July – August 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...

Department of Justice Sues to Block Anthem/Cigna, Aetna/Humana Mergers as Companies Plan to Fight Back

Susan Morse, – Healthcare Finance News

Anthem and Aetna plan to pursue in court the Department of Justice's injunction to block their respective mergers with Cigna and Humana, according to statements from both insurers.

The DOJ filed the injunctions Thursday to block Anthem's $53 billion proposal to buy Cigna and Aetna's proposed $37 billion takeover of Humana, in deals that would reduce the number of large insurers from five to three.

"Today we filed to block the mergers," Attorney General Loretta Lynch said. "These mergers would fundamentally reshape the health insurance industry. They would leave much of the multi-trillion dollar health insurance industry in the hands of three mammoth insurance companies and restrict competition in key markets."

The DOJ said the proposed mergers of Anthem with Cigna and Aetna with Humana would harm consumers and are illegal due to antitrust laws. No amount of divestiture can remedy the problem, the DOJ said.

Deputy Associate Attorney General Bill Baer said there is nothing to show that these concerns could be solved through divestiture.

"Will the status quo be preserved?" he said. "We have zero confidence that proposals made to us come close to meeting that standard."

Both Anthem and Aetna countered that the mergers are in the best interest of consumers.

"Anthem is fully committed to challenging the DOJ's decision in court but will remain receptive to any efforts to reach a settlement with the DOJ that will allow us to complete the transaction and deliver its benefits at a critical time when American consumers are seeking high quality healthcare services with greater value at less cost," Anthem said through spokeswoman Jill Becher.

The merger with Cigna would improve Anthem's mission of improving consumer choice, quality and affordability, she said.

"Today's action by the Department of Justice (DOJ) is an unfortunate and misguided step backwards for access to affordable healthcare for America," Anthem said. "The DOJ's action is based on a flawed analysis and misunderstanding of the dynamic, competitive and highly regulated healthcare landscape and is inconsistent with the way that the DOJ has reviewed past healthcare transactions."

"Aetna and Humana today announced plans to vigorously defend the companies' pending merger in response to a U.S. Department of Justice (DOJ) lawsuit seeking to block the transaction," Aetna said. "A combined company is in the best interest of consumers, particularly seniors seeking affordable, high-quality Medicare Advantage (MA) plans. The Aetna-Humana transaction offers tremendous value to consumers."

Meanwhile, the American Medical Association said it applauds the DOJ efforts to block the creation of what it called two health insurer corporate goliaths, giving them unprecedented market power.

"The prospect of reducing five national health insurance carriers to just three is unacceptable," said Andrew W. Gurman, M.D., AMA president. "Today's action by the DOJ acknowledges the AMA's concern that patients' interests can be harmed when big insurers acquire rivals and develop strangleholds on local markets. Allowing commercial health insurers to become too big and exert control over the delivery of health care would be bad for patients and vitality of the nation's health care system."

The Aetna/Humana injunction took some in the industry as a surprise, as it revolved around the Medicare Advantage market and divestiture was seen as remedy to anti-competition concerns.

But the DOJ said Thursday that more seniors are turning to Medicare Advantage, making that an important market.

The deal would cut out Humana as a fierce player, the DOJ said, shrinking the number of insurers in the market from four to three.

The cases date back to July 2015 when the deals were proposed. On Thursday, the S&P weighed in on the effect of ratings.

The worst-case scenario is for the DOJ to reject the mergers outright through a civil lawsuit with no clear resolution, the S&P said.

"We believe fighting it in court could be a difficult path given the additional time/resources required and the limited history of success in past cases," said S&P. "However, both merging parties would have at least some incentive to pursue this route, as they have invested close to a year in pre-merger planning and stand to pay sizable termination fees if the deals don't go through."

Aetna would have to pay Humana $1 billion; and Anthem would have to pay Cigna $1.8 billion.

For more information on this article or to view the complete story please use the following link: http://www.healthcarefinancenews.com/news/anthem-answers-department-justice-complaint-cigna-merger

NCDS Perspective: Anthem and Aetna are two of the largest, and most difficult carriers to work with, for both providers as well as patients. Resolving claim denials and customer service issues with both carriers is an ongoing, tedious task which prolongs payments to providers and frustrates patients. Denials can be erroneous or come with no explanation, and getting these carriers to reprocess their own error often requires the completion of a form for every claim. Patients can become frustrated when contacting their foreign, outsourced call centers, getting no information on their claims or why it wasn't processed correctly. Through our years of experience speaking to countless patients covered by these insurance carriers, many have voiced their dissatisfaction with the policies. We applaud the efforts of the DOJ to prevent these two carriers from gaining substantially greater power, which thus far remains self-serving. This motion is a step in the right direction to protect subscribers as well as providers, and NCDS is closely following this story. We will keep you updated on related news and events.

CMS Releases Proposed 2017 Medicare Physician Fee Schedule

www.aanem.org

On July 7, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule updating payment policies and payment rates for physicians under the Medicare Physician Fee Schedule (MPFS) for 2017. CMS estimates a +1% impact in payment on neurology and physical medicine and rehabilitation physicians; although, ultimately, the result could differ when the final rule is published in the fall. A few key areas addressed in the proposed 2017 MPFS include:

Expanding eligible telehealth services. CMS is proposing to make payment through new codes, initial and subsequent, used to describe critical care consultations furnished via telehealth.

Gathering data on activities and resources involved in 10- and 90- day global surgical procedures. CMS is proposing to collect claims-based reporting about the number and level of pre- and post-operative visits; survey a representative sample of practitioners about the activities involved in and the resources used in providing pre- and post-operative visits.

Chronic Care Management (CCM) and Transitional Care Management (TCM). CMS is proposing to remove potential barriers to furnishing and billing CCM and TCM services.

Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services. CMS is proposing changes to capture the range and intensity of nonprocedural physician activities (E/M services) and the "cognitive" work of certain specialties.

Medicare Shared Savings Program (MSSP). CMS intends to update ACO quality reporting which includes changes to the quality measure set, updates to align with the Physician Quality Reporting System (PQRS) and the proposed Quality Payment Program (QPP).

For more information please see the link below: https://www.aanem.org/News/Practice/CMS-Releases-Proposed-2017-Medicare-Physician-Fee

HHS Announces Major Initiative to Help Small Practices Prepare for the Quality Payment Program

Over the last few weeks, the Department of Health and Human Services (HHS) has made several important announcements related to the Quality Payment Program, which has been proposed to implement the new, bipartisan law changing how Medicare pays clinicians, known as the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. Today, we are announcing $20 million to fund on-the-ground training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer.

These funds will help provide hands-on training tailored to small practices, especially those that practice in historically under-resourced areas including rural areas, health professional shortage areas, and medically underserved areas.

"Doctors and health care providers in small and rural practices are critical to our goal of building a health care system that works for everyone," said Secretary Burwell.

http://www.hhs.gov/about/news/2016/06/20/hhs-announces-major-initiative-help-small-practices-prepare-quality-payment-program.html?utm_source=July+2016&utm_campaign=Understanding+MACRA&utm_medium=email

10 Things to Know About CMS' New Mandatory Cardiac Bundle

Emily Rappleye – Becker's Hospital Review

CMS proposed Monday a new mandatory bundled payment program for heart attacks and bypass surgeries that includes changes to the existing Comprehensive Care for Joint Replacement Model as part of its larger goal to shift Medicare from quantity to quality incentives.

1. The new bundled payment models apply to cardiac care and extend the existing CJR model to include hip and femur fractures. Medicare fee-for-service patients admitted for heart attacks and bypass surgeries are eligible for the new cardiac bundled payment program.
2. The bundle makes hospitals accountable for the cost and quality of care provided during the inpatient stay and for 90 days after discharge. Hospitals will be paid a fixed target price for each episode of care, and those that hit higher quality targets will qualify for a higher target price.
3. Hospitals will be chosen from 98 randomly-selected metropolitan statistical areas for the cardiac bundling program.
4. Under the proposed rule, the bundles are set to begin on July 1, 2017. CMS proposed implementing the program in phases to allow hospitals to adapt to the new model and establish processes to support it. Downside risk is not added in until the second quarter of the second performance year, beginning April 2018.
5. Hospitals would receive quality-adjusted target payments for each episode of care. These target payments will be based on a blend of historical hospital specific and regional data, and adjusted based on case complexity.
6. At the end of each performance year, hospitals that meet quality standards can earn additional payments based on cost. This means CMS compares the actual spending for each episode to the target prices paid to the hospital. Those that are able to deliver care for less than the target price are paid the achieved savings. Hospitals that exceed the target are required to repay Medicare.
7. The proposed rule also includes a model to test cardiac rehabilitation services. The model aims to test if payments incentivize use of cardiac rehabilitation during the 90-day period following hospital discharge.
8. CMS said the cardiac bundle, as well as the CJR bundle, could qualify as Advanced Alternative Payment Models in 2018 under the Medicare Access and CHIP Reauthorization Act. The proposed rule for the cardiac bundle established pathways for physicians to potentially qualify under the Quality Payment Program for Advanced APMs. This is the more lucrative track under MACRA, which determines physicians' Medicare payment adjustments in place of the sustainable growth rate formula. The bundles would meet the requirements under the proposed rule for MACRA, meaning physicians could earn an additional lump-sum bonus.
9. Additionally, the proposed rule indicates that CMS plans to build on its Bundled Payments for Care Improvement Initiative. This includes a new voluntary bundled payment program that would begin in 2018, and could also potentially qualify as an Advanced APM under MACRA.
10. CMS is taking feedback on the proposals for 60 days, until September 24. The full text of the proposed rule is available here.

For the complete article please visit the link below: http://www.beckershospitalreview.com/finance/10-things-to-know-about-cms-new-mandatory-cardiac-bundle.html

ICD-10 Humor: A Man Walks Into a Lamppost…

Carl Natale – ICD10watch.com

The Twittersphere is busy with quotes from the story. ICD-10 codes are punchlines for jokes that you can tell at parties with non-healthcare friends. Everyone will laugh when they learn the medical profession will be tracking how many people get struck by turtles.

Do a search for #ICD10 or some variation on Twitter, and you will find countless tweets celebrating the comical injuries that can be succinctly documented. I remember what Daniel Duvall, medical officer for the CMS Hospital and Ambulatory Policy Group, said about why all those codes exist. He said that private organizations representing medical specialties wanted codes that recognized specific diagnoses for their reporting and tracking.

Someone reminded me of an interview I had with Jim Jacobs, senior vice president and product management and health information management for QuadraMed. He explained the need for extreme specificity. "If you want to understand outcomes and understand the protocols that are working, the protocols that have measured benefits, then you need quite a bit of specificity."

http://www.icd10watch.com/blog/icd-10-humor-a-man-walks-a-lamppost

W220.2XA : Man Walks into Lamppost

NCDS Perspective: Interestingly, the extreme detail of ICD-10 has become more relevant in the past months with the introduction of Pokemon Go. There are several social media outlets and news sources reporting injuries related to the Pokemon Go app that has swept the nation. Many coders are finally finding use for diagnoses that have otherwise gone unused! ERs have reported a spike in incidents related to the new mobile game, ranging from scrapes, a police car crash, broken bones and most noteably: W61.62XD – Struck by duck, subsequent encounter.

Medicare's Readmission Penalties Hit New High

Jordan Rau – KHN.org

The federal government's readmission penalties on hospitals will reach a new high as Medicare withholds more than half a billion dollars in payments over the next year, records released Tuesday show. The government will punish more than half of the nation's hospitals — a total of 2,597 — having more patients than expected return within a month.

The new penalties, which take effect in October, are based on the rehospitalization rate for patients with six common conditions. Since the Hospital Readmissions Reduction Program began in October 2012, national readmission rates have dropped as many hospitals pay more attention to how patients fare after their release.

The penalties are the subject of a prolonged debate about whether the government should consider the special challenges faced by hospitals that treat large numbers of low-income people. Those patients can have more trouble recuperating, sometimes because they can't afford their medications or lack social support to follow physician instructions, such as reducing the amount of salt that heart failure patients consume. The Centers for Medicare & Medicaid Services says those hospitals should not be held to a different standard.

Medicare said the penalties are expected to total $528 million, about $108 million more than last year, because of changes in how readmissions are measured.

Medicare examined these conditions: heart attacks, heart failure, pneumonia, chronic lung disease, hip and knee replacements and — for the first time this year — coronary artery bypass graft surgery.

The fines are based on Medicare patients who left the hospital from July 2012 through June 2015. For each hospital, the government calculated how many readmissions it expected, given national rates and the health of each hospital's patients. Hospitals with more unplanned readmissions than expected will receive a reduction in each Medicare case reimbursement for the upcoming fiscal year that runs from Oct. 1 through September 2017.

http://khn.org/news/more-than-half-of-hospitals-to-be-penalized-for-excess-readmissions/

Ohio Medical Group Hacked, More Than 105k Documents Stolen

Alyssa Rege – Becker's Hospital Review

A Ukrainian hacker claims to have hacked Gahanna, Ohio-based Central Ohio Urology Group and stolen more than 105,000 internal documents containing patient information, according to a ZDNet report. The hacker, who took responsibility for the breach on Twitter, allegedly uploaded nearly 200GB of data onto a Google Drive.

An image released on the individual's Twitter account allegedly revealed patients' personal health records. But the majority of the files in the breach appeared to be internal documents relating to billing and insurance issues, according to the report.

Reporters at ZDNet said an initial search of the documents found non-password protected Excel documents containing log files detailing surgeries performed at the hospital. The information included physicians' names, the times of various surgeries and the types of drugs used during the procedures, according to the report.

The attack was allegedly carried out using an SQL injection, in which hackers insert malicious code into a server that can read and extract data in a database. The hacker also claimed to carry out the attack for "political purposes," according to the report.

For the complete article please visit: http://www.beckershospitalreview.com/healthcare-information-technology/ohio-health-system-hacked-more-than-105k-records-stolen.html

NCDS Perspective: Do you have a compliance program in place to protect your practice from potential dangers and pitfalls that present when handling sensitive, patient information and PHI? According to the Identity Theft Resource Center the health and medical sector sits at the top of the list for hacks, boasting 42.5% just in 2014 alone. That number has continued to trend up for three years and experts estimate that due to the black market value of medical information the trend will only continue, making medical data/patient insurance information the most desirable form of black market identity theft. While data breeches can almost seem inevitable, you can control the what information hackers can and can't get ahold of by implementing strategies within your practice to ensure sensitive information isn't viewed by or exposed to the wrong person. Personalized practice compliance is just one of the many services NCDS Medical Billing offers. Whether your practice has twelve providers or just one, partnering with NCDS to form a comprehensive compliance program for your practice is an invaluable solution to prevent the right information in the wrong hands.

NCDS
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