The Blame Game

Whose fault is it when the insurance company gives you wrong information?

BY LYNN HOMISAK, PRT

To Our Readers: *There are no foolish questions. Chances are that if you have a question or concern in your practice, others are experiencing a similar situation. We're here to help. PM [doctor and staff] readers are encouraged to submit questions to lynn@soshms.com which will be printed and answered in this column anonymously.*

Subject: In and Out

Dear Lynn,

In just one year, I've gone through 13 different staff people. You don't have to tell me how costly that is; I already know. I can't seem to pinpoint, however, WHY they leave so soon after being hired. Care to share your thoughts?

About a year ago, we addressed a similar question concerning an ongoing revolving door of staff. [See PM February 2017 issue] What was not mentioned in the previous post were some universal reasons why staff leave their employ.

- They realize they don't enjoy the work.
- They are given too much [or not enough] responsibility.
- They have difficulty getting along with their co-workers.
- Their employer is a poor manager, micro-manager, poor communicator, doesn't care, etc.
- They haven't received adequate training to set them up for success.
- Their pay and benefits are too low.
- Their job and/or hours are not as described or no longer fit their schedule.
- There are too many employee rules.
- They feel under-appreciated.
- Their skills are under-utilized.
- There are unfair office politics.
- They feel uncomfortable/frustrated with the way the office functions [money management, customer service, billing/coding methods, HIPAA or OSHA breaches, etc.].
- There are life circumstance—relocation, marital/relationship status, children, family, illness.

Staff turnover upsets flow and efficiency in the office, disrupts teamwork and productivity and creates patient concern.

Staff turnover is uneconomical for the practice from every standpoint. It upsets flow and efficiency in the office, disrupts teamwork and productivity and creates patient concern. Imagine what your patients are thinking every time they come into your office and there is a new face to deal with. Are they wondering … why can't Dr. ____ hold on to people? Is the doctor difficult to work for? Are the staff unqualified or undesirable? Is this a poor work environment?"

It's time to stop the guesswork and find out. Determine which of the above check boxes [or other reasons] best explain your revolving door. The way to do that is with an Exit Survey*. Most employees want to leave in good standing for referral reasons, so ask if they would kindly fill out one final form. Sure, there may be employees who choose not to take part, while others are glad to cooperate and some actually happy to get things off their chest.

Be prepared because you may not like what you hear. Individuals who feel they have nothing to lose often provide the most honest responses. And don't brush off the negative comments from an upset employee as "just opinions." Instead, treat these criticisms and grievances as gifts, real insights, and allow yourself to be open to listening and learning. You will absolutely benefit from the feedback.

*I am happy to share this complimentary form with PM readers. Simply email lynn@soshms.com and write "Exit Survey" in the subject line.

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Blame Game *(from page 63)*

Subject: You Got Some 'Splainin' to Do!

Dear Lynn,

How do I explain co-pays, co-insurance and deductibles to our patients?

As simply as possible. Co-insurance was established by insurance companies so that both they and the patient share the responsibility of the patient's healthcare cost. The patient payment responsibility for each visit will depend on the services they receive and the cost of those services. If they chose a plan, for example, with an 80/20 co-insurance, the insurance company will pay 80% of allowed charges and the patient pays 20%. Patients are responsible for the amount that the insurance company does not allow.

A co-pay, on the other hand is a set payment the patient makes to the doctor for each visit and the insurance is responsible for the rest.

You might want to further clarify that the difference is that with co-pays, a patient knows their responsibility up front as it is a set payment; whereas, with co-insurance, they won't know how much they owe until the service[s] are performed.

A deductible is the out-of-pocket amount the patient agrees to pay to the physicians before their benefits kick in. Their plan premiums are based on how much of a deductible they choose, i.e., lower premiums = higher deductible and vice versa.

Subject: The Blame Game

Dear Lynn,

We are faced with a recurring problem. When we call insurance companies for our patient to see if they have orthotic coverage, we are told that it is an allowable service and they will pay a certain percentage. We document all the details, for example, whom we spoke to, the date, time, etc. However, when the EOB is returned and they deny coverage, guess who gets blamed? Patients get angry at us and some even refuse to pay, saying, "You told us the insurance would pay!" How does it become our fault when the insurance company gave us the wrong information in the first place?

Patients need to understand that any time you call the insurance company on their behalf to check coverage, it is a courtesy call for patients.

Patients need to understand that any time you call the insurance company on their behalf to check coverage, it is a courtesy call for patients. You are not obligated to call. However, many offices implement such a 'we'll call' policy in order to have firsthand information regarding the patient's financial responsibility. While there are the occasional outliers who will place unwarranted blame on the office as you point out, most patients really do appreciate your offer to intervene for them. They realize that you can do it faster and more accurately.

In the interest of educating the patient, the following is a scripted message that may help communicate this policy:

"Mrs. Jones, as a courtesy to you, I am happy to call your insurance company on your behalf to find out if orthotics are covered under your specific plan. The agents there are usually very helpful. However, they never fail to end the conversation by telling us that this [information] is not a guarantee of payment so I do want to be sure to pass that on to you along with the orthotic benefit information I am given. Now, if you are still concerned that they might not pay, I suggest you call them as well to double-check the information. And to make it easier for you, I can provide you with an easy-to-follow form* that has all the same codes, fees, and dates that we used when we called so there is no discrepancy."

Suggesting to patients that they participate in this process may not eliminate your call to the insurance company, but it will encourage more overall transparency and promote more patient financial responsibility. Above all, it should solve any future episodes of the no-winner "blame game" and wasn't that the whole objective in the first place?

*For a complimentary copy of this form, email lynn@soshms.com and include "Insurance benefits form for patients" in the subject line]. **PM**

Ms. Lynn Homisak, President of SOS Healthcare Management Solutions, carries a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management's Lifetime Achievement Award and was inducted into the PM Hall of Fame. She is also an Editorial Advisor for Podiatry Management Magazine and is recognized nationwide as a speaker, writer, and expert in staff and human resource management.