Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

We Get Letters & E-Mail

When It Comes to Insurance, You Have a Choice

Dear Editor:

I agree with Dr. Cole ["The Moral Dimension of Network Participation: Let's Stop the Abuse," Sept. 9 issue] that we have an obligation to put our patients' needs before that of the insurance companies. When I first started practicing, new doctors were essentially told to "take insurance and watch your practice grow quickly." At the time, as a profession we optimistically thought that accepting insurance would allow us to see a larger percentage of people; but alas, the percentage of people we see has grown by only a miniscule amount since we got on board with the insurance companies.

It did not take me long to realize that the insurance companies devalued chiropractic, and patients thought our care was worth a co-pay and no more – because we had taught them so. I decided I could not support an industry that devalued chiropractic.

Eighteen years ago, I opted to go all-cash. I set my fee as the average amount for my area. I became skilled at meeting the public. Every patient I see is educated about the real value of chiropractic care.

When it comes to the issue of insurance, I explain to patients that I don't accept any because I do not agree with the way insurance companies dictate patient care. I tell them I believe care should be the choice of the patient, with solid advice from the doctor. Patients agree with and appreciate this.

Yes, I have lost plenty of patients to other offices that did accept their insurance. Most often, it's the patients who just choose us for location. Referrals already know I don't take insurance, but they also know they can expect the very best care and personal service in my office. They choose quality care over a cheap co-pay.

I recently attended a chiropractic convention and sat in on an insurance seminar. I was *amazed*. Doctors were practically weeping with stories of abuse by insurance companies. To some of them, I said, "You do have a choice, you know" – they looked at me like I was crazy. But doctors, I swear, you *do* have a choice. You are chiropractors; we have a proud heritage of going against the norm. You are intelligent, strong and capable. Not only do you have a choice; you have an obligation to your profession and your patients.

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An Insider's Look at Managed Care

Dear Editor:

Understanding the managed care system is important to the 21st-century doctor of chiropractic. Accountability-focused managed systems of health care are escalating in breadth and influence as the principles of the federal health care reform initiative expands across all disciplines of health care. Dr. Cole's article, "The Moral Dimension of Network Participation: Let's Stop the Abuse," attempts to educate and create awareness of managed care activities; however, the article includes a number of inaccuracies regarding the operational functions by managed care organizations. Let's review the topic areas addressed by Dr. Cole that are important to understand and consider in future discussions related to the delivery of health care services.

Documentation and Accountability: With the passage of the Patient Protection and Affordable Care Act (PPACA), all stakeholders in the health care delivery arena have a new paradigm that must be recognized and adhered to. The president and Congress have required the terms *bending the cost curve* and *accessibility, accountability, and affordability* to be implemented by all – including practitioners – who deliver health care services to improve the quality of health of individual Americans.

The requirement for the submission of clinical documentation to verify medical necessity has long been a cornerstone for accountability and management of health care quality and costs. Up to the present time, a routine requirement for documentation of the rationale for services rendered has been limited in application by health plans to mostly in-network providers under HMO products. As a result, many health plans have begun to initiate more routine requirements for all providers in their PPO products and for out-of-network providers. These documentation requirements enforce long-standing insurance contract provisions that only "medically necessary" or "reasonable medical expenses" will be considered for reimbursement. Accurate and timely documentation of care allows for the doctor to be accountable for the charges that are being billed on behalf of the member.

Practitioner Involvement and Input: To obtain input from practicing doctors, managed care organizations (MCOs) have instituted a specific committee or groups of committees that reviews the current scientific evidence, including valid guidelines and original scientific literature about safety, efficacy, and appropriateness of care. These quality-management committees evaluate evidence and quality in an exacting and precise manner, and establish policies about the appropriateness of specific chiropractic procedures, techniques and devices based on the evidence. In doing so, the committee considers the clinical effectiveness, diagnostic utility, safety and overall risk/benefit to the patient. These committees are comprised of experts in a variety of health care fields (for example, clinical practice, research and epidemiology); and they include actively practicing providers. Accreditation standards that managed care organizations adhere to require these processes to be in place. The primary guiding principle to this process is favorable patient health outcomes and safety.

Financial Incentives: Dr. Cole suggests that managed care organizations have a financial incentive to deny or not approve care. This is contrary to accreditation standards as well as all state regulations that speak to this matter. For example, individuals in the employ of managed care organizations are precluded from receiving reimbursement, incentives or other remuneration for denial of care. And in most organizations, there is an organizational "firewall" between the clinical team and the operations teams that manage the financial matters of the company. Some providers have voiced concern for retaliation by managed care for advocating care for their patients – again, this is contrary to established law.

Reimbursement: The reimbursement methodologies in the new paradigm of health care delivery and financing between health plans, managed care organizations and the employer will vary dependent on a variety of factors including, but not limited to, the benefit design and member financial responsibility. Possible models may include capitated (per member, per month) models,

fee-for-service models, administrative services payment, or a combination of these. With the establishment of accountable care organizations and medical homes, virtually all future financial arrangement between all stakeholders will include incentives for increased quality of care and health improvement that will be objectively measured. State exchanges will also address these reimbursement methods and models in various ways. The successful provider will continue to be educated about how to provide patient care and how to manage the various reimbursement models that may support the patient.

In addition to changing reimbursement models and cost-reduction strategies, the provider community will also be held accountable for improving quality of care and objectively measured health improvement results. The traditional fee-for-service model will likely remain, but with a number of opportunities for additional reimbursement through pay-for-performance incentives. The incentive programs may include completion and retention of third-party certification programs, compliance with objective and measurable improved health quality measures, utilization of health information technology, and implementation of other practice-related quality standards.

Appeals Process: In his discussion, Dr. Cole states that when proper and appropriate care cannot be provided, "we must make a decision not to support such abuse of our patients." Managed care organizations have the same goal as the doctor: to ensure appropriate, medically necessary, cost-efficient, safe services are delivered to patients. When there is a disagreement with the managed care organization about what care the patient may need, there are several avenues for appeal through the managed care organization, and in some cases, state external review organizations. These rights extend to both the provider and member/patient and are governed by state and federal regulation, and URAC and NCQA accreditation and certification standards, respectively.

Provider Participation: ASH Networks agrees with Dr. Cole that managed care participation is an individual business decision or choice that cannot be discussed with a peer or an association. There are numerous statutes, federal and state, related to anti-trust activities, and violations of these statutes should not be encouraged by either individuals or associations. Each doctor assesses their need for additional patients and the opportunity for the business relationship with the managed care company to direct patients to their office. The doctor will assess the requirements of the managed care plan and assess their personal willingness to work within an accountable management system for the benefit that system provides to their practice.

ASH Networks also agrees with Dr. Cole that managed care participation is an individual choice by the practitioner. The decision-making process by the practitioner must weigh the clinical and administrative functions in their office and how those activities connect with the MCO. During the pre-contracting review phase, the provider considering participation should review the managed care organization's public Web site for clinical guideline information and review all materials submitted by the managed care organization during the application process. If information about guidelines and clinical /administrative requirements is not publicly available, the provider should request these and review them before signing an agreement. This is important because an MCO contract has various requirements you will need to follow if you wish to continue participation and retain the ability to be reimbursed for treatment to the MCO's members.

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