December 7, 2012

The Honorable John Boehner
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

The Honorable Harry Reid
Senate Majority Leader
U.S. Senate
Washington, DC 20510

Dear Speaker Boehner and Majority Leader Reid:

On behalf of the Healthcare Billing and Management Association and the thousands of physicians we work for, we are writing to urge Congress to avert the pending 26.5% reduction in the Medicare physician fee schedule (MPFS) Conversion Factor on January 1, 2013. Should this cut occur as scheduled, we have no doubt that thousands of physicians will either dramatically curtail the number of Medicare patients they will see in their practice or, in the most extreme cases, no longer accept Medicare patients.

Either way, millions of Medicare beneficiaries will surely see a precipitous drop in the availability of medical care they have come to expect and deserve.

As you well know, the Medicare SGR formula that is causing this problem is long overdue for reform. Each year for nearly a decade, Congress has avoided the problem and continually adopted short-term "fixes." This simply cannot be allowed to continue.

Medicare beneficiaries deserve to know that the quality healthcare they have come to rely upon will be there when they need it.

We further call upon you and your colleagues to address this issue now, during the lame duck rather than simply pushing off the tough decisions until the new Congress convenes in January.

Finally, whatever SGR fix you agree upon – whether short-term or long-term – must be enacted prospectively, not retrospectively. In other words, act now or some time prior to January 1, rather than postponing action on a fix until the 113th Congress convenes.

Enacting a retroactive "fix" to the SGR problem is expensive and will add unnecessary costs to both the provider and to Medicare, effectively wasting millions of dollars that would be better spent on patient care.

Billing companies are retained by physicians to handle the business aspects of a busy medical practice. As medical business experts or member companies are intimately familiar with what it costs a physician to submit a medical claim and get paid for the services they render.

Submitting medical claims is already unnecessarily expensive. Asking providers to resubmit claims – which is what is necessary when you retroactively "fix" the SGR problem – only adds to the cost of doing business.

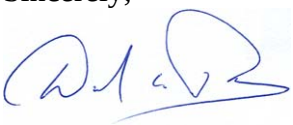
To assist you and your colleagues in appreciating the cost of a retroactive SGR fix, we have produced two charts (copies attached). Chart 1 is a basic flow chart which provides a visual description of the steps (both automated and manual) an uncomplicated medical claim goes through in order to get paid by a Health Plan. Chart 2 is a basic flow chart which provides a visual description of the steps (both automated and manual) an uncomplicated claim must go through when you fix the SGR problem retroactively.

As you might imagine, the more steps a claim must go through, and more importantly the more "manual" steps a claim must go through, adds to the cost of getting that claim processed. In many instances, the cost to a medical practice of reprocessing a claim when you retroactively "fix" the SGR is higher than the value of the claim.

For these reasons, we urge you to pass the longest possible SGR fix this year (2012).

We recognize that new payment methodologies may be necessary to maintain the long-term viability of the Medicare Trust Fund and we look forward to working with you to design a payment system that is efficient and results in encouraging physicians to provide medically necessary, quality services to the Medicare population.

Sincerely,



Don Rodden, CPA, CHBME
President
HBMA

Process a Medicare Claim goes through in order to get paid

Payor fee schedules are loaded into practice management system with effective date 1/1. Automated process.

Physician provides services. Claim prepared and submitted electronically for beneficiary's insurance. Automated process

Electronic claim for services sent to insurance. Automated process.

Insurance payment deposited electronically in provider's account. Automated process. Electronic explanation of decision received from payor. Information includes payment, adjustments and patient responsibility (if any). Automated process. If necessary, claim is forwarded to secondary insurance from primary payor or by practice management system. Automated process.

Payment from secondary insurance deposited electronically in provider's account. Automated process. Electronic explanation of decision received. Information includes payment, adjustments and patient responsibility (if any). Automated process. If secondary payor does not process electronically, manual posting of transaction required.

Patient statement (if any) generated. Automated Processes.

Minimal human intervention and work required to process claims. If electronic processes not used by payor, typically only one step of human intervention required.

Claims Process if SGR is fixed Retroactively

Medicare fee schedule reloaded with retro effective date. Automated Process.

Practice management system flags all affected accounts as unresolved due to the differences in payments, adjustments and patient balance. Allowable amount adjustments require manual processes to review and make corrections.

Medicare explanations with corrected claim allowable, payment, adjustments and patient balances received. Matching electronic payments received. Hundreds or thousands of corrections for pennies typical.

Manual reposting of payments, adjustments and patient balances required to correct account transactions.

Primary payor claim is forwarded to secondary insurance (if any) from primary payor or by practice management system. Automated system process.

Corrected secondary explanation of payment, adjustment, and patient balance received. Matching electronic payment received.

Manual reposting of payments, adjustments and patient balances required to correct account transactions to match primary and secondary amounts.

Decision to send patient statements for very low amounts vs. write-off amount, due as cost exceeds payment amount due.

Beneficiary calls regarding new explanation of benefit

Human involvement to repost and correct primary and secondary transactions and handle beneficiary calls is required at virtually every step of the process. Cost is exponential and far exceeds payments from SGR retroactive correction.

Note: It is not unusual for either the patient or the secondary payer to pay twice on the same claim in a retro-payment environment. For example, some insurance companies pay the appropriate coinsurance on the original claim and then pay the full amount (rather than just the difference) again when the reprocessed claim comes through. This results in an over-payment and requires the provider to go to the expense of issuing a refund to either the insurance company or the patient.