

Dog Days of Medicine

Well, the “dog days” of Summer are here again and the pace is slower. Everyone is reviewing their practice and making changes in the plans to deal with the business of medicine. More time in the doctor's lounge at lunch leads to more stories about reimbursement and recommendations from all of the so called “experts” that wax eloquent about the problems and solutions for the turmoil we all call third party payers.

More stories arise about the request for more information and non-reimbursable expenses that seem to be levied exponentially over the last few years. Of course, the information is requested to help justify tests to confirm a suspected diagnosis. This is done in the name of quality assurance and cost containment!

Last week, I received a request from an internist that asked if I thought doing a pulmonary function study was a reasonable request when a patient presented with increasing shortness of breath. I am sure that if the physician had just diagnosed COPD and ordered one of the usual medications for this problem, the medical director would have requested more information about the necessity for this medication without appropriate studies.

These problems and questions led me to think about how some of the managed care companies waste so much money in the process of saving a dollar. When a sick individual comes to the hospital and ultimately has problems that require a prolonged stay, the “insurance police” (aka case managers) are pushing for the patient to be prepared for transfer to a lesser level of care as soon as the patient begins to show the slightest bit of stability. It is also interesting that some patients disappear from some levels of care and all the physicians have not been notified. The physicians that have expended time and energy in getting this patient to reverse the down hill spiral, are now put in the position of seeing their efforts go half way across town to a new group of physicians. These physicians may well not be equipped to handle the problem due to lack of experience or lack of resources at that facility. Then, when the patient deteriorates and 911 is called to transfer the patient back to the Acute Care facility, the patient is deemed too sick to go to the original facility. Now another set of physicians are asked to render care to a patient with a problem that has been dumped into their care with little or no information about the patient's condition, or family dynamics.

This scenario can't be cost effective. The consultative costs for new physicians, costs for repeat X-ray and laboratory information compound the added cost to the company. Repeat consultations for physical therapy and other ancillary services would also be required. The failure in the ability to transfer usable information between care givers, in my opinion, is extreme.

Not infrequently, when the shifting of care occurs four or five times the patient's ability to survive this ordeal decreases rapidly. A patient, that has had large sums of money and time invested in his illness, begins to falter and then ends up in long term care. The total costs are astounding. Unfortunately, the insurance carrier puts the blame on the

physicians and finds some care unneeded and will refuse to reimburse for services they deem unnecessary.

These same insurance companies reward their CEOs multimillion dollar bonuses for cost accounting. The physician, unfortunately, has to fight for the extra \$15 charged. Granted, not all cases end up like this. Enough of these cases exist that all physicians will be touched by this problem at one time or another. The problems of quality of care are a byproduct of this scenario. Quality of care issues beget complaints from families and may lead to legal problems. The insurance industry then blames the doctor for the quality of care. "Doctor, we would never force you to do things against your medical judgment," says the Medical Director.

How can we regain any control over our patients? The answer is not yet derived. We must, somehow, regain control of our patients and medicine because we are quickly becoming only a replaceable cog in the wheel of the insurance companies. If we don't do what is required, we will be replaced by computers and paramedic personnel. We must become informed and involved. We must begin to use our Society's affiliations to put pressure on legislators and third party payers. We need to communicate to the public that manipulation of patients and service providers does not improve the patient's care and in fact may decrease quality while increasing risks and costs.

The Society is in the process of sending a questionnaire to each physician. We are going to list the TOP INSURANCE PROVIDER rankings. You will receive the lists and we ask that you have your billing agent or staff answer the questionnaire and submit it for review. We will publish the data and will consider releasing it to employers for their review. Maybe it is time we begin to fight back!! Quality health care is becoming more difficult to provide. We must get involved and must demand to have a presence in the decision making process.

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