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Flip the Logic! Make Insurers Work for You Through Medical Reimbursement

A practical guide with 12 tips for physicians to use reimbursement to their advantage

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ABSTRACT

The author offers an introduction to medical reimbursement aimed at physicians themselves, explaining how it works: the patient pays for the appointment, submits the paperwork to the insurer, and later receives the amount stipulated in the contract. He argues that, because it is generally higher than the fee paid to in-network providers, reimbursement is a short-term solution each physician can adopt individually to improve their financial situation and, indirectly, to pressure insurers into offering better contracts. The text criticizes de-listing over low fees and abusive contracts. It then presents twelve practical tips, addressing topics such as where to find the reimbursement amount, the red tape imposed by insurers, the difference between a fixed amount and a percentage, the clinical autonomy of the non-network physician, the required documentation, and the ethical guidance of the patient. It also mentions the Medical Reimbursement Course as a teaching initiative.

KEYWORDS: *medical reimbursement; health insurance; provider networks; health insurers; practice management; ethics*

You have certainly heard of medical reimbursement, but do you really know how to use it? Here we will offer an introduction to medical reimbursement aimed at the physician.

How does it work? The patient pays for the appointment, is seen by the physician of their choice, submits the paperwork to the health insurer, and later receives the amount previously stipulated in their contract with the insurer.

It sounds very simple, but if we keep looking at it in such a simplistic way, we will continue to have few reimbursement patients and not understand why. In truth, we have to break down this entire process to try to understand the what, the how, the when, the where, and the why.

How can we optimize each step to try to improve things for us physicians, for our patients, and consequently for the insurer as well.

I see a great deal of discussion and many proposals from societies, associations, cooperatives, and others, but they are always different from one another, not complementary, long-term projects that succumb to external and internal political shifts. I believe that medical reimbursement is the short-term solution that each physician can pursue individually to improve their own financial situation and, indirectly, that of the entire medical community. Follow my reasoning: by starting to use reimbursement, the physician begins to earn more. Understanding that the reimbursement amount is higher than the in-network fee, the physician will avoid signing on to a network for low fees and will choose to keep working through reimbursement. They will end up leaving net-

works and avoiding abusive contracts. And if everyone does the same, insurers will have to greatly improve the value of their negotiation offers in order to finally get physicians to join their networks. One thing leads to another, and along this path, you who started with reimbursement are already benefiting from the outset.

Below I set out 12 basic tips that every physician needs to know about using medical reimbursement:

1. The patient's reimbursement amount is set out in the contract with the health insurer; when the patient took out and signed the contract with the insurer, that amount was defined there, whether in an appendix or a schedule, but that amount is in the contract. The patient has access to it, can check it whenever they wish, and can also show it to the physician. But there are easier ways to obtain this information than looking at the contract.
2. It is possible to find out the reimbursement amount most of the time. For both consultation fees and reimbursement amounts for procedures and surgeries, it is relatively easy to obtain this information by contacting the insurer. However, obtaining an advance estimate of the reimbursement amounts for hospital expenses is difficult.
3. Red tape exists and serves one purpose and one purpose only: to make using medical reimbursement harder, discouraging its use. Few insurers make it easy and honestly promote its use. Since reimbursement is "more expensive" for the health insurer, they will always try to steer their clients toward their own or in-network providers, because in-network physicians have already submitted to far inferior negotiations. With red tape getting in the way, the patient may end up going to a physician from the network directory out of convenience. And that same patient will never know how much the in-network physician is being paid for the appointment.
4. The reimbursement amount for both consultations and procedures is, most of the time, far higher than the contracted amount the physician who is in the insurer's network will receive. Think about that. Is it worth joining the network? This is because, during network-enrollment negotiations, the physician accepted lower amounts in exchange for patient volume. The tip lies in not accepting abusive contracts and in having your limit clearly defined. Know how to say no to a bad contract. Do not accept it simply because someone else will. It is better not to be in the insurer's network than to be in it and keep complaining about the terrible amounts you receive. Choose to work with reimbursement, and you will not regret it.
5. In most contracts, reimbursement is a fixed amount and not a percentage of the procedure. This is a common mistake. If the patient thinks this way, they will imagine that reimbursement is bad, because they will always have to pay the other percentage; but if they understand that it is a fixed amount and that it is possible to practice the very highest-quality medicine at that fixed amount, we shift paradigms. Excepted here are cases of co-payment, which are a little more complicated in order to prevent abuse.
6. The physician who is not in-network suffers no negative influence on their practice as a physician: there are insurers that impose limits on tests, plans that impose limits on procedures per month, systems that make honest "self-ordering" of tests to quickly solve the patient's problem more difficult, the notorious claim denials, and much more. Medical practice must be based on clinical judgment and the best scientific evidence, not on the insurer's economics.
7. Study all the insurers operating in your field and in your city. No one can do this for you. Go out and take out a plan for yourself and your family, understand who the players in your area are, understand how they operate, what their advertising is. Pay attention to "freedom of choice" and "reimbursement system," because at the point of sale there is a great deal of fanfare about this, and after the purchase there are many difficulties in using it. Talk to the brokers and see what they say about it. I see many people complaining and complaining, as service providers to a given insurer and, worst of all, they are also customers of the same insurer. Break the cycle.
8. If you are the only specialist in a given field in a city, you need not have any plan. You can work by reimbursement alone with all insurers. This is the perfect situation, in which you hold all the power, information, and time — the pillars of a negotiation — and you can not only negotiate excellent contracts but also refuse to accept indecent offers.
9. The time to be reimbursed is, on average, about 30 days, but better insurers will be faster and some try to make it as difficult as possible by requesting more documentation (often even unlawful), which can take more than 30 days; so it varies greatly from insurer to insurer. You are on the patient's side. You want to make it work. And you will help them however you can.
10. Basic paperwork required: the receipt or invoice, with the physician's name, specialty, medical registration number (CRM), date, corporate tax ID (CNPJ) if a legal entity and personal tax ID (CPF) if an individual, which procedure was performed, with the respective codes. But this may vary depending on each insurer.
11. Many physicians issue two or three receipts with different dates to reach their private-practice fee; this is not ethical, and the patient senses that something is

wrong, so be careful with this. Remember that you may charge for the follow-up visit — charging for the follow-up is ethical (no patient is identical at the first appointment and at the follow-up). By charging for the first appointment and the follow-up, you have two receipts to be reimbursed. Your private patient, whom you charge more and who includes reimbursement, has just become cheaper than the reimbursement patient who pays for the appointment and the follow-up.

12. You must know how to guide your patient; you will have to make their reimbursement as easy as possible. Physicians who do not understand reimbursement end up "spoiling the reputation" of the system for those who use it seriously. Whoever treats reimbursement the same as private practice is helping neither the patient nor the system. The patient pays more to have a plan with a right to reimbursement, so we have an obligation to help them use it properly and, if possible, with us.

There are currently initiatives to publicize and teach the use of medical reimbursement online, with the Medical Reimbursement Course (http://curso.reembolso.med.br) and a Facebook group.

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