patients



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Where (else) can I work **after I opt out of Medicare?**

- Places that WANT to privately contract with Medicare Part B patients:
 - Direct Primary Care clinics
 - Other forms of private medicine
- Places that NEVER bill Medicare Part B:
 - **Correctional Medicine (prisons and jails)**
 - Prisons = clinically closer to DPC (chronic and prevention focus)
 - Jails = clinically closer to an urgent care (withdrawal, more emergencies, less follow up)
 - Veterans Administration (some NEVER bill... others may secondarily bill)
 - Hospice Administration-Only
 - Occupational Medicine (Workers Comp) Only (OH, ND, WA & WY = state administered)
- Places that have a creative exception to bill Part B on a modified basis:
 - Emergency Department – If they will apply the GJ claims modifier to all claims
 - Urgent Care – If they will apply the GJ claims modifier to all claims
 - Exception – You cannot see any of your DPC member patients and bill this way

<https://www.dpcfrontier.com/opted-out-moonlighting>



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Don't You Wish All Your Patients...

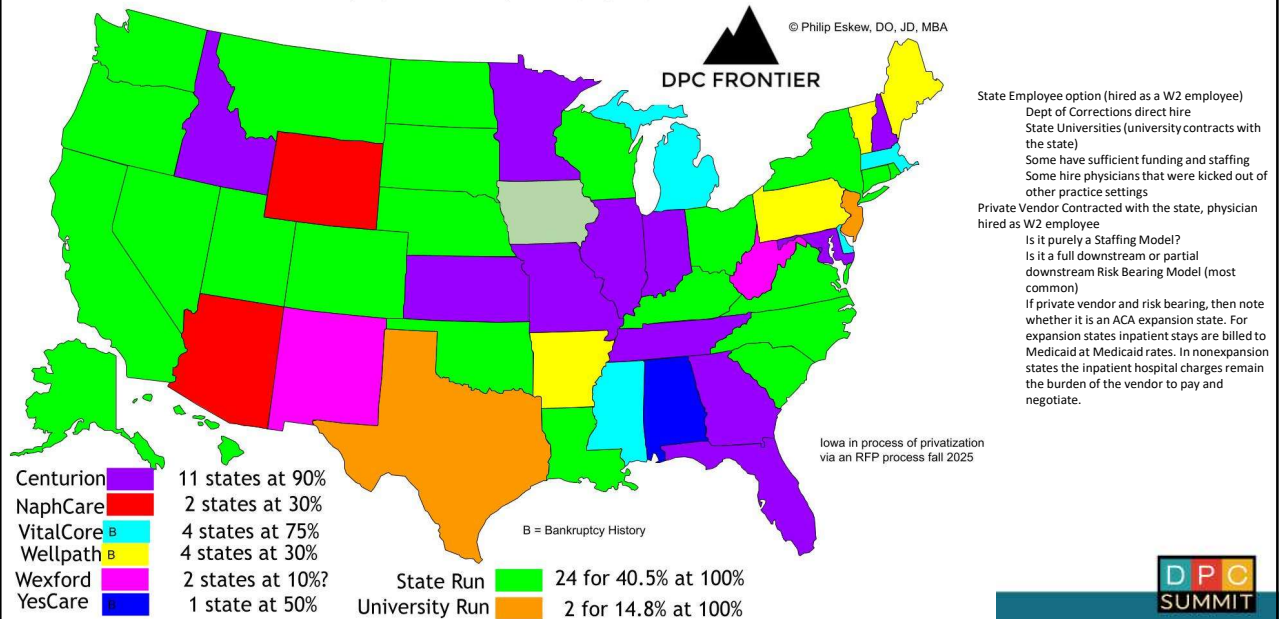
- Lived in a gated community?
- Valued safety more than anything else?
- Had free healthcare, housing, food, and clothes?



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2025 Prison Health Care By State

of states and % of company focused on prisons (vs jails)



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Legal Topics in Correctional Medicine

- Case Law via Estelle v Gamble (1976), Farmer v Brennan (1994) & Brown v Plata (2011)
 - Deliberate indifference violates a person's constitutional rights
 - 8th Amendment prohibits "cruel and unusual punishment" (post-conviction/prison)
 - 14th Amendment due process violation (pre-conviction/jail)
 - Bivens vs 42 U.S.C. § 1983 used to provide damages
 - Bivens claim is a civil rights lawsuit filed against a federal official for violation of a person's civil rights (this approach allows for monetary damages)
 - No malpractice caps apply. No need for an expert witness. Heard in Federal Court (usually defense prefers)
- Torts (Negligence / Medical Malpractice)
 - Expert witness needed outside "Res Ipsa Loquitur" (often needed to survive motion to dismiss)
 - State malpractice caps apply. Heard in State Court (usually plaintiffs prefer state court)
- Advanced Directives / Capacity
 - "He's incompetent" (legal statement) vs "He's incapacitated" (medical statement)
 - Incompetent to stand trial vs incapable of achieving informed consent
 - Competency tends to stick (once determined) and capacity can vary by the hour & decision complexity
- Privacy (HIPAA) still applies, but there are broader security exceptions
- Americans with Disabilities Act applies
 - Affects MAT for OUD. Make sure the facility has an ADA coordinator.
- State Medical Board Complaints are common (cheaper, easier, faster than litigation)
- National Practitioner Databank Report Implications (only malpractice in YOUR name)



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Clinical Difference Prisons vs Jails

- Prisons (More like outpatient family medicine, nursing home)
 - Usually incarcerated > one year
 - Inmates more likely to be programming and have jobs
 - Clinical work oriented around prevention and chronic conditions
 - KOP meds, hospice program, dialysis onsite
 - Historically less withdrawal, but varies with facility security efforts
- Jails (More like an urgent care or ER)
 - Usually incarcerated less than one year (average length of stay = 14 days)
 - Unlikely to have time to pursue programming or employment
 - Clinical work oriented around acute & emergent conditions (withdrawal)
 - Disproportionate amount of podiatry, callus and ulcer treatment
 - More chest pain and abdominal pain



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Correctional Medicine – In a Direct Primary Care-Ish Manner?

- Prisons vs Jails & Small vs Large
 - You will likely prefer prisons (continuity of care)
 - You will likely prefer smaller facilities (better follow up with consistent panel)
- Be like Direct Primary Care
 - Preferably no co-pay
 - Longer face to face visits
- Avoid Third Party Fee For Service mentality. No coding!
- Utilization management decisions
 - Local
 - Collegial & Educational
 - Timely
 - Involving patient interaction rather than a mere chart review



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Co-Pay for care in State Prisons

AL \$4 AK \$5 AZ \$5 AR \$3 CA \$5 CO \$3 CT \$3 DE \$4
 FL \$5 GA \$5 HI \$3 ID \$5 IL \$5 IN \$5 IA \$3 KS \$2
 KY \$3 LA \$3 ME \$5 MD \$2 MA \$3 MI \$5 MN \$5 MS \$6
 MO \$0 MT \$0 NE \$0 NV \$8 NH \$3 NJ \$5 NM \$0 NY \$0
 NC \$5 ND \$3 OH \$2 OK \$4 OR \$0 PA \$5 RI \$3 SC \$5
 SD \$2 TN \$3 TX \$100/yr UT \$5 VT \$0 VA \$5 WA \$4
 WV \$5 WI \$7.50 WY \$0 Federal \$2

Summary:

41 states charge a co-pay averaging \$4.18 + Feds at \$2
 8 states do not charge any co-pays (MO, MT, NE, NM, NY, OR, VT, WY)
 Texas charges a \$100 annual fee
 Inmate pay often starts around \$0.12 per hour



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Medicare Part D Coverage

- Deductible stage: If your Medicare plan has a deductible, you pay all out-of-pocket costs until you reach the full deductible. No Medicare drug plan may have a deductible more than \$615 in 2026. Some Medicare drug plans don't have a deductible.
- Initial coverage stage: After you reach your full deductible (if your plan has a deductible), you'll pay 25% of the cost as coinsurance for your generic and brand-name drugs until your out-of-pocket spending on covered Part D drugs reaches \$2100 in 2026 (including certain payments made on your behalf, like through the Extra Help program). Then, you'll automatically get "catastrophic coverage."

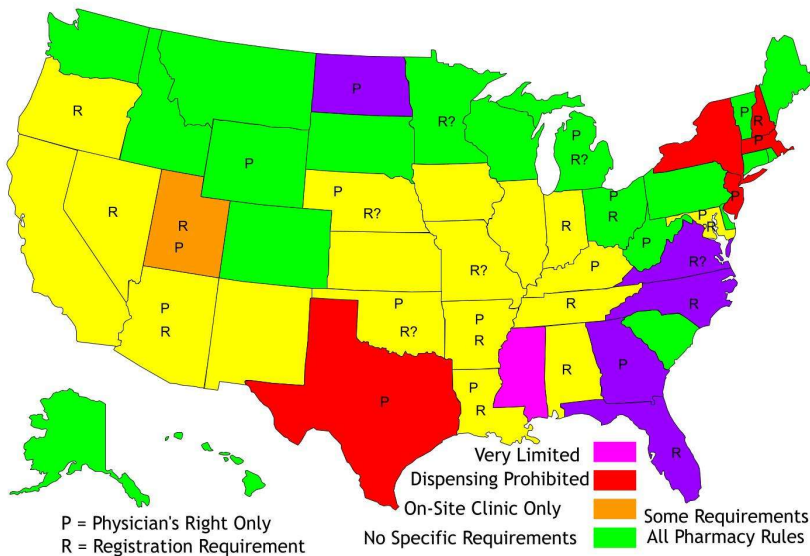
<https://www.medicare.gov/health-drug-plans/part-d/basics/costs>



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May I still dispense Medications for a Medicare Part D patient?

Physician Dispensing Regulations



Yes, assuming it is permitted in your state.

Remember that this will NOT apply to their deductible or their yearly out of pocket max when you dispense the medication directly (since you are not billing the Medicare Part D entity as a pharmacy).

<https://www.dpcfrontier.com/dispensing-medications>



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Dispensing Medications

- Florida - \$100 fee
- Louisiana - \$75 fee
- **Maryland - \$1050 fee, long application**
- **Massachusetts – Prohibited**
- Montana – \$ Fee with registration (amount unknown)
- Nebraska - **\$625 Fee**
- **Nevada - \$300 Fee (paid again with any address change), voluminous application & rules**
- **New Hampshire – Prohibited**
- **New Jersey – Prohibited** (except **student health ctr**, fam planning/prenatal clinics)
- **New York – Prohibited** except if **>10 miles from a pharmacy**, allergies, oncology, AIDS, or **affiliated with a postsecondary institution**
- North Carolina - \$75 Fee
- Oregon - \$100 Fee
- **Texas – Only in specific rural areas (county with fewer than 5,000 people, office not within 15 miles of a pharmacy), otherwise prohibited**
- **Utah – onsite clinic only** (unless oncology med), **prepackaged (no pill counter)**, \$110 fee
- Virginia - \$240 fee

Registration?
 Fee?
 Physician only – or NP or PA too?
 May you repackage?
 Delegation? (zero in Mississippi)
 Policy Autonomy? (See GA example)

<https://www.dpcfrontier.com/dispensing-medications>



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Why Might Medicare Patients Be Less Likely To Join Your DPC Practice?

- Less Price Sensitive
 - Part B deductible = \$257 then 20% of each billed office visit amount
- Your practice is likely charging (older) Medicare patients a higher monthly fee than it charges other (younger) patients
- Patients prefer physicians near their own age (if you are younger)
- Patients may already be resigned to seeing multiple specialists and may have concluded that broad scope primary care as a concept died years ago
 - Common mentality in suburban and urban settings
 - Less common hurdle in rural or frontier settings

<https://www.medicare.gov/basics/costs/medicare-costs>



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What are the Steps to Opting Out of Medicare?

- “Participating physicians and practitioners may opt out if they file an affidavit that meets the criteria and which is received by the carrier at least 30 days before the first day of the next calendar quarter showing an effective date of the first day in that quarter (i.e., **January 1, April 1, July 1, October 1**).” [From CMS Benefit Policy Manual (Rev. 147, 08-26-11) Sec. 40.17]
- Note that a participating physician must give his or her carrier **30-days’ prior notice** by sending in the opt-out affidavit with an effective date of the beginning of the next quarter. The physician may not provide private contracting services until the first date of the next quarter that is at least 30 days after receipt of the notice by the carrier. For example, the carrier must receive the notice from the physician by **Sept. 1** if the physician seeks to provide private contracting services beginning on **Oct. 1**.
- Notify your patients that you are opting out of Medicare.
- File a copy of the following affidavit with proof of delivery (such as certified mail, return receipt requested) that you keep in your records along with a copy of your opt out affidavit, by sending your affidavit to **“each carrier that has jurisdiction** over the claims that the physician or practitioner would otherwise file with Medicare.”
- Install procedures to ensure that your office never files a Medicare claim, and never provides information to a patient that enables him to file a Medicare claim.
- Mark your calendar to have Medicare patients re-sign a new private contract every two year’s on the anniversary of your opt out effective date. While Physicians opting out on or after June 16, 2015 will no longer need to renew their opt out every two years, **CMS currently still requires patients to renew the private contract every two years.**

<https://aapsonline.org/opting-out-of-medicare-a-guide-for-physicians/>



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Medicaid –May a DPC physician privately contract with a Medicaid patient for covered services?

- Participating
 - Still privately contract even when “signed up?” Unlikely...
 - Do not participate and privately contract unless you like to litigate
- Never Enrolled / Disenrolled
 - This is your default status. Essentially uncredentialed.
 - Free to private contract (**except in CO & KY**) but orders (Rx, Labs, DME) are ignored
- "Ordering and Referring Only" Status
 - Credentialed so that orders are honored, but with freedom to privately contract.
 - Required option must be created per the ACA, but not all states bothered to comply
- Opted Out?
 - No. This status does not exist with Medicaid. Wrong/Confusing terminology
 - Please do not tell people you “Opted Out of Medicaid”



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Which States Prohibit Any Medicaid Private Contracting [No Matter Your Status]?

- Colorado (via legislation)
 - “Colorado law (C.R.S. § 25.5-4-301(I)), provides that **no Health First Colorado member shall be liable for the cost**, or the cost remaining after payment by Health First Colorado, Medicare, or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law **applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled** in the Colorado Medical Assistance Program (C.R.S. § 25.5-4-301(II)). This law applies **even if a Health First Colorado member agrees to pay for part or all of a covered service.**”
- Kentucky (via prior governor executive order)
 - If a provider renders a Medicaid-covered service to a recipient, regardless of if the service is billed through the provider’s Medicaid provider number or any other entity **including a non-Medicaid provider**, the recipient shall not be billed for the service.

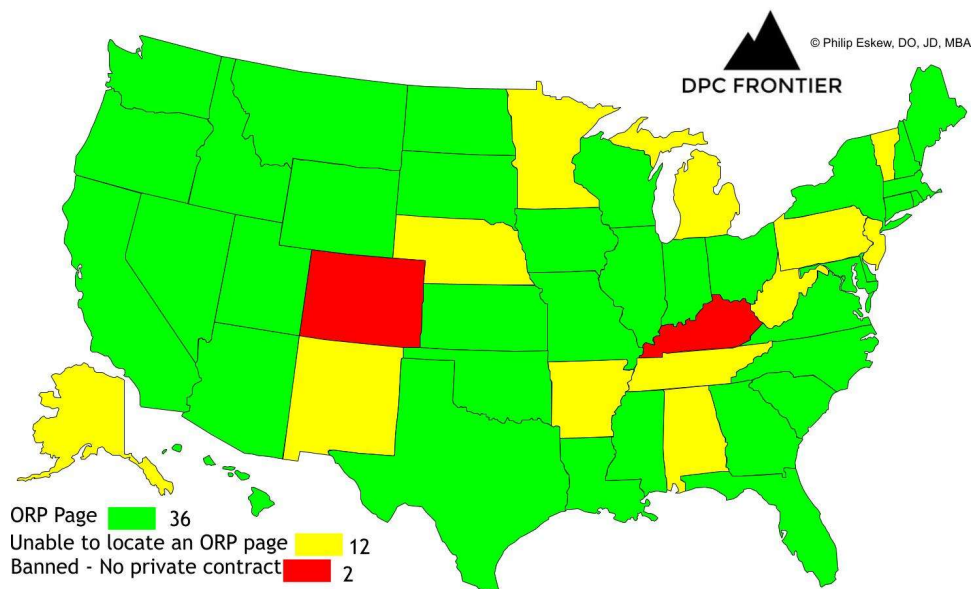
<https://hcpf.colorado.gov/policy-statement-billing-medicaid-members-services>



<https://www.dpcfrontier.com/kentucky>

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Medicaid ORP Status Summary



<https://www.dpcfrontier.com/medicaid>



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What is TRICARE?

- “TRICARE is the health care program for uniformed service members, retirees, and their families around the world. TRICARE is managed by the Defense Health Agency under leadership of the Assistant Secretary of Defense (Health Affairs).”
- Tricare Young Adult Select Monthly Premium \$337
- Common catastrophic cap around \$1,288
- \$300 Individual Deductible

https://tricare.mil/Publications/Costs/costs_fees



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TRICARE Provider Types

- “[A]ll TRICARE providers must be authorized/certified under TRICARE Regulation and must have their authorization/certification status verified by the regional contractors in each region.”
- **Network Providers**
 - If you decide to become a network provider, you will sign a contractual agreement with the regional contractor in your region. You will:
 - Agree to provide care to TRICARE beneficiaries at a **negotiated rate**.
 - Accept the beneficiaries' copayment or cost share as payment in full.
 - **File claims with TRICARE** for the remaining amount.
- **Non-Network Providers**
 - If you don't want to sign a contract, you can be a non-network provider, but you **must be certified by the regional contractor**. As a non-network provider you can decide to be a "participating provider" or a "non-participating provider."
 - **Participating providers agree to file claims for beneficiaries**, to accept payment directly from TRICARE and to accept the TRICARE allowable charge as payment in full for their services.
 - **Non-participating providers do not agree** to accept the TRICARE allowable charge **or file beneficiary claims**.
 - **Non-network providers can choose to participate on a claim-by-claim basis**. You don't have to be participating or non-participating all of the time.

This is how people wish Medicare worked! Case-by-case flexibility!
 East Region = East of Mississippi River = Humana Military
 West Region = West of Mississippi River = TriWest Healthcare Alliance

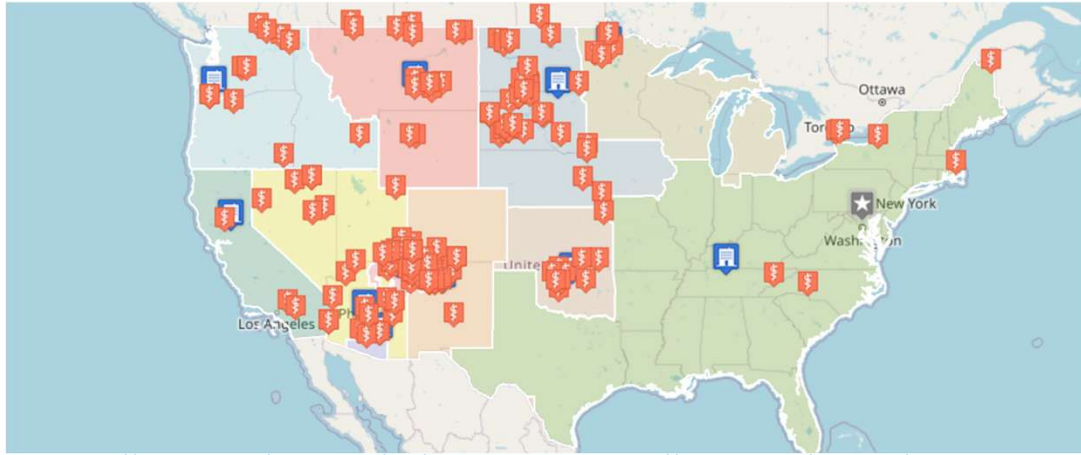
<https://dha.mil/Working-with-DHA/Become-a-TRICARE-Provider>



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Indian Health Service

- 573 federally recognized American Indian & Alaska Native tribes & villages.
- Provider newsletter not updated since Nov 2017 <https://www.ihs.gov/provider/>



<https://www.ihs.gov/provider/>

<https://www.ihs.gov/location/>



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Indian Health Service

PRC = Utilization Management Fund Rationing

- “The Indian Health Service is **funded each year through appropriations** by the U.S. Congress. The Indian Health Service is **not an entitlement program**, such as Medicare or Medicaid. The Indian Health Service is **not an insurance program**. The Indian Health Service is not an established benefits package.”
- “Direct health care services are services provided at an IHS/Tribal/Urban facilities/**Purchased/Referred Care (PRC)** are services that the IHS is **unable to provide in its own facilities**. PRC are provided by non-IHS health care providers and facilities. PRC payments are authorized based on clearly defined guidelines and are **subject to availability of funds**. The Indian Health Service cannot always guarantee that funds are always available. Funds appropriated by the U.S. Congress currently cover an estimated **60% of health care needs** of the eligible American Indian and Alaska Native people.”
- “Unfortunately, that means that services obtained under PRC must be prioritized, with **life-threatening illnesses or injuries** being given highest priority. The patient medical referral is reviewed by PRC to determine if the medical need is within the available funding at that time. It also means that the **IHS formulary** (the list of drugs and medicines available from IHS pharmacies) may not include all drugs and medicines, but will include most of the ones that have proven to be beneficial and cost-effective.”



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Health Sharing Ministries

- May point patients your direction as ministries prefer transparency
- Do not ask or expect a ministry to pay the patient's monthly fee
- Avoid analogies of "not insurance" at the state level
- When referred outside your practice, patients legally are "uninsured"
- Altrua Healthshare (tax status is less clear – has a letter from CMS)
- Christian Healthcare Ministries
- Liberty HealthShare
- Medi-Share (Christian Care Ministry)
- Samaritan Ministries
- Zion Health (formed post ACA, DPC Focused, does not "avoid fine")

<https://www.dpcfrontier.com/health-sharing-ministries>



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Gospel Light Mennonite Church Med. Aid Plan v. N.M. Office of the Superintendent of Ins.

- 2023 U.S. Dist. LEXIS 121271 *
- GOSPEL LIGHT MENNONITE CHURCH MEDICAL AID PLAN d/b/a **LIBERTY HEALTHSHARE**, BREANNA RENTERIA, LAURA SMITH, and TAMMY WATERS, Plaintiffs, v. NEW MEXICO OFFICE OF THE SUPERINTENDENT OF INSURANCE, and JENNIFER A. CATECHIS, Interim Superintendent of Insurance, in her official capacity, Defendants
- Allegations:
 - Liberty has been selling and administering illegal health insurance under the guise of a faith-based health care sharing ministry as a way to avoid paying taxes and state and federal government oversight.
 - Liberty officials used member contributions to pay inflated service costs to companies operated by friends and relatives instead of using the money to pay member medical expenses, leaving members stuck with paying large medical bills on their own.
- Portions dismissed on motion, other arguments going to trial
- Ohio Attorney General had 288 complaints against Liberty
- BBB listed 1,114 complaints against Liberty
- Liberty paid \$352 million in medical expenses for members
- Served 70,000 families nationwide in 2020
- Statement of Christian belief without church affiliation requirement

United States District Court for the District of New Mexico, July 14, 2023, Filed, Case No. 1:23-cv-00276-MLG-KK



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“BUCA” Plans

- Generally prohibit private contracting for “any covered services”
- The DPC practice must “accept assignment”
- Rarely have the equivalent of Medicaid OPR status
 - Could ask to be credentialed with no obligation to bill
 - More important with an HMO than a PPO since the PPO is more likely to continue to follow orders from out of network physicians
- Avoid any contractual obligations to spend extra time on their utilization management or prior authorization processes
- Follow 90 or 180 contract exit notice periods remaining aware of your state’s patient abandonment law (medical practice act)



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Prior Authorizations & Non-Formulary Meds

- Find a link to the 100-page formulary and send it to the patient
- Ask the patient to attend any appeal phone calls and complete all prior auth forms with you (so they fully understand the burden)
- Consider the Greg Zydiak, MD approach
 - Offer to complete the insurance company’s PA for payment to you
 - Send [Gary Gibson, MD v Medco Health Solutions of Columbus North Ltd.](#)
- If you have a policy to NOT complete prior auths – inform patients
- Should you charge an itemized prior authorization fee outside the membership fee?
- BCBS has filed suit against Out of Network DPC practices for **COMPLETING** Pas (place on the state “watch list”)

<https://www.cigna.com/static/www-cigna-com/docs/medicare/plans-services/2025/formulary-extra.pdf>
<https://www.dpcfrontier.com/blog/2016/2/20/prior-authorizations-price-transparency>



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Utilization Management Example

- Eric Tennant (Bridgeport, WV) died in 2025
- Cholangiocarcinoma treated with chemo and radiation for 3 years
- Histotripsy recommended to treat liver tumor with ultrasound
- “After KFF Health News and NBC News posed a series of questions to UnitedHealthcare and the Public Employees Insurance Agency about Eric’s case, the agency reversed course. PEIA decided to cover his treatment. But the approval came too late. Eric was hospitalized in late May and prescribed medication that prevented him from undergoing histotripsy at that time.”

<https://kffhealthnews.org/news/article/prior-authorization-denials-cancer-treatment-west-virginia-death/>



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Utilization Management

- Supposed to apply “objective” guidelines/criteria to determine medical need
 - Often done by artificial intelligence and rubber stamped
 - 1:4 physicians report it has caused a serious adverse event
 - Could report rubber stamper to the medical board...
- Why did UnitedHealth Group purchase Change Healthcare?
 - Because Change Healthcare maintains InterQual (sale contested on antitrust grounds)
 - Now we know why BCBS switched to MCG (after court allowed the sale)
 - https://providers.anthem.com/docs/gpp/KY_CAID_InterQualMCGCareGuidelines.pdf?v=202212081628
- InterQual (Optum)
 - Charge for access to their criteria which they update annually
 - You can still request a determination criteria outline page (at no cost to you)
 - Applied to assess the need for a consult, but only criteria for initial consult
- Milliman Clinical Guidelines (MCG) (Hearst Health)



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Utilization Review (FBOP Example)

- Prospective (prior to service delivery and use of resources) review of requests for specialized medical, mental health, and dental services that cannot be provided in the HSU.
- Concurrent (during service delivery and use of resources) review of the use of inpatient medical and mental health beds and specialty services; monitoring the span of treatment and length of inpatient stay; tracking orders for services to ensure services are completed in a timely manner; and managing catastrophic care cases by providing care in a cost-effective setting.
- Retrospective (after service delivery and use of resources) review of the efficacy of care and resource utilization.

https://www.bop.gov/policy/progstat/6031_005_cn-2.pdf



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Utilization Review (FBOP Example) Prospective Examples Common to Family Medicine

- Usually Required:
 - Consults: orthopedics, cardiology, gastroenterology, urology, general surgery
 - Diagnostics: MRI, CT, Ultrasound
- Usually Waived:
 - USPSTF Level A & B preventive screenings
 - Optometry for DFE for diabetic patients

https://www.bop.gov/policy/progstat/6031_005_cn-2.pdf



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Utilization Review (FBOP Example)

- **Medically Necessary**
 - Emergent (often default approval with *retrospective* review)
 - Non-Emergent: not immediately life-threatening, but without care the inmate could not be maintained over time without significant risk of:
 - Serious deterioration of an otherwise manageable condition leading to premature death.
 - Significant reduction in the possibility of repair later without **present** treatment.
 - Significant pain or discomfort that impairs the inmate's participation in activities of daily living.
- **Medically Acceptable – Not Always Necessary**
 - Joint Replacement, Septoplasty, ACL repair, Carpal Tunnel Release
- **Limited Medical Value**
 - Skin Tags, Lipomas, Blepharoplasty
- **Extraordinary**
 - Investigational or affect another's life (organ transplant)

https://www.bop.gov/policy/progstat/6031_005_cn-2.pdf



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Utilization Management Determination

- Approved (if you study and include the magic words!)
- Alternative Treatment Plan (ATP) (aka denial)
- Did they suggest something meaningful (a real plan)?
- Did they play dumb and suggest something you already tried?
- Were you following their suggestion only to have a new request fail?
- Did you request a peer to peer (and invite the patient to attend)?
 - Remember that reviewing nurses are practicing nursing
 - Remember that reviewing physicians are practicing medicine
 - This means the patient could report them to nursing or medical boards



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Patients May Decline Insurance Pricing Fictitious “Negotiated Discounts” via HITECH

- Section 13405(a) of the HITECH Act requires that when an individual requests a restriction on disclosure pursuant to 45 CFR § 164.522(a)(1)(vi), “A covered entity **must agree** to the request of an individual to restrict disclosure of protected health information about the individual to a health plan if:
 - (A) The disclosure is **for the purpose of carrying out payment or health care operations** and is not otherwise required by law; **and**
 - (B) The protected health information pertains solely to a health care item or service for which the **individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.**”

Some states have HMO and Medicaid exceptions. Federal law trumps all over private health plans and applies within Medicare.

<https://www.dpcfrontier.com/hitech>



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Should You Obtain Hospital Privileges?

- Will this mandate ER on call duties for unassigned patients?
- Will this mandate continued board certification?
- Will the hospital charge a credentialing fee?
- Have you reviewed the hospital staff by laws to ensure a low risk of sham peer review?



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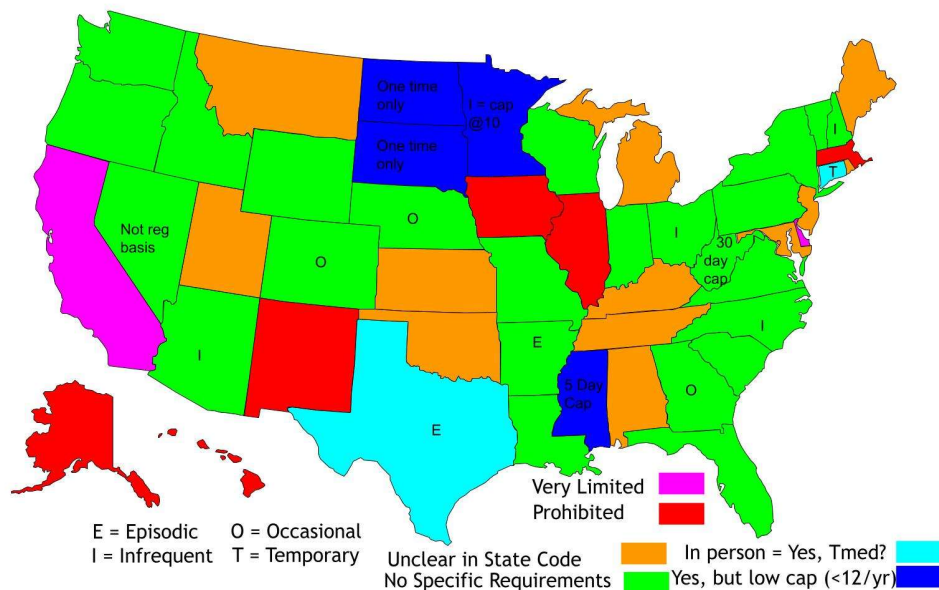
How do you get (your favorite) specialist involved?

- Primary care physicians commonly seek the advice of a specialty consultant. Consultant physicians often provide this advice via telemedicine. Traditionally to establish a treatment relationship with a patient the consultant physician must also be licensed in the state where the patient is located (assuming the patient is not willing/able to travel TO the consultant). **If the specialist is interested in seeing the patient via telemedicine along with the primary care physician** (this could often be a three way conversation for DPC practices), then there are many states where **the consultant does not need to have a license** in the state where this patient is located.



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Consultant State Licensure Exceptions



<https://www.dpcfrontier.com/consultants>



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Summary of Your Homework Action Items:

- State Medical Practice Act (Read it all please! Something will surprise you!)
 - Definition of Direct Primary Care (often added near the insurance code)
 - Collaboration Rules, Ownership (CPOM) rules, Fee splitting (marketing) rules, Specific CME rules, Addiction Medicine Restrictions
 - Dispensing regulations (may also requiring reading board of pharmacy documents)
- Medicare Approach:
 - “Participate” to Preserve full moonlighting flexibility (build a waitlist first) & decline DPC Medicare part B patients initially
 - Opt out of Medicare (2-year commitment) – moonlighting in correctional medicine (maybe VA, hospice, IHS)
 - Play the old fee for noncovered services (old-style concierge) legal game (not cheap, keeps 3rd part FFS hassles)
- Medicaid Provider Manual language
 - Participating Status, OPR Status, or Not enroll (disenroll). No flexibility in KY or CO.
- Contracts
 - Medical Malpractice Insurance Agreement (appropriate amounts? Included benefits?)
 - Old & New Employment Agreements (negating noncompetes, avoiding paybacks, timing your post-bonus departure)
 - Stopping third party insurance agreements (watch notice timelines, navigate any patient abandonment concerns)
 - Brokers, Marketers, EMRs, Labs, Wholesalers, Membership Management, Payroll / HR / Accounting / Benefits software
 - DPC patient membership agreement & Large Employer Service Agreements & Health Sharing Ministry or TPA Agreements
- HIPAA and HITECH Compliance
 - Hospitals often violate patient’s rights (this is easier as a small DPC practice) Ransom wear insurance? (via vendor?)
- TRICARE, Health Sharing Ministries, BUCA prior authorizations and & utilization management = which are worth it?
- Sham Peer Review Risk - Do you *want* to have any hospital privileges? Does it make orders or moonlighting easier?



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Live Content Slide

When playing as a slideshow, this slide will display live content

Social Q&A for DPC Legal 101: Medicare, Medicaid, Tricare, IHS, PPOs, & HMOs – Addressing Each DPC “Opt Out” Type Decision



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Questions?

- Where does Emma Jean work?
 - Radiology
- What did the Psychiatrist say to the utilization management physician when he showed up complaining about his work?
 - I understand you are in denial about your denials

