MONEY MATTERS

Goals, Objectives and Disclosures

In this time of financial crisis, many patients are finding it difficult to pay for the healthcare they need. At the same time, many physicians are struggling to be paid for the medical care they render. This article aims to explore both sides of the issue and, through case studies, to help physicians work more effectively within a decidedly faltering economic system not only for the fiscal strength of their practice but also, and most importantly, for the physical and emotional health of their patients.

Learning Objectives: At the completion of this activity, participants will be able to:

- Incorporate in their office practice seven specific principles designed to clarify billing issues for patients.
- Respond appropriately to patients who try to save healthcare dollars by asking the physician to see two patients in one visit.
- Take four steps to help patients in financial difficulty try to meet their healthcare needs.

Accreditation: Coverys designates this enduring material for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity meets the criteria of the Massachusetts Board of Registration in Medicine for risk management study.

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Medium and Method of Participation: For successful completion of this online activity, physicians will read the provided article and answer supplied questions for a maximum of 1 AMA PRA Category 1 Credit™.

Author: Linda M. Greenwald, MS, RN
Advisor: Diane McKenna, Director, Healthcare Provider Education, Coverys

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Target Audience: Physicians, all specialties.

Estimated Completion Time: The estimated time to complete this activity is one hour.

Date of Release & Term of Approval: This activity was released on January 1, 2009, is reviewed annually and will expire on January 1, 2014.

Hardware/Software Requirements: Minimum System Requirements: 486/66 MHz processor (Pentium processor recommended) Internet Browsers Supported: Microsoft Internet Explorer, version 6 and higher, Microsoft Internet Explorer 8 (recommended), Firefox 3.6 (includes Mac), Chrome 4, Safari 4 (Q1 2011) Browser Security Settings: must be set to the “default setting” to ensure the application runs smoothly. If the security settings are not set to the “default,” go to the browser security settings and enable the option for “active scripting” or “scripting of java applets.” Advanced Browser Settings (for Internet Explorer Users): Ensure that Java Virtual Machine is installed. Plug-ins: Users must have the following most current plug-ins installed: Macromedia Flash, Adobe Acrobat Reader and Microsoft Media Player.
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Few have been left untouched by the current economic crisis. Investment giants have crumbled and banks have fallen while individuals everywhere continue to contemplate next steps as they watch their pension, college, and 401(k) fund balances decline. Physicians and their patients have been granted no immunity from the financial meltdown. As prices climb, savings fall, and credit tightens, many physicians are finding it increasingly difficult to collect the monies owed them by patients who may put their physician’s bill at the bottom of a pile that also includes shutoff notices from public utilities, foreclosure notices from mortgage companies, and overextended credit notices from oil companies, groceries, pharmacies, department stores, and a myriad of others.

The view is slightly different from the patient perspective. For some patients, the current economic downturn is offering a number of unattractive, and often health-denying choices. Postponing or canceling care they cannot afford is the choice of some, including many who are stockpiling the money in their health savings accounts (HSAs) rather than spending it, as intended, to cover healthcare costs. Some are coping by diluting medications, splitting pills, or sharing prescriptions with a spouse or friend. Others, including many in high risk categories, are opting for healthcare ignorance as they decide against such important screening tests as mammograms and colonoscopies lest they learn they have a medical problem requiring an expensive next step they cannot afford.

Another group of patients has chosen a more creative, albeit in some cases a more fraudulent, way of meshing their healthcare needs with their declining finances: they seek out the care they need and then fail to pay for it. Some patients deny that the care was ever given, others seek care in the name of another person. In a few instances, patients have filed for bankruptcy immediately after receiving care, and in at least three cases known to Coverys, patients have billed their care to a credit card and then called the credit card company claiming that the care was never given.

What are the rights and responsibilities of the physician in these situations and what is his or her role in advocating or recommending care for the patient who needs medical attention that he or she cannot afford? Those are two of the issues addressed in the paragraphs that follow.

The Patient’s Perspective

Since foreclosure became a routine part of the national vocabulary in the late summer of this year, pundits from almost every discipline and geographic area have been measuring the impact of the current economic crisis on everything from the gross national product to the political musings of Joe the Plumber. Strangely absent from their words and charts has been any mention of the impact of lost homes, lost jobs, and lost savings on healthcare. The reason may lie in the fact that for many Americans, healthcare was an unaffordable luxury long before the current financial meltdown became a reality.

As early as 2001, almost half of the personal bankruptcies declared in this country were linked to healthcare issues. Medical debt remains a leading cause of personal bankruptcy. Catastrophic illness is certainly a factor in a number of cases. Other less dramatic issues are likely to have had an
equal or greater impact on money in medicine: high insurance deductibles and unmanageable co-pays, inadequate insurance coverage, arbitrary exclusions or after-the-fact denials of payment by some insurance companies, and for certain high risk individuals with individual insurance policies, premiums costing as much as or more than a mortgage or rent payment.

According to a recent study carried out jointly by The Boston Globe and the Blue Cross Blue Shield of Massachusetts Foundation, 13 percent of the state’s residents reported being unable to pay for at least some health services within the past year; an additional 13 percent failed to fill at least one prescription. The problem is hardly limited to one state. One quarter of the 2,000 who participated in a recent national study by Time and the Rockefeller Foundation admitted that cost had kept them from seeing a physician in 2008, an increase of seven percent over the preceding year.

If these figures are an indictment of the business of American medicine, they are also a sad commentary on the health of the American patient. Some patients who are unable to pay the high cost of healthcare are choosing to take chances with their health instead. One diabetic whose health plan had a $2,000 deductible chose to reduce the number of scheduled visits he made to his endocrinologist, a patient with lupus opted not to fill a prescription but rather to “live with the pain” when she could find no affordable healthcare insurance, and a woman with a catastrophic health policy that carried a $6,000 deductible put off having a mammogram because, in her words, “I’m afraid they’ll find something and I can’t afford to do anything about it.”

Refused screening tests, missed follow-up appointments, a failure to obtain routine care, pill sharing or prescription skipping, and delayed elective surgical procedures are creating a population of sicker patients often requiring longer and more sophisticated treatments. Having gambled with their healthcare and lost, some of these patients find their medical problem compounded by crushing debt when they reach a point of medical crisis. The patient with lupus mentioned above “lived with” her pain until it became intolerable. She then went to a local emergency department where she was treated with an IV narcotic. She was sent a bill for $10,000.

For many patients, the burden is far worse: they lose their life or the life of a loved one to the economics of healthcare. The seven-year-old daughter of an uninsured woman suffered an asthma attack. The child’s pediatrician is reported to have directed the mother to take the child to an emergency department for immediate care, a recommendation the mother declined because of her lack of insurance. The child died.

**The Physician’s Perspective**

If patients are hurting in the current economic climate, so too are physicians. Many physicians are simply writing off as uncollectible some of the money they are owed by patients. The sums are sizable. In some instances, unpaid bills total 10 percent of revenue.

Contributing to some of the outstanding bills are a number of $15 and $25 co-pays or deductibles that go unpaid when the patient “forgets” to bring cash, check, or credit card. Increasing numbers of cases, however, are attributable to the high deductible insurance plans that at the end of 2007 covered over 6.1 million Americans. Some of these plans, many of them deemed “catastrophic,” require the patient to pay between $1,000 and $5,000 or more before insurance pays anything. The low premium of the plan makes it attractive to many; the deductible makes it unaffordable to all but a few.

A different problem is encountered with the HSAs that are now being promoted by some as an alternative to traditional healthcare plans. The contributions an individual makes to HSAs are usually both tax-exempt and invested. If left untouched from year to year, they may accrue a great deal of interest. Many individuals believe it is in their best interest not to withdraw funds from their HSA for their healthcare needs, as intended, but rather, to contribute increasing funds to the account, which is then transformed into a savings or retirement account. Unfortunately, as the HSA balance increases, the physician is left unpaid. In an attempt to collect at least some of the monies owed them, some physicians are charging patients a fee for a co-pay or deductible that is not paid at the time professional care is given. At least one Coverys-insured practice is increasing a patient’s outstanding balance by a percentage of that balance total in attempt to cover legal fees and/or collection costs. These two solutions are not legally appropriate in some states. Before considering them as practice protocols, physicians should seek legal advice.

Some physicians are balance billing, a practice that may be proper in some circumstances but prohibited by state law in others. Federal law prohibits any balance billing of Medicare accounts.  Physicians and their billing services need
to be aware of the balance billing regulations in their state.

Referring or, in some cases, selling or auctioning a medical debt to a collection agency is another approach now being widely used by many physicians. One family physician reported that he referred $9,000 to collection last year. To recover some of the costs — and losses — associated with third-party collection, some physicians are charging their patients a percentage of the unpaid balance reported to the collection agency. Because the legality of this tactic is questionable in many states, physicians should seek legal advice before implementing such a tactic. Finally, other physicians are using agencies that pursue debtors with tactics that, although compliant with the federal Fair Debt Collection Practices Act, are often aggressive to the point of intimidation. The result in some cases is to drive the patient out of the healthcare system altogether.

Collection agencies have long had a role in the recovery of monies that are rightfully owed. However, physicians are cautioned to approach with great care a strategy that may result in the credit rating of a patient being unnecessarily or unfairly jeopardized or destroyed. In a number of cases, bills referred to collection were later determined to be overdue not because the patient hadn’t paid them but because the patient had assumed his or her healthcare insurer had paid them. One woman, for example, found herself caught between her automobile insurer and her health insurer when she was involved in a motor vehicle accident. Representatives of the two companies had argued back and forth about payment of the insured’s emergency department bill, but neither paid. The woman learned of the overdue account only when a collection agency contacted her.

The Risk Management Perspective

By one report, over 70 million Americans are currently burdened with medical debt and/or are having problems paying their healthcare bills. Many of them will make an honest effort to meet their financial obligations. Some will simply not be able to pay all that they owe. Because each debt is invariably colored by the circumstances of those who owe it, no one approach to debt collection is applicable to all situations. However, there are some general principles that physicians may use as billing guidelines.

- Develop a billing policy and apply it uniformly to all patients. The policy may address such issues as co-pays and the practice’s philosophy with respect to billing third party payers, self-pay patients, sliding fee scale, balance billing, billing for missed appointments, credit cards, misuse and possible rescinding of a billing privilege. Because federal and state laws govern some of these issues, physicians may wish to seek legal advice before adopting a comprehensive billing policy.

- Discuss an overdue account with the patient and determine if there are contributory factors that might argue for leniency on the part of the physician.

- Do not refer an account to collection without first notifying the patient and giving him or her opportunity to discuss and, if possible, arrange for settlement of the account.

- Make sure the treating physician knows the names of all patients whose accounts are being referred to collection.

He or she may be aware of extenuating circumstances that may argue for postponing any action regarding collection.

- Do not use an unpaid medical bill as a reason for denying care. The healthcare needs of an active patient should be considered without regard to any unpaid balances.

- Consider a sliding fee scale for patients in financial need.

- Consider terminating the professional relationship with a patient who makes no attempt to fulfill his or her financial obligation to the practice. Termination should not take place when the patient is in medical crisis.

Unfortunately, not all patients are fiscally responsible. A fair number will leave their physician’s bill unpaid while extending every effort to make a car payment or pay a retail store bill. Many of the members of this group erroneously believe that an unpaid medical bill will have no impact on their credit rating. A plethora of websites are available to convince them of the fallacy of their thinking. For those who continue to disbelieve, a highlighted note in an overdue bill or collection notice would be appropriate.

At the ethical extreme of the payment spectrum are those patients who seek needed medical care and then use any of a number of different stratagems, up to and including fraud, to avoid paying for it. Some of the more creative tactics called into the Risk Management Department’s telephone referral are presented here.

Someone else’s insurance card: A new patient recently came in and presented an insurance card that turned out to be someone else’s. The insurance company won’t pay. What
can I do to collect the fee for the office visit?

Very little – unless you have some way of tracking the patient down or he/she tries to make an appointment for a return visit, at which point you should confront him/her. Your best approach to this particular issue should be preventive.

**Risk Management Guidelines**

- **Require a picture identification** of all new patients and all patients with new insurance.
- **Develop a written policy** that addresses management of the situation in which a patient has no picture identification.
- **Stress to staff the importance of comparing the information** on a patient’s insurance card with the information given to the office by the patient.

**Credit cards:** One of my patients paid the cost of a recent visit with a credit card. She then called the credit card company to say she had been billed for services she never received. The credit card company called me, stating they will withhold payment until I can provide “proof of service.” The patient has refused to sign an authorization that would allow me to release her record. What recourse do I have?

The HIPAA Privacy Act allows physicians to release patients’ personal health information without patient authorization in order to be paid. The amount of information that is released in this case should be the minimum necessary to indicate that the patient was in the office and that care was provided. Details about diagnosis and treatment should be withheld until and unless specifically requested, at which point you may wish to consult with an attorney to determine how best to proceed.

This patient is trying to get free care. You may wish to consider either terminating your professional relationship with her or refusing her the right to pay for any future professional services with a credit card.

**Risk Management Guidelines**

- **Establish a written office policy with respect to credit cards** and share it with patients. Share this policy with patients at their first visit and post it in the office in a visible place.
- **Consider asking patients paying with a credit card to sign a form at each visit agreeing to have the office apply the cost of the visit to their credit card.**
- **Consider prohibiting the use of credit cards** by patients who have misused or abused them in the office.
- **Consider the immediate termination of patients who engage in any fraudulent office-related activity.**

**Bankruptcy:** I terminated my professional relationship with a patient because she never paid her bills and refused to set up a payment schedule. Today, that patient called to say she has a urinary tract infection and wants an appointment. When I reminded her that her professional relationship with the practice had been terminated, she replied, “I declared bankruptcy. Now everything’s all right and I want to come back.” Do I have to take her back?

Assuming you sent her (and have a copy in her medical record of) a letter of termination, complete with reason and guidelines for finding a new healthcare practitioner, you’re under no obligation to begin a new professional relationship with this patient. If the earlier termination was simply a verbal understanding, then technically she is still a patient and should probably be given another chance. If this is the case, you would be wise to have her sign a statement of intent to meet her financial obligations to the practice – and then hold her to it. If there are any signs that the patient is lapsing into her old pattern of financial irresponsibility, written termination should be considered sooner rather than later.

**Risk Management Guidelines**

- **Take care terminating the professional relationship with a patient who declares bankruptcy.** Personal bankruptcy is not, in and of itself, a reason for terminating the professional relationship with a patient whereas a pattern of non-payment may be.
- **Make sure that termination of the professional relationship is in writing and accompanied by a notice period of at least 30 days and recommendations about finding a new physician.** A patient is still a patient until the relationship is ended in writing.
- **Include a copy of the termination letter in the medical record.**

**One visit, two patients:** Some of my patients have begun coming to office visits with family members or friends they want me “to take a look at.” Their hope, I believe, is to save the money involved in two visits. However, it’s taking my time. I am now billing for two visits but have had calls from enraged patients who refuse to pay the cost of seeing the
second person. I can’t afford to give away my time. What recourse do I have?

Only patients with whom you have an established relationship should be seen in the office. Each should have his or her own medical record that includes, at the least, a history, physical examination, and allergy status. If the second person in the visits you describe is such a patient, you have two options. The first is to examine the patient as requested, record your findings in the patient’s medical record, and then bill for the care provided. To avoid any surprises, you may consider informing both “patients,” before you perform the examination, that you’d be happy to look at the second person, as requested, but that it is your policy to send a bill for all patient care. The alternative is to ask the second person to schedule an appointment.

If the second person is not a patient of the practice, the best approach is to say you are unable to see the person at that point and then either refer him or her to his or her own physician or suggest setting up an appointment with you as a new patient.

**Risk Management Guidelines**

- **Provide care only to patients.** From a risk management perspective, physicians should refrain from examining individuals unless or until they become patients.

- **Bill appropriately for all care given to patients.**

**Exceeding scope of practice: Some of my patients have admitted to me that in the interest of saving money, they are trying to minimize the number of physician visits they make. They then ask me, a gynecologist, for an opinion on problems that have ranged from rheumatology to allergy. How can I help them?**

By listening to them empathetically and then explaining to them that you do not have the expertise to offer the kind of specialized help they may need. Exceeding one’s scope of practice may seem an accommodating gesture in the short term. In the longer term, however, Coverys’ closed claim files indicate that it may lead to harm for the patient and litigation for the physician.

**Risk Management Guidelines**

- **Work within your scope of practice.** Using a patient’s financial situation to justify exceeding the scope of practice will prove an unacceptable tactic in a medical malpractice case.

- **Be prepared to be held to the standard of care of a second physician,** in whose specialty you are practicing, even for a single patient.

- **Offer to help patients who cannot afford private medical care.** Patients who are denying themselves even basic care because of financial reasons should be directed back to their PCPs or, alternatively, to clinics, walk-in centers, or other lower-cost health delivery sites.

**Divorced parents:** The divorced father of one of my pediatric patients is responsible for paying the child’s medical bills. He is not paying them. I like the family and don’t want to terminate my care of the child. However, I worry about breaching confidentiality by letting the mother know that her child’s bills are unpaid.

It is not a breach of confidentiality to discuss anything about the child’s care, including cost, with either parent, assuming neither has had parental rights terminated. The mother should be told that you are not being paid. It is her responsibility, not yours, to find a solution to the payment issue with her ex-husband. You may want to let her know that you want to work with her but will be forced to ask her to seek care for the child elsewhere if no payment arrangement can be made. If she fears approaching her ex-husband you may want to consider consulting an attorney to determine how best to proceed.

**Risk Management Guidelines**

- **Speak directly with the patient about unpaid bills.** It is the patient’s responsibility to deal with the payer, whether that be an insurance company, a parent, or a divorced spouse.

- **Consider consulting an attorney** for direction if there are questions about approaching a potentially hostile payer.

**Office issues:** One year ago, a patient came into my office and my staff forgot to obtain his co-pay. This lapse recently came to light and the patient was sent a bill for the overdue amount. When he didn’t respond, we sent a collection notice. He came to the office to protest the bill and engaged in a heated discussion with the receptionist in front of other patients. The patient is now threatening to sue for harassment. What do you suggest I do?

In this case, you might want to simply apologize for the oversight that resulted in the bill’s being delayed and then agree to absorb the loss. Another issue you need to address in this case is the fact that a personal discussion took place in front of other patients. Discussions about finances should be considered as personal as discussions about diagnoses and should take place in a private area, out of earshot of other patients.
Risk Management Guidelines

- Set aside a private space in the office for discussions about finances.
- Limit telephone discussions about patients’ financial matters to areas that are outside the hearing of other patients.
- Take responsibility for your office’s errors and be willing to absorb the resulting loss when necessary.

In these financially stressed times, some physicians have found themselves confronted with a different kind of problem than those discussed above. Many call Coveys with concerns such as the following:

Clinical issues: One of my oncology patients would probably do well with a chemotherapy protocol that is new to the market. However, his insurance will not pay for it. Since my patient wouldn’t be able to pay out of pocket, I’m not sure whether to tell him about it and risk disappointing him when he realizes how financially unreachable it is or simply say nothing.

You should tell him about the new protocol and let him decide whether or not it’s affordable. You may not know all of the resources available to him. If they are, indeed, as limited as you suspect, you need to investigate with him any and all alternative options that are open, including clinical trials.

Risk Management Guidelines

- Whenever possible, refer patients with severe financial limitations to social service agencies or networks that might be able to help them.
- Determine if cost is a factor in a patient’s refusal of a test or procedure and then, whenever possible, suggest alternatives.
- Help patients prioritize their medical needs whenever the needs exceed the ability to pay for them.
- Stress the importance of follow-up and, if necessary, consider working out a lenient payment schedule with a patient who is likely to forego needed follow-up for reasons of cost.

Conclusion

Healthcare has not escaped the negative impact of the current economic downturn. Many of the health-related issues that were serious before late summer have now become critical. Some patients are compromising their health because they can’t afford the cost of healthcare. Many physicians, on the other hand, are being forced to use an array of never-before-considered collection options simply to remain financially viable. There is no easy answer. Definitive action may be indicated when the trust of the physician is violated by a patient who resorts to scam and fraud. In other circumstances, however, the need is for compassion, understanding, and patience as all of us, patients and physicians alike try to survive the current economic free fall.

References

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CME Test
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