

NCDS *update*

A Billing Industry Newsletter for Clients

Keeping your office up-to-date on industry and insurance changes, late-breaking billing & reimbursement news, and general inter-office communication...

THE RFI – THE MOST MISUNDERSTOOD REPORT FROM NCDS

NCDS STAFF PROVIDES EXCLUSIVE TIPS AND TRICKS FOR HANDLING AND MINIMIZING THIS REPORT

RFI

The Origin - The RFI is short for Request For Information. This report was developed over a decade ago to streamline the communication between NCDS and your office staff when billing information is incomplete or additional information is required.

How It Benefits Your Practice – Not every claim can be billed out with just the information provided on the billing sheet. The reasons for NCDS sending you an RFI are numerous, but the bottom line is that providing the requested information to our office allows us to bill your claim correctly, and that process translates to payment to your practice.

The Details – The RFI gives you an itemized listing by patient and service date with a description of the problem and what is being requested. It can be anything from medical

records, notes, an additional CPT code, patient insurance information, etc. It is important to remember that your claim cannot be billed until this information is received; electing to not complete or return the RFI is synonymous with rendering services to patients for free!

RFI's are generated for one of two reasons:

DID YOU KNOW ?

1. Bad patient demographics
2. Incomplete encounter forms

How can this information be bad? Lazy patients can make more work for you. If fields on a registration are incomplete or if the insurance ID card he/she supplies is old, expired, no longer valid, these are all reasons RFI's get generated. Patients that feel inconvenienced by completing a new form every year only inconvenience you when their information is outdated.

Insurance companies make it more and more difficult every day to get your claims paid. When a billing sheet lacks information that only increases the delay in your payment. Additionally, insurance companies are constantly changing the amount of information they require submitted with a patient's treatment. Taking a few minutes at the end of every day to review the billing sheets before scanning them to NCDS can save you hours of time completing the RFI. We know the RFI can be an inconvenience for you, but it is the only way we are able to get the information necessary to get that claim to the insurance, and get payment to your practice.

**REMEMBER, AN RFI DELAYED IS A PAYMENT DELAYED!
MANY OTHER BILLING OFFICE OVERLOOK THESE DETAILS,
BUT WITH NCDS, NOTHING SLIPS THROUGH THE CRACKS!**

HOW TO MINIMIZE YOUR RFI

Now that you know more about the RFI, its use and the process, please review the best ways to avoid getting an RFI. Below we have compiled a list of helpful tips from our Processing Department and Client Services Department managers; the two departments at NCDS that generate the bulk of the RFIs that find their way to your office. These tips are taken directly from items frequently found on the RFI and can be avoided! If these tips are followed, it will reduce and potentially eliminate RFI reports to your office. Please feel free to contact Betsy or Susan at our office for assistance in refining your internal process with the RFI.

RFI TIPS AND BEST PRACTICES:

- If any of the patient's information has changed REQUIRE the patient to complete an updated Patient Registration.
- This should be done at the start of every calendar year with every patient as a policy to ensure patient information is current. Changes are easy to forget over a year's time.
- Review the registration after a patient completes it. If any fields are left blank return it to the patient and request they complete all of the information.
- Take a moment to look at the ID card the patient has provided to you to ensure it is current. Patients that supply bad insurance information is the #1 delay in payment.
- Scan patient registrations and encounter forms/ billing sheets/ treatment sheets on the same day and time.
- Put the patient's birth date on billing sheet. This removes any confusion when there are two patients with the same name.
- Make sure the patient's name is written on payment log sheets, not the person on the check. If you don't know who is making the payment when it is received, neither do we.
- Double check ALL billing sheets before scanning them to make sure they have a diagnosis and CPT code marked.
- If a medication is administered to the patient make sure the name of the drug, dosage and NDC code are listed.
- For all BWC claims notes should be sent with the billing sheet.
- For SELF PAY billings, review the billing sheet to ensure a price is marked for billing and always collect payment when the patient is seen!
- Make sure the patient's name & birthdate are legible.
- Make sure the date of service is marked on the billing sheet.
- SCAN DAILY

Keep in mind that the best opportunity to get the information from the patient is when he or she is standing in front of you. This opportunity to get additional information, a copy of the insurance card, or a payment for services is greatly reduced and sometimes eliminated once that patient walks out the door.

Also, please remember NCDS does not want to generate these RFIs to you. By sharing this information with you and we hope to streamline the process for your office staff which can only expedite payment to you!



MILLIONS UNINSURED ON PATCHWORK MEDICAID EXPANSION MAP

BY: JENNIFER LUBELL, AMEDNEWS STAFF

Washington -- As most states wrapped up their 2013 legislative sessions, many of them closed the door on their most likely opportunities to expand Medicaid under an optional provision of the Affordable Care Act. When time expired on those sessions, more than half the states were on track to reject the expansion, at least for its first year. Still, it's possible that a few states may decide to revisit the issue before the scheduled start of Medicaid expansion in 2014. "I don't think this map is settled" on state actions to expand Medicaid, said Caroline Pearson, a vice president at Washington consultant Avalere Health LLC. "In theory, you could see some states take this up again in the fall."

The Affordable Care Act promises an enhanced federal match rate to cover additional coverage costs for any state that expands eligibility for its Medicaid program up to an effective rate of 138% of the poverty level. For the first three years of expansion, the federal government would cover all costs of caring for the newly eligible, with states eventually taking on up to 10% of expansion costs. But many states aren't taking the deal. According to the most recent projections by Avalere Health at this article's deadline, 26 states won't expand their Medicaid programs in 2014. These are the 19 states that have rejected expansion an additional seven that are leaning against it.

If this projection holds true in 2014, it means that 5.3 million fewer low-income people will gain access to this public insurance option. "Of those, 3.4 million will remain uninsured; the rest will qualify for exchange subsidies," Avalere's analysis stated. The subsidies refer to funds available to individuals earning between 100% and 400% of poverty who would be eligible to apply for federal premium tax credits to buy coverage from state insurance marketplaces — although the subsidies are no guarantee that all of them will take up coverage.

Twenty-two states and the District of Columbia are expanding Medicaid, and an additional two are leaning toward expansion. As a result, Avalere expects that Medicaid enrollment will increase by 5.5 million people in the first year.

The projections reveal just how divided the nation is on this ACA provision, as well as how diverse physician opinions on the issue have been. In Kentucky, which recently joined the pool of expansion states, the governor predicted significant financial benefits for the state. At least 300,000 more constituents will obtain coverage, announced Gov. Steve Beshear, a Democrat, in early May. Expansion also will "dramatically improve the state's health, create nearly 17,000 new jobs and have a \$15.6 billion positive economic impact on the state" between fiscal 2014 and 2021, when the expansion is fully implemented, according to a statement from Beshear's office.



Although Kentucky GOP lawmakers oppose the plan, Kerri Richardson, the governor's communications director, said Beshear might try to revise Medicaid eligibility rules on his own. "Legislative committees review new or amended regulations, and may accept or reject them under certain circumstances. However, the governor may then choose to implement those regulations" over objections by those committees, she said. Mississippi, on the other hand, remains one of the firm holdouts among the nonexpansion states. Instead of seeing it as a cost-saver, Republican Gov. Phil Bryant maintains that any expansion of Medicaid "would result in tax increases for Mississippians or cuts to critical spending in areas like education, public safety and economic development," said Mick Bullock, the governor's communications director and press secretary.

In Florida, Democratic lawmakers have been pressuring GOP Gov. Rick Scott to call a special session to revisit Medicaid expansion after state House and Senate lawmakers failed to agree on the issue. This outcome leaves "more than 1 million uninsured Floridians in the lurch," while threatening the state's businesses with \$150 million in fines under the ACA employer coverage mandate, the state Senate's Democratic Caucus wrote in a May 6 letter to Scott.

Percentage of health professionals accepting Medicaid	
Five richest cities	
Washington	31%
San Francisco	36%
San Diego	42%
Seattle	47%
San Jose, CA	51%
Average rate	41%
Percentage of health professionals accepting Medicaid	
Five poorest cities	
Detroit	31%
Philadelphia	42%
Baltimore	44%
Indianapolis	53%
Memphis, Tenn.	54%
Average rate	44%

Some states are pursuing alternatives to traditional expansion, such as Arkansas, which recently enacted a plan to expand Medicaid using a premium assistance model. Under this plan, Medicaid would pay to enroll new eligibles in private exchange plans that follow Medicaid cost-sharing and benefits rules, Pearson said. The Centers for Medicare & Medicaid Services has indicated that it would be willing to work with Arkansas and other interested states to authorize this type of model, most likely through the Medicaid waiver process, she said.

Some states that expand traditional Medicaid are going to see an enrollment surge that strains the network of doctors who do take Medicaid, she said, especially in states that see major program growth in the initial years. A recent analysis from HealthPocket Inc., a website that ranks and compares health plans, said health professionals reported low acceptance rates of Medicaid patients. Expansion might give more individuals insurance cards, but that might not translate into seeing a physician.

"If the current Medicaid acceptance rates hold true for 2014, timely access to care for those relying on Medicaid is likely to become more difficult as enrollees increase for an already inadequate pool of doctors," said Kev Coleman, HealthPocket's head of research and data.

For the complete article please visit the following website:
<http://www.amednews.com/article/20130520/government/130529985/2/>

FRAUD RECOVERIES ON THE RISE

BY: STEPHANIE BOUCHARD, HEALTHCARE FINANCE NEWS

GlaxoSmithKline, \$3 billion. Abbott Laboratories, \$1.5 billion. Merck, \$950 million. Senior Care Action Network, \$323.7 million. Actavis, \$202.6 million. The numbers are eye-popping. Now for the jaw drop: of these top five healthcare False Claims Act settlements in 2012, all were initiated by whistle-blowers.

The healthcare industry is on notice: Fraud recoveries in the healthcare sector are on the rise and whistle-blowers are the biggest weapon in the fight against fraud. "We think it's very effective," said Charles Miller, a spokesperson at the Justice Department. "Whistle-blowers have been a major factor in helping the government curtail – or at least recoup – funds that were gained through fraud and abuse."

The year 2012 was a record-setting year for healthcare fraud recoveries, according to the Department of Justice (DOJ). Recoveries under the False Claims Act topped \$3 billion, bringing the four-year federal recovery total to more than \$9.5 billion.

Fraud cases in healthcare are on the rise because fraud is the industry's core business practice, said Patrick Burns, the co-director of Taxpayers Against Fraud (TAF). Healthcare is a commodity, Burns said, and while commodity pricing is generally a "race for the basement," that's not the case in healthcare. In healthcare, he said, it's a race to the ceiling. "The primary product of the healthcare field – whether it's hospitals, drugs, or services – is not providing healthcare. It's billing," Burns said. "The competitive advantage in healthcare isn't that you have a better product. There are multiple ways that you can increase the billing. For example – in a world in which you have five, six or seven perfectly good statins, which one do you write a prescription for? The answer is the one [from the drug company] paying you the money. That's a kickback. ... This is how it goes. How much does it cost us? Billions and billions and billions of dollars."

Amendments to the False Claims Act strengthening qui tam provisions, and a focus by the federal government on combating fraud and abuse in the Medicare and Medicaid programs, have contributed to the growth in whistle-blower cases.

Because of their size and the nature of their payment programs, Medicare and Medicaid are vulnerable to abuse, and those vulnerabilities lead many people to take advantage, said Colette Matzkie, a lawyer who represents whistle-blowers for law firm Phillips & Cohen in Washington, D.C.

"There's an increasing awareness, both in Congress and in the administration, that there's a lot of money – billions of dollars – lost to fraud within the Medicare and Medicaid programs," she said.

To read the complete article please visit the following link: <http://www.healthcarefinancenews.com/news/fraud-recoveries-rise?page=1>



HOT TOPICS IN COMPLIANCE

ICD-10: READY OR NOT, IT'S COMING

Providers have become very comfortable using the traditional ICD-9 codes and that will soon be coming to an end. With the upcoming implementation of ICD-10 providers will need to be vigilant in their own self-education. ICD-10 will change codes you are used to, delete and replace others, and form a dozen new, more specific codes for a condition you used to only use one diagnosis in the past. Submitting correct claims will start with you as the provider. NCDS cannot emphasize enough to our valued clients how important it is to embrace and educate yourself on the changes that will be coming with ICD-10; your revenue will depend on it.



AUDITS AND PENALTIES:

Providers need to be aware that the government has placed the burden of proof on the provider. Physicians need to be increasingly aware of the laws and regulations, obtain the correct patient demographics and insurance information from the patient being treated, verify insurance eligibility and thoroughly document each and every patient visit. As the government has become strained for revenue to fund new healthcare programs, provider audits have yielded copious amounts of money due to inadequate documentation by the provider. Coming in 2014, Medicare will penalize providers that bill the wrong Medicare MCO, following the principle that it is the provider's responsibility to know what coverage a patient has prior to submitting the claim.

NEW SCANNING REQUIREMENTS TO BE IMPLEMENTED

As part of the ongoing compliance process it is necessary for NCDS to require more information to be sent with the patient demographic scans received from your office. As an ongoing effort to ensure claims are billed out correctly every time, we will now be requiring the following information with EVERY patient insurance card that is scanned:

- Patient Name
- Effective Date of that Insurance
- Whether that insurance is Primary or Secondary

Why is this information required: By adding this information your practice will be documenting each insurance card with the required details for compliance. Extensive research by NCDS has determined that numerous denials and RFIs can be avoided by including these three key pieces of information. These easy additions to your insurance ID card scans will also assist our staff in correctly billing your claims without added calls to the insurance or inconvenience to your patients, which also will reduce the number of RFIs you receive for patient insurance and demographic issues!

Patients often have insurance on file when we receive an updated insurance card. When it is received without the effective date or Primary/Secondary distinction, we do not know if this replaces the existing insurance or if it should be added as the secondary insurance. We also do not know how long this new insurance has been effective. An insurance card received without an effective date leads to a number of questions on the patient's account. Does this card apply to prior claims that have already been billed? Does it apply to just this claim? Should claims be rebilled?

The addition of this information should take no extra time by your staff but will greatly improve the billing process for your practice!

NCDS PROVIDER POLL: DO YOU USE SOCIAL MEDIA WITH YOUR PATIENTS?

Social media has penetrated our lives and it is clear that it is here to stay. NCDS wants to know, do you communicate with patients via social media outlets? Numerous articles are available regarding social media and the roles they play in medical practices and we would like to know if our providers utilize these avenues with their patients. Please email info@ncdsinc.com and let us know how you connect!

