Managing Your Dermatology Practice

Dealing With Deadbeats

Unfortunately, every practice has its share of deadbeats, whom I define not as patients who fall on hard times and are unable to pay, but those who are able to pay and do not.

The worst kinds of deadbeats are the ones who not only don't pay you, but accept checks from insurance companies and then spend the money themselves. Such crooks must be pursued aggressively, with all the means at your disposal.

BY JOSEPH S. EASTERN, M.D.

The best way to deal with them, however, is to prevent them from owing you money in the first place.

Whenever possible, require all payments at the time of service. In the case of elective surgeries, require a substantial deposit in advance, with balance due at the time of service. When that is impossible, maximize the chances you will be paid by ensuring all available payment mechanisms are in place.

In two previous columns I've described how hotels, rental car companies, and other businesses record credit card information to ensure that they will be paid, and I've shown you how to do the same thing. (If you missed those columns, go to www.skinandallergynews.com and click on "The Archive Collection" on the left-hand side.) Patients who fail to pay their credit card bills are the credit card companies' problems, not yours.

For big-ticket cosmetic procedures where you anticipate the fees will exceed credit card limits, arrange a realistic payment schedule in advance, and have the patient complete a credit application. You can find forms for this online at allbusiness.com, lawdog.com, and other sites. (As always, I have no financial interest in any product or business mentioned in this column.)

In some cases, it may be worth the trouble to run a background check. There are easy and affordable ways to do this. Dunn & Bradstreet, for example, will furnish a report containing payment records and details of any lawsuits, liens, and other legal actions for as little as $30. The more financial information you have on file, the more leverage you have if a patient later balks at paying his or her balance.

Always take before and after photos, and have all patients sign a written consent giving permission for the procedure, assuming full financial responsibility, and acknowledging that no guarantees have been given or implied. This defuses the common deadbeat tactics of professing ignorance of personal financial obligation and/or dissatisfaction with results.

Despite all your precautions, deadbeats inevitably will slip through on occasion. However, even then you have options in dealing with them.

Collection agencies are the traditional first line of attack for most medical practices. Ideally, your agency should specialize in handling medical accounts, so it will know exactly how much pressure to exert to avoid charges of harassment. Delinquent accounts should be submitted earlier rather than later to maximize the chances of success; my manager never allows accounts to age more than 90 days, and, if circumstances dictate, she refers them sooner than that.

When collection agencies fail, think about small claims court. You'll need to learn the rules for filing in your state, but most charge a nominal fee and place a limit of $5,000 or so on claims. No attorneys are involved. If your paperwork is in order the court will nearly always rule in your favor, but it will not provide the means for collection. In other words, you'll still have to persuade the deadbeat to pay up. However, in many states a court order will give you the authority to attach a lien to property, or garnish wages, which often provides enough leverage to force payment.

What about the deadbeats who rip you off twice—by refusing to pay and then stealing the insurance check, too? First, check your third-party contract; sometimes the insurance company or HMO will be compelled to pay you directly and then go after the patient to get back its money. (They won't volunteer this service, however. You'll have to ask for it.)

If that's not an option, consider reporting the misdirected payment to the Internal Revenue Service as income to the patient, by submitting a 1099-miscellaneous income form. Be sure to notify the deadbeat that you will be doing this. More often than not, the threat of such action will persuade the patient to pay up; but if not, at least you'll have the satisfaction of knowing he or she will have to pay taxes on the money. ■

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Experts Call for FDA Reform, Changes in Clinical Trial Design

BY MARY ELLEN SCHNEIDER
New York Bureau

Boston — Any proposals to reform the Food and Drug Administration should meet the test that the changes would have prevented the arthritis drug Vioxx from getting to the market, Dr. David J. Graham said at the annual meeting of the American Public Health Association.

Dr. Graham, an FDA scientist who testified before Congress in 2004 about the unwillingness of FDA officials to recognize safety problems with Vioxx (rofecoxib), was among a panel of experts who called for changes at the FDA and reforms in the way that pharmaceutical companies design clinical trials.

The criticism comes on the heels of a report from the Institute of Medicine that recommends significant reforms at the FDA, including the establishment of performance goals for safety.

The FDA has been "captured" by the industry and has taken on the value system of the pharmaceutical companies, said Dr. Graham, of the FDA Office of Surveillance and Epidemiology, who was speaking as an individual and not on behalf of the agency.

FDA officials now see their jobs as getting drugs on the market as fast as possible, Dr. Graham said. "We have at FDA a lack of checks and balances."

FDA leadership was quick to rebut those charges. The vast majority of physicians, scientists, and staff members at the FDA reject the concept that the agency is beholden to the drug industry, Dr. Steven Galson, director of the Center for Drug Evaluation and Research (CDER), said in an interview.

In light of calls for reform, FDA officials have already taken a series of steps over the last 2 years to try to improve the processes within the agency, Dr. Galson said. For example, the agency has created a new drug safety oversight board that includes individuals from the FDA and other government agencies to provide advice on drug safety issues, and it has increased the number of staff working in the postmarketing safety area. FDA officials have also redesigned the drug label so that physicians can quickly see the key information they need to make prescribing decisions. And the agency has a long to-do list of reforms aimed at promoting early detection of safety problems and improving communication with physicians and patients.

But the biggest advances in drug safety are more likely to come from basic science advances, he said. These advances, which the FDA is trying to foster through its Critical Path Initiative, will help scientists better predict which drugs in development will run into safety problems later. "The best way to improve drug safety is by improving the science of drug development," Dr. Galson said.

But the FDA also should improve its postmarketing surveillance, said panelist Dr. John D. Abramson, a clinical instructor in the department of ambulatory care and prevention at Harvard Medical School, Boston. The current system—in which physicians voluntarily report drug-related adverse events—does not work, because it's passive, he said. The FDA could instead be doing epidemiologic studies to monitor side effects in the entire population taking a drug.

Panelists also took aim at how the pharmaceutical industry designs clinical trials. Drug trials are conducted primarily to maximize return on investment to shareholders by emphasizing benefits of the drug and minimizing risks, Dr. Abramson said.

Reforms should be structured in such a way that companies will have to spend more time on innovative drugs and less time developing 'me too' products.

Drug companies used to simply provide financial support for studies, but they now also design the study and keep the research, said panelist Dr. Marcia Angell, former editor-in-chief of the New England Journal of Medicine and a senior lecturer on social medicine at Harvard.

One possible way to limit the influence of pharmaceutical companies in study design would be to create an arm of the National Institutes of Health that would oversee the design of trials, Dr. Angell said, adding that such a body could be wholly or partially funded by industry. Registration of clinical trials at their inception should be a requirement to enroll human subjects, she said.

The panel also criticized the FDA statute that requires new drugs to show effectiveness compared with placebo, but does not require a new drug to be better than existing medications on the market. This leads to approval of drugs with limited benefits and unknown risks, Dr. Angell said.

She cited Vioxx as an example of a drug that should never have been approved because it had only marginal benefits over existing drugs to treat the same condition. In Dr. Angell's opinion, any FDA reform should require that approval of a new drug be based on comparison with existing medications to treat the same condition. Such a change would force drug companies to spend more time on innovative drugs and less time developing "me too" products, she said.

In an interview, CDER's Dr. Galson agreed that more innovation needs to come from pharmaceutical companies, and said that Congress must be careful to ensure that any additional regulatory authority doesn't hamper innovation.

Members of Congress also will have a chance to weigh in on FDA reform when the Prescription Drug User Fee Act (PDUFA) comes up for reauthorization in 2007. The PDUFA law, originally passed by Congress in 1992, set up a system in which the pharmaceutical industry pays user fees to the FDA in exchange for the agency's agreeing to meet certain deadlines in the review of drug applications. ■