MedBillsAssist

# Medical Claims Solutions

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## Health Care Law—More Surprises

Last March 2010, then-House Speaker Nancy Pelosi uttered the now-famous words, "We have to pass the bill so that you can find out what is in it, away from the fog of the controversy."
She was talking about the Patient Protection and Affordable Care Act (PPACA). I remember being very upset about her statement. In my opinion everyone in congress should have known what is in the law and their vote should have been based on merit, not on the need to move it along.

The ugly face of the unknown is showing as parts of the law become effective. The latest oversight is Medicaid* eligibility. The way the law is written, in some circumstances, it permits an early retired couple with $65,000 annual income to qualify for Medicaid.

According to CMS* chief actuary Richard Foster, this situation keeps him up at night. He is even more upset about the fact that there is no urgency to correct this mistake.

The actuary's office said the early retirees eligible for Medicaid would be in addition to an estimated 16 million to 20 million new people that the PPACA already brings into the program, by opening it to childless adults with incomes near the poverty level.

It's unclear how much it would cost to cover the retirees.

Of course the critics are interpreting this in many ways. "The fact that this is being discovered now tells you, what else is baked into this law?" said Former Utah governor Mike Leavitt, who served as Health and Human Services secretary under President George H.W. Bush. "It clearly begins to reveal that the nature of the law was to put more and more people under eligibility for government insurance."

It is difficult to decipher if this was just an oversight or a deliberate effort to move more people under government run program.

It is not clear how many these newly eligible retirees would actually join a medical insurance program for the poor, but not paying for medical insurance may be an attractive option for some. That is until they figure out that most doctors do not accept Medicaid.

## Quote of the Quarter

*$14 to $18 … is the likely value of a stolen medical identity, as opposed to $1 to $5 for a stolen credit card number, according to Greg Porter, founder of Allegheny Digital, speaking at a recent HIPAA Summit in Washington, D.C.*

## The Perfect Patient

This week I had a pleasure speaking with a Perfect Patient. We connected through her search for a surgeon to meet her specific medical need. She wanted a skilled doctor who had done similar surgeries with great success, who had a kindness within, and a physician who accepts her insurance. This is a tall order to fill, but she set out to do just that. She looked at a list of her in-network doctors, then searched the internet search, then reached out to her network to verify information even further. She visited the first doctor, asked questions and ended up with more questions. The physician's eagerness to schedule a surgery, while ignoring his own protocol sent up a flag.

Our conversation ended with giving her even more resources to check and look over. I also provided her with some ideas how to shorten waiting time to see another doctor and schedule surgery.

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# CT Scans - How Much is too Much?

Proper diagnosis is an important part of medicine. When the doctor knows what is wrong with us we have a better chance to get treated and hopefully cured. Physician have many choices and options to do so. Simple x-rays are a good start, but when more information is needed doctors turn to CT Scans. Options run from a regular to one with dies injected into the body.

If and when we stop to think about these options we need to consider additional information, such do we really need a CT Scan that equal to the radiation of about 350 chest x-rays? If we do, do we need two CT Scans, one without the die and one with the die? According to many radiologist, a person rarely needs both. Yet, some doctors order one after the other. In 2008 about 75,000 patients received both CT Scans. Concerns about these scans are dual; harming the patients with unnecessary radiation exposure is one and cost is the other. Doctors and patients must consider benefits against harm. The problem with cost is very obvious. In 2008, Medicare alone paid out 25 million for these tests. The number varies greatly from one hospital to another, but some hospitals performed these dual tests on 80 percent of their Medicare patients. Interestingly these dual tests were mostly ordered in small community hospitals. Memorial Medical Center of West Michigan in Ludington performed two scans for 89 percent of its Medicare chest problem patients. The occurrence of double scanning is less than one percent in major university teaching hospitals. A few large hospitals have had problems as well. St. John Health System in Tulsa double-scanned 80 percent of its Medicare outpatients in the same year. We need to remember the precious balance between physicians and hospitals. A test is ordered by a physician and performed by a hospital. There is a prior authorization process in place with insurance companies; therefore doctors need to justify CT Scans in advance. Medicare works in a different way; it only reviews once the test is billed, and as long there is diagnosis to justify it, Medicare will make the payment.
Next month, the Center for Medicare and Medicaid Services is expected to release figures for 2009, but according to people who have seen the numbers, the practice of double scanning chest patients has

## Definitions:

**Medicaid** is a state and federal medical insurance program primary designated to help low income families and children.

**CT SCAN** Computer Axial Tomography is a series of –rays that show the human body in slices

**CMS** Center for Medicare and Medicaid Services

# Double Digit Error Rates

Our health care reimbursement system is so complex that even insurance companies have a problem correctly paying claims. A recently released annual National Health Insurance Report Card produced by the American Medical Association (AMA) shows **19.3 percent claim processing error.** The report card represents in-network claims payment. Basically these are the claim problems the doctor's staff has to solve to ensure proper payments. This extra administrative follow up cost an estimated 1.5 billion.

At times the insurance explanations are misleading or too confusing to decipher. As a result these balances can end up as patient responsibilities. It is then the patient decision to pay or call his/her insurance for an explanation.

**MedBillsAssist**

Our Mission is to represent our clients' best interests. We work on your behalf in an ethical manner in compliance with state and federal regulations.

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# Legal Issues or Who is in Trouble this Time?

Three employees of the Solstice Wellness Center, a Brooklyn-area clinic that purported to specialize in providing physical therapy and various diagnostic tests, have pleaded guilty in connection with a $3.4 million Medicare fraud scheme, announced the Departments of Justice and Health and Human Services (HHS). According to court documents, Dmitry and Aleksey Shteyman and Shvedkin were involved in a scheme to pay cash kickbacks to Medicare beneficiaries to induce the beneficiaries to visit Solstice.

At their plea hearings, they admitted that they paid kickbacks to the beneficiaries so that Medicare could be billed for services and diagnostic tests that were not medically necessary. As a result of the fraud scheme, Medicare was billed more than $3.4 million for services that were not actually rendered and that were not medically necessary.