

UPDATES FROM BARATZ & ASSOCIATES, P. A. *FOR THE HEALTHCARE INDUSTRY*

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MEDPAC ADDRESSES GROWTH OF ANCILLARY SERVICES IN PHYSICIANS' OFFICES

MedPAC is an independent congressional agency established to advise the U.S. Congress on issues affecting the Medicare program from payment policies, quality of care, and access to care issues, as well as other areas of analysis. Each year MedPAC reports to Congress twice with recommendations and analysis. The most recent report was issued in June 2010 and one of its areas of discussion was the growth of ancillary services in physicians' offices. As MedPAC is having an increasingly stronger voice in the healthcare legislative landscape, we should pay attention to their comments.

Stark prohibits physicians from referring Medicare patients for "designated health services" (DHS) such as imaging, radiation therapy, home health, durable medical equipment, clinical laboratory tests and physical therapy - to entities with which they have a financial relationship, unless the relationship fits within an exception. The in-office ancillary services (IOAS) exception allows physicians to provide most DHS to patients in their offices under certain conditions. MedPAC feels that "many physicians have expanded their practices to provide diagnostic imaging, clinical laboratory testing, physical therapy and radiation therapy. These services - particularly diagnostic imaging - account for a significant share of Part B revenue for certain specialties."

"There is evidence that some diagnostic imaging and physical therapy services ordered by physicians are not clinically appropriate."

In 2008, CMS noted, "the migration of expensive imaging equipment, pathology services, and therapy services to physicians' offices and asked for comments on whether the IOAS exception should be changed." Although physicians argue that the ability to diagnose and treat patients rapidly is justification for the use of IOAS for such services, MedPAC states that, "there is evidence that physician investment in ancillary services leads to higher volume through greater overall capacity and financial incentives for physicians to order additional services." MedPAC used Medicare claims data to examine the frequency with which these IOAS covered services occurred on the same day as an office visit and found that physical and occupational therapy is rarely provided on the same day as the office visit and that less than 50 percent of advanced imaging, ultrasound and clinical laboratory, and pathology services are performed on the same day as the office visit, with about 50 percent of standard imaging studies (X-Rays) performed on the same day. MedPAC feels this questions the rationale used for supporting the IOAS exception for these services. Fees that are not associated with volume would potentially curb this issue.

Possible interim policies that MedPAC has put forward include:

- excluding therapeutic services such as physical and occupational therapy from the IOAS exception;
- limiting the exception to physician practices that are clinically integrated;
- excluding diagnostic tests that are not usually provided during an office visit from the exception;
- reducing payment rates for diagnostics tests performed under the exception;
- improving payment accuracy and expanding payment rates to include multiple related services; and,
- adopting a carefully targeted prior authorization program for advanced imaging services.

This topic will continue to receive significant attention as health care reform continues to evolve and reductions in the Medicare program are sought. It may take quite some time to fully address these issues but we feel that they will start to be addressed.

(For more detailed information see the MedPAC June 2010 Report To The Congress, Aligning Incentives in Medicare Chpt 8 Pages 213 – 232)

RACS...HOW ARE THEY DOING?

In June 2010, CMS released the Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3 - Year Demonstration. This report is an update to the Evaluation Report released in July 2008 which included information through March 27, 2008 and continues with information through March 9, 2010.

Noted in the update is that through March 9, 2010 providers chose to appeal 12.7 percent (76,073 claims) of the RAC determinations. Overall, the data indicates that of all the RAC overpayment determinations (589,238), 8.2 percent (48,993) were overturned on appeal. Some of these numbers have been refined as the process has moved forward and CMS now believes that these results are a more accurate reflection of what has occurred.

Although, overall, 64.4 percent of those items appealed seems like a favorable result for providers, it means that 91.8 percent (540,245) of overpayment claims were upheld which is a very strong return for RACs and would indicate that there is little reason to not plough forward with this program and other programs that pursue the return of dollars to the Medicare program.

Further development and refinement of these types of recovery methods are expected in the months and years to come so review your practice and make sure you are up to speed on coding and documentation requirements.

WHITE HOUSE FACT SHEET – NEW PATIENT’S BILL OF RIGHTS

On June 22, 2010 the White House released a fact sheet on the Affordable Care Act – Patient’s Bill of Rights. Some highlights:

- September 23, 2010 most plans stop insurance companies from imposing pre-existing condition exclusions on your children; ban insurers from: 1) taking away coverage based on an unintentional mistake on an application, 2) setting lifetime limits on coverage, 3) restricting their use of annual limits on coverage.
- For plans starting on or after September 23, 2010, rates insure that the patient can: 1) choose the primary care doctor they want from the plan’s network, 2) that they can see an OB/GYN without a referral, 3) do not require prior approval before receiving emergency care at a hospital outside their plan’s network.

Other items:

- Reviewing insurers premium increases
- Requiring 85 percent of your premium dollars to be spent on medical care
- Allowing children under 26 to remain on parent’s coverage
- July 1, 2010 begins program to enroll in insurance regardless of being locked out due to pre-existing conditions.

Other changes coming can be found on the government website.

(http://healthreform.gov/newsroom/new_patients_bill_of_rights.html)

NOTE: FOR ADDITIONAL INFORMATION AND RESOURCES MAKE SURE YOU CHECK OUT OUR NEW WEBSITE: <http://www.baratzcpa.com>

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