

PRESIDENT'S UPDATE

New York State Ophthalmological Society

January 2008

2008 MEDICARE CODING PROGRAMS SLATED

NYSOS will be sponsoring its annual Medicare Coding & Billing Seminars in five cities throughout New York during March 2008. A full course description and registration information were sent to NYSOS members in the Fall issue of the *NYSight* magazine. The information is also available at www.nysos.com/2008coding.pdf.

In addition to presenting policy and payment changes for the coming year, the 2008 seminar series will examine new opportunities for the coming year and an interactive review of case studies examining practice patterns and revenue generation.

Be sure to reserve a place for you and your staff at the discount rate by completing and returning the registration form by the early bird deadline of February 29, 2008.

MARK YOUR CALENDARS FOR OPHTHALMOLOGY LOBBY DAY

The NYS Ophthalmological Society will hold its Annual Lobby Day on Tuesday, April 29, 2008 in Albany, NY. The day will begin with a breakfast briefing on key bills before the State Legislature followed by physician visits with their State Senate and Assembly Representatives. Following legislative visits, the group will reconvene for a debriefing and lunch.

Each year attendance at the program has grown and we hope to break all previous records at our 2008 Lobby Day event. We urge you to plan to attend and do your part to educate lawmakers and help insure that medical eye care in New York State is not compromised.

Please register by calling the NYSOS office at (518) 438-2020, and staff will work with you in scheduling visits with your elected representatives.

CALL FOR HOBIE AWARD NOMINATIONS

The NYS Ophthalmological Society is accepting nominations for its highest honor - The Hobie Award. The Award was established in 1999 to recognize the contributions of Hobart "Hobie" A. Lerner, MD for more than four decades of service to organized ophthalmology. It is presented each year to the NYSOS member Ophthalmologist who demonstrates outstanding commitment to his patients, community or profession.

The nominee must be a member of NYSOS who has demonstrated a pattern of service in one of the three areas for which The Hobie Award was established: 1) Humanitarian or Community Service; 2) Political Advocacy; or 3) Research/ Professional Practice.

A copy of the Award guidelines and nomination form is available on the NYSOS website at <http://nysos.com/2008hobie.pdf>. If you wish to nominate a colleague for the 2008 honor, please be sure to return the requested nomination materials **by May 1, 2008**.

MEDICAL COMMUNITY MOURNS THE LOSS OF DR. MOONEY

It is with sadness that we report the passing of long time NYSOS member Robert M. Mooney, MD after a battle with cancer. A wake will be held at Clark Funeral Home in Katonah, NY. Calling hours are Thursday, January 17 from 7:00-9:00 pm, and Friday, January 18th, 2:00-4:00 and 7:00-9:00 pm.

REVISED FEES POSTED TO MEDICARE CARRIER WEB SITES

As reported previously, Congress acted at the end of December 2007 and passed the Medicare, Medicaid and SCHIP Extension Act of 2007 (S.2499). The planned 10.1% reduction in payments was postponed until the end of June 2008. Instead, the new law gives physicians a 0.5% increase in the overall Conversion Factor for the first six months of 2008. You may or may not see increases in individual services as practice expense RVU changes and other factors come into play.

The fees that were posted on the Medicare carrier web sites had to be revised to reflect the new 2008 Medicare Fee Schedules and are available at:

NGS - www.empiremedicare.com/partbny/billing/fees/fees2008.htm

GHI Medicare - www.ghimedicare.com/provider/2008fee.html

UMD - www.umd.nycpic.com/physician-fees.html#Fee2008

These Fee Schedule amounts and Limiting Charges will be effective for dates of service January 1, 2008 and onward until Congress acts again at the end of June 2008. If Congress does not act by that time, a 10.1% decrease is expected for the remainder of 2008.

There is normally a deadline of December 31, 2007 for physicians to decide if they would be "participating" or "non-participating" physicians for 2008. However, the new deadline to notify carriers of changes in participation status is February 15, 2008.

CMS had been asked whether participation decisions for 2008 will be binding for the entire year or only for six months, and whether there will be another participation period before the 0.5% payment update expires on June 30, 2008. At present, it is CMS position that participation decisions made by Feb. 15, 2008 will be binding for the entire year. If new information becomes available you will be kept apprised through this publication and postings on the NYSOS website (www.nysos.com).

Once you have had a chance to review the revised fees, you may need to contemplate your continued participation or some other arrangement. If you are considering a change in your participation status, be sure to review the next article which outlines the three billing methods under Medicare.

BILLING ARRANGEMENT OPTIONS UNDER MEDICARE

There are basically three Medicare billing arrangement options available to physicians:

- Sign a participation agreement and accept Medicare's allowed charge as payment in full.
- Elect to be a non-participating physician, which permits them to bill patients for somewhat more than the Medicare allowance.
- Become a private contracting physician agreeing to bill patients directly and forego any payment from Medicare either to the patient or the physician.

Physicians who want to change their status from participating to nonparticipating or vice versa should do so as soon as possible. Once made, the decision is irrevocable except where the physician's practice situation has changed significantly, such as relocation to a different geographic area or a different group practice. To become a private contractor, physicians must give 30 days notice before the first day of the quarter the contract takes effect. Those considering a change in status should have first determined that they were not bound by any contractual arrangements which require them to be participating doctors.

Participating Physicians

Participating physicians must agree to take assignment on all Medicare claims, which means that they must accept Medicare's approved amount as payment in full for all covered services for the duration of the calendar year. The patient is still responsible for the Medicare deductible and 20% coinsurance but the physician cannot bill the patient for amounts in excess of the Medicare allowance.

Medicare provides a number of incentives for physicians to participate:

- The Medicare payment amount for participating physicians is 5% higher than the rate for non-par physicians.
- Directories of PAR physicians are provided to senior citizens groups and to individuals who request one.
- Carriers provide toll free claims processing lines to PAR physicians and processes their claims more quickly.

Non-Participation (Non-PAR)

For Non-PAR physicians, the full payment schedule is set at 95% of the full payment schedule for PAR physicians. Non-PAR approved amounts are 95% of the PAR amounts for the same service.

Limiting charges for non-PAR physicians are set at 115% of the Medicare approved amount for non-PAR physicians (please see NYS law information below).

Since Medicare payment schedule amounts for non-PAR physicians are 95% of payment rates for PAR physicians, the 15% limiting charge translates into only 9.25% above the PAR approved amount for the service.

How to Decide

When considering whether to participate, physicians must determine whether their total revenues from balance billing would exceed their revenues as PAR physicians, particularly in light of collection costs, bad debts, and claims for which they do accept assignment. The 95% payment rate is not based on whether physicians accept assignment on the claim, but whether they are PAR physicians; when non-PAR physicians accept assignment for their low-income or other patients, they still receive only 95% of the amount PAR physicians receive for the same service.

A non-PAR physician would need to collect the full limiting charge amount roughly 35% of the time they provided the service for the revenues from the service to equal those of PAR physicians.

Remember, in NYS, the NYS limiting charge law is set at 105% of the non-PAR fee schedule amount for all Medicare covered services, except 99201 - 99215 and 99341 - 99353 (office and home visits, respectively). For every \$100.00 participating fee impacted by the NYS limiting charge law, the non-participating physician loses \$0.25.

Assignment acceptance, for either a PAR or non-PAR physician, also means that the Medicare carrier pays the physician the 80% Medicare payment. For unassigned claims, even though the physician is required to submit the claim to Medicare, the program pays the patient, and the physician must then collect the entire amount for the service from the patient.

Private Contracting

Provisions in the Balanced Budget Act of 1997 give physicians and their Medicare patients the freedom to privately contract to provide health care services outside the Medicare system. Private contracts must meet specific requirements:

The physician must sign and file an affidavit agreeing to forgo receiving any payment from Medicare for items or services provided to any Medicare beneficiary for the following 2-year period (either directly, on a capitated basis, or from an organization that received Medicare reimbursement directly or on a capitated basis);

Medicare does not pay for the services provided or contracted for;

The contract must be in writing and must be signed by the beneficiary before any item or service is provided;

The contract cannot be entered into at a time when the beneficiary is facing an emergency or an urgent health situation.

In addition, the contract must state unambiguously that by signing the private contract, the beneficiary: gives up all Medicare payment for services furnished by the "opt out" physician; agrees not to bill Medicare or ask the physician to bill Medicare; is liable for all of the physician's charges, without any Medicare balance billing limits; acknowledges that Medigap or any other supplemental insurance will not pay toward the services; and acknowledges that he/she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

To opt out, a physician must file an affidavit that meets the above criteria and is received by the carrier at least 30 days before the first day of the next calendar quarter. There is a 90-day period after the effective date of the first opt-out affidavit during which a physician may revoke the opt-out and return to Medicare as if they had never opted out.

Sample affidavits and patient agreement forms are available on your Medicare carrier website.

EBCBS CLARIFIES USE OF PATIENT WAIVERS

A recent article in an Empire Blue Cross Blue Shield (EBCBS) publication prompted a request for clarification on the use of waivers when a service is or could be non-covered. The waiver usually comes into play if a provider knows that a service is or will not be covered by Empire and the member signs a waiver before or at the time of service. Empire does not encourage the use of such waivers but understands that physicians still use this method to insure payment for non-covered procedures.

However, in the article they posted, EBCBS was trying to educate physicians on when and why a waiver is used, as there has been problems with some physicians making patients sign a waiver when the service was covered under their contract.

A waiver is to be signed before the claim is submitted when a provider is "certain" that a service is not covered. However, as far as services that are non-covered it would depend on the patients contract. Each contract may be different, so there would not be any way to create a general list of non-covered services or be certain that a service is non-covered.

In this event, physicians are urged to use their best judgment in these scenarios where there may be a chance that the service will be covered after they have had the patient complete a waiver form and billed them. In these cases, a refund to the patient would be in order.

EBCBS requires that the cost of the service be on the waiver form as well. Therefore, the physician may list what the (non-covered) cost is on the waiver so the patient knows how much will be charged if EBCBS deems the service to be non covered, investigational, etc. There is no particular format for this waiver form mandated by EBCBS. You may want to amend the following to reflect a form to be used in your office.

Date _____

Dear _____,

Your health insurance, Empire Blue Cross Blue Shield, does not pay for all of your health care costs. EBCBS only pays for benefits allowed under your subscriber contract.

When you receive an item or service that is not a covered benefit, you are personally responsible for paying.

The purpose of this waiver form is to: 1) advise you about whether or not your insurance will cover this item or service; and 2) advise you that you will have to pay for them yourself. We have determined that EBCBS will not pay for the following item or service: (Enter Type of Service) on this date (Enter Date of Service).

The cost to you will be: \$_____.

In the event that EBCBS does pay for this item or service and we have billed you already, we will refund the proper amounts due after review of co-payments, coinsurance, and deductible amounts. Please sign below.

I understand that I am financially responsible for any items or services, which are not covered by my insurance plan.

Signature: _____

MEDICARE HIC NUMBER CHANGES FOR 2008

As reported previously, when the Health Insurance Claim Number (HICN) and name of the beneficiary do not match on the submitted claim, Medicare carriers, intermediaries, and A/B MACs will return the claim to the provider as unprocessable. When non-institutional providers submit claims to Medicare carriers or A/B MACs that do not result in a match on name and HICN, the claim is returned with reason code 140 (Patient/Insured health identification number and name do not match).

In addition, effective January 7, 2008, on ALL Medicare Summary Notices, the first 5 digits of the HICN will be replaced with "XXX-XX" to avoid displaying the Medicare beneficiary's personally identifiable information (PII). This applies to pay, no pay, and duplicate copies of the MSN.

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