Third-Party-Free Surgical Practice

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With the onslaught of government intrusion into medical practices and declining revenues under decades of price controls, physicians are turning to new practice models. This movement started slowly 10 to 12 years ago but has accelerated in the past 6 years because of the Patient Protection and Affordable Care Act (ACA). This article concerns the conversion of a surgical specialty practice of neuro-otology into a third-party-free practice (TPFP).

Our Practice Transition

We became partners at the Ear and Balance Institute, now located in Covington, La., in July 2000. In 2001, we received notice that the Centers for Medicare and Medicaid Services (CMS) would be reducing the allowed payment for electronystagmography (ENG) to an amount lower than our costs. Our options included: 1) "Shrink" the ENG test in order to get the costs lower than the payment. 2) Opt out of Medicare and charge a reasonable cash price. We decided to opt out of Medicare and charge a price at which our overhead would be covered and we would make a small profit.

After we opted out of Medicare, our revenue went up. Many of the Medicare patients still came to see us because we had a reputation for providing good service. Of course, some Medicare patients stopped seeing us and cited our payment policy as the reason. However, the empty clinic spots were soon filled by patients with better-paying insurance plans. Later, many of the patients who left us came back.

Recognizing the general trend of increasing bureaucracy and lowered payment from commercial insurers, from 2001 to 2005 we gradually eliminated insurance contracts. In November 2005, we cut ties with our last insurance company. We have been a TPFP since then.

During the 5-year transition to TPFP, we witnessed intermittent drops in revenue after cutting a contract, followed by a usually quick return to the revenue baseline. However, after eliminating our last contract in 2005, we saw a more prolonged decline in revenue of 35 percent over the course of 2 years before there was rebound (Table 1). The counterbalance to this drop in revenue was a drop in overhead. We had gone from 11 full-time employees to only five FTEs in that time. We were concerned about our drop in revenue, but had prepared for this inevitability by eliminating debt, both professionally and personally, and having a cash reserve.

In the 4 years following the nadir of our revenue decline, we saw our revenue grow by a multiple of 2.5, such that our revenue was 60 percent higher than when we cut our last contract, with the still significantly reduced overhead. We liken our practice after 2005 to starting a new practice and building it from scratch.

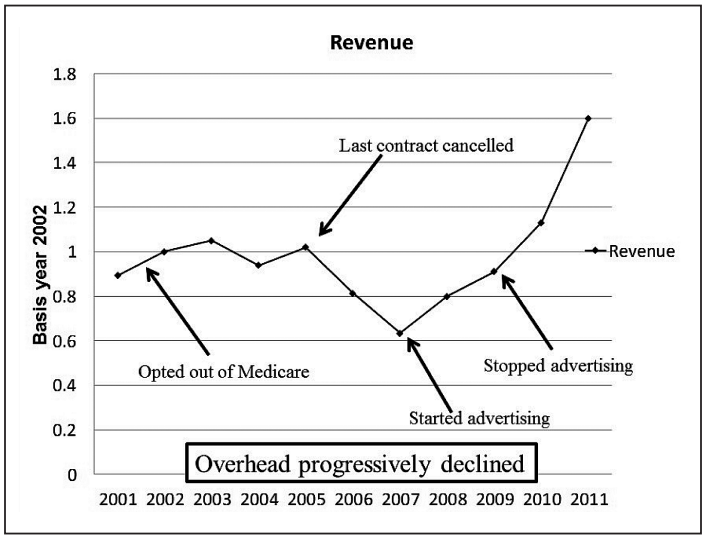

Table 1. Revenue Chart for Our Practice As We Transitioned to a Third-Party-Free Practice

It would seem that we were at a disadvantage with respect to our competitors, considering that we charged cash at the time of service and almost everyone else would accept the patients' insurance and their nominal co-pay. However, by not being contracted with any insurance company we had tremendous advantages. We could spend as much time with each patient as was needed.

Evaluation of vertigo and dizziness requires an extensive history and physical examination. In the third-party payment system a physician is paid about as much for a two-minute visit for cerumen removal as for an hour-and-a-half visit with a vertigo patient. Vertigo patients require extensive vestibular and auditory testing, all of which is underpaid by the third-party system. Lastly, vertigo/dizzy patients require extensive education and counseling, none of which is paid for by the third parties.

Because of these difficulties, many of my colleagues have responded by simply eliminating the evaluation of vertigo/dizziness from their practices. Among those who continue to see vestibular patients, many limit the number of dizzy patients they will see. Others have the dizzy patient seen by the physician assistant, nurse practitioner, or resident. Keep in mind that the AMA procedure code (CPT or Current Procedural Terminology) and hence allowed fee is the same regardless of the qualifications or expertise of the person seeing the patient.

In our practice, a neuro-otologist with 7 years of specialty residency and fellowship training, plus more than 20 years' experience in the field sees dizzy patients—not the PA, NP, or resident. We do this in a timely manner and typically spend an

hour or more on a patient's initial visit. We do the extensive testing and the education/counseling personally. Because we have much more experience and expertise than the PA, NP, or resident, we are better able to resolve patients' problems expeditiously. We can do this because we can charge a reasonable fee and not have to deal with insurance companies or Medicare. We actually get paid what we charge. If our competitors practiced like this while contracted with the third-party payers, they would go bankrupt.

We know our patients more intimately because of the time we spend with them. Consequently, we can better order appropriate testing and obtain approval in peer reviews. This avoids running up high costs of tests and prevents our patients from denials of their insurance claims.

Our practice is not a HIPAA-covered entity (not subject to the Health Insurance Portability and Accountability Act) because we do not transmit any covered transactions electronically. We need not comply with Meaningful Use (MU) since we do not accept any money from CMS. Similarly, we do not participate in PQRS or any other government, bureaucratic alphabet soup, nonsensical demands that are currently badgering physicians in America. We work for our patients and no one else.

When patients call the office, they are told in advance the cost of the visit and/or testing prior to scheduling the appointment. There are no surprise bills afterwards. Patients can decide to schedule after hearing the cost. At the time of service, the patient pays us. In return, we give the patient a claims form that he can submit to his own insurance company for direct reimbursement to the patient. The patient's reimbursement depends on the contract he has with his insurance company. We have no accounts receivables, and we don't send out bills.

Objections to TPFP

When we transitioned to a TPFP, less than one percent of physicians had a cash-based practice. Most of our colleagues thought our practice would soon go bankrupt. However, we looked to the future anticipating one of three choices for physicians: 1) Quit clinical medicine. 2) Transition to a TPFP. 3) Become an employee. Time has proven our predictions correct.

According to the Physicians Foundation Survey of more than 20,000 physicians (Table 2), the number of physicians in TPFP was less than 1 percent in 2008, but had grown to 7.2 percent in 2014 with an additional 13.3 percent anticipating a change to a cash-pay practice model in the near future.[1] Of course, the contravening trend in medicine is to leave private practice for hospital employment. In the same poll, 62 percent of doctors were private practice owners in 2008, and that number has dropped to only 35 percent in 2014. We would expect this trend to continue as the burdens mount on doctors who continue their relationship with CMS and private insurers.

Bureaucratic burdens, reduced payment, and growing overhead associated with third-party contracts is an unsustainable business model.

Physicians Foundation Survey	2008	2014
Employment	38%	53%
Private Practice Owners	62%	35%
TPF Practice	<1%	7.2% **

**13.3% plan to transition to TPFP in the future

Table 2. Physician Foundation Survey of >20,000 Doctors

Most patients completely understand the TPFP concept. The group from whom we've heard the most objections is physicians. We can categorize them into four basic types:

1. "If I don't accept insurance, they'll just go down the street to my competitor."

Yes, this is true. But is that necessarily a bad thing? Patients who don't want to pay a reasonable price, especially given that there will be some insurance reimbursement for your services, don't value your services. They see no more value in you compared with the doctor they don't know who takes their insurance. They weren't really your patients to begin with. They came to see you only because you were on their insurance plan.

However, some patients will continue to see you. They value you and what you have done for them. These are truly your patients. Among the patients who leave you, many will come back. Once they see that a visit with the local medical mill gives them only five to 10 minutes of time with the doctor (if they get to see a doctor at all), they'll realize the value of your visits.

You will be surprised by which patients stay with you and which leave. The immediate assumption is that your well-to-do patients will stay with you and your more budget-conscious patients will leave. Our experience is that this is not necessarily so.

New patients will show up. The movement of medicine to a more "cookbook" approach will work fine for 60 to 80 percent of patients, but for many it won't. Of the patients who don't fit into the cookie-cutter mold of what is prescribed by "best practices," many will be disaffected and will need an actual doctor to diagnose them. The current third-party system doesn't pay doctors to spend enough time with patients to figure out anything complicated. If a doctor on the third-party system spends a lot of time with his patients, he will go bankrupt or be reprimanded by corporate bosses.

If you charge a reasonable price for your time, have reduced your overhead, and provide value for your patients, you will have enough patients to pay your bills and bring home a salary. Your patient volume may be lower and your gross revenue may be lower, but your net revenue (a.k.a. take-home pay) may be comparable.

2. "You can do it because you're so specialized."

Of course, the most common physician specialties to do TPFP are the primary-care specialties. So, this criticism comes from those who have barely looked into the whole issue. However, we also have competition. We do not have a monopoly on neuro-otology care. In fact, there are several physicians specializing in neuro-otology who are more conveniently

located for the majority of our patients in the metropolitan areas surrounding us. Because we get superior outcomes, we've developed a reputation that brings in patients from all over the U.S. and from outside the country. Many of our colleagues see this and automatically assume that we can do a TPFP because we have such a practice. However, it's actually the other way around. We have an international referral base because we are a TPFP. We had a solid practice with referrals from all over the region before transition to TPFP 10 years ago. But going third party free allowed us to excel at what we do. It wasn't until after we dismissed our last insurance contract that our geographic referral expanded. In fact, because our cash prices are significantly lower than those of our competitors, we are particularly attractive to foreigners who come from countries with socialized medicine. Since they have no insurance, they pay cash with no chance for reimbursement. Our cash prices are at least 75% lower than our competitors' cash prices for comparable services. Example: A full audiovestibular workup for a recent patient at a major university medical center was $30,000. At our office, it was less than $4,000 for similar but even more extensive testing.

3. "I can't do it because my tests, surgeries, hospital stays, etc. are too expensive."

This is true only if you charge unreasonable prices. Many physicians do not know the cost for them to deliver a particular service, and hence have no idea what they should charge for any one service. Forget about what your current cash charges are. These are fantasy and they do not reflect the reality of what you are getting paid by the private insurers or Medicare.

The surprising revelation to many physicians is that they can charge less and often maintain the same income. The distortions of sky-high charges and a multitude of discount prices for insurance contracts have left physicians with no idea how much they actually get paid for any one service. TPTP physicians find that they can charge roughly one-quarter of what they were charging when on the third-party system and bring home a similar income. This happens because you will actually be paid 100 percent of your charges every time. In your old practice, you would occasionally be paid handsomely for one patient and then be denied payment for another. This uneven payment results in one group of patients' fees subsidizing another group. When all "pay their fair share," you find you don't have to charge nearly as much.

4. "It is immoral to deny medical care to those who can't pay."

It is only immoral to deny medical care in the context of a life-threatening emergency. This represents a small fraction of medical care. Most care concerns quality of life rather than life or death. In fact, emergencies (life-threatening or not) represent less than 2 percent of medical care.[2] I don't know any physician who would withhold medical care in an emergency, regardless of the prospect for getting paid. However, for the other 98 percent of medical care, it is immoral to deny payment to the physician rendering care.

On the other hand, the third-party-payer system is the immoral situation. Because the physician has one "boss" seeking service from him (the patient) and is being paid by another "boss" (the insurers or Medicare), he has two masters. This is conflict of interest. Which master will he follow? Many physicians are strong patient advocates, but in the above scenario, being a patient advocate courts financial ruin. In TPFP, the patient is the one requesting services and the one who is paying. Consequently, the physician works for the patient and no one else, so there is no conflict of interest.

In TPFP you can give charity care or offer discounted care to a select group of your patients. The difference, however, is that you get to decide when and who will receive your charity, not the federal government or a private insurance company.

In the typical practice with insurance contracts, amounts owed by each patient vary tremendously for the very same service. This is why most doctors' offices cannot give patients a price quote in advance. By contrast, in TPFP all patients are charged the same price for the same service and they are told in advance. Which is immoral—multiple different prices for the same service unknown to the patients in advance, or the same price for each patient mutually agreed upon before the service is rendered?

Why NOT To Do a Third-Party-Free Practice

The main reason someone might not want to have a TPFP is to make more money. The easy way to make money in medicine in 2015 is to sign up for every insurance plan. Then have your staff schedule double-booked appointments every 10 minutes. In doing this, you would generate a lot of revenue. However, the quality of the medical care you would deliver would be poor at best. Such "medical mills" are being advocated by medical practice consultants.

By contrast, TPFP is not nearly as lucrative. However, if you keep your overhead low and provide quality care and time for your patients, you will make a reasonably good income. More importantly, you will be able to spend time with your patients and you will be much happier in your medical practice. And your conscience will be clear.

Ways to Start a Third-Party-Free Practice

There are three ways to get to a TPFP: 1) never start a third-party practice to begin with; 2) stop all contracts "cold-turkey"; 3) wean your practice gradually from the contracts.

Never starting a third-party practice is only applicable to physicians coming straight out of residency or changing jobs/locations. We think this is a great option for those in that situation. They will have a longer lead-up time to build their practice/patient base, but once they do, it will be a more sustainable practice than that of their colleagues who are at the whim of the insurance industry. The biggest problems we see with this approach is that developing a reputation, and hence a practice, takes time. Keeping your personal and professional debt in check is essential for this approach.

Dropping all of your third-party contracts "cold turkey" is difficult for most because of personal and professional overhead

that has accumulated. Of course, in this situation you will have already developed a reputation and patient base, so the big issue is debt-to-overhead ratio. However, for those who have their overhead under control and sufficient savings stashed away, this is the quickest way to transition to a TPFP.

Weaning off third-party contracts is probably the easiest method and the one we chose. We did it over the course of 3 years. It allows for a more gradual adjustment in your practice. Eliminating one or two contracts every 6 months to a year could be the best option for most physicians.

Probably the first third-party payers you need to consider eliminating are Medicaid and Medicare. Our rationale for this is based on more than just the low fees, often less than the cost of providing your services. Beyond that, Medicare is the third-party payer that mandates significant bureaucratic office procedures by force of law (HIPAA, MU2, PQRS, etc.) that greatly increase your overhead. Worse, it sets you up for audits that can result in significant financial penalties or even criminal prosecution. That doesn't happen with the private insurance companies. Once you have opted out of Medicare, your overhead will be lower, and your revenue will be higher.

Next we recommend eliminating the worst-paying contracts and the ones that have the highest "headache factor"—the ones that require significant staff time to obtain payment. It may also be best to first get rid of the contracts that are a smaller percentage of revenue. However, when you are weaning off the third-party contracts, you need to keep in mind that the time you spend seeing patients who are on insurance contracts is time you cannot spend seeing cash-paying patients. When you are transitioning to a TPFP, there comes a tipping point at which, unless you take the plunge and eliminate the last third-party contracts, you run the risk of disenfranchising your new cash-paying patients.

Price Adjustments

You will find that your charges need to be adjusted to more realistic levels. The current fee schedules put together by CMS and private insurers are price controls. One problem with price controls is that they inevitably assign the wrong price to just about every service. Some things are undervalued and some overvalued. The current "cash charges" of most physicians' practices are wildly overpriced for the services offered, and are virtually never paid. If you suddenly start charging these fantasy prices, you will find that not many patients will be willing to come see you. An adjustment to your prices to reflect services' true value is in order.

The services that are overvalued get done and are done frequently. Those that are undervalued either don't get done or are done infrequently. The key to making a living as a third-party-free physician is to focus on the services that are undervalued and hence ignored by your colleagues. Probably the biggest undervaluation is on your time. Physicians are not paid to counsel their patients, so this area gets neglected. As physicians, we can all offer our patients more time. In fact, this is the basis behind concierge medicine practice models. Our practice niche is vertigo, but there are many niche areas undervalued by the third-party system.

How Much Should You Charge?

The first step in figuring out what you should charge is to identify your costs per patient. For an office-based physician, this is fairly straightforward. Take your overhead for a year and divide it by the amount of time you are seeing patients. Now you know how much it costs to see patients per hour. Obviously, you cannot charge lower than this figure for an hour of your time, or you won't be able to pay your bills. For a surgeon, this is a little bit trickier because you have to also factor time in the operating room and the hospital as well as post-operative visits. Remember, as a surgeon, it's not just operating time—you have a loss of economic opportunity while you are in the OR lounge. This needs to be included in your calculations. So a 5-minute placement of pressure-equalizer (PE) tubes in the OR will take you 5 minutes plus whatever amount of time is required for anesthesia, recovery, turnaround time, etc. However, a PE tube placed in your office with topical anesthesia may only cost you 5 minutes and the cost of the tube along with the other expendables—much less total cost to you.

Next, identify an annual salary and divide that by the number of clinical hours. This hourly salary can be added to the hourly overhead figure. The result is what you should be charging your patients on an hourly basis.

In addition to time and overhead, another factor to consider is complexity. The more complex and more challenging a medical problem, the more you can and should charge. For the simpler and less challenging things, you should charge less. Because you are the one setting the fees, you can change your fees reflecting changes in your practice and areas of expertise. You will no longer be at the whim of CMS fee schedules.

Finally, once you have determined your practice charges, they are not set in stone or subject to some government/insurance diktat. Regularly reassess your charges to determine whether you are overpricing or underpricing your services. Like most businesses, we feel it is probably better to keep your charges on the lower end of your calculations initially. We increase our fees roughly every year to reflect inflation. Every year your fees stay the same represents a fee cut in the form of inflation. You may not recognize this, but if you do not raise your fees every year, your real income will drop every year.

Fees should be paid at the time of service, and surgical fees should be paid in advance. You cannot take surgery back once it is done, and you cannot withdraw care once you've done surgery on a patient. Your resentment over not being paid and yet continuing to have to work will affect your patient care, and if the patient is unhappy about any aspect of the surgery, he will be reluctant to pay you.

Involving Your Staff with the Transition

The best-laid plans can be torn asunder by an office staff that doesn't buy into the transition to TPFP. You should discuss your plan, time-line, and goals with your staff. If they fear you have not been reasonable in your approach, or if they fear that they may be laid off, they'll start looking for other jobs.

Fear of work-hour reduction is also common. Education of the staff to this new practice model is essential. Among your staff, the person answering the telephone needs to understand the concept best of all.

When a patient calls saying, "I'd like to make an appointment. My insurance is XYZ," and staff replies, "Oh, we don't take your XYZ insurance," both the patient and the insurance have been rejected.

The following is a much better response: "We'll be happy to see you. Dr. X is an independent physician and works directly for patients. You'll be able to use your out-of-network insurance benefits. We have fixed fees, the same for all patients, and payment is due at the time of service. We'll provide you with a completed claim form for your insurance, and they'll pay you directly based on your plan. We will always tell you how much your visit will cost before we provide any services, so you'll never get an unexpected bill from our office. Other services such as lab and imaging can still be done at in-network facilities to maximize your benefits. We've also worked out significant discounts for cash prices with local facilities for these services. And we'll help with any pre-certification/authorizations required by your insurance."

Instead of rejecting the patient, you've just educated him about your practice. At least initially, we strongly urge a telephone script for your receptionist to use.

What Not to Do When Starting a Third-Party-Free Practice

Among the mistakes we've seen by our colleagues, the biggest by far is having too much debt or too much overhead. It doesn't matter if it is personal or business debt or overhead. You need to be prepared for a revenue decline. If you are carrying substantial debt, you may not be able to follow through on your transition to TPFP. Focus on eliminating debt and reducing any unnecessary overhead.

If you are considering a TPFP transition, adding a partner is a big mistake. Your partner will be competing with you for this smaller pie of patients who are willing to pay out of pocket for medical services. Or worse, your new partner continues to accept third-party payments, and all of your patients go to him. We wouldn't recommend getting a new partner until after you successfully transition to TPFP. Your partner also needs to repudiate any third-party contracts.

Do not run a satellite office that accepts insurance contracts while you are trying to transition to TPFP. Patients won't come to see you in your new office if your office across town accepts their insurance.

Lastly, you shouldn't practice medicine "as usual." Most private medical practices, in order to survive, have tilted to a "medical mill" model. If you practice in a similar manner when you start your TPFP, you will fail. On the other hand, if you are a physician who has been spending a lot of time with patients, and you are going broke because the insurance payment reimbursement doesn't adequately compensate for your time, you can practice medicine the same way and be successful with a TPFP.

Negotiating Cash Prices

The major laboratories offer wholesale prices to physician offices, typically one-tenth or one-twentieth what a hospital would charge a patient. The patient pays the physician's office and goes to the lab for the blood draw. The lab bills the physician. We recommend adding a small administrative fee to the wholesale price for the administrative time managing this.

Similarly, imaging centers will give your patients significant discounts when they pay cash in advance. We have bargained for lower prices by playing one center against another.

Currently, CMS publishes how much every hospital in America charges and how much CMS pays for every single diagnosis-related group (DRG). Typically, the hospitals are charging eight or ten times what they actually receive from CMS. The CMS payment should be kept in mind when negotiating cash prices for your patients with the hospital—if possible, before your patients need the service. If there are a handful of procedures you commonly perform, negotiate the hospital charges for these cases in advance so that you can notify the patient in advance. We would recommend suggesting a price that is somewhat higher than the CMS payment, emphasizing that this will be cash in advance for the procedure. Cash in advance is better than a promise for more money later that may not materialize.

Explore competing options: other hospitals or ambulatory surgery centers. Surgery centers are also willing to bargain and generally will accept a lower cash price than the hospital.

Conclusion

We have no regrets about our decision to become a TPFP. We have been successful in preserving our autonomy, preserving and improving the patient-physician relationship, maintaining medical privacy, keeping costs down, eliminating bureaucratic intrusion, and making the practice of medicine fun. Although making the transition to a TPFP can be challenging and scary at times, it is ultimately very rewarding. It is our opinion that a private TPFP is the best way to preserve the integrity of the medical profession and the sacred patient-physician relationship.

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