

“We Attack at Dawn”

If organized medicine is our army and effective legislation our shield, what composes the weapons? Many would say that we have no weapons. Many would say that organized medicine has no teeth. Let them say what they wish, but our weapons are composed of action, commitment, unity, dedication, diligence, and perseverance!

Upon speaking to some of our colleagues – most are not aware of the Arizona Medical Association's Alliance and their work on the “timely payment project”. This is a very important project, so much so, that I've allocated this editorial to this matter. This topic involves all of us and our pocketbooks.

Wouldn't you love to be responsible for sending an auditor from the Department of Insurance into an insurance company (at the insurance company's expense) and disrupt their lives for a change? If you wish to improve your cash flow and increase your cash receipts, well then my friends read on!

Why is it that physicians continue to work so hard, yet have to fight to collect money for services rendered? The battle continues yet many physicians simply don't have the time or energy to combat this essential part of the practice.

Over the past 21 years I have heard, just like you, every imaginable excuse supporting the delay tactics by insurance carriers on why a claim has not been paid. Never did I anticipate the piles of paperwork, the amount of time left on hold, or the complexities of obtaining referrals, authorizations, approvals, and scheduling a CT Scan or MRI. Another term for this type of obfuscation is referred to as the “hassle factor”. A recent call to a carrier offered 12 different options so as to better services my needs. By the time I hit option number 10, I seriously considered a root canal to be less painful.

The frustration is beyond words but it has taught me the importance of perseverance and sheer relentlessness. The truth of the matter is clear and simple, collecting money for services rendered is becoming a new art form which several spouses from various practices and specialties around the valley are presently doing, and doing well. Thankfully, there is a group of spouses, most of them whom are located in Tucson, who are making headway towards timely payments for medical practices. Last month, I had that opportunity to meet in Tucson with Sandy Goodsite, originator of the ArMA Alliance's “Timely Payment Project” and two representatives from the State Department of Insurance, as well as Alice Parkin, President of the ArMA Alliance and Susan Vose, a volunteer for the data entry portion of the project. It was very enlightening and encouraging.

A grievance form was developed to outline all of the criteria which the State Department of Insurance requires health insurance companies to report in areas of grievances regarding non-payment. These reports are mandated twice a year. Last year among the 8,000 physicians in Arizona, the State Department of Insurance incurred approximately only 15,000 grievances that were passed through to them by the health insurance companies. That is less than TWO per physician!

If an insurance company can be proven to be guilty of under-reporting, the State Department of Insurance can send an auditor in at the company's expense. The "Project" asks that physicians do the following:

- Use a common grievance form.
- Blank out all privacy protected patient data for the ArMA Alliance's copy.
- Send the original to the insurance company.
- Send a copy of the form to:

Alliance Project
P.O. Box 32498
Tucson, AZ 85751-2948

Project volunteers are currently entering the data into a software program that is designed to do the following:

- Count grievances and sort by insurance company.
- Create a grievance letter.
- Create a report for the Department of Insurance, twice annually by insurance company, to verify the number of complaints that they are reporting.

Because we are hopeful that legislators will attempt to further empower the Department of Insurance to protect physicians from the lack of timely payments, the Arizona Medical Association Alliance has developed software to accomplish the tasks listed above for medical practices, and has developed a website at www.armaalliance.org where physicians can join for an annual fee of \$20.00. This will allow you to create the grievance letter to both the health insurance company and the "Timely Payment Project" as well as allowing you to keep statistics on problems with payments that will be helpful when contract renewal rolls around.

The ArMA Alliance invites you to participate. For information on this project or to join, call 520-298-9167 or get a copy of the grievance form for your practice (a copy of this form immediately follows this article).

I encourage you and your office staff to participate in this innovative approach to making a difference in timely reimbursements. The majority of medical specialties in the Maricopa County area are experiencing delays so let's take concerted efforts to act rather than complain.

A piece of key legislation passed in 2000 that supports physicians in their attempt to receive timely payments of claims. As we all know HB 2600, the Managed Care Accountability Act, contains prompt payment provisions in its language. The following outlines many of HB 2600 key points:

- The Department of Insurance is responsible for the regulatory oversight of insurance companies. In the DOI's determination of the financial condition of the health care insurer, information concerning provider contract disputes may identify indicators of regulatory problems, liquidity problems or network deterioration.
- HB 2600 requires all health care providers to approve or deny clean claims within 30 days of receiving the clean claim or as specified in a provider's contract.

- HB 2600 requires the health care insurer to pay a clean claim within 30 days of approving the claim.
- In the event that a clean claim is not paid within the specified time, the health care insurer is required to pay interest on the claim at a legal rate beginning on the date the payment was due.
- For the purposes of determining whether or not a claim shall be approved or denied, the health care insurer is required to request in writing additional information from the provider within 30 days after receiving the claim.
- HB 2600 requires the health care insurer to notify the provider of all the specific reasons for delay in approving or denying the claim.
- HB 2600 requires the health care insurer to approve or deny a claim within 30 days of receiving the additional information or as specified in the provider's contract.
- In the event that a claim needing additional information is not paid within the specified time period, the health care insurer is required to pay interest on the claim beginning on the date payment was due at the legal rate.
- HB 2600 prohibits a health care insurer from delaying payment of clean claims or paying less than the contracted rate without reasonable justification.

Wow! Sounds like a mouthful, and that is not all that the bill encompasses. So here you go, put it to use! If you have any questions regarding the "Timely Payment Project" call 520-298-9167.

I would like to extend a special thanks to Kathleen Baldree for her work with Sandy Goodsite and Barbara Leff in putting this informative piece together.

See you next month!

Mark E. Baldree, M.D.
President