November — December 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...

Eight Questions Your Patients Should Be Asking You

By: Matt Dallman, Billing-Coding Advantage

1) Do I really have Medicare? Once you qualify for Medicare, you have the option to choose a Medicare Advantage Plan. They may offer additional benefits that traditional Medicare does not cover; however, it is important to note that these plans are completely separate from each other.

2) When is it important to open the mail from my insurance carrier? While it is our job to navigate through insurance policies to get your claims paid, insurance carriers will often reach out to the patient for additional information before approving payment on any given treatment date. There are three different pieces of information that your carrier may request from you, based on your condition or type of treatment:

A. Coordination of Benefits. This is to make sure that they are your primary carrier, and that your claims shouldn't be processed by another carrier first.
B. Accident details. There are certain codes that suggest a patient may have been involved in an accident. In this case, the carrier will send out a questionnaire for accident details to determine whether or not a worker's compensation or no fault insurance carrier should be responsible for the claims instead.
C. Pre-existing questionnaire. These are often sent to patients who have been members of a given carrier for less than a year when claims are first received. These questionnaires can easily be avoided by submitting proof of prior coverage to your insurance carrier when your new policy begins.

3) Is my Doctor really in my network? Each insurance carrier has several different plans or products that they offer to the public to purchase. It is very difficult to determine which healthcare providers are participating. It is always best to contact your insurance provider for the most current information on network status.

4) Why did my doctor collect a $50 copay, when the EOB states I should only pay $46? For example, a 15 minute office visit may reimburse the doctor $46 according to their contract with an insurance carrier. If, in this scenario, the patient's co-pay is $50, the insurance carrier will pay nothing to the doctor and the patient should only have to pay the $46. While most doctors are willing to work with patients on their portion of the costs, with a payment plan or reduced cost, they are contractually obligated to collect these payments from patients.

5) Why are there 5 different bills for my surgery? Sorting out medical bills after a surgical procedure can be overwhelming and confusing. From the pre-operative screening to the final post-operative follow up appointment, there are several different healthcare providers that may bill for services rendered:

A. Physician charge for pre-operative screening (taking history and/or physical)
B. Lab charge for pre-operative screening (blood testing)
C. Professional surgeon charge for surgery (the doctor who actually performs the surgery)
D. Facility charge for surgery (the place surgery is performed, including equipment, nurses, etc.)
E. Anesthesiology charge for surgery (the doctor who administers and monitors general anesthesia)

To be proactive, you may want to check your insurance benefits for each of the different types of medical charges associated with a surgical procedure. Additionally, the facility may be participating with your insurance plan and the physician performing the surgery may not be. In this case, there may be additional patient responsibility.

6) Why do I have a deductible and a co-pay for the same visit? Although your doctor may be participating with your insurance plan, there may be additional costs to you when certain diagnostic tests or x-rays are performed. In an effort to cut down on costs, many health insurance providers have implemented "cost-sharing" on office procedures. If you are unsure or concerned about incurring additional charges during your examination, you should discuss it with your doctor or the doctor's billing office to avoid any surprises.

7) Why does the explanation of services on my EOB indicate a 45 minute visit, when I was only in the doctor's office for 20 minutes? For example, the code 99215 can be chosen for the visit for either 40 minutes of treatment time or a visit of High complexity. So, even though you may not have been in the office for the full 40 minutes, if your case qualifies as highly complex, the use of the 99215 code is acceptable and valid. The different levels of complexity follow strict guidelines that are monitored by medical review and random audits.

8) I was treated by Dr. Smith; why does my insurance statement list Dr. Doe? When a physician develops a private practice, he or she must create a business entity for tax purposes. If Dr. Smith is a physician employee of John Doe, MD PC, any treatment rendered by him would be billed to the insurance carrier under the business name of John Doe, MD PC. Thus John Doe, MD PC will show on the insurance explanation of benefits.

For the complete article please visit: http://www.billing-coding.com/detail_article.cfm?ArticleID=5220&email=mickp@ncdsinc.com

NCDS Perspective: NCDS cannot stress enough how important many of these pieces of information are when it involves patient understanding. Gone are the days where a patient comes for a visit and the insurance takes care of everything. A patient's education on his/her insurance now goes hand in hand with the provider's reimbursement in many cases. Consider point #2 above. If a patient does not respond to his/her insurance's written requests for these pieces of information the insurance carrier will not process the provider's claim! Additionally, if you consider point #5 patients are constantly confused about the different components of a visit at the hospital. NCDS receives daily calls related to this issue. Patients often assume that because they paid the hospital the provider's bill should be included in that charge. Please keep these important FAQs in mind when patients have questions at your office. NCDS is always just a phone call away!

Customer Call Center to Service CareSource Members

SidneyDailyNews.com

DAYTON — CareSource, a Dayton-based nonprofit, health plan will team with Xerox (NYSE: XRX) to provide a customer care operation in Indianapolis. Xerox will hire and employ approximately 200 Indiana residents, manage the call center, and train the staff to support new work from CareSource.

CareSource is a leader in developing customer care strategies to ensure the highest levels of service for members. The new Xerox customer care center will enhance the consumer experience by supporting those who want to learn more about CareSource product lines, including CareSource's new Just4Me health plan available in Kentucky, Indiana and Ohio through the federal Health Insurance Marketplace.

In November, CareSource expanded the footprint of the CareSource Just4Me insurance product to Indiana and Kentucky after enrolling more than 30,000 Ohioans. Xerox customer care agents will handle a wide range of member and provider inquiries including ID card requests, coordination of benefits education, eligibility inquiries, and premium payment processing for the CareSource Just4Me insurance product line.

For more information on this article please visit:
http://www.sidneydailynews.com/news/business/150707806/Customer-Care-Call-Center-to-Service-CareSource-Members

NCDS Feedback: Why is improved customer care important to providers? In our prior newsletter we brought CareSource to your attention with an article about their large patient expansion, which has resulted in a surge of claims to the carrier. News that the carrier has expanded their customer care is a positive sign for providers, where CareSource currently sits at the top of the "problem carrier" list. With call hold times averaging 1-2 hours for claim status and reprocessing requests, many providers have had enough excuses from CareSource. The news of this article is a reassuring sign the company is working to improve on a clearly strained service division. NCDS is hopeful provider care will follow in the expansion of services, but continues to monitor claims for payment and accuracy.

Just 17% of Hospitals Have Met MU Stage 2

Ellie Rizzo – BeckersHospitalReview.com

According to CMS data collected to Nov. 1, 2014, just 17 percent of hospitals - 840 - have successfully attested to Meaningful Use Stage 2. In total, 1,903 hospitals have successfully attested to MU in 2014, with 221 new participants in the MU program.

The struggle to meet MU standards continues, as only 38 percent of eligible hospitals and critical access hospitals have met a MU stage as of September 2014. More than 3,900 hospitals must meet Stage 2 measures and objectives in 2015, according to a release from CHIME.

Only 2 percent of eligible professionals have attested to meaningful use so far in 2014, with 11,478 attesting to Stage 2. More than 260,000 EPs will need to have met Stage 2 measures and objectives by February 2015, according to the release.

http://www.beckershospitalreview.com/healthcare-information-technology/just-17-of-hospitals-have-met-mu-stage-2.html

What is PQRS?

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

CMS.gov Centers for Medicare & Medicaid Services

The program provides an incentive payment to practices with EPs (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]). EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer).

Beginning in 2015, the program also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. This website serves as the primary and authoritative source for all publicly available information and CMS-supported educational and implementation support materials for PQRS.

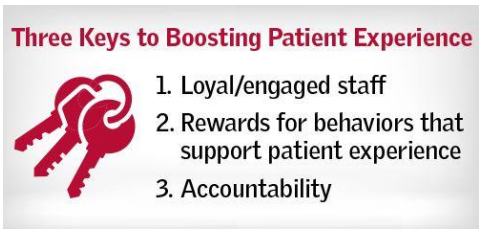
For more information on PQRS plus helpful links and tips please visit: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/

No Employee Satisfaction No Patient-Centered Culture

By: Marianne Aiello, HealthLeadersMedia.com

While aesthetic improvements have been proven to make a positive impact on patients, they don't get to the crux of the issue for many hospitals and health systems: fostering a patient-centered culture. Scripps Health and Ardent Health Services are two organizations excelling in this arena, focusing on staff satisfaction and engagement, as well as tracking a number of metrics as a means to improve the patient experience.

"Nurse and staff loyalty and engagement play the most important role in generating patient loyalty—it's where we begin," says Kevin Gwin, vice president of patient experience and communications for Ardent Health Services.



"I cannot ask our employees to change, if our relationship with them is not in the right place. I must ensure we're staffed appropriately, they have the tools and equipment they need, they have trust in administration and their supervisor, they receive consistent, accurate communication and they feel recognized and valued before I ask more of them on the patient side."

Staff satisfaction is a driver for any type of patient experience improvements, says Vic Buzachero, corporate senior vice president, innovation/HR/performance management, for Scripps Health. "Staff that have their needs met can focus on the needs of the patient," he says. "Years ago, Sears conducted a definitive survey and study that indicated that customer satisfaction and sales increased with employee satisfaction."

For the complete article please visit: http://healthleadersmedia.com/content/MAR-310472/No-Employee-Satisfaction-No-PatientCentered-Culture##

MyCare Ohio Information for Providers

By: Akanksha Jayanthi, BeckersHospitalReview.com

What is MyCare Ohio? MyCare Ohio is an Integrated Care Delivery System (ICDS) that uses managed care plans to coordinate physical, behavioral, and long-term care services for Ohioans who are eligible for both Medicaid and Medicare benefits (sometimes called the dual-eligible population).

Why is MyCare Ohio Happening? Nearly 200,000 individuals in Ohio receive both Medicare and Medicaid benefits, but there is little coordination between the services provided by these programs. In the past, this has resulted in fragmented care and wasted resources

In 2012, the Department of Medicaid sought approval through the Centers for Medicare and Medicaid Services (CMS) to design and implement a system for integrated care delivery for individuals with dual-eligibility. The Department of Medicaid received federal approval to run a three-year demonstration program which uses a managed care approach to better connect Medicare and Medicaid services. MyCare Ohio aims to integrate physical, behavioral and long-term care services into a seamless experience for the individual.

How Does MyCare Work with Providers? In order to integrate payment and services for MyCare beneficiaries, Medicare and Medicaid will both pay into a capitated managed care model. MyCare Managed care plans will work to improve coordination along the full continuum of Medicare and Medicaid benefits. Providers can be paid full Medicare rates when they deliver services to MyCare enrollees.

How Will Providers Be Reimbursed? MyCare plans can pay providers at full Medicare rates. In order to make this work,80 percent of funds will come from Medicare, and 20 percent of funds will from Medicaid. Providers should carefully review all contracts with MyCare Managed Care Plans to ensure they will receive the full Medicare rate, as plans may contract to pay less than 100 percent of Medicare rates. Providers will submit one claim and receive one payment for services delivered to MyCare patients.

For the complete article or more information on the MyCare plan please visit: https://www.osma.org/mycare

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

Medicare Releases Slew of Payment Rules

By: Elise Viebeck, TheHill.com

The Centers for Medicare and Medicaid Services (CMS) released nearly 3,000 pages of regulations late Friday finalizing 2015 payment rates for various providers and services in the Medicare program, including physicians.

The agency also revised the workings of several smaller quality initiatives related to end-stage renal disease, ambulatory surgical centers and hospital outpatient care, and adjusted aspects of the fee schedule for durable medical equipment within Medicare.

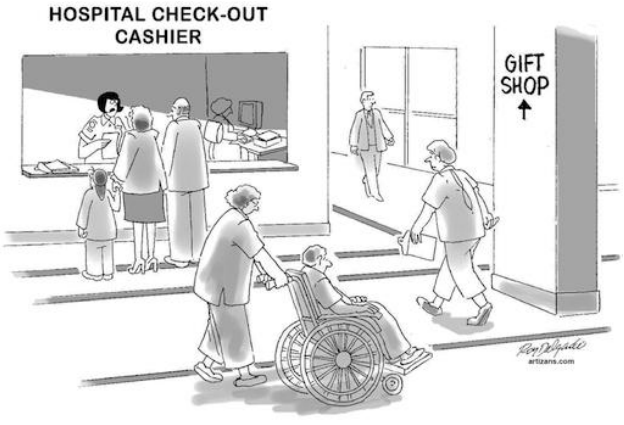
"These rules are a part of the broader strategy driving greater value in health care," said CMS Administrator Marilyn Tavenner in a statement.

"By collaborating and building on best practices across the health care system, we can deliver the results of higher quality care and lower costs that consumers, providers, purchasers, and businesses deserve."

CMS highlighted the creation of a new payment to support chronic care management, efforts to combine and streamline payments related to a single patient's hospital care, and the expansion of the Physician Compare website.

"CMS has finalized policies to significantly expand the quality measures available on this website by making group practice and individual physician-level measures available for public reporting, including patient experience measures," the agency said in a memo to reporters.

For the complete article and list of rules and payment regulations please visit: http://thehill.com/policy/healthcare/222511-medicare-releases-slew-of-payment-rules and follow the links at the bottom of the article.



" If you can't pay your bill, at least buy something from our gift shop. "

NCDS
Medical Billing

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