Billing Practices

by Danielle Ofri

One of the pleasures of being a salaried physician at a city hospital is that I don't have to worry about money. Unlike my colleagues in private practice, I do not have to ask whether my patients can pay for their medical care. I treat everyone as I see fit and as the resources permit, and someone else handles the finances.

Recently, however, our hospital has been caught up in efficiency fervor. It is trying to get money from those patients who can pay, increase the productivity of the medical staff, and generally increase its revenue. This has resulted in hordes of new initiatives, forms, pre-authorizations, QAs, and the like. From my perspective, much of this is annoying busywork in my already chaotic day.

On the other hand, I don't want my hospital to go bankrupt. I'd like to help it recoup legitimate revenue that is otherwise lost because of poor documentation. In theory, I have every reason to support the hospital in its endeavor to remain solvent, even profitable, because extra monies mean more services for patients. But this is a theory, and theories are always less lustrous and logical when unfurled next to the gritty details of real patient care.

John Manchester (I have changed his name and some details in his story) was like most of my patients in that he lacked health insurance. But he was unusual in that he was of upper middle class upbringing, an intellectual/artist/musician living in a white, liberal section of the city. At fifty-five, he maintained an active physical, social, and cultural life. A collision with a New York City taxi brought him to our orthopedic ward with a leg fracture. Just after beginning his rehab, he suffered a blood clot in that leg, landing him on the medical ward, where our paths crossed.

Mr. Manchester was a delightful patient, equal parts dry wit, amiable grouchiness, and wide-ranging artistic interests. He possessed more than a passing knowledge of the *baglamas*, a Greek stringed instrument resembling the lute. He collected jazz 78s from the Mississippi Delta, sang ballads in his youth, was an early proponent of computerized graphic design, and now earned a living doing a collage of small but intriguing jobs, none of which provided health insurance.

The days were long and boring for Mr. Manchester, as he lay immobilized in his bed. On rounds we chatted about our common interests and he recounted his job teaching salsa on the Borscht Belt circuit—his most recent gig.

Mr. Manchester was bored because nothing was happening—no procedures, tests, or other active interventions. We were waiting. Warfarin, the blood thinner pill, takes many days to reach a therapeutic level. The level is checked daily via blood test, and the dose is then carefully adjusted. While the warfarin is slowly ramping up, a patient with a blood clot must also be given heparin, an intravenous blood thinner that works immediately. Intravenous heparin must be administered round-the-clock, which requires that the patient remain in the hospital.

In the world of patients with health insurance, there is a newer and far more expensive version of heparin called low-molecular-weight-heparin (LMWH) that can be given by a simple shot, like insulin, one or two times a day. Without need for round-the-clock intravenous heparin, patients with blood clots don't even need to be admitted to the hospital: they are treated at home, self-administering LMWH with the help of a visiting nurse until the warfarin level is therapeutic. Without health insurance, patients are consigned to the hospital for a week or more while the warfarin lurches up to a safe level.

Paradoxically, it is actually cheaper to send a patient home with the more expensive LMWH. But monies are not fungible: our society has determined that a hospital *must* provide care if an uninsured patient requires urgent treatment. It does *not* allow for expensive medications at home, even if that would save money for society in the long run.

Miraculously, it turned out that Mr. Manchester had access to health insurance. Because he was the victim of a motor vehicle accident, the car insurance of the driver was required to cover all medical costs associated with his injuries. So his hip surgery would be covered, and as long as I certified that the blood clot was a direct result of this injury, Mr. Manchester could go home with the LMWH and a visiting nurse.

As soon as this insurance "boon" became clear, we set about arranging Mr. Manchester's discharge. After four days of calling, faxing, photocopying, notarizing, and otherwise filling out endless paperwork, Mr. Manchester went home, learned how to inject the LMWH, and took his warfarin pills. Every day a phlebotomist arrived at his apartment and drew the blood test to measure the warfarin level. But then the problem arose: who was going to follow up on the results of the blood tests and tell Mr. Manchester how much warfarin to take each evening? While in the hospital, his daily blood tests were reviewed by the interns, along with all their other patients' results, and then the warfarin dose would be decided upon during afternoon rounds. But now Mr. Manchester's blood tests were traveling to a lab far away, and Mr. Manchester was no longer on the interns' roster.

It would now fall to me to work this out. On the first day after his discharge, I dialed multiple numbers until I

tracked down the lab where his blood tests were sent. Turns out, they were shipped to a lab nearly ninety miles away and didn't arrive until after six o'clock. At home that evening, I called the lab again and again, as the clock ticked later and later. Finally, at 9:45 p.m.—fifteen minutes before closing—the results were available. I called Mr. Manchester at home and calculated the dose he needed. He was still shaky on injecting himself with the LMWH, and I spent twenty minutes explaining the procedure, realizing how difficult it was to explain something so visual only in words.

The next day, it was the same routine. I started calling the lab around 8 p.m. Four calls later, just shy of closing time, the results were ready.

On the third day, I began calling at 9 p.m. The results, of course, were not ready. While waiting to make my next call, I became engrossed in reading and didn't notice the time. My pager went off at 10:15; it was Mr. Manchester calling me about his warfarin dose, but the lab had already closed. I felt bad, and apologized to Mr. Manchester, promising to be more vigilant the next day.

This went on for an entire week, and my evenings became devoted to remembering to call first the lab—not too early, not too late—and then Mr. Manchester. My nightly chats with him were always pleasant, and I was happy that Mr. Manchester was able to be in his own home and not at the hospital—a much better experience for a patient—but it was turning out to be a lot of work for me. I didn't mind it from a medical perspective; after all, that *is* the role of a doctor. And while my days are filled with such annoying though important tasks, it was frustrating that all this work was taking place on my free time in the evening—something I had precious little of. But my patient was receiving better medical care this way. In principle, I agree that this is part of a doctor's lot: when there is extra work to do on a patient's behalf, we do it. It is the price we pay for being in this (mostly) rewarding profession.

One day, as I glanced back at all the time I was investing in this case, it dawned on me that lots of money was being saved by my after-hours work. I was the very model of cost-efficiency: I was keeping Mr. Manchester out of the hospital, saving thousands upon thousands of dollars. How wonderful! But was *my* time worth anything? Certainly the patient was happier. Certainly the insurance company paying for his care was delighted. And all this was possible because I was spending my evenings calling and coordinating care. Had I not performed this task, Mr. Manchester would still be in the hospital, and the hospital would be generously reimbursed by the insurance company for my medical services.

I could not imagine billing for my after-hours phone calls. Even though I was "delivering" the same medical care—in terms of medical decision-making, risks, responsibilities, and liabilities—as I would in the hospital, it seemed unsavory to request reimbursement. And that related back to the pleasure of being salaried: not having to worry about billing for my time.

On the other hand, shouldn't the hospital, at the very least, be earning some money for the care I was delivering? It was legitimate medical care, after all, that could occur only because my hospital employs me, credentials me, insures me. It has invested a lot in me, and I was performing work on its behalf. Was it not entitled to the fruits of my labor?

The irony is that if I were lazier, and had refused to take on this after-hours job, the hospital would get reimbursed quite handsomely for Mr. Manchester's hospitalization. My extra work had deprived my hospital of legitimate revenue—money that keeps it available for indigent and uninsured patients.

My conscience was further piqued when Mr. Manchester finished his one-week supply of injectable LMWH. This is usually long enough to bridge most patients to an adequate warfarin level, but his blood level had barely budged. It was clear that he would need another week. It turned out—after many rounds of phone calls—that we could not find a single pharmacy in Manhattan that would accept the insurance. Apparently the process to get reimbursed was so Byzantine that no pharmacy was willing to undergo the risk unless the patient paid the money up front. But Mr. Manchester did not have $500 cash handy.

I approached our hospital's pharmacy. To my surprise, they handed over a week's supply, knowing full well they'd never get paid for it. (Again the irony: if Mr. Manchester had remained hospitalized, the pharmacy would have been fairly reimbursed.) Feeling guilty—but also beamingly proud of the pharmacy for putting patient care ahead of economics—I accepted this $500 package and sent it on to Mr. Manchester.

A week later his warfarin level was still not quite therapeutic, and I begged the pharmacy again. And again, a human being there sympathized and gave me the medicine. And again, I was distressed that the pharmacy would not get reimbursed for its good deed.

Part of me feels uncomfortable even raising this issue of payment; it seems indecorous. Certainly physicians are trained to think of the patient, not about money. And those of us who choose to work in salaried positions often do so precisely for this freedom *not* to have to think about payment for each thing we do. Yet I don't want my hospital to be unfairly penalized.

Perhaps it is time to shift away from the Balkanization of inpatient services, outpatient treatment, home care, pharmacy costs, and physician labor, and instead view the patient's medical treatment as an organic whole. Otherwise there is no incentive to invest the work required to increase efficiency and patient care efficacy. Obviously, it will take a broad societal commitment. As a physician who spends her time in the clinic rather than the boardroom, I am not optimistic. However, as I am not infrequently surprised by a patient who defies the medical statistics of a disease, I remain open-minded that our bureaucrats may someday defy the policy odds as well.