May – June 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…

Medicare Benefits Coordinator

Did you know that patients with traditional Medicare can contact their insurance to have them forward their claim directly to the patient's secondary insurance carrier? This is a great advantage to all providers because it reduces the time between when Medicare pays and when the patient's secondary insurance pays on the balance. This is also a great benefit for your patients because once Medicare is updated with the secondary insurance information Medicare will forward all of their claims (not just yours!).

Patients can Call: 855-798-2627

Please take advantage of this opportunity by making patients aware of this information. Many providers like to post signage with this information displayed in the lobby/waiting room to make patients aware of the benefits they can experience just by making a simple phone call! Due to HIPAA reasons Medicare will not accept this information from a third party or billing office.

ICD-10 Update

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

Insurers Once on the Fence Plan to Join Health Exchanges in 2015

By: Reed Abelson, New York Times

In a sign of the growing potential under the federal health care law, several insurers that have been sitting on the sidelines say they will sell policies on the new exchanges in the coming year, and others plan to expand their offerings to more states.

"Insurers continue to see this as a good business opportunity," said Larry Levitt, a health policy expert at the Kaiser Family Foundation. "They see it as an attractive market, with enrollment expected to ramp up in the second year." Eight million people have signed up for coverage in 2014, and estimates put next year's enrollment around 13 million.

UnitedHealth Group and Cigna, which were notable in their caution about the exchanges last year, are expected to enter more markets this year. In Washington State, United is among four new insurers that have told state regulators they are interested in offering plans in 2015. **For the complete article please visit:** http://www.nytimes.com/2014/05/26/your-money/health-insurance/insurers-once-on-the-fence-plan-to-join-health-exchanges-in-15.html?ref=healthcarereform&_r=0

Screening Tools for Depression in Primary Care

Laura K. Kerr and Len D. Kerr, NCBI

Depression is projected to become the leading cause of disability and the second leading contributor to the global burden of disease by 2020. It is estimated that the devastation caused by depression—defined as the number of years lost to death or disability—by 2020 will be surpassed only by heart disease.

Primary care physicians treat more than 50% of patients with mental disorders, and depressive disorders are accurately diagnosed in less than half of the patients who are affected. A patient's culture, gender, and/or predominance of somatic symptoms can impede the detection of depression. This is reflected by biases found in self-reporting screening tools used to detect depression. In this article, we discuss the limitations of self-reporting screening tools for depression with respect to culture, gender, and somatic symptoms and suggest ways to use the results of screening tools to improve the detection of depressive disorders.

Interested in Billing Medicare for Annual Depression Screening?

Primary Care Physicians can bill Medicare once a year for this screening when the following criteria are met:

- CPT code is G0444 for Annual Depression Screening
- Use appropriate diagnosis V79.0
- Fee schedule is $17.10
- If a patient schedules an appointment that has Depression like symptoms, the provider can bill for Depression screening, as long as screen for depression is done (example of a DST [depression screening tool]: questionnaire, PHQ-9 form can be found at http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf).
- If the Patient is being seen for something other than depression, and the Physician does a depression screening, he can bill for an office visit with a 25 modifier and the G0444 (Medicare will sometimes pay, sometimes deny, so make sure the notes are documented that a screening was done)
- Can NOT be billed on same day as IPPE or AWV (this screening is included in both of those visits)
- Nurse or a Physician can bill for a Depression Screening
- The beneficiary pays nothing on this code; no coinsurance, copay or deductible.

Please contact Susan Mobley, Processing Manager at NCDS at susank@ncdsinc.com for more information on billing this screening.

Even Without Expansion, 40,000 More Hoosiers Join Medicaid

By: J.K. Wall, Indianapolis Business Journal

Even without expanding eligibility for Indiana Medicaid, the program had enrolled 40,577 more Hoosiers as of March than it had in the same month last year. More than 15,000 of that year-over-year increase occurred in March alone this year, as a flood of people here and nationally sought coverage before Obamacare would hit them with a tax for going uninsured.

More than 1,094,000 Hoosiers are now enrolled in Medicaid.

The pace of new enrollment could be inflated a bit because the numbers include participants in the state's Healthy Indiana Plan insurance plan, some of whom have been allowed to stay in the program a few months longer than planned, due to the disastrous rollout of the Obamacare insurance exchange. Healthy Indiana Plan eligibility was reduced this year to a cap equal to the federal poverty limit because Obamacare now provides tax subsidies for private insurance to anyone with an income equal to the federal poverty limit or greater. "It would be difficult to attribute the recent increase in enrollment to any one factor," Jim Gavin, a spokesman for the Indiana Family and Social Services Administration, wrote in an email.

"While there has been increased application activity in recent months, with some applications being transferred to us from the federal marketplace," Gavin added, referring to the Obamacare insurance exchange, "I would also point out that total enrollment includes Healthy Indiana Plan enrollment, which is higher this month due to increased applications AND the fact that some of our members over the federal poverty level hadn't yet transitioned to exchange plans." However, the pace of enrollment is actually a bit slower than predicted by a 2012 analysis by the Indianapolis office of Milliman Inc., a Seattle-based actuarial firm hired by the state government. Milliman expected Medicaid enrollment to grow 91,000 by this time in 2015 due to what it called Obamacare's "woodwork effect."

Milliman expected enrollment to roughly double from 2014 to 2015. If that prediction proves true, it means Indiana would end up with about 81,000 additional Medicaid enrollees, not 91,000.

Milliman's forecast figured each new Medicaid enrollee would cost the state an average of $885 per year. If that cost proves accurate, the additional 40,000 Medicaid participants added so far will cost the state more than $35 million each year. The "woodwork effect" would be created, Milliman said, by Obamacare's "individual mandate" tax on those who failed to obtain health coverage, by an increase in referrals to the Medicaid program due to the launch of Obamacare's online health insurance exchanges and because some employers might stop offering coverage if its employees could gain coverage through either Medicaid or the exchanges.

The individual mandate tax this year will equal $95 per adult or 1 percent of a household's income. Indiana Medicaid restricts enrollment to adults now making just 25 percent of the federal poverty limit, or less than $6,000 per year for a family of four.

Children are covered even if their household income is as high as 250 percent of the federal poverty limit, or up to $59,625 per year for a family of four.

For more information please visit: http://www.ibj.com/even-without-expansion-40000-more-hoosiers-join-medicaid/PARAMS/article/47159

6 Remarkable Quotes from Medical School Commencement Speeches

By: Molly Gamble, BeckersHospitalReview.com

"No one talks to you about money in medical school, or how decisions are really made… But as you look across the spectrum of healthcare in the United States — across the almost threefold difference in the costs of care — you come to realize that we are witnessing a battle for the soul of American medicine."

— Atul Gawande, MD, surgeon at Brigham and Women's Hospital in Boston and writer for The New Yorker*, at the University of Chicago Medical School's 2009 commencement.*

"You see, today you take a big step into power… You may not notice your power at first…But this will be true: In return for your years of learning and your dedication to a life of service and your willingness to take an oath to that duty, society will give you access and rights that it gives to no one else."

— Donald Berwick, MD, former acting administrator of CMS and current gubernatorial candidate in Massachusetts, at Yale Medical School's 2010 graduation ceremony.

"When the genome was sequenced in 2000 for the first time in my presidency — and we spent a lot of your tax money to finish that — as a non-scientist, the most interesting thing to me was the immediate conclusion that genetically, all human genomes were 99.9 percent the same."

— President Bill Clinton at the Mount Sinai School of Medicine 2010 commencement in New York City.

"If I were to ask members of this audience what were the most important advances in medicine during the 20th century, most would make a similar list: X-rays, for both diagnosis and treatment; antibiotics, which have largely eradicated bacterial disease; cell culture, which led to the polio vaccine; noninvasive imaging, especially magnetic resonance imaging, or MRI, for early detection of cancer and other conditions; genetic engineering, which is the basis of most new medicines; the list could go on. These medical advances have one thing in common: They were all discoveries made in the pursuit of knowledge for its own sake, with no idea of any application, no purpose in the prevention or cure of disease."

— Roger Kornberg, PhD, professor of structural biology at Stanford (Calif.) School of Medicine, at the school's 2008 commencement.

"Patients do not put their trust in machines or devices. They put their trust in you.

— Margaret Hamburg, MD, commissioner of the Food and Drug Administration, at Stanford School of Medicine's 2012 graduation ceremony.

"So here we are — in a situation where people, many of whom see themselves as consumers rather than patients, want more from us as healthcare providers and administrators, in fact they demand it. And we're increasingly constrained by systems that are proven to be inefficient and less effective than other countries. I once called it a 'nonsystem' in a health policy paper, and an astute review wrote back this quip: 'If you think it's not a system, try to change it.'

— Robert Califf, MD, director of Duke Translational Medicine Institute and professor of cardiology with Duke School of Medicine, at Duke School of Nursing's 2010 commencement.

To read the complete article in its entirety please visit: http://www.beckershospitalreview.com/leadership-management/6-remarkable-quotes-from-medical-school-commencement-speeches.html

Too Early to Calculate Success of ACA Marketplaces

By: Eric Whitney, KaiserHealthNews.Org

Over $7 billion of taxpayer money went into creating the health law's insurance marketplaces, and about 8 million people signed up. But some experts say it's actually still too early to declare these markets a success or failure. So, what *can* we say about what the public is getting for its money?

The marketplaces, including Healthcare.gov and 14 state-run exchanges, are long-term investments. They have to work in the short-term, but also be desirable places for buyers and sellers to get together for years going forward.

"You could look at health insurance and see the same thing: Do people want to sell their policies on there? Or is it growing in magnitude? Those are sort of standard metrics of success for marketplaces, and we should apply them to [the exchanges]," he says.

Eight million people showed up to buy insurance on the exchanges in the first six months. But will it be a good enough deal to bring them back? Will more insurers jump in? Holtz-Eakin says we don't know enough yet to conclude which state's exchanges are successful.

"I think we know the outliers, we know the big failures in Oregon and Maryland, for example. We know what appear to be the great successes in places like Kentucky, which is quite cheap and have a big fraction of people signed up. In between, it's pretty hard to make the case we know who's better than someone else," he says.

He says insurance exchanges are long-term investments. They should last for decades and every state that set up its own had similar up-front costs, like hiring technology companies to create their online shopping sites.

"A lot of the programming, the computer set up is the same regardless of how many people enroll. So, by that number, California is going to look better than Rhode Island," Gruber says. "If you infer from that that California is better than Rhode Island, it's sort of like inferring that we should never let small states do anything."

It's also nearly impossible to compare Healthcare.gov states with those that did their own exchanges, based on the financial information the White House is releasing so far. And some states got millions or tens of millions of dollars in outside help from private donors. Even celebrity endorsements.

There's just not enough information right now for economists like Holtz-Eakin pass judgment on the Affordable Care Act's marketplaces. He says they're only part of the picture of the federal health law's success anyway.

"I think the focus on the exchanges per se is a natural fallout from Healthcare.gov melting down at the beginning," he says, "but it's really not the right metric for success or failure."

The public won't know whether that's what they got for the tax money they spent on exchanges until well after this November's elections.

Next year, though, federal grant funding for state exchanges starts running out. The challenge for these new marketplaces now is to grow on their own. Most have still only enrolled a fraction of the uninsured people in their states.

For the complete article please visit: http://www.kaiserhealthnews.org/Stories/2014/May/27/Economics-of-Obamacare-marketplaces.aspx?utm_source=khn&utm_medium=internal&utm_campaign=viewed

Medicare Advantage Plans to See Increased Payments

HBMA Washington Report, April 2014

After months of speculation that CMS would reduce Medicare payments to Medicare Advantage plans for 2015, CMS announced that plans would receive 0.4 percent boost in their payment rates next year.

According to CMS officials, the increase occurred in part due to healthier enrollees signing up for both Medicare Advantage and traditional fee-for-service plans, resulting in lower spending on the health insurance system for the aged.

CMS had come under intense pressure from both health plans and many Members of Congress from both parties prior to releasing the final rate announcement.

The rate announced in the "Call Letter" is an estimate of the overall net change for plans' payments in 2015. Individual plan payments will vary based on various geographic and demographic factors.

According to the preliminary assessment issued by CMS earlier this year, the Medicare Advantage rate was going to be reduced by an average of 1.9 percent compared to 2014 rates.

According to a statement released by CMS, the changes that were primarily responsible for the change in payment rates were:

- A new projection for Medicare's growth trend factor
- A revised risk adjustment methodology to account for the influx of baby boomers in the Medicare program
- A CMS decision to phase-in a new MA risk adjustment model that began this year and is used to adjust plan payments and bids based on enrollees' health status and demographic characteristics.
- A delay in a new policy limiting how MA plans use in-home wellness or risk assessment visits to adjust the payments they receive.

Finally, CMS announced that enrollment in Medicare Advantage plans had grown by more than 5 percent compared to last year.

Breaches of Physician Data Lead to Identity Theft and IRS Scam

Physicians across the country have been experiencing problems filing 2013 tax returns; so far more than 150 physicians have reported fraudulent returns filed in their name. Many of the affected physicians were not aware that elements of their identity had been stolen for the purpose of filing a tax return and seeking a tax refund in the name of physician until filing a return and receiving information from the IRS that a return had already been filed. In some cases, refund checks were received before a return had been filed, which means the scam is costing physicians real money.

Officials speculate that the widespread theft of health care provider's identities is most likely due to a previously unknown breach of social security numbers and addresses, possibly from a large national database such as those at national pharmacy chains, national health plans or the federal government itself. An investigation is underway by the IRS, the Secret Service and other agencies, but to date there have been no arrests or charges filed. More information regarding this IRS scam can be found on theIRS website.

Physicians who are concerned that they have been or may be targeted by this scam are encouraged to visit www.experian.com/fraud and place themselves on a 90-day credit fraud alert.

For more information on this article please visit: http://www.osma.org/news/release.dT/breaches-of-physician-data-lead-to-identity-theft-and-irs-scam/2409

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