

NCDS update

A Billing Industry Newsletter for Clients

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

MEDICARE SIGNATURE REQUIREMENTS: NEW REGULATIONS IMPACT REIMBURSEMENT

Details provided by www.palmettoqba.com

Effective in April 2010 guidelines for signatures required on medical records submitted to any CMS contractor have become even more stringent. CMS mandates a signature on all documents submitted for medical review and "the signature for each entry must be legible and should include the practitioner's first and last name." It is also advised to include any/all applicable credentials following the signature. According to Palmetto GBA:



The purpose of a rendering/treating/ordering practitioner's signature in patients' medical records, operative reports, orders, test findings, etc., is to demonstrate that services submitted to Medicare have been accurately and fully documented, reviewed and authenticated. Furthermore, it confirms the provider has certified the medical necessity and reasonableness for the service(s) submitted to the Medicare program for payment consideration.

Medicare will accept handwritten, electronic and digital signatures, as well as the electronic version provided by your EMR system. However, you must ensure that the signature you provide falls within the CMS standard of 'acceptable' signatures.

Please make sure all supporting documentation includes an acceptable signature. A copy of the 'acceptable' and 'unacceptable' examples provided by CMS will accompany this newsletter on NCDS' website. We strongly encourage all providers to visit the Palmetto GBA website at the link below to review the specific requirements for signatures:

<http://www.palmettoqba.com/palmetto/providers.nsf/vMasterDID/84HSY38833?opendocument>

NCDS FEATURED AT OSMA SYMPOSIUM



NCDS was pleased to have the opportunity to showcase its billing talents to several hundred providers and staff at the OSMA Symposium on April 9, 2010. Other industry leaders in EMR systems, insurances companies, malpractice insurance and medical office solutions were on hand to provide the attendees with detailed, hands-on information. NCDS is always looking for the opportunity to expand its already exceptional client base.

Please contact sales@ncdsinc.com for more information on new business opportunities and new client referrals.

WHO WILL CARE FOR THE NEWLY INSURED? NATIONAL HEALTHCARE FOR THE UNINSURED SPOTLIGHTS A SHORTAGE OF PHYSICIANS TO PROVIDE MEDICAL CARE

Statistics and Excerpts taken from 'Health Reform's Next Challenge...' By Kevin B. O'Reilly, AMEDnews Staff, Posted April 12, 2010

Monumental healthcare reform legislation signed into law in March of 2010 boasts coverage for the uninsured but can the country's current physician base manage the onslaught of new patients seeking treatment for health problems that have long been neglected?



Concerns are growing as fast as the shortage of healthcare professionals. According to The American Medical Colleges' Center for Workforce Studies the national deficit for physicians is currently estimated at 160,000 by 2025, with the reality being far worse than speculation. In an industry with increasing medical student debt, accelerating malpractice premiums and decreasing reimbursement from Medicare/Medicaid and private carriers experts forecast a devastating shortage of physicians.

The nationwide average currently stands at a ratio of 79.4 physicians to 100,000 residents. Ohio and Michigan are fortunate and rank just above the national average at ratios of 80.0 and 84.4 physicians to every 100,000 residents, respectively. The physician bases in other states are not as prosperous, with some regions supplying less than 60 physicians per 100,000 residents.

The impending shortage of physicians to care for millions points to a tough road ahead for providers. Some primary care providers are already being forced to turn away new patients due to the complexity of long-overlooked, neglected medical problems. Others are already examining options to restructure their practices, adding more medical assistants and nurse practitioners to buffer an increasing patient base. Meanwhile, physician compensation continues to look grim with more insurance plans cutting back on reimbursement and hiring independent auditing agencies to trim the fat.

While only time will tell how deeply the physician to population ratio will impact providers, we can be certain that "We are now fighting a war with too few troops," said Dr. Cooper, senior fellow at the University of Pennsylvania's Leonard Davis Institute of Health Economics. "Nothing's going to be the way it used to be. Practices will have to be reorganized. This is not to do with legislation, but with the real world that takes care of real patients."

To read the full article please visit:

<http://www.ama-assn.org/amednews/2010/04/12/pr10412.htm>

FEE SCHEDULE TO INCREASE IN JULY



For the Ohio area Anthem BC/BS has made changes to its fee schedule that will impact claims rendered on or after July 15, 2010. Providers can see increases in covered services for Blue Traditional, Blue Access, Blue Preferred, Blue Priority SM and Anthem Medicare Advantage for the following procedure codes:

- Office Visit 99213 fee schedule increases by 4.0%
- Office Visit 99214 fee schedule increases by 3.0%
- Office Visit 99215 fee schedule increases by 3.0%
- Hospital Visits (99217-99239) fee schedule increases by 3.0%

These changes mean that providers rendering the above services will receive increased reimbursement on these claims. NCDS will be adjusting its billing fees to accommodate Anthem's increases and ensure your reimbursement is maximized!



SGR AND MEDICARE REIMBURSEMENT UPDATE

Details provided by www.palmettoqba.com and The American Medical Association www.amednews.com

The **Continuing Extension Act of 2010** was signed by President Obama in April 2010. This law is retroactive to April 1, 2010 and again temporarily extends the zero percent update to the MPFS through June 1, 2010. Claims that were previously being held have been released for payment and Medicare has resumed issuing payments with a 14-day turnaround.

As the June 1, 2010 deadline looms ahead there is no foreseeable solution to the numerous problems stemming from Congress' inaction. The American Medical Association has continued to be outspoken on behalf of physicians and as of 2009 said "it no longer would support temporary measures to forestall doctor pay cuts under the sustainable growth rate system, insisting that Congress enact a permanent SGR repeal that would align rates more closely with physician costs." They have advocated growing concern to Congress that these cuts will decrease the number of physicians willing to provide services to Medicare patients, as well as increase the number of physicians willing to opt out of Medicare participation entirely. Additionally, the cuts ignore the reality that the cost of providing care has increased significantly while reimbursement remained consistent for ten years or more.

A number of different proposals are currently floating through Congress, including but not limited to payment cuts, freezing payment levels for several years and/or abandoning the current reimbursement model. Though many advocate freezing the physician reimbursement rate for 2010, this would mean a 26% cut would be imminent in 2011. If rates are frozen or if the current model is abandoned the estimated cost would be upwards of \$276 billion, according to the Congressional Budget Office.

NCDS will continue to keep you updated of any changes as information becomes available. For more information on SGR changes or the AMA's activity on behalf of physicians please visit:

<http://www.ama-assn.org/amednews/>

**** SEE THE MAY 28, 2010 CLIENT ADVISORY FOR MORE ****

HEALTH REFORM LAW IMPACTS PROVIDERS: PHYSICIAN MEDICARE ADVISORY PANEL CUT AFTER 18 YEARS

EXCERPTS FROM DOCTORS' MEDICARE PANEL DISBANDED AFTER 18 YEARS, BY CHRIS SILVA, AMEDNEWS STAFF, POSTED MAY 17, 2010

Washington – A federal advisory panel that provided the means by which physicians communicated Medicare administrative issues to the federal government was quietly eliminated by a provision tucked away in the health system reform law enacted earlier this year.

The Practicing Physicians Advisory Council, a 15-member board that met quarterly with federal officials to discuss matters pertaining specifically to Medicare fee for service, was officially disbanded on March 23. A provision in the health reform law repealed the section of the Social Security Act that created the council in 1992.

Council members were informed of the dismantling in an April 16 letter from Health and Human Services Secretary Kathleen Sebelius. The secretary announced that because PPAC was being discontinued, the council's June meeting would not take place.

PPAC members said they hoped they could have kept working with CMS on fee-for-service administrative issues that are important to physicians, and they were disappointed to hear the council was ending.

"It sent out the message that our input was not wanted or desired, and that's very disheartening," said Joseph Giaimo, DO, a Florida pulmonary care physician and board member of the American Osteopathic Assn. "It's disconcerting, because the philosophy of the health reform bill is to move forward in a timely fashion with innovative ideas. A lot of provisions in the new bill are about streamlining health services, and that's what PPAC was about."

To view the article in its entirety please visit:

<http://www.ama-assn.org/amednews/2010/05/17/qvsa0517.htm>



U.S. Department of Health & Human Services

According to CMS there are other options available for providers to communicate concerns to the Centers for Medicare & Medicaid Services including:

- The Medicare Provider Feedback Group, which holds an annual town-hall meeting as well as more frequent, smaller sessions to hear physician feedback on fee for service and operational issues.
- Public comments on proposed Medicare regulations published in the *Federal Register*.
- Physician Open Door Forums, conference calls that are held every six weeks (www.cms.gov/opendoorforums).
- Occasional town-hall meetings on Medicare fee-for-service initiatives.
- The CMS website for physicians
- (www.cms.gov/center/physician.asp).
- CMS regional office physician relations staff.
- Medicare contractor resources, including "Ask the Contractor" calls and Provider Outreach & Education Advisory Groups.

For more information visit: <http://www.cms.gov/>