November - December 2009

NCDS update

A Billing Industry Newsletter for Clients

HAPPY HOLIDAYS!

Keeping your office up-to-date on industry and insurance changes, late-breaking billing & reimbursement news, and general inter-office communication…

MEDICARE 2010 PHYSICIAN FEE SCHEDULE UPDATE (AS OF DECEMBER 1, 2009)

BY: BILL FINERFROCK, HBMA WASHINGTON REPRESENTATIVE

As has been previously reported, the House has approved legislation that would repeal the current SGR formula and replace the current flawed formula with a new formula for determining annual updates to the fee schedule conversions factor. This was originally included in the House healthcare reform bill but later removed from that legislation and approved as a stand-alone piece of legislation.

The Senate attempted to pass a permanent SGR fix; however, this legislation failed. Consequently, a short-term fix has been included in the healthcare reform bill currently pending before the Senate.

The problem with the House passed SGR bill (as was the case with the earlier bill considered by the Senate) is the bill is not "paid for". Fixing the SGR problem will result in higher than expected outlays from the Medicare Trust fund. If Congress fails to provide the funding necessary to pay for the SGR fix, then the money will come out of the Medicare Trust fund thereby accelerating the date at which the fund becomes bankrupt.

The temporary SGR fixes the Congress has approved in the past have used very creative budget gimmicks to hide the cost of the problem. At some point that bill will become due.

I do not believe Congress will be able to complete action on healthcare reform before the end of 2009. Therefore, it is imperative that separate SGR legislation move through Congress so something can be put onto the President's desk by the middle of December. CMS has indicated that they will need several days of lead-time to prevent the SGR cuts from taking place on January 1, 2010.

My "best guess" on how Congress will deal with this is that they will do what they've done in the past, approve another one-year fix (most likely a .5% increase rather than the projected 21.2% cut). And, as they've done in the past, the Congress will use budget gimmicks to push off the cost of the fix until next year's budget.

The HBMA Government Relation's Committee continues to monitor this situation very closely and HBMA has urged Congress to approve a permanent fix to the SGR problem and find the resources to pay for the fix.

Primary care physicians who include a mental health diagnosis code will received a reduced service fee of 50%. ICD-9 codes for depression, dementia, memory loss and the like will reduce the payment for E/M services. IF YOU ARE NOT TREATING FOR MENTAL ILLNESS DO NOT INDICATE IT AS A DIAGNOSIS ON YOUR ENCOUNTER FORM or you will not receive full reimbursement.

Welcome Dr. Collaco… the newest provider to contract with NCDS… It is with great pride that we say **thank you to all our clients** for allowing us to continue to serve you into our **25th year in business** !!

INTERESTING ONLINE EXTRAS

Reference these articles by going to the Client Newsletter section of **www.ncdsinc.com**, select this issue and click the links in the .pdf for easy access to these important topics.

American Medical News: Medicaid would cover 15 million more people under health reform bills
http://www.ama-assn.org/amednews/2009/11/30/gvsb1130.htm

American Medical News: House passes major Medicare payment reform; what will the Senate do?
http://www.ama-assn.org/amednews/2009/11/30/gvl11130.htm

Associated Press: Senate set to open stormy debate on health care
http://www.boston.com/news/nation/washington/articles/2009/11/30/senate_set_to_open_stormy_debate_on_health_care/

USA Today: Key players to watch in Senate heath care debate
http://www.usatoday.com/news/washington/2009-11-29-health-debate-senators_N.htm

The Washington Post: Even if health bill passes soon, wait for reforms could be long: Major provisions would take effect in 2014; enforcement in doubt
http://www.washingtonpost.com/wp-dyn/content/article/2009/11/29/AR2009112902425.html

Cleveland Plain Dealer: If federal health care reform includes an "opt-out" provision, would Ohio use it?
http://www.cleveland.com/open/index.ssf/2009/11/if_federal_health_care_reform.html

Kaiser Health News: Seven Things You Didn't Know Were In The Senate Health Bill
http://www.kaiserhealthnews.org/Stories/2009/November/30/Senate-Health-Bill-Secrets.aspx

The Centers for Medicare and Medicaid Serivces announced "heightened scrutiny" and "more complete accounting" of Medicare fee-for-service (FFS) claims has resulted in a 2009 FFS error rate of 7.8 percent, or $24.1 billion, compared to 3.6 percent in 2008.

CMS officials said they will "take further steps to ensure":

- providers are submitting all required clinical and medical documents to support a claim;
- providers' signatures on medical documents are legible;
- a provider's claims history can no longer be used to fill in missing treatment documentation; and
- medical information from a healthcare provider be included to support durable medical equipment claims, in addition to records from suppliers.

These efforts are designed to provide the CMS with more complete information about errors so it can better target improper payments, HHS officisls said. – From: Healthcare Finance News

Current Health Care News Bits

FTC extends enforcement deadline for identity theft Red Flags Rule. At the request of Members of Congress, the Federal Trade Commission is delaying enforcement of the "Red Flags" Rule until June 1, 2010, for financial institutions and creditors subject to enforcement by the FTC. **- THE FEDERAL TRADE COMMISSION**

House Bill 122 aims to create standards for health insurer physician ranking programs in Ohio. Specifically, it will:

- Ensure that physician rankings are not based solely on cost and clearly identify the degree to which any rankings are based on cost.
- Use established national standards to measure quality and cost efficiency, including measures endorsed by the National Quality Forum and other generally accepted national standards.
- Employ several measures to foster more accurate physician comparisons, including risk adjustment and valid sampling.
- Disclose to consumers how the program is designed and how doctors are ranked, and provide a process for consumers to register complaints about the system.
- Disclose to physicians how rankings are designed and a process to appeal incorrect rankings.
- Nominate and pay for an independent ratings examiner, with expertise in efficiency measurement, to oversee compliance.

- OSMA This Week - The Pulse of Health Care in Ohio

More states cutting Medicaid physician pay. Nine states are increasing Medicaid pay for physicians next year, but 13 are making cuts. This shifts the balance from last fiscal year, when 19 states increased pay and eight cut it. **Michigan** has made cuts both years.

State that increased pay in 2009 but are cutting it for 2010: **Ohio**, Maryland, Hawaii, and Colorado **- Kaiser Family Foundation**

For 2010, the Medicare deductible is $155.00 a year; and the coinsurance is 20%. The Part B premium is $110.50 a month. Under Part B, all enrollees are subject to a monthly premium, an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. **– CMS CR 6690**

Medicaid enrollment grew by an average of 5.4 percent in fiscal year 2009, the highest rate in six years, according to a recent report by the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. **– Healthcare Finance News**

Update your Medicare PECOS information or face denials on claims requiring a referring physician. Effective for DME claims beginning in January (1/4/10), if the referring provider is NOT in PECOS, the claim will be rejected. In addition, the provider must be in a specialty (listed in the article) authorized to order the DME. For NON-DME claims, if the billed service requires an ordering or referring provider and the ordering/referring provider is NOT in PECOS the claim will be denied UNLESS the ordering/referring provider is the Carrier/MACs claims system. In this case, it APPEARS that the claim will be paid. **– CMS MM#6421 & MM#6417**

U.S. physicians lag on EMR use

But American patients can access care more quickly than can those in many other countries, an international survey of doctors found.

By Doug Trapp, amednews staff. Posted Nov. 19.

Patients in the United States wait less time to see primary care and specialty physicians than do patients in 10 other countries, but they have more difficulty paying for prescription drugs and health care. Physicians in this country are much less likely to use electronic medical records and to be offered financial rewards for quality gains than are doctors outside of the U.S.

A Commonwealth Fund survey of more than 10,000 primary care doctors in 11 countries, released Nov. 5, highlights the differences between the public/private U.S. health system and the entirely public systems of nations such as the United Kingdom. The survey -- conducted from February to July -- included doctors in Australia, Canada, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, the U.K. and the U.S.

Only 46% of U.S. physicians said they use EMR systems that have more than a billing function. Only Canadian doctors reported less use, at 37%. In contrast, virtually all doctors in the Netherlands, Norway and New Zealand said they used full EMRs.

Access to care was better in the U.S, though. Only 28% of patients in the United States tell their physicians they face long waits to see specialists, the second lowest of the surveyed countries. In contrast, 75% of Italian and Canadian doctors said their patients reported long wait times for appointments with specialists. The report is online:

www.commonwealthfund.org/content/publications/in-the-literature/2009/nov/a-survey-of-primary-care-physicians.aspx

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Carefully consider your options for EMR/EHR. The #1 mistake is overlooking the major impact this practice change will have on your productivity, which directly effects cash flow and reimbursements. Contact NCDS for suggestions and recommendations if you are interested in beginning your evaluation of EMR/EHR.

WANTED: More Excellent Clients Just Like You!

We appreciate your business and thrive on working with great clients like you. By recognizing the value of our services and referring your friends and colleagues we:

- Minimize marketing and advertising costs and pass those savings on to you.
- Keep our company healthy and growing so we are in business long into the future.
- Exponentially increase our market experience, insurance carrier knowledge and patient demographic database.
- Get to work with only the best clients; finding new opportunities and ways to serve you better and bring you improved business solutions.

Who else should be talking to NCDS about our services? Let us know!

If you know a physician or medical practice that may be interested in or in need of our services please refer them to NCDS. Thank You!

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