Welcome to PMI’s Webinar Presentation

Brought to you by:
Practice Management Institute®
pmiMD.com

Meet the Presenter…

Maxine Inman Collins, MBA,
CPA, CMC, CMIS, CMOM

On the topic:
Out of Network Billing
Welcome to Practice Management Institute’s Webinar and Audio Conference Training. We hope that the information contained herein will give you valuable tips that you can use to improve your skills and performance on the job. Each year, more than 40,000 physicians and office staff are trained by Practice Management Institute. For 30 years, physicians have relied on PMI to provide up-to-date coding, reimbursement, compliance and office management training. Instructor-led classes are presented in 400 of the nation’s leading hospitals, healthcare systems, colleges and medical societies.

PMI provides a number of other training resources for your practice, including national conferences for medical office professionals, self-paced certification preparatory courses, online training, educational audio downloads, and practice reference materials. For more information, visit PMI’s web site at www.pmiMD.com

Please be advised that all information in this program is provided for informational purposes only. While PMI makes all reasonable efforts to verify the credentials of instructors and the information provided, it is not intended to serve as legal advice. The opinions expressed are those of the individual presenter and do not necessarily reflect the viewpoint of Practice Management Institute. The information provided is general in nature. Depending on the particular facts at issue, it may or may not apply to your situation. Participants requiring specific guidance should contact their legal counsel.

CPT® is a registered trademark of the American Medical Association.
Out of Network Billing

Brought to you by
Maxine Collins, MBA, CPA, CMC, CMIS, CMOM
Practice Management Institute®
Director of Compliance, Audits & Education
CoreMDPartners, LLC

TO REFRESH OUR MEMORIES

- Healthcare Insurance – A contract that guarantees payment to the insured or assigned party for medical costs incurred for illness and other contracted healthcare in return for the payment of premiums by the insured.

- Contract is between the policyholder and a third party payer or government program to reimburse for all or a portion of the cost of medically necessary treatment or preventive care.
DOES EVERYONE UNDERSTAND ALL OF THE CONCEPTS?

- Do the insured parties understand their insurance contracts?
- Do the appropriate personnel in the medical office have access to and understand all of the contract provisions and products?
- Do the insurance carriers want all of us to understand the contracts?
- If we understand some of it today, will it change tomorrow?
- How did we get to this point in our Healthcare system?
- Sometimes we have to look back in time, in order to move forward.

THE FOLLOWING INFORMATION COMES FROM THE FOLLOWING SOURCES:
ASSOCIATED PRESS, TUESDAY, APRIL 18, 2006, “STUDY: HEALTH INSURERS ARE NEAR-MONOPOLIES”.
UNDERSTANDING HEALTH INSURANCE. 8TH EDITION, MICHELLE A. GREEN, JOANN C. ROWELL, THOMPSON, DELMAR LEARNING.
CENTERS FOR MEDICARE AND MEDICAID, WWW.CMS.HHS.GOV, VARIOUS PUBLICATIONS.
### BRIEF HISTORY OF U.S. HEALTHCARE SYSTEM

<table>
<thead>
<tr>
<th>DATE</th>
<th>EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1860</td>
<td>1st Health insurance policy - The Franklin Health Assurance Company of Massachusetts. Provided health care coverage for injuries that did not result in death.</td>
</tr>
<tr>
<td>1863</td>
<td>False Claims Act. Enacted to regulate fraud associated with military contractors selling supplies and equipment to Union army. Used by Federal agencies to regulate conduct of contractors that submit claims to federal government. Amended in 1986 to increase civil monetary penalties to impose a maximum of $10,000 per false claim, plus three times the amount of damages that government sustains</td>
</tr>
<tr>
<td>1910</td>
<td>For 50 cents per month, the Western Clinic in Tacoma, Wa. Offered medical services to lumber mill owners and their employees.</td>
</tr>
<tr>
<td>1920</td>
<td>Introduction of prepaid health plans. 1st contracts between employers and local hospitals and physicians developed – specified medical services provided for a predetermined fee that was paid monthly or annually. Forerunner of today’s managed care.</td>
</tr>
<tr>
<td>1929</td>
<td>1st Blue Cross Policy – Justin Ford Kimball, an official at Baylor University in Dallas introduced a plan for school teachers. Guaranteed 21 days of hospital care for $6 per year. Other groups of employees in Dallas joined. Attracted nationwide attention.</td>
</tr>
<tr>
<td>1937</td>
<td>Kaiser Foundation Health Plans created to finance medical care for Kaiser employees and families.</td>
</tr>
<tr>
<td>1939</td>
<td>First attempt at National Health Care? The Wagner National Health Act of 1939 proposed that federally funded national health program be administered by states and localities. Caused extensive debate. Congress did not pass into law.</td>
</tr>
<tr>
<td>1945</td>
<td>President Harry S. Truman supports a universal health plan which included private insurance for those who could afford it and public welfare for the poor. Congress did not pass.</td>
</tr>
<tr>
<td>1948</td>
<td>The World Health Organization developed the International Classification of Disease. You know the rest of the story.</td>
</tr>
<tr>
<td>1955</td>
<td>The nationally recognized Health Maintenance Organization (HMO), Kaiser-Permanente, was created.</td>
</tr>
<tr>
<td>1966</td>
<td>Social Security Amendments of 1965 implemented which created the Medicare and Medicaid programs. Made comprehensive healthcare available to millions of Americans. Originally administered by the SSA.</td>
</tr>
<tr>
<td>1973</td>
<td>HMO Act of 1973 – Authorized Federal grants and loans to private organizations that developed HMOs – which provided healthcare to subscribers in a given geographic area. Defined a Federally qualified HMO certified to provide health care services to Medicare and Medicaid enrollees. Required most employers with more than 25 employees to offer HMO coverage if local plans were available.</td>
</tr>
<tr>
<td>1977</td>
<td>HCFA – Health Care Financing Administration is created with the Dept of Health and Human Services. Medicare and Medicaid programs transferred to HCFA. Now called CMS.</td>
</tr>
<tr>
<td>1981</td>
<td>The Omnibus Budget and Reconciliation Act – a Federal legislation expanded the Medicare/Medicaid Programs and provided states with flexibility to establish HMOs for Medicare/Medicaid.</td>
</tr>
<tr>
<td>1982</td>
<td>The BCBS Association created – a merger of the BC Assn and the National Assn of Blue Shield.</td>
</tr>
<tr>
<td>1983</td>
<td>Prospective Payment System (PPS) implemented DRGs (Diagnosis Related Groups) for Hospital Inpatient stays.</td>
</tr>
<tr>
<td>1988</td>
<td>Medicare required Physicians to submit ICD-9-CM codes on HCFA 1500 forms.</td>
</tr>
<tr>
<td>1988</td>
<td>The Clinical Laboratory Improvement Act</td>
</tr>
</tbody>
</table>
### BRIEF HISTORY OF U.S. HEALTHCARE SYSTEM

<table>
<thead>
<tr>
<th>DATE</th>
<th>EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>HCFA requires all physicians to submit claims on behalf of Medicare patients, regardless of the Dr.'s participation status in the Medicare program.</td>
</tr>
<tr>
<td>1989</td>
<td>The National Committee for Quality Assurance (NCQA) was established to implement standards to assess managed care systems.</td>
</tr>
<tr>
<td>1991</td>
<td>Evaluation and Management codes created by the American Medical Assn.</td>
</tr>
<tr>
<td>1991</td>
<td>New version for HCFA 1500 – required use for all government claims.</td>
</tr>
<tr>
<td>1992</td>
<td>Resource Based Relative Value Scale implemented. Replaced the regions “usual and reasonable” payment basis; converted to a fixed fee schedule calculated according to RBRVS for Physicians. Converting to a reimbursement system based on costs.</td>
</tr>
<tr>
<td>1996</td>
<td>National Correct Coding Edits developed to promote national correct coding methodologies and to eliminate improper coding. Edits developed based on coding conventions defined in the American Medical Associations CPT Manual (copyright by the AMA).</td>
</tr>
<tr>
<td>1999</td>
<td>Home Health Prospective Payment System implemented.</td>
</tr>
<tr>
<td>2000</td>
<td>The Outpatient Prospective Payments System implemented for Hospital-based Medicare outpatient claims using Ambulatory Payment Classifications (APCs).</td>
</tr>
<tr>
<td>2000</td>
<td>The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act required implementation of a $400 billion prescription drug benefit for Medicare beneficiaries and improved the Medicare Advantage (formerly Medicare+Choice benefits.</td>
</tr>
</tbody>
</table>

### OTHER SIGNIFICANT CHANGES IN 21ST CENTURY FOR HEALTHCARE

<table>
<thead>
<tr>
<th>DATE</th>
<th>EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Consumer driven health plans introduced to encourage individuals to locate the best healthcare at the lowest price.</td>
</tr>
<tr>
<td>2001</td>
<td>HCFA named changed to CMS on June 4th.</td>
</tr>
<tr>
<td>2002</td>
<td>IRF PPS – The Inpatient Rehabilitation Facilities Prospective Payment Systems implemented as required by the BBA of 1997.</td>
</tr>
<tr>
<td>2002</td>
<td>PROs became QIOs – Quality Improvement organizations.</td>
</tr>
<tr>
<td>2002</td>
<td>EIN – Employer ID # adopted by DHHS as the standard ID to be used in health care transactions.</td>
</tr>
<tr>
<td>2002</td>
<td>Medical Privacy Standards – DHHS develops federal privacy standard to protect patients’ medical records and other health information to health plans, doctors, hospitals, and other health care providers (a provision of HIPAA).</td>
</tr>
<tr>
<td>2003</td>
<td>Medicare Modernization Act of 2003 – Provided Medicare recipients with prescription drug savings and additional health care plan choices by allowing private health plans to compete. Also, under this Act, Practice Management Institute’s CMC named as a CMS Nationally Recognized Coding Certification!</td>
</tr>
<tr>
<td>2003</td>
<td>The Medicare Prescription Drug, Improvement and Modernization Act (MMA) – added new prescription drug and preventive benefits and provided extra assistance to people with low incomes.</td>
</tr>
<tr>
<td>2005</td>
<td>IPF PPS – The Inpatient Psychiatric Facility Prospective Payment System implemented on 01/01/05 as a requirement of the BBRA of 1999.</td>
</tr>
</tbody>
</table>
OTHER SIGNIFICANT CHANGES IN 21ST CENTURY FOR HEALTHCARE

<table>
<thead>
<tr>
<th>DATE</th>
<th>EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>May 23rd – Regulation took effect. Applications began for the Standard Unique Health Identifier for Health Care Providers – the NPI – Conversion period experienced delays, but in May, 2007 several covered entities under HIPAA required to use National Provider Identifier. Final deadline for all covered entities was May 23, 2008.</td>
</tr>
<tr>
<td>2006</td>
<td>AMA study shows that in 166 of 294 Metropolitan areas (56%), a single insurer controlled over 1/3 of the HMO and PPO business. For the top insurers, not only do they control the largest share of enrollees, they are also the biggest purchasers of health care. That means that they can dictate prices and terms of coverage. Over 400 mergers took place in last decade. There have been double-digit premium hikes from 2001 to 2004.</td>
</tr>
<tr>
<td>2007</td>
<td>Implementation of PQRI – Physician Quality Reporting Initiative on July 1st. Voluntarily participating physicians could earn a bonus of 2% of total Medicare allowable submitted on claim forms. This eventually evolved into the mandatory PQRS Program (Physician Quality Reporting System) and the bonus opportunities continued to decline until the point in time where physicians were penalized for not participating in the program. Starting in 2015, physicians penalized for not successfully participating in PQRS.</td>
</tr>
<tr>
<td>2009</td>
<td>American Recovery and Reinvestment Act – major revisions to HIPAA rules and regulations. Also introduced the HITECH provisions of the Act leading to security of electronic transactions in healthcare. Also in 2009, Meaningful Use Incentives began for use of EHR which eventually evolved into penalties for failure to meet MU requirements.</td>
</tr>
<tr>
<td>2010</td>
<td>The Patient Protection and Affordable Care Act – Sweeping provisions in Healthcare coverage for citizens of U.S. U.S. Citizens must have health coverage for a penalty imposed in 2014 for lack of coverage with exceptions for those with financial hardships.</td>
</tr>
<tr>
<td>2011</td>
<td>Various incentive programs implemented by CMS for PCPs, General Surgeons in Health Care Shortage Areas.</td>
</tr>
<tr>
<td>2011</td>
<td>Annual wellness visits paid covered by Medicare.</td>
</tr>
</tbody>
</table>

YOU KNOW THE REST OF THE STORY

• Accountable Care Organizations development
• Value-based Modifier Program implemented; then -
• MACRA – The Medicare Access and CHIP Reauthorization Act signed into law on April 16, 2015. Replaces former Incentive Programs with an all-inclusive program.
  – Replaces PQRS, the Value-Based Modifier Program, and Meaningful Use.
• MIPS – New program that determines Medicare payment adjustments and is an acronym for the Merit-Based Incentive Payment System which uses a composite score to indicate a bonus or a reduction in Medicare payments. Started on 01/01/2017 and is composed of four performance categories:
  – Quality (PQRS/VBM)
  – Meaningful Use
  – Clinical Practice Improvement (CPI) and
  – Resource Use.
• Most private carriers have announced a shift to the Quality reporting system in some fashion by 2018-2020.
• Why would any provider be confused?
# Average Annual Growth, Health Care Spending Eras 1960-2013

## Average Annual Growth, Health Spending Eras 1960-2013

<table>
<thead>
<tr>
<th>Era</th>
<th>Description</th>
<th>National Health Expenditure (NHE)</th>
<th>Personal Health Care (PHC)</th>
<th>Gross Domestic Product (GDP)</th>
<th>Average Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961-1965</td>
<td>Pre-Medicare and Medicaid</td>
<td>8.9 7.6</td>
<td>8.3 6.2</td>
<td>2.1 6.5</td>
<td>3.6 1.4</td>
</tr>
<tr>
<td>1966-1982</td>
<td>Coverage Expansion and Rapid Price Growth</td>
<td>10.0 6.8</td>
<td>10.1 6.8</td>
<td>7.8 9.2</td>
<td>2.9 6.1</td>
</tr>
<tr>
<td>1997-1989</td>
<td>Rapid growth in prices</td>
<td>11.9 7.2</td>
<td>12.0 6.9</td>
<td>5.1 8.5</td>
<td>4.0 4.4</td>
</tr>
<tr>
<td>1993-2002</td>
<td>Payment Change and Managed Price Growth</td>
<td>13.2 6.6</td>
<td>14.1 5.8</td>
<td>4.5 9.9</td>
<td>7.9 2.1</td>
</tr>
<tr>
<td>1999-2002</td>
<td>Care Consolidation and Reallocation</td>
<td>13.4 6.4</td>
<td>14.0 4.7</td>
<td>3.7 6.9</td>
<td>3.6 3.2</td>
</tr>
<tr>
<td>2005-2010</td>
<td>Managed care backlogs and public payer changes</td>
<td>13.8 6.3</td>
<td>14.4 5.8</td>
<td>3.2 5.7</td>
<td>3.3 3.0</td>
</tr>
<tr>
<td>2005-2012</td>
<td>Faster Slower Growth</td>
<td>14.1 6.2</td>
<td>14.7 5.8</td>
<td>3.7 6.9</td>
<td>3.8 2.0</td>
</tr>
<tr>
<td>2003-2007</td>
<td>Study slowdown in spending</td>
<td>14.4 6.1</td>
<td>15.0 5.7</td>
<td>3.2 6.9</td>
<td>3.0 2.7</td>
</tr>
<tr>
<td>2008-2013</td>
<td>Impact of the Great Recession and modest recovery</td>
<td>14.7 5.9</td>
<td>15.2 5.6</td>
<td>2.2 2.5</td>
<td>0.9 1.5</td>
</tr>
<tr>
<td>1961-2013</td>
<td>Historical Spending</td>
<td>15.2 5.5</td>
<td>15.5 4.4</td>
<td>4.7 6.7</td>
<td>3.3 3.5</td>
</tr>
</tbody>
</table>

### Health Expenditure per capita, 2013 (or nearest year)

WHAT’S WRONG WITH THIS PICTURE?

Michael Neidorff
Centene

$22 million in 2016
+ 6% from 2015

Fierce Healthcare,

OTHER HEALTH INSURANCE CARRIERS’ CEO SALARIES IN 2016

• Humana (#2) - Bruce Broussard - $ 19.7 million
  – (compared to $ 10.4 million in 2015)
• Aetna – Mark Bertolini - $ 18.7 million
  – (up from 17.3 million in 2015)
• Anthem – Joseph Swedish - $ 16.5 million
  – (up from 13.6 million in 2015)
• United Healthcare – Stephen Hemsley- $ 17.6 million
  – (increase from $14.5 m in 2015)
• Cigna – David Cordani - $ 15.3 million
  – (took a pay cut from $ 17.3 in 2015)
• Molina Healthcare – J. Mario Molina $ 10.0 million
  – (slightly lower than $10.3 m in 2015)

PHYSICIAN EARNINGS BY REGION 2016

- Physician Earnings by region reported in study of Medscape’s 2016 study which included 19,200 physicians in 26 specialties:
  - North Central - $296,000
  - Southeast - $287,000
  - South Central - $286,000
  - Northwest - $283,000
  - Great Lakes - $283,000
  - West (Calif) - $281,000
  - Southwest - $277,000
  - Mid-Atlantic - $268,000
  - Northeast - $266,000


MOST REWARDING ASPECT OF BEING A PHYSICIAN?

- According to the Medscape Physician Compensation Report 2016, Carol Peckham | April 1, 2016:
  - “Gratitude/relationship with patients - 34%”;
  - “Being good at what I do/Finding answers, diagnoses – 32%”;
  - “Knowing that I am making the world a better place – 72%”;
  - “Making good money at a job I like – 11%”;
  - “Being proud of being a Doctor – 6%”;
  - “Nothing – 2%.”
DECLINING REIMBURSEMENT

“NARROW NETWORKS”
2018 CMS PROPOSED PHYSICIAN FEE SCHEDULE RELEASED 07/13/17

- **Overall Payment Update and Misvalued Code Target**
- **2018 proposed update under PFS - +0.50% established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.**
- However, this rate will be reduced by 0.19 % due to the misvalued code target recapture amount under the Achieving Better Life Experience (ABLE) Act of 2014.
- Therefore, in this proposed rule, CMS has proposed code changes that would achieve 0.31% in next expenditure reductions. If finalized, these changes would not meet the misvalued code target of 0.50%, therefore, requiring the -.019 % overall reduction to PFS payments for services.
- **After applying these adjustments, and the budget neutrality adjustment to account for changes in RVUs, all required by law, the proposed 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.**


---

**What is “MACRA”?**

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

**What does Title I of MACRA do?**

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over **volume**
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**
**Physician Fee Schedule Updates:**

- PFS 0.5% update 7/1/15-12/31/15
- PFS 0.5% update CY2016 - CY2019
- PFS 0.0% update CY 2020-2025
- MIPS & APMs will drive payment 2019 onward
- Beginning with CY 2026 - 0.75% APM update
- Beginning with CY 2026 - 0.25% update for other PFS services

**OUT-OF-NETWORK BILLING**

**CURRENT TRENDS**

**PROS AND CONS**
OUT-OF-NETWORK – VOLUNTARILY OR NON-VOLUNTARILY?

• Most private carriers base their reimbursement on a % above Medicare. When Medicare reimbursement declines, so do the other payers. It is becoming more difficult for a solo physician practice to survive under these situations.
• Another issue that is impacting the scene is what is called “narrow networks.”
• Even though some physicians make the decision to go “out-of-network” because of low, unacceptable reimbursement, many others may find themselves in an “out-of-network” situation because an insurance carrier has dropped them from their contract.

ADVANTAGES/DISADVANTAGES

• Major disadvantage of being an “in-network” provider is:
  – Healthcare physician is forced to accept very low reimbursement rates
  – Trade-off between securing the quantity flow of patients and discounting fees
  – Contract terms restrictive and favor insurance carrier
• More physicians are choosing to go “out-of-network”:
  – Choose to forego participation in the PPO and HMO networks and not to enter into managed care contracts
• Major advantages of being an “out-of-network” provider:
  – Usually higher reimbursement
• Major disadvantages:
  – Frequency of denied claims increases
  – Missing referrals of patients from PPO/HMO plans and many carriers refuse to accept assignment of benefits between patients and the practice.
THE CURRENT TRENDS

- Growth of “narrow networks” — many of the healthcare exchanges seem to be accelerating the trend of pushing physicians out of contracted plans.
- One recent study shows that around 70% of the plans on the exchanges are narrow, especially in terms of hospitals that are contracted. (Source: MedPage Today; Practice Management – Reimbursement, “Out of Network”; “More Money but Some Problems” by Leigh Page, Contributing Writer, December 28, 2013; referring to a report by McKinsey and Company.)
- Growth of out-of-network brings up the issue of “balance-billing”.
- Since the physician is not a contracted provider in an out-of-network situation, they are not bound by the discounted fee arrangements and they can bill the patient for services the insurance carrier does not reimburse.
- This brings up the issue of reimbursement based on “reasonable and customary” and how that is calculated.
- Many states are now highly concerned and are establishing laws to prevent high, unexpected medical bills for the patient.

HEALTH INSURERS

Some removed the language – “reasonable and necessary” and replaced it with fee reimbursement schedules for calculation of out-of-network claims based on a % of Medicare rates – which many believe to be unreasonably low.
“UCR”

- Usual, customary and reasonable – Reflects the amount paid in a geographic area that is based on what providers normally charge for the same or similar service. The UCR is often used to determine the “allowable” amount paid by the insurance carrier.
- Some plans also base their allowable by calculating based on Medicare rates.
- Over the years, this issue continued to cause problems for providers.

THEN CAME THE NEW YORK CASE

Andrew Cuomo, New York State Attorney General in 2008:
- Conducted an investigation into what he believed to be “under-reimbursement of out-of-network claims” by most insurers.
- Investigated “industry-wide” – “typical, customary and reasonable underpayments that were impacting consumers in New York state and nationwide.
- Mr. Cuomo – referred to the information that was gathered as: A “scheme by health insurers to defraud consumers by manipulating reimbursement rates by using a defective and manipulated database (Ingenix).
- He also stated that the insurers were using this flawed database with full knowledge that it artificially and intentionally well below “reasonable and customary” reimbursement rates.
- Investigation found that by using the database which distorted “reasonable and necessary” the insurers were able to keep reimbursements artificially low and force patients to absorb a higher share of the costs.
NEW YORK CASE

• Mr. Cuomo stated, “Getting insurance companies to keep their promises and cover medical costs can be hard enough as it is, but when insurers create convoluted and dishonest systems by determining the rate of reimbursement, real people get stuck with excessive bills and are less likely to seek the care they need.”


NEW YORK CASE - CONTINUED

• The Result?
  – Mr. Cuomo spearheaded multi-million-dollar settlements with most of the major insurance companies, with those funds to be applied to a replacement database to calculate out-of-network payments more consistently with the actual prevailing rates and reasonable and necessary standard.
  – U.S. Senator John Rockefeller, chairman of the Senate Commerce, Science and Transportation Committee at that time solicited information for 18 different insurance companies that used the Ingenix database. (Ingenix is owned by United Healthcare).
AMERICAN MEDICAL ASSOCIATION

- In January, 2009 the American Medical Association announced a settlement of its massive class-action federal lawsuit against UHC for $ 350 million.
- A non-profit organization called FAIR Health was established to work with leading academic researchers to create an enhanced database utilizing a fair and open methodology for collecting and analyzing healthcare provider charges Nationwide.
- Website: www.fairhealthconsumer.org.
- Tools and data developed by FAIR should provide realistic and more competitive out-of-network reimbursement rates.
- Are the insurers using these?


FAIR HEALTH

- A national, independent, nonprofit organization
- Goal is to bring “transparency” to healthcare costs and health insurance information:
  - Established in October, 2009 and was implemented as part of the settlement of an investigation by New York State into certain health insurance industry reimbursement practices. These practices had been based on data that was compiled by a major insurer.
  - Fair Health was formed to create a trusted, objective, fair source of data to support the adjudication and processing of health claims. Fair Health’s mission is to provide these services:
    - By gathering research through various means to support actual fair costs for medical services rendered.
    - Overseeing nation’s largest collection of data on healthcare claims by analyzing over 23 billion billed medical and dental procedures.
    - To reflect claims experience for over 150 million privately insured persons.
    - Also gathering information on claims data of more than 55 million beneficiaries of the Medicare program.
    - Fair Health licensing its privately billed data and also has data products which include benchmarks and other important data to compare cost of procedures for patients and industry.
    - Fair Health provides a free consumer website that enables consumers to estimate and plan healthcare expenditures and, in addition, offers educational modules and services for consumers to learn the basics of health insurance and its coverage.

OUT-OF-NETWORK – SIGNS OF THE END TO BALANCE BILLING?

• Your wife becomes ill and you have to take her to the Emergency Room at the nearest Hospital.
• You have good insurance through your employer.
• Your wife is admitted and must undergo surgery. Surgery is successful, wife is fine.
• You are unaware, however that, although the hospital is in network, the physicians that saw your wife in the ER and the surgeon are not in-network providers under your insurance plan.
• You receive bills from these out-of-network providers for thousands of dollars that you did not expect! You are under terrific burden and pressure to pay these bills.
• A common example of what is happening across the U.S. Could even be that you are diagnosed with a serious illness and not only have to worry about your condition, but must also worry about how to pay these unexpected large bills for healthcare!
• Several states across the United States are developing laws to address these issues – especially for Emergency care.
• Many feel that a Federal law is needed to protect patients from this problem.
• It has become a national, controversial issue.

21 STATES WITH SOME TYPE OF PROTECTION FOR PATIENTS FOR “SURPRISE MEDICAL BILLS”

• By Kris Kwolek on February 20, 2017
• POSTED IN GOVERNMENT ISSUES
• In addition to H.B. 307 (discussed in a prior post), H.B. 1566 and its companion bill, S.B. 507, propose to expand the requirement for mediation of balance bills.

• Currently, Chapter 1467 of the Texas Insurance Code requires a facility-based physician to mediate balance bills upon the request of the patient if the patient is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer –

• For an amount greater than $500 and either -
  – (i) the facility-based physician fails to disclose projected amounts for which the patient may be responsible and the circumstances under which the enrollee would be responsible for those amounts; or
  – (ii) the facility-based physician makes the disclosures but the amount billed is greater than the maximum amount projected in the disclosure.

TEXAS HOUSE BILLS - CONTINUED

• H.B. 1566, authored by Rep. John Frullo (Dist. 84, Lubbock) and S.B. 507, authored by Sen. Kelly Hancock (Dist. 9, Dallas/Tarrant County) would expand the mediation requirement above to apply to:
  – (i) “emergency care providers;” and
  – (ii) facility-based providers that are not physicians.
• The term “emergency care” is not defined, but, because the term “facility-based” should encompass providers working in a hospital or free-standing emergency department, the changes seem targeted at urgent care clinics that do not meet the definition of a “facility” – those clinics that only submit claims for professional services (CMS 1500 paper claim) and do not bill for facility services (CMS UB-04 paper claim).
BILLING “OUT-OF-NETWORK”

WHAT ARE THE SECRETS?

OUT-OF-NETWORK BILLING IS COMPLEX

• According to the staff writers at Channel Sponsor – Coding/Billing/Collections (Sponsored by National Medical Billing Services) in the article “How to win in today’s out-of-network world”, April 12, 2017:
  – “With the right approach, providers can significantly improve reimbursement rates, financial results, and the bottom-line”.

• The article goes on to explain that Health insurance companies use a couple of tactics to reduce providers' OON payments by:
  – On a case-by-case basis, attempt to negotiate a settlement with the restriction that the provider agrees to not “balance bill” the patient. This settlement offer is often faxed to the provider and provides a short turn-around response.
  – Or, the insurance carrier “simply re-prices the bill down to “reasonable and necessary”, which is typically close to the Medicare. The insurance company simply re-prices the OON bill “down to 50% or less of billed charges based on their determination of what is “reasonable and customary”. 
THIRD PARTY AGREEMENTS WITH INSURANCE CARRIERS TO REDUCT REIMBURSMENT

• As we noted at the beginning of the webinar, insurance companies have a wealth of resources and are able to hire third party vendors to help them save big bucks provider reimbursement through various bill reduction methods.
• Using 3rd party rental network agreements to reduce OON reimbursement globally. These serve as the “middlemen” to reduce reimbursement by offering a reduced settlement but quick turn around of accepted fees.
• Many providers are simply not aware of the complexities of these negotiations and simply settle for “something”, rather than chancing not getting reimbursed at all.

OTHER ISSUES OF OUT-OF-NETWORK

When insurer carriers do not accept assignment of benefits (AOB):
– Check goes to patient
– Some carriers have policies that all AOBs are rejected. Provider then has to collect from patient which could result in increasing debt collection policies; which could result in public relations problems
– Therefore, some practices just “write-off” balances to bad debt – which could impact revenue
– Health insurers state that it is simply a contract issue – insisting they cannot accept an AOB because of the lack of privity of contract with the provider – that privity only exists between the patient and their own members.
– Providers must be aware of the rules and regulations and ensure that they provide the appropriate patient education up front, along with specific written instructions and information concerning out-of-network terms and processing to ensure appropriate reimbursement.
HELPFUL HINTS

Provide patients with instructional information explaining:

- Your physician/practice is Out-of-Network, what that means and have them sign a written document that states that you instructed them and that they understand the consequences.
- Advise them that checks will be sent in some instances to the patient because the insurer may not accept the AOB.
- Have written policies and procedures and paperwork issued to the patient that explains to them what to do when they receive checks (how to endorse them, where to send them, all information necessary for them to understand that the debt is due to the provider of the services).
- Get accurate contact information for billing staff.

HELPFUL HINTS

- Provide contact to the patient to contact the billing staff or representative for any questions about out-of-network claims and payments.
- Advise them about how the EOB will read so that they understand any large balances due from the patient and what that means; let them know that many times these will be appealed.
- Get email address and cell phone #s from patients.
- Get AOB and authorization to discuss patient medical information and to file appeals on their behalf if necessary.
- Give patients copies of filed appeals and get them to contact insurance carrier.
- If the insurance carrier has a stated Appeal process and specific forms – use them.
EFFECTIVE OON CLAIM PROCESSING AND APPEALS

1. Start the registration process off correctly. Get all required information – demographics, precertification, preauthorization, eligibility, etc. Get a copy of the patient's insurance card!! – Important!!!

2. Document all preauthorization, pre-certifications, compensable injury (if W/C or accident, etc.). View and determine insurance product and coverage for each patient, securing the Out-of-Network benefits prior to rendering services. Discuss any adverse findings with patient and provider, if necessary.

3. Use online resources to verify information and gather other needed facts.

4. Make sure you have a well-drafted, complete Assignment of Benefits signed and dated by patient.

5. Ensure that you have provided the appropriate notice Out of network services in writing to the patient.

6. Be aware of acceptable ICD-10-CM codes that are to be linked to CPT code(s) to substantiate medical necessity according to the payer guidelines.

7. Know the acceptable modifier(s) to use based on the payer’s website information. Unfortunately, we have some differences in which modifier(s) are accepted by different insurance carriers.

8. Make sure you file all necessary CPT code(s) and that the procedure/service/supply is properly documented in the medical record.

9. File a complete, accurately coded 1st claim! Don’t give them any reason to deny or underpay!

10. Communicate with the payers on a continuous basis and escalate communications when necessary.

11. Use the insurance carrier’s Claim Form for Appeals if there is one available. Attach all information that can get the claim paid successfully.

12. Communicate with physician/provider when necessary.

13. Communicate with patient anytime necessary concerning balance billing.
WHAT CAN PROVIDERS DO?

1. Appeal all out-of-network claims! (Per Thomas J. Force, Esquire in the cited article)
2. “Cite the precedents created by:
   – The former New York Attorney General’s Investigation and settlements (the Code Blue Report);
   – Senator Rockefeller’s investigation and report findings
   – The UHC AMA settlement, and
   – The various class actions that have emerged since the UHC AMA settlement”
3. Realize if your Out-of-Network Claims are being under-reimbursed and if increased payment is warranted.
4. “Unique”, he states, “to appeal claims with providers generally used to appealing only denials.”
   • Mr. Force’s states – “practitioners should appeal all out-of-network paid medical claims, without exception. You will be surprised by the results. My clients frequently receive 80 to 100% of charges after appeal.”

Source: How to Obtain Increased Reimbursement on Your Out-of-Network Claims

AETNA: Does your member ID card have “NAP” on the front?

That stands for National Advantage™ Program. And it has benefits for you:

– You can get discounts for out-of-network care from NAP providers. Your out-of-pocket costs may be less than your costs for seeing other providers who are out of network.
– If you get care from an NAP provider, you won’t get a balance bill. You will pay your usual cost sharing for out-of-network care.
– Check your most recent ID card to see whether your plan has the program. Some plans that used to have NAP no longer have it.
IMPORTANT! OUT-OF-NETWORK BENEFITS FOR PATIENT?

In-Network vs Out-of-Network Providers:
- Receive highest level of benefits
- No claims to file in most cases (network provider will usually file the claims)
- No balance billing, network providers cannot bill for costs exceeding the allowed amount.

With out-of-network providers:
- Receive out-of-network level of benefits (reduced level from network)
- May have to file own claims
- May be billed for charges exceeding the allowed amount

BCBSTX WEB SITE INFORMATION

- In-Network vs Out-of-Network Providers
- With in-network providers:
  - Receive highest level of benefits
  - No claims to file in most cases (network provider will usually file the claims)
  - No balance billing, network providers cannot bill for costs exceeding the allowed amount.
- With out-of-network providers:
  - Receive out-of-network level of benefits (reduced level from network)
  - May have to file own claims
  - May be billed for charges exceeding the allowed amount
Information on Payment of Out-of-Network Benefits – UNITED HEALTHCARE

- Certain health care benefit plans administered or insured by affiliates of UnitedHealth Group Incorporated provide "out-of-network" medical and surgical benefits for members.
- With out-of-network benefits, members may be entitled to payment for covered expenses if they use doctors and other health care professionals outside of the UnitedHealthcare network.
- The member or health care professional, depending on whether or not the member has assigned his or her claim, may send a claim for such out-of-network professional services to be paid by a UnitedHealth Group affiliate. The UnitedHealth Group affiliate will pay based on the terms of the member's health care benefit plan that in many cases provides for payment for amounts that are the lower of either:
  - the out-of-network provider's actual charge billed to the member, or
  - "the reasonable and customary amount," "the usual, customary, and reasonable amount," "the prevailing rate," or other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services.
- Based on what other healthcare professionals in a geographic area charge for their services.

UNITED HEALTH CARE - What is FAIR Health?

- FAIR Health is a not-for-profit company, independent of UnitedHealth Group affiliates, established following the New York Attorney General's ("NYAG") investigation into alleged conflicts of interest related to the ownership and use of Ingenix, Inc.'s Prevailing Healthcare Charges System database ("PHCS Database") and Medical Data Research database ("MDR database") and the fairness of their rates. Ingenix, Inc. ("Ingenix"), now known as Optum Insight, Inc. ("Optum Insight"), is a wholly-owned subsidiary of UnitedHealth Group Incorporated.
- Under a January 2009 settlement agreement between UnitedHealth Group Incorporated and the NYAG, Ingenix's PHCS and MDR Databases closed following the establishment of the new database to be owned and operated by FAIR Health.
- FAIR Health provides health care consumers with an estimate of how much out-of-network services will cost them. Health care consumers can access FAIR Health's Consumer Price Lookup.
UNITED HEALTHCARE – FAIR HEALTH INFORMATION

- The following example illustrates the information gathered by FAIR Health in the FH Benchmark Database: FAIR Health receives charge information of health care professionals who perform colonoscopies in a particular geographic area for a particular time period. The charges of these health care professionals for colonoscopies are arranged from low to high and then percentiles are identified from that arrangement. Here is a simplified illustration of a percentile chart for a colonoscopy for one geographic area:
  - CPT code Description 50th 60th 70th 75th 80th 85th 90th 95th
  - 45378 COLONOSCOPY $764 $783 $859 $887 $907 $939 $1008 $1105
- Affiliates of UnitedHealth Group frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals, but plan designers and administrators of particular health care benefit plans may choose different percentiles for use with applicable health care benefit plans.
- Members may contact the customer service line of the applicable UnitedHealth Group affiliate shown on the back of the member's health identification card to learn of the percentile applicable to the member's health plan.

QUESTIONS?

- THANK YOU!
Questions?

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp