March – April 2013

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…

Breaking Down the Biggest Buzzword In Congress

The Origin: SEQUESTRATION – A legal term referring generally to the act of valuable property being taken into custody by an agent of the court and locked away for safekeeping, usually to prevent the property from being disposed of or abused before a dispute over its ownership can be resolved.

How We've Come to its Recent Application: The term has been adapted by Congress in more recent years to describe a new fiscal policy procedure originally provided for in the Gramm-Rudman-Hollings Deficit Reduction Act of 1985 -- an effort to reform Congressional voting procedures so as *to make the size of the Federal government's budget deficit a matter of conscious choice rather than simply the arithmetical outcome of a decentralized appropriations process in which no one ever looked at the cumulative results until it was too late to change them*. If the appropriation bills passed separately by Congress total more money than what Congress earlier laid down for itself in the annual Budget Resolution, and if Congress cannot agree on ways to cut back the total (or does not pass a new, higher Budget Resolution), then an "automatic" form of spending cutback takes place. This automatic spending cut is what is called "sequestration."

Under sequestration, an amount of money equal to the difference between the cap set in the Budget Resolution and the amount actually appropriated is "sequestered" by the Treasury and not handed over to the agencies to which it was originally appropriated by Congress. In theory, every agency has the same percentage of its appropriation withheld in order to take back the excessive spending on an "across the board" basis. However, Congress has chosen to exempt certain very large programs from the sequestration process (for example, Social Security and certain parts of the Defense budget), and the number of exempted programs has tended to increase over time -- which means that sequestration would have to take back gigantic shares of the budgets of the remaining programs in order to achieve the total cutbacks required, virtually crippling the activities of the unexempted programs.

http://www.auburn.edu/~johnspm/gloss/sequestration

SEQUESTRATION, an NCDS Analysis:

By: Jessica Meyers

Using a bunch of legal and political jargon, this information tells us that Congress has spent more than what is allotted to them, over an extensive period of time. In the past Congress has simply voted to raise the debt ceiling to match the amount they were spending, which from a budget perspective essentially justified the overspending and eliminated any incentive to keep spending in check. However, this time around the Democrats and Republicans have not been so willing to compromise together. Some could not agree on where/how to cut spending (to scale things back to the allotted budget amount) and others could not agree on a vote to raise the debt ceiling again. Basically, because Congress could not agree one way or the other the excess spending has been frozen.

On the up side, everyone wants the government to operate within its means, and not spend more than is allotted. Accountability is an important example for any government to set for its people. However, on the down side, the overspending has gone on for so long that the way we function as a country and a society is largely dependent on the over-appropriation of those funds. Numerous government programs are set to be impacted by the estimated $85 billion in cuts imposed by the sequester.

Unfortunately for the medical industry, spending cuts on Medicare are a reality. Part A and B physician reimbursement will be cut by 2% across the board for providers of service as of April 1, 2013, and depending on legislative action more cuts could be made in the future. NCDS, as always, is keeping a close watch on the legislative process to keep you informed of what is on the horizon impacting you and your practice.

Which Programs Did the Sequester Cut?

Few federal programs were spared from the cuts other than the Medicaid and CHIP programs. The White House Office of Management and Budget sent its outline for the cuts to House Speaker John Boehner (R-Ohio) Friday. Here are the healthcare-related cuts, according to a report by Politico:

HHS mental health programs — $168 million

- National Institutes of Health medical research funding — $1.6 billion
- World Trade Center Fund — $10 million
- Health insurance exchange grants — $44 million
- Prevention and Public Health Fund — $51 million
- Centers for Disease Control and Prevention — $303 million
- Food and Drug Administration — $209 million
- IRS enforcement (which some speculate could affect collections related to the Patient Protection and Affordable Care Act) — $267 million

http://www.beckershospitalreview.com/racs-/-icd-9-/-icd-10/which-health-programs-did-the-sequester-cut.html

CMS: No More Delays With Move to ICD-10

By: Charles Fiegl, AMEDNEWS Staff

WASHINGTON The mandated transition by billers throughout the health system to the more complex ICD-10 diagnosis codes will go forward without any further delays, the Centers for Medicare & Medicaid Services stated in a Feb. 6 letter to the American Medical Association.

Acting CMS Administrator Marilyn Tavenner made the case for moving forward with ICD-10 to modernize the health care system. Halting its implementation, which has been ongoing since 2009, would mean relying on outdated ICD-9 codes that soon will be incompatible with general health care needs and new technologies, she stated.

"Many in the health industry are under way with the necessary system changes to transition from ICD-9 to ICD-10," Tavenner wrote. "Halting this progress midstream would be costly, burdensome, and would eliminate the impending benefits of these investments. Many private and public sector health plans, hospitals and hospital systems, and large physician practices are far along in their ICD-10 implementation and have devoted significant funds, resources and staff to the effort."

In December 2012, the AMA and about 80 other organized medicine groups had requested that CMS stop ICD-10 implementation. The AMA House of Delegates had approved official policy to advocate for abandoning ICD-10. Costs related to training and infrastructure upgrades could be enough to force physicians out of business, the organizations said.

Practice administrators also have shared the AMA's concerns. MGMA-ACMPE, the medical practice management association, projects that adopting ICD-10 would cost a 10-physician practice $285,000. The implementation price for smaller practices is about $83,000.

Overlapping federal regulations, such as those governing electronic health records and quality reporting under Medicare, also make the ICD-10 mandate especially burdensome, organized medicine groups have said.

"The American Medical Association harbors serious concerns with the significant burden of the ICD-10 mandate and will continue to convey these points to policymakers in Washington," said AMA President Jeremy A. Lazarus, MD. "As the current compliance deadline grows closer, the AMA will continue educating members on how to best prepare for what will be a very disruptive change for physicians."

The Obama administration had delayed the ICD-10 implementation deadline by one year, to Oct. 1, 2014, in a September 2012 regulation. Physicians must use ICD-10 codes on claims to payers for services starting Oct. 1, 2014, or else those claims will be rejected. Tavenner stated in the letter that the extension offered physicians and administrators time to train office staff, upgrade practice software and conduct appropriate testing.

"Many industry comments strongly favored a one-year extension, indicating it was a good balance that allowed additional time for those concerned about meeting the original Oct. 1, 2013, date, with minimal disruption to entities whose implementation efforts were already under way," she wrote.

Furthermore, the agency believes ICD-10 is an important factor for several integrated programs that will modernize the health care system so it can provide better care, improve health and lower costs.

To view the complete article please visit:
http://www.amednews.com/article/20130304/government/130309977/7/

ICD-10 Perspective from Certified Professional Coder Lydian Miller:

My personal preparation for ICD-10 has shown me the potential benefits of the change. The more knowledgeable I am about ICD-10 before it takes effect, the more quickly I will be able to process claims for our clients. The biggest benefit I see to our clients is the potential to get claims paid more efficiently due to the specific information we can provide to the insurance companies in the initial transmission of data.

CMS Begins Process of Exploring New Electronic Transaction Standards

By: Rodney J. Moore, Healthcare Finance News

Although new HIPAA electronic transaction standards have been put on the backburner, the Centers for Medicare & Medicaid Services (CMS) has begun the process of mapping out how those new standards will function. Part of that process is to figure out what the impact of moving to new standards will be on the healthcare industry, and to do that it has awarded a contract to revenue and payment cycle management company Emdeon.

The Nashville, Tenn.-based company will create an analytical methodology to define the processes and tools needed to move electronic transaction standards to a new version.

According to CMS, the intent of the project is to greatly reduce the likelihood of technical issues going undetected until after the standards are adopted and to eliminate the negative impacts such issues would have on the healthcare industry.

Debbie Meisner, vice president, regulatory strategy at Emdeon, said the testing program is not being driven by the health reform law, but is instead a result of industry testimonies on the need to test the standards before they are adopted. Those in the industry expressed a desire to avoid delays in implementation due to a need for errata and to avoid issues around the business impacts of the standards. Meisner said the program does not address EFT-only transactions.

"The intent is to use the 6020 version of the HIPAA transactions as a pilot for testing new versions of the HIPAA transactions and provide feedback to CMS on the results," Meisner said. "The Department of Health and Human Services is looking to address the concerns of the industry with regards to adopting standards that have not been tested." The pilot does not address electronic funds transfers (EFTs), said Meisner, nor operating rules, added Amanda Woodhead, corporate communications manager at Emdeon. Woodhead said Emdeon's original solicitation did include operating rules, but was ultimately separated into two solicitations.

Emdeon will approach the testing program in three phases. In phase one, Emdeon will perform extensive analysis on the changes that have been introduced in the new version. This will include gap analysis reports, analytics where appropriate and recommendations on any challenges that the industry will face as a result of the changes.

The second phase will be the development of the translations between the current 5010 version and 6020, followed by testing of the translations to determine if there are any outstanding issues that will need to be addressed. The final phase will be evaluating the lessons learned from the pilot and providing recommendations for testing new versions in the future. Emdeon said its project with CMS is expected to be complete by September.

For more information about this article please visit:
http://www.healthcarefinancenews.com/news/cms-begins-process-exploring-new-electronic-transaction-standards

Nurse Practitioners Hemmed In by Scope of Practice Laws and Payment Policies

Tammy Worth, Contributing Writer,
Healthcare Finance News

As the debate around using nurse practitioners to stem the predicted physician shortage continues to heat up, a new policy brief from the National Institute for Health Care Reform points to barriers that are preventing the fullest use of NPs.

The report, released in February, found that state scope of practice laws and payment policies are two of the biggest challenges to expanding care provided by nurse practitioners.

Scope of practice laws regulate how nurse practitioners can practice, including whether or not they can prescribe medications, create treatment plans or work without physician oversight. States vary widely in their regulations, but according to the report, 25 states require some oversight by a physician for all of these services. The report looked at six states – Arkansas, Arizona, Indiana, Maryland, Massachusetts and Michigan – to see how these regulations impacted the use of nurse practitioners in primary care.

Study authors found that requiring oversight by a primary care doctor prohibits many nurse practitioners from working in more rural areas where there is often a dearth of providers. Respondents in the report also said it was a challenge to find physicians to collaborate because doctors may not receive compensation.

While scope of practice laws often receive the most attention, it was really a combination of those and payment challenges that were inhibiting practice, said Tracy Yee, a co-author of the study.

"A misconception is that the solution or silver bullet for expanding provider capacity would be to liberalize scope of practice regulations," she said. "States need to also look at their Medicaid programs because they have control over that."

Yee said some states, like Arizona, have independent practice laws, but nurse practitioners can't sustain a practice because they can't get reimbursed. One solution would be for Medicaid and private payers to allow nurse practitioners to be reimbursed directly or be listed as preferred providers.

Tay Kopanos, vice president of governmental affairs for the states at the American Association of Nurse Practitioners, said the study's findings are similar to what her organization has seen. "When nursing organizations would go forward to adopt rules and regulations, there has always been this friction point between medicine and nursing," she said. But there has been some movement in scope of practice regulations. She said there are 12 states with bills this legislative session that would move toward full practice authority. And only a small handful of states, including Utah and Arkansas, don't recognize nurse practitioners in their Medicaid program. And only a small handful of states, including Utah and Arkansas, don't recognize nurse practitioners in their Medicaid program.

"I am hopeful that there is an awakening that healthcare isn't owned by one profession," Kopanos said. "But it is the strength of multiple disciplines providing care for patients in multiple settings that will be good for patients."

For more information on this article please visit the following:
http://www.healthcarefinancenews.com/news/nurse-practitioners-hemmed-scope-practice-laws-and-payment-policies

NCDS Enrollment Services

Did you know that the enrollment team at NCDS is knowledgeable and educated on numerous services related to insurance enrollment and keeping your credentialing current? In addition to standard carrier enrollment, NCDS also provides regular CAQH and NPI maintenance for its providers. As more and more insurance carriers are utilizing the CAQH as its primary resource for provider information it is imperative this information stays current and up to date… Your receivables depend on it! Our professional, skilled staff is here to make this process seamless for your practice, eliminating any interruption in your reimbursement due to outdated information. Additionally, if you are considering growing your practice in the coming months, NCDS is also available for services such as adding practice locations and practice change of address. Please contact Mick Polo at 888-876-8833 extension 23 or mickp@ncdsinc.com for more information on how these services can help your practice!

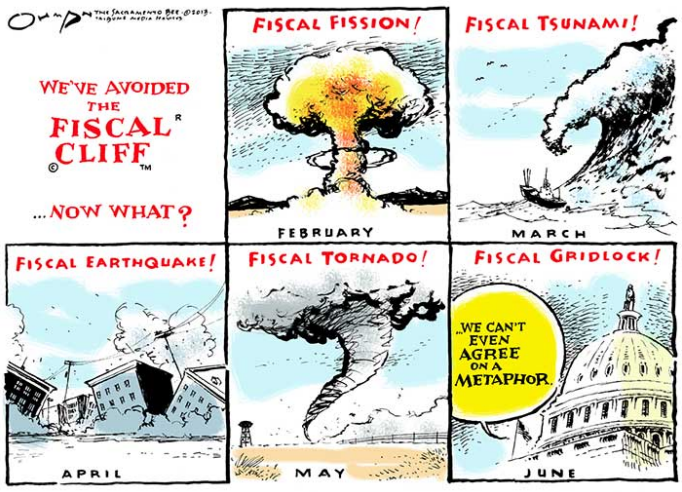
3 Years of PPACA: The 5 Biggest Changes in Healthcare Since the Law's Passage

By: Molly Gamble and Bob Herman, Becker's Hospital Review

Saturday, March 23, marked the three-year anniversary of President Barack Obama's Patient Protection and Affordable Care Act. The legislation has undergone and continues to experience a bevy of challenges since its enaction, but it's recently gained broader acceptance as the law of the land. To mark the law's 3rd year, we've compiled a list of top 5 changes for hospitals under the PPACA.

1. **Payment reform tied to quality measures.**
2. **Accountable care organizations.**
3. **New provider-payor partnership models.**
4. **More robust fraud-fighting efforts.**
5. **Uncertainty around Medicare and Medicaid.**

For the complete article visit:
http://www.beckershospitalreview.com/hospital-management-administration/3-years-of-ppaca-the-5-biggest-changes-in-healthcare-since-the-laws-passage.html



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