

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 REVENUE OVERVIEW: WHAT'S HAPPENING AND WHERE IS YOUR MONEY?

For months Medicare payments have been in limbo due to pending legislation and debate in Congress. Beginning in March claims were held by Medicare contractors in anticipation of Congressional action, only to be released and later paid at the same rates. This continued throughout the months of April, May and most notably June, where all providers saw a significant decrease in Medicare revenue due to Medicare halting payments for all services rendered on or after June 1, 2010.

Legislative action (and inaction) circulated around Medicare payments and in May Congress failed to extend the physician fee schedule freeze which allowed a 21.3% cut in your Medicare payments to take place effective May 28, 2010. It was not until June 25, 2010 that Congress approved legislation to rescind the 21.3% SGR cut and instead put a 2.2% increase in place, which is valid until November 30, 2010. Since this legislation is only temporary we can expect the same headache beginning December 1, 2010, when the 2.2% increase expires and providers once again face a 21.3% cut in their payments.

Following the June 25, 2010 legislation Medicare released a statement informing providers they will begin processing claims at the new rate as of July 1, 2010. Medicare payments began coming through as of July 8th reflecting the increased Medicare fee schedule. For all providers this was a much needed boost in revenue, since claims held throughout the month of June significantly impacted receipts.

So what is next for providers? Medicare has resumed normal claims processing and revenue will continue to flow with the added bonus of the 2.2% increase until the December 1, 2010. At that point physicians face a staggering 23.5% cut (the original 21.3% plus the 2.2% added on in June). According to the HBMA a second SGR cut of 25% is set to take place January 1, 2011 unless Congress takes the necessary action now to implement a permanent solution.

There is no current proposal for a resolution to this very complex issue, and no way to tell to what extent Medicare revenue will be disrupted (and for how long). The only certainty recognized by physicians nationwide is that a permanent fix is required for this problem and temporary solutions are costly and ineffective. Regardless of political affiliation the AMA as well as the HBMA strongly urge physicians to contact their elected officials; it is the best way to make your voice heard and facilitate change. The HBMA has created a helpful resource for contacting your representatives that is clear cut and easy to use; please visit the following link for more information:

<http://capwiz.com/hbma/home/>



U.S. HEALTHCARE SYSTEM RANKED LAST OF SEVEN COUNTRIES

BY: BERNIE MONEGAIN, HEALTHCARE FINANCE NEWS

New York – The U.S. healthcare system comes in last for performance among seven industrialized nations despite spending the most, according to a new Commonwealth Fund report.

The nation received low marks for spending on administrative costs, use of information technology, re-hospitalization and duplicative medical testing.

Despite having the most expensive healthcare system, the United States ranked last overall compared to Australia, Canada, Germany, the Netherlands, New Zealand and the United Kingdom.

The research measured five performance areas: quality, efficiency, access to care, equity and the ability to lead long, healthy, productive lives.

While there is room for improvement in every country the United States stands out for not getting good value for its healthcare dollar, ranking last despite spending \$7,290 per capita on healthcare in 2007 compared to the \$3,837 spent per capita in the Netherlands, which ranked first overall.

To view the full article please visit Healthcare Finance News at: <http://www.healthcarefinancenews.com/news/us-healthcare-system-ranked-last-seven-countries?page=0,0>

CARDIOLOGY DIAGNOSTIC IMAGING:

Effective October 18, 2010, Anthem is changing the status of precertification for cardiology diagnostic imaging services from voluntary to **required**. For all dates of service November 1, 2010 and after precertification is mandatory and required for claims processing. Precertification requests may be submitted by visiting www.anthem.com>Provider(enter state)>MyAnthem or by contacting the American Imaging Management Call Center (AIM), which manages the precertification for Anthem, at 1-800-554-0580



Please remember, as insurance companies impose more stringent guidelines making the reimbursement process more difficult the first step you can take to combat this is in your own office. Make sure your staff is aware of the importance of precertifications and authorizations – it's literally the difference between taking a check to the bank and going home empty handed.

Its anniversary time! This August commemorates 25 years in business for



NCDS! We extend a heartfelt thank you to all our valuable clients; it is because you excel at serving your patients that we are able to excel at serving you.



FEE SCHEDULE CHANGES

Effective September 1, 2010 both Aetna and Cofinity will be changing their fee schedules from the Average Wholesale Price (AWP) to the Average Sale Price (ASP) as outlined by the Centers for Medicare & Medicaid Services (CMS) plus six percent. These changes will affect all Aetna HMO, indemnity and PPO benefit plans as well as all Cofinity PPO plans. For more information please visit www.aetna.com and/or contact Cofinity Customer Service at 1-800-831-1166.



Additionally, Medical Mutual has amended its fee schedule that will take effect for dates of service starting on September 1, 2010. Should providers wish to review the fee schedule updates Medical Mutual will be making the information available for reference beginning July 1, 2010 via their secure Provider ePortal at www.medicalmutual.com. Please see their website for more information.



As of July 1, 2010 Paramount Healthcare has announced major modifications to their PPO fee schedule. Effective October 1, 2010 the new PPO fees will more closely reflect those outlined by the CMS fee schedule.



NCDS is already prepared to accommodate these changes and will be closely monitoring payments made by these carriers after this change has been implemented to ensure providers are receiving maximum reimbursement.

SCAN CONFIRMATIONS!

NCDS has made a number of exciting new changes allowing your staff to receive instant confirmation when scan files are received. This is a much anticipated improvement that can be just as helpful to your staff as it is to ours. Now your staff can receive an email as soon as the file is received onto our system, assuring the file has been received for processing.



If no confirmation is received your staff can simply re-transfer the file to our system via your computer's completed folder without any phone calls or timely delays. This system has been designed to make the process even smoother for your staff and avoid situations where rescans

are necessary. But please remember, this process will only work if you or your staff checks for confirmations after scans are sent!

Setting up your practice to receive emails for scan confirmations is quick and easy! All you need to do is contact our office and speak to Susan Mobley or Jessica Meyers at 1-800-556-6236 ext. 25 and 26 (respectively). We are able to accommodate several email addresses should you and your staff desire receipt of confirmation.

SPECIALIST SPOTLIGHT

A special thanks to our providers of ophthalmology as we head into another long, hot summer. July is National UV Safety Month and August is Cataract Awareness Month. We are pleased to acknowledge these providers as their efforts and research help keep patients' vision protected from harmful sun damage as well as treating cataracts and vision loss.



DEFENSIVE MEDICINE TO AVOID LIABILITY LAWSUITS IS WIDESPREAD

BY: TANYA ALBERT HENRY, CORRESPONDENT AMEDNEWS.COM

Whether a physician practices in a surgical or nonsurgical specialty, lives in New England or the Mountain states, one thing is the same: The vast majority of doctors practice defensive medicine to protect themselves from medical liability lawsuits.

About nine in 10 physicians said doctors order more tests and procedures than patients need so they can protect themselves against lawsuits, according to a study in the June 28 *Archives of Internal Medicine*.

The only statistically significant difference was among men and women: Nearly 93% of male physicians agreed that doctors order more tests. Nearly 87% of females believed that to be true.

And 91% of the 1,231 physicians surveyed nationwide agreed that doctors will not stop using unnecessary diagnostic tests without protections against unwarranted lawsuits.

"The general sentiment is that there is a problem," said internist and study co-author Tara Bishop, MD, associate in general internal medicine at Mount Sinai School of Medicine in New York City. "Many physicians feel they are vulnerable to malpractice lawsuits even when they practice competently within the standard of care."

The study notes that the cost of defensive medicine is estimated to be \$60 billion annually.

"Even if the true cost of defensive practices was only a fraction of this amount, it would still represent a significant source of cost savings," study authors concluded. They are calling for policymakers to "consider reforms that curb defensive medical practices as they work to identify strategies to reduce health care spending and promote efficient, high-quality health care."

In a commentary accompanying the study, Sen. Orrin G. Hatch (R, Utah) wrote that he and several colleagues have tried to address the costs of defensive medicine but have met opposition.

"These proposals have taken a variety of forms, including caps on noneconomic damages ... limitations on joint and several liability, and heightened evidentiary standards for punitive damages ... Unfortunately, trial lawyers associations have successfully blocked tort reform, arguing that people with low incomes will not be able to find trial lawyers to take their cases on contingency if settlements are capped."

Hatch said he hopes that Americans "will demand in larger numbers that real reforms be enacted to address this problem."

To view the full article please visit [Amednews.com](http://www.ama-assn.org/amednews/2010/07/12/prsb0712.htm) at: <http://www.ama-assn.org/amednews/2010/07/12/prsb0712.htm>

