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Bayshore Independent Updater

Florida Legislation—Denied claims? Not so fast...Appeal it!

Have you received notices that you owe the health insurance company money because they later found that the member was "not eligible at the time of service" for a reimbursement you already received?
Or,
Have you ever been denied reimbursement for a service because it wasn't "authorized"?

Florida Legislature

Until now, most practices and facilities have had little recourse. Without modification to the "Authorization" or "Utilization Management" portion of the provider/facility agreement, the standard language usually reads something like "Plan shall not pay for services requiring pre-authorization whereby [you] failed to obtain such authorization…".

Under the 2009 Florida Congress modification to F.S. 641 & 627 (the laws which governs HMO's in Florida), you have several rights. Let's take a look at the eligibility clause first:

> "(11) A health insurer may not retroactively deny a claim because of insured ineligibility: (a) More than 1 year after the date of payment of the claim; (b) If the health insurer verified the eligibility of an insured at the time of treatment and provided an authorization number; or (c) If, at the time of service, the health insurer provided the insured with a magnetic or smart identification as provided in s. 627.642 that identified the insured as eligible to receive services." (see 1.1)

As such, if you follow these steps, you are provided the right to contest any denial received at a later date due to ineligibility.

Secondly, as is the case with many specialists, procedures requiring authorization can be tricky. Even when your staff contacts the insurers, conflicting

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Are you ready for Electronic Medical Records?

Have you incorporated/converted EMR or EHR to your practice? If not, you are not alone. According to a report by MIT in February of this year, less than 25% of practices have moved to EMR. The Obama Administration now seeks to encourage you to move your practice into the digital world by offering incentives worth between $40,000 and $65,000. They are also threatening to enforce undisclosed penalties over time for those who don't, yipes!

Pondering on who-what-when-where-why-how to get it done? Practices have to deal with several concerns. Moving towards EMR requires a significant change in practice methods, conversion costs, staff training and potential productivity loss. How can you avoid this? For one, when selecting an EMR, know the company before signing on the dotted line. If possible, speak to the administrator or a physician in some of the practices they've incorporated.

Especially important is to find out if they have installed their software in a practice with the same/similar specialty. This is important because everything from the flow of a patient through

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Bayshore Insurance Underwriters

In This Month's Issue:

- Florida HMO laws are being modified. Are you affected?
- Time again for Medicare Open Enrollment. Don't forget to ask all your recurrent patients.
- New Markets: What does this mean for you?

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What's Old is New… Clinics are the growing trend

*"It's so much easier to get all my services here and I see all of my friends, **** Medical Center knows how to treat us"*

Quoting an unnamed elderly patient

Reprinted with consent of Provider Resource Group, Inc.

In recent years, more and more practices have consolidated to become multi-specialty practices or "clinics". In South Florida, this trend seems to have caught on with much enthusiasm. As the Latin community has grown, the concept of health clinics has become less foreign. While many in the U.S. may feel that the idea of going to a "Health Clinic" for treatment has a negative connotation, this is not so with many of our Hispanic Americans. In most Latin countries, health clinics are the standard. As such, there is a comfort level with this model.

What makes these practices succeed may include a variety of items. For one, by consolidating the services offered under one roof (i.e. Primary Care, Cardiology, Dermatology, Gynecology, and Diagnostic services, etc.), patients have a one-stop-shop for their coordinated services. In many cases, these services include transportation and pharmacy. For the elderly, this can be very beneficial as it solves their transportation needs, controlling expenses and creating a comfortable atmosphere. Many clinics have the extra mile by arranging benefit cost reductions (copayments and coinsurance) with the major insurance companies to offer reduced patient responsibilities.

Also, some of created social settings (coffee shops, card tables, etc.) to keep their patients occupied. When asked about why he chose to have his Medicare Advantage plan with a clinic based HMO, the elderly patient said "It's so much easier to get all my services here and I see all of my friends, **** Medical Center knows how to treat us".

Taking this one step beyond, some of these clinics in the Florida market have expanded their reach by forming their own Medicare Advantage HMO's. The idea is to control utilization, hospitalization and thus, their overall risk. If done right, these can be very successful.

Solo and smaller practices do have some advantages. Patient choice is virtually non-existent under this practice model. Medicare requires limitations on variation of benefits offered so these practices can only go so far with their copay/coinsurance reductions. If you are a specialist, your independence from a committed group/clinic practice allows you to work with many referral sources and coordinate care with physicians you feel most comfortable.

Ultimately, the choice is up to the consumer…for now.

Medicare Update for Oct—Dec, 2009

Medicare Update—Points of Interest for 2010

Medicare has released their 2010 premiums along with the deductibles and co-insurance rates.

The 2010 Part A (Hospital) Deductible is $1,100

The 2010 Part B (Physicians) Deductible is $155 with the same 20% co-insurance.

For 2010, Skilled Nursing Daily Deductible is $137.50 for days 21 to 100.

For Part D (Prescription Drugs), Medicare has published the following:

Initial Deductible from $295 to $310

Initial Coverage Limit from $2,700 to $2,830

Out-of-pocket Threshold (the donut hole) has moved from $4,350 to $4,550

The minimum cost-sharing in Catastrophic Coverage moves from $2.40 for generics and $6.00 for all others to $2.50 / $6.30.

As a Major Coding note, please remember that CMS is removing reimbursement for Consultation Codes. See excerpt below:

"CMS is also proposing to stop making payment for consultation codes, which are typically billed by specialists and are paid at a higher rate than equivalent evaluation and management (E/M) services. Practitioners will use existing E/M service codes when providing these services instead. Resulting savings would be redistributed to increase payments for the existing E/M services."

As an offset, CMS proposes the following:

"CMS is proposing to increase the payment rates for the Initial Preventive Physical Exam (IPPE), also called the "Welcome to Medicare" visit to be more in line with payment rates for higher complexity services."

For more info, follow the link: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3469

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information regarding the need for authorization can confuse all of us. The new legislation proposed requires that you have right to appeal for medically necessary services regardless of your contractual obligations.

"(3) If a ~ claim is denied because the provider, due to an unintentional act of error or omission, failed to obtain authorization or obtained only partial authorization, the provider may appeal the denial and the health maintenance organization must conduct and complete within 30 days after the submitted appeal a retrospective review of the medical necessity of the service. If the health maintenance organization determines that the service is medically necessary, the health maintenance organization must reverse the denial and pay the claim. If the health maintenance organization determines that the service is not medically necessary, the health maintenance organization shall provide the provider with specific written clinical justification for the determination." (see 1.1)

These are only excerpts of the new legislation provision as proposed in the 2009 Florida House Resolution but the entire legislation is important for you to understand. It is good practice to review your collections efforts with your billing staff (or outside billing company if applicable) and verify if their collections letters reference the Federal and state statutes. According to several sources, these tactics deliver the best results. Considering the impact this has on your bottom line, you should make eligibility and authorization measures a standard in your practice.

Note: 1.1 – Excerpts above were taken directly from the Florida Senate House Resolution for 2009. For the complete text, refer to:
http://www.flsenate.gov/data/session/2009/House/bills/billtext/pdf/h024300.pdf

"Are you ready for EMR?"..Continued from Page 1

treatment in a practice, to the data

collection (i.e. labs, diagnostic studies) follow patterns usually consistent by specialty. Consider this, if an EMR consultant has installed twenty OB/Gyn's successfully, this doesn't necessarily mean they could successfully work with a neurosurgeon as the two specialties have very different modalities of assessment, observation, lab work, diagnostic impressions, etc.

Another important consideration is how easy is it to manipulate the flow of data entry.

- Does it allow for multiple points of entry? For example, can you use a stylus or does it require a keyboard?
- Can you use voice recognition software? Is it included?

These as well as many other factors can either help or hinder your work-flow.

Lastly, it is important to know how the record-keeping software integrates into the billing software. EMR software should "drive" the billing. Procedure and diagnosis should convert directly from one to the other. Generally, both the EMR and billing software should work seamlessly. Otherwise, you lose revenue simply by needing your staff to spend valuable time doing double-entry. Even if you utilize an outsourced billing company, most modern billing organizations have software that accept downloads of EMR data.

While there are many considerations, never underestimate the value of research. A little expense properly spent on a good consultant will save your practice significantly. And no, not all consultants are the same. Make sure you find the one that can adapt to the way YOU practice and not the one that wants to tell you HOW to practice. He or she may not have practice experience. Don't be afraid to ask him or her for a resume and multiple references. After all, you are paying them for their service.

As an editorial note, we at BIU want to remind practices that use of EMR is listed in the top three items under the "Best Practices" guidelines. In addition to the advantages in the article above, some malpractice insurers include whether or not you incorporate EMR in their risk assessment.

Letter from our President

Dear Clients,

On behalf of all of us at Bayshore Insurance Underwriters, I would like to wish you and your staff a happy, healthy and prosperous holiday season. We appreciate your business and are all sincerely thankful to service your business.

As the year ends, 2010 brings new and exciting opportunities. We at BIU are working diligently to prepare for a new year with new options for our clients. We remain committed to placing your business with companies that meet our stringent expectations. As you know, BIU markets your business with only "A" rated companies with underwriters who understand the unique risks associated with medical liability. As such, you can be assured that we will strive to keep your premiums at a minimum while always providing the most comprehensive coverage for your practice or facility.

From all of us at the BIU family to you and yours, have a wonderful holiday and Happy New Year!

Bayshore Insurance Underwriters

Sincerely,

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Risk Management Minute

Have you checked your HIPAA compliance lately? PHI (Private Health Information) has become a source of malpractice (as expected).

It's worth a spot check with your staff. Often, the simple things are the ones that go unnoticed:

1. Ensure that first and last names are not used unless in the privacy of a room. It is generally accepted to verify patients by their first name only in the lobby area.
2. Ensure that names on medical records are not visible from any patient area. Remember, the record storage file cabinets must be covered if they are located within visible range of being read.
3. Don't leave charts unattended.
4. Make sure sign-in sheets are using peel-away strips (These can be a bit expensive but some tell me that the Pharmacy Reps supply them now).
5. If you've had staff turn-over, don't forget to update your HIPAA officer with Medicare.
6. While on that note, make sure the staff have received and signed acknowledgement for HIPAA training. In a Medicare audit, they will ask for this.
7. Turn all patient-related paperwork within view face-down while not immediately being worked on.

These are only some of the more common steps to remember. It's important to routinely review the HIPAA policies. Many consultants recommend at least a quarterly audit by your HIPAA Officer.

BIU Risk Team

Community Service

Profiles in BIU:

Bayshore Insurance Underwriters was proud to support the 2009 Relay for Life at Baptist Hospital in South Miami.

BIU supported Lynn Brown in her effort to raise donations for cancer research. Her team finished in first place with the themed banner "Giant Panda's of Sichuan China". Altogether, the Relay event raised over a hundred-thousand dollars for ACS research.

Congratulations to Lynn Brown and all of those supporters of the American Cancer Society and the Relay for Life.

BIU invites you to get active in the cause. If you would like to learn more on how you can partner with BIU and contribute, please contact us at info@bayshoreinsurance.com.