INTRODUCTION TO REIMBURSEMENT

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DISCLAIMER

- Not everything we say will necessarily be true for all time, or for all payers. Things change.
- Comments reflect best current practices
- Providers are expected to do their own investigation, and stay current
- Opinions expressed are those of the presenters, and do not reflect opinion or policy of any of our sponsors, or any organization
THE BASICS

- Theoretically, all you should need to submit a claim and receive full, timely, and appropriate reimbursement should be a diagnosis code, and a procedural code...

- But it doesn’t work that way – at least not anymore
MEDICINE HAS BECOME A VERY COMPLEX BUSINESS

- Mixture of procedural and cognitive services, labs, x-rays, materials, supplies, devices
- Payers have become major players, and establish rules under which they will pay claims
- If you don’t “play by their rules”, reimbursement may be delayed, decreased, or denied; and you may not be able to recoup the difference from the patient
MEDICINE HAS BECOME A VERY LEAN BUSINESS

- Gross profitability of the past is a thing of the past
- Must be lean and efficient
- Must know how to appropriately bill and document the services you provide so as to ensure timely, appropriate and maximum available reimbursement
MEDICINE HAS BECOME A VERY RISKY BUSINESS

- By contract, statute, and regulation, payers have tremendous clout; with authority to:
  - Withhold payment
  - Demand refund of payment - sometimes extrapolated over the universe of your patients
  - Federal programs also retain authority of fines, penalties, imprisonment, and license revocation
APPROPRIATE/ACCURATE CODING AND DOCUMENTATION SUPPORTS:

- Timely reimbursement of maximum available fees
- Timely recognition of charges that are patient responsibility
- Decreased risk of audit, fines, penalties
- Greater efficiency, with resultant greater profitability
- And it supports and reflects better patient care!
We look to Medicare policy as the highest standard/authority in determining appropriate coding, documentation, and coverage issues.
WHY MEDICARE?

- Highest level qualifying criteria
- If you meet Medicare’s criteria, you will meet virtually any payer’s criteria
- Medicare sets the direction; others follow within 1-2 years
- Medicare has the heaviest hammer for abuse or overutilization
- Standards apply for all Federally-funded programs (military, postal service, etc.)
MEDICARE REIMBURSEMENT IS BASED UPON MULTIPLICATION OF SEVERAL COMPONENTS

- Conversion Factor
- Geographic Index
- RVU value

And the total package must be “budget neutral”
BUDGET NEUTRAL

- Sustainable Growth Rate Formula ("SGR")
- Federal law
- Increases in medical spending must be budget neutral
- So in the event of increased expenditure, they must decrease future payments (by adjusting the conversion factor)
MEDICARE CONVERSION FACTOR

1999  $34.7315/RVU
2000  $36.6137
2001  $38.2581
2002  $36.1992
2003  $36.7856 (initially $34.5920)
2004  $37.3374 (initially $35.1339)
2005  $37.8975
2006  $37.8975
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…see a trend?
As overall medical expenditures continue to rise each year, unless Congress fixes the (flawed) SGR, each year there will be the threat of 20+ % decreases in the Medicare conversion factor, until Congress passes (yet) another temporary patch.

Think “kick the can down the road”
In the absence of legislative action, physician’s fees under Medicare will decrease 25.0% in FY 2015
SGR

- The US Congress was “expected” to finally and permanently “fix” the flawed SGR in 2014.

- Instead, they passed their 17th temporary “patch” (signed into law by President Obama on April 1, 2014), which also contained a one sentence phrase that delayed ICD-10-CM for at least one more year.
Unless there is a Congressional “fix” for the current Medicare reimbursement formula, physicians’ reimbursement is expected to decrease 31% over the next 6 years (6% per year); while physicians’ expenses rise 19% or more in the same interval.

(Part B News; Feb 2005)
Everyone wants/expects a raise each year

It won’t come from rising Medicare fees

It will likely not come from rising fees from payers

The answer is efficiency (Jon Hultman)
YOUR GOAL…

Be as efficient in your coding and documentation as possible

Ensure appropriate and timely payer reimbursement for all the medically necessary services you provide

Provide prompt and clean designation of charges which are patient responsibility (and collect those at time of service)
And THAT’S why you’re here....