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Class-action lawsuits vindicated the medical community, but did things really change?

By KATALIN GOENCZ

The recent refusal by the U.S. Supreme Court to hear an appeal that would have prevented class-action status by six large health insurers is another victory for underpaid doctors. The RICO case against Humana Inc., HealthNet, Pacificare, The Prudential Insurance Company of America, United HealthCare Corp., Wellpoint Health Networks, UnitedHealth Group Inc. and Unitedhealth Care Inc. will be heard in Miami this year.

In September, Cigna settled and agreed to pay $140 million in reimbursement to physicians and legal fees, as well as to fund a new nonprofit foundation. In May 2003, Aetna agreed to pay $170 million in reimbursement and legal fees, as well as to fund a new nonprofit foundation.

The legal success provided more than long overdue reimbursements. It was also a promise from these insurance companies to be more open and honest about their business practices. The executive director of the Connecticut State Medical Society, Tim Norbeck, said, "These suits were never about the money. They were all about changing the system and moving forward."

Benefits from the class-action lawsuits

The Physicians' Foundation for Health Systems Innovations and the Physicians' Foundation for Health Systems Excellence were created by the Cigna and Aetna settlements, respectively. The foundations will work to introduce more technology, such as electronic medical records, as well as provide grants for practice improvements, therefore improving the delivery of care.

Has anything really changed since Aetna settled 22 month ago?

These settlements attempt to ensure that HMOs will stop the practice of underpayments and denials. The foundations will work to improve practices and electronic medical records will increase the percentage of correct payments. However, some of the reasons for underpayments have not yet been eliminated. Contracts must be updated and fee

schedules verified. The ever-changing requirements that begin before treating a patient have not disappeared.

Since the introduction of HMOs, the rules for medical providers have grown exponentially. A typical physician's office staff no longer consists of nurses and a receptionist. Practices have expanded to employ additional staff members to provide their offices with HMO expertise, ranging from verification of coverage to prior authorizations to checking for specific coverage information. Most of these additional staff members' work is focused on generally ensuring that the medical practitioner will receive payment for the services provided. Moreover, many offices employ an additional staff member solely to bill for services rendered to ensure that billing rules and coding requirements have been met.

Although the role of the doctor has not changed, the environment surrounding patient care has transformed drastically. A billing specialist has to ensure that each service is pre-approved, carefully documented, coded and submitted to the correct payor. As a result of the constantly changing rules and regulations, insurance cards are often outdated and missing information, which requires additional calls to the insurance company. This research results in time wasted on hold, as well as the frustration of punching in endless numbers to reach a hierarchical menu that serves as a gatekeeper for customer service.

At one time, all these mostly administrative burdens ensured that the practitioner would be issued correct payment. However, most medical providers have faced disappointment upon receiving payment in a lesser amount. One would expect that the explanation of benefits would clarify terms and thereby ensure that the payment would be correct. However, when payment is received, the staff has to analyze it to ensure proper payment. Each insurance carrier has its own explanation of benefits format that ranges from just reimbursement to detailed analysis of reimbursement.

In the best-case scenario, incorrect payment also comes with a clearly documented reason for the revised figure, and any necessary corrections can be made in a timely manner. In other cases, the payment is reduced without any clear reason, which means additional phone calls have to be made just to identify the reason for underpayment. In the worst-case scenario, there is no information other than a check for services. This situation requires additional phone calls, with the hope of quickly locating a knowledgeable insurance representative at the other end who can explain how the reimbursement was calculated.

Thus, it becomes the responsibility of the office staff member who posted a payment to decide whether to accept this erroneous payment as payment in full or to further investigate the correct rate of reimbursement and therefore pursue full compensation. Hopefully, the practice was provided with a fee schedule at the time of contracting so that a comparison could be made to determine the error. In other cases, only the patient's policy provisions are discovered, with disappointing results.

These efforts take time and require an understanding of coverage and knowledge of contracting issues. Fighting any incorrect payment is a difficult task and requires in-depth knowledge, persistence and a substantial amount of time. Most office managers are proficient in identifying these underpayments, but time is of the essence. It requires time to research and time to react, all before the time limit to file for additional payment expires. An office manager's time taken away from daily duties may result in further underpayments to services provided at the present time.

Three options, one solution

What are the medical professional's options? One option is to outsource the entire billing and accounts receivable process and hope to locate a reputable company. Outsourcing these tasks requires time away from practicing medicine or managing a medical office to locate, research and interview firms that would be able to provide this service. This will add a financial burden and an additional responsibility to monitor this out-of-office service.

Another option is hiring additional office staff and hoping that person is knowledgeable in underpayments. However, this person will need training, additional office space and a computer terminal. It will be another added cost to running a practice.

A viable option is to outsource the underpaid accounts only. This will ensure that an underpaid account specialist will review all problematic payments with a history of errors. The added benefit of following up on every underpayment is that it puts the insurance company on notice, effectively changing the physician profile. The underpayment specialist would create an underpayment tracking system, which could be a valuable tool for identifying patterns of underpayments. It also could be used as a practice tool to improve flaws in the billing/coding procedures. This also will keep the receivables part of the medical practice within the control of the office manager. The success rate can be easily assessed on those accounts by the increased revenues.

Until the government and the attorneys figure out how to permanently correct the problem, keep fighting for every dollar you are owed.

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