The Best of Manage My Practice – October, 2011 Edition

As we finish off another month here at MMP, we wanted to go back over some of our most popular posts from the month and get ready for another busy, productive, and meaningful month. Presenting, **The Best of Manage My Practice, October 2011**!

- Are you ready for the holidays? How about the New Year? Even though it's still a few months off, make sure you don't see an interruption in your practice's cashflow by getting ready for the January 1st 5010 deadline!
- CMS has released the Premiums and Deductibles for Medicare patients for 2012, so you can start informing staff and patients now. More importantly, will 2012 be the year that you get serious about collecting deductibles at the time of service?
- Mary Pat's "Collection Basics"series about the fundamentals of Revenue Cycle Management in Physician offices is now at part three! Check out Patient Collections Basics: Developing a Financial Assistance Program.
- One of Healthcare's most misunderstood and underutilized documents– the Medicare Advance Beneficiary Notice- is changing for 2012. Make sure you're ready.
- And finally, the Office of the Inspector General (OIG) of he department of Health and Human services has released its 2012 Work Plan for areas it will concentrate on investigating. Better safe than sorry! Mary Pat goes over the highlights here.

We've started this monthly wrap-up to make sure you don't miss any of the great stuff we post throughout the month on Manage My Practice, but we also want to hear from you! What were your

favorite posts and discussions this month? Did we skip over your favorite from October? Let us know in the comments!

2012 Medicare Deductibles and Premiums: Is This the Year You'll Collect Deductibles at Time of Service?

- CMS just announced the new numbers for premiums and deductibles for 2012. Now is the ideal time to think about Medicare deductibles and what your policy is on collecting deductibles at time of service.

If you've been hesitant to collect deductibles, ask yourself if you can handle the loss or delay of payment of $140 per Medicare patient. Most practices can't. If you are thinking about collecting deductibles and other front-end collection techniques, my book "The Smart Manager's Guide to Collecting at Checkout" is your guide to making it happen for your healthcare group. **Click here** to read more.

MEDICARE PART B (covers a portion of the cost of physicians' services, outpatient hospital services, certain home health

services, durable medical equipment, and other items)

- In 2012, the **Part B deductible will be $140**, a decrease of $22 from 2011.
- The standard Medicare Part B monthly premium will be **$99.90 in 2012**, a $15.50 decrease over the 2011 premium of $115.40.
- The standard premium is set to cover one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over, plus a contingency margin. The contingency margin is an amount to ensure that Part B has sufficient assets and income to (i) cover Part B expenditures during the year, (ii) cover incurred-but-unpaid claims costs at the end of the year, (iii) provide for possible variation between actual and projected costs, and (iv) amortize any surplus assets. Most of the remaining Part B costs are financed by Federal general revenues. (In 2012, about $2.9 billion in Part B expenditures will be financed by the fees on manufacturers and importers of brand-name prescription drugs under the Affordable Care Act.)
- The largest factor affecting the contingency margin for 2012 is the current law formula for **physician fees, which will result in a payment reduction of about 29 percent in 2012.** For each year from 2003 through 2011, Congress has acted to prevent smaller physician fee reductions from occurring. The 2012 reduction is almost certain to be overridden by legislation enacted after Part B financing has been set for 2012. In recognition of the strong possibility of increases in Part B expenditures that would result from similar legislation to override the decrease in physician fees in 2012, it is appropriate to maintain a significantly larger Part B contingency reserve than would otherwise be necessary. The asset level projected for the end of

2012 is adequate to accommodate this contingenIn 2012, Social Security monthly payments to enrollees will increase by 3.6 percent. The dollar increase in benefit checks is expected to be large enough on average to cover the increase in the Part B premium of $3.50 that most beneficiaries will experience. For those who were paying the standard premium of $115.40, their benefits checks will only increase.

MEDICARE PART A (inpatient hospital, skilled nursing facility, and some home health care)

- Approximately 99% of Medicare beneficiaries do not pay a premium since they or their spouses have at least 40 quarters of Medicare-covered employment
- Some enrollees age 65 and over and certain persons with disabilities who have fewer than 30 “quarters of coverage” obtain Part A coverage by paying a monthly premium **($451 for 2012)** set according to a statutory formula.
- Those who have between 30 and 39 “quarters of coverage” may buy into Part A at a reduced monthly premium rate which is **$248 for 2012**, the same amount as in 2011.
- The Part A deductible paid by a beneficiary when admitted as a hospital inpatient will be **$1,156 in 2012**, an increase of $24 from this year’s $1,132 deductible.
- The Part A deductible is the beneficiary’s cost for up to 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay an additional **$289 per day for days 61 through 90 in 2012**, and **$578 per day for hospital stays beyond the 90th day** in a benefit period.
- For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 in a benefit

period will be **$144.50 in 2012,** compared to $141.50 in 2011.

MEDICARE PART D (medications)

- The estimate for the average **2012 Part D premium for basic coverage is $30.** This is slightly lower than the actual average for 2011 of $30.76.
- The estimate for the average 2012 Part D premium for supplemental coverage is $8. The estimate for the **average 2012 total Part D premium is $38.**

MEDICARE ADVANTAGE PLANS (replacement for traditional Medicare)

- On average, Medicare Advantage premiums will be 4 percent lower in 2012 than in 2011, and plans project enrollment to increase by 10 percent.
- Of people with Medicare, 99.7 percent continue to enjoy access to a Medicare Advantage plan, and benefits remain consistent with those offered in 2011.
- Those who enroll in Medicare Advantage plans may have different cost-sharing arrangements. On average Medicare Advantage premiums will be 4 percent lower in 2012 than in 2011, and plans project enrollment will increase

Collections Basics – Part 1: Know Your Payers

In a traditional healthcare setting, the revenue cycle begins with the insurance companies who pay the majority of the bill. There are multitudes of payers and each payer can have many plans. How can a healthcare organization catalog this information, keep this information updated and make this information easily accessible to staff so they can discuss payments with patients in an informed and confident way?

Start by breaking your payers into five main categories as a logical way to organize the data.

1. Payers with whom you have a contract
2. Payers with whom you do not have a contract
3. State and Federal government payers (Medicare, Medicaid, TriCare)
4. Medicare Advantage payers
5. Patients

Payers with whom you have a contract

Your organization has signed a contract with a payer and you have agreed to accept a discounted fee called an allowable, and to abide by their rules. What is the information you need to collect?

- A copy of the contract
- A detailed fee schedule, or a basis for the fees, such as “150% of the 2008 Medicare fee schedule.”
- Any information about the fees being increased periodically based on economic indicators, or rules (notification, timeline, appeals) on how the payer can change the fee schedule.
- The process and a contact name for appealing incorrect

payments.

- Information on what can be collected at time of service. Hopefully your contract does not have any language that prohibits collections at time of service, but you must know what the contract states.
- Process for checking on patients' eligibility and benefits: representative by phone, interactive voice response (IVR), website or third-party access.

The contract allowables should be loaded into your practice management system so you can calculate the patient's responsibility at check-out and you can identify incorrect payments at the time of check-posting. If your practice management system does not have this feature, you will need a cheat sheet for each contracted payer, showing the most common services, the allowables, and the percentages of the allowables for fast calculation of the patient's portion at check-out. The same or a modified cheat sheet will work for the check posters so they can verify the payer is reimbursing according to the contract.

Your cheat sheet should look like this:

Plan A							
Service	Allowable	20%	40%	50%	60%	80%	90%
99213	75.00	15.00	30.00	37.50	45.00	60.00	67.50

The check-out staff will write the patient's portion on the encounter form (you may call it a charge ticket, fee ticket, rounding slip, or superbill), add the numbers together and give the patient the total. Alternately, the computer system will total the patient's portion based on the payer and the plan for the check-out person.

The balance of the information collected will be used to develop a payer matrix that might look something like this:

Payer	Employers	Collectible At TOS	Elig/Benefit Verification	Plan Year	Contract Dates	How to Notify
XYZ	WalMart	Deductible & Co-Pay	website	July-June –	Exp Dec 2013, must neg. <Aug1, 2012	Call June Jones at 1-800-555-1212
	State Employees	Deductible & Co-Ins.	Website	Jan –Dec	same	same

Another excellent way your organization can catalog payer and plan information is electronically in a document management system such as **FileConnect,** which I use and recommend.

FileConnect is an electronic filing cabinet with many great attributes, one of which is particularly helpful in this scenario. Every time there is a change in a payer contract, or a new plan is added by a local employer, you can update the staff's spreadsheet tools simultaneously and the newest version will be instantly available on their desktops.

Payers with whom you do not have a contract

Your primary payers in your community or region will most likely offer you a contract. Payers with less covered lives will not find it worthwhile to contract with healthcare providers, so you must decide how you will work with these companies and with these patients.

You are not required to file claims with payers that you are not contracted with. Most healthcare providers do file claims with non-contracted payers to ensure patient satisfaction. Where providers may differ, however, is whether or not they will ask patients with non-contracted payers to pay in full at time of service, and assign the payment to the patient OR ask the patient to pay only the expected patient portion at time of service and assign the payment to the provider. This decision will be made as part of your Financial Policy

(covered in Part 2.)

State and Federal government payers (Medicare, Medicaid, TriCare)

There has been a tremendous discussion in healthcare for the last several years about physicians limiting how many Medicare patients they will see, or even discontinuing to see Medicare patients completely. The rate at which Medicare pays is not enough to support the provision of services in most ambulatory practices, so some physicians do not participate in the Medicare program but still see Medicare patients (the fee they can charge Medicare patients is federally controlled and is called the "limiting" charge) or have opted out of the Medicare program altogether and will see Medicare patients on a cash basis only.

If a practice does accept Medicare patients, whether participating or not, there are set amounts to be collected from patients with Medicare – deductibles and co-insurance, as well as services that are never covered by Medicare.

Make sure that current Medicare allowables for your locality are loaded into your computer to do the math for you. You can use the same type of spreadsheet shown above to develop a cheat sheet of 80% of the Medicare allowable.

Service	Medicare Allowable	20% Owed by Patient
99213	66.74	13.34

What is confusing to most providers is what an insurance that is secondary to Medicare will pay. Many providers do not collect any fees at time of service for Medicare patients with a secondary payer, as there may or may not be any balance left that is the patient's responsibility.

Medicaid pays less than Medicare does, and based on the very

low fee schedule, many ambulatory providers will not accept Medicaid patients. Many Medicaid patients must depend on health departments, hospital clinics, federally-qualified health centers (FQHCs) and rural health clinics (RHCs) for care.

Tricare may be accepted on a case-by-case basis. A healthcare provider does not need to accept the health insurance for retired military across the board, and may decide individually whether to accept a Tricare patient or not.

Medicare Advantage

Medicare Advantage Plans, formerly called Medicare Choice + and now called Medicare replacement plans or Medicare Part C, are plans offered by non-government payers which replicate Medicare benefits for seniors, sometimes offering enhanced benefits as part of the package. There are several types of Medicare Advantage Plans, but the main types are local or regional HMO plans which require you to sign a contract, and the Private Fee For Service Plans (PFFS), for which no contract is required. If you see a Medicare Advantage PFFS patient, you have in essence agreed to accept their terms. The one thing you should ask prior to accepting a Medicare Advantage PFFS plan/patient, is what percentage and what year of Medicare rates are they paying.

Patients

So we finally arrive at the payer with whom most healthcare entities have the most difficulties – the patient. Why is it so difficult to collect from patients?

First, as we have seen throughout this article, insurance can be very confusing. Without a plan for organizing and sharing information, a healthcare provider may have significant difficulty assessing the patient’s payment responsibility.

Second, it has been a cultural norm until recently that patients do not have to pay at time of service, with the exception of their co-pay, and will be billed for their portion after insurance pays.

We know now that we must collect the correct payment at time of service. This is the only way to reduce the administrative expense of billing the patient for the balance and/or refunding the patient if too much has been collected. This is also the only way to maintain adequate cash flow as much of what used to be paid to the providers from insurance companies has now become the responsibility of the patient. Higher co-pays, higher co-insurance and most of all, extremely high deductible plans have left patients owing much more out-of-pocket and largely being unprepared to pay it at time of service.

In the next part of this series, Collections Basics Part 2: Develop Your Financial Policy, we will discuss setting up your financial policy so both patients and your staff can understand it, and how to collect from patients according to your policy.

My Notes on the March 22, 2011 CMS Open Door Forum on Physician Quality Reporting System (PQRI) for the

Beginner

Today's CMS Open Door Forum was a good one. The slides (**pdf here**), although reviewed quickly during the call, are a comprehensive resource for anyone needing in-depth information on qualifying for incentives through PQRI. The information is complex, but anyone can start the process tomorrow and successfully get their check (next year.)

PQRI has been renamed PQRS.

These are the key points of the information presented:

1. You can tell if you are **eligible** for the incentive program by checking the main PQRS site **here**. Scroll down to Downloads and click on "List of Eligible Professionals."
2. There is **no registration** required to report quality data.
3. PQRS should not be confused with incentives offered for ePrescribing or meaningful use of a certified Electronic Health Record – these are three distinct systems.
4. There are new Physician Quality Reporting Measure Specifications every year – use the correct year.
5. Reporting can be done as **individual eligible providers or as groups,** however groups needed to be self-nominated by January 31, 2011, so that door is closed for this year.
6. Eligible providers can choose to report for 12 months: January 1""December 31, 2011 or for 6 months: July 1-December 31, 2011 (claims and registry-based reporting only.)
7. There are **two reporting methods for submission of measures groups** that involve a patient sample selection:

30-patient sample method and 50% patient sample method. An “intent G-code” must be submitted for either method to initiate intent to report measures groups via claims. If a patient selected for inclusion in the 30-patient sample did not receive all the quality actions and that patient returns at a subsequent encounter, QDC(s) may be added (where applicable) to the subsequent claim to indicate that the quality action was performed during the reporting period.
Physician Quality Reporting analysis will consider all QDCs submitted across multiple claims for patients included in the 30-patient samples.

8. Eligible professionals who have contracted with Medicare Advantage (MA) health plans should not include their MA patients in claims-based reporting of measures groups using the 30 unique patient sample method. **Only Medicare Part B FFS patients** (primary and secondary coverage including Railroad Medicare) should be included in claims-based reporting of measures groups.
9. **Choose which group measures** OR individual measures (3 minimum) you want to report on based on your method of reporting. Review your choices **here.**
10. If you plan to report using a registry or EHR, make sure the systems are qualified by checking **here.**
11. Here is the **schedule** for PQRS incentives and “payment adjustments” (financial dings.)

- Incentives (based on the eligible professional’s or group’s estimated total Medicare Part B PFS allowed charges)
    - 2007 ”“1.5% subject to a cap
    - 2008 ”“1.5%
    - 2009, 2010 ”“2.0%
    - 2011 ”“1%
    - 2012, 2013, 2014 ”“0.5%
- Payment Adjustments (you lose money)
    - 2015 ”“98.5%

- 2016 and subsequent years ”“98.0%

What follows are the Questions and Answers from the listeners.

Q: Do PQRS measures need to be reported once per encounter or once per episode?

A: It depends on the measure. Check the list to see what each measure requires.

Q: Is there a code to submit if we cannot qualify due to low numbers of Medicare patients?

A: No, CMS will calculate this and will know you cannot qualify and you will be exempt from the payment adjustment.

Q: Can both admitting physicians and consulting physicians submit the same quality codes?

A: Yes, all eligible providers working with a patient can report the same code if appropriate.

Q: How do we know if we qualified for the eRx incentive for 2010?

A: Payments will come early fall and feedback reports will be available that break down each provider’s incentive.

Q: For the eRx incentive, is it 10 eRxs before June 30, 2011 and 25 before January 31, 2011 for each PROVIDER or each PRACTICE?

A: Each provider.

Q: What is the difference between the numerator and the denominator in PQRS?

A: The numerator is the clinical quality action (for instance, putting a patient on a beta blocker) and the denominator is

the group of patients for whom the quality action applies (which patients with appropriate diagnoses are eligible for beta blocker therapy.)

Q: Do all the preventive measures in this group have to be utilized?

A: Not all measures will apply to all patients, for instance mammograms for females only.

Q: Is there a code to be placed on the claim that says a measure is not applicable for this patient?

A: No.

Q: How do you know if a measure code on a claim has been accepted?

A: You will receive a rejection code on your EOB that indicates the code was submitted for information purposes only. Remittance Advice (RA) with denial code N365 is your indication that Physician Quality Reporting codes were passed into the National Claims History (NCH) file for use in calculating incentive eligibility.

Q: How can a new provider get started with quality reporting?

A: Any provider can start any time by reporting through claims, a registry or an EHR.

Q: Should providers bill for PQRI under their individual number or under their group number?

A: Under their individual number.

Q: Can a physician delegate the eRx process to a staff member, just as they might have a nurse write a prescription for them?

A: Yes.

Q: Can you clarify the three incentive programs and which a

practice can participate in at the same time?

A: The Physician Quality Reporting System, eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs.

The Physician Quality Reporting System incentive can be received regardless of an eligible professional's participation in the other programs.

There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are able to also receive the eRx incentive.

If participating in the Medicare or Medicare Advantage options for the EHR Incentive Program, eligible professionals can still report the eRx measure but are only eligible to receive one incentive payment. Eligible professionals successfully participating in both programs will receive the EHR incentive.

Eligible professionals should continue to report the eRx measure in 2011 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2011 will be analyzed to determine if a 2012 eRx Payment Adjustment will apply to the eligible professional.

If an eligible professional successfully generates and reports electronically prescribing 25 times (at least 10 of which are in the first 6 months of 2011 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2013 eRx payment adjustment.

The transcript and a recording of today's call will be posted on the CMS website within a few weeks.

Image via Wikipedia

Dear Mary Pat: How Do I Handle Chart Audit Requests From Payers?

When a payer or health plan calls your practice and requests records or requests an on-site visit to review charts, follow this guideline:

1. Be professional at all times. Audits can be nerve-wracking and can be a drain on internal resources, but there is always something to be learned from the process.
2. Ask for the request in writing, to include the names of the patients whose charts will be accessed, the dates of service covered under the audit, the name of the auditor, the specific reason for the audit, what the result from the audit will entail (warnings, sanctions, grading, etc.) and if the result will be published in any form anywhere. Request that the specific information culled from the audit be shared with your practice in an usable form.
3. Review your contract with the payer for any language related to the payer's rights to access information, the description of the information, and any payment due to the practice for the labor and resources used in producing the records. Check with your state insurance laws for any information regarding such requests. Note that Medicare Advantage plans do not have contracts with practices, so you do have the right to charge for the labor and resources necessary to produce records.
4. When the information arrives from the payer, confirm that the patients named in the audit have records in

your practice.

5. If the explanation for the audit is unclear, request more in-depth information in writing.
6. Review records or charts requested by the payer and be sure to remove any documentation that does not specifically refer to the dates being included in the audit. Do not give the entire chart to the auditor.
7. For practices with EMRs, print the appropriate documentation for the auditor if they request an on-site visit. Do not give the entire chart to the auditor.
8. If you are satisfied that all requirements are being met by the payer, schedule the audit, or arrange for records to be sent. If coming on-site, arrange for a quiet place for the auditor to review records, preferably close to you so you can observe, answer questions and ask questions.
9. Analyze the feedback received to improve any areas needed and document your effort as a part of your compliance plan. Have all practice employees sign off on any compliance plan updates.

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.)

What Health Care Providers Need To Know About Medicare and the RAC

By Carla Hannibal, CMM,CPM,CIMBS

Recovery Audit Contractors (RACs) will pursue corrections of Medicare claims by auditing for overpayments and underpayments under Part A or B of the title XVIII of the Social Security Act. Health care providers will be affected as Medicare has recently contracted with RACs for 2009 and beyond. RACs will audit every United States and Peurto Rico health care provider who files with Medicare. The audit and recovery plan is expected to be in place by 2010 in all 50 states and Puerto Rico on a permanent basis. Based on findings, if compliance with Medicare billing rules is not up to standard, penalties may be assessed including fines and in severe cases, the loss of Medicare billing privileges.

What should providers do?
Health care providers would be wise to ensure their offices are in compliance because Medicare will not provide any specific guidance to the physician or provider of care outside of basic written guidelines. RAC contracts fees are contingency-based which means they will have every incentive to find errors. It should be noted that each RAC's contingency fee is established during contract negotiations with CMS and varies for each RAC.

Region A: 12.45%
Region B: 12.50%
Region C: 9.00%
Region D: 9.49%

For practices, internal changes need to be established to monitor documentation and coding for compliance as well as establishing a framework to track RAC requests. These are not new requirements to providers. The provider application and contract clearly states that it is the sole responsibility of the Physician to follow all documentation rules and regulations, coding and billing rules 100% of the time. Offices setting up compliance guidelines should appoint someone who will be responsible for monitoring compliance within the practice.

Is there a limit to what records RACs will audit?

Yes there is a medical records limit, established by NPI, of records the RAC will audit.

”¢ Solo Practitioner
Limit = 10 medical records/45 days

”¢ Partnership of 2-5 individuals
Limit = 20 medical records/45 days

”¢ Group of 6-15 individuals
Limit = 30 medical records/45 days

”¢ Large Group (16+ individuals)
Limit = 50 medical records/45 days

What are the RACs focusing on?

Under the program, RACs will focus on CMS-established payment criteria and will consist of both automated claims history reviews from the CMS database as well as complex clinical reviews of patient medical records. Specific areas of concentration include “not medically necessary services” (or those not meeting the established CMS clinical payment criteria), non-covered services, incorrectly coded claims, duplicate services and incorrect payment amounts.

What is involved in the RAC claims audit process?

The Process consists of six phases.

I. Data Screening & Claim Selection

II. Medical Record Request

III. Record Review and Status Determination

IV. Post Review Notification

V. Overpayment Recoupment

VI. Post Determination- Other Provider Options and Data Tracking

Does the RAC program cover Medicare Replacement policies?

No the RAC program does not detect or correct payments for Medicare Advantage or the Medicare prescription drug benefit.

What happens after a RAC audit?

In those cases of overpayments, the physicians may choose to send a rebuttal of the findings directly to the RAC within 15 days of receiving the RAC's letter identifying an overpayment. However this does not stop the clock on the 120-day time period during which you can request a redetermination (first level appeal) from your Medicare contractor or on the interest accrued when money is not refunded to CMS within 30 days of request. If the RAC discovers that an underpayment has been made to the provider then the RAC will inform the carrier or intermediary who will proceed with the claim adjustment and payment to the provider.

When does all this begin?

Implementation will take place on a rolling basis in 3 phases which began 10/1/08. The schedule for the program rollout can be found **here.**

Will your practice be ready?

Carla Hannibal, CMM, CPM, CIMBS is President of Hannibal Professional Services, LLC (HPS). HPS is a practice management company that provides services for small to medium-sized physician groups. Carla is a writer, speaker, trainer and highly skilled manager with 27 years of clinical and administrative experience in the healthcare industry. Her

experience in the healthcare industry ranges from claims processing to practice management. If you need more information on RAC, or help in implementing a compliance process in your practice, Carla can be reached at 623-204-8992.

Basics for Healthcare Managers: Medicare Parts A, B, C & D with 2009 Premiums & Deductibles

With the Centers for Medicare and Medicaid Services (CMS) revealing yesterday what the Medicare premiums and deductibles will be for 2009, it seems like a good time to brush up on Medicare and what choices providers have in enrolling and participating in Medicare.

Medicare is a 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)

TRADITIONAL/ORIGINAL FEE-FOR-SERVICE MEDICARE

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 $1,068 deductible for 2009, paid by the beneficiary when admitted as a hospital inpatient, is an increase of $44 from $1024 in 2008. Part A helps cover:

- inpatient care in hospitals
- 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 2009: $96.40/month (no change from 2008.) 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 2009, the Part B deductible will be $135, the same as it was in 2008. Part B helps cover:

- doctors' services and outpatient care
- some services of physical and occupational therapists
- some home health care

Medicare Part D – Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with

Medicare. In 2008, the deductible is $275, in 2009 it will be $295.

MEDICARE HEALTH PLANS (MEDICARE ADVANTAGE)

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, health maintenance organizations (HMOs) and 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.

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 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 Organ. (PPO), or a Health Maintenance Organization 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 Medicare fee schedules 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? Try **CMS** or **Medicare**.