New Guidelines for Insurance Payments Benefit Physicians

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VCC may sound like new college basketball conference, but it's actually a term that could be adversely affecting your practice's revenue without your knowledge. Moreover, there's now something you can do about it.

First, let's define the term. The acronym, VCC, stands for "virtual credit card." Essentially payment cards, virtual credit cards are temporary, typically single-use, time-bound, computer-generated cards. The "card" is not a physical document per se, it's a series of data -- each has its own unique card number, expiration date, and CVV number. They are increasingly used for financial transactions, as they avoid the natural fraud and abuse that occurs when a physical card gets into the wrong hands.

Although VCCs have merit for payment transactions, they have created a significant issue for medical practices. Financial technology companies – fintech, for short – sell the cards to health insurance companies who use them to generate payments. Instead of the

insurance company having to manage the financial transactions, the payment processing is passed onto the fintech company. And guess who pays for the security and convenience of the new financial transaction? You do. The fee is passed on to the *payee*, and most often, you agreed to it when you accepted electronic funds transfer in your participation agreement with the insurer. Although the fees typically range from 1 to 3%, they can have an impact on your bottom line.

An equally challenging impact is the fact that a third-party now involved – the fintech company being paid to process the payments. It's not uncommon for the payment to be separated from the information about the payment, which is necessary to associate the payment with the correct guarantor. This so-called "reassociation" is crucial for effective and efficient revenue cycle management. When payments and associated information get out of sync, havoc in the business office reigns.

After years of suffering from these largely unknown fees, physicians finally received good news from the Centers for Medicare & Medicaid Services (CMS) in March. CMS issued guidance that an insurer cannot require physicians to receive EFT payments or reassociation services from its selected fintech vendor. However, the onus is on the medical practice to communicate with the insurance company.

A practice may request a health plan to comply with national standards for electronic payment transactions. This includes the required one-to-one matching of funds to transaction information.

The health plan may not force practices to use their business associate (the so-called fintech company that is processing payments) in order to receive payments.

The new guidelines extend the requirements to all health plans, whether you are a participating provider – or not.

CMS has issued a complaint portal should you find that your health plans are not in compliance.

A good place to start may be reviewing the guidance from CMS. Then, set up a meeting with your biller or business office team; ask them about the remittance process regarding insurance payments. Do they have trouble matching associated payments with patients' services? (A warning sign may be a high number of credits, as those often indicate that there were payments – but problems applying them.) Are fees being taken out by your health plans for payment processing? (Look at your remittances, as they are often poorly marked – no one wants you to see that fees are being applied.)

The new CMS guidelines take some time to review, but avoiding these fees pays off in the long run.

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