

# CMS OFFICE MANAGER

A newsletter to provide medical office staff with information on health insurance.

May/June 2000

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## Feedback • Ideas • Articles

If you have any of these please let us know by **phone** at (720) 859-1001 or 1-800-654-5653, ext. 6328, fax at (720) 859-7509 or e-mail at [marilyn\\_rissmiller@cms.org](mailto:marilyn_rissmiller@cms.org).



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## Hassle Factor Project SLOW PAY

Slow insurance payments continue to be a major concern for many physicians and their staff, locally as well as nationally. The results of last year's CMS Timely Payment survey appear to validate these concerns. The survey results showed that at the high end, the average time it took to receive payment was 72.2 days, while the low end was an average of 40.7 days. The overall average of all insurance plans and all respondents was 50.5 days.

CMS shared the survey results with the representatives of the HMO Association at the April meeting of the Joint CMS/CHMOA Committee. We took this opportunity to present the survey information to the group as a first step toward a continuing dialogue regarding the overall issue of claims processing timeliness. Some of the plans wanted more information and asked to meet with us individually so they could get specifics on how *their* performance was viewed.

The timely payment law that took effect 1/1/2000 was discussed, and the HMO members were asked if they had made any provisions for monitoring and paying interest due. Two of them (PacifiCare and Rocky Mountain HMO) indicated that they were in the process of updating their computer systems to *automatically* track late payments and access the additional charges due for interest. We advised the HMO Association that we (through the CMS members) would be monitoring the effectiveness of the law, as well as compliance with payment of interest charges that are owed.

In our office manager group meetings the timely payment law continues to be a hot topic of discussion. Everyone still has lots of questions and "what ifs," but our advice remains the same:

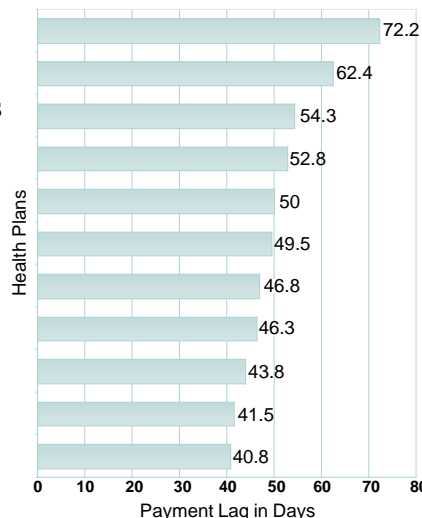
1. Know/follow each plans' "clean claim" requirements;
2. Know which claims are protected under the Colorado law;
3. Monitor those claims and when they are outside of the timeframes outlined in the statute, follow-up with the insurance plan;
4. Keep CMS advised regarding continuing late payments.

Let us know if you have a specific question on the timely payment law and we will get you the answer.

### Average Payment Delays by Top Colorado Plans

High was 72.2 days  
Low was 40.7 days

Overall average was 50.5 days  
(all plans/respondents)



# Colorado State Legislation

The 2000 Colorado state legislative session ended on May 3<sup>rd</sup>. Following is the status of some of the bills the CMS Government Relations staff was monitoring for members:

**SB 54, Creation of Organ Donation Registry (Pascoe) - *Bill passed and is awaiting the Governor's signature***

**SB 71, Concerning Use of Moneys Received Pursuant to the Tobacco Litigation Settlement (Anderson):** Bill was amended to include provisions of both SB 71 and HB 1388, approximately 80% of the money is to go for health care, the amendments also included the Governor's reading program. ***Bill passed and is awaiting the Governor's signature***

**SB 138, Concerning the Requirement of an Insurer with a Managed Care Arrangement under Motor Vehicle Insurance to have an Internal Appeal Process, and, in Conjunction Therewith, Notifying the Covered Person of the Right to Appeal the Internal Decision to the Personal Injury Protection Examination Panel (Sullivant) - *Bill passed and was signed by the Governor***

**SB 143, Concerning the Ability of Residents Receiving Medicare to Purchase Pharmaceuticals at the Rate Offered to Medicaid Participants (Matsunaka) - *Bill died***

**SB 148, Concerning Contracts Between Health Insurance Companies and Health Care Providers (Evans):** Bill was amended and outlaws contract provisions that subject the physician to financial disincentives based on the number of referrals made to participating providers (when such referrals are done in accordance with the carrier's utilization review policies). ***Bill passed and is awaiting the Governor's signature***

**SB 150, Concerning the Rights of Persons with Health Insurance Coverage in Colorado (Thiebaut) - *Bill died***

**HB 1058, Failure to Truthfully Respond to BME Complaints (Morrison):** Bill was amended to require that failure to respond in an honest, materially responsive, and timely manner is considered unprofessional conduct. ***Bill passed and was signed by the Governor***

If you want to see the complete listing of the bills CMS monitored this session and you have access to the internet, you may check the CMS Web page for updated legislative information. Go to the CMS Home Page (<http://www.cms.org>), select "CMS for Physicians" then select "Heard on the Hill" for the list of CMS legislative activity. Or you can contact the CMS Government Relations staff at (720) 859-1001 or 1-800-654-5653.

## DOI looks at "No Pay"

The reoccurring problem of physician organization insolvency has prompted the Colorado Division of Insurance (DOI) to set up a task force to look at provider risk. William J. Kirven III, Commissioner of Insurance, spoke to the CMS Managed Care Task Force members regarding his perception of the problems and his goals to resolve them. He is convinced that there has been a breach of trust between insurers and physicians and that this has led to a breakdown of the relationship. He believes this is one of the biggest contributors to the problems in Colorado's healthcare system.

Mr. Kirven is very concerned about the "double pay" statute. He feels that the law leaves a lot of opportunity for abuse by all parties. The law also allows the plans to submit an *alternative mechanism* to the DOI that if accepted will exempt them from the risk of double payment. Last year, four major insurers applied for and were given exemption. On February 17, 2000, Mr. Kirven wrote a letter withdrawing this exemption. In light of recent financial failure of some physician organizations and the fact that individual physicians did not get paid, it became clear that the alternative mechanisms did not work either.

The Commissioner wants the task force to look at the double pay statute and with representation from all stakeholders (health plans, CMS, physicians, and a couple of the largest provider groups) discuss possible ways to resolve this problem. He doesn't want to stop with the no pay issue; he wants to continue to act as a catalyst for discussions between physicians and carriers regarding other problems.

## In Other Words, I Want My Claim Paid . . .

Whether the process is called a review, an appeal or a request for reconsideration, the bottom line is you want your claim paid. Each plan or insurance carrier has a slightly different procedure or terminology involving what we will generically refer to here as an *appeal*. To have your efforts "pay off" you will need to do your homework and be persistent.

- \* For each plan you work with, know how and where they want the appeal request submitted. (Some will take specific types of appeals over the phone, while other types have to be in writing with a copy of the remittance statement.) Generally, this information should be provided in the plan's provider manual.
- \* Clearly and concisely state the problem and your rationale why the claim should be paid or adjusted. (When possible provide documentation that supports your point of view, such as references to other "national" policy or interpretation.)
- \* Remember there is usually more than one level of appeal. If you feel you are right, don't stop at the first "NO". (However, to ensure that the next level of appeal is effective include a copy of your original request, supporting documentation, the plan's response and a cover letter indicating why you believe the initial review was incorrect.)

Following these steps does not always guarantee a positive outcome. But it should ensure that your request has been given the consideration it deserves.

*You can help us too - CMS is currently working with some of the insurers to develop a standardized appeal form. If you run across a plan that has a good appeal process in place please let us know so we can look at it as a possible model.*

## What About a Compliance Plan?

*This is a question we get asked a lot. An effective compliance plan can be a very good means of increasing the effectiveness of your inter-office communication. But, in order for the plan to succeed, there must be a commitment from everyone in the office not only for the implementation but also for the ongoing process. No matter how a compliance plan is developed, the basic elements of the plan remain the same. Joan Elfeld, independent consultant, provides the following information on the seven elements and their purpose.*

### 1. A clear commitment to compliance

This is a valuable component of the process. Should infractions be noted, the OIG expects pro-active measures, rather than a programmed defense. Replacing over reactions with written protocols addressing reform of the systems, correction of the coding and billing errors, and ongoing resolution of the problematic issues is a positive action and will be considered as such should an OIG audit occur. Timelines with established deadlines developed for the implementation of the changes are critical to the process.

### 2. Appointment of a trustworthy compliance officer with a high level of responsibility

It is the officer's responsibility to insure that the protocols are written and understood by all levels of staffing, especially those in supervisory positions.

### 3. Effective training and education program

Much of the revenue loss is due to lack of knowledge of coding, improper use of modifiers, and non-alignment with carrier rules and regulations. Because of this, denials are not appealed and accounts are not reconciled to insure that carriers have paid according to their own fee schedule. Effective training becomes the basis for identifying all of the areas of coding and billing that require attention. This is a direct benefit to the physician office, clinic or organization.

### 4. Auditing and monitoring

The ability to identify the areas of concern and then put a system in place for correcting them is considered by the majority of practices to be the most advantageous reason for conducting the baseline audit. The audit serves as a "report card" of the documentation, coding and billing process. The importance of this exercise cannot be overstated.

### 5. Communication

Communication is critical to the process. Being able to continue the identification of those problems that may be "considered fraudulent or abusive" is vital to the success of the plan.

### 6. Internal investigation and enforcement

This is an ongoing process that pertains to any *perceived* incidences of miscoding, misrepresentation of the services, or continuous errors on the part of well-intentioned staff. It is necessary to proceed with these investigations to perform due diligence and to insure that those who may have misunderstood the protocols are offered the opportunity to correct their errors and be brought into alignment with compliance.

### 7. Response to identified offenses and application of corrective action initiatives

This element pertains to physicians or staff (at any level) who refuse to follow the directives set forth in the organizations compliance plan. If the issues cannot be resolved within the structure of the organization, the expertise of a designated health care attorney with a proven track record for resolving physician compliance issues may be required.

Utilizing the elements of a working compliance plan is definitely a win-win proposition when viewed as a method of satisfying not only the compliance criteria, but also as a means of enhancing the coding, billing/reimbursement effort and producing accurate claims that may increase revenue.

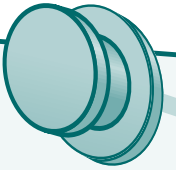
## Sloans Clarifies Their Claim Filing Instructions

*Sloans Lake is an organization that offers cost containment programs, including their PPO network, to third party payers of health care costs. In recent meetings with Sloans Lake staff we discussed the confusion that can arise when claims are sent to them but they keep no record in their system. (In fact, other than delay in payment, the majority of complaints we receive regarding Sloans are related to lost claims and claims filing problems.) In response to our discussions, Lauris Grabeklis, Assistant Vice President of Operations has asked us to publish the following clarification.*

Sloans Lake Managed Care (SLMC) has responsibility for repricing the majority of claims it receives for its PPO products. Information on repriced claims is available on the SLMC system for inquiry via a telephone call or through the SLMC web site ([www.sloanslake.com](http://www.sloanslake.com)). However, claims for certain groups are NOT entered into the SLMC system. Although SLMC is the managed care provider network for these groups, their claims are forwarded directly upon receipt to be repriced and processed by the carrier, TPA, or insurer. SLMC will have no information about the status of these claims, including receipt, as they do not reprice them. (For that reason, follow up calls for these claims should be made directly to the payor.)

Providers are encouraged to submit those claims that are not repriced by SLMC **DIRECTLY** to the carrier, TPA, or insurer. The SLMC provider contract listing report that your office receives bimonthly has information about groups whose claims can be directly submitted to their payor. If you need a copy of this listing, contact SLMC's Provider Services Department at 303-504-5342.

Also, to expedite claims handling it is extremely important that all of the required fields on the HCFA 1500 form be completed, including the name of the insurance company and the SLMC internal insurer number. Beginning in March 2000 SLMC began to track all claims returned to a provider's office for insurance or additional information. SLMC staff report that a high number of claims need to be returned to obtain this information. Without knowing the insurance company, group name, or auto carrier name, SLMC staff cannot complete the repricing of these claims and get the documents forwarded to the correct payor. (Complete information on the claim filing requirements is in the Sloans Lake Managed Care Provider Manual.)



**When you feel interest is owed on delinquent claims incorporate the following statement (or a similar one) in your correspondence with the insurer:**

**C.R.S. 10-16-106.5 requires prompt settlement of health insurance claims. A clean claim must be paid, denied or settled within 30 days after receipt if submitted electronically and 45 days if submitted hard-copy. We believe the following claims are clean and are outside of the required processing timeframes. These claims were filed electronically/hard-copy [indicate whichever applies to your claims] on \_\_\_ (date) \_\_\_ and interest is now due. If you disagree please indicate your reason, otherwise we will expect prompt settlement as interest at the rate of 10% annually continues to accrue.**

## In Response to Your Question. . .

We have received a number of inquiries on the following:

**Question:** When time is used as an over-riding factor in selecting the level of E&M code, how is the documentation changed?



**Response:** If the doctor spends over 50% of the visit time face-to-face with the patient counseling him or her, time can be used in selecting the level of E&M code. Each one of the visit codes has a typical time listed as part of its description in the *CPT*. For example, if the doctor spends 25 minutes with the patient and at least 13 minutes of that time was spent counseling him or her on the treatment options or prognosis of a newly diagnosed condition code 99214 could be used. (The time listed for code 99214 is 25 minutes.) When time is used to select the code, the other key components (history, exam or medical decision-making) do not all necessarily need to be documented. However, the total time of the visit needs to be documented in the patient's chart along with a note indicating the face-to-face time spent counseling the patient. In addition there should be a general description of what was discussed.

If you have a question you would like us to research for you, you can fax it to us at (720) 859-7509.

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P.O. Box 17550  
Denver, Colorado 80217-0550

## Resources

- Your number 1 resource - the Colorado Medical Society, Health Care Financing Department has moved. Our new fax number is (720) 859-7509, the new main number is (720) 859-1001. We are now located at 7351 Lowry Blvd., Denver, Colorado 80230.
- Watch your insurance bulletins and newsletters for information on upcoming workshops or training opportunities. Medicare and Medicaid have both scheduled theirs for this coming summer.
- The CMS Hassle Factor Project is scheduled to meet with the Office Managers in Glenwood Springs on Wednesday, June 14<sup>th</sup>, and with the Arapahoe Medical Office Managers on Wednesday June 21<sup>st</sup>. (Thank you to the Fort Collins Office Managers for having us up there this month.)