November – December 2017

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...

D.C. Week: Trump Declares Opioid Abuse a Public Health Emergency

SHANNON FIRTH, MEDPAGETODAY.COM

WASHINGTON -- President Trump definitively called the opioid epidemic a public health emergency and a House committee pressured the Drug Enforcement Administration to give up the names of drug companies suspected of "pill-dumping," threatening a subpoena.

In a long-awaited move, President Trump on Thursday declared the nation's opioid addiction epidemic to be a "public health emergency," freeing up government agencies to put more resources toward fighting the epidemic.

"This epidemic is a national health emergency, unlike what we've seen in our lifetimes," Trump said, speaking from the East Room of the White House. "As Americans, we cannot allow this to continue. It's time to liberate our communities from the scourge of drug addiction. We can be the generation that ends the opioid epidemic."

The opioid crisis has not abated, with 64,000 people dying in 2016 from opioid overdoses, Trump noted. He said more attention should be focused on getting people not to start taking drugs in the first place. "The fact is, if we can teach young people -- and people, generally -- not to start, it's really, really easy not to take them. And I think that's going to end up being our most important thing."

But Tracy Jackson, MD, of Vanderbilt University, disagreed. "The idea that the 'Just Say No,' prevent all exposure to drugs [campaign] is a reasonable thing -- there have been decades and decades of scientific literature that do not bear that out to be the case," she said in a video interview with *MedPage Today*.

A member of the House Energy and Commerce Committee threatened to subpoena the Drug Enforcement Administration (DEA) over a request for documents on opioid "pill-dumping" in West Virginia.

The DEA's response to provide the documents to the committee was deemed "unacceptable" and "inexcusable." Specifically, the committee demanded to know why, after 6 months, it hadn't received the names of companies involved in pouring an excessive volume of prescription opioids into rural parts of West Virginia. For example, in the town of Kermit (population 400), 9 million hydrocodone pills were distributed over a 2-year period, according to an article in the *Morning Consult.*

"This is a very basic question: Who are the suppliers?" said committee chair Sen. Greg Walden (R-Ore.). Walden issued the subpoena threat.

The Trump administration wants to give doctors more time with patients by rolling back the regulatory requirements foisted on physicians over the years.

"I'd like to think of regulatory reform in terms of painting a house," said Seema Verma, administrator for the Centers for Medicare and Medicaid Services.

"Typically, repainting needs to occur every few years, and before you do it, you need to strip the layers of paint underneath," she continued. "Unfortunately, during past administrations CMS has been simply applying new layers of paint without taking this essential step."

Verma announced the launch of a "Patients over Paperwork" initiative, geared towards scrapping or reducing regulations while lowering healthcare costs and enhancing patient care.

Pinpointing opioid addiction in seniors can be challenging, but early identification is key to tackling the abuse epidemic, according to a panel discussion here Tuesday.

"Unfortunately, many prescribers think they can tell by looking at someone, who may or may not have a [opioid abuse] problem," said Andrew Kolodny, MD, co-director of the Opioid Policy Research Collaborative at Brandeis University in Waltham, Massachusetts, at the event.

Patients can, and do, hide their addiction issues. Identifying a substance use problem in seniors, who are often isolated and can have other illnesses that impact their gait and cognition, can be challenging, noted Kathleen Cameron, MPH, senior director for the Center for Healthy Aging at the National Council on Aging.

That is why having clear, objective data to track prescriptions as well as patients' interactions with pharmacists and providers is so important, Kolodny said.

For the full article : https://www.medpagetoday.com/Washington-Watch/Washington-Watch/68860?xid=nl_mpt_DHE_2017-10-30&eun=g259640d0r&pos=2

Ohio Medicaid Open Enrollment is November 1ST – 30TH 2017

For initial Medicaid recipients just receiving their benefits individuals will receive an enrollment notice informing them to call the Ohio Medicaid Consumer Hotline at (800)324-8680 to select a managed care plan. If a selection is not made, a plan will be assigned. Assignment is based on previous managed care enrollment and/or prior services received. Then a patient will have 90-days from the date of enrollment, to switch to a different managed care plan. When open enrollment ends, you have to stay with the health plan you picked. When open enrollment starts again, you can stay with your current plan or pick a different plan. When changing plans, coverage begins on the first day of the following month.

What this means for your practice: To prevent reimbursement delays due to coverage changes please make sure scheduling and front desk staff ask for an updated insurance card. Also asking Medicaid patients if they've selected a new MCO during open enrollment can help get you the right information for billing.

Here are a few helpful links to better understand the open enrollment process for your patients:
https://www.caresource.com/ohiomedicaid/enroll/
http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/FAQ%E2%80%93IndividualsEnrolled-BCMH.pdf

CMS Medicare Training Requirement

CMS recently issued a requirement related to the settlement of the *2013 Jimmo v. Sebelius* class action lawsuit. The settlement addresses the delivery of skilled nursing services to Medicare beneficiaries and applies to nursing facilities, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met).

The settlement agreement is intended to clarify that when skilled nursing or skilled therapy services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration.

Medicare providers are required to review this training to ensure services are provided and coverage determinations are adjudicated accurately in accordance with existing Medicare policy.

Information on this training and the settlement can be found at: https://www.buckeyehealthplan.com/providers/resources/provider-training.html

Flu Vax May Improve Outcomes in Other Illnesses

Michael Smith – MedPageToday.com

TORONTO -- Even when the flu vaccine doesn't prevent disease, it can ease some of the consequences, researchers said here.

In a small single-center study, vaccinated patients admitted to hospital with the flu were significantly less likely to need mechanical ventilation and to suffer acute kidney injury, according to Twinkle Chandak, MBBS, of the Berkshire Medical Center in Lenox, Massachusetts.

And for several other adverse outcomes, there was a trend favoring vaccination, Chandak reported at CHEST, the annual meeting of the American College of Chest Physicians.

Chandak said most vaccine studies tend to look at how well the drug prevents disease, but in the case of seasonal vaccines protection is never complete, so it's important to know about critical disease outcomes in the presence or absence of vaccination.

But the findings are probably not completely unexpected for clinicians, commented CHEST session co-moderator Keith Wille, MD, of the University of Alabama at Birmingham.

"I think we feel that the vaccine helps," although it's nice to have data to support that suspicion, he told *MedPage Today,* adding that responses to the vaccine are known to be highly variable.

Chandak's group noted that the predominant circulating strain of influenza in the 2015-2016 flu season was the pandemic strain -- H1N1pdm09 -- that first emerged in 2009-2010 and has been part of seasonal vaccines every year since.

The investigators took advantage of that fact to evaluated outcomes among vaccinated and unvaccinated patients who were admitted to their 300-bed community teaching hospital from September 2015 through April 2016.

For the complete article please visit: https://www.medpagetoday.com/MeetingCoverage/CHEST/68863?xid=nl_mpt_DHE_2017-10-30&eun=g259640d0r&pos=4

Top 11 Gripes Physicians Have With Patients

Rose Schneider Krivich – MedicalEconomics.com

It is a known fact that physicians are burnt out. They have to deal with the uncertainty that is healthcare policy in 2017, as well as payment and electronic health record frustrations, to name a few. So, it is no surprise that these complications and stresses have bled over into interactions with patients.

We asked primary care physicians from around the country what their top gripes with patients have been, and their answers may surprise you—or relate to you wholeheartedly. Read on to find out what they had to say.

1. Patients coming in asking for HCV, HIV, STI testing but no method of payment and are not high risk. Most patients think the systems should pay for everything.
2. They are unwilling to come out of denial of their condition thus not take test meds, refuse to take meds or just forget their meds.
3. Last minute cancels or no-shows.
4. It's usually rude, entitled behavior that sets me off. Advocating for your own care doesn't mean being uncivil and simply mean and unpleasant to staff or physicians. You can't get very far being disrespectful to the people that are ultimately trying to help you. Relationship building is still important in a patient-physician relationship – for both the physician AND the patient.
5. Families coming to the doctor's office and arguing, letting children play with everything in the exam room, including the drawers, no place to sit since there is so many in the family. Unable to talk to the family with the constant distractions from the family.
6. Failure to follow instructions or to use common sense and then blaming the medical profession for the mess they made.
7. Non-compliance with medication instructions – either taking none, less than, or more than prescribed doses.
8. We ask them to arrive 30 minutes prior to their appointment hoping they will arrive at least 15 minutes early to fill out forms, pay copay, update insurance, etc. at the front desk. Then this allows time for the nursing staff to update history, meds, etc. and triage. Most come in exactly at the appointment time or even within our 15-minute late grace period. Then they complain that we are running behind and they had to wait. Yet these very patients want us to fix 15 problems in the 15 minute appointment time that has already passed due to their tardiness!
9. Expectation that they can receive all of their healthcare (follow up of chronic illnesses and several acute problems) in one annual physical exam visit.
10. Acting uninformed about their deductibles and copays. They claim they do not know about their financial responsibility regarding their insurance plan, but have the expectation to receive medical services in the face of an outstanding balance.
11. Facebook is not for diagnosing your shortness of breath, you're not having anaphylactic response if you're walking and talking fine and asking for the nearest vending machine.

http://medicaleconomics.modernmedicine.com/medical-economics/news/top-11-gripes-physicians-have-patients?page=0,11

CMS Releases Physician Fee Schedule for 2018: 6 Things to Know

Ayla Ellison – BeckersHospitalReview.com

CMS issued its 2018 Medicare Physician Fee Schedule on Thursday, which cuts Medicare payments for services provided by certain provider-owned off-campus hospital departments. Here are six things to know about 1,250-page final rule.

1. Physician payment rates will increase 0.41 percent in 2018 compared to this year. CMS arrived at this increase after accounting for a 0.5 percent increase required by the Medicare Access and CHIP Reauthorization Act and a negative 0.09 percent adjustment required under the ABLEA Act of 2014.

2. CMS will reduce current physician fee schedule payment rates for services provided at certain off-campus provider-based departments. Last year, CMS implemented Section 603 of the Bipartisan Budget Act of 2015. Under this section, certain off-campus provider-based departments that began billing under the Outpatient Prospective Payment System on or after Nov. 2, 2015, are no longer paid for most services under the OPPS. Instead, these facilities began to be paid under the physician fee schedule Jan. 1. For 2018, CMS will pay hospitals 40 percent of the OPPS payment rate for these services. Hospitals are currently paid 50 percent of the OPPS rate. Dedicated emergency department services and off-campus provider-based departments that meet the 21st Century excluded from the payment rate changes.

3**. Hospital groups are concerned.** America's Essential Hospitals President and CEO Bruce Siegel, MD, said, "We're particularly troubled that these cuts for off-campus, provider-based departments — an additional 20 percent reduction to rates already cut in half by regulation last year — come without an analysis of how they might harm patient care. The cuts run counter to CMS' goal of integrated, coordinated healthcare."

Tom Nickels, executive vice president of the AHA, said, the AHA is concerned CMS' "continued short-sighted policies on the relocation of existing off-campus provider-based clinics will prevent patients and communities from having access to the most up-to-date, high-quality services."

4. CMS will pay for new telehealth services. CMS added the following codes to the list of covered telehealth services for 2018:

- HCPCS code G0296: Visit to determine low-dose computed tomography eligibility
- CPT code 90785: Interactive complexity
- CPT codes 96160 and 96161: Health risk assessment
- HCPCS code G0506: Care planning for chronic care management
- CPT codes 90839 and 90840: Psychotherapy for crisis

5. CMS is delaying implementation of the Medicare Appropriate Use Criteria Program for advanced diagnostic imaging until Jan. 1, 2020. The AUC Program would begin with an education and operations testing year in 2020, meaning physicians would start using AUCs and reporting this information on their claims.

6. The final rule establishes payment to rural health clinics and federally qualified health clinics for regular and complex chronic care management services, general behavioral health integration services and psychiatric collaborative care models. To receive payment for these services, rural health clinics and federally qualified health clinics would use two new billing codes.

For the full article please visit: https://www.beckershospitalreview.com/finance/cms-releases-physician-fee-schedule-for-2018-6-things-to-know.html

EPIC Hit with Lawsuit over "Double Billing" for Anesthesia Services

Rajiv Leventhal – Healthcare-Informatics.com

Epic Systems, the Verona, Wisconsin-based health IT giant, is facing a lawsuit in which the complainant has attested that the vendor's software defaults to double-billing for anesthesia services, resulting in the government being overbilled by hundreds of millions of dollars.

According to a *Law360* report last week, as well as other media reports, Epic's billing software wrongly "defaults to charging for both the applicable 'base units' for anesthesia provided on a procedure, as well as the actual time taken for the procedure, resulting in payers being overcharged for anesthesia, relator Geraldine Petrowski said in an amended complaint in June that was unsealed [Nov. 2]," according to *Law360*.

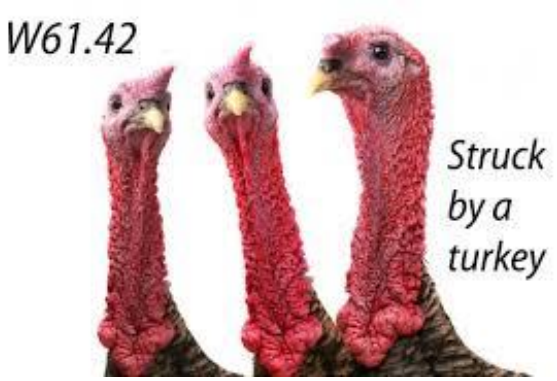
"This unlawful billing protocol has resulted in the presentation of hundreds of millions of dollars in fraudulent bills for anesthesia services being submitted to Medicare and Medicaid as false claims," Petrowski said. Petrowski served in various roles at Raleigh, N.C.-based WakeMed Health "between 2008 and 2014, serving as hospital liaison for the healthcare system's implementation of Epic's software, during the course of which she came across the anesthesia billing issues, developing 'major concerns' about incorrect billing, she said, according to *Law360.*

The lawsuit attested that Epic acted with "deliberate ignorance and/or reckless disregard of the truth," which led to the fraudulent billing. Under the False Claims Act, defendants are liable for treble damages and civil penalties between $5,000 and $10,000 for each false claim.

Earlier this year, eClinicalWorks, and some of its employees, paid $155 million to resolve a False Claims Act lawsuit in which the company allegedly violated federal law by misrepresenting the capabilities of its software and for allegedly paying kickbacks to certain customers in exchange for promoting its product, according to the U.S. Department of Justice.

For the complete article please visit: https://www.healthcare-informatics.com/news-item/ehr/epic-hit-lawsuit-over-double-billing-anesthesia-services

Happy Thanksgiving from NCDS! Tell Patients to Watch Out for Those Turkeys!



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NCDS Medical Billing
7550 Lucerne Drive Suite 405
Middleburg, Hts., OH 44130-6503