DOES DOING YOUR HOMEWORK PAY OFF?

By Dean Mason, LO
FUSTRATIONS AND PROBLEMS

For those who accept reimbursement from third parties (insurance), practice management can be difficult to say the least. Therefore, it is important to “do your homework” to keep frustration and problems at the minimal level. This means taking time, often a significant amount, to ferret out the information that prevents your billing from processing the first time.

HIPAA has had some positive effects on the health care business. The goal was to bring disparate communications and billing information into a single, cohesive whole. This has occurred for the most part. There was a time when each insurance entity used codes peculiar to them and you had to remember which codes were used for which diagnosis or procedure. Talk about frustrating!

Now, there is a universal set of codes, and that certainly does simplify things. Every office has a notebook, a clipboard, or a rolodex with all the quirks pertaining to a specific carrier. Then comes ICD-10, with a new and entirely different method of defining diagnoses. Fortunately, our procedure codes remained the same. Be thankful for small miracles.

With the implementation of the Affordable Care Act (ACA) comes more twists and turns. For better or worse, ACA is part of our universe. We must deal with it for as long as it is around.

One of the hallmarks of ACA is the significant increase in deductibles and co-payments. Once a high deductible plan
was $500.00 annually. Today, most of the bronze level plans (chosen by a majority of those who have ACA plans) have deductibles between $4000 and $6000.00. There is an insurance card carried by these patients, and it means literally nothing to you. The patient is responsible for this amount UP FRONT. This translates to you, as the practitioner, having to find out how much the patient deductible and co-pay is, and if it has not been met for the year, collect it from the patient up front, or try and get it following delivery. It is always a good policy to know the status of deductibles/co-pays for each patient. After all, it is your livelihood we speak of.

This will certainly involve time on the phone speaking with insurance representatives. Plan on LOTS of time on the phone. Not only do you wait, but many companies play their “advertising” messages while on hold. Not only are you inconvenienced, but also propagandized at the same time. You are lucky if the only thing you hear is bad music on hold.

Medicare Advantage plans can have different rules than standard Medicare plans do. Their hook is that they offer additional services to the beneficiaries, most of whom do not use them anyway. One issue to understand, Advantage plans are operated by major insurance companies and in most cases, if you are not contracted with these companies, you are out of network and cannot serve them or you will receive an even more reduced reimbursement. Check first before you

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start a patient to see if you can even complete the services.

Accountable Care Organizations are the next new thing to make our lives more difficult. Essentially, it is a network within a network. Practices that are using the ACO model will require you to be part of their internal network.

Another new concept is the Dual Eligibles program. This is supposedly a seamless Medicare/Medicaid program that “simplifies” billing to a Medicaid contractor that processes the claims and produces one reimbursement check for both programs. This currently is in place in three states, my own of Ohio being one of them. Advertised as cost saving program where both government entities get together to provide a cohesive care plan for dual eligible beneficiary, in Ohio, it turned out to be a nightmare for providers.

Two days before New Year’s the state Medicaid department send out an email entitled “general information for Medicaid providers” that turned out to be nothing of the sort. Most providers don’t read these “general information” messages as they usually are just this side of spam. This one was not. It informed everyone that effective January 1 that Ohio would no longer be covering deductibles and copays for certain professions, ours included. Then we come to find out that the “reimbursed at Medicare allowable” meant sixty-five

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percent of Medicare allowable as the insurance companies decided it should be. One wonders where the other thirty-five percent is going. And to make matters even more interesting, we must constantly check to see if the annual deductible is paid because if it is not, it’s on you too, and you can’t bill the patient for it. Oh, and don’t forget, the two percent withholding for “sequester” that is still being collected for many services.

WHAT CAN YOU DO?

While this is all very disconcerting, it is the situation as it exists. Practitioners have to base their business decisions on what they want to do and how little they will take for their work. Certainly the cost of obtaining goods has not been reduced even as our reimbursements have not been raised.

USE TECHNOLOGY: All insurance carriers now have a website where you can go to do research work. These websites contain a lot of information, though you still will have to wait to talk to a human at some point in the transaction.

GO PAPERLESS: The advent of websites also allows you to submit your claims through these websites. You will find out fairly quickly if there is a problem with a claim and then correct it. There are quirks with these programs as well, so be prepared for them. The advantage is that it takes at least two weeks out of the reimbursement schedule by not dealing with paper claims.

HIT THE PHONES: Spend the time at the outset to check for eligibility and patient responsibilities. Time is money, your time, your money.

Just as the physicians have to practice defensive medicine, pedorthists have to practice preventive insurance reimbursement. Know what you are up against and plan accordingly. The ones watching out for you is you, and the PFA. If you have specific questions, either contact PFA or email to: d.mason@pedorthics.org. PFA

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