Regulation Is Not a Four Letter Word

Here's a history of improvements in insurance billing productivity, with suggestions for the future.

BY RICHARD RETTIG, DPM

It is particularly exasperating when an insurance company retroactively retracts payments months or years later. It is also frustrating when you cannot get quality eligibility and coverage information online.

Back in the old days, there was no HCFA 1500 form. Every insurance company was free to have their own billing form, requesting different information. Beginning in 1975, the American Medical Association (AMA) along with the Uniform Claim Form Task Force (made up of representatives from the Health Claim Financial Administration (HCFA), now Centers for Medicare and Medicaid Services (CMS), AMA, and many other payer organizations) developed the universal claim form, which was the precursor to the HCFA 1500 (now CMS-1500).

Back in the old days, Common Procedural Terminology (CPT), (copyright, AMA) coding was not mandatory or uniform. For instance, in Pennsylvania, when billing Highmark Blue Shield for Medicare claims in the past, we were not permitted to use the 11055-57 codes for keratosis debridement. They were not recognized codes. We were supposed to use A9080 with a "YJ" modifier, then M0101 for "routine care" and they could not be combined with mycotic toenail codes. In 1983, HCFA merged CPT with its own Common Procedure Coding System (HCPCS) and mandated that CPT be used for all Medicare billing. It was still years before our Medicare carrier adopted these rules. Because of HCFA's influence on the commercial insurance companies, as well as individual and facility providers, and perhaps some mandate or law, the CPT procedure coding system soon became the standard for all insurance companies (with apologies for certain rogue practices by Humana and United).

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Stockbyte

Back in the old days, we had a different provider identification number for each insurance company. Now we use the universal NPI number for all. This was mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Another productive rule is the universal Electronic Data Interface (EDI) standards for billing and Electronic Remittance Advices (ERAs) based on the ANSI ASC X12N 837P format that allows all insurance companies to process claims using the same data set, and allows for standardized ERAs and electronic posting. Another mandate still being rolled out is required electronic funds transfer (EFT) for seamless automatic deposits.

Ideas to Implement

All these changes have promoted greater efficiency for billing and practice management. We have come a very long way in the last 30 years,

Continued on page 74

Regulation (from page 73)

but there are still many problems that plague us that have simple solutions. Here are some ideas that could be implemented:

We currently have a variety of ways to get eligibility information online for many, but not all insurance companies. Some are better than others, but none are perfect. We usually use a company called Navinet for this information. The insurance companies pay Navinet for maintaining this database and access to it, either voluntarily or by mandate. Many companies do not have this service and we need to call each company, a labor-intensive process. Sometimes we get a one-page printout with no useful information. Sometimes we get a 42-page printout with limited useful information (pages of information on mental health benefits, PT, chiropractic, etc.).

Is the deductible met? Medicare Advantage programs are particularly problematic—they don't even offer this information; when we call, the representatives act like we are speaking a foreign language! Is the office visit with its affiliated co-pay independent of the deductible? Usually, but not always, and that information is never given online.

All insurance companies have ID cards, and most of them are plastic and have—or used to have—a magnetic stripe on the back. Most of us have credit card processing devices in our offices, a cheap machine that reads electronic stripes and transmits the information electronically (they are converting to chips). Suppose we had a second machine that would interface with a company like Navinet. A simple swipe would instantly identify the patient and the insurance company and the exact insurance contract.

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Like a credit card processor, it would also securely identify who the requestor is, so that the information returned would be specific for podiatry. It would know if you were in or out of that network. And it should be mandated that the deductible policies be clearly identified.

There could be a disclaimer that the current deductible amount met is subject to change due to unprocessed billings from other providers. The costs would be borne exactly as now, by the insurance companies in contract with national healthcare information companies like Navinet, McKesson, Emdeon, etc. Like mandated universal coding, CMS-1500 forms, and NPI ID numbers, this eligibility and benefit information should be universally required of all insurance companies.

Another new source of information is the "payment estimator". Many insurance companies offer this now, yet there are still many glitches. With the credit card reader, we could input CPT codes, and it could respond with expected payment amount and patient responsibility. Preferably, the output device would be our computer monitors, with a print button as needed. All this could be done with a USB swipe reader and all data entered directly from our keyboards.

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We all carry credit cards in our pockets. What a fantastic efficiency device! You can be on vacation and purchase a hat in Milan, or perhaps a $15,000 18k gold watch in St. Moritz. The merchant swipes your card, and once it goes through, the merchant has no worries about getting paid. If you don't pay your credit card bill, the merchant will never get a post-purchase retraction from the bank. The merchant has a contract with his local bank; you have a contract with your credit card issuing bank. Visa and Mastercard are involved, and even though they are all separate private companies, everything gets magically processed seamlessly through one terminal.

That is how we should envision the future of medical billing, using companies again like Navinet, McKesson, Emdeon, etc. Maybe we could input our billing codes directly from the same program. Maybe we could get paid instantly for these codes, with EFT payment within 48 hours, just like the credit card processing. Since the billing would be done in real-time, there would be no lag period where the deductible information would be outdated.

Let's relate another scenario. You get onto an elevator along with "Miss Helpful". Miss Helpful sees another person 100 yards away apparently walking towards the elevator. She holds the door for this person. Isn't she being polite and nice? Maybe I am an old grump, but I think she is very rude. It isn't like the last train of the night leaving the station, so that if the other person misses it, there isn't another one coming until tomorrow. Maybe she's in no hurry, but what about you and the others on the elevator? She thinks she is so nice, but she never asks for your permission. So she was doing a 'favor' at your expense. No, it's not a huge deal, but it is an example leading to the next point.

"Grace" Periods

When we check an insurance company for eligibility, they will report the patient as eligible on July 1st, for instance, even if the premium has not yet been received from the patient or his/her employer. They grant a 'grace period'. What happens if that payment is never received? Eventually, they will declare the patient retroac-

Continued on page 76

Regulation (from page 74)

tively ineligible and deny or retract the claims paid. Wasn't the insurance company being so nice in extending that grace period? Like Miss Helpful on the elevator, they are extending something at your expense, without your permission. They are involuntarily making the provider the fall guy. This must be outlawed. Like the jeweler in St. Moritz, it should not be our problem.

Another cause of retroactive adjustments is retroactive changes to the responsible insurance company. These lead to large swaths of retroactive retractions of months' worth of claims. Then we are left with the task of billing the "new" insurance company which will initially deny for untimely billing. What a headache. Suppose we needed a pre-certification? Like the hat salesman in Milan, it shouldn't be our problem.

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At any given time, there must be one insurance company of record, verified by the swipe eligibility device or by virtue of approved payment. If there are future changes, then the two insurance companies should have a system of their own to adjust responsibility and payments between themselves, by universal agreement. This should be mandated.

All of these suggestions would improve productivity and efficiency. And they are doable right now. Past improvements were made only due to mandates and laws like ERISA, the Patient Protection and Affordable Care Act, Omnibus Health Regulation Amendment Act, HIPAA, etc. If these suggestions are picked up by the AMA and the APMA and added to a future bill, our lives would all be improved. We need to liaison with the AMA as they are so much larger than us. There will be future bills. We should demand no less. **PM**

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