MedBillsAssist

Medical Claims Solutions

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Pay Cuts for Doctors

Finding a physician whom we like and trust isn't an easy process. Once we find him/her we naturally want to keep the relationship in good order. What would you say if your next call to make an appointment would yield a response that your doctor is no longer taking your insurance or Medicare?

If the present law doesn't change that could easily happen to many patients in the nation.

Physicians are scheduled for a 21% Medicare pay cut next year. A similar scenario occurred last summer when the scheduled cut was 10.5%. While congress went on recess all payments to physicians were suspended. Some doctors chose to close their doors and go on vacation, while others continued to work without being paid. When returned in July, Congress had to override President Bush's veto of House Resolution 6631, the Medicare Improvement for Patients and Providers Act, to stop the cut. The new law addressed many other areas, however it failed to correct the shortcoming in the methodology of the Sustainable Growth Rate (SGR). This flawed formula mandates physician rate cuts almost every year. Unless congress reviews and corrects this mistake physicians will continue to face potential pay cuts. As a result more physicians will choose to limit their Medicare patients, or worst yet, will opt out of Medicare altogether.

At the same time, rates for hospitals increase, because it is tied to the Medicare Economic Index (MEI), which is Medicare's measure of the increasing costs of providing medical services.

Payments to the managed Medicare programs are already costing more than of traditional Medicare, yet there are no scheduled cuts to that program.

Quote of the Quarter

"The closest things to government-run public plans that exist in America today are the Veterans Administration and state Medicaid agencies. Anyone using state employee plans to make the case that public plans exist is engaging in bait-and-switch games with the truth and with the English language."

— Walton Francis, an economist and primary author of CHECKBOOK's Guide to Health Plans for Federal Employees

Nothing is Wrong with Our Healthcare

The US delivers high quality healthcare for those who can afford it. The only problem is the cost. According to the OECD data in 2008 the US spent $6,014 per capita on healthcare. That is more than double than any other nation. There is no actual research that will tell us how much was spent on administration and how much on actual medical care. One can only guess on the cost of administration. Following is a simple example of just that. A common chest x-ray that Medicare pays a nationwide average of $23.80 has 83 pages of documentation, called Local Coverage Determination. How much does it cost to maintain that document in federal and state levels? Could we assume that costs more than several chest x-rays? Agreeing to pay all chest x-rays when ordered by a physician should eliminate the need for Medicare and insurance companies to manage rules, hospital billing departments to check for compliance with the rules, doctor's offices to ensure compliant coding, and insurance company software programs to examine and apply all the correct rules. Simply paying medical services may cost less than regulating and administering them. Other nations dispense medical care according to doctor's orders. They've eliminated the middle man. In the US it is impossible to eliminate the insurance companies, Medicare and Medicaid. What we need to do is eliminate added layers of administration.

The only federal mandate should state that insurance companies must provide coverage for anyone who applies for it. The cost can not exceed 3% of their income. The policy pays all procedures that are ordered by a physician and payment is 90% of charges. 10% will be paid by the beneficiary.

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Hospital Lifetime Caps on Medicare

Medicare part A provides payment for inpatient care in a hospital and nursing home settings. The way coverage designed for these services can be difficult to understand. To begin, hospital coverage operates based on the length of the stay and a 60 day reset. The first level is 60 days of hospitalization that "only" costs the patient a $1,068 deductible. The second level covers the next 30 days, the patient is now responsible for $267 per day. The last level covers the next 60 days, but will only do so once during the lifetime of the policy. These days increase the daily patient cost to $534 per day.

Once a person has used up 150 continuous days or 150 days without a gap of 60 days between inpatient stays, the patient has exhausted their Medicare benefit and will now be responsible for any remaining inpatient charges. Medicare Part B will now cover any outpatient related services. If this person is hospitalized again in 61 days, the patient's coverage will reset and they will again be covered up to 90 days of inpatient service.

The lifetime reserve days do not all need to be used in one stay. If a patient stays 97 days in the hospital, they will still have 53 lifetime reserve days left to use. However, once all of these days are exhausted there is no way to restore them.

This Medicare system of inpatient care is often referred to as the 60-30-60 rule. *More information on nursing home coverage in the next issue!*

Definitions:

SGR-Sustainable Growth Rate: a federal formula that mandates physician pay cuts.

OECD* Organization for Economic Co-operation and Development: an international organization that compare policy experiences, seek answer to common problems and coordinate international policies.

CDPH: California Department of Public Health.

The Uninsured

This is about time to look into that dreadfully high number of uninsured. According to the census bureau, we now have 47 million people who are uninsured. What is behind this number?

About 35 million of these people actually have access to either employer or government based insurance, they simply haven't applied for their benefits. There may be numerous reasons for failing to apply. Some of those eligible for employer sponsored medical insurance simply aren't interested in getting coverage, while others don't realize they qualify for state funded insurance. In some cases coverage may simply be too expensive. The true number of uninsured falls at approximately 12 million. Many states have made provisions to allow all residents access to insurance. Massachusetts has even mandated it. Yet, there are still those willing to pay a penalty instead of getting coverage.

MedBillsAssist

Our Mission is to represent our clients' best interests. We work on your behalf in an ethical manner in compliance with state and federal regulations.

We tailor our service to your specific needs.

We work with claims in collection or track and resolve claim problems for the entire family.

When you need a patient advocate to negotiate with medical providers and insurance companies, give us a call.

Medicare trained specialist.

Licensed in Connecticut, New York and Virginia.

Who is in Trouble this Time?

The California Department of Public Health (CDPH) has levied its first administrative penalty against Bellflower Medical Center. CDPH recently enacted two state laws intended to protect confidential patient information. The state assessed the maximum penalty of $250,000 for Bellflower Medical Center's failure to prevent unauthorized access to patient information.

According to the report, nearly two dozen employees accessed a patient's electronic medical record without authorization. The hospital reported these incidents to the state, installed confidentiality safeguards to patient records and added additional privacy training. The snooping employees were terminated.

Federal HIPAA law already provides this protection and the new federal HITECH Act requires further privacy protection and reporting. In many ways, California law duplicates existing federal regulations.