January – February 2014

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...

Forgiving Patient Copays Can Lead to Unforgiving Consequences

By: Martin Merritt, PhysicianPractice.com

At one time in America, there was no such thing as "health insurance." Patients negotiated directly with hospitals and doctors, and paid what they could, often on a sliding scale, according to ability. Eventually, health insurance entered the market, easing the burden of healthcare costs. It didn't take long to realize the ordinary rules of supply and demand would not apply, if the insurance company, not the patient, was responsible for the bill. Copayments, deductibles, and coinsurance developed as a check against overutilization. If the patient had some "skin" in the game, this would provide some disincentive, though not absolute, but some hedge against over-use. This protective requirement, though necessary, is at times at odds with AMA Code of Ethics Opinion 8.03, which holds: "The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."

In the current economy, as available dollars are becoming scarce, insurance carriers have begun checking up on the collection of copayments, deductibles, and coinsurance. With greater regularity, physicians and hospitals are receiving letters requesting proof, in perhaps five randomly selected cases, that the provider has collected, or sufficiently attempted to collect the portion of fees which is the patient's responsibility. This comes as a shock to many providers, who in keeping with Opinion 8.03, and the historical tradition of sliding scales, based upon ability to pay, have subordinated financial ability to pay in favor of the higher duty to care for the patient's need.

It is important to understand, however, forgiveness of copayments could land you in hot water. Therefore, doctors must understand the rules regarding waiver of copayments. AMA Opinion 6.12 addresses the ethical considerations: Opinion 6.12 - Forgiveness or Waiver of Insurance Copayments Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through copayments. By imposing copayments for office visits and other medical services, insurers hope to discourage unnecessary healthcare. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a copayment for the care. Physicians commonly forgive or waive copayments to facilitate patient access to needed medical care. When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment. A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer's payment but waive the copayment for all patients.

Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers.

Where the insurance contract requires a doctor to make reasonable attempts to collect the patient's portion, an open question surrounds the definition of "reasonable attempts to collect the debt." Historically, doctors could satisfy the requirement by sending at least three letters attempting to collect the debt. However, the Office of Inspector General (OIG) has taken the position that **the routine waiver of copayments could constitute a criminal kickback in Medicare cases.** This has emboldened private insurers, who are relying upon this contractual provision as a basis for a post-payment recoupment audit. **If a provider cannot demonstrate efforts to collect from the patient, the carrier may demand a refund for any benefits paid across a large patient population.**

Providers should be aware of this new emphasis upon patient responsibility. My advice would be to proactively get ahead of the problem. Contact your insurance representative to find out what is expected of you and document the response. By all means, if you are a physician and you receive a letter from an insurance carrier requesting proof of attempts to collect, do not ignore it. A failure to cooperate could constitute grounds for termination of the contract with the payer.

Because this emphasis upon collection of copayments is a fairly recent phenomenon, even if you have been deficient in the past, you may be able to satisfy the carrier by demonstrating a corrective plan of action going forward.

For more information on this article please visit: http://www.physicianspractice.com/blog/forgiving-patient-copays-can-lead-unforgiving-consequences?GUID=330817E2-F2AD-4C5E-A8DE-8050631E0F2F&rememberme=1&ts=20122013

Featured App: Readdle's Scanner Pro

As more and more providers operate using laptops, smartphones, iPhones and iPads NCDS wanted to keep providers aware of technology that improves the business process (and helps to make the billing process just a little bit easier!). This issue we are featuring Readdle's Scanner Pro. This incredible app scans and saves a digital version of a paper document, white board, note, etc., turning your iPhone or iPad into a portable scanner and the document into a pdf file. Scanner Pro utilizes edge detection to find the edges of the document being captured then adjusts and modifies the page for professional presentation. You can download it today from the App Store or by visiting apple.com.

Lawmakers Continue to Negotiate SGR 'Doc Fix'

Washington Report, HBMA

The HBMA Government Relations Committee has been closely monitoring Congressional efforts to repeal/replace the Sustainable Growth Rate (SGR) formula. On Thursday afternoon (2/6) the House Ways and Means Committee, House Energy and Commerce Committee, and Senate Finance Committee leadership introduced a bi-partisan/bi-cameral bill to repeal and replace the Medicare Sustainable Growth Rate (SGR) formula. The Congressional sponsors have provided a section-by-section summary for your review. In addition to formally repealing the SGR, the bill:

- Provides for annual automatic payment updates of 0.5% for five years (2014 – 2018)
- Discontinues automatic updates for 5 years, beginning in 2018
- Consolidates the three existing Medicare quality programs into a single value-based incentive the Merit-based Incentive Payment (MIP) Program
- Provides for increased Medicare payments based upon score on a (MIP), beginning in 2018
- Would resume annual automatic updates beginning in 2024. All providers would receive an update, but the amount of the automatic update would vary from .5% to 1%
- Provides incentives, such as a 5% bonus to providers who receive a significant portion of their revenue from an APM, for providers to switch to alternative payment models (APMs)
- Expands the availability of Medicare data to patients and certain qualified entities

While this framework agreement is encouraging, and represents significant progress on repealing and replacing the much maligned SGR formula, none of the sponsors of the legislation has formally provided any information on how they propose to pay for this fix. Although official estimates have not been finalized, preliminary estimates appear to put the cost of this proposal somewhere in the neighborhood of $120 - $130 Billion over 10 years.

This means that before the bill can be voted upon, the sponsors must identify savings or new revenue of a comparable amount.

Several Congressional offices expressed considerable disappointment that the so-called Extenders were not included in this proposal. They indicated that they intend to continue pushing House and Senate leaders to include the Extenders in the final package. They noted that because the budgetary offsets have not been finalized, an opportunity to include the Extenders is possible if they can find the money necessary to pay for the extensions.

Perspective and Insight from NCDS:

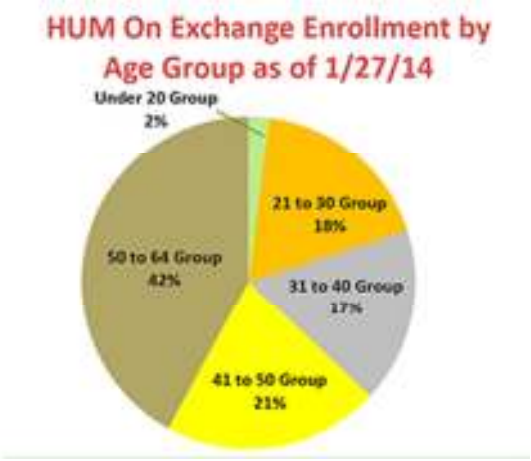
The SGR is the rate that Medicare uses to control rising costs. This rate means that the amount Medicare pays physicians for an average Medicare patient can't increase faster than the economy as a whole, but it is flawed. In recent years the American economy has experienced a substantial downturn, coupled with the upturn of healthcare costs and expenditures. In 2002 cuts were made to physician reimbursement and each subsequent year cuts loomed until Congress passed measures for a temporary fix. Because of these temporary fixes, an even greater mess has been created, requiring either a cut in reimbursement upwards of 40%, or a complete overhaul of the process that is used to calculate the reimbursement levels for physicians. Given the rising cost of healthcare, and the number of years this 'fix' has been delayed, any of the above solutions will be very costly to taxpaying Americans. However, a much needed fix will prevent threatened cuts to physician Medicare reimbursement each year.

Humana ACA Enrollees Younger than Expected

By: Jay Hancock, KaiserHealthNews.org

Here's more fodder for the debate over whether older, sicker members will swamp insurance plans created by the Affordable Care Act. Insurers have wondered whether enough younger, healthier "invincibles" would sign up through online exchanges to subsidize folks with poorer health. The worry was that, without their premiums, expenses for older folks would drive up average costs and make plans less affordable.

"While still early, as we analyze the demographics of our exchange membership, we are seeing enrollees skewing a bit more to the younger side," Humana CEO Bruce Broussard told stock analysts on a Wednesday conference call.



Source: Humana (based on Humana internal sales reports)

About 35 percent of those who enrolled by the end of January were between 21 and 40, Humana said. That's still below the portion of consumers that age in the general population. About 82 percent of Humana's new members are getting federal tax credits to help pay the premiums, Broussard said — many of them probably younger and with lower incomes.

More than 200,000 people had applied to Humana plans offered through the exchanges by the end of January, the company said.

The proportion of Humana's younger exchange applicants has been slightly rising with time, bolstering arguments that younger consumers would wait to sign up until software in the online marketplaces was working well.

Last week WellPoint reported it had received about 500,000 applications for individual policies sold through the exchanges. Members were generally older than the general population, but not more than expected, WellPoint said.

For more information please visit: http://capsules.kaiserhealthnews.org/index.php/2014/02/humana-aca-members-younger-than-expected/

CMS to Release Physician Pay Data

HFMA, January 14, 2013

Medicare officials said they plan to begin releasing details of what the program pays physicians in a couple months. The U.S. Department of Health and Human Services (HHS) will begin releasing information on payments to individual physicians upon request and will publish aggregate data sets about physician pay.

The planned payment data release followed a 2013 federal judge's decision to strike down a decades-old ban on releasing Medicare physician data due to privacy concerns. The judge ruled privacy concerns were secondary to the public interest of disclosing payment data. Such data could fuel examinations of Medicare waste and fraud.

HHS officials said the disclosures would come through individual Freedom of Information Act requests for physician pay data. The agency plans to use a "balancing test" to determine which information should be released, according to a final rule detailing how the disclosures will occur.

"As [the Centers for Medicare & Medicaid Services (CMS)] makes a determination about how and when to disclose any information on a physician's Medicare payment, we intend to consider the importance of protecting physicians' privacy and ensuring the accuracy of any data released as well as appropriate protections to limit potential misuse of the information," Johnathan Blum, deputy administrator of CMS, said in a Tuesday blog post.

The new policy came on the heels of other CMS efforts to increase public access to health data through www.healthdata.gov, which include newly available statistics on Medicare spending, utilization, and quality.

In May 2013, CMS released information on the average charges for the 100 most common inpatient services at more than 3,000 hospitals nationwide.

In June 2013, CMS released average charges for 30 selected outpatient procedures.

For the complete article please visit: http://www.hfma.org/Content.aspx?id=21244&utm_source=Real

A Glimpse at Patient Responsibility Under Some Obamacare Exchange Plans

Self-Pay Snapshot for Insurance Exchange Plans

	Average for a Bronze Plan	Average for a Silver Plan	Average for a Gold Plan	Average for a Platinum Plan
Deductible for an individual	$5,081	$2,907	$1,277	$347
Deductible for a family	$10,386	$6,078	$2,846	$698
Physician visit	30% of physician visit expense charged to patient as coinsurance fee	$32	$24	$16
Specialist visit	30% of specialist visit expense charged to patient as coinsurance fee	$56	$46	$30
Annual cap on out-of-pocket costs for individual	$6,267	$5,730	$4,081	$1,855
Annual cap on out-of-pocket costs for family	$12,569	$11,495	$8,649	$3,710

Source: HealthPocket.com. Used with permission.

Out-of-pocket caps apply to covered medical services from in-network healthcare providers. Nonemergency services provided outside of a health plan's network can result in higher out-of-pocket costs, and annual caps do not apply.

Please be aware of the substantial out-of-pocket expense for some of the average programs under the new insurance exchange. Patients with these plans will owe a balance so remember to collect a payment up front when the patient is present for the appointment!

Highlights of Major Code Set Differences

ICD-9-CM	ICD-10-CM
Codes are 3 to 5 characters in length	Codes are 3 to 7 characters in length
First digit may be alpha (E or V) or numeric. Digits 2 through 5 are numeric.	Digit 1 is alpha, digits 2 and 3 are numeric, and digits 4 through 7 are alpha or numeric.
Lacks laterality	Codes include laterality (e.g. codes identifying right versus left)
Excludes notes may indicate mutually exclusive conditions, or conditions that are included in other codes or categories elsewhere	ICD-10 uses Excludes 1 and Excludes 2 notations. Excludes 1 is for mutually exclusive codes, and Excludes 2 means "not included here."

Source: American Medical Association

2014 Medicare Physician Fee Schedule

CGS, Ohio's Medicare Part B provider, has compiled the 2014 Physician Medicare Fee Schedule. This is a comprehensive listing by CPT code that includes the Participating and Non-Participating fee schedules. While this list is only valid through 3/31/14 (unless the SGR fix is implemented) it is a very thorough and comprehensive compilation of provider fees.

To view the 2014 Fee Schedule Spreadsheet please follow the link:

http://www.osma.org/files/documents/news-articles/2014-medicare-fee-schedule-physician.pdf

Additionally, another resource provided by CGS allows providers to look up a specific code to display the fee schedule for 2013/2014. NCDS encourages providers to bookmark this page for easy website access:

http://www.cgsmedicare.com/ohb/coverage/fees/fees.html

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