Managing Your Dermatology Practice

Slashing Accounts Receivable, Part II

I knew my December 2005 column, which suggested asking each patient for a credit card number and billing balances to the card account as they come in, was an idea whose time had come. But I was quite unprepared for the huge volume of feedback—more, by far, than any column before it. (If you missed that column, you'll find it at the Web site, www.skinandallergynews.com. Click on "The Archive Collection" on the left-hand side.)

BY JOSEPH S. EASTERN, M.D.

Questions and requests for copies of my letter of explanation and consent form continue to pour in, even now. Many of the questions are similar, so I've decided to answer the more common ones this month.

Don't your patients object to signing, in effect, a blank check?

Some did object initially—mostly older people. Nowadays a wide chasm seems to have formed in financial philosophies, right at about age 35. If you're older than that, for example, when you receive your checking account statement each month you probably say, "Thank goodness they still include copies of my canceled checks." If you're younger, you probably say, "Why do they send all this *paper* with each statement?"

But when we explain that we're doing nothing different than most restaurants and online businesses, and it will work to patients' advantage by decreasing the bills they will receive and the checks they must write, most come around.

And they're not "signing a blank check"—all credit card contracts give cardholders the right to challenge any charge against their account, and we remind them of that.

Once you've collected the credit card information, where do you store it, and how do you keep it secure?

We keep it in the patient's chart, where it is guarded with the same level of security as the rest of that patient's privileged information.

Some offices prefer to store it all in one place—a Rolodex-type container, or an Excel (or Quickbooks, or similar) computer file, for example—protected by locked cabinets, passwords, and any other precautions that might be necessary.

Couldn't this be considered "balance billing" and therefore illegal?

This is not "balance billing," which is asking patients to pay the difference between your normal fee and the insurer's normal payment. If you have a contract with the insurer, that's illegal—or more precisely, it's a breach of your contract. What you charge to the patient's credit card is the portion of the insurer-determined payment not paid by the insurer. For example, you bill $200, the payer approves $100 and pays 80% of that. The remaining $20 is the patient's responsibility, and that is what you charge to the credit card, rather than sending the patient a statement for that amount.

We instituted this policy after you suggested it in your American Academy of Dermatology course. So far one patient has called to ask if it is legal, and one insurance company has inquired about it. How do you respond to such queries?

Of course it's legal. (See above.) Ask those patients if they question the legality every time they check into a hotel or rent a car. We have had no inquiries from insurers, but my response would be it's none of their business.

You have every right to collect the patient-owed portion of your fees, and insurance companies have no say in how you do it.

How do you handle patients who refuse to hand over a number, particularly those who claim they have no credit cards?

We used to let refusers slide, but as of Jan. 1, we've made the policy mandatory. Patients who refuse without a good reason are asked, like any patient who refuses to cooperate with any standard office policy, to go elsewhere. Life's too short. And "I don't have any credit cards" does *not* count as a good reason. *Everybody* has credit cards in this day and age, except deadbeats with such awful credit that you don't want them anyway. My office manager does have authority to make exceptions on a case-by-case basis, however.

One surgeon I know asks "no credit card" patients to pay a lawyer-style "retainer" of $500 which is held in escrow and used to pay receivable amounts as they come due. When presented with that alternative, most suddenly remember that they do have a credit card after all.

Do you envision using this policy to enforce any no-show charges a practice might have?

I had not, but now I am. Excellent suggestion! ■

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Medicare Invests in Pay-for-Performance Demo Projects

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

Washington — Provider groups are behind the curve when it comes to anticipating acceptance of pay-for-performance programs, Jeff Flick said at a health care congress sponsored by the Wall Street Journal and CNBC.

Take, for instance, the Premier Hospital Quality Incentive Demonstration program funded by the Centers for Medicare and Medicaid Services, under which hospitals report data on 34 quality measures, said Mr. Flick, the CMS regional administrator in San Francisco.

The program gives a bonus each year to the 20% of hospitals with the highest score, but those who have not improved a certain amount after 3 years are penalized, he said.

When the program was launched several years ago, "The American Hospital Association said, 'No hospital is going to do this,' " Mr. Flick said. "Hospitals are afraid to even report information about quality, but the idea that they could be penalized financially . . . the [AHA] thought it would never happen. But there were 300 hospitals on board immediately."

Similarly, the American Medical Association recently said it did not support CMS's new physician voluntary reporting program, under which physicians would volunteer to report 36 pieces of data on their practices. The AMA's opposition "is not a shock; those kinds of organizations are very nervous about this," said Mr. Flick. "But it is a very important step that CMS is taking, and it is physicians saying, 'I want to report information because I'd like to know if my performance varies in a significant way from my peers.' "

Many physicians are ready to start focusing on quality, he continued. "They want to publish information, they want to know how they compare, they want to be paid based on performance. That doesn't mean the AMA is necessarily going to support it."

The program uses G-codes to enter the data, which can make for a bit of a hassle for physicians not familiar with them. "If every physician in this country had an [electronic health record], this would be easy; I think this would be done," he said. "Today we would be really paying based on performance. Maybe just thinking about the G-codes will drive people into an EHR." ■