Medicare for 2010: Deductibles and Premiums Update

Medicare is a federal health insurance program created in 1965 for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare Part A – 99% of patients don’t pay a premium for Part A (hospital insurance) because they or a spouse already paid for it through their payroll taxes while working. The $1,100 deductible for 2010, paid by the beneficiary when admitted as a hospital inpatient, is an increase from 2009. Part A helps cover:

- inpatient care in hospitals (excluding the physician fees), including critical access hospitals
- skilled nursing facilities (not custodial or long-term care)
- some hospice care
- some home health care

Medicare Part B – Part B (outpatient/doctor insurance) base premium for 2010: $96.40/month (no change from 2009.) Premiums are higher for single people over 65 making more than
$85K per year and for couples making over $170K. Part B premiums cover approximately one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general revenues. In 2010, the Part B deductible is $155. Part B helps cover:

- physician fees in the hospital
- physician fees in their offices and other outpatient locations
- other outpatient services (x-rays, lab services)
- some services of physical and occupational therapists
- some home health care

**Medicare Part C** – Medicare now offers beneficiaries the option to have care paid for through private insurance plans. These private insurance options are part of Medicare Part C, which was previously known as Medicare+Choice, and is now called Medicare Advantage. Medicare Advantage expands options for receiving Medicare coverage through a variety of private insurance plans, including private fee-for-service (PFFS) plans, local health maintenance organizations (HMOs) and regional preferred provider organizations (PPOs), and through new mechanisms such as medical savings accounts (MSAs), as well as adding payment for additional services not covered under Part A or B.

**Medicare Part D** – Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. The so-called “doughnut hole” is the amount the patient pays between the initial coverage limit of $2,830 and the out-of-pocket threshold of $4,550 – a total of $1720 that the patient is responsible for.

- **Initial Deductible:** $310
- **Initial Coverage Limit:** $2,830
- **Out-of-Pocket Threshold:** $4,550
COMPARISON OF MEDICARE PLANS

Original Medicare Plan

WHAT? The traditional pay-per-visit (also called fee-for-service) arrangement available nationwide.

HOW? Providers can choose to participate (“par”) or not participate (“non-par”). Participating providers accept the Medicare allowable and collect co-insurance (20% of the allowable.) Reimbursement comes to the providers. Non-participating providers may charge 15% more (called the “limiting” charge) than the Medicare allowable schedule, but the patient will receive the check, which is why some non-par practices require payment at time of service for Medicare patients. To be able to charge patients for non-covered services, patients must sign an ABN before the service is provided.

Original Medicare Plan With Supplemental Medigap Policy

WHAT? The Original Medicare Plan plus one of up to ten standardized Medicare supplemental insurance policies (also called Medigap insurance) available through private companies.

HOW? Medigap plans may cover Medicare deductibles and co-insurance, but typically will not cover anything Medicare will not. Medicare primary claims will “cross-over” to many Medigap secondary claims so the practice does not have to file the secondary Medigap claim. Patients may still have a small balance that is cost-prohibitive to bill for.
Medicare Coordinated Care Plan

WHAT? A Medicare approved network of doctors, hospitals, and other health care providers that agrees to give care in return for a set monthly payment from Medicare. A coordinated care plan may be any of the following: a Health Maintenance Organization (HMO), Provider Sponsored Organization (PSO), local or regional Preferred Provider Organization (PPO), or a Health Maintenance Organization (HMO) with a Point of Service Option (POS).

HOW? You have to have signed a contract or be grandfathered in (called an “all-products” clause) under an existing contract to see patients and get paid. Primary care providers may have to provide referrals and/or authorization for specialty services and providers. A PPO or a POS plan usually provides out of network benefits for patients for an extra out-of-pocket cost.

Private Fee-For-Service Plan (PFFS)

WHAT? A Medicare-approved private insurance plan. Medicare pays the plan a premium for Medicare-covered services. A PFFS Plan provides all Medicare benefits. Note: This is not the same as Medigap.

HOW? Most PFFS plans allow patients to be seen by any provider who will see them. PFFS plans do not have to pay providers according to the prevailing Medicare fee schedule or pay in 15 days for clean claims. Providers may bill patients more than the plan pays, up to a limit. It would be a good thing to notify patients if your practice intends to bill above the plan payment.

Need more? Click on CMS (provider-oriented) or Medicare (patient-oriented.)
How to Develop a New Financial Policy For Your Practice: A Short Course

I’ve had lots of questions about financial policies since I did a webinar on patient collections last year. Here’s a short course on developing a new financial policy for your practice. The topic is addressed more comprehensively in my book.

I dislike financial policies that are long and wordy. I prefer a simple format that everyone can understand and use.

The format I recommend is one with three columns titled:

1. Your Plan
2. What You Do
3. What We Do

Here’s an example of how the three columns would read:

**Your Plan**

Medicare

**What You Do**

Pay your deductible ($155 for 2010) and co-insurance (20% of the allowable.)

**What We Do**

We will file Medicare for you.
I use the front of the financial policy to list all the variations of plans that the practice accepts. For instance, the Medicares might include:

- Medicare
- Medicare/Medicaid
- Medicare/supplemental policy
- Medicare Advantage Plan (HMO/PPO)
- Medicare Advantage Plan (PFFS)
- Medicare secondary (MSP)
- Railroad Medicare

Lump together any like plans that you will treat the same. Then decide what you will expect from the patient at time of service or after, and what the practice commits to doing. Don’t forget to address patients being seen out-of-network and self-pay patients.

I use the back of the policy to cover everything that you would like the patient to sign off on. This could include:

- Receipt of Notice of Privacy Policies
- Receipt of Advance Directives/Living Will info
- Agreement to Financial Policy
- Assignment of Benefits to Practice
- Guarantee of Payment

When you put a new policy in place, you have a number of options to educate patients. Here are some:

- Put the policy on your website.
- Send a copy of the policy to all new patients.
- Discuss the policy when you call patients to remind them of their appointment.
- Discuss the new policy at check-in and/or check-out and let patients know it will be in effect at their next visit.
- Circle the patient’s plan on the front, have the patient sign the financial policy on the back, and give them a
How you decide to educate the patients will depend on how much time you have between making the appointment and seeing the patient and the type of practice you have – primary care versus sub-specialty.

Also, don’t forget to educate your staff. If they have not had to discuss money before, they will need some coaching and some practice.

If you’d like a free copy of my sample financial policy, shoot me an email at marypatwhaley@gmail.com.

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**Dear Mary Pat: How Can I Stop Staff From Comparing Salaries?**

You probably can’t.

But that doesn’t mean I haven’t been guilty of trying to in the past. I have typically had a policy in my personnel handbook saying staff can be terminated for discussing wages. But should you really follow through with that threat? Some managers probably have, but I wonder if it is just a convenient excuse to terminate an employee. I would not terminate an employee because s/he did something that is so, well, human.
Employees are going to talk and most will compare wages because they are anxious to know if they are being treated fairly or if someone else in a comparable job is making more per hour. Fair is a word I formerly hoped would be used to describe me as a manager, but the longer I work managing staff, the less I really believe there is a “fair.” There is no absolute fair in my mind because it is very difficult to treat two people exactly the same. No two people have exactly the same training, experience and talents, or attitude, so trying to place an exact value on their services is difficult. Each of us believes we bring something special to the job, but how does one assess that quality?

The best that can be done, I believe, is to be ready to justify and defend why you are paying any staff member what you are paying them. Be ready for that question, as it is sure to come.

Photo credit: © Elvinstar | Dreamstime.com

There is No Such Thing as a 10-Minute Office Visit

I sat at the checkout desk in my practice last week for the first time and as always, it was a revelation. If you haven’t worked your check-in and check-out desks recently, I highly recommend it.

An insured patient that I checked out was shocked when I said the charge for her visit was $100. She said, “But he was only in the room for ten minutes!” I was briefly at a loss for
words. I recovered, we agreed on a payment plan, I made a note on her encounter form for the billing office and she left.

I’ve been thinking about our conversation, and thinking about what that $100 is supposed to cover...

1. First, we scheduled the appointment, which was a walk-in, so it took several people to take the message, pull the medical record (paper charts), call the patient to assess the problem, determine the need for the appointment and schedule it.
2. When the patient arrived, we checked to make sure her address and phone were the same, quickly checked her eligibility to make sure the insurance on file was still in force, and asked for a photo ID for red flags. An encounter form was generated at the nurse’s station to notify her of the patient’s arrival.
3. The nurse called her from the reception area, weighed her, and took her into an exam room to take her vitals, take a brief chief complaint, review the medications she is taking and check to see if she needed any chronic medication refills while she was there.
4. The physician came in to see her, asked about any changes since she’d last been seen, reviewed her history of present illness and examined her. He talked to her about her illness and described a treatment plan for her upper respiratory infection given her chronic health problems.
5. He prescribed a medication for her problem, updated her medication list and made a copy for her to take with her.
6. He marked the encounter form with the level of service and her diagnoses and gave her the form to take to the check-out desk.
7. He refiled the medication reconciliation in the chart, finished documenting the visit, and placed the chart in
the bin to be refiled. The chart was filed, and the encounter form was sent to the billing office.

8. At the billing office the charges and any payment was posted and the claim was filed. If there was no problem with the claim, it electronically passed through two scrubs and a final one at the payer.

9. If payment was not denied for any of a dozen reasons, the payment would arrive at the billing office and would be posted.

10. Since the patient did not pay at the check-out desk, the patient-responsible balance is billed to the patient. If the patient pays on the first statement, it has taken 45 to 60 days to receive complete payment. Since the patient has BCBS, there is a negotiated rate, so the payment will not even total $100.

I know that patients often say “But he only spent 10 minutes with me.” Checking back with the provider, I find it was typically longer. Patients tend to underestimate the time as it goes very fast.

The total visit encompassed the work of the phone operator, the medical records clerk, the triage nurse, the check-in person, the nurse, the doctor, the check-out person and the biller. It took 8 people, and at least 45 minutes of work to make that appointment happen. Plus, that visit had to help pay the expenses for the rent, the utilities, malpractice insurance, medical supplies, computers, phones and janitorial services.

The practice, the patients and the overseers of healthcare want each visit to be non-rationed, safe, high-quality, error-free, holistic, pleasant, clean, accurate, efficient and reimbursable. It’s what we all want. And it ain’t cheap.

Photo credit: © Oleg Pidodnya
Double Effect (as applied to terminal sedation)

The philosophical principle or rule of double effect, attributed to the 13th century Roman Catholic philosopher Thomas Aquinas, states that even if there is a foreseeable bad outcome, like death, it is acceptable if it is unintended and outweighed by an intentional good outcome — the relief of unyielding suffering before death.

The principle has been applied to ethical dilemmas in realms from medicine to war, and it is one of the few universal standards on how end-of-life sedation should be carried out.


Definition of a Group Practice (Stark)

The Group Practice Definition (courtesy of HealthNoob.com)

Under Stark, a group practice is a physician practice that meets the following conditions:

Single Legal Entity.

The group practice must consist of a single legal entity operating primarily for the purpose of being a physician group practice in any organizational form recognized by the State in
which the group practice achieves its legal status.

**Physicians.**

The group practice must have at least two physicians who are members of the group (whether employees, or direct or indirect owners). Stark defines a member of the group as a direct or indirect owner of a group practice (including a physician whose interest is held by his or her individual professional corporation or by another entity), a physician employee of the group practice, a locum tenens physician, or an on-call physician while the physician is providing on call services for members of the practice. An independent contractor is not a member of the group.

**Range of Care.**

Each physician who is a member of the group, must furnish substantially the full range of patient care services that the physician routinely furnishes, including medical care, consultation, diagnosis, and treatment, through the joint use of shared office space, facilities, equipment, and personnel.

**Services Furnished by Group Practice Members.**

Substantially all of the patient care services of the physicians who are members of the group (that is, at least 75% of the total patient care services of the group practice members) must be furnished through the group and billed under a billing number assigned to the group, and the amounts received must be treated as receipts of the group. Patient care services must be measured by one of the following:

- The total time each member spends on patient care services documented by any reasonable means (for example, time cards and appointment schedules.)
- Any alternative measure that is reasonable, fixed in advance of the performance of the services being measured, uniformly applied over time, verifiable, and
Distribution of Expenses and Income.

The overhead expenses of, and income from, the practice must be distributed according to methods that are determined before the receipt of payment for the services giving rise to the overhead expense or producing the income.

Unified Business.

The group practice must be a unified business having at least the following features:

Centralized decision making by a body representative of the group practice that maintains effective control over the group’s assets and liabilities; and

Consolidated billing, accounting, and financial reporting.

Volume or Value of Referrals.

No physician who is member of the group practice directly or indirectly receives compensation based on the volume or value of referrals except as provided under the specialty rules for productivity and profit shares.

Physician-Patient Encounters.

Members of the group must personally conduct no less than 75 percent of the physician-patient encounters of the group practice.

Special Rules for Productivity Bonuses and Profit Shares

The special rules for productivity bonuses and profit shares allow a physician who is in the group practice to be paid a share of overall profits of the group or a productivity bonus based on services that he/she has personally performed (including services “incident to” those personally performed services), provided that the share or bonus is not determined
in any manner that is directly related to the volume or value of referrals of DHS by the physician. CMS now takes the position that diagnostic-testing services cannot be billed as “incident to” but practices that provide physical therapy can, however, bill physical therapy services as “incident to” services (provided that all of the “incident to” requirements are met).

The Stark regulations specifically set forth examples of formulas that will be deemed not to relate directly to the volume or value of referrals. For example, a group’s profits will be deemed not to relate directly to the volume or value of referrals if revenues derived from DHS are distributed based on the distribution of the group practice’s revenue attributed to services that are not DHS payable by any Federal health care program or private payer.

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**Patient Collection Question #1: How Do I Know What to Collect at Check-Out?**

*My book on front-end collections* has been doing really well and I’m pleased that a number of people have called me or emailed me with questions. Here’s one question that a number of people have asked — “Can you tell me more about knowing what to collect from the patient at check-out”?
Hopefully, you have followed my advice and collected co-pays and previous balances before the visit. The portion that you collect after the visit is the co-insurance and the deductible.

The guideline on collecting after the visit is directly related to the allowables on the services the patient received. Allowables are the amount that payers consider payment in full. Of the total allowable, a portion will come from the payer and the balance will come from the patient. Knowing that percentage is the secret to collecting at the check-out desk. **The percentage of the allowable that the patient will pay is the critical piece of information you need to successfully and accurately collect after the visit.**

Allowables fall into three categories:

1. The Medicare allowable for your area of the country, or state, for the current year. If you participate with Medicare, you have an allowable, if you do not participate with Medicare, you have a limiting charge that you must use for Medicare patients.
2. The allowables for the payers with whom you have contracts and have agreed to accept their rate for their subscribers.
3. The rates paid by payers with whom you do not have a contract. Their payment for out-of-network services (non-contracted physicians) will determine the amount owed by the patient.

**How Do You Collect This Information – Medicare**

Medicare allowables are published every year, both in the federal register and online at the CMS (Centers for Medicare and Medicaid) website. If you are fortunate enough to have a practice management system that loads this information automatically for you, you are golden. If not, you will need to enter these manually. The good news is that very few
practices need to add more than 50 – 100 allowables to get started.

You can also use a paper cheat sheet to fill in your top 50 – 100 codes. Make a chart with your fee, the Medicare allowable, and the 20% of the allowable that Medicare patients must pay at every visit. A note of caution – many Medicare patients have secondary coverage and it can be difficult to know what the secondary coverage will pay. Most practices will not collect anything for patients with secondary coverage because it can mean a lot of refunds have to be written when the secondary payments come in.

How Do You Collect This Information – Payers You Have Contracted With

If you have a contract with a payer, they must furnish you with a full allowable fee schedule, or with an payment model. For example, their payment model may be 150% of the 2007 Medicare schedule. You will need to go to the CMS lookup page [here](#) and get these allowables for your services for 2007 and multiply it out.

Example: the 2007 allowable for 99213 established patient office visit is $56.98 for North Carolina (use your locality)

If the payer is paying 150% of that allowable, it will be $85.47, and if the patient has to pay 20% of that allowable, they will owe $17.09. Don’t forget to include the deductible in this equation, as the patient will need to satisfy the deductible before the payer will pay you 80% of their allowable.

Some practice management systems will have the ability to take that information and calculate it for you, so be sure to ask your vendor about this before you do the work.

If you are constructing a manual cheat sheet, you’ll have your fee (even though it doesn’t come into play, I suggest
practices always keep their fee on cheat sheets, so staff can bring anything unusual to the administrator’s attention. Also as you increase fees, you have a handy visual.) Add the payer’s allowable, and calculate the percentage the patient will owe.

Use this same sheet for your payment posters to make sure you are getting paid the correct amount if your practice management system doesn’t do this for you.

By the way, if an insurance company that you have contracted with refuses to give you a schedule of allowables or a payment model, contact your state medical society, your state insurance commissioner, or your state legislators for help.

How Do You Collect This Information – Payers You Have Not Contracted With

If you do not have a contract with a payer, getting information on their allowables can be tough. Some practices will have the patient pay in full and either file the claim for the patient, or give/mail the patient a claim form for them to submit. In this case, you do not need the allowables. If your specialty has higher in-office fees due to tests, etc., it may be difficult for a patient to pay $250 – $500 in full at time of service. You may want to consider one of these strategies for collecting at time of service:

1. Collect a deposit based on the total charge. Let the patient know it is an estimate and that more or less may be owed. I do not believe in sending statements. In my book I recommend using a payment portal to securely store patient credit cards, and adjust the remaining balance up or down according to the actual payment. As payments come in you can develop a knowledge base for what different payers and plans will pay. This will assist you in estimating the patient’s portion more accurately over time.
2. You can give patients information about the services they most likely will receive at their visit and ask them to call their payer and get information on payment. This is a great strategy. If patients are shocked about their portion, they may want to reconsider becoming your patient. The last thing you want is a patient who is surprised by the payment due after they have received the services. Some payers supply subscribers with allowable information on their website.

3. You can usually get the allowable information by phone if you have the subscriber’s information, or if you have the subscriber on a three-way conference call, or in the room with you. This is more typically done when the subscriber is contemplating surgery or an expensive procedure and you are working on a payment plan, or outside financing with them.

Knowing what the patient owes and making arrangements for payment in full at time of service is one of the most significant things you can do to increase your receipts and decrease your accounts receivable. No practice can afford to “wait and see what insurance pays” and bill the patient months after the service has been rendered.

Click here to view “The Smart Manager’s Guide to Collecting at Check-Out.”

Is Your Practice Focusing on These Top Ten Preventive
If you don’t have the following ten items on a manual checklist or in your EMR, you might want to add them. Any time I hear someone list things that improve quality of life and downstream health, I think to myself “This is future reimbursement criteria.” Actually, several of these are already included as measures in the **2010 PQRI (Physician Quality Reporting Initiative) list**.

I came across this list on the physician blog “The Examining Room by Dr. Charles”. Dr. Charles writes:

> “These items were chosen by the National Commission on Prevention Priorities, and highlight those preventive services including immunizations, screenings, preventive medications, and counseling that give “the most bang for the buck.”

1. Discuss Daily Aspirin Use
2. Childhood Immunization
3. Smoking Cessation Advice and Help to Quit
4. Screening for Alcohol Misuse and Brief Counseling
5. Colorectal Cancer Screening
6. Hypertension Screening
7. Influenza Immunization
8. Vision Screening
9. Cervical Cancer Screening
10. Cholesterol Screening

Get ahead of the curve, and discuss with your providers how you can give your patients more bang for their preventive care
buck by making these ten items standard questions in your practice.

Read more on Dr. Charles blog [here](#).

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**UPDATE: SubroShare® Focuses on Payers, Not Physicians**

I received an email today from SubroShare® founder and CIO Stephen Ambrose, letting me know that SubroShare® has changed its marketing model from what he described in his [recent interview here](#).

He describes the new model:

> It was thought at one time that the health providers, by knowing about when a payer PURCHASED CRRs, could thereby use such information to effect reimbursement. However, this has proven to not be applicable on an individual provider to payer basis – and actually a hindrance to interested payer clients.

Steve goes on to say that it is now clear that the two clients of SubroShare® will be **payers** and **outsourced provider networks** such as third-party administrators (TPAs), repricing agencies and preferred provider organizations (PPOs). Physicians and care providers will not be marketed to as:

> In fact, there are NO benefits to the Provider ”“ they are simply mandated to participate. The information that is submitted by the Provider is known as ROI Data, and is simply an extension of the obligation they already have to provide the patient’s payer with TPL/COB information.

**Coming soon to a contract near you:** a clause requiring you to
submit attorney requests for medical records to the payer.

Electronic Medical Record Guru Rosemarie Nelson Reveals Best EMR Product on the Market Today

Okay, okay, so I shamelessly lured you into reading this post by telling you Rosemarie Nelson would reveal the “best” EMR product on the market, and she really does, only not in the way you wish she would. Read on to the end of this post for her EMR advice.

It was my pleasure to talk with Rosemarie Nelson after she had given her third presentation (!) at the North Carolina MGM Fall Meeting at Pinehurst this past October. As we visited, I realized I’ve been listening to Rosemarie talk about electronic medical records for at least 10 years. If you don’t know Rosemarie, she’s a running fanatic, an EMR guru, Principal Consultant with Medical Group Management Association (MGMA) and she has 15 years of consulting in operations and
technology under her belt.

When I asked her why it’s so hard to implement electronic medical records in a physician’s office she said: “Medical practices are a home-grown industry, really a cottage industry, so every single one is different. **There are specialty differences and workflow differences and many EMR vendors don’t know how to address this.**”

Rosemarie particularly enjoys helping groups to fix poorly implemented systems and often finds that **vendors have not carefully looked at the way the client physicians work before selling them a system.** She has experienced the many unique ways that practices operate, and why they operate that way, and has been able to bring EMR success to over 300 practices during her tenure.

Rosemarie recommends that practices take electronic records a bite at a time. She suggests that **groups start with one component, maybe ePrescribing, or messaging or electronic test results, and get it working really well.** Although vendors might prefer that a group follow its timeline, there is no reason that a practice cannot set its own timeline. Finding out if a vendor will be flexible to a group’s unique needs and timeline is a must-have question when developing a RFP (Request for Proposal.)

The dichotomy of the physician (“make it so”) and the administrator (“take it slow”) is another challenge medical practices face. **Many physicians want EMR to happen quickly and painlessly with no interruption of workflow.** Rosemarie suggests to these physicians that they should “refer their business to a specialist (her), just as they would refer their patient to a specialist.” Working through the process takes time.

Here are some other observations from Rosemarie:

- “Apply the EMR as a tool to the operations, it is not an
“Accept the incremental benefits” of the electronic medical record. “All or nothing is a losing proposition.”

On the Stimulus Money for implementing EMR: “Do it because of the benefits and if you qualify for the stimulus, all the better.”

On preparing an RFP (Request for Proposal): “Define the deliverables, the timeline and the money and focus on your practice’s absolute needs.”

On scanning old paper records into the EMR, she says “Only 25% of documents stored are ever used again.”

On savings using ePrescribing (besides the Medicare bump): “ePrescribing can save each FTE provider $15,000 per year on average.”

On using electronics to make the medical practice more efficient, “A typical primary care practice might get 85-100 patient calls per day. Try to offload 30% of those calls per day to electronics – ePrescribing, patient secure messaging, electronic lab results, appointment requests, etc.”

On her favorite client story: “A cardiologist who did not want to do ANYTHING differently, saw me two years later and told me that EMR was the best thing that had ever happened in his practice!”

Her favorite tip: “Add your website address to your appointment reminder calls!”

And…her most asked question ever – Tell Me Which EMR to Buy, to which she replies, “There really is more than one good product out there. Buy the one that matches your needs and your workflow the best, and it will be the right one for you!”

You can reach Rosemarie Nelson here: RosemarieNelson@alum.syracuse.edu