May – June 2016

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…

Physicians Bleed Money to Report Quality Metrics

Dave Parks – Modern Medicine Network

Fifty years ago, Avedis Donabedian, MD, MPH, of the University of Michigan, published his seminal paper, "Evaluating the Quality of Medical Care," and created a framework that is still used to measure healthcare quality. Donabedian divided quality measures into three categories: structure, processes and outcomes.

Efforts are now underway to expand his paradigm into a potent, data-driven network of quality measures, with the hope of streamlining and vastly improving America's healthcare system.

In the short term, this initiative has turned into an expensive, burdensome, data-wrestling nightmare for many medical practices, says Lawrence P. Casalino, MD, PhD, MPH, a family physician who is a professor in the Department of Health Policy at Weill Cornell Medicine in New York, New York.

Casalino and associates published an article in the March edition of *Health Affairs* entitled, "U.S. Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures." The article is based upon a survey of about 400 primary care, cardiology, orthopedic and multispecialty practices, providing a "back-of-the-envelope" calculation of how much time and money is being spent to computerize quality data that are of very limited use, says Casalino.

After years of work, payers and providers still haven't agreed upon common measures that would allow easy entry and use of data. There are now hundreds of quality measures. Clinicians and their staffs are spending about 15 hours per week, per doctor, to enter a hodgepodge of quality data into computers. That adds up to about $40,000 a year per physician, or $15.4 billion nationally, just for quality measures, according to the study.

Having good quality measures is important for a variety of reasons, including the movement toward value-based medicine, in which quality and outcomes impact payment. Computerizing the information is part of an even more complicated and costly switch from paper to electronic health records (EHRs). "In the long run, we're going to be glad we have EHRs, but we're kind of sacrificing a generation of physicians to the transition right now," Henley says.

Only 27% of survey respondents thought the quality data now being collected was moderately or very representative of the actual quality of care being delivered. "It's pretty dismaying that the practices don't see these measures as useful even though they see themselves putting in more time than ever," says Casalino.

Coincidently, the Core Quality Measures Collaborative recently released a set of core measures to align and harmonize quality indicators used by all private and public payers. "It's just a mess out there," says Douglas E. Henley, MD, FAAFP, executive vice president of the American Academy of Family Physicians and a participant in that project. "Our involvement in the Core Measurement Collaborative was to work with public and private payers to see if we could get some order out of this chaos." He is hopeful that the measures will be adopted in 2017, and private payers will adopt them as they renew contracts over the coming 18 to 24 months.

"As we get better measures, then we'll swap out one measure for another and become more outcomes oriented, which is where everybody wants to go," Henley says. "Eventually, we'll get to the point with technology and electronic registries where a lot of this burden, which is now very manually orientated, can occur by simply extracting data directly from EHRs, rather than somebody in the clinic having to key in all this information."

The system will allow doctors to manage populations of patients, while improving the quality of care. "That's the Holy Grail we're moving toward," Henley says.

Meanwhile, the movement to data-driven systems has created enormous job growth in one particular area—medical scribes who often tail behind physicians as silent partners to input data. Kristin Hagen, executive director for clinical informatics/wellness at the American College of Medical Scribe Specialists, says there are already about 15,000 scribes working in the nation's health system, and predicts that by 2020, there will be 100,000.

NCDS Perspective: A primary complaint from patients since the widespread implementation of EHRs is the lack of focus, attention and concern received from the provider. Research has shown that the introduction of the computer in the exam room has created a void between patient/provider bond, and patients most definitely notice. Many patients have echoed the sentiment, "but he was only in the room for 5 minutes and never looked up from his laptop the whole time."

But what if there were an easier way? The need for documentation is more critical than ever but you became a physician to help your patients, not to push around paperwork. What if there was a solution that saved your time, helped you return your focus to patient care and eliminated this hassle? What would that be worth to your practice?

Did you know that NCDS Medical Billing offers an affordable, comprehensive, PQRS Solutions Program that will help you save time, meet quality metrics and avoid penalties? Make it easy, save your time, your staff's time and keep your attention where you want to spend it. Contact Mick Polo at NCDS today for more information on this program at mickp@ncdsinc.com or 440-234-8833 ext. 23. Enrolling in our PQRS solutions is an easy, convenient way to manage your PQRS needs, with a service fee of $300 and all of the solutions you need for your practice.

For the complete article on quality metrics please visit:
http://medicaleconomics.modernmedicine.com/medical-economics/news/struggle-continues-physicians-spend-more-154-billion-annually-report-quality-metrics?page=0,1&cfcache=true

Thousands of ICD-10 Codes to be Added in October

HBMA.org

The Centers for Medicare and Medicaid Services (CMS) along with the Centers for Disease Control and Prevention (CDC) announced that 5,594 ICD-10 CM/PCS Codes will be added on October 1st, the beginning of the 2017 fiscal year. This figure includes 1,943 diagnosis codes and 3,651 hospital inpatient procedure codes. Readers of the Washington Report will recall that CMS paused updates to the code leading up to the transition to ICD-10 to ease the transition process for providers. While many in the industry have praised the transition to the new coding system as a success, HBMA conducted an internal survey which indicates a number of issues that still need to be addressed. While the transition was certainly not the apocalyptic event some were worried about, the lingering challenges have continued to cause headaches for many billing companies. These challenges include a decrease in coding productivity, and an increase in claims denials that could be exacerbated as payers require greater coding specificity in October. The HBMA ICD-10 survey results were featured in an ICD-10 Monitor blog post authored by HBMA President, Holly Louie earlier this month.

NCDS Perspective: With the addition of more diagnostic codes there exists the possibility for new types of denials if/when various insurance companies do not have the updated ICD-10 codes 'loaded' into their system. We will continue to monitor these changes as the October implementation time frame grows closer.

For more information please see the link below: **http://www.beckershospitalreview.com/finance/how-obama-s-2017-budget-takes-on-surprise-medical-billing.html**

6 Tips for Medical Practices to Enhance Billing and Collections Process

Megan Wood – Becker's ASC Review

1. **Fill out claims, well**. Make sure to pinpoint which payer should receive which claim.
2. **Submit claims every day**. Follow up on every outstanding claim until it's paid in full.
3. **Pull in the patient for rejection and denials**. Include the policyholder on calls with the payer, as they can be more convincing.
4. **Establish a standardized billing process**. Create a step-by-step billing and collections process, and don't stray from it.
5. **Employ a billing company**. Find a billing company that is committed to healing patients and delivering funds.
6. **Understand the contract**. Don't shy away from enforcing the contract's terms with payers.

http://www.beckersasc.com/asc-coding-billing-and-collections/6-tips-for-medical-practices-to-enhance-billing-and-collections-process.html

NCDS Perspective: The tips above outline a solid approach to your billing and collections process and with NCDS you have the solid billing expertise in place to make sure that your practice is in the best hands. Once you have submitted your billing to us we ensure detailed claim follow up is achieved, patients are contacted when information is requested, the best billing practices are employed and when patients have questions they are serviced with polite, friendly, local staff. Additionally, NCDS is not afraid to fight for you with the payers! NCDS offers a variety of different services outside of our standard billing agreements, one of which is contract negotiations. Should you find your practice is in need do not hesitate to contact us today!

Quality Payment Program: Delivery System Reform, Medicare Payment Reform, & MACRA

CMS.gov
Centers for Medicare & Medicaid Services

The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs)

How does the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reform Medicare payment?

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes create a Quality Payment Program (QPP):

- Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services.
- Making a new framework for rewarding health care providers for giving better care not more just more care.
- Combining our existing quality reporting programs into one new system.

These proposed changes, which we've named the Quality Payment Program, replace a patchwork system of Medicare reporting programs with a flexible system that allows you to choose from two paths that link quality to payments: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models.

What's the MACRA Quality Payment Program?

- The MACRA QPP will help us to move more quickly toward our goal of paying for value and better care. The Quality Payment Program has two paths:
- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)
- MIPS and APMs will go into effect over a timeline from 2015 through 2021 and beyond.

What's the Merit-Based Incentive Payment System (MIPS)?

The MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured on:

- Quality
- Resource use
- Clinical practice improvement
- Meaningful use of certified EHR technology

What are Alternative Payment Models (APMs)?

APMs give us new ways to pay health care providers for the care they give Medicare beneficiaries. For example:

- From 2019-2024, pay some participating health care providers a lump-sum incentive payment.
- Increased transparency of physician-focused payment models.
- Starting in 2026, offers some participating health care providers higher annual payments.

Accountable Care Organizations (ACOs), Patient Centered Medical Homes, and bundled payment models are some examples of APMs.

For more information on MIPS, APMs, MACRA please visit CMS at: **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html**

Molina Prior Auth Update

Effective April 11, 2016 providers must submit prior authorization (PA) requests for inpatient admission (including ER) and outpatient services via the Web Portal or fax. Molina Healthcare will no longer accept these requests via phone or email.

Requests must include a valid working diagnosis at the time of the submission. This can include signs and symptoms, but not "rule out."

This update will improve efficiency and turnaround time by ensuring requests and supporting documents are received at the same time.

Access the Web Portal at https://Provider.MolinaHealthcare.com . Outpatient service requests can be submitted via Clear Coverage.

To fax, send the forms (www.molinahealthcare.com/Providers/OH under the "Forms" tab) and supporting documents to:

Medicaid (includes MyCare Ohio Medicaid): 866-449-6843
Medicare (includes MyCare Ohio Medicare): 877-708-2116
Marketplace: 855-502-5130

Telemedicine Empowers Patients, But Challenges Physicians

John D. Fanburg JD, Edward V. Hilzenrath JD – Medical Economics

The rapid expansion and evolution of telemedicine in the U.S. brings with it increased access at lower costs for patients and growing competition for physicians from providers with regional, national and international reputations.

What used to be local marketplaces, in which physicians treated patients in their immediate geographic areas, has the potential to develop into a national marketplace characterized by a small number of providers dominating the healthcare landscape.

To date, 29 states and the District of Columbia have enacted legislation requiring some form of reimbursement by private insurers for telemedicine services, many times at levels equivalent to in-person services. In the past year alone, more than 200 pieces of telemedicine-related legislation have been introduced in 42 states.

Approximately 15 million people used telemedicine services in 2015, according to the American Telemedicine Association, a 50% increase from 2013. National insurers such as Cigna and Aetna continue to expand their coverage of telemedicine services. Meanwhile, telemedicine providers continue to increase the number of patient visits and are raising millions of dollars in the capital markets to fuel further growth.

The expansion of telemedicine has been slowed by state regulatory requirements and federal and state laws limiting reimbursements. For example, Medicare currently reimburses for telemedicine only for a limited number of Part B services in specific geographic areas. Medicare beneficiaries are eligible for telemedicine services only if they present from an originating site in a rural "Health Professional Shortage Area" or in a county outside of a "Metropolitan Statistical Area," both areas typically underserved by healthcare professionals.

NCDS Perspective: Has your practice considered adding Telemedicine to the services you provide to your patients? If you are interested in finding out more about an exclusive offer available through our partners at Mend contact NCDS today!

For more the complete article or more details please visit: http://medicaleconomics.modernmedicine.com/medical-economics/news/telemedicine-empowers-patients-challenges-physicians?cfcache=true

Medicare's Drug-Pricing Experiment Stirs Opposition

Julie Appleby – The Washington Post

A broad proposal by Medicare to change the way it pays for some drugs has drawn intense reaction and lobbying, with much of the debate centered on whether federal regulators would have too much power over drug prices.

Among the controversial details is a nationwide experiment that would test various ways to slow spending on drugs provided in doctor's offices, clinics, hospitals and cancer infusion centers. Scheduled to start in 2017, payments would be more closely linked to how well the drugs work — something that officials say drugmakers, insurers and benefit managers are already trying in the private sector.

One possibility would be for Medicare to earmark "therapeutically similar" medications and set a benchmark that it would pay for anything in that category. The reference price, for example, might be the cost of the drug the agency considers the most effective in the group. The goal would be to narrow the wide variability — often hundreds or thousands of dollars a year — in what is paid for similar drugs.

Such an approach is common in Europe but has long been fought in the United States by conservatives, many economists and pharmaceutical companies. Medicare says it would be applied only to some drugs. The proposal would not affect most prescriptions that patients get through their pharmacies.

The industry's "biggest nightmare is that the Obama administration decides to do something like reference pricing," said Paul Heldman, an analyst with Heldman Simpson Partners. "Then the government would be making a decision that two products are similar and Medicare should reimburse at the rate of the lower-cost one."

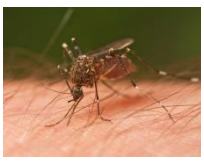
Administration officials say a range of actions is needed to slow spending in the Medicare Part B program, which has grown from $11 billion in 2007 to $22 billion in 2015. Their proposed regulation, which was released in March, also would change the Part B formula for reimbursing doctors and hospitals when they provide chemotherapy and related drugs.

"It's a pretty explosive document," said Dan Mendelson, president of the consulting firm Avalere Health. "There's a hot button in it for everyone."

For more information on this article please see the following link: https://www.washingtonpost.com/politics/medicares-drug-pricing-experiment-stirs-opposition/2016/05/24/f9b102d2-21d0-11e6-9e7f-57890b612299_story.html

Zika Virus: Birth in U.S

It was confirmed Tuesday May 31st that the second case of Zika-related birth-defects in the United States has been documented. A baby girl was born in New Jersey with microcephaly, also having calcification and dilated ventricles in the brain, according to physicians. The CDC confirmed the mother came from Honduras for treatment after symptoms of Zika developed. The first birth documented in the United States was back in January, a baby born in Hawaii also having microcephaly. The CDC is closely monitoring the Zika virus and how it affects pregnant women in the United States.



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