November – December 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…

How to Keep Your Practice Running Smoothly through the Health Insurance Marketplace Transition

By: Jessica Meyers, NCDS

Healthcare.gov has gone live, bringing the Health Insurance Marketplace to the fingertips of millions of Americans. This Marketplace, also known as "The Exchange," is intended to help bring access to care for the uninsured. As it is still in the early stages of implementation the impact on physician practices is not yet known. What is known is that it is believed that more patients will have access to care than before. With more patients there is greater revenue potential but simultaneously a greater risk for rejected claims and insurance denials. There are a few important avenues you should follow to safeguard your practice against potential pitfalls.

- First, request the patient complete a new registration at the start of the New Year, every year. The inconvenience it may cause to the patient is marginal compared to the inconvenience it causes to the provider when claims deny due to bad insurance information.
- Request the patient to verify his/her coverage at every appointment. This is increasingly important for both the health insurance exchange as much as it is for the ever growing Medicaid population; patients bounce from one program to the next on a monthly basis and physicians are left to figure out plan changes after insurance rejections are received for billed services.
- Identify new insurance cards that are products of The Exchange.
- Request your staff take a few quick moments to verify coverage and benefits (the phone number to do this is on the back of every insurance ID card and takes less than a minute per patient).

Whether under the Health Insurance Marketplace or under private insurance plans through a patient's employer, coverage and benefits vary greatly. Many plans have reduced benefits to make coverage more affordable, leaving patients without coverage for the very services they are in your office to receive. Checking coverage and benefits can help educate your staff and the patient, as well as provide an opportunity to obtain payment when the patient is present. As some providers experience a new wave of patients with new coverage under the Exchange, it is important to remember that coverage does not equate to free treatment. Educating staff on these imperative steps will make all the difference in claims reimbursement and the bottom line for your practice!

Administration Launches Program to let Users Circumvent Healthcare.gov

FoxNews.com

Trouble with the HealthCare.gov site appears to be so widespread that the Obama administration has opened the door for Americans to circumvent the site altogether.

Under a plan announced Friday by the Centers for Medicare and Medicaid Services, the government would allow people to deal directly with insurance companies instead of through the federally run exchange website. The move comes as the administration's self-imposed Nov. 30 deadline for fixing the site is just days away, and officials acknowledge it may not be fully operational by then.

The pilot program announced by CMS would initially launch for residents in Ohio, Florida and Texas, and is the latest effort to give users an alternative to the troubled site.

"This is one more way we are working to offer consumers a variety of ways to enroll in affordable coverage," agency spokeswomen Julie Bataille said in announcing the pilot project. "By strengthening the multiple channels to enroll in quality, affordable coverage … we are ensuring that every American who wants it can gain access to these new coverage options."

Bataille said that direct enrollment has "been there from the start." But the option was limited by the website problems, which have been fixed to the extent that insurance companies can now send applications to the site to assess enrollees' eligibility for coverage and potential discounts on premiums, she said.

Though the option could help Americans frustrated by the HealthCare.gov's crashes, slow response times and other problems, it is another acknowledgement that the site probably will not be working for everybody by the administration's Nov. 30 deadline. Officials originally vowed to fix the site by then. As the extent of the site's problems became apparent, officials lowered the bar on that goal -- vowing instead to significantly improve the site by the end of the month.

White House spokesman Josh Earnest said Monday that improvements to the site are on schedule, including faster response times, and that it should be able to handle 50,000 concurrent users. "If there are more than 50,000 people trying to use the website, individuals can choose to receive an email from CMS when the traffic on the website has been reduced," he said.

In another development, GoHealthInsurance.com announced Monday that it has become the first private insurer to integrate with the so-called Federal Data Service Hub --- which includes IRS, citizenship and other personal information. So Americans can now use that as well to bypass the federal site and enroll in health plans under ObamaCare that kick in next year.

http://www.foxnews.com/politics/2013/11/25/administration-going-to-plan-b-on-exchanges/

Half of New Medicaid Eligibles are 'Young Invincibles'

By: Anthony Brino, HealthcarePayerNews.com

The new face of Medicaid may be underemployed millennials, but that may bode well for Medicaid's finances. Young adults ages 19 to 34 account for more than half of those newly eligible for Medicaid, according to a new Urban Institute study.

Of the almost 10 million young adults eligible for Medicaid under the ACA, about 20 percent of are be students, 42 percent are working and 18 percent are unemployed, and some of them are already using social services. According to the Urban Institute study, 25 percent have children covered by CHIP and 28 percent live in a household with someone getting SNAP food benefits.

About 5.4 million currently uninsured young adults eligible for Medicaid live in states expanding coverage for those earning up to 138 percent of the federal poverty level, and 4.3 million young people estimated to be eligible for Medicaid live in states that are not expanding eligibility under the Affordable Care Act.

While the idea of young people like graduate students getting Medicaid enrages some health reform critics, more young people in the program could ease state and federal budget burdens over the next few decades, with preventative care made available upstream.

Overall the 19 to 34 year-olds "will be a healthy population," said Urban Institute researcher Lisa Dubay, who authored the study.

But, she added, there are a number of young people who are likely to end up working low wage jobs and living in poverty for most of their adult lives and they're also at high risk of developing multiple chronic health programs and possibly ending up with dual Medicaid and Medicare benefits.

In the states expanding Medicaid eligibility, most full-time minimum wage earners and the long-term underemployed and unemployed will be able to get access to primary care, which could prevent or offset the onset of diseases like diabetes in middle age, Dubay said.

In the short term, more generally healthy millennials in Medicaid could help sustain new payment models like capitated contracts. And in the long term, if most of those beneficiaries decide to get preventative care, it could also bode well for Medicare's finances as those populations age.

For more information on this article please visit: http://www.healthcarepayernews.com/content/half-new-medicaid-eligibles-are-young-invincibles

United Healthcare Community Plan Changes - January 1, 2014

Effective January 1, 2014 United Healthcare Community plan is transitioning to a new enrolment and payment system.

All patients will be issued new identification cards as well as new subscriber ID numbers. This means that we cannot bill with the current ID numbers for these patients as of January 1, 2014, so it is another great reminder to get an updated card copy from patients. The bulletin from United Healthcare Community Plan also states that changes will be made to the prior authorization process but no further information is available on that at this time. Please watch for further updates from NCDS!

CMS: Chronic Care Management, SGR Main Issues for Physician Pay in 2014

By: Bob Herman, BeckersHospitalReview.com

CMS has a released final rule for Medicare's physician fee schedule, starting Jan. 1, and physicians are expected to see a 20.1 percent reduction to their Medicare payments. Under current law, physicians and other providers will face the pay cut based on the sustainable growth rate. The SGR is the formula used to adjust Medicare physician payment rates.

This past March, and also in the proposed rule, CMS said physician payments would have to be slashed 24.4 percent to make up for previous overrides of the SGR. The revised reduction of 20.1 percent is due to physician pay adjustments CMS calculated for this year. Members of Congress are currently working on both temporary and permanent fixes to the SGR. Every year since 2003, Congress has overridden the SGR so physicians would not have to endure sizable cuts to their Medicare pay.

The American Medical Association has made vigorous calls to repeal the SGR, describing it as a flawed formula. "The clock is ticking. At stake are innovations that would make Medicare more cost effective for current and future generations of seniors," Ardis Dee Hoven, MD, president of the AMA, said in a statement. "These innovations are not possible if physicians are worried about drastic cuts to Medicare rates that have remained almost flat since 2001, while the cost of caring for patients has gone up by 25 percent…repealing the SGR this year will give Medicare a firm and stable foundation so physicians can pursue delivery innovations that help improve care and reduce costs."

Another major provision of Medicare's 2014 physician fee schedule final rule is the emphasis on primary care services. In the proposed rule, CMS said it would create separate payments for physicians who manage and coordinate care for Medicare patients with chronic health conditions. Under the final rule, which mirrors the proposed rule, Medicare would pay primary care physicians for "non-face-to-face complex chronic care management services for Medicare beneficiaries who have multiple, significant chronic conditions," or two or more conditions. This would go into effect in 2015. CMS said it hopes this policy would improve the management and decrease the costs of chronic diseases.

"Healthcare is changing, and part of delivery system reform is recognizing this and making sure payment systems account for these changes," CMS Principal Deputy Administrator Jonathan Blum said in a news release. "We believe that successful efforts to improve chronic care management for these patients could improve the quality of care while simultaneously decreasing costs, through reductions in hospitalizations, use of post-acute care services and emergency department visits."

In addition, CMS confirmed it will expand payments for physicians who use telehealth services. Specifically, CMS will include sites designated as health professional shortage areas. CMS also finalized several changes to physician quality reporting initiatives associated with Medicare payments. For example, CMS added 57 new individual measures and two measure groups under the Physician Quality Reporting System. Now, the PQRS will have 287 individual measures and 25 measure groups in 2014.

Overall, CMS expects Medicare payments to physicians will total $87 billion in 2014. CMS will publish the rule on Dec. 10.

To view the full complete article please visit: http://www.beckershospitalreview.com/racs-/-icd-9-/-icd-10/cms-chronic-care-management-sgr-main-issues-for-physician-pay-in-2014.html

Insurance Markets Reached 20% of October Enrollment Target

HFMA, November 13, 2013

The deeply troubled federal and state-run health insurance markets garnered about one-fifth of their planned applicants in the first month of enrollment, federal health officials announced.

The U.S. Department of Health and Human Services (HHS) announced Wednesday that 106,185 people selected private insurance coverage and another 396,261 applicants qualified for Medicaid or the Children's Health Insurance Plan (CHIP) in October through the marketplaces, also known as exchanges.

Another 975,407 applicants have made it through the process by applying and receiving an eligibility determination, but have not yet selected a plan.

"We expect enrollment will grow substantially throughout the next five months, mirroring the pattern that Massachusetts experienced," HHS Secretary Kathleen Sebelius said in a release. "[These are] also numbers that will grow as the website, HealthCare.gov, continues to make steady improvements."

The private insurance enrollments amounted to about one-fifth of the 494,620 people federal officials projected would sign up for health insurance by Oct. 31, according to released administration documents.

The number enrolled in private plans is likely lower than 106,000 because this figure includes people who have not yet officially enrolled by paying the first month's premium.

The 14 state-run marketplaces garnered most of the private plan enrollments. State-run marketplaces garnered 79,391, or 75 percent, of the approved applicants. Similarly the state-run exchanges enrolled 212,865, or 54 percent, of the successful Medicaid/CHIP applicants.

Federal officials emphasized that low enrollment echo the early low enrollments in other large federal healthcare initiatives, such as the Federal Employees Health Benefits Program (FEHBP), Medicare Part D, and CHIP.

OSMA Asks CMS to Investigate UHC Physician Terminations

Ohio State Medical Association, November 14, 2013

The Ohio State Medical Association (OSMA) has formally asked the Centers for Medicare & Medicaid Services (CMS) to investigate potential network adequacy issues in light of United Healthcare's recent decision to terminate physicians from its Medicare Advantage plans.

The OSMA has expressed the same concerns to UHC and UHC leaders have confirmed to the OSMA that they are reviewing whether the selected terminations have in fact placed some patients at a severe disadvantage by losing the only quality health care available to them in proximity of where they live.

UHC will not say how many Ohio doctors received termination letters or how many have been reinstated based on appeal.

For the complete article please visit: http://www.osma.org/news/release.dT/osma-asks-cms-to-investigate-uhc-physician-terminations/2283

Less Than 10 Months and Counting NCDS is Preparing... Is Your Practice Preparing?

NCDS has attended numerous seminars and conferences in preparation for the upcoming ICD-10 conversion. Slated to take effect October 1, 2014 the ICD-10 conversion will re-map tens of thousands of diagnostic codes.

Utilizing the Changes of ICD-10 in Dictation: Of extreme importance is the practitioner's ability to educate himself/herself on the changes within ICD-10 and use it when documenting patient files/records. Notes and dictation will be required more than ever before, and should be expected as a prerequisite for billing on nearly every claim. Providers must be able to dictate using the ICD-10 methodology, not the old codes of ICD-9.

More importantly, providers should start to "Think like ICD-10." Here is a perfect example for a ENT Specialty Provider:

- ICD-9 Diagnosis of 381.01 for Acute Serous Otitis Media will be mapped to 8 different codes! Included are:
  - H65.00 Acute serous OM, unspecified ear
  - H65.01 Acute serous OM, right ear
  - H65.02 Acute serous OM, left ear
  - H65.03 Acute serous OM, bilateral
  - H65.04 Acute serous OM, recurrent, right ear
  - H65.05 Acute serous OM, recurrent, left ear
  - H65.06 Acute serous OM, recurrent, bilateral
  - H65.07 Acute serous OM, recurrent, unspecified ear
- If dictation is not as specific as possible, the default code of H65.00 will have to be used. However, even though ICD-10 is not yet in place, insurance companies already state unspecified codes eventually not be considered for payment.

Another example for a primary care provider is included:

- ICD-9 Diagnosis of 780.79 for Other Malaise and Fatigue will be mapped to 4 different codes! Included are:
  - G93.3 Post viral fatigue syndrome
  - R53.1 Weakness
  - R53.81 Other Malaise
  - R53.83 Other Fatigue
- Providers will have to select the most specific diagnosis related to the patient's condition in ICD-10 and the dictation and documentation in the patient's record must support the selection of that diagnosis code.

2014 – Medicare Deductible

Please be advised that Medicare's deductible for the 2014 calendar year will be $147 with a coinsurance rate of 20%. This is important to remember for all of your Medicare patients, especially those without any secondary insurance carrier, as the patient will owe all of the claim balance, or a portion after Medicare processes. Remind and encourage staff members to collect these payments upfront when the patient is present in the office!

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