



Paul E. Okamoto, D.C.

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Collection/Payment Methods Part B - Private Health Insurance (The eighth installment of this series)

In the early days, insurance companies did not cover chiropractic care; thus collection was simple, as patients would just pay as services were rendered. Then the insurance industry started to include chiropractic in their payment benefits. The typical scenario was a \$50 or \$100 deductible and then the insurance would pay 80%. This was slightly more complicated than the early days, but the patient portion was easily determined. This type of coverage still exists in the marketplace, but is becoming less common. With the spiraling costs of medical care, I anticipate that this will more than likely become a "dinosaur."

Now the days of managed care are here. There are preferred provider organizations (PPO) and health maintenance organizations (HMO), which have their own separate policies and rules. The benefit for the new provider is that the more organizations or panels that he/she can join, the more access that he/she will have to see more patients. The downside is that every company has different reimbursement rates, all of which request some degree of discounted fees. Some pay reasonably well, but others pay quite poorly. For the new practitioner, a poor reimbursement patient is better than no patient at all. Thus my suggestion for a new DC is to try to get on as many panels as possible. However, as the patient base increases, the DC can evaluate each panel and choose his/her participation. Additionally, many managed care companies have policies that require paperwork to justify ongoing treatment. The doctor must understand each company and fully comply with the paperwork requirements.

Medicare typically covers those 65 years of age or older and those who have permanent disability. To function in this system, you must obtain a Medicare number. Medicare only pays for the adjustment of a spinal subluxation and requires a primary diagnosis, which is a regional dysfunction diagnosis code number and a secondary diagnosis that is associated with the location of the primary diagnosis. You must choose whether to be a participating or non-participating provider. If you choose to participate, your reimbursement rate is slightly higher and your name is included in the provider book. Each Medicare patient has a yearly deductible that must be paid before the program starts to pay.

A participating provider collects all non-covered services (*exam, x-rays, therapy*) as well as the 20% of the adjustment charge or 100% if the deductible has not been satisfied. Deductible charges only apply to the adjustment. Medicare will then send

the remaining 80% to the doctor. A non-participating provider collects all fees from the patient who is then reimbursed for 80% of the adjustment fee. Whether a DC decides to be participating or not, Medicare establishes the maximum allowable fee that a doctor can charge for the adjustment. By law, both categories of doctors must bill Medicare for all services rendered. Additionally, the doctor must make the determination and notify Medicare for each visit if the adjustment is for active treatment (*commonly curative treatment*) versus preventative or maintenance. Medicare will only pay

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for active treatment and requires that each visit must note justification for treatment, which is included in the PART criteria (*Pain/tenderness, Asymmetry/misalignment, Range of motion abnormality, and Tissue/tone changes*). Each visit must have two criteria noted, and one of which must be asymmetry or range of motion abnormality. If these justifications are not provided, Medicare can deem that treatment medically unnecessary and require the doctor to pay the patient back. Additionally, fines and penalties can be issued. The only way to opt out of Medicare is to not treat Medicare patients.

There are also Medicare replacement plans. These have come on the scene in recent years and differ from supplemental plans. Although private insurance companies administer both types of plans, replacement plans actually replace Medicare Part B (doctor visits) as the primary carrier. A supplemental policy pays only the portion of the covered services that Medicare does not pay (*20% of the adjustment*). On occasion, I have encountered a supplemental plan that will pay 80% of the non-covered services (*exam, x-rays, and therapy*), but most do not. Commonly, they only pay for Medicare-covered services.

Private Insurance, commonly called major medical insurance, pays only for curative treatment unless otherwise specified. It does not pay for maintenance, preventative, or wellness care. Thus, if you have a wellness practice in which patients are seen on an ongoing set schedule, i.e. monthly or bi-monthly, etc., you should not be billing insurance for your services. I will say that I understand the rationale behind wellness care. This type of care can prevent or delay conditions that would potentially be able to save insurance companies millions of dollars annually. However, private insurance is by definition sickness insurance. That is why offices that build wellness practices are commonly cash practices.

My typical protocol for treatment recommendations is to give the patient two options. He can choose to receive only pain relief. I explain that this type of care is like patching a tire, where the major underlying problem remains. The second option is to undergo a certain amount of treatment in order to bring maximum benefit and then release that person from care. Both options would be payable by major medical insurance, as both fit under the definition of curative care. When I release the patient, it is explained that if and when symptoms return, to call right away for follow-up treatment.

With regard to collection protocols and private insurance, the typical starting point is to obtain the patient's insurance card and call the company to find out the benefits. One would assume that the benefits quoted are the same as benefits paid, but that is not always the case. The companies will commonly tell you what is quoted is not a guarantee of payment, and, on occasion, I have found that what is paid is dramatically different than quoted. In those situations, an unpleasant result can occur. Since insurance companies usually pay 30-90 days after insurance is billed, it can be quite difficult to try to collect additional monies from the patient for services previously rendered. A patient typically believes that is the responsibility of the doctor's office to collect the difference between the amount quoted and the actual amount paid.

As a result of having several of these situations, I decided that our office would have guidelines that any new patient with insurance must understand. First, the insurance contract is between the insurance company and the patient. If there are any disagreements regarding payment, it is between them to work it out. However, we state that our office will do everything possible to assist with paperwork that may justify payment. Second, as a convenience to the patient, the office will wait for payment from the insurance company, assuming that the anticipated payment is forthcoming. If payment is either denied or is not what is anticipated, monies owed the office will immediately become due and payable by the patient. Lastly, our office will collect at least 50%, and, in many cases 100%, of the first visit charges, even if that creates an apparent credit for the patient. We will then collect the patient portion percent quoted on each subsequent visit. Once the first insurance payment is received, office staff can then generally ascertain a ballpark figure what future payments should be. If there is a credit from the first insurance payment, the

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patient has the choice of either receiving a refund check or applying the credit to future charges. I would much rather owe the patient than have the patient owe me and attempt to collect months later for misquoted charges.

Deductibles are what the patient must pay before insurance benefits kick in. Thus the patient should pay 100% of the charges until the deductible is satisfied. Generally speaking, the deductible applies only once a year. Usually it is a calendar year, but may be according to the patient's renewal policy year, such as July 1 to June 30. The deductible does not need to be met only by your office, but is determined by an accumulation of medical provider charges. As a result, if the patient has seen other providers prior to coming to you, he/she may have already satisfied the deductible. When you call the insurance company, it is wise to ask if any portion of the deductible has been met.

On a final note, although a doctor may feel sympathy toward a patient's financial situation, it is commonly against the law to write-off a patient's deductible or co-pay. Writing off the patient's percentage is also looked down upon, particularly forbidden when a doctor makes it a practice to regularly write-off patient portions indiscriminately. If you encounter a case where there is true hardship and you want to write off the patient portion percentage, you should make a notation in the file that you are doing so due to financial hardship. Yet I make it a practice to never write-off the deductible or co-pay.

I hope this provides some overview of the major medical portion of the practice. Be blessed!

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*Previous installments of this series can be found on our website, www.christianchiropractors.org