November – December 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…

ICD-10 Transition Successful So Far, but Patient Care Takes a Hit:

GREG SLABODKIN – HEALTH DATA MANAGEMENT

Two new polls show mixed results since the Oct. 1 ICD-10 compliance date went into effect. While a survey by consulting firm KPMG found 79 percent of responding healthcare organizations believe the code transition has been successful to date, a separate survey of doctors by physician social media network SERMO indicates the new billing codes are taking time away from patient care.

In the KPMG survey of 298 attendees conducted during a Nov. 9 webcast, 28 percent of participants responded that the transition has been "smooth" and another 51 percent found "a few technical issues, but overall successful." At the same time, 11 percent described their experience with the code set as a "failure to operate in an ICD-10 environment."

KPMG survey respondents said the biggest challenges they perceive with ICD-10 include rejected medical claims, clinical documentation and physician education, reduced revenue from coding delays, and information technology fixes. The survey found that 42 percent of participants indicated that all of these challenges are part and parcel of ICD-10., while just 11 percent of respondents said they did not expect those challenges to arise.

In the SERMO survey, physicians were asked if the new requirement to use ICD-10 has taken away time from patients. Two-thirds of responding doctors said yes. The poll of 1,249 physicians was conducted from November 20 to 30.

Although doctors strongly indicated that the code switchover has detracted from patient care, that percentage is down significantly from a SERMO poll last month that asked members if ICD-10 was taking their time away from patient care. At that time, 86 percent said it had negatively impacted patient care while only 14 percent said it had not.

KPMG has not attempted to gauge physician productivity as a result of the ICD-10 implementation. However, Ellis says that the firm has been reaching out to its clients since the Oct. 1 compliance date went into effect and has found that coder productivity has been negatively impacted.

"Organizations cannot look at ICD-10 as a one-time, Y2K-type event. This is very far-reaching and goes way beyond Oct. 1," concludes Ellis. "There is a direct correlation between clinical documentation and revenue cycle. If you have poor documentation, it will impact your bottom line."

He hastens to add that the opposite is also true. "Organizations that institute better documentation will see an increase in revenue, so for those 11 percent who are struggling right now I would highly encourage them to do an ICD-10 assessment from a clinical documentation improvement, revenue cycle optimization, and EHR optimization perspective."

To read this article in its entirety please visit the following: http://www.healthdatamanagement.com/news/Patient-Care-Takes-Hit-with-ICD-10-51649-1.html

Humana Updates Preauthorization and Notification Lists for 2016

On Jan. 18, 2016, Humana will update preauthorization and notification lists for all commercial fully insured plans [e.g., health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO) and exclusive provider organization (EPO)], Medicaid plans and Medicare Advantage (MA) and dual Medicare-Medicaid plans. Please note that prior authorization, precertification, preadmission, preauthorization and notification are all used to refer to the preauthorization process.

For MA Private Fee-for-Service (PFFS) plans, notification is requested, not required. In addition, certain services outlined in the preauthorization and notification lists may not be applicable for Chicago, Nevada or California health care providers affiliated with an independent physician association (IPA) via a capitated arrangement. Health care providers may refer to their provider agreements for additional information or requirements concerning preauthorization. Updates to the lists include the following:

1. The following services will be added to Humana's commercial, Medicare Advantage and dual Medicare-Medicaid preauthorization lists:

Cardiac ablation, Transesophageal echocardiogram (TEE),Cardiac computed tomographic angiography (CCTA),Myocardial perfusion imaging single photon emission computed tomography (MPI SPECT),Pulse volume recording, Transcatheter valve surgeries, including transcatheter aortic valve replacement (TAVR) and MitraClip, Electrophysiology study (EPS), EPS with 3D mapping.

2. The following services will be added to Humana's commercial, Medicare Advantage and dual Medicare-Medicaid preauthorization lists:

Hip arthroscopy, Knee arthroscopy, Shoulder arthroscopy, Hammertoe surgery, Bunionectomy. Preauthorization determinations for these services will be made by OrthoNet®, a utilization management company.

3. Preauthorization requirements for pain management and spinal surgery services have been expanded to include Humana individual commercial products. These preauthorization and notification requirements apply to the following services:

Pain Management: Pain infusion pumps (back and neck pain only), Spinal cord stimulator devices, Facet injections, Epidural injections (outpatient only)

Spine Surgery: Spinal fusion, other decompression surgeries, Kyphoplasty, Vertebroplasty

The preauthorization determinations are made by OrthoNet.

For the complete notification and more information please visit: https://www.humana.com/provider/support/publications/your-practice-newsletter/2016-preauthorization-lists

Ohio Among Better States for Physician Access, Survey Says

Dayton Business Journal

The survey is based on 33 variables including physicians per capita, medical residents per capita, urgent care centers, retail clinics, insurance rates per capita, and states that expanded Medicaid through the Affordable Care Act.

Although patient access to physicians varies from place to place, the issue of physician availability is a broad one tied to federal policies and national goals, said Mark Smith, president of Merritt Hawkins.

"As the health care system evolves, there will be clear access 'haves' and access 'have-nots,' and the rankings reflect these imbalances," Smith said.

To improve access to physicians, the federal government needs to remove its current cap on funding for physician training, which is inhibiting physician supply as demand for doctors is growing, Smith said.

Massachusetts, New Hampshire, Vermont, Delaware and Maryland have the best physician access, according to the report. Mississippi, Texas, New Mexico, Nevada and Oklahoma have the least.

For more information please visit:
http://www.bizjournals.com/dayton/blog/morning_call/2015/11/ohio-among-better-states-for-physician-access.html

An Update from the NCDS Compliance Committee:

To ensure compliance and HIPAA privacy all clients are reminded of the following:

- Never use patient information in the subject line of an email
- When discussing patient information within the body of an email, limit the amount or type of information disclosed. To do this you can abbreviate the first or last names like "XX-9876 J. Smith" or "Jay S. Dob 01/21/80"

If we all do our part we can ensure that patient data remains safe and in compliance with HIPAA standards. While subtle, these small changes keep patient health information safe but do not limiting the ease and convenience offered by email communication.

Sincerely,
The NCDS Compliance Committee

Fun Fact of the Day:

Physicians Decry Broken Promise of Medicare Raise in 2016

Robert Lowes – MedScape

The law that repealed Medicare's sustainable growth rate (SGR) formula for physician pay called for an annual raise of 0.5% from 2016 through 2019 as part of a transition to value-based reimbursement.

When Congress passed the law in April, some leaders of organized medicine noted that the modest raise lagged behind the inflation rate, but said it was better than nothing. It was certainly better than the disastrous 21% pay cut that the SGR formula would have triggered in 2016. Medical societies sold their membership on the legislation, called the Medicare Access and CHIP Reauthorization Act (MACRA), in part by saying it would stabilize Medicare rates for several years.

However, the promised raise of 0.5% turned into a 0.3% pay cut in the fine print of the final 2016 Medicare fee schedule released last week. The reason? The Affordable Care Act (ACA) and several other laws that set Medicare reimbursement policy trumped MACRA. Organized medicine isn't taking it too well.

"Physicians were told that they would get an increase, and they're not," said Wanda Filer, MD, president of the American Academy of Family Physicians (AAFP). "It's a morale breaker."

In its 2016 fee schedule, the Centers for Medicare and Medicaid Services (CMS) walked through the math that produced the tiny pay cut in 2016. It involves the fee schedule conversion factor, a dollar amount that gets multiplied by the relative value units (RVUs) assigned to thousands of physician services. A mid-level office visit (CPT billing code 99213) with an established patient, for example, is worth 2.04 RVUs. The current conversion factor is roughly $35.93. Multiplying 2.04 by that amount yields a national payment amount of $73.30.

MACRA duly increases that conversion factor by 0.5%. However, CMS math also lowers the conversion factor by 0.02% to reflect a RVU "budget neutrality adjustment," a routine bookkeeping exercise. That adjustment alone would not have wiped out the MACRA increase and then some. The real culprit was an additional 0.77% decrease that CMS introduced because it did not meet a certain cost-savings target.

That savings target originated with the ACA, which requires CMS to periodically identify and adjust RVUs for physician services that are underpaid or overpaid, with an emphasis on overpaid. These misvalued services, or misvalued codes as they're often called, typically arise when advances in medical technology shorten the time and expense needed to perform a service while the payment rate remains the same.

This ACA provision was the prelude to a law called the Protecting Access to Medicare Act (PAMA) of 2014, which told CMS to fix enough misvalued services to reduce Medicare fee-for-service spending on physician services by 0.5% each year from 2017 to 2020. On the heels of PAMA, the Achieve a Better Life Experience (ABLE) Act of 2014 moved the start date up to 2016, and increased the savings target to 1.0% for that year.

CMS managed to only correct enough misvalued codes for a savings of 0.23%, according to the 2016 fee schedule. Because it fell short of the 1% mark, the agency said, it is obliged under PAMA to reduce total fee-for-service spending on physicians by 0.77% to make up the difference. The two reductions cancelled the MACRA increase and yielded a conversion factor of roughly $35.83 in 2016, 0.3% less than in 2015.

For more information on this article please visit: http://www.medscape.com/viewarticle/853878

ANTHEM UPDATE

HCPCS Drug Codes	Description	Frequency Limit
J0129	Orencia, 10 mg	100 per date of service
J0585	Botox / Botox cosmetic, 1 unit	400 per date of service
J0586	Dysport, 5 units	200 per date of service
J0717	Cimzia, 1 mg	400 per date of service
J0897	Prolia/Xgeva, 1 mg	120 per date of service
J1453	Fosaprepitant (Emend), 1 mg	150 per date of service
J1750	Iron dextran, 50 mg	20 per date of service
J2353	Octreotide, depot form for intramuscular injection, (Sandostatin, depot) 1 mg	40 per date of service
J2357	Injection, omalizumab, 5 mg (Xolair)	90 per 14 days
J2469	Injection, palonosetron HCl, 25 mcg (Aloxi)	10 per date of service
J2507	Pegloticase (Krystexxa), 1 mg	8 per date of service
J3489	Zoledronic acid, 1 mg	5 per date of service
J7312	Dexamethasone, intravitreal implant (Ozurdex), 0.1 mg	14 per 90 days
J7325	Hyaluronan or derivative (Synvisc or Synvisc-One), 1 mg	96 per date of service
J9031	BCG (intravesical) per instillation (Theracys/Tice Bcg)	1 per date of service
J9047	Carfilzomib (Kyprolis), 1 mg	60 per date of service
J9202	Goserelin acetate implant (Zoladex), per 3.6 mg	3 per date of service
J9217	Leuprolide acetate (for depot suspension), 7.5 mg (Lupron Depot, Eligard)	6 per date of service
J9395	Fulvestrant (Faslodex), 25 mg	20 per date of service

Effective for dates of service on or after March 1, 2016, we are adding frequency limits to the drugs listed in the table below. These limits are based on FDA approval and/or manufacturers' dosage guidelines. Unless otherwise noted, these maximums are per date of service.

For all providers rendering these drugs to Anthem patients, the above chart can be a valuable reference tool. Knowing the frequency limits prior to providing the service helps to avoid receivables pitfalls after the fact. Making patients aware of their insurance coverage, as well as responsibility they may incur always helps to improve the communication between doctor and patient, as well as prevents any surprises when the patient receives a bill.

For the complete update from Anthem BCBS please visit: https://www.anthem.com/provider/noapplication/f1/s0/t0/pw_e241838.pdf?refer=ahpprovider&state=oh

CMS FINALIZES PHYSICIAN FEE SCHEDULE FOR 2016: 10 THINGS TO KNOW

ALYA ELLISON – BECKER'S HOSPITAL REVIEW

CMS released its final 2016 payment rule for physicians on Friday, which includes a provision that will establish payment rates for end-of-life care planning.

Here are 10 things to know about the physician fee schedule for 2016, which is the first final rule issued since the repeal of the sustainable growth rate formula by the Medicare Access and CHIP Reauthorization Act of 2015.

Advance care planning: 1. Consistent with recommendations from the American Medical Association and other stakeholders, the 2016 rule establishes separate billing codes and rates for two advance care planning services provided to Medicare beneficiaries by physicians and other practitioners — a change that was proposed in July.

2. Advance care planning is currently covered under a "Welcome to Medicare" visit available to all Medicare beneficiaries. However, beneficiaries may not need these services when they first enroll. "Establishing separate payment for advance care planning codes provides beneficiaries and practitioners greater opportunity and flexibility to utilize these planning sessions at the most appropriate time for patients and their families," said CMS.

CMS.gov Centers for Medicare & Medicaid Services

3. CMS is also finalizing payment for advance care planning when it is included as an optional element of the "Annual Wellness Visit."

Value-Based Payment Modifier 4. Under the Value-Based Payment Modifier program, physicians can receive payment incentives for providing high-quality, efficient care, while those who underperform may be subject to a downward payment adjustment.

5. The 2016 rule finalizes a proposal to apply the Value Modifier to nonphysician eligible professional groups such as physician assistants and nurse practitioners, beginning with the calendar year 2018 payment adjustment period.

Physician Compare 6. The physician fee schedule for 2016 contains several changes to the Physician Compare website, including the use of star ratings.

7. "Benchmarks are important to ensuring that the quality data published on Physician Compare are accurately understood," said CMS. On Physician Compare, the benchmark would be displayed as a five-star rating under the final rule.

8. CMS is not finalizing the proposal to include a visual indicator on profile pages for group practices and individual providers who received payment bonuses for the Physician Value-Based Payment Modifier.

Stark Law 9. The rule establishes a new exception to the physician self-referral law to permit hospitals, federally qualified health centers and rural health clinics to make payment to physicians for the purpose of compensating non-physician practitioners under certain conditions.

10. The 2016 rule also finalizes a new exception permitting timeshare arrangements for the use of office space, equipment, personnel, items, supplies, and other services.

For more information on this article please visit: https://mail.google.com/mail/u/0/?tab=wm#label/Advisory%2FNewsletter/150ce7bd03a76096

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