MedBillsAssist

Medical Claims Solutions

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The Healthcare Law is Here to Stay

The healthcare law (Patient Protection and Affordable Care Act) is here to stay. It survived the supreme court's review. Our dysfunctional congress does not have enough votes to overturn it. While the bill is far from perfect, it has done much good already, and will continue to do so. We are now moving onto bickering about state exchanges.

In 2014 the healthcare law will be fully implemented, which opens up the marketplace with state exchanges. The exchanges are online markets where consumers can shop for private insurance subsidized by the federal government. About 18 states will run their own exchanges, while about 11 will partner with the federal government and another 18 will leave it to be handled by the federal government.

By January 2014 all Americans are required to have health insurance. These exchanges are set up to find affordable medical insurance in each state.

Another piece of this law is already in force. Insurance companies are required to refund a percentage of premium money that was not spent on medical care. This is called the medical loss ratio. It varies between different types of plans by a small percentage point. Some groups and individuals have already received refunds of premiums due to this provision of the law.

Another important piece of this legislation is the elimination of pre-existing condition reviews. This has a major impact on those whom were unable to secure insurance coverage in the past.

The Medicaid expansion (insurance for low income citizens) part of the law didn't survive the supreme court legal review. It is still frustrating to me when I hear of people abusing the system while others are afraid to seek care due to cost. We still spend too much on administration, that slows care and frustrates many. We still have a lot of work ahead, but this is a start.

Mental Health Coverage

There is a lot of misunderstanding about mental health and substance abuse care. Numerous excellent facilities and specialty organizations that potentially save the lives of troubled teenagers and adults who get over their heads with drugs, alcohol and/or mental illness.

Unfortunately, most of these safe places are not compliant with insurance requirements, nor they are approved by Medicare.

Cost for care is a significant burden for families. A month or two can easily end up costing $50,000 or more. Most places ask for money up front and insurance reimbursement varies. Some facilities work hard to get services approved while others really don't understand anything about insurance.

There were occasions when I had to piece a bill together to get a proper claim submitted to insurance.

The best way to address financials and potential insurance reimbursement options is up front. If the facility is unsure about insurance it is a good idea to call your insurance company and discuss requirements before a family member is admitted. The best way to go about this is by requesting a prior authorization. This can be simply done by calling the Behavioral Health contractor and tell them about the facility and the planned service. This is one of the times when your insurance company is your best ally.

Quote of the Quarter

Quoting the funny Dave Barry :

"My therapist told me the way to achieve true inner peace is to finish what I start. So for today, I have finished 2 bags of M&M and a chocolate cake. I feel better already."

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Medicare - Open Enrollment

It is that time of the year again; Medicare open enrollment is upon us. This is the time to review present coverage and decide if your combination of Medicare plans are still suitable for you. Open enrollment started on October 15th and will end on December 7th.
Unfortunately, this is also a time of marketing overload. It is easy to get lost in all the mailings. The only letters should be considered carefully are those that are arriving from your present plans.

This is the time when insurance companies make changes in the formularies. If there is a removal of a drug you are presently taking it may be the time to change companies. Some of these prescription providers may have decided to stop offering your present policy. A discontinued policy must be replaced with another to ensure continuous coverage. Other changes in policies, such as price increases, are just as important, because this can cause increase in premium, and decrease in benefits.
The same applies to Medicare Advantage plans. There could be change in terms, co-insurances, co-payments and monthly premiums. So, even if you are happy with your current plan check the materials to be sure it is still meeting your

Definitions:

PPACA: Patient Protection and Affordable Care Act

Medicare Advantage Plan: a Medicare private insurance plan replacing traditional Medicare.

Formulary: a complete list of drugs offered by any prescription policy.

PDP: Medicare Prescription Drug Plan.

Medicare Therapy Coverage

There are two significant changes taking place with Medicare therapy services. The therapy caps/limits have been tightened. Limitations now apply to hospital based therapies and the almost automatic exceptions have been replaced with medical review. This change is new and most Medicare contractors are struggling to move paperwork fast enough to meet demand. Unfortunately this is forcing patients and providers to delay care.
The good news is that The Center for Medicare Advocacy lawsuit is finally coming to fruition. Centers for Medicare & Medicaid Services (CMS) have agreed to settle the Improvement Standard case. When the judge approves the proposed agreement CMS will revise the Medicare Benefit Policy Manual to correct language that requires patient condition to improve. The new Medicare manual will allow therapy services for patients with chronic conditions to receive physical, speech and occupational therapy services, simply to maintain a person's condition.
For decades, Medicare beneficiaries, particularly those with long-term or debilitating conditions have been denied necessary care based on the "Improvement Standard".

Legal Issues or Who is in Trouble this Time?

Preet Bharara, a US district attorney, announced today that the United States has filed and simultaneously settled a civil fraud lawsuit against the Westchester County Health Care Corporation, doing business as the Westchester Medical Center ("WMC") for submitting false reimbursement claims to Medicaid.
The government's complaint alleges that Westchester Medical Center billed Medicaid for millions of dollars of outpatient services at its mental health center that lacked the core documentation required by Medicaid regulations, didn't return money when it overbilled the government and avoided dealing with compliance issues and instead focused on maximizing billing.
The settlement requires WMC to pay $7 million in civil damages under the False Claims Act. $3.5 million will go to the Federal Government and $3.5 million will go to New York State.

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