

**“Survivor - Medical Island” – Your
New Reality Show**
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You have lost the immunity challenge. The tribal council has decided. You have been voted off the island (out of the plan). This very well could be the words you are going to hear from insurance plans that your office participates in. Just like the popular reality television show “Survivor”, the medical community is facing a new reality. There is wave of change moving through the business of medicine. This change is known as “Economic Credentialing”. The American Medical Association defines economic credentialing as “the use of economic criteria unrelated to quality of care or professional competence in determining a physician’s qualifications for initial or continuing hospital medical staff membership or privileges.” The insurance companies are distorting this idea and defining it as a way to determine participation in their health care plans.

As medical costs skyrocket, insurance companies are looking for new ways to save money. One of these ideas gaining in popularity is to identify which doctors are cost effective. By including only these “cost effective” doctors in their plan, it becomes a way to save money. One insurance company, United Healthcare, is already implementing a system to do just that. However, the concern becomes what criterion is being utilized to determine a cost effective practitioner and what happens to quality of care? In this system doctors will be “rated” on cost efficiency. Doctors are then “tiered” in the insurance directory identifying them as highly rated. This rating is thought to be based upon criteria such as evidence-based standards, cost efficiency and surgical complications. Consumers can look through the directory and choose one of these highly rated doctors and there will be incentives for them to do just that. Co-pays and premiums would be reduced by selecting a highly rated physician. This plan helps insurance companies place more of the financial burden on consumers and forces consumers to make decisions based upon their out of pocket. Systems such as this are already in place for prescription coverage. Generic versus name brand determines the consumers co-pay.

Many insurance plans are already profiling doctors billing patterns to determine those that fall 2 standard deviations beyond the norm. These doctors are flagged for close examination of the CPT codes used to determine exact billing patterns. Many times these flagged doctors are put on probation by the insurance company to reduce their costs of care. Eventually, if there is no change in cost, the doctor is removed from participation by the insurance company. Most insurance companies are looking at cost per patient to determine efficiency. However, the overall picture of total cost, including medications, referrals, and tests will soon be the standard. The computer age is here and technology is helping insurance companies to define every aspect of care.

What can you do as a practitioner to be prepared for this wave of close examination? The primary goal of every practice must always remain patient outcomes. So begin by examining your practice to determine if you are achieving high patient outcomes. Poor patient outcomes could be an indication that you are not practicing cost effectively. Look closely at how you specifically treat different medical pathology in your office. Examine your protocols. Question the procedures, the medications, right down to the supplies you use. Are there more efficient ways of working? While decreasing costs to provide care does not necessarily guarantee patient outcomes, it does allow your practice to be competitive for health care dollars.

Begin by utilizing the same tools that the insurance companies use to determine your statistics of care. Many of the larger insurance companies will provide statistical practice profiles by simply requesting one. If a company will provide it, request it. It would be to your advantage to see what the insurance companies are seeing. Most of these profiles compare you to your peers. This gives you a baseline to work from. For Medicare, The American Podiatric Medical Association publishes Medicare’s Part B BMAD information. This is available to all APMA members (www.apam.org). This statistical analysis is broken down by state, code and frequency. While this breakdown is not an exact science of how you should practice, it does

provide you with a general idea of how you're doing compared to your peers and the rest of the country. Most medical billing software can run statistical billing reports by week, month and year. If your office software cannot do this, then perhaps you need to consider updating to software that can compete in today's world. These reports are best if you run them on a regular basis, at least quarterly. Yes, you need to look at these reports! Examine how you are reporting your services to insurance companies on the claim forms. Be as specific as possible on diagnosis codes used. This will help in the long run when you are profiled and assigned a dollar amount to each diagnosis. Instead of showing a large cost for the blanket diagnosis of foot pain on every patient, your profile will truly reflect the medical conditions you are treating. You do not want to provide an inaccurate picture of your practice by failing to report the most specific diagnosis for each patient treated.

Most importantly, implementing practice efficiency should be at the center of your plan. Not only will this help improve patient outcomes, but it will directly affect your bottom line. There are many roads to improvement. I suggest you take the fast track. If you are not a member of your state podiatry association, become one immediately. The state associations are conduits of information on problem solving and trends with respect to insurance companies. You may be able to help your association educate insurance companies on rationale for costs to provide care. Good medical care is not always the most inexpensive option. Insurance companies need to be reminded of this. There should be a team effort between your state podiatry association and the insurance companies that addresses these issues in an effort to maintain a proper balance of outcomes and cost. Second, the issues of practice management need to be addressed very seriously. Treat your office as a business that needs a plan. Practice management is more than just learning how to make money. It is learning to be cost effective. The American Academy of Podiatric Practice Management sponsors 3 major seminars each year. If you have not attended one of these seminars you are definitely at a disadvantage. Better yet, become a member of the Academy and let their experts give you the tools to improve your office efficiency and practice management. Visit their website for more info www.aappm.org. If you want to be a "survivor" in the medical health care field, don't let the insurance company tribal council vote you off their plan (island). Practice smart, be efficient, and stay ahead of the wave of change.

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