How Doctor’s Get Paid in 2010

[Treatment is Only the Beginning in the Changing Billing and Medical Reimbursement Ecosystem]

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[Prologue Workshop 2010]

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Today’s Objectives
[Workshop 2010]

UPON WORKSHOP COMPLETION:

1. You will understand some of the challenges and changes to medical provider reimbursement.
2. You will be able to appreciate the various coding systems used by medical providers.
3. You will understand the billing and contract models that are required of physicians.
4. You will appreciate the expertise required for successful physician billing practices:
   – Cash conversion cycles.
   – Various health policies, rules and regulations.
   – Patient Protection and Affordable Care Act.
Doctor Payment Models
[The Fluid Path from Inception to 2010]

- **Pre-World War II:**
  - [cash, crops, meat, barter]
- **Post-World War II:**
  - [wage & price controls]
- **Fringe Benefit:**
  - [3rd party private Indemnify]
- **Medicare:** Title XVIII
  - [Par & Non-participating]
- **Medicaid:** Title XIX
  - [Federal and State]
- **Fee-for-Service:**
  - [Private-for-Profit]
- **Federal:** VA, Tri-Care, IHS, PHS, S-CHIP
- **Managed Care 90s:**
  - [HMOs, PPOs, MAPs]
- **Capitation:**
  - [Partial and full reimbursement]
- **HSAs/Concierge Medicine:**
  - [Cash care]

**Future care:** [3 tiers: PPACA]
Medicare Imploding

[Proto-typical Patient Cost Drivers]

ADVERSE DEMOGRAPHICS

- **Workers**: Decreased from 6:1 to 2:1
- **Enrollees**: Increased from 20-60 M
- **Elderly**: Increased to 16% US pop.
- **MC Trust Fund**: Ballooning [IOUs]
- **Life Span**: Increased 70 to 78 years
- **Medicare Part A**: Hospital $1,100 year.
- **Medicare Part B**: Doctor deductible $155 with $96.40/ month premium.
- **MC Part D**: Doughnut Hole [$2,830 - $4,550] for 2010
- **Uninsured**: 30 - 40 million?

**Federal Insurance**: Now > 51% of US population; already nationalized?

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Medicare Imploding

[Proto-typical Medical Cost Drivers]

MEDICAL COST DRIVERS

- **Office Overhead**: HR [35-75%]
- **Student Debt Loads**: [> $140,000]
- **eMRs**: [$44,000 - $66,000 per MD]
- **Liability**: [Malpractice phobia = 7%]
- **Pharma**: [Chemo/oncology/chronic]
- **Supply-Side Demand**: [MD decides]
- **Technology**: *[Deus ex-machina]*

**Medical Provider**: Expensive pen / writing orders!
Enter Managed Medical Care

[Corporate Structural - Venue Dislocation]

- **Staff Model**: Most restrictive with employed MDs who treat members central location with closed panels.

- **Group Model**: Doctors not employees who treat non-members private office.

- **Network Model**: MDs who may/may not have exclusive contracts.

- **Independent Practice Association**: Independent MDs who see open panel patients in self-administered offices.

- **Mixed Model**: Combination of the above types; the most flexible type.
Medical Reimbursement Comparisons
[Medical “Payment” Paradigm Shift]

TRADITIONAL (Fee-for-service)  MANAGED CARE

- Full fee as payment [“retail” biz model]
- Individualized patient focus
- Active acute healthcare focus
- Rendered in office or hospital
- High profit margin - fewer patients

- Discounted fees [“whole-sale” business model]
- Population cohorts treated
- Chronic disease focus
- PCP controls referral utilization
- Lower margins - more patients

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Managed Care Risks and Benefits

[Doctor versus MCO]

Alleged Provider Benefits

- Increased patients load.
- Stable patient load.
- Predictable cash flows.
- Faster cash-conversion cycle.
- Referrals and community visibility.
- Reduced office HR expenses.

Insurance Carrier Benefits

- Known medical expenses (Fixed costs; not Variable).
- MDs bear economic risk.
- Less staff - “clean” claims.
- Lower costs - scale economies
- Patients controlled and doctors carefully managed.

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Indemnity Retail Reimbursement

[Understanding the FFS Cash-Conversion-Cycle]

PAYMENT FLOW CHART

- Doctor gets chart … evaluates patient
- Documents visit
- Performs tests, x-rays, txs, etc.
- Marks superbill, or e-claim form
- Submits claim

- Insurer accepts “clean” or “dirty” claims
- Claims resubmission, as needed
- Reimbursement (snail or e-mailed) to doctor
- Funds (posted) to ledger or software.

CYCLE TIME: 30 days - 2 years
[ARs: 60-150 days - time decay]

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International Classification Diseases
[What they are - How they work]

CHARACTERISTICS

• ICD-9 alpha numeric code for disease classes, not billing.
• WHO-1900, updated every 3-10 years; ICD-10 [2013].
• HHS offers ICD-9 [CM] for MDs and facilities.
• Diagnostic Statistical Manual Mental Disorders, 4th Edition [DSM-IV].

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THE S.O.A.P. FORMAT Example

Subjective: “I was gardening and noticed my wrist was swollen and itched like crazy”

Objective: Red rash with circular oozing papules and swollen skin. Small tennis bracelet tight.

Assessment: Rule out rues dermatitidis versus nickel allergy.

Plan: Soap soaks, OTC calamine lotion with Rx oral diphenhydramine or [benadryl]. Possible future patch testing.


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Current Procedural Terminology® Codes
[What they are – How they work]

CHARACTERISTICS
Medical, Surgical and Diagnostic task & service billing code numbers [5 digit] of AMA used by payers:

- Thousands updated annually
- Trademarked ®
- Office Visits: [brief, inter, extended]

ANNUAL INCOME: $ 60-M / year

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Resource-based Relative Value System and Billing Rates

[How Payments Schemes are Determined]

MEDICARE PAY CALCULATIONS

- Resource-based Relative Value System (RBRVS) … aka
- Relative Value Units (RVU)
- Three Inputs for RVUs:
  - Formula: WC + LC+ OC
  - Specialists overvalued?
  - Primary care undervalued?
RBRVUs and Billing Rates

[Flip Chart Exercise]

GIVEN SAMPLE: # 44970
[Appendectomy]

Medicare Conversion Factor [MCF] X RVU:

- MCF = $36.01 [2009]
- RVU = 14.27

PAY CALCULATION TBD:

MCF X RVU = $36.01 X 14.27 = Medicare pays surgeon

$513.62
**WHAT IT IS?**

- Official standard billing form used by doctors submitting MC/MD claims.

- Also used by some private insurers and managed care plans.

- Contains patient demographics, but no ICD-9, CPT®, HCPC codes, etc.

- Generic billing form.
Physician “Super-Bills”

[Itemized Medical Specialty Invoice for Patients]
Advanced Beneficiary Notice [ABN]
[Opting-Out of Medicare Per Treatment]

NO MEDICAL NECESSITY

• Not consistent with symptoms or diagnosis of the illness or injury under treatment; *and*

• Not necessary and consistent with general medical standards (i.e., not experimental); *and*

• Furnished primarily for the convenience of patient or doctor; *and*

• Furnished at the most appropriate level of safety for the patient.

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Billing Fraud and Abuse

[Understanding the Difference]

BILLING FRAUD DEFINED

• Activity where economic or non-economic gain [drugs, sex] obtained without earning it.

• Billing for care not provided; or rendered by an inappropriate provider [LPN for MD].

• Billing for non-covered services.

• Submitting false claims.

BILLING ABUSE DEFINED

• Healthcare activity where medical providers overuse or misuse services.

• Upcoding and service fragmentation are common.

• Billing for un-necessary services, procedures or tests [“malpractice phobia”].

• CMS - “Although some practices may be considered abusive, they may evolve into fraud.”

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How Much Fraud
[Rules and Regulations]

OFFICE INSPECTOR GENERAL
[$32-Billion Dollars in 2006]

Deficit Reduction Act of 2005
& Policy Revisions 2009

• False Claims Acts [3x damages].
• Medicare Integrity Program [MIP].
• Fair Accurate Credit Transaction Act, with “red flags” [December 2010].
• Computerized data-mining medical claims “spider-web” technology.
Fragmented Billing
[Ala Carte Services]

• Charging for each individual component of a procedure.
• Surgery “skin-thru-skin”.
• Old: Increase costs [4,000%] in hospitals and 10-15% in private offices.
• New: May save money by controlling utilization.

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“Fixed Price”

- Charging for the entire procedure.
- Surgery “skin-to-skin”
- **Old:** Decrease medical costs.
- **Medicare's National Correct Coding Initiative** [CCI]
Up-Code and Down-Code Billing

[Over and Under Exuberance]

UP-CODING

A fraudulent or abusive practice in which medical provider services are billed for higher CPT® codes than were actually performed, resulting in a higher payment by Medicare or 3rd-party payers to the doctor.

DOWN-CODING

1. A practice of third-party payers where a CPT® code is reduced to a less complex or lower cost code than reported.

2. The emergent practice of some “fraud-phobic” doctors to deliberately undercode claims to reduce the likelihood of fraud allegations.
Medicare Billing Penalties
[Physician “Bounty-Hunters”]

How Patients Help Detect Fraud
• Read Explanation of Benefits for matching care.
• Look type & number provided.
• Look at date provided.
• Look at services billed.
• Look at payments.
• Don’t lend Medicare card.

Patients receive $100 – $1,000 BONUS for reporting & conviction of fraud.

Nancy Dickey MD: [Past AMA President]
Injection Code Story: surgical code
Balance Billing
[The Conundrum]

THE PAYMENT SCHEMES

• Cash Care = pay a negotiated bill
• FFS = bill patient the balance, or “accept insurance”
• Medicare = accept it; or not [but cannot bill more than 115%]
• Managed care = accept the contracted rate; cannot bill remainder [balance billing].

Are doctors aware / unaware?
Are patients aware / unaware?

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Capitation Reimbursement

**Definition**

Fixed payment amount regardless of the quantity or intensity of care delivered.

- Actuary Utilization Rate
- Under-capacity: Empty treatment rooms.

Successful Docs: No patients in the waiting room; very counter-intuitive.
Capitation Reimbursement

[Flip Chart Exercise]

**GIVEN:**
- Doctor paid 200 cents [$2] per Patient / per Month
- 1,000 patient contract
- $1,000 X $2 = $2,000 / month
- Actuary Utilization Rate [20%]

**CALCULATION:**
- 1,000 patients X 20% = 200 pts/month
- $2,000/200 pts = $10 patient / 3 pts/hr
- 200/25 patient days = 8 days.
- $2,000 / 8 days = $250 per day.

**KEY FACTOR:** Utilization Rate

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Concierge Medical Practice
[Getting Off the Entire Medicare Grid]

What it is - How it Works

- Private, Cash or Direct Pay Medicine
- Must opt-out of Medicare for 2 years
- Retainer fees: $1,500 – $3,500/ year
- Reduced paperwork and scrutiny
- Doctor Access 24/7/365, email, etc.
- Ancillary service offerings [smoke/weight loss/exercise]
- More time spent with patients [3,000 patient load reduced to 300-600 patients]

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Pro Bono Medical Care
[Non-Compensated Medical Services]

RECENT TRENDS

• Survey revealed 40% MDs doing less pro-bono due to managed care income.
• Volunteers in Healthcare – American Academy of Family Physicians – offers a patient record system to track free care to uninsured.
• Includes tracking and storing information on patients, MDs, visits, clinics and referrals.

GOOD LUCK!

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Patient Protection Affordable Care Act

[March 23rd 2010]

HR 3590 PROVISIONS

• Mandates HI purchase [$695 or 2.5% earned income]
• 40% tax Cadillac plans 2018
• 3.8% increase payroll taxes 2013 [>$200,000 - $250,000]
• AGI deduction medical expenses to 10% [IRS - A]
• Affect on doctor pay..? Probably down!

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References
[How Doctor’s Get Paid in 2010 – June Workshop]

Institute Medical Business Advisors, Inc

• www.MedicalExecutivePost.com
• www.HeathcareFinancials.com
• www.BusinessofMedicalPractice.com

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Applying the Knowledge

[Co-lead Table Exercise]

- How will this information change the way you approach your business?
- How will you apply the learning elements with your teams and colleagues?
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Institute of Medical Business Advisors Inc
[Bridging the Gap Between Mission and Margin]

Thank You!

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