

WHAT
INSURANCE COMPANIES

DON'T WANT YOU TO KNOW

**HOW
TO BEAT
THEM**

AT THEIR OWN
GAME



The **secret tactics** they use to keep **more money** than you think and use it to **audit** other chiropractors

BRIAN CAPRA D.C.



"I've known Dr. Brian Capra for many years and have seen his admirable purpose and passion for the chiropractic profession. His efforts to create a book to give context to chiropractors on the issue of insurance should warrant some notice. I have been critical of the insurance industry for many years and have created programs to help chiropractors end insurance dependency. The goals of 3rd party payers and the goals have chiropractors do not come close to aligning. Take a look at what Dr. Capra has learned about the insurance industry - it will open your eyes."

Dr. Patrick Gentempo



"Dr. Brian Capra is an innovative leader at the intersection of chiropractic and technology. The EHR/practice management system he and his team has created drives continuous improvement in workflow and efficiency. Brian is an expert at workflow design for chiropractic and other healthcare facilities. He has remarkable insight to help providers address their biggest challenges, be more profitable, and well as the vision and foresight to know what the profession, individual practices and patients will need in the future. In word, Brian is remarkable."

Dr. Jay Greenstein



"If you are going to play the insurance game in Healthcare today - then you'd better play it right. The moment you file a claim, you step into the ring with a heavyweight. You'd better have done your homework. Any misstep can cost you dearly. Even if you consider yourself a "Cash Practice" or "Cash-Like" you are still subject to the rules of the game. Ask any "non-participating provider" that's been whacked."

Dr. Brian Capra's "What Insurance Companies Don't Want You to Know" is mandatory reading for anyone "in the fight" that's looking to play within the rules, maximize your returns and not get hurt. It's an easy read and a quick study - definitely worth your time."

Dr. Stephen Franson - *The Remarkable Practice*



"Having spent the greater part of 16 years in the coding, compliance and insurance world of chiropractic I have seen things come and go. You see people that are so called experts that have made a career on attempting to scare doctors and staff into compliance. You see new software's come and go that make promises but yet it all leaves a doctor more confused and living in fear."

After meeting Dr. Brian Capra I was not sure if he would fall into the same category as others. I took me only a few months to realize he was different. He was not interested in scaring anyone but rather empowering them. Dr. Capra has touched this profession in many different ways but this book is another example of his attempt to create mental freedom for the chiropractor and their team. Dr. Capra and I agree that if we can remove fear, replace it with belief we can get chiropractors back to loving and serving as they were created to do. A must read for all offices!"

Bharon Hoag - *OneChiropractic*



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ABOUT THE AUTHOR

DR. BRIAN CAPRA graduated in 2002 and started his practice in Princeton, New Jersey. After a short time, he built a practice of approximately 400 visits per week with a mix of cash and insurance. He wanted to outsource his billing and focus on what he felt was most important—getting new patients and taking great care of them.

After several attempts to outsource with less than optimal success, he had a chance encounter with two gentlemen. One was a Wall Street technology executive from the largest bank in the world, and the other was a computer science Princeton graduate. Together they opened Dr. Brian's eyes to a new reality in technology and automation. Using artificial intelligence (AI) and patented technology as well as providing real insight into how the insurance industry really works, they showed Dr. Brian what it would take to beat insurance companies at their own game.

Dr. Brian implemented the new methodology, and his insurance collections immediately increased 40%. Seeing the amazing results, Dr. Brian realized that the new methodology could also be used for other parts of the practice, including patient retention and compliance. He felt compelled to bring it to the rest of the profession.

In 2004, the three men formed a partnership and began developing the **Genesis Chiropractic Software and Billing Network**.

It was—and still is—the only cloud-based platform that leverages patented AI and automation to help providers streamline their entire practice. Across the country, thousands of users have seen dramatic improvement in their patient retention, revenue per visit, and compliance, as well significantly lower overhead and staff management hours.

Practices that use Genesis range from 100% “cash” practices to multi-discipline offices seeing anywhere from less than 100 visits per week to more than 3,000 visits per week. They enjoy the flexibility of outsourcing their billing or keeping their billing in-house with an unprecedented level of control, transparency, and accountability.



If you are going to play the insurance game in healthcare today, then you'd better play it right. The moment you file a claim, you step into the ring with a heavyweight. You'd better have done your homework. Any misstep can cost you dearly. Even if you consider yourself a "cash practice" or "cash-like," you are still subject to the rules of the game. Ask any non-participating provider that's been whacked.

Dr. Brian Capra's What Insurance Companies Don't Want You to Know is mandatory reading for anyone "in the fight" that's looking to play within the rules, maximize your returns, and not get hurt. It's an easy read and a quick study—definitely worth your time.

—Dr. Stephen Franson – The Remarkable Practice



For almost ten years I have had the opportunity to work side-by-side with Dr. Brian Capra for the benefit of our mutual clients. During this time, we've seen clients succeed in practice with a top notch collection percentage, all while giving the doctor balance between the time spent in the system and compliance.

—Dr. John Davila – Custom Chiro Solutions



Dr. Brian Capra is an innovative leader at the intersection of chiropractic and technology. The EHR/practice management system he and his team have created drives continuous improvement in workflow and efficiency. Brian is an expert at workflow design for chiropractic and other healthcare facilities. He has remarkable insight to help providers address their biggest challenges, be more profitable, and have the vision and foresight to know what the profession, individual practices, and patients will need in the future. In a word, Brian is remarkable.

—Dr. Jay Greenstein



I have personally known Dr. Brian Capra for the last 10 years. We originally began working together, because he was my coaching client, then also worked with him as he began Genesis, the compliance, documentation, billing software. This means I know Dr. Brian on a very close personal and professional level.

He is a person of his word. He is honorable, has integrity, trustworthy and he loves people. His first desire is to help people and contribute to their success and personal growth. He has mastery of his knowledge of technology, stemming from his passion and life purpose to keep people safe and protect them from the pitfalls and liabilities of compliance in today's world, while creating a profitable and sustainable business that fulfills your purpose, while giving you confidence and freedom.

I strongly urge every coaching client in Elite Chiropractic Coaching to use Genesis and develop a relationship with Dr. Brian.

I trust him with my most valued relationships and am honored to call him my lifelong friend.

—Dr. Fred DiDomenico – Elite Coaching



Since starting with the Genesis AI platform in 2016, I have had more time off in practice (seven weeks) and have had record collection months. I highly recommend the software, only if you want more money and more free time.

—Dr. Peter Martone



Genesis includes everything your practice needs for efficiency, patient care, and your bottom line. There is simply nothing else like it in today's EHR market! Because we've chosen Genesis for our office, we are confident you should do the same.

—Dr. Deed Harrison – CBP

FROM THE AUTHOR

My intention in this book is to pull the proverbial curtain back and help you see what the insurance companies are really up to—what their real motivation is. I promise you, you've never heard this information before. At first, it might surprise you. It might make you feel overwhelmed, frustrated, and powerless. Stay with it. There is something you can discover in this book, and there is something you do about insurance companies.

Beating them at their own game is not as scary as it sounds. It can be done in less time and with less stress and money than it is costing you right now. Just like we teach our patients, all you need is a new paradigm.

If you are going to win at anything, you need to know the rules of the game, and you need to know your opponent. The more you know, the better your chances will be to succeed.

The problem I see is that most doctors are taking a checkers mentality in a chess game. I aim to end this and empower you with the tools and know-how to beat the opponent at its own game.

DR. BRIAN CAPRA

PRESIDENT/FOUNDER – GENESIS CHIROPRACTIC SOFTWARE

PART 1

What Insurance Companies Don't Want You To Know

Chapter 1

Insurance Companies' Strategy: How They Really Make Their Money

A lot of doctors I speak to think insurance companies have it out for chiropractors because they hate what we do. But I can tell you that it is not about our philosophical approach to health and wellness or musculoskeletal conditions. They really do not care about any of that. What they care about is whether they will pay or not pay. The insurance process is currently so automated that I can assure you that there is not a person sitting at a desk in the insurance company holding on to your money because they do not like chiropractors.

An insurance company is big business. Just like any other business, it is made up of three things:

1. People

2. Process
3. Technology

They use those three things to make as much profit per unit as possible. In this case, the unit is an insurance claim. That being said, you will soon start to see that they actually love chiropractic, just not for the reasons we may hope for.

For years, I thought insurance companies made their money by collecting premiums and then not paying claims. That meant they would increase their profit per claim substantially. But if you think about it, if insurance companies simply denied claims, they would look really bad in the eyes of their customers, the patients.

What they really want to do is make it look like they are trying to pay claims but the doctor is simply not cooperating in some way, shape, or form. The name of the game is slowing down payment or taking the money back after they've already paid the claim and the customer is satisfied—that is, an audit.

Think about the audit from the customer's (the patient's) perspective. They are covered for a visit or visits, and then they get a letter from the insurance company stating that their doctor is being audited. Their visit is still paid, and the insurance company looks like the good guy. But the doctor looks like the bad guy. We'll look at this more in a bit.

But there is more to the story.

How They Really Make Their Money—Paradigm Shift

To begin to understand insurance companies' motives and, more importantly, what you can do about it, you just need to follow the money. Here is a little known fact: *More than 50% of insurance companies' profits come from interest.* This is also known as *float*—or interest on money that should have been paid to you but was

somehow delayed.

I will show you in this book how the interest starts building the moment you are finished seeing your patient. Before I realized this, I thought they made money on collecting premiums and simply not paying claims. Not so.

Chapter 2

How They Rig the System

We are getting to the root of the issue, but there's a little more to the story. When I started Genesis Chiropractic Software, I partnered with people from the Wall Street financial technology world. One of my partners is the former CIO (chief information officer) of the top bank in the world. Another is a Princeton University grad with a computer science degree and extensive experience, specifically in building AI technology for hedge fund transactions. *Why is that important?*

It turns out that insurance claim transactions between the doctor and the insurance company are rather simple. When my partners first looked at the process, their first reaction was this: "Oh, we can just get them to pay these claims in *real time*. The transactions on

Wall Street are way more complex, and they involve many people at the same time. The only difference is that everyone involved gets paid by the end of the day. *It's the law!*

Did you hear that? ***It's the law!***

Here's where it starts to get interesting.

Far more complex transactions happen every day on Wall Street, right? So why wouldn't insurance companies do the same? And the technology already exists to make that happen. Why isn't there a law that says doctors get paid for a visit by the end of the day? That's a great question. I'm glad you asked.

But remember, I already said they make money on interest, right? And you know there is no *good reason* you don't get paid at the end of the day. I'm sure you're probably starting to see what's going on here. Insurance companies start collecting interest *as soon as you've seen the patient*.

But that doesn't answer this question: **Why isn't there a law that makes them pay you by the end of the day?**

Collusion and Consolidation

We have all heard a lot in the news about collusion when it comes to politics. Well, here is real collusion that is well known and even legal. Seventy percent of US citizens are covered by just three insurance companies. Why? The big companies have gobbled up the little ones. But why?

Not to be more profitable, but to be more powerful!

Gaining legal power by consolidation

1. **Oligopoly** – An oligopoly is not a monopoly. It is an economic structure in which just a few companies affect but don't technically control an industry. And they don't prevent

each other from having a major influence on the market. A monopoly is when one company has total control of an industry or product. An oligopoly has many of the same benefits as a monopoly, but the most important benefit is that an oligopoly is *more legal*, and a monopoly is *illegal*.

2. **Insurance companies make the rules** – Since the insurance industry is an oligopoly, just a few insurance companies have all the money, they have all the lobbying power, and they make the laws and rules by default.

Did you notice that I said *more legal* above? I'm glad you caught that. What laws are in place to prevent this? That is another great question.

Antitrust exemption: This is amazing—don't skip it!

Rigging a marketplace by working together—as an oligopoly—could still be considered a violation of antitrust laws. These laws prevent companies from having exclusive control and thus *price fixing*. You might remember the huge antitrust case against Microsoft—*United States v. Microsoft*. In a capitalist economy, monopolizing is taken very seriously.

Let's say every chiropractor got together and said we would no longer accept less than \$45—or maybe even \$1,000—from insurance companies for an adjustment. Insurance companies would report it to the federal government. Those chiropractors would immediately be shut down. The insurance companies would be correct, because doctors cannot collude against insurance companies. Antitrust laws are important because they protect consumers.

The law applies to every industry, right? Nope! It turns out that there are a few exceptions. Guess which industry is one of those exceptions. You got it—the insurance industry. They are legally

allowed to collude against all physicians, not just chiropractors. And they've used their massive resources to successfully lobby for laws that protect them even further.

*Even if we could prove they were rigging the system,
we have zero recourse!*

If you want more information on this, read about the McCarran-Ferguson Act of 1945, a federal law that exempts insurance companies from most federal regulations, including some antitrust laws.

So there is your answer.

Why aren't there laws that make insurance companies pay at the time of service?

Because they have all the power, and their power is actually enabled and protected by the US government.

They get to make all the rules!

Chapter 3

Their Tactics and Their Rules

Recap

1. The patient is the insurance company's customer, not yours.
2. The system is rigged in the insurance company's favor by design. They make the rules.
3. They are legally protected by the federal government.
4. They make money on interest.

So how do insurance companies pay claims, make a lot of money (from interest), and still look good in the eyes of their customers?

5 Generic Tactics They Use

1. Make it difficult for you to get the claim to them in real time.
2. Make it difficult to prove necessity and deny claims, especially in real time.
3. Pay very slowly.
4. Pay less than they should.
5. Take the money back much later after their customer is satisfied and out of the picture.

Making Patients Hate You Instead of Them

Think about this from the patient's perspective. They have no idea about the things we've already discussed. They just want to get their visits paid for because they paid their insurance premiums.

Of the five items above, which one makes insurance companies look bad in the patient's eyes? **None of them!**

1. It is the doctor who has to make the claim properly.
2. It is the doctor who must show why this care was necessary.
3. It is the doctor's fault it is taking so long for the insurance company to pay for your visit (see tactics 1 and 2).
4. It is the doctor who charged you more than is reasonable for your area.
5. It is the doctor who billed you fraudulently. Now we have to investigate.

They make the rules, right? What are the rules that help them save face with the patient while they hold on to your money?

The Rules

1. Insurance companies have 30 days to process a claim instead of paying in real time.
2. Each patient's coverage is different.
3. They have a very complex coding system that determines what they pay you. The codes are actually not *really* necessary to pay. The complexity is really there to make it very difficult for you to submit the correct claim in real time, slowing down or preventing payment and increasing the interest they collect.

With only the list below and its possible combinations, the chance of making a mistake is in the hundreds of thousands.

- a. Diagnosis codes, ICD-10 (ICD-11 is coming, believe it or not)
 - b. Diagnosis code ordering
 - c. CPT codes
 - d. Modifies
 - e. Diagnosis code linking
 - f. Number of units
 - g. Timed codes
 - h. One-on-one Vs group
 - i. Levels of codes. Exams and re-exams, for example
4. **HCFA** – The complexity increases more with the submission form/bill/HCFA. It needs to be sent with a lot of information. Anything that is incorrect is grounds for denial and/or delay.
 5. **Remittance Advice – The EOB**
 - a. Taking an EOB (Explanation of Benefits) and posting the line items takes a highly skilled employee, but they leveraged technology to send the EOB to

you. We'll cover more on the economies of scale, the workforce, and technology a little later.

- b. Every payer has his or her own denial codes and format, which significantly slows down your posting.
- c. **Underpayments** – Finding an underpayment means your staff needs to remember every CPT allowable or contracted amount for every payer. When something is underpaid, it is almost impossible to find. It looks like it was paid after all. Over the course of your career, this could cost you tens of thousands of dollars. *Very sneaky, if you ask me.*

6. Documentation

- a. **Ambiguous requirements** – Subjective, objective, ADL, assessment, plan. Functional improvements, outcome assessment tools. Blah, blah, blah. Thirty compliance “experts,” 30 different opinions.
- b. **Matching documentation to the coding** adds yet another level of complexity. Most technology does not help you get this right—your documentation matching your codes for each visit. Lots of systems say they have fast notes, but what about the coding complexity? Does it warn you when you've made a mistake? Are they really looking at insurance companies' trends and improving this over time? Are they reviewing real-life claims data and updating the system to make sure your claims are accurate? *More on this later when we get into beating them at their own game!*

It is all nonsense really. They know it. Now you know it.

Chapter 4

Kicking You While You're Down

Recap

1. We know how and why insurance companies rig the system and make all the rules.
2. We know the rules and tactics they use to look good in the patient's eyes and still make tons of money.

What's next? How can they tighten the screws just a little more before they deliver the fatal blow?

As if all the leverage they have and all the rules they've made weren't bad enough, they just keep swinging. In this chapter, we are going to look at a few more tactics that fly under your radar.

What are they doing with all of that money? Investing in their business, of course. Specifically:

1. People – much cheaper people
2. Processes
3. Technology
4. The Audit

1. People – Cheap Workers

When it comes time for workers, they outsource. There are literally unlimited resources in India, the Philippines, and many other emerging countries.

1. It comes down to this. You have to call them and pay US dollars, say \$15 per hour, and they pay their workers less than \$1 per hour.
2. You are one person; they have unlimited people.

2. Process

Every manual step you take costs you money. They want to make this process very expensive for you, and therefore manual.

Your manual steps

1. Benefit verifications
2. Pre-certifications
3. Hunting and pecking for codes, modifiers, linking, ordering, units, and so on
4. Documenting every visit, hoping you're getting it right
5. Submitting the claim to a clearing house (God forbid that you would send them by paper)

6. Correcting claims in the clearing house before they get sent
7. Posting EOB
8. Finding unpaid claims, underpayments, and denials in aging reports
9. Submitting to secondary payers
10. Calling insurance companies for denials, underpayments, benefit verifications, pre-certifications
11. Submitting supporting medical necessity documentation and appeals
12. Resubmitting claims
13. Collecting patient balances

Their manual steps

1. Answer the phone when you call on a claim, benefit verification, or pre-certification
2. Auditing you

3. Technology and Automation—How Can You Compete?

What technology are insurance companies investing in?

1. They build a massive database in the cloud, collecting data across all chiropractors and other physicians.
2. Their AI looks for trends and finds outliers for
 - a. coding
 - b. documentation
 - c. follow-up
3. The AI then automates the rest based on what it is learning. They automate:
 - a. claim receipts

- b. payments
- c. denials
- d. underpayments
- e. pre-certification parameters
- f. identification of the best candidates for post-payment audits

4. The Audit

1. They've paid you, and now they want all the money back (plus penalties and interest, of course).
2. They send letters to your patients and even visit their homes in some cases.
3. Your legal defense costs climb.
4. You face losing your license with your state board.
5. You're completely distracted from practicing.
6. The mental stress weighs on you and your loved ones.
7. What do they get out of it? It's a simple calculation—a 13:1 return on investment. Between the payments they take back, the penalties, and the interest, they get *\$13 back for every \$1 they invest in a post-payment audit*. What a racket!

Somehow, you look like the bad guy or gal!

Chapter 5

The Fatal Blow

Let's All Go "Cash"

So let's give them the fatal blow—let's all go "cash." Not so fast!
Do you really think they haven't thought of that?
But here's their fatal blow: Make it so difficult for you to compete that you want to give up, only to realize that you cannot.

Just when you think you are out, they pull you back in!
—*The Godfather*

You can get more in depth on this topic by visiting
www.principledcash.com.

There are several reasons why there is really no such thing as a fully “cash” practice.

The “Cash” Myths

1. A lot of doctors believe that “going cash” means that if they collect payments from their patient (and give them a super bill), they can avoid all liability, billing hassles, and documentation and coding compliance.
2. Doctors believe they are more principled when they go cash.

The “Cash” Truth

1. State boards are now requiring Medicare level (or higher) medical necessity and coding. So you’re never really off the hook with documentation or coding. It is now a standard of care requirement, not just an insurance company requirement.
2. You *must submit* claims to Medicare for patients in active care. It is the law. You cannot collect fees from Medicare patients up front for active care.
3. Even if a patient pays you in cash and submits a super bill to their insurance company, insurance companies and state boards can still audit you (see the Principled Cash website).
4. Patients want to use their insurance. A lot of cash practices give their patients super bills and have the patient submit the claim to their insurance company. We already know that insurance companies are a pain to deal with. Why would we think the customer experience is improved by asking them to do something that is a pain in the neck (no pun intended)? We’ll talk about how we can make this really

simple for a practice later on, but for now, just keep this in mind. Patients want to use their insurance, and they do not want the hassles you are trying to avoid. One little denial from the insurance company, and they will just stop coming in, especially since the insurance company will likely blame you for the denial.

5. Going cash means nothing in terms of principle. The way you measure principle and your ability to communicate it is by PVA (patient visit average). How long do patients stay in your office? More principled practices have patients convert to lifetime care regardless of who pays for that care at various points.

I have been in cash-only practice for five years and practicing for over ten. We see a very high volume of patients. I have been using Dr. Brian's systems before and after going cash, and I can tell you from experience, there is nothing like it. I would never practice without it again.

—Chris Zaino

Wrong Question

The question we should *not* be asking: *How can we see patients and avoid coding and documentation and other compliance requirements?* It is a reality we cannot escape.

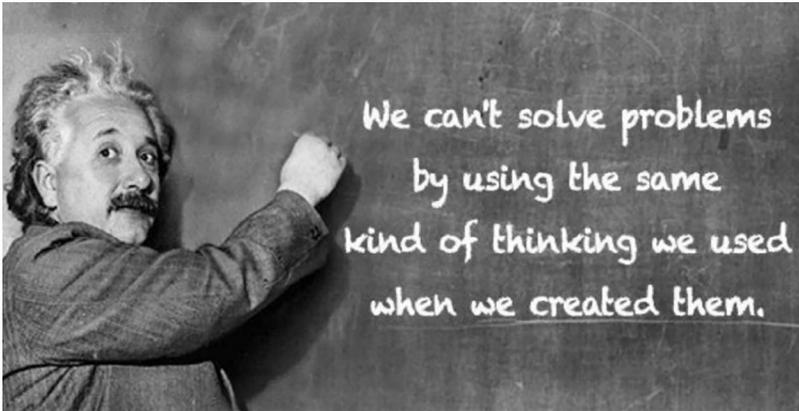
Correct Questions

1. How can we see patients, regardless of who is paying at any given point, and have systems in place that make it feel like a cash practice for the doctor and staff?
2. How do we convert patients to lifetime care regardless of who is paying at any given point?

Fight Back

It's a hard pill to swallow. They have you where they want you. So how can we band together and beat them at their own game? Here's the short answer:

*We must change the way we are thinking about this game
and the way we are currently fighting back.*



After all, insurance companies are playing chess, and we are playing checkers.

I hope by now that you see I have been looking at this chess board for many, many years while others have no idea they are playing chess. Others are building services and technology, all based on a false premise or paradigm. This will all go away someday, or they can make it go away by “going cash.”

“Contradictions do not exist. Whenever you think that you are facing a contradiction, check your premises. You will find that one of them is wrong.”

—Ayn Rand

It is an inconvenient truth and a reality. I am a realist. I never wanted to get into this field, but when I found this information,

when I realized there was something I could do to help other chiropractors, I simply had to take action. I closed a very successful (yes, principled) practice to take on this battle. I found a way to actually beat insurance companies at their own game.

I've spent 13 years and literally millions of dollars to make this a reality. I would have made much more money simply practicing and turning a blind eye. In that way, it has cost my family as well. I had no promise I would ever see a return on this investment.

Today, thousands of users are leveraging this new methodology I put together to build large, principled, lifetime care, massively profitable practices. They are collecting both cash and insurance, while maintaining compliance with relative ease. They do this in as little or less time as it would take them to be a cash practice.

We are in a time when chiropractors are struggling due to overwhelming demands. They're not just insurance demands—they're all the demands that go into managing a business, professionally and personally.

In the next chapter, I will go into what it takes to level the playing field and free you up to do what you do best: serve more patients! You will learn how to play chess like a master with the big boys and girls.

PART 2

How We Can Beat Them
at Their Own Game—
Together

Chapter 6

Leveling the Playing Field

Vultron

When I was a kid, there was a Marvel comic book called *Vultron*. There were basically five superheroes who drove around in their own individual robotic lions. When they came up against a really formidable opponent, they were able to join all their lions together and form one gigantic warrior-shaped robot. Of course, working together, they were able to defeat the enemy that would have otherwise destroyed them individually. Today, my son watches *Power Rangers*. It's basically the same concept.

Judo

Judo is a very well-known martial art. The main idea is to use your opponent's aggression or momentum against them. So when the opponent swings at you, for example, you move out of the way at the same time you push them or throw them in the direction in which their momentum was already taking them.

Ultron-Judo

Take these two concepts and smush them together. That's how we beat them at their own game. We use their momentum and their own tactics, band together using a more powerful technology than we have individually, and destroy our formidable foe.

As we've been learning about insurance company strategies and tactics, I told you about the three components of any business:

1. People
2. Process
3. Technology

We also discussed one very specific process they have: the audit.

We have dived into each component and seen how insurance companies are really just leveraging people, process, and technology from a totally different perspective or paradigm than we are.

If we are going to win, we need a paradigm shift in how we think about our businesses and how we play the game.

People

1. Insurance companies have unlimited cheap labor.
2. Their highly paid staff only works on things that have a huge return on investment—audits, for example.

We have been doing the opposite. We've been paying our highest paid employees to call insurance companies, verify benefits, enter charges, enter EOBs, and dig into reports looking for claims to follow up on.

That's gotta stop...if we wanna win.

Process

All these things—missed visits, new patient checklists, re-signs, inventory management, credit card charges, documentation, coding, EOB posting, charge entries, claim submission, failed claim identification, secondary submission, patient statements, cash patient statements—they all matter.

And they are not going to go away. But we can certainly be more efficient and effective by using AI and automation.

Asking your awesome biller to do a good job with inferior technology is like sending them into a nuclear war with a stick.

Technology

Technology—that's a big one. Remember, insurance companies leverage huge databases, automation, and AI, forcing your *people* to follow every manual *process* at a huge cost to you, both in terms of money and liability. Buying technology that addresses only one component of your practice while not addressing the big picture is a mistake.

Until 2004, there was no way to beat insurance companies at their game or even compete. No small practice could afford enterprise-level technology that could compete. Now there is a way.

The Internet changed everything. Here is the new solution—Genesis.

In 2004, we started a company built in the cloud. This was before the cloud was a thing to most doctors.

It was a new approach, leveraging people, process, and technology to beat insurance companies at their own game, optimizing revenue, retention, and compliance in far less time, regardless of your cash/insurance payer mix. It is a new system and paradigm. It is smart, and it learns. It allows doctors to band together with one technology and use the insurance companies' tactics against them.—Ultron and Judo, if you please. It has a life of its own. I named it **GENESIS**.

Advantages

1. With all of our clients submitting claims through one database, we could analyze data across all insurance companies all over the country—*the same way insurance companies analyze us*.
2. The cloud provided more HIPAA compliance for patient data than traditional systems like ChiroTouch or Platinum (more on this later).
3. We could now leverage AI and automation, just like the big boys, and alert doctors in real time about coding and compliance risks.
4. Real-time transparency was achieved. Now a doctor could see exactly how many claims needed follow-up and in real-time accounts receivable numbers from anywhere there was an Internet connection. No more digging through reports, unless you have time for that sort of thing.
5. Providers with more than one practice, or multi-specialty offices, could link them in the cloud and aggregate their own performance metrics.

6. It was not just for insurance. We could also leverage automation to improve patient retention and staff efficiency, even for cash patients.
7. Better technology development—on the fly—old systems are written in hieroglyphics. Cloud-based systems have the distinct advantage of being able to change the language as new ones are developed. It's like building and refitting an airplane while it's in the air.

Billing Network: The Network Effect

For the first time in the history of the profession, there was a *billing network* that any provider could join. When they joined, they were working with thousands of other users all over the country and contributing their data to the cause. (NOTE: In case you are wondering, no doctor could see another doctor's data. Doctors maintain ownership of their own data.). *It is a legal way to band together and fight back!*

Artificial Intelligence

With patented technology, we now could leverage AI. It is the first step and goes hand-in-hand with automation.

AI helps find *exceptions*. These are critical items that affect your patient retention, your cash or insurance collections, and your compliance.

Here are some examples of *exceptions*—things AI can identify with zero work for you or your staff.

Practice-specific

- A claim that is in the process of being created but is missing modifiers, linking, proper diagnosis codes, correct procedure codes

- A claim that is not supported by the daily note
- A visit that has not been billed out (even if it's cash) or is missing a signed note
- A patient that does not have a future appointment or has a missed visit that needs to be rescheduled
- A pre-certification that has expired
- A patient with an expired care plan
- A patient who is coming in for a re-sign, a re-exam, or a future visit and needs something done prior to that visit
- A credit card on a patient's account that has expired
- Inventory that is low and needs to be reordered
- A claim that is missing critical data on the claim or associated patient account
- A claim that was created by a specific provider in your office that is in network, where another provider is not
- A claim received by the insurance company
- A claim that was received but no EOB came back
- A claim that was fully paid but needs to be submitted to secondary
- A claim where one code was paid, another code was denied, and a third was slightly underpaid
- A claim that was fully processed but still has a patient balance
- A claim with a patient balance where there is a credit on the patient's account
- Payer-specific exceptions
- Provider-specific exceptions
- Specialty-specific exceptions

- Region of the US exceptions

Global

- One insurance carrier in one state changed coding requirements.
- A diagnosis code or procedure code has a high rate of denial.
- Allowable rate trends for certain carriers general or specific to your office.

Reports suck

Automation is *key* to beating insurance companies. They have it; why shouldn't we?

A lot of technologies brag about their reports. That's great. I would say that Genesis has the best reports in the industry by far. But so what?

If you look at all the expectations above, each one is really a report. Do you or your staff have time to look at every one of these every day, let alone address each item? I would argue that you do not even have time to look at one of them or even determine if anything was done about each and every exception every day.

Business Management

There are *three very important steps* to managing any business or process.

1. **Quantify** the work that needs to be completed.
2. **Delegate** the work to someone who knows how to do it and wants to do it.
3. **Verify** that the work was done each and every day.

Numbers 1 and 2 are relatively easy to do. You make your checklists, you hand them to staff members, you determine who is responsible for each one, and you periodically train your staff on them.

The management paradox

Where we all fall short is Step 3—verifying that the work was finished. As a chiropractor, you wear two hats. You are a business owner/manager, and you are an employee in the business. Being an effective manager *and* employee at the same time is (was) virtually impossible.

It is like asking you to be the conductor of an orchestra and the violin player in that orchestra at the same time. How could you be effective at listening to what everyone else is doing *and* being excellent at your own craft? It's nearly impossible—until now.

*But clearly a system that is smart enough to find every exception
and stick them in reports is not enough.*

Chapter 7

The Paradigm Shift

W*hat if* you didn't have to go to reports anymore?
What if, by the end of the day, you were able to verify only the exceptions that were *not* addressed by you or your staff?

This is where we change the game and level the playing field.

Every exception is *mission critical*. A missed patient visit is as important as an insurance claim that needs follow-up, which is as important as a note that was not created, which is as important as a care plan that is expired.

Automation

Automation does two things:

1. Eliminates unnecessary manual tasks.
2. Finds exceptions and brings them to you and your staff. *No more digging through reports.*

Step 1 - Eliminate manual tasks. Genesis has *62% more automation* than any other system. Eliminating manual steps means you and your staff only work on things that are necessary and that will give you a high return on investment compared to what it is costing you to do them.

The cost to do unnecessary manual steps is calculated by the hourly wage of the person doing them times the time it takes to do them. That adds up to the *hidden costs* in other technologies.

1. Benefit verification
2. Claim creating from your daily notes and exams
3. Claim submission in real time
4. Claim EOB posting, even the paper ones
5. Secondary, tertiary submissions
6. Paper claim submission
7. Patient balance processing
8. Patient statements
9. Failed claims (claims that need follow-up) identification
10. Patient visit reminders
11. Patients rescheduling visits

Step 2 - Find the exceptions and *bring them to you.* Finding exceptions, which needs manual labor, is yet another hidden cost. In other systems, at best, you and your staff have to go to reports to find these items.

1. Claims that need follow-up
 - a. Not paid
 - b. Underpaid
 - c. Denied
 - d. Documentation requests
2. Inventory that needs to be reordered
3. Patients who do not have a future appointment
4. Patients with no care plan or with an expired care plan
5. Patients with an expired pre-certification
6. Visits missing documentation and/or claims
7. Patients with an expired credit card
8. Patients who are coming in for a re-sign or re-exam next visit and need care plans or other preparations

Genesis Brings Them to You

Yes. Genesis brings every exception to you or your staff in the form of a *task or claim* (if it is an insurance claim that needs manual attention). This is a game-changer because it focuses you and your team on the things that matter most—things that will actually get you paid, help keep your patients under care, and keep you compliant. The thing that gets you paid is following up on the claims that need follow-up. Everything else is just extra manual labor. They are a distraction, and the cost is high.

Here are some examples:

EXAMPLE 1 – A new patient is checked in

You haven't completed your note or exam. Or maybe you have not submitted the claim that was created from your note.

1. There is a task sitting there to remind you (complete note/exam, submit claim) before you leave for the day.
2. Simultaneously, a task was created for your financial CA to verify benefits (which is one click) and create the financials based on your recommendations for care (created in your exam, step 1 in this example).

Important Note About Tasks (before we go on to more examples)

Tasks are critical action items that are specific to the patient they are related to. You can do anything from within that task.

- In the example above, you can click on the tasks and create your new patient exam inside the task, and it is saved on the patient account.
- At the same time, your CA can see the exam from their task and act accordingly.

No more chasing files around the office!

Two ways to see tasks

1. Your own view - Shows you only the tasks you have for the day
2. Team View - Shows you a list of your entire staff and the number of tasks they each own

The team view is where you take your management to the next level.

At any time, you can see exactly what the backlog of tasks is across your entire team, including yourself.

Efficiency

- Because staff is not looking for work in reports anymore, they are much more efficient and actually doing meaningful work.
- Because they complete the task inside the task, they are not wasting time clicking all over the place.
- You do not need to look at dozens of reports anymore. You see one number. You see how many exceptions were not addressed yet. We call this Single Point Management. This is the verify step that is so often missed in the three key steps to business management.

Accountability

- Everyone knows what everyone else has to do for the practice's success.
- In every task, there is a full audit trail for every action and/or note made.
- A username, date, and time stamp are added to every action taken.
- No more he said/she said.

Teamwork

1. Now staff can lend a helping hand to someone who is overwhelmed for the day.
2. You can identify team members who need more training,

who are in the wrong position in your practice, or who are not a good fit for your office.

3. Nothing is left undone at the end of the day—nothing!
4. New staff members can see exactly what they are responsible for. You can embed videos in each type of task, training them in the process they should be following for each type of task.

Example 2 - A re-sign visit is coming up

A patient checks into your office, and their re-sign visit is coming up soon (let's say three visits from now for this example).

A lot of things have to happen to make sure that visit is effective at converting that patient to more care.

1. You/your staff has to tell the patient what to expect.
2. The re-sign/re-exam/X-ray visit needs to be scheduled.
3. Maybe the patient has to fill in some paperwork before that visit.
4. New X-rays need to be taken, and a re-exam needs to be performed.
5. Insurance benefits need to be re-verified.
6. You need to complete your re-exam (including recommendations) and X-ray report.
7. A financial has to be created.
8. The re-sign/report of findings visit needs to be scheduled.

How do we leverage automation and Single Point Management to optimize conversions? Here is one way to do it.

Three days/visits before the re-sign visit

When the patient checks in (this can be automated at a kiosk) and Genesis knows it is three visits (this is customizable, by the way) before the patient's last visit in their care plan:

1. The patient is sent an appointment reminder by text or app.
2. A pop-up tells the patient to see the front desk.
3. A customizable pop-up on the front desk tell your staff what to do:
 - Educate the patient about their upcoming re-exam/ re-sign visit.
 - Give them paperwork or send a secure link so they can fill it out online.
 - Schedule the re-exam.
4. Tasks are automatically created for you and your staff.
 - Verify benefits
 - Schedule re-exam
 - Send the patient re-exam paperwork so they can fill it out online from home.
5. The doctor sees the patient, creates their note, and bills the visit (to insurance or cash, same process).
 - If the doctor forgets to sign a note or submit charges, they will get a task to remind them.

On the day of the actual re-exam/re-sign visit

1. The patient is sent an appointment reminder by text or app.
2. A pop-up for the patient and the front desk occurs.
3. The staff is reminded of the patient's re-exam visit.
 - Re-sign ROF (report of findings) is scheduled.
 - The patient is taken to the exam room.
4. Tasks are created.
 - Finish exam and X-ray reports.
 - Create financial
 - Schedule re-sign/report of findings
5. The doctor sees the patient, creates their note, and bills the visit (to insurance or cash, same process).
 - If the doctor forgets to sign a note or submit charges, they will get a task to remind them.

At the re-sign ROF visit

1. The patient is sent an appointment reminder by text or app.
2. A check-in pop-up reminds the staff to take the patient to the ROF room.
3. Tasks are created.
 - Take payment.
 - Schedule out visits.
 - Give patient appointment calendar for new care plan.
4. The doctor sees the patient, creates their note, and bills the visit (to insurance or cash, same process).
 - If the doctor forgets to sign a note or submit charges, they will get a task to remind them.

If any visit is not billed out, even for cash, a separate task will notify you.

Why pop-ups and tasks?

You may have noticed that some pop-ups and tasks are redundant. That is true. The reason we do this is that pop-ups, while very useful, are not trackable. That means we cannot see if they were not completed. When a task is created simultaneously, it is sent to a specific person or role so there is accountability. It is very simple to close a task. This way, at the end of a day, you can see what was not completed on one screen—the *Team View*.

Integrations

It's important to note that third-party integrations help patient retention and, in turn, revenue. For example, text appointment reminders and online patient scheduling apps help remind your patients of visits. They eliminate the need to call every patient and allow patients to reschedule their own visits, thus reducing no-shows.

Payment processing systems can set up recurring payments for a patient care plan. Payments automatically post to the patient's account. Genesis keeps track of credits and debits and even balances out insurance visits, only after the insurance company has fully processed the claim and the follow-up person says the claim is completed.

As you can see, we've eliminated most of the manual labor. Genesis focuses you and your team on mission-critical action items that will improve patient retention, compliance, and overall income in far less time than ever possible before.

Proven results

Because we are leveraging AI and big data analysis, we are able to see the before-and-after difference it makes for clients. The synergy between patient retention and revenue cycle management (that's

billing) using **Single Point Management** is astounding.

Practices that use the Genesis methodology, or **Single Point Management**, see an increase in revenue of 62%, an increase in compliance of 32%, and an increase in patient retention of 23%—all in 33% of work hours compared to any other technology or service on the market.

Chapter 8

Taking Chiropractic to the Next Level

The Research

Working together by leveraging technology to decrease overhead, save time, increase patient retention, simplify compliance, increase collections, and keep insurance companies on their toes is great. But it is not enough. We can do more.

The cloud gives us (our profession) one more very important advantage: research data.

We can now enter our patients' subjective and objective findings into one standardized, centralized system. Each visit is paired with coding and reimbursement data.

Now We've Got 'Em

It is now possible for us to show that chiropractic is the most cost-effective way to improve not only musculoskeletal conditions but overall health and well being. The possibilities are endless.

Genesis has teamed up with universities, researchers, and organizations to do just that.

Note: As a provider, you never have to share your patient and reimbursement data for research purposes if you do not want to.

Chapter 9

Streamlined Interface

You might be thinking this all seems complicated. There is some truth to that. Winning isn't easy, but the work it takes is not all on your shoulders. The smartphone is more complicated than your old flip phone, but you were willing to do what it took to learn the new interface because of the tremendous value it brought to your life.

Genesis is like that smartphone, and it's also like an iceberg. There is a lot to it, but most of the work is hidden—automated—and you do not have to look at it. For the office that uses Genesis, there are only a few places that you need to get used to interacting with it. Some of these are similar to what you are used to with other software, like the keypad on your smartphone. Then there is what is

different. Here is a breakdown of what is the same, what is similar, and what is different.

What Is the Same?

Features that are the same are more advanced with Genesis, but there is a smaller learning curve.

1. Scheduling
2. Reports
3. Patient information and transactions

What Is Similar?

Documenting your visits.

What Is Different?

1. The biggest difference is what we call the *workbench*. That is where you and your staff find all the tasks Genesis is bringing to you. Remember, these tasks are mission-critical for revenue, patient retention, and compliance. The fact that you do not have to find them anymore means you've just saved a ton of time every day for you and your team. The fact that in many cases Genesis is finding things that are frequently missed means your business will grow.
2. There is no more wasted time looking for work in reports. There is no more wasted time doing work that could be automated. Now you just do the work that comes to you and make sure everyone did their work by the end of the day, just by looking at one number.

If you can make this little but massively important shift in how technology is being used to beat insurance companies and serve more patients in a compliant way, you will experience a new level of freedom and satisfaction you would have never thought possible before.

The following chapters are questions Genesis receives all the time. Many times, there are misconceptions about how various software platforms address these issues. For example, the traditional problems that doctors encounter with outsourced billing services no longer exist when they use Genesis. Many older software companies say that cloud-based software is less secure or that cloud-based software prevents doctors from owning their patient data. I am not sure if they are purposely not telling the truth or if they simply do not know the truth. In either case, you should know the truth about cloud-based software, so I've included a chapter dedicated to that.

PART 3

Frequently Asked Questions

Chapter 10

When Should You Outsource?

D*isclaimer:* I own Genesis. Many of our clients outsource their follow-up to us. You might think that makes me biased. The truth is that many of our clients keep billing in-house as well. Each practice is different. Genesis makes a profit in either case, so my real incentive is to make sure every practice has real control over their insurance department and that we offer the best option for them. Since we offer both in-house and outsourced support, Genesis clients have the option to switch back and forth as their needs change.

Step 1: Choose the Right Technology

As you can see, if you do not have Single Point Management with everything integrated in the cloud, you are behind the eight ball.

Step 2: Gain Control, Accountability, and Transparency

Leveraging the Genesis system means you can see exactly how many claims need follow-up at any given time, from anywhere. You can see if your accounts receivable is within normal limits.

What is within normal limits?

The national average for AR >120 days is 17.7%. That means that on average, any given doctor does not collect 17.7% of the money he or she should from insurance companies. Statistics prove that if it takes you longer than 120 days to collect money owed to you, the chances of ever collecting it go down to almost 0%.

With Genesis, you see how many claims need follow-up each day (and if your staff is keeping up) and your % AR > 120 days in real time.

The Genesis average

Across thousands of users, our average client % AR > 120 days is 7%. Many are 0%. Do the math: $17.7\% - 7\% = 10.7\%$ increase in collections when using Genesis.

Step 3: Decide What's Best for Your Practice and Be Flexible

You may already have a superstar biller. Leveraging Genesis will make their life easier and more efficient. My personal opinion is always to

outsource because a great biller could also be great at doing other things in your office like helping get new patients. That being said, if you keep things in-house with Genesis and, God forbid, something happens to your biller and you need to outsource, it is as easy as flipping a switch. Genesis can take over right where the biller left off, with no fall in income. You can even outsource some billing such as Medicare only, for example, to Genesis.

Step 4: Track the Results

Regardless of what direction you go, with Genesis you always have a simple way to see if your billing department is up to par. You are no longer in the dark. You have more control and accountability than you have with any other in-house solution, even when you outsource with Genesis. The choice is yours. You are in control.

Chapter 11

What to Look For in a Billing Company

As we have seen, Genesis has automated everything with the exception of following up on claims that need a phone call. So the word *billing* in *billing company* really does not apply anymore. We are really a follow-up company. For clients who keep things in-house and use Genesis, they really do not have a *billing department* anymore. They have a *follow-up department*.

What You Do Not Want

Sometimes it is easier to think about what you do *not* want rather than what you *do* want. We've already covered what you do want and why. Here is what you do not want in a billing company:

1. No automation, just lots of experience

- You do not want a company that does not have automation and just says they have lots of experience or are really great billers. Genesis has been in the business for 14 years and processes millions of claims for practices all over the country. We have many expert certified coders (hundreds, actually) with lots of experience on our team. You might be saying, *So what?*
- One biller does not know more than what insurance companies have built into their AI. What happens tomorrow when the insurance company changes tactics? Are billers looking at data across thousands of practices and millions of claims? Are they building new automation and AI to fight back against insurance companies' tactics? Can one very experienced person follow up on millions of claims?

2. No accountability

- I used to outsource to a company that would send me lots of reports every month. Guess what? I never had time to look at them. If you cannot see top-down reporting of their work in real time, forget it. How many claims need follow-up today? What is your AR > 120 days? Then drill down into reports from there if you want to or need to. That's what Genesis offers. Billing companies love to talk about their reports and how they log into your system. No good. No control, no transparency, no accountability. You will wind up not trusting them.

3. They don't outsource follow-up

- I know what you're thinking. I don't want to speak to someone in India. Of course not. We would never ask a client to do that. With Genesis, you always speak to a resource in the United States. But we do want the insurance company to speak to someone in India (or another country). Why? Because they are doing the same thing. Remember how we said they have unlimited manpower? If we are going to beat them at their own game, we *must* do the same. Outsourcing your claims follow-up while still giving you transparency is one of our secret weapons. We have hundreds of follow-up resources in other countries driving insurance companies crazy every day. They are managed by resources here in the United States. They are only paid when you get paid.

4. They use another software

- If they are using another software, then no thank you. I shouldn't have to explain all the reasons that this is a deal breaker. Your practice management end *must* be tied to your billing and follow-up if you want real control, transparency, accountability, and a chance to beat insurance companies at their own game.
- Even if you are using another cloud-based system, it is not enough. That would mean the biller is using the same exact system. But what about Single Point Management? Yes, control and transparency.

5. Low fees and what they mean

- A billing service should be charging only a percentage of what you collect from the insurance company—not on copays and deductibles. You want them to have all their incentive focused on getting the money you deserve from insurance companies. The average fee for this in chiropractic is between 6% and 10%. The number varies based on what your average collection per claim is. Anything lower is a big red flag. It means they are probably not going to follow up on every single claim and that they will just take the easy money. Since most of them have junk technology, you'll never really know.
- The low fee also tells you they are not investing in technology and are most likely using the system you already have and logging in remotely or using some other system. See #4 above. That's a deal breaker.
- Some billing services advertise a very low percentage, but then you find out it is a percentage of what you charge. Some of our clients actually want this for some reason, and we do it. However, you'd better make sure you have a way to see everything they have done on any claim and have a way to know they are following up on every single claim that needs it.
- Some charge a lower percentage but take a percentage of everything you collect, including cash, copays, and deductibles. Watch out for that one.
- Another pitfall of low fees is that no system (except Genesis) can track underpayments. So while they give you a low percentage, you never really see the income from your underpayments. They just do not have the technology or enough workers to go after that money for you. It could cost you tens of thousands of dollars per year. If you do not keep

insurance companies accountable, they will continue to take advantage, and it will only get worse.

Chapter 12

The 3 Biggest Mistakes when Choosing Software

Mistake #1: Rushing

I totally understand that most doctors get into the software search because they've finally hit a breaking point. They can't stand something about their software, and they want a quick fix. Maybe their software company got bought out or is going out of business.

It's a lot like what patients experience. They are in pain and just want a "crack," thinking that will solve their problem and prevent it in the future.

This is where you get taken advantage of. You get on a call with ChiroTouch, ChiroFusion, or Platinum, and they immediately jump to all the fancy features specific to the "pain" you came in with. They

show you a very low *price*, and your problems are solved—at least you think they are.

The cause of your real problem is still there. You have decreased collections, lower patient retention, less compliance, and your staff is still running to dozens of reports missing steps, losing patients—and you are managing by fire.

Switching systems is a decision you only want to make once. You don't want to rush. A mistake could cost you thousands of dollars. And even though you may be losing thousands per month, it is hard to justify spending more money. Switching systems is also draining on your team, so even if you switch and then realize you've made a mistake, it may be too much on your team to ask them to switch again anytime soon.

Lessons

1. Take your time. Look for solutions, not features, to your real business management problems.
2. Do not buy on *price* alone. Remember all the hidden costs that occur without automation and Single Point Management. They are real.

Mistake #2: Old Technology

Platinum, ChiroTouch, and others are built in a software language that is the equivalent of Sanskrit—ancient. It means they are limited to the functionalities of that language. Future improvements will be extremely limited.

Cloud-based systems have many advantages. The software language can be improved over time with no interruption to your system. It is like repairing a plane while you're flying it. Genesis literally has a completely different language now than when we started.

That means that new capabilities will be added, and you will

never realize it. It means better integrations with other technologies. It means your data are more secure (see the next chapter for more on this). Don't forget that it also means you are joining a network of doctors using data to beat insurance companies at their own game.

No cloud, no centralized data, no research.

Lesson

Go with the cloud and join a system like Genesis that is using collective data analytics to help the profession.

Mistake #3: Price vs. Cost

There is a huge difference between *price* and *cost*.

A flip phone's *price* is less, but the *cost* of not having a smart-phone is huge. A phone is just one of the many examples out there.

You get on a demo system, they show you a low price, you buy it, and it costs you for the rest of your career.

Proven return on investment (ROI)

Why don't they ask you about your practice—your goals, your dreams, your patient volume, your no-show rate, your reschedule rate, your accounts receivable numbers, your collections, your documentation time, your management hours? If they did, they could tell you how much your current solution is *costing* you, right? Then you would know what kind of return you would get on their *price*.

Software is not like a car. It is not an expense. It is more like a house, which is more of an asset. You should be able to calculate what your return will be if you buy it.

The reason you never hear this conversation is because other systems were never built for ROI. They were built for a quick sale. They

are not looking at before-and-after data across thousands of users, especially if they are not in the cloud, since that would be impossible. They simply could never tell you what your ROI would be.

Even a cloud-based system without Single Point Management could not give you an ROI. Any claims they make about improved collections and efficiency are anecdotal at best.

With Genesis' **Dream Practice Analysis**, we do just that. We look at where your practice is, and we can show you what the real *cost* of your current system is or another one you are considering.

- If your accounts receivable are high, retention is low, collections per visit are low—what is that *costing* you?
- How much time is your staff spending doing things that Genesis will automate? What is that *costing* you?
- A true *cost* of ownership is what you want. Slow down and take the time to do it.
- *Price* is a relative number and should always be looked at in the context of *cost*.

Lesson

Software should never *cost* you anything. You should get an ROI on your investment (the *price*). You should be looking for a software that can prove an ROI specific to your practice.

Chapter 13

What Software Companies Don't Want You to Know About Your Data Security and Liability

8 Secrets of Software Companies and the Truth You Need to Know

I have spent close to 14 years building cloud-based software for doctors. I was a pioneer in that area. Patient data security was always at the top of my list of concerns.

Many software companies have been spreading misinformation about data security and your level of exposure. I stop short of calling them lies because based on what I hear software companies saying, it is probably more a lack of knowledge and experience.

As a doctor, that bothers me. What if I had listened to them and then realized later how much they were actually costing me?

Here are eight facts software companies do not want you to know:

1. There are two types of systems

There are basically two types of software systems: client server and cloud- or Web-based.

- Client server means the server and data are stored in the doctor's office. Then other computers in that office connect to that internal server. All the computers and the server have to have software installed on them. The software needs to be updated on a regular basis. Examples are ChiroTouch and Platinum.
- Cloud- or Web-based means the server and data are stored in the cloud—or more accurately, stored on a server that is in a data center connected to the doctor's practice by the Internet. The software is also stored on those servers. You can think of it like the online version of QuickBooks. Genesis is a cloud-based product.

2. You still own your data if it is stored in the cloud

Here is where the misinformation starts. Client server software companies have been telling doctors that if their data are on a cloud server, they don't own them. There's no other way to say it—it is a big fat lie. You always own your own data. It doesn't matter where the server is.

3. You can access your data if you switch software companies

Of course you can. Client server companies have been telling clients just the opposite for years: "If you ever leave that company, you can't access your data again." It is a scare tactic—misinformation—for several reasons. First, if a company ever held your patient data and would not give you access to it, it would be illegal. By law,

cloud-based systems must store PHI (protected health information) for seven years (or whatever the legal requirement is for your state). Your ability to access data if and when you switch software companies is actually much better in the cloud. We'll look at that in more detail later.

If you are going to go with a cloud-based solution, you should make sure the company has extensive experience and a long track record. Do not choose a cloud-based company that just happens to pop up or a client server company that suddenly decides to build a cloud-based version of their product. Even though they seem similar, they are very different. I can tell you this based on 15 years of experience with cloud-based technology.

4. A cloud-based company cannot hold your data hostage if you leave

Maybe software companies are unaware of this, or maybe it's another case of misinformation. Or maybe they have no clue about running a business. But I have my own opinion. There are legal and contractual protections against exactly this. From that perspective, your data are more than safe should you decide to go with a cloud solution, assuming it spells that out in your agreement with them, which it should.

The truth is that we are all in business, so let's think about this pragmatically as well. Imagine what would happen from a PR standpoint if a cloud-based system withheld access to a former client's patient records. It just doesn't make sense. In the age of Twitter, Facebook, and other social media outlets, withholding access to a client's data for no real reason, legal or not, would be just plain stupid. Most cloud-based systems have a clause in their contracts that covers former clients who need to gain access to patient files.

Again, consider the alternative. You buy a new client server system. You use it for a few years. You decide to go in another direction. Maybe you choose to move to the cloud. Five years later, a patient has a legal case unrelated to your practice and requests records that

were on your old client server system from seven years ago. By law, you are required to provide them.

You go into the dark recesses of your office where your old server is. Hopefully, you still have a computer connected to the server. In any case, you haven't fired up either of those babies in five years. Who are you going to call? How will you get the records? What if the server doesn't even turn on?

If you don't have a computer hooked up to that computer, you'll need to do so. Will a new computer be compatible? In any case, it will need to have the software installed on it. If you don't have the software anymore, do you think that old software company will actually give you a license? What if they were bought out in the meantime? (By the way, there's a reason all those client server systems are getting bought out.)

5. My data are safest on the cloud

PHI data are some of the most valuable data on the black market. This is the question you should be asking: Where will a hacker most likely try to get that data? You might think it makes sense for them to go to a large data center where the most data are stored. But here is the correct answer: They will go where it is easiest to get the data.

6. We know the hardest place for a hacker to try to get data

My software is cloud-based, so our data are stored in a HIPAA-compliant data center similar to the data centers that store Wall Street information. The data center's security system requires biometric scanning just to enter the building. The power source to the center has diesel generator backups in case of a catastrophe. The data centers are among the first to receive diesel gas, even when there is a shortage and even before the gas stations get it. There is 24/7 security on site. Data security is their business, so the data center has the latest fire-wall protection measures in place and is constantly updating them.

It's like a Fort Knox for data. The connection from the doctor's office to the data center has the latest banking-level encryption required by law. Every keystroke is protected.

If you were a hacker, would that be the place you would go? Consider the alternative.

We have talked to doctors who were told that keeping their data in their own office was safer. Their office network does not likely have firewalls, and it is probably not updated on a regular basis. There are many holes in the system that a hacker could penetrate. For example, many of these systems tout online patient forms that send intake forms to the software. The problem is that it also leaves a big fat hole that a hacker can penetrate. If a software company finds a vulnerability in its system, how do they deploy a fix to protect your data? The only way is through a software update that would have to be performed manually at your office. Would they really be able to reach out to thousands of practices and make sure it is performed correctly? If I were a hacker, I would do a Google search for physicians in any given area and start hacking. They are the weakest, most vulnerable link.

7. You are liable if your data are stolen

You bet. Big time. If your data are stolen because of negligence (e.g., using software like one of these client server systems), the fines are all yours. That software company has zero liability. Even if they were liable, I would bet they have insurance against those types of claims. They will never feel it. But it *will* put you out of business.

One the other hand, with a cloud-based system, you have basically outsourced the liability since the system is entirely contained and HIPAA-compliant. If the data center gets hacked, you will most likely have zero liability. Cloud-based software companies typically carry hefty data security insurance policies.

What will it cost you if your data are stolen?

The fines are considerable. Remember, each patient record that is compromised, even if that patient has not been in your office for some time, counts as one occurrence. It is also based on *per occurrence* and *per year* you've had that patient record. So if you have a patient's data on file and you haven't seen that patient in seven years, that would count as *seven violations*. The minimum fine is \$100, and the maximum fine is \$50,000 for *each* violation (see details below).

There are 4 categories

CE stands for covered entity, which could be your office in the following cases:

Category 1: A violation that the CE was unaware of and could not have realistically avoided had a reasonable amount of care been taken to abide by HIPAA Rules

Category 2: A violation that the CE should have been aware of but could not have avoided even with a reasonable amount of care (but falling short of willful neglect of HIPAA Rules)

Category 3: A violation suffered as a direct result of willful neglect of HIPAA Rules in cases where an attempt has been made to correct the violation

Category 4: A violation of HIPAA Rules constituting willful neglect where no attempt has been made to correct the violation

Not sure which category these examples fall under? That's a great point. Guess what? You'll have to pay a lawyer just to figure that out and argue that point.

The fines

Category 1: Minimum fine of \$100 per violation up to \$50,000

Category 2: Minimum fine of \$1,000 per violation up to \$50,000

Category 3: Minimum fine of \$10,000 per violation up to \$50,000

Category 4: Minimum fine of \$50,000 per violation

Potential jail time

Tier 1: Reasonable cause or no knowledge of violation – up to 1 year in jail

Tier 2: Obtaining PHI under false pretenses – up to 5 years in jail

Tier 3: Obtaining PHI for personal gain or with malicious intent – up to 10 years in jail

Source: <http://www.hipaajournal.com/what-are-the-penalties-for-hipaa-violations-7096/>

8. The government *will* enforce these laws

There is a major misconception about this. In the early years of HIPAA, the government did not effectively enforce many HIPAA violations. It was a typical example of the government coming up with a great law but forgetting it would be only as good as their ability to enforce it. So they didn't for a while.

With the economic downturn and the lack of revenue, the government started getting creative. That, combined with the rise in data security awareness got the government's attention. Who better to recapture revenue from than rich doctors? The Obama administration hired private parties to find violations. These HIPAA mercenaries are paid a percentage of the penalty received by the government.

The tiers and categories were signed into law in 2009 by president Obama as part of the *American Recovery and Reinvestment Act*. That was in the very early days of his administration and may have been the first bill he signed.

Yes, the government will enforce these laws.

In Summary

1. Do you own your data if it is in the cloud? Yes, always.
2. Do you have access to your data in the cloud? Yes, always.
3. Is your data safer in the cloud? Yes, much safer.
4. Do you have more liability in the cloud? No, much less.

What Should You Do?

1. In my opinion, every practice owner should contact a HIPAA compliance attorney and request a referral to an insurance carrier that will cover you in case of a data breach.
2. Hire a data security company with experience in HIPAA compliance. Put a plan in place to fix issues you may have. That will go a long way to protect you from past and future violations.
3. Move to a more secure system in the cloud. Again, I am biased here, but there is a reason the biggest software providers are moving to the cloud as data security becomes a bigger concern.

***Disclaimer:** I am not an attorney, and this book should not be considered legal advice in any way. Always consult with your attorney for legal advice on these matters.*

Chapter 14

Software Support Pitfalls

Where Software Support and Training Go off the Rails

Software companies are notorious for overpromising and underdelivering. After you've paid for the software and start using it, you realize you're not getting the support you need.

At Genesis, we've identified what the problems really are:

- Having to stop your busy day and call the vendor every time you need support
- Wasting time on hold
- Leaving voicemails and sending emails that disappear into a black hole
- Forgetting that you sent the email or left a voicemail until days later when you need that problem solved again

- No way of knowing if someone is going to get back to you with an answer
- Getting their call when it's not convenient for you

What You Really Need

What you really need is help when and where you need it. Usually, that's in a specific part of the system. You need help relative to that problem in that part of the system. You don't want to search the entire help system just so you can find the answer you need. You need the answer to your specific question right then and right there.

What about new staff members? Who trains them? How often does that happen? You start on a system with the staff you have, and then you get a new team member. Who trains that person? Usually, the person who left is the person who knew the system the best. So how do you get the new staff member into the system and proficient in the system right then and there without you or someone else being responsible to train them?

Genesis provides consistent training. If we didn't, you wouldn't get the most out of the system. I hear this all the time about other systems: "I don't really use all of it. I don't really know all of it." This is an important concept. You need to be able to improve how you use the system over time, especially with Genesis. During the onboarding process, it's easy to get the basic training on Genesis, but there's so much more to Genesis. We make sure you get more and more out of the system as you go.

The Onboarding Phase

What data can be transferred from other systems? I get this question a lot, so it's worth taking a minute to go over it. Patient demographics—name, birthdate, phone numbers, email address, mailing address—can be exported from most other systems and uploaded to Genesis.

What cannot come over from other systems? The short of it is that data are stored differently in each system. They include billing and accounts receivable information (although you can add what the patient balance was in your old system), care plan data, images such as X-rays, and so on.

The key to getting really great support with Genesis starts in the beginning with the onboarding process. Transitioning to a new system is never easy. There's a lot that has to happen. Each new Genesis practice is assigned an onboarding manager who is dedicated to making sure everyone in the practice gets the training they need and that the practice is on track for the go-live date. Transitioning to Genesis usually takes six to eight weeks.

On the first video call, the onboarding manager reviews things like these:

- Practice style, goals, and the go-live date
- Generating logins for each staff member
- System setup such as appointment types, fee schedules, hours of operation
- Mapping out the training steps for each staff member
- Sending test insurance claims
- Applicable third-party integrations such as credit card processing
- Each staff member's required training tasks and how to use them

- Showing the owner/office manager how to track the staff's training progress
- Where to find help in the system and how to reach the support team
- The schedule for future onboarding calls

After the Onboarding Phase

Training tasks

Training tasks are role-specific for the practice, which means a CA's tasks are different from an office manager's tasks and a doctor's tasks. Each staff member gets a series of tasks, one at a time. Each task is on a specific part of Genesis they will need to know. The task contains a training video and other explanation content, if needed.

As staff members complete their training tasks, the Genesis team reviews them for accuracy and completion. If there are questions or corrections that need to be made, all of that is logged inside that specific task—sort of like a chat transcript. If screen-share training is needed on that task, there is a link the staff member can click on to schedule the session with the next available Genesis team member. That is a key step in the process that ensures everyone is “getting it” before the go-live date. In some cases, it also helps reassess if the go-live date is still realistic or needs to be adjusted.

You're starting to see how we've eliminated unnecessary phone calls and emails and improved results, accountability, and tracking.

Showing the owner or office manager how to track the staff's training tasks is the key step in transitioning to this new type of technology. In essence, this step is training the owner/office manager how to manage their staff using Single Point Management for everything in the practice moving forward.

New Staff Members

New staff training is vital to the ongoing success of a practice. Most software companies are unaware when a practice adds staff. At Genesis, we know exactly when that happens. In essence, we treat each new staff member the same way we did in the onboarding process. We proactively reach out and make sure their training tasks are mapped, ensuring a smooth transition to your office.

Keep in mind that since Single Point Management is sending them tasks anyway, they are well aware of the things they need to do every day in your office. All you and your staff have to do is teach them how you would like them to handle each type of task.

Many times, practice owners feel like they are held hostage by their current staff because one or two of them know everything about the software. If one of them were to leave, the practice would be in turmoil. The above ensures that will never happen again.

The Transition Phase

Everybody has a plan until they get hit.

—Mike Tyson

The onboarding and go-live steps are important, but we want practices to get the most out of Genesis. Since it is such a different way of using technology and the system is so advanced, there is always room to improve. In many ways, the onboarding process is like basic training. You have enough to be very dangerous. That's where most software companies leave you and where practices get hit with reality and need the most support. Not at Genesis. That is where the transition phase begins.

After a practice completes its onboarding phase training and they've gone live, Genesis still has an integration manager checking in with you on a weekly basis, scheduling meetings, screen sharing

with you and your team, and making sure you're still getting the most out of the system and applying it to the practice-specific needs.

Live in-person events

Nothing can replace in-person training. At Genesis, we offer in-office training, but for many practices, it is not cost-effective. Live training events bridge the gap and are much more cost-effective. There are no office distractions, just focused hands-on training in a classroom setting.

We realize that many providers are very busy. They have their personal life, their practice, and their travel to events for continuing education and motivation. Adding another seminar, while it is important, can be overwhelming. Many times, Genesis will have a live training event right before or after another seminar that doctors like to attend. ChiroFEST is one example. Genesis clients come a day early for our training event and then stay for ChiroFEST to get the motivation they need—all in one trip.

Live trainings are usually topic-specific with some added time for open questions and answers.

Contextual help

One great way Genesis supports its clients is with what we call contextual help. It's really frustrating to open a task, make a phone call, or send an email every time you have a question about the system. So we've eliminated phone calls. We've eliminated emails that are not accountable. We don't want you to wait on hold or leave voicemails that may never be answered.

When a practice does leave a voicemail or sends an email to Genesis, it automatically opens a support task to the Genesis support team. Genesis clients can see that support task inside their account,

so they can be sure we got it. The Genesis team will reply inside the task and include a screen share scheduling link in the task in case the practice needs further clarification.

The practice should be able to find the answer to their question from the part of the system they are in. That means they do not have to go to a general help page and type in their question. If they are using the scheduler and have a question, they are able to get an answer on the scheduler screen. That is where contextual help comes in. That means the help is in the context of the part of the system you are in.

How does that work? When a practice is on the schedule, for example, they see a ? (question mark) symbol. When they click on it, that opens all the support and training content specifically for the schedule, including best practices documentation, videos, and tutorials. In most cases, the answer to the question is right there.

Day-to-day support

Phone calls are useful when there is an emergency such as *I can't log in to Genesis*. But if every Genesis client called for every little question, at some point, everyone would be waiting on hold. We ask our clients to make a call only in case of an emergency.

But I want to talk to a person

No problem. The above comment does not mean clients can't talk to a live person. It means we want to avoid aggravation for clients and triage their questions. When a practice opens a support task with a question, they get an answer quickly in most cases. If the answer is not sufficient, they can click on a link and schedule a time that is best for them for a one-on-one support call. No more emails, no more waiting on hold. Problem solved.

HIPAA Compliance

Another really important reason to open a task rather than send an email is HIPAA compliance. Sending an email about a patient in your practice is a big no-no. Since Genesis is on the cloud, we can actually see your practice and the patient you are referring to when you open a support task inside of Genesis. When a practice opens a support task, they can tie that question to a specific patient so the support team can provide the correct answer for that specific patient. Genesis is fully ONC-certified and HIPAA-compliant. That's another problem solved and a tremendous liability avoided.

Facebook

We created a Genesis Nation private Facebook group for Genesis clients only. Here, Genesis shares new features, best practices, and updates. Genesis clients can ask each other questions and collaborate. Many times, this is where we learn about new feature requests and ideas from clients so we can improve Genesis.

What If I Am Not Satisfied with Support?

Inside each task, there is a rating option. If a client is not happy with support, they can give it a low rating. That alerts the entire Genesis organization. This type of feedback is vital to the ongoing improvement of the Genesis support team, processes, and materials. We strongly encourage it.

We also use something called a Net Promoter Score (NPS). It's a research-based way to get customer feedback. The theory is that the best way to determine if a customer is happy with the service is to ask a standard question—*Based on your interaction today, how likely are you to recommend us to your friends on a scale of 1 to 10?* If it is not a 9 or a 10, we follow up with this: *What can we do or could*

we have done to make it a 10? You can use this system with patients, too. Since we've implemented NPS, our support procedures have improved drastically. Of course if it's a 10, we'll ask who you want to refer to Genesis.

Getting Started with Genesis

Ideally, by now you see how Genesis could save you and your team a tremendous amount of time and how it can improve your collections, patient retention, and compliance.

We can actually prove the results you would get if you decided to switch to the Genesis Network. But how? We have real data across thousands of users and have been comparing before and after case studies. We've built a very robust opportunity analysis that allows you to see the *real cost* of your current solutions or the *cost* you would incur by switching to one of the other popular systems on the market today.

We call this analysis the Dream Practice Analysis. When you schedule a time with one of our product consultants, they will:

1. Do a quick review of Single Point Management in Genesis and show you how that works.
2. Show you some other features and functionalities of Genesis.
3. Capture some of your practice statistics for the Dream Practice Analysis.
4. Discuss product options and pricing designed specifically for your practice.

Genesis is not a fit for every practice. We only look to build long-term mutually beneficial relationships. Hopefully, we are a match for your practice. If so, our consultant can send you an agreement, which you can sign digitally in seconds, and you can start the onboarding process discussed in the earlier chapter.

If you are serious about improving your collections, patient retention, compliance, and staff productivity, and if you are ready to gain unprecedented freedom, click the link below and you can immediately schedule a screen share time with us.

*Go to www.GenesisChiropracticSoftware.com to schedule now.
Click on the bottom of the page.*

Contacting the Author

You can always reach me by email at
drbrian@GenesisChiropracticSoftware.com
or call Genesis at 877-601-5986.