July – August 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...

Why is Your Doctor Typing? Electronic Medical Records Run Amok

By: Steve Denning, Forbes

It was only a short while ago when a visit to the doctor was a face-to-face conversation. The doctor would ask questions. He was interested in what I said. He listened to my responses and we discussed what to do. It was a positive interaction. In the last year or two, there's been a shift. Much of my time with doctors has been spent watching them type.

Surely, I said, computerized medical records generate benefits. They are easily retrievable. They can be transferred from one practice to another and accessible to the many different service providers—hospitals, laboratories, specialists, radiology and so on—that might be involved in any one patient.

"In theory, perhaps," he replied. "But in practice, it's a horrible and costly bureaucracy that is being imposed on doctors. I spend less time with patients, and more time filling out multiple boxes on forms that don't fit the way I work. Often I am filling out the same information over and over again. A lot of it is checking boxes, rather than understanding what this patient really needs."

What about retrieving information? Isn't that easier?

"Again, in theory, retrieval should be easy and quick," he said, "But you can't flip through these records the way you do with a paper file and easily find what you want."

But at least now you can get the records electronically?

"Sometimes," he said. "But each network has its own system and often the systems are incompatible. The systems don't talk to each other. So transferring records from one system to another becomes another nightmare."

But why do you type while the patient is there?

"Filling out these forms and checking all the boxes takes me a lot of time," he said, "If I don't do it now, I will spend half the night trying to remember the discussion and typing up the results of the day's visits."

What we are seeing here is the implementation of Obamacare—the Affordable Care Act—which has provided reimbursement incentives and an electronic medical records deadline for those who adopt electronic medical records (EMR).

My doctor is not alone in seeing problems with the way that electronic medical records are being implemented. A recent survey published in Health Affairs by Julia Adler-Milstein, Carol Green and David W. Bates, estimates that doctors who install electronic medical records systems should expect an initial loss of around $44,000 on their investment. Almost two-thirds of the practices using electronic records would lose money even with government subsidies, the researchers said.

For the complete article and survey please visit: http://www.forbes.com/sites/stevedenning/2013/04/25/why-is-your-doctor-typing-hint-think-agile/

Medicare Physician Quality Reporting: Tale of the Tape

By: Charles Fiegl, AMEDNEWS.com

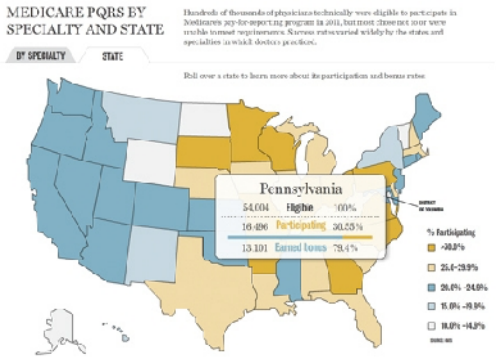
Unless trends change significantly in 2013, the key determinants of whether a particular physician will be able to avoid a Medicare pay-for-reporting penalty are his or her specialty and the state in which the doctor practices.

These demographics are not the only factors of success in Medicare's physician quality reporting system. But prior years of experience in the initiative, including the most recent year for which data are available, indicate that location and specialty are good indicators of the likelihood of compliance with a program that starts lowering pay by 1.5% in 2015 for doctors who don't participate in 2013.

"Once we understand the rules, we are pretty good at playing by them," said Lee Hilborne, MD, a professor of pathology and laboratory medicine at the David Geffen School of Medicine at the University of California, Los Angeles.

Pathologists have done relatively well in PQRS. The latest trends report from the Centers for Medicare & Medicaid Services showed that 63% of pathologists eligible for PQRS had submitted quality data codes in 2011. The specialty was just behind emergency medicine, which had a participation rate of 67%.

While some physicians are having measured success in PQRS, others find that the program does not fit well into their practices. Congress created PQRS, and physicians first reported quality measures on claims for Medicare services in 2007. Doctors and other health professionals have earned millions in bonuses from the program, but in 2015 the incentives will be replaced with penalties for physicians who don't report.



The 2015 penalty will be based on PQRS participation in 2013. So if an eligible physician does not report at least one PQRS measure, the minimum threshold for participation this year, his or her pay rates will be cut by 1.5% in two years' time.

The American Medical Association, along with state and specialty societies, strongly have opposed the Medicare penalties. Thousands of physicians were penalized in 2012 and 2013 under a separate Medicare electronic prescribing initiative. Noncompliant physicians also face e-prescribing penalties in 2014 and additional reductions if they do not meet meaningful use requirements for electronic health record systems by 2014. That EHR penalty takes effect in 2015, too.

To view the full article and an interactive map by specialty visit: http://www.amednews.com/article/20130715/government/130719973/4/?utm_source=nwltr&utm_medium=heds-htm&utm_campaign=20130715

WellCare Medicaid Contract Termination

Effective July 1, 2013 WellCare of Ohio, Inc., will no longer be participating in the Ohio Department of Job and Family Services (ODJFS) Medicaid Managed Care program. This change does not affect your provider relationship or responsibilities if you participate in WellCare's Medicare Advantage plan(s).

Providers should continue to bill for covered services rendered for eligible dates of service. Claims will be accepted through June 30, 2014.

For patients that present a WellCare card for a current visit this card is no longer valid and you will need to request an updated insurance card. Bad insurance information is the #1 reason claims reject! Please help us by obtaining the current information from the patient when they are in the office.

Providers Overlook ICD-10 Value Equation

Diana Manos, Healthcare Finance News

An new national survey shows that, despite the one-year delay in ICD-10 compliance, many healthcare providers do not understand the value of the medical diagnostic codes that will be used beginning Oct. 1, 2014. The eHealth Initiative survey, conducted in partnership with the American Health Information Management Association, reveals a lack of communication around the benefits and value of the new ICD-10 code set, which was expanded to improve the quality of care, research and surveillance with more accurate and specific data.

"Many providers are focused on the tough parts of this transition. They believe they are going to lose money and that it will negatively impact workflow," said Jennifer Covich Bordenick, chief executive officer of the eHealth Initiative, in a news release. "This new system should ultimately help us better measure patient care. But, until we get over the implementation hump, it will be hard for some to see the forest through the trees and see the real value."

The vast majority of respondents expect to encounter a wide range of barriers to ICD-10 implementation within the first six months of the compliance deadline, which will prevent them from fully realizing the potential benefits and improvements. According to researchers, the survey was conducted in May and June of 2013, and was comprised of a variety of questions that examined the perceived effects, benefits, challenges, and opportunities presented by the implementation of ICD-10. Some key results from the survey of 281 hospital executives, physicians and others include:

- 26% reported that they had no specific goals to leverage ICD-10 other than for claims processing.
- 59% percent of clinic and physician practices expect a significant decline in revenue.
- Only 16% of respondents expect higher revenue after ICD-10 implementation.
- The most significant barriers to ICD-10 include: staffing and training; workflow and productivity; lack of knowledge; and cost of software upgrade.

The one-year delay of ICD-10 compliance was implemented by the Centers for Medicare & Medicaid Services to give providers additional time to prepare their organizations, train their staff and test and upgrade their systems. http://www.healthcarefinancenews.com/news/providers-overlook-icd-10-value-equation

House Bill Would Raise Some Medicare Patient Fees

AMEDNEWS.COM

Wealthier seniors would pay higher Medicare premiums, and a co-payment for home health services would be required under Medicare reform legislation introduced in the House on July 19. House Ways & Means Committee members drafted a bill seeking to modernize patient cost sharing in Medicare, said Rep. Dave Camp (R, Mich.), the committee's chair. The reforms would save about $60 billion combined over 10 years.

"Seniors deserve real solutions that will preserve and protect this vital program for current and future beneficiaries," Camp said. "There has been strong bipartisan support for advancing commonsense solutions to ensure these programs are on a more fiscally sound path, and there is no reason why we cannot work together to achieve that goal."

Home health remains one of the few Medicare benefits with no patient cost-sharing requirement. The co-pay amount would be set at $100 beginning in 2017 if the legislation were enacted.

Patients earning more than $85,000 would pay higher premiums for Part B and Part D coverage, the bill states. Beneficiaries also would see $25 increases in their deductibles in 2017, 2019 and 2021. The 2013 deductible is $147 for the year.

To view this article online please visit: http://www.amednews.com/article/20130729/government/130729934/10/

Medicaid Outsources Overpayment Recovery Process to HMS

Does this logo look familiar? The Ohio Department of Medicaid has contracted with Health Management Systems, Inc., (HMS) to supplement its Medicaid Third Party Liability recovery activities. You may start receiving reports from HMS identifying Medicaid expenditures that this organization has identified as having third party insurance coverage through a commercial carrier.

HMS is auditing various Medicaid claims, often several years old for the potential to recoup funds they believe Medicaid paid in error. They provide a website login where the provider can verify if the recoupment is valid or if it is invalid and can dispute the recoupment.

What you need to do: Please forward any and all notifications from HMS to NCDS in your daily scans as soon as you receive them. This will allow ample time for our team of client service specialists to review each recoupment request for validity and dispute if/when needed. It is important not to ignore these requests, as Medicaid will automatically recoup the payments if no response is given.

Important Reminder: A P.O. Box Cannot be Used as a Patient's Address

Due to compliance changes as well as changes related to electronic claims submissions all of the major insurance carriers will immediately reject a claim when a PO Box is entered in the address field of the patient's demographics. When a patient completes his/her registration please take an extra moment to review this information and request he/she list a valid address on their demographic sheet to avoid rejected claims and RFIs.

New Scanning Requirements… Are you in Compliance?

In our last newsletter we informed all of our valued clients that NCDS now requires more information to be sent with the patient demographic scans received from your office. This is specifically to ensure your claims are billed out correctly every time. Many clients are still not including this information with their demographic scans and it is imperative for accurate billing the first time, every time. Please note the following on the copied insurance ID cards you send:

- Patient Name
- Effective Date of that Insurance
- Whether that insurance is Primary or Secondary

These changes should be seamless and take minimal effort for your staff because the patient is there in the office. Please take the time to add this information so your claims get paid the first time they are billed. If you have any questions about this change please contact our office at 800-556-6236 and speak with Susan Mobley, Processing Manager, at extension 25 or email susank@ncdsinc.com.

House Bill Would Stop EHR Penalties for More Medical Practices

By: Charles Fiegl, AmedNews.com

Washington Lawmakers have introduced legislation that would require the federal government to offer more hardship exemptions to physicians to stop Medicare payment cuts for failing to meet electronic health records meaningful use standards. The House bill, introduced by Rep. Diane Black (R, Tenn.), would create additional hardship exemptions for single-doctor practices and physicians approaching retirement.

The 2009 law creating the Medicare and Medicaid EHR incentive program established payment reductions that begin in 2015 for eligible physicians and other health professionals. The incentive structure pays Medicare bonuses of up to $44,000 over five years, although bonus payments sent after April 2013 are reduced by 2% because of the recent federal budget cuts known as sequestration.

Physicians must adopt EHRs and begin to meet meaningful use requirements by July 2014 to stop the penalty from taking effect in 2015. The penalty would reduce Medicare pay by 1% for the first year and grow to 3% by 2017. The existing list of hardship exemptions would extend to physicians in solo practice, the proposed legislation states. The other hardship would be an option for physicians who are 62 or older by the last day of 2015, or who would reach age 62 by 2020.

The American Medical Association wrote a May 30 letter voicing support for the proposal. The AMA particularly approved of the provisions adding hardship exemptions for solo physicians and those nearing retirement.

"While the Medicare/Medicaid meaningful use program has helped jump-start the use of EHRs, we are still in the early stage of progress due to technological, regulatory, as well as other challenges," the AMA letter stated. "These challenges must be overcome in order to increase physician participation rates and maximize the benefits of this technology for our nation's health care delivery system."

For the full article please visit AmedNews at:
http://www.amednews.com/article/20130617/government/130619944/6/

SGR Repeal Bill Moves to Full House Vote

David Pittman, MedPage Today

WASHINGTON -- Some national and state physician medical societies are voicing concern with one provision of a bill to replace Medicare's sustainable growth rate (SGR) formula -- a bill that now awaits a vote before the full House of Representatives. The groups say the Medicare Patient Access and Quality Improvement Act of 2013, which the full Energy and Commerce Committee approved in a 51-0 vote Wednesday morning, errs by not giving certain savings in Medicare back to undervalued services.

But there will certainly be time for the physician groups to have their concerns addressed. Even optimistic supporters of an SGR repeal admit it'll be tough to have a bill signed into law by the end of the year and before the SGR's scheduled 25% pay cuts take effect.

The bill, H.R. 2810, directs the Centers for Medicare and Medicaid Services (CMS) to identify services it overpays and reduce those payments by 1% each year from 2016 to 2018. However, CMS traditionally redirects that money back to services it deems undervalued. H.R. 2810 doesn't specify that CMS take that step, and physician groups say that could undermine planned payment increases the bill provides.

The American Academy of Family Physicians, American College of Physicians, American College of Surgeons, American Medical Association, California Medical Association, Medical Society of New Jersey, Michigan State Medical Society, Pennsylvania Medical Society, and Texas Medical Association all signed a letter last week voicing this concern to lawmakers.

"The bill would remove savings realized from relative value unit (RVU) reductions out of the payment pool rather than allowing them to be redistributed to other physician services," the letter read. "CMS began to focus on RVU corrections in such services in 2009, and since that time reductions have been made in over 500 services. As of this year, over $2.5 billion [is] to be redistributed to other physician services, and we anticipate further significant payment redistributions will be made when the final 2014 fee schedule is implemented."

H.R. 2810 has several elements, but starts with repealing the SGR and providing 5 years of stable Medicare payments beginning next year, with reimbursements growing 0.5% for each year between then and 2018. Starting in 2019, physicians can choose to report certain quality measures and have traditional fee-for-service payments adjusted based on how doctors compare to peers on those measures. Physicians can receive a 1% bonus if they perform well and receive a 1% penalty in payments if they don't.

Physicians may opt out of this quality-incentive program if they participate in an alternative payment model such as a patient-centered medical home, accountable care organization, or some yet-to-be-determined model.

Physicians who decline to report their quality data or participate in an alternative payment model will receive a 3% cut in payments starting in 2019. Lawmakers did make a few technical, bipartisan changes to the bill intended to flesh out the bill's intent, but didn't revisit the RVU issue except to include a line saying nothing prevents CMS from increasing undervalued codes. Lawmakers also changed components of the alternative payment model section are spaced out differently and changes are made to certain Medicare payment programs, Rep. Mike Burgess, MD (R-Texas), said Wednesday.

"For example, the amendment adds a requirement that CMS report to Congress on the feasibility of, and recommendations to implement, clinical decision support mechanisms in the Medicare program," Burgess added.

For the full article please visit MedPage today at:
http://www.medpagetoday.com/PublicHealthPolicy/Medicare/40768