March – April 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…

SGR Patch and ICD-10 Delay Approved by Congress

HEALTHCARE BILLING & MANAGEMENT ASSOCIATION

The United States Senate has joined the House of Representatives and passed legislation to prevent a 24% cut in physician fee schedule payments from occurring tomorrow (4/1) as previously scheduled. Instead, Medicare physician fee schedule payments will continue to be paid as they have been for the past 3 months. Although the legislation must be signed by the President in order to become effective, the President has indicated that he will sign this legislation once it reaches his desk.

The so-called SGR Patch approved by Congress will be in effect for 12 months, expiring on March 31, 2015. Between now and then, Congress will have to enact a permanent fix or enact another patch to prevent a huge drop in Medicare Physician payments next April 1.

In addition to preventing the SGR related reduction, Congress approved language extending various other Medicare provisions slated to expire at Midnight tonight. These include:

- Extends Medicare work Geographic Practice Cost Index (GPCI) floor for 1 year
- Extends Medicare therapy cap exception process for 1 year
- Extends Medicare ambulance add-on payments for 1 year
- Extends Medicare adjustment for Low-Volume hospitals for 1 year
- Extends Medicare-dependent Hospital (MDH) program for 1 year

In addition to these "extenders" Congress also approved a one-year delay in the effective date of the ICD-10 transition. As you know, ICD-10 has been scheduled to take effect on October 1, 2014. Due to Congressional intervention, the new effective date will be October 1, 2015.

NCDS Perspective:

Our first priority is our clients and maintaining/improving their reimbursement for the services and time they provide to their patients. It is a great benefit to physicians that *action was taken* to prevent a 24% cut in physician Medicare reimbursement as of April 1st. However, in objectively reviewing the issue at hand, Congress has implemented another temporary fix, only delaying the inevitable reality that a permanent solution is required. This means a year from now physicians' reimbursement will again hang in the balance, waiting on a resolution from Congress.

In addition the passage of this bill has delayed ICD-10 implementation another year. NCDS has already conducted testing and we see this as an opportunity to take the next year to further assist clients with education and embracing this change. It offers more time to prepare as well as an opportunity to defer any costs associated with converting over to a new code system.

Casting Aside Reform Bill, Congress Passes Another Medicare Patch

AMERICAN MEDICAL ASSOCIATION

"The AMA is deeply disappointed by the Senate's decision to enact a 17th patch to fix the flawed sustainable growth rate (SGR) formula," AMA President Ardis Dee Hoven, MD, said in a statement following the vote. "Congress has spent more taxpayer money on temporary patches than it would cost to solve the problem for good."

The $21 billion patch was passed in a vote of 64 to 35, which took place on the eve of an SGR-imposed payment cut of 24 percent. The patch will extend the current 0.5 percent update through the end of the year and freeze payment rates from January to March of next year.

"This bill perpetuates an environment of uncertainty for physicians, making it harder for them to implement new innovative systems to better coordinate care and improve quality of care for patients," Dr. Hoven said.

Also included in the bill are a variety of other revisions and "extenders," including:

- The secretary of the U.S. Department of Health and Human Services will be permitted to continue the suspension of post-payment audits by Medicare retrospective audit contractors through June 2015.
- The Medicare sequester cuts will be revised in 2024 to increase their impact, saving the federal government an estimated $4.9 billion at physicians' expense.
- Implementation of the ICD-10 code set would be delayed 12 months until Oct. 1, 2015. Transitioning to the new code set will be extremely costly for physicians, and the AMA continues to work to stop its implementation altogether.

Despite some positive provisions included in the bill, physician groups have pointed to the greater overall loss as Congress defaulted to a temporary patch even when an unprecedented bipartisan legislative policy for repealing the SGR formula was at last on the table.

"Remarkable progress was made this past year in reaching a bipartisan, bicameral agreement on policy to repeal the SGR, and the AMA encourages Congress to continue its work and resolve outstanding issues," Dr. Hoven said. "On behalf of Medicare patients and physicians across the country, it is critical that we achieve permanent Medicare physician payment reform."

To review the article in its entirety please visit the following link:
http://www.ama-assn.org/ama/pub/ama-wire/ama-wire.page?plckController=Blog&plckBlogPage=BlogViewPost&UID=e38cf47a-fc5f-473b-9234-c9e714c1c8f0&plckPostId=Blog%3ae38cf47a-fc5f-473b-9234-c9e714c1c8f0Post%3a1df04ec4-5b9b-44fd-ab5d-fedb497acf69&plckScript=blogScript&plckElementId=blogDest

The Pitfalls of Medicaid MCO's: A Danger to Non-Participating Providers

Jessica Meyers, NCDS

Effective 2014 there are five Medicaid MCPs (Managed Care Plans) active within Ohio in addition to the traditional fee-for-service program: Paramount Advantage, Caresource, Buckeye Community Health Plan, United Healthcare Community Plan a*nd Molina Healthcare. Many providers have reviewed* the benefit/reimbursements for these MCP's and have decided not to participate. However, we have found that patients frequently switch from one MCP to another, from month to month, hopping from Medicaid fee-for-service to Buckeye, then a month later switching back to Medicaid fee-for-service. This often happens with or without the patient's knowledge and rarely do the patients supply the most current information, leaving the burden on the shoulders of the provider.

Providers wishing to not participate with any of the Medicaid MCOs are strongly urged to ***check the patient's eligibility for every visit.*** The easiest way to do this is to call the Interactive Voice Response (IVR) at 1-800-686-1516 and select menu option 3. Please contact NCDS for more information on how to quickly and easily check your patient's eligibility. It will be the difference between a paid claim and an adjustment!

According to the state Medicaid website, providers that are not participating with a Medicaid MCO ***cannot hold patient's liable for charges*** for services rendered when a patient was enrolled in that MCO. Medicaid deems it the provider's responsibility to check eligibility for each visit and holds the patient unaccountable. Please see the link below for more detailed information on this Medicaid Provision.

http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/ProviderComplaintFAQs.pdf

At 6 Million, PPACA Exchange Enrollment Reaches Benchmark

By Helen Adamopoulos, Becker's Hospital Review

Days before the end of open enrollment, the Patient Protection and Affordable Care Act health Insurance exchanges have enrolled 6 million people, achieving the most recent Congressional Budget Office benchmark, according to a report from The Hill.

President Barack Obama announced the news during a conference call with navigators and volunteers.

Analysts previously doubted the exchanges would be able to sign up 6 million people by the end of the 2014 open enrollment period on Monday: Earlier this month, Avalere released an analysis estimating only 5.4 million would sign up for health plans through the exchanges by the end of the 2014 open enrollment period.

Still, although 6 million people have signed up for plans, analysts estimate that 1 million of them have not yet paid their first monthly premium, meaning they don't have coverage yet, according to The Hill.

To read the complete article please visit: http://www.beckershospitalreview.com/news-analysis/at-6-million-ppaca-exchange-enrollment-reaches-benchmark.html

Healthcare.gov Woes Frustrate In-Person Helpers Around the Country

By: KHN Editors, Kaiser Health News

Last minute health insurance shoppers nationwide turned up in record numbers online Monday, and they also showed up in person at clinics, county health departments and libraries to sign up for Obamacare on the last official day of open enrollment.

OBSTACLES IN CLEVELAND: A steady stream of people filed through the doors of the Neighborhood Family Practice, a free clinic on Cleveland's near west side Monday, but Leah Pallant, an outreach and enrollment coordinator at the clinic expected many of them to leave without actually selecting a plan before the midnight deadline.

Joyce Jones, who works two part-time jobs, arrived at the clinic late Monday morning after trying to use the website on her own. "I didn't like what I was seeing because as you look at the deductibles, all I can say is 'wow,' because you have to pay all that before your bill even gets paid," Jones said. "So that's why I chose to come in to talk about it and see if I can get a better plan."

In Ohio, 83 percent of those who have signed up for plans on the exchange have qualified for financial assistance. And Jones will have more time to shop due to another late change in the rules. Federal officials have said they will grant extensions to those who tried to start an application on the website and couldn't finish.

http://capsules.kaiserhealthnews.org/index.php/2014/04/healthcare-gov-woes-frustrate-in-person-helpers-around-the-country

Pre-authorization Required for Aetna Medicare Advantage Members

Effective June 16, 2014 a number of services will require preauthorization for Aetna Medicare Advantage Members. Preauthorization will be required through MedSolutions, the company that provides the authorization services for the Aetna commercial plan. Procedures requiring preauthorization include:

- High tech outpatient diagnostic imaging procedures- MRI/MRA, nuclear cardiology, PET scan, CT scan including CTA
- Non-emergent outpatient stress echocardiography
- Non-emergent outpatient diagnostic left and right heart catheterization
- Insertion, removal and upgrade of elective implantable cardioveter defibrillator, cardiac resynchronization therapy defibrillator, implantable pacemaker
- Polysomnography (attended sleep studies)

To submit preauthorization requests to MedSolutions please:

- Call 1-888-693-3211
- Fax 1-888-693-3210
- www.medsolutionsonline.com

Authorization requests must be submitted to MedSolutions, Aetna will not assist you with these requests.

NCDS strongly advises all clients rendering these services to contact MedSolutions and obtain preauthorization prior to services being rendered. This is one more avenue insurance companies are using to skirt the responsibility of paying claims. Denials for claims that require authorization are becoming more and more prevalent and this is a situation that can be easily avoided by a quick call, fax or visit to the website. Don't let *your bottom line* be affected by this insurance provision. Be proactive with every patient!

Anthem Medicare Advantage – Change to Preventative Coverage

Effective for dates of service on and after 01/01/2014 Anthem Medicare Advantage has made the decision to no longer cover routine physical exams, including but not limited to CPT codes:

- 99381 – 99387
- 99391 – 99397

The change to no longer cover routine physicals further aligns Anthem's Medicare program in keeping with traditional Medicare. Anthem's program will continue to provide benefits for Medicare covered services including:

- Initial preventative physical exam (welcome to Medicare preventative visit)
- Annual Wellness Visit (AWV)

The knowledge of what services are covered by which carriers is especially important for providers when rendering services to patients. If an Anthem Medicare Advantage patient wishes to schedule one of the services above that are no longer covered under their plan you can have the patient sign an ABN (advance Beneficiary Notice) prior to the service, which states the patient will pay for the service if insurance does not cover it. If no ABN is received with the billing sheet please be aware that the patient's insurance carrier will likely deny the claim, leaving no balance for the patient.

It is an unfortunate reality that as hard as providers work to care for their patients, insurance companies will work that much harder to avoid responsibility for the claim. As you can deduce from the above, selecting the appropriate CPT code at the time of service will save valuable time in getting the claim billed and getting your reimbursement for the service. For more information on the above changes from Anthem Medicare Advantage, or insurance specific issues please contact our Processing Manager, Susan Mobley at susank@ncdsinc.com or 800-556-6236 extension 25.

For more information on the Medicare ABN please visit: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf

Top 5 Medical Claim Denials

By: Kevin Fuller, Healthcare Finance News

Medical claims denials are a hassle and can lead to financial difficulties and yet so many of them can be easily avoided. Brian Fugere, COO of RemitDATA, a comparative analytics provider, recently talked with *Healthcare Finance News* to identify the top five most common claims denials.

1. **Duplicate claims.**
2. **Claim lacks information.**
3. **Eligibility expired.**
4. **Claim not covered by insurer.**
5. **Time limit expired.**

NCDS recommends scanning patient registrations and billings at the end of each day and staff scanning this information should take an extra moment to review the information for completeness. All registrations should be filled out and all billing sheets should have at least one CPT code and one diagnosis code selected. Additionally, making a copy of the patient's identification card, insurance card and calling to check insurance benefits at every appointment is standard procedure at all of the most successful medical practices!

http://www.healthcarefinancenews.com/news/top-5-medical-claim-denials

AMA: ICD-10 Impact Assessment Checklist

By: Carrie Pallardy, Becker's Hospital Review

The American Medical Association released an ICD-10 Checklist to help physician practices make a successful transition by the October 1st deadline. Here are 11 things the AMA recommends to do when assessing the impact ICD-10 will have on a physician practice.

- **Create a list of all electronic systems and work flow processes that use ICD-9**
- Create a list of vendor contact information
- **Identify all staff that work with ICD-9**
- **Identify all possible work flow changes that will need to be switched to ICD-10**
- Identify the practice's billing service, if applicable
- Identify the practice's clearinghouse(s)
- Identify a contact for each of the practice's payers
- **Contact vendors to determine their ICD-10 implementation plans**
- Contact the practice's billing service, if applicable, to identify their ICD-10 implementation plans
- Contact payers to determine their ICD-10 implementation plans
- **Identify any internal work flow processes that will need to be changed for ICD-10**

http://www.beckershospitalreview.com/icd-10/ama-icd-10-impact-assessment-checklist.html

NCDS Perspective:

Even though the ICD-10 deadline has been pushed back one year it is still imperative to educate yourself and your staff. If the list above seems like too much to handle there's good news… NCDS is *ready* for ICD-10! To simplify the responsibility of our provider offices we have noted the points above in **bold** that directly apply to the internal practices of your office and staff. While NCDS is prepared to troubleshoot any issues with billing your claims under ICD-10 we cannot affect change within the physical operations of your practice or your EHR/EMR vendor. NCDS strongly encourages all providers and staff to educate themselves on the changes that will come with the implementation of ICD-10, encouraging providers to take the ounce of prevention so you don't need the pound of cure!

"I'll have an ounce of prevention."

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