Reasons for Switching to a Patient Pay Practice
from Grant Gerner, MD

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Dear Patients,

Before explaining the reasons for our switch to a patient pay/fee for service practice, let me get you up to speed with where we've come from since opening our practice.

My wife, Wendy, and I opened our skin cancer practice in December 2014. For the first three years it was just the two of us. Wendy did all of the "front desk" work while I did all of the "patient care" work. Through word-of-mouth only, our practice grew steadily. Within two years we had to start limiting new patients to only those who were at high risk for skin cancer. Considering that I am not a dermatologist and started a practice that is a sub-specialty of dermatology, there was real risk of this practice failing. But the early fears of failure were gradually relieved by the steadily increasing demand for our service. Now, after over eight years of practice I have found more than 2,000 skin cancers including 74 melanomas. To date, none of those skin cancers had spread beyond the skin and none of my patients have died of any of those skin cancers. This is strong evidence that performing detailed skin examinations by looking at all of a patient's spots with a dermatoscope is effective in detecting skin cancer early and saving lives.

At the beginning of our skin cancer practice experiment, because we were committed to serving the whole community, we went through the extensive process of credentialing and contracting with Medicare, Medicaid, and as many of the private insurers as possible. We wanted our patients to be able to use their health care coverage to access our services. But because of those contracts, our fees have been regulated by Medicare and private insurance companies. Medicare has not given us a significant pay increase in the eight years of our practice but has steadily increased its reporting requirements and its regulatory burden. Private insurances have been even worse. They have steadily cut our reimbursements since we started. Our attempts to negotiate a better contract rate from insurance companies have resulted in a "take it or leave it" response. Ours is a small practice and insurances won't negotiate with small practices. Furthermore, insurance claims denials have become more frequent, requiring Wendy to spend many, many hours every week fighting simply for us to get paid.

By the third year of the practice we began experimenting with medical assistants to help with my patient flow and receptionists to allow Wendy to work from home. We concluded that having only a receptionist is the best balance between efficiency and simplicity for our small practice. This model allows Wendy to work from home doing all the "practice management" work: coding, billing, regulatory, bookkeeping, payroll and fighting denied claims.

In April, 2019, Wendy was diagnosed with Stage IV cancer. It's a rare cancer called "carcinoid" or NET (neuroendocrine tumor). While her cancer is growing very slowly it is currently incurable. This diagnosis has made us reflect deeply about the time we have and how best to use it. Simply put, Wendy spending her time fighting with insurances to pay us and filing all of the regulatory reports required by Medicare, Medicaid and insurances is frustrating, aggravating and a waste of her precious time. By switching to a patient pay practice model Wendy will no longer have to spend time fighting denied claims or completing the ridiculous quality measures reporting required by Medicare and Medicaid. She'll be able to use her new found free time to pursue any path that makes her happy. This is the main reason we need to switch to a cash model practice.

The other reason we need to switch is financial. There is a public perception that all doctors are rich. That is simply not true. Back in the '60's, before Medicare and Medicaid took

effect, it was true that most doctors were wealthy. Since then, and especially since the advent of HMOs and PPOs in the '80's, doctors have been seeing their wages dwindle. Not long ago I had a friend who was a plumber and another an electrician and when we discussed income both of them made substantially more than I did as a family physician.

Before learning dermoscopy, I considered starting a cosmetic practice, doing lasers, Botox, fillers, dermabrasion, etc. Had I done that, I would have easily doubled or even tripled my current income. But that's not what I want to do. I became a doctor to help people and to save lives. And to me there is nothing more interesting and challenging than using my dermatoscope to examine patients and find their skin cancers at the earliest stage possible. It's very gratifying!

In the past eight years all of our overhead expenses have increased. That includes office rent, malpractice insurance, equipment upgrades and service plans, medical records software, and a hefty increase in the cost for our personal health insurance. And, while I know that I am doing a better job than ever of finding and treating skin cancer, Medicare has not given raises that come close to keeping up with inflation. And insurances have consistently cut our reimbursement. Increased overhead and decreased revenue is a recipe for any business to fail.

At the same time, medical insurance companies continue to report record profits. Their CEO's and share holders are collectively making billions a year by denying health care to subscribers and by cutting reimbursements to doctors and medical organizations. The health care system in the U.S. is badly broken. Wendy and I can't fix that. All that we can do is try to survive as a small practice. By making the switch to a patient pay model we hope to be able to continue our very important work of finding skin cancers early, before they spread and threaten people's lives, and before they need large, risky, deforming surgery.

What saddens both Wendy and me is that some of our patients who need our care the most will not be able to afford the cost of their care. While there are options for them to see local or regional dermatologists, to my knowledge there are no dermatologists who perform examinations by looking at all of the patient's spots with a dermatoscope, as is my routine. Most early skin cancers do not look suspicious to the naked eye. So even the most experienced dermatologist, if they only perform a naked eye exam or use a magnifying glass, will not be able to detect the early skin cancers that I routinely find and remove. Nor to my knowledge are there any practices locally that utilize digital dermoscopy, which greatly enhances one's ability to safely monitor questionable lesions instead of simply biopsying anything that looks a little suspicious.

The fact that some of the high risk patients in our practice will not have access to this kind of care for financial reasons is very distressing to both Wendy and me. But if our practice does not survive financially, then we will be forced to do something else to make a living. If that happens then no one will benefit from the skills and techniques we offer. Switching to a patient pay model is the only path for our practice to survive. Hopefully it will.

If after reading this you have any questions, concerns or suggestions please contact us at grantgerner@grantgernermd.com or wendy@grantgernermd.com.

Sincerely,
Grant Gerner, MD