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When and Why Chiropractors Should Drop an Insurance Company

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Some time ago, I wrote an article titled, "How to Decide to Drop an Insurance Company" (*Dynamic Chiropractic*, June 3, 2009, Vol. 27, Issue 12) that detailed the steps you need to take to remove yourself from being a provider for a particular insurance plan. What I would like to discuss in this article are the strategies and specific techniques surrounding the "when" and "why" issues. In other words, *when* should you drop and insurance company and *why* you should do it.

The *When*: 5 Steps to Take Before Making a Decision

In order to make an informed decision that you won't regret in the future, there are five concrete steps that comprise the "when" of dropping an insurance payer:

1. Fee Schedule Fact-Finding. Many chiropractors routinely moan about low reimbursements, but to accurately determine how bad a payer's reimbursements truly are, create a chart that includes your commonly used CMT codes, E/M codes, X-ray codes and rehab codes. By making a "Top 10" list of your most frequently billed codes and listing each payer's reimbursements side by side, you will then have a good idea of how different (or similar) their fee schedules are. Outliers will be obvious.

2. Compare Insurance Reimbursements to Cash Fees. Next, compare the fees for your top payers to what your non-insured patients are paying and document a percentage difference. If you charge $50 for a 98941 adjustment, a non-insured (cash) patient will pay $50 (100 percent) of your fee. Insurance A, on the other hand, may reimburse you $35 due to contractual discounts, representing 70 percent of your billed charges. Insurance B may pay $40, representing 80 percent.

Do this exercise for your commonly billed procedures that you listed in step 1 and find out the percentage of billed charges that you are receiving, on average, from each payer.

3. Calculate Any Network or Application Fees. Many insurance payers now charge a fee for credentialing or joining their network and for continued participation in their network. While the application or credentialing fees are typically one-time expenses or ones that only occur every few years, some insurance plans have hefty yearly network fees. You need to put these fees into the comparison chart you are creating so that you can calculate a plan's overall worth.

4. Estimate How Many Patients Are on the Plan. Your practice-management or billing software should be able to provide you with the number of patients who have a particular insurance. If possible, only include "active" patients (those who have been in your office in that year).

5. Rate the Payer's Reimbursement Policies. In this final step, you are trying to assess how good or bad the payer's reimbursement policies are. After all, a payer who pays relatively well per procedure, but severely limits the number of procedures it reimburses, is much different than a payer with a great fee schedule and good reimbursement policies. If there are no policy limits on how many procedures (or what dollar limit) the payer will pay per visit, give it an "A." If the payer

has "moderate" limits (e.g., it will reimburse only up to three codes per date of service or have a dollar limit per date of service), then give it a "C." If the payer has restrictive limits (e.g., will only reimburse one or two CPT codes per visit or an extremely low capitated rate), that payer should be given an "F."

The *Why*: Putting It All Together

To get the "why" of dropping an insurance company, let's look at the bottom line. Supposedly, you are running a for-profit business. I have met only a few chiropractors who legitimately run a 501(c)3 nonprofit corporation, but unfortunately have run into scores of DCs who run their clinics profitably. So, the most important "why" in terms of dropping an insurance plan is that it is not profitable to do business with that company.

In step 1, you should be able to find the payers who have the worst fee schedules. Some pay so poorly that this alone can be a good reason why you should no longer do business with this insurance company. If it's not so obvious, take the bottom-tier payers from step 1 and look at the comparisons in step 2. In other words, if they pay poorly, but they are still paying relatively better than your cash patients, then maybe that's not so bad. On the other hand, if a payer reimburses poorly and is significantly worse than cash, this is a problem.

Steps 3 and 4 allow you to look at an insurer from a different perspective based on the number of patients you have on the plan. After all, a marginal payer (from steps 1 and 2) can still be a keeper if you have enough patients to justify remaining on the plan. Similarly, if you have enough patients, then the network fees may be justifiable; on the other hand, relatively few patients may not warrant a plan with high network fees.

Finally, if you are still on the fence, examine reimbursement policies. A poorly paying fee schedule, relatively few patients on the plan, and restrictive reimbursement policies is a strikeout, in my opinion. There is probably no reason to continue with a payer with bad scores in all categories. On the other hand, payers who have mixed results in the previous categories, but who have relatively good reimbursement policies, may have just enough going for them to keep them on board for another year.

Review Annually for Best Results

The steps above should be repeated annually for the best results. Payers routinely change their policies, reimbursements or requirements. In turn, this has the potential to change whether or not you should continue to do business with them.

Too many chiropractors moan that XYZ insurance company dropped their rates this year and then proceed to do nothing about it. So, what do you think XYZ insurance will do next year? Insurance companies are in the business of making a profit. If they raise premiums and lower reimbursements, their profit margin grows. Our silence and inaction is consent to their business practices.

Many states have laws that prohibit how much premiums can be raised; therefore, for most insurance companies the big profits are made be lowering reimbursements, raising the requirements necessary to getting reimbursed, or both.

The only way we successfully navigate these waters is by carefully watching and applying meaningful data to our practices and making sound business decisions based on that data. Notice, complaining is not part of the equation. I have yet to see a chiropractic office become more profitable by increasing the amount of moaning and groaning. But I have seen many offices make

the choice to run their business *as a business* and thrive. Hopefully, this article will help you do the same for your own practice.