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Back Talk

Collection/Payment Methods
Part C - Third-Party Claims
(The ninth installment of this series)

In prior articles, I have written about the cash and private insurance portions of the doctor's practice. I would next like to address guidelines for third-party reimbursement.

The most common categories of third-party cases are worker's compensation, automobile accidents, and slip and falls. In third party cases, liability must be proven. When liability is established, then reimbursement is possible.

Assurance for reimbursement typically occurs through one of three means - assignment of benefits, lien, and promise to pay. In an assignment, the transfer of rights occurs from one party to another. In the medical arena, this transfer is commonly called assignment of benefits, where a patient will sign a form that allows or assigns benefits to be paid to the doctor.

A lien is a form of security granted over an item of property to secure the payment of debt. A common occurrence of lien is found in home construction. The property cannot be sold without the lien holder being paid. In the medical arena, a doctor's lien can be used against the judgment proceeds at the time of settlement, so that the patient's attorney will pay the doctor when settlement occurs.

The promise to pay is just what it states. The attorney may not need to acknowledge a lien if he/she has agreed to pay the doctor out of settlement proceeds. On rare occasions, the liable company may agree to pay the doctor.

Let's start with worker's compensation. Every state has specific rules, and they can vary greatly. In order to be reimbursed for your services, you must have a thorough understanding of the worker's compensation system for that state. If you live on the border between states, as I do you, must determine which state to file the claim and follow that specific state's rules.

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In all categories of third-party claims, the major issue is proof that an injury occurred and the diagnosis given is a direct result of the specified incident. This is particularly true with worker's compensation. Commonly, statements are required from the employer, injured worker, and the doctor, so that the insurance claims adjustor can make a determination if a work injury occurred or not. In the past, the majority of injuries claimed were from a single incident, such as a strain or fall. One curveball you should know is that automobile accidents that occur while at work are commonly considered worker's compensation, rather than personal injury. These single incident injuries were typically easy to prove, as there were witnesses and associated evidence of injury, i.e. bruising, spasm, broken bones, automobile body damage, etc. Nowadays, with the specialization of work, a new type of work injury has come on the scene due to repetitive activities, i.e. carpal tunnel, tendonitis, bursitis, etc. Theses are inherently more difficult to prove, as they occur over a period of months or years, but are not impossible. If a permanent impairment results, some states may also pay for palliative care.

I should briefly cover federal worker's compensation. As a general rule, I have found that anything on the federal level is not simple and forthright. The

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most common cases involve injuries to postal service workers. Federal worker's compensation will pay for the exam and adjustments. Similar to Medicare, they will not pay for any therapy. The Medicare reimbursement rate for the adjustment is applied to the federal worker's compensation claim. Because of past difficulties with determining regulations, lost billings, etc., I have decided to not deal with the federal worker's compensation system.

Let's address personal injury. Although worker's compensation could be included under the heading of personal injury, the most common associations with personal injury are motor vehicle accidents and slip and falls. Most states either have personal injury protection (PIP) or Med-pay inclusions in a person's auto insurance policy. This portion will pay medical benefits for injuries associated with the auto accident and pay no matter who is at fault. Once again, each state has different rules and reimbursement guidelines. You should also understand that if the case is a liability case with the other party at fault, the liable company will rarely pay the doctor directly for services rendered.

Commonly, the liable company will only pay the patient or legal representative *(the patient's attorney)* a lump sum amount at the time of settlement. The usual scenario is that you will receive reimbursement from the patient's insurance company under the PIP or Med-pay portion of their policy. Once the claim has been settled, it is common practice for the liable company to reimburse the patient's company for monies paid to medical providers. No matter which reimbursement manner is used, our office explains financial expectations to each patient early on to make sure that the payment procedures are clearly understood. This pre-emptive policy will minimize any misunderstanding and prevent a future rift that may develop between the patient and the doctor's office regarding outstanding bills.

If the patient does not have PIP or Med-pay or if the policy limitations have been reached, you are potentially out in the cold. I recall one case in which the patient did not have PIP, racked up several thousand dollars of services, settled with the liable party, received a settlement check, and then moved out of town, leaving me with the bill. It was a painful but educating lesson to not be naive, but to do necessary follow-up to insure reimbursement for associated services.

In cases with no PIP or that have reached limitations, there are other places you may look for reimbursement. If the patient is a passenger in the vehicle, the first place to look is to the driver's insurance. If the policy limitations are reached, you can then look to the PIP or Med-pay, even if the patient was not in his/her own vehicle. If the patient is a minor and is living with a relative, you can also look to the relative's PIP even though the relative was not involved in the accident and the vehicle involved was not the relative's car.

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However, the most common place to look to after the initial PIP or Med-pay is the patient's personal major medical health insurance. Thus it is wise with any third-party claim to obtain this insurance information at the onset of care. These companies will not pay as long as there are funds available with the automobile carrier. However, if there are no medical benefits or if the benefits have been exhausted, then the major medical insurance will pay. This is called subrogation. Once again, when the settlement occurs, the liable company typically reimburses the insurance companies that have paid.

In such cases where a doctor is sticking his/her neck out with no assurance of reimbursement, I commonly will recommend or request that a patient utilize the services of a personal injury attorney who will agree to pay me out of the settlement when funds are disbursed. If I can obtain the agreement of an attorney either by his/her signature on a doctor's lien or a promise to pay, I have some assurance that someday I will be paid. There are two downsides to this situation. First, settlement typically occurs years after the injury has occurred. Thus the money will remain on the books. Secondly, the patient's

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attorney may approach you and ask that you take a reduction in your fees. I can think of three different scenarios. Some attorneys routinely ask all medical providers and institutions to take a significant discount on services rendered. The second situation is that some doctors regularly rack up bills that are so high it creates difficulty for the attorney to obtain a settlement sufficient enough to pay all medical bills and still have money left over for the patient. The third scenario is where I know that in a specific case, I choose to extend treatment beyond what is customary with the hope that additional benefit may occur, realizing that my billings are higher than an attorney may reasonably be able to negotiate.

In those cases where I knew that my services were justified and my bills reasonable, I do not agree to a cut. This occurs in the majority of cases. However, there have been cases due to circumstances on my part that I knew that I would need to take a cut on my outstanding bills. In those situations, I was happy to receive a portion of payment. When faced with the proposal of taking a cut or not, my advice is to evaluate each case separately and make a decision based upon the merits of the case.

The last category is slip and fall. The common situation is where a person either falls in a store, on an uneven sidewalk, or in a hole that was not properly marked with caution. In each case, negligent liability on the part of the owners must be determined. However if clear liability does not exist, then a successful suit may be improbable and you will likely not obtain payment for your services. The key word is negligent. Liability responsibility in slip and fall cases are the most difficult to determine, as it must be proven that the property owner was negligent.

With each category of patient, the more credit extended, the more paperwork that is required to assure payment. The cash patient requires the least paperwork, major medical insurance requires more, and third- party claims require the most. Yet paperwork serves the purpose of some guarantee of payment.

In my next article, I will cover paper reviews and independent medical examinations and how you can be prepared, both preemptively and after the fact.