In clinical medicine, problems or complications sometimes arise that require additional testing and the concerted efforts of one or more specialists. This situation, with which we, as physicians, are familiar is not unlike the required cooperation and diligence that the GLMS staff put forth in working with medical practices and their challenges with managed care organizations. Just as publishing a case history on an interesting patient is important for education in the medical realm, reporting concerns or problems with payors is essential for the fiscal health of your medical practice business. The viability and strength of our practices will ultimately enable us to serve our patients in the best and most efficient way possible. The following are but a few of the examples of the success stories that involve medical practices, problems with insurance providers and the interventions by GLMS.

CASE #1:

A previously healthy medical practice with an evenly distributed insurance payor mix presents with concerns regarding preauthorization of a diagnostic test for a patient. The ordering physician makes not just one, but two phone calls to complete the necessary paperwork required to initiate the precertification process. The first phone call, made between actually seeing patients in the office, was conducted with an individual whose command of the English language was suboptimal and therefore misunderstood a request for the specific diagnostic test. This misunderstanding necessitated a follow up phone call the following day to further clarify and obtain permission to do the testing. The physician reviewing the request did not have the equivalent training as the ordering physician, and therefore couldn't understand the necessity of the ordered test. The requested test was denied. The patient was sent instead to a specialist for further evaluation and testing, requiring another copay from them and additional time by the patient and added expense for the insurance company. This situation and the frustration from the ordering physician was brought to the attention of the GLMS reviewing committee and the representatives of the insurance company who, after further investigation into the incident concluded that it was an isolated incident and continue to monitor the precertification process with feedback from the physician members and staff at the medical society.

CASE #2:

The practice of a colleague of yours calls to ask advice and discuss the following concern regarding an insurance company with a significant amount of patients in your practice. Their astute business manager has noticed that a particular insurance company often takes longer than others to process claims. Reimbursement often is delayed because of this, causing an interruption in cash flow. You refer your colleague to the professionals at GLMS, who have arranged quarterly meetings with insurance representatives to discuss these issues. The problem is brought to their attention at the next meeting, and soon reimbursements are being received in the time frame commensurate with other insurance carriers.

CASE #3:

You run into an obstetrics colleague of yours in the physicians' lounge of the local hospital and you begin commiserating over some problems involved in dealing with insurance companies. The practice manager of your colleague's practice is frustrated because she has tried to solve the problem and has enlisted the help of GLMS through the hassle log. The problem is that many claims to a particular insurance company are rejected for missing or duplicate attachments. After a meeting with the medical society staff, the insurance representatives begin working more closely with the office and through re-education and training of both their employees and the office staff, are able to resolve the claims issues.