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Health Care Reform: Scratching the Surface of Inclusions

The health care reform bill, formally titled the Patient Protection and Affordable Care act (PPACA) was signed into law in late March. The dust is still settling, legal challenges from at least 13 states are threatened, and the total impact of the bill is still not entirely clear.

Here's some information we've gathered so far:

- There is an expectation that approximately 16 million people will be added to Medicaid.
- Medicaid reimbursements will adjust upward in 2013 and 2014 for primary care providers and pediatricians.
- The bill provides provisions to increase the number of primary care providers being trained.
- Annual "wellness visits" will be covered for Medicare patients. It is not yet clear if this is the kind of service we traditionally think of as a preventive service, or an extension of a type of visit covered as the IPPE.
- Co-pays and deductibles will be removed from certain Medicare preventive and screening services.
- PQRI participation will be a requirement. Non-participation by 2012 will result in escalating revenue decrease from Medicare.
- One of the less clear outcomes is the development and role of an Independent Payment Advisory Board that will be formed based on PPACA.
- Denial of health care coverage based on pre-existing conditions will end. However, this will occur in stages over a period of time. For children, this will phase in the fall of 2010. For adults, the phase in will occur in 2014. There is also a temporary back-up plan that will be available for people with pre-existing conditions who have been uninsured for six months. Enrollment in the plan is designed to provide subsidies with which to purchase health care policies.
- Most Americans who do not purchase a health care policy by 2014 will be required to pay a per year penalty for not having health insurance.

- For all Medicare claims occurring on or after January 1, 2010, providers will be required to submit claims within one calendar year from the date of service. For services before January 1, 2010, claims must be submitted by December 31, 2010. (Previously, claims could be submitted within three calendar years from the year in which the services were furnished.)
- Medicare and Medicaid overpayments must be reported and returned within 60 days after the date when the overpayment is identified. When you report an overpayment, you must also provide a written explanation of the reason for the overpayment. Failure to report and return an overpayment may be subject to a penalty.
- All providers will be required to develop and implement a compliance program; however, this requirement will not be effective until CMS adopts regulations that specify what needs to be included in the program and the effective date.
- Beginning January 1, 2011 through 2015, Medicare will pay a 10% bonus to primary care providers participating in Medicare.
- Payment restructuring to the Medicare advantage program.

Medicare Conversion Factor

One issue the Health Reform package did not address or resolve is the SGR (Sustainable Growth Rate) methodology or the imminent implementation of the 21% Medicare conversion factor cut.

The latest effort to hold off the 21% Medicare conversion factor cut expired on March 31st. Medicare is currently holding claims for the first 10 working days in April in anticipation of a fix. It is anticipated that Medicare will begin processing claims based on the reduced conversion factor on April 15th.

There is currently a proposed bill in Congress that would pass another extension until June 1st.

If this occurs and a permanent solution is not in place by June 1st, look for Medicare to hold claims for the first ten working days of June.

So far there's no word on when Congress will try to address a permanent solution. According to health care congressional observers, the Senate would prefer to hold off on a permanent fix to the SGR problem until after fall elections.

Quick Coding Tips: The Chief Complaint Statement

1. *How comprehensive is your statement? Statements like "med check" and "follow-up" aren't sufficient to fully support medical necessity for the encounter. Expand your statement to include the conditions, problems or symptoms requiring the med check or follow-up (i.e. "follow-up hypertension").*
2. *Is your statement accurate? "Routine follow-up" isn't accurate if the patient is presenting with an exacerbation of their chronic problem.*

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