March – April 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...

Obama Signs Overhaul of How Medicare Pays Doctors

WASHINGTON — Ending years of last-minute fixes, President Barack Obama on Thursday signed legislation permanently changing how Medicare pays doctors, a rare bipartisan achievement by Democrats and Republicans. The bill overhauls a 1997 law that aimed to slow Medicare's growth by limiting reimbursements to doctors. Instead, doctors threatened to leave the Medicare program, and that forced Congress repeatedly to block those reductions.

Obama signed the legislation Thursday in front of reporters and photographers, sitting alone and coatless in balmy spring weather on the patio of the White House Rose Garden. The Senate passed the bill two days ago; the House approved it in March.

Obama praised Republican House Speaker John Boehner and House Democratic Leader Nancy Pelosi for negotiating the legislation. He said the new law helps Medicare by giving assurance to doctors about their payments.

"It also improves it because it starts encouraging payments based on quality, not the number of tests that are provided or the number of procedures that are applied but whether or not people actually start feeling better," Obama said. "It encourages us to continue to make the system better without denying service."

The bill blocked a 21 percent cut in Medicare payments that was due to take effect this month. It also revamps how physicians will be paid in the future, by providing financial incentives for physicians to bill Medicare patients for their overall care, not individual office visits.

Noting the unusual bipartisan nature of the bill, Obama said, "I hope this becomes a habit."

In Congress, Boehner praised Pelosi for "her indispensable leadership in helping tackle these challenging issues."

"It was achieved by working together to find common ground," Boehner said Thursday at a ceremonial appearance with Pelosi, who's more typically his legislative antagonist.

As the measure neared passage, the federal Centers for Medicare and Medicaid Services said that without action, it would start making payments at the lower rates on Wednesday.

But the agency said Thursday it was already making most payments at the new full rates, even ahead of the president's signature.

That's a different scenario than federal officials and lawmakers described earlier this week, when Senate and House leaders were fending off 11th-hour objections and shepherding the legislation to final congressional approval.

Congressional leaders warned lawmakers to act quickly to prevent those cuts from taking effect. The Centers process about 4 million claims daily — enough to potentially trigger a flood of complaints from doctors and Medicare's elderly beneficiaries that legislators wanted to avoid.

http://www.bostonherald.com/news_opinion/national/2015/04/obama_signs_overhaul_of_how_medicare_pays_doctors

To Medicaid MCO or Not To Medicaid MCO – That is the Question... Or Is It?

Jessica Meyers – NCDS Medical Billing

Are you a Medicaid provider? Do you accept any of the Medicaid MCOs? If you answered yes to either question, which most providers do, you will want to pay special attention to this information.

Many providers enroll in Ohio Medicaid, then review the Managed Care Organizations (also known as MCOs, which include CareSource, Buckeye Community Health Plan, Molina, UHC Community Plan and Paramount Advantage) to determine which enrollments would be beneficial for their practice. Many providers choose to accept regular state Medicaid, and then CareSource or Buckeye, but we want to caution you against the pitfalls of picking and choosing.

First, Medicaid places the burden of eligible coverage on the provider at the time the service is rendered. This means that Medicaid believes it is the provider's responsibility to verify coverage before every service. For example, if you accept Buckeye and not CareSource, and you see a patient that gave you Buckeye but you did not verify the eligibility prior to treatment, that patient's coverage could have switched to a CareSource (which you do not accept), with or without the patient's knowledge. According to Medicaid, this is the provider's responsibility to verify, not the patient and the provider *cannot* hold the patient liable for this charge.

Second, if you contract with regular state Medicaid and not any of the MCOs, the provider is still responsible if the patient was covered by an MCO even if you are out of network. Here is a common scenario where many providers are impacted: For example, let's say you are called to see a patient in the hospital. The hospital demographics state the patient has Buckeye insurance and you accept Buckeye. However, after Buckeye is billed, you receive a denial stating "Eligible by other Insurance," and it turns out the patient's MCO switched to a different MCO that you do not accept. Medicaid guidelines state you cannot charge the patient; if you accept one of the MCOs the patient is protected under the Medicaid umbrella of coverage. Accepting one MCO makes you responsible to all MCOs, and if you are selective in your enrollment that can make a big difference in your reimbursement.

Choosing to participate in Medicaid and/or the MCOs is a decision every provider must make for him/herself based on what is best for their practice. NCDS wants to make providers aware of all of the scenarios that can arise, prior to providers being in a situation where payment cannot be obtained due to these Medicaid loopholes.

Ohio Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

National Doctors' Day

National Doctors' Day is held every year on March 30th in the United States. It is a day to celebrate the contribution of physicians who serve our country by caring for its' citizens. The first Doctor's Day observance was March 30, 1933 in Winder, Georgia. Eudora Brown Almond, wife of Dr. Charles B. Almond, decided to set aside a day to honor physicians. This first observance included the mailing greeting cards and placing flowers on graves of deceased doctors. On March 30, 1958, a Resolution Commemorating Doctors' Day was adopted by the United States House of Representatives. In 1990, legislation was introduced in the House and Senate to establish a national Doctor's Day. Following overwhelming approval by the United States Senate and the House of Representatives, on October 30, 1990, President George Bush signed S.J. RES. #366 (which became Public Law 101-473) designating March 30th as "National Doctor's Day."

AMA Interests Edged Out by AHA, BCBS Lobbying

Elizabeth Earl – BeckersHospitalReview.com

The American Hospital Association and Blue Cross Blue Shield spent nearly double on lobbying in 2014 compared to the American Medical Association.

Although the AMA has spoken out repeatedly against the meaningful use program and the push for rapid EHR adoption, the programs have rolled on.The AMA spent more than $19 million in 2014 to lobby against the adoption of ICD-10 and meaningful use implementation, according to *Healthcare Dive*.

However, the AHA spent $20.75 million, and BCBS spent $21.3 million to lobby for ICD-10 and EHR adoption, a combined total of more than $42 million. Both financially benefit from ICD-10 and EHR use, according to the report. Although CMS has allowed for some delays in implementation and leniency on deadlines, the AMA's multiple letters for the removal of particular requirements or the delay of ICD-10 implementation have been largely unsuccessful.

Tech companies also laid out significant funds to lobby Congress in 2014 — Google alone spent $17.5 million, and GE spent $16.3 million, according to *Wall Street Cheat Sheet*.

http://www.beckershospitalreview.com/healthcare-information-technology/ama-interests-edged-out-by-aha-bcbs-lobbying.html

Refunds and Unclaimed Funds

Recent shortages in state revenues have caused many states to look to their department of unclaimed funds and more specifically, who is not reporting to it. Recent provider audits by Unclaimed Funds can put you at the mercy of the state if overpayments are not reported correctly and accurately. If you are looking to report refunds to your department of Unclaimed Funds (many scenarios include refunds that were mailed but returned undeliverable, refunds where the patient is deceased with no next of kin, etc.) but not quite sure where to start we've included a link below that will be a helpful resource. Providers can simply click on their state and the site will direct you right to the Unclaimed Funds office of that state.

http://unclaimed.org/reporting/

A Cheat Sheet for 25 Health IT Terms

Elizabeth Earl – BeckersHospitalReview.com

While NCDS makes every effort to give as much detail as possible to our providers and their staff, it is important to be aware of some of the new and ever-changing terminology, especially as ICD-10 closes in. The list below includes excerpts of the buzzwords circulating through the healthcare field. Please be sure to visit the link at the end for the whole list and explanations:

Breach: The illegal access of a health organization's information, data breaches have proliferated in recent years. There have been 1,140 health data breaches alone since 2009, according to ProPublica.

E-prescription: Converting from the traditional paper, e-prescriptions are sent across systems from providers to pharmacies for patients to pick up without the phone calls, lost paper prescriptions or possible fraud.

EHR: Electronic health records are the digital storage of a patient's medical information in a documented format, able to be exchanged and accessible from multiple locations on a practice's EHR platform.

Encryption: Data encryption is the codifying of information into an unreadable state using algorithms or ciphers. It plays a key role in the secure transmission of information, particularly patient data.

HIE: Health information exchanges are slowly but steadily inching their way into the market.

HL7: A set of international standards for the sharing, exchange, integration and retrieval of healthcare information, they are dictated by Health Level 7, an international organization. The standards include best practices to enhance clinical management and practice.

ICD-10: The abbreviation for the International Codex of Diseases, 10th edition. The deadline for implementation of the code system for classifying treatments and medical conditions in the U.S. falls on Oct. 1, 2015, although it has been delayed several times.

Meaningful use: A set of standards measuring how a provider is using an EHR system and its functionality. Many providers and organizations have protested that the regulations are too burdensome, and the rate of attestation has lagged.

Portal: An access point to an online system. The term is frequently applies to patient potals, an access interface tool where patients can access their medical records and log into a healthcare organization's system to make appointments, manage prescriptions and ask questions, among other functions.

System architecture: An overarching term to refer to the way an information system is built. Architecture varies from system to system and defines the way it is maintained.

Telehealth/telemedicine: The use of telepresence or video conferencing to conduct medical consultations or treatments from a distance. It is a quickly growing sector and has provided access to many rural residents with limited physical access to medical services.

Vendor: A term for a company that sells and maintains an IT system. It can refer to EHR vendors, general platform vendors or a variety of other IT management companies, but a vendor-healthcare organization relationship has become a central one to the operation of the medical industry.

For the complete article please visit:
http://www.beckershospitalreview.com/healthcare-information-technology/a-cheatsheet-for-25-health-it-terms.html

ICD-10 Implementation Date:

October 1, 2015

AMA: MU, ICD-10 Most Pressing Issues for Docs in 2015

Rajiv Leventhal – Healthcare-Informatics.com

The administrative load on physicians and competing regulatory programs—such has meaningful use and ICD-10— rank highest among the American Medical Association's (AMA) most pressing issues for clinicians in 2015.

According to AMA, studies show that one of the greatest frustrations to physicians is the time and expense they must devote to administrative and regulatory requirements, pulling time away from patient care without a direct benefit to care delivery or health outcomes. "At the top of many physicians' lists of things that need to change are unhelpful EHR systems and unachievable meaningful user requirements. According to data the Centers for Medicare & Medicaid Services (CMS) released in mid-December, more than 50 percent of eligible professionals will face payment penalties next year because they could not fulfill meaningful use requirements," AMA's list reads. The association says that it will continue to push for the adoption of solutions to the one-size-fits all meaningful use program, as outlined in a blueprint submitted to CMS in October.

What's more, regarding ICD-10, AMA says that it has advocated for end-to-end testing, which will take place between January and March, and this should provide insight on potential disruptions from ICD-10 implementation, currently scheduled for Oct. 1. The physician-based AMA has maintained an anti ICD-10 stance; its president, Robert Wah, M.D., recently characterized the planned implementation of ICD-10 as analogous to the dark forces controlling the galaxy in the movie "Star Wars."

For the complete article and more information Please visit:
http://www.healthcare-informatics.com/news-item/mu-icd-10-highest-ama-s-top-10-physician-issues-2015

Medicare Is Stingy In First Year of Doctor Bonuses

Jordan Rau – KaiserHealthNews.Org

Dr. Michael Kitchell initially welcomed the federal government's new quality incentives for doctors. His medical group in Iowa has always scored better than most in the quality reports that Medicare has provided doctors in recent years, he said. But when the government launched a new payment system that will soon apply to all physicians who accept Medicare, Kitchell's McFarland Clinic in Ames didn't win a bonus. In fact, there are few winners: out of 1,010 large physician groups that the government evaluated, just 14 are getting payment increases this year, according to Medicare. Losers also are scarce. Only 11 groups will be getting reductions for low quality or high spending. "We performed well, but not enough for the bonus," said Kitchell, a neurologist. "My sense of disappointment here is really significant. Why even bother?"

Within three years, the Obama administration wants quality of care to be considered in allocating nine of every 10 dollars Medicare pays directly to providers to treat the elderly and disabled. "Without having any indication that this is improving patient care, they just keep piling on additional requirements," said Dr. Mark Donnell, an anesthesiologist in Silver City, N.M. Donnell said he only reports a third of the quality measures he is expected to. "So much of what's done in medicine is only done to meet the requirements," he said.

http://kaiserhealthnews.org/news/medicare-is-stingy-in-first-year-of-doctor-bonuses/

Why One Physician is Forgoing EHRs

Akanksha Jayanthi – BeckersHospitalReview.com

Jeffrey Singer, MD, a general surgeon in the metropolitan Phoenix area, is one such physician unwilling to adopt and implement EHRs, and he will knowingly face Medicare reimbursement penalties over the next five years.

In an opinion piece published in the *Wall Street Journal*, Dr. Singer said his choice to not participate in meaningful use is due to EHRs harming patients more than helping patients.

Meaningful use, he wrote, was inspired by models used at large integrated health systems, such as Oakland, Calif.-based Kaiser Permanente and the Department of Veterans Affairs. HHS launched a five-year pilot program in 2008 to start using EHRs, and required EHRs nationwide just one year later. Dr. Singer argues the government moved forward with this national program without dedicating enough time to studying them. "By moving forward without sufficient evidence, lawmakers ignored the possibility that what worked for Kaiser or the VA might not work as well for Dr. Jones," he wrote.

Additionally, Dr. Singer wrote EHRs are lowering quality of care and raising healthcare costs.

"[EHRs] force me to physically turn my attention away from patients and toward a computer screen — a shift from individual care to IT compliance," Dr. Singer wrote. "This is more than a mere nuisance; it is an impediment to providing personal medical attention."

Dr. Singer points to studies to demonstrate a shared concern among physicians regarding EHRs. He refers to a 2014 survey by Medical Economics that indicated 67 percent of physicians are dissatisfied with EHR functionality, and Deloitte found 75 percent of physicians said EHRs do not save them time. "Doctors reported spending — or more accurately, wasting — an average of 48 minutes each day dealing with this system," Dr. Singer wrote.

Dr. Singer explained that as physicians spend more time on EHRs, they can't see as many patients as they used to, so they increase costs for the patients they do see. Additionally, the costs of implementing EHR systems (approximately $162,000 for the average five-physician primary care practice and an additional $85,000 the first year for maintenance, according to the Agency for Healthcare Research and Quality) are passed onto patients, he wrote.

In terms of lessened record errors and increased efficiency, Dr. Singer wrote his experiences suggest otherwise. He said EHRs assume patients are all average patients, prohibiting physicians from tailoring consultations to the individual.

He explained, "When I'm in the treatment room, I must fill out a template to demonstrate to the federal government that I made 'meaningful use' of the system. This rigidity inhibits my ability to tailor my questions and treatment to my patient's actual medical needs. It promotes tunnel vision in which physicians become so focused on complying with the EHR work sheet that they surrender a degree of critical thinking and medical investigation."

Regarding patient safety concerns, Dr. Singer simply refers to the first Ebola patient in the U.S., whose initial misdiagnosis is said to stem from an error in the EHR.

Dr. Singer concluded his piece by urging an end to the mandatory EHR requirements, suggesting such a proposal should be a key element in the Republican Party's healthcare agenda.

"Congress has devoted scant attention to this issue, instead focusing on the larger ObamaCare debate," Dr. Singer wrote. "For all the good intentions of the politicians who passed them, EHRs have harmed my practice and my patients."

http://www.beckershospitalreview.com/healthcare-information-technology/opinion-why-one-physician-is-forgoing-ehrs.html

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