Implementing Private Pay Services in a Payer Participating Practice

With Sonda Kunzi, CEO of Coding Advantage and
Jim Eischen, Esq. of the Eischen Law Office

virtual practices

Agenda for Today

- Overview
- Recap from last week
- Adding private pay revenue models
  - Key benefits
  - The reimbursement mindset
  - Cash compliance for participatory providers
  - Solving the puzzle
- Reengaging the payer system
- Next steps

Who is this session for?

- Practice owners seeking to optimize revenue and professional satisfaction by combining private pay models such as membership and bundled programs while participating in the payer system.
- Medicare participating practice owners and managers that currently incorporate cash services seeking current guidance on how to compliantly do this in 2021 and beyond.

Recap

- Five key changes that make root cause medicine financially feasible for practices and patients within the payer system.
  1. Bill for time spent prepping for and documenting visits (on the same calendar day of the visit) including prolonged visits (beyond 99215) in15-minute increments
  2. Code on the basis of time OR medical decision making (MDM) – rewarding root cause providers for work with more complex patients
  3. Parity in the value of telehealth and in-person visits – including virtual group visits
  4. Utilize health coaches in combination with a tech platform for RPM
  5. Dramatic reduction in note-taking requirements for providers to bill higher level E/M codes

Recap: 12 Month Care Path
New patient w diabetes & hypertension

Recap: Care Path Economics

2020 values

- Total provider time: 5.65 hours/ patient
- Net revenue/ patient (net of coaching cost): $1,067.61
- Net revenue/ hour: $188.96

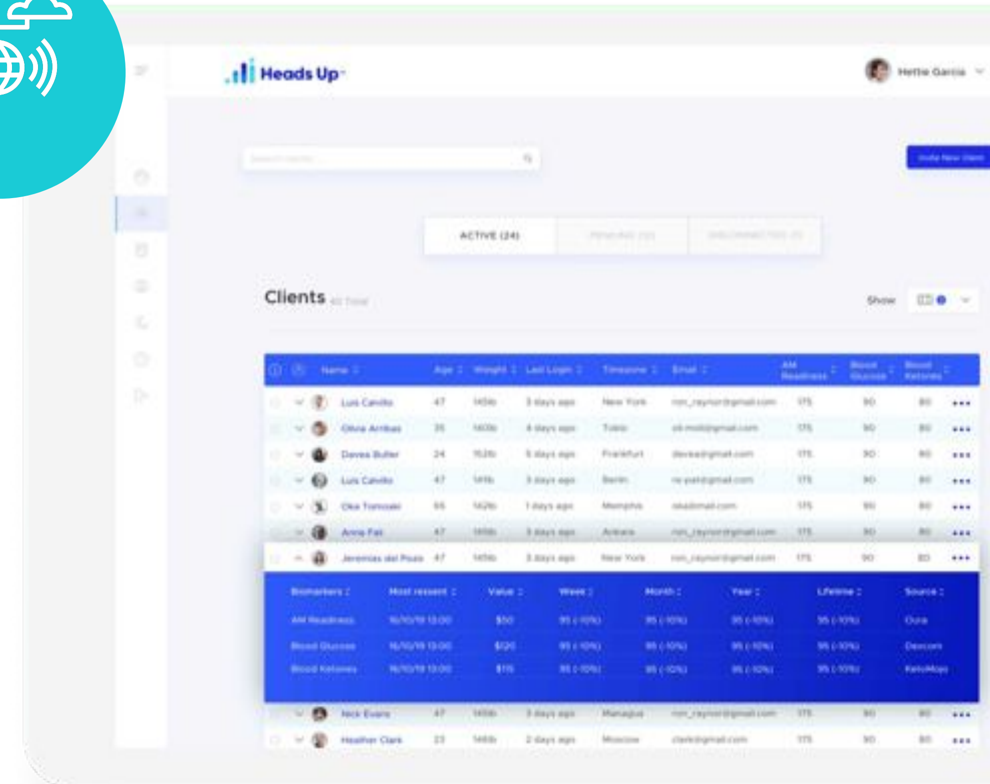
2021 Values

- Net revenue/ patient (net of coaching cost): $1,610.12
- Net revenue/ hour: $284.98

An increase of $96.02/ hour (51%)

Adding RPM: $3038 per patient over 12 months

Coming Soon – Health Coach RPM Training



Certification course for health coaches

RPM basics

Device selection and setup

Client onboarding

Billing thresholds

Patient engagement

Contracting kit for coaches and providers

Pre-register at:

headsuphealth.com/remote-patient-monitoring-course

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Jim Eischen

Jim Eischen has over 32 years of experience practicing law, and for the last ten (10) years, he has developed a national reputation as a private direct medicine, healthcare business planning and regulatory compliance attorney. Jim frequently lectures on healthcare & wellness business planning, data privacy compliance, and avoiding professional burnout..

Jim is a national expert in the creation and implementation of private direct practice models, and how to create effective healthcare/corporate platforms. In 2018 and again in 2020 he re-wrote the private direct medicine compliance chapter of the California Medical Association's physician legal handbook. His legal analysis is peer-reviewed.

To better distribute guidance on private direct practice formation and operation best practices and compliance solutions, he formed www.loftylearning.com. Lofty Learning delivers educational insight to a wide audience via live/taped/audible webinars.

Jim continues to practice law and assist with practice and business formation projects throughout the US as Eischen Law Office.

Why Consider Adding Private Pay Models to a Payer Participating Practice?

Key Benefits

- Patient engagement/ outcomes
- Value optimization
- Revenue optimization
- Scalability beyond yourself
- Turning your practice into a transferrable asset

The Problem with the Reimbursement Mindset

- Many root cause practices use a cash menu of one-off services
- Dolling out care in defensible doses & reimbursing as services delivered rather than on subscription/whole health basis does not serve you or your patients.
- Confusion about integrating plan reimbursement, causes providers to recreate the old menu and fail to access the power of subscription and bundled programs.
- The solution:
  - *Bill plans for plan-covered care services*
  - *Frame private fee services as outside plan & eligible for HSA/FSA/HRA*

Is Root Cause Medicine “Covered” by Insurance?

- Even prior to 2021, when root cause medicine was provided in a plan-covered care event, the event is considered covered.
- It has always been safe to assume that your services are covered by Medicare absent careful structuring, framing, and modeling.
- Do not assume that simply labeling services “functional medicine” means that it is not covered by Medicare.

Cash Compliance for Medicare Participatory Professionals

- US cash medical practices *must implement Medicare/ Medicaid compliance*
- If you are a participating provider, you may not ask a Medicare patient to pay a second time for services for which Medicare has already paid.
- Basic Medicare Compliance: *Cash allocated to explicitly non-covered services*
- With Medicare expansion of care coordination/telehealth coverage and the 2021 E/M changes, *you must do careful allocations of cash to non-covered services*

So, What is NOT Covered by Medicare?

- Annual routine regardless of condition/medical necessity physicals (or ”checkups” or exams) not delivered based on medical necessity (with exam-related guidance)
- Education and technology: is not necessarily covered healthcare, but instead: health coaching, generalized education, health data services, tech services
- Functional, integrative, hormone, anti-aging: For practices that combine cash services with plans, the best practice is to integrate that into routine exam services as Medicare will continue to expand “alternative” care reimbursement.
- **You get to make the choice.**

The Solution

- Basic Medicare Cash Care Compliance: ***Routine Regardless Of Medical Necessity Exams & Related Communication Support*** *(Not Chronic Care Management Or Covered Care Coordination....)*
- Or: ***Health Coaching*** & ***Technology Services*** *Outside Medical Care/Coverage*

Routine Regardless of Medical Necessity Exams

- Routine regardless of medical condition or necessity exams or checkups and communication services directly connected to supporting those exams or checkups, remain outside Medicare coverage.
- The Social Security Act explicitly bars Medicare from reimbursing for services
  - "…not reasonable and necessary for the diagnosis or treatment of illness or injury…." or for "…routine physical checkups…." 42 U.S.C. Section 1395y(a)(1)(A) and (a)(7).

Routine Regardless of Medical Necessity Exams

- Root cause exams fit the definition of Medicare-excluded checkups or exam services as they are “routine” and <u>not</u> dependent on justification as both “reasonable and necessary to diagnose” illness.
  - They are delivered regardless of immediate medical need, do not focus on diagnosing a specific condition, and therefore easily framed as outside Medicare coverage.
- Root cause practices can deliver routine exam and communications services AND bill Medicare/plans for plan-covered diagnosis & treatment, and the specific preventative & care coordination services as plans do now cover (RPM, CCM, AWV, care coordination).

Routine Regardless of Medical Necessity Exams

- AND: Routine exams that integrate a reference to "diagnosis" and related communication services that support those exams can be framed as eligible medical expenses such that they easily qualify for HSA/FSA/HRA funding under existing laws (routine exams can be "diagnostic" and remain outside Medicare coverage).
  - Provide appropriate documentation to the patient (invoice/ proof of payment)
- **Physical Examination (Publication 502)**
  - You can include in medical expenses the amount you pay for an annual physical examination and diagnostic tests by a physician. You don't have to be ill at the time of the examination.
- **Medical Information Plan (Publication 502)**
  - You can include in medical expenses amounts paid to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician.

What Medicare Covers

- Evaluation & Management/E&M covered: *even if you integrate FM/alternative services into your E&M*
- Medically indicated non-routine diagnosis & treatment covered: *even if you integrative FM/alternative services into diagnosis and treatment*
- Medically necessary testing is covered, but proactive health testing (genomic/microbiome/routine or annual)is <u>not</u> covered: *even if you integrate FM/alternative services into your routine exam.*
- Electronic communication mostly "bundled" with E&M diagnosis/treatment, CCM, care coordination are covered (<u>vs. communication connected to non-covered services are not covered)</u>

Framing Your Membership or Program

- The key concept to understand is that you actually are able to choose which services to frame in connection with the routine exam and communications.
- This can apply to evergreen annual subscriptions (memberships) and also to time-bound, objective-specific programs.

Key Takeaways

- ***Don't*** automatically opt-out of Medicare, don't assume plan reimbursement is not possible for root cause medicine.

- ***Do*** engage in standard private direct fee compliance,
- ***Do*** document patient agreements and marketing as Medicare compliant
- ***Do*** implement strong consent documents
- ***Do*** frame cash services as eligible for HSA/FSA/HRA funding

Next Step

- Tell us what you are thinking.
- Complete a simple 6 question survey, and we will offer specific guidance on resources to support your vision.

How to Reach Jim

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Reengaging the Payers

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Reengaging With the Payers

Opportunity during PHE to take advantage of waiver 1135

- Allowing **opted-out** physicians and NPPs to terminate their opt-out status early and enroll in Medicare
- Medicare temporarily waiving the following to become re-enrolled:
    - Application fees
    - Background checks
    - Site visits

Reengaging with the payers

Commercial payers may have special contracting in place.

- This will be a payer-by-payer decision on how credentialing will be handled and if new policies are in place to facilitate contracting
- COVID-19 related services are generally paid similarly with or without regard to in network status during the PHE.

Examples of healthcare payer information on expediting credentialing process:

- UnitedHealthcare is temporarily updating credentialing policies to implement provisional credentialing for out-of-network providers who are licensed independent practitioners and want to participate in UHC networks. https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-credentialing-updates.html
- Some of the BCBS companies at the state level have addressed the PHE in the credentialing process. BCBS of Massachusetts has a PHE credentialing application. https://provider.bluecrossma.com/ProviderHome/wcm/connect/e4ac3e24-aab3-4b90-b91a-28aff0d5a2eb/Public_Health_Emergency_Credentialing_Application_MPC_030620-1N.pdf?MOD=AJPERES

Next Step

- Complete a simple 10 question survey to arrange a free consultation with the Coding Advantage team to explore the opportunity to reengage the payer system.