January – February 2015

NCDS update

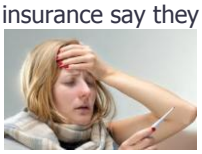
A Billing Industry Newsletter for Clients

Keeping your office up-to-date on industry and insurance changes, late-breaking billing & reimbursement news, and general inter-office communication...

Why More Sick Americans Are Avoiding the Doc

KARA BRANDEISKY – MONEY MAGAZINE JAN/FEB 2015

These days it's not just kids who are scared of the doctor: According to a recent Gallup poll, 33% of people say they've put off medical treatment because of the price, the highest level in the 14-year history of the poll. And it's not only the uninsured who are concerned: 34% of those with private insurance say they are skipping care.



The most likely culprit? Rising out-of-pocket costs. The average deductible for Americans who get single health care coverage through employers has more than doubled since 2006; those with a family PPO plan and a shared deductible saw a spike of 89% in the same period. Postponing treatment can be dangerous, of course, and is likely to backfire when it comes to cost cutting, since delaying care may result in pricey complications.

Rather than ignoring your health, try shopping around. Your employer or insurer probably has an online tool that lists what you'll pay for various services and procedures from local providers. On a high-deductible plan? Use your health savings account to cover as many expenses as possible.

NCDS Perspective: These expensive premiums impact providers just as much as patients. Providers risk a decreasing patient base when patients forego care, and fewer patients can mean fewer receipts. Additionally, for many patients that see the doctor but decide the bill is too expensive providers are faced with lengthy collection efforts to attempt to recover what is due. To prevent this providers should develop a policy for their practice, post this information so it is visible to patients and keep office staff abreast of the policy. Prompt pay signage in the waiting room works well for many practices so patients can see there is an alternative if they lose their insurance coverage. Having signage and a policy in place keeps patients aware that your practice is there to care for them regardless of their insurance coverage. Additionally, a policy of this nature can give a staff member fielding a potential cancellation phone call an avenue to keep the patient coming in for care.

Billing Medicare for Chronic Care Management (CCM)

99490

Between January and December of 2015, CMS will allow separate payment under the Medicare Physician Fee Schedule (PFS) for Chronic Care Management (CCM) services using CPT code 99490. These services are non-face-to-face care management/coordination services for select Medicare beneficiaries who have two or more chronic conditions.

100 Things to Know About Medicare Reimbursement

HELEN ADAMOPOULOS – BECKERSHOSPITALREVIEW.COM

It's often said that where Medicare goes, private payers will follow. Medicare continues to play a prominent part in various reform movements, such as the shift from fee-for-service to value-based payments and the push for greater price transparency. The program's pay rates and policies have the potential to act as a catalyst for change nationwide, or to provoke coast-to-coast controversy (as has been the case with the new two-midnight rule). NCDS has included some of the most noteworthy points of the list below. Feel free to review the complete article by visiting: http://www.beckershospitalreview.com/finance/100-things-to-know-about-medicare-reimbursement.html

51. In July, CMS released its proposed rule that would update the Medicare Physician Fee Schedule for calendar year 2015. The 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.

Medicare.gov
The Official U.S. Government Site for Medicare

54. 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 OIG 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. "In order to address the potential for misvaluation of surgical services, we are proposing to value include in these procedures for all services provided on the day of surgery, and to pay separately for services actually furnished after the day of the procedure beginning in 2017."

63. Every year since 2003, Congress has enacted a short-term legislative patch to delay the SGR cuts, a practice MedPAC said has provoked uncertainty and anger among providers and anxiety among beneficiaries. The latest patch — passed as part of the Bipartisan Budget Act of 2013 — will delay a required 24 percent Medicare pay cut and provide a 0.5 percent payment update for physicians through March 2015.

85. Medicare RACs have performed a vast number of audits in the four-plus years since their launch, recouping almost $2.25 billion in Medicare funds from hospitals and other providers from July through December 2013 alone. In fiscal year 2012, Medicare RACs identified $2.4 billion in improper payments, according to CMS. Of that total, $2.3 billion were overpayments.

86. According to CMS, ensuring accuracy, efficiency and effectiveness are key to RAC success. Maximizing transparency, minimizing provider burden and developing provider education are areas of focus as well, according to the agency.

87. RACs are paid with contingency fees. In FY 2012, Medicare RACs earned up to 12.5 percent of their recovery total, except for claim types that involved durable medical equipment. In 2012, Medicare RACs received $142.3 million overall in contingency fees, while returning $1.9 billion to the Medicare Trust Fund (after accounting for costs and appeal reversals).

What's New in 2015

Below is a list of updates received from CGS. Please take a moment to get familiar with this important provider information.

Sustainable Growth Rate (SGR)

- The Protecting Access to Medicare Act of 2014 provides for a 0% update to the physician fee schedule (PFS) for services furnished between January 1, 2015 and March 31, 2015
- Current law requires physician fee schedule rates to be reduced by an average of 21.2% from the calendar year 2014 rates effective April 1, 2015, unless Congress makes changes.

CMS.gov
Centers for Medicare & Medicaid Services

Incentive Programs

- 2015 Payment Adjustments: eligible professionals and group practices who did not report data on Physician Quality Reporting System (PQRS) quality measures for covered professional services during the 2013 program year will see a payment adjustment to the PFS for dates of service beginning in 2015.
- The applicable percent for payment adjustments under PQRS are as follows:
  - -1.5% adjustment in 2015
  - -2.0% adjustment in 2016 and subsequent years
- PQRS Help Desk can be reached Monday – Friday 7:00 AM-7:00 PM CST at 1-866-288-8912 or Qnetsupport@hcqis.org

Find Fee Schedules

- All fee schedules are available on the CGS webpage or follow this link: **http://www.cgsmedicare.com/partb/fees/index.html**
- Another good resource is the CMS PFS Look Up Tool, which you can access through this link: **http://www.cms.gov/apps/physician-fee-schedule/overview.aspx**

Dollars & Cents Updates

- The calendar year Part B Deductible is $147
- Therapy caps for 2015 include:
  - PT+speech language pathology $1,940
  - OT: $1,940

First EHR Penalties Target About 257,000 Eligible Professionals, 200 Hospitals

Dec. 23—About 200 hospitals face penalties under the first round of the federal electronic health record (EHR) incentive program, while nearly 257,000 providers will receive payment adjustments on New Year's day, CMS officials announced during a Dec. 17 press briefing. Eligible professionals facing penalties will be alerted by mail for failing to meet the Medicare EHR Incentive Program's Stage 1 meaningful-use criteria in 2013, officials said.

The penalties will result in a 1 percent reduction of each penalized hospital's or provider's total Medicare payments.

For some eligible professionals, the penalties will be compounded for failure to comply with CMS's Electronic Prescribing (eRX) Incentive Program. The agency also announced that 28,000 eligible professionals will incur a separate 1 percent penalty for noncompliance with this program, which ended in 2013 (although electronic prescribing via certified EHR technology is still a meaningful-use requirement for eligible professionals under the Medicare EHR Incentive Program.

For the full article text please visit: http://www.hfma.org/Content.aspx?id=26736&utm_source=Real%20Magnet&utm_medium=Email&utm_campaign=62053935

What Concerns Physicians the Most About Value-Based Care?

Emily Rappleye – BeckersHospitalReview.com

The majority of physicians are most concerned with getting penalized for factors they cannot control. Most physicians prefer traditional payment models, according to a recent survey from Deloitte Center for Health Solutions. Unsurprisingly, primary care physicians are more likely than specialists to support value-based care, according to the report. So what are physicians concerned about in terms of value-based care? Approximately 560 physicians in a variety of specialties answered, expressing the following concerns regarding value-based care models.

- 78% of physicians are most concerned with getting penalized for factors they cannot control.
- 78% of physicians are concerned value-based care models will overlook quality improvements that do not fall under specific performance goals.
- 70% worry it will limit their ability to make care decisions for the patient.
- 62% of physicians overall are concerned performance goals will be unreasonable in value-based care models.
- Primary care physicians are most concerned with care innovations, including the incorporation of telehealth (70%), while surgical specialists and non-surgical specialists report less concern (45% and 51%, respectively).

For more information on this article please visit: http://www.beckershospitalreview.com/hospital-physician-relationships/what-concerns-physicians-about-value-based-care.html

RAC Reforms Leave Providers Skeptical

Christopher Cheney – HealthleadersMedia.com

Despite changes designed to improve audits of medical service billings to Medicare, healthcare providers are still crying foul. Change is coming to Medicare's Recovery Audit Contractors program this year, but healthcare providers do not expect the reforms to take hold for several months and say the claims review program is deeply flawed. The Centers for Medicare & Medicaid Services is implementing a set of changes to the RAC program, with the agency marshaling the initiative on three fronts:

- Reducing provider burden
- Enhancing CMS oversight of audit contractors
- Increasing program transparency

RAC
Recovery Audit Contractors to perform Manual Medical Reviews
ARE YOU PREPARED?

The reforms include a dozen measures designed to ease the administrative burden on providers such as requiring RACs to have a "contractor medical director" who is a physician. "While we're pleased that CMS has acknowledged the administrative burden on providers, they're still tinkering around the margins," says Melissa Jackson, senior associate director for policy at the Washington, DC-based American Hospital Association. "Financial incentives drive RACs to make inappropriate denials of claims. Change won't come until RACs face financial penalties for poor performance."

RAC reforms are being implemented as part of new contracts CMS is awarding to the program's audit contractors. The originals were signed in 2008, and existing contracts are slated to expire in 2016.

Please visit: http://healthleadersmedia.com/content/HEP-312294/RAC-Reforms-Leave-Providers-Skeptical

Medicare Payment Reforms Spark Calls for Sweeter Incentives

Cheryl Clark – HealthleadersMedia.com

Expect a lot of lobbying by hospital organizations to scale back the federal government's plans to drastically raise the percentage of Medicare payments linked to value-based care, says one observer.

Today, more than half of Medicare payments are linked to quality measures, such as those that depend on performance in the value-based purchasing and readmissions programs, or in innovative structure like the four bundled payment models and ACOs.

But the Obama Administration's pledge Monday to raise that level to 85% by 2016 and to 90% by 2018—and from 20% to 30% for payments made to providers participating in accountable care and bundled payment models—may be an impossible goal. At least without some major changes to the rules, several healthcare analysts say.

"I'm happy it's on the table and it's great that we have some targets. But the likelihood that we can be as successful as they imagine, I think that's very low," says Paul Keckley, managing director of the Navigant Center for Healthcare Research and Policy Analysis. "If you back into those numbers, it means they have to accelerate the VBP and avoidable readmissions programs big time," he says. Keckley predicts a lot of lobbying by hospital organizations and others to scale back the three-year timeline in the months ahead.

Increasing the dollars at risk in those programs, and the hospital-acquired condition program, which max out at 2%, 3%, and 1% of a hospital's DRG payments, would take an act of Congress to amend the Patient Protection and Affordable Care Act.

For the complete article please visit: http://www.healthleadersmedia.com/page-1/HEP-312714/Medicare-Payment-Reforms-Spark-Calls-for-Sweeter-Incentives

More Than Half of Physicians Plan to Skip MU Stage 2 in 2015

Akanksha Jayanthi – BeckersHospitalReview.com

Meaningful use has been a bumpy ride for many eligible providers and hospitals, and it appears a number of physicians are calling it quits. According to a survey from *Medical Practice Insider* and SERMO, 55 percent of physicians do not plan to attest for meaningful use stage 2 in 2015. The poll gathered responses from approximately 2,000 physicians.

Patient engagement was an often-cited reason for physicians choosing to forgo meaningful use attestation. One cardiologist said, "I did stage 1 in years one and two, but it's almost impossible to do stage 2. It requires patients to have emails and engage in my EHR. Well, I have a lot of patients in their 80s and 90s, and they don't have computers, let alone email," according to the report.

Other physicians indicated the lack of workflow usability and excessive time consumption as a reason to not attest, according to the report.

For more information please visit: http://www.beckershospitalreview.com/healthcare-information-technology/more-than-half-of-physicians-plan-to-skip-mu-stage-2-in-2015.html

Skipped Care A Side Effect of High-Deductible Health Plans

Lisa Stiffler, The Seattle Times – KaiserHealthNews.Org

Cammi Chase was thrilled to think she had solved the conundrum that is individual health insurance. Thanks to the Affordable Care Act and federal subsidies, last December Chase moved her family from an $800-a-month plan to one that cost about $240. "I felt like we hit the jackpot," she said.

But last spring when Chase was struck with an unexpected illness, the Seattle woman was shocked to realize how little her new health insurance plan — a Health Savings Account (HSA) with a deductible of roughly $5,000 — would cover.

High-deductible and HSA plans are appealing because of their lower monthly premiums. But many consumers don't realize how much money they'll spend out-of-pocket with these plans through copays and coinsurance if they get sick. Despite being insured, this kind of coverage can drive people into debt or cause them to skip needed care for fear of unaffordable medical bills.

The problem isn't likely to improve anytime soon. During the first open enrollment to purchase insurance from online health marketplaces under the ACA, more than one-third of the 150,000 individual policies sold through Washington's Healthplanfinder exchange were "bronze" level plans with more limited coverage. The plans for 2015 with the highest deductibles will require a consumer to spend $6,600 (with some exceptions), before an insurance company starts paying the full cost of their health-care bills.

http://kaiserhealthnews.org/news/skipped-care-a-side-effect-of-high-deductible-health-plans/

76% of Physicians Don't Like CMS Quality Reporting Programs

By: Jacqueline Fellows, HealthLeadersMedia.com

An overwhelming number of practices surveyed say Medicare's quality reporting programs have a negative or significant negative impact on practice resources. They also say the programs negatively impact efficiency, morale, and staff time. A new survey of physician practices shows a high rate of dissatisfaction with several Medicare programs that are meant to improve quality and cost.

The Medical Group Management Association (MGMA), representing more than 33,000 executives and administrators of medical practices, surveyed more than 1,000 medical groups in October to assess how three quality reporting programs under Medicare Part B are affecting patient care and processes. The Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM), and Meaningful Use EHR incentives (MU-EHR) are supposed to work in tandem to improve the quality and cost of patient care. But many providers who responded to MGMA's survey say the programs are not helping their organizations achieve those goals.

"Medicare has lost its focus with its physician quality reporting programs," said Anders Gilberg, MGMA senior vice president of government affairs, in a statement earlier this week. "Each program has its own set of arcane and duplicative rules which force physician practices to divert resources away from patient care."

An overwhelming number of practices (76%) responded that Medicare's quality reporting programs had a negative or significant negative impact on practice resources. Providers also report that the programs negatively impact efficiency, morale, and staff time.

For the complete article please visit: http://www.healthleadersmedia.com/content/PHY-309844/76-of-Physicians-Dont-Like-CMS-Quality-Reporting-Programs

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