

# Medical Society of New Jersey

## MLS TESTIMONY AT SENATE COMMITTEE MEETING, MAY 8, 2008

### INTRODUCTION

Good afternoon Senators, ladies and gentlemen. My name is Melinda Salahi. Thank you for allowing me to speak today on behalf of my physicians, my billing company and most importantly on behalf of all patients in the State of New Jersey.

**What happens when there is no requirement for insurance carriers to pay a physician directly when a legal assignment of benefits is on file? It severely impacts a patient-physician relationship. Patients are confused and embarrassed when they directly receive checks that belong to their doctor, which further acts as a deterrent to the patient returning to their doctor for much needed medical treatment. When a physician or his staff are forced to confront the patient to turn over payments that should have been sent to the physician in the first place it becomes an uncomfortable situation for everyone. The faith and trust that previously flourished between a patient and their physician is callously destroyed and eventually severed.**

Failure to enact this proposed amendment shall guarantee insurance companies the ability to continue to interfere with the patient-physician relationship. By contrast, requiring insurance companies to reimburse providers directly, pursuant to the proposed amendment, will ensure the sanctity of this special relationship, as well as the patient's ability to receive proper and timely medical treatment.

As Bill 114 properly sets forth, insurance companies must be required to honor the assignment of benefits for the many reasons I will explain to you.

I offer a unique prospective on the issue at hand for the following reasons. In the early 1970's I began my career in the medical field in the Medical Records Department, and later as a respiratory therapy technician at St. Barnabas Medical Center in Livingston, NJ – the largest healthcare system in New Jersey today. Part of my work in the record department involved coding diagnoses – at a time when codes were *only* used for statistical purposes. I was involved with the utilization of coding at the inception and forefront of this process, long before insurance companies adopted it for billing purposes and their use became critical for proper reimbursement purposes. It was at St. Barnabas that I met and married my husband of almost 35 years – a general, vascular and one of the pioneers in bariatric surgery in New Jersey. I have been billing for 32 years – at first throughout my husband's career, and then later as my small company grew to code, bill and manage the follow-up for 15 practices - approximately 30 physicians in total. My husband has not been practicing for 7 years now due to health reasons. I am the owner of MLS Medical Billing Services located in Scotch Plains, NJ. My current clients encompass a variety of specialties and sub-specialties. Throughout the years I have managed my various clients' practices with the utmost diligence, accuracy and personalized care possible. I have also guided and counseled my clients in practice management with the knowledge I had compiled over the years, at the same time realizing the need to adjust policies due to the ever-changing health care industry.

I have experienced first-hand how insurance companies' red-tape and administrative processes have failed to prioritize the patients' best interests and treatment. Rather, as this reimbursement scheme highlights, their failure to focus on the patient-physician relationship further impedes proper treatment and follow-up care, causing sometimes far worse medical issues than originally diagnosed. Indeed, this is an administrative nightmare which at best causes the doctor to work for free - and at worst can be devastating to a patient's physical and mental health.

The physician trains from between nine to sixteen years depending on their specialty. He is required to perform at a very high level during training, as well as in his practice, with the ultimate goal of improving or saving the life of a fellow human being. As the wife of a surgeon I am acutely aware of the sleepless nights and the stress and fatigue that a physician deals with every day of his life. I know the hours spent to save a life and the despair and sadness when bad news must be told to a family still holding out hope. Conversely, the joy when a fragile life is saved makes it all worth the while. The patient-physician relationship is based on trust and develops into a special bond and is further nourished over time with honest and heartfelt communication. It is a sacred relationship that does not deserve to be disrupted by any outside influences. This relationship should not be manipulated or undermined by any entity.

### **THE CURRENT CRISIS**

Inconsistent practices make it impossible to know when to contact a patient regarding reimbursement, and insurance companies oftentimes refuse to notify the provider that a check was even mailed.

Forcing a provider to go on a virtual scavenger hunt to determine if a payment was made, who received it, when it was sent or received and how much was paid is a recipe for disaster.

#### **When a patient receives an insurance check directly:**

- Patients become embarrassed, confused and resentful that they are being contacted for financial issues.
- The patient may believe the reimbursement is a refund or a rebate – especially in light of the high cost of health insurance
- The patient may choose to keep the check for themselves
- The patient may refuse to inform the provider that they received the reimbursement - thereby basically severing their relationship
- This causes the patient to fail to return for follow-up care, which leads to poor communication and the lack of necessary medical follow-up

There is no legitimate basis in law or fact to deny a provider reimbursement for the work he or she has performed. Denying assignments of benefits has historically proven **moreover, that reimbursing anyone other than the provider, is no different than failing to reimburse at all.**

While the common perception of physicians is that of Porche driving, overpaid professionals, this is neither the truth in light of the current rate of reimbursements - nor a basis to deny reimbursement. In fact, the typical physician today is one that completes residency and is in debt for 200 – 300 thousand dollars. Today's physician is one who is struggling to make the payments

on his Ford Taurus, and a professional worrying about how they will afford their children's college tuition.

In an elective setting the patient with out-of-network benefits will sign the assignment of benefits at the doctor's office expecting that this will ensure that the physician will be reimbursed directly for the services rendered. Most patients cannot usually afford to pay a physician directly for a medically necessary major surgical procedure – thus, the reason that they carry health insurance. Why should carriers be allowed to blatantly disregard the patient's requested signed legal assignment of benefits? What other professional performs a service in good faith, yet is not quite sure when, by whom, or how much he might be reimbursed?

For purposes of today's discussion I want to clarify that not all commercial carriers refuse to honor the assignment of benefits – many honorably do so. **However, New Jersey's largest commercial carrier, Horizon, has resorted to many destructive practices and they are mainly why I am here to address you today.** Horizon has consistently refused to offer any logical explanation as to how, when and why some checks go to the physician and some go to the patient. For the very same patient who received the very same treatment one month apart, in the same calendar year – who is still covered under the same plan – we see one payment go to the provider and one go to the patient. It is not unreasonable then to conclude that this is meant to cause confusion to all parties.

As my physician's billing representative, my office is not even allowed to speak to a "live" person at Horizon anymore because my physician is not on their panel. To obtain claim status information my staff heavily relies the internet websites of the carriers or the automated voice response systems. Our choices on both of these types of media are even more limited than a participating provider therefore, one could even conclude that this is a type of discrimination. We interpret the information from these sources and expect the information to be correct and accurate. However, much to our dismay this information many times is incorrect or misleading.

When my staff discovers that a patient was paid directly, they immediately attempt to contact the patient to please endorse the check and sign it over to my client. Many patients will deny receiving any monies and are quite insulted that we even called them for payment. Some patients truly didn't receive the check – it is in fact sent to my provider a week or two later – contrary to what was told to our office. Other patients deny receiving any checks because they have already spent the check. In some cases, the claim was processed and perhaps the check was even cut, but it doesn't reach the patient for another week or two – again, contrary to the information that we were given.

Despite our sincere attempts to be polite, tolerant and professional with these patients, the damage has already been done. Patients feel that the doctor no longer trusts them or wants to treat them. They are embarrassed even if they do in fact send the check to the provider - but just not soon enough to prevent our initial telephone call. The rates of patient non-compliance in forwarding insurance payments to the provider are directly related to lower income urban areas when compared to the more affluent suburbs. **However, the disruption to the practice and the patient-physician relationship is unfortunately a chronic constant.** Unless a patient - or a family member – actually works in the health insurance industry they have no idea about the process or terminology - regardless of their level of education or socioeconomic status.

Senators, imagine if you received a check for \$5000. You are highly educated and law abiding citizens and would do your best to get this check to whom it belongs. Regardless, it is work that you have to do that was surely unexpected. Now imagine the average citizen who is struggling financially receiving the same check. They would be confused and certainly tempted to spend it. They would also resent having to resolve this apparent “mistake.”

A specialist’s practice depends on his or her referral sources for the majority of their practice volume. Some patients, angry that they received payments directly – especially payments that are less than the charges submitted – many times go directly to their primary care physician and express their anger to them. HIPAA and ERISA guidelines strictly forbid my specialist from discussing anything other than the medical or surgical care with a patient’s primary physician. A specialist’s charges and resultant insurance reimbursements are confidential and between that specialist and the patient. Therefore, the carrier’s practice of paying the patient directly impacts a specialist’s referral sources as well.

Patients are overwhelmed with the paperwork when they receive payments directly, and cannot begin to comprehend the reimbursement statement – especially when the explanation of benefits contains payments for multiple providers. Patients are sometimes forced to write multiple checks to different providers and are confused and angry. One patient even called their carrier and demanded that future payments be mailed directly to her physician’s office. The carrier denied her request.

My staff has very disturbing conversations with patients when we become aware – or suspect that payments went to the patient. Some of the documented discussions include the following examples:

“I called my insurance company about the check and they told me to just deposit it – maybe I won’t even get a bill from my doctor!”

Or...

“Oh, I got a check but I didn’t know what it was for so I sent it back to the insurance company.”  
*It will then require the patient to do all of the work – if they are willing – to obtain a replacement check. For an older or very ill patient this is unfair to them, but our hands are tied since the carrier will not deal with us directly. These dilemmas sometimes take months to resolve.*

Another example...

*The patient sends the whole check to the first listed hospital or physician on the eob. Then it is a mess of refunds and takes months to settle correctly to accurately disburse the mixed eob payments.*

Or...

*The patient had several office visits and received all of the checks directly. She then proceeded to declare bankruptcy.*

Example...

*Two different patients with the same MLS physician had surgeries. Both patients’ spouses were the subscribers under their plan and the spouses received the monies. Neither patient knew their estranged spouses’ new addresses due to the bitter separations and divorce proceedings. One patient stated, “my husband is holding onto the checks to get back at me.” The patients never returned to the practice for further much needed follow-up care, do not have the funds to pay the*

*doctor themselves and apologized profusely. This put both patients at risk for post-op complications/infections for non-compliant follow-up.*

And lastly...

*A patient underwent extensive major surgery with an excellent outcome. She received multiple checks totaling several thousand dollars. She proceeded to go to her primary care physician and complained that the surgeon he referred her to was harassing her for money. She kept us going for almost 2 months insisting that she returned the check to the insurance company because she didn't want to be involved. The carrier refused to give us any information, however after much pressure on the carrier they finally revealed to us that the check had been cashed by the patient 2 months prior.*

The result of direct patient payments are so seriously disruptive to the relationship with the doctor that the end result is usually that the patient avoids the doctor - thus all means of constructive communication are lost. Malpractice attorneys cite that one of the most common reasons for lawsuits against physicians result from a breach in communication.

At the present time, my physicians are forced to accept checks of \$10 per month towards cashed insurance checks that patients received for amounts in the thousands. Patients who ultimately end up with our collection attorneys are actively litigated. Fees are charged to my client for serving of subpoenas, wage garnishing and other various distributions. Most distressing is that these patients received excellent health care, really wanted and expected their physician to be paid by their health plan, but when the payment came to them directly it was just too tempting.

The timing for this legislation to be passed could not be more appropriate. In this current economic crisis affecting so many of us, if a patient receives a check for \$2000 – and they're having trouble paying the mortgage this month - the patient will most likely chose to pay their mortgage. The need for the middleman – MLS – is crucial here and our timing is critical. However diligent my staff may be, it is almost impossible to prevent the above scenario from happening again and again. Sadly, when the patient ends up in collection the end result is not what anyone wanted. The physician provided services in good faith and with excellent outcome but was never paid for services rendered. Most upsetting is that the patient's credit will be negatively impacted for a lengthy period of time.

### **SUMMARY**

Throughout the last 25 years many carriers adopted various “tactics” to obtain or keep physicians on their panels. However, no one could foresee or imagine that the situation could reach these levels – but sadly, this is what we witness everyday. We see it firsthand and deal with it as professionally and delicately as we can, but it is solely caused by the manipulation and undermining of some insurance carriers. The excessive amount of time spent in performing these “search and find” tasks is frustrating when our primary job at MLS should be to accurately code, bill and follow-up comprehensively on all patient accounts. I realize that I am advocating for a small fraction of New Jersey physicians here today but I know that our examples are representative of most physicians throughout the State of New Jersey.

I am aware that this type of legislation was passed years ago in many states nationwide. Let us put an end to this continued conflict in New Jersey. Let us stop allowing the interference of these

intentional variables to diminish the importance of the patient care. Recently, our own Governor Corzine who was himself unfortunately involved in a motor vehicle accident was perhaps the recipient of some insurance checks. He saw the need to sign into legislation this very same issue – however, it was limited to reimbursement for Ambulance Services only. This proposed legislation to honor assignment of benefits for physicians in New Jersey is paramount to the well being of all New Jersey citizens and now is the time for this legislation to be passed.

I hope that I have been able to demonstrate to you just how beneficial this legislation will be - which will result in only positive effects for patient care in New Jersey. I am an advocate of this legislation as a New Jersey citizen, a daughter, the wife of a physician, the mother of a physician, a sister of a physician, a small business owner who carries Horizon Health Insurance coverage, a billing manager who represents 30 physicians and also a patient. If we can – through this legislation - take this small step, it will have a dramatic effect in rebuilding the patient-physician relationship and trust. If you pass this legislation, patients will not be subjected to billing nightmares, doctors will get paid for services rendered, insurance carriers will not have to spend valuable resources dealing with both their members’ and the physicians’ calls and appeals. Everyone wins. Weigh all of these benefits and you will see that there is no downside. That is the experience of other States that have passed this legislation.

We will see a better outcome for all involved, in turn creating a ripple effect that will only enhance the current and future medical community, and strengthen the patient’s successful medical and surgical care and ultimate excellent patient outcome.

Senators, I thank you for taking the time to hear my statements. I would be happy to answer any questions that you might have.