

NEWS BREAK

June 17, 2010

Medicare-Senate Failed to Pass Bill-What to Do About Claims?

The so-called "tax extender" bill failed to clear a 60-vote hurdle in the Senate on Wednesday. The bill, which would among other things stop the 21-percent Medicare physician payment cut, was faced with strong opposition from Republicans and moderate Democrats over the bill's cost.

Senate Democratic leaders have begun working on a scaled back version of the bill. The revised bill would likely postpone the Medicare cut only through November. The House-passed version of the bill would have postponed the cut for two years, and provided a 2.2-percent payment update for the remainder of this year and a 1-percent payment update for 2011.

What to Do About Claims?

Last week, the Centers for Medicare & Medicaid Services (CMS) instructed Medicare contractors to hold claims for services provided in June for an additional three business days beyond the original 10 business day hold. This means that carriers will begin processing claims with the 21% cut on Friday, June 18th. CMS acknowledges that the additional delay could pose cash flow problems for some physicians.

The choice between not getting paid from Medicare at all or getting paid 79% of current rates places physicians between a rock and a hard place with no good options. If Congress fails to act before Friday, then carriers will start processing June claims at the reduced rates. Once the House and Senate act to avert the cut, claims will be processed as follows: (1) where the submitted charge is higher than the new rate, the contractor will automatically reprocess the claim; and (2) if the submitted charge is lower than the new rate, the physician should call the contractor. To avoid the hassle of reprocessing, practices that can afford it may wish to hold claims themselves until after the issue is resolved.

CMA's Position

CMA is outraged by Congress' inability to protect health care for senior citizens and provide stable funding for Medicare. These repeated short-term fixes simply postpone a growing problem, making it harder to achieve the long-term goal of fully repealing the faulty sustainable growth rate (SGR) formula. While the entire California congressional delegation and Senators Barbara Boxer and Dianne Feinstein have all voted to support long term fixes, moderate Senators from Midwestern and Southern states are stymieing progress on this issue. CMA is demanding that Congress work harder to solve this problem once and for all.

CMA and others in organized medicine continue to aggressively advocate for a permanent repeal of the SGR. We believe Congress must fix Medicare now. Congress knows the faulty formula Medicare uses to pay doctors does not work, but it has not fixed the problem. We need a rational Medicare physician payment system that automatically keeps up with the cost of running a practice and is backed by a fair, stable funding formula.

What Can You Do?

It remains unclear whether the leaner package will be able to win the 60 votes needed to avert a Republican filibuster and push the measure to passage. If Congress does not pass a bill before the payment hold expires Today, Medicare carriers will be forced to begin processing claims with the 21-percent cut.

Call Senators Dianne Feinstein and Barbara Boxer today and thank them for supporting long term SGR and GPCI fixes. Ask them to keep the pressure on their Senate colleagues so that the problem is resolved once and for all. Use the toll-free AMA hotline to contact Senators Feinstein and Boxer (800/833-6354). Just enter your zip code and you will automatically be connected.

United Healthcare and Ingenix Settlement

For years, United Healthcare Corp. and other major insurers relied on the Ingenix database to calculate the market rates for physicians who provided out-of-network care. But the database, owned and operated by United Healthcare, manipulated data to intentionally low ball the rates, according to state and federal authorities who investigated in 2008. The result was that doctors providing out-of-network services were systematically underpaid by United, and often patients ended up paying some of the cost not covered by the insurer.

In 2009, United reached a legal settlement with authorities to abandon Ingenix and pay \$50 million for the creation of an independent agency to more accurately assess market rates for health care services. Once that independent database is established, United must use it to determine reimbursement for out-of-network services for at least five years.

United and Ingenix also settled class action lawsuits brought by patients and providers, essentially agreeing to pay \$350 million to compensate for the underpayments. As part of that process, physicians must decide by July 27, 2010, whether to participate in the settlement or opt out or object. By opting out, a physician could sue United directly for damages caused by Ingenix but could not make a claim for funding through the class action settlement fund.

A court hearing is scheduled for September 13th to approve the final United settlement. Those participating will have until October 5th to submit claims for payment. To qualify, physicians must have provided – and billed for – out-of-network care covered by the insurer to a patient enrolled in United or one of its affiliates anytime between March 15, 1994 and Nov. 18, 2009. **This includes services to patients covered by PacifiCare.**

Physicians' settlement amounts will be determined by a number of factors. However, in general, the amount will be the difference between the UCR value of the service provided and the amount prescribed by the Ingenix database. Settlement checks will be processed and delivered after October 5th, when all claims are due.

CMA has set up an online resource center to help physicians understand the terms of the settlement and what they need to do to opt out, object or submit claims for payment. Visit <http://www.cmanet.org/settlements/> to find a detailed guide to the settlement agreement, claim forms and other helpful documents or contact MMCMS and those documents can be mailed or e-mailed to you.

SIGNIFICANT DATES TO REMEMBER

July 27, 2010 – Deadline for class members to opt out or object to the settlement.

Sept. 13, 2010 – Court hearing to approve the final settlement.

Oct. 5, 2010 – Deadline to submit claims for payment from the settlement fund.

REMINDER-New MBC Requirement Effective June 27th

As previously reported, the California Office of Administrative Law (OAL) recently approved regulations (Title 16, California Code of Regulations section 1355.4) promulgated by the Medical Board of California (MBC) that would require physicians practicing in California to inform their patients that they are licensed by the Medical Board of California, and include the Board's contact information. The regulations will go into effect on June 27, 2010.

The signage information must read as follows.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Physicians may provide this notice by one of three methods:

- Prominently posting a sign in an area of their offices conspicuous to patients, in at least 48-point type in Arial font.
- Including the notice in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file, stating the patient understands the physician is licensed and regulated by the board.
- Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

SAMPLE LETTERS AND POSTERS ARE AVAILABLE BY CONTACTING MMCMS.

