ONSLOW RADIOLOGY CENTER
299 Doctors Dr.
Jacksonville, NC 28546

We are a small radiology practice owned by a solo radiologist from Jacksonville, NC. We currently have 10 employees, both full and part-time. We are a physician/provider referral based office only. Dr Howard has been in practice for 26.5 years and is a board certified radiologist.

1. The methodology that CSC is currently using for Medicare patients with dual enrollment with Medicaid is of great concern to us. I have seen our write-offs increase greatly. Since we serve a farming community as well, we have many, especially widows, with Medicaid as their supplement. The additional write offs from Medicaid is resulting in payments less than even the Medicaid fee schedule. This methodology is unfair and is hurting not only the small practices, but larger ones as well. An extra $500 a day may not seem a large amount to some, but with a small practice, it is tax paying and voting employees' salary. We are facing either laying people off, cutting hours or possibly having to close our practice. I do not like either option forced on us by a "billing methodology".

I have spoken previously with CSC about this methodology. CSC places the blame on a DMA directive. DMA, in turn, replies that it is the way CSC set up the billing system.

Providers are now considering no longer participating with Medicare as well as Medicaid because of this issue. Providers are required to file Medicaid if Medicare is primary payer. This again will hurt our elderly and disabled who require these services. Since 2007, specialists have had no increases in fee schedules but have been continually cut at rates as high as 20%. However, the government continues to require more with equipment certifications, physician certifications, registered and qualified personnel, continuing education and electronic records. Unfortunately our operating expenses continue to increase rapidly.

2. Telephone representatives with CSC are inadequately trained for their positions. They readily admit to having no medical or insurance billing backgrounds and simply do not have the ability they need for those positions. Being able to consult a manual is simply not good enough. They may be well-versed in how a computer system is set up and works, but they do not understand the billing process.

3. Telephone messages left for those in management are rarely returned or require a 3 to 4 weeks wait. By that time, the problem(s) have compounded and escalated. I personally am still waiting for calls from messages left 4.5 weeks ago.

4. Clearing houses are still struggling with this system wrote with its own set of codes and rules.

5. Explanation of benefits (EOB) or payments from CSC are very difficult to read, taking much time and effort to post payments. CSC explanation again is that the EOB is set up the way DMA wanted it. I question this answer. CSC also processed co-pays at $5 instead of the $3 required by Medicaid. I have yet to see any additional payment from CSC

6. Self-referral: Provider practices across our state are having expensive x-ray equipment, labs, and pharmacies installed in their offices. Technicians bring portable ultrasound equipment into their offices. Providers are no longer required to refer these diagnostic studies to a specialist, but are directly profiting by having this equipment "in house". Hospitals are buying up all practices possible and requiring that all diagnostic studies be referred to them. Physicians have even threatened to terminate a patient when the patient requested to go elsewhere. The potential for abuse is tremendous. Radiology especially has become an over-utilized tool to make up for provider cuts since providers are no longer being required to refer outside of their practices. Studies are being performed in offices that are unqualified to do so.
7. X-ray over-reads are also on the rise. Providers request radiology studies and then do another "interpretation" of the study after it has already been read by a certified radiologist. This provider is then paid for his/her additional interpretation.

8. Other providers are reluctant to voice their concerns because of the threat of an audit and subjected to large fines for any possible error. Providers in Onslow County say they would rather close their practices than face retribution. This kind of intimidation is unacceptable.

In my opinion, NC TRACKS, an approximately $495 million project, was not ready for implementation. It is backed up by the state auditor who advised the system not go live on July 1. This implementation and methodology has resulted in extreme hardships to many providers with resulting lay offs, closures, and loans on practices; gifted providers who have spent years taking care of our North Carolina senior citizens. What a shame.

Susan Fountain
Office Manager
26.5 years experience

Onslow Radiology Center-5 Common procedures with Medicare-Medical dual enrollment

Before July 1 2013

CT Abd/Pelvis Stone protocol (74176):	1350.00
Medicare write off:	-1131.13
Allowed amount:	218.87
Sequestration	- 3.50
Medicare pd:	- 171.60
Co-pay	43.77

Balance to Medicaid (co-pay)	43.77
Medicare x 73.9% (Medicaid pd)	-*32.35*
Additional Write off	11.42

After July 1, 2013

CT Abdomen Pelvis (stone)	$1350.00
Medicare write off:	-1131.13
Medicare allow:	218.87
Sequestration:	- 3.50
Medicare pd	171.60
Co-pay:	43.77

Co-pay to Medicaid	43.73
Medicaid payment now:	*0.00*

Total Allowed and Paid amounts **$203.95**

(Medicaid paid co-pay amount x 73.9%)

Methodology now: If allowable is > or = Medicaid Fee Schedule "0" payment

New Methodology Allowable: 175.14
Medicaid Fee Schedule: ***$179.77***

Paid less than Medicaid fee schedule

Since Medicaid pays 73.9% of Medicare fee schedule, there will **NEVER** be a payment made on any Medicare/Medicaid crossover claims unless deductible has not been met or denied procedure is covered by Medicaid.

Before July 1 2013

Chest x-ray (71020)	$100.00
Write off	- 70.91
Medicare allow:	29.09
Sequestration:	- .47
Medicare pd:	22.80
Co-pay:	5.82

Co-pay to Medicaid	5.82
Co-pay x 73.9% paid	4.30
Additional write off	1.52

New Methodology Allow: $23.27
Straight Medicaid Allow **$25.44**
Paid less than Medicaid Fee Schedule

After July 1, 2013

Chest (71020)	$100.00
Medicare adj	- 70.91
Medicare allow:	29.09
Sequestration:	- .47
Medicare pd	22.80
Co-pay:	5.82

Co-pay to Medicaid:	5.82
Medicaid payment	0.00
Additional write off	5.82

Before July 1 2013

KUB (kidneys ureters bladder 74000)	$100.00
Medicare write-off	- 61.69
Medicare allow	23.31
Sequestration	- .37
Medicare paid:	18.28
Co-pay Balance:	4.66

Co-pay to Medicaid	4.66
Co-pay x 73.9%	- 3.45
Additional write off	1.21

New Methodology Allow: $18.65
Medicaid Fee Schedule: *20.34*

Paid Less than Medicaid Fee Schedule

After July 1, 2013

KUB:	$100.00
Medicare write off	- 61.69
Medicare allow	23.31
Sequestration:	- .37
Medicare paid	18.28
Co-pay Balance	$ 4.66

Co-pay to Medicaid	4.66
Medicaid payment	0.00
Additional write off	4.66

Before July 1 2013

CT Head (71250)	725.00
Medicare write off	-525.50
Medicare allow	199.50
Sequestration:	- 3.19
Medicare paid:	- 156.41
Co-pay Balance:	39.90
Co-pay to Medicaid	39.90
Medicaid 73.9% paid	29.49
Additional write off	10.41

New Methodology Allow: 159.60
Medicaid Fee Schedule: ***227.29***

Paid less than Medicaid Fee Schedule

After July 1, 2013

CT Head	725.00
Medicare write off	-525.50
Medicare allow	199.50
Sequestration	- 3.19
Medicare paid	- 156.41
Co-pay Balance	39.90
Co-pay to Medicaid	39.90
Medicaid paid	0.00
Add'l write off	39.90

Before July 1 2013

Ultrasound Pelvis (76856)	275.00
Medicare write off	- 155.96
Medicare allow	119.04
Sequestration	- 1.90
Medicare paid	93.33
Co-pay balance	23.81
Co-pay to Medicaid	23.81
Medicaid 73.9% paid	15.28
Additional write-off	8.53

New Methodology Allow: 93.33
Medicaid Fee schedule *96.48*

Paid less than Medicaid Fee Schedule

After July 1, 2013

Ultrasound Pelvis	275.00
Medicare write off	-155.96
Medicare allow	119.04
Sequestration	- 1.90
Medicare paid	93.33
Co-pay balance	23.81
Co-pay to Medicaid	23.81
Medicaid paid:	0.00
Add'l write-off	23.81

Onslow Radiology Center

This is a typical day (excluding patient names and medical information) posted from September 24, 2013 demonstrating the write offs for patients having Medicare and Medicaid.

Patient chart	Charges	Medicare write off	Additional Medicaid write off
00001	1350.00	1134.63	86.80
00002	100.00	71.38	5.82
00003	160.00	36.95	9.43
00004	195.00	133.04	12.60
00005	3100.00	2557.96	110.17
00006	95.00	59.05	7.31
00007	415.00	249.23	29.09
00008	1720.00	1134.63	29.99
00009	1350.00	1134.63	43.77
00010	150.00	69.50	17.09
00011	2135.00	1749.18	81.40
00012	230.00	115.05	23.36
Totals:	$11000.00	$8445.23	$456.83

We did a total of 16 exams for 12 patients. Our total payment was a Medicare payment of $2097.94 and a "0" Medicaid payment. Each exam involved 7 specially trained employees. This averages out to about $130 per study. Divide that by the number of needed employees pay rate and operating expenses and you will get a negative number.

These figures demonstrate why many good and much-needed doctors are closing their doors or selling out. Is there any other field where government pays so little for so much?