SHOW ME THE MONEY

Surviving the Reimbursement Runaround

The facts are startling, but painfully familiar to California physicians. Medi-Cal reimbursement rates trail far behind those of other states, ranking a sorry 42nd place. Medicare reimbursement rates can't keep up with the rising cost of delivering healthcare to the elderly. And according to Michael J. Sexton, MD, a San Rafael emergency physician and chair of the California Medical Association's (CMA) Board of Trustees, even reimbursement rates physicians receive through commercial insurers are 30%–40% lower than those in other states.

By Laurel DiGangi

"If you look at all the issues of reimbursement," says Dr. Sexton, "California is at the bottom of every level."

He blames the business practices of California's for-profit HMOs for worsening a difficult situation.

"Physicians already have inadequate money coming in, and when we actually perform a service that the insurance company has agreed to pay us for, we can't get them to pay," he says. "It's a firmly held belief among physicians that insurance companies engage in unfair business practices on purpose because they can get away with them."

Whatever the intent, these business practices—bundling, downcoding, denial of claims and slow payment, among others—provide endless hassles that are both time-consuming and expensive.

But support is available to help physicians succeed in this struggle. According to James T. Hay, MD, an Encinitas family practitioner and vice speaker of the CMA House of Delegates, economic advocacy is the association's No. 1 priority, based on surveys of member and nonmember physicians.

To that end, CMA has developed resources to educate physicians in the finer points of reimbursement and provide the tools needed to get paid.

"The most important thing for physicians is to be informed, and that's where we come in."

—Reesa Wilkie
Associate Director for Medical Practice and Economic Advocacy, California Medical Association

To the Rescue

Leading physicians in the battle to secure fair reimbursement is Reesa Wilkie, CMA's associate director for medical practice and economic advocacy, a position she's held for almost four years.

"Physicians feel, and rightfully so, that they are helpless in getting fair reimbursement because the managed-care organizations have so much power in this marketplace," she says.

Delayed reimbursement creates administrative costs that add to the expense of managing a practice.

"It's just become an unbearable environment for many doctors," Wilkie says. "They're feeling financially squeezed."

Her knowledge of, and passion for, reimbursement advocacy comes from her background as a nurse and former director of reimbursement for a 400-physician medical group. She views her CMA position as a vehicle to help physicians stay in business so they can care for patients, and she strongly believes relief will come.

Hot Lines and Hassle Logs

Headed by Wilkie, CMA's reimburse-

ment advocacy program gives physicians direct assistance with specific problems. A physician who needs to discuss a particular reimbursement quandary can call CMA's Reimbursement Hot Line (888/401-5911).

In addition, CMA members with Internet access can find a wealth of reimbursement information and resources by visiting the association's website (www.cmanet.org) and logging onto the "Members Only" home page. Under "Select a Topic Area" (in the lower-right corner), use the drop-down menu to choose "Reimbursement Advocacy." This page features a link to a "Hassle Factor Log," where physicians can ask questions, report concerns and access dozens of informational documents (including the CMA On-Call Index) about protective laws and strategies to get paid.

In addition, members can download a free copy of the *Reimbursement Survival Kit* through CMA's online bookstore.

"Doctors who use the website absolutely love it," Wilkie says. "There are sample letters that physicians can download and personalize on their own letterhead, information about how to get paid, how to deal with denials, what to do in a bankruptcy, how to appeal claims through Medicare and private insurance, and much more."

For physicians who lack Internet access, problems may also be reported via regular mail or fax. Simply complete the Hassle Factor Log in CMA's *Reimbursement Advocacy Survival Kit,* which can be ordered through the Hot Line by calling 888/401-5911.

Tracking Hard Evidence

Wilkie emphasizes the importance of contacting CMA through its Hot Line or Hassle Factor Log— even when a particular reimbursement problem has been resolved—so association representatives can input the information into a data base and see where major problems occur. Wilkie's department tracks problems by specific payer, from Medicare to PPOs and HMOs.

"We can also see if certain issues are regional or statewide, and whether certain problems are specific to solo doctors, medium groups or large groups," Wilkie says.

CMA uses the information culled from this data base in lobbying efforts, legislative work and regular meetings with payers, including Medi-Cal, Medicare, the Department of Health Services and individual health plans. According to Wilkie, the data base allows CMA to go into meetings with hard, rather than anecdotal, evidence.

"We can bring in examples, and we can ask them to address the individual problems with CMA physicians who have complained," Wilkie says. "We can also say, 'Don't tell us that this isn't a problem because we know it is.'"

Legislative Solution

The CMA-sponsored AB 1455, the Unfair Payment Practices Law passed last year, requires health plans to employ speedy, impartial and cost-effective dispute-resolution procedures. It also requires the Department of Managed Health Care (DMHC) to investigate and enforce penalties on health plans that en-

gage in unfair payment practices.

CMA and the DMHC are currently discussing draft regulations to this bill so that it can be effectively enforced. Unfortunately, the insurance companies are also lobbying the DMHC to implement the regulations in their favor.

"We expect to win some battles and lose others," Wilkie says.

One extremely important step that assists CMA's lobbying efforts is to report unfair payment patterns to the DMHC. Unless physicians report these practices, there is no public evidence the problems exist.

The CMA website provides a form for reporting such practices to the DMHC. To access it, log onto the previously mentioned "Reimbursement Advocacy" page, click on "Reimbursement from HMOs and Other Payors," and then click on "Report Unfair Payment Practices." Physicians may also contact the DMHC directly through its hot line (877/525-1295).

"We are also tracking problems so that we can regulate the regulator," Wilkie says. "We want to make sure that the DMHC is following up on complaints."

The Waiting Game

Physicians are all too familiar with the following scenario: You send a claim to a payer, only to wait months to be reimbursed.

But under California law, HMOs and their contracting entities are required to pay uncontested claims within 45 days; other third-party payers and their contracting entities must do so within 30 days.

AB 1455 is designed to ensure that late-paying plans incur interest penalties that must be automatically included in reimbursement, with additional penalties if they fail to do so.

"Clearly, these organizations [that pay late] are businesses that look at their bottom line at the end of every quarter," Wilkie says. "It won't be until those penalties are sufficiently large for us to deter this behavior."

One hefty fine of $100,000 was imposed upon HealthNet for failure to pay claims within the guidelines set by law. In addition, the DMHC slapped PacifiCare last year with a cease-and-desist order related to past-due claims.

"These fines are so new that it's hard to say what the impact is," Wilkie says. "One of our concerns has been that the fines will be substantial enough to deter the activity. We have to wait and see."

CMA offers form letters demanding payment with interest on its website and within the *Survival Kit.*

Stalling Tactics

Unfortunately, that 30- or 45-day time period within which payment must be received doesn't begin until the payers receive the actual claim—or say they do.

"The longer payers can stall, the longer they can float the benefit of having the premium money in their accounts, rather than paying us," notes Dr. Hay.

Thus, claims are often conveniently "lost."

Wilkie encourages physicians to submit claims electronically so they can be better traced, but she admits the elec-

tronic route isn't a good solution for many physicians because payers often require paper attachments. These attachments necessitate use of the postal service and result in—no surprise here—more "lost" claims.

Many physicians have taken successful, albeit extreme, measures to combat lost claims, such as hand delivery or certified mail.

"It's unfortunately an expensive way to fight this problem," Wilkie says.

She hopes the AB 1455 draft regulations will state there is a "presumption that a claim has been received if a physician can demonstrate that he or she has sent it."

This would place the burden of proof on health plans, forcing them to show a claim has not been received.

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Vice Speaker, CMA House of Delegates

When Payers Just Say No

"Denial of claims is one of the most egregious problems that physicians have in getting paid appropriately," says Dr. Hay.

A payer can legitimately deny an unclean claim that doesn't include the necessary paperwork, but sometimes the "cleanliness" of a claim is disputable. Dr. Hay's office contracts with a billing company that turns over denied claims in seven days, but it's an expensive proposition.

"Every time you bill and have to rebill, it generates another cost for physicians," he says.

Wilkie notes that certain claim denials are downright illegal and that physicians must always evaluate the reason for the denial.

For example, if a payer states a patient was ineligible at the time of service and the physician has taken steps to determine that the patient was, indeed, eligible, it's unlawful for the payer to deny the claim. CMA provides a form letter on

its website that physicians can use in this situation.

"Many times, payers do this stuff because they think they can get away with it," Wilkie says, "but when you cite the law, they'll stop doing it."

Bundling

Most physicians are confounded by the practice of "bundling," in which insurance companies, HMOs and PPOs decide against paying for the individual services a physician provides, but rather bundle them to create one reduced payment.

"Bundling is one of the most difficult problems to solve and one that doctors have the least success with," Wilkie says, noting that some bundling is appropriate and outlined in the CPT. But payers often develop their own guidelines, which can vary.

Wilkie has three suggestions for physicians plagued by bundling: Be aware of CPT guidelines, use appropriate modifiers, and document your services.

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Emergency Medicine, San Rafael
Chair, CMA Board of Trustees

"Physicians hate to document their services because it's very time-consuming," she says, "but they'll have no chance of successfully appealing their services if they're not properly documented."

To combat bundling, CMA has requested that AB 1455 require health plans to fully disclose the fees they intend to pay for each and every service, as well as reveal payment rules with respect to bundling.

"That way, when a physician enters a contract, he has some idea what the impact is going to be," Wilkie says.

CMA is also requesting that the DMHC force the plans to use CPT and Medicare guidelines as these payment rules.

Downcoding

Payers can also arbitrarily downcode, determining a claim for one type of service should be paid for a less expensive one.

"We dispute the downcoding, but to do so we have to supply other documentation," says J. Brennan Cassidy, MD, a family practitioner in Costa Mesa and member of CMA's Board of Trustees. "And sometimes, downcoding is just a way for the insurance company to delay the payment that eventually comes."

According to Wilkie, physicians can fight back by keeping detailed documentation, although she admits the documenting guidelines are "ridiculously complicated and time-consuming."

Dr. Hay agrees documentation helps, but generates increased costs.

"Documentation helps on the appeal side, but you don't send your records with the first bill," he says. "And if you do have to appeal, it costs you time and money to pull appropriate records and send them to an insurance company."

The Cost to Healthcare

Dr. Cassidy believes the overall reim-

CMA Reimbursement Resources

Reimbursement Hot Line (888/401-5911)

Available to CMA members and nonmembers

- To report concerns and trends, and for direct assistance with reimbursement problems.
- For information about CMA's mini-consultation program, educational seminars, publications and other reimbursement-related assistance.
- Call to order the *Reimbursement Advocacy Survival Kit* ($20 members; $75 nonmembers).

Online (www.cmanet.org)

Full access to members; limited access to nonmembers

- Download free *Reimbursement Advocacy Survival Kit.*
- Access CMA On-Call Index.
- Report concerns and trends, and receive e-mail assistance with reimbursement problems through CMA's Hassle Factor Log.
- To report unfair payment practices to the Department of Managed Health Care, access the "Members Only" site, select "Reimbursement Advocacy" in the drop-down menu, select "Reimbursement from HMOs," and then choose "Report Unfair Payment Practices."

Fax

CMA On-Call Index
800/592-4262
$1 per page for members; $2 per page for nonmembers

- To order information on a topic, you'll need a fax machine, CMA ID number and credit card. To order a free list of topics, order document #9999.

CMA Says Physician Group Entitled to MICRA Protections

Plaintiffs' attorneys in medical malpractice cases are constantly trying out new legal theories to gain exemption from the $250,000 cap on noneconomic damages provided by MICRA (California's Medical Injury Compensation Reform Act).

This cap is essential to controlling professional liability premiums in the state and averting yet another healthcare crisis.

In the latest threat to the $250,000 cap, a trial court in Southern California recently issued a ruling that, if upheld, will annihilate the crux of MICRA.

The court ruled a partnership composed strictly of physicians and formed for the purpose of practicing medicine is not a "healthcare provider" and, thus, not entitled to MICRA's protections.

The case is now pending in the California Court of Appeals, Fourth Appellate District.

The California Medical Association, California Healthcare Association and California Dental Association have filed a friend-of-the-court brief in *Allen v. Los Alamitos Medical Center* to remind the court of MICRA's statutory framework and its crucial role in maintaining the provision of medical care in the current healthcare environment.

The brief argues a physician group is entitled to the benefits of the statute, particularly where its liability for professional negligence is premised on the acts of the group's employee/physician.

For additional information on the case, contact CMA's legal information specialists (415/882-5144).

—CMA Alert

bursement situation will grow worse before it gets better because politicians and the general public fail to identify with a problem until it reaches crisis proportions (i.e., when access to care is compromised because physicians can no longer afford to practice).

"Physicians are leaving the state, taking early retirement and changing their course of direction in the middle of their careers," he says.

In some areas of Southern California, the cost of housing is so high that primary-care physicians—particularly those who are in the process of starting a practice—cannot afford to buy a home in the communities where they work, he notes.

Wilkie, however, is optimistic that legislative efforts, proposed regulations and physician empowerment can help improve reimbursement.

"The most important thing for physicians is to be informed," she says, "and that's where we come in."

She stresses the importance of having up-to-date resources, including the most current coding reference books. (CMA has negotiated discounts with many vendors.)

In addition to the information offered through CMA's hot line, website and print publications, educational seminars, sponsored forums and one-on-one consultations with advocates are available.

"If I didn't believe we could win this fight, I wouldn't be fighting," Wilkie says. ❖

Laurel DiGangi is a freelance writer in Burbank and regular contributor to Southern California Physician.