Dynamic Chiropractic

Playing the Insurance Game

YOU CAN HAVE YOUR CAKE AND EAT IT, TOO

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When I discuss insurance with doctors, I often find that they don't fully understand what is involved in determining *how* they want to deal with health insurance carriers. Sure, they ask the right questions about whether they should become a "cash practice" or "in-network" or "out-of-network" provider with carriers; but quite often they make the wrong decision because that decision is based on what they believe will be the easiest way to build a practice. The result: They soon find themselves struggling to keep their doors open.

There are at least four ways you can play the "insurance game," as I call it. The following is a description of these game plans, along with important information that should be considered before determining which one is the best for you. Note that unless specifically stated, this article is referring to health insurance carriers.

1. Cash Practice

In my experience, the number-one reason doctors want to have a *cash practice* is because they don't want to deal with insurance carriers. They want to reduce their overhead and increase their cash flow. In a cash practice, patients pay in full at the time of the service and typically are given one "super bill" to send to their insurance carrier for processing and hopefully reimbursement. However, there are some other things to consider:

- Federal laws require that you submit claims directly to Medicare for almost all Medicare services that are considered reasonable and medically necessary for most manual manipulation to the spine to correct subluxations. (There are a few exceptions to this rule.) Medicare will not accept "super bills" from patients; therefore, in most cases, you will not be able to treat these patients and will have to refer them to another chiropractor (whose office will do the billing for them). Medicare doesn't allow chiropractors to "opt out." However, you can be a non-participating provider who submits claims to Medicare for patients, but does not accept assignment (meaning box #27 on the CMS-1500 is checked "no").

- Remember that just because you are not accepting assignment with the carrier doesn't mean you don't have the same documentation requirements.

- If the carrier requests additional information from you and you don't give it to them because you are "not in the insurance business," you run the risk of losing a patient. The patient will more than likely perceive this as a lack of cooperation and leave you for a provider who will do the billing for them, doesn't require payment in full at the time of service, and will accept assignment. There is also the possibility that they might report you to the state board if they are unhappy.

- You may be able to offer time-of-service discounts or prepaid plans if your state allows them.

- If the patient has benefits with an out-of-network provider, the patient's claims should be processed. If there is a deductible and it has been met, the patient should receive reimbursement directly from the carrier.

- Your "super bill" should be a completed CMS-1500 form with box #13 left blank. Box #13 indicates whether the patient has assigned benefits to your office; since they have already paid you in full, this should not be completed. Better yet, go the extra mile and send the claims in electronically for your patients. They will have their claims processed much faster than paper claims.

- Verify the patient's benefits. Why provide super bills if there are no out-of-network benefits?

2. Out-of-Network Provider

- Many health care policies have chiropractic benefits available for services your patients receive, even though you are not in-network. In some cases, the patient may have a deductible or larger co-pay than with in-network providers.

- You can choose, on a case-by-case basis, to either accept assignment (have the insurance carrier pay you directly) or not accept assignment (have the patient pay you in full, meaning if any reimbursement is owed, it will go directly to the patient).

- Some offices give the patient a choice of paying in full with reimbursement going directly to the patient or paying their portion and having the balance come directly to the provider.

- Keep in mind that some carriers will clearly state that if you are out-of-network, they will not send reimbursement directly to you, even if the patient requests it. When verifying benefits, always ask if payment will come directly to your office with a valid assignment of benefits.

- Typically you will have up to one year from the date of service to submit claims to the carrier.

- If you are accepting assignment, the patient will be responsible for the remaining balance that is not paid by the carrier.

3. In-Network Provider

- You will have to apply with the carrier to become a participating provider and in most cases, when you sign the contract you will agree to accept a reduced fee for services.

- You will have your name on a list of participating providers. Patients may choose to come to you because they typically have a smaller co-pay than the out-of-network providers and in some cases they do not have a deductible or much smaller one than with an out-of-network provider.

- You must accept assignment (have the insurance carrier pay you directly). You may only be able to collect the co-pay and/or deductible portion from the patient. When the carrier processes the claims and you receive the Explanation of Benefits (EOB) or Remittance Advise (RA), it will indicate how much is the patient's responsibility. If you charged more than the allowed amount, you will have to write off the difference between the charged amount and allowed amount.

- Some carriers will require that you submit a request for authorization to treat the patient. Some

require that it be done on the first visit and some require it after a predetermined number of visits. Unless you receive authorization, you will not receive payment and you may not be able to collect anything from the patient for services that are not authorized.

- Some carriers prohibit you from collecting for non-covered services even though you may consider them medically necessary; other carriers will allow you to collect for non-covered services if the patient is advised in advance and signs a notice stating that the services is not covered and that they have agreed to pay for it personally. Some carriers will provide you with the form. Read your contract carefully.

- Claims must be filed within the time frame stated in your contract. Depending on the contract, that could be anywhere from 15 days to one year from the date of service. If claims are not submitted in a timely manner you will not receive payment from the carrier and not be able to collect the balance from the patient.

- Your contract may also require that you take reduced fees for work-related injuries or personal-injury claims. *Caution*: You may sign a contract to be a provider with one carrier and find that you are a provider with many other carriers who are not listed in your contract. These may be referred to as "silent PPOs." Again, read your contract very carefully.

- Because you are in-network and already accepting a reduced rate, you may not be allowed to offer time-of-service discounts or a prepaid plan.

4. Combination In/Out-of-Network Provider

You can have your cake and eat it, too. You can have a practice in which you are in-network with select carriers and out-of-network with others. I have found that most providers think it is an all-or-nothing situation, which is far from the truth. Practice due diligence and if you are considering becoming an in-network provider, take a hard look at the contracts. Consider the timely filing requirements, allowed amounts, and if the contract with the carrier will link you as a provider to other carriers.

Quite often I receive calls and e-mails from doctors who have so-called "cash practices," telling me that they want to start to bill insurance for their patients and need to know what to do. Truth be told, with most carriers almost everything is exactly the same, except that box #13 on the CMS-1500 claim form needs to be completed.

On the other hand, I have doctors who contact me stating that they want to stop billing insurance and switch to a "cash practice," and want to know how to go about doing so. If you are in-network and would like to get out-of-network, I suggest you read, "How to Drop an Insurance Company" by Tom Necela, DC, which appeared in the June 3, 2009 issue of *DC*. He provides practical advice and emphasizes that it doesn't have to be black or white.

Finally, I recommend that you always take the time to contact the insurance carriers to verify benefits for your patients, regardless of what type of practice you have. Verification can be done via the Internet, but in most cases you will have to call them to determine if payments can come directly to your office. Remember that the benefits quoted are "not a promise or guarantee," but most of the time they are correct. Taking the time to do the verification can prevent some very uncomfortable situations.

If you would like a sample insurance verification form, e-mail me at lisa_bilodeau@hotmail.com and put "IV" in the subject box.

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