Thriving Under Medicare

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By Theresa Defino [1]

How to make Medicare work for you

When she was a child, Lynne Carr-Columbus, DO, dreamed of following in the footsteps of her physician father. Today she is a sought-after pain management specialist and thriving businesswoman in Palm Harbor, Fla., with a practice built on Medicare.

But, as the old song goes, she works hard for the money. Carr-Columbus spends a minimum of $15,000 annually, or between 1 percent and 2 percent of her revenue, on marketing. She accepts many speaking engagements and is routinely quoted by the press. Carr-Columbus also has a state-of-the-art Web site to attract patients, and she conducts consultations by e-mail, for a fee. Her practice has a small store, and she sells items online as well. She also regularly mails promotional materials about the practice and its services to her own patients and potential patients. Materials are tailored to each group. Carr-Columbus gives a flyer to patients as they leave after an appointment. "Every piece of paper that goes out of here has some marketing material attached to it," even patient statements, she says.

New physicians in town are also a target. "I look in the newspaper to see who is new and we will mail them a packet," Carr-Columbus says. "We probably send packets to 10 to 20 physicians a month." She spent $8,000 to develop her Web site, which she says brings in five or six new patients a week. She keeps track of her referral sources from every new patient to determine which form of marketing is working for her practice. "We pay a Webmaster and she uses her magic to keep us high in the search tools," Carr-Columbus adds.

Why all the extras? Because, she says, her practice has absorbed Medicare cuts of "at least 15 percent to 20 percent" since 1994. As a provider in a state with a large elderly population, Carr-Columbus cannot turn her back on Medicare -- 85 percent of her revenue comes from the program -- so her marketing efforts are essential to building back lost income.

"I never thought when I went to medical school that I'd be doing this kind of marketing," she says, adding: "I am still not making what my father made when he was a surgeon in the glory days." For Carr-Columbus, as for some other specialists, the heavy reliance on Medicare has meant participating in the evolution of her field. "As pain physicians we are forced to do 90 percent of our procedures in the office. When I first started out, we did most of our procedures in the surgery center."

Spinal procedures, for example, are now done in her procedure room, which is stocked with a crash cart with emergency medications and equipment, including a defibrillator. X-rays are done in her fluoroscopy suite. Equipping the lead-lined suite involved a "huge cost," Carr-Columbus says.

For all her innovation with marketing, the solo practitioner chooses to bill Medicare the old-fashioned way -- on paper -- because Medicare is still developing the electronic format for sending claims attachments. To reduce denials, Carr-Columbus includes procedure notes and operative reports with all her claims.

She has structured her arrangements with other providers to best meet her needs. For example, she leases space to a mental health therapist, and the physical therapist who treats her patients is not an employee, but provided by an employment agency.

Love, disgust, longing, and loathing. In the 30 years that Mel Lair has handled Medicare billing, she has experienced them all.

Now, as her feelings are again running positive about the program, the administrator of Dialysis Associates in Fort Worth, Texas, finds her group on the cutting edge of Medicare itself. The practice's nine physicians are part of a "pay for performance" demonstration project that is measuring care delivered to diabetic patients.
Lair says her doctors are more than ready to participate in a test of the latest quality indicators for payment. In the past, the group tried to show commercial payers how good its care was, in hopes of increasing payments, but found that payers were "only interested in the lowest rate to pay, not quality."

"Thirteen years ago we got together different quality indicators" and presented them to various managed care companies, Lair recalls. "It didn't mean diddly."

She is hoping things might be different with Medicare. With a high volume of either transplant patients or those with end-stage renal disease (ESRD), the practice relies on Medicare for 55 percent of its revenue. Over time, she and the physicians have come to see the program as preferable to commercial insurance.

"When I started you had to learn what the ESRD rules were, and way back then, you'd file a claim for insurance, and boom, they paid it. Medicare was a hassle. When managed care plans came in, it just kind of flipped. Insurance became a hassle and Medicare became a breeze."

One of the biggest problems Lair cites with commercial payers is the number of times a claim is "lost" or not received -- something she says happens "very seldom" with Medicare.

But her practice has also had to learn to adjust to the government's changing whims, like keeping up with new benefits. We keep in touch with organizations that tell us what other people are doing," including attending annual meetings for their specialty society, Lair says.

For instance, after Lair learned about the new "Welcome to Medicare" physical, she took steps to encourage her physicians to offer this visit to appropriate patients, and to schedule an EKG, which is part of the physical.

Coping with changes that seemingly happen "overnight" is also a hallmark of dependence on Medicare. The biggest change in Dialysis Associates' history came at the start of 2004. Before that, physicians were paid a flat capitation rate for visiting patients on dialysis, but starting last year Medicare switched to a system that based the payment on the number of visits made, and imposed other requirements for payment.

If you see the patient four times you get the highest payment," Lair explains. "One of the dialysis patient visits has to be a comprehensive assessment, or the physician won't get paid at all for that patient."

Lair informed the physicians of the impending change and they agreed to strive for four monthly visits per patient. The four-visit payment is higher than the monthly capitation rate used to be. But as is often the case with Medicare, reimbursement for a medication the physicians frequently administer decreased at the same time.

Reliance on Medicare has forced other changes in the practice. Two years ago the practice made the difficult decision to shut down the office lab, which had operated for the previous 12 years.

"The doctors liked it because they would have immediate results. And it was convenient for the patients. But we were losing money on it," Lair says.

Stretching staff while meeting Medicare patients' needs is an ongoing battle, and one that demands constant creativity and innovation. The physicians at Dialysis Associates, for example, understand the importance of patient education but had struggled to devote the time to it they thought was necessary.

By working with representatives of drug companies, the office established a fund to pay for a dietician and a social worker, who conduct patient education for patients new to dialysis.

But funding has been diminishing over time. So instead of abandoning the visits, which are well-received by patients and their family members, Lair plans to investigate whether her local Medicare carrier would cover the service as a group visit if it was led by one of the physicians.

In addition to approaching a carrier about coverage decisions, Lair recommends that offices boost their Medicare revenues by identifying new services that can be provided in the office. For example, her practice now offers venous mapping on-site, which used to be done in the hospital.

At the Huntsville, Ala., family practice of Weston Welker, they like to see the faces of their elderly patients.

"If you see a friend less often than once a year, you will forget details of his or her life," Welker explains. "That is the same thing with our family practice patients. We are building a relationship."

About 35 percent of the practice's revenue is from Medicare, a portion that has "slowly risen as I have gotten older," says Welker, 53. Like many physicians, Welker has a love-hate relationship with Medicare, which he calls "cumbersome" and "autocratic," while also acknowledging it "has been very good to us."
Although some would disagree, Welker says in his experience, "If you use the system correctly, Medicare pays as well or better than your local BlueCross BlueShield plan."

One key is accurate coding. Welker recommends that physicians, not just billing or coding staff, attend coding seminars regularly, advice he follows himself. The office also invested in information technology, implementing an EMR three years ago. Now he carries a laptop from room to room. Seeing patients who are chronically ill on a strict schedule is another strategy he has adopted. Many chronically ill patients are Medicare beneficiaries, although, of course, many beneficiaries are in good health. While Welker says many physicians spread out office visits or try to avoid them with phone calls, he has learned over the years that "the more you see a patient in the office for problems, the less likely they are to end up in the hospital.

"In the past, patients would just come in when they could or when they desired to," says Welker, who has been in practice 23 years. "I realized that the more often I see the patients, the happier they are, and the healthier they are. No one leaves the office without an appointment to come back. ... The longest they go between appointments is three months."

To maximize Medicare revenue and meet patient needs, the practice also offers a variety of laboratory and other tests. Five years ago Welker started providing an advanced lipid analysis, which is covered by Medicare. His office draws the blood, then ships it overnight to a lab in California. Results are faxed back to the office in about two weeks. All results from tests and analysis are reviewed with Medicare patients in person during an office visit; no longer are these discussed by phone.

The office also does allergy testing and hypertension work-ups, has a DEXA scanning machine for measuring bone mineral density, a treadmill for cardiac patients, and a general X-ray device that is used for everything from sinus to chest pictures.

"I do colonoscopies at the hospital," Welker adds. "Any procedure you can do will augment your income."

Welker also takes every opportunity to appear on television or in radio spots. Like Carr-Columbus, he has found that local news crews are often hungry for medical professionals who can help fill airtime - and he is happy to oblige, as they will also announce upcoming monthly talks he holds in his office. These 90-minute discussions, designed to draw new patients, have focused on cholesterol, diabetes, and AIDS, among other topics. His practice also held a health fair in the office's parking lot, with radio stations participating, as another way to attract patients.

Theresa Defino, an editor for Physicians Practice, last wrote about financial checkups for your practice in the April issue. She can be reached at tdefino@physicianspractice.com.

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