

The Doctor's Office

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NUMBER 138
NOVEMBER 1993

Don't get trapped when third parties go bankrupt

A few years ago, this headline would have read: "Don't get hurt if one of the third parties you deal with has financial difficulties." How times have changed in the past few years!

- In 1990, BCBS/West Virginia *failed financially...and failed to pay more than \$40 million owed to medical providers.*
- More than a dozen other BCBS plans are currently reported to be "financially shaky."
- In 1991 alone, 37 private-sector life/health insurance companies "failed."
- Since 1989, at least 65 HMOs have gone out of business...either through formal bankruptcy proceedings; or by just shutting their doors and walking away from "their" problems. The most damaging of these failures: *\$200 million* in back-claims, that providers never collected when Maxicare Health Plan went bankrupt.

How great is your financial risk?

Total your October income from *all* third parties except Medicare/Medicaid and there's your worst-case scenario. That's how much *hard cash* you could lose if every third party you deal with were



to "fail" during the coming year.

And then there's the Government.

The present Administration is determined to "do something" about America's "healthcare crisis"...and what they "do" could cause a major shakeout in the medical insurance industry. We have only one comment on that score: If *your* third parties are going to be shaken out of the system, *we want you to get your money first!*

As of this writing, that's as bad as it gets. Now: here's what you can do to make it better!

1. Don't do business with losers. Just as you check out the credit-worthiness of individual patients before letting them run up more than a few hundred dollars in past-due bills, *check out the financial stability of third-parties who expect you to give them a "line of credit" worth several thousand dollars per month.*

Your hospital may be in the Managed Care business...

If they are, they're in an ideal position to look after patients' best interests... maintain the hospital's financial stability...and provide *you* with steady work plus reasonable reimbursements.

- Have your accountant or lawyer (or both!) review the company's financial records for the past several years, and put some tough questions to management: What's your current net worth, assets, debts, and cash flow? What's your cash-to-claims ratio? How about your premium reserves; do you have enough to cover 45 days' worth of claims? Are your profit margins better than two percent? Consistently? How about 1.5 percent?

- Don't expect much from the "little guy." HMOs with fewer than 50,000 enrollees, and IPAs with fewer than 2,500 members, are very vulnerable in times like these; they just don't have resources to leverage when the competition gets tough. If you do contract with small third parties, get the most favorable terms you can, and be prepared to bail out *pronto* when you see signs of trouble (slow payments, fewer subscribers, low cash reserves). If you already have a contract with a little guy, monitor your receivables...and prepare to negotiate with any "bigger guy" who may (soon!) buy the little guy out.

- Talk to Employee Benefits Managers at firms that have contracts with the third party. Are they pleased with the service? Are they looking forward to renewing the contract? Are most of the plan's clients long-term (more than three years) or short-term (less than one year)? It takes three years to *stabilize* the relationship.

- Find out *who* is covered by the plan: a high percentage of low-demand patients, such as prime-of-life working couples? A large number of high risks, who are

certain to demand more medical care than current premiums can cover? A healthy mix? Let the demographics tell you: Is this company likely to pay out more money than it takes in next year? If so, *get away from the plan this year!*

- Talk to other providers who hold contracts with the plan. Do they represent the best in your community? Are they pleased with the plan's patient load, support services, and reimbursements? Or do they feel "stuck"?

- Demand to know: "What is your current reimbursement turnaround time?" Worse than 50 days? Uh, oh! Cash flow too low! Get your coat and go!

- Ask about claims denials. Too many? They may be pressuring physicians to deny necessary medical care to their patients... which means the plan will soon be telling you how to practice medicine! Too few denials? Just as dangerous; the plan is probably losing money because it doesn't know how to manage healthcare cost-effectively.

- Ask who *owns and runs* the company. Find out if the owners are respected in the insurance industry, and how long the managers have been at their jobs. *Longevity* is 18 months or better; less than 18 months is *shortevity*, and a sign of low commitment.

- Avoid "hold-harmless" clauses like the plague. Many third-party contracts contain a clause that says something along the lines of, "Patients will be held harmless for any claims not paid by this company, for any reason." In other words, if the company "fails," you cannot legally collect

from the patient. Strike that clause out of the contract. You may want to have the plan's enrollees sign a statement along the lines of: "I agree to pay for all services provided to me, if my insurance company cannot or will not pay...for any reason." (In some states, third-party enrollees are "held harmless" by law; so there's not much a provider can do to collect from patients if a third party does go bankrupt.)

- Make sure the contract *requires* the third-party to inform you *automatically* of "revisions" in reimbursement schedules, covered services, and changes in the plan's fiscal standing. Most third-party contracts offer to provide this information "on request"—so you could miss out on signs of trouble if you don't ask.

- Insist on a clause that allows you to terminate the contract if a payer falls more than 60 days behind in its payments.

- **Finally, put a reasonable limit on the number of patients each third party can send you.** If you don't, you may find yourself running your practice on the third party's terms as long as they stay in business...and losing a major percentage of your income if they go out of business or you find you can't live with their rules.

2. If a third party does go bankrupt, be the first to "go where the money is." There's always *something* left when a firm fails; and there's always *somebody* who puts that something in his or her pocket or purse. We want *you* to be that *somebody*; so:

- If the payer is state-regulated (HMOs usually are *not*), file your claim with the state "guaranty fund," designed to cover payments owed by defunct third parties. "Guaranty" is, of course,

one of those funny terms that convey one idea and mean the opposite. You'd think this fund would *guarantee* to cover all outstanding claims; but what it *does* is to pay a percentage of the money owed, after a long and discouraging waiting period, *to the providers who get their claims in early* and who meet certain criteria. Notice what we emphasized: **GET YOUR BILLS IN EARLY.**

- Contact employers, labor unions, and other parties that signed the third-party contract. These parties may not be protected by a "hold harmless clause," and you may be able to tell them "Send me the money!"

- *Contact your lawyer...if the uncollected debts are great enough.* You may be able to convert third-party patients to private-pay...relieving you of the obligation to provide services to patients who'll never be legally obligated to pay for those services. You may be eligible to sue employers on grounds of "negligently contracting with a financially unstable third party." Your attorney should be able to find out who has the "deep pockets" and how to reach into them.

In today's medical marketplace, third-parties and managed care organizations control most of the patients...and practically all the patients who have significant financial resources. This makes physicians doubly vulnerable: you practically have to sign up with third parties if you want to market your services to the patients they control; but you have no control over the financial future of those third



parties.

Your hospital may be in the Managed Care business. If they are, they're in an ideal position to look after patients' best interests...maintain the hospital's financial stability...and provide

you with steady work plus reasonable reimbursements.

If they aren't, you may want to encourage other doctors in your area to band together to form IPAS and offer your own managed care plans.

Become an "EMT" (Emergency Manager of Time)

Emergencies—genuine medical crises—can cause even the most conscientious doctor to fall behind schedule or get to the office *late*. Hospitals—realizing there is a "Golden Hour" that can mean life or death for accident victims—maintain Medic units staffed with EMTs. Practices—realizing there's a "Leaden Hour" that can turn waiting patients into nervous, *nasty* people—may want to name a staff member as "EMT." Someone who can respond in an *Emergency*, and *Manage* to keep patients...placid...at least for the *Time* being.

Just as a hospital EMT has life-support equipment on board the Medic unit, so there are a number of "sanity-support" options available to the Practice EMT:

Honesty. As soon as you learn the doctor will be late, go to the reception area and say, "I'm sorry; the doctor will be delayed* about XX minutes for this (legitimate reason). We do respect your time, so we have some ways to help you make the most of the time until Doctor _____ arrives.

**Again, please excuse us for this inconvenience." Then mention the options available to patients.

Rescheduling. Once people know how long the delay will be, they

can make an *informed decision* on whether to wait or reschedule. (Yes: they make the decision; taking you off the hook!) Invite *everyone* who prefers to reschedule to come to the reception desk *right away*. This lets you know how much *time* the doctor will not have to spend with pre-scheduled patients when he or she *arrives*. You already know how much *time* will be lost during the doctor's *delay*. Now: if you can reschedule an amount of time equal to the *delay*, you will *not* have to call patients scheduled to be seen later in the day and ask them to reschedule their appointments. What if everyone in the waiting room chooses to wait it out? At least you'll know how many patients must be called and told, "I'm sorry; the doctor will be delayed XX minutes for *this* legitimate reason. Would you mind coming in XX minutes later? Or would you prefer to have me reschedule your appointment?"

Free phone calls. People arrested by police have a traditional right to "one free [local] phone call." Patients "arrested" by a delay in a doctor's schedule will appreciate using your phone to call the babysitter, the dentist, the husband—whoever is next on *their* appointment schedule—and say

* *Doctors are never "late" (gives the idea they had a choice in the matter); they are *delayed* (through no fault of their own). Doctors aren't "away from" the office (discouraging!); they are always about to *arrive* (which is always encouraging).

something along the lines of, "Look, I'm at the doctor's office and I can't make bail—can you reschedule my appointment/turn the oven to 375 degrees/whatever?"

Education. You probably have "take-one" pamphlets on exercise, dieting, childhood diseases, adult stress, first aid, the basic symptoms of diseases you treat. Take a pamphlet you're familiar with, and invite patients to a *consumer education* session in your conference room.

Storytelling. Same as "Education," but directed to kids, based on Dr. Seuss instead of JAMA, and with more of an *entertainment* value. (Kids may be entertained by Dr. Suess, and adults may be educated by Pt Ed.)

Videos. Same as "Education" and "Storytelling," only you have to buy a TV and VCR to go with them. Works best when you're busy.

Snacks. Crackers; fruit juices; fresh fruit...anything that can be stored easily, handed out readily, and eaten by the staff if the doctor isn't delayed before it spoils.

Place mats. Restaurants have them: they're printed with puzzles and games, and the server brings a can of crayons so customers can doodle in case the entrees are ...delayed. Printers and ad agencies in your area may design such busy pieces, and offer them to medical practices.

Hand-held video games. Same as "Place Mats," but more expensive.

Toy rotation. Pull a toy from the shelf every month and put it away. Bring it out three months later, and the kids will think it's something new.

You can change the "leaden hour" into a Golden Opportunity

to keep waiting patients not merely placid, but *pleased*. Maybe not thrilled that the doctor has been delayed; but satisfied that your EMT has *arrived*...with a selection of great ideas to make waiting time Entertaining, Meaningful, and Tension-free.



What's a "funding company"? And do you need one?

Funding companies exist because millions of Americans have no medical insurance, yet they still need (elective as well as acute and emergency) medical services. They also exist because someone found a new way to get between doctors and their patients and make money.

Funding companies work very much like (but not exactly like) credit card issuers: they loan money to patients (who must repay with interest), and pay the doctor's bills immediately (minus a service charge). In other words: Here's one more credit option for the practice that wants to speed up its cash flow.

Funding companies deny credit to patients they consider poor credit risks. Can't blame them for that; but that's the first fact to consider when deciding whether or not to get involved with them:

- Often the patients they reject as "poor risks" are the very patients you should reject as "credit customers."
- The patients they accept are people who would probably pay you anyway...eventually. Which means the funding company doesn't bring in "more money"; but they do bring in the same amount of money, faster.

Potential problems with funding companies:

1. *Their contracts may not offer a **nonrecourse clause**.* This means that if the patient doesn't pay, the company can demand reimbursement from *you*. We suggest that you *avoid* doing business with any financing agency that does not guarantee you in writing: "Once we take over the loan, you're **free and clear...forever!**"

2. Their "discount fees" may be considerably higher than those charged by credit card issuers. Most bank cards charge between two percent and five percent; but funding companies may charge eight percent or more!

3. Funding companies are likely to be much tougher collectors than your own staff, or even a collection agency that services mostly medical providers ... and your practice's reputation could be affected by their collection tactics.

Potential benefits of funding companies:

1. Their line of credit is usually higher than those offered by credit card issuers.

2. They're easy to do business with. They have fast, toll-free information/application service. It may be possible for them to approve faxed credit applications while the patient is still in your office...and deposit the funds electronically, the same day, into your bank account.

Before you talk to any funding company, talk to your hospital. Hospitals are the first places funding companies go for new business when they move into a market...so that's where you'll find honest, objective information about their advantages and their disadvantages. Ask your hospital Patient Accounts people:

- Which funding companies, if any, do you trust?
- What criteria separate the good from the bad?
- How can I negotiate the most favorable contract?
- Which ones do you trust?

Funding companies are new ...just as computers were once new. The first practices to "go com-

puter" had a lot of bugs to work out...a lot of software problems... and they paid top dollar for every step they took along the electronic trail. Today, "going computer" is a lot easier.

As funding companies grow more familiar to medical practices ...as the novelty wears off and competition sets in...their fees

may go down and the value of their services go up. We don't know if that's what'll happen... but as long as there are credit cards and bank loans and insurance options for most of the people in your market, you may not want to be the first practice in town to find out!

To recruit new patients, "Read 'em their (insurance) rights!"

Millions of Americans already belong to some Managed Care (MC) organization or are covered by insurance policies they don't understand. Think about what this really means: physicians will not only "respond to medical needs" as identified by the patient; they will "provide benefits" as defined by the Care Manager.

Many patients who become enrolled in insurance plans are average folks, who can explain their symptoms, and have some idea of the needs those symptoms indicate, but they won't know what in thunderation their benefits are. Insurance contracts are written in Legalese (it's a rule!), presented to members by company representatives who think in Legalese, and given out to people who never look at them until they need medical care ... at which point they say, "I'd better call the doctor and see what in thunderation this thing means."

Is that an extra "hassle" for you? NO; it's a new OPPORTUNITY!

People need to know what their benefits are. They trust their doctor and his/her staff to

explain those benefits. So, why not set aside an hour-or-so period each week for patients to come in with questions or problems about their benefits. You don't need to know everything, you just need to know where to look for the answer that will help the patient.

The cost of providing such a service is minimal. Let's face it, you're providing it anyway every time you help a patient solve an insurance problem. Why not schedule the time to make it easier for you to control and advertise the service to let patients know how much your practice really does care about their welfare?

Patients have every right to know how their actual care will be affected by the decisions, the rules, and the Legalese contracts drawn up by their "managers." There's no one those patients trust more than your insurance expert to explain the level and the value of that care; and there's no one who stands to gain more, in terms of new patients as well as community relations, by "reading insurance patients their rights."



Complete this form! You could win \$100!

Collecting in the 90s is becoming more and more difficult, and knowing and using effective collections techniques is a must. That's why we're holding a **Collecting in the 90s Contest**.

Here's how to enter:

On this page you'll find four common stalls that patients use to avoid paying their bills. Simply use the space below each one to write, in your own words, the response you would use to encourage the patient to pay. For instance, if the patient says,

Patient: "I forgot my checkbook."

You might say,

Your response: "That's okay. We also accept VISA and MasterCard."

That's it. Just photocopy this form, write in your responses and send them to:

Collecting in the 90s Contest

The Doctor's Office

1861 Colonial Village Lane

P.O. Box 10488

Lancaster PA 17605-0488

We'll be looking for your entry.

Your name _____ Title _____

Practice name _____

Practice address _____

Telephone _____

Patient: "My husband/wife pays the bills."

Your response: _____

Patient: "I have insurance."

Your response: _____

Patient: "I don't have my wallet."

Your response: _____

Patient: "I'm unemployed right now."

Your response: _____

Good luck!

The case for making telephone time, billable time

How much time does your doctor spend on the telephone, talking to patients...talking to colleagues about patients...talking to friends and relatives of patients? If the answer is: "a significant part of his/her workday," ask a second question: "How should your doctor be *paid* for all this time?"

A working person's time always has a *value*. You may choose to consider all this valuable time as an *investment* in Patient and Community Relations or you may see it as "part of the service," just as restaurants see cream and sugar as "part of the coffee." Or...you may decide that it is fair, it is logical, and it is becoming increasingly necessary to *bill patients for time they spend with the doctor on the phone*.

It is fair to charge for telephone time when your doctor provides services that would be billable if the patient received them in the office: new diagnoses based upon test information; changes in medication or treatment course; reporting test results that require extensive medical explanation; counseling the patient (or family members); evaluation of episodic information leading to a medical decision?

It is logical for referring and consulting physicians to bill for telephone time spent discussing a mutual patient's condition and medical options? Sure it is. Don't lawyers, accountants, and other business consultants charge you for professional guidance, planning, and advice given over the phone?

It is becoming more and more necessary—as expenses continue



to spiral upward, and all kinds of activists seek "ceilings" to place on physician incomes to seriously consider asking patients to pay for *the time they take from your doctor*.

Some **SERIOUS** considerations:

Third parties usually will *not* pay for "over-the-phone services" ...despite the fact that CPT codes 99371 thru 99373 are *provided* to code services rendered by phone. Doesn't the very fact that those codes *exist* establish over-the-phone care as a valuable, *reimbursable* service? Valuable, yes: the value of your doctor's medical expertise is perceived, but compensation for it is often bundled into Evaluation and Management codes.

Patients—millions of them—would be amazed, offended, or outraged at the very idea of paying for "just a few minutes of my doctor's time" on the phone. Why do patients feel that way? "They never did it before!" is the standard answer. So prepare for a

firestorm of criticism if you happen to be the *first* practice in town to begin charging by the service instead of by the location.

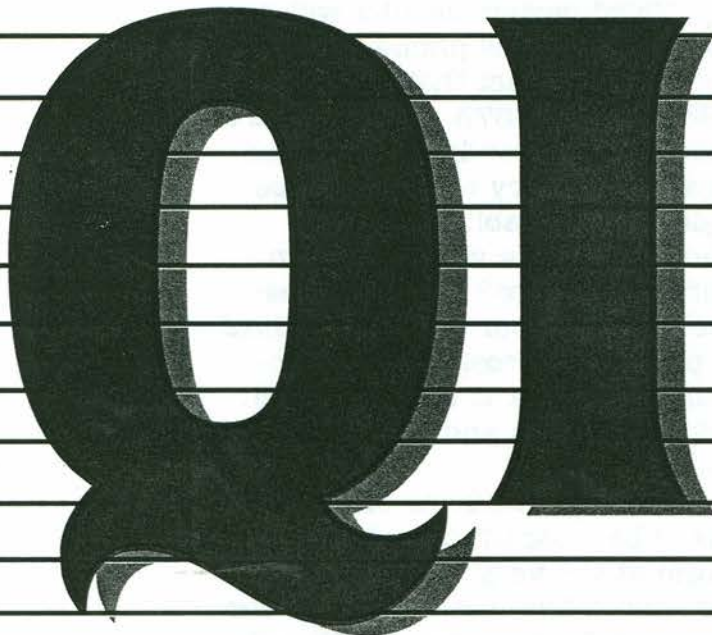
Finally, there's Medicare, which considers telephone consults, "a non-covered service that should be bundled into the OV code." **How you can start billing all of "them" for your doctor's time.**

First, build telephone consults into your fees. When you negotiate Managed Care contracts, when you submit claims to private insurers, insist upon your CPT Code 99371-99373 rights to be reimbursed for *the time you spend serving their customers.* Sure, they'll resist...which is why you should always negotiate from a position of strength: "This practice is especially attentive to your policies; this practice provides quality care and personal service

to your subscribers; and in order to provide these benefits, it is appropriate that we should be paid for our time."

Second, extend this pricing policy to fee-for-service patients. Simply announce—in your Patient Information Brochure, Patient Newsletter, and/or discreet signs in the reception area—that: "A reasonable fee will be charged for medical consultations and services provided during telephone conversations; fees will be in keeping with those already paid by HMOs and private insurance carriers."

Patients may not be thrilled by the new pricing policy, but at least they'll realize: "Our doctor *did* do it before; and the insurance companies paid it before we did!"

A large, bold, black graphic of the letters 'QI' is centered on a background of horizontal lines. The 'Q' is a classic serif font with a small tail at the bottom. The 'I' is a simple, thick vertical bar. The entire graphic is set against a background of approximately 15 horizontal lines, similar to a notepad or a page from a lined notebook.

OOPS! Q1 should be QI.

On page 12 of our September 1993 issue we reported on a new modifier that could be used for consults that are done the day before or day of a "global surgery" procedure, but that aren't really part of that procedure. We mistakenly referred to the modifier as Q1, but the **correct modifier is QI**. Those of you who are involved in consults for "global surgeries" will want to make a note of this.



Enter our First Class Mail contest and you could win \$50.

Send your practice management ideas (no clinical subjects please) to:

First Class Mail
The Doctor's Office
 P.O. BOX 10488
 1861 Colonial Village Lane
 Lancaster PA 17605-0488

Idea: DEcycle your FAX paper consumption

All FAXed documents require a cover letter...which is useful to the receiving office, but a total waste of resources as far as the sending office is concerned.

To conserve paper, we applied a dry-erase laminate to our standard cover-letter form. Now when we FAX, we write the covering message with an erasable marker, and erase it after the FAX has been received.

We've sent about 1,000 FAXes since we started using our "recyclable" cover letter...and saved about 999 sheets of paper.

Lori Hanson, Front Desk Supervisor
 Northwest Family Physicians
 Plymouth MN

Idea: Create a (3x5) computer Trouble-Shooter's Guide

Whenever one of our staff members overcomes a processing problem on the computer, or finds an easier way to do a computer process, we write down what we did and how we did it on an index card, and put the card in a file velcroed to our CPU.

This system allows us to pass on trouble-shooting ideas to one another and to part-time staff, and reduces the number of calls we must make to our (expensive!) software consultants.

Marcia K. Minton, Office Manager
 Nephrology Associates
 Evansville IN

Idea: Ask referral patients for a "scheduling reference"

When we see a new patient, the initial consultation takes a full hour. To protect our schedule against no-shows, we ask every patient for a home phone number, work number, and the name of the physician who referred him or her to us. If we cannot reach the patient at home or at work to confirm the appointment, we call the referring physician's office and ask if there are any other phone numbers where the patient may be reached.

This gives us an extra opportunity to confirm the appointment...and gives referring practices an opportunity to tip us off about chronic no-shows.

Joanie Mathews, Office Manager
 John E. McWhorter, M.D.
 Bridgewater NJ

Lessons in CPT: What is a "separate procedure"?

If you're a student of the CPT (and most billing specialists have to be), you've probably wondered just what that little phrase in parentheses—(separate procedure)—means. After all, isn't just about everything in the Radiology, Surgery, and Medicine sections of the CPT a "separate procedure"?

Actually, (separate procedure) is CPT-ese for "These procedures are usually a component of a larger surgical procedure, and thus are not billed separately, under the global surgery rules. However, occasionally, these procedures are done on their own and can be billed as a "separate procedure."

For instance, let's say CPT,

45300 a proctosigmoidoscopy is performed, a rectal polyp is discovered and the polyp is subsequently removed. Code 45300 would not be separately billable, it would be considered as part of the major procedure, the polyp removal. However, if the proctosigmoidoscopy did not indicate surgery, it could be billed separately. Other common examples (of separate procedures) include:

- 19100 Biopsy of breast, needle (separate procedure)
- 32700 Thoracoscopy, exploratory (separate procedure)
- 92020 Gonioscopy with medical diagnostic evaluation (separate procedure)

Back pay to 1989 for some MSP assigned claims

Get out the calculator! It may be one more annoying math project, but the payoff could be worth it. If your Medicare carrier used different formulas to calculate Medicare secondary payments for assigned versus unassigned claims, and you took assignment, you could collect!

It used to be that, if you accepted assignment, you couldn't receive more than the Medicare allowable from the combined payments of the primary payer and

Medicare. Now a revised policy says you can be paid a combined amount equal to the third party payer's allowable charge—if that charge is higher than the Medicare allowable—and back to 1989!

It's up to you to work through the math and see if that's how your secondary payments were figured to decide if the extra pay will be worth the cost of resubmitting. Carriers will review these claims only if you ask them to, so you must take the initiative.

