Spring 2023 Edition

ADVANCED DATA SYSTEMS RCM

MEDICS*RCM* INSIGHTS FOR OPHTHALMOLOGY

Articles of interest in the World of Ophthalmology Revenue Cycle Management, Billing, Consolidated Workflow, and Industry News

Presented by ADS RCM and our MedicsRCM Services for Ophthalmology
- Driving Clients' Revenue, Productivity, and Efficiency -

2023 Ophthalmology Coding Updates and Halley's Comet

Halley's Comet happens every 75 years, so mark your calendars for 2062, and we'll start sending reminders in 2060.

But what happens every year? The government tweaks its rules for reimbursement! So what's new for ophthalmology in 2023? A lot. It's actually more than we can include here in InSights, but a good outline with details and tables can be seen on Review of Ophthalmology.

After reading through, you can try your best to deal with coding nuances as an in-house exercise by your staff for every patient.

A better solution may be to outsource and offload all of this to an RCM company with a staff who knows ophthalmology billing and with the automation platform to support scrubbed and accurate claims on first submissions. MedicsRCM and our team of ophthalmology billing professionals are ready to assist.

The Notice of Benefit and Payment Parameters (NBPP) for 2024

Yes, the 2024 NBPP has been finalized by CMS, but what does that mean? Viewing from the proverbial 20,000 feet, here are the bullets:

- Health equity will be improved by requiring qualified health plans on the individual health insurance marketplace along with other plans falling within specific categories to align with network adequacy standards where previously, there were exceptions that left room for coverage and care disparities.

- Qualified health plans will have until plan year 2025 to comply with appointment wait time standards. CMS will release the appointment wait time standard guidelines at a later date. Said differently, there will be a wait time on the wait time guidelines.

- The final rule eliminated the non-expanded bronze metal level standardized plan option. So, any issuers that offered qualified health plans on the federally-facilitated or state-based marketplaces on the federal platform will have to eliminate the bronze metal level standardized plan option from their offerings.

Two items were not finalized: (1) a standardized plan option regarding generic and brand-name drug cost-sharing tiers, and (2) the Meaningful Difference (MD) standard which, was designed to group plans to assess each one's deductibles to determine if the plans were sufficiently distinct. In the final rule, CMS limited the number of non-standardized plan options instead of employing the MD standard.

Several other aspects were finalized, details of which can be seen in the CMS press release.

3.32% Increase in 2024 Medicare Advantage Payments

The 3.32% increase translates into an estimated boost of $13.2 billion to Medicare Advantage (MA) Part D payments. That's the good news from HHS.

In addition to the payment increase, MA and Part D payment methodologies were made, including technical and clinical updates to the risk adjustment model. Specifically, the risk adjustment model will transition from the ICD-9 coding system to ICD-10, which will help align MA payments with current healthcare practices and other federal healthcare programs.

Finalized revisions will remove specific codes from the hierarchical condition category (HCC) that have a broader variation in diagnosing and coding, as they also don't predict costs.

Full details can be seen in the CMS press release.

The No Surprises Act: Some Initial Impressions

The No Surprises Act (NSA) was enacted in December 2021. By February 2022, it reportedly had already avoided 2 million surprise billing incidents. A more recent report encompassing the first nine months of 2022 put the avoided number at 9 million, and 275k in arbitration claims.

Even with that, another report at the time showed how consumers were still receiving statements about which they were surprised and which could result in consumer complaints. The report notes that the number of complaints isn't higher because patients may not know they can complain; that something called "The No Surprises Act" even exists.

In any case, compliance is required. A great way to ensure compliance is by getting out-of-network alerts in advance and, ideally, while scheduling appointments either through your RCM vendor's platform or your in-house system. Secondarily, you'll also want to see a listing of any in-network providers who could be selected instead.

(MedicsRCM, with our rules engine-based MedicsPremier platform, supports out-of-network alerts as described. MedicsPremier is also available from ADS if an in-house system is preferred.)

Prior Authorizations News Flash

Unless your ophthalmology setting has access to an automated prior authorizations (PAs) resource, getting PAs will always be a burden.

But making PAs perhaps somewhat less oppressive is how a new federal rule seeks to reduce Medicare Advantage (MA) insurance plans' PA efforts on physicians while ensuring that enrollees have the same access to necessary care that they would receive under traditional fee-for-service Medicare.

For some time, there's been criticism about MA plans engaging in aggressive marketing, overbilling the federal government, and, yes, for using PAs as an excuse to deny care when PAs weren't needed. The Office of Inspector General (OIG) reported that 13% of PA requests denied by MA plans in 2022 should've been approved.

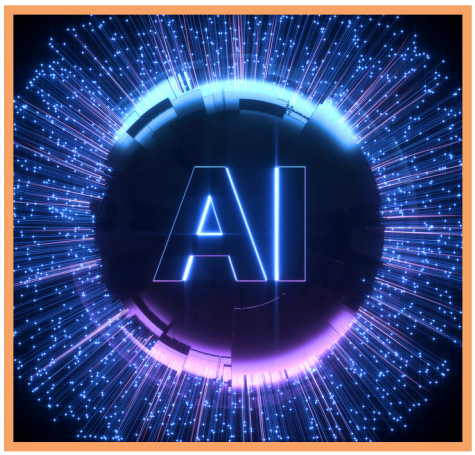
Now MA plans will be required to:

- Ensure that a PA, once obtained for a patient, remains valid for as long as needed for medical necessity, avoiding disruptions in care.
- Conduct an annual utilization management policies review.
- Make sure healthcare professionals with relevant expertise review denials based on medical necessity before denials are finalized.

While the new rule can help with PAs relative to MA plans, your ophthalmology setting may still be overwhelmed with non-MA plan-related PAs. MedicsRCM supports an automated PA option alleviating unnecessary hours of staff time in obtaining them manually.

Artificial Intelligence (AI) in Ophthalmology

AI is taking a prominent seat in ophthalmologic treatment. Here are a few examples:



- Autonomous AI exams linked with higher adherence to annual diabetic eye disease testing
- Image analysis ideal for AI in ophthalmology
- AI referral may increase health equity in diabetic eye disease
- Smartphone AI systems may help detect glaucoma

These are only four recent articles of dozens going back over the past two years on AI for ophthalmology.

While most articles address AI on the clinical level, as do these four, AI also has its place on the financial, operational, and workflow aspects of ophthalmology practice management. Specifically, the outsourced RCM service or the in-house automation system you use should be AI and machine learning (ML)-architected. A built-in, user-defined rules engine (RE) would complete the circle.

AI, ML, and RE all promote self-operating, hands-off automation, which eliminates staff time on “busywork” routines that are mundane but are nonetheless needed.

The MedicsPremier platform used by MedicsRCM, and to which clients have unlimited and transparent access, supports robust AI, ML, and RE technology. The result empowers our automation to do what automation is supposed to do: enable our clients to operate efficiently with minimized human input.

Issues with Younger Medicare Beneficiaries

Before anyone rolls their eyes over the “After all, how many younger Medicare beneficiaries can there be?” question, the answer is that 13% of people covered by Medicare are under age 65. That’s 8 million beneficiaries. So the number is not insignificant.

That group reported there are more concerns about cost and about having worse access to care. As expected, the same group said lower satisfaction levels about care. All of this is compared with the over- 65 age group.

The report notes how the younger group was more likely to be Black or Hispanic and have an income under $20,000. Younger beneficiaries were in fair or poor health, having six or more chronic conditions, three or more functional limitations, and at least one cognitive or mental impairment.

One solution to the mentioned issues might be expanding Medicare Savings Programs' eligibility with cost-sharing assistance under Medicaid. Medigap coverage could also help with the care experience.

Click here for the Health Affairs report.

Up to $3k in Out-of-Pocket Costs for Pediatric Hospitalizations

But this is an ophthalmology newsletter.

True, but we're only citing the headline and the link below as a real-world example of how much patients pay as personal responsibility amounts and why patients are often cited as the third largest payer group in the US, behind only Medicare and Medicaid. You probably see that in your own setting.

It's why you need every patient payment feature possible in your technology arsenal including, those that proactively address the problem, such as:

- Access to a patient responsibility estimator and copayments as part of scheduling appointments
- Eligibility verifications and out-of-network alerts in advance and, ideally, on scheduling appointments
- Automated prior authorizations when needed
- Insurance discovery whenever coverage information is missing or incomplete
- Balance-due texts that are trackable with patients paying through their texts
- Patient portal with online payments
- Accepting payments - including gift cards and coupons - for purchasable products and non-medical appointments (cosmeticians and aestheticians)

Keeping your patient A/R tightly managed is possible if you have the tools. MedicsRCM and our rules engine-based MedicsPremier platform support your effort to drive patient payments as described above.

Click here for the JAMA report on out-of-pocket pediatric costs.

Eye on Ophthalmology Fraud

This incident culminated in March 2022, but the message is still relevant.

An ophthalmologist with five practice locations in the NYC upstate region, in NYC, and in CT was sentenced to 96 months in prison for his role in orchestrating a seven-year scheme to defraud insurance payers by submitting millions of dollars in upcoded procedures and then for also falsely obtaining governmental loans earmarked to assist small businesses during the pandemic. The second issue happened while he was facing charges for the billing scheme.

The doctor pleaded guilty to all charges before a US District Court judge.

In addition to the prison term, the doctor was sentenced to five years of supervised release and was ordered to pay both a forfeiture payment of $3.6 million and that same amount in restitution. Of course, the doctor also lost his medical license.

It was noted by the prosecutor that, adding insult to injury, the doctor submitted patients who couldn't pay upcoded bills to a collection agency, damaging their credit.

Victims included Medicare, private insurance, and patients, as mentioned.

The FBI, HHS, and OIG were the investigating agencies.

Full details can be seen here.

1. Fraudulent treatment, such as for prescribing controlled substances
2. Billing for services not provided
3. Misrepresenting the nature of services provided to patients
4. Auto accident scams
5. Misrepresenting credentials or remedies (quackery)
6. Submitting false cost reports
7. Obtaining illegal remunerations
8. Providing unnecessary or substandard healthcare services

Knowing and avoiding these instances will help ensure you're not at risk. The list should be memorized and posted. It might be worthwhile to have a training session on them.

How can we help? MedicsRCM makes ensures your claims are submitted at their highest possible value per payer without over-coding. In that way, you're assured of no-risk maximized reimbursements.

We also alert when E/M coding can be better (another way to derive optimal reimbursements) and that your NCCI edits are correct whenever a patient's claims should be bundled into one master claim.

Recap: know the list, and please be in touch for an overview of how we can help you drive revenue and productivity!

Remodeling, Revamping, and Rehabbing your Office

According to a recent article written by an ophthalmologist, you might have a loyal patient base. Still, as patient populations age and are more knowledgeable now than ever, subspecialists and new procedures are being sought.

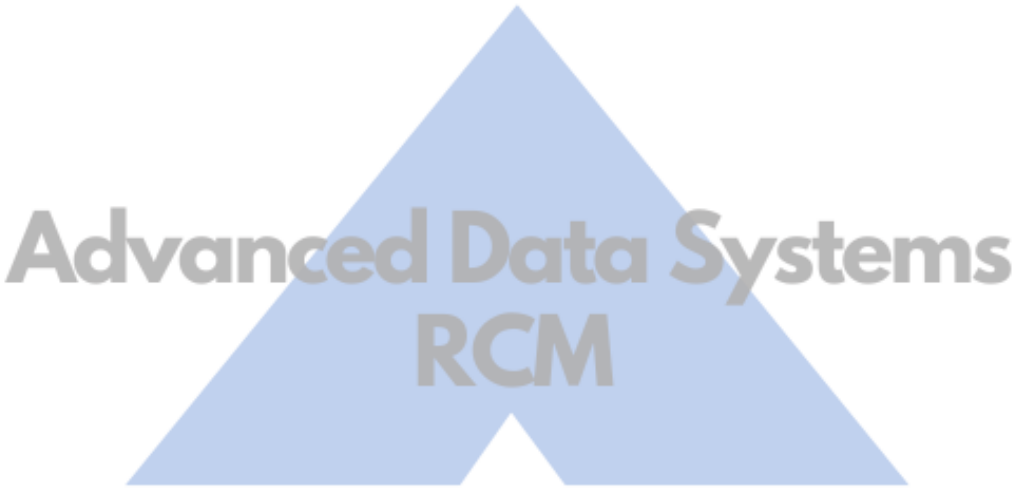
Another point mentioned as part of overall remodeling is replacing staff who leave. While we can't help with office renovations, we can help alleviate staffing issues with our outsourced workforce. Clients can consolidate their staffing on many levels, making them exponentially more efficient, streamlined, and profitable.

Whether you remodel or not, we'll help alleviate staffing concerns, and guarantee to increase your revenue in 90 days!

Insourcing

If you prefer to keep your billing in-house, the same platform we use – MedicsPremier – is available from ADS. MedicsPremier can be implemented on our cloud or your server. We're happy to schedule a system overview.

Enjoy the Spring, and we'll see you over the Summer!



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