July – August 2014

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…

Final Rule Establishes New ICD-10 Compliance Date

GREG SLABODKIN – HEALTHDATA MANAGEMENT

Four months after President Obama signed into law a one-year delay in the ICD-10 code switchover, the Centers for Medicare and Medicaid Services has announced a final rule establishing October 1, 2015, as the new ICD-10 compliance date.

The final rule, scheduled to be published in the *Federal Register* on August 4, implements Section 212 of the Protecting Access to Medicare Act (PAMA) of 2014 which became law on April 1 delaying the ICD-10 implementation deadline from October 1, 2014 to October 1, 2015. The final rule's executive summary acknowledges that "many in the healthcare industry had invested time and resources in system upgrades, testing, training, and undertaking the necessary changes to workflow processes" to meet the original ICD-10 deadline but argues that the new compliance date will help less prepare prepared stakeholders.

"This deadline allows providers, insurance companies and others in the healthcare industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015," states CMS in a July 31 press release. "While many providers, including physicians, hospitals, and health plans, have completed the necessary system changes to transition to ICD-10, the time offered by Congress and this rule ensure all providers are ready."

For more information or to view the article in its entirety please visit: http://www.healthdatamanagement.com/news/Final-Rule-Establishes-New-ICD-10-Compliance-Date-48526-1.html?CMP=OTC-RSS

What is the Sunshine Act?

The Physician Payments Sunshine Act (Sunshine Act) requires manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs to report certain payments and items of value given to physicians and teaching hospitals. The Centers for Medicare & Medicaid Services (CMS) has been charged with implementing the Sunshine Act and has called it the *Open Payments Program.* As part of this program, manufacturers are now required to submit reports on payment, transfer and ownership information. Physicians have the right to review their reports and challenge reports that are false, inaccurate or misleading. *However, the timeframe for initiating disputes and having data corrected or publicly marked as disputed is extremely limited*.

The AMA website is a great resource for the Sunshine Act. For key steps physicians should take and other resources visit: **http://www.ama-assn.org/ama/pub/advocacy/topics/sunshine-act-and-physician-financial-transparency-reports.page?**

Dueling Federal Appeals Court Decisions Threaten the ACA; But No Immediate Impact for Ohio

OSMA – OHIO STATE MEDICAL ASSOCIATION

Two federal appeals courts this week released conflicting decisions about the legality of offering tax credit subsidies for health insurance purchased from federally-established exchanges, pushing a key provision of the Affordable Care Act (ACA) into limbo and likely destined for U.S. Supreme Court action.

At issue is whether the ACA gives the federal government authority to provide tax credit subsidies to individuals who purchase plans from federally-established health insurance exchanges. The law allows the federal government to set up exchanges to allow people to purchase health insurance in states which elected to not do it on their own. Ohio is one of 36 states which declined to set up an exchange under the federal healthcare law, leaving it up to the federal government to do it instead. But Tuesday's dueling rulings are not expected to have an immediate impact until a higher court gets involved in the case.

The debate is largely over a single sentence in the ACA, Section 1401, which states that subsidies will be extended to people who buy insurance "through an exchange established by the state." Some observers indicate that line clearly suggests that subsidies can only be offered through state exchanges – and not through the federal exchange. The confusion arises, however, from another portion of the law which gives the federal government permission to establish and operate an exchange on a state's behalf.

These rival statements contained in the ACA helped trigger litigation which resulted in Tuesday's conflicting court decisions – one from the U.S. Appeals Court for the District of Columbia Circuit and the other from the Fourth Circuit Appellant Court in Richmond, Va.

The Internal Revenue Service (IRS) issued a rule in 2012 to fix what it termed an "oversight" in Section 1401. The rule allowed low-income individuals to receive subsidies in both state and federally run exchanges. That triggered multiple lawsuits against the IRS rule. On Tuesday, in Halbig v Burwell, a three-judge panel at the D.C. circuit court voted 2-to-1 against the IRS rule, saying the federal agency lacked the authority to allow subsidies to be provided by an exchange that is not run by a state.

But just hours later, a second ruling upholding the subsidies was issued on a related case, King v. Burwell, by a three-judge panel at the Virginia court. In a unanimous ruling, that court said the relevant ACA language discussing subsidy calculations for federal exchange plans is "ambiguous and subject to multiple interpretations," so it is possible to read the ACA in a way that would allow tax credits when a health plan is purchased on federally established exchange.

For the complete article please visit: https://www.osma.org/Public-Affairs/News/Dueling-Federal-Appeals-Court-Decisions-Threaten-t

Ohio BWC: New Provider Billing/Reimbursement and Rules Review for Health Partnership Program

Ohio State Medical Association, OSMA.org

The Ohio Bureau of Workers' Compensation released a revised Provider Billing and Reimbursement Manual earlier this week. Providers should reference this guide as a first resource for provider policy and reimbursement information.

Every five years BWC is required to review pertinent sections of the Ohio Administrative Code (OAC). Over the next several months, BWC plans to send rule revisions in four separate sections externally to medical and rehabilitation association stakeholder lists for public comment. The rule revisions include three portions for Chapter 4123-6 (Health Partnership Program operational rules, medical rules, Qualified Health Plan) and Chapter 4123-18 (Vocational rehabilitation). To join BWC's medical and rehabilitation association stakeholder lists, please send an email to: providerlistserv@bwc.state.oh.us.

House Votes to Sue President Obama over PPACA

Ayla Ellison, Becker's Hospital Review

In a 225-201 vote, the U.S. House of Representatives has passed a resolution that gives the House GOP authorization to proceed with its lawsuit against President Barack Obama, according to a report from *The Hill*.

The lawsuit is narrowly focused on the Patient Protection and Affordable Care Act and the president's alleged abuse of authority when he decided to defer the PPACA's employer mandate, which requires employers with 50 or more employees to provide health insurance coverage. The employer mandate was originally slated to take effect this year, but it will now gradually be implemented through 2016.

House Speaker John Boehner (R-Ohio) is the force behind the lawsuit, and he said the purpose of filing the complaint against the president is to protect the Constitution.

The basis of the lawsuit is that when President Obama deferred the requirement that employers provide health insurance beginning in 2014, he failed to uphold his constitutional duty to enforce the law. A debate on the merits of the lawsuit was held in the House Rules Committee July 16. During the debate, interpretations of the Constitution were offered by four witnesses: Price Foley, a professor of law at Florida International University College of Law; Johnathan Turley, a law professor at George Washington University; Simon Lazarus, a former associate director of public policy for President Jimmy Carter; and Walter Dellinger, who served as an acting solicitor general under President Bill Clinton.

To read the full story or for more information on the law suit visit: http://www.beckershospitalreview.com/legal-regulatory-issues/house-votes-to-sue-president-obama-over-ppaca.html

ACA to Give Refunds to 36,000 Ohioans

By: Jack Torry, MyDaytonDailyNews.com

The federal government said today that nearly 36,000 people in Ohio will receive refunds from their health insurance companies because of a requirement in the 2010 health law that insurers spend the vast majority of premiums on patient care.

The U.S. Department of Health and Human Services calculated that insurance companies will refund $1.2 million to Ohio families, which averages about $69 per family. They will receive either a refund check in the mail, a reimbursement to their debit cards, or a reduction in their future premiums.

The government estimates that across the country, nearly 7 million people will receive about $330 million in refunds, which averages about $80 per family.

Under what is known as the 80-20 rule, insurance companies are required to spend at least 80 percent of the premiums they collect for costs of physicians, hospitals and prescription drugs.

The rule declares that if the insurers use more than 20 percent of the premiums for what the government considers profits or administrative costs, such as devising the plan and selling it to consumers or companies.

Health and Human Services Secretary Sylvia Burwell said in a statement that the rule "is bringing transparency and competition to the insurance market, ensuring that consumers are continuing to receive value for their premium dollars."

Critics of the administration, however, point out that a $69 refund is a tiny fraction of the annual premium costs of a family plan, which can be $10,000 or more. In addition, they point out that any time the administration changes health insurance regulations, it imposes an administrative cost on the insurer.

For more information please visit: http://www.mydaytondailynews.com/news/lifestyles/health/aca-to-give-refunds-to-36000-ohioans/nqmXB/

Say Goodbye to the Name Catholic Health Partners

By: Tom Demeropolis, Cincinnati Business Courier

Ohio's largest health system changed its name to Mercy Health from Catholic Health Partners, effective Thursday. The name change signifies the system's "evolution to one unified team, focused on high-quality care, increased efficiencies and lower patient costs," according to a news release.

"Our new name is a symbol of the new way we are working together to improve the health of the communities we serve," Michael Connelly, Mercy Health's president and CEO, said in the release. This approach to serving and healing demonstrates our commitment to making healthcare easier as our more than 1,000 physicians and 32,000 employees strive to make lives better – mind, body and spirit – to help our patients be well."

The former Catholic Health Partners already operates under the Mercy name in Cincinnati and four other markets – Toledo, Lorain, Springfield and Paducah. In Cincinnati, Mercy Health operates five Mercy Health hospitals. The Mercy Health name will be phased into all system facilities over the next several years. The system's website will change tomercy.com.

http://www.bizjournals.com/cincinnati/news/2014/07/24/say-goodbye-to-the-name-catholic-health-partners.html

Court Considers: Can Doctors Sue Insurers for Underpaid Claims?

American Medical Association, July 15, 2014

At stake in a case before an appeals court is physicians' right to bring a lawsuit against an insurer that fails to pay correctly for medically necessary services provided to a covered patient. Physicians are weighing in as the court considers whether a previous ruling that bars such action should stand.

In *North Jersey Brain and Spine Center v. Aetna*, a physician practice that received assignments of benefits from patients with employer-sponsored health plans sued the insurer for denying and underpaying medically necessary surgeries for three different patients. The claims were brought to court only after the practice exhausted internal appeals processes with the insurer.

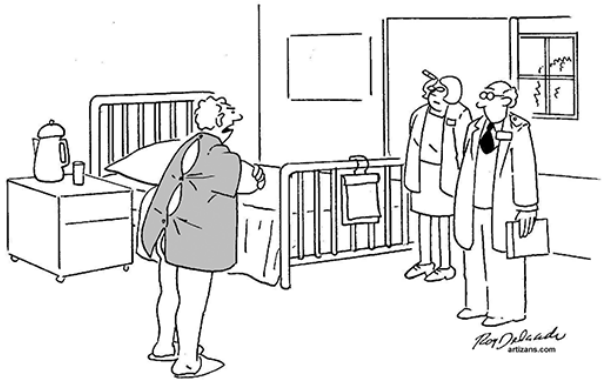
The district court in which the case originally was heard ruled that physicians must have more than the standard assignment of benefits to give them grounds for a lawsuit. The decision goes against decades of previous court rulings, accepted practice and the intention of the Employee Retirement Income Security Act (ERISA). The case now is being heard by a U.S. court of appeals in Philadelphia.

"Physicians are willing to provide medical care without demanding … up-front payments because they are confident that, if necessary, they can pursue remedies under ERISA for improperly denied insurance benefits," the Litigation Center of the AMA and State Medical Societies and the Medical Society of New Jersey said in a friend-of-the-court brief filed last week.

"The district court's holding … that patient assignments only transfer ERISA rights if they explicitly include some unspecified magic language is completely inconsistent with settled federal common law, the purpose of ERISA and the reasonable expectations of physicians and patients," the brief said. "If the district court's decision is affirmed, it will harm physicians and patients alike."

Supporting physicians' ability to deal directly with insurance companies when there is an issue with how a claim has been paid not only saves the patient who may be ill from dealing with overwhelming administrative processes but also prevents financial constraints from interfering in the patient-physician relationship.

For more information or to read related articles please visit:
http://www.ama-assn.org/ama/pub/ama-wire/ama-wire.page?&utm_source=BHClistID&utm_medium=BulletinHealthCare&utm_term=071614&utm_content=MorningRounds&utm_campaign=BHCMessageID#plckblogpage=BlogPost&plckpostid=Blog%3Ae38cf47a-fc5f-473b-9234-c9e714c1c8f0Post%3A50eb3981-87fe-4fc9-9bfd-97d0b51956ab



" The one thing they could reform in healthcare is these gowns. "

CMS Proposes Changes to Physician Fee Schedule in 2015: 11 Things to Know

Helen Adamopoulos, Becker's Hospital Review

CMS has released a proposed rule that would update the Medicare Physician Fee Schedule for calendar year 2015. Here are eleven things to know about the PFS and the proposed rule.

1. Medicare uses the PFS to reimburse providers for covered physicians' services provided to Medicare Part B beneficiaries.

2. The proposed rule doesn't contain proposals or announcements concerning the PFS update or the sustainable growth rate, a statutory formula meant to control growth in Medicare spending on physicians' services. Since the PFS rate and SGR-related cuts are determined under a statutory formula, CMS cannot change them. The final figures will be announced in the final rule issued in November. Every year since 2003, Congress has enacted a short-term legislative patch to delay double-digit cuts determined by the SGR. In April, the latest patch was passed, protecting physicians until the end of March 2015. Before that patch took effect, CMS estimated the PFS update for calendar year 2015 would be -20.9 percent.

3. In order to emphasize primary care, CMS has proposed making separate payments for chronic care management services, starting in 2015. The proposed rule includes a payment rate of $41.92 for the CCM services code, which could be billed no more than once per month for each qualified patient.

4. As part of an ongoing effort to identify and review misvalued codes, CMS has proposed adding 80 codes to the list of those that could potentially be misvalued.

5. Also under the misvalued code initiative, CMS has proposed converting all 10- and 90-day global codes to 0-day global codes beginning in calendar year 2017. "The Office of the Inspector General has identified a number of surgical procedures that include more visits in the global period than are being furnished," CMS states in a news release.

6. CMS has proposed adding annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services to the list of services that can be provided to Medicare beneficiaries under the program's telehealth benefit.

7. CMS is required to review and, if needed, adjust malpractice RVUs every five years.

8. As required by law, the proposed rule would also ault geographic price indices for the PFS.

9. Under the proposed rule, CMS would begin collecting data on services furnished in off-campus provider-based departments by requiring physicians to report a modifier for services administered in these settings.

10. The proposed PFS rule would waive the deductible and coinsurance associated with anesthesia related to screening colonoscopies.

11. The proposed rule also includes several measures meant to increase transparency. For instance, it includes a provision that would ensure all revisions to payment inputs underpinning final PFS payment rates would be subject to public comment before being used for payment. Additionally, CMS has proposed eliminating the continuing medical education exclusion under the Sunshine Act, which would require pharmaceutical and medical device companies to report payments to physicians for CME.

To read the full article please visit:
http://www.beckershospitalreview.com/finance/cms-proposes-changes-to-physician-fee-schedule-in-2015-11-things-to-know.html

NCDS
Medical Billing

7550 LUCERNE DRIVE SUITE 405
MIDDLEBURG, HTS., OH 44130-6503